Kalamazoo County Retained Protocols (2023)

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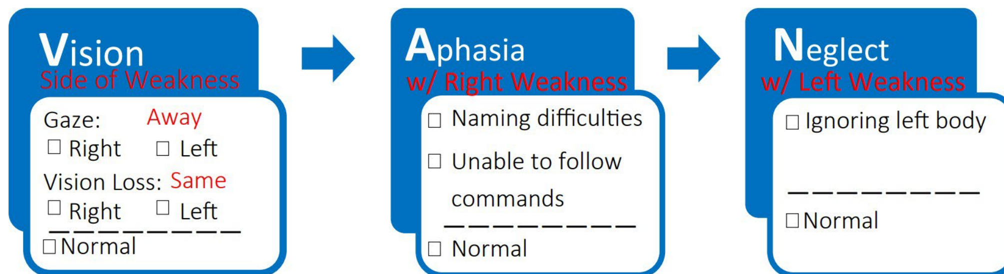
Stroke or Suspected Stroke

1. Follow **General Pre-hospital Care Protocol.**
2. Assess blood glucose level per ***Altered Mental Status (3-1)*** protocol
    A. If less than 60 mg/dL, administer glucose per ***Altered Mental Status (3-1)*** protocol
3. If seizure witnessed or suspected, follow ***Seizures (3-4)*** protocol.
    A. Be aware new onset seizure in elderly patients may be sign of stroke
4. Screen for unilateral arm weakness
    A. If unilateral arm weakness is present, proceed with **VAN** score
        i. **V** - Assess for visual field deficit (gaze preference OR vision loss)
        ii. **A** - Assess for aphasia (unable to follow commands: close eyes, make fist OR difficulty naming common objects: pen, watch)
        iii. **N** - Assess for neglect (does not recognize left side of body, neglects left side of body when simultaneously touching both arms or both legs)
            1. If **any** V, A, **OR** N is positive, patient is "***VAN POSITIVE***"
            2. Preferentially transport VAN Positive stroke patient to Comprehensive Stroke Center if transport time is less than 60 min
            3. If *V, A,* **&** N are *negative*, patient is "*VAN Negative*." Proceed to Cincinnati Prehospital Stroke Scale



    B. If unilateral weakness is absent, proceed with remainder of Cincinnati Prehospital Stroke Scale (CPSS)

5. CPSS (Any deficit is considered POSITIVE for stroke)
    A. Facial droop (have patient show teeth or smile)
    B. Arm drift (have patient close eyes and hold both arms straight out for 10 seconds)
    C. Abnormal speech (have patient say "the sky is blue in Michigan")
    D. If positive for stroke per CPSS, transport to the nearest primary stroke center
6. Document time **last seen normal** for patient, if known
7. Minimize scene time, notify destination hospital as soon as possible and begin transport.
8. Initiate vascular access. (DO NOT delay scene time for IV.)
9. Monitor ECG. (DO NOT delay scene time for ECG monitoring.)

Initial Date: 1/23/2019
Revised Date: 11/15/2023

Hostile MCI

8.4

This Protocol is intended to be used under the direction and in conjunction with law enforcement.

The purpose of this protocol is to provide guidance for the responsibilities for triage, treatment and evacuation of injured individuals following Hostile MCI incidents and to provide for the safety of personnel when responding to scenes of violence. To coordinate with Law Enforcement (LE) to effectively mitigate the incident while maximize lifesaving and life preserving opportunities.

Definitions

Hostile MCI: Any type of multi-casualty incident (MCI) in which EMS personnel may be exposed to harm as a result of active (or potentially active) violent or threatening act(s). LE should be the initial lead agency at such incidents. LE will address the threat and provide security in accordance with agency guidelines. EMS will address medical treatment and patient transport.

Rescue Task Force (RTF): A multi-disciplinary team comprised of EMS and LE personnel designated to operate in the Warm Zone. LE personnel will provide dedicated protection for EMS personnel. Other public safety resources (e.g., non-EMS fire service) may be included in the RTF for support. EMS personnel will establish a Casualty Collection Area in the Warm Zone as directed by LE Command. The RTF will provide assessment and immediate lifesaving treatment to patients within the Warm Zone and transport patients from the Warm Zone to the Transport Unit in the Cold Zone. RTF/EMS personnel should not be used for extracting victims from Hot Zones.

Hot Zone: Any area in the incident scene in which there is a real or potential direct threat to personnel. LE Command is responsible for defining the Hot Zone. Areas that have not had a primary search by LE personnel should be considered as a Hot Zone.

Warm Zone: Any area in the incident scene where there is a potential hostile threat to personnel, but the threat is not direct and immediate. This is the area of operation for the RTF.

Cold Zone: Areas where there is little or no threat. EMS conducts treatment and transport operations in this area. Unified Command will be located in this area.

Unified Command: Unified Command includes law enforcement, EMS, and other appropriate response agencies. LE is considered the lead agency within Unified Command. EMS should be represented within the Unified Command. Initially, EMS may be assigned as a subordinate operations resource under LE Command.

Contact Teams: LE personnel who have a primary task of neutralizing any active threat and conducting primary and secondary searches for additional threats.

Extraction Teams: LE personnel who have a primary task of searching for and extracting living casualties from the Hot Zone to the Warm or Cold Zone.

Force Protection Teams: LE personnel who have a primary task of protecting RTF and other personnel and who are assigned to the RTF with EMS personnel.

Operational Considerations

1. Unified Command shall determine, in advance when possible, the structure and design of teams intended to function as a RTF for the purposes of providing lifesaving interventions for patients within a warm zone and the extraction of those patients.

2. RTF will only be deployed when the following conditions are in place:
   A. Unified Command has been established that includes EMS in a Command or subordinate role.
   B. A specific Warm Zone has been defined (subject to revisions per tactical considerations)
   C. A dedicated LE Force Protection Team is assigned to the RTF

3. EMS personnel are responsible for coordinating transportation of injured individuals and accountability for those injured individuals.

4. Consider early requests for additional EMS resources.

5. The Regional Medical Coordination Center (MEDCOM) should be notified early and is responsible for alerting hospitals.

6. Personal Protective Equipment, when available, should be donned by EMS personnel assigned to the RTF. This may include ballistic vests and helmets. While PPE is desirable, it is not required for RTF personnel, per LE Command direction.

7. If EMS personnel unknowingly or inadvertently enter a scene of violence prior to coordinating with LE, they shall leave the area immediately.

8. LE will provide security for all areas at an incident where EMS may be working. The level of protection shall be determined by Unified Command.

Patient Movement, Triage, Treatment, and Transport

A. Casualty Collection Point (CCP)

1. The CCP is a forward location where victims can be assembled for movement from areas of risk to the treatment area. It is a temporary location to stage and triage patients until a formal treatment area is created. Although the CCP may be used to relocate patients away from the hot zone, hazard mitigation remains the priority.

2. The CCP will typically be in the warm zone in close proximity to the injured persons. Law Enforcement shall provide continuous security measures to protect personnel and patients at the CCP.

B. Rescue Task Force (RTF)

1. A Rescue Task Force is a group of responding law enforcement (LE) and EMS personnel who enter the warm zone to effect a rescue of injured persons inside the warm zone. EMS personnel will determine immediate care, triage and evacuation decisions.

2. The primary focus is to evacuate injured persons to the casualty collection point. Medical treatment in the warm zone should be limited to that necessary to sustain life, such as opening the airway, controlling life threatening bleeding, decompressing tension pneumothorax (ALS only).

3. The number of personnel assigned to the RTF should be limited to the number needed for the mission. RTF composition should include, when practical, a mix of basic and advanced life support personnel.

4. LE personnel will control movement of the RTF.

Triage

1. EMS personnel shall triage patients using SALT triage.

2. Ambulatory victims not requiring RTF intervention may be directed by LE/RTF to self-evacuate.

3. Primary treatment is for control of major hemorrhage, basic airway management, and decompression of suspected tension pneumothorax (decompression is ALS only).

Treatment/Transport

1. On scene treatment should be minimal and that needed for life saving purposes.
2. When possible and prudent, the highest priority patients should be transported first.
3. Treatment management should be aimed at minimal level care unless there is no other care or transport preparation to be done. ALS level care should be minimal, if any.
4. An EMS Transport Unit Leader shall assign patient destinations
5. While ambulance transport is ideal, transport in non-licensed vehicles is appropriate and permissible under the Michigan Public Health Code. Such vehicles may include, but are not limited to LE and fire vehicles, wheel chair vans, busses, and private vehicles. When possible, an EMS provider should accompany the patient in the non-ambulance vehicle. Destination should be based on Regional Trauma Triage Protocol.
6. Air medical transportation should be considered when large numbers of casualties are present and/or long distances to definitive care.

Equipment

1. Transporting EMS agencies must maintain equipment listed in Appendix A for each primary ambulance in service for emergency calls. Ambulances in reserve, assigned to stand-bys, or dedicated to non-911 transports are exempt from this requirement, but may carry this equipment as available.

Appendix A

5th District Regional Medical Control Authority Network

MCI Bag Equipment Inventory List

QTY	Item(s)
5	CAT Tourniquets
5	High Strength Pressure Dressings
5	Nasal Pharyngeal Airways (1ea. Size 7.0, 7.5, 8.0, 8.5, 9.0)
3	14ga 3.25” Decompression Needles
2	Hyfin Chest Seals
1	Full Size Mega Mover
1	Pair of Trauma Shears

Use of Basic Life Support Ambulances for 911 Responses And Other EMS Response Incidents

Initial Date: 6/20/23
Revised Date: 6/20/23

8.16a

Authority: MCL 333.20919(e)

Description: This protocol is issued to authorize the use of licensed basic life support (BLS) ambulances (when staffed by at least one KCMCA-authorized EMT-II) for use in 911 and other EMS incidents.

Kalamazoo County has a long-standing requirement for advanced life support (ALS) ambulances to respond to all 911 and other non-scheduled EMS incidents. This protocol will continue to require an ALS response to Priority 1 and 2 EMS incidents but will permit a BLS ambulance response to Priority 3 EMS incidents.

In addition, a hand-off from ALS to BLS ambulance personnel when clinically appropriate as specified below.

Furthermore, in the event that an ALS ambulance is not readily available (including via in- or out-of-county mutual aid), it will be permissible to respond a BLS ambulance (when staffed by at least one KCMCA-authorized EMT-II). An ALS intercept should be considered for patients who are in need of ALS-level care and where the transport time to the hospital is longer than the time to ALS intercept. However, for time-critical conditions in which ALS care is not likely to change outcomes and would likely result in delayed access to definitive care (e.g., stroke), ALS intercepts may not be appropriate.

Ambulance services unable to staff sufficient numbers of ALS ambulances will attempt to add BLS ambulances staffed by qualified personnel.

I. BLS Ambulance for Transport of Non-ALS Patient Following Priority 1 and 2 EMS Responses

A. A BLS ambulance should be dual-dispatched with ALS when certified EMS dispatcher anticipates likelihood of patient not requiring ALS care
B. Patient has been assessed by paramedic and determined to meet the criteria below.
C. Criteria for BLS Transport (should meet all of the following)
   1. Patient has stable vital signs, (pulse between 50 and 110, RR>12/<20, SBP>100, SpO2 >92% without acute respiratory distress) and is alert AND,
   2. Patient does not (or is unlikely to) require ALS care while being transported to the hospital (BLS personnel may transport patient with saline lock) AND,
   3. Patient does not require cardiac monitoring (e.g., chest pain, dyspnea, syncope) AND,
   4. Arrival of BLS ambulance is likely to be less than the ALS transport time to the hospital.

D. Handoff Process
   1. ALS personnel are required to provide BLS personnel with a complete hand-off including complete medical history, pertinent physical exam findings, vital signs, and treatment provided and response.
   2. ALS personnel provide BLS personnel with a KCMCA EMS Field Note form with above information.

E. ALS Responsibilities
   1. Provide assessment and care consistent with KCMCA protocols
   2. Assure patient meets criteria above
   3. Provide verbal and written hand-off to BLS personnel
   4. Remain with patient until transfer of care to BLS personnel

F. BLS Responsibilities
   1. Assure that patient meets clinical criteria
   2. Receive verbal and written handoff from ALS personnel and obtain any additional information prior to transport
   3. Provide continued BLS care consistent with KCMCA protocols with a Level II EMT providing care in patient compartment
   4. In the event of an unanticipated medical emergency requiring ALS care, request an ALS intercept or continue to destination hospital alerting them as to change in condition (whichever provides most timely access to ALS care)
   5. Provide verbal and written (using KCMCA EMS Field Notes) hand-off to hospital personnel
   6. Document EMS encounter (including ALS component) per protocol

G. Examples of patients appropriate for BLS transport
   1. Minor trauma without concerning mechanism of injury or special trauma considerations (e.g., pregnant, blood thinners), and not needing ALS medications (e.g., analgesia)
   2. Opioid overdose with successful reversal with naloxone and with stable vital signs and normal level of consciousness
   3. Suspected alcohol intoxication with stable vital signs, alert, normal blood glucose, alert, no recent seizure, no evidence of trauma, no concern for co-toxins
   4. Behavioral health condition with patient with stable vital signs, alert, and fully cooperative who have not required (or anticipated to need) physical or pharmacologic restraint
   5. Patient was found hypoglycemic, has received ALS care resulting in normal level of consciousness, and not taking oral or long-acting anti-hyperglycemic medications.

6. Patients who have received analgesia (e.g., fentanyl IV/IN) and otherwise meet criteria
7. Note: Patients who meet above criteria who have a saline lock in place (no IV fluid infusion) who otherwise meet the above criteria may be transported by BLS

H. ALS Release to MFR Personnel Pending Arrival of BLS Ambulance
   1. In the event an ALS ambulance is needed to respond to another emergency and, after determining a patient is appropriate for BLS transport as described above, it is permissible for the ALS unit to temporarily transfer care of the patient to MFRs pending the arrival of the BLS ambulance provided MFR personnel, on scene, are comfortable with handoff

II. Use of BLS Ambulance as Sole Ambulance Response to Priority 3 EMS Incidents

A. It is permissible to dispatch a BLS ambulance to Priority 3 EMS incident
   1. An ALS ambulance will be dual-dispatched when EMS dispatch identifies potential need for pre-hospital analgesia based on information obtained from caller.
   2. An ALS ambulance should be requested by BLS or MFR personnel on scene if patient found with moderate to severe pain
   3. When a BLS unit is available within a 20-minute response time, ALS should not be dispatched to Priority 3 incidents even if an ALS unit is closer, provided analgesia not anticipated
   4. A BLS ambulance may replace an ALS ambulance on Priority 2 and 3 incidents when on-scene MFRS have determined the patient is not in need of ALS care

B. ALS will be requested by BLS when the patient fails to meet the criteria for BLS transport (IB)

III. Use of BLS Ambulance for Response when ALS not Readily Available

A. An ALS response continues to be the standard for all Priority 1 and 2 EMS requests through 911 and other unscheduled out-of-hospital incidents.

