SREMS REMAC	**Susquehanna Regional EMS Council, Inc.** Broome, Tioga, and Chenango Counties **REMAC Policy Statement** *Supersedes/ Updates: NEW* *Reference NYS Public Health Law/BEMS Policy statements*	No. 375 Date: November 14, 2019 Re: Medical Control Page 1 of 6

INTRODUCTION / OVERVIEW

The Susquehanna Regional Emergency Medical Advisory Committee (REMAC) serves the respective geographical area encompassed by the Susquehanna Regional Emergency Medical Services Council, and includes the relationships, territories and practitioners in the counties of Broome, Chenango and Tioga. Its operational funding is received from the New York State Department of Health, under contract with an administrative sponsor, which currently is the Susquehanna Regional EMS Council, Inc.

The Susquehanna Regional Medical Advisory Committee has formulated this Medical Control Plan in order to ensure the continuity of high-quality prehospital emergency medical care in this three-county area.

DEFINITION OF MEDICAL CONTROL AND STATEMENT OF PURPOSE

Medical Control is defined in Article 30, Section 3001.15 as:

1. advice and direction provided by a physician to certified first responders, emergency medical technicians or advanced emergency medical technicians who are providing medical care at the scene of an emergency or en route to a health care facility and;
2. indirect medical control including the written policies, procedures and protocols for prehospital emergency medical care and transportation developed by the State Emergency Medical Advisory Committee, approved by the State Council and the Commissioner and implemented by the Regional Medical Advisory Committees.
3. Under the direction of a physician shall mean a Physician, Physician Assistant, Nurse Practitioner or Registered Professional Nurse that meets or exceeds those requirements established in NYCRR Title 10, Section 405.19.

All aspects of the organization and provision of emergency medical services (EMS), including both basic and advanced life support, require the active involvement and participation of physicians. These aspects include: design of the EMS system prior to its implementation; continual review of the system; and operation of the system from initial access to prehospital contact with the patient through delivery of the patient to the emergency department. All prehospital medical care may be considered to have been provided by one or more agents of the physicians who participate in the prehospital system. REMAC, Agency Medical Directors and direct and indirect Medical Control Physicians have assumed the oversight for such care.

Medical oversight is the complex task that involves the direction of the EMS system and providers in the overall clinical management of patients.

Medical Control/oversight of prehospital emergency care may be accomplished through direct voice communication with prehospital emergency medical personnel (direct control) or through the provision of care in accordance with patient care protocols developed and promulgated by physicians (indirect control), and physician supervised quality assurance activities.

Every pre-hospital ambulance or rescue service is required to look at an identifiable service medical director who is responsible for all aspects of indirect control (off-line) of that service. All training of emergency medical personnel, including supervision of training, re-training, continuing education, ongoing performance evaluation through audit, review and critique sessions, and other appropriate components, shall be under the general supervision of a Medical Director. (In an instance of an unforeseen absence of an agency medical director, the REMAC chairperson will serve as that agency's interim agency medical director until the position can be filled).

PARTICIPATING HOSPITALS

All facilities designated under Article 28, Section 3401 of the Public Health Law as hospitals and/or their off-campus sites (hospital extension clinics) with the capacity to receive patients by ambulance will assume the responsibility of assuring familiarity of their medical and nursing staff with prehospital capabilities and levels of care, and cooperation with regional system planning and development, Quality Assurance/Quality Improvement (QA/QI) activities, etc. Participating facilities will provide both assessment of prehospital care as well as individual and or aggregate outcome information related to the performance of prehospital care to the REMAC for the QA/QI process according to Article 30 Section 3004-A.1.

MEDICAL CONTROL FACILITIES

MEDICAL CONTROL HOSPITAL – DEFINITION, ROLES AND RESPONSIBILITIES

A Medical Control Hospital is an emergency department/services as defined under Sections 405 and 708 of the NYS Hospital Code which provides direct Advances Life Support (ALS) and Basic Life Support (BLS) physician direction for patients being brought to that facility or to a participating (receiving) hospital.

A Medical Control Hospital must meet the following criteria:

1. Have an emergency department, which meets all standards for emergency department/service as defined under Sections 405 and 708 of the NYS Hospital Code.
2. Maintain VHF/EMS Radio Base station and compatible telephones connected to regional communications systems to communicate with BLS and ALS units and Medical Control Hospitals. Review radio practices of medical control.
3. Assume the responsibility for the care and maintenance of necessary communications equipment within the institution.
4. Use and have available NYS BLS protocols and Collaborative ALS protocols approved by the Susquehanna Regional EMS REMAC.
5. Replenish medical supplies used by field units for those patients brought to that facility, as appropriate.

