

Medical Program Director Handbook



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Office of Emergency Medical Services and Trauma System

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<http://www.doh.wa.gov/hsqa/emstrauma/>

MPD Handbook Hyperlink Navigation Instructions

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I. Medical Program Directors – Duties and Responsibilities

A. Overview

1. Medical Program Directors (MPDs) are physicians recognized to be knowledgeable in their county's administration and management of pre hospital emergency medical care and services.
2. Legal Authority: MPD duties are required by statute [RCW 18.71.212](#) and are described in [WAC 246-976-920](#). These responsibilities at the County level include “on-line” and “off-line” medical control, developing written protocols and directing patient care, and being a conduit of information from local EMS&TC systems to State staff for purposes of the training, certification, audit and discipline of EMS providers.
3. Limits to delegation of duties to other physicians: MPDs may delegate duties to other physicians except for the Duties listed below. The delegation must be in writing, and the MPD must notify Department of Health (DOH) in writing within 14 days. [WAC 246-976-920 \(2\)](#). (Appendix [D-1](#) and [D-2](#)).
 - a. Adopting prehospital patient care protocols to direct EMS/TC certified personnel in patient care;
 - b. Recommend to the department certification, recertification, or denial of certification of EMS/TC personnel;
 - c. Recommend to the department disciplinary action to be taken against EMS/TC personnel, which may include modification, suspension, or revocation of certification.
4. Limits to delegation of duties to non-physicians: MPDs may delegate duties relating to training, evaluation, or examination of certified EMS/TC personnel, to qualified non-physicians. The delegation must be in writing with notification to the DOH (i.e., course applications, EMS Evaluator Applications, etc).
5. MPDs may enter into EMS/TC medical control agreements with other MPDs.
6. Recommend denial of certification to the department for any applicant the MPD can document is unable to function as an EMS provider, regardless of successful completion of training, evaluation or examinations.
7. Utilize protocol examinations to determine the knowledge and abilities of IV technicians, airway technicians, intermediate life support technicians or paramedics prior to recommending applicants for certification or recertification (intended for reciprocal certification candidates, and not appropriate for reexamining EMS personnel participating in an OTEP).

B. Duties and Responsibilities

1. Medical Control

The direction of medical care provided by certified EMS/TC personnel in the prehospital EMS/TC system. MPDs must provide medical control and direction of EMS/TC personnel in their medical duties, by oral and/or written communications.

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- a. **Develop and Adopt Protocols** – for additional information, see [“Developing, and Implementing Prehospital Patient Care Protocols”](#).
 - 1) **Prehospital patient care:** Personally adopt written prehospital patient care protocols that are consistent with state standards and published protocols. [WAC 246-976-920\(c\)](#).
 - a) MPDs may use delegate input in protocol development and implementation, but cannot delegate responsibility for formal adoption of prehospital patient care protocols.
 - b) Protocols may not conflict with regional Patient Care Procedures or with the authorized care of the certified prehospital personnel as described in [WAC 246-976-182](#).
 - c) MPDs may **NOT** establish protocols that vary from protocols published by the DOH without specified written approval from DOH-OEMSTS. Any deviation from DOH published protocols must be provided to the DOH in writing by the MPD and approved in writing by the DOH-OEMSTS.
 - 2) **Controlled Substances:** Establish protocols for storing, dispensing and administering controlled substances. [WAC 246-976-920](#)
 - a) In accordance with state and federal regulations and guidelines.
 - b) Bring to the attention of certified personnel. A written communication is recommended. (Appendix [D-3](#) and [D-4](#)).
 - 3) **Special Training:** Develop and approve protocols for specialized training identified in [WAC 246-976-021 \(5\)](#).
 - 4) **Scope of Practice:** MPDs must **NOT** provide protocols for functions that are not within the scope of practice, which is based on Washington State DOH approved curricula and published protocols.
- b. **Patient Care Procedures:** Participate with local and regional EMS/TC councils and emergency communications centers to develop and revise regional Patient Care Procedures (PCPs). [WAC 246-976-920 \(e\)](#).
 - 1) PCPs are operational guidelines focused on who responds, when and where. It also includes who transports and to what facilities and must NOT be confused with patient care protocols, which deal with the treatment of the patient.
 - 2) Participation during the development or revision of PCPs is to provide a medical perspective and can be accomplished in person or via written communications.
 - 3) MPDs must work within the approved regional PCPs. [WAC 246-976-920 \(g\)](#)

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- c. **Regional Plans:** Participate with local and regional EMS/TC councils to develop and revise regional plans and make timely recommendations to the regional council (on issues related to prehospital patient care delivery). [WAC 246-976-920 \(f\)](#).
 - 1) MPDs must work within the approved regional plan. WAC 246-976-920 (g).
 - a) As an example, if the plan indicated that all trauma patients will be sent to the regional trauma center, and yet the MPD's online direction was to the contrary, the MPD would not be working within the approved plan.
 - 2) MPDs and their delegates should be familiar with all components of the regional EMS and Trauma System Plan impacting prehospital patient care delivery.
 - a) Special focus should be on the Prehospital and All Hazards sections of the Regional Plan. Regional Plans are located at: www.doh.wa.gov/hsga/emstrauma/publications.htm#RegionalEMSandTraumaDocuments.
 - b) The Mass Casualty – All Hazards Field Protocols are state protocols that establish the standard for field performance. As these protocols are still under development additional protocols will be added. They are found at: www.doh.wa.gov/hsga/emstrauma/download/allhazprot.pdf
- d. **Medical Control Agreements** - MPDs may enter into EMS/TC medical control agreements with other MPDs by utilizing Appendix [D-5 - Inter-County BLS & ALS Medical Control Agreement for EMS & Trauma Care](#).
 - 1) The purpose of the Medical Control Agreement is to allow personnel in neighboring counties to function within multiple counties without requiring them to acquire the specific approval of multiple MPDs.
 - 2) The MPD(s) initiating this process coordinates the acquisition of signatures of any other participating MPDs.
 - 3) Also, all MPDs signing this instrument agree to ensure that participating certified field personnel with licensed, verified and affiliated services function under similar BLS, ILS and ALS protocols.

2. Supervise EMS Training and Audit Medical Care Performance

- a. MPDs must oversee the content of what is being taught to all levels of certified EMS/TC personnel as well as the quality of education and skills received during training. [WAC 246-976-920 \(h\)](#). Supervision includes clinical and field internship requirements as provided in each approved EMS curriculum.

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- 1) This does not mean that MPD must be personally present to oversee the instruction; however, it may be advantageous for the MPD to occasionally perform unannounced visits to training sites to ensure personnel are being instructed according to the approved program.
- b. **Supervision of Initial Training:**
- 1) Includes reviewing and approving each [EMS Training Course Application](#).
 - 2) May include periodic visits and participation in initial EMS training programs.
 - 3) May include periodic participation in course labs, skill evaluations and clinical/field internships.
 - 4) Verification and approval of course completion documents. Initial EMS training courses may utilize the [BLS, ILS /ALS Course Completion Verification](#) to document course completion. All EMS courses must provide certificates or letters/memos of successful course completion to those individuals successfully completing the course. A course is not considered complete until all aspects of the course are successfully completed, which includes any practical skill examinations.
- c. **Supervision of Continuing Education:**
- 1) Includes reviewing and approving EMS recertification training. These requirements may be performed through Continuing Medical Education (CME) or an Ongoing Training and Evaluation Program (OTEP).
 - 2) May include periodic visits and participation in CME and OTEP training.
 - a) Continuing Medical Education
 - (1) Participation in courses, practical skills examination and the state written certification examination and, if appropriate for the certification level, skill maintenance requirements.
 - b) Ongoing Training and Evaluation Program
 - (1) Review and approval of OTEP content, evaluation methods and evaluation tools.
 - (a) Agencies may change their OTEP to meet the needs of EMS. MPDs are required to approve any changes to currently approved OTEP and forward to the OEMSTS for formal approval.
 - (b) OTEP Handbooks are available from the EMS office.
 - (2) Review and approval of [EMS Evaluator Applications](#) for MPD signature.

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d. **Training Equivalents for Required CME and OTEP**

- 1) The DOH has evaluated a number of the WMD training topics and has determined if they are equivalent to state required CME and OTEP topics. A chart with this information is included in the following document located on our web site:
www.doh.wa.gov/hsqa/emstrauma/download/allhazardinfo.pdf

e. **Special Training** - approve course curriculum, lesson plans, and course instructional personnel, who must be experienced and qualified in the area of training.

f. **Periodically Audit the Medical Care Performance of EMS/TC Certified Personnel**

- 1) MPDs must review field skill performance. Skill review can be based on the required number of procedures for a given skill, i.e., intubations. This area of responsibility should be incorporated into the MPD's quality improvement (QI) program (See III, [Quality Improvement Program for MPDs](#)).
 - a) Skill Maintenance Audits
 - (1) EMS providers are required to maintain practical skill proficiency through CME and other skill training sessions.
 - (2) An MPD may require remedial or additional training for providers whose skills are in need of improvement.
 - b) Run Reviews
 - (1) Medical Incident Reports (MIR) completed after each emergency call must be available for MPD review and study if necessary.
 - (2) The MPD may utilize the information provided on the MIR during quality improvement sessions.

g. **Recommend Senior EMS Instructors (SEIs) for recognition**

- 1) MPDs must assess the instructional capabilities of individuals applying to become SEIs and provide a recommendation for recognition or non-recognition to the DOH.

h. **Utilize Examinations** – MPDs may utilize protocol examinations to determine the knowledge and abilities of IV technicians, airway technicians, intermediate life support technicians or paramedics prior to recommending applicants for certification or recertification (intended for reciprocal certification candidates, and not appropriate for reexamining EMS personnel participating in an OTEP).

i. **Training Forms**

- 1) The most current training forms are available on the OEMSTS web site at <http://www.doh.wa.gov/hsqa/emstrauma/publications.htm>.

3. Recommending Certification, and Denial of Certification of EMS/TC Personnel

- a. MPDs must recommend EMS/TC personnel for certification, recertification, or denial of certification, following a review of an applicant's ability to perform, based on educational achievements and testing (Please contact DOH Office of EMSTS at 1-800-458-5281, if you have any questions regarding testing).
- b. Once the MPD has determined the individual's ability to perform and the MPD is reasonably assured of the applicant's association with a DOH licensed prehospital EMS agency, the MPD can make their recommendation for certification/recertification or denial of certification.
- c. It is then the applicant's responsibility to get the application to the appropriate state office for processing.

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- d. Denial of certification may be recommended for any applicant the MPD can document is unable to function as an EMS provider, regardless of successful completion of training, evaluation or examinations.
 - 1) Such denial could be made for failure to meet CME or skills maintenance requirements.
 - 2) Denial could also result from an individual's inability to function due to physical or mental difficulties.

