

Bylaws of the Genesee County Medical Control Authority

ARTICLE I - ORGANIZATION AND MISSION

1.0 Organization Name. This organization shall be known as the Genesee County Medical Control Authority, ("Authority"). The Authority has been designated by the Michigan Department of Consumer & Industry Services as responsible for medical control for emergency services for Genesee County, as provided by MCLA 333.20918 the Authority shall be administered by member hospitals. The member hospitals shall, however, establish and appoint an advisory body for the Authority, the Medical Control Board ("Board"). Except as otherwise required by law, provided in these bylaws, or as specified by the Authority, the Authority shall be vested with all corporate powers, which shall be exercised upon action by the members and designated representatives to the Authority.

1.1 Place of Business. The Authority shall maintain its principal place of business within Genesee County.

1.2 Non-Profit Operation. The Authority shall be operated exclusively for charitable, scientific, and educational purposes as a nonprofit organization for the benefit of the citizens of Genesee County. No individual member of the Authority shall have any title to or interest in the organizational property or earnings, in his or her individual or private capacity. Likewise, no part of the net earnings of the Authority shall inure to the benefit of any individual member of the Authority's advisory Medical Control Board. No substantial part of this Authority's activities shall consist of carrying on propaganda, endorsement of individual commercial services, or otherwise attempt to influence emergency medical care within Genesee County to an individual, private, or commercial group benefit. Neither shall the Authority participate in or intervene in any political campaign on behalf of any specific candidate for public office.

1.3 Mission and Scope of Activities. The mission and scope of the activities of the Authority shall include, but not necessarily be limited to, the following:

- 1.3a To establish written protocols for the practice of life support agencies and licensed emergency medical services personnel within Genesee County in accordance with those procedures established by the Michigan Department of Community & Industry Services and as set forth in the Public Health Code. The protocols established shall include all the following [Ref. MCLA 333.20919(1)]:

The acts, tasks, or functions that may be performed by each type of emergency medical services personnel licensed under Part 209 of the Public Health Code; and

The appropriate dispatching of a life support agency based upon medical need and the capability of the emergency medical services system.

- 1.3b To encourage and assist with the training and education of both health care providers and the general public in the provision of emergency medical care.
- 1.3c To foster and promote research and to improve methods of emergency medical services delivery within Genesee County.

ARTICLE II – MEMBERSHIP

2.0 Membership of Authority. Each hospital licensed under Part 215 of the Michigan Public Health Code and which operates a service for the admission and treatment of emergency patients within Genesee County shall be eligible for membership in the Authority. Membership shall be granted upon receipt of a letter of request for membership from an eligible hospital. Each member hospital shall be represented on the Authority by the member's Chief Executive Officer or their designee. In addition, the Authority shall consist of one representative designated by the County of Genesee and the current Medical Director of the Board.

The hospital members of the Authority designated the Healthcare Council of MidMichigan (hereafter known as HCM) as their collective representative and given it day-to-day responsibility for all dealings on behalf of the Authority with the advisory Board, the State of Michigan, and others in all matters concerning the Authority.

2.1 Membership of Medical Control Board. The Board shall consist of up to eighteen (18) members as follows:

- one licensed emergency department physician representative from each member hospital;
- one licensed emergency department nurse representative from each member hospital;
- one 911 representative;
- one licensed provider from each provider level of pre-hospital care in Genesee County (MFR, BLS, LALS, ALS). At least two of the representatives will be of the private sector, with no more than one from an agency;
- one Genesee County government EMS provider;
- one the City of Flint government EMS provider;
- the currently serving chairperson of the Education Committee.

2.2 Disclosure of Conflict of Interest. All conflicts of interest must be brought to the full attention of the Board and the Authority upon appointment to the respective body. Conflicts such as financial interests in an ambulance company or other conflict which may influence the voting of a member is subject to full disclosure.

2.3 Appointments and Vacancies on Board. All members of the Board shall be appointed and approved by a majority vote of the Authority membership at the Authority's November meeting. Any Board member may be removed from office with or without cause by a two-thirds vote of the Authority membership, at any time. Vacancies occurring on the Board for any reason shall be filled by appointment upon a majority vote of the Authority. A member of the Board elected to fill a vacancy shall serve on the Board for the unexpired portion of that term only. A Board member who fails to attend 75% of the meetings of the Board without excused absence may be subject to removal and a new Board member shall be appointed.

ARTICLE III - MEETINGS

3.0 Notice of Meetings. Written notice of the time and place of all meetings of the Authority and Board shall be mailed to the respective members and the designated representatives at least five (5) business days before the date of the meeting by regular mail. Notices shall be sent to the address designated by the member of designated representative for such purposes. Notice of special meetings shall state the purpose of the meeting, and no business may be conducted at a special meeting except of the business specified in the notice that was mailed of that meeting.

3.1 Regular and Special Meetings. Regular meetings of the Authority and the Board shall be held at the offices of the HCM or such other place as may be designated. Special meetings of the Board may be called by the Medical Director or Co-Medical Directors and/or upon the request of not less than five (5) members or designated representatives to the Board. Minutes of all meetings shall be taken and copies thereof distributed to members and designated representatives to the Board in a timely manner.

3.2 Quorum and Voting. A quorum shall be the majority of the then duly appointed members and/or designated representatives on a committee, the Board, or the Authority, as the case may be. When a quorum is present, a vote by the majority of those present at a meeting of a committee, the Board, or the Authority, shall constitute the act of that body, unless a greater than majority vote is required by law or otherwise provided for within these bylaws. A committee may, however, make a recommendation to the Board or the Authority by majority vote of the committee members present notwithstanding the absence of a quorum at that meeting. At all meetings each member or designated representative shall have one vote per membership, representative organization, or office, as the case may be.

3.3 Presence at Meeting. A member or designated representative of a committee, the Board, or the Authority may participate in any meeting of these bodies, as appropriate, by means of conference telephone or other equivalent equipment or means, so that all persons at the meeting and the individual not physically present, can hear and converse with one another. Participation in the meeting in this manner, if available, constitutes the presence of that individual at that meeting. This section shall not, however, be construed to require that such means of participation be provided for every meeting or any particular meeting.

ARTICLE IV - OFFICERS

4.0 Medical Director. In every even numbered year at the first regularly scheduled meeting following the annual meeting of the Authority, the Authority shall by majority vote elect an individual(s) to serve as Medical Director or Co-Medical Director(s). The Medical Director(s) shall serve as the Chairperson of the Board.

4.1 Election of Officers. In every even numbered year, at the first regularly scheduled meeting following the annual meeting of the Authority shall elect an individual to chair all meetings of the Authority. Likewise, at the first regularly scheduled meeting following the annual meeting of the Authority, the Board may choose to nominate from its' membership officers as the Board then determines necessary to fulfill the functions of the Board. The Medical Director or Co-Medical Director(s) and all others elected shall serve a term of two years until their successors have been designated and approved, or their positions discontinued.

No person may execute, acknowledge, or verify any instrument in more than one capacity. No officer shall concurrently hold office in any other county/region pre-hospital care or emergency medical services system.

4.2 Removal of Officers. Any officer, except the Medical Director or Co-Medical Directors may be removed from office with or without cause upon the vote of two-thirds (2/3) of the members and designated representatives on the Authority. The Medical Director or Co-Medical Director(s) may be similarly removed from office by similar action by the Authority. Any officer proposed to be removed shall be mailed notice, by regular mail, of such intent and the special or regular meeting at which the issue will be discussed and/or voted upon, at least five (5) business days in advance of such meeting. The affected officer shall have the right to appear at such meeting and be heard prior to the taking of the vote.

4.3 Vacancies. In the event of a vacancy, for whatever reason, prior to the expiration of the term, in the position of Medical Director or Co-Medical Director(s), the Authority shall elect a successor to serve the remainder of the unexpired term. Similarly, the Board shall elect successors to fill any other vacant offices.

ARTICLE V - DUTIES

5.0 Medical Director. The Medical Director or Co-Medical Director(s) shall be a hospital-based emergency physician, practicing within Genesee County. Such physician shall be board certified or eligible in Emergency Medicine. The Medical Director or Co-Medical Director(s) shall direct the Board and implement and comply with the policies and procedures for the Genesee County Emergency Medical System in accordance with the statutory requirements and regulations and directives of the Michigan Department of Consumer & Industry Services. The Medical Director or Co-Medical Director(s) will have the authority to summarily proceed, without prior consultation, to effect corrective or disciplinary action concerning any system participant.

As Chairperson of the Board, the Medical Director or Co-Medical Directors shall have the power to make the executive contracts in the ordinary course of business of the Board upon prior approval of the Authority; to execute other legal instruments upon prior approval of the Authority; and to perform the normal duties of the chief policy officer of the Board, subject only to the directives of the Authority. The Medical Director or Co-Medical Director as Chairperson shall preside at all meetings of the Board and have such other powers and duties as may be designated by the Board and/or Authority.

ARTICLE VI - COMPENSATION

Except as specifically provided by the Authority, no member or designated representative shall be entitled to compensation for services rendered in connection with the Authority, the Board, or any committees thereof. The Authority may, however, grant compensation to those individuals, such as the Medical Director or Co-Medical Directors whose services are beyond the scope of that involved in the average member or representative.

ARTICLE VII - COMMITTEES

The Authority and the Board may each respectively create such committees as are deemed necessary to conduct their ordinary business. Typically committees would include Quality Assurance, Protocol Development, Education and Training, and Disaster Planning. All Board standing committees and their chairpersons shall be created and appointed by the Medical Director or Co-Medical Directors and approved by a vote of the Board. All Authority standing committees and their chairpersons shall be created and appointed by a vote of the Authority. Committee terms shall be provided for officers. Other committees shall be similarly established as necessary. All committees shall meet and report as provided by the vote of the Board creating them and shall have the Medical Director or Co-Medical Director(s) as an ex officio member of each.

ARTICLE VIII - INDEMNIFICATION

Each person who is or was a member of the Genesee County Medical Control Board and/or an officer of the organization and/or a person who serves or has served at the request of the organization, shall be indemnified by the participating Genesee County hospitals or system of hospitals from any and all claims, costs, actions, causes of action, loss or expenses resulting from the performance of duties as designated in MCL 333.20919.

ARTICLE IX - AMENDMENTS

These bylaws may be amended by two-thirds (2/3) vote of the membership of the Genesee County Control Board then in office and approval of the participating Genesee County Medical Control Authority. All members shall be provided with written proposed bylaw changes at least ten (10) days prior to the meeting where changes will be made.

ARTICLE X - FISCAL YEAR

The fiscal year shall be defined from the first day of July through the last day of June, inclusive.

ARTICLE XI - DISSOLUTION

In the event of dissolution of the Genesee County Medical Control Authority, all assets, real and personal, shall be distributed and disbursed to satisfy all debts and/or claims. Any residual funds would be disbursed to the funding institutions, organizations, and agencies in a percent amount equal to their annual contribution to the operation of the Authority.

Bases and Posts

A base is a permanent building or other permanent physical location, owned or rented by an EMS agency. A base must be staffed 24 hours a day, seven days a week. A base must have all of the following:

- Restroom facilities
- Land line telephone
- Sleeping quarters (only for agencies that require personnel to work more than 12 continuous hours)
- Showering facilities be available to all personnel(only for agencies that require personnel to work more than 12 continuous hours)
- Clothing standards policy for appropriate multi-gender sleeping concerns (only for agencies that require personnel to work more than 12 continuous hours)
- Ambulance parking with appropriate signage
- Fire extinguishers
- Smoke alarms
- Eye wash station
- Handicap accessibility where appropriate or as required by law
- Vehicle cleaning station available at at least one base location
- Meet OSHA and MIOSHA requirements
- Posted instructions outside the building for walk up patients

Anything that does not meet this definition is considered a post.

A company may utilize a base and/or a post in Genesee County once the following requirements are met:

- Written agreement to staff each base 24 hours a day, 7 days a week.
- Written agreement to be within one mile of the base or post when not on a call.
- CAD equipment will no longer be used to establish posts. Instead companies must install AVL equipment at the 911 centers in order to post in Genesee County. Also once one company installs AVL equipment all companies using CAD equipment must convert to AVL within 30 days to continue posting.
- Company must notify the GCMCA office 10 business days prior to establishing new bases and posts, before closing a base or post or before changing the location of a base and post. Bases and posts must be designated as ALS, LALS, or BLS.
- If an ALS base or post is using a BLS rig as backup, the company is responsible for relaying that information to the 911 Centers when they receive a call.
- All agencies will be required to maintain a minimum rig to base ratio. For agencies with three bases or less the agency will have one extra rig (unmanned) in addition to the number of manned rigs for each base. For agencies with four to six bases the agency will have two extra rigs (unmanned) in addition to the number of manned rigs for each base. For agencies with more than six bases the agency will have three extra rigs (unmanned) in addition to the number of manned rigs for each base.

