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SFA BILL ANALYSIS

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Senate Bill 404 (as enrolled) **PUBLIC ACT 375 of 2000**
Sponsor: Senator Dale L. Shugars
Senate Committee: Health Policy
House Committee: Health Policy

Date Completed: 1-30-01

RATIONALE

Emergency medical services (EMS) provide care to thousands of people each year who are experiencing some type of medical emergency. As prescribed in the Public Health Code, the Department of Consumer and Industry Services (DCIS) is responsible for the development, coordination, and administration of EMS systems. An EMS system is a comprehensive and integrated arrangement of the personnel, facilities, equipment, services, communications, and organizations necessary to provide EMS within a particular geographic area.

Part 209 of the Code regulates EMS, and includes provisions that prescribe the duties of the Statewide Emergency Medical Services Coordination Committee. Part 209 was adopted in 1990 to replace the Comprehensive Emergency Medical Services Act, which had expired in 1989. It was suggested that some of the provisions of Part 209, which was amended few times since 1990, needed to be updated and revised to ensure the proper delivery of EMS to the public.

CONTENT

The bill amended Part 209 of the Public Health Code to require the Department of Consumer and Industry Services to develop and implement standards for all EMS education program sponsors, and review and approve education program sponsors; revise examination standards for obtaining an EMS personnel license, including requiring that an examination adhere to standards developed by certain nationally recognized organizations; require the Emergency Medical Services Coordination Committee to advise the DCIS regarding curriculum changes for EMS education programs; revise the membership of the EMS Coordination Committee; expand immunity from liability provisions for EMS personnel to include services provided in a clinical setting, under certain conditions, and extend immunity to other specified individuals and entities involved in emergency medical services, including persons and entities involved in the development of EMS protocols; expand the list of protocols that a medical control authority must develop; revise provisions concerning appeals of medical control authority decisions; require that full-time freestanding surgical outpatient facilities be allowed to participate in the development of medical control authority protocols; revise DCIS responsibilities regarding inspection of life support vehicles; and redefine "emergency patient".

DCIS Requirements/Educational Programs

Previously, the DCIS was required to review and approve education programs for EMS personnel. The bill, instead, requires the DCIS to review and approve education program sponsors and ongoing education program sponsors. (The bill defines "education program sponsor" as a person, other than an individual, that meets the standards of the DCIS to conduct training at the following levels: medical first responder, emergency medical technician, emergency medical technician specialist, paramedic, and EMS instructor-coordinator. An ongoing sponsor is a sponsor that provides continuing education for EMS personnel.)

The bill requires approved education and refresher programs to be coordinated by a licensed EMS instructor-coordinator commensurate with level of licensure. Approved programs conducted by ongoing education program sponsors must be coordinated by a licensed EMS instructor-coordinator.

The bill also requires the DCIS to develop and implement standards for all education program sponsors and ongoing education program sponsors

based upon criteria recommended by the Statewide Emergency Medical Services Coordination Committee and developed by the Department. The Committee also must advise the DCIS concerning requirements for curriculum changes for EMS educational programs; and on minimum standards that each life support agency has to meet for licensure.

An education program sponsor that conducts education programs for paramedics and that receives accreditation from the joint review committee on educational programs for the EMT-paramedic or other organization approved by the DCIS as having equivalent expertise and competency in the accreditation of paramedic education programs, must be considered approved by the Department, if the education program sponsor submits an application to the DCIS that includes verification of accreditation, and maintains accreditation.

Previously, the DCIS, at least annually, had to inspect or provide for the inspection of ambulance operations and nontransport prehospital life support operations. The bill provides instead that, at least annually, the DCIS must inspect or provide for the inspection of each life support agency, except medical first response services. (Under Part 209, "life support agency" includes an ambulance operation, nontransport prehospital life support operation, aircraft transport operation, or medical first response service.) As part of the inspection, the DCIS will have to conduct random inspections of life support vehicles. If the DCIS determines that a life support vehicle is out of compliance, the Department must give the life support agency 24 hours to bring the vehicle into compliance. If the vehicle is not brought into compliance in that time, the DCIS must order it taken out of service until the life support agency demonstrates to the Department, in writing, that the vehicle has been brought into compliance.

The bill provides that receipt by the DCIS of an application for licensure of an ambulance, nontransport prehospital vehicle, or aircraft transport serves as an attestation to the Department by the operation that applies for the license that the ambulance, nontransport prehospital vehicle, or aircraft transport meets the minimum standards required by the DCIS. An inspection is not required as a basis for licensure renewal, unless otherwise determined by the DCIS.