4. Recommend disciplinary action to be taken against EMS/TC personnel

- a. "Disciplinary Action": means the imposition of sanctions determined under the Uniform Disciplinary Act (UDA) process through the DOH.
- b. MPDs must use the DOH [Below Threshold Determination Guidelines](#) when deciding whether MPD remedial counseling is in order or whether to make a written referral to the DOH.
- c. Sanctions may include suspension, or revocation of certification, when continued certification is detrimental to public health. Lesser sanctions may be imposed, such as modification to a lower level of certification, remedial education, monitoring, censure, reprimand, probation, or other corrective action as appropriate to safeguard public health.
- d. **Due Process Rights of Licensed Providers**
 - 1) Certified providers have a right to "due process" before their property interests are impacted by state-imposed sanctions. Use of the [Administrative Procedures Act \(ADA\)](#) by DOH ensures due process.
 - 2) A provider's "property interests" can be adversely impacted by an MPD's exercise of medical control to the extent that the MPD's action adversely affects the certified EMS provider's interest in being employed. In other words, if the MPD precludes the provider from the opportunity to continue at the same level of certification. Even restricting protocols can have an adverse impact if it results in any form of pay loss, such as demotion or termination. If this happens, it requires "due process".
 - 3) Corrective actions, such as verbal or written warnings or counseling, are generally not significant enough to generate a "due process" issue under the [APA](#). However, it is best to leave the decision of whether to exercise the due process protections of the [APA](#) procedure to OEMSTS staff.
 - 4) The MPD can restrict the use of protocols or otherwise negatively impact a provider's property rights outside of a DOH initiated process only if **all** of the following exist:
 - a) **Credible evidence (documented) that a certified individual represents a critical and immediate threat to public health and safety**, and
 - b) The restriction has been approved by DOH, and

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- c) The provider has been given an opportunity to respond to the allegations.
- 5) In the event of a restriction of a provider's use of protocols by an MPD, DOH will immediately initiate an investigation and may proceed with summary suspension in situations involving a restriction of protocols.
- e. MPDs are not required, nor are they to engage in any investigative action unless it is with the assistance of a DOH investigator. However, MPDs can engage in fact finding in order to determine if the matter warrants DOH involvement.
- f. **Description of The Disciplinary Process**
 - 1) [WAC 246-976-191](#): Grounds for denial, revocation, or suspension of an EMT certificate include, but are not limited to, evidence that a certified provider has violated the provisions of the UDA, which includes the following:
 - a) Has been guilty of misrepresentation in obtaining the certificate.
 - (1) EXPLANATION: Misrepresentation would be if an individual lied about his/her age (need to be 18 or older to enter training), professional history, or possession of a high school diploma, or a General Equivalency Diploma (GED).
 - b) Has engaged, or attempted to engage in, or represented him/herself as entitled to perform, any service not authorized by the certificate.
 - (1) EXPLANATION: Unauthorized service can be an EMT who performed an IV on a patient without proper certification.
 - c) Has demonstrated incompetence or has shown him/herself otherwise unable to provide adequate service.
 - (1) EXPLANATION: Incompetence can be the failure to perform even the more routine functions. However, this is usually documented on more than one occasion.
 - d) Has violated or aided and abetted in the violation of any provision of [RCW 18.73](#) or the rules and regulations promulgated thereunder.
 - (1) EXPLANATION: A violation of RCW 18.73 can be the falsification of records. Also, aiding and abetting in a violation of RCW 18.73 can be enabling the falsification of records.

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- e) Has demonstrated unprofessional conduct in the course of providing services.
 - (1) EXPLANATION: Unprofessional conduct can be unsanitary personal habits as well as abusive language while attending patients.
 - f) Has violated written patient care protocols which have been adopted by the approved MPD and which have been acknowledged in writing by the certified individual.
 - (1) EXPLANATION: Evidence of failure to follow written protocols is a serious matter. However, you must make sure that you have provided the certified person with protocols appropriate to the level of certification. The best way to perform this function is to have a witness present when distributing the protocols, or, more appropriate, send the protocols to EMS personnel via certified mail.
 - g) Has failed to maintain skills.
 - (1) EXPLANATION: Failure to maintain skills and/or CME often go “hand in glove”. EMS personnel need to understand the importance of documenting their CME and that you are the approval point for this process.
- 2) Tracking the Disciplinary Process
- a) Only the DOH is authorized to take definitive corrective action that affects a person’s certification (property interest). (Appendix [D-6 – Steps in a Disciplinary Action](#)).
 - b) Process for disciplinary action:
 - (1) A written report containing allegations must be submitted to OEMSTS, Licensing and Certification prior to initiating any investigative action.
 - (2) MPDs must consult with OEMSTS, Licensing and Certification in all forms of corrective actions.
 - (3) In order to take disciplinary action against certified EMS personnel, the DOH must issue a Stipulation to Informal Disposition or a Statement of Charges alleging the violations involved and notifies the individual of his/her right to request a hearing.
 - (4) Certified EMS personnel may appeal any decision on either the Stipulation or the Statement of Charges made by the Secretary of the DOH, or designee, in accordance with the [UDA](#) and the [APA](#).
 - c) Processing Reports of Employee Misconduct:
 - (1) The report to DOH should provide a clear description of the incident(s) or situation.

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- (2) A report is not required if disciplinary action is taken by the certified person's employer regarding inadequate work performance, not in any way associated with the EMS certification.
 - (3) A report initiated by the MPD must be immediately submitted to OEMSTS Licensing and Certification. OEMSTS Licensing and Certification will review the allegations and then may forward the matter to the Investigative Services Unit.
 - (4) Anyone who has either witnessed an act, or has knowledge of the alleged misconduct by certified EMS personnel, should be identified in the report.
 - (5) The certified person's employer may be informed by DOH in cases of suspected misconduct.
 - (6) The EMS provider will be provided an opportunity by DOH to respond to the allegations.
 - (7) Time limits in processing an investigation may vary from case to case, depending on case complexity and departmental workload.
 - (8) If a completed investigation, and other documents referring to the allegation, does not reveal misconduct, DOH may close the case without further action. This decision would be shared with the certified person and his/her employer.
 - (9) Where the Licensing and Certification Section determines that incompetence or unprofessional conduct may have occurred, the report shall be forwarded to the AG to prepare an order for probation, modification, suspension, revocation, etc., of the certificate.
- 3) Suspected Criminal Activity: The MPD must first contact law enforcement regarding any suspected criminal activity. Suspected criminal activity must also be brought to the attention of DOH for formal action.

5. Counseling and Remedial Action

a. Substance Abuse Monitoring Program

- 1) The MPD role in issues of substance abuse is to advise the DOH. The DOH has a substance abuse monitoring program. Additional information is available in [Appendix F](#) and on the DOH, Washington Health Professional Service (WHPS) web site, located at: <https://fortress.wa.gov/doh/hpga1/HPS2/WHPS/default.htm>.

b. Counseling

- 1) Counseling can be considered a mutual exchange of ideas or opinions between people pertaining to a problem.

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- 2) Successful counseling is changing the attitude and behavior of the counselee. It may not be the advice that is the catalyst to the change, but the opportunity to see the facts. Another approach is “selling” the individual on adopting an improved attitude and behavior. The session should aim at bringing clarity to the analysis of the problem so the counselee can distinguish between the emotional and the factual aspects of the situation. However, it is important to remember that we must first hear the counselee out, and then pinpoint the facts that may have been distorted or ignored. The employer of the counselee should be involved in this process.
- 3) At this point, we need to emphasize, in greater detail, the damage the counselee is doing to his/herself by failing to make the necessary improvements. Also, we must now clearly identify the ultimate consequence the counselee will pay if he/she does not correct the problem. This action must be in writing and signed by the MPD and the EMS certified person. Under no circumstances should we ever ignore continued violations.
- 4) Finally, there is the need for follow-up, which is critical to the whole process. The counselee must know whether his/her training and skills are adequate or whether further improvement is necessary. Additional counseling may be required to resolve the problem.
- 5) Recommended Process:
 - a) First we suggest you review Appendix [D-7 – Checklist for Counseling](#). Next, consider utilizing Appendix [D-8 - MPD Oral Counseling Record](#). In this situation, the performance of the certified person does not warrant a written memo nor does it necessitate notifying his/her employer. It simply provides the MPD with a mechanism to document the attempt to improve performance or behavior.
 - b) If the results were less than satisfactory, the MPD should initiate written counseling (Appendix [D-9 – Sample Counseling Memo](#)). If this effort is unsuccessful, the MPD will need to recommend to the DOH OEMSTS, Licensing and Certification Section, corrective action with the certified person. Appendix [D-10 - Situations Requiring Consultation with the Department of Health](#) contains a list of specific conditions that would necessitate such action.
- 6) Policy Statement on Counseling
 - a) All information regarding personnel counseling should be submitted to OEMSTS Licensing and Certification at:
Section Manager, Licensing and Certification
Office of Emergency Medical Services and Trauma System
PO Box 47853
Olympia, Washington 98504-7853

II. Legal Issues

A. Restrictions on Discretion of MPD Authority

1. MPD failure to perform the mandatory duties may:
 - a. Be grounds for termination of MPD certification
 - b. Create personal liability for the MPD.
2. MPDs have choices about how they get the job done.
 - a. Mandatory duties are NOT discretionary. Discretionary choices must be based on sound medical information and must be impartial. Discretionary decisions, if made impartially and reasonably, do not create personal liability for the MPD.
3. There are things MPDs are NOT authorized to do. Examples of activities not authorized:
 - a. Assignment of calls to specific ambulance services.
 - b. Allowing EMT–Basics to perform ALS skills.
4. Other laws that MPDs should consider.
 - a. A variety of state and federal laws do apply to MPDs. These include anti-trust, public records, civil rights, conflict of interest, and administrative due process, as addressed in the Uniform Disciplinary Act ([UDA](#)) and the Americans With Disabilities Act ([ADA](#)).

B. Liability Issues

Along with MPD duties comes the question of the enforcement of these responsibilities and issues of potential liability for omission, or negligent performance of MPD duties.

1. Protection from liability for acts of subordinates and delegates.

- a. MPDs are not liable for acts or omissions of certified EMS personnel done in good faith under the supervision and control of a physician, MPD or MPD delegate while rendering emergency medical service - [RCW 18.71.210](#).
- b. MPDs are not liable for acts or omissions of their delegates or agents performed in good faith in the course of their duties - [RCW 18.71.215](#).

2. Expanded immunity for prehospital providers.

1990 Legislation expands the protection of all prehospital providers, provided services are rendered in accordance with approved regional plans, and are within the provider's scope of practice. It does not apply to acts or omissions constituting gross negligence or wanton misconduct.

3. Law Suit Defense

- a. **Hold harmless.** The department of health is required to defend and hold harmless the MPD and MPD agents in carrying out MPD duties. [RCW 18.71.215](#), [RCW 4.92.060](#), [RCW 4.92.070](#).
- b. **Defense by the State.** The state will defend MPDs ([RCW 18.71.215](#)) providing the three following conditions exist. Our Attorney General makes this decision.
 - 1) The MPD has personally performed the mandatory duties of protocols, recommendation for certification/recertification/denial of certification, and recommending disciplinary action to the Department.
 - 2) The MPD has made discretionary decisions based on impartial, medically defensible (but not necessarily universally endorsed) reasoning.
 - 3) The MPD has acted in “good faith” and not outside the scope of authority granted by law to MPDs.
 - a) “Good Faith” - Example: If an MPD was to provide all personnel under his/her medical control with protocols, and one or more EMTs misplaced the document which resulted in a compromise in patient care, the MPD would have acted in “good faith”. The fact the EMT compromised patient care and litigation materialized would probably not fall back on the MPD. However, if it did, the DOH would defend the MPD.
- c. **No State Defense.** The State will NOT defend MPDs who act:
 - 1) In “Bad Faith”. Example: If an MPD knowingly were to provide some EMTs under his/her medical control with protocols that allowed for the administration of drugs like Lidocaine, Albuterol, and Narcan, while at the same time providing the other EMTs with the minimum standard, there would be the appearance of “bad faith”. The reasons for the appearance are twofold. First, there is the issue of allowing a level of practice without the appropriate training and certification. Next, there would be the matter of creating a double standard within the community. If litigation were to result based on one or both of the conditions, the DOH would not defend the MPD.
 - 2) Outside the scope of authority granted by law to MPDs.
- d. **Personal immunity:** The general rule is: state officers, agents, and employees, acting in good faith, legally, and within the scope of their authority, are not individually liable to third parties for official acts or omissions of discretionary duties.
 - 1) Discretionary duties: require exercise or judgment/choice and involve equitable decision of what is just and proper under the circumstances.