B. Criteria: In the event that no ALS unit is available to respond (including in- and out-of-county mutual aid) to Priority 1 and 2 incidents or if the anticipated response time of an ALS unit exceeds the projected time interval for BLS response to hospital arrival, a BLS ambulance (when staffed by at least one KCMCA-authorized EMT-II) may be used to respond to the incident.

C. BLS Responsibilities
   1. Provide BLS care consistent with KCMCA protocols with a Level II EMT providing care in patient compartment

2. Determine if an ALS intercept is indicated considering patient acuity and transport time to the hospital. ALS intercept should only be considered if ALS arrival faster than ED delivery.
3. In the event of an unanticipated medical emergency warranting ALS care, request an ALS intercept or continue to destination hospital alerting them as to change in condition (whichever provides most timely access to ALS care) NOTE: Cardiac Arrests occurring while in transport to the hospital should be managed in a stationary ambulance supported by closest MFRs per KCMCA Protocols.
4. Provide verbal and written (using KCMCA EMS Field Notes) hand-off to hospital personnel
5. Document EMS encounter (including ALS component) per protocol
6. Complete an online KCMCA incident report detailing circumstances

IV. BLS Ambulance Response to Echo Level Calls

A. A BLS ambulance should be dual-dispatched with ALS to Echo Level incidents when likely closer than ALS ambulance, regardless of response times

B. BLS ambulance should return to service (including while on scene) whenever services no longer needed

V. Quality Improvement and Reporting Sentinel Events

A. All BLS responses occurring under this protocol will be reviewed by the EMS agency and reported weekly to KCMCA in a format acceptable to KCMCA.

B. Sentinel Event: Any BLS response under this emergency protocol to a Priority 1 or 2 incident without ALS or to a Priority 3 incident resulting in a need for ALS care, and/or any emergency transport to the hospital will be considered to be a sentinel event and must be reported to KCMCA by both the BLS personnel and by the agency (along with e-PCR) within 24 hours of the incident. EMS dispatch centers must document attempts / no availability of timely ALS resources for each occurrence under this protocol.

I. Purpose:

A. This protocol defines prerequisite and on-going requirements for prehospital provider privileges within the Region 5 Medical Control Authority Network (R5MCAN). The R5MCAN Prehospital Provider Passport (R5PPP) is designed to ensure consistent, high provider quality while supporting a unified and efficient approach to prehospital clinical care throughout the 9 counties of Region 5. Current participating counties within Region 5 include: Allegan, Barry, Berrien, Branch, Cass, Calhoun, Kalamazoo, St. Joseph, and Van Buren.

II. Ambulance Personnel Configuration Requirements:

A. Provider definitions are recognized in a consistent manner across the region though MCA's may allow for those provider levels defined in this protocol to function in different capacities based on local needs and provider availability. MCA's may select one or more options from the table below to indicate local requirements.

Allegan: (2)	**Barry: (1), (3)**	**Berrien: (1), (3)**	**Branch: (2)**	**Cass: (1), (3)**
Calhoun: (2)	**Kalamazoo: (2), (4)**	**St. Joseph: (1)**	**Van Buren: (2)**	

Option 1:	By selecting this option the MCA allows for Level I paramedics to operate with an EMT II for the purpose of responding to pre-hospital 911 emergency requests for service.
Option 2:	By selecting this option the MCA requires Level I paramedics to operate with another Level I paramedic or Level II paramedic (EPIC and CCP included) for the purpose of responding to pre-hospital 911 emergency requests for service.
Option 3:	By selecting this option the MCA allows for a BLS level ambulance comprised of two EMT II providers to respond to pre-hospital 911 emergency requests for service.
Option 4:	By selecting this option Pass-ported paramedics who work greater than **eight (8)** shifts per **quarter** in an MCA other than their initially sponsored MCA are required to have an interview with the local medical director.

III. General Requirements:

A. The R5PPP is an optional provision. Providers may remain credentialed in their local (home) MCA and are not required to become regionally credentialed.

B. All pre-hospital care providers must be employed by a MDHHS approved agency operating in one of the R5MCAN counties at the licensure level they will be operating at as a regionally credentialed provider.

C. Establishment or advancement of R5MCAN privileges may only be initiated through a letter of recommendation from the employing agency in concert with the approval of the local / home MCA.

D. Regionally credentialed providers must participate successfully in continuing education and evaluation, online training, and online communication as defined by the R5MCAN.

E. Pre-hospital care providers must remain in good standing with the R5MCAN Credentialing Requirements as well as in good standing in each of the 9 MCA's within the R5MCAN, meeting all

Pre-hospital Provider Passport

license, certification, competency, and training requirements as described in Appendix 1.

F. The R5MCAN does not recognize grace periods or pending status for any license or certification without written permission from an R5MCAN EMS Medical Director.

G. Paramedic I and II candidates are required to have an interview with an R5MCAN approved EMS Medical Director and/or his/her designee. This interview may be conducted either in-person or virtually utilizing approved patient care scenarios and scoring criteria as set forth by the R5MCAN

1. All paramedic interviews conducted after protocol implementation must be recorded and the recording made available to the approved R5MCAN EMS Medical Directors for their discretionary review.
2. If a paramedic fails to pass the standardized interview they may retain their local/home MCA credentials but will not be approved under the R5PPP until successful completion of the interview process.
3. Remedial interviews will be conducted with the same medical director if possible.

IV. Recognized Credentials and Specific Requirements:

A. Emergency Medical Technician (EMT) II

1. Description:
   a) An EMT II can function as the lead crew member of a BLS ambulance or a second crew member on an ALS ambulance.
2. Scope of Practice:
   a) Functions as a second provider on an ALS vehicle under the direction of a Paramedic.
3. Specific Requirements:
   a) Credentialing requirements as defined by Appendix 1.

B. Paramedic I:

1. Description:
   a) Paramedic I status is awarded to individuals who have completed the R5MCAN approved probationary paramedic program and have met all requirements as defined by R5MCAN Prehospital Provider Passport protocol.
2. Specific Requirements:
   a) Successful completion of the probationary paramedic program.
   b) Successful oral interview with an approved R5MCAN EMS Medical Director(s) or his/her designee.
   c) Credentialing requirements as defined by Appendix 1.

C. Paramedic II:

1. Description:
   a) The paramedic II is an experienced paramedic who has demonstrated the ability to function independently in critical situations.
2. Specific Requirements:
   a) Current paramedic I with a minimum one year of field experience.
   b) Special consideration for previous external experience or exceptional performance may be considered for accelerated status at the discretion of the R5MCAN EMS Medical Directors.
   c) Successful oral interview with an approved R5MCAN EMS Medical Director or her/his designee.
   d) Current licensure, certifications, and competencies as described in Table 1.

D. Enhanced Paramedic Inter-facility Care (EPIC)

1. Description:
   a) The provider with EPIC credentials may provide treatment and inter-facility transport of patients whose care exceeds the scope of practice for paramedic I and II.
2. Scope of Practice:
   a) The EPIC paramedic will function to the limits defined by the protocols within the county of origin for specialty care transports not to exceed those defined by the EPIC protocol as adopted by the MCA of origin of the transport.
3. Specific Requirements:
   a) Current paramedic II credentials.
   b) R5MCAN approved EPIC training course completion and current certification.
   c) Currently recognized EPIC training is based on protocols developed by the WMRMCC. Additional programs may be approved at the discretion of the R5MCAN.

E. Critical Care Paramedic (CCP):

1. Description:
   a) The provider with CCP credentials may provide treatment and inter-facility transport of patients whose care exceeds the scope of practice for paramedic I and II.
2. Scope of Practice:
   a) The CCP will function to the limits defined by the protocols within the county of origin for specialty care transports.
3. Specific Requirements:
   a) Current paramedic II credentials.
   b) R5MCAN approved CCP training course completion and current certification.
   c) Currently recognized critical care paramedic programs include University of Maryland Baltimore College (UMBC) and University of Iowa. Additional programs may be approved at the discretion of the R5MCAN.

V. Agency Responsibilities:

A. It is the exclusive responsibility of the employing agency to maintain records and ensure compliance with the R5MCAN Pre-hospital Provider Passport protocol for all credentialed employees.
B. An agency will provide evidence of compliance as requested by the R5MCAN within two business days of inquiry.
C. It is the exclusive responsibility of the agency to provide employees with the communication technologies required to participate with the R5MCAN.

V. Investigations and Disciplinary Action:

A. Participating MCA’s agree to report sentinel events involving R5PPP credentialed personnel to the R5MCAN PSRO.
B. Incidents occurring outside a provider’s local/home MCA may be jointly investigated by participants from both the home MCA and the MCA in which the event occurred.
C. If, after investigation, remedial or disciplinary action is warranted, this will be issued by the provider’s home MCA and reported to the R5MCAN PSRO.
D. If a regionally credentialed provider is subject to formal disciplinary action, demotion in standing or revocation of licensure, this action will apply and be enforced across the local /home MCA and the other participating counties of the R5MCAN.

VI. Implementation:

A. Paramedics currently operating in a participating MCA at the time this protocol is implemented may be grandfathered into R5PPP status at the joint agreement between the sponsoring EMS agency and the R5MCAN provided the EMT / Paramedic candidate(s) meet(s) the minimum standards described in Appendix 1. This provision includes a caveat that the provider must have successfully completed an in-person or virtual interview with an R5MCAN approved EMS Medical Director.

Appendix 1:

R5 Prehospital Provider Passport Requirements					
	EMT II	Paramedic I	Paramedic II	EPIC	CCP
Michigan License Requirement	EMT	EMT-Paramedic	EMT-Paramedic	EMT-Paramedic	EMT-Paramedic
ICS 100	Yes	Yes	Yes	Yes	Yes
ICS 200	Yes	Yes	Yes	Yes	Yes
ICS 700	Yes	Yes	Yes	Yes	Yes
MI-CIS Awareness		Yes	Yes	Yes	Yes
MI-CIS Operations 1		Yes	Yes	Yes	Yes
R5MCAN Protocol Test (annual requirement)	Yes	Yes	Yes	Yes	Yes
Basic Cardiac Life Support (BCLS)	Yes	Yes	Yes	Yes	Yes
Advanced Cardiac Life Support (ACLS)		Yes	Yes	Yes	Yes
Basic Disaster Life Support (BDLS)		Yes	Yes	Yes	Yes
ITLS or PHTLS Or other approved equivalent	Yes	Yes	Yes	Yes	Yes
PEPP, PALS, EPC (2yr renewal) or other approved equivalent	Yes	Yes	Yes	Yes	Yes
Patient Encounters	5 patient encounters as 3rd rider	75 Initially; +12 Per Quarter (ALS attending)**	250 Initially; +12 Per Quarter (ALS)**	250 Initially; +12 Per Quarter (ALS)**	400 Initially; +12 Per Quarter (ALS)**

* Consideration will be made for completion of equivalent CE coursework within same timeframe.
** May include calls performed at non-R5MCAN services

Kalamazoo County Medical Control Authority System Protocol

PREHOSPITAL CARE PROVIDER REINTEGRATION

Initial Date:5/19/23
Revision Date

8.17c

I. Purpose:

This protocol ensures that all providers who are separated from response capability due to illness, injury, FMLA, military service, or any other condition, have a smooth transition back to independent practice with competency commensurate with that of EMS system credentialed providers.

II. General Requirements

A. Providers must meet criteria, determined by the elapsed time the provider was separated from the Kalamazoo County Medical Control Authority (KCMCA), before being reinstated as a KCMCA credentialed EMT or Paramedic.
B. Providers in reintegration require supervised practice with a KCMCA Field Training Officer (FTO) and are only permitted to engage in patient care under the direct supervision of an FTO.
C. Providers will have documentation of their performance completed by the FTO using the KCMCA Bi Weekly Provider Evaluation.
D. During that time, the FTO is responsible for ensuring that the provider is competent in their role as a KCMCA EMS provider.
E. Providers engaging in patient care are responsible for demonstrating competency in skills, knowledge, and abilities detailed in the system protocols and procedures upon completion of the reintegration phase.
F. The FTO will make a recommendation to the ALS agency and KCMCA when the provider has demonstrated competency and is ready to return to independent duty.
G. For providers separated from employment for greater than one year, this policy will not apply. Providers separated from employment for greater than one year will be required to reenter the system through the standard KCMCA credentialing and training process.

III. Provider Responsibilities

A. 3 - 6 months of separation
   1. Complete all KCMCA Online Training Modules that were missed.
   2. Complete, at a minimum, 25 patient contacts within the KCMCA system, with an FTO.
   3. Medical Director Interview: At KCMCA discretion dependent on provider's level of EMS activity during separation. KCMCA, agency and

provider will attempt to obtain documentation from other EMS agencies as applicable.

4. Pass the applicable KCMCA Protocol test with a score of 85% or better.
5. Provide documentation of required certifications for credentialing level desired, as outlined in KCMCA Credentialing Protocol 8.17.

B. 6 - 12 months of separation

1. Complete all KCMCA Online Training Modules that were missed.
2. Complete, at a minimum, 50 patient contacts within the KCMCA system with an FTO.
6. Medical Director Interview: At KCMCA discretion dependent on provider's level of EMS activity during separation. KCMCA, agency and provider will attempt to obtain documentation from other EMS agencies as applicable.
3. Pass the applicable KCMCA Protocol test with a score of 85% or better.
4. Provide documentation of required certifications for credentialing level desired, as outlined in KCMCA Credentialing Protocol 8.17.

IV. Agency Responsibilities

1. The ALS agency will verify the provider's state license and official time separated from the KCMCA EMS system.
2. The ALS agency, in cooperation with KCMCA, will develop the provider's reintegration plan in accordance with this protocol, and meet with the provider to review and begin the reintegration process.
3. The ALS agency will advise KCMCA of start of reintegration period, and will advise KCMCA of FTO assigned to candidate.
4. The ALS agency will notify the provider when the reintegration plan is complete, only then is the provider cleared to function independently in the KCMCA system at the credentialing level assigned.

PREHOSPITAL CARE PROVIDER REINTEGRATION

Initial Date: 5/19/23
Revision Date:

8.17c

Length of Separation	Completion of Missed Online Learning Modules	Successful Completion of KCMCA Protocol Test	Minimum Number of Patient Contacts in KCMA With FTO
3 to 6 Months	YES	85% Passing Score	25
6 to 12 Months	YES	85% Passing Score	50

Requirements for Ambulance Services Requesting Medical Control

Initial Date: 10/21/21
Revised Date: 10/21/21 8.32

I. Purpose: This protocol is intended to describe the requirements and procedures for ambulance services desiring to operate within Kalamazoo County and requesting medical control from KCMCA. KCMCA has a compelling interest in assuring the highest quality emergency medical services for the citizens and visitors of Kalamazoo County.

II. Advanced Life Support Requirement: Only ambulance services licensed at the advanced life support level will be considered for medical control.