Revised: April 2007

State Approved: June 5, 2007

Implementation Date: August 1, 2007

Description of the EMS System

Genesee County is served by Medical First Responders, Basic EMTs, EMT Specialists and Paramedics. Located throughout the County are volunteer, public and private services to provide care at the First Responder, Basic, Limited Advanced and Advanced levels of care. All services and individual providers are licensed by the State of Michigan and must operate in accordance with P.A. 375 of 2000.

The entire Genesee County pre-hospital care system is monitored by a Medical Control Authority, Sec 20918 of P.A. 368 of 1978 as amended, that is comprised of the Chief Executive officers from the participating health care facilities, one representative of Genesee County and the physician Medical Director. Final authority rests with this body as provided for under the state department. The Medical Control Authority receives technical and administrative advice from the Medical Control Board and subcommittees. Participation in the Genesee County Medical Control Board is encouraged and available to all pre-hospital providers and agencies.

Basic life support personnel communicate with advanced life support personnel or limited advanced personnel and health care facilities and Limited Advanced and Advanced life support communications between Specialists or Paramedics and participating health care facilities is achieved through radio means via VHF (HERN). Critical patients being transported into Genesee County via non-advanced life support services are to notify Genesee County Central Dispatch of their need for advanced life support assistance. Following such an intercept, a Genesee County advanced life support service will establish radio contact with the appropriate receiving facility.

Medical Control is required to establish written protocols, Sec. 20919 of PA 375, to provide pre-hospital health care provider with guidelines for treatment of specific ailments. Basic, limited, and advanced life support treatment are supervised by the on-line medical control physician available on a 24-hour basis at each receiving health care facility.

The protocols have been designed to facilitate speed and efficiency in the delivery of pre-hospital care. Based on clinical assessment and judgment, EMS personnel; may proceed with "Pre-Radio Contact" treatment. "Post-Radio Contact" orders are designed to serve as a guide for anticipated physician orders. In the event of complete communication failure (radio as well as telephone), Post-Radio Contact guidelines are to serve as standing orders to be performed by the paramedic.

All complaints within the system are reported to the Medical Director or designee and reviewed by the Professional Standards Review Organization as outlined in the Professional Standards Review Organization Procedures.

Revised: March 2006

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Implementation Date: November 27, 2006

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P.A. 78 of 1997 (Bennett Bill)

All GCMCA transporting agencies wishing to participate with Act 78, Public Act of 1997, known as the "Bennett Bill" must meet the requirements of the legislation and the Michigan Department of Consumer and Industry Services, EMS Division.

These are the requirements that will be followed prior to licensure by the State EMS Division:

1. Submit copy of the complete Conditional Upgrade License Application to the GCMCA offices, including all required attachments for Medical Control review.
2. Applications will be reviewed by Medical Control and a letter of recommendation will be issued by the GCMCA if all requirements are properly met.
3. Submit required application and documentation to MDCIS.

After receiving the license from the State EMS Division, the following requirements must be followed:

1. Contact Medical Control Coordinator to set up the following:
 - A. Purchase of medication kits.
 - B. Purchase of IV kits.
 - C. Purchase of Advanced Airway equipment.
 - D. Present proof of equipment which meets the minimum standards of the State EMS Division at the level which you are conditionally licensed to function.
2. All GCMCA protocols and policies must be followed at all times.
3. Agencies providing ALS service under the Bennett Bill will not be allowed to be routinely dispatched for intercepts since they will not have coverage at all times.
4. Monthly quality improvement requirements must be strictly adhered to.
5. A GCMCA approved ALS Run Report form will be utilized.
6. A written report on the progress made by the ambulance operation on the plan of action to permanently upgrade the level of licensure, including, but not limited to information on training, equipment and personnel, will be submitted to the GCMCA every six months.
7. All IV and medication kits will be stored in a locked compartment of the vehicle and will be accessed only by those personnel who are licensed and approved to use them.
8. All agencies must develop an internal quality assurance process that includes appropriate levels of experience with endotracheal intubation, intravenous starts and knowledge of GCMCA protocols.
9. Company will, at their expense, install CAD equipment (or arrange to use existing equipment) at central dispatch that will allow dispatchers to know the status of the agency at all times.

Protocol Development and Review

According to MCL 333.20919, a local medical control authority shall establish written protocols. The following is a brief outline of how protocols will be developed and implemented in Genesee County:

1. Protocol Committee Membership:

- A. Appointments: Chairperson and members appointed by Medical Director.
- B. Term: 1 year.
- C. Meetings: Every other month with additional meetings as deemed necessary. Minimum of 6 meetings per year.
- D. Membership: Minimum requirements (9):
 - 3 - ED Physician from a GCMCA approved facility
 - 1 - ALS public provider
 - 1 - ALS private provider
 - 1 - BLS provider
 - 1 - MFR provider
 - 1 - 911 representativesOther members may be appointed to the committee as deemed appropriate and/or necessary by the Medical Director.
- E. Chairperson: ED Physician appointed by Medical Director.
- F. Attendance: 75% required attendance with semi-annual assessment.
- G. Quorum: One ED Physician and greater than 50% of voting members.

2. Responsibilities:

A. Protocol Development: On an ongoing basis the committee will assess the current Genesee County EMS system in an effort to identify system deficiencies or areas needing improvement. The committee will work to address identified deficiencies or weaknesses through changes to existing protocols or the development of new protocols to the extent that the law allows.

B. Protocol Review: Every three years the committee will review the entire set of GCMCA Protocols to ensure that existing protocols are up to date and meet the system's current needs and expected standards. The committee will also review protocols periodically when major changes or standards are developed or occur to ensure that protocols reflect current operational and clinical standards.

C. Protocol Approval Process and Medical Director Involvement: Once a protocol has been approved by the committee it will be forward to the GCMCA Board and all EMS agencies for review. Following approval by the GCMCA Board it will be forward to the GCMCA Authority for review and approval. Upon approval of the GCMCA Authority, the GCMCA Medical Director shall give final approval to the protocol and authorize its submission to the state.

D. **Protocol Implementation:** Once a protocol has been approved by the state, it will be disseminated to all EMS agencies, hospital emergency departments and any other individual or agency that has purchased a GCMCA Protocol Book. Included in the mailing will be a copy of the protocol in its final form, a copy of the protocol highlighting changes made and a memo that details the changes. The memo will also outline when the protocol will go into effect. Each protocol will have approval and implementation dates clearly listed on it. Each protocol will also have a facsimile of the Medical Director's signature to show that it has been reviewed and approved by the Medical Director.

3. **Reporting:** To GCMCB and EMS Medical Director.

4. **Committee Actions:**

All protocols developed by the committee and approved with a majority vote of the members present at an official meeting will be forward to the GCMCA Board and Authority for final review and approval.

Education Committee

While the GCMCA is not required by law to provide the EMS community with education programs, the leadership of the organization recognizes that importance of assisting the provider community in staying informed on the latest trends in patient care. Therefore the GCMCA has established an Education Committee. The following is a brief outline of the membership and function of this committee:

1. **Education Committee Membership:**

- A. Appointments: Chairperson and members appointed by Medical Director.
- B. Term: 1 year.
- C. Meetings: Every other month with additional meetings as deemed necessary.
Minimum of 6 meetings per year.
- D. Membership: Minimum requirements (6):
 - 1 - ALS public provider
 - 1 - ALS private provider
 - 1 - BLS provider
 - 1 - MFR provider
 - 1 - ED Nurse
 - 1 - established hospital EMS education programOther members may be appointed to the committee as deemed appropriate and/or necessary by the Medical Director. At least one member of the committee must be a licensed Instructor Coordinator.
- E. Chairperson: At the call of the Medical Director.
- F. Attendance: 75% required attendance with semi-annual assessment.
- G. Quorum: Greater than 50% of voting members.

3. **Responsibilities:**

A. **Assessment of Educational Needs:** On an ongoing basis the committee will assess the current Genesee County EMS system in an effort to identify areas of need for system education. This is most likely to focus on areas that where education programs are not already available to the EMS providers, but they are not limited to these areas.

B. **Education Program Implementation:** The committee will develop and implement education programs based upon assessment of needs or through recommendations made by the GCMCA Authority or Board.

3. **Reporting:** To GCMCB and EMS Medical Director.

4. **Committee Actions:**

All education programs developed by the committee and approved with a majority vote of the members present at an official meeting will be forward to the GCMCA Board for final review and approval.

Cancellation of Dispatch Ambulance:

In the event that the first responding BLS/LALS vehicle believes that Advanced Life Support care is unnecessary, he or she will cancel the responding ALS unit and contact on-line medical control as soon as possible en route. MFRs may only cancel a medical unit when there is no patient.

Appropriate dispatch personnel may cancel a pre-hospital care provider only if one of the following conditions exists:

1. a patient cannot be located by on-scene response personnel (i.e., police or medical first responder);
2. patient proceeds in a privately owned vehicle;
2. obvious dead-on-scene.
3. a closer or more appropriate EMS unit is dispatched

No other person(s) are authorized to cancel or terminate pre-hospital EMS services.

911 dispatchers and 911 supervisory personnel may inform EMS personnel that they are dispatching a paramedic should additional information become available. However, 911 dispatchers and 911 supervisory personnel will not cancel or refuse paramedic support when requested by on scene or enroute to scene EMS personnel. 911 dispatchers and/or 911 supervisory personnel who are not on scene, have no authority to refuse ALS support when requested by EMS personnel on scene or EMS personnel going to the scene.

NON-MEDICAL PERSONNEL ATTEMPTING TO DICTATE LACK OF NEED FOR ALS/BLS MEDICAL INVOLVEMENT:

Any calls through a 911 agency relating to potential medical injuries will mandate dispatching of EMS personnel. Non-Medical personnel (i.e., police, fire fighters, etc.) will not cancel on blunt dispatches of medical EMS personnel to the scene when a 911 agency has determined medical assistance may be needed. They may instruct a 911 agency that they need EMS involvement, but cannot cancel or refuse it when requested.

Updated 11/21/02

Dispatch Policy

Upon receiving information that an apparent medical or trauma problem exists, the appropriate dispatch center shall attempt to quickly ascertain the severity of the medical or trauma problem. The 911 dispatch center will follow the instructions of a GCMCA Board approved EMD system to identify the appropriate Tier level of a call. At that point, the appropriate dispatch center will notify the closest most appropriate pre-hospital emergency vehicle(s) for that region and dispatch according to their EMD system. Each EMS agency dispatch center must also use a GCMCA Board approved EMD system and be able to verify that dispatchers are certified in that system. The agency must ensure that all communications by the dispatcher be recorded.

Dispatch personnel can opt to alter the status of a call at any time based upon additional information received.

The dispatched unit may only run lights and sirens to Tier I calls and only as long as it does not jeopardize the safety of the crew (e.g. weather conditions, road construction). The dispatched unit will not run lights and sirens to Tier II calls. A unit dispatched to an inter-facility transfer may only run lights and sirens to a call involving an emergent, unstable patient.

If an EMS unit is dispatched to a Tier II call and they determine that their services are needed for a second purpose enroute to that call (e.g. MVA), they must stop to determine the nature of the second request for assistance and notify 911 of the delay. If an EMS unit is dispatched to a Tier I call and they determine that their services are needed for a second purpose enroute to that call (e.g. MVA), they must continue to their originally dispatched location and notify 911 of the second request for assistance.

State Approved: November 8, 2007

Implementation Date: January 1, 2008, EMD certification by April 1, 2008

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Order of Report to Medical Control & Communication Content

The purpose of this policy is to provide a uniform reporting format for EMS personnel. The format is designed to provide the minimum desired patient information in a complete, concise outline. Information should be summarized within one minute. One should remember that radio communications are monitored, and that such communications may become public information. For this reason, the use of patient names is to be avoided, except in unusual circumstances.

Communications should be brief and pertinent.

After establishing contact with medical control, the EMS unit will give a radio report in the following format:

1. Identify Ambulance Service (agency name);
2. Identify yourself (i.e. A185);
3. Identify priority of patient;
4. Approximate age and sex of patient;
5. Chief complaint(s). (If hospital requests, include history and nature of the problem (if traumatic, the cause of the injury, i.e., motor vehicle accident, and cause of significant injuries);
6. Vital signs and level of consciousness (Priority 1 & 2 patients only);
7. Estimated time of arrival;
8. Other information as requested by the receiving hospital;
9. Status updates of changes in patient's conditions in route;
10. Submit completed written run report to hospital.