The bill eliminated a requirement that the DCIS promulgate rules to establish and maintain minimum requirements for patient care equipment and safety equipment for life support vehicles; publish lists of the minimum required equipment; and submit proposed changes in requirements to the Statewide Emergency Medical Services Coordination Committee. The bill requires the DCIS to promulgate rules to establish requirements for licensure of life support agencies, vehicles, and individuals licensed to provide emergency medical services, and other rules necessary to implement Part 209. The Department must submit all proposed rules and changes to the Statewide EMS Coordination Committee and provide a reasonable time for the Committee's review and recommendations before submitting the rules for public hearing.

The bill requires the DCIS to develop, with the advice of the Committee, an emergency medical services plan that includes rural issues.

Previously, Part 209 required the DCIS to develop a program of hospital inventory; develop a program of categorization of hospital emergency department capabilities; and assist in the development of EMS portions of the Statewide health priorities. The bill eliminated these requirements.

EMS Examinations/Fees

Part 209 prescribes the requirements that an individual must meet to obtain a license as a medical first responder, emergency medical technician, emergency medical technician specialist, paramedic, or EMS instructor-coordinator. Among other things, the individual must obtain a passing grade on written and practical examinations prescribed by the DCIS. Under the bill, within six months of its effective date (i.e., by July 2, 2001), the DCIS must require each first-time applicant for an EMS personnel license (except a medical first responder license) to pass an examination that is a written and practical evaluation approved or developed by the National Registry of Emergency Medical Technicians, or other organization with equivalent national recognition and expertise in emergency medical services personnel testing and approved by the DCIS.

The bill requires an emergency medical technician, emergency medical technician specialist, or paramedic to pass a written examination and a practical examination proctored by the DCIS or its designee. Within three years after the bill's effective date (i.e., by January 2, 2004), a medical first responder must pass a written examination proctored by the DCIS or its designee, and a practical examination approved by the Department. The practical examination must be administered by the instructors of the medical first responder course. The DCIS or its designee may proctor the practical examination. The fee for a required written examination must be paid directly to the National Registry of Emergency Medical Technicians or other organization approved by the DCIS.

The bill requires the DCIS to provide for the

development and administration of an examination for EMS instructor-coordinators.

Under Part 209, an applicant for renewal of a license must pay a renewal fee. The bill reduced the fee from $50 to $25 for an EMS instructor-coordinator. Previously, an EMS instructor-coordinator had to pay a $100 late fee if he or she attempted to renew a license after it expired. The bill reduced the late fee to $50. The bill established a $50 late fee for a medical first responder. If an applicant for renewal of an EMS personal license fails to notify the DCIS of a change of address, he or she must pay an additional $20 fee.

The bill specifies that an individual who seeks license renewal is not required to maintain national registry status as a condition of renewal.

Medical Control Authority/Protocols

Part 209 requires the DCIS to designate an organization as a medical control authority for emergency medical services in each Michigan county, or multiple county area. The bill provides that each hospital and licensed freestanding surgical outpatient facility that operates a service for treating emergency patients 24 hours a day, seven days a week, and meets the standards established by medical control authority protocols, must be given an opportunity to participate in the ongoing planning and development activities of the designated local medical control authority. (Previously, this requirement applied to a licensed hospital operating a service for admitting and treating emergency patients.)

Under Part 209, a medical control authority must be administered by the participating hospitals. The bill also provides that a medical control authority must accept participation in its administration by a licensed freestanding surgical outpatient facility if the facility operates a service for treating emergency patients 24 hours a day, seven days a week, determined by the medical control authority to meet the applicable standards established by medical control authority protocols.

Under Part 209, the participating hospitals within a medical control authority must appoint an advisory body for the authority. Previously, the participating hospitals also had to appoint a medical director of the authority, with the advice of its advisory body. The bill requires the authority to appoint the medical director, with the advice of the advisory body. Previously, the medical director had to be board certified in emergency medicine or practice emergency medicine and be certified in advanced cardiac life support and advanced trauma life support by a national organization approved by the DCIS. Under the bill, if the director is board certified in emergency medicine, he or she must be certified by a national organization approved by the DCIS. The bill specifies that the medical director is responsible for medical control for the EMS system served by the medical control authority.