III. Emergency Service to Local Unit(s) of Government: Applications for medical control will only be considered from ambulance services who have secured a written contract for emergency (911) services with one or more local units of government within Kalamazoo County and upon the written request of such local units of government. Medical control will only be approved for geographical areas under contract to local units of government.

IV. National Accreditation Standards: It is KCMCA's expectation that all ambulance services will operate in accordance with the standards for national accreditation as established by the Commission on the Accreditation of Ambulance Services (CAAS) or other comparable accrediting organization accepted by KCMCA. In the event of suspension, revocation or lapse in accreditation, agency will immediately contact KCMCA in writing of accrediting body's action as well as written plan to redeem or maintain accreditation.

V. Application Process

A. Applicants must contact in writing KCMCA to express interest in conducting ambulance service operations within Kalamazoo County.
B. Applicant meets with KCMCA staff for overview of process and system orientation.
C. Applicant submits the following information to KCMCA:
   i. KCMCA EMS Agency Application
   ii. Comprehensive plan to meet CAAS (or other accrediting organization accepted by KCMCA) standards

iii. Comprehensive plan to meet KCMCA protocols iv. Supporting documentation

D. KCMCA staff reviews and investigates application.
E. KCMCA staff request additional information from applicant as needed
F. KCMCA staff conducts credentialing evaluations of proposed personnel to include written and oral protocol examinations and skill assessments in accordance with applicable KCMCA protocols
G. Application presented to KCMCA Board of Directors
H. Application approved or rejected by KCMCA Board of Directors
I. Applications rejected will be returned to applicant with explanation of basis for rejection of application
J. Applications approved for medical control will be endorsed by KCMCA Medical Director for Michigan licensing.
K. The applicant must submit to KCMCA a comprehensive, detailed plan describing how the applicant will meet these standards. Upon review, KCMCA may accept or reject such plan.
L. Applications from ambulance services licensed in Michigan will only be considered when the applicant (or parent organization) is accredited by CAAS or other comparable accrediting organization accepted by KCMCA. Formal accreditation must be extended to the Kalamazoo County area serviced by the ambulance service at the time the organization is next re-accredited.
M. Applicants not currently licensed in Michigan (or those who are not partly or wholly owned by a Michigan-licensed ambulance service) must be accredited by CAAS or other comparable accrediting organization accepted by KCMCA, within 18 months of beginning operations within Kalamazoo County. A single 12-month extension may be granted by KCMCA when delays in achieving accreditation are determined by KCMCA to be attributed to the accrediting organization.

VI. **Compliance with KCMCA Requirements:** The applicant must submit to KCMCA a comprehensive, detailed plan describing how the applicant will comply with all KCMCA protocols. Such plan must include provisions for the following:

A. Complying with Paramedic and EMT credentialing protocols

B. Complying with Emergency Medical Dispatching protocols
C. Complying with KCMCA Mandatory Equipment Lists
D. Complying with KCMCA Quality Improvement protocols

VII. ALS Agency Participation: ALS agencies seeking medical control from KCMCA will participate in meeting and activities associated with the following:

A. Kalamazoo County Medical Control Authority (KCMCA)
B. Region 5 Medical Control Authority Network (RMCAN)
C. Cardiac Arrest Registry for Enhanced Survival (CARES)
D. 5th District Medical Response Coalition (5DMRC)

VIII. Suspension of Requirements: KCMCA reserves the right to suspend these requirements when deemed in the best interest of public health and safety.

PREHOSPITAL CARE PROVIDER CREDENTIALING

Initial Date 4/17/2014
Revision Date 8.17

I. Purpose:

A. This policy defines prerequisite and on-going requirements for pre-hospital care provider privileges within Kalamazoo County.

II. General Requirements

A. All prehospital care providers must be employed by a KCMCA recognized agency in Kalamazoo County at the licensure level for which the provider will be functioning.
B. Establishment or advancement of KCMCA privileges may only be initiated through a letter of recommendation from the employing agency.
C. All EMT or higher licensed individuals must attend KCMCA system orientation at the first available session. All Paramedics entering the KCMCA system must attend county orientation prior to practicing paramedic level skills.
D. Credentialed EMT and paramedic providers must participate successfully in education and evaluation, online training, and online communication as defined by KCMCA.
E. Prehospital care providers must remain in good standing with KCMCA by meeting all license, certification, minimum competency, and training requirements (Table 1).
F. KCMCA does not recognize grace periods or pending status for any license or certification without written permission from the Medical Director.

III. Recognized Credentials and Specific Requirements

A. Medical First Responder (MFR)

1. Description:
   a) The MFR provides immediate response to medical emergencies or functions as a second crew member on a BLS ambulance.
2. Scope of Practice:
   a) The MFR provides Basic Life Support (BLS) care as defined by KCMCA State Protocols. The MFR may also aid ALS crews by providing additional assistance with care, or documentation.
3. Specific Requirements:
   a) Compliance as described in Table 1

B. Emergency Medical Technician (EMT) I

1. Description:
   a) An EMT I functions as a second crew member on a BLS ambulance.
2. Scope of Practice:
   a) Provides BLS care as defined by KCMCA protocols
3. Specific Requirements:
   a) Attend KCMCA system orientation
   b) Successful completion of skill competency assessment as defined by KCMCA.
   c) Credentialing requirements as defined by Table 1.

C. Emergency Medical Technician (EMT) II

1. Description:
   a) An EMT II can function as the lead crew member of a BLS ambulance or a second crew member on an ALS ambulance.
2. Scope of Practice:
   a) Provides BLS care as defined by KCMCA protocols care.
   b) Functions as a second provider on an ALS vehicle under the direction of a paramedic II or higher credentialed provider.
3. Specific Requirements:
   a) Attend KCMCA system orientation
   b) Successful completion of skill competency assessment as defined by KCMCA.
   c) Credentialing requirements as defined by Table 1

D. Probationary Paramedic

1. Description:
    a) The probationary paramedic is the initial entry point for any licensed Paramedic in the State of Michigan who wishes to practice within the KCMCA, and
    b) Enters into a KCMCA approved probationary paramedic program.
    c) Special consideration for previous experience or exceptional performance may be considered for accelerated probationary status at the discretion of the Medical Director.
2. Scope of Practice:
    a) While partnered with a Paramedic Field Instructor (PFI) the probationary paramedic functions within the parameters of the probationary paramedic program. The probationary paramedic may provide paramedic level care including attending to a patient as a single paramedic. The level of function of the probationary paramedic is at the discretion of the PFI.
    b) While partnered with a Paramedic II the probationary paramedic functions at the basic life support (BLS) level with allowable exceptions.
        (1) Should the Paramedic II be directly supervising activity, the probationary paramedic may perform IV and patient assessment skills.
3. Specific requirements:
    a) Successful completion of KCMCA system orientation and skill competency evaluation.
    b) Remain an active participant in good standing with the probationary paramedic program.
    c) Demonstrate pursuit of minimum county certifications for Paramedic I (see Table 1).
    d) Credentialing requirements as defined by Table 1.

E. Paramedic I

1. Description:
    a) Paramedic I status is awarded to individuals who have completed the KCMCA approved probationary paramedic program and have met all requirements as defined by KCMCA protocol.
2. Scope of Practice:
3. A paramedic I has full system privileges and may staff an ALS ambulance with someone of the same credential level or higher.
4. Specific Requirements:
    a) Successful completion of the probationary paramedic program.
    b) Successful oral interview with the Medical Director or his/her designee.
    c) Credentialing requirements as defined by Table 1.

F. Paramedic II

1. Description:
    a) The paramedic II is an experienced paramedic who has demonstrated the ability to function independently in critical situations.
2. Scope of Practice:
    a) The paramedic II may be partnered with an EMT II or higher credentialed individual in the KCMCA EMS system.
3. Specific Requirements:
    a) Current paramedic I with a minimum one year of field experience.
    b) Special consideration for previous experience or exceptional performance may be considered for accelerated status at the discretion of the Medical Director.
    c) Successful oral interview with the Medical Director or her/his designee
    d) Current licensure, certifications, and competencies as described in Table 1.

G. Paramedic Field Instructor (PFI)

1. Description:
   a) The PFI is an experienced paramedic II who has demonstrated the ability to function independently in critical situations and demonstrates the desire and ability to teach others.
2. Scope of Practice:
   a) The PFI functions with all privileges of a paramedic II.
   b) The PFI provides oversight to probationary paramedics as a function of a KCMCA approved probationary paramedic program.
3. Specific Requirements:
   a) Current Paramedic II with a minimum one year in position.
      (1) Special consideration for previous experience or exceptional performance may be considered for accelerated status at the discretion of the Medical Director.
   b) Successful oral interview for PFI status with the Medical Director or his/her designee
   c) Current licensure, certifications, and competencies as described in Table 1

H. Critical Care Paramedic (CCP)

1. Description:
   a) The provider with CCP credentials may provide treatment and inter-facility transport of patients whose care exceeds the scope of practice for paramedics.
2. Scope of Practice:
   a) The CCP will function to the limits defined by the protocols for specialty care transport.
3. Specific Requirements:
   a) Current paramedic II credentials.
   b) KCMCA approved CCP training course completion and current certification.

IV. Agency Responsibilities

A. It is the exclusive responsibility of the employing agency to maintain records and ensure compliance with the KCMCA credentialing protocol for all credentialed employees.

B. An agency will provide evidence of compliance as requested by KCMCA within two business days of inquiry.

C. It is the exclusive responsibility of the agency to provide employees with the communication technologies required to participate with KCMCA.

Table 1: Credential Requirements							
	MFR	EMT I	EMT II	Probationary paramedic	Paramedic I	Paramedic II	PFI
Michigan License Requirement	MFR	EMT	EMT	EMT-Paramedic	EMT-Paramedic	EMT-Paramedic	EMT-Paramedic
ICS 100	Yes	Yes	Yes	Yes	Yes	Yes	Yes
ICS 200	Yes	Yes	Yes	Yes	Yes	Yes	Yes
ICS 700	Yes	Yes	Yes	Yes	Yes	Yes	Yes
ICS 800							
Basic Cardiac Life Support (BCLS) (Healthcare Provider)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Basic Disaster Life Support (BDLS)				Yes	Yes	Yes	Yes
Approved terrorism awareness course					Yes	Yes	Yes
Advanced Cardiac Life Support (ACLS)					Yes	Yes	Yes
ITLS or PHTLS Or other approved equivalent			Yes*		Yes	Yes	Yes
PEPP, PALS, EPC (2yr renewal) or other approved equivalent			Yes*		Yes	Yes	Yes
Patient encounters			5 patient encounters as 3rd rider	10 patient encounters	75 Initially; +12 Per Quarter (ALS attending)**	250 Initially; +12 Per Quarter (ALS attending)**	400 Initially; +12 Per Quarter (ALS)
Successfully completes annual KCMCA competency testing			Yes	Yes	Yes	Yes	Yes
MI CIS Awareness					Yes	Yes	Yes
MI CIS Operations 1					Yes	Yes	Yes

* Consideration will be made for completion of equivalent CE coursework within same timeframe.
** May include calls performed at non-KCMCA services

Emergency Medical Services Dispatching & Response Protocol

Purpose:
The purpose of this protocol is to establish medical call processing procedures, assure optimal utilization of available resources, and provide a process for reporting call processing and response time targets within the Kalamazoo County Medical Control Authority.

Definitions:

ALS	Advanced Life Support
BLS	Basic Life Support
ECHO call	A call in which a patient is known to have ineffective breathing or is not breathing
EMD	Emergency Medical Dispatcher
EMS	Emergency Medical Services
KCMCA	Kalamazoo County Medical Control Authority
LALS	Limited Advanced Life Support
MCI	Multiple Casualty Incident
Med-Zero	A call received by the PSAP, which has a high probability for a life-threatening emergency
MFR	Medical First Responder
Priority 1	Real or potential life threatening emergency
Priority 2	Unknown or non-life threatening emergency
Priority 3	Non-life threatening emergency
PSAP	Public Safety Answering Point
RLS	Red Lights and Siren
Zone	Predefined response region

Overview:
Call processing procedures will result in the prioritization of a call. This prioritization is based upon a KCMCA-approved medical prioritization system. The prioritization will result in dispatching emergency medical response agencies as either Priority l, Priority 2, or Priority 3 as described below. Note that these are dispatch priorities: Emergency medical personnel should deliver appropriate patient care based upon their assessment of the situation once they arrive on scene.

The EMD is responsible for determining the initial response priority. The priority may be upgraded or downgraded as additional information becomes available. This process may be initiated by information obtained by the responding MFR agencies, however the final decision remains with the EMD. If the EMD changes the priority based on additional information, the EMD will notify the PSAP and the PSAP will then notify other responding MFR's.

MFR and KCMCA approved ALS agencies are encouraged to most appropriately utilize their resources in accordance with this protocol. Procedures outlined by this protocol are meant to enhance the EMS system, without reducing EMS resources

Unit Response Guidelines

A. Medical First Responder Response
    a. Priority 1
        i. Response required
        ii. Response mode: RLS permitted
    b. Priority 2
        i. Response required
        ii. Response mode: RLS permitted
            1. May be downgraded to non-RLS response when the responding ALS unit is closer
            2. If the ALS unit is responding RLS and diverted to another call, the MFR unit should be notified by radio and permitted to respond RLS
    c. Priority 3
        i. Response not required (pre-determined by agency)
        ii. Response mode: Non-RLS
        iii. May be asked to respond by EMD for assistance in certain situations
    d. Exclusions
        i. Licensed nursing homes (excluding cardiac or respiratory arrest)
        ii. Physicians' offices/medical centers within physician office (per protocol)
        iii. KCMCA exempted site having own MFR services (industrial, private business, etc.)
    e. Calls requiring staging
        i. Initial response mode (all priorities): non-RLS
        ii. Once cleared to enter a scene, if not at staged location, response mode should be in accordance with the determined priority of the call

B. Advanced Life Support
    a. Priority 1
        i. Response mode: RLS permitted
    b. Priority 2
        i. Response mode: non-RLS
            1. May upgrade to RLS response, if closer to the scene than the responding MFR unit
            2. If diverted to another call while responding RLS, the MFR unit responding non-RLS should be notified by radio and permitted to respond RLS.
    c. Priority 3
        i. Response mode: non-RLS
    d. Exclusions
        i. None
    e. Calls requiring staging
        i. Initial response mode (all priorities): non-RLS
        ii. Once cleared to enter a scene, if not at staged location, response mode should be in accordance with the determined priority of the call

C. Basic Life Support Response
    a. Priority 1 (If no ALS Response Available)
        i. Response mode: RLS permitted
    b. Priority 2 (If no ALS Response Available)
        i. Response mode: non-RLS

c. Priority 3
    i. Response mode: non-RLS
d. Exclusions
    i. None
e. Calls requiring staging
    i. Initial response mode (all priorities): non-RLS
    ii. Once cleared to enter a scene, if not at staged location, response mode should be in accordance with the determined priority of the call
f. See KCMCA Protocol 8.16 *Use of Basic Life Support Ambulances for 911 Response And Other EMS Response Incidents*.