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- 2) Judgment, for acts or omissions made in good faith within MPDs scope of authority, is paid by the state [RCW 4.92.075](#). NOTE: The statute grants immunity only to the official; the agency is still liable for torts of the official.
- 3) State officials and their agents who take action in accordance with advice from the AG's office are personally protected from liability. [Day v Martin](#), 64 W2d 511 (1964).
- 4) Public duty doctrine: The state is immune from liability unless the plaintiff can show the state had a duty to the individual rather than a duty to the public, ([Honcoop v State](#)).

4. Good Samaritan Law

- a. Good Samaritan Law, [RCW 4.24.300](#) and [RCW 4.24.310](#), no liability for persons (including but not limited to volunteers) rendering emergency care without compensation, at scene, of emergency, unless the act constitutes gross negligence or wanton misconduct.

5. Uniform Disciplinary Act (UDA):

As licensed physicians, MPDs are personally subject to the [UDA](#). Failure to comply with the UDA can result in withdrawal of MPD certification.

- a. Certified emergency medical service personnel are also subject to the UDA, so MPD supervision of their training, performance and discipline must comply with the due process standards of the UDA procedures. See "[Due Process Rights of Licensed Providers](#)"

6. Federal and state Anti-trust law:

Federal and state anti-trust law prohibits contracts, combinations, and conspiracies in restraint of trade and commerce (federal law requires interstate commerce).

- a. Joint action: express or implied agreement between two or more persons.
- b. Anti-competitive purpose or effect.
- c. Injury.
- d. NOTE: Sovereign actions of the State Legislature, Supreme Court, agencies, and officials are immune if:
 - 1) Acting under articulated legislative mandate for regulation.
 - 2) Conduct is actively supervised by the state.

7. Americans with Disabilities Act (ADA):

- a. The [ADA](#) ensures that disabled persons receive reasonable accommodations. Information and technical assistance on the ADA is available at www.ada.gov

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8. Civil Rights Laws:

Equal protection (application) of laws to all citizens.

9. Public Records Law:

Records generated by MPDs may be subject to disclosure under the [Public Records Law](#). Please refer any request to see your records to DOH without delay. Careful screening will be required to remove confidential material and daily fines may be assessed for unreasonable delay in responding to these requests. [Definitions pertaining to Disclosure Laws](#).

a. Open Public Meetings Act:

- 1) "Public Agencies" may include a committee or other group created by or pursuant to statute", the term is to be broadly interpreted and may include regional council meetings, etc.
- 2) "Public Agencies" must hold all meetings openly and publicly and permit all persons to attend, except as specifically excepted in statute. [RCW 42.30.110](#).
- 3) Each member of a governing body who attends a meeting where action is taken in violation of the Open Public Meetings Act is subject to personal liability in the form of a civil penalty of \$100. [RCW 42.30.120](#).
 - a) "Action" means the transaction of the official business of a public agency by a governing body.
 - b) "Meeting," means meetings at which action is taken.

10. Conflicts of interest:

- a. Using the position to secure special privileges.
- b. Use of confidential information for personal gain.
- c. Personal involvement in contracts made by the officer or the body on which he/she serves.
- d. Receiving compensation, gifts or gratuities for special consideration.
- e. Later benefit from matters handled during service.
- f. Activities likely to require disclosure of confidential information.

11. Summary:

- a. To avoid liability, MPDs **MUST**:
 - 1) Perform all statutory duties as identified in [WAC 246-976-920](#)
 - a) Reasonably (perform duties "in good faith").
 - b) Do not exceed authority.
 - c) Provide clear delegation, where duties are delegated (Appendix [D-1](#) and [D-2](#))
 - d) Create and maintain documentation.

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- e) Check with the Department whenever in doubt.
- 2) Remember that DOH wants you to succeed. Resources are available to help you with the mandatory duties, while recognizing that you are the medical expert.

III. Quality Improvement (QI) Program for MPDs

A. Effective Quality Improvement is basic to achieving the mission of EMS&TS

1. To establish and promote a system of emergency medical and trauma care services. Such a system provides timely and appropriate delivery of emergency medical treatment for people with acute illness and traumatic injury, and recognizes the changing methods and environment for providing optimal emergency care throughout the state of Washington.

B. QI Authority and Protection

1. [WAC 246-976-920](#) provides that MPDs must audit the performance of field personnel.
 - a. In essence, this is a responsibility for each MPD to ensure an effective quality assurance/improvement program for prehospital services in their county.
 - 1) All participants are state certified and subject to periodic mental and physical evaluation through the MPD.
 - 2) Policies and Procedures for situations requiring [counseling/remedial action](#) or [disciplinary action](#).
2. [WAC 246-50-020](#) provides the components of a DOH approved QI program.
3. Participants in QI programs approved by DOH under [RCW 43.70.510](#) are not subject to an action for civil damage for such QI activity. This statute also provides confidentiality and exemption from courtroom discovery for DOH approved QI programs ([Attachment 1](#)).
4. Members of the QI Committee are held harmless by the DOH when the function is in accordance with [RCW 18.71.215](#) and [WAC 246-976-920](#).

C. QI Committee Make -up

1. Each county QA Committee should be composed of the MPD as chairperson, delegates, and certified EMS personnel providing care in that county. Emergency department physicians/staff should be included.
 - a. The application process for all participants in the QI Committee includes the use of the Department's confidential form, which addresses chemical dependency, and other areas of concern ([Attachment 2](#)). These forms are available by e-mail at emtpe exams@doh.wa.gov
 - b. The MPD shall notify the DOH of the specific individual makeup of the county QI Committee, including member names; and is responsible to notify the DOH, in writing, of changes.
 - c. **Committee Members** and **non-members participants** shall sign a confidentiality form ([Attachment 1](#)) to participate in any QI meeting.

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- 1) Access to information will be limited to participants in the QI process.
- 2) Patient confidentiality will be assured based on the participant's signed confidentiality form and the enforcement of any breach in the agreement by DOH.

D. QI Committee Activities

1. Identifying and Collecting Documents and Records
 - a. The MPD, with the assistance of the physician delegates, is responsible for identifying any documents demonstrating negative outcomes to be used in the QI process.
 - b. The primary document to identify negative outcomes is the Incident Report Form.
 - 1) Delegates are the most likely points of identification because the majority are emergency physicians who initially receive the patients and their accompanying incident report form
 - 2) Agency medical services officer (MSO) may assist in this process by conducting "in-house" run reviews while the MPD and/or his/her delegate are also reviewing the same document.
 - 3) Typical instructions to delegates will be to review whether the patient received the appropriate level of care (BLS, ILS, or ALS) and whether the care provided was appropriate for the patient's condition.
 - 4) Negative outcomes identified through the review of the incident report forms shall be reported by the MPDs to the QI Committee.
 - c. Documents to be used for QI purposes must be identified by a footnote or stamp on the document indicating "QI Work Product".
2. Review and Evaluate Information
 - a. Information used to analyze QI activities shall include individual incident reports, and local and/or state registry data and meeting minutes of discussions that took place.
 - b. The QI Committee shall use current standards and actual field performance documented on incident reports as a basis for QI evaluations as a basis for QI evaluations:
 - 1) Current standards consist of:
 - a) Washington State approved curriculum, State and MPD protocols, Regional Patient Care Procedures, County Operating Procedures, and the Washington State Trauma Triage Tool.
 - b) CPR, Obstructed Airway and external defibrillation following current nationally accepted standards.
 - c) Infection Control Procedures following the most current approved [Infectious Disease Prevention for EMS Providers curriculum](#).

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- 2) MPD patient care protocols (sample protocols for various certification levels are provided at the following URL address: <http://www.doh.wa.gov/hsqa/emstrauma/publications.htm>).
- c. Minimum Educational and Performance Standards may be discussed during QI meetings
 - 1) The OEMSTS has established minimum educational and performance standards for all levels of certified personnel.
 - 2) These standards have been communicated to all providers. This communication takes place at the initial stages of training and is also performed during the recertification cycle.
 - a) The educational process (initial or continuing) is used to establish a basis for proper patient care, update the provider to newer treatment modalities, and remediate perceived deficiencies.
3. Utilizing QI to Improve EMS and Trauma Care
 - a. Physician delegates will assist MPDs in this process by identifying areas of concern, and the MPD will review their recommendations for appropriateness of actions and compliance with patient care protocols.
 - b. The MPD shall be responsible for steps to improve the quality of the health care provided, utilizing training and counseling authority as well as training and system design responsibility.
 - c. MPDs are allowed to engage in counseling and remedial training during QI sessions when the threshold is at the lowest level.
 - d. Situations above the lowest threshold level must be brought to the attention of the DOH, who will determine the extent of any further action.
4. Reporting Violations
 - a. All MPDs and their delegates have received instruction in the Health Professions Quality Assurance (HPQA) Threshold Process for reporting violations in treatment and/or transport of patients ([Attachment 3](#)).
 - b. If corrective action through QI is ineffective, or the individual's failure to meet state standards exceeds the HPQA threshold, the MPD will bring the matter to the attention of the Licensing and Certification Section of the OEMSTS (DOH) for action.
5. Maintaining Documents and Information
 - a. Records Maintenance Procedures will be according to the provisions contained in [RCW 43.70.510](#).
 - 1) All documents regarding patient information are maintained in a confidential file, under the supervision of the MPD.
 - 2) The records will be maintained in a secure place, and only made available for quality improvement purposes.
 - 3) The members of the QI Committee would have access to the records authorized by [RCW 18.71](#).

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E. QI Committee Responsibilities

1. MPDs, delegates, and certified personnel have been informed of the necessity for compliance with all associated RCWs ([18.73](#), [18.71](#), [70.186](#)) and reporting of inappropriate care and/or actions will be in accordance with the [UDA](#). A summary of the UDA is provided in [Attachment 4](#)
2. MPDs are required to provide the OEMSTS with monthly overview reports ([Attachment 5](#)), which are required to identify any QI activity.
3. QI activities shall be reported to the L&C Committee for review.
4. Obtaining the QI Program
 - a. Information regarding the QI Program will be provided by the MPD to all licensed and/or verified services in the county. All directors of services will be asked to make the information available to all certified employees, regardless of whether they are paid or volunteer.

F. MPD Workshops:

Workshops are provided for MPDs and delegates covering issues related to quality improvement, safety and injury prevention, responsibilities for reporting professional misconduct, legal aspects of providing healthcare, improving communication with healthcare recipients, and causes of malpractice claims.

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Appendices

Appendix A: DOH – Office of EMS and Trauma System

Brief History of Emergency Medical Services

Federal

Until the late 1960s, few areas in the nation provided adequate prehospital emergency medical care. The prevailing thought was that care began in the hospital emergency department. Rescue techniques were crude, ambulance attendants poorly trained, and equipment minimal. There was no radio communication and no physician involvement.

The beginning of emergency medical care as we know it today in the United States (U.S.) can be traced to a report published in 1966 by the National Academy of Sciences - National Research Council (NAS-NRC), Division of Medical Sciences, committees on Trauma and Shock. Accidental Death and Disability: The Neglected Disease of Modern Society identified trauma as the leading cause of prolonged disability and the fourth major cause of death in the U.S. This landmark study called for sweeping changes in training ambulance personnel, and staffing hospital emergency departments and intensive care units. The report also suggested guidelines for identifying hospitals by their emergency care capability and guidelines for funding trauma research. "The White Paper," as the report came to be called, increased awareness among the public as well as the federal government.

With the National Highway Safety Act of 1966, Congress authorized the U.S. Department of Transportation (U.S. DOT) to provide funds to states for ambulances, communications, training programs and statewide planning. These funds, and the 24 recommendations of the NAS-NRC report, became the foundation and main goals for many emergency medical services (EMS) systems throughout the states.

