Clinical Policies and Procedures

September 13, 2023

Approval and Change Tracking

This page provides tracking of policy changes.

Change #	Policy	Update	Effective Date
1	DNR	Added TX DNR Form	09/13/2023
2	Medication Storage	Added ALS medication securing on BLS resource	09/13/2023

Document Name:	Approval and Change Tracking	Document Effective Date:	10/01/2022
System Medical Director / CMO	Jeffery L. Jarvis, MD, MS, EMT-P		

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Ambulance Capabilities

1. **Purpose.** This policy defines the use and designation of all MedStar ambulances by Operations in the MAEMSA System to facilitate reliable response to all levels of ambulance calls.
2. **Scope.** This policy applies to MedStar Operations outlining the designation, staffing, and use of BLS, ILS, MICU and CCT Ambulances in the MAEMSA System.
3. Unit Inventory and Staffing Requirements.
   - 3.1. BLS Ambulances are "Basic Life Support with MICU Capability" units.
     - 3.1.1. Such units shall be equipped and staffed as required by the Texas Department of State Health Services EMS Provider License regulations, contractual requirements, and OMD requirements. They must be equipped, at a minimum, to support the Basic level of protocol.
     - 3.1.2. Basic credentialed personnel may be assigned to work on BLS Ambulances with at least a Basic credentialed partner and may function within stated policy, protocol, and credentialed scope of practice.
   - 3.2. MICU Ambulances are "MICU Ambulance" units.
     - 3.2.1. Such units shall be equipped and staffed as required by the Texas Department of State Health Services EMS Provider License regulations, contractual requirements, and OMD requirements.
     - 3.2.2. Advanced credentialed personnel may be assigned to work on MICU Ambulances with at least a Basic credentialed partner and may function within stated policy, protocol, and credentialed scope of practice.
   - 3.3. SCT Ambulances are "MICU Ambulance" units.
     - 3.3.1. Such units shall be equipped and staffed as required by the Texas Department of State Health Services EMS Provider License regulations, contractual requirements, and OMD requirements.
     - 3.3.2. CCP credentialed personnel may be assigned to work on SCT Ambulances with at least an Advanced or Basic credentialed partner and may function within stated policy, protocol, and credentialed scope of practice.
4. Appropriate use of BLS Ambulances
   - 4.1. BLS Ambulances may be used for BLS eligible determinants designated by the Medical Director and operate under the Basic protocols and procedures.
   - 4.2. BLS Ambulances may be assigned to non-BLS eligible determinants as long as an ALS resource is also assigned along with the BLS ambulance.
5. Appropriate use of MICU Ambulances
   - 5.1. MICU Ambulances may be used for all call determinants and operate under the Advanced protocol and procedures.
6. Appropriate use of SCT Ambulances

6.1. SCT Ambulances are to be used for critical care transfers and operate under the CCP protocols and procedures.

7. Changes in Patient Condition While Engaged in a Transport.
   7.1. Any treatment beyond the clinician's credentialed scope of practice must be ordered by direct on-line medical direction. In case the condition of a patient deteriorates, personnel should provide the indicated stabilization within their scope, immediately notify Medical Control, and request appropriate orders. If it is an inter-facility transfer that originated at a hospital, the team should return to the facility if still near the sending facility; otherwise, transport should continue to the receiving facility. In extreme cases, proceed to the nearest appropriate facility for additional evaluation of the patient.
8. Additional Policies Required of MedStar. MedStar shall establish policies for identifying when a BLS Ambulance has been utilized for non-BLS eligible determinants. This information should be provided to the OMD monthly.

Continuing Education

1. **PURPOSE.** To ensure the education provided in the MAEMSA System is accurate, objective, relevant, and efficient. Additionally, it is designed to ensure proper tracking of continuing education activity in accordance with DSHS rules and regulations.

2. **SCOPE.** This policy applies to any MAEMSA agency personnel that are teaching a continuing education class using the Office of the Medical Director (OMD) Texas DSHS education certificate number.

3. **PROCEDURE**

3.1. **DEFINITIONS**

3.1.1. Activity: Any class, lecture, online education, video, PowerPoint, or other means of forum or delivery that is intended to provide continuing education credit hours.

3.1.2. Conflict of Interest: Any situation that has the potential to undermine the impartiality of a person because of any actual or perceived benefit they may receive. This can include professional, financial, or social, or other benefits.

3.2. **Overview**: Upon development of a new training program, it will be submitted to the OMD for approval. Following approval, it should be taught in accordance with this policy. Following the class, specific documentation will be submitted to the OMD for CE hour processing. It is the responsibility of the individual practitioner and their agency to maintain tracking of hours for recertification purposes.

3.3. **Process:**

3.3.1. Upon development of an activity that is intended for continuing education hours, it shall be submitted to the OMD with the "Continuing Education Activity Face Sheet" and the "Education Documentation" form attached *a full thirty days prior to the planned first instruction date.*

3.3.2. Once approved, the program will be valid for *two years*, at which time a reevaluation will occur. The OMD will review the program and provide feedback for the following:

4.3.2.1 Accuracy: All material should be accurate, current, complete, and properly referenced. Plagiarism is unacceptable in all forms.

4.3.2.2 Objectivity: All material should be medically and ethically impartial and correct. Any conflicts of interest must be reported to both the OMD and the individuals receiving the education prior to any classes taking place.

4.3.2.3 Relevancy: Any material presented should be relevant and beneficial to the individuals receiving it.

4.3.2.4 Efficiency: All material should be delivered in a way that is concise and respectful of the recipient's time and skills. Organization is imperative.

4.3.2.5Following OMD approval, activities may be scheduled and taught in accordance with each agency's policies. A list of preapproved activities may be obtained by contacting the OMD.

3.4. All instructors must obtain the following forms from OMD, complete and return them *prior* to any instruction:
- 3.4.1. "Biographical Data Form" (POL – EDU – 001.02)
- 3.4.2. "Conflict of Interest Disclosure Form" (POL – EDU – 001.03)

3.5. Upon completion of the program, the following shall be submitted to the OMD within ten business days:
- 3.5.1. Completed activity face sheet (POL – EDU – 001.01)
- 3.5.2. Completed roster (POL – EDU – 001.04)
- 3.5.3. Completed evaluations (POL – EDU – 001.05)
- 3.5.4. Completed and graded quizzes/tests

Note Any packets not received within ten business days of the activity date may not be awarded credit.*

3.6. Upon receipt of a complete and accurate packet by the OMD, continuing education certificates will be issued by the OMD to the agency's designated training representative for disbursement to students. *It is the responsibility of the individual practitioner and their agency to track and maintain continuing education hours for recertification purposes.*

Credentialing Requirements

1. **Purpose:** This policy describes the initial and maintenance requirements of credentialing for MAEMSA System clinicians to provide patient care.
2. **Scope:** This policy applies to all state-certified personnel that provide clinical care within the MAEMSA System

3. Basic (EMT-B, EMT-I, or EMT-P)

3.1. Initial Credentialing requirements:
- 3.1.1. Current EMT-B (or above) by the Texas Department of State Health Services (TDSHS)
- 3.1.2. OMD Approved Cardiac Resuscitation Certification
- 3.1.3. Successful completion of Basic Clinical Knowledge Assessment (Score of 78% or higher)
- 3.1.4. Initial skills verification through OMD-approved skills competency assessment
- 3.1.5. Successful completion of the FTO program