Pre-hospital treatment, utilizing Basic, Limited, or Advanced EMS skills, is permitted to the extent of the standard operating protocols listed. Radio contact and direct communications with the Medical Control physician must be made as soon as possible.

*Direct communication may be interpreted as utilization of VHF, telephone contact, or 800 mhz.

Since most GCMCA protocols include pre-radio contact decisions and treatments, communication prior to loading the patient is not required.

Should communication fail, continue patient care protocols.

Communications systems failure should be reported to the appropriate involved agencies.

Telecommunication

1. Communications between EMS personnel and the hospital emergency facility will be directed by physician, nurse, or approved physician designee with ALS training.
2. Communications involving orders for continuing medical care will be handled in the hospital emergency facility by an identified physician or designee. The EMS personnel involved will also be identified.
3. The facility will maintain a written and/or recorded record of communications with EMS personnel providing out-of-hospital medical care.
4. If the patient is seriously ill or injured enough that orders for medical care are required, the EMS personnel should establish communications as soon as possible with the hospital emergency facility.
5. In the event of communication failure the unit is to follow the direction of the appropriate protocol.

Agency Vehicle Inventory

Each EMS agency in Genesee County (MFR, BLS, LALS or ALS) must submit a list of current vehicles as part of the annual relicensure process. This list should include vehicle I.D. number, year, make, level of licensure of each vehicle and current license plate for each vehicle operating in the fleet. Also submitted should be the GCMCA-issued vehicle number as it corresponds to the vehicle I.D. number. This requirement can be met by submitting Part 2 of the license (if the agency adds the GCMCA-issued vehicle number) or a memo containing the required information.

Any vehicle changes made throughout the year must be submitted to the Genesee County Medical Control Authority. Notification may be completed by either submitting Part 2 of the license (with the addition of the GCMCA-issued vehicle number) or a memo containing the required information.

In addition, all vehicles licensed by an agency will be considered to be mechanically fit if they comply with the state's Ambulance Safety Inspection checklist. All units must be in compliance with this check list at all times. As part of an agency's annual Letter of Compliance submitted with their annual relicensure, an agency must submit signed documentation from a licensed certified mechanic that all vehicles are in compliance with this checklist. (see appendix, Quality pg. 1706 for actual form)

Application to Provide Service/Upgrade Level of Service in Genesee County

Agencies desiring to provide emergency medical services in Genesee County or wishing to upgrade their existing licensure level must satisfactorily complete the application process as outlined below.

1. Submit letter of application indicating the specific geographic area to be served, the desired level of licensure, the proposed base location, and type of service (transporting or non-transporting).
2. Submit a completed original of the GCMCA Authorization for Release of Information and Release from Liability.
3. Submit a completed Questionnaire for Provider Applicants.
4. Submit a copy of Articles of Incorporation (if incorporated) or the Genesee County business registration (Doing Business As) DBA (if not incorporated).
5. Submit a personnel roster including the name, address, licensure level, and license expiration date. This information will be kept confidential and not released to the Board. The list is to include all the following personnel who will be involved in the Genesee County operation:
 - A. President/Chief Executive Officer
 - B. Director of Operations
 - C. Director of Training/Education
 - D. Quality Assurance Coordinator
 - E. Dispatch Supervisor
 - F. All medical personnel
7. Submit communications certificate, list of frequencies used in mobile radios and at the dispatch facility, the primary and secondary dispatch frequencies and the agency's internal dispatch protocols, policies and procedures. Include documentation of dispatch training requirements and records, pre-arrival instructions and computer-aided dispatch capabilities.
8. Submit the completed MDCIS application.
9. Submit proof of vehicle, unemployment and medical liability insurance.

The application packet must be presented in the order stated above and separated by numbered tabs. The applying agency must submit two copies of the application for review by the Genesee County Medical Control Board and Authority. The completed applications should be submitted at least two weeks prior to the next meeting of the Genesee County Medical Control Board. Meetings are held on the third Wednesday of January, March, May, July, September and November.

The Medical Control Board will review the completed application and may direct a reference review and investigation. The Board may withhold support of the application based upon adverse findings in the investigation process. The recommendation of the Board will be forwarded to the Authority for final action.

All new agencies will be placed on probation from the first day of operation for a period of 6 months. During that probation period new agencies will have regular run record audits and frequent unannounced base inspections.

Revised: September 2005
State Approved: January 26, 2006
Implementation Date: November 27, 2006

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Requirements for Agency Application for Relicensure

All EMS agencies serving Genesee County must submit the following information as part of their application for relicensure to the Administrative Offices of the Genesee County Medical Control Authority (GCMCA) no later than March 13th of every year:

- Part I agency application
- Valid liability insurance certificate
- Vehicle documentation (Part II of the application or documentation as outlined in the Agency Vehicle Inventory Protocol)
- Valid vehicle insurance certificate
- Current employee/volunteer roster (including employee name, address, level of licensure, and license expiration date.) This information will strictly be for Medical Control use only. (i.e. education program notification, PSRO issues)
- Signed Letter of Compliance (See Appendix)

GCMCA staff will review the application and supporting information for completeness. Staff will then forward the necessary information to the Genesee County Medical Control Board, who will recommend approval or denial of applications. If an agency is approved, the application will be signed by the Medical Director, and returned to the agency.

Advanced Airway Management

1. Endotracheal Intubation:

- A. Cuffed endotracheal tubes are not to be used in infants and small children.
- B. The following list may be used as a guide in determining the catheters:

<u>Age</u>	<u>Endotracheal Tube (Internal Diameter)</u>	<u>Suction Catheters</u>
See "Pediatric Respiratory Arrest" Protocol for Infants and Children		
Adult (female)	8.0 to 8.5 mm	12 Fr.
Adult (male)	8.5 to 9.0 mm	14 Fr.

One size larger and one size smaller should be allowed for individual variations.

- C. Apneic Patients: may be intubated using the endotracheal tube. You are allowed two (2) initial attempts at intubation (remember to hyperventilate patient between attempts). If unable to successfully intubate after two (2) attempts, contact Medical Control for further orders.
- D. Non-Apneic Patients: nasotracheal intubation may be considered for airway control in patients with suspected c-spine injury or those in respiratory distress, only with the approval of the receiving medical control physician.
- E. In certain circumstances, Medical Control may grant permission for additional attempts at intubation.
- F. Tube position will be confirmed by examination, auscultation and CO₂ detector as soon as practically possible. Use of CO₂ detector will be documented on the run sheet. CO₂ detector will not be used in patients in cardiopulmonary arrest because CO₂ detectors are unreliable on cardiac arrest patients.

2. Combitube (ALS, BLS, & LALS)

- A. Indications
 - 1. Unconscious and unable to maintain airway with absence of gag reflex.
- B. Contraindications:
 - 1. Patient under 5 feet tall
 - 2. Patient between 4 and 5 ½ feet tall use Combitube designed for these patients.
 - 3. History of caustic ingestion.
 - 4. History of known esophageal disease.
 - 5. Known or suspected foreign body obstruction of the larynx or trachea.
 - 6. Presence of a tracheotomy
 - 7. Massive facial trauma preventing intubation.
- C. Instructions
 - 1. Follow the directions as supplied with the Combitube or Combitube designed for the patient.
- D. Documentation
 - 1. The following must be documented on the patient run record
 - a. Indication of Combitube placement
 - b. Number of attempts of placement; number of providers
 - c. Time required for successful placement

- d. Placement confirmation by chest rise and chest and gastric auscultation
- e. Oxygen saturation before and after Combitube placement (if available)
- f. Combitube port used for ventilation
- E. Record vital signs and pulse oximetry saturations (if possible) at a minimum of every 10 minutes after any change in patient condition or change in treatment.
- F. Reassess tube placement following every patient movement.
- G. Record Combitube removal and reason for removal should it occur.

ALS Intercept

- A. Upon arrival, assess patient for airway status:
 - 1. If patient has Combitube in place, assess for placement by chest and gastric auscultation.
 - a. Confirm appropriate port for effective ventilation and continue ventilation.
 - b. If pulse oximeter is available and accurate, measure oxygen saturation
 - (1) If saturation <92%, reconfirm position
If saturation remains <92%, prepare to intubate
 - (2) If saturation >92%, continue ventilation with Combitube
 - 2. If any questions regarding ability to ventilate effectively via Combitube, prepare for intubation.
 - B. To intubate around Combitube:
 - 1. Prepare intubation equipment and endotracheal tube.
 - 2. Prepare suction equipment
 - 3. Deflate pharyngeal balloon (blue balloon).
 - 4. Make one attempt to visualize larynx and intubate under direct visualization;
 - (a) If successful, continue with step E.
 - (b) If unsuccessful,
 - (1) deflate the distal balloon (white balloon)
 - (2) remove the Combitube
 - (3) visualize the larynx and intubate under direct visualization
 - 5. Confirm endotracheal placement via chest and gastric auscultation.
 - 6. If unable to intubate patient, replace the Combitube and attempt ventilation with the Combitube according to instructions.
 - 7. Record oxygen saturation if pulse oximeter is available.
 - C. Record vital signs and pulse oximetry saturations (if available) at a minimum of every 10 minutes or after any change in patient condition or change in treatment.
 - D. Reassess tube placement following every patient movement.
 - E. Record Combitube removal and reason for removal.
3. **Cricothyrotomy (Needle):**
- A. Field diagnosis indicates an airway obstruction not relieved by manual techniques, suctioning, or direct laryngoscope.

- B. Locate cricothyroid membrane.
 - C. Prep side with providone iodine.
 - D. Attach largest catheter to a 10 ml syringe.
 - E. Withdraw plunger as you advance needle through the membrane and aim caudally 30-40 degrees when you hear/feel a "pop".
 - F. Advance catheter, withdraw stylet and oxygenate with 100% O₂.
4. **Nasal Intubation Procedure:**
- A. Indications
 - 1. Long term
 - 2. Burns
 - 3. Cervical spine concern.
 - 4. Unable orally, after three (3) attempts
 - B. Technique
 - 1. Hyperventilate patient with 100% oxygen.
 - 2. Gather equipment and select correct size ET tube (adult #7). Turn in BVM adapter snugly.
 - 3. Lubricate nare and tube end with Xylocaine jelly as needed.
 - 4. Insert ET tube into nare against septum.
 - 5. Advance tube down, NOT along, curvature of nare; use three-point finger touch.
 - 6. If resistance is met, rotate tube to left or right.
 - 7. May need to flex head slightly, depress trachea, or lift jaw up (if c-spine is not a concern); be gentle.
 - 8. Listen to air exchange, if breathing, for loudest sound; advance the tube.
 - 9. Observe external area around "cords" for tube to help locate distal end position of tube if you have problems.
 - 10. Once tube is in trachea, advance to approximately 22 cm on adult female or 23 or 24 cm on adult male; inflate cuff.
 - 11. Check for bilateral breathe sounds. If present, ventilate; if not, pull tube.
 - C. Possible Complications
 - 1. Intubation of esophagus
 - 2. Severe nosebleed
 - 3. Further injury of c-spine
 - 4. Vomitus
 - 5. Aspiration of vomitus
 - 6. Perforation of esophagus/pharynx
 - 7. Intubation of right main stem bronchus
 - 8. Bronchospasm
 - 9. Laryngospasm
 - 10. Hypoxemia
 - 11. Cardiac arrhythmias
 - 12. Coughing/gagging

Dead on Scene – Pronouncement of Death

Any patient who suffers a cardiac arrest must have CPR initiated promptly to give him or her the best possible chance of survival. Granted there are many situations in which the evidence of death is so overwhelming that initiation of cardiopulmonary resuscitation is not justified. It is the purpose of this protocol to give guidelines to assist in making this decision.

PROCEDURE

The following categories may be pronounced dead on scene:

1. Definite rigor mortis.
2. Putrefied, decayed or frozen bodies (however, vigorous resuscitation efforts are indicated in an arrest related to hypothermia or low body temperature and cold exposure).
3. Decapitation.
4. Open head wounds with gross outpouring of cranial contents.
5. Documented (in writing) terminal illness with written orders from the patient's physician not to start CPR. Compliance with "special needs patient protocol."
6. Drowning with documented submersion for 2 hours or more - cold.
7. Burn victims with charred remains + no signs of life.
8. Multiple amputation with no signs of life.
9. Extremity lividity with no signs of life.

If none of these are met (1-9), CPR + patient care protocols are to be initiated.