In November 1973, Congress passed Public Law 93-154, otherwise known as the Emergency Medical Services Systems Act, which initially, authorized \$170 million to be distributed over three years. Congress later extended this legislation through 1979, authorizing a total of \$215 million. The funds were directed toward the further improvement of emergency medical services across the country by developing regional EMS systems. In order to receive these funds, the grantee (states and their communities) had to agree to implement 15 specific components. The controlling philosophy of the program was that by improving prehospital emergency services in general, victims of trauma would be better served.

In 1981 the passage of the Consolidated Omnibus Budget Reconciliation Act (COBRA) effectively eliminated all federal funding for EMS. Program guidance, previously provided by the Department of Health and Human Services (DHHS) to regionalized EMS systems, ceased. Funds previously available through the DHHS EMS categorical grant program were folded into the Preventive Health Block Grant administered by U.S. DOT and DHHS. Only a small portion of this money, however, was available for EMS activities. These funds were given to the states, which in turn disbursed the money to formally established regional EMS systems. Some areas have developed strong, efficient systems of prehospital emergency medical care: many others have not. Today, in the technologically advanced country, there are still major differences between regions in the quality of their prehospital care.

Washington State

There was a time - prior to 1966 - when most ambulance services were provided by a mortician, private ambulance services or the fire department. Sometimes the services operated from ambulances. Other times they utilized inappropriate vehicles such as the mortician's hearse or a station wagon, usually accompanied by poorly trained staff. This situation began to change in 1966 when Washington became a major recipient of Highway Traffic Safety funds. Substantial improvement occurred in basic life support (BLS) systems, especially training and emergency medical communications.

In 1971 the legislature amended Revised Code of Washington (RCW) 18.71 to include paramedic certification as part of the Physicians' Practice Act. This amendment empowered local Health Officers of the University of Washington to certify paramedic personnel. In 1973 the legislature developed RCW 18.73, titled "Emergency Medical Care and Health Services". This new legislation sought to establish minimum baseline standards for patient care, which included inspection and licensing of prehospital emergency medical services. In 1978, RCW 18.71 was revised again to include the Department of Social and Health Services, along with the University of Washington, as certifying agencies of paramedic personnel. It also established three levels of advanced life support personnel: I.V. Technicians, Airway Technicians and Paramedics. Specific educational and skill maintenance requirements were set for each level.

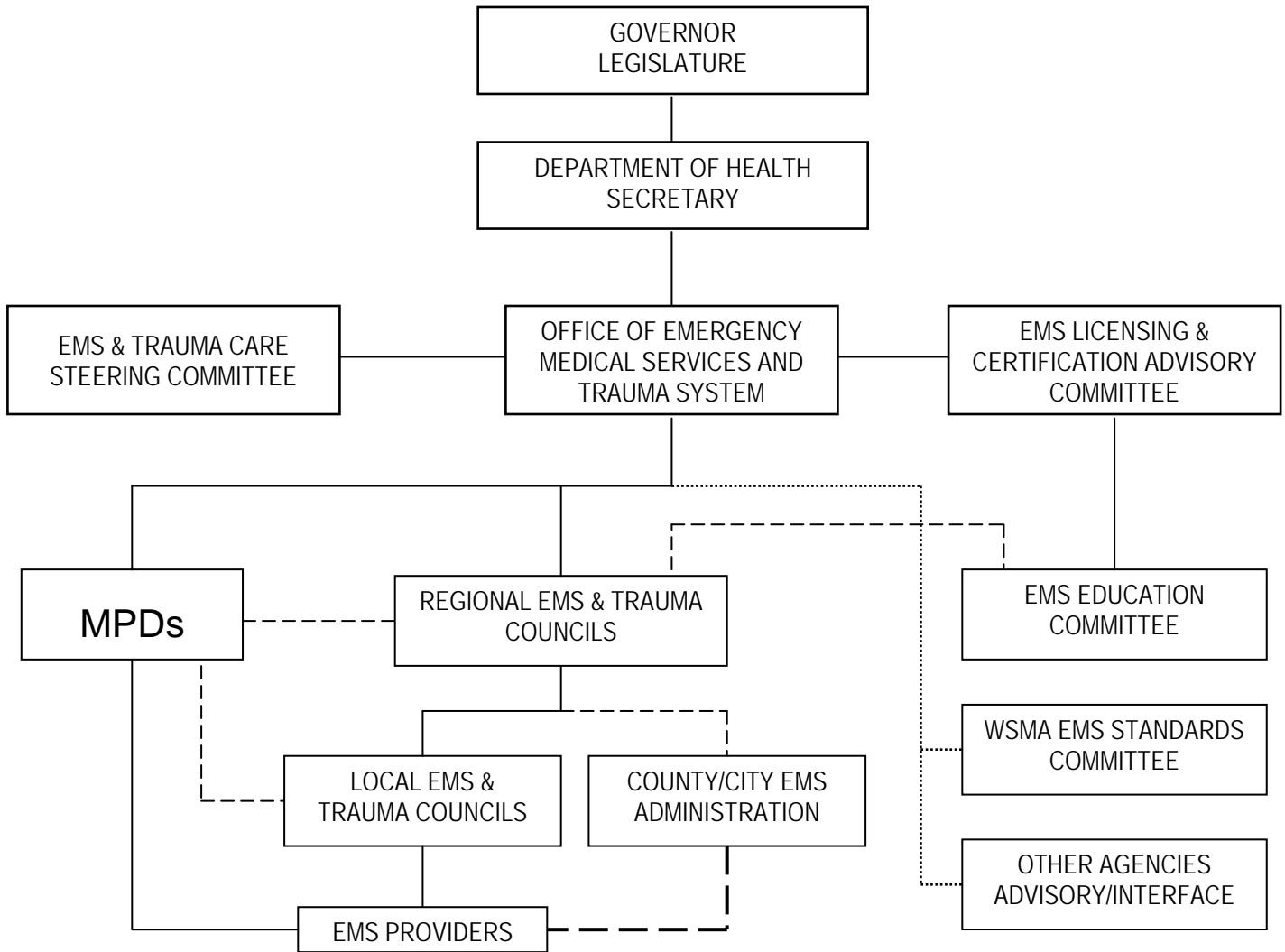
From 1974 to 1979, when federal funding ceased for Washington, the state received in excess of \$4 million from the U.S. Department of Health and Welfare. In 1979 the state was fortunate to have EMS leaders and a legislature with foresight. They amended RCW 18.73 to provide guidelines for the continued development and improvement of EMS systems. Regional EMS councils were created and made a key component in the state EMS planning process. Approximately \$2.5 million was provided for the state program. In 1983, the legislature again took action to revise and update EMS legislation. The law extended EMS personnel categories to include First Responders. This law also gave official recognition to Medical Program Directors and local EMS councils.

The next major EMS legislation occurred in 1988. The legislature recognized the need to address trauma care in Washington State, enacted House Bill 1713. Funds were appropriated to study the need for, feasibility of, and implementation of a statewide trauma system. The Governor appointed a 20 member Trauma Advisory Committee in June 1988 to oversee the project. In all, over 150 people served on five technical advisory committees. The 30-month study produced a seven-volume report, which described components of a functional, most favorable trauma care system for the state. The legislature received recommendations based on study findings for trauma system implementation in Washington.

The 1990 Legislature responded by enacting Substitute Senate Bill 6191, known as the "Statewide Emergency Medical Services and Trauma Care System Act." This comprehensive act substantially amends RCW 18.73 (ambulance and aid service licensure, certification of BLS personnel, and related administrative matters) and RCW 70.168 (health planning). (See Appendices for complete wording of RCWs 18.71, 18.73 and 70.168.) The Statewide Emergency Medical Services and Trauma Care System Act establishes the basis for a well-coordinated, integrated statewide EMS and trauma care system. A system that is developed and managed by the Department of Health (DOH) and provides optimal care to all citizens of, and visitors to, Washington State.

Office of Emergency Medical Services and Trauma System

Washington State EMS and Trauma System - Schematic Overview



LEGEND

- Communication and coordination responsibility as defined in RCW
- Communication and coordination responsibility, which was developed throughout the years, but without RCW requirement
- - - - - Communication and coordination responsibility as defined in WAC
- . - . - Local Ordinances, as applicable

Office of EMS and Trauma System Informational Web Links

[DOH Organization Chart](#)

[Office of Emergency Medical Services and Trauma System](#)

[Injury Prevention](#)

[Regional Council Information](#)

[EMS and Trauma Systems Advisory Committees](#)

Counties and EMS and Trauma Care Regions in Washington State

WEST REGION

Grays Harbor
Lewis
Thurston
1/2 Pacific (North)
Pierce

NORTH REGION

San Juan
Island
Whatcom
Skagit
Snohomish

NORTH CENTRAL REGION

Okanogan
Chelan
Douglas
Grant

SOUTHWEST REGION

Wahkiakum
Cowlitz
Clark
Skamania
Klickitat
1/2 Pacific (South)

SOUTH CENTRAL REGION

Kittitas
Yakima
Benton
Franklin
Walla Walla
Columbia

EAST REGION

Ferry
Pend Oreille
Stevens
Lincoln
Spokane
Adams
Whitman
Garfield
Asotin

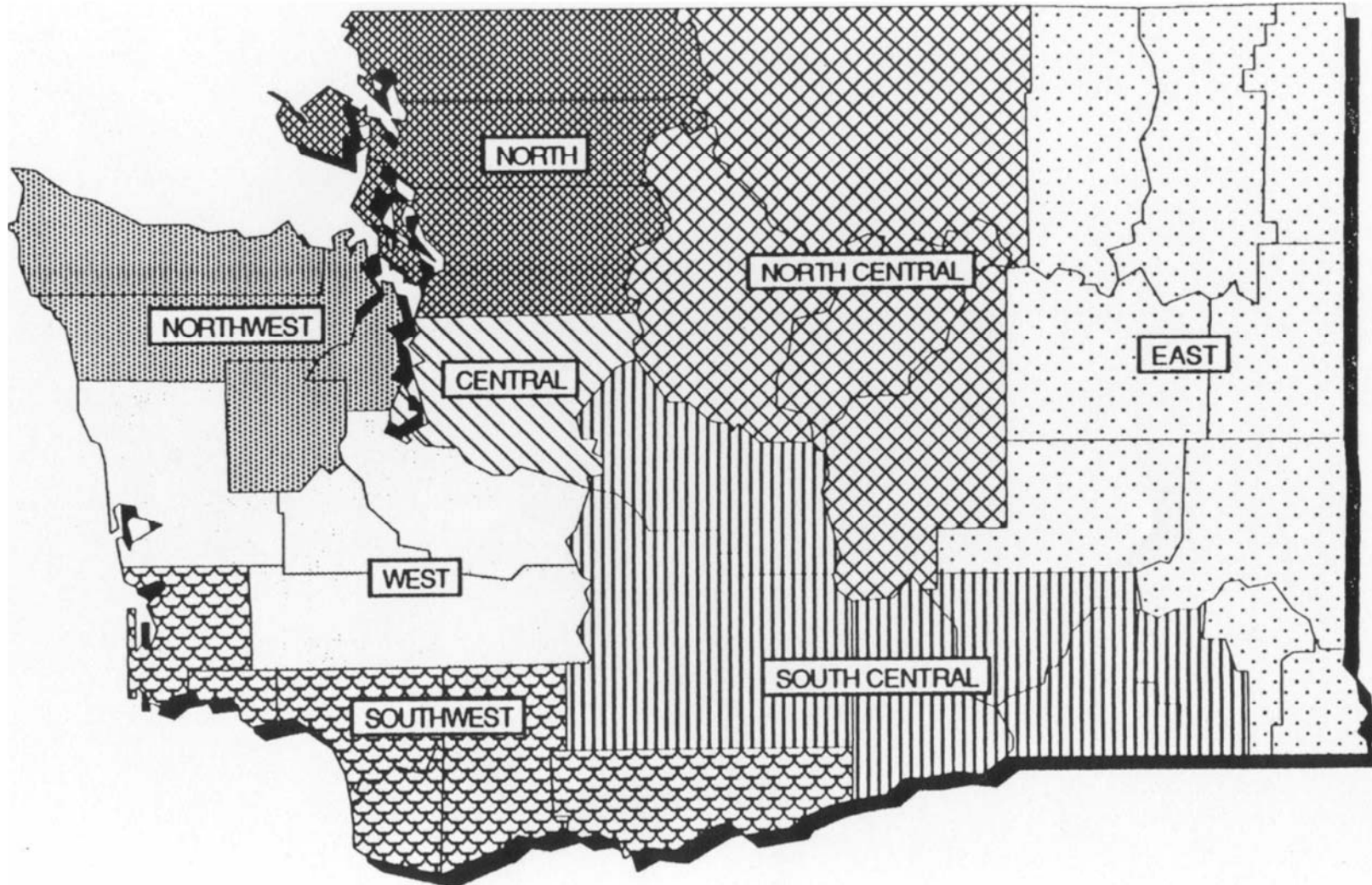
NORTHWEST REGION

Clallam
Jefferson
Kitsap
Mason
West Olympic

CENTRAL REGION

King

Map of EMS and Trauma Regions in Washington State



Appendix B - Statutes And Rules

The links listed below will open the most current version of the document identified.

