IDAHO EMS MEDICAL SUPERVISION HANDBOOK

IDAHO DEPARTMENT OF HEALTH & WELFARE

TABLE OF CONTENTS

ACRONYMS

ACLS – Advanced Cardiac Life Support

ALS – Advanced Life Support

AEMT – Advanced Emergency Medical Technician

BLS – Basic Life Support

BTLS – Basic Trauma Life Support

CE – Continuing Education

CPAP – Continuous Positive Airway Pressure

CPR – Cardiopulmonary Resuscitation

DNR – Do Not Resuscitate

ECG – Electrocardiogram

EMR – Emergency Medical Responder

EMS – Emergency Medical Services

EMSPC – Emergency Medical Services Physician Commission

EMT – Emergency Medical Technician

EPC – Emergency Pediatric Care

HAZMAT – Hazardous Materials

ILS – Intermediate Life Support

LMA – Laryngeal Mask Airway

MSP – Medical Supervision Plan

NREMT – National Registry of Emergency Medical Technicians

OM – Optional Module

PALS – Pediatric Advanced Life Support

PCR – Patient Care Report

PEEP – Positive End-Expiratory Pressure

PERCS – Pre-hospital Electronic Record Collection System

PHTLS – Pre-Hospital Trauma Life Support

POST – Physician Orders for Scope of Treatment

QA/QI – Quality Assurance / Quality Improvement

SoP – Scope of Practice

SVT – Supraventricular Tachycardia

WMD – Weapons of Mass Destruction

INTRODUCTION

This guide is an introduction to the role, obligations and responsibilities of an Idaho Emergency Medical Services (EMS) Medical Director in conjunction with Idaho Codes § 56-1011 through § 56-1023; the Idaho Administration Procedures Act (IDAPA) 16.01.07, "Emergency Medical Services – Personnel Licensing Requirements", IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services Physician Commission"; IDAPA 16.02.03, "Emergency Medical Services"; and the State of Idaho EMS Physician Commission Standards Manual, Edition 2012-1.

In Idaho, licensed EMS Providers are only able to provide emergency medical services under the supervision of a designated Medical Director. Providers are individually licensed at four levels of care: Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT) and Paramedic. This guide will provide an overview of medical direction for EMS agencies in Idaho and serve as an introduction into this important healthcare role.

Please review the document "Providing EMS in Idaho" posted on the website.
http://healthandwelfare.idaho.gov/Portals/0/Medical/EMS/Providing_EMS_in_Idaho.pdf

The EMS Physician Commission can be contacted for information, clarification, and guidance by email at EMSPhysicianComm@dhw.idaho.gov, or through the Bureau of EMS and Preparedness at 208-334-4000, toll free at 1-877-554-3367, Fax 208-334-4015, or mail to P.O. Box 83720, Boise, ID 83720.

The Bureau of EMS and Preparedness (Bureau) website www.idahoems.org
The EMS Physician Commission website www.emspc.dhw.idaho.gov

MEDICAL SUPERVISION OVERVIEW

EMS in Idaho requires medical supervision, defined as medical direction from a licensed physician to licensed personnel affiliated with a licensed ambulance, air medical or nontransport service. This medical supervision includes, but is not limited to: establishing standing orders and protocols, reviewing performance of licensed personnel, providing instructions for patient care via radio or telephone, credentialing of EMS Providers, and other oversight. The Idaho Emergency Medical Services Physician Commission (EMSPC) describes this physician oversight in two main categories:

- Direct (On-Line) Supervision
  - » Contemporaneous instructions and directives about a specific patient encounter provided by a physician or designated clinician to licensed EMS Providers
- Indirect (Off-Line) Supervision
  - » Specific instructions, directives and protocols designed to guide licensed EMS Providers without the need for direct and real-time physician oversight
    - *See Medical Supervision Plan, page 18*

Qualifications to be an EMS Medical Director in Idaho are:

- Willingness to accept responsibility for the medical direction and supervision of the activities provided by an EMS agency and their licensed EMS Providers
- Commitment to obtain and maintain knowledge of the contemporary design and operation of EMS systems
- Commitment to obtain and maintain knowledge of Idaho EMS laws, regulation and standards manuals

Medical Directors may also have additional or optional responsibilities within their organization or agency. These could include, but are not limited to:

- Serving as a course physician for EMS education programs
- Acting as a liaison between EMS and other parts of the medical community

MEDICAL DIRECTOR AND AGENCY AGREEMENT

EMS Medical Directors are required to have a written agreement with each EMS agency they supervise. Agreements vary from agency to agency, but must, at a minimum, include the following elements:

