House Legislative Analysis Section

Manufacturer's Bank Building, 12th Floor
Lansing, Michigan 48909
Phone: 517/373-6466

EMERGENCY MEDICAL SERVICES ACT

House Bill 4952 as enrolled
Third Analysis (7-3-90)

Sponsor: Rep. Michael J. Bennane
House Committee: Public Health
Senate Committee: Health Policy

THE APPARENT PROBLEM:

The Comprehensive Emergency Medical Services Act (Public Act 79 of 1981) became Part 207 ("Emergency Medical Services") of the Public Health Code. The act was adopted in 1981 and was scheduled to lapse on September 30, 1989. It replaced the Emergency Personnel Act (Public Act 290 of 1976), which was repealed in 1978 when the revised public health code (Public Act 368 of 1978) was adopted.

At the request of the Department of Public Health, legislation has been introduced which would reenact, with some changes, the emergency medical services section of the Public Health Code.

THE CONTENT OF THE BILL:

The bill would repeal — and then re-enact, with some changes — the Comprehensive Emergency Medical Services Act (Public Act 79 of 1981), which became Part 207 (Emergency Medical Services) of the Public Health Code. It also would amend a number of other sections of the health code to bring them into accord with the newly re-written part and would specify that references in any laws to earlier acts governing emergency medical services would be considered to be references to the bill.

The following are some of the major changes that the bill would make:

- Medical control authorities would be mandatory for all areas rather than permissive (though hospital participation would remain voluntary);
- a new 29-member "Emergency Medical Services Coordinating Committee" (with four non-voting members) would replace the existing nine-member statewide emergency medical services advisory council;
- license fees would be increased and late fees would be added;
- the present nine categories of EMS service providers would be reduced to four types of EMS service providers, capable of providing four levels of life support;
- two kinds of agencies that could provide on-the-scene life support only would be authorized, along with ambulance operations (which could provide all levels of life support on the scene and transport the patient to a health facility) and aircraft transport operations (which could transport patients between facilities);
- immunity provisions would be expanded;
- the emergency medical needs of rural areas would be studied.

Emergency medical service workers. Presently, the law defines nine kinds of workers involved in providing emergency medical services, some of whom are licensed, some of whom are certified, some of whom are "authorized," and some of whom merely operate licensed communications facilities.

The bill would replace these nine kinds of EMS workers with four kinds oflicensed emergency medical services personnel. It would:

- delete four of the existing kinds of workers ("advanced emergency medical technician," "certified advanced cardiac life support provider," "communications personnel," "driver," and "emergency department registered nurse");
- replace two kinds of workers ("ambulance attendant" and "advanced emergency medical technician") with the new (and roughly corresponding) categories of "medical first responder" and "paramedic;"
- retain two kinds of workers ("emergency medical technician" and "emergency medical technician specialist"); and
- change "emergency medical technician instructor-coordinators" (who now must be certified) to "emergency medical services instructor-coordinators" (who would have to be licensed).

In order to get a license as an EMS worker, an individual would have to be at least 18 years old, have successfully completed the appropriate education program approved by the DPH, have attained a passing score on the DPH written and practical examinations, and met any other requirements of the bill. A medical first responder who had not successfully completed an education program would be "grandparented" in until December 31, 1992, if the department determined that he or she was performing the functions of a medical first responder on the effective date of the bill and met the other requirements. The DPH could issue a 120-day temporary nonrenewable license to someone who had successfully completed all the requirements except for the required examinations, but someone holding a temporary license could practice only under the direct supervision of someone holding a comparable or higher regular license (i.e. a temporarily licensed paramedic could practice only under the direct supervision of a regularly licensed paramedic, a temporarily licensed EMT specialist could practice only under the supervision of a regularly licensed EMT specialist or a paramedic, and so forth). Finally, the DPH could issue licenses to individuals licensed in other states with comparable standards if they met the bill's requirements, there were no disciplinary actions pending against them, and any sanctions that may have been imposed were no longer in force.