Revised Code Of Washington – Pertinent to EMS & Trauma Systems:

[RCW 4.24.300 – Good Samaritan Act](#) [RCW 4.24.310 – Persons Rendering Emergency Care or Transportation](#)

[RCW 4.24.470 – Liability of Officials and Members of Governing Body of Public Agency](#)

[RCW 4.92.060 – Action Against State Officers, Employees, Volunteers, or Foster Parents - Request for Defense](#)

[RCW 4.92.070 – Action Against State Officers, Employees, Volunteers, or Foster Parents –Defense by Attorney – Legal Expenses](#)

[RCW 4.92.075 – Action Against State Officers, Employees, or Volunteers – Judgment Satisfied by State](#)

[RCW 18.71 - Physicians, 18.73 - Emergency Medical Care and Transportation Services and 70.168 – State-Wide Emergency Medical Services and Trauma Care \(EMS/TC\) System Act](#)

[RCW 18.130 – Uniform Disciplinary Act](#)

[RCW 34.05 – Administrative Procedure Act](#)

[RCW 42.17.020 – Definition of Public Record](#)

Washington Administrative Codes – Pertinent to EMS & Trauma System:

[WAC 246.976 – Emergency Medical Services and Trauma Care System](#)

[Office of the Code Reviser – All Statutes \(RCWs\) and Rules \(WACs\)](#)

[ADA Information](#)

[Americans With Disabilities Act of 1990](#)
[Information and Technical Assistance](#)

Appendix C – OEMSTS - Training Forms, Publications & Reports

The links listed below will open the OEMSTS web site containing the forms and documents identified.

[Emergency Medical Services and Trauma System Web Site: - Publications and Reports](#). This is where you will find the most current updates of the following documents:

Training information

Training course applications and forms

Curricula

Protocols

Regional information, etc.

Emergency Medical Services and Trauma System Statutes and Rules (RCWs & WACs)

Certification processing information.

Appendix D – Licensing & Certification Document Examples

D-1 – Sample Delegation of On-Line Medical Control

On-line medical control (supervising physician) over personnel from state licensed emergency medical services providers is hereby specifically delegated.

Accepted:

Delegated Physician

Date

Medical Program Director

Date

Mail to: Section Manager
 Licensing and Certification Section
 Office of Emergency Medical Services and Trauma System
 P.O. Box 47853
 Olympia, Washington 98504-7853

Office of Emergency Medical Services and Trauma System

D-2 – Sample Delegation of Off-Line Medical Control

Off-line medical control (training physician) over personnel from state licensed emergency medical services providers is hereby specifically delegated.

Accepted:

Delegated Physician Date

Medical Program Director Date

Mail to: Section Manager
Licensing and Certification Section
Office of Emergency Services and Trauma System
P.O. Box 47853
Olympia, Washington 98504-7853

D-3 – Sample Protocol Distribution Communication

TO: J.J. Gage, Paramedic
FROM: Buck James, M.D., MPD
SUBJECT: PATIENT CARE PROTOCOLS

(Option A)

The following represent patient care protocols that all ALS personnel within my medical control must follow (per RCW 18.71)

(Option B)

Attached you will find patient care protocols for ALS personnel within my medical control. Please note that RCW 18.71 requires you to follow these protocols.

(Next paragraph – for either option)

You are responsible to review these protocols as soon as possible. It is important that you acknowledge receiving and reviewing these protocols. Failure to inform me within two weeks may result in my recommendation to the Department of Health to withhold or withdraw your certification. You may use the attached form memo to respond. (See Example E)

Signature

Date

Office of Emergency Medical Services and Trauma System

D-4 – Sample Protocol Receipt Communication

TO: Buck James, M.D., MPD
FROM: J.J. Gage, Paramedic
SUBJECT: PATIENT CARE PROTOCOLS

The purpose of this memo is to inform you that I have received your patient care protocols. Furthermore, I have reviewed these protocols and will abide by their direction.

Signature

Date

D-5 – Inter-County BLS & ALS Medical Control Agreement for EMS & Trauma Care

1. It is agreed that all basic life support (BLS) and advanced life support (ALS) training and certification requirements for emergency medical services personnel in the counties participating in this agreement shall meet or exceed all applicable Washington State BLS and ALS standards.
2. It is agreed that all requirements for licensing and verification of ambulance and aid services in the counties participating in this agreement shall meet or exceed all applicable Washington State standards.
3. It is agreed that all prehospital emergency medical services and trauma care provided under this agreement shall comply with all applicable regional plans, patient care procedures, and prehospital patient care protocols, and the Washington State Emergency Medical Services and Trauma Care System plan.
4. Certified personnel and licensed ambulance and aid services in the counties participating in this agreement are identified in Appendices A through X, as attached or later modified.
5. It is agreed that certified personnel on licensed ambulance or aid services from counties participating in this agreement may respond to inter-county and/or inter-regional emergency medical calls as provided in applicable regional plans and the Washington State Emergency Medical Services and Trauma Care System plan.
6. It is agreed that certified personnel shall be subject to prehospital patient care protocols adopted in the county of certification.
7. This agreement becomes effective on the date it has been signed by all applicable Medical Program Directors and acknowledged by the Washington State Department of Health.
8. This agreement may be terminated by any Medical Program Director upon thirty days written notice to all other below signed Medical Program Directors or successors and the Washington State Department of Health.
9. This agreement shall remain in effect unless and until terminated as provided in paragraph 8.

Medical Program Director	County	Signature	Date
Medical Program Director	County	Signature	Date
Medical Program Director	County	Signature	Date
Medical Program Director	County	Signature	Date
Medical Program Director	County	Signature	Date
Medical Program Director	County	Signature	Date
State of Washington Department of Health (Title of individual)		Signature	Date

D-6 – Steps in a Disciplinary Action

1. The Department of Health, Licensing and Certification Section receive a complaint.
2. The Licensing and Certification Section reviews the complaint to determine if it warrants an investigation, based on the following. If it does, the file is forwarded to the Investigation Services Unit (ISU) for action. If it does not, the case is closed and the respective parties are notified of the decision.
 - a. Category I violations are minor in nature or create low risk of harm.
 - b. Category II violations are moderate in nature or create moderate risk of harm.
 - c. Category III violations have resulted in severe injury or create a significant potential for severe injury. They constitute top priority investigation.
3. . Alleged violations are prioritized by ISU.
4. The Licensing and Certification Section receives an investigative report from ISU and decides what action to take (options).
 - a. **Stipulation to Informal Disposition** is an attempt to resolve matters without admitting to guilt but agreeing to corrective action.
 - b. **Statement of Charges** is a formal proceeding with significant disciplinary action.
 - c. Close the file to lack of substantial evidence.
5. All participants are then notified regardless of what action is taken.

In steps 4a and 4b, the Assistant Attorney General is involved in advising and preparing legal documents.
6. The Department of Health offers the opportunity to have a hearing regardless of whether the action is a Stipulation to Informal Disposition or a Statement of Charges.
7. An administrative law judge conducts the hearing and provides the final decision in the matter.
8. Any sanctions that result are determined and imposed by the Department of Health. Sanctions are monitored for compliance by the Department of Health.



D-7 – Check List for Counseling

1. Acquiring the necessary facts:

- a) Did I contact OEMSTS Licensing and Certification for advice on this action?
- b) Did I allow the counselee the opportunity to tell his/her side of the story?
- c) Did I involve the counselee's immediate supervisor in the action?
- d) Did I consider other sources of information; i.e., run reports, and other aspects?
- e) Did I hold my interviews privately to avoid embarrassing the counselee?
- f) Did I exert every effort to avoid letting personalities affect my decision?
- g) Did I clearly state how the counselee can prevent a similar situation in the future?

2. Follow-up

- a) Have I reviewed this case within the time frame specified?
- b) Have I made a determination as to whether further counseling is necessary?
- c) If there have been adequate improvements, have I complimented the counselee?
- d) If improvements have not been made, have I identified the next possible course of action with the counselee?
- e) Have I contacted OEMSTS Licensing and Certification with the suggested course of corrective action?
- f) Has OEMSTS Licensing and Certification communicated to me approval of the suggested course of action?
- g) Have I received formal notification of the course of action from OEMSTS Licensing and Certification?

Office of Emergency Medical Services and Trauma System



D-8 – MPD Oral Counseling Record

Certified Person's Name _____ Certification Level _____

Service Affiliation _____ Supervisor's Name _____

What behavior needed attention? (Briefly note each)

- 1. _____

- 2. _____

- 3. _____

What actions will be taken by the certified person and when? (Briefly note each)

- 1. _____
_____ Target Date _____
- 2. _____
_____ Target Date _____
- 3. _____
_____ Target Date _____

A review of accomplishments for this plan of action is _____

What were the results? _____

MPD Signature _____

Date _____

Cc: Licensing and Certification Section

D-9 – Sample Counseling Memo

TO: J.J. Gage, Paramedic
FROM: Buck James, M.D., MPD
SUBJECT: SKILL IMPROVEMENT

You probably recall our conversation last month where I identified your need to improve your intubation skills. You informed me that you would take measures to improve your skills.

As of the date of this memo, I have not seen any improvement in your intubation skills. Therefore, I am requiring you to complete an ACLS course within the next 60 days. Proof of course completion must be submitted to me within the time period specified.

Failure to comply with this request may result in a request for formal action by the Department of Health, Office of Emergency Services and Trauma System, Licensing and Certification Section.