Emergency Medical Call Processing Time Targets:

	Time Interval	Compliance
PSAP notified to time EMD notified	≤ 60 seconds	≥ 90%
EMD notified to time unit notified	≤ 120 seconds	≥ 90%
Unit notified to time PSAP notified*	≤ 15 seconds	≥ 90%

- PSAP notified – Time that PSAP picks up the call
- EMD notified – Time that EMD picks up the call
- Unit notified – Time that the EMD assigns a call to an ambulance
- *For calls initially received by EMD

Advanced Life Support Unit Response Time Targets:

	Zone 1*		**Zone 2***	
Priority	Time Interval	Compliance	Time Interval	Compliance
1	≤ 10:00	≥ 90%	≤ 14:00	≥ 90%
2	≤ 14:00	≥ 90%	≤ 16:00	≥ 90%
3	≤ 20:00	≥ 90%	≤ 20:00	≥ 90%

- The time the responding unit is notified will be used to evaluate the response time interval.
- The Advanced Life Support Unit response time target begins upon the time the unit is notified by the EMD.
- The Advanced Life Support Unit response time target ends upon arrival of the Advanced Life Support Unit to the physical address or staged location.
- * See Appendix A for additional detail of Zone 1 and Zone 2

Note:

- KCMCA emergency medical call processing and EMS agency response time targets are the minimal acceptable standards. Municipalities may elect to enter into a contract with KCMCA authorized EMS agencies to provide response times that are less than the KCMCA response time targets.

Call processing procedures:

1) Emergency medical calls received at a PSAP
   a) The PSAP telecommunicator should determine if the caller is in need of police, fire and/or EMS.
   b) If the call is determined to be an EMS call, the PSAP telecommunicator shall obtain and confirm the location of the call (address) and call back telephone number of the caller.
   c) Once the call location and callback telephone number are obtained, the PSAP should conference the call immediately with the EMD (goal within 60 seconds of answering the initial call)
   d) If the caller indicates any of the Med-Zero conditions, the appropriate MFR's shouldbe dispatched "Med-Zero." (See Appendix B)
      i) The PSAP telecommunicator should not ask any additional questions about the medical problem unless trying to determine scene safety or the need for additional equipment. Questions geared toward eliciting Med-Zero criteria should not be asked.
      ii) If a Med-Zero is assigned, the telecommunicator will state to the EMD, "This is [PSAP name] with [MFR agency name]. We have a Med-Zero on a [Chief complaint]."
   e) Upon conferencing, the telecommunicator will identify their PSAP to the EMD and the confirmed address and callback number, of which, the phone number confirmation should be deferred to the end of the call.
   f) The PSAP will stay on the line until a dispatch priority is announced.
   g) The PSAP will acknowledge the priority of the call. ThePSAP dispatcher will announce "PSAP off" when disconnecting from the call.
   h) The PSAP dispatcher will dispatch MFR's per the priority of the call.
      i) If advised of an ECHO level call, please see Appendix C.

2) Emergency medical calls received at an Emergency Medical Dispatch center:
   a) Prior to initiating priority dispatch protocols, the EMD shall obtain and confirm the address and call back telephone number of the caller.
   b) The EMD should prioritize all requests for EMS using KCMCA-approved medical priority dispatch protocols, including pre-arrival instructions.
   c) Prioritization, including address and phone number verification as well as ambulance notification should be completed within 120 seconds of answering the call.
   d) For Priority 1 and 2 calls, notify the appropriate PSAP within 15 seconds of the time the ambulance is notified.
      i) When an ECHO level call is identified, the EMD will announce this to the PSAP and follow the procedure outlined in Appendix C.

3) ALS Dispatch
   a) Dispatch the closest appropriate ALS unit.
      i) The dispatcher is responsible to assure that the ALS unit dispatched is likely to meet response time target.
      ii) In the event that the ALS Unit is unlikely to meet this target the dispatcher must seek mutual aid per procedure in Appendix D.
      iii) The dispatcher should continue to respond the initial ALS unit until the mutual aid agency verifies they have a closer available unit.
      iv) In the event that resource availability changes, the involved Emergency Medical Dispatch centers should coordinate the appropriate response.

4) Responding ALS Unit
   a) Acknowledge and repeat priority and location of the call to the EMD.

b) Notify the appropriate MFR agency on the appropriate communication channel of the following:
   i) ALS agency and unit identifier
   ii) Priority (emergency vs non-emergency)
   iii) Address
   iv) Responding from location

Reporting requirements

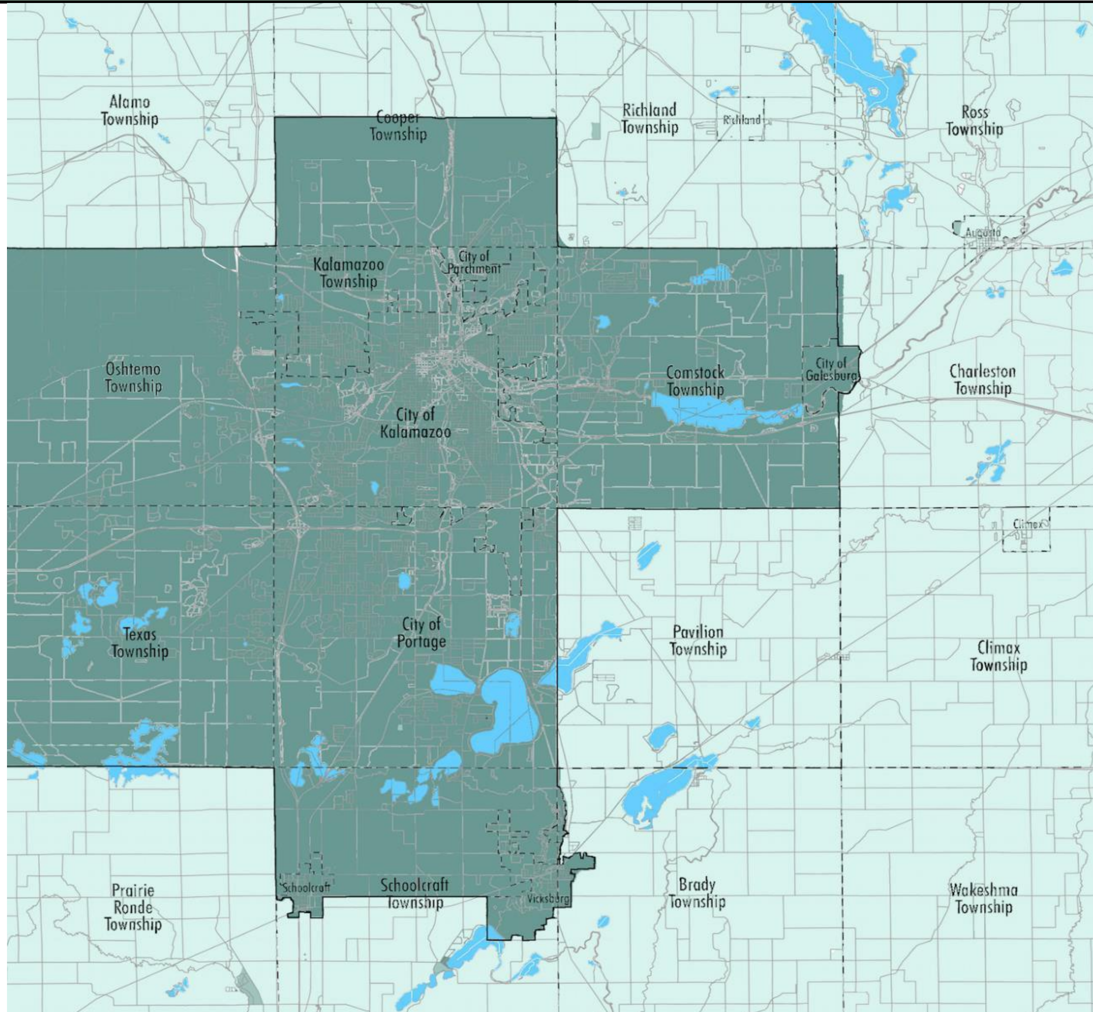
1. Reporting delayed responses
    a. The EMD center must complete an exception report in all cases where the response time exceeded established response time standards. This is to include the following:
        i. Location/status of responding ALS unit at time of dispatch
        ii. Route taken to scene
        iii. Time call received
        iv. Time call address determined
        v. Time unit was notified
        vi. Time ALS unit arrived
        vii. Response time interval
        viii. Notification time of second agency, if delayed response anticipated
        ix. Explanation of delayed response and prevention steps taken
    b. Response time exception reporting
        i. All response intervals that exceed the standards by ≥ 50% of the response time targets should notify KCMCA within 24 hours of occurrence. A root cause analysis should be submitted within 5 business days.
        ii. The responding agency will document the cause of all response time intervals that do not meet the standard. In conjunction with performance reports, the agency will report exceptions and corrective action. The agency may report aggregate data, trended with correction taken at the system level, or report as individual responses with corrective action taken case-by-case.
2. Mutual Aid Responses
    a. Fifteen days after the reporting period (determined by KCMCA), responding agencies should provide the following information when requesting mutual aid/transferring a call to another provider.
        i. Agency requesting mutual aid
            1. Call priority
            2. Time call prioritized
            3. Time mutual aid is requested
        ii. Agency providing mutual aid
            1. Time notified by agency requesting mutual aid
            2. Time unit notified
            3. Time ALS unit arrives to the physical address
3. When an ALS Unit is dispatched as a Priority 3 and meets Priority 1 transport criteria or presents as cardiac/respiratory arrest, that shall be a reported event and an exception report is required. A review of the call will be performed by KCMCA.
4. Acceptable exceptions: The responding agency may request that an exception be excused if that agency can adequately demonstrate that the cause of a missed response was beyond the reasonable scope of control, determined by KCMCA.

Performance Reporting Guidelines

1. Fifteen days after the reporting period (determined by KCMCA), provider agencies should provide a performance report, of the time interval(s), to the medical control authority. This report should contain the following:
   a. A summary, in two-minute intervals up to 20 minutes, for each category of response.
   b. A list of all Zone 1 and Zone 2 responses that includes date, time, municipality, received call time, unit notified time, on-scene time; sorted by priority and response interval (fastest to slowest).

Appendix A: Zone 1 & Zone 2

Zone 1	Zone 2
City of Galesburg	Alamo Township
City of Kalamazoo	Brady Township
City of Parchment	Charleston Township
City of Portage	Climax Township (and Village of Climax)
Comstock Township	Cooper Township (D Avenue and North)
Cooper Township (D Avenue and South)	Pavilion Township
Kalamazoo Township	Prairie Ronde Township
Oshtemo Township	Richland Township (and Village of Richland)
Schoolcraft Township (W Avenue and North)	Ross Township
Texas Township	Schoolcraft Township (W Avenue and South)
Village of Schoolcraft	Village of Augusta
Village of Vicksburg	Wakeshma Township



Appendix B: Med-Zero Criteria

I. Breathing problems/trouble breathing
II. Cardiac arrest
III. Eltrocution or lightning strike
IV. Serious Bleeding
V. Unconscious or not alert
VI. Seizure
VII. Traffic accidents with known or unknown injuries
VIII. Any situation that involves more than one patient
IX. Childbirth—when the baby is seen or is out
X. Entrapment of any type, when the patient is still entrapped
XI. Other conditions in which the probabability for life threatening emergency is high

Appendix C: Response to ECHO Calls

Purpose: To define the process for the assignment of resources when a request for service is received, which meets the criteria for ECHO level response.

1. Medical First Responder
    a. The MFR PSAP dispatcher, when notified by the EMD that the call is an ECHO level call, will assign the call to the MFR unit per standard protocol, if not already assigned.
    b. The MFR PSAP should alert other public safety resources in the immediate area for ECHO level calls.
    c. Municipalities are encouraged to expand the use of mutual aid resources in an effort to decrease the response time of MFR resources for ECHO level calls. Agencies are encouraged to broaden the current scope of agreements to manage the response of their assets and personnel in a manner consistent with the intent of this document
2. Advanced Life Support
    a. The EMD center, after dispatching the ALS unit, should poll other KCMCA approved agencies, for any response expected to exceed 5:00 minutes.
    b. If another KCMCA approved ALS unit is determined to be closer, the call will then be turned over to the closer agency.
3. Other Ambulance Resources
    a. The EMD center should consider non-KCMCA approved transport agencies to first respond to ECHO level calls.
    b. The EMD center should consider KCMCA approved BLS agencies to first respond to ECHO level calls.

Appendix D: Use of Mutual Aid

In the event that the provider does not have ALS Unit resources immediately available, that can reasonably be expected to meet the response time requirements, that provider must rapidly seek closer mutual aid through other KCMCA approved ALS Unit providers.

1. Upon receiving an emergency request for service, the initial agency should determine if they are able to meet the KCMCA approved response time interval.
   a. If an emergency unit is available at the initial agency, the dispatcher should continue to respond the ALS unit until the mutual aid agency verifies they have a closer available unit.
   b. For extended response times, the agency should consider Non-KCMCA approved ALS units.
2. In the event that the initial ALS agency is unable to meet the response target interval, a secondary ALS provider should be contacted at the time the initial agency is aware that they are unable to meet the KCMCA approved response time interval.
   a. Upon notification, the mutual aid agency's (KCMCA or Non-KCMCA) estimated time of arrival to the response location should be requested.
   b. If the mutual aid agency is unable to meet the time standards, the ALS agency that is closer to the call will be responsible for the call.
   c. In the event that resource availability changes, the affected EMD centers should coordinate the appropriate response.
   d. In the event that a non-KCMCA approved ALS unit is sent on an ALS call, a turnover report should be submitted by the initial agency.

I. Background and Guidelines

Medical Priority Dispatch call taking procedures include recommendations for various situations, but do not mandate the staging of EMS resources. EMS staging should be a collective and communicated decision between call-takers and responders based on situational analysis.

In consideration for the safety of EMS providers, the following guidelines for staging resources/sending law enforcement concurrently to the scene should be considered as EMS responders are dispatched:

1. As Emergency Medical Dispatch call taking protocols are followed, the suggestion to stage resources/solicit assistance from law enforcement should be considered, but does not mandate the staging of EMS resources.

2. In the judgment of call takers/responders, any sense during the call taking and dispatch process that there may exist a real or potential threat to responders on scene, EMS resources may stage.

3. If staging is determined by field providers or 911 call takers to be prudent, the *rationale* for "staging" resources should be communicated to responding units. Consider using terminology such as "recommend stage" followed by a reason such as "questionable information from caller."

4. EMS responses that call for "staging" should be non-emergent to the staging area until it has been determined that there is no need for staging and the priority of the call has been determined by the Emergency Medical Dispatcher.