EMS service operations. Presently there are three levels of emergency medical services that can operate outside of a hospital: ambulance operations, advanced mobile emergency care services, and limited advanced mobile emergency care services, with the latter two services defined primarily in terms of emergency techniques that they are allowed to provide (such as endotrachial intubation, defibrillation, drug administration and intravenous lifelines, etc.).

OVER

The bill would authorize four kinds of "life support agencies," three of which would be roughly comparable to existing EMS service operations and a new, fourth category, "aircraft transport operation." The bill would basically define life support agencies by the levels of life support that would be allowed and by whether or not patients could be transported from the scene of an emergency to a health care facility. Two kinds of EMS operations ("medical first responders" and "nontransport prehospital life support operations") could treat patients at the scene of an emergency but could not transport them, one ("aircraft transport operations") could only transport patients from one health facility to another. Only ambulance operations could both treat patients at the scene of an emergency and transport them to a health facility. Medical first responders (which would include police and firefighters only when dispatched for medical first response life support) could provide "medical first response" at the scene of an emergency prior to the arrival of an ambulance; nontransport prehospital life support operations could provide basic life support, limited advanced life support, and advanced life support at the scene of the emergency (but not move the patient to a health facility for further treatment); and ambulance operations would be able to transport a patient from the scene of an emergency to a health facility for further treatment and could be licensed to provide all levels of life support, from medical first response through advanced life support.

Generally, EMS agencies would be prohibited from operating without a license, from operating above their approved life support levels, and from doing certain kinds of advertising. They would be required to have at least one appropriately staffed and equipped vehicle available at all times. Ambulances and nontransport prehospital operations would be required to respond to all requests originating in their service areas (or ensure that there was a response) and to operate only under the direction of their medical control authorities. Only licensed ambulances and aircraft transport operations could transport patients, the latter only upon written orders from a physician and only between health facilities. If a police or firefighting agency was sent out to provide medical first response life support, it would be subject to provisions governing medical first response services.

If the DPH decided that grounds existed for taking action on (denying, suspending, or revoking) an agency's license but that such action might be detrimental to residents in the agency's service area, it could issue a one year nonrenewable conditional license and set conditions to protect the public health, safety, and welfare.

Local governments could operate ambulance operations or nontransport prehospital life support operations (or contract for such services) and pay for the costs of the service through available funds, including federal or private funds, fees for the services, or special assessments.

Duties of the Department of Public Health. The bill would retain many of the present duties of the Department of Public Health, change or delete others, and add some new duties.

The department would continue to be responsible for a number of functions with regard to emergency medical services such as:

- developing, coordinating, and administering a statewide EMS system;
- promoting public education on EMS;
- developing and coordinating a statewide EMS communication system;
- helping develop the EMS parts of the state health plan;
- collecting any data necessary to assess the quality and need for EMS services throughout the state;
- developing and maintaining standards for licensing EMS services and personnel (including annual inspections of ambulance operations and nontransport prehospital life support operations).

With some changes from present law, the department would continue to be required to:

- license all emergency medical services personnel and agencies;
- provide EMS resources for disasters and disaster drills;
- develop a program to inventory hospitals that have special care capabilities or that meet trauma center standards, including developing criteria for categorizing hospital emergency department capabilities every three years;
- develop and implement field studies on emergency medical services after review by the state EMS services committee;
- promulgate (with comment from the state EMS services committee) various rules to implement the bill, including rules to establish and maintain minimum standards for ambulances and for EMS vehicle patient care equipment and safety equipment (instead of publishing recommended equipment lists for emergency medical services vehicles) and the advertising of EMS services;
- designate medical control authorities — usually on a countywide basis — and develop recommendations for appropriate territorial boundaries for medical control authorities (rather than simply approving organizations as medical control authorities); and
- review and approve education programs for EMS personnel, as well as programs for relicensure.