- Identification of the EMS Agency
- Acknowledgement of the Medical Director's authority
- Effective date
- Expiration date or the provision for automatic renewal
- Assurance of Medical Director access to relevant agency, hospital or medical clinic records
- Plan for medical supervision

Other agreement elements to consider:

- Terms of employment
- Limitations on other employment
- Expected number of hours required per pay period
- Sick leave and/or vacation time
- Formal training on EMS medical direction for the Medical Director
- Representation at conferences, state meetings, etc.
- Supplied items (badges, radio, pager, uniforms, vehicle, etc.)
- Compensation, reimbursement for expenses, liability insurance or other benefits
- Establishing the agency's scope of practice, policies, procedures and protocols

Both parties to the agreement may choose to have the document reviewed by an attorney to ensure the necessary items are detailed and that both parties are treated equitably.

Per the EMSPC Standards Manual, the Medical Director will provide the Bureau with documentation of the agreement annually or upon request. This would be required when an agency changes medical directors. The medical director can submit an email or letter to the Bureau attesting to the agreement, or submit the agreement. *A sample medical director and agency agreement can be found on the website.*
http://healthandwelfare.idaho.gov/Portals/0/Medical/EMS/SampleMedicalDirectorAndAgencyAgreement.doc

SCOPE OF PRACTICE

The scope of practice (SoP) of licensed EMS Providers in Idaho is established by the Idaho EMSPC. SoP describes each level of licensed EMS Provider (EMR, EMT, AEMT and Paramedic) and identifies the allowable skills and interventions each Provider is able to perform.

Licensed EMS Providers receive training and demonstrate competency in each skill and intervention that lies within their *floor*. Floor skills are basic proficiencies included in Idaho's approved EMS curricula. They establish a standardized baseline SoP for licensed EMS Providers. Floor skills must be verified by examination and state EMS licensure; additionally, prior to practicing emergency medical services, all Providers must also be credentialed by the EMS Medical Director. (*See Credentialing, page 10, for more on credentialing and the process therein.*)

If so desired, the Medical Director may restrict the SoP for the licensed EMS Providers under their supervision; conversely, the Director may also expand the SoP through the use of optional modules (OMs) that have been designated by the EMSPC and meet the requirements of the Bureau. These local scope modifications may be done at the agency level, blanketing all licensed EMS Providers at the agency, or on a case-by-case basis for each individual Provider.

Skills and interventions designated as OMs must be authorized by the Medical Director. These skills are above the floor skills of the specified level of EMS licensure. The Medical Director must ensure that licensed EMS Providers receive appropriate initial *and* continuing training for the OMs. Because state licensing does not address OM skills and interventions, the Medical Director must take an active role in verifying competency of their OMs.

Training for OMs designated as 2,OM must be conducted according to the approved curriculum for the level where the skill or intervention exists as a floor skill.

- The training must provide for all didactic, psychomotor, lab and clinical learning over the skills as described in the National Education Standards and the Idaho EMS Curricula (IEC).

- The student must be trained and evaluated to the depth and breadth of competency for the level of training where the skill exists as a floor skill.
- Psychomotor exams conducted according to the Idaho EMS BLS Exam guide or the NREMT Advanced Exam procedures are required for all OM skills where the skill exam is required as a floor skill.

There is a formal tracking process for OMs which is administered by the Bureau. The requirements align with the EMSPC Standards Manual. For more information or to review the approval process, contact the Bureau directly or visit the Optional Module Resources page on the website.
http://healthandwelfare.idaho.gov/Medical/EmergencyMedicalServicesHome/Education/OptionalModuleResources/tabid/1966/Default.aspx

(*See Appendix B for the EMSPC approved Addendum to Medical Supervision Plan for Optional Modules*
http://healthandwelfare.idaho.gov/Portals/0/Medical/EMS/OM_Addendum_2013.pdf

and Appendix C for a sample optional module credentialing matrix.
http://healthandwelfare.idaho.gov/Portals/0/Medical/EMS/OM_Credentialing_Matrix.xls)

CREDENTIALING

The EMS Medical Director is responsible for the credentialing of licensed EMS Providers under their supervision. Credentialing is the local process for verifying of competency and privilege by which licensed EMS Providers are authorized to provide medical care. It is an extension of the agency's affiliation requirement and is required for an EMS Provider to practice. Credentialing must stay within a Provider's established SoP.