Under Part 209, a local medical control authority must establish written protocols for the practice of life support agencies and EMS personnel within its region, as specified in the statute. In addition, the bill requires an authority to develop and adopt protocols to do the following:

-- Define the process, actions, and sanctions a medical control authority may use in holding a life support agency or personnel accountable.
-- Ensure that if the medical control authority determines that an immediate threat to the public health, safety, or welfare exists, appropriate action to remove medical control immediately may be taken until the medical control authority has the opportunity to review the matter at a medical control authority hearing. The protocols must require that the hearing be held within three business days after the authority's determination.
-- Ensure that if medical control has been removed from a participant in an EMS system, the participant does not provide prehospital care until medical control is reinstated, and that the medical control authority that removes the medical control notify the Department within one business day of the removal.
-- Ensure that a quality improvement program is in place within a medical control authority and provide data protection as provided in Public Act 270 of 1967 (which provides for the release of information for medical research and educational purposes under certain circumstances, and provides for the confidentiality of data).
-- Ensure that an appropriate appeals process is in place.

Part 209 permits the DCIS to deny, revoke, or suspend an EMS personnel license upon finding certain violations as specified in Part 209, including that an individual is not performing in a manner consistent with his or her education or licensure. The bill adds that if an EMS licensee is not performing in a manner consistent with his or her approved medical control authority protocols, the DCIS may deny, revoke, or suspend the individual's license.

Medical Control Authority: Appeals

Previously, a medical control authority had to provide an opportunity for an affected person to appeal a decision of the authority; after appeals to an authority were exhausted, the individual could apply to the DCIS for a variance from the authority's decision.

The DCIS could grant a variance if it determined that that action was appropriate to protect the public health, safety, and welfare. The bill, instead, requires a medical control authority to provide an opportunity for an affected participant in an EMS system to appeal a decision of the Authority. Following appeal, the authority may affirm, suspend, or revoke its original decision. After appeals to the authority have been exhausted, the affected participant in an EMS system may appeal the authority's decision to the Statewide Emergency Medical Services Coordination Committee.

The Committee must issue an opinion on whether the actions or decisions of the authority are in accordance with the Department-approved protocols of the authority and State law. If the Committee determines in its opinion that the authority's actions or decisions are not in accordance with its approved protocols or with State law, the Committee must recommend that the DCIS take any enforcement action authorized under the Code. (Previously, the Committee had to provide the DCIS with advisory recommendations on appeals of a medical control authority's decisions.)

Part 209 provides that if an affected person appeals a decision of a medical control authority, the authority must make available the medical and economic information it considered in making its decision. Previously, the Department was responsible for reviewing that information and issuing findings. Under the bill, the Statewide Emergency Medical Services Coordination Committee has that responsibility.

Liability Immunity

Under Part 209, unless an act or omission is the result of gross negligence or willful misconduct, the acts or omissions of a medical first responder, emergency medical technician, emergency medical technician specialist, paramedic, or medical director of a medical control authority or his or her designee, while providing services to a patient outside a hospital, or in a hospital before transferring patient care to hospital personnel, that are consistent with the individual's licensure or additional training required by the medical control authority, do not impose liability in the treatment of a patient on those individuals or any of the other individuals listed in Part 209. The bill extends the immunity to acts or omissions of a covered individual while he or she is providing services to a person in a clinical setting; to services that are consistent with an approved procedure for a particular education program; and to services consisting of the use of an automated external defibrillator on an individual who is in or is exhibiting symptoms of cardiac distress.

Further, the bill extends immunity to an individual acting as a "clinical preceptor" of a Department-approved education program sponsor. (The bill defines a "clinical preceptor" as an individual who is designated by or under contract with an education program sponsor for purposes of overseeing the students of an education program sponsor during their participation in clinical training.) The limitation on liability granted to a clinical preceptor applies only to an act or omission of the preceptor relating directly to a student's clinical training activity or responsibility while the preceptor is physically present with the student during the activity, and does not apply to an act or omission of the preceptor during a time that indirectly relates or does not relate to the student's clinical training activity or responsibility.

The bill also extends immunity to the following:

-- The medical director and individuals serving on the governing board or committee of the medical control authority, and an employee of the medical control authority.
-- An education program medical director, education program instructor-coordinator, education program sponsor, and education program sponsor advisory committee.
-- A student of a DCIS-approved education program who is participating in an education program-approved clinical setting.
-- An instructor or other staff employed by or under contract to a DCIS-approved education program for the purpose of providing training or instruction for the education program.
-- A life support agency or an officer, member of the staff, or other employee of the life support agency that provides the clinical setting.
-- The hospital, or an officer, member of the medical staff, or other employee of the hospital that provides the clinical setting.

The bill provides that, unless an act or omission is the result of gross negligence or willful misconduct, the acts or omissions of any of the following persons, while participating in the development or implementation of protocols under Part 209, or holding a participant in the EMS system accountable for DCIS-approved protocols under Part 209, do not impose liability in the performance of those functions:

-- The medical director and individuals serving on the governing board, advisory body, or committees of the medical control authority or employees of the medical control authority.
-- A participating hospital or freestanding surgical outpatient facility in the medical control authority or an officer, member of the medical staff, or other employee of the hospital or outpatient facility.
-- A participating agency in the medical control

authority or an officer, member of the medical staff, or other employee of the participating agency.