If one of the above criteria is met, then pre-hospital personnel can begin the following procedure for obtaining a pronouncement of death:

1. Present to the online medical control physician results of the physical examination, including vital signs, cardiac monitoring or use of AED (if applicable) and summary of patient's condition, including:
 - a. present problem
 - b. past medical history, especially as it relates to any terminal illness that may be present
 - c. applicability of advance directives or presence of durable power of attorney, physician and/or family members and their agreement in limiting life support.
2. Online medical control physician will then do one of the following:
 - a. pronounce death
 - b. request initiation or continuance of basic/advanced life support
 - c. request further information or clarify issues.
3. Document time of pronouncement of death and names of online medical control physician and hospital on the GCMCA Run Record. The pink copy of the record should be given to the hospital staff or left with either the body removal service or an officer on scene.
4. Notify local police authority if not already on scene.
5. If EMS personnel need to move a body in an effort to assess if one of the nine categories of obvious death are present, or if the scene is disturbed for any reason by EMS personnel, the crew must notify the appropriate law enforcement personnel on scene of such movement or of any disturbance in the scene. Such movement or disturbance shall also be discussed with the Medical Examiner Scene Investigator (MESI) from the Medical Examiner Office if one is on scene and recorded on the run sheet. If a MESI is not on scene, a copy of the run sheet with documentation about movement or disturbance of the body or scene must be left with law enforcement or OTHER APPROPRIATE personnel for a MESI.
6. EMS may:

- a. leave the scene once police, hospice, physician, nurse, body removal service, or funeral home personnel are on scene.
 - b. Transport the body to the appropriate facility.
7. The police officer on scene will contact MESI and MESI will determine whether the body removal service shall be called or whether a funeral home will be called to pick up the body.

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1103a

Do-Not-Resuscitate

A Do-Not-Resuscitate order is applicable to all prehospital life support agencies and personnel. A Do-Not-Resuscitate order may be executed by an individual 18 years of age or older and of sound mind **OR** by an individual 18 years of age or older and of sound mind, and adherent of a church or religious denomination whose members depend upon spiritual means through prayer alone for healing **OR** by a patient advocate of an individual 18 years of age or older. Per Attorney General Opinion 7056, a court appointed guardian of a developmentally disabled adult ward, does **not** have the authority to sign this form on behalf of a disabled adult ward when that ward is not of sound mind.

1. EMS providers shall not attempt resuscitation of any individual who meets ALL of the following criteria:
 - A. 18 years of age or older.
 - B. Patient has no vital signs. This means no pulse or evidence of respiration.
 - A. Patient is wearing a Do-Not-Resuscitate identification bracelet which is clearly imprinted with the words “Do-Not-Resuscitate Order,” name and address of declarant, and the name and telephone number of declarant’s attending physician, if any.

OR

The EMS provider is provided with a Do-Not-Resuscitate order form for the patient. Such an order form shall be in substantially the form outlined in Annex 1 or 2 and shall be dated and signed by all parties.

2. A patient wearing a “Do-Not-Resuscitate order” identification bracelet, or who has executed a valid “Do-Not-Resuscitate order” form, **but who has vital signs, shall not be denied** any treatments or care otherwise specified in local protocols.
3. If a Do-Not-Resuscitate order form is presented and is not substantially in the form as outlined in Annex 1 or 2, or is not complete and signed by all parties **resuscitation will be initiated** while Medical Control is being contacted for direction.
4. In the event care has been initiated on a patient, and subsequently a valid Do-Not-Resuscitate order form is identified, and the patient meets the criteria in Item I. above, discontinue resuscitation.
5. A Do-Not-Resuscitate order will not be followed if the declarant or patient advocate revokes the order. An order may be revoked at any time and in any manner by which the declarant or patient advocate is able to communicate this intent. **Resuscitation efforts will be initiated** and EMS personnel shall contact on-line Medical Control to advise them of circumstances.
6. An “ambulance report form” will be completed for runs handled within this protocol. The ambulance report form will clearly specify the circumstances and patient condition found by the EMS providers, and describe the Do-Not-Resuscitate documents involved.

Epi-Pen/Epi-Pen Jr.

The following protocol is optional for all BLS, LALS and ALS providers. Epi-pen/Epi-Pen Jr. is used for to treat life-threatening anaphylaxis. If a provider decides to use Epi-Pens as part of the their standard equipment on all of their rigs, the company will be responsible for all costs associated with using the medication

1. Providers choosing to use Epi-Pen/Epi Pen Jr. must:
 - A. Obtain a signed drug authorization from the Medical Director for each purchase of the medication
 - B. Purchase locked drug boxes to securely store the medication
 - C. Design a tracking system to ensure that outdated medication is not being used
2. Indications/contraindications
 - A. Indications
 1. Life-threatening allergic/anaphylactic reactions
 - B. Contraindications:
 1. No absolute contraindications
 2. Caution use caution in patients with heart disease, high blood pressure, and stoke
3. Administration of Epi-Pen and Epi-Pen Jr.
 - A. Unless radio attempt failed, be in direst contact with Medical Control Physician
 - B. Determine which Epi-Pen is to be used.
 1. EPI-PEN
 - a. Patients between age of 11 and 70 years.
 - b. Patient over 32 kg.
 2. EPI-PEN JR.
 - a. Patients of age 2 to 11 years.
 - b. Patients under 32 kg.
 3. Consult with Medical Control for patients who are outside these parameters.
 - C. Administration
 1. Follow the packet insert for administration procedures and proper dosing
4. Be alert for reactions following administration for the drug.
5. Closely monitor the patient's condition.
6. Record all patient condition information and medication administration on the GCMCA Run Record.

Refusal of Care

Any and all individuals that are involved as patients or potential patients should receive proper evaluation, treatment and transportation to the appropriate medical facility. Pre-hospital personnel should utilize the refusal of care procedure in situations in which a patient refuses evaluation, treatment, and/or transportation. Individuals who are competent may object to treatment or transportation by EMS personnel. MCL 333.20969 “If emergency medical services personnel, exercising professional judgment, determine that the individual’s condition makes the individual incapable of competently objecting to treatment or transportation, emergency medical services may provide treatment or transportation despite the individual’s objection unless the objection is expressly based on the individual’s religious beliefs.”

1. A competent individual is:
 - A. One who is awake, oriented, and is capable of understanding the circumstances of the current situation.
 - B. Does not appear to be under the influence of alcohol, drugs, or other mind altering substances or circumstances that may interfere with mental functioning.
 - C. Is not a clear danger to self or others.
 - D. Is 18 years of age or older, or an emancipated minor.
 1. “Emancipated Minor” is one who is married, is a parent, or has been granted emancipation by the court.
2. Procedure for Competent Individual or Responsible Party Refusing Care or Transport:
 - A. Determine that the individual is refusing to allow the proper evaluation, or necessary treatment, or necessary transport to the appropriate medical facility.
 - B. Determine the mental status and extent and history of injury, mechanism, or illness.
 1. Ensure that the patient is conscious, alert, oriented, and understands (mental reasoning) their condition. (Patient GCS = 15)
 2. Unless the patient specifically refuses, do a complete physical assessment.
 - C. Clearly inform the patient and or responsible party (parent/guardian) of the potential consequences of their decision to refuse treatment and/or transport to a definitive-care facility, and ensure that the patient and/or responsible party fully understand this.
 - D. All measures should be taken to convince the patient to consent, including enlisting the help of family or friends.
 - E. If the patient continues to refuse, the patient and/or responsible party may then sign a "Refusal of Care" form (See Appendix). Ensure that the following information is communicated to the patient or responsible party:

1. That the release is against medical advice.
2. That it applies to this instance only.

3. That EMS should and can be requested again if necessary or desired.
- F. After the "Refusal of Care" form is signed, it must be witnessed.
- G. If the patient or responsible party will not sign the release, then document this on the EMS run report. If available, witness signatures should be obtained on the "Refusal of Care" document with additional comment from EMS provider of the circumstances surrounding the refusal
- H. Where it is possible, patients will be left in the care of family, friends, or responsible parties.
- I. Carefully document the assessment and vital signs, including all issues and circumstances indicated on the GCMCA Run Record.
3. Procedure for the Individual Incapable of Competently Objecting to Treatment or Transport:
 - A. Contact online medical control as soon as practical and follow applicable treatment protocols.
 - B. Any patient with an urgent/life-threatening illness or injury who is incapable of competently objecting to treatment or transportation shall be transported by EMS for further evaluation and treatment.
 - C. Police assistance may be sought if needed.
 - D. A patient with non-urgent/non life-threatening illness or injury who is incapable of competently objecting to treatment or transportation should be transported for further evaluation and treatment after consultation with on-line medical control.
4. Procedure for the Minor Patient Refusing Care of Transport:
 - A. A minor is any individual under the age of 18 and who is not emancipated.
 - B. In general, minor patients are unable to consent or refuse consent for medical care. Such permission can only be provided by the minor's parent or legal guardian.
 - C. Treatment and transport of real or potential life-threatening emergencies will not be delayed by attempts to contact the parent or guardian.
 - D. For all emergency and non-emergency patients, contact online medical control.
5. Form Requirements
 - A. All refusal forms must be in triplicate.
 1. One copy to the patient
 2. One copy to GCMCA
 3. One copy to the Agency

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1107

Termination of Resuscitation

Medical Cardiac Arrest

- A. Medical cardiac arrest patients undergoing attempted resuscitation will not be transported emergently unless return of spontaneous circulation (ROSC) is achieved or transport is ordered by online medical control. These patients will have resuscitation continued at the scene for at least 25 minutes unless advanced procedures (i.e. endotracheal intubations or IV/IO) are unsuccessful in which case prompt transport will be initiated. Temporary return of pulse qualifies as ROSC.

If the ALS crew believes a prolonged resuscitation at the scene will be unduly distressing to the patient's family or bystanders transport may begin prior to the termination of resuscitation. If the resuscitation can not be safely and efficiently performed on scene transport may begin whenever deemed appropriate by the ALS crew.

- B. Online Medical Control should be contacted as soon as practical during the resuscitation attempt. If the resuscitation has been unsuccessful after at least 25 minutes (ALS Time without ROSC), the resuscitation may be terminated with the permission of online medical control unless there is persistent ventricular fibrillation in which case prompt emergency transport will be initiated. Once resuscitation is initiated by BLS or LALS it may be terminated only at the direction of online medical control. The ALS crew may elect to continue the resuscitation for longer than 25 minutes or during transport. Online Medical Control will be informed that the ALS crew has elected to continue the resuscitation. ROSC, i.e. return of a pulse, resets the 25 minute clock and transport should be initiated.
- C. Once resuscitation is terminated the pre-hospital personnel will provide information to the family which should include medical control procedures for termination of resuscitation. The family should also be informed of the Genesee County process for removal and transport of the body (See Dead on Scene Protocol).
- D. Any non-resuscitated patient should be processed as directed in the GCMCA Dead on Scene Protocol.

Blunt or Penetrating Traumatic Arrest

- A. Blunt or penetrating traumatic arrest patients who do not meet criteria for withholding resuscitation should have full resuscitation and prompt transport initiated (see Resuscitation and Transport, 1-10). For patients in which this resuscitation has not resulted in a return of spontaneous circulation after 15 minutes or in whom the patient access and transport time to an ED or Trauma Center is greater than 15 minutes, termination of resuscitation attempts should

be considered. Contact online medical control for approval when termination is considered.

- B. Once a determination is made to terminate resuscitation the GCMCA Dead on Scene Protocol should be followed.