II. EMS Staging "Triggers"

The following triggers should be **considered** for potential EMS resource staging: This consideration would be qualified by the type of responder, i.e., the licensed EMS resource being dispatched serves as a law enforcement agency or a fire department that would mitigate the incident (as appropriate).

- Known or suspected weapons involved or accessible on scene
- Incident is product of violence: Victim or other parties have been indicated as violent and are believed to still be on scene or will return to scene shortly
- Caller demonstrates hostility toward dispatcher/responders

The following **should not** be considered as situations that *mandate* staging:

- An intentional overdose without other indications of violent threat on scene
- Nursing home/long term care facility incident (Facility staff are present to assist and there is considered to be an extremely low probability of weapons with likelihood of injury to responders.)

- Attempted suicide without other evidence of threatening behavior (most attempted suicides)
- Violence against self (patient) and patient is unconscious

911 Call Takers, EMS Dispatchers and EMS responders have the latitude to make staging decisions based on caller information and a situational assessment upon responder arrival on scene, using experience and judgment. In consideration of the safety of all responders, dispatch personnel should take steps to afford law enforcement resources are dispatched immediately, if requested. This may require a request for mutual aid during times of high call volume.

Situations in which EMS was unnecessarily directed to stage or where staging may have been indicated but not recommended should be reported to KCMCA using the KCMCA incident report form

DEFINITIONS:

- R5MCAN: Region 5 Medical Control Authority Network
- EMS: Emergency Medical Service
- LOCAL: EMS agencies and hospitals that commonly work together as defined in appendix 7
- MCA: Medical Control Authority
- ALS: Advanced Life Support
- ADM: Automated Dispensing Machine (e.g. Pyxis® or Omnicell®)
- EMS Provider: An emergency medical technician (EMT) or paramedic
- Paramedic: An advanced provider of pre-hospital emergency medical care with formal training that includes, but is not limited to, human physiology, pharmacology and medication administration techniques.

LEGAL AUTHORITY:

This procedure has been developed in accordance with the State of Michigan EMS Protocols and, where delegated tasks and responsibilities are concerned, with section 333.16215 of the Michigan Public Health Code and R 338.490(5) of the Pharmacy – General Rules adopted by the Michigan Board of Pharmacy.

PURPOSE:

The R5MCAN EMS medication bag and controlled substance box regional exchange program is designed to improve the efficiency of the pre-hospital care system through the standardization of the EMS formulary of medications (type, quantity, and concentrations), simplification of the restocking procedures for perishable supplies, and the reduction of EMS personnel and pharmacy management time through the ability to re-stock at various transport destinations throughout Region 5. This procedure outlines the **participation, responsibilities, exchange procedures, accountability, and oversight** processes for the Region 5 EMS medication bags and controlled substance boxes. The procedure also provides guidance to ensure that the pharmacies receive all appropriate paperwork, thereby remaining compliant with applicable rules, regulations, policies and laws. All activities undertaken through the implementation of this procedure are to promote and ensure the universal ability for Region 5 EMS agencies to restock/exchange EMS medications at any participating hospital in the region. Despite procedural variance among the region's hospitals, a mechanism will be in place to allow for timely medication bag/box exchange for Region 5 EMS agencies including those not serving as primary EMS affiliates to hospitals.

PARTICIPATION:

1. This procedure applies to all hospital pharmacies, EMS agencies and MCAs participating in Region 5 as members of the Region 5 Medical Control Authority Network (R5MCAN).
2. Selection of the R5MCAN EMS Medication Bag and Controlled Substance Box Regional Exchange Program as a pick option in the MCA agreement will signify adoption of this procedure and will allow an MCA and its corresponding EMS agencies/pharmacies to enter into the medication bag exchange system.
3. Each participating EMS agency should have a replenishment agreement with the hospital(s) it plans to exchange with. See Appendix 2 for a sample agreement.
4. Each participating MCA must have a minimum of one identified representative and one alternate to serve on the R5MCAN EMS Medication Bag Oversight Committee. Each MCA is encouraged to have an EMS and a pharmacy representative on the Oversight Committee.
5. The R5MCAN EMS Medication Bag Oversight Committee will meet on a regularly scheduled basis to review incident reports / concerns, follow up on inquiries, evaluate system performance and evaluate process improvement opportunities.
6. A regional formulary, based on the State of Michigan EMS Protocols, will be used to stock the bags/boxes in a uniform configuration to ensure interoperability between Region 5 pharmacies and EMS agencies. See Appendix 3 for contents lists, including pictures, for R5MCAN medication bags and controlled substance boxes.

7. MCA's electing to participate in the R5MCAN EMS medication bag and controlled substance exchange program are required to approve this system protocol by checking the appropriate MCA box below and submitting the adopted protocol for approval with a formal effective date to the MDHHS along with a medical director signature on the corresponding physician signature page presented in appendix 12.

☒Allegan County MCA ☒Barry County MCA ☒Berrien County MCA
☒Branch County MCA ☒Calhoun County MCA ☒Cass County MCA
☒Kalamazoo County MCA ☒St. Joseph County MCA
☒Van Buren County MCA

RESPONSIBILITIES:

1. **MCA Responsibilities:**
   A. Participating MCAs will promote a relationship with local hospital pharmacies and EMS agencies ensuring communication pathways are in place to optimize system performance and accountability with regard to medication use and exchange.
   B. MCA physicians and staff agree to communicate changes in EMS medication bag/box formulary to system providers and pharmacists as changes are made by the R5MCAN EMS Medication Bag Oversight Committee.
   C. In collaboration with local EMS agencies and local pharmacies the MCA will ensure a process is in place to allow for EMS agency medication exchange.
   D. MCAs agreeing to participate in the EMS Medication Replacement and Exchange procedure must agree to enforce the provisions of this procedure.
   E. Each medical director or his/her designee at each participating MCA is responsible for ensuring MCA compliance with this procedure.

2. **Pharmacy Responsibilities:**
   A. Pharmacies will ensure a process is in place to restock and exchange EMS medication bags and controlled substance boxes.
   B. Pharmacies will ensure that EMS medication bags and controlled substance boxes are stocked in compliance with the regional medication formulary.
   C. Pharmacies will arrange for a secure environment for EMS medication bags and controlled substance boxes that are restocked and awaiting pickup or are used and have been dropped off for exchange.
   D. In collaboration with local EMS agencies and the local MCA, pharmacies may elect to have a process is in place that delegates limited re-stock of common use items within the EMS medication bags to paramedics who have received appropriate, documented training. At a minimum, a process for "full-bag" exchanges with local and regional EMS agencies will be in place at each participating hospital.
   E. Pharmacies may have a separate exchange process for local EMS agencies versus non-local regional EMS agencies.
      i. **Example:** A paramedic from a local EMS agency who has been granted access to the EMS Pyxis (or the designated, secured EMS restock cabinet) may perform limited paramedic re-stock when transporting to their local hospital(s). When transporting away from their local hospital(s) to another hospital in the region, the paramedic would do a full-bag (1 for 1) exchange.
   F. Pharmacies are required to routinely inspect EMS medication bag and EMS controlled substance box contents in compliance with the administrative rules of the Michigan board of pharmacy (R 338.486(4)(c)) and replace medications as necessary.
      i. Pharmacies are responsible for verifying that all pharmacy-stocked supplies and medications listed on the regional medication and equipment formulary are present and in-date upon stocking/restocking. See Appendix 4 for a sample pharmacy EMS bag restocking sign-off form.
      ii. Whenever possible, medications that are 60 days or less away from

expiration will be rotated out of the medication bags and controlled substance boxes.

iii. After restocking, controlled substance boxes and the pharmacy-stocked compartments of the medication bags will be secured by pharmacy, utilizing numbered green tamper-resistant locks.

iv. In instances where the medication bag comes to pharmacy for restocking, pharmacy staff will *also* verify that all EMS agency stocked medications listed on the regional medication formulary are present and in-date. That pouch will then be sealed with a green lock with the item name and expiration date of the next item to expire in the compartment written on it.

v. Each EMS medication bag and controlled substance box shall have a label indicating the bag/box number, stocking hospital/pharmacy that filled it, fill date, next medication to expire, date of expiration, and the name or initials of the individuals that filled/checked it.

G. Medication bag and controlled substance box contents remain the property of the participating pharmacies.

H. The Pharmacist in charge at each participating hospital is responsible for assuring compliance with this procedure.

3. **EMS Agency Responsibilities:**

A. Paramedics are responsible for turning in used medication bags and/or controlled substance boxes in a serviceable condition free from trash, contaminated waste and any potential sharps. Unsecured sharps and biohazard materials left in / on bags may result in disciplinary action by the agency.

B. Paramedics will complete the appropriate documentation for medications/supplies used.

C. Paramedics will use the numbered red seal provided in the medication bag or controlled substance box to secure and tag a used/expired bag/box, alerting the pharmacy that attention to the bag/box is needed.

D. EMS agencies are responsible for cleaning bags that become soiled or contaminated. In the event that a bag needs to be decontaminated or cleaned, an EMS agency may contact its local hospital pharmacy to arrange for securement of medications and to sign out a temporary replacement bag for use during the cleaning process.

E. In collaboration with local pharmacies and their local MCA, EMS agencies will have the option to establish a process for limited paramedic re-stock of common use items within the EMS medication bags. At a minimum, a process for “full-bag” exchanges will be in place at participating region 5 hospitals.

F. EMS agencies, in collaboration with the R5MCAN EMS Medication Bag Oversight Committee, will ensure paramedics receive documented training in the procedure for limited paramedic restocking and appropriate alternatives in case of omission/error in restocking before being delegated the authority to perform limited paramedic restock.

G. EMS agencies will provide an end user agreement (Appendix 5) to the appropriate hospital pharmacy representative at each hospital granting access for each paramedic who will have access to an ADM or locked cabinet for the purpose of medication bag and controlled substance box exchange.

H. EMS agencies are responsible daily for ensuring that all medication bags and boxes in their possession are current, without expired medications, and have appropriate seals and labels in place. Expired medications will be exchanged with the local hospital pharmacy.

I. EMS agencies are accountable for the security of the bags / containers and the contents therein issued to their control by the participating pharmacies.

J. EMS agencies are responsible for maintaining a chain of custody for EMS controlled substance boxes, including a procedure for documenting a dual sign off at least every 24 hours using the R5MCAN EMS Agency Controlled Substances Box Log Sheet (see Appendix 6) or an acceptable equivalent that has been approved by the R5MCAN EMS medication bag oversight committee.

K. EMS agencies that do **not** have a one-to-one controlled substance box-to-truck assignment process will maintain a locked cabinet or safe in a fixed location. The cabinet will require TWO access means/keys and TWO State of Michigan Licensed EMS providers one of whom must be a paramedic to be present simultaneously for access.
L. All applicable sign in/out documents (agency/hospital) must be fully completed for both bags and controlled substance boxes being issued/returned.
M. The participating EMS agency director/manager or his/her designee is responsible for assuring compliance with this procedure.

Issuance of R5MCAN EMS Medication Bags and Controlled Substance Boxes

1. R5MCAN EMS medication bags will be uniquely numbered in a permanent fashion, both inside and outside, using the format 5D-YY-###. Controlled substance boxes will also be uniquely numbered in a permanent fashion using the format 5D-YY-###, and will be configured in such a way as to permit a visual inspection of the contents without opening the box.
2. Each medication bag and controlled substance box will have a restocking label prominently affixed to the outside of the bag/box, following the format below.

REGION 5 MEDICAL CONTROL AUTHORITY NETWORK
HOSPITAL NAME AND PHARMACY PHONE # PRE-PRINTED
FILL DATE: ____________ TECH/RPH: _____________
GREEN LOCK #: _____________ RED LOCK #: _____________
NEXT TO EXPIRE: _____________ EXP DATE: _____________
BAG/BOX #: _____________

3. Refer to Appendix 3 for contents lists for R5MCAN medication bags and controlled substance boxes.
4. Any supplemental regional medication kits (such as the “TXA Kit”) must be individually labeled. Contents of these kits may be detailed in Appendix 3 or included as an additional appendix.
5. The R5MCAN EMS Medication Bag Oversight Committee will assign each EMS agency a number of bags and boxes consistent with their number of licensed ALS vehicles.
6. The R5MCAN EMS Medication Bag Oversight Committee will assign each participating hospital pharmacy a number of bags and boxes consistent with their expected volume of exchanges.
7. Additional bags and/or boxes will be issued to EMS agencies at the discretion of the local EMS Medical Director or his/her designee.
8. For special events requiring additional ALS vehicles or EMS staff to be in service, EMS agencies may contact their local hospital pharmacy to arrange to sign-out additional medication bags and/or controlled substance boxes temporarily.

EXCHANGE PROCEDURES:

1. EMS Medication Bags

A. R5MCAN EMS medication bags contain the following pockets:
   i. Blue pocket – IV supplies, restocked by paramedic / EMS provider.
   ii. Green pocket – Frequently used medications and supplies, paramedic or pharmacy restocked depending on facility/agency agreement and paramedic qualifications.
   iii. Black (main) pocket – Medications restocked by pharmacy
   iv. Red pocket – Sharps container
   v. Yellow pocket – Controlled substance box restocked by pharmacy
B. Refer to the R5MCAN EMS Medication Bag and Controlled Substance Box Exchange Matrix (Appendix 7) for exchange procedures specific to each participating hospital. Hospitals without 24 hour on-site pharmacy services may have procedures for “after

hours" that differ from those during normal business hours.

C. Paramedics must fill out the R5MCAN EMS Medication Bag Refill Form (Appendix 8) for any medications or supplies used from the black or green compartments when turning in the bag for restocking by pharmacy. The R5MCAN EMS Medication Bag Refill Form should be placed in the used bag after completion.

D. When paramedic stocked compartments of the EMS medication bag are opened in the course of patient care, paramedics may restock those compartments following hospital-specific procedures with the following stipulations.

   i. Paramedics must have successfully completed the R5MCAN limited paramedic restock training module before being granted ADM or medication cabinet access (if available).
   ii. The hospital is one of the EMS agencies local hospital(s) as defined in appendix 7 and must allow limited paramedic restock.
   iii. Paramedics are responsible for verifying that all paramedic stocked supplies and medications listed on the regional medication and equipment formulary are present and in-date upon stocking.
   iv. Paramedic stocked compartments must be secured by a white lock with the identifier of the EMS agency, the name or initials of the paramedic restocking the compartment, and the name and expiration date of the next item to expire in the compartment written on it.

E. When the pharmacy stocked compartment of the EMS medication bag is opened in the course of patient care, paramedics are to exchange the medication bag itself for another bag at the destination hospital.

   i. When turning in a used medication bag, the paramedic must ensure trash, contaminated waste and any potential sharps have been removed from the bag and then seal the pharmacy stocked compartment with the included red tag.
   ii. The paramedics must remove the LOCKED controlled substance box, sharps box, and IV kit from the open bag, moving those items to the new medication bag obtained from the destination hospital.
   iii. If the bag exchange is occurring at a hospital in the region that is NOT the agency's "local" hospital, or one without a provision for paramedic restock, a full bag exchange will be done. In those cases, any used compartments will be sealed with a red tag and the paramedic will remove the LOCKED controlled substance box, sharps box, and IV kit from the open bag, moving those items to the new medication bag obtained from the destination hospital.