When a licensed EMS Provider affiliates with an agency, it is the responsibility of the Medical Director to determine whether the Provider has been properly trained and is prepared to provide medical care. An initial process should be in place to verify the new Provider's licensure and training, along with conducting competency assessments. The new Provider should also be oriented to specific agency operations, local policies, procedures and protocols.

For new hires and ongoing credentialing, the Medical Director may consider using a credentialing checklist that the licensed EMS Provider(s) and agency administrator(s) complete and submit to the Medical Director for review and evaluation. The Medical Director may appoint a designee/signature authority who may conduct the review in their stead. (*See Appendix D for a sample initial credentialing worksheet.*)
http://healthandwelfare.idaho.gov/Portals/0/Medical/EMS/SampleCredentialingWorksheet.doc

These credentialing records should be included in each personnel file. These documents and files should be made available by the agency for the Medical Director or their designee to review at any time. As a common practice, the Medical Director may select a number of personnel files for review. The credentialing process is best completed with a final interview between the Provider and the Medical Director. This affords the Medical Director an opportunity to interact with the Provider while continually evaluating the Provider's ability to provide medical care. (*See Appendix E for a sample credentialing checklist.*)
http://healthandwelfare.idaho.gov/Portals/0/Medical/EMS/SampleCredentialingChecklist.doc

A master list that includes all affiliated EMS Providers should be maintained which allows the Medical Director, at the completion of the process, to track and sign off on a Provider's successful credentialing. Consequently, the Medical

Director may withdraw approval of a licensed EMS Provider to practice when they fail to meet or maintain established proficiencies.

Credentialing reviews will include the following:

- Verification of Idaho EMS license
- Affiliation with current EMS agency and all other EMS agency, hospital and/or medical clinic affiliations
- Completion of an EMS agency orientation with an overview of policies, procedures, protocols, communication procedures, facility destination policies and other unique system features

Recommended additional items that may be reviewed during credentialing:

- Driver's license
- Current CPR card
- NREMT registration(s)
- Current ACLS, PALS, EPC, PHTLS, BTLS certifications
- Education records
- Instructor status
- Course Coordinator designations
- Criminal history background check
- Any previous, inactive agency affiliations
- Employment history and references
- Continuous verification of skills competency

Upon completion of the credentialing process, the Medical Director may issue the licensed EMS Provider with documentation indicating approval to provide patient care as well as any modifications to the individual's SoP. Skills competency verification for Provider license renewal and OM authorization may also be considered part of the credentialing process. (*See Appendix F for a sample credentialing process form.*)
http://healthandwelfare.idaho.gov/Portals/0/Medical/EMS/SampleCredentialingProcessForm.doc

Though routine credentialing does not need to be reported to the Bureau, Idaho Code § 39-1393, http://legislature.idaho.gov/idstat/Title39/T39CH13SECT39-1393.htm, mandates that any withdrawal of approval to provide medical care must be reported, in writing, within fifteen days of the withdrawal.

PROTOCOL DEVELOPMENT

One of the more basic, but daunting, tasks of medical direction is that of protocol development. While licensed EMS Providers are educated on standard treatments for specific conditions, it is through the use of protocols that patient care is delivered. Protocols are written orders from the EMS Medical Director that give guidance to licensed EMS Providers on how to respond in certain situations, what Providers are able to do when treating patients and when to call in for additional instructions. They are important educational tools and quality improvement instruments (*see Quality Assurance and Quality Improvement, page 14*).

Protocols are to be included in the Medical Supervision Plan (*see Medical Supervision Plan, page 18*). The Idaho EMSPC requires Medical Directors to review agency protocols at least every two years to ensure protocols are up-to-date and appropriate. At a minimum, the EMSPC requires agencies to maintain the following policies, procedures and protocols:

- Air Medical Dispatch Guidelines
- Do Not Resuscitate (DNR) and Advanced Directives
- Safe Haven Guidelines
- Dispatch and Deployment
- Communication Procedures
- Patient Refusal
- Treat and Release
- Determination of Death
- Termination of Resuscitation
- Documentation (Patient Care Reports)
- Hospital and Facility Destinations
- Medical Treatment Protocols (Adult and Pediatric)
- Safe Haven Guidelines
- Authorized Equipment
- Disaster Response
- Scene Management
- Off-Duty EMS response
- Physician-on-Scene
- Modification of Response
- Triage, Treatment, Transport

Protocols and procedures fit within three broad categories: Medical Treatment Protocols, Medical Procedures, and Administrative Policies and Procedures. Medical Treatment Protocols consist of clear descriptions of what licensed EMS Providers should provide for patient assessment and care. If an agency deploys multiple levels of Providers, the protocols must clearly specify the actions appropriate for each level. Medical Procedures outline how Providers should

conduct specific interventions and skills step by step. Administrative Policies and Procedures summarize operational and procedural considerations rather than patient treatment. Examples include: patient refusal protocols, air-medical utilization and inter-facility transfer procedures.