4. Biennial Maintenance Requirements:
- 4.1.1. Current EMT-B Certification (or above) by TDSHS
- 4.1.2. Biennial minimum of 32 CE Hours, which includes 100% completion of Medical Director CEs
- 4.1.3. Current OMD Approved Cardiac Resuscitation Certification
- 4.1.4. Successful completion of all current System Education Modules
- 4.1.5. Successful completion of the skills competency assessment
- 4.1.6. Successful completion of the Basic Clinical Knowledge Assessment

5. **Intermediate (A-EMT, EMT-I, or EMT-P)**

5.1. Initial Credentialing requirements:
- 5.1.1. Current EMT-I (or above) by the Texas Department of State Health Services (TDSHS)
- 5.1.2. OMD Approved Cardiac Resuscitation Certification
- 5.1.3. Successful completion of Basic Clinical Knowledge Assessment (Score of 78% or higher)
- 5.1.4. Initial ALS Assist skills verification through OMD-approved skills competency assessment
- 5.1.5. Successful completion of the FTO program

Credentialing Requirements

5.2. Biennial Maintenance Requirements:
- 5.2.1. Current EMT-B Certification (or above) by TDSHS
- 5.2.2. Biennial minimum of 32 CE Hours, which includes 100% completion of Medical Director CEs
- 5.2.3. Current OMD Approved Cardiac Resuscitation Certification
- 5.2.4. Successful completion of all current System Education Modules
- 5.2.5. Successful completion of the skills competency assessment
- 5.2.6. Successful completion of the Basic Clinical Knowledge Assessment

6. **ALS Assist or Advanced (EMT-P or LP)**

6.1. Initial Credentialing requirements:
6.2. Current EMT-P or LP by the Texas Department of State Health Services (TDSHS)
6.3. OMD-approved Cardiac Resuscitation Certification
6.4. Successful completion of Paramedic Clinical Knowledge Assessment (Score of 78% or higher)
6.5. Successful completion of OMD-approved patient scenarios.
6.6. Holds the following certifications: AMLS, Trauma Card (PHTLS, ITLS), Pediatric Card (PEPP, EPC, PALS), and ACLS*
6.7. Initial skills verification through OMD-approved skills competency assessment
6.8. Successful completion of the FTO program
6.9. Final interview and recommendation by Medical Director.
6.10. Biennial Maintenance Requirements:
- 6.10.1. Current Paramedic Certification (EMT-P) or Licensure (LP) by TDSHS.
- 6.10.2. Current OMD Approved Cardiac Resuscitation Certification
- 6.10.3. Biennial minimum of 74 CE Hours, which includes 100% completion of Medical Director CEs
- 6.10.4. Successful completion of all current System Required Education Modules
- 6.10.5. Successful completion of Advanced Clinical Knowledge Assessment.
- 6.10.6. Successful completion of Advanced skills verification assessment

Credentialing Requirements

7. **Mobile Healthcare Paramedic – MHP (EMT-P or LP)**
   - 7.1. Initial Credentialing requirements:
     - 7.1.1. Meet Advanced level credentialing requirements.
     - 7.1.2. Successful completion of MHP Clinical Knowledge Assessment
     - 7.1.3. Successfully achieve advanced certification (CP-C) within 18 months of hire.
   - 7.2. Biennial Maintenance Requirements:
   - 7.3. Meet Advanced credential maintenance requirements
   - 7.4. Current advanced certification (CP-C)
8. **Critical Care Paramedic - CCP (EMT-P or LP)**
   - 8.1. Initial Credentialing requirements:
     - 8.1.1. Meet Advanced level credentialing requirements.
     - 8.1.2. Successful completion of CCP Clinical Knowledge Assessment
     - 8.1.3. Successfully achieve advanced certification (CCP-C, CCEMTP, or FP-C) within 18 months of hire.*
   - 8.2. Biennial Maintenance Requirements:
     - 8.2.1. Meet Advanced credential maintenance requirements
     - 8.2.2. Current advanced certification (CCP-C, CCEMTP, or FP-C)
9. **Extended Absences – Return to Work Re-credentialing**
   - 9.1. >30 days: Credentialed level initial requirements without FTO time at OMD discretion
   - 9.2. >90 days: Credentialed level initial requirements

*Nursing equivalent courses are accepted.

Do Not Resuscitate

1. **Purpose**. Chapter 166 of the Health and Safety Code establishes Out-of-Hospital Do-Not-Resuscitate (OOH DNR) Orders. The chapter allows the development of a local DNR policy that complies with the State-wide DNR protocol adopted by the Board of Health.

2. **Scope**. This policy applies to all System providers and in all cases of out-of-hospital events including cardiac arrests that occur during inter-facility transports.

3. **DNR Form and Identification of Patients**.
   3.1. EMS personnel may only accept the original or a copy of the standardized DNR Order form developed by the Texas Department of State Health Services.
   3.2. EMS personnel may accept an approved OOH DNR bracelet or necklace (identification device) as proof that an OOH DNR order form has been executed by or issued on behalf of the person wearing the identification device.
   3.3. When presented with a "DNR Order," EMS personnel should make every effort to identify the patient as the person for whom the OOH DNR Order has been executed or issued. Relatives, friends, neighbors, documents, ID bracelets, or other identification may be used as sources of identification.

4. **Honoring an OOH DNR Order**.
   4.1. When presented with a DNR Order, EMS personnel are to review the form to make sure that it is correctly completed and signed as required by the Health and Safety Code. If the order appears valid, the OOH DNR Order shall be honored.
   4.2. EMS personnel are not required to honor an OOH DNR Order that does not comply with the Health and Safety Code.
   4.3. EMS personnel may honor OOH DNR Orders executed in another state if there is no reason to question the authenticity of the order of identification device.

5. **Revocation of an OOH DNR Order**.
   5.1. The patient may revoke an OOH DNR Order, or the patient may direct someone in his or her presence to destroy the order and remove the patient's identification device.
   5.2. A qualified relative, legal guardian or patient's agent having medical power of attorney (or a person acting on behalf of any of these persons) may revoke the OOH DNR Order.
   5.3. The patient's physician may revoke the OOH DNR Order.
   5.4. In case of a revocation of the OOH DNR Order, EMS personnel shall document the name of the person who revoked the order, the date, time, and location of the revocation.
   5.5. Upon revocation of the OOH DNR Order, EMS personnel shall provide care for the patient as required by protocol.

Do Not Resuscitate

6. **Disputes related to OOH DNR Orders**. In case a dispute arises regarding an OOH DNR Order, EMS personnel shall contact On-Line Protocol Guidance (OLPG) for direction and assistance.

7. **Pregnant Persons and OOH DNR Orders**. EMS personnel may not withhold cardiopulmonary resuscitation or certain other life-sustaining treatment from a person known to be pregnant.

8. **Other presented DNR paperwork**. A request to withhold resuscitation efforts by a verifiable Medical Power of Attorney (mPOA) may be honored. If other forms of DNR orders are presented to EMS personnel, OLPG must be contacted for direction.

Figure: 25 TAC §157.25 (h)(2)

OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Print Form

STOP DO NOT RESUSCITATE

This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort care will be given as needed.

