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## ACRONYMS

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<tr>
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<th>Description</th>
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<tr>
<td>ACLS</td>
<td>Advanced Cardiac Life Support</td>
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<tr>
<td>ALS</td>
<td>Advanced Life Support</td>
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<tr>
<td>AEMT</td>
<td>Advanced Emergency Medical Technician</td>
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<td>BLS</td>
<td>Basic Life Support</td>
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<tr>
<td>BTLS</td>
<td>Basic Trauma Life Support</td>
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<tr>
<td>CE</td>
<td>Continuing Education</td>
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<tr>
<td>CPAP</td>
<td>Continuous Positive Airway Pressure</td>
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<td>CPR</td>
<td>Cardiopulmonary Resuscitation</td>
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<td>DNR</td>
<td>Do Not Resuscitate</td>
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<td>ECG</td>
<td>Electrocardiogram</td>
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<td>EMR</td>
<td>Emergency Medical Responder</td>
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<td>EMS</td>
<td>Emergency Medical Services</td>
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<td>Emergency Medical Services Physician Commission</td>
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<td>Emergency Medical Technician</td>
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<td>EPC</td>
<td>Emergency Pediatric Care</td>
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<td>HAZMAT</td>
<td>Hazardous Materials</td>
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<td>ILS</td>
<td>Intermediate Life Support</td>
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<td>LMA</td>
<td>Laryngeal Mask Airway</td>
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<td>MSP</td>
<td>Medical Supervision Plan</td>
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<td>NREMT</td>
<td>National Registry of Emergency Medical Technicians</td>
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<td>OM</td>
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<td>PALS</td>
<td>Pediatric Advanced Life Support</td>
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<td>PCR</td>
<td>Patient Care Report</td>
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<td>PEEP</td>
<td>Positive End-Expiratory Pressure</td>
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<td>Pre-hospital Electronic Record Collection System</td>
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<td>QA/QI</td>
<td>Quality Assurance / Quality Improvement</td>
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<td>SoP</td>
<td>Scope of Practice</td>
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<td>SVT</td>
<td>Supraventricular Tachycardia</td>
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<td>WMD</td>
<td>Weapons of Mass Destruction</td>
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INTRODUCTION


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.
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 16

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
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 Idaho EMS Bureau with documentation of the agreement annually or upon request. *(See Appendix A for a sample medical director and agency agreement.)*
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 9, 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 approved by the EMS 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.

There is a formal approval process for OMs which is administered by the EMS Bureau. The requirements align with the EMSPC Standards Manual. For more information or to review the approval process visit www.IdahoEMS.org or contact the EMS Bureau directly. (See Appendix B for the EMSPC approved Addendum to Medical Supervision Plan for Optional Modules and Appendix C for a sample optional module credentialing matrix.)
The EMS Medical Director is responsible for the credentialing of licensed EMS Providers under their supervision. Credentialing is the local process for verify 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. For EMRs and EMTs, the Medical Director may also appoint a designee/signature authority who may conduct the review in their stead. For AEMTs and Paramedics, however, the review must be conducted by the Medical Director. (See Appendix D for a sample initial credentialing worksheet.)

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.)

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 and protocols regarding communications, facility destinations 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.)*

 Though routine credentialing does not need to be reported to the Idaho EMS Bureau, the EMSPC Standards Manual 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 13).

Protocols are to be included in the Medical Supervision Plan (see Medical Supervision Plan, page 16). 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 Idaho EMSPC recently formed a working group to develop statewide protocols that will be introduced during the fall of 2012 and maintained by the Idaho EMSPC. These protocols will be available to any agency that chooses to implement them.

See Appendix G for examples of proposed statewide protocols and Appendix H for a list of recommended protocols.
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.

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). 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 Idaho EMS 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 Idaho EMS 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 15).

As per Idaho Statutes 39-1392b, all peer review records are confidential and privileged.

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”._
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 Idaho EMS Bureau upon request.

