



Monroe Livingston Region Program Agency

Division of Prehospital Medicine, University of Rochester

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To: All EMS Providers

From: Jeremy T. Cushman, MD, MS, EMT-P 
Regional Medical Director

RJ (Terry) Fairbanks, MD, MS, EMT-P 
REMAC Chair

Date: DRAFT

Re: Advisory 09-09: Protocols and BEMS Policy 09-10

NYS DOH BEMS has released Policy 09-10 which addresses minimum qualifications and expectations of agency medical directors. Further, it outlines the requirements for medical direction by all BLSFR agencies that provide defibrillation. Also stated within this policy is the following:

“All EMS agencies must carry a copy of the Statewide Basic Life Support Adult & Pediatric Treatment Protocols and the applicable Advanced Life Support written protocols either on their person and/or on each responding vehicle; the appropriate written protocols need to be available to the provider from the time of dispatch through patient transport to a definitive care facility.”

In speaking with the NYS DOH BEMS, electronic copies of protocols will suffice to meet this requirement for those agencies that carry laptops for field use.

At this time, the regional Program Agency is unable to provide each agency with a printed copy of the protocols for each responding vehicle. However a single, indexed, complete set of the printed 2010 MLREMS Protocols, Policies, and Procedures will be distributed to each agency at the end of January.

The 2010 MLREMS Protocols have been approved by the state and will be released in late January 2010. An on-line educational component requiring 20-30 minutes to review along with a post-test will be released at that time as well. These materials will require completion by every provider practicing within the MLREMS region by April 1, 2010. Additional information will be forthcoming at the time of the educational program's release in late January.

With any questions, do not hesitate to contact the MLREMS Program Agency via the University of Rochester, Division of Prehospital Medicine.



I Purpose

This policy was written in consultation with of the State Emergency Medical Advisory Committee (SEMAC). It is intended to provide assistance to Emergency Medical Service (EMS) agencies and physician medical directors so that they may better understand medical direction for patients of all ages at the agency level. The policy should clarify and expand upon the definitions contained in Policy Statement # 95-01, Medical Control, issued May 31, 1995. It is also the intent of this policy to define the roles and responsibilities of the EMS agency, the agency medical director the Regional EMS Council (REMSCO) and the Regional Emergency Medical Advisory Committee (REMAC) in relation to this topic. While the Department recommends that every agency providing pre-hospital emergency medical care have a physician medical director, it is a requirement for the agencies described below;

- All Ambulance Services providing Defibrillation.
- All Ambulance Services providing any level of Advanced Life Support (ALS).
- All Basic Life Support First Response agencies providing Defibrillation¹.
- All Advanced Life Support First Response Agencies.
- All entities authorized to provide Public Access Defibrillation (PAD) under § 3000-b of Public Health Law (PHL) shall have an Emergency Health Care Provider (EHCP).
- All entities authorized to provide Epinephrine Auto Injectors (epi-pen) under § 3000-c of Public Health Law (PHL) must have an Emergency Health Care Provider (EHCP).

An **EMS Service Medical Director** shall mean a physician, licensed by New York State and approved by the local REMAC with whom the agency has a professional relationship.

An **Emergency Health Care Provider (EHCP)** means: (I) a physician with knowledge and experience in the delivery of emergency medical care; or (II) a hospital licensed under article twenty-eight of the NYS Public Health Law that provides emergency medical care and with whom the Public Access Defibrillation or Epinephrine Auto Injector program provider entity has a written collaborative agreement.

¹ While Basic Life Support First Response agencies are encouraged to interact with a physician medical director for all patient care responses, these agencies are only required to have a medical director involved in training, use and quality improvement of the defibrillation program.

II Selecting an EMS Service Medical Director

- For Basic Life Support (BLS) and Advanced Life Support (ALS) ambulance services or Advanced Life Support First Response Services (ALS-FR), the provisions of Policy Statement 95-01 regarding service medical director states that the physician must be approved by the REMAC as having met their credentialing policies and procedures.

The Responsibilities of the EMS Service Medical Director

Unless otherwise provided for in statute, rule or policy the responsibilities of an EMS Service Medical Director shall include, but not be limited to:

- 1) Assure that service certified EMS personnel are oriented to the protocols promulgated by the SEMAC and the REMAC(s) for the area(s) of operation of the service,
- 2) Interact with REMAC in the development of protocols, the regional Quality Improvement (QI) process and in disciplinary issues,
- 3) Active development, review and participation in the Quality Improvement program developed by the service as part of the Regional Council's Quality Improvement program, as required in PHL §3006, or §3004-a,
- 4) Participate, as necessary, with the service's certified EMS personnel in Continuing Education Programs and the re-certification process,
- 5) Verify, by affirmation provided by the department, that he/she serves as the medical director for the EMS service,
- 6) Working with the agency's providers on issues and questions regarding all ages of patient care,
- 7) Participate/interact in other activities that relate to the provision of medical care or affect the patient care provided by the EMS service.