Person's full legal name _____ Date of birth _____ ☐ Male ☐ Female

A. Declaration of the adult person: I am competent and at least 18 years of age. **I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Person's signature _____ Date _____ Printed name _____

B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:

I am the: ☐ legal guardian; ☐ agent in a Medical Power of Attorney; OR ☐ proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above-noted person's:

☐ spouse, ☐ adult child, ☐ parent, OR ☐ nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person: I am the above-noted person's attending physician and have:

☐ seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR ☐ observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature _____ Date _____ Printed name _____ Lic # _____

E. Declaration on behalf of the minor person: I am the minor's: ☐ parent; ☐ legal guardian; OR ☐ managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____

Printed name _____

TWO WITNESSES: (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

Witness 1 signature _____ Date _____ Printed name _____

Witness 2 signature _____ Date _____ Printed name _____

Notary in the State of Texas and County of _____. The above noted person personally appeared before me and signed the above noted declaration on this date: _____.

Signature & seal: _____ Notary's printed name: _____ *Notary Seal*

[Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner]

PHYSICIAN'S STATEMENT: I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Physician's signature _____ Date _____

Printed name _____ License # _____

F. Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative: The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____

Signature of second physician _____ Date _____ Printed name _____ Lic# _____

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.

Person's signature _____ Guardian/Agent/Proxy/Relative signature _____

Attending physician's signature _____ Second physician's signature _____

Witness 1 signature _____ Witness 2 signature _____ Notary's signature _____

This document or a copy thereof must accompany the person during his/her medical transport.

Emergency 911 Calls from within a hospital

1. **Purpose.** This policy addresses when a patient calls for an ambulance within a hospital. This policy does not apply when a person or patient is calling from other types of care facilities.

2. **Scope.** This policy applies when a person contacts the MedStar Communications Center within a hospital requesting an ambulance for care. This policy describes the procedure to follow when providing care to this patient.

3. **Appropriate action to follow.** If a person within a hospital contacts the Communications Center requesting an ambulance, the following procedure will be followed:
   - 3.1. **Properly EMD the call:** The call will be screened utilizing current procedures and then confirm that the patient is calling from within the hospital.
   - 3.2. **Provide instructions:** If the person is calling from within the hospital, they should be instructed to immediately report to the Triage Nurse or Charge Nurse and inform them that they have contacted 911 requesting an ambulance.
     - 3.2.1. Explain to the person that an ambulance may not be dispatched by their request and that it must be requested by the hospital personnel.
   - 3.3. **Contact the Hospital:** The Communications Specialist should immediately contact the charge nurse of that ED or hospital by phone and advise them of the situation.
   - 3.4. **If the person is outside of the hospital:** If the patient requesting the ambulance is outside of the hospital, or there is any confusion, the Communications Specialist should follow regular 911 call procedures. If the patient is on hospital grounds, transport should be to that hospital's emergency department.

4. **If the hospital then requests an ambulance:** If the hospital requests an ambulance for the patient, the Communications Specialist should follow the process for inter-facility transfer.

Emergency Care Attendants

1. **Purpose.** The purpose of this policy is to establish care guidelines for First Responders trained at the Emergency Care Attendant (ECA; Texas Department of State Health Services) / Emergency Medical Responder (EMR; National Registry of EMTs)

2. **Scope.** This policy applies to all MAEMSA System providers credentialed at the ECA / EMR Level.

3. **Protocol variations.** ECA / EMR providers will generally operate under the "Basic" level in the EPAB protocols, with the following modifications. ECA / EMR:

   3.1. May provide general first aid as per Basic level protocols.
   3.2. May administer oxygen as per protocol at the Basic level.
   3.3. Are required to have available epinephrine auto-injectors and be trained in their use; they may not administer IM injections otherwise.
   3.4. May administer naloxone (Narcan) as per the Basic level protocol for suspected opioid intoxication; they may not administer intra-nasal medications otherwise.
   3.5. Are permitted to assist with patient self-administration of nitroglycerin (already prescribed and available on-scene) if the systolic blood pressure is greater than 100, as per the ***Ischemic Chest Pain/Acute Coronary Syndrome/STEMI*** protocol.
   3.6. May administer aspirin as per the ***Ischemic Chest Pain/Acute Coronary Syndrome/STEMI*** protocol.
   3.7. May administer oral glucose as per the ***Altered Mental Status/CNS Depression and Diabetic Emergencies*** protocols.
   3.8. May administer Isopropyl Alcohol as per the Adult and Pediatric ***Nausea and Vomiting*** protocol.
   3.9. May not administer CPAP.
   3.10. May not administer nebulized medications.
   3.11. May not perform spinal motion restriction; patients who may have suffered spinal trauma should have manual cervical spine stabilization performed until higher-level providers arrive.

Emergency Care Attendants

4. Required medications/equipment for ECA / EMR First Responders:
   - 4.1. Oxygen, with BVM, nasal cannula, and non-rebreather devices in both adult and child sizes
   - 4.2. Emergency childbirth kit
   - 4.3. Epinephrine auto-injector in both pediatric and adult doses
   - 4.4. Aspirin
   - 4.5. Oral glucose
   - 4.6. Naloxone
   - 4.7. Isopropyl Alcohol pads
   - 4.8. Basic bandaging / splinting materials
   - 4.9. Blood pressure cuff with stethoscope
   - 4.10. Glucometer
   - 4.11. Manual suction device

Equipment Failure

1. **Purpose.** This policy describes the process of reporting equipment failures

2. 2.**Scope.** This procedure applies to all MAEMSA System providers who experience an equipment failure while providing patient care.

3. **Overview.** If while rendering patient care, a provider experiences a failure of any piece of equipment, it must be reported to OMD and as per the agency's policy. This may also include the manufacturer and the proper State/Federal agencies.

4. **The Process.**
   - 4.1. The provider experiencing the equipment failure should retain the specific item and all associated components if possible.
   - 4.2. Package the item in a biohazard bag if it is contaminated with human fluids.
   - 4.3. Turn the item into their Agency's designated individual as stated in their SOPs and/or Policies & Procedures.
   - 4.4. The Agency should then report the failure to the Office of the Medical Director.
   - 4.5. The Agency should then report the failure to the manufacturer.
   - 4.6. Together, the Agency, OMD, and the manufacturer will determine if a report to State and/or Federal agencies should be made.

Examination and Testing

1. **Purpose.** The OMD relies on periodic examinations as a tool to assess retention of required knowledge and mastery of skill performance among EMS personnel.

2. **Scope.** Exams and scores may include, but not be limited to, the review of any Texas Department of State Health Services EMS certification examination results, periodic protocol examinations, and periodic skills evaluations.

3. **Procedure.**
   3.1. Initial Credentialing of System Providers Written Examinations.
   3.2. The OMD requires all System providers to pass the following verification exams to
   3.3. be credentialed:
   3.4. State Certification Exam or its equivalent established by receipt of state certification
   3.5. Protocol-based evaluation examination:
      3.5.1. Successful completion of a skills verifications packet
      3.5.2. Multiple choice clinical knowledge assessment exam

   3.6. The Medical Director may elect to omit a subscale or exam from these criteria and may, at any time, replace these requirements with other exams or requirements.
   3.7. Personnel must pass the clinical knowledge assessment exam with a score of at least 78%.

   3.8. **Medical Director Interview.**
      3.8.1. Individuals seeking credentials at the ALS Assist, Advanced, MHP, or CCP level must participate in an interview with the Medical Director or designee to discuss their practice of medicine.
         3.8.1.1. This meeting will be the final credentialing step for that individual.
      3.8.2. Unsuccessful credentialing
         3.8.2.1. The maximum number of attempts at any part of the credentialing process is 3. The Medical Director or designee may suspend the credential of a person who fails a step. Personnel who fail part of the credentialing process may successfully complete another re-test no earlier than 72 hours and up to 15 days after a failure of a re-test only when permitted by their employer. A maximum of two re-tests are allowed. The Medical Director will then make the determination of that individual's ability to function within the System.