2. EMS Controlled Substance Boxes

A. Refer to the Regional EMS Medication Bag and Controlled Substance Box Exchange Matrix (Appendix 7) for exchange procedures specific to each participating hospital. Hospitals without 24 hour on-site pharmacy services may have procedures for "after hours" that differ from those during normal business hours.

B. EMS ALS units should only operate with a confirmed LOCKED controlled substance box on board. Under NO circumstances will an open box go into service.

C. Paramedics exchanging controlled substance boxes must be in uniform and have a valid picture ID (either a driver's license or agency/regionally issued ID).

D. When a controlled substance box is used, the R5MCAN Controlled Substances Documentation Form (Appendix 9) must be completely filled out prior to exchanging the box.

   i. Any medication waste and/or disposal of empty vials must be witnessed and cosigned on the controlled substances documentation form by a registered nurse, pharmacist, or physician.

E. A copy of the **EMS patient care record (PCR) or 5th District EMS Field Notes (appendix 1)** must be placed in the controlled substance box being turned in.

   i. The PCR/5th District EMS Field Note serve as a record of the prescription for the administration of medications given to a patient as prescribed in protocol or by

medical control.

ii. PCR/5th District EMS Field Note must list the date of service, EMS agency run number, medication(s) administered, any wasted medication(s), name of the paramedic administering the medication and the corresponding controlled substances box number.
iii. PCR/ePCR/5th District EMS Field Note must include the wasted medication type, amounts, and volumes in addition to the narcotics box number and broken green tag number.

F. When turning in a used controlled substance box, the paramedic must ensure trash, empty vials, contaminated waste and any potential sharps have been removed from the box and then seal it with the pharmacy-included, numbered red lock. The red lock number must match the one written on the box's label.
G. Upon receiving a used box from an EMS service, pharmacy staff will check to assure that it is properly sealed with a red tag and includes a fully completed R5MCAN Controlled Substances Documentation Form and EMS PCR/5th District EMS Field Note. The submitted documentation will be checked by the pharmacist against the remaining contents of the box to assure accountability, with deficiencies reported as described in the next section.
H. Pharmacies must carefully document paramedic narcotic utilization and restocking of controlled substance boxes. See Appendix 10 for a sample documentation log. PCRs/Field Notes, R5MCAN Controlled Substances Documentation Forms, and restocking logs must be saved for five years.
I. Restocked controlled substance boxes must be secured by the pharmacist with a numbered green lock. Prior to taking a new controlled substance box, the paramedic must ensure that the box is properly secured/stocked, drugs are inaccessible, and that the green lock number matches the one written on the box's label.

ACOUNTABILITY:

1. Incident Reporting

A. Controlled substance boxes that appear damaged from routine use / normal wear and tear must be reported to the R5MCAN EMS medication bag oversight committee via the R5MCAN on-line occurrence form and the box must be taken to the EMS agency's local hospital pharmacy for change out.
B. Discrepancies found on pharmacy inspection of the medication bags should be reported to the Oversight Committee via the R5MCAN on-line occurrence form.
C. Any suspected system diversion of controlled substances including but not limited to a missing controlled substance box, missing controlled substance vials in a box, evidence of tampering with controlled substance vials (including missing caps or vial breakage), or evidence of suspicious damage to / tampering with a controlled substance box, will immediately be reported to Kalamazoo County Medcom at **(269)-226-3366** .
    i. Kalamazoo County Medcom will notify the on-call R5MCAN EMS medication bag oversight committee member.
    ii. The R5MCAN EMS medication bag oversight committee member will immediately notify the local MCA medical director, EMS agency manager / director, and the appropriate hospital pharmacy.
    iii. The R5MCAN EMS medication bag oversight committee member will assist local level entities in the coordination of a timely formal investigation. Law enforcement investigation will be included as needed.
    iv. Report of missing controlled substances will be made to the State of Michigan Board of Pharmacy and to the U.S. Drug Enforcement Agency by the pharmacy in accordance with State and Federal laws and regulations.
    v. Pharmacies may, based on hospital policies, test patients that have received pre-hospital narcotics.
D. Local Medical Control Authorities in cooperation with pharmacies may require that EMS controlled substances be tested prior to waste at any time.
E. Suggestions for process improvement should be forwarded to the R5MCAN EMS

Medication Bag Oversight Committee.

2. **EMS Medication Bag and Controlled Substance Box Audits:**
   A. All EMS medication bags and controlled substance boxes used in the regional exchange program must be accounted for on a monthly basis. On the first Tuesday of each month, each EMS agency, MCA or pharmacy having EMS medication bags or controlled substance boxes must perform an accounting of medication bags and controlled substance boxes between 6AM and 9AM and then log the bag or box numbers into the R5MCAN on-line audit form prior to noon that same day.

APPENDICES:

1. 5DMRC Field Note
2. SAMPLE DOCUMENT ONLY--R5MCAN EMS Agency Replenishing Agreement
3. R5MCAN EMS Medication Bag Contents List with Images
4. Sample R5MCAN Pharmacy EMS Bag Restocking Sign-off Form
5. R5MCAN Medication Bag and Controlled Substances Regional Exchange Program End User Agreement
6. Sample R5MCAN EMS Agency Controlled Substances Log Sheet
7. R5MCAN EMS Medication Bag and Controlled Substance Box Exchange Matrix
8. R5MCAN EMS Medication Bag Refill Form
9. R5MCAN Controlled Substances Documentation Form
10. Sample Hospital Controlled Substance Box Restocking Log
11. Sample R5MCAN EMS Medication Bag Exchange Log
12. R5MCAN Medical Director Signature Page

Appendix 1

5th District EMS Field Note

5th District EMS Field Notes MFR/AMB. Run # ________ / ________

Date __________ Incident Location ______________________

MFR Agency ______________ Amb.Svc./Unit ______________

Destination ______________ Med. Control ______________ Time ___ : ___

Patient Name ______________________ Age/Sex ____ [] M [] F

Address ______________________ DOB ___ / ___ / ___

City/State/Zip Code ______________ Phone ( ) ________

Med/Surg Hx ______________________

[]None []Asthma []Cancer []Cardiac []CHF []COPD []CVA []Diabetes []ETOH []HTN []Renal []Seizures

Meds ______________________

[]None [] ASA []Lasix []Lipitor []Lisinopril []Metformin []Norvasc []Synthroid []Vicodin []Warfarin []Zocor

Allergies ______________________

[]NKDA []PCN []Sulfa [] Keflex []Codiene []Morphine []Demerol []Vicodin []ASA []Motrin []Latex []Tape

IV: Time ___ : ___ Location ________ Size ____ ga. Att. ____ Rate ________

VITALS					
Time	P	R	B/P	SpO2	BLG

MEDICATIONS/PROCEDURES		
Time	Med/Proc	Amt/Size

Notes ______________________

______________________ Hospital Personnel Name/Signature

______________________ EMT/Paramedic Name/Signature

Appendix 2
SAMPLE R5MCAN EMS Agency Replenishing Agreement
(Agreement between EMS Agencies and local/primary pharmacy)

EMS Agency Replenishing Agreement

Date:____________________

EMS Agency Name:_________________________	Hospital Name:______________________________
EMS Agency Address:________________________	Hospital Address:____________________________
EMS Agency Manager:________________________	Hospital Representative:_______________________
EMS Agency Manager Phone Number:___________	Hospital Representative Phone #:________________
EMS Agency Manager Email:__________________	Hosp. Representative Email:____________________

Please accept this letter as a formal contract for __________________________________, a State of Michigan licensed hospital herein identified for the purposes of this contract ("**Contract**") as "**Hospital**", to provide to ____, a State of Michigan licensed emergency medical services (EMS) provider herein identified for the purposes of this Contract as the "**EMS Agency**", medications, medical supplies, and other items (collectively, the "**Supplies**") necessary for the care and transport of patients.

1. **Replenishment of Supplies**. **Hospital** agrees to provide Supplies to EMS Agency on a "replenishment" basis, to replace EMS Agency's medications, medical supplies, and other agreed upon items used in the transport of a patient by EMS Agency to a Hospital facility. To request the replenishment of non-pharmaceutical Supplies, EMS Agency will provide a report to the Hospital as requested detailing the specific type and amount of Supplies used on the transported patient and requested for replenishment. With respect to pharmaceutical Supplies, EMS Agency will complete a Pharmacy Requisition Form, requesting only those pharmaceutical items used in the transport of a patient and necessary for replenishment. EMS Agency shall present the Pharmacy Requisition Form to Hospital's Pharmacy Department for fulfillment. Hospital will make reasonable efforts to promptly provide the requested Supplies; however Hospital makes no guarantee regarding the availability of any particular Supplies.

2. **Purchase Price; Payment**. Hospital will provide Pharmaceutical Supplies to an ambulance provider at no charge. Hospital will charge flat service fees on each EMS bag replenished based on recommendations by the Region 5 Medical Control Authority Network (R5MCAN) and will be invoiced on a regular agreed upon frequency. Payment is due within thirty (30) days of the date of the invoice. The parties represent that the purchase price for the Supplies is the fair market value for such Supplies and that this Contract does not take into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made under any state or federal health care program.

3. **Record Keeping**. The parties mutually agree to maintain records detailing the type, and amount, of Supplies used as well as the patient transport to which the purchase of Supplies related ("**Records**"). The parties agree to maintain the Records for a period of at least five (5) years from the date the Records were created. Each party further agrees to provide copies of the Records to the other party within **48 hours** of a written request. The parties shall promptly make

the Records available to the Secretary of the Department of Health and Human Services upon request.

4. **Patient Billing**. The parties agree that EMS Agency shall have the sole right to bill patients, insurance providers, and/or state or federal health care programs for use of the Supplies. EMS Agency agrees to issue all bills for the Supplies in compliance with applicable state and federal health care program payment and coverage rules and regulations.

5. **Representations and Warranties**. EMS Agency represents and warrants that (i) it has all necessary licenses and/or permits to use the Supplies; (ii) it will use all Supplies in accordance with the manufacturer's instructions or in the manner specified by direct medical control oversight; (iii) it will use all Supplies in accordance with all local, state, and federal laws and regulations; (iii) all reports, records, and documents, in whatever form or format, provided to Hospital will be true and complete; and (iv) it will only request the Supplies necessary to replenish items used in the transport of a patient to Hospital's facility. Hospital expressly disclaims all warranties, express or implied, with respect to the Supplies, including the warranty of fitness for a particular purpose. Hospital makes no representations regarding the quality or safety of the Supplies and disclaims all liability for the Supplies and EMS Agency's use of the Supplies.

6. **Insurance**. EMS Agency will obtain and maintain insurance, at its own cost and expense, during the term of this Contract in coverage amounts no less than $1,000,000 per occurrence and $3,000,000 annual aggregate, naming Hospital as an additional insured, and covering, at a minimum, (a) general liability; (b) professional liability; (c) workers' compensation with statutory limits; and (d) any other coverage reasonably necessary to protect EMS Agency and Hospital, as well as their theirs agents and employees from any claims arising from its obligations under this Contract. EMS Agency agrees to provide certificates of insurance, evidencing required insurance coverage, upon execution of this Contract.

7. **Indemnification**. Each party agrees to indemnify, hold harmless and defend the other and its affiliates, officers, directors, agents and employees from and against any claims, damages, liabilities, expenses, or losses (including attorneys' fees) arising from the performance or breach of this Contract by the indemnifying party or the acts or omissions of the indemnifying party or its employees or agents; provided that neither party shall assume any liability for any act or omission of the other party or its employees or agents. EMS Agency will indemnify, hold harmless and defend Hospital and its affiliates, officers, directors, agents and employees from and against any third party claims, damages, liabilities, judgments (including related attorneys' fees) arising from EMS Agency's use or misuse of the Supplies. The parties expressly agree that Hospital's liability under this Contract shall be limited to the total amount paid by EMS Agency to Hospital for Supplies.

8. **Independent Contractor**. Nothing in this Contract is intended to create an employer/employee relationship or a joint venture relationship between the parties.

9. **Corporate Compliance**. Through the implementation of this Contract, each party acknowledges the commitment to legal compliance and agrees to conduct all transactions which occur pursuant to this Contract in accordance with all applicable federal, state and local laws and regulations. Any material violations of applicable law will be considered a breach of this Contract. By signing this Contract, EMS Agency represents and warrants that neither it nor any of its employees is, or has been, excluded from participation in any federally and/or state funded health care programs, including but not limited to Medicare, Medicaid, and CHAMPUS. EMS Agency agrees to promptly notify Hospital of any proposed or actual exclusion, of it or any of its employees, from any federally and/or state funded health care program.

10. **No Exclusivity**. Each party acknowledges that no representation, inducement or condition not set forth herein has been made or relied upon by either party, and that the Contract will in no way be construed or interpreted to be an exclusive arrangement between Hospital and EMS Agency.

11. **Confidentiality**. EMS Agency agrees not to disclose to third parties any nonpublic or proprietary information regarding Hospital or its business, operations, plans, strategies or patients, including the existence and terms of this Contract, or to use such information itself for any purpose other than performing this Contract, without Hospital's prior written approval. Except as otherwise expressly provided in this Section, Hospital and EMS Agency hereby mutually covenant and agree (i) to keep the terms of this Contract, including the pricing (collectively, the "**Confidential Information**"), strictly confidential, and (ii) not to disclose the Confidential Information to any third party. Hospital and EMS Agency may disclose the Confidential Information to any entity with which they are affiliated, in the usual and customary operation of business, including, but not limited to, disclosure to third party auditors and attorneys. In addition, the foregoing confidentiality obligation shall not apply to information that is required to be disclosed by law; provided, however, that the receiving party so required to disclose shall first notify the disclosing party to enable it to seek relief from such requirement, and render reasonable assistance requested by the disclosing party in connection therewith. This Section and the confidentiality obligations contained herein shall survive the expiration or earlier termination of this Contract.

12. **HIPAA**. EMS Agency agrees to comply with the health information privacy provisions of the Health Insurance Portability and Accountability Act of 1996 and all regulations thereunder ("**HIPAA**"), as well as all policies, procedures and practices of the Hospital relating to HIPAA privacy, confidentiality and security of patients' health information. EMS Agency further acknowledges and agrees that from time to time HIPAA may require modification of this Contract for compliance purposes. Each party will cooperate with, and assist, the other party to ensure full compliance with HIPAA with regard to this Contract. EMS Agency agrees to execute a HIPAA Business Associate Agreement or similar agreement upon request by Hospital.