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

- Credentialing of licensed EMS Providers (*see page 9*)
- Indirect (off-line) medical supervision
  - Standing orders and treatment protocols (*see page 11*)
  - Authorized optional modules (*see page 7*)
  - Continuing education (*see page 15*)
  - Methods for quality assessment and improvement (*see page 13*)
  - 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.

See Appendix K for the Medical Supervision Plan development guide.
INDEPENDENT CONTRACTOR AGREEMENT

AGREEMENT made and entered this ___ day of ________, 20__ by and between ____________________, an Emergency Medical Services (EMS) agency of the state of Idaho ("Service"), and Dr. ________________ ("Contractor").

WHEREAS, the Service and the Contractor desire to enter into an agreement for the provision of professional services for the Contractor to assist the Service as an Emergency Medical Services Medical Director (EMSMD), and;

WHEREAS, the Service is duly authorized and empowered to enter into such an agreement, and the Contractor is duly authorized and empowered to enter into such an agreement on behalf of Service;

NOW THEREFORE, in consideration of the above recitals, the agreements, covenants, conditions and mutual promises herein set forth, it is hereby agreed as follows:

1. Services Provided. The Service and the Contractor agree that the Contractor shall provide services as an EMSMD as directed by the Idaho EMS Physician Commission. The Service and the Contractor agree that Contractor will have responsibility for both on-line and off-line medical direction.

2. Duties of Contractor. The Contractor shall oversee all medical aspects of both rescue and dispatch in _____________________. EMSMD authority and responsibilities will include those established in the rules of the Idaho EMS Bureau, including but not limited to:

   ▪ The EMSMD will hold responsibility and ultimate authority of medical oversight of both structure and operations, including both direct and indirect medical oversight.

   ▪ The EMSMD shall maintain liaison with other physicians, including Medical Directors and local emergency department physicians, and attend regional and state meetings.

   ▪ The EMSMD is to interact with regional, state and local EMS authorities to ensure standards, needs and requirements are met and resource utilization is optimized.
The EMSMD is to provide liaison with the state Department of Health and state EMS Advisory Committee.

The EMSMD will collaborate agency chief officers on a procedure for the management of complaints involving EMS and hospital emergency departments.

The EMSMD will direct the development of agency Standard Operating Guidelines (SOG) and policy development as it relates to EMS.

The EMSMD may appoint supervising physicians for direct medical control and for indirect medical control in his / her absence.

The EMSMD shall evaluate pre-arrival instructions rendered by the agency personnel and maintain direct participation in the agency system evaluation and continuous quality improvement process.

- Direct Medical Oversight:

Direct medical oversight is the contemporaneous medical consultation and direction provided by the on-duty emergency department physician at _________ by telephone or radio to EMS providers in the field. This consultation will be consistent with the SOG and scope of practice of the credentialed EMS Providers.

- Indirect Medical Oversight:

Indirect Medical Oversight is provided by the EMSMD who is responsible for the ultimate medical accountability and appropriateness of the system including overall system design, implementation and evaluation.

- Prospective:

- The EMSMD will develop, review and approve EMS protocols or guidelines for all certified EMS Providers at the agency, with the option to amend or adjust to meet specific needs.
• The EMSMD will advise individual agencies on continuing education for EMS providers to meet state and national requirements and guidelines and to meet identified quality goals.

■ The EMSMD will review and approve, before implementation, new and emerging technologies in ambulance and rescue equipment, supplies and operations.

■ The EMSMD should be involved with local and regional EMS for disaster and mass-casualty planning.

■ The EMSMD should be involved in coordination of activities such as mutual aid, backcountry rescue, tactical and HAZMAT exposures.

■ Retrospective:

  • The EMSMD will oversee a quality assurance program that includes evaluation of EMS Providers.

  • The EMSMD may provide individual consultation and written evaluation of each or any EMS Provider at his / her discretion.

  • The EMSMD will provide counseling to specific EMS providers if inappropriate care is rendered. The EMSMD may withhold or qualify credentials of any EMS Provider as deemed necessary.

  • The EMSMD should be involved in disciplinary proceedings of EMS providers when patient care issues are involved.