3.9. **Maintaining Credentialing**

3.9.1. All existing credentialed personnel within the System are required to follow all requirements listed in the Continuing Education Policy and the Credentialing Requirements Policy to maintain their OMD credentialing.

3.9.2. **Study guides and materials**. Personnel are responsible for gathering their own study materials. The OMD will provide an electronic copy of the approved protocols and textbooks or study guides for OMD-sponsored specialty courses.

Field Training Officers

1. **Purpose.** The OMD is responsible for credentialing emergency medical services personnel. That process depends on the integrity of the Field Training Officer (FTO) program within the System. The objective of the FTO Selection Process is to assure that a standardized method for selection of FTOs will be used in a consistent manner and to assure that the Medical Director or designee will participate in the selection process.

2. **Scope.** The FTO assignment procedure applies to the MedStar and First Responders. While the Medical Director is a participant in the selection of FTOs, these personnel are employees of that individual Agency and must comply with their specific policies.

3. **The Selection Process.** Each agency is responsible for organizing the FTO selection process. At minimum, the Agency shall implement a non-biased, non-discriminatory selection process that allows candidates to compete based on their qualifications. The Medical Director or designee shall be a participant in the selection process.

5. **Final Selection.** The Medical Director or designee will provide Agency a written confirmation of recommended candidates. The Medical Director, in cooperation with the agency, shall have final approval of all FTO personnel.

6. **Allowance for alternate training programs:** If a First Responder agency does not use an FTO-based process, the clinical training process for that agency will be reviewed and approved by the Medical Director or designee.

7. Due to the diverse nature of FRO training, OMD will work with individual FRO agencies to develop agency-specific FTO selection criteria and training.

Helicopter EMS (HEMS) Utilzation

1. **Purpose**. The OMD is responsible for establishing guidelines for the role of helicopter utilization in emergency care. The OMD recognizes the benefit of this specialized service but also realizes it must be used appropriately and safely.

2. **Scope.** This policy applies to System providers responsible for initiating a helicopter response. All HEMS requests must be done through the MedStar Communication Center.

3. **Appropriate use of helicopter transport.** There are circumstances that will require the expeditious use of HEMS transport. These include, but are not limited to:
   3.1. Patient inaccessible due to terrain or environmental conditions (i.e., high water, mud, rough terrain).
   3.2. Extended travel time of a critical patient (greater than 30 minutes) to an appropriate receiving facility due to distance or traffic.
   3.3. As an additional resource during a Mass Casualty Incident (MCI) with critically injured patients.

4. **Requesting Emergency Helicopter Support.**
   4.1. **Initiating a Standby/Launch Request.** "Standby" status places the helicopter crew on alert for possible scene response. A launch order or "alert go" physically request the helicopter and flight crew to lift-off and proceed to the requested location. Provide the height and weight of the patient (if known) at the time of launch request. A standby/launch request through the MedStar Communication Center may be initiated by any of the following:
      4.1.1. Any first responding unit or MedStar unit.
      4.1.2. Fire and Civil Defense personnel.
      4.1.3. State and Local Law Enforcement personnel.
      4.1.4. Industrial safety personnel.
   4.2. **Who May Cancel the Helicopter:** Once launched the helicopter will only be cancelled by:
      4.2.1. The initiating official/agency or ALS-Assist / Advanced provider on-scene after patient contact has been established, and:
         4.2.1.1. Performance of a proper patient assessment, and
         4.2.1.2. Notifying Fire Department incident commander of decision
         4.2.1.3. If disagreement concerning cancellation exists between the incident commander and credentialed provider, the ultimate decision will be made by the highest credentialed provider on-scene.

Helicopter EMS (HEMS) Utilzation

5. **Safety**. The decision to launch is totally under the control of the helicopter pilot. Factors influencing flight safety for the patient and HEMS personnel will always take precedence in this decision.
   5.1. All personnel within the System shall complete a Helicopter Safety training program as part of their orientation or continuing education program.

6. **Documentation.** A full patient care form must be completed for each patient transported by a helicopter.

7. **QA/QI.** All HEMS utilization will be reviewed through the QA process.

Incident Command System

1. **Purpose.** The uniform EMS Ordinance requires the OMD to set standards for patient care. Large or complex incidents require specialized policies to establish a unified command structure, common terminology, and an incident action plan (IAP). The objective is to assure that rescuers remain safe and that single resources are utilized effectively and efficiently as they treat and transport patients in an organized fashion.

2. **Scope.** This policy applies to all MedStar agencies during a large-scale incidents or a Mass Casualty Incident (MCI).

3. **Procedure Overview.** All emergency events will be managed in accordance with the nationally recognized Incident Command System (ICS) as established by the Federal Emergency Management Administration. The Fire Department Incident Commander (IC) will direct the overall operation at the scene. Emergency medical services will operate as a Branch within the ICS structure and will make medical decisions in cooperation with the IC. Patient care must never be delayed due to a jurisdictional dispute.

4. **Training.** Supervisory level personnel within the MedStar system shall complete, at least, basic level ICS training published by the Federal Emergency Management Agency Emergency Management Institute or an equivalent course. All medical personnel should be familiar with ICS and mass casualty response plans.
5. **Emergency Medical Services Operation.** At any scene requiring a unified command structure, EMS personnel will provide care according to medical protocols and within their scope of medical training and qualifications.
   - **5.1.** The Fire Department Incident Commander is in command of the incident and the scene. In the event that a MedStar ambulance paramedic is the first to arrive at a scene, that individual will act as the IC until relieved by the Fire Department IC.
   - **5.2.** The first MedStar ambulance personnel on-scene will be responsible for patient treatment and transport.
   - **5.3.** The MedStar Advanced Paramedic, along with a Firefighter, will be in charge of the Triage, Treatment, and Transport areas (T-3).
     - 5.3.1. The MedStar Basic provider, along with a Firefighter, will triage all patients to the designated areas within the T-3 by utilizing START.
   - **5.4.** The Fire Department personnel on-scene will be responsible for:
     - 5.4.1. Initial triage of victims & Strike Teams to extricate victims to the casualty collection points.

5.5. Requests for additional resources shall be directed to the Incident Commander.

5.5.1. When emergency helicopter service is needed, the Incident Commander is responsible for securing an appropriate landing site and for all safety procedures.

5.5.2. The Appropriate destination-facility decisions will be made with consultation between the MedStar Advanced paramedic and helicopter personnel, taking into consideration patient and/or family wishes when appropriate.

6. **Patient hand-offs**

6.1. Patient care initiated by an OMD credentialed responder shall be continued until the MedStar ambulance paramedic arrives and assumes care for the patient, **with the exception of a hazmat situation**.

6.2. In the event of disagreement in patient care, On-Line Medical Control will be contacted immediately for appropriate orders. All incidents of this nature will be forwarded to the Medical Director for review.

Incident Disposition and Cancelation

1. **Purpose.** This policy establishes criteria for various dispositions for First Responders and MedStar ambulances, including cancelation.

2. **Scope.** This policy applies to all System agencies.

3. **Disposition reasons for EMS-related calls for service.**

3.1. First Responder disposition of calls.

3.1.1. **Assist a Citizen:** Upon completion of a clinical evaluation, the First Responder determines that a person needs assistance unrelated to an acute or deteriorating medical condition and there is no need for an ambulance. Appropriate documentation should be completed by the First Responder.

