Kalamazoo County Retained Protocols (2023)

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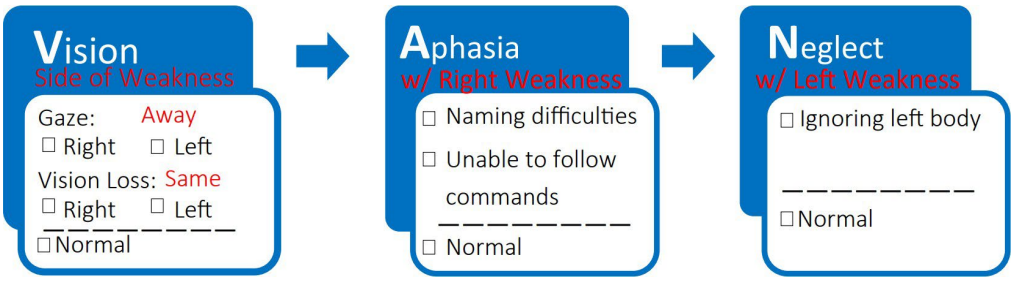
Stroke or Suspected Stroke

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.)

Region 5 Medical Control Authority Network
Special Operations Protocol

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.

Hostile MCI

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

KALAMAZOO COUNTY MEDICAL CONTROL AUTHORITY (KCMCA)
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

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

KALAMAZOO COUNTY MEDICAL CONTROL AUTHORITY

PREHOSPITAL EMS SYSTEM OPERATIONAL Requirements

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.

Kalamazoo County Medical Control Authority System Protocol

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

Initial Date Date: February 17, 2022
Revision Date:

Section 8-30 (S)

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 Dispatchcenter:
   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

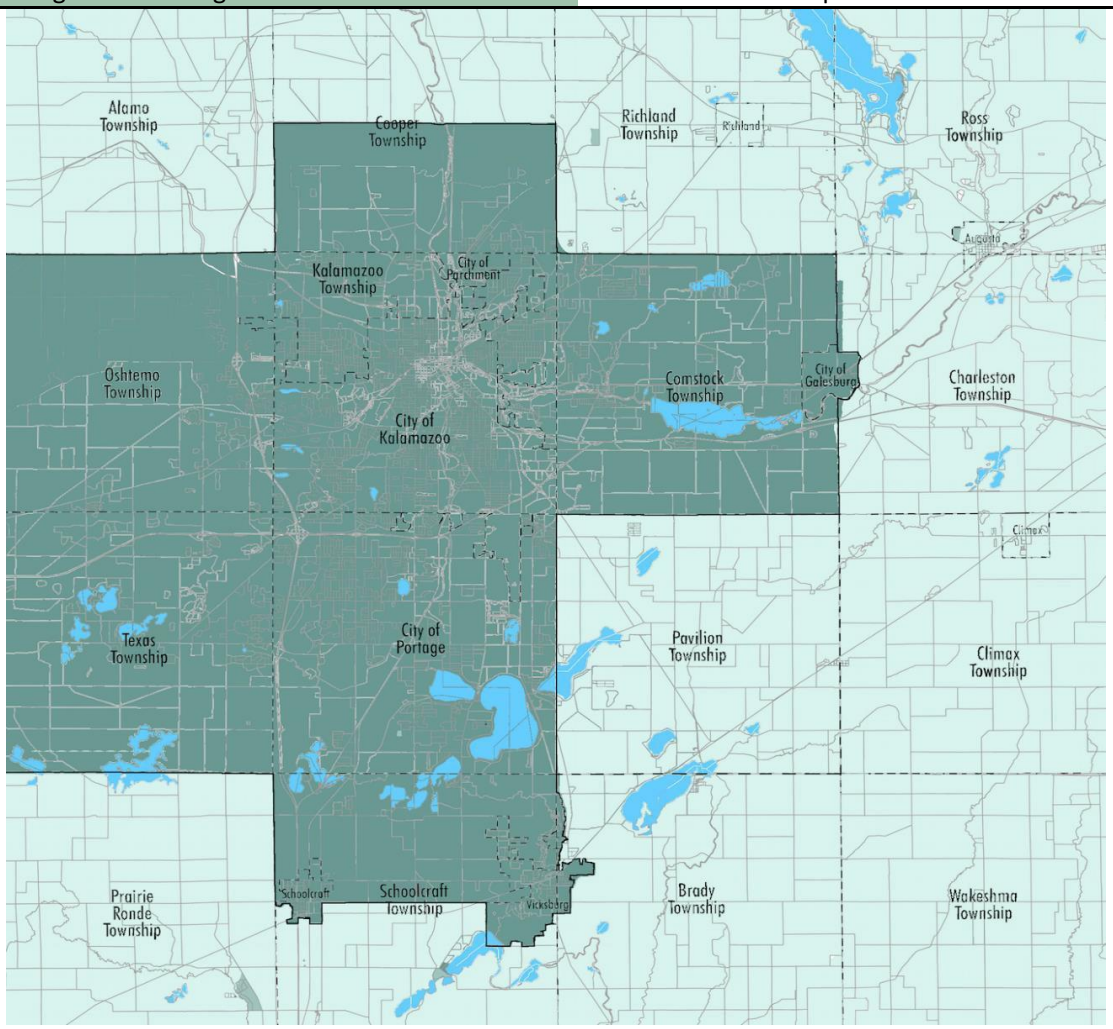
1. Reporting delayed responses
   a. The EMD center must complete an exception report in all cases where the response time exceeded established response time standards. This is to include the following:
      i. Location/status of responding ALS unit at time of dispatch
      ii. Route taken to scene
      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.