3. Term of Agreement. The term of this agreement shall be for the period beginning on the effective date hereof and ending ____________. However, either party may terminate this agreement without cause before the end of the term by providing thirty (30) days' written notice of such termination to the other party.

4. Compensation. Service agrees to pay Contractor as compensation for general and specific assignments as determined by the Idaho EMS Physician Commission.

Contractor Agreement – Page 3 of 6
5. Entire Agreement. This instrument constitutes and embodies the entire integrated agreement between the parties relative to utilizing the Contractor’s services as a Contractor. The parties agree that all prior and contemporaneous oral and written agreements, between and among themselves and their agents and representatives, relating to the Contractor services as a Contractor are merged into and superseded by this agreement.

6. Amendment. This agreement may be altered, amended, modified or revoked only by written instrument duly executed by the parties hereto.

7. Waiver. The failure of any party to insist upon strict performance of any of the obligations contained herein shall not be deemed a waiver of any rights or remedies that said party may have, and shall not be deemed a waiver of any preceding or subsequent breach in the performance of any of the terms and provisions contained herein by the same or any other person. No covenant, term or condition, or the breach thereof, shall be deemed waived, except by the written consent of the party against whom the waiver is claimed.

8. Assignment. Contractor may not assign, sub-contract or delegate his / her rights and duties hereunder to any person or entity without the prior written consent of the Service.

9. Authority of Board. Contractor understands and agrees that only the Service is empowered to alter, amend, modify, revoke and permit waiver, assignment, sub-contract and delegation under this agreement on behalf of Service. Contractor shall not rely upon any representation, warranty or other statement by any other contractor or agent of Service, and any such reliance by Contractor shall be at Contractor’s peril and shall not give rise to any claim or cause of action, in law or equity, against Service, its contractors or agents.

10. Representations. Contractor agrees and warrants that in entering into this agreement, it has relied upon no representations, express or implied, of Service, its contractors or agents or of the Board that are not expressly stated herein.

11. Successors and Assigns. Unless otherwise provided in this agreement, this agreement inures to the benefit of, and will be binding upon, the parties and their respective heirs, representatives, successors and permitted assigns.

12. Third-Party Beneficiary Rights. This agreement is not intended to create, nor shall it
be in any way interpreted or construed to create, any third party beneficiary rights in any person not a party hereto unless otherwise expressly provided herein. It further is not intended to create any substantive or procedural right for an applicant not otherwise provided in code.

13. Construction. No presumptions shall exist in favor of or against any party to this Agreement as a result of the drafting and preparation of this agreement. The headings and captions of paragraphs of this agreement are for convenience only and shall not be deemed to be relevant in resolving any question of interpretation or construction of this agreement.

14. Severability. If any term or provision of this agreement shall, to any extent, be determined by a court of competent jurisdiction to be invalid or unenforceable, the remainder of this agreement shall not be affected thereby, and each term and provision of this agreement shall be valid and be enforceable to the fullest extent permitted by law.

15. Governing Law and Venue. All disputes arising out of or related to the formation, interpretation, performance and enforcement of and under this agreement shall be governed by the laws of the state of Idaho. The Contractor hereby consents to the jurisdiction and venue of the state courts of Idaho to resolve any and all such disputes with Service; the Contractor waives all defenses to such jurisdiction and venue including, but not limited to, any defense based upon inconvenient forum.

16. Service of Notices. Any notice hereunder may be served upon Service by certified mail to Service at __________________________________________, and any notice may be served upon Contractor by certified mail to __________________________________________. Notice by certified mail shall be deemed complete upon the date of the postmark by certified mail. Either party may change the address for services of notice by written notice to the other party.

17. Hold Harmless Clause. _____________________ agrees to indemnify, defend and hold harmless Contractor from any and all claims, costs, liability, judgment, complaint, judicial review petition or cause of action filed against Contractor relating to a claim based upon acts or omissions of Contractor performed within the scope of his / her duties under this agreement, no matter pursuant to this agreement, no matter what the basis of the claim, complaint or liability may be, including negligence but excluding the intentional and willful misconduct of Contractor. _____________________ retains the right to determine legal counsel to represent Contractor in any such claim, cost, liability, judgment, complaint, judicial review petition or cause of action filed.
against Contractor in his / her individual capacity, subject to the approval of Contractor, which approval shall not be unreasonably withheld. Contractor shall not be liable to Service for any activities of Contractor undertaken by Contractor pursuant to this agreement, no matter what the basis of the claim, complaint or liability (including contribution) may be, including negligence, but excluding the intentional and willful misconduct of Contractor.