3.1.2. **No Patient Found:** Upon arrival and after every reasonable effort to find the patient and potential errors have been ruled out, and no patient found. This includes calls to a false/non-existent location.

3.1.3. **Dead on Scene:** Upon arrival, First Responders have identified that a patient is dead as described in the appropriate protocol. Appropriate documentation should be completed by the First Responder.

3.1.4. **Against Medical Advice (AMA):** Anytime a patient or their parent/guardian demonstrates capacity and communicates a refusal of treatment or transport, the First Responder is to complete the appropriate documentation as required by OMD.

3.1.5. **Refusal Without Demonstration of Capacity:** Anytime a patient or their parent/guardian communicates a refusal of treatment, or transport, and is unable to demonstrate capacity, the First Responder is to complete the appropriate documentation as required by OMD.

3.1.6. **Release at Scene (RAS):** Anytime an individual meets the definition within the RAS protocol, The First Responder will complete the RAS documentation as required by OMD.

3.1.7. **Treat**-in-place Alternative: Anytime a patient is treated without transport utilizing any currently implemented treat-in-place alternative. (Telehealth or protocol)

3.1.8. **Care transferred to MedStar personnel** (or agencies responding for mutual aid).

Incident Disposition and Cancelation

3.2. MedStar Ambulance disposition of calls.

3.2.1. **No Patient Found:** Upon arrival and after every reasonable effort to find the patient and potential errors have been ruled out, no patient can be found. This includes calls to a false/non-existent location.

3.2.2. **Dead on Scene:** Upon arrival, MedStar personnel have identified that a patient is dead as described in the appropriate protocol. Appropriate documentation should be completed by MedStar personnel.

3.2.3. **Against Medical Advice (AMA):** Anytime a patient or their parent/guardian demonstrates capacity and communicates a refusal of treatment or transport, the First Responder is to complete the appropriate documentation as required by OMD.

3.2.4. **Refusal Without Demonstration of Capacity:** Anytime a patient or their parent/guardian communicates a refusal of treatment, or transport, and is unable to demonstrate capacity, the First Responder is to complete the appropriate documentation as required by OMD.

3.2.5. **Release at Scene (RAS):** Anytime an individual meets the definition within the RAS protocol, MedStar personnel will complete the RAS documentation as required by OMD.

3.2.6. **Transfer of care:** When care is transferred from one MedStar provider to another (for example, due to an equipment failure and change to a new ambulance, multiple patients on scene with additional transporting resources, care assumed by Mobile Integrated Health (MIH) provider or Critical Care Paramedic (CCP)). The first on-scene MedStar personnel will document their care, then transfer the chart electronically to the next care provider.

3.2.7. **Transport to ED:** Identified patient is transported to the emergency department.

3.2.8. **ET3 Telehealth – Treatment in Place:** Identified patient has accepted telehealth visit and agreed to treatment on-scene with referral to primary care physician, or a scheduled in-home urgent care visit, or a scheduled in-home visit by crisis outreach team.

3.2.9. **ET3 Telehealth – Alternate Destination Transport:** Identified patient has accepted telehealth visit and agreed to transport to MHMR clinic or Urgent Care.

3.2.10. **MIH Call Complete**: This disposition is to only be used by MIH and CCP providers with patients enrolled in MIH programs. In conjunction with OMD, MedStar will create more descriptive codes, as needed, to properly identify specific programs.

Medical Professionals on Scene

1. Purpose. Medical professionals at the scene of an emergency may provide assistance to pre-hospital care personnel and should be treated with professional courtesy.

2. Scope. This policy applies to OMD-credentialed providers

3. Physician On-Scene
   - 3.1. Prior to arrival of OMD credentialed providers
     - 3.1.1. An on-scene physician who is caring for a patient may retain responsibility for patient care, provided that physician accepts full legal and medical responsibility.
     - 3.1.2. The on-scene physician will be placed in contact with On-Line Medical Control (OLMC), who may authorize that physician to issue orders to OMD credentialed providers. Once authorized by OLMC, the on-scene physician must accompany the patient to the hospital.
   - 3.2. After arrival of OMD credentialed providers
     - 3.2.1. A physician arriving after care has been initiated by the prehospital team will be placed in contact with OLMC before becoming involved in patient care.
     - 3.2.2. OLMC, the prehospital care team, and the on-scene physician will work collaboratively if granted permission by OLMC.
4. Responding to Physician's Offices:
   - 4.1. The OMD credentialed providers will comply with medical treatment requests the physician makes within his/her office as long as the orders are within the provider's scope of credentialing, and OMD protocols. Any orders that are in conflict with above should be discussed with OLMC.
   - 4.2. If the physician gives orders that are to be carried out during transport and are outside protocol, the paramedic will discuss these orders with OLMC once in the ambulance to assure that OLMC agrees with the orders and that the orders comply with the protocols of the System.
5. Poison Control
   - 5.1. Poison Control Center Specialists are authorized to direct medical care related to the medical toxicology and/or hazardous material exposure aspects of patient care if contacted for direction limited by credentialed scope and protocols. Care may be limited by supply and medication available for treatment.

Medical Professionals on Scene

6. Care established by other medical professionals
   6.1. Orders by nurses, nurse practitioners, physician assistants, and other State-certified providers are not applicable to System providers.
      6.1.1. If on arrival of OMD credentialed personnel, the patient is under the direct care of another medical professional, and if the patient and medical professional desire to continue as such, provide care in parallel with the medical professional and within the treatment protocol; if care beyond the credentialed scope of practice is requested, contact OLMC (e.g., OB – FHT monitoring)
      6.1.2. A medical professional arriving after care has been initiated by the prehospital team will be placed in contact with OLMC before becoming involved in patient care.
7. Critical Care Ground and Air Medical Transport Teams
   7.1. The patient will remain in the care of the transport team. OMD credentialed providers may assist in patient care at the request of the transport team as long as the care is within the credentialed scope and protocol.
8. Services and Equipment.
   8.1. If approved by OLMC, the services, and equipment of the emergency vehicle will be made available to the on-scene physician or medical professional.

Medical Treatement of an Employee

1. **Purpose.** This policy is a process to describe the clinical practice of treating ill or injured employees of the System,

2. **Scope.** This procedure applies to all credentialed providers who are rendering patient care to an ill or injured employee of the System.
3. **Overview.** If an Agency's employee is either ill or injured, that person should be treated as a "patient" and all the OMD Protocols, Procedures, and Policies apply to care for that individual. An employee requiring medical care must have a patient care record completed whether or not they are transported to a hospital or if they are released by other means (AMA, RAS, etc.). A credentialed provider may not administer any type of medical treatment to another employee without properly following OMD protocols, procedures, and policies.

4. **Process.**

4.1 If an Agency's employee is ill or injured, proper medical attention should be activated and initiated. The 911 system should be activated if necessary.

4.2 If the Agency's employee refuses transport, then the proper AMA protocol should be followed. An incident must be created, and the proper patient care record documented fully.

4.3 Any deviation from this process is prohibited by the Medical Director and may lead to disciplinary action by the agency, state, and federal oversight authorities.

4.4 Personnel should refer to agency-specific standard operating procedures for any agency-specific requirements of notification or referral.

Medication Storage

1. **Purpose.** The Drug Enforcement Administration, and the Texas DSHS require the Medical Director to assure that all medications purchased under his/her license are stored and secured according to laws and regulations.