Signature

Date

Cc: Certified Person's Supervisor
Licensing and Certification Section

Office of Emergency Medical Services and Trauma System

D-10 – Situations Requiring Consultation With The Department of Health

The DOH must be consulted when an MPD is aware of issues including, but not limited to:

1. Repeated failure to follow MPD protocols and/or standing orders.
2. Repeated failure to maintain patient confidentiality.
3. Has engaged in the use of alcohol or a controlled substance that affects the certified EMS person's ability to render care according to procedures or protocols.
4. Represents that he/she is qualified at any level other than his/her current certification.
5. Repeated abandonment of a patient to a lesser level of care.
6. Alters any Department certificate or possesses any such altered certificate.
7. Violates probation.
8. Cheats and/or assists another to cheat on a Department examination
9. Assists another to obtain certification by fraud, forgery, deception, misrepresentation or subterfuge.
10. Illegally dispenses, administers or distributes any controlled substance.
11. Has been convicted of a gross misdemeanor that affects his/her ability to function under certification.
12. Falsifies any patient record.
13. Failure to provide the Department with true information pertinent to certification, recertification, etc., upon request.
14. Falsifies any application for certification or recertification.
15. Has demonstrated incompetence or has shown himself/herself otherwise unable to provide adequate service.
16. Has been convicted of a felony.
17. Has failed to complete continuing education requirements and/or any MPD remedial training.
18. Violates any rule or regulation that would jeopardize the health or safety of a patient, or has a potential negative affect on the health or safety of a patient.
19. Performs any medical procedure beyond those permitted by the MPD.
20. Performs any medical procedure beyond those provided in approved training.

CARDIOLOGY EMERGENCIES

CHEST PAIN

I. Scene Size-Up/Initial Patient Assessment

II. Focused History and Detailed Physical Exam

A. Signs and Symptoms

1. Chief complaint

a) Typical: **Angina** - sudden onset of discomfort

(1) Usually of brief duration, lasting three to five minutes, maybe five to 15 minutes; never 30 minutes to two hours

(2) Usually relieved by rest and/or medication

b) Atypical: **AMI** - duration of 30 minutes to two hours

2. Denial

3. Contributing history

Note: When a paramedic system exists, ALS rendezvous shall be arranged as soon as possible as directed by local or regional patient care procedures or when directed by medical direction/control.

III. Management

A. Clear the airway, provide oxygen and/or ventilatory assistance as necessary, if not done during Initial Patient Assessment (see Airway Obstruction, page 55; see Oxygen Delivery page 71; see Suctioning, page 79)

B. Nitroglycerin (see page 70)

1. Patient's own, physician prescribed Nitroglycerin available; assist patient with self administration of Nitroglycerin, after consulting on or off line medical control

a) Patient systolic BP >100

b) Given every 3-5 minutes (max. 3 doses)

2. If patient's own, physician prescribed Nitroglycerin not available or appropriate;

a) Continue oxygen

b) Allow patient to achieve safe position of comfort

C. Provide IV therapy as necessary (see page 64)

IV. Ongoing Assessment

V. Transport

Appendix E – Quality Improvement Attachments

Attachment 1 – Patient Confidentiality and Exemption from Discovery

(In accordance with [RCW 43.70.510](#))

Policy:

It is the intention of the Quality Improvement Process to use the information gathered to improve patient care and prevent medical malpractice through improved systems performance.

Pledge of Confidentiality:

All attendees of Quality Improvement or Review meetings will sign a pledge of confidentiality, which will also act as a record of attendance. At each meeting, the pledge of confidentiality will be read into the minutes. (See below)

Documentation:

Patient records will be identified by the run number. Patient information cannot be publicly disclosed without written permission of the patient or guardian, or by court order. All committee handouts shall be labeled “Confidential Quality Review Document/Privileged Information/Not Authorized for Distribution”. All copies of the confidential documents and minutes will be collected at the end of the meeting and destroyed.

Minutes:

Minutes from the meetings will be reviewed and approved by the members, collected and destroyed following the meeting. One copy of the minutes will be kept in a locked cabinet, for the purpose of record by the EMS Quality Coordinator. Any case specific information presented during meetings will be held in strict confidence among those attending the meeting. All references to identifying information will be omitted from meeting minutes.

Reports:

A report of activities from each Review Committee will be forwarded monthly to the chair of the EMS Quality Improvement Committee. This report will contain recommendations for systems changes, requests for study projects, trends of note, and successes. There will be no information in this report that will identify a patient or provider.

Access to Information:

All members of quality review committees and those who have been invited to attend by members of the committees, have access to view or discuss patient, provider, and systems information when the patient and the provider’s identifying information has been obscured. It is the obligation of the attendees to keep all information confidential and to protect it against unauthorized intrusion, corruption, and damage.

Attachment 2 – QI Committee Application

QI COMMITTEE APPLICATION

Washington State Emergency Medical Services and Trauma System

Part 'D' - Personal Information

CONFIDENTIAL

Certification of health care professionals is designed to protect the citizens of Washington State from unsafe health care. As part of the certification process, all applicants for certification are required to answer the same, legally defensible, personal data questions, narrowly focused to the fitness to practice the essential skills of this profession.

Part 'D' must be completed by all applicants and returned directly to the Department of Health to maintain confidentiality. Please follow the instructions below:

- 1. Detach and review this portion of the application. Make sure you have provided complete and accurate information.
2. Return only Part D of the application in the enclosed envelope. Please include all information required below.

Form fields for personal information: LAST NAME, FIRST NAME, M.I., ADDRESS, CITY, STATE, ZIP CODE, SOCIAL SECURITY NUMBER, COUNTY OF PRIMARY EMPLOYMENT.

1. Do you currently have a medical condition which in any way impairs or limits your ability to provide EMS with reasonable skill and safety? If 'yes', please explain. Includes sub-questions 1a and 1b regarding treatment and field of practice.

If you answered 'yes' to question #1, the Department will make an assessment of the nature, severity, and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in '1b' to determine if you are eligible for certification and whether conditions should be imposed.

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to provide EMS with reasonable skill and safety? If 'yes', please explain. Includes definition of 'Chemical substances'.

3. Are you currently engaged in the illegal use of controlled substances? Includes definition of 'Illegal use of controlled substances'.

QI COMMITTEE APPLICATION (continued)

- | | Yes | No |
|--|--------------------------|--------------------------|
| 4. Have you ever been diagnosed as having, or have you ever been treated for: Pedophilia, exhibitionism, voyeurism or frotteurism? | <input type="checkbox"/> | <input type="checkbox"/> |
| "Pedophilia" means: An unnatural desire for sexual relations with children. | | |
| "Exhibitionism" means: An abnormal impulse that causes one to expose the genitals to one of the opposite sex. | | |
| "Frotteurism" means: Recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a non-consenting person. | | |
| "Voyeurism" means: Deriving sexual pleasure from observing the sexual activity of others. | | |

If you must answer "yes" to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.

- | | | |
|--|--------------------------|--------------------------|
| 5. Have you ever been convicted, entered a plea of guilty, no contest (nolo contendere) or a plea of similar effect, or had prosecution or sentence deferred or suspended in connection with: | | |
| a. The use or distribution of controlled substances or legend drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A charge of a sex offense? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any other crime other than <i>minor</i> traffic infractions? (For example: Driving While Intoxicated (DWI), Driving Under the Influence (DUI), and Reckless Driving). | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been found in any civil, administrative, or criminal proceeding to have: | | |
| a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Committed any act involving moral turpitude, dishonesty or corruption? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Violated any state or federal law or rule regarding the practice of a health care profession? If "yes", explain and provide copies of all judgments. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions and agreements. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended or restricted by a state, federal or foreign authority? Have you ever surrendered such credential to avoid, or in connection with, an action by such authority? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you previously provided the Department of Health with information regarding any "yes" answers? | <input type="checkbox"/> | <input type="checkbox"/> |

PLEASE NOTE: If you have answered "yes" to any of the above questions, you must submit a brief written statement and all relevant documents with this portion of the application. Please do not *re-send* documents which you have previously provided to this office to explain any "yes" answers.

APPLICANT STATEMENT: (This portion must be signed by the applicant)

"I hereby affirm and declare that the above information is true and correct, and that any fraudulent entry may be considered sufficient cause for rejection or subsequent revocation of my certification."

Applicant's original signature only	Date
-------------------------------------	------

Phone #

Attachment 3 – Below Threshold Determination Guidelines

I. Below Threshold Determination Guidelines

A. Purpose:

1. The purpose of these guidelines is to provide criteria and framework for the consistent identification of complaints that fall below the threshold level established by the statutory mandated disciplining authorities. In order to conserve scarce resources and to expedite the resolution of complaints above the threshold, the DOH, the disciplining authority, does not pursue complaints below the threshold.

B. What is A Below The Threshold Determination Complaint:

1. Below Threshold Determination Complaints are complaints that would not likely result in a Statement of Charges, of a Stipulation to Informal Disposition, if investigated. While it is possible that a Stipulation to Informal Disposition, Notice of Correction or No Cause for Action determination may result, the nature of the complaint does not appear to warrant allocation of resources for investigation.
2. Any complaint that is classified as Below Threshold may be reconsidered for investigation if new documentation is received, if a pattern of the violation occurs, or if the disciplining authority deems that an investigation is appropriate.
3. Complaints that are not within the disciplining authority's statutory mandated jurisdiction shall be classified as No Jurisdiction complaints and will not be classified as Below Threshold Complaints.
4. If a complaint or violation fails to meet the definitions in this section, it may not be closed under the Below Threshold Determination Policy.

C. Generally, When Can A Complaint Be Categorized As Below Threshold?

1. Generally, a complaint may be classified as a Below Threshold when one of the following is true:
 - a. When the allegation set forth in a complaint or violation poses minimal risk of harm or impact to the public health, safety and welfare, **OR**
 - b. When an investigation determines that a violation is Below Threshold, **OR**
 - c. The complaint, if investigated, would likely not result in a Statement of Charges or Stipulation of Informal Disposition, but may result in a Closure with No Cause for Action.

D. What Kinds of Cases Typically Are Below Threshold?

1. Communication Issues – The complaint appears to be the result of unintentional miscommunication, mistranscription, or mistake of fact.
2. Personality Disputes – This category includes but is not limited to personality disputes that involve rudeness or minor verbal abuse.
3. Complainant Credibility – The complainant has previously demonstrated a lack of credibility.
4. Isolated Complaints.
5. Single or non-pattern complaints with little or no patient harm.

6. Repeated complaints of a similar nature could warrant further investigation.
7. Aged or Dated Complaints – Aged or dated complaints may be considered **below threshold**.
8. Otherwise Resolved Complaints – Complaints where the alleged violation has been resolved by another state agency, federal government, other entity, or the respondent, and other measures are not necessary to protect the public.
9. Expired License – Complaints, which solely allege that a practitioner is **practicing with an expired license for a short period of time**.

II. No Jurisdiction Determination

- A. This category involves complaints where the allegations are determined to be beyond or outside the sphere of authority of the disciplining authority. Each program's case management team must identify a specific statute or administrative code section that has been violated by the subject matter identified in the complaint or investigation report. In some cases this determination is not possible until after an investigation is conducted.
- B. Complaints of unlicensed practice shall be referred to the Unlicensed Practice Unit in accordance with **Division Policy No. D10**.
- C. The following are examples of complaint allegations that would fall into the No-Jurisdiction category:
 1. Personnel Issues – Personnel issues that do not fall within the scope of the Uniform Disciplinary Act, a health care profession's practice act or administrative code.
 2. Misdemeanors Irrelevant to Professional Practice – Conduct which is considered a misdemeanor in a court of law, but it is not directly related to the practice of the profession.
 3. Fee Disputes – Fee disputes between the practitioner and patient or client are not normally within the jurisdiction of the disciplining authority.