Kalamazoo County Medical Control Authority System Protocols

GUIDELINES FOR EMS STAGING

Intial Date: October, 2015 **8.31**

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
- BLS: Basic Life Support
- ADM: Automated Dispensing Machine (e.g. Pyxis® or Omnicell®)
- EMS Provider: An emergency medical technician (EMT) or paramedic who provides pre-hospital emergency medical care and who has formal training that includes, but is not limited to, human physiology, basic 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 R338.3665 of the Pharmacy – General Rules adopted by the Michigan Board of Pharmacy.

PURPOSE:

The R5MCAN BLS medication regional replacement and 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 BLS medication bags. 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 BLS 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 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 BLS Medication Bag 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 is encouraged to have a replenishment agreement with the hospital(s) it plans to exchange with.

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 in a uniform configuration to ensure interoperability between Region 5 pharmacies and EMS agencies. See Appendix 1 for contents lists, including pictures.

7. MCA's electing to participate in the R5MCAN BLS medication bag exchange must 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 2.

☒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

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 BLS medication bag 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 BLS 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 BLS medication bags.
B. Pharmacies will ensure that BLS medication bags are stocked in compliance with the regional medication formulary.
C. Pharmacies will arrange for a secure environment for BLS medication bags 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, a process for 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 (e.g. exchange through ADM vs exchange through central pharmacy).
F. Pharmacies are required to routinely inspect BLS medication bag contents and replace medications as necessary in compliance with the administrative rules of the Michigan Board of Pharmacy (R 338.486(4)(c)).
    i. Pharmacies are responsible for verifying that all supplies and medications listed on the regional BLS medication bag formulary are present and in-date upon stocking/restocking. See Appendix 3 for a sample pharmacy BLS 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.

iii. Modular components within the bags will be secured with tamper tape after stocking, so it's clear when a component has been used.

iv. After restocking, medication bags will be secured by pharmacy, utilizing numbered green tamper-resistant locks.

v. Each BLS medication bag shall have a label indicating the bag 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 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. EMS Providers are responsible for turning in used medication bags in a serviceable condition free from trash, contaminated waste and any potential sharps. Unsecured sharps and biohazard materials left in bags may result in disciplinary action by the agency. Bags will be secured with the numbered red tamper-resistant lock supplied with the bag.

B. EMS Providers will complete the appropriate documentation (Appendix 4) for medications/supplies used.

C. EMS agencies are responsible for cleaning bags that become soiled or contaminated. In the event that a bag needs to be decontaminated or cleaned, the EMS agency should coordinate with its local hospital pharmacy to have the bag checked and relocked after cleaning.

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

E. EMS agencies are responsible daily for ensuring that all medication bags 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.

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

G. All applicable sign in/out documents (agency/hospital) must be fully completed for bags being issued/returned.

H. The participating EMS agency director/manager or his/her designee is responsible for assuring compliance with this procedure.

ISSUANCE OF R5MCAN BLS MEDICATION BAGS:

1. R5MCAN BLS medication bags will be uniquely numbered in a permanent fashion, both inside and outside, using the format 5D-YY-###B.
2. Each medication bag will have a restocking label prominently affixed to the outside of the bag, following the general 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 1 for contents lists, including pictures.
4. The R5MCAN EMS Medication Bag Oversight Committee will assign each EMS agency a number of bags consistent with their number of licensed BLS vehicles.
5. The R5MCAN EMS Medication Bag Oversight Committee will assign each participating hospital pharmacy a number of bags consistent with their expected volume of exchanges.
6. Additional bags will be issued to EMS agencies at the discretion of the local EMS Medical Director or their designee.
7. For special events requiring additional BLS vehicles or EMS staff to be in service, EMS agencies may contact their local hospital pharmacy to sign-out additional medication bags temporarily.