Immunity from Liability for Medical Direction

Article 30 § 3013 (5), of PHL: Notwithstanding any inconsistent provision of any general, special or local law, any physician who voluntarily and without the expectation of monetary compensation provides indirect medical control², shall not be liable for damages for injuries or death alleged to have been sustained by any person as a result of such medical direction unless it is established that such injuries or death were caused by gross negligence on the part of such physician.

III Selecting an Emergency Health Care Provider for Public Access Defibrillation or Epinephrine Auto Injector Programs

² PHL Article 30 § 3001 (15) "Medical control" means: (a) advice and direction provided by a physician or under the direction of 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 (b) 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 emergency medical services council and the commissioner, and implemented by regional medical advisory committees.

- For organizations engaged in the PAD program, PHL §3000-b 1 (B) requires the selection of an Emergency Health Care Provider (EHCP). An EHCP is defined as “(I) a physician with knowledge and experience in the delivery of emergency cardiac care; or (II) a hospital licensed under article twenty-eight of this chapter that provides emergency cardiac care.”
- For organizations engaged in the epi-pen program PHL §3000-c 1(B) requires the selection of an Emergency Health Care Provider (EHCP). AN EHCP is defined as (i) a physician with knowledge and experience in the delivery of emergency care; or (ii) a hospital licensed under article twenty-eight of this chapter that provides emergency care.

IV Responsibilities of a Public Access Defibrillation Program EHCP

- 1) §3000-b.1(E) states that, “The Emergency Health Care Provider (EHCP) shall participate in the regional quality improvement program pursuant to subdivision one of section three thousand four-A of this article.”
- 2) §3000-b.1(D) requires every use of the defibrillator to be reported promptly to the agency’s EHCP. It will be the EHCP’s responsibility to receive and review these reports of use. They must also communicate any concerns relating to the use of the device to the provider.
- 3) Serve as the physician of record for the purposes of purchasing the AED by the PAD program.

V Responsibilities of an Epinephrine Auto Injector Program EHCP

- 1) §3000-c.3(c) requires every use of an epinephrine auto injector to be reported to the agency’s EHCP. It will be the EHCP’s responsibility to receive and review these reports of use. They must also communicate any concerns relating to the use of the device to the provider.
- 2) It will be the responsibility of the EHCP to oversee the acquisition and deployment of the devices and to assure the quality control standards implemented by the manufacturer are maintained.
- 3) Serve as the physician of record for the purposes of purchasing or issuing a prescription for the program to obtain epinephrine auto injectors.

VI Immunity from Liability for EHCP

3000-B (4) Application of other laws.

- a. Operation of an automated external defibrillator pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability.
- b. Operation of an automated external defibrillator pursuant to this section shall not constitute the unlawful practice of a profession under title VIII of the education law.

3000-C (4) Application of other laws.

- a. Use of an epinephrine auto-injector device pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability.
- b. Purchase, acquisition, possession or use of an epinephrine auto-injector device pursuant to this section shall not constitute the unlawful practice of a profession or other violation under title eight of the education law or article thirty-three of this chapter.
- c. Any person otherwise authorized to sell or provide an epinephrine auto-injector device may sell or provide it to a person authorized to possess it pursuant to this section.

VII Implementation:

- All EMS agencies should immediately identify a physician medical director that meets the criteria set forth by the REMAC.
- All EMS agencies must carry a copy of the Statewide Basic Life Support Adult & Pediatric Treatment Protocols and the applicable Advanced Life Support written protocols either on their person and/or on each responding vehicle); the appropriate written protocols need to be available to the provider from the time of dispatch through patient transport to a definitive care facility.
- REMSCOs, when receiving a Notice of Intent to provide Public Access Defibrillation or Epinephrine auto injectors, shall assure the Emergency Health Care Provider meets the requirements detailed in the applicable laws.
- REMACs shall establish, maintain and make available, annually, the policies and procedures established for the credentialing of physicians as service medical directors in the region. They shall also maintain and make available, annually, the list of physicians who have met those credentialing policies and procedures and are serving as medical directors.
- Physicians asked to serve as EMS agency Medical Directors of BLS services shall maintain a ratio of physician to certified providers that is no greater than 500:1. An Advanced Life Support Ambulance or First Response service must maintain a physician to certified provider ratio of no greater than 100:1. However, physician may not be the medical director for more than 10 services, unless approved by the local REMAC. These ratios were developed and approved by the SEMAC as part of Policy Statement # 95-01.

Issued and Authorized
Director - Bureau of EMS