EMS Agency Responsibilities

As part of the Genesee County Medical Control and 9-1-1 emergency dispatch systems, EMS agencies:

1. Shall operate in accordance with P.A. 375 of 2000.
2. Shall ensure that all paramedic level active field employees have current ACLS certification.
3. Shall immediately notify the appropriate 911 center of any need for additional ambulance at the scene of a call to which that public safety agency has dispatched the company.
 - A. Any additional units will be dispatched by a 911 center according to the GCMCA dispatch protocol.
4. Shall immediately notify the appropriate 911 center of Tier 1 calls the company received via its private line if the response time will be more than 8 minutes so that a potentially closer unit may be located. For responses of 8 minutes or less there is no need to notify the appropriate 911 center.
5. Shall allow responding Paramedic to board private BLS ambulance.
6. Shall drive a non-transporting ALS unit to a receiving hospital or return a paramedic to his non-transporting unit promptly at the completion of the call.
7. Shall carry at least one box of latex-free gloves on every licensed EMS unit in service at all times for use in cases where the provider has knowledge that the patient has a latex allergy.
8. Shall report by written means any missing, lost or stolen drug boxes to the GCMCA within 24 hours of the disappearance of the box.
9. Must reapply to operate in Genesee County if they have been suspended by the state or GCMCA for more than 30 days.
10. Shall carry 25 triage tags on every licensed EMS unit. These tags should be used for mass casualty incidents. These types of incidents are defined as any situation where the EMS system is overwhelmed. Each agency is required to provide periodic training on the use of triage tags.
11. Must employ at a minimum one state licensed Instructor Coordinator (IC) if the agency is licensed at the ALS level.
12. Must report any failure of an agency dispatch recording system to the GCMCA. The agency will report both at the time the recording system fails and when the failure has been corrected.
13. Will be considered to operate under a mutual aid system in Genesee County due to the fact that there are no geographic boundary limitations on EMS agencies and that the existing 911 systems contact the closest, most appropriate EMS unit.
14. Shall report efforts to provide positive support to the community beyond its normal course of duties and responsibilities (i.e. – CPR courses, education programs, community service programs, etc.). The agency shall provide a report to the GCMCA as part of their annual relicensure (this item does not apply to agencies that have achieved CAAS accreditation).
15. Shall demonstrate an equipment maintenance program that shall include the following items (as it applies to the agency): stretcher, ECG

1200

monitors/defibrillators, AEDs and portable ventilators. The maintenance program

- should follow the manufacture's recommended guidelines. The agency must submit a copy of their equipment inventory list and inspection report to the GCMCA as part of their annual relicensure.
16. Shall submit detailed information on their existing and proposed communications and recording systems as part of their annual relicensure. Additionally, any proposed changes to communications or recording systems must be submitted to GCMCA 30 days prior to implementation.
 17. Shall provide to GCMCA detailed information on structure and organization that shall include at a minimum the following (as it applies to your agency): owner(s), operations manager(s), dispatch coordinator/supervisor(s), quality assurance coordinator and safety officer. Each position shall be listed on an organization chart and submitted to GCMCA at the time of relicensure or whenever staffing or organizational changes occur.
 18. Shall develop a policy that requires all employees to follow local, state and federal laws and regulations.
 19. Shall follow the state's MEDCOMM requirements.
 20. Shall conduct criminal background checks on all EMS providers at the time the agency hires employees and at the time of the employees' relicensure with the state. At a minimum the agency should conduct a background check that utilizes the Michigan State Police's Internet Criminal History Access Tool (ICHAT) and a national search of the U.S. Department of Justice's National Sex Offender Registry. Any felonies identified by the agency must be reported to the state department responsible for EMS oversight.
 21. Shall participate in at least one disaster exercise annually, and report participation as part of their annual relicensure.
 22. If an agency receives a complaint on a violation of GCMCA Protocols, they must do one of the following: 1) conduct an internal investigation of the alleged violation. If a protocol is found to have been violated that caused harm to a patient, had the potential to cause harm to a patient or resulted in disciplinary action by the agency, the agency must notify the GCMCA Administrative Offices with the results of the investigation and the action taken by the agency. The case will then be reviewed by the GCMCA PSRO; 2) submit the complaint to the GCMCA Administrative Offices for review by the PSRO.
 23. Shall ensure that each life support vehicle that is dispatched and responding to provide medical first response life support, basic life support, or limited advanced life support is equipped with an automated external defibrillator (AED) and that all personnel that will use an AED is properly trained to utilize the device.

Drug and Supply Purchase Authorization

The purpose of this protocol is to establish a system for agencies to obtain the necessary documentation for drug and supply purchase authorization forms. It will also allow Genesee County Medical Control Authority the ability to track and preview the information before forwarding it onto the Medical Director.

The proper procedure to obtain the required information for these forms will be as follows:

1. The agency will submit a completed request form to Genesee County Medical Control Authority. All information other than that required of the Medical Director must be completed 100%.
2. Staff will review the information and assure that it is not allowing the Medical Director's information to be used for unlimited purposes.
3. Staff will contact the Medical Director and explain the items being authorized, the information required and request a signature if applicable.
4. Staff will fill in the necessary license information that has been provided to Genesee County Medical Control Authority by the Medical Director.
5. A copy of the fully completed form will be made and kept on file before the original is returned to the agency.

EMS Personnel Response Protocol

In cases when an EMS agency receives a call from a 9-1-1 agency, a prompt response is required. If there is any delay on the part of the EMS agency or its personnel (i.e. trains, mechanical failure, problems in locating call, etc.), the originating 9-1-1 agency should be contacted immediately.

All calls received and accepted by an EMS agency from a 9-1-1 agency require that the EMS agency's ALS/BLS/LALS vehicle be in the unit and responding within (3) three minutes or less. If for some reason an agency cannot have its EMS personnel in the unit and responding to a call in three (3) minutes or less, the agency should notify the originating 9-1-1 agency of the anticipated delay. The 9-1-1 dispatcher will then determine if the expected delay will still qualify the contacted EMS agency to receive the call. Each agency will submit compliance with this protocol on a monthly basis as part of their PSRO report submission.

All calls received and accepted by a MFR agency from a 9-1-1 agency require that the MFR agency's licensed MFR vehicle be on the road within six (6) minutes from the time the MFR agency is toned out by the 9-1-1 agency.

All EMS personnel are prohibited from utilizing or distributing any form of photographic media or equipment while on duty with a licensed EMS agency. The only exception would be for EMS personnel who are also acting as law enforcement officers and are required to use photographic media as part of their law enforcement duties.

Infectious Disease Notification

Pursuant to Michigan Public 419 of 1994, the following procedure will serve as a guide for action to be taken in the event that and exposure to potential infectious disease occurs.

1. Exposure:
 - A. Blood and/or body fluids splashed into eyes, nose, and/or mouth
 - B. Blood and/or body fluids coming in direct contact with open cuts or other breaks in the skin
 - C. Puncture wounds or cuts to the skin with contaminated needles or other sharp instruments, including human bites
 - D. Intimate contact with oral secretions such as would occur with mouth-to-mouth resuscitation
 - E. Close contact with actively coughing patient with suspected active Tuberculosis
2. Procedure:
 - A. EMS personnel will stay informed with regard to current practices and knowledge related to infectious diseases and Universal Precautions
 - B. All EMS agencies will adhere to OSHA regulations as identified in OSHA final Bloodborne Standard USDL: 91-618
 - C. EMS personnel who feel an exposure has occurred should complete the State of Michigan First Responder Provider Request for HIV and/or Hepatitis B Testing of Emergency Patient Form (See Appendix). A copy of the completed form should be given to the nurse manager at the hospital that received the patient involved in the exposure, who will forward the form to the appropriate Infection Control personnel.
 - D. Hospitals shall respond to the First Responder Provider Request form:
 1. If the hospital determines that an exposure did occur they shall:
 - a. If no diagnostic tests for the presence of infectious diseases were performed during the patient's hospital stay, then the hospital will inform the individual who completed the First Responder Provider Request form that the information is unknown
 - b. If diagnostic testing for infectious disease were performed, the results, whether positive or negative will be reported to the individual completing the First Responder Provider Request form
 2. If the hospital determines that no exposure occurred it must be documented on the First Responder Provider Request form.
 - E. Patient confidentiality must be maintained. Failure to do so is a violation of the law.

Physician on Scene

There are situations when a physician, will attempt to provide assistance at the pre-hospital scene.

1. EMS personnel should document the arrival of another physician on scene and notify the online medical control physician.
2. The physician on scene is required to provide proper identification.
3. EMS personnel should inform the online medical control physician immediately that the physician on scene requests to provide medical direction and care.
4. If the online medical control physician feels the physician on scene may adequately care for the patient, then transfer of responsibility should be documented in writing.
5. The physician on scene should be informed that once responsibility of patient care has been accepted, he should accompany the patient to the destination unless released by the online medical control physician. In addition, the physician will be responsible for the review and signing of the run record.
6. If the online medical control physician does not wish to transfer responsibility for patient care to the physician on scene, or if the physician on scene does not agree to EMS guidelines or the physician on scene is not providing acceptable care to medical control instructions then EMS personnel will continue with patient care as directed with the online medical control physician.
7. If the physician on scene inhibits patient treatment, law enforcement personnel may be notified for assistance.
8. It should be noted that liability responsibility for the patient at the scene rests with the online medical control physician. Decisions regarding the release of medical care responsibility to other physicians will be given careful consideration.

Transporting and Non-Transporting ALS Interface

The intent of this protocol is to conserve resources, while maximizing quality treatment for the patient. The protocol outlines the interface of non-transporting and transporting ALS.

1. Once a transporting ALS unit arrives on scene, the non-transporting ALS unit will disengage from the scene and return to service to be available for future Tier I calls. The transporting ALS unit may request that the non-transporting unit continue to assist on a call after they arrive if it appears that the patient would benefit from the additional resource.
2. The first medic on scene will be the team leader for patient/scene control, and will maintain that lead until patient is delivered to the hospital unless the first medic has disengaged from the call (as noted in #1 above).
3. If the first medic on scene assesses the patient and determines that additional paramedic assistance is not necessary, the first medic can cancel a second medic unit if one has been dispatched.
4. If the non-transporting ALS provider opens his or her drug box before the transporting unit arrives, they may exchange the box with the transporting unit. If such an exchange occurs medics from both units should inspect the box to ensure that the appropriate quantity of narcotics is in the box. Additionally, any medications used should be noted on both run sheets with accompanying notations as to which crew administered them. The drug box exchange should also be noted on both run sheets.
5. If possible the non-transporting ALS provider's run sheet should be completed and the hospital copy provided to the transporting ALS crew for submission to the hospital. When definitive patient care would be delayed, the non-transporting ALS provider can complete the run sheet after the transporting crew has departed. In these cases the run record must be submitted to the hospital within 24 hours. Avoiding delays in patient care is the first priority.

Revised: July 2006

State Approved: September 27, 2006

Implementation Date: November 27, 2006

1205

Tobacco Protocol

Tobacco use is one of the hardest habits to break. The pre-hospital Emergency Medical Services (EMS) system supports any programs that can make a difference in reducing patients and staff exposure to tobacco use. The goal is to have a healthy environment, free of primary and second-hand smoke and the remnants of other tobacco products. In an effort to achieve this type of environment in the EMS system this protocol will limit the use of tobacco products in designated “Tobacco Free Areas, Facilities, and Grounds.”

Tobacco Free Areas include:

- Ambulances,
- Pre-hospital care areas where EMS providers are involved in providing patient care,
- Hospital grounds, except designated area(s)
- Must be in compliance with current: “Genesee County Regulation to Prohibit Smoking in Enclosed Places” ordinance.

Adapted: July 2006

State Approved: September 26, 2006

Implementation Date: November 27, 2006

1206

Unsafe Scene and Staging Protocol

1. If a potentially violent and/or dangerous situation is encountered and there is no police assistance immediately available and/or forthcoming, the first priority is for the safety of the EMS personnel. Decisions regarding treatment of the potential patient must be made with safety of responding EMS personnel in mind. Responding EMS personnel should not place themselves at unnecessary risk.
2. All available information should be carefully analyzed. Determine if dispatch information, coupled with the exterior observations indicate a potentially dangerous situation or otherwise unsafe incident.
3. If the determination is made by the responding personnel using either information from the dispatcher or from initial observations at the scene that this is a dangerous situation, the responding unit should park one block down and one block over from the incident location (or a reasonable distance) unless another staging location has been selected by the dispatcher. If this location is still unsafe, the responding unit should find and move to a more secure area. If the unit does move the 911 center should be notified of the change. The responding EMS unit will make the decision whether the incident location is safe enough for them to enter the scene. They are not required to proceed if directed by the general public, police or any other person unless they feel comfortable that the scene is safe and secure.
4. They should remain in a safe location until the police arrive, the incident is terminated in some way or they determine that the conditions are safe for their entry to the incident location. The EMS agency dispatcher will contact the 911 Center every 20 minutes after the unit arrives on scene to get an update on the status of the call.
5. EMS personnel are not in the business of supplying police services. EMS personnel should not place themselves in combative or otherwise personally hazardous situations while attempting to deliver medical services.
6. EMS agency dispatchers should do everything in their power to determine the safety of the scene to which their personnel are being sent to. Agency dispatchers should exercise a high degree of suspicion on all calls that suggest a violent or hazardous scene. Calls such as assaults, shootings, stabbings, suicide attempts or psychological problems are recognized as scenes that could be unsafe.
7. If the EMS unit is advised to stage by the 911 Center, then they should respond without lights and sirens unless specifically directed otherwise by the 911 Center.
8. When an EMS unit is dispatched as a standby unit for fire incidents they will do the following:
 - a. Report to the Fire Incident Command Officer or Staging Officer.
 - b. Ensure that EMS personnel, equipment and vehicle are in a safe location.
 - c. Establish a triage location for potential firefighter or citizen care.
 - d. Personnel are not to leave the location until they have been released by fire incident command.