6. Provide facilities for EMS clinical training and recertification.
7. Participate in prehospital QA/QI activities as defined in Sections 405 and 708 of the NYS Hospital Code as well as the Regional Medical Advisory Committee. Provide QA/QI reports and outcome data to the Susquehanna REMAC on an as requested basis. It is understood that the REMAC is a physician body involved in maintaining the utmost patient confidentiality. REMAC can only perform its role to improve prehospital care, design new protocols, and etc. with the help of the hospitals through the use of patient outcome data.
8. Provide medical direction for agencies transporting patients to their facility and the area First Responder Units as appropriate.
9. Participate in regional EMS planning activities as appropriate (e.g., REMAC, Regional Council).
10. Designate a physician Medical Director to be in charge of overall coordination of medical control in that facility.
11. Have physician staff capable of providing Medical Control physically present in the emergency department and immediately available 24 hours a day.
12. All Medical Control physicians are required to take the online SREMS Physician/PA/NP/RN Medical Control/Medical Director Exam.
13. Have appropriate designated hospital personnel sign transfer of care on PCR.
14. Provide training to ED RNs and physician extenders regarding the BLS and ALS protocols.
15. Medical Control Physician may evaluate the patient's choice of medical facility and determine if the patient's status, coupled with the hospital's current access status permits transport to the facility of choice.

The Medical Control Hospitals participating within the Susquehanna region are as follows:

- Chenango Memorial Hospital
- Our Lady of Lourdes Hospital
- United Health Services
    - Binghamton General Hospital
    - Wilson Memorial Regional Medical

Hospital outside the Susquehanna region operating under a mutual REMAC agreement:

- Robert Packer Hospital

MEDICAL CONTROL PHYSICIANS

Each medical control physician (physician, physician assistant, nurse practitioner or registered professional nurse-meeting the education requirements above) must be trained in and thoroughly familiar with:

a. NYS BLS and Collaborative ALS protocols

b. Communications system

c. Understanding of the level of training of Certified First Responders (CFR), Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians (AEMT), Critical Care (CC) and Paramedics and their corresponding scope of practice.

d. Medical control system and expectations of a Medical Control Physician

e. Provide on-line (direct) physician direction for prehospital patients and provide secondary transfer management for patient transports.

f. Complete medical control records

g. Complete the online SREMS Physician/PA/NP/RN Medical Control/Medical Director Exam and be approved by one REMAC as having met their credentialing policies and procedures

When providing medical control for a patient being transported to a different hospital, the medical control physician must notify the receiving hospital with the following:

1. Patient's presenting problem and treatment
2. Medical control orders given to the ALS provider
3. All ALS and BLS treatment done for the patient under standing orders or on-line medical control
4. Patient's response to therapy
5. Receiving hospital ED physician may sign off on PCR record

MEDICAL CONTROL FACILITY MEDICAL DIRECTOR
ROLE AND RESPONSIBILITIES:

Each medical control hospital is to identify one physician as the Medical Control Director whose duty is the overall coordination and medical accountability of the medical control system in his/her facility. He/she will report to REMAC, provide a summary of all QA/QI initiatives and patient outcome data.

Qualifications of a Medical Control Director are as follows:

1. An emergency department physician who is not in residency training.
2. American Heart Association certified as both a basic and advanced cardiac life support (ACLS, ATLS) provider.
3. American College of Surgeons certified in Advanced Trauma Life Support.
4. Trained in the use of NYS BLS and Collaborative ALS protocols, system configuration, and communication.
5. Be an active participant in REMAC. It is suggested that the physician nominated by the CEO of each regional hospital for REMAC membership be the medical control facility medical director.