III. Notice of Correction and Notice of Violation Guidelines

- A. Criteria and conditions under which a Notice of Correction (NOC) and a Notice of Violation (NOV) are employed are identical with one exception: whether or not the infraction is identified as part of a technical assistant visit requested by the credentialed provider (and is appropriately addressed through the mechanism of a notice), a NOTICE OF VIOLATION is utilized. If the infraction is identified under any other circumstances (and is appropriately addressed through the mechanism of a notice), a NOTICE OF CORRECTION is utilized. Consequently, the guidelines presented in this section apply to both types of notices.
- B. Typical Cases Where Violations and Corrections Should be Utilized Include:
 1. Second time violations that were below threshold level the first time.
 2. Continuing education violations where the licensee did not complete all necessary hours or classes taken were not appropriate.
 3. Minor infection control violations
 4. Late renewals
 5. Minor inspection violations

6. Minor record keeping/reporting problems
7. Name tag violations
8. Utilizing out of date references
9. Advertising violations
10. Failure to release records
11. When mandatory client or patient public disclosure statements do not meet requirements
12. Addressing patterns of minor medication errors during a limited time period

C. What Are Notices Of Correction And Violation?

1. An administrative mechanism whereby the licensee is notified that violation of a statute or rule has been documented and the licensee is provided a reasonable period of time to correct the violation. Notices of Violations are used instead of Notices of Correction when the infraction is identified during a technical assistance visit that was requested by the licensee. Notices of Correction and Violation cannot be appealed under the APA.

D. What is Achieved By Utilizing Notices?

1. By utilizing notices of occurrence of a violation, as well as education and assistance to the licensees and the correction of the areas of violation, a lengthy legal process or record of formal disciplinary action is not necessary.

E. What Information is Provided Externally When Utilizing A Notice Of Correction Or Violation?

1. A copy of the Notice provided to the complainant after approval and issuance to the respondent. A closure letter is provided to all parties.
2. A Notice should not be reported to professional organizations, other states, or national practitioner data banks unless these parties make a public disclosure request.
3. Notices should be disclosed as a public record if requested.
4. Mailing lists for Notices should not be maintained (note: in effect, such lists would be considered as reporting Notices of Correction).
5. Names of Notice respondents should not be placed in board or commission minutes.
6. No reporting of Notices should be made to the media, unless specifically requested by the media.

F. What Documentation Is Included In Notices Of Correction And Violation?

1. A description of the condition that is not in compliance and a specific citation to the applicable law or rule including the text of the applicable law or rule;
2. A statement of what action or condition is required to achieve compliance;
3. The date by which the agency requires compliance to be achieved;
4. Notice of the means to contact any technical assistance services provided by the agency or others;

5. Notice of when, where, and to whom a request to extend the time to achieve compliance for good cause may be filed with the agency.
- G. What Steps Should Be Taken If A Notice Is Issued And The Practitioner Fails To Correct The Unlawful Conduct?
1. Upon verification that the practitioner failed to correct the infraction identified in the Notice of Correction or Violation, the disciplining authority may then issue a Statement of Charges or Statement of Allegations.

IV. Statement of Allegations and Stipulation to Informal Disposition Guidelines

- A. What are a Statement Of Allegations (SOA) and a Stipulation To Informal Disposition (STID)?
1. A Statement of Allegations is an administrative notification of an alleged violation.
 2. A Stipulation To Informal Disposition is an agreement to achieve compliance through imposed sanctions without formal disciplinary action.
- B. What Documentation Is Required To Accomplish a Statement Of Allegations and Stipulation To Informal Disposition?
1. Statement of the facts leading to the allegation of charges.
 2. Statement of the acts asserted to constitute unprofessional conduct or inability to practice with reasonable skill and safety.
 3. Statement that the stipulation is not to be construed as a finding of unprofessional conduct or inability to practice.
 4. Statement that the agreement is not reportable under [RCW 18.130.110](#), but is disclosable under the state public records requirements.
 5. Acknowledgement that a finding of unprofessional conduct or inability to practice, if proven, constitutes grounds for discipline.
 6. Agreement by the respondent that sanctions under [RCW 18.130.160](#) may be imposed except as limited by [RCW 18.130.172](#).
 7. Agreement by the disciplining authority to forgo further disciplinary action.
- C. What Is The Text Of Statutes Governing The Use Of Statements Of Allegations And Stipulations To Informal Disposition?
- D. [RCW 18.130.172](#) – Evidence Summary and Stipulations.
1. Prior to serving a statement of charges under [RCW 18.130.190](#) or [18.130.170](#), the disciplinary authority may furnish a statement of allegations to the licensee or applicant along with a detailed summary of the evidence relied upon to establish the allegations and a proposed stipulation for informal resolution of the allegations. These documents shall be exempt from public disclosure until such time as the allegations are resolved either by stipulation or otherwise.
 2. The disciplinary authority and the applicant or licensee may stipulate that the allegations may be disposed of informally in accordance with this subsection. The stipulation shall contain a statement of the facts leading to the filing of the complaint; the act or acts of unprofessional conduct alleged to have been committed or the alleged basis for determining that the applicant or licensee is unable to practice with reasonable skill and safety; a statement that the stipulation is not to be construed as a finding of either unprofessional conduct or inability to

practice; an acknowledgement that a finding of unprofessional conduct or inability to practice, if proven, constitutes grounds for discipline under this chapter; and an agreement on the part of the licensee or applicant that the sanctions set forth in [RCW 18.130.160](#), except RCW 18.130.160 (1), (2), (6), and (8), may be imposed as part of the stipulation, except that no fine may be imposed but the licensee or applicant may agree to reimburse the disciplinary authority the costs of investigation and processing the complaint up to an amount not exceeding one thousand dollars per allegation; and an agreement on the part of the disciplinary authority to forego further disciplinary proceedings concerning the allegations. A stipulation entered into pursuant to this subsection shall not be considered formal disciplinary action.

3. If the licensee or applicant declines to agree to disposition of the charges by means of a stipulation pursuant to subsection (2) of this section, the disciplinary authority may proceed to formal disciplinary action pursuant to RCW 18.130.090 or 18.130.170.
4. Upon execution of a stipulation under subsection (2) of this section by both the licensee or applicant and the disciplinary authority, the complaint is deemed disposed of and shall become subject to public disclosure on the same basis and to the same extent as other records of the disciplinary authority. Should the licensee or applicant fail to pay any agreed reimbursement within thirty days of the date specified in the stipulation for payment, the disciplinary authority may seek collection of the agreed amount in the same manner as enforcement of a fine under [RCW 18.130.165](#).

V. Statement Of Charges Guidelines

A. What Is A Statement of Charges (SOC)?

1. A formal initiating document alleging a violation of the UDA.

B. What is Achieved By Utilizing a SOC?

1. Issuance of a SOC will result in a final order, usually an agreed order or an order issued pursuant to a hearing. The disciplinary order will contain sanctions necessary to protect or compensate the public any also include requirements designed to rehabilitate the credential holder or applicant.

C. Generally When Should A SOC Be Utilized?

1. Violations(s) are moderate to severe in nature.
2. Violations(s) result in moderate to severe injury.
3. Violations(s) create a moderate to severe risk of harm.
4. Failure to comply with a previous disciplining authority order, STID, NOC or NOV.
5. Failure to reach agreement on a STID.
6. A clear pattern of behavior that violates the UDA.

* Fines are included in the sanctions available to the disciplining authority for inclusion in a final order (RCW 18.130.160(3) issued after a hearing is held, or when the order is stipulated to by the respondent and the disciplining authority. Fines are limited to a maximum of five thousand dollars per violation per event. They are by definition punitive, and should not be considered a means to recover program costs associated with pursuing a complaint.

7. Substantiated violation(s) of a specific rule or statute AND the disciplining authority has determined that the respondent's conduct was the reason for the violation.
8. After investigation, the evidence indicated the practitioner is unable to practice with reasonable skill and safety,
9. There is strong evidence to support violation(s).
10. When revocation or suspension of a credential or the placing of any conditions on the credential is required to assure public protection.
11. When allegations, if proven, would require reporting to national practitioner or national association data banks (so that other states would know about that practitioner's unprofessional conduct.)
12. When notice to the media, etc. is required for public protection.
13. When remedial action by the practitioner is necessary to ensure public protection.

Attachment 4 – The Uniform Disciplinary Act (UDA)

THE UNIFORM DISCIPLINARY ACT (UDA)

INTRODUCTION

Your certification is a personal property right, and as such, may be removed through “due process” for violations of the Uniform Disciplinary Act (UDA). When you are applying for certification, it is critical that you complete the application yourself, and that you answer all questions accurately. Please do not copy or modify the application form, including the Part D Confidential form. An altered, incomplete, or incorrectly completed application cannot be processed and will delay your possible certification.

1. What is the UDA?

RCW 18.130, or the *Uniform Disciplinary Act (UDA)*, consists of laws governing the licensure and discipline procedures for health and health-related professionals and businesses. These rules and regulations strengthen and consolidate disciplinary procedures for licensed and certified health and health care-related professions and agencies.

2. What is the intent of the UDA?

The legislature created the UDA to provide standardized procedures for the enforcement of laws so as to assure the public of adequate professional competence and conduct by health care providers.

3. Is the UDA something new?

The UDA has been in place for health care professionals since 1986. In 1992, the legislature incorporated EMS personnel into the UDA.

4. Who has the authority to enforce the UDA?

The "disciplinary authority" has the responsibility for enforcement. The disciplinary authority means the Department of Health (DOH) or board, such as the Medical Quality Assurance Commission.

5. What are other functions of the agency or commission under the UDA?

- A. To grant or deny licenses/certification.
- B. The DOH may enter into a contract with certified personnel for substance abuse treatment and monitoring. In this fashion, the certified person may be afforded the opportunity to continue his/her practice. In the past, individuals would have had their certification suspended.

6. In considering the UDA, what kind of questions must the DOH ask when certifying or recertifying personnel?

- A. The DOH must require sufficient information from the individual that would demonstrate his/her ability to comply with the standards, rules and regulations.
- B. The DOH must determine no visible threat to public health and safety before certifying or recertifying applicants.

Examples of these questions are as follows:

- 1. Have you ever been found in any proceeding to have violated any state or federal law or rule regarding the practice of a health care profession?
- 2. Have you ever been convicted of abusing a child, developmentally disabled person or vulnerable adult?

7. What are the conditions where a license/certification may be restricted, denied or revoked?

- A. Commission of any act involving moral turpitude, dishonesty, or corruption relating to the nature of the person's profession (whether the act constitutes a crime or not).
- B. Misrepresentation or concealment of information in obtaining a license/certification.
- C. False or fraudulent advertising.
- D. Incompetence, negligence or malpractice which results in injury to the patient.
- E. Suspension of a license in any state.
- F. The possession, use, prescription for use or distribution of controlled substances or legend drugs.
- G. Violation of any state or federal law regulating the profession.
- H. Failure to cooperate with the disciplinary authority.
- I. Failure to comply with an order by the disciplinary authority.
- J. Performing beyond the scope of practice.
- K. Misrepresentation or fraud.

- L. Failure to adequately supervise staff to the extent of placing health and safety at risk.
- M. Contact with the public while suffering from a contagious or infectious disease that involves a serious risk to public health.
- N. Conviction of any gross misdemeanor or felony relating to the practice of a person's profession.
- O. Involvement in criminal abortion.
- P. Agreeing to cure or treat a disease by a secret method.
- Q. Willful betrayal of practitioner/patient privilege.
- R. Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts.
- S. Current misuse of alcohol or drugs.
- T. Abuse of a client or patient, or sexual contact with the patient or client.

8. *What is the responsibility of an agency or individual to report violations of the UDA?*

According to the UDA, agencies whose employee(s) may have engaged in A through T above are required to bring such matters to the attention of the DOH, specifically, EMS Licensing and Certification (the "disciplinary authority"), within 30 days. The act also requires any person, not just agencies, to bring matters to the attention of the DOH. Any person means also reporting yourself.

9. *Is there any legal protection for individuals acting on behalf of the agency or commission?*

Yes, members of commissions or individuals such as the Medical Program Director (MPD) are immune from liability in any action, civil or criminal, based on any disciplinary proceeding so long as it's within their duties and responsibilities.

10. *Is there any protection for individuals who bring a complaint to the attention of the DOH regarding unprofessional conduct or inability to practice with reasonable skill and safety?*

Individuals providing such information in good faith to the DOH are granted immunity from civil liability.

