

HEMS
System Protocols – Facility and Service Participation
Supplemental Letter of Compliance for Additional Service

2020-21 Renewal

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AGENCY: _____ **Initial** _____ **Renewal** _____ (check one)

LEVEL OF LICENSURE: _____

Non-Transporting Services: Name of Transporting EMS Service _____

Section 1: Must meet requirements in Step 1 before proceeding to Step 2.

Please answer the following question to determine your agency's compliance with the EMS Act. (P.A. 368 of 1978 as amended) to be licensed by MDCH to operate in the HEMS MCA:

1. Detail in the space below the agency's emergency service area meeting the HEMS protocol response time criteria and the jurisdiction the service area is located:

2. Does your agency have at a minimum 1 (one) ambulance available 24-hours a day, 7 days a week to respond only to emergencies within the service area identified above, meeting HEMS MCA response time criteria? Yes: _____ No: _____

a. If yes, provide the address/location of the ambulance dedicated to respond only to requests for emergency response within the service area.

b. If yes please attach a three month 24-7 staffing schedule for the ambulance dedicated to respond only for emergency request.

3. What documentation can be provided to support that a minimum of 1 (one) ambulance is available 24 hours a day, 7 days a week to respond only to requests for emergency response within the service area described in question 1, above. (check all that are applicable, but at least one and attach documentation):

____ Jurisdiction municipal 9-1-1 provider (*no documentation needed*)

____ Contract with jurisdiction to provide 9-1-1 response/transportation

____ Letter (or contract) from authorized jurisdictional representative recognized the presence of and availability of 1(one) ambulance to respond to request for emergency response within the service area described in question 1.

____ Other documentation of the presence of and availability of 1 (one) ambulance to respond to requests for emergency response within the service area described in question 1. Meeting HEMS MCA protocol response time requirements, such as run reports of actual emergency responses from the current 12 month license period etc.

4. Agency PCR data is submitted to MI-EMIS: YES _____ NO _____

Name of Program used: _____

Is the program compliant with NEMIS version 3 Image Trend Elite system? YES _____ NO _____

MCA Name: HEMS, Inc. (Wayne County)

MCA Board Approval Date: April 11, 2013, March 12, 2015, March 10, 2016, March 14, 2019

MDCH Approval Date: August 15, 2013

MCA Implementation Date: October 12, 2013, April 1, 2015, April 1, 2016

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5. EMS personnel submit PCR or Field note (protocols 7.15 & 7.15(S) & 8.29) to ED Staff before leaving the ED to facilitate the transfer of patient care: YES____ NO____
6. EMS Agency & Personnel complete annual protocol updates & training: Yes____ No____
7. EMS Agency utilizes Alternate Staffing Protocol: YES____ NO____. (If No skip rest of questions)
 - a. Agency complies with required Alternate Staffing reporting requirements as outlined in protocol 8-16. Yes____ No____

Section 2: Facility and Service Participation	<u>YES</u>	<u>NO</u>	<u>N/A</u>
1. When providing primary emergency response service agency assures a response time meeting the following protocol response time criteria:	___	___	___
<ul style="list-style-type: none"> • Maximum response time of eight (8) minutes For ninety (90%) percent of the runs (when a response time for BLS does not exceed and average of four (4) minutes. • Additional consideration will be given to population density and square mile coverage. It is expected that the more sparsely populated areas of the MCA may have response times up to fifteen (15) minutes. 			
2. Agency has verified, via the Department license verification website, that assigned medical personnel are currently licensed in accordance to Department regulations and has attached a personnel roster including license #s and expiration dates.	___	___	___
3. Transporting Units – Agency complies with minimum staffing requirements set forth by HEMS.			
BLS Unit – (1) EMT-B & (1) MFR	___	___	___
LALS Unit – (1) EMT-S & (1) EMT-B	___	___	___
ALS Unit or 12 Lead Unit* – (1) Paramedic & (1) EMT-S	___	___	___
Expanded Scope Transfer* – (1) Expanded Scope of Practice Paramedic & (1) Specialist	___	___	___
Critical Care – (1) CCT Paramedic & (1) Paramedic	___	___	___
* (Alternate Staffing may apply)			
4. Non Transporting Units – Agency complies with Minimum staffing requirements set forth by HEMS.			
MFR – One MFR	___	___	___
BLS – One EMT-B	___	___	___
LALS – One EMT-S	___	___	___
ALS – One Paramedic	___	___	___

MCA Name: HEMS, Inc. (Wayne County)

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5. Agency agrees to provide mutual aid to all agencies in HEMS when available.	___	___	___
6. EMS personnel within the agency are compliant with current NIMS training courses.	___	___	___
7. Agency EMS Communications are in compliance with the MEDCOM plan and HEMS EMS Communications Interoperability protocol.	___	___	___
8. The agency verifies that all EMS personnel meet skill competency with regards to Department, Regional and HEMS protocol requirements.	___	___	___
9. Assigned medical personnel of agency are current in the following: MFR- BLS Card, EMT-B/ BLS Card, EMT-S/ BLS Card, Paramedic, Expanded Scope of Practice Paramedic & CCT Paramedic – BLS & ACLS Card, and the agency has attached a personnel roster with the expiration dates.	___	___	___
10. Agency complies with the Department and HEMS equipment requirements.	___	___	___
11. Agency has made provisions for continued maintenance of bio-medical communication-telemetry equipment.	___	___	___
12. Agency participates in HEMS integrated Agency-System Quality Improvement and PRSRO to preform professional practice review functions including review of prehospital care provided in the MCA & recommendations for improvements of such care, based upon approved protocols.	___	___	___
13. Agency has made provisions for continued maintenance of EMS Vehicle.	___	___	___
14. Number of Vehicles:	Non -		
	Transporting	Transporting	
MFR	___	___	
BLS	___	___	
LALS	___	___	
ALS	___	___	
Critical Care	___	___	

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15. Number of Personnel: Please be as accurate as Possible. This information will be used by HEMS Public Health, and others for the continued improvement And care of the personnel within the HEMS MCA.