The goal of EMS is to prepare for and provide the best possible patient care. Uniform protocols and procedures allow for improved communication and a consistent approach while providing clear expectations. It is important to remember that protocols and procedures need to take into account local and regional community resources and attributes.

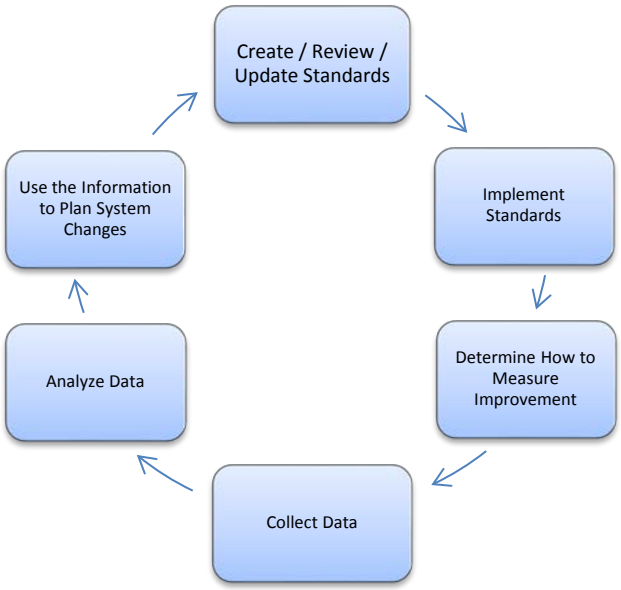
The EMSPC has developed statewide protocols and procedures for medical directors to adopt as a resource. They are available on the website and will be reviewed annually for updates. The Bureau can have printed copies prepared for field users as well. Contact the Bureau for further information at 208-334-4000 or toll free at 1-877-554-3367.
http://healthandwelfare.idaho.gov/Portals/0/Medical/EMS/EMSPC_protocols.pdf

QUALITY ASSURANCE AND QUALITY IMPROVEMENT

Quality assurance and quality improvement (QA/QI) will not occur without the willingness to admit mistakes or problems, examine failure, and make the needed changes. Further information may be found in "A Leadership Guide to Quality Improvement for Emergency Medical Services Systems"
http://healthandwelfare.idaho.gov/Portals/0/Medical/EMS/LeadershipGuideToQualityImprovement.pdf

Having strong and visionary leadership to guide an organization will steer employees in the right direction. EMS Medical Directors have ultimate responsibility for the quality of care provided within a system; a solid quality assurance program is key. Often, QA/QI seems like an intimidating task. Start small. Understand that QA/QI is a continuous process. Looking at data from a retrospective view and only one factor at a time will make QA/QI feel less complicated.

Below is an example of a QA/QI process continuum. The continuum does not have a beginning or end because it should be an ongoing process. For an EMS system where standards are already in place, the Medical Director may begin at any point in the process. The collection of data or various types of quantitative material is essential to any QA/QI process. This gives the agency and Medical Director something that can be measured and analyzed. A communication plan is important to disseminate change and implement new standards.



While retrospective, record reviews can offer good insight into the quality of care that is being provided by an agency's licensed EMS Providers, in addition to personal observations or comments from patients or other medical professionals. It is good practice to review all calls where the patient refuses care or transport as well as any calls where the patient's condition deteriorated while under the care of the licensed EMS Providers.

Each agency should have an individual responsible for internal chart reviews and maintenance. This individual is able to assist the Medical Director with identifying any charts requiring or needing further review (*see Appendix I for a sample records review form*).
http://healthandwelfare.idaho.gov/Portals/0/Medical/EMS/SampleRecordsReviewForm.doc
IDAPA 16.02.03, "Emergency Medical Services", requires records of each non-transport vehicle, ambulance and air medical responses to be maintained. The following data are required at a minimum:

- Name of ambulance service
- Date of response
- Time call received
- Time en route to scene
- Time of arrival at scene
- Time service departed scene
- Time of arrival at hospital or other destination
- Location of incident
- Description of patient illness/injury
- Description of pain management
- Patient destination
- Ambulance unit identification
- Identification and licensure level of each responding crew member
- Response outcome

The Medical Director may expand on these minimum requirements, if desired.