State Approved: November 8, 2007

Implementation Date: January 1, 2008

1207

Time Synchronization Standard

Purpose: To provide accurate and uniform time information for documentation and quality improvement purposes.

Policy: The national atomic clock operated by the United States National Institute of Standards and Technology (NIST) will be used as the uniform time synchronization tool throughout the Genesee county Medical Control Authority. All agencies' equipment and personnel time pieces will be synchronized to the NIST. Standard synchronization checks will be made of all agencies' equipment by that agency.

Policy Detail:

1. Access to a NIST atomic clock is available via the internet at <http://www.time.gov>. This site provides a snapshot time. That is, the time display is static and must be manually updated by clicking onto "update now" button. Synchronization to the NIST will be no more than 30 second variations.
2. Agency equipment synchronization will be done every Wednesday morning from 8:00 a.m. until 10:00 a.m. Equipment includes, but is not limited to dispatch clocks, digital tape recorders, computers, cardiac monitors, AED personal radios, EMS rigs, pages wall/table/standing clocks, and cell phones.
3. Personnel watch synchronization will be the responsibility of the individual providers and done at the beginning of each shift worked.
4. Daylight-savings time changes will be made at 0200 on the appointed dates.
5. Genesee County Medical Control Authority Emergency Departments' synchronization policies will be the responsibility of that facility, however, it is recommended that patient care involving the receipt of EMS patients follow similar, uniform, NIST time synchronization methodology.

EMS Personnel Responsibilities

As part of the Genesee County Medical Control Authority, EMS personnel:

1. Shall operate in accordance with P.A. 368 of 1978.
2. Shall have ACLS certification if licensed and operating as a paramedic.
3. Shall allow responding Paramedic to board a private BLS ambulance.
4. Shall drive a non-transporting ALS unit to a receiving hospital or return a paramedic to his non-transporting unit promptly at the completion of the call.
5. Must pass a GCMCA-administered examination on the GCMCA Protocols at the time of relicensure with the state.
6. Shall wear a GCMCA-issued identification badge at all times when actively working in the EMS system, which must be displayed in a way that is easily visible to the general public. The ID will be issued after personnel have presented the following to GCMCA and will be renewed when their state-issued EMS license expires:
 - ❖ State-issued EMS license
 - ❖ ACLS currency (paramedic only)
 - ❖ CPR Card
 - ❖ Valid driver's license
 - ❖ A completed GCMCA application form
 - ❖ Verification that they have passed a GCMCA-administered examination on the GCMCA Protocols
7. Shall follow all local, state and federal laws and regulations.

Equipment and Supplies Exchange

As part of the normal course of operation, EMS providers often use equipment and supplies on patients in the pre-hospital setting that are replaced by the receiving hospital. In Genesee County the only items eligible for replacement are as follows:

7. I.V. Sets
8. I.V. Solutions
9. Southeast Michigan Regional Drug Box and A-Pack

These items are only to be replaced on a one-to-one exchange policy. This means that for every item used by the EMS provider, only one of equality size, type and quantity is to be taken from the hospital as a replacement.

State Approved: November 8, 2007
Implementation Date: January 1, 2008

1210

Note: Anytime that a box or line is not used or the information is unavailable it must be crossed out with a line or an X mark.

1. **BLS LALS ALS:** Check appropriate box for your vehicle.
2. **Date:** Indicate the date of the run.
3. **Service:** Name of your agency.
4. **Run #:** Internally issued.
5. **Vehicle I.D.:** At a minimum either the last four digits of the VIN or GCMCA-issued rig number.
6. **Hospital:** Name of the location the patient is taken to.
7. **Transport Priority:** Circle appropriate priority (see GCMCA Operational Protocols – Transportation Guidelines).
8. **Incident Location:** Address if available or nearest area crossroads for P.I.
9. **Incident Twp/ City:** Name of the city or township of the incident location. (City or township must also be circled.) .
10. **Zip Code:** List the postal zip code of the incident location.
11. **Time Call:** List time you received the call.
12. **Time Start:** List time you were enroute.
13. **Time Scene:** Time arrived on location.
14. **Time Depart:** Time left location.
15. **Time Destination:** Time arrived at hospital.
16. **Mileage Start:** Odometer reading at beginning of call.
17. **Mileage Scene:** Odometer reading at location.
18. **Mile Destination:** Odometer reading at hospital.
19. **ALS Req/ON:** Time ALS was requested by BLS/LALS after BLS/LALS was on scene/time ALS checked in on location. This item is not used by ALS, and should be crossed out when not used.
20. **Final Disposition:** Check ALS or BLS to indicate the status of the call upon arrival at the hospital.
21. **Determined By:** Indicate who decided upon the final disposition - the EMT, the Paramedic or the hospital. Check ALS - Unavailable if ALS was requested but was unable to respond.
22. **Communications:** Circle the method of communication used.
23. **Destination:** Indicate how the receiving hospital was chosen. Closest should only be marked when medical condition warrants hospital other than patient preference. Diverted should only be used during an ambulance hold and this must be documented in the narrative. Only specialty cases are pediatrics, burn, and OB/GYN. All other calls should be documented as patient preference.
24. **Name:** Indicate patient's name.
25. **Age:** Enter patient's age - if unknown estimate and enter (est.).
26. **Sex:** Check "m" for male or "f" for female.
27. **Address:** List patient's home address, including city, state, and zip.

28. **DOB:** Indicate the patient's birthdate.

Fields "Phone" through "Medicaid #" are provided for billing purposes and are not reviewed for quality assurance purposes.

29. **Allergies:** List patient's allergies.
30. **Medical History:** Circle applicable conditions.
31. **Other:** List patient's other medical problems or conditions.
32. **Current Meds:** List all prescriptions currently being used by the patient.
33. **Car Seat** Indicate yes or no in cases of P.I. accidents.
34. **Seat Belts:** Indicate yes or no in cases of P.I. accidents only.
35. **Birth Time:** Indicate time of delivery in OB calls.
36. **Dispatch Info:** Original reason for emergency call as given by dispatch. (Medical is not an acceptable entry, must be more specific (i.e. Chest pain, Seizure, PI, etc.)
37. **Tier:** Indicate the tier of the call type. (See GCMCA Operational Protocols – Dispatch Policy.)
38. **Chief Complaint:** Reason patient gives for needing emergency assistance.
39. **Narrative:** Detail the course of treatment, patient's response and other pertinent information.
40. **Medical Release:** The patient must sign if he or she refuses treatment. One witness signature is required.
41. **Patient Assessment Checklist:** Check the appropriate patient condition box for:
A) Pupils B) Skin C) Skin Color D) Pulse
E) Breath Sounds F) Abdomen G) Skeletal/Muscle (check the box to indicate no deficit is present in the listed extremities.)
42. **Vital Signs:** Indicate patient's temperature in appropriate cases; list the time and results of assessment of blood pressure, pulse, respirations, Glasgow Coma Scale, SAO₂ and glucose (if appropriate); indicate bodily areas affected by trauma and type of trauma.
43. **Patient Mgmt:** Indicate the interventions personally performed in the areas of:
A) Airway Management B) Spinal Immobilization
C) Oxygen Provided D) Limb Stabilization
E) Splints Applied F) Bleeding Care
G) Failed IV/IO & Extrication Minutes
44. **Time Course of Treatment/Meds PTCL/MC:** List the time, describe treatment and/or medications given and indicate whether the treatment was provided on orders from standing orders (PTCL) or directly from Medical Control (MC). Must have signature verifying waste of narcotics (if appropriate).

NOTE: THIS SECTION MUST BE COMPLETED BY ALL PROVIDERS IF IVs OR MEDS HAVE BEEN ADMINISTERED.

45. **Drug Box:** Document the old drug box (the one used on this run) and

the new drug box received from hospital pharmacy. The drug box number should be documented on all runs, even if the box has not been used. If the box has not been used, the old drug box number should be noted and a line should be drawn through the new drug box area. If the box was used, both the old and new drug box numbers should be documented.

- 46. **Driver:** Indicate name of ambulance driver on the run.
- 47. **Paramedic:** List name of paramedic on the call.
- 48. **EMT:** List name of Basic provider(s) on the call.
- 49. **Other:** List any other professional on scene that rendered care.
- 50. **Recorded By:** Indicate name of individual completing the run record.
- 51. **MD/DO Signature:** Providers must obtain the physician's signature when IVs or Meds have been administered, otherwise leave blank.

In case of a refusal of care, a line must be drawn through all of the boxes/areas to be considered complete.

State Approved: November 8, 2007
Implementation Date: January 1, 2008

1302

Note: Anytime that a box or line is not used or the information is unavailable it must be crossed out with a line or an X mark.

1. **Date:** Indicate the date of the run.
2. **Agency:** Name of your agency.
3. **Run #:** Internally issued.
4. **Station #:** Internal station # that rig is responding to the call from.
5. **Vehicle #:** Internal number of vehicle responding to the call.
6. **Incident Location:** Address if available or nearest area crossroads for P.I.
7. **Jurisdiction:** Name of the city or township of the incident location.
8. **Call Time:** List time you received the call.
9. **Start Time:** List time you were enroute to the call.
10. **Scene Time:** List time you arrived on scene.
11. **Cleared Time:** List time you cleared the scene.
12. **Response Miles:** List the # of miles as shown on the odometer from the time you leave the station until you arrive on scene.
13. **Name:** Indicate patient's name.
14. **Age/DOB:** Enter patient's age - if unknown estimate and enter (est.).
Put a slash mark and indicate the patient's birthdate.
15. **Phone:** Indicate the patient's home phone number if available.
16. **Sex:** Check "m" for male or "f" for female.
17. **Address:** List patient's home address, including city, state, and zip.
18. **Dispatch Info:** Original reason for emergency call as given by dispatch.
(Medical is not an acceptable entry, must be more specific (i.e. Chest pain, seizure, PI, etc.)
19. **Tier:** Indicate the tier of the call type as indicated by dispatch.
20. **Chief Complaint:** Reason patient gives for needing emergency assistance.
21. **Allergies:** List patient's allergies.
22. **Medical History:** Check applicable conditions.
23. **Other:** List patient's other medical problems or conditions not listed in Medical History.
24. **Current Meds:** List all prescriptions currently being used by the patient.
25. **Patient Assess:** Check the appropriate patient condition box for:
A) Pupils B) *Skin C) Burns D) Skin Color
E) Pulse F) AED G) Breath
*Note any rashes found on the line after "other" for skin
26. **Vital Signs:** List the time and results of assessment of blood pressure, pulse, respirations, and Glasgow Coma Scale
27. **Patient Mgmt:** Indicate the interventions personally performed in:
A) Spinal Immobilization B) Oxygen Provided
C) Splints Applied D) Pulse OX (if available)
E) Bleeding Care
28. **Narrative:** Briefly list any information not previously documented in the above sections that is pertinent to the care provided to the patient.
29. **Transported to:** Check or name the location the patient is transported to.

30. **Ambulance Co.:** Name of the ambulance company that transported the patient.
31. **ALS/BLS:** Check if the ambulance that transported the patient was ALS or BLS.
32. **Unit #:** List the vehicle number for the ambulance that transported the patient.
33. **Echo Unit:** If an ECHO unit assisted an ambulance crew, indicate the name of that provider(s).
34. **Recorded By:** Indicate name of individual completing the run record.
35. **Other(s):** List any other professional(s) on scene that rendered care.

Professional Standards Review Organization

The Professional Standards Review Organization (PSRO) is responsible for the oversight of the quality of care provided to patients and appropriate protocol compliance within the EMS system.