11. *How is a complaint brought against a health care professional licensed or certified in this state?*

If someone believes they have been treated, or observed someone being treated in an unprofessional, unskilled way, or that the health care provider was impaired, they have a right to bring these concerns before the disciplinary authority.

12. *What is the complaint process?*

When a complaint is received, either in writing or over the phone, followed in writing, it is recorded and analyzed to determine if the DOH has the authority over the complaint. If so, an investigation is conducted to determine if there is sufficient evidence to proceed with legal action. If there is, a Statement of Charges or a Stipulated Performance Agreement will be prepared by the Attorney General's Office to be carried out by the DOH.

13. *Does the licensee or certified person have any recourse in this matter?*

Yes, the person may enter into a Stipulated Performance Agreement in lieu of a hearing. The other possibility is to request a formal hearing in 20 days or less wherein the person may contest the allegation(s) contained in the Statement of Charges.

14. *Who are the routine participants in the disciplinary process?*

- A. The person(s) who is providing the complaint, which may be the MPD.
- B. The person whose conduct or performance is identified in the complaint.
- C. The person's supervisor, and most likely the MPD.
- D. The DOH Investigations Unit.
- E. The DOH EMS Licensing and Certification Section.
- F. The State Attorney General.
- G. The Judge.

Summary: The intent of the DOH is to enforce the UDA. However, it is also the intent of the DOH to ensure that all persons are afforded rights under the Administrative Procedures Act (APA) which assures "due process". The best protection providers have is to practice within their scope of care; follow medical protocols and procedures; and assure thorough and accurate documentation of the care provided.

If you have any questions on the UDA, please contact:

EMS Licensing and Certification Section
(360) 236-2845 or 1-800-458-5281, Ext. #1

Attachment 5 – Monthly Medical Program Director Report

EXHIBIT 2

MONTHLY MEDICAL PROGRAM DIRECTOR REPORT

MEDICAL CONTROL ACTIVITY FOR THE MONTH OF _____
COUNTY _____

MEDICAL CONTROL ACTIVITY	# OF HOURS	WORK PERFORMED BY		
		DELEGATE	ADMIN STAFF	SELF
Patient Care Protocol				
* Certification & Recertification				
Corrective Action				
• Counseling				
• * Decert., etc.				
Training				
QI				
Patient Care Procedures				

*** ACTIVITY CAN NOT BE DELEGATED AND MUST BE DONE BY MPD**

Comments: _____

 Medical Program Director Signature

 Date

Appendix F – Washington Health Professional Services (WHPS)

WHPS – Voluntary Substance Abuse Monitoring Program

Definition

- a. **Philosophy:** It is the philosophy of the program that the chemically impaired professional must be intervened upon. It is believed that these individuals must not be discarded, but facilitated into a recovery process that will ensure the public safety in the most cost-effective manner possible, and at the same time treat the professional and maintain their goal of practice in their chosen discipline.
- b. **Goals:**
 - 1) It is the ultimate goal of the program to provide an accountable, cost-effective unification of the processes for identification, assessment and monitoring of the state's healthcare professionals in a manner that ensures maximal protection of the public safety.
 - 2) The second goal is to offer a system that will attract the professional on a self-referral basis rather than traditional discipline procedures. This would ensure a higher likelihood of early entry into recovery and arresting the disease process prior to high-risk patient care situations.

Monitoring Compliance: The program will regularly monitor the treatment program of each professional. This will include, but not be limited to, the following:

- a. **Random Urine Analysis:** Upon admission to the program, if it is deemed necessary, each professional will agree to regular, random, observed urinalysis upon request. A refusal to submit will be considered a positive test. All reports are to be directed by the professional to be sent directly from the lab to the program. Failure to respond to a request for a drug screen will be considered a positive test.
- b. **Contracts for Program Requirements:** Each professional shall participate in developing their own contract for meeting the requirements of the program. These contracts shall be reviewed on a regular basis and shall include all pertinent information gathered by program staff throughout the year, including reports of support group facilitators.
- c. **Work Site Monitors:** All participants who are employed in professional positions are required to have a work site monitor. These individuals will have regular contact with the monitoring program, most particularly in the event of behavioral changes, which may be indicative of relapse. The monitor will check on job performance, communicate with the monitoring program manager and be involved in the re-entry contract. Consent will be obtained to allow for full communication between the primary individuals. They are given monthly evaluation forms to communicate the professional's status to the program.
- d. For those individuals in private practice, random on-site visits by program staff will be arranged and a network of professionals in recovery will be recruited to function as support resource and work site monitors.
- e. **Twelve Step Participation:** Most participants will be required to attend a minimum number of Alcoholics Anonymous, Narcotics Anonymous or other 12-step program meetings each week. Attendance will be verified by signature and given to the monitoring program manager.

- f. **Professional Support Groups:** Support groups will be established, utilizing professionals in the community, to facilitate the re-entry process. These groups will take place on a weekly basis, and will be structured to meet the particular needs of the group members. Each facilitator must be familiar with the treatment of chemical dependence and, if recovering, have at least five years continuous abstinence. The facilitator will monitor and report attendance and status of the professional to the program manager and help in dealing with the process of relapse. The program manager will be actively involved in the recruitment and training of facilitators around the state, and will maintain ongoing contact with them. The appropriate program manager will conduct site visits quarterly.
- g. **Work Restrictions:** Individualized restrictions may be implemented for the professional to help in the recognition of the important role of work in recovery. Under no circumstances will a professional be allowed to work in any situation not fully divulged to the program staff in advance, and not a part of the individual recovery plan.
- h. **Reassessments:** Unless relapse behavior has been demonstrated (requiring more frequent evaluations), annual face-to-face evaluations are conducted by the staff of each professional involved in the program. Each point of the recovery contract is addressed to assure complete compliance by the participant. Reassessments are more frequent for those who have relapsed or have had difficulty with compliance.

Completion/Termination: Upon successful completion of the recovery contract, the professional may graduate from the program. All involved individuals, such as work site monitors, disciplinary boards, etc., are so informed of the fact. Failure to successfully comply with all aspects of the program will result in a referral back to the disciplinary board for appropriate action. Under no circumstances shall the overall length of involvement be shorter than three years.

Outreach And Education: The relative success of the program will be dependent upon the involvement of the designated professions. Program staff will facilitate publicizing of it, and the Executive Director and program managers will provide outreach and education to the assigned professional groups, to hospitals and other healthcare facilities, and to the various professional education facilities. Information and education regarding chemical dependence will be provided to the various groups in cooperation with the associations of each, as well as towards specialty groups identified as high-risk categories. Handout materials will be developed and sent to all sites where professionals are employed or contracted, and a newsletter shall be developed and mailed. In addition, the general public shall be informed through the use of print and electronic media about the activities of the program.

Accountability: The program will submit monthly reports describing program activity to DOH. Quarterly reports to the Department and the respective boards will describe all program activities, including number of participants by discipline, type of referrals, intervention, and outreach and education activities. An annual accounting will also be provided to the Department and each board.

Additional information may be obtained from the WHPS web site at

<https://fortress.wa.gov/doh/hpqa1/HPS2/WHPS/default.htm>

Appendix G – Developing and Implementing Prehospital Patient Care Protocols

Developing, and Implementing Prehospital Patient Care Protocols

1. “**Prehospital Patient Care Protocols**” are the written procedures adopted by the MPD that direct out-of-hospital care provided to the emergency medical or trauma patient by EMS personnel.
 - a. Protocols shall be based upon the patient’s medical needs and the treatment to be provided.
 - b. The procedures shall meet statewide minimum standards for trauma and other prehospital care services ([RCW 70.168.015](#)). They may exceed state minimums if specifically authorized in writing by DOH.
 - 1) **PREHOSPITAL PATIENT CARE PROTOCOLS MAY NOT CONFLICT WITH REGIONAL PATIENT CARE PROCEDURES (PCPS)**, which are administrative guidelines for triage, selection of treatment facility, and personnel requirements. PCPs are the responsibility of the regional/local EMS and Trauma Care Councils.
 - 2) **MPDS MAY NOT HAVE PROTOCOLS THAT VARY FROM PROTOCOLS PUBLISHED BY THE DEPARTMENT OF HEALTH (DOH) WITHOUT SPECIFIC WRITTEN APPROVAL FROM DOH-OEMSTS.** Any deviation from DOH published protocols must be identified to the DOH in writing by the MPD and approved in writing by the DOH-OEMSTS.
 - 3) Prehospital Patient Care Protocols are intended to:
 - a) Provide direction for the use of appropriate emergency medical care procedures, based on the Washington State approved training curricula for each specified certification level (identified in [WAC 246-976-021](#)), to be used by EMS certified personnel while working under the direction of the County Medical Program Director;
 - b) Provide for the standardization of pre-hospital care in Washington State;
 - c) Provide base hospital physicians and nurses with an understanding of what aspects of patient care have been taught to EMS personnel and what their treatment capabilities may be;
 - d) Provide EMS personnel with a framework for pre-hospital care and an anticipation of supportive orders from Medical Control;
 - e) Provide the basic framework on which Medical Control can conduct quality improvement programs.
 - 4) Prehospital Patient Care Protocols are NOT intended to:
 - a) Be a replacement for “on-line” medical control;
 - b) Be a teaching manual for EMS personnel.
 - c) Interfere with the wishes of the patient or family.
 - 5) Once developed and adopted, the MPD has an obligation to make sure these protocols are in the possession of all EMS personnel in the community.
 - 6) MPDs must NOT provide protocols for functions that are not within the scope of practice of the certified individual, which is based on their training.

- 7) Standing Orders/off-line protocols are directions for patient care which do not require verbal contact with medical control

2. Developing Prehospital Patient Care Protocols

- a. Develop local consensus. There should be a core of committed EMS healthcare providers (e.g., SEIs, EMS coordinators, nurses, ED physicians, etc.) with the authority to develop off-line protocols. It is essential for the core group to be well read and up-to-date on the latest EMS literature.
- b. Determine field limitations (e.g., communications deficiency, geographic impediments, traffic density). Standing orders/off-line protocols may need to be written which give consideration to field limitations, and permit the provider a greater degree of medical intervention.
- c. Make sure the process or assessment is appropriate.
 - 1) Is it medically appropriate for my providers?
 - 2) Can it be implemented legally in my system?
 - 3) Can the providers afford the equipment necessary to support a skill or medical intervention?
 - 4) Will it improve patient care?
 - 5) What are the critical conditions to treat or identify?
 - 6) What treatment, if any, can the provider give, or should transport be the treatment of choice?
 - 7) Even if done correctly, does the procedure, skill or act benefit patient care or just take up valuable time? (Consider time delay in weighing the “usefulness” of equipment or medication.)
- d. Utilize the following protocol components and format ([Appendix D-11 – Sample Intravenous Therapy Technician Protocol](#)).
 - 1) Scene Size-up and Initial Patient Assessment.
 - 2) Focused History and Physical Examination.
 - 3) Management.
 - 4) Ongoing Assessment.
 - 5) Transport.

3. Implementing Prehospital Patient Care Protocols

- a. Establish countywide in-service training to review. Consider practice scenarios during continuing education programs.
- b. Implement on a pilot basis. Consider re-evaluation on an annual basis. Resist more frequent updates that can lead to confusion. Modify existing protocols ONLY after education and only if there is a reason for change.
- c. Provide written protocol testing to reinforce knowledge and the importance of delegated medical role.
- d. Implement new protocols ONLY after education – purpose, content and validity.
- e. MPD ensures written acknowledgment of provider receipt of patient care protocols during the certification and recertification application process.

Embedded Secure Document

The file <http://www.doh.wa.gov/hsqa/emstrauma/download/WACS/