Records must be maintained by the agency and submitted to the Bureau at least quarterly in a Bureau-approved format. There are two approved methods agencies may choose to submit patient care records (PCR): manual and electronic.

- Manual: This method utilizes a Bureau-specific paper bubble sheet that is filled out, sent to the Bureau and recorded. It has limited use and is not

recommended for all settings; however, it may be adequate and appropriate for smaller agencies with a low call volume.

- Electronic: This method utilizes the Pre-hospital Electronic Record Collection System (PERCS) application. This internet-based application is funded and supported by the Bureau and meets national data submission standards. It is a statewide data system that allows agencies the flexibility to collect their own data and upload it to the Bureau directly. The PERCS application enables agencies to securely collect, analyze and report pre-hospital data while granting the Medical Director access to review records.
    - *Visit www.idahopercs.org for more on the PERCS application.*

Following the records review, providing feedback is considered continuing education for the Providers and helps the Medical Director know what kind of care is being provided in the community (*see Continuing Education, page 16*).

As per Idaho Statutes 39-1392b, all peer review records are confidential and privileged.
http://legislature.idaho.gov/idstat/Title39/T39CH13SECT39-1392b.htm

EMS agencies often focus on the most easily measured items to begin a quality improvement program rather than the broader, more universal issues. Medical Directors and agency administrators must work together with staff members to evaluate, plan and change. (*See Appendix J for a series of questions that may help in initiating a QA/QI process.*)

CONTINUING EDUCATION

To maintain their license, EMS Providers must complete a certain number of continuing education (CE) hours in various venues and categories. EMS Medical Directors should be actively involved in the CE process for the Providers they supervise. This includes not only approving CE, but also instructing on a regular basis. The content should include a general review of anatomy, physiology and the applicable protocols. CE is intended to raise the educational standard among Providers and should include material other than that found in entry-level textbooks—remember to include new and recent advancements in medical treatment and research. Practicing skills is an important part of CE and gives the Medical Director an opportunity to observe their Providers and assist with skills maintenance.

Run Reviews are an excellent form of both quality assurance and CE. The Medical Director can reinforce important clinical issues pertaining to signs, symptoms and selected treatments. Involve the crew and have them discuss certain aspects of the call such as dispatch, response, initial presentation, treatment and transport. It is suggested to include any hospital follow-ups and patient outcomes in the discussion as well.

To ensure an EMS Provider maintains a comprehensive and well-rounded education, Idaho requires that a Provider have a variety of CE in various categories and venues. Some of these venues lie specifically with the Medical Director; for example, the CE venue titled *Agency Medical Director Approved Self Study or Directed Study*. An agency Medical Director may identify an educational component or module they feel is important to their agency and approve that venue for all Providers.

Additional venues can be found in Section 310 of IDAPA 16.01.07, "Emergency Medical Services – Personnel Licensing Requirements".
HTTP://ADMINRULES.IDAHO.GOV/RULES/CURRENT/16/0107.PDF

MEDICAL SUPERVISION PLAN

The Medical Supervision Plan (MSP) is considered the *how* of medical direction. It is how the EMS Medical Director ensures their agencies' and Providers' competency and quality of care. While the Medical Director is responsible for developing, implementing and overseeing a Medical Supervision Plan (MSP), other EMS personnel may assist in this process. The MSP will provide information for on-scene, educational and proficiency standards. The MSP will be provided to the Bureau upon request.

At a minimum, the MSP must consist of the following elements:

- Credentialing of licensed EMS Providers (*see page 10*)
- Indirect (off-line) medical supervision
  - Standing orders and treatment protocols (*see page 12*)
  - Authorized optional modules (*see page 8*)
  - Continuing education (*see page 17*)
  - Methods for quality assessment and improvement (*see page 14*)
  - Provisions for mass-casualty incidents and/or disaster response
  - Off-duty response of EMS Providers
  - Triage treatment and transport guidelines
  - Scene management
  - Patient destinations
  - Air medical services utilization
  - Policies for predicted patient non-transport scenarios
  - Criteria for cancelation or modification of EMS response
  - Authorized equipment
  - Communications guidelines
  - Documentation of services
  - Utilization of bystanders
- Direct (on-line) medical supervision
  - Identification of designated clinicians
  - Continuous (24/7) availability plan
  - Procedures for preexisting relationships with patients
  - Methods for communication (radio, cellular phone, tablet, etc.)