13. **Access to Records**. The parties agree to treat this Contract as falling under Section 1861(v)(1)(I) of the Social Security Act and the regulations issued at 42 C.F.R. Part 420, and to make available to the Comptroller General of the United States, the Department of Health and Human Services ("**HHS**") and their authorized representatives, for a period of five (5) years after the latest furnishing of Supplies under this Contract, access to the books, documents and the records, and such other information as may be required by the Comptroller General or the Secretary of HHS to verify the nature and extent of the cost for Supplies provided by EMS Agency.

14. **Term/Termination**. The term of this Contract will commence on the date this Letter is fully executed by the parties and shall continue for a term of one (1) year. This Contract shall automatically renew for successive one (1) year terms, unless terminated earlier. Either party may terminate this Contract at any time, by thirty (30) days' prior written notice. In addition, this Contract may be terminated immediately by Hospital if Hospital determines in its sole discretion that EMS Agency has violated a state or federal law or regulation, or that this Contract no longer complies with state or federal laws or regulations. EMS Agency shall have continued liability upon termination for the amounts accrued and owing under the Contract as of the termination date.

15. **Governing Law**. The terms and conditions of this Contract shall be governed, construed, interpreted and enforced in accordance with the domestic laws of the state of Michigan, excluding choice of law principles. No waiver by either party of any right or remedy under this Contract, or

delay in the exercise thereof, will constitute a waiver of any other right or remedy.

16. **Assignment**. EMS Agency will not assign this Contract or delegate any duties without prior written consent of Hospital. Hospital may assign this Contract to any of its subsidiaries.

17. **Arbitration**. **Hospital** may, at its exclusive option, require that any controversy or claim arises out of or relating to this Contract be settled by binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association by one arbitrator appointed in accordance with said rules. Any controversy or claim will be arbitrated on an individual basis and will not be consolidated in any arbitration with any claim or controversy of any other party. The parties specifically instruct the arbitrator to consider rulings, orders, and awards (either interim, interlocutory, partial or final) of equitable relief, including directing specific performance or issuing an injunction, particularly if an award of money damages alone would not sufficiently compensate the claiming party. Judgment on the arbitrator's award may be entered in any state or federal court having subject matter jurisdiction and located in the Western District of Michigan, and the parties hereby irrevocably consent to the jurisdiction of such courts for the purpose of enforcing any such award. The arbitrator will allocate in the final award all costs incurred in conducting the arbitration in accordance with what the arbitrator deems just and equitable under the circumstances provided that each party will pay for and bear the cost and expense of its own experts, evidence, and legal counsel.

18. **Survival**. Contract terms and rights under the Sections of this Contract titled Representations and Warranties, Insurance, Indemnification, Confidentiality and Arbitration will survive any termination or expiration of this Contract.

19. **Use of Hospital's Name**. EMS Agency will not use the names, trademarks, service marks or logos of Hospital or any of its affiliates in any written materials, including without limitation, press releases, advertisements, websites or other promotional materials, without Hospital's prior written consent.

20. **Entire Agreement**. This Contract constitutes the entire agreement between the parties with respect to its subject matter and supersedes any prior oral or written agreements concerning same. This Contract may be modified only by a writing executed by both parties. The Contract may be executed in two or more counterparts (including by means of faxed or e-mailed signature pages), each of which will be deemed an original, and all of which together will constitute one and the same instrument. Photocopies, facsimile transmissions and other reproductions of this executed original (with reproduced signatures) will be deemed original counterparts of this Contract. Electronic signatures and electronically transmitted documents are binding.

Appendix 2
SAMPLE R5MCAN EMS Agency Replenishing Agreement
(Agreement between EMS Agencies and local/primary pharmacy)

Please execute this Contract and return a copy to ____________________________ via email, sent to:_
______________________________________ Any notice to the above mentioned hospital under this Contract must also be provided to this email address.

AGREED AND ACCEPTED:

EMS AGENCY Representative	**HOSPITAL Representative**
By: ______________________ (Signature)	By: ______________________ (Signature)
______________________ (Type or Print Name)	______________________ (Type or Print Name)
Its: ______________________ (Type or Print Title)	Its: ______________________ (Type or Print Title)
Date: ______________________	Date: ______________________

EXHIBIT A

PHARMACY REQUISITION FORM

ATTACHED

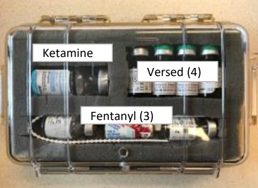
Appendix 3

R5MCAN EMS Medication Bag Contents List

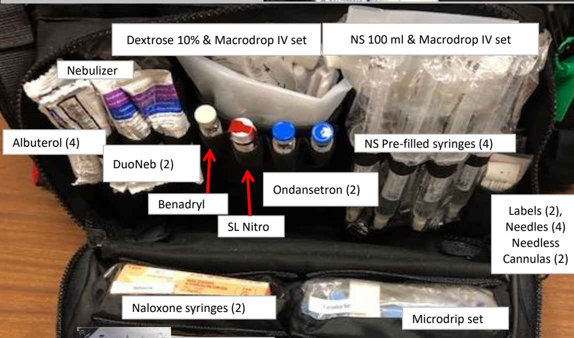
TXA - KIT - Hospital Stock

PAR	Medication / Item	Description
1	TXA	1g/10mL vial
1	Inclusion/Exclusion Card	
1	Medication Added Label	
Controlled Substance Box - Hospital Stock		
3	Fentanyl	100mcg/2ml vial
4	Midazolam	5mg/1ml vial
1	Ketamine	500mg/5ml vial
1	Red Tag	Used to seal used box
Green Pocket MEDICATIONS - Medic Stock		
3	Acetaminophen + oral syringes	160mg/5ml
3	Acetaminophen	325mg tab
4	Albuterol	2.5mg/3ml
8	Aspirin	81mg blister pack tab
1	Dextrose 10%	250ml w/ Macro set
1	Diphenhydramine	50mg/1ml vial
2	Duoneb (Albuterol/Ipratroprium)	0.5mg/3ml
3	Ibuprofen Liquid	100mg/5ml
3	Ibuprofen	200mg tab
1	Ketorolac (Toradol)	15mg/1ml vial
1	Methylprednisolone	125mg/2ml vial
2	Naloxone	2mg/2ml pre-fill
2	Naloxone	4mg nasal spray
1	Nitroglycerin	0.4mg (25 count bottle)
2	Ondansetron Vial	4mg/2ml vial
2	Ondansetron ODT	4mg single dose
1	Prednisone	50mg oral tablet
2	Sodium Chloride 0.9%	100ml w/ 1 Macro set
Green Pocket EQUIPMENT - Medic Stock		
2	Medication Cannula - Needleless	
1	Microdrip IV set	60gtts/ml
1	Nebulizer	
2	Needles 18/19ga	1.5" Safety
2	Needles 22/23ga	1.5" Safety
2	Piggyback Labels	Colored
2	Syringe	1ml
2	Syringe	3ml
2	Syringe	5ml
2	Syringe	10ml
2	Syringe	20ml
4	Sodium Chloride 0.9%	10ml Pre-fill

Controlled Substance Box LAYOUT



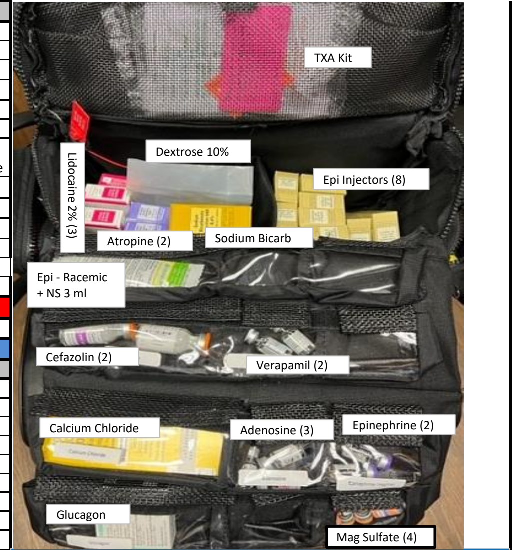
Green Pocket Interior Folded LAYOUT



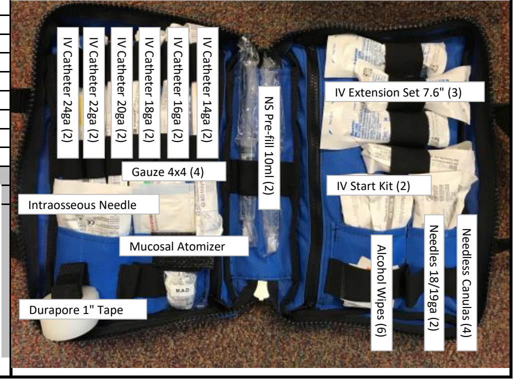
Main Compartment - Hospital Stock

PAR	Medication	Description
3	Adenosine	6mg/2ml vial
2	Atropine	1mg/10ml pre-fill
1	Calcium Chloride 10%	1g/10ml pre-fill
1	Dextrose 10%	250ml bag
2	Epinephrine	1mg/1ml vial
8	Epinephrine	1mg/10ml pre-fill
1 ea	Epinephrine - Racemic 2.25% + NS 3mL ampule	0.5ml ampule + 3 mL ampule
1	Glucagon	1mg vial w/ 1ml sterile H2O
3	Lidocaine 2%	100mg/5ml pre-fill
4	Magnesium Sulfate	1g/2ml vial
1	Sodium Bicarbonate 8.4%	50mEq/50ml pre-fill
2	Verapamil	5 mg/2ml vial
2	Cefazolin	1g powder vial
Red Pocket - Medic Stock		
1	Sharps Container	1.4Quart
Blue Pocket (IV Kit) EQUIPMENT - Medic Stock		
PAR	**Item**	**Description**
6	Alcohol wipes	
4	Gauze	4x4
1	Intraosseous needle	EZ IO / Jamshidi
2	IV Catheter 14ga	1&1/4"
2	IV Catheter 16ga	1&1/4"
2	IV Catheter 18ga	
2	IV Catheter 20ga	
2	IV Catheter 22ga	
2	IV Catheter 24ga	
2	IV Extension set	33" with 4-way stopcock
3	IV Extension set	7.6"
2	IV Start Kit	W/ Chlorhexidine 2% prep
1	Macrodrip IV set	10 or 15gtts/ml
4	Medication Cannula - Needleless	
1	Microdrip IV set	60gtts/ml
1	Mucosal Atomizer Device	LMA MAD300
2	Sodium Chloride 0.9%	10ml Pre-Fill
2	Sodium Chloride 0.9%	500ml bag
1	Tape (Durapore / Transpore)	1"

Main Compartment LAYOUT



IV Kit LAYOUT



EMS Medication Bag Restocking Sign-Off Sheet

Date: _______________

Bag Number: ______________

Green Lock Number (Main compartment): _________________

Green Lock Number (Frequently used compartment): _________________

Technician: ________________ Pharmacist: _________________

EMS Medication Bag Main (Black) Compartment

Medication/Supply Item	Quantity	Refill	Earliest Exp. Date (Min of 1 month)
TXA Kit (see label for contents)	1		
Red lock	1		N/A
Sodium Bicarb 50mEq/50mL syringe	1		
Dextrose 10% 250mL	1		
Atropine 1 mg/10 mL syringe	2		
Lidocaine 2% 100mg/5mL syringe	3		
Epinephrine 1mg/10mL syringe	8		
Racemic epinephrine 2.25% 0.5mL vial + Sodium chloride 0.9% 3mL vial for nebs	1 of each		
Cefazolin 1g vial	2		
Verapamil 5mg/2mL vial	2		
Calcium chloride 1 gm/10 mL syringe	1		
Adenosine 6mg/2mL vial	3		
Epinephrine 1mg/1mL vial	2		
Glucagon 1mg vial w/1mL sterile water	1		
Magnesium sulfate 1g/2mL vial	4		

EMS Medication Bag Restocking Sign-Off Sheet

EMS Medication Bag Frequently Used (Green) Compartment

Medication/Supply Item	Quantity	Refill	Earliest Exp. Date (Min of 1 month)
Albuterol 2.5mg/3mL	4		
Duoneb (albuterol/ipratropium) 3mL	2		
Nebulizer (Ref # 0210)	1		N/A
Dextrose 10% 250mL & primary IV tubing set	1 ea.		
NS 100mL (2) & primary IV tubing set (1)	2/1		
Diphenhydramine 50mg/1mL	1		
Nitroglycerin 0.4mg (25 count bottle)	1		
Ondansetron 4mg/2mL vial	2		
Sodium chloride 0.9% 10mL syringe	4		
Medication cannula - needleless	2		
Needles 18/19ga 1.5” safety	2		
Needles 22/23ga 1.5” safety	2		
Medication Added labels	2		N/A
Naloxone 2mg/2mL syringe	2		
Naloxone 4mg nasal spray	2		
Microdrip IV set 60gtts/mL (Item # 2C8548)	1		N/A
Acetaminophen 160mg/5mL (+ 2 oral 12mL syringes, capped and individually bagged)	3		
Ketorolac 15mg/1mL vial	1		
Ondansetron ODT 4mg single dose	2		
Prednisone 50mg tablet	1		
Methylprednisolone 125mg/2mL	1		
Acetaminophen 325mg tab	3		
Ibuprofen liquid 100mg/5mL	3		
Ibuprofen 200mg tablet	3		
Aspirin 81mg blister pack tab	8		
Syringe 1mL	2		
Syringe 3mL	2		
Syringe 5mL	2		
Syringe 10mL	2		
Syringe 20mL	2		

Appendix 5
Paramedic Certification of Training for Drug Bag/Box Exchange

_____________________________ **(EMS agency)** certifies that ________________________ **(Paramedic)** has completed the formal training required for participation in the R5MCAN medication bag and controlled substance box regional exchange program. By signing this agreement the aforementioned parties acknowledge the importance of maintaining correct and proper levels of pre-hospital supplies and medications as prescribed by the R5MCAN. Further, both parties agree to maintain bag integrity, ensure medication expiration compliance, and participate with ongoing medication bag / controlled substance box audits as necessary to ensure end user accountability and overall program success. The above listed parties agree to document and report any issues related to the medication exchange program or those affecting the delivery of patient care to their local medical control authority and the R5MCAN medication exchange program oversight board in a timely manner. The above listed EMS agency agrees to inform the appropriate pharmacy representative at any hospital who has received this agreement if the above listed paramedic no longer meets the regional medication bag and controlled substances exchange program criteria or is no longer employed with the agency.