MFR	_____
EMT-B	_____
EMT-S	_____
Paramedic	_____
Expanded Scope of Practice Paramedic	_____
Critical Care	_____
Total # of Agency Employees (include all support)	_____

I ATTEST THAT THE INFORMATION PROVIDED IS ACCURATE AND TRUE. AUTHORIZED SIGNATURE FOR THE EMS AGENCY:

Contact Information/Agency:

Chief/CEO: _____
Telephone: _____ Fax: _____
Email: _____

(Signature) (Date)

ALS/Coordinator: _____
Telephone: _____ Fax: _____
Email: _____

Training Coordinator: _____
Telephone: _____ Fax: _____
Email: _____

CQI/PSRO Liaison: _____
Telephone: _____ Fax: _____
Email: _____

Agency Physician Director: _____
Telephone: _____ Fax: _____
Email: _____

(Signature) (Date)

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Check List: (Attachments) Upload to electronic application or submit paper documents to HEMS

THE FOLLOWING ARE REQUIRED DOCUMENTS FOR LSA RENEWALS

- ___ Include EMS Agency Annual Letter of Compliance (MFR-BLS-LALS & ALS)
- ___ Include completed HEMS Personnel roster of Licensed EMS Personnel in HEMS (list must have license number, expiration date, license level (MFR-BLS-LALS & ALS and skill completion dates)
- ___ Attach a 3 month Schedule 24-7 staffing outlined in Section 1, 2B. (MFR-BLS-LALS & ALS)
- ___ LALS and ALS services must include the Annual Pharmacy System “Memorandum of Understanding”

OPTIONAL FORMS ARE REQUIRED IF YOUR LSA OFFERS THESE SERVICES

- ___ Include Additional Service Application (EMD, 12 Lead, BLS Nebulized Bronchodilator, Critical Care (See Section 12 HEMS Protocols)
- ___ Documentation of use for MFR Agencies using i-gel[®] and/or Blood Glucose Testing
- ___ included & required for Helicopter Services is the Helicopter Letter of Compliance
- ___ Includes ALT Staffing (ALS) request and documentation for annual license period

Date: _____

Agency: _____ **Initial** _____ **Renewal** _____ **(check one)**

As of the date indicated above, I hereby certify that the above indicted agency complies with the requirements of the Wayne County Medical Control Board (HEMS) for the continued participation in the following supplemental services: (Check all that apply/approved)

___ **MFR Agency i-gel[®] Supraglottic airway** - adopted use of and conducts initial and annual training.

Date of most recent training: _____

___ **MFR Agency Blood Glucose Testing** - adopted use of and conducts initial and annual training.

Date of most recent training: _____

___ **BLS Nebulized Bronchodilator Program** - Agency operates the BLS Nebulized Bronchodilator Program under the supervision of a physician who is responsible for the oversight of the Quality Improvement program and training curriculum.

___ **12 Lead Program** – Agency operates the 12 lead program under the supervision of a physician who is responsible for the oversight of the Quality Improvement program and training curriculum.

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_____ **Interfacility ALS Expanded Scope of Practice Transfer and/or Critical Care Transfer Program** – Agency operates the Interfacility ALS Expanded Scope of Practice Transfer and/or Critical Care Transfer Program in compliance with protocols 8.15 & 8.15B under the supervision of a physician who is responsible for the oversight of the Quality Improvement program and training curriculum.

Please provide CCT MEDCOM Numbers: _____

_____ **EMD Program** - Agency operates the Emergency Medical Dispatch program under the supervision of a physician who is responsible for the oversight of the Quality Improvement program and training curriculum. Provide name of Program: _____

EMD Training Coordinator: _____ Physician: _____

_____ **Helicopter Agency Annual Letter of Compliance** – Agency will submit annual Department license renewal application along with letter of compliance at least 60 days prior to renewal date. **Agency** meets all state and federal aircraft equipment and safety standards and agrees to submit proof upon request of HEMS. **Agency** agrees to provide referring agencies within HEMS with training in appropriate procedures to be used when operating with helicopter EMS services. **Agency** will submit copies of patient care reports for transports within HEMS to HEMS PSRO within 72 hours of transport.

_____ **Quality Improvement** - Agency has in place an internal Quality Improvement program which includes a formal peer review process which interacts actively with the professional review/QI program conducted by HEMS through the Wayne County Medical Control Advisory Board under MDPH approved protocols. All QA materials including correspondence between Agencies QI program and Wayne County EMS system's QI program are handled as confidential in accordance with applicable section of State Law.

I certify that the agency complies with all training requirement and maintains records of all required training for personnel trained under the protocols set forth by HEMS (Wayne County Medical Control Board) and the records are available for inspection by the Department and HEMS. The agency assures that additional equipment requirements as defined in the protocols are met.

Chief/CEO Signature: _____

Chief/CEO – Printed: _____

Telephone: _____ **Fax:** _____

Email: _____

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