For more detailed information on the MSP, please reference the Idaho EMSPC Standards Manual which can be found on the website www.emspc.dhw.idaho.gov .
http://healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=DlWYPF5feWA%3d&tabid=1609&portalid=0&mid=4278

Medical Supervision Plan development guide
http://healthandwelfare.idaho.gov/Portals/0/Medical/EMS/MedicalSupervisionPlanDevelopmentGuide.doc

Appendix H – *Recommended Protocols*

This list is designed to assist EMS Medical Directors and agency administrators in the development of agency protocols. While several of the listed topics may not apply to all agencies within the state, those topics listed in boldface are specifically required; they are referenced in IDAPA 16.02.02 and the Idaho EMSPC Standards Manual.

ADMINISTRATIVE PROTOCOLS

- Child Abuse
- Children with Special Healthcare Needs
- **Communication with Medical Control**
- Death and Dying
  - **Determination of Death**
  - Deceased Subjects
  - Discontinuation of Pre-hospital Resuscitation
  - **Do Not Resuscitate (DNR) Comfort One, Physician Orders for Scope of Treatment (POST)**
- **Documentation of the Pre-hospital Primary Care Report (PCR)**
- Documentation of Vital Signs
- Domestic Violence
- **Emergency Medical Dispatch**
  - **Cancellation or Modification of EMS Response**
  - Deployment
  - **Level of EMS Response**
- **Equipment Authorized for Patient Care**
  - Equipment Failure
- **Infant Abandonment – Safe Haven Act**
- **Mass Casualty, Disaster or Event Response**
  - Multiple Person Incident Rapid Evacuation
  - **Scene Management for Multiple Agency Response**
  - Scene Rehabilitation
  - Weapons of Mass Destruction (WMD) Protocol – Cyanide
  - WMD Protocol – HAZMAT
  - WMD Protocol – Nerve Agents
  - Vaccination Administration
- **Off-Duty EMS Personnel Providing Care**
- Patient Self-Medication
- Patient without a Protocol
- **Physician-on-Scene**
  - **Bystander Physician**
  - **Medical Director or Designee**
  - **Patient's Personal Physician**
- Poison Control
- Professional Disciplinary Procedure
- Pulseless Electrical Activity
- **Radio Communications**
- **Triage**
  - Trauma Center Triage Criteria
  - Triage Algorithm
- **Treatment** *(see Adult and Pediatric Protocols Below)*
- **Transport**
  - **Air Medical Services Transport**
  - **Hospital / Facility Destination**
  - Hospital Diversion
  - Inter-Facility Transport
  - **Nontransport of Patients**
  - Non-Paramedic Transport of Patients
  - Safe Transport of Pediatric Patients

PROCEDURAL AND EQUIPMENT PROTOCOLS

- 12-Lead Electrocardiogram (ECG)
- Airway
  - Bouge-Assisted Intubation
  - Intubation Confirmation – Esophageal Bulb
  - Laryngeal Mask Airway (LMA)
  - Nasotracheal Intubation
  - Orotracheal Intubation
  - Respirator Operation
  - Suctioning, Advanced
  - Suctioning, Basic
  - Ventilator
    - Positive End-Expiratory Pressure (PEEP)
    - Continuous Positive Air Pressure (CPAP)
- Blood Glucose Analysis
- Capnography
- Cardio-Pulmonary Resuscitation (CPR)
- Cardioversion
- Chest Decompression
- Cricothyrotomy
- Decontamination
- Defibrillation
  - Automatic
  - Manual
- External Pacing
- Fire Scene Response
- Impedance Threshold Device
- Intranasal Medication Administration
- Naso-Gastric Tube
- Orthostatics
- Pulse Oximetry
- Restraints
- Splinting
- Thrombolytic Screen
- Tourniquet Application
- Venous Access
  - Existing Catheters
  - Extremity
  - Intraosseous, Manubrial
  - Intraosseous, Tibial
- Vital Sign Assessment
- Wound Care