-- A nonprofit corporation that performs the functions of a medical control authority.

EMS Coordination Committee

Part 209 establishes the Emergency Medical Services Coordination Committee in the DCIS, and requires the DCIS Director to appoint the 25 voting members of the Committee. Of the voting members, three must be appointed from a Statewide organization representing labor, that deals with EMS. The bill provides that at least one of the three must be a member of the Michigan Professional Fire Fighters Union or its successor agency.

Further, of the 25 voting members, two previously had to be consumers, at least one of whom was a resident in a county with a population of 100,000 or less. The bill instead requires the appointment of one consumer, and one individual who is an elected official of a city, village, or township located in a county with a population of 100,000 or less.

"Emergency Patient"

Previously, under Part 209, "emergency patient" meant an individual whose physical or mental condition was such that he or she was, or could reasonably be suspected or was known to be, in imminent danger of loss of life or of significant health impairment. The bill instead defines "emergency patient" as an individual with a physical or mental condition that manifests itself by acute symptoms of sufficient severity, including but not limited to pain, such that a prudent layperson possessing average knowledge of health and medicine may reasonably expect to result in serious dysfunction of a body organ or part; serious impairment of bodily function; or placing the health of the individual or, in the case of a pregnant woman, the health of the patient or the unborn child, or both, in serious jeopardy.

MCL 333.20902 et al.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

Providing EMS to the public is a vital component of the overall delivery of health care in the State. In the last three decades emergency medical services have experienced a steady evolution, from funeral home station wagons with a flashing red light to ambulances equipped with sophisticated life-saving machinery run by highly trained personnel. Today's EMS system is composed of several elements that must work together to achieve successful patient outcomes; these components include 9-1-1 communication systems; EMS personnel with various levels of training; equipment; ambulance operations; and hospital emergency rooms and their staff of health professionals. Perhaps to a greater degree than required by any other area of health care, there needs to be a clear determination of the obligations and duties of the personnel involved in EMS systems.

The provisions that governed EMS systems had applied for nearly 10 years, and many in the EMS community believed that the law needed to be revised to correct various problems, and to address the many changes that have occurred in health care during the past decade. The bill provides a comprehensive update of the EMS provisions. Among other things, the bill requires the implementation of standards for EMS education providers; revises EMS personnel licensing examinations, and institutes an examination for medical first responders; requires random inspections of ambulance operations; clarifies the role of the medical director in medical control authorities; specifies the responsibilities of medical control authorities; expands immunity from liability for EMS personnel, including persons involved in the development of EMS protocols; and adds the "prudent layperson" standard to the definition of "emergency patient". These provisions, and others in the bill, will strengthen the efficiency and quality of EMS systems, and ultimately improve the delivery of EMS to the public.

Supporting Argument

Under the bill, EMS licensure examinations must be developed by the National Registry of Emergency Medical Technicians (NREMT) or an equivalent nationally recognized, DCIS-approved testing service. According to testimony submitted to the Senate Health Policy Committee, more than 40 states currently use the NREMT in some manner to provide testing services for their candidates. Instituting the national exam will assure the DCIS that applicants in Michigan receive a reliable, valid, legally defensible exam that is developed by a team of expert exam writers. In addition, the DCIS will be able to offer reciprocity, without delay, to nationally registered EMS providers who move to Michigan.

Supporting Argument

A growing number of freestanding ambulatory care centers offer a valuable resource to treat and/or manage acute injury or illness, and more and more hospitals are choosing to reorganize their operations using this type of facility. It is important that these EMS providers be allowed to participate in medical control authorities' development activities and administration. Reportedly, however, individual

authorities decided, without consistency throughout the State, whether these facilities could participate. Under the bill, medical control authorities must accept participation by full-time freestanding surgical outpatient facilities that meet the standards established by authority protocols.

Legislative Analyst: G. Towne

FISCAL IMPACT

According to the Department of Consumer and Industry Services, this bill will result in a cost saving to the State, resulting from the change to the national registry examination, of approximately $60,000. Previously, the State had a contract with a private firm to prepare the exam. Additionally, the bill provides for a new $20 fee to be assessed on those licensees who fail to notify the State of a change of address. The Department estimates that approximately 1,500 renewal applications are returned each year, which would generate $30,000 in restricted revenue.

Fiscal Analyst: M. Tyszkiewicz

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