1. **Membership:**
 - A. Appointments: Chairperson and members appointed by Medical Director.
 - B. Term: 1 year.
 - C. Meetings: Monthly with additional meetings as deemed necessary. Minimum of 8 meetings per year.
 - D. Membership: Minimum requirements (9):
 - 3 - ED Physician from each GCMCA approved facility
 - 1 - ALS public provider
 - 1 - ALS private provider
 - 1 - BLS provider
 - 1 - MFR provider
 - 2 - "911" representativesOther members may be appointed to the committee as deemed appropriate and/or necessary by the Medical Director.
Ex-Officio: Medical Director, GCMCA Executive Director, and GCMCA Coordinator
 - E. Chairperson: ED Physician appointed by Medical Director.
 - F. Attendance: 75% required attendance with semi-annual assessment.
 - G. Quorum: One ED Physician and greater than 50% of voting members.
4. **Responsibilities:**
 - A. Incident Review: To assess, investigate and when necessary, make recommendations to GCMCB pertaining to issues of concern regarding non-compliance with protocols posed by any person(s) regarding Genesee County EMS activities. Investigations will be processed according to the Incident Review Process (5).
 - B. Audits: To regularly assess quality assurance processes performed by pre-hospital care agencies.
 - C. PSRO 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: Assessment of agencies and facilities applications, reapplications, and compliances to GCMCA protocols, policies, and PSRO.
3. **Reporting:** To GCMCB and EMS Medical Director.
4. **Committee Actions:**
- A. Incident Assessments:
Will be reviewed for EMS system, individual provider and/or agency:
1. Accuracy of demographics, times, mileage, etc
 2. Accuracy of patient assessment
 3. Appropriateness of treatment
 4. Compliance with protocols
 5. Competency of procedures
 6. Communications
 7. Completeness of documentation
 8. Any information that may impact patient care
- B. Incident Recommendations:
1. Absolution, complaint unfounded, unsubstantiated or not of consequence
 2. Education/protocol change
 3. Trending
 4. Written warning
 5. Written Reprimand
 6. Corrective action plan
 7. Probation
 8. Suspension
 9. Recommend revocation of license - through Michigan Department of Community Health (MDCH).
5. **Incident Review Process:**
- A. Alleged incidents must be submitted to the GCMCA in writing by fully completing the GCMCA Incident Report (Appendix pg. 1704) An incident number will be assigned to each incident allegation filed for tracking purposes.
- B. The EMS agency(s) and/or individual(s) involved with the alleged incident will receive written notice of the complaint. A written response from the EMS agency(s) and/or individual(s) will be required within 12 business days. However, more urgent matters may require a more urgent response and is at the discretion of the Medical Director.
- C. Details of the alleged incident, and any responses received from the EMS agency(s) or individual(s) will be presented at the next regularly scheduled PSRO meeting or special PSRO meeting, if necessary.
- D. PSRO members will review the alleged incident for any violation of items listed in the incident assessments (Section 4A) and by majority vote of the members present decide a course of action as outlined in the incident recommendations (Section 4B). Actions taken as listed in 4B 4-6 will be reported to the GCMCB at the next regular meeting and will not be provider specific. Recommended actions as listed in 4B 7-9 will be forwarded to the GCMCB for approval and will be provider specific.

E. In the event that an EMS agency(s) or individual(s) whose privileges are suspended from Medical Control, the EMS agency(s) or individual(s) shall not provide pre-hospital care until medical control is reinstated. MDCH will be notified within 1 business day of suspension or revocation of medical oversight for an EMS agency(s) or individual(s).

F. In cases of gross negligence or complete disregard for GCMCA protocols, in which there is immediate threat to the public health, safety, or welfare the Medical Director may order the immediate temporary suspension of medical control privileges from an agency(s) or individual(s). A hearing of the GCMCB must be held within 3 business days to determine a permanent decision.

G. Appeals of actions may be requested as outlined in the Appeals Protocol.

6. **EMS Radio Communication:**

All radio communications between an emergency department and EMS personnel must be taped by the emergency department. These taped radio communications must then be stored for a minimum of 120 days. Any requested transmissions can be requested and reviewed by the Professional Standards Review Organization

7. **Peer Review Confidentiality:**

Information and data is confidential professional/peer review PSRO information of the GCMCA. It is protected from disclosure pursuant to the provisions of MCL 333.21518, MCL 333.20175, MCL 322.21515, MCL 331.533 and other State and Federal laws. Unauthorized disclosure or duplication of PSRO information is absolutely prohibited.

Run Record Guidelines

Guidelines:

- A. All agencies are required to use the most recent version of the approved GCMCA Run Record/GCMCA MFR Run Record. No alterations may be made to the run record. Only one record should be completed per responding unit per call. The run record should only document information obtained by or interventions done by the crew that is completing the run record unless something that has been done by another crew is clearly documented on the run record. The hospital copy of the run record must be submitted to emergency department staff before the crew on the call leaves the hospital unless there are extenuating circumstances that require the provider to leave the hospital, in which case the run sheet must be submitted within 24 hours of completion of the call. If additional information needs to be added or changes need to be made to the run record, an addendum must be completed and a copy submitted with the agency run record submission information.
- B. ALS, LALS, and/or BLS provider are required to complete a run record for calls that have any type of patient care contact – including assessments, any transports terminating in a hospital emergency facility, any DOA patient, any direct admission to a hospital and any transfer. Non-transporting agencies are to provide a copy of the completed run record to the transporting agency.
- C. MFR providers are required to complete an MFR Run Record when patient care contact (e.g. patient assessment, medical interventions) has been made. A copy of the run record is to be provided to the transporting agency.
- D. All GCMCA Run Records must be in triplicate form (1 copy to Agency, 1 copy to Hospital, 1 copy to GCMCA), unless a drug box is used, in which case a fourth copy must be provided to the pharmacy.

Submission:

1. Include all runs originating in Genesee County.
2. Run records for the prior month must be submitted to the GCMCA Administrative Office by the 15th day of the following month. At least one run record is required for each call and/or transport. Electronic run forms are acceptable as long as the following conditions are met:
 - A. Copy must be printed at the hospital to be given to ER staff.
 - B. Must contain all of the same data elements as the hard copy version of the run record and when printed must look the same as the hard copy run record.
 - C. Electronic run records must be saved on a disk and the disk is must be submitted to the GCMCA Administrative Office by the 15th day of the month.
3. Each agency is required to perform a monthly review of their GCMCA Run Records. The agency must review at least 10% of or all runs (minimum of 35). The company may choose to review more if they wish. All run records used in the review need to be submitted

separately from the other run records with the report form attached. If a portion of the run records are used for this review, then the run records used must be randomly selected from the total records produced by the agency.

4. A PSRO Report/MFR PSRO Report form (See Appendix) must be completed as part of the review and attached to the records used to conduct the review. If using electronic run forms an electronic form must be completed and saved on a disk submitted to GCMCA. If an agency has more than one level of licensure (e.g. ALS, LALS, BLS) a separate report will be done for each licensure held. The form(s) and run records are to be submitted as described above. When completing the review the following documentation criteria should be followed:

A. Volume Indicators

Volume indicators should list the total number of runs for the month by category. Do not report the total number of runs used in the review.

- a. # runs – The total number of all emergency calls dispatched by 911 or that were generated through agency’s private line and were determined to be an emergency call. This number includes cancellations. This number does not include inter-facility transfers.
- b. # basic transports – The total number of patients whose final destination was a hospital emergency department or other GCMCA-approved facility and that were provided with Basic Life Support (BLS) care and a run record was generated. This is only for patients transported as the result of activation of the 911 system or that were generated through agency’s private line and were determined to be an emergency call.
- c. # advanced transports – The total number of patients whose final destination was a hospital emergency department or other GCMCA-approved facility and that were provided with Advanced Life Support (ALS) care and a run record was generated. This is only for patients transported as the result of activation of the 911 system or that were generated through agency’s private line and were determined to be an emergency call.
- d. Refusals of Care – The total number of calls that resulted in a signed refusal by the patient. This figure also includes cases where the patient refused transport but also refused to sign the refusal form and the crew documented the incident on the run record.
- e. Cancellations – The total number of calls dispatched by 911 or that were generated through agency’s private line and were determined to be an emergency call, but no patient run record was completed. This includes any call that the crew responds to by leaving their base or post, but failed to make patient contact for whatever reason.
- f. Tier I Calls – The total number of Tier I calls as assessed and dispatched by 911 or that were generated through agency’s private line and were determined to be an emergency call. This number

includes refusals of care, cancellations and transports ending at a hospital emergency department or other GCMCA-approved facility. This number does not include inter-facility transfers.

- g. Tier II Calls – The total number of Tier I calls as assessed and dispatched by 911 or that were generated through agency's private line and were determined to be an emergency call. This number includes refusals of care, cancellations and transports ending at a hospital emergency department or other GCMCA-approved facility. This number does not include inter-facility transfers.
- h. Transfers – The total number of non-emergency inter-facility transfers.

If done correctly items #b, #c, #d and #e should equal #a. Additionally, items #f and #g should equal #a.

B. Call Info

All boxes and lines on the call information section of the run form are to be completed. This includes rig level of licensure, hospital, priority, incident location, incident twp/city, call times, call miles, ALS request, final disposition, determined by, communications, and destination facility. Take note that either twp or city must be circled and a name of a twp or city entered to receive 100% in this section. Agencies with more than one base must record the base responded from.

3. Patient Info

The following fields must be 100% complete to be credited:

- 1. Name - enter "unknown" if name is not known
- 2. Age - estimate if unknown and indicate "est" or "approx"
- 3. Gender
- 4. Birth date
- 5. Address
- 6. City
- 7. State
- 8. Zip

4. Patient History

List allergies, other health problems and medications on lines provided. Indicate current conditions by circling the appropriate type. If restraints and/or birth time are not applicable indicate NA or draw a line through the area.

5. Dispatch/Complaint Info

Complete dispatch box with information given from 911 agency and complete chief complaint with the information given by the patient once on scene.

6. Patient Assessment

All boxes must be 100% complete or a line must be drawn through the boxes if not able to perform assessment. Reason for inability to obtain assessment should be noted in the narrative section.

7. Vitals/Course Treatment/Medications

A full set of vitals should be listed and they should be in sequential order. "0" should not be used in any vitals box unless that vital sign is absent. The Glasgow Coma Scale should always be noted. A temperature should be noted or "N/A" entered on cases where temperature is not applicable. ALS/LALS are required to have pulse oximetry on board and note readings when appropriate. Treatment rendered and medication given to the patient should also be noted in this section. Vital signs taken and treatment/medication given should both be entered in this section in chronological order as they occur. (i.e. on the first line the time and the vitals would be recorded and on the second line the time and the establishment of an IV would be recorded.)

8. Patient Management

All areas are to be 100% complete with a line drawn through the boxes when non-applicable to the case.

9. Drug Box/Narcotics Waste

On runs where a drug box and/or A-Pack is used, the old and new drug box/pack must be noted. If there are narcotics wasted, there must be a signature from an emergency department doctor or nurse.

10. Provider Names

Must be 100% complete to be given full credit; the physician's signature and printed name are required when IVs or medication has been administered.

11. Appropriate Treatment Rendered

Check "yes" if care was given according to patient management protocols. Appropriate standards of patient care are according to the written, approved Genesee County protocols.

12. Adequate Narrative

Check "yes" if the narrative supports the chief complaint and the progress of treatment rendered.

13. Response Time

Enter minutes from time entered in "call" box to time entered on "scene" box in call info section of run form. Response time should be an average of all runs used in the review.

14. Response Miles

Enter the number of miles from "start" to "scene" on call info section of run form. Response miles should be an average of all runs used in the review.

Revised: April 2007

State Approved: June 5, 2007

Implementation Date: October 1, 2007

1310

Appeals Process

EMS personnel, agencies, and/or facilities upon notification of GCMCB and/or GCMCB subcommittees, actions including those of the PSRO and Protocol subcommittees, may request an appeal in writing within 30 days of receipt of such actions. Lack of request within 30 days shall deem the actions accepted by involved EMS personnel, agencies, and/or facilities.

If an appeal is requested, an Appeal Review Committee is to meet within 14 calendar days of receipt of written request for appeal. The Appeal Review Committee shall be comprised of a total of five members including: one (1) ED Physician, one (1) ED nurse, one (1) MFR, one (1) EMT and one (1) Paramedic. The Medical Director and GCMCA Staff shall attend the Appeals Review Committee meeting. The Appeal Review Committee shall review the actions of the GCMCB and/or any decisions of a GCMCB Subcommittee as well as material supplied by the parties requesting appeal. After review of the materials and actions, the Appeal Review Committee, by closed ballot vote, may uphold, reject and/or modify the decision of the GCMCB and/or any GCBMBCB Subcommittee. The Appeal Review Committee will recommend final action to the Medical Director. The Medical Director may veto the Appeal Review Committee's decision. In the event of a veto, the issue will be referred back to the GCMCB. A veto will be over-ridden only by a two-thirds vote of the full GCMCB.

After appeals to the medical control authority have been exhausted, the affected participant in an emergency medical services system may appeal the medical control authority's decision to the statewide emergency medical services coordination committee.