The bill would no longer require the department to:

- annually inventory the emergency medical services available in the state;
- provide a way for hospitals to appeal the categorization of their emergency departments;
- report to the legislature and the governor at least every three years on the extent to which the state health plan has been implemented on emergency medical services;
- carry out certain functions with regard to health systems agencies;
- approve and license nurses qualified in emergency medical services;
- register nonemergency transportation vehicles.

A new charge to the DPH would be to conduct a study of rural EMS health care needs, actively involving rural communities and rural EMS services providers. The study would have to be completed within 18 months after the bill took effect and submitted to the House and Senate committees dealing with public health.

Finally, the bill would allow (but not require) the department to promulgate rules (a) requiring EMS agencies to submit their records and data for periodic evaluation and (b) establishing a grant program (or contracting with outside agencies) to provide training, public information, and help to medical control authorities and emergency medical services systems.

MORE

State Emergency Medical Services Coordination Committee. Presently, the chairperson of the Health Facilities and Agencies Advisory Commission appoints four task forces to advise the commission, one of which is a nine-member statewide emergency medical services advisory council, whose members are appointed by the governor. The advisory council is charged with generally advising the governor, legislature, and department on issues concerning emergency medical services and with promoting voluntary provision of first response capability throughout the state. It also advises the DPH on developing state standards for ambulances and for minimum patient care equipment, serves as the appeal body for hospitals appealing the categorization of their emergency departments by the DPH, establishes and appoints technical advisory committees composed of providers, and reviewed the development of EMS services in health systems agencies.

The bill would do away with this council and replace it with a 29 member "state emergency medical coordination committee," four of whose members would be non-voting ex officio members. The 25 voting members would be appointed by the director of the DPH, with a set number of members representing various provider groups, labor, and consumers. Two of the ex officio members would be from the legislature (a representative appointed by the Speaker of the House and a senator appointed by the Senate Majority Leader), one would represent the DPH, and one would be appointed by the Department of Management and Budget to represent the Office of Health and Medical Affairs. Representation from counties with smaller populations would be ensured by requiring that at least eight of the voting members be from (or do business in) a county with a population of not more than 100,000, while at least one voting member would have to be from a county with a population of not more than 35,000. At least one member would have to be from Detroit.

The committee would have to meet at least twice a year, with its meetings subject to the Open Meetings Act. Reimbursement for committee members would be set by the legislature.

The committee would continue to serve as advisory task force to the Health Facilities and Agencies Advisory Commission, and would carry out a number of other functions, including:

- helping coordinate and provide information on EMS programs and services, as well as serving as a liaison between groups and individuals involved in the EMS system;
- advising the legislature and the DPH on EMS matters throughout the state and making recommendations to the DPH on developing a comprehensive statewide EMS program;
- advising the DPH on appeals of local medical control decisions, on vehicle standards for ambulances, on minimum patient care equipment lists, and on standards for advertising EMS services;
- appointing, with the DPH's advice and consent, a statewide quality assurance task force, which would be responsible for making recommendations to the DPH concerning approval of medical control authority applications, revisions concerning medical control authority protocols, and EMS field studies, and which would conduct any other quality assurance activities requested by the director of the DPH;
- at the request of the director of the DPH, participating in educational activities, special studies, and the evaluation of emergency medical services.

Medical Control Authorities. The Department of Public Health would be required to designate a medical control authority (MCA) for each county (though, if appropriate, it could designate an MCA for part of a county or for two or more counties), assuring that there was a "reasonable relationship" between the existing EMS capacity and the estimated demand for EMS services in that area.

Hospitals would be able to participate or not in their locally designated medical control authorities. Participating hospitals would administer the authority, appointing an advisory body for the authority and, with its advice, a physician as the medical director of the authority. The advisory body would, at a minimum, have to include representatives from each kind of EMS provider and worker in the authority's boundaries, though no more than ten percent of the membership could be employed by the medical director. The medical director would have to either be board certified in emergency medicine or practice emergency medicine and be nationally certified in both advanced cardiac life support and advanced trauma life support.