EXCHANGE PROCEDURES:

1. R5MCAN BLS medication bags contain the following components:
   A. R5 BLS Chest Pain Kit (pink/red label)
   B. R5 BLS Respiratory Kit (blue label)
   C. R5 BLS Opioid Overdose Kit (green label)
   D. R5 BLS Anaphylaxis Kit (yellow label, in light-protected bag)
   E. R5 BLS GI Kit (brown/orange label)
   F. Numbered red tamper-resistant lock
2. 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.
3. EMS Providers must fill out the R5MCAN BLS Medication Bag Utilization Form (Appendix 4) to identify medications or supplies used and include it when turning in the bag for exchange.
4. EMS Providers may be asked to fill out the R5MCAN BLS Medication Bag Exchange Log (Appendix 6) when exchanging bags, based on individual pharmacy procedures.

ACOUNTABILITY:

1. Discrepancies found on pharmacy inspection of the BLS medication bags should be reported to the Oversight Committee via the R5MCAN on-line incident report form.
2. Suggestions for process improvement should be forwarded to the R5MCAN EMS Medication Bag Oversight Committee.
3. All BLS medication bags 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 BLS medication bags must perform an accounting of medication bags and log the required information into the R5MCAN on-line audit.

APPENDICES:

1. R5MCAN BLS Medication Bag Contents List with Images
2. R5MCAN Medical Director Signature Page
3. Sample R5MCAN Pharmacy BLS Medication Bag Restocking Sign-off Sheet
4. R5MCAN BLS Medication Bag Utilization Form
5. R5MCAN Medication Bag and Controlled Substances Regional Exchange Program End User Agreement
6. Sample R5MCAN BLS Medication Bag Exchange Log
7. R5MCAN EMS Medication Bag and Controlled Substance Box Exchange Matrix

Region 5 Medical Control Authority Network
System Protocol
R5MCAN BLS Medication Replacement and Exchange

Date: 1/27/2025 9.9(s)

Appendix 1

R5MCAN BLS Medication Bag Contents List

R5 BLS Chest Pain Kit

PAR	Medication / Item	Description
4	Aspirin 81 mg	Chewable tabs
1	Nitroglycerin 0.4 mg SL	1 bottle

R5 BLS Respiratory Kit

PAR	Medication / Item	Description
2	Albuterol 2.5mg/3mL	Amps for nebulization
1	Nebulizer	

R5 BLS Opioid Overdose Kit

PAR	Medication / Item	Description
2	Naloxone 4 mg	Nasal Sprays

R5 BLS GI Kit

PAR	Medication / Item	Description
2	Ondansetron 4 mg	ODT tabs

R5 BLS Anaphylaxis Kit - in Amber Baggie

PAR	Medication / Item	Description
1	Epinephrine 1mg/mL	1 vial
2	1 mL syringe	Luer-lock tip
2	1 inch safety needle	23-25 gauge
4	Alcohol prep pads	
1	Epinephrine dosing card	

R5 MCAN
Region 5 Medical Control Authority Network

MCA Name: Kalamazoo County Medical Control
MCA Board Approval Date: 1/27/25
MDHHS Approval Date: 7/26/2024, 1/24/2025
MCA Implementation: 9/10/2024, 1/27/2025

Appendix 2 - Medical Director Acknowledgement/Approval

To submit the proposed R5MCAN ***BLS Medication Replacement, Exchange and Accountability protocol*** to the State of Michigan Bureau of EMS, Trauma and Preparedness for review and approval, please sign and date below on behalf of your respective MCA if approving the protocol.

MCA	Name (signature)	Title	Date
Allegan County	Joshua Mastenbrook, MD	Medical Director	11/15/24
Barry County	Jen Mervau, DO	Medical Director	N/A
Berrien County	Jonathan Beyer, DO	Medical Director	11/18/24
Branch County	Luke Saski, MD	Medical Director	11/25/24
Calhoun County	Stephanie Van Alsten, MD	Medical Director	11/16/24
Cass County	Brian Queen, MD	Medical Director	11/15/24
Kalamazoo County	William Fales, MD	Medical Director	12/2/24
St Joseph County	Christopher Milligan, DO	Medical Director	11/15/24
Van Buren County	Thomas Mikulski, DO	Medical Director	11/18/24

Appendix 3 – Sample R5MCAN BLS Medication Bag Restocking Sign-Off Sheet

Date: _____

Bag Number: _____

Green Lock Number: _____

Technician:_____Pharmacist: _____

Make sure all kits are in date and tamper taped!