EMS Agency Name:________________________________

Paramedic Name:__________________________________

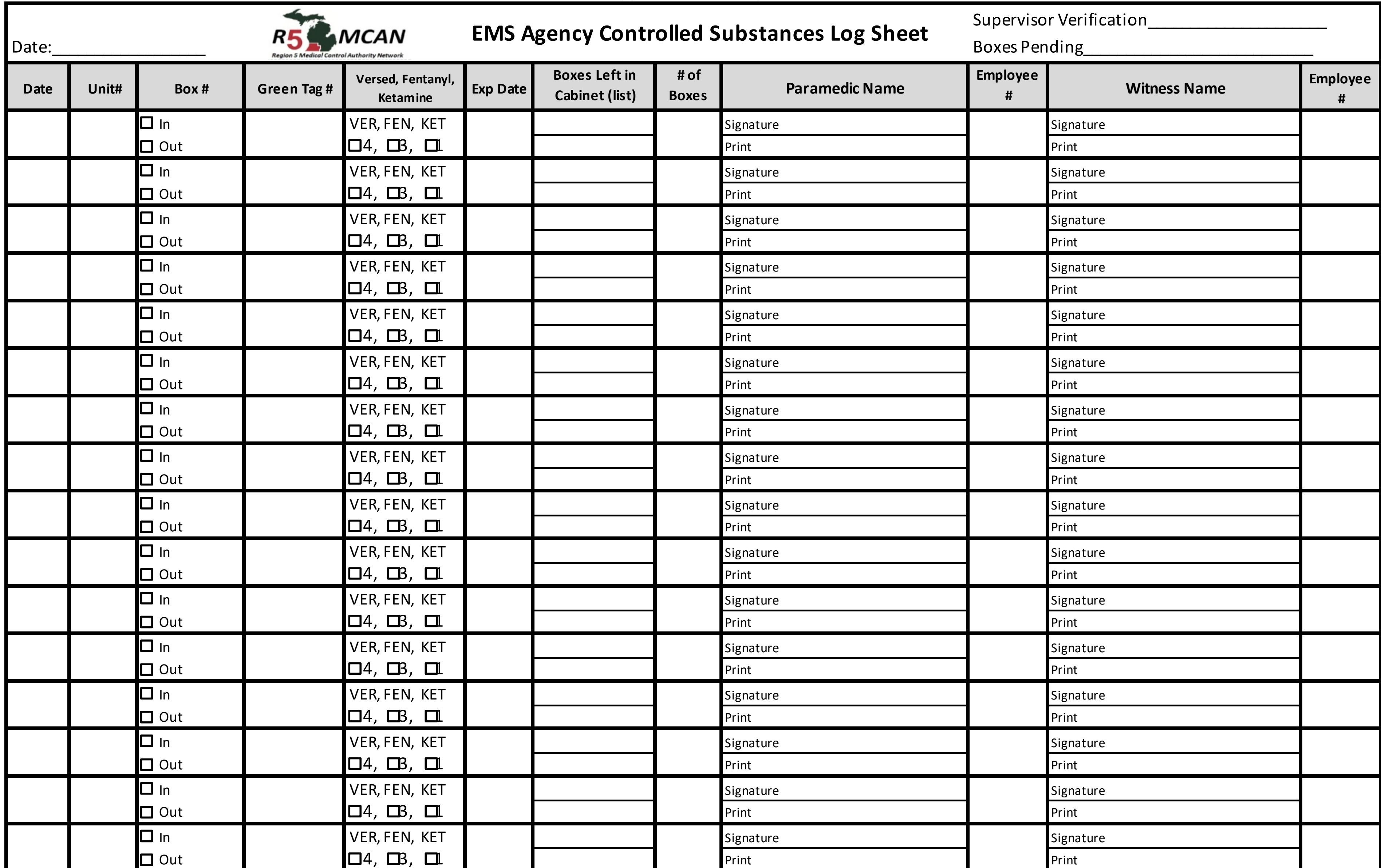
Paramedic Signature:_______________________________ **Date:____________**

Supervisor Name:_________________________________

Supervisor Signature:_______________________________ **Date:__________**

Appendix 6
EMS Agency Controlled Substance Accountability Log

Appendix 6 - Sample



Date:________________

R5 MCAN
Region 5 Medical Control Authority Network

EMS Agency Controlled Substances Log Sheet

Supervisor Verification____________________

Boxes Pending_________________________

Date	Unit#	Box #	Green Tag #	Versed, Fentanyl, Ketamine	Exp Date	Boxes Left in Cabinet (list)	# of Boxes	Paramedic Name	Employee #	Witness Name	Employee #
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	
		☐ In ☐ Out		VER, FEN, KET ☐4, ☐3, ☐1				Signature Print		Signature Print	

Rev. 2-2018

Appendix 7
EMS Medication Bag and Controlled Substance Exchange Matrix

Hospital	Inpatient Pharmacy Hours	Used Bags Taken/Left Where?	New Bags Obtained From Where?	Medic Self-Stock Allowed?	Approved "Local" EMS Agency(ies)	Medic Self-Stock Items Obtained From Where? (Or N/A)	Used Narcotic Boxes Taken/Left Where?	New Narcotic Boxes Obtained From Where?
Allegan General Hospital	M-F: 0700-1900 SAT: 0800-1800 SUN/HOL: 0800-1600	See ED RN for exchange bag clipboard, use padlocks to lock used bags & leave in dirty utility closet.	Locked closet next to security office/ED entrance (key on exchange bag clipboard)	No	Wayland EMS Life EMS AMR Plainwell EMS	N/A	Ortho ADM (see pharmacy staff or house supervisor @ night shift)	Ortho ADM
Borgess Lee	M-F: 0700-1800 WE/H: 0800-1200	ED RN (locked med room)	ED RN (locked med room)	No	N/A	N/A	ED ADM (RN obtains)	ED ADM (RN obtains)
Borgess Medical Center	24/7	EMS ADM (flip sign to "used")	EMS ADM	Yes	Wayland EMS Plainwell EMS Life EMS LifeCare SCEMS PrideCare	EMS ADM	EMS ADM	EMS ADM
Borgess PIPP	0800 - 1630	EMS ADM	EMS ADM	Yes		EMS ADM	EMS ADM	EMS ADM
Bronson Battle Creek	24/7	EMS Pyxis	EMS ADM	Yes	LifeCare	EMS ADM	Inpatient Pharmacy	Inpatient Pharmacy
Bronson Lakeview	M-F: 0730-1700 WE/H: 0730-1200	Locked cabinet in ED	ED ADM (VBEMS access, others RN access)	No	VBEMS Life EMS PrideCare	N/A	EMS bag, which is then placed in the locked cabinet in ED	EMS bag, which is then placed in the locked cabinet in ED
Bronson Methodist	24/7	ED Pharmacist Workstation	EMS ADM	Yes	Life EMS PrideCare SCEMS	EMS ADM	EMS ADM	EMS ADM
Bronson South Haven	M-F: 0730-1700 WE/H: 0800-1200	EMS ADM	EMS ADM	No	SHAES PrideCare Van Buren Covert	N/A	EMS ADM	EMS ADM

M-F = Monday-Friday WE/H = Weekends and Holidays ADM = Automated Dispensing Machine (Pyxis, Omnicell, etc.)

Appendix 7
EMS Medication Bag and Controlled Substance Exchange Matrix

Hospital	Inpatient Pharmacy Hours	Used Bags Left Where?	New Bags Obtained From Where?	Medic Self-Stock Allowed?	Approved "Local" EMS Agency(ies)	Medic Self-Stock Items Obtained From Where? (Or N/A)	Used Narcotic Boxes Taken Where?	New Narcotic Boxes Obtained From Where?
Promedica Coldwater Regional Hospital	M-F: 0600-2200 WE/H: 0730-2000	Locked cabinet in ED (Medic obtains key from ADM)	Locked cabinet in ED (Medic obtains key from ADM)	No	LifeCare	N/A	ED ADM	ED ADM
Lakeland Niles	0700 to 1900	EMS ADM	EMS ADM	Yes	Medic 1 PrideCare SMCAS	EMS ADM	Inpatient pharmacy (if open), otherwise with RN from ED ADM	
Lakeland St. Joseph	24/7	Inpatient Pharmacy	Inpatient Pharmacy	Yes	Medic 1 PrideCare SMCAS	EMS ADM	Inpatient Pharmacy	Inpatient Pharmacy
Lakeland Watervliet	0730 to 1600	Locked cabinet in ED	Locked cabinet in ED	Yes	Medic 1 PrideCare SMCAS	EMS ADM	ED ADM (with RN)	ED ADM (with RN)
Oaklawn	24/7	Inpatient Pharmacy	Inpatient Pharmacy	No	N/A	N/A	Inpatient Pharmacy	Inpatient Pharmacy
Spectrum-Pennock Hospital	M-F: 0630-2300 WE/H: 0730-1600	Inpatient Pharmacy during open hours, **NO EXCHANGE** after hours		No	N/A	N/A	Inpatient Pharmacy during open hours, **NO EXCHANGE** after hours	
Sturgis	M-F: 0730-1600	Locked cabinet in ED (Medic obtains key from ADM)	Locked cabinet in ED (Medic obtains key from ADM)	Yes	LifeCare	Locked cabinet in ED (Medic obtains key from ADM)	ED ADM (with RN)	ED ADM (with RN)
Three Rivers	M-F: 0600-1800 WE/H: 0700-1700	Locked area outside of the ED (inform Pharmacy)	Locked area outside of the ED	Yes	LifeCare SCEMS Three Rivers FD	ED ADM	ED ADM	ED ADM

M-F = Monday-Friday WE/H = Weekends and Holidays ADM = Automated Dispensing Machine (Pyxis, Omnicell, etc.)

PLUE Sticker

Appendix 8

EMS MEDICATION BAG REFILL FORM

Date: ________ Incident #: __________ EMS Bag Number: ______________ EMS Agency: ________________

Unit #:________ Paramedic Name (print):_________________________ Paramedic Employee #:____________

EMS Medication Bag Main (Black) Compartment (Stocked by Pharmacy)

Paramedic to secure the compartment with the enclosed **RED** lock **before** turning in the bag.

Quantity Used (Quantity Stocked):

____ (3) Adenosine 6mg/2mL vials

____ (2) Atropine 1 mg/10 mL syringes

____ (1) Calcium chloride 10% 1 gm/10 mL syringe

____ (2) Cefazolin 1g vials

____ (2) Epinephrine 1:1000 1mg/1mL vials

____ (8) Epinephrine 1mg/10mL syringes

____ (1) Glucagon 1mg vial w/1mL sterile wáter

____ (3) Lidocaine 2% 100mg/5mL syringes

____ (1) Dextrose 10% 250mL bag

____ (4) Magnesium sulfate 1g/2mL vials

____ (1) Racemic epinephrine 2.25% 0.5mL vial w/
(1) Sodium chloride 0.9% 3mL vial for nebulization

____ (1) Sodium Bicarb 8.4% 50mEq/50mL syringe

____ (1) TXA Kit

____ (2) Verapamil 5mg/2mL vials

EMS Medication Bag Green Compartment (Stocked by Paramedic)

Paramedic to confirm all supplies and medications are present and in date, then secure the compartment with a **WHITE** lock containing the EMS agency name, paramedic initials, and next expiring medication date written **LEGIBLY**.

Quantity Used (Quantity Stocked):

_____ (3) Acetaminophen 160mg/5mL+ (2) oral syringes

_____ (3) Acetaminophen 325mg tabs

_____ (4) Albuterol 2.5mg/3mL

_____ (2) Albuterol/ipratropium (Duoneb) 3mL

_____ (1) Nebulizer

_____ (8) Aspirin 81mg blister pack tabs

_____ (1) Dextrose 10% 250mL w/10gtts set

_____ (1) Diphenhydramine 50mg/1mL

_____ (3) Ibuprofen liquid 100mg/5mL

_____ (3) Ibuprofen 200mg tablets

_____ (1) Ketorolac 15mg/1mL vial

_____ (1) Methylprednisolone 125mg/2mL

_____ (2) Naloxone 2mg/2mL syringes

_____ (2) Naloxone 4 mg nasal sprays

_____ (1) Nitroglycerin 0.4mg (25 count bottle)

_____ (2) Ondansetron 4mg ODTs

_____ (2) Ondansetron 4mg/2mL vials

_____ (1) Prednisone 50 mg tablet

_____ (4) Sodium chloride 0.9% 10mL syringe

_____ (2) Sodium chloride 0.9% 100mL w/ (1)10gtts set

_____ (2) Medication cannulas - needleless

_____ (1) Microdrip IV set 60gtts/mL

_____ (2) Needles 18/19ga 1.5” safety

_____ (2) Needles 22/23ga 1.5” safety

_____ (2) Medication Added colored labels

_____ (2) Syringe 1mL

_____ (2) Syringe 3mL

_____ (2) Syringe 5mL

_____ (2) Syringe 10mL

_____ (2) Syringe 20mL

Completed form must be legible and accurate!

Appendix 9

R5MCAN Controlled Substances Documentation Form

Controlled Substances Documentation Form

Date:_________ Patient Name:__________________________ Green Lock #:_________________

EMS Agency: _________ Unit:___ Incident #:__________ Red Lock #:____________________

Description	Expiration Date(s)*	Amount Administered	Amount Wasted	Paramedic Name/Signature	Name/Signature of Wasting Witness
Ketamine 500mg/10ml (1)					
Midazolam 5mg/1 ml (4)					
Fentanyl 100mcg/2ml (3)					

***Paramedic to confirm integrity of, and document expiration dates for, all unused vials.**

NOTE: All controlled medication use and wastage must include documentation of a witness, which may be an RN, physician, or a pharmacist.

Controlled Substances Documentation Form

Date:_________ Patient Name:__________________________ Green Lock #:_________________

EMS Agency: _________ Unit:___ Incident #:__________ Red Lock #:____________________

Description	Expiration Date(s)	Amount Administered	Amount Wasted	Paramedic Name/Signature	Name/Signature of Wasting Witness
Ketamine 500mg/10ml (1)					
Midazolam 5mg/1 ml (4)					
Fentanyl 100mcg/2ml (3)					

***Paramedic to confirm integrity of, and document expiration dates for, all unused vials.**

NOTE: All controlled medication use and wastage must include documentation of a witness, which may be an RN, physician, or a pharmacist.

Controlled Substances Documentation Form

Date:_________ Patient Name:__________________________ Green Lock #:_________________

EMS Agency: _________ Unit:___ Incident #:__________ Red Lock #:____________________

Description	Expiration Date(s)	Amount Administered	Amount Wasted	Paramedic Name/Signature	Name/Signature of Wasting Witness
Ketamine 500mg/10ml (1)					
Midazolam 5mg/1 ml (4)					
Fentanyl 100mcg/2ml (3)					

***Paramedic to confirm integrity of, and document expiration dates for, all unused vials.**

NOTE: All controlled medication use and wastage must include documentation of a witness, which may be an RN, physician, or a pharmacist.

Appendix 10

Sample Hospital Controlled Substance Box Restocking Documentation Log

Date of Use	Used Box #	Versed 5mg/1mL Used	Fentanyl 100mcg/2mL Used	Ketamine 500mg/10mL Used	EMS Agency	Red Tag #	New Green Tag #	New Red Tag #	Technician/ Pharmacist Initials
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Appendix 11

Sample R5MCAN EMS Medication Bag Exchange Log

EMS Medication Bag Exchange Log (full used-new bag, one for one exchange)

Date/time	Drug Bag # **In**	Drug Bag # **Out**	Agency/Unit #	PRINTED name	Signature