Local medical control authorities would be required to establish, with the DPH's approval, written protocols for life support agencies and licensed EMS personnel practicing in the authority's area. (The bill would specify a number of requirements for the development and adoption of written protocols, including circulation of written drafts, comparison with established protocols, and allowing emergency protocols.) The protocols would specify what each kind of licensed EMS practitioner could do and would ensure that life support agencies dispatched their services appropriately based upon medical need and the EMS system's capabilities. With the approval of the DPH, the protocols could be more stringent in their standards for equipment and personnel (except for medical first responders), but would have to provide an appeals process and consider whether negative medical or economic impacts outweighed the benefits of those additional standards.

Fees. Presently, license fees for ambulance attendants, emergency medical technicians (EMTs), advanced EMTs, and EMT specialists are $5 every three years. EMT instructor-coordinators must be licensed, but pay no fees. Ambulance operations must pay an annual vehicle license fee of $10 for each ambulance in operation.

The bill would exempt from having to pay fees both medical first responders and volunteers who worked for agencies that did not charge for their services. The bill would set new fees as follows:

	Annual fee/renewal	Late fee
Ambulance operation	$100/year + $25/vehicle	$300/$100 per vehicle
Nontransport prehospital life support operation	$100/year + $25/vehicle	$300/$100 per vehicle
Aircraft transport operation	$100/year + $100/airplane	$300/$100 per vehicle
Medical first response service	no fee	no fee

OVER

	3-year license fee	Renewal	Late fee
Emergency medical technician	$ 40	$25	$ 50
EMS specialist	$ 60	$25	$ 50
Paramedic	$ 80	$25	$ 50
EMS instructor-coordinator	$100	$50	$100

The bill would specifically prohibit the legislature from using the fee increases as a basis for reducing the amount of general fund money appropriated to the DPH.

License actions. Currently, the DPH may deny, revoke, or suspend an individual's EMS license (certification, or authorization) for a number of reasons, including when an individual got his or her license fraudulently, illegally used (or distributed) drugs, practiced with an expired or suspended license, violated (or helped others violate) Part 207 of the code, didn't perform up to his or her training, or was physically or mentally incapable of carrying out his or her duties. The bill would add to this list of grounds for license action conviction of a crime that adversely affected the individual's ability to practice safely and competently.

HIV notification. The bill would amend the section of the health code (added by Public Act 490 of 1988) that requires notification of emergency services workers, under certain circumstances, when the worker helps or transports an emergency patient that later tests positive for human immunodeficiency virus (HIV) or other infectious agent. Presently, the code requires health facilities to notify emergency services workers (police officers, fire fighters, ambulance attendants, emergency medical technicians, emergency medical technician specialists, and advanced emergency medical technicians) when the worker is exposed to an emergency patient who later tests positive for an infectious agent and, at a minimum, of the appropriate infection control measures to take. Only if the emergency worker submits a written request, however, does the health facility have to tell the worker when an emergency patient is HIV infected. "Notification" can mean that the health facility notifies the chief elected official of the local governmental unit employing (or otherwise having "jurisdiction over") the worker, and must take place within two days after the facility gets the test results (or receives a written request).