2. **Scope.** This policy applies to medications required on ambulances, first responder vehicles, special teams, and other response-capable System vehicles.

3. **Procedure**
   3.1. Storage of Medications in the Field.
      3.1.1. Schedule II - IV Medications will be secured by field personnel while on duty either:
         3.1.1.1. on the person of the Paramedic that accepted receipt of the medications and is assigned to the apparatus, or
         3.1.1.2. in a locked container on the apparatus, where the only person with the key or combination is the Paramedic that accepted receipt of the medications and is assigned to the apparatus, or
         3.1.1.3. during EMS standby services, in a locked container in a designated first aid room where the only person with the key or combination is the Paramedic assigned to the room.
      3.1.2. When the crew is not physically inside the unit, all other medications and equipment will be secured on the apparatus by locking all exterior doors or compartments. The crew members assigned to that unit are the only personnel authorized to unlock the unit.
      3.1.3. The Paramedic that accepted receipt of the medications on Special Teams, such as the Bike Team, Mounted EMS Team, other Ad Hoc teams, or other response capable System vehicles, will secure all Scheduled medications on their person.
   3.2. Securing of ALS medications on a BLS resource
      3.2.1. Agencies will have a policy/procedure addressing the securing of ALS medications on a unit when being utilized as a BLS resource.

4. **Reconciliation.**
   4.1. All System agencies that carry controlled substances must have a reconciliation policy and procedure in place. OMD may conduct reconciliation record audits to assure compliance with this policy.

5. **Drug Adulteration.**
   5.1. All medicines stored in the field must be stored according to current Texas DSHS rules and regulations. This includes all manufacturer temperature recommendations. Proper temperature storage techniques should be maintained by each System agency.

Patient Destination

1. **Purpose.** The purpose of this policy is to establish patient destination guidelines.

2. **Scope.** This policy includes all patient transports within the jurisdiction of the Metropolitan Area EMS Authority System.

3. **Selection of a Destination Facility.** The selection of a destination facility must balance the goal of delivering the highest quality patient care with respecting the individual patient's rights and desires to make an informed choice. To accomplish this, patients will be transported to the closest, most appropriate facility using the following criteria in the order listed.
   3.1. Once it has been determined that a patient has decisional capacity, and if medically appropriate, they shall be transported to the hospital of their request.
   3.2. If the patient is unable to communicate, the patient is to be taken to the hospital of immediate family request, as medically appropriate
   3.3. If the family's facility preference is not known, the patient is to be taken to the closest, most appropriate facility.
   3.4. Special patient needs may dictate transport to a hospital that may not be the closest but is the most appropriate facility for that patient's medical care needs (i.e., burns, major trauma, stroke, STEMI). See **Designated Specialty Receiving Facilities** (below).
   3.5. If a patient calls for EMS while within 250 yards of a full-service hospital's campus, the patient shall be transported to that hospital's Emergency Department unless dictated as in 3.4.
   3.6. If a patient has been seen and discharged from an Emergency Department of a full-service hospital within 24-hours, the patient shall be transported back to that Emergency Department unless an exception exists as outlined in 3.4.
   3.7. Cardiopulmonary Arrest patients, if transported, should be transported to the closest full-service hospital.
   3.8. Credentialed providers shall not encourage patients to utilize one facility over another.

4. **Resolving Conflicts.** The following guidelines are to be used if the decision to transport the patient to the closest appropriate or other facility results in a conflict with the patient or family of the patient.
   4.1. In all cases, the patient or family are to be assisted to make an informed decision. As long as patients have decisional capacity, their informed decision will be honored. The patient's present medical condition and the reasons for transport to the closest appropriate medical facility should be discussed with the patient or family if the patient lacks capacity. If the patient or patient's family, as allowed in 3.1 or 3.2 above, insists on transport to another facility (other than a recommended facility based on patient condition or clinical need), their informed decision will be honored as described in this policy.

5. **Age-Specific Transport Guidelines.** Any unresponsive patient with secondary sex characteristics shall be treated as an adult patient and transported to an adult-care facility. The following table establishes the age-related guidelines for selecting adult or pediatric destination facilities while recognizing the rules set forth in sections 3 and 4 (above).

	Adult Care	Cook Children's
Medical/Trauma Emergencies	≥15 Years	< 15 Years*
Psychiatric Emergencies	≥13 Years	< 13 Years

*Under certain circumstances, individual patients who are 15-years old or older and who have established relationships with pediatric specialists may be transported to a pediatric care facility. If in doubt, consult with OLMC.

*Patients who are exhibiting both an acute medical and psychiatric emergency (e.g., overdose with AMS) should be transported using the Medical/Trauma Emergency criteria

6. **Emancipated Minors.** Current laws dictate who may be declared an emancipated minor.

7. **Police Custody.** A patient who is under the custody of a police officer and who is being transported to a hospital for assessment/treatment, including those under an application for detention, may be transported to any hospital that is selected by the police officer as long as medically appropriate and as meets the age requirements in this policy.

8. **Correctional Facility Patients.** Patients being transported from correctional facilities are to be transported as follows:
   8.1. Most federal correctional facilities have agreements with local hospitals. Patients should be transported to facilities in accordance with such agreements. MedStar paramedics should ask an appropriate official who is responsible for the patient to select the destination facility.
   8.2. Other jails or detention facilities – patients are transported to facilities selected by the police officer responsible for the patient.

9. **Designated Specialty Receiving Facilities.** A list of approved Specialty Receiving Facilities is available on each tablet, on the intranet, and in the smartphone app.
   9.1. **Trauma -** Patients who meet American College of Surgeons trauma activation criteria should be transported to an OMD-approved trauma facility.
      9.1.1. **Burn-** Patients with significant 2nd or 3rd-degree burns, as detailed within the Burn protocol, should be transported to an OMD-approved Burn center.
      9.1.2. Cardiac - Patients experiencing ST-elevation myocardial infarction should be transported to an OMD-approved PCI-capable facility.

9.2. **Stroke -** Patients experiencing acute stroke symptoms should be transported to an OMD-approved stroke facility. A decision tool for transport to Primary vs. Comprehensive Stroke Center is defined in the Stroke Protocol.
9.3. **Obstetrics** – gravid patients > 20-weeks' gestation should be transported to an OMD-approved facility with OB capabilities.
9.4. **Sexual Assault** – patients with suspected or verbalized complaints of sexual assault should be transported to an OMD-approved facility with SANE capabilities.
9.5. Designation of Specialty Receiving Facilities will occur based on the below criteria:
9.5.1. **Trauma** – facilities that are approved by the Texas Department of State Health Services as a Level I, II, III, or IV trauma facility; or are in pursuit of such designation.
9.5.2. **Cardiac** – facilities that perform 24/7 percutaneous coronary intervention (PCI) for STEMI-patients and are accredited, or in pursuit of accreditation, by the Joint Commission, American Heart Association, or the American College of Cardiology
9.5.3. **Stroke** – facilities that are designated by the Texas Department of State Health Services as a Primary or Comprehensive Stroke Center
9.5.4. **Obstetrics** – facilities that have a 24/7 Labor & Delivery unit
9.5.5. **Sexual Assault** – facilities that have formalized Sexual Assault Nurse Examiners (SANE), and necessary equipment, available 24/7

10. Registries and Collaborative Data Sharing. The EPAB has further approved that all hospitals that wish to participate as Designated Specialty Receiving Facilities will participate in the appropriate registries (e.g., trauma, stroke) and will share outcome information with the OMD so as to determine the appropriateness of care.