18. Workers’ Compensation. While performing duties within the scope of the professional services, as set forth herein, Contractor shall be covered under Service’s workers’ compensation liability policy.

19. Attorney’s Fees. If either party hereto brings an action or proceeding to enforce the terms of this Agreement or to declare rights hereunder, the prevailing party in any such proceeding, action or appeal thereof, shall be entitled to reasonable attorney fees.

EXECUTED and effective as of the day and year provided herein.

_____________________,

By:

_____________________,

Attest: ________________

_____________________,

CONTRACTOR:
## Appendix B – Addendum to Medical Supervision Plan for Optional Modules

### Addendum to Medical Supervision Plan for Optional Modules

**EMSPC SOP OM's 2012-1**

Optional module skills are identified by the EMS Physician Commission and may be adopted by the agency medical director. Instructions and requirements to add optional modules to agency personnel are available on the Idaho EMS web site [www.idahoems.org](http://www.idahoems.org) or click on the link tile. This form may be submitted as an OM Addendum for EMS Bureau approval when signed by the medical director. Please check the box next to each OM for the level of provider that are to be trained and credentialed for this agency. Proof of credentialing by the agency medical director must be submitted to the EMS Bureau prior to individuals practicing the optional module skills.

### BLS or higher agency license

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<th>AEMT-85</th>
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<td>12-lead EKG Acquisition</td>
</tr>
<tr>
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<td></td>
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<tr>
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<td>End tidal CO2 Monitoring/Capnography</td>
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<td>Taser Barb Removal</td>
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<td>Epi Auto-injector</td>
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<tr>
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<td>CO Oxymetry</td>
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<td>CPAP</td>
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<tr>
<td>Spinal Immobilization Seated</td>
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### ILS or higher agency license

<table>
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<td>CPAP</td>
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<td>chest pain only</td>
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<td>Impedance Threshold Device</td>
</tr>
<tr>
<td>Blood Glucose Monitoring</td>
<td></td>
<td>Intubation- Medication Assisted (paralytics), (RSI)</td>
</tr>
<tr>
<td>CO Oxymetry</td>
<td></td>
<td>Pelvic Immobilization Device</td>
</tr>
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<td>Epi Auto-injector</td>
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<td>Taser Barb Removal</td>
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<td>Impedance Threshold Device</td>
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<td>Intramuscular (IM)</td>
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<td>CPAP</td>
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<td>Pelvic Immobilization Device</td>
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<td>Impedance Threshold Device</td>
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<td>Pulse Oximetry</td>
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<td>Intubation- Medication Assisted (paralytics), (RSI)</td>
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<td>Subcutaneous Injection</td>
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<td>Taser Barb Removal</td>
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</table>

### ALS or higher agency license

As Medical Director for this EMS agency, I have approved the checked OM’s for training, credentialing and practice.

Medical Director Signature: ______________________ Date: __________

Optional Module Addendum
Addendum to Medical Supervision Plan for Optional Modules

EMSPC SOP OM’s 2012-1

Optional module skills are identified by the EMS Physician Commission and may be adopted by the agency medical director. Instructions and requirements to add optional modules to agency personnel are available on the Idaho EMS web site www.idahoems.org or click on the link tile. This form may be submitted as an OM Addendum for EMS Bureau approval when signed by the medical director. Please check the box next to each OM for the level of provider that are to be trained and credentialed for this agency. Proof of credentialing by the agency medical director must be submitted to the EMS Bureau prior to individuals practicing the optional module skills.