RESPONSIBILITIES OF THE MEDICAL CONTROL HOSPITAL MEDICAL DIRECTOR

The Medical Director will:

1. Be a member of the REMAC, and will participate regularly in its functions.
2. Mediate prehospital issues and problems concerning medical control as appropriate.
3. Assure adequate training and familiarity of all emergency department physicians and nursing staff with:
    a. Prehospital medical control system and issues
    b. Understand the level of training of CFR's, EMT's, AEMT, CC's and Paramedics and their corresponding scope of practice
    c. Quality assurance concerns

d. Prehospital/hospital interface and cooperation

4. Facilitate compliance with all regional medical control policies, procedures and protocols.
5. Direct and facilitate an on-going review of the functioning of the medical control system and quality assurance program including regular ALS run reviews. When the medical director notices a significant deviation from protocol, it is his/her responsibility to contact the on-line physician, agency Medical Director and provider (EMT, AEMT, CC or Paramedic) involved as soon as possible and resolve the problem in question.
6. Have the right to request, due to serious protocol violations, the suspension of privileges for the provider, with the agreement of REMAC Chair. This would be pending a full review of the incident in question by the Agency Medical Director, REMAC and/or Program Agency. All complaints will be submitted in writing following the current REMAC CQI Reporting/Complaint Process policy.
7. Participate regularly in EMT, AEMT, CC and Paramedic level training in his/her area.

GENERAL MEDICAL CONTROL POLICIES AND GUIDELINES

The Susquehanna REMAC adopted the NYS BLS protocols along with the Collaborative ALS protocols for patient care, triage and transfer.

The decision regarding the patient destination depends on many factors and is not always able to be determined by a simple protocol or rule. Among the factors in the decision are:

1. Patient, family, or physician preference.
2. Type and critical nature of the patient's complaint.
3. Proximity to hospitals.
4. Categorization or destinations of hospitals for specific care capabilities.
5. Emergency department access status.
6. Capabilities of continuous telephone/radio contact with Medical Control Facility.

In general, the patient should be taken to the nearest appropriate facility, with due consideration given to the patient/family preference.

Communications – In certain situations, the on scene provider should establish contact with medical control within twenty minutes of patient contact. Contact can be established via VHF or UHF radio or telephone. Where factors preclude direct contact, the prehospital provider can establish medical control contact through the agency/county dispatcher.

When medical control has been established, the patient/physician relationship is also established and medical command assumes responsibility for the patient's care.

QUALITY ASSURANCE/QUALITY IMPROVEMENT PROCESS/REPORTING RELATIONSHIP OF MEDICAL ADVISORY QA/QI COMMITTEE

RESPONSIBILITIES:
Regional emergency medical advisory committees shall develop policies, procedures, and triage, treatment, and transportation protocols which are consistent with the standards of the state emergency

medical advisory committee and which address specific local conditions. Regional emergency medical advisory committees, may also approve physicians to provide on line medical control, coordinate the development of regional medical control systems, and participate in quality improvement activities addressing system-wide concerns. Hospitals and prehospital medical care services shall be authorized to release patient outcome information to regional emergency medical advisory committees for purposes of assessing prehospital care concerns. Regional quality improvement programs shall be presumed to be an extension of the quality improvement program set forth in Section 3006 of the public health law, and the provisions of subdivisions two and three of Section 3006 shall apply to such programs.
Direct ongoing CQI activities.

1. Review applications for all new ALS services and approve/disapprove all new ALS services in their area.
2. Review policies and protocols especially the impact and ramifications of that policy/protocol.
3. Review all matters of individual and agency practice, suspensions and remediation and assist agency medical directors in these matters.
4. Review quarterly agency reports of CQI activity.
5. Serve as a subcommittee of REMAC.

AGENCY MEDICAL DIRECTOR

"Service medical director" means a physician identified by an EMS service who has been approved by one or more REMAC(s) as having met their credentialing policies and procedures, who is directly responsible for the medical care provided by the certified EMS personnel of that EMS service, and who provides and participates in the EMS service's quality improvement program. No physician may act as service medical director for more than 10 EMS services. A ratio of physician to certified EMS personnel supervision must be provided as follows:

a. 500:1 for certified EMS personnel who provide Automated External Defibrillation
b. 100:1 for certified EMS personnel who provide advanced life support- provided the maximum number of personnel to be supervised by an individual physician may not exceed 500 AED or 100 ALS personnel
c. A medical director of any advanced life support system with 10 or more advanced life support agencies and/or 100 or more advanced emergency medical technicians (AEMT, CC or P) shall designate associate physicians.

PROVIDER CREDENTIALING PROCESS- Refer to current REMAC policy

REGIONAL CQI PROCESS- Refer to current REMAC policy