The bill would amend this section of the code to appropriately reference the new kinds of emergency workers and to require that workers "demonstrate" in writing to the health facility that they were exposed to "the blood, body fluids, or airborne agents" of the emergency patient or that they did participate in providing treatment or transportation to the emergency patient in question. The bill would strike existing provisions that say that a health facility is in compliance with the notification requirements if it notifies the chief elected official of the appropriate local governmental unit. Instead, the bill would require that the facility attempt to notify the potentially exposed worker directly, or, failing that, notify the workers' employer. If the employer cannot be identified, the facility would be required to notify the medical control authority or chief elected official. If the medical control authority or chief elected official cannot notify the potentially exposed worker, they would be required to document in writing their attempts to notify the worker and the reasons why they were unable to do so. For purposes of this section on notification, "emergency patient" would be defined as someone who was transported to an organized emergency department in a licensed hospital (or other facility routinely available for the general care of medical patients). (The new Part 209, "Emergency Medical Services," defines "emergency patient" to mean "an individual whose physical or mental condition is such that the individual is, or may reasonably be suspected or known to be, in imminent danger of loss of life or of significant health impairment.")

The bill also would give civil and criminal immunity to health facilities (or their agents) that complied in good faith with the notification requirements in this section of the code.

Immunity provisions. Under present law, ambulance attendants, EMTs, EMT specialists, and advanced EMTs (as well as their backup staff) are immune from liability when giving care consistent with their training, unless there is gross negligence or willful misconduct.

The bill would give immunity to medical first responders, EMTs, EMT specialists, paramedics, and medical directors of a medical control authority while providing services to a patient either outside a hospital or in a hospital before transferring patient care to hospital personnel, providing that the act or omission was (a) consistent with the individual's licensure and training and (b) was not the result of gross negligence or willful misconduct. Backup staff (the authorizing physician, the medical director, communications personnel, the life support agency and staff, the hospital and staff, the governmental unit, or emergency personnel from outside the state) also would be given immunity under these conditions. The bill specifically would not limit immunity from liability otherwise provided by law for anyone covered by this section.

Repeal. The bill would repeal Part 207 of the Public Health Code.

Note: The enrolled bill makes reference, in Section 20191(1), to paramedics licensed under "section 30950." This apparently, is a typographical error, since paramedics are licensed under the new Part 209, section 20950.

FISCAL IMPLICATIONS:

According to the House Fiscal Agency, the fiscal year 1989-90 appropriation passed by the legislature included $150,000 for the emergency medical services program contingent upon the fee increase proposed in the bill. The $200,000 generated by the fee increases would mean that no additional general fund money would be needed by the Department of Public Health for the program. The 2.2 percent budget reduction (which in this case would amount to $15,700) should not cause major problems for the program. (7-3-90)

ARGUMENTS:

For:

The part of the health code governing emergency medical services was enacted in 1981. Since then, a number of changes have taken place in the provision of emergency medical services ("prehospital care") and this part of the health code is now outdated in a number of respects. The bill would update this part of the code, taking into consideration the advances made over the last several years in the provision of emergency medical services.

MORE

Against:

The bill would replace the existing nine-member statewide EMS advisory council, which has four consumer members, with a 29-member state EMS coordination committee, only two of whose voting members would be consumers. Not only would this proposed committee be too unwieldy and unable to function effectively, it also would be composed overwhelmingly of provider representatives (only two of the voting members would represent consumers, while only three would represent labor). For the sake of efficiency and to maintain strong consumer representation, the committee's composition should be changed.

Response: Since the committee will be dealing with highly technical matters involved in the provision of EMS services, it is only sensible to make sure that the expertise of providers in emergency medical services is adequately represented.

Against:

While some increase in fees may be necessary, the amounts proposed in the bill seem rather steep. Such significant fee increases, moreover, might discourage people who volunteer their services from getting involved in emergency medical services, and rather than discourage volunteers, the fees ought to encourage their participation.

Response: The fee increases, while substantial compared to the existing fees, are not unreasonable. EMS worker licenses are for three years, so, for example, the EMT annual fee costs would average out to less than $15 a year — hardly an undue burden for this profession. What is more, EMS operations usually pay their staff's license fees anyway, so the increased fees should not constitute a hardship for anyone. Finally, the bill exempts from fees volunteers who work for EMS operations that do not charge for their services, so the fee increase should not affect the level of participation by volunteers in these operations.