11. **Non-traditional Emergency Care Facilities.** A non-traditional emergency care facility is a facility that is structurally separate from a hospital (that may be affiliated or unaffiliated with a Hospital network) and which receives an individual and provides emergency care. These facilities are <u>not</u> considered full-service hospitals. Currently approved Non-traditional Emergency Care Facilities are available on the Specialty Receiving Facilities List

12. Definitions of Hospital Divert Status
12.1. **Full Divert** – A hospital is CLOSED to ALL patients, including walk-in and EMS traffic.
12.1.1. Ambulance-only divert (where the facility remains open to walk-in traffic) is NOT permitted
12.1.2. When a facility formally declares an *Internal Disaster* and has closed to any new patients (EMS or walk-ins), they will be placed on Full Divert.
12.1.3. Examples of causes of Internal Disasters include, but are not limited to:
12.1.3.1. Structural damage to the facility, e.g., fire, explosion, flood, etc.
12.1.3.2. HazMat incidents
12.1.3.3. Hostage/Bomb Threat/Active Shooter situations
12.2. **Specialty Divert** - When a specific resource (e.g., all radiology, cardiac catheterization lab, etc.) is temporarily unavailable, leading to an inability to care for a specialized patient population

12.2.1. Trauma Divert

12.2.1.1. Trauma Divert may occur when a designated trauma facility no longer meets the requirements of a trauma center, e.g., no available OR/ICU bed, surgeon unavailable, etc.

12.2.1.2. Trauma divert may only be initiated with the agreement of the facility's on-duty Emergency Physician and Trauma Surgeon

12.2.1.3. Before a Level 1 or 2 Trauma facility will be placed on Trauma Divert, the Emergency Physician or Trauma Surgeon must first get approval from the other Level 1 or 2 trauma facility who will be responsible for receiving incoming trauma patients. The facility requesting divert must contact the MedStar Communication Center, who will then independently verify with the open facility before placing the requesting hospital on divert.

12.2.1.4. If all designated Trauma Centers simultaneously require Trauma Divert status, Trauma Divert status shall be removed system-wide. During such times, the MedStar Communication Center will aid with the appropriate distribution of trauma patients.

12.2.2. Cardiac Divert

12.2.2.1. Cardiac Divert may occur when a designated Cardiac facility no longer meets the requirements of a PCI center, e.g., no available cath lab, Interventional Cardiologist unavailable, etc.

12.2.3. Stroke Divert

12.2.3.1. Stroke Divert may occur when a designated Stroke facility no longer meets the requirements of a Primary or Comprehensive Stroke center, e.g., no available CT scanner, etc.

13. **Outpatient Hemodialysis Facilities -** During a Presidential and/or Texas Governor declared disaster, individuals receiving dialysis for the management of their End Stage Renal Disease (ESRD) may be taken to outpatient hemodialysis treatment facilities, if appropriate. Patients will be evaluated for any significant exacerbation of their ESRD symptoms and for any other acute medical conditions to ensure an appropriate destination for treatment. Patients requesting transport for dialysis, AND who are asymptomatic or have mild complaints consistent with their typical pre-dialysis symptoms (e.g., weight gain, edema, shortness of breath, fatigue, nausea/vomiting), may be transported to an outpatient dialysis facility.

14. **Divert Process** – The following process shall be followed for all changes to Divert status (Full or Specialty):

14.1. The Administrator on Call (AOC) for the facility requesting divert will notify the MedStar Communications Center of the type and expected duration of diverting and the names and direct phone numbers of the facility's on-duty Emergency Physician and AOC.

14.2. For Specialty Divert, MedStar Communications Center will notify the Medical Director, CEO, and Field Crews of facility divert status and timeframe.

14.3. For Full Divert, the below steps will be followed:

14.3.1. The Communications Center will dispatch a MedStar Operations Supervisor to the facility to meet with and offer assistance to the facility AOC and on-duty Emergency

Physician.

14.3.2. After this meeting, the Operations Supervisor shall initiate a conference call with the MedStar AOC, CEO (or designee if unavailable), and the Medical Director on-call

14.3.2.1. The ultimate responsibility of approving a Divert status lies with the Medical Director, as per Texas Medical Board Rule §197.3

14.3.2.2. Once the conference call has been completed, the MedStar AOC will notify the MedStar Communications Center to page on-duty field providers and managers regarding the hospital facility's divert status.

14.3.3. The facility must also update and notify local (e.g., EMResources/NCTTRAC, Emergency Operations Center) and state authorities (e.g., DSHS).

14.3.4. The facility's status shall be verified with the facility's AOC at least every 2-hours by the Operations Supervisor.

14.3.5. The MedStar AOC, CEO, Medical Director, and Facility AOC shall confer by conference call and review hospital divert status every six hours.

15. **After-Action Review**

15.1. Following any Full Divert activation, an after-action review will be held within 72-hours to include the following stakeholders:

15.1.1. Hospital CEO, CMO, or COO

15.1.2. MedStar CEO

15.1.3. Medical Director

16. **System-wide Disasters and Patient Overload**

16.1. In rare circumstances, such as prolonged public health emergencies, multiple System hospitals may be overwhelmed by large patient volumes in their Emergency Departments.

16.2. In these instances, a distributed patient allocation process may benefit the hospitals and patients of the System,

16.3. The decision to activate a distributed patient allocation process will be made by discussion amongst the MAEMSA Hospital Resource & Continuity Committee

16.3.1. Current members include the System Medical Director, MedStar's CEO and Chief Legal Officer, and representative CEOs from Baylor S&W, Cook Children's, Texas Health, Medical City, and JPS.

16.3.2. Decisions regarding this process will be communicated to the Emergency Department Medical Directors and/or EPAB representatives

Protocol Maintenance

1. **Purpose.** The Protocols, Procedures and Policies (PP&P) of the Office of the Medical Director (OMD) are based on current scientific data, evidence-based best-practices, and standards of care, where these are available. All PP&P are reviewed and approved by the Emergency Physicians Advisory Board (EPAB) of the Metropolitan Area EMS Authority (MAEMSA), which may include board-certified physicians representing a variety of specialties – e.g., emergency medicine, cardiology, pulmonology, public health, trauma surgery, psychiatry and critical care. This policy provides guidance on how these documents will be reviewed and revised to incorporate current best-practice and scientific advances in clinical care

2. **Scope.** This policy applies to OMD and all OMD-approved First Responder Organizations (FROs).

3. **Procedure.**
   - **3.1. Protocol Review and Revision**
   - **3.2. Periodic Review:**
     - 3.2.1. Current protocols related to all aspects of patient care, including specialty programs, will be reviewed by OMD at a minimum every 3-years.
     - 3.2.2. Revisions may be made in whole or in part and will be submitted to EPAB for review and approval.
   - **3.3. Approval of revisions, notification to affected personnel and necessary training:**
     - 3.3.1. Once EPAB approves any revisions to current PP&P, OMD will replace the existing electronic file with the revised document.
     - 3.3.2. MedStar Operations as well as the EMS coordinator of each First Responder Organization will be notified of any changes and will provide electronic copies of the revised document.
   - **3.4.** Any required training for approved changes will be developed by OMD in collaboration with all applicable agencies.
   - **3.5. Immediate Revision:**
     - 3.5.1. Revisions to PP&P may be implemented by the Medical Director prior to the next regularly scheduled EPAB meeting and submitted to EPAB at the next regularly scheduled meeting.
   - **3.6. Biennial Protocol Competency:**
     - 3.6.1. To ensure maintenance of clinical competency, MedStar and participating FROs may be tested in part or in whole, biennially with any protocol update or revision.
   - **3.7. Eligibility to Request Review:**
     - 3.7.1. Members of the Metropolitan Area EMS Authority (MedStar, FRAB, or EPAB) or receiving hospital or other facility may request a review of PP&P by OMD.