ADULT PROTOCOLS

- Abdominal Pain
- Airway, Adult
  - Airway, Adult – Failed
- Allergic Reaction
- Altered Mental Status
- Asystole
- Atrial Fibrillation
- Back Pain
- Behavioral Emergencies
- Bites and Envenomations
- Bradycardia
- Burns
- Cardiac Arrest
- Chest Pain / Suspected Cardiac Event
- Childbirth / Labor
- Dental Problems
- Drowning / Near-Drowning
- Electrical Injuries
- Epistaxis
- Extremity Trauma
- Eye Injury / Eye Complaints
- Fever
- Head Trauma
- Hypertension
- Hyperthermia
- Hypotension / Shock, Non-Traumatic
- Hypothermia
- Induced Hypothermia
- Intravenous Access
- Multiple Trauma
- Obstetrical Emergencies
- Overdose / Toxic Ingestion
- Pain Control
- Patient Safety
- Police Custody
- Post-Resuscitation
- Pulmonary Edema
- Respiratory Distress
- Seizure
- Spinal Immobilization Clearance
- Suspected Stroke
- Supraventricular Tachycardia (SVT)
- Syncope
- Trauma Arrest
- Universal Patient Care
- Ventricular Fibrillation
- Ventricular Tachycardia
- Vomiting / Diarrhea
- Wide Complex Tachycardia with Pulse
- Well Persons Check

PEDIATRIC PROTOCOLS

- Airway, Pediatric
- Allergic Reaction
- Altered Mental Status
- Bradycardia
- Burns
- Extremity Trauma
- Head Trauma
- Hypotension
- Multiple Trauma
- Newly Born
- Overdose / Toxic Ingestion
- Pain Control
- Pulseless Arrest
- Respiratory Distress
- Seizure
- SVT
- Vomiting / Diarrhea

Records Review Form

Date: _____

Run #_____ Crew: _____

Standard	Yes	No	Comment
2 Sets of VS?			
Protocol Followed			
Narrative			
Signatures			
Call involves: • Cardiac Arrest • Chest Pain • Respiratory arrest or airway compromise • Major Trauma • Stroke • Unconscious • Pediatric • Use of restraints • Any protocol deviation			If yes, then refer to medical director for review.

Medical Director Review:

_____

_____

_____

_____

_____ _____

Medical Director Signature Date

Appendix J – *Questions to Help Initiate a QA/QI Process*

NHTSA / HRSA: "A Leadership Guide to Quality Improvement for Emergency Medical Services"
http://healthandwelfare.idaho.gov/Portals/0/Medical/EMS/LeadershipGuideToQualityImprovement.pdf

Process

- Is dispatch scripted and prioritized?
- Are timepieces synchronized between crew, station, and dispatch at the beginning of each shift?
- Are internal time standards consistent with local, regional, and national standards?
- Do the assessment & treatment protocols meet local, regional, and national standards?
- Was the patient care report completed accurately to reflect the events of the call?
- Are communications recorded for later review, if necessary?
- Is real-time data gathered in a way that can be readily used for statistical analysis?
- Is there a review process for bad outcomes?

Empowerment

- Does the crew have the knowledge and authority to create a safe zone for patient care?
- Does the crew understand how to work in concert with other agencies, Good Samaritans, and bystanders during multi-response situations?
- Do employees understand how to resolve differences of opinion with respect to patient care?
- Are training officers encouraged to tailor education programs to alleviate weaknesses?
- Do unions work with the organization to require remediation plans for staff who fail to meet individual standards?

Customer Service

- Is the caller treated with respect and concern?
- Does the dispatcher help calm frantic callers?
- Is the patient treated with compassion and respect?
- Are the needs of family members and/or other concerned individuals met?
- Are privacy issues handled appropriately and according to law?
- Are complaints handled by people with the authority to make decisions, including financial ones with regard to patient billing?
- Does the crew interact well with other agencies and public services?

Organizational Culture

- Do employees feel free to make improvement suggestions that are considered fairly?
- Are employees freely able to admit mistakes in order to learn from them?
- Do employees understand the expectations of their EMS system?
- Do employees understand their rights and responsibilities in the EMS system?
- Does the leadership provide the crews with the equipment and resources to meet the community standard of care?
- Is the organization staffed to meet the usual call volume?
- Does the organization plan for future staffing, equipment, and other needs?
- Does the budget meet the required and expected needs?
- Does the organization collect reliable information and use it to locate weaknesses in the system?
- Does the organization regularly review internal policies and procedures with the goal of improving the organization?
- Is organizational leadership willing to make the effort to evaluate their system and make the changes necessary to improve?

Administering Quality Improvement

- Administration/Medical Director meetings
    - What areas need the most improvement?
    - Who will gather and analyze the data?
    - How long will it take to gather and analyze data?
    - What are the possible results of the analysis?
    - Latest EMS research
    - Realistic/reasonable goals
- Meetings/forms/interviews with staff
    - How do you actually do _____? (every little step)
    - Why do you think _____ didn't work properly?
    - What are your ideas for making _____ work better?
- When a problem seems to rest in an individual
    - Attitude of teaching and improvement before punishment
    - Due process
    - Remediation
- Making changes
    - Getting universal support and involvement
        - Be a cheerleader, not a dictator
        - Everyone in the system needs to know the plan and be allowed to comment
    - Communicate why change is being made and expected results
        - Notification
        - Training
        - Questions/Answers
    - Follow-up (is everyone doing it the new way?)
    - Positive feedback
- Re-cycle through the process
    - Measure improvement
    - Fine-tune changes

Congratulate everyone and publicize (at least internally) the improvement!