Acronym Protocol

When completing a GCMCA run record, the EMS provider documenting the run must ensure that no acronyms are used unless they are on the following list:

♀	Female
♂	Male
AAA	Abdominal Aortic Aneurism
A/O	Alert and Oriented
AAOx3	Awake, Alert, Oriented x 3 [person/place/time]
AC	AnteCubital vein or fossa (IV)
ACLS	Advanced Cardiac Life Support
AED	Automated External Defibrillator
AFC	Adult Foster Care
AICD	Automatic Implanted Cardioverter/Defibrillator
AIDS	Acquired Immune Deficiency Syndrome
ALS	Advanced Life Support
AMA	Against Medical Advice
AMI	Acute Myocardial Infarction
AOS	Arrived On Scene
ARDS	Acute Respiratory Distress Syndrome
ASHD	Arteriosclerotic Heart Disease
ATF	Arrived to Find
B/P	Blood Pressure
BBB	Bundle Branch Block
BCLS	Basic Cardiac Life Support
BGL	Blood Glucose Level
BLS	Basic Life Support
BP	Blood Pressure
BSI	Body Substance Isolation
BVM	Bag Valve Mask (Ambu Bag (tm))
C(line over)	With
C/O	Complains Of
C/P	Chest Pain
CA	Cancer
CABG	Coronary Arterial Bypass Graft
CAD	Coronary Artery Disease
CC	Chief Complaint
CCU	Cardiac Care Unit
CDC	Center for Disease Control
CHF	Congestive Heart Failure
CNS	Central Nervous System
CO	carbon monoxide
COPD	Chronic Obstructive Pulmonary Disease
CP	Chest Pain
CPAP	Continuous Positive Airway Pressure

CPR	Cardio-Pulmonary Resuscitation
CRF	Chronis Renal Failure
CSF	Cerebral Spinal Fluid
CVA	Cerebro-vascular Accident
CXR	Chest X-Ray
D5W	Dextrose 5% in Water (IV)
DC	Disconnect/Discontinue
DIB	Difficulty in Breathing
DJD	Degenerative Joint Disease
DM	Diabetic Mellitus
DNR	Do Not Resuscitate
DOA	Dead On Arrival
DOB	Date Of Birth
DUI	Driving Under the Influence
DVT	Deep Vein Thrombosis
DWI	Driving While Impaired/Intoxicated
Dx	Diagnosis
ECF	Extended Care Facility
ECG	Electro CardioGram
ED	Emergency Department
EEG	ElectroEncephaloGram
EENT	Ears, Eyes, Nose And Throat
EJ	External Jugular (IV)
EKG	ElectroCardioGram (old, from German ElectroKardioGram)
EMD	Emergency Medical Dispatcher
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EMT-B	Basic
EMT-I	Intermediate
EMT-P	Paramedic
EMT-S	EMT-Specialist
EPI	Epinephrine
ER	Emergency Room
ESRD	End Stage Renal Disease
ET	EndoTracheal (tube)
ETA	Estimated Time of Arrival
ETC	Endo-trachael Combitube
ETOH	Ethanol (Ethyl Alcohol)
ETT	EndoTracheal Tube
FB	Foreign Body
FD	Fire Department
FF	Firefighter
Fx	Fracture
GCS	Glasgow Coma Scale
GOA	Gone on Arrival
GSW	Gunshot Wound

HBV	Hepatitis B Virus
HERN	Hospital Emergency Radio Network (HEAR is also acceptable)
HR	Heart Rate
HTN	Hypertension
Hx	History
IC	Incident Commander
ICU	Intensive Care Unit
ID	Identification / Identify
IDDM	Insulin Dependent Diabetic Mellitus
IV	Intravenous
JVD	Jugular Vein Distention
KED	Kedrick Extrication Device
KVO	Keep Veins Open
LE	Lower Extremities
LLQ	Left Lower Quadrant
LMA	Laryngeal Mask Airway
LMP	Last Menstrual Period
LOC	Level of Consciousness
LPM	Liters Per Minute (Oxygen)
LPN	Licensed Practical Nurse
LR	Lactated Ringers (IV solution)
LUQ	Left Upper Quadrant
LZ	Landing Zone (aeromedical)
MC	Medical Control
MCI	Mass Casualty Incident
MCP	Medical Control Physician
MD	Medical Doctor
MDI	metered dose inhalers
ME	Medical Examiner
MEI	Medical Examiner Investigator
MOI	Mechanism Of Injury
MRI	Magnetic Resonance Imaging
MVA	Motor Vehicle Accident
MVC	Motor Vehicle Crash
NAD	No Apparent Distress (Interchangeable)
NC	Nasal Cannula
NKA	No Known Allergies
NKDA	No Known Drug Allergies
NP	Nurse Practitioner
NPA	Nasopharyngeal Airway
NPO	Nil per Mouth (Nothing by Mouth)
NRB	Non-ReBreathing (mask)
NS	Normal Saline (IV)
NSR	Normal Sinus Rhythm
NT	NasoTracheal
NTG	Nitroglycerin (Sublingual)
NVD	Neck Vein Distention

O (line through)	Negative / Absent
O (+ inside)	Positive / Present
O2	Oxygen
OD	Overdose
OLMC	On-Line Medical Control
OPA	Oropharyngeal Airway
OTC	Over The Counter
PA	Physician Assistant
PCR	Patient Care Record/Report
PD	Police Department
PDA	Property Damage Accident
PEA	Pulseless Electrical Activity (cardiac)
PI	Personal Injury Accident (MVA involving injuries)
PMH	Past Medical History
POV	Privately Owned Vehicle
PPE	Personal Protective Equipment
PSH	Past Surgical History
PRN	As Needed
PT	Patient
PTCL	Protocol
RA	Rheumatoid Arthritis
RN	Registered Nurse
RSI	Rapid Sequence Induction
RUQ	Right Upper Quadrant
Rx	Prescription
S (line over)	Without
S/S	Signs and Symptoms
SaO2	O2 Saturation (pulse oximetry)
SCBA	Self Contained Breathing Apparatus
SIDS	Sudden Infant Death Syndrome
SL	Sublingual
SSN	Social Security Number
SVT	Supraventricular Tachycardia
Sx	Suction
Sz	Seizure
TIA	Transient Ischemic Attack
T&R	Treat and Release
TOT	Turned Over To
Tx	Treatment
Txp	Transport
URI	Upper Respiratory Infection
UTI	Urinary Tract Infection
UTO	Unable To Obtain
V-fib	Ventricular Fibrillation
V-tach	Ventricular Tachycardia
Y/O	year-old

Ambulance Hold Policy

When a shortage of Emergency Department resources or temporary Emergency Department overload precludes the provision of timely and appropriate care, patients will be directed to another appropriate facility.

A. **Hold Types:** The following are the various types of holds that could occur:

COMPLETE AMBULANCE HOLD:

The emergency department is non-functional (i.e., explosion, fire, power failure, etc.).

ADULT MONITORED BED HOLD:

The hospital has no available beds for patients requiring this level of care and the hospital emergency facility is unable to accept additional monitored patients.

ALS TRAUMA HOLD:

The hospital has no available beds for patients requiring this level of care and is not able to stabilize trauma patients.

HIGH RISK PREGNANCY HOLD:

The hospital has no beds available for patients with high risk pregnancy.

PEDIATRIC HOLD:

The hospital has no available monitored beds in the pediatric unit.

BURN HOLD:

The hospital has no available beds in the burn unit.

- Unstable patients and patients in cardiopulmonary arrest will be taken to the nearest appropriate hospital emergency facility for stabilization regardless of hold status.
- When a hospital places one type of hold they can accept other types of patients.

B. **Notifications:** Once the hospital initiates the hold policy, the hospital will notify the other Genesee County hospitals and all EMS agencies serving Genesee County through EMSsystems. All system participants will be required to maintain a pager at their dispatch center or emergency department to receive these notifications.

C. **Exceptions:**

- Priority 1 (Operational Section – p. 1403 GCMCA Protocol Book) cases may override a hospital hold status if approved by the receiving hospital.
- If all 3 Genesee County hospitals go on the same type of hold; all 3 will open to normal traffic as outlined in the Transportation Guidelines (Operational Section-p. 1404-GCMCA Protocol Book).
- The current Mass Casualty Disaster Plan supercedes this protocol in the event of a disaster declared by the Genesee County Emergency Management Office.

D. Reporting:

The Genesee County hospitals will report hold dates and times to the GCMCA on a quarterly basis. These reports will include the date the hospital went on a hold, the time the hold began, the reason for the hold, the type of hold and the total time the hold lasted.

E. COBRA/EMTALA Statement: The patient's ability to pay for emergency medical services or reimbursement status will not be a factor in determining holds.

Helicopter/Air Transport Protocol

Helicopter/air transport within Genesee County is generally not indicated because of its often complicated and prolonged arrival-on-scene time, transport of patients to institution time, and transport time between the helicopter and ambulance involved.

When helicopter transport is potentially indicated, the Medical Control physician will determine if it is indicated and Medical Control will make the contact with the helicopter service for their involvement in the case. No other personnel, facility, ambulance or paramedic service will initiate contact with the helicopter service.

Patient Injury Classification

EMS personnel will assign all persons with a priority rating which describes the condition of the patient at the time of transport. The ratings that may be assigned are as follows:

- Priority I - Critically ill or injured patients. Patients with unstable VS. Patients with a suspected disease process or mechanism of injury which poses immediate threat to life.
- Priority II - Less serious medical or traumatic condition which pose no immediate threat to life but require urgent evaluation and/or intervention Stable VS. or where patient's condition could be potentially expected to deteriorate.
- Priority III - Non-urgent conditions which will require attention but not immediate treatment.
- Priority IV - Hopelessly injured/non-salvageable.

Transportation Guidelines

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

1. Facility of patient's choice.
2. If patient is a minor, or incompetent, facility of family or guardian choice.
3. In matters of life and death or loss of limb, the closest appropriate facility as determined by the medical control physician and the pre-hospital provider.
4. EMS Personnel must consider when a patient's/patient's relative choice would endanger the patient due to:
 - A. increased transport time;
 - B. lack of appropriate facilities capable of addressing patient's specific problems;
 - C. over-burdening of facilities for any reason(s) (i.e., ambulance hold, disaster).
5. If facility of choice is an extreme distance away, removing the EMS vehicle from availability for an extensive period of time (i.e., out of county), an alternative choice may be allowed with approval by online medical direction.
6. No other individuals (police, fire, other physician) shall be allowed to determine the destination of a patient without prior approval from online medical direction.
7. GCMCA recognized Freestanding Surgical Outpatient Facilities (FSOFs) may receive patients via ambulance with the following exceptions:

Patients With:

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

The following criteria must be met in order for a facility to be considered a GCMCA recognized FSOF:

- A. Must maintain appropriate JCAHO and/or AOA accreditation.
- B. Must be operational 24 hours a day.
- C. Must be licensed by the Michigan Department of Community Health as a free standing outpatient surgical facility (FSOF).

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

8. In the event that a BLS or LALS transporting rig is more than 5 minutes from an in-hospital emergency facility and is in need of an ALS provider for appropriate patient treatment, the BLS/LALS agency will contact the appropriate 911 agency to request an ALS intercept. The intercept should not cause more than a brief delay in transport. Intercepts are to take place at a fixed meeting location. The responding ALS unit will maintain communication with the intended intercept vehicle. Upon meeting with due care and caution, members of the ALS vehicle should board the intercept vehicle bringing appropriate equipment. All units operating in the Genesee County Medical Control region shall cooperate and provide all necessary verbal information to coordinate an intercept.

Trauma Destination Protocol

Cases meeting the following criteria will be transported to Hurley Medical Center unless communication between field personnel and receiving hospital determines otherwise:

1. **Pediatrics** - Overall clinical appearance of the pediatric trauma patient may be the prime indicator of the priority status. The following should be used in making the determination on pediatric trauma destination:
 - Respiratory Distress:
 - Altered Mental Status, color or muscle tone

Anatomy and mechanism of injury:

- Any penetrating Injury (excluding extremities and superficial wound in which the depth can easily be determined).
-OR-
 - Second or third degree burns involving 10% or greater body surface area or involving perineum, hands or face
-OR-
 - Paralysis
-OR-
 - Amputation proximal to the wrist or ankle
-OR-
 - Ejection from a moving motor vehicle
-OR-
 - Death in compartment
-OR-
 - Injuries sustained as a result of extreme deceleration or falls in excess of ten feet will be evaluated at scene. On-line medical control may be used to confirm destination.
-OR-
 - Any pedestrian - motor vehicle accident greater than 5 miles per hour
2. **Burns** - Patients with greater than 5 percent 3rd degree; or greater than 15 percent 2nd degree; or respiratory burns; or burns involving hands, feet, face, perineum.
 3. **Pregnancy** - Trauma patients in 2nd or 3rd trimester.
 4. **Amputations** - any extremity amputation above the wrist or ankle

All other trauma cases not meeting the above criteria will be transported to the closest most appropriate facility. Final destination for trauma patients will be decided between field personnel and receiving hospital.