Safe Haven – Baby Moses

1. **Purpose.** As a MAEMSA System first responder agency that is recognized by the Texas Department of State Health Services under Chapter 773 of the Health and Safety Code as a First Responder Organization, in-service fire apparatus, or any MedStar ambulance, or ambulance station may be considered a "Safe Haven" for voluntary drop-off of children who appear to be 60-days old or younger in accordance with Texas Family Code, this policy defines the procedure for the care of an infant left at a recognized location.
2. **Scope.** This policy applies to all System providers.
3. **Procedure.**
   - **3.1. Assessment and Care**
     - 3.1.1. Perform initial assessment:
       - 3.1.1.1. Complete physical exam
       - 3.1.1.2. Gather complete family medical history
       - 3.1.1.3. Gather complete patient medical history
       - 3.1.1.4. Provide care:
   - **3.2. Provide care as indicated in accordance with OMD protocol**
   - **3.3. Transport**
     - 3.3.1. The newborn is to be transported to the closest full-service pediatric facility for further evaluation and treatment.
   - 3.4. **Notification**
     - 3.4.1. Notification is to be made to the Texas Department of Family and Protective Services regarding the surrendered newborn and destination of transport.

Medications, Equipment, Devices, and Supplies

(M.E.D.S)

1. **Purpose.** The uniform EMS Ordinance requires the Medical Director to set standards for patient care. Standards are to include vehicles and onboard equipment. This policy establishes the standards for equipment and supplies.

2. **Scope.** This policy applies to System ambulances, first responder vehicles, and special teams.

3. **Procedure.** All vehicles will be equipped per the approved inventory. Proposed changes in the inventory are to be submitted to the OMD for approval.

   3.1. **Brand Specific Items**: In certain cases the OMD may specify a particular brand of supply or equipment. The decision to specify a particular brand will be based on evaluation of available products and through the participation of representatives from agencies that will use the item.

   3.2. **Approved Inventory:** Each ambulance and FRO primary apparatus utilized in first response and transport shall carry at minimum the equipment and drug inventory listed on the applicable minimum inventory equipment and drug list signed by the Medical Director

   3.3. **Evaluation of New M.E.D.S.** This procedure is to assure that all new M.E.D.S is introduced into the MAEMSA System with the Medical Director's approval.
      3.3.1. The System agency will research and suggest new equipment.
      3.3.2. The System agency and the Medical Director agrees to perform a field trial (if necessary) on the specific equipment.
      3.3.3. The recommendation is brought to the Medical Director for approval.
      3.3.4. The Medical Director accepts or rejects the proposal.
      3.3.5. If the trial proposal is accepted, the System agency's designated personnel will perform a clinical field trial.
      3.3.6. If the trial proposal is rejected the item will be dropped from consideration but may be reviewed again later by the Medical Director if deemed necessary.

3.3.7. Once a clinical field trial is completed a representative of the System agency will present all available data to the Medical Director for review.
3.3.8. The Medical Director members will approve or reject the implementation of
3.3.9. The new item based on the following:
Logistics
3.3.9.1 Training requirements
3.3.9.2 Implementation constraints
3.3.9.3 Recommended items may require approval by the MAEMSA or RRO's municipality.

4. **Implementation of New Equipment**
5. If approved by the Medical Director and MAEMSA or FRO's municipality:
   5.1. The new equipment will be ordered by the Agency in a timely fashion.
   5.2. The Agency will perform all the necessary training of field personnel.
   5.3. The OMD will compose the applicable protocol and/or procedure for the new item.
   5.4. After the OMD has deemed that the proper training has been completed, the new equipment will be implemented in the field.
6. If rejected by the Medical Director the item will be dropped from consideration, but may be reviewed again at a later time if deemed necessary.

7. **Expiration of medications and supplies**
8. Expiration dates should be checked monthly and items replaced as they expire.

Upgrading Ambulance Responses

1. **Purpose.** This policy establishes the circumstances under which System first responder personnel may request a MedStar Ambulance response upgrade, the process for upgrading a response, and related QA activities.

2. **Scope.** This policy applies to First Responder personnel and affects response priority upgrades. The call would be upgraded based on the EMD criteria.

3. **Procedure.** Certain conditions may become apparent during initial contact with a patient that may not have been identifiable by an EMD, or that had a delayed onset, and that may warrant a response upgrade by MedStar.
   3.1. If a first responder arrives at the patient's side and identifies any of the following findings, conditions, or situations, a response upgrade to Priority 1 is warranted:
   3.2. Airway:
      3.2.1. There is complete airway obstruction; or
      3.2.2. The patient's airway cannot be maintained.
   3.3. Breathing:
      3.3.1. The patient has severe difficulty breathing;
      3.3.2. The patient cannot be ventilated.
   3.4. Circulation:
      3.4.1. An unanticipated cardiac arrest occurs or has occurred;
      3.4.2. Uncontrollable bleeding is present; or
      3.4.3. Severe loss of blood has occurred.
      3.4.4. Altered Level of Consciousness:
         3.4.4.1. The patient becomes unresponsive; or
         3.4.4.2. Status seizures.
      3.4.5. An upgrade to a Priority 2 may be requested if the first responder finds the patient's clinical condition to be urgent.
   3.5. **Requesting a Response Upgrade**. The first responder shall request a response upgrade by contacting their respective dispatch center and asking them to contact the MedStar

Upgrading Ambulance Responses

3.5.1. Communication Center for the purpose of upgrading a response priority. The reason for the upgrade is required when making such a request. The MedStar Communication Center will upgrade the response based on current EMD criteria.

3.6. **Audit of Upgrade Requests**. MedStar and each First Responder agency that has requested a response upgrade during the month shall conduct a 100% QA review of upgrade requests. The QA review shall meet the following requirements:

3.6.1. A cooperative review shall be conducted each month by MedStar's Communication Compliance Manager, the First Responder EMS coordinator, OMD representative, and other personnel who may be needed;

3.6.2. Together, they shall

3.7. Review the initial dispatch and the request for the upgrade;

3.8. Review of the first responder patient care report and the ambulance medic patient care report;

3.8.1.1. A QA report shall be provided to the Medical Director and shall include the total number of upgrade requests, the number of appropriate requests, and a qualitative summary of possible improvements to the process.

Walk-In Patients

1. **Purpose.** The purpose of this policy is to establish a uniform method of managing a person's arrival at fire or EMS stations requesting (explicit or implied) medical assistance.

2. **Scope.** This policy applies to all MAEMSA System agencies and their personnel.

3. **Compliance with Safe Haven Law(s).** See Safe Haven – Baby Moses

4. **Procedure.**
   4.1. **Walk-ins**. When a person arrives at a fire or EMS station requesting medical assistance or who is in obvious medical distress, personnel should:
   4.2. Perform initial assessments and administer indicated care in accordance with OMD protocol;
   4.3. Make indicated notifications as required by agency policy; and
   4.4. Request a MedStar ambulance.