CC Paramedic-98

- Arterial Line Monitoring and Access Only
- BiPAP
- Blood Chemistry Analysis
- Blood Products Administration
- Chest Tube Placement
- IABP Monitoring & Management
- ICP Monitoring
- Invasive Hemodynamic Monitoring
- IV Programmable Volume Infusion Device
- Maintenance of Blood Administration
- Pacing-Transvenous & Epicardial
- PEEP-Therapeutic (>6cm H2O pressure)
- Pericardiocentesis
- Plasma Volume Expander Administration
- Ventilators, Automated- Enhanced Assessment & Management.

CC Paramedic-2011

- Arterial Line Monitoring and Access Only
- Blood Products Administration
- Central Line Placement
- Chest Tube Placement
- Cricothyrotomy-Surgical
- IABP Monitoring & Management
- ICP Monitoring
- Invasive Hemodynamic Monitoring
- IV Programmable Volume Infusion Device
- Pacing Permanent/ICD
- Pacing-Transvenous & Epicardial
- Pericardiocentesis
- Plasma Volume Expander Administration
- Umbilical Initiation
- Urinary Catheterization
- Ventilators, Automated- Enhanced Assessment & Management.

Date Stamp
Received
EMS Bureau Use
Date Stamp Compliance
Approved

As Medical Director for this EMS agency, I have approved the checked OM’s for training, credentialing and practice.

Medical Director Signature
Date

Optional Module Addendum
# Optional Module Skills Credentialing

**Certified Date:**

<table>
<thead>
<tr>
<th>License #</th>
<th>First Name</th>
<th>Last Name</th>
<th>Acetylsalicylic Acid (Aspirin)</th>
<th>Blood Glucose Monitoring (BSGM)</th>
<th>CO Oximetry (COX)</th>
<th>Continuous Positive Airway Pressure Adult (CPAP)</th>
<th>Epinephrine Auto Injector (EPI)</th>
<th>Glucagon (GLGN)</th>
<th>Impedance Threshold Device</th>
<th>Intramuscular Medication (IMI)</th>
<th>Pelvic Immobilization Devices</th>
<th>Pulse Oximetry (POX)</th>
<th>Subcutaneous Medication (SBQ)</th>
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### Appendix D – Sample Initial Credentialing Worksheet

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<th>Name</th>
<th>ID number</th>
<th>Idaho EMS expires</th>
<th>NREMT expires</th>
<th>CPR Card expires</th>
<th>Completed Agency Orientation</th>
<th>Completed Agency Skills proficiencies completed</th>
<th>Competency objectives completed</th>
<th>Previous service approved</th>
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<tr>
<td>Maxwell, Marietta</td>
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<td>O’Toole, Sean</td>
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</table>

I affirm that the above individuals have met the requirements for credentialing for Marvel County Fire Department.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Name</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terry R. Hamilton</td>
<td>Terry R. Hamilton</td>
<td>EMS Training Officer</td>
<td>04/29/12</td>
</tr>
</tbody>
</table>

The above individuals are approved to provide patient care at the EMT level in addition to the following optional modules:

- **Blood Glucose Monitoring - Automated**
- **Epinephrine Auto-Injector**
- **Glucagon**

- **✓**

<table>
<thead>
<tr>
<th>Signature</th>
<th>Name</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>George E. Mason, MD</td>
<td>George E. Mason, MD</td>
<td>EMS Medical Director</td>
<td>05/11/12</td>
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</table>
### Appendix E – Sample Credentialing Checklist

<table>
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<tr>
<th>Name</th>
<th>ID</th>
<th>Date Completed</th>
<th>Annual</th>
<th>Semi-Annual</th>
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<tbody>
<tr>
<td>Butler, Gretchen D.</td>
<td>47201</td>
<td>07/17/12</td>
<td>(all skills)</td>
<td>(bold skills only)</td>
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#### AIRWAY / VENTILATION / OXYGENATION

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<tr>
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<th>Training/Testing</th>
<th>Date</th>
<th>Initials</th>
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<tr>
<td>Airway – Nasal</td>
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<tr>
<td>Airway – Oral</td>
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<tr>
<td>Bag-Valve-Mask (BVM)</td>
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<tr>
<td>Cricoid Pressure (Sellick)</td>
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<tr>
<td>Demand Valve – Manually triggered, flow restricted, ventilation</td>
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<tr>
<td>Head-tilt/chin-lift</td>
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<tr>
<td>Jaw-thrust</td>
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<td>Jaw-thrust - Modified (trauma)</td>
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<tr>
<td>Modified Chin Lift</td>
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I hereby affirm that the above individual is proficient with the above skills.