Expiration dates – 3 months strongly preferred, 1 month minimum

Module/Supply Item	Quantity	Refill	Expiration Date
Red Lock	1		N/A
BLS Chest Pain Kit	1		
BLS Respiratory Kit	1		
BLS Opioid Overdose Kit	1		
BLS Anaphylaxis Kit	1		
BLS GI Kit	1		

Appendix 4

BLS Medication Bag Utilization Form

Date:_____Incident #:_____BLS Bag Number:_____BLS Agency: _____

Unit #:_____EMT Name (print):_____EMT Employee #:_____

R5 BLS Chest Pain Kit		
Quantity Used	**Quantity Stocked**	**Medication / Item**
	4	Aspirin 81 mg chewable tabs
	1	Nitroglycerin 0.4 mg SL
R5 BLS Respiratory Kit		
Quantity Used	**Quantity Stocked**	**Medication / Item**
	2	Albuterol 2.5mg/3mL amps for nebulization
	1	Nebulizer
R5 BLS Opioid Overdose Kit		
Quantity Used	**Quantity Stocked**	**Medication / Item**
	2	Naloxone 4 mg nasal sprays
R5 BLS Anaphylaxis Kit - in Light-protected bag		
Quantity Used	**Quantity Stocked**	**Medication / Item**
	1	Epinephrine 1mg/mL vial
	2	1 mL Luer-lock syringes
	2	1 inch safety needle, 23-25 gauge
	4	Alcohol prep pads
	1	Epinephrine dosing card
R5 BLS GI Kit		
Quantity Used	**Quantity Stocked**	**Medication / Item**
	2	Ondansetron 4 mg ODT tablets

Completed form must be legible and accurate!

MCA Name: Kalamazoo County Medical Control
MCA Board Approval Date: 1/27/25
MDHHS Approval Date: 7/26/2024, 1/24/2025
MCA Implementation: 9/10/2024, 1/27/2025

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

_____**(EMS agency)** certifies that _____ **(Paramedic/EMT)** 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/EMT /Name:_____

Paramedic/EMT Signature:_____ **Date:**_____

Supervisor Name:_____

Supervisor Signature:_____ **Date:**_____

MCA Name: Kalamazoo County Medical Control
MCA Board Approval Date: 1/27/25
MDHHS Approval Date: 7/26/2024, 1/24/2025
MCA Implementation: 9/10/2024, 1/27/2025

Appendix 6

Sample R5MCAN BLS Medication Bag Exchange Log

R5 MCAN
Region 5 Medical Control Authority Network

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

MCA Name: Kalamazoo County Medical Control
MCA Board Approval Date: 1/27/25
MDHHS Approval Date: 7/26/2024, 1/24/2025
MCA Implementation: 9/10/2024, 1/27/2025

R5 MCAN
Region 5 Medical Control Authority Network

Appendix 7

EMS Medication Bag and Controlled Substance Box 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?
Ascension Borgess Allegan Hospital	M-F: 0700-1630 WE/H: 0900-1300	See ED RN for exchange bag clipboard. Secure used bags in ambulance closet.	Locked closet next to security office/ED entrance (key on exchange bag clipboard)	Yes	Life EMS	Locked cabinet in ED	ED ADM (with RN)	ED ADM (with RN)
Ascension Borgess-Lee Hospital	M-F: 0800-1700 WE/H: 0800-1200	ED RN (locked med room)	ED RN (locked med room)	No	Edwardsburg Newberg SMCAS	N/A	ED ADM (RN obtains)	ED ADM (RN obtains)
Ascension Borgess Medical Center	24/7	EMS ADM (flip sign to "used")	EMS ADM	Yes	Wayland EMS Plainwell EMS Life EMS LifeCare	EMS ADM	EMS ADM	EMS ADM
Ascension Borgess-Pipp Hospital	0800 - 1630	EMS ADM	EMS ADM	Yes		EMS ADM	EMS ADM	EMS ADM
Bronson Battle Creek	24/7	EMS ADM	EMS ADM	Yes	LifeCare MAFFAA VBEMS	EMS ADM	Inpatient Pharmacy	Inpatient Pharmacy
Bronson Lakeview	M-F: 0730-1700 WE/H: 0730-1200	ED ADM	ED ADM	Yes	VBEMS Life EMS	ED ADM	ED ADM	ED ADM
Bronson Methodist	24/7	Pharmacy Tech Workstation (by EMS ADM)	EMS ADM	Yes	Life EMS VBEMS LifeCare	EMS ADM	EMS ADM	EMS ADM
Bronson South Haven	M-F: 0730-1700 WE/H: 0800-1200	EMS ADM	EMS ADM	Yes	SHAES VBEMS Covert Life EMS	EMS ADM	EMS ADM	EMS ADM