Appendix K – *Medical Supervision Plan Development Guide*

The MSP can include more than the criteria that are on this list, and it can be submitted in an organizational structure that differs from the one below. Including this table at the beginning of the MSP, with page numbers referenced in your plan, will assist the Bureau to verify that your agency is in compliance with the listed requirements.

Please include the agency or agencies name(s), area(s) of service, and medical director's name in the introduction.

A. EMS Personnel Credentialing Process *Describe procedures; include copies of forms and policies, etc.* *(See* Credentialing of EMS Personnel *for additional information.)*	**EMSPC Standards Manual** Page 8	**Located on MSP page**
1. Bureau License Verification		
2. Affiliation to the Agency		
3. Qualifications, Proficiencies, and Affiliation Review		
4. EMS Agency Orientation		
a. EMS Agency Policies		
b. EMS Agency Procedures		
c. Medical Treatment Protocols		
d. Radio Communications Procedures		
e. Hospital/facility Destination Policies		
f. Unique System Features (if any)		
B. Indirect (Off-line) Supervision *(See* Protocols *and* Quality Improvement *for more information)*	**EMSPC Standards Manual** Page 9-10	
1. Written Standing Orders and Treatment Protocols (including direct [on-line] supervision criteria)		
2. Description of authorized optional psychomotor skills and patient care interventions (as defined by the Commission)		
3. Initial and Continuing Education (in addition to those required by the Bureau)		
4. Methods of Assessment and Improvement		
5. Periodic Assessment of Psychomotor Skill Proficiency		
6. Medical Supervision of Licensed EMS Personnel in Disaster or Incident Response		
7. Off-Duty EMS Response		

8. Credentialing of EMS Personnel for Emergency Response		
9. Emergency Response Based on Dispatch Information		
10. Triage, Treatment, and Transport Guidelines		
11. Scene Management for Multiple Agency Response		
12. Patient Destination Determination Criteria		
13. Utilization of Air Medical Services		
14. Patient Non-Transport Scenarios • Patient refusal • Treat and release • POST, DNR, and other valid orders • Determination of death • Termination of resuscitation • Other non-transport scenarios		
15. Cancellation/Response Modification Criteria		
16. Equipment Authorized for Patient Care		
17. Medical Communications Guidelines		
18. Documentation Methods and Elements		
19. STEMI policies and protocols (see STEMI Toolkit on website for more information)		
20. Policy for recognition and utilization of bystander providers not credentialed by local EMS system		
C. Direct (On-line) Supervision	**EMSPC Standards Manual** Page 10	
1. Physicians designated to provide direct supervision *(Include contracts or agreements with hospitals, physicians, etc. to provide direct supervision)*		
2. Clinicians designated to provide direct supervision (if any) *(include written agreements describing roles & responsibilities, and authorization from a supervising physician for Physician Assistants)*		
3. On-scene supervision procedures *(see* Protocols*)* • Designated physician supervisor • Patient's private physician • Bystander physician • EMS Provider-supervisor		
D. Supervision and Training of EMS Students *Include if your agency participates in EMS Training Programs*	**EMSPC Standards Manual** Page 10	

1. Clinicals		
2. Internships		
3. Ride-Alongs		
4. Other Training		
E. Other Suggested Components		
1. Bureau Notification Requirements and Deadlines *(who is responsible for reporting to the Bureau and when?)*		
2. Deployment of Personnel Resources *(Describe staffing, call schedule, call response, etc.)*		
3. Collaboration With Other Medical Directors		
4. System Integration *(describe how this service will integrate with the local, county, or regional disaster preparedness plans)*		
5. Contracted Training Services *(Identify locations that will provide training services for the agency)*		
6. Quality Improvement Plan *(See* Quality Improvement *for more information)*		
7. Interfacility Transfer (if applicable) • Hospital <-> Nursing Home • Hospital <-> Hospital • Home <-> Hospital • Personnel Used (for patients needing higher level of care than available by agency)		
8. Review-Update Procedures and Timelines • Protocol Review • Credentialing Review • Equipment/Facilities Review • Staffing Review		

Appendix L – *Acknowledgements*

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