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<th>Marjorie Trope</th>
<th>FTO</th>
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# Sample Credentialing Process Form

**Provider** ____________________________  **Agency** _____________________

- **Level of Credentialing:**
  - ☐ EMR
  - ☐ EMT
  - ☐ AEMT
  - ☐ Paramedic

- **State EMS Licensure** _________________________________  Exp ________
- **CPR** _________________________________  Exp ________
- **ACLS (paramedic)** _________________________________  Exp ________
- **PALS (paramedic)** _________________________________  Exp ________
  
  *(Please provide copies of above certification cards)*

**Signature of Preceptor and Date**

- **Agency Orientation** _____________________________  Date ____________
- **Skills Verification** _______________________________  Date ____________
- **Field Training Program** __________________________  Date ____________

The above provider has successfully completed all requirements for credentialing for the

______________________ EMS Agency and is fully credentialed at the level of

______________________.

Provider understands and agrees to adhere to all requirements for continuous credentialing
within the system. Failure to do so will result in loss of credentials and need for recompletion
of the process.

______________________  ______  ______________________  ______

Provider Signature  Date   Medical Director Signature  Date
Appendix G – Proposed Statewide Protocols Examples

Airway, Adult

Pearls
- For the purposes of this protocol a secure airway is when the patient is receiving appropriate oxygenation and ventilation.
- Do not assume hyperventilation is psychogenic – use oxygen, not a paper bag.
- If an effective airway is being maintained by BVM with continuous pulse oximetry values of ≥ 90, it is acceptable to continue with basic airway measures instead of using a BIAD or intubation.
- An ‘intubation attempt’ is defined as insertion of the laryngoscope blade into the mouth or insertion of the endotracheal tube through the nares.
- Paramedics and AEMTs should consider using a BIAD rather than intubation if a difficult airway is anticipated.
- Paramedics should consider drug-assisted intubation in awake patients as well as patients who are persistently combative despite sedation.
- Ear-to-sternal notch patient positioning will improve your laryngoscopic view. However, maintain C-spine immobilization for patients with suspected spinal injury.
- Sellick’s maneuver, BURP maneuver and/or external laryngeal manipulation should be used to assist with difficult intubations.
- Although ETCO₂ detection is the preferred method to confirm ETT and BIAD placement, multiple methods must be used such as esophageal tube detector device, auscultation of breath sounds, absence of epigastic sounds, ETT missing, chest rise and patient response (e.g., pulse oximetry, skin color, heart rate).
- If 1st intubation attempt fails, make an adjustment and try again:
  - Different laryngoscope blade size or type
  - Gum Elastic Bougie
  - Different ETT size
  - Change cricoid pressure
  - Apply external laryngeal manipulation, e.g., BURP maneuver (Back [posterior], Up, and to p’s Right Pressure)
  - Change head positioning to achieve ear-to-sternal notch patient positioning (unless C-spine immobilization indicated)
- It is important to secure the ETT and BIAD well. Consider a c-collar to better maintain placement.
- If breath sounds are decreased on the left after intubation, check your ETT depth & consider R mainstem intubation.

Performance Improvement Suggestions
- Documentation of pulse oximetry.
- Documentation of ventilatory rate.