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

MCA Name: Kalamazoo County Medical Control
MCA Board Approval Date: 1/27/25
MDHHS Approval Date: 7/26/2024, 1/24/2025
MCA Implementation: 9/10/2024, 1/27/2025

Appendix 7

EMS Medication Bag and Controlled Substance Box 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?
Holland Hospital	24/7	To Pharmacy	From Pharmacy	Yes	Life EMS	In cabinet in ED stored in cassettes (must complete paperwork). Keys on cabinet.	To Pharmacy	From Pharmacy
Oaklawn	24/7	Inpatient Pharmacy	Inpatient Pharmacy	No	MAFFAA LifeCare	N/A	Inpatient Pharmacy	Inpatient Pharmacy
Insight Coldwater Hospital	M-F: 0600-2200 WE/H: 0730-1600	Locked cabinet in ED (Medic obtains key from ADM)	Locked cabinet in ED (Medic obtains key from RN)	No	LifeCare	N/A	ED ADM	ED ADM
Corewell Lakeland Niles	M-F: 0700-1900 WE/H: 0700-1500	Locked Cabinet in ED	Locked Cabinet in ED	Yes	Medic 1 SMCAS VBEMS	EMS ADM	ED ADM (with RN)	ED ADM (with RN)
Corewell Lakeland St. Joseph	24/7	Inpatient Pharmacy	Inpatient Pharmacy	Yes		EMS ADM	Inpatient Pharmacy	Inpatient Pharmacy
Corewell Lakeland Watervliet	M-F: 0730-1600 WE/H: 0730-1200	Locked cabinet in ED	Locked cabinet in ED	Yes (with RN)		ED ADM (with RN)	ED ADM (with RN)	ED ADM (with RN)
Corewell Pennock Hospital	**NO EXCHANGES –** no longer keeping R5 bags/boxes							
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 Sturgis Fire	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 3 Rivers Fire SEPSA Fire Authority Edwardsburg	ED ADM	ED ADM (with RN)	ED ADM (with RN)

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

MCA Name: Kalamazoo County Medical Control
MCA Board Approval Date: 1/27/25
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MCA Implementation: 9/10/2024, 1/27/2025

White – EMS Yellow – Fire/MFR Tan – Hospital For used CSB, include a photocopy of top page

R5 MCAN
Region 5 Medical Control Authority Network

EMS Field Notes

Date:_____

Patient Name:_____DOB: _____Gender (circle): F M NB

Address:_____City/State/Zip:_____

Incident Location:_____Destination: _____

Agency MFR:_____EMS:_____Unit:_____Incident #: _____

CC:_____LKW/Onset Time: _____

Med/Surg Hx: _____
□None □Asthma □COPD □Cancer □Afib □CHF □HTN □CAD/AMI □Stroke □Diabetes □Renal □Seizures

Medicines: _____
□None □Eliquis □Xarelto □Warfarin □Plavix □Aspirin □Insulin □Benzos □Narcotics □Erectile Dysfxn Med

Allergies: _____
□None □PCN □Sulfa □Keflex □Codeine □Morphine □Fentanyl □Norco □ASA □Motrin □Tylenol □Latex □Tape

Time	HR	RR	BP	SpO2	Procedure/Med (name, dose, route)/IV (site, size, #attempts)

Notes: _____

CSB #:_____Green Lock #:_____Red Lock #: _____

Description	Expiration Date(s) of UNUSED vials*	Amount Given	Amount Wasted	Paramedic Name/Signature	Name/Signature of Wasting Witness
Ketamine 500 mg/5 mL (1)					
Midazolam 5 mg/1 mL (4)					
Fentanyl 100 mcg/2 mL (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.

_____ _____

Hospital Personnel Name/Signature EMT/Paramedic Name/Signature

MCA Name: Kalamazoo County Medical Control
MCA Board Approval Date: 1/27/25
MDHHS Approval Date: 7/26/2024, 1/24/2025
MCA Implementation: 9/10/2024, 1/27/2025