Protocol 1-2011

This protocol was created by the Idaho EMS Physician Commission (EMSPC) and may not be altered without written approval from the Idaho EMSPC.
Universal Patient Care Protocol

Scene safety / Additional resources
Bring all necessary equipment to patient's side
Demonstrate professionalism and courtesy

PPE (consider airborne or droplet if indicated)

Immediate Life Threat?
Yes ➔ Go to specific Protocol as appropriate
No ➔ Special Health Care Needs? POST?
Consider as appropriate:
- Pediatric Assessment Procedure
- Adult Assessment Procedure
- Spinal Immobilization Clearance #12

Refusal of Care Protocol #59
Refusing Care?
- Cardiac or Traumatic Arrest?
  ➔ Cardiac Arrest Protocol #20A
  Traumatic Arrest Protocol/Termination of Resuscitation #20

Airway Protocol
Adult 1/Pediatric 4

Vital signs (Temperature if appropriate)
If available, consider Pulse Oximetry
Consider Supplemental Oxygen
If available, consider Blood Glucose
If available, consider 12 Lead ECG
Consider Cardiac Monitor
Consider Vascular Access Protocol #9

Go to specific Protocol as appropriate
Consider ALS Rendezvous/Air Medical Transport

Patient doesn't fit a protocol?
Need to deviate from a specific protocol?
Contact Medical Control

Pearls
- All patient contacts require completion of a patient care report including refusals of care, treat & releases and other scenarios that result in non-transport by EMS.
- Pulse oximetry and temperature documentation is dependent on the specific complaint.
- The pediatric patient fits on the Broselow-Luten tape or is <12 years of age. If a patient does not fit either criteria, the patient is considered an adult for the purposes of these protocols.
- Timing of transport should be based on patient's clinical condition.
- 12 Lead EKG acquisition should not delay stabilization of the ABCs or patient transport.
- Never hesitate to contact medical control for the patient who refuses transport.
- Ask if the patient has a Medical Emergency Health Care Information form, especially adults and children with special health care needs.
- Does the patient have a POST, Living Will or other Advanced Directive?

Protocol 13-2012
This protocol was created by the Idaho EMS Physician (EMSPC) and may not be altered without written approval from the Idaho EMSPC.
Near Drowning

History
- Submersion in water regardless of depth
- Possible trauma to C-spine
- Possible history of trauma (i.e., diving board)
- Duration of immersion
- Temperature of water or possibility of hypothermia
- Age

Signs and Symptoms
- Unresponsive
- Mental status changes
- Decreased or absent vital signs
- Vomiting
- Coughing
- Apnea
- Stridor
- Wheezing
- Rales

Differential
- Trauma
- Intoxication
- Barotrauma
- Decompression sickness
- Post-immersion syndrome

Universal Patient Care Protocol 13

Diving injury or suspicion of cervical spine injury?

Yes

Spinal Immobilization Clearance Protocol 12

No

Cardiac Monitor
Pulse Oximetry

P B

Yes

Wheezing?

Consider CPAP for respiratory distress, if available

B O

Assist with prescribed Albuterol MDI or other beta agonist

A B

Nebulized Albuterol 2.5mg
With Ipratropium 0.5mg
(if available)

Rewarm the patient
- Remove wet clothing
- Hot packs, warming blankets
- Maximize ambient temperature

Hypothermia?

Yes

Notify Receiving Destination

Pearls
- Have a high index of suspicion for possible spinal injuries.
- All natural bodies of water in Idaho are considered cold water.
- Survival after 1 hour of immersion in cold water is rare. Consider transitioning from rescue to recovery after 1 hour of cold water immersion.
- Respiratory distress may be delayed. Therefore, all near drowning patients should be transported for evaluation.
- Decompression illness may require hyperbaric therapy.

Performance Improvement Suggestions
- Documentation of immersion time
- Documentation of immersion mechanism

Protocol 52-2012

This protocol was created by the Idaho EMS Physician Commission (EMSPC) and may not be altered without written approval from the Idaho EMSPC.
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
- 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

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Run #__________________ Crew: ________________________________________________

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**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:**
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Medical Director Signature

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

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 EMS 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.

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

**E. Other Suggested Components**

1. EMS Bureau Notification Requirements and Deadlines *(who is responsible for reporting to the EMS 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

This guide has been made possible by the acquisition, analysis and interpretation of the information contained herein; the substantial contributions of content; the comprehensive input on concept and design; and the critical editing and revisions by the following individuals:

Curtis Sandy, MD, Idaho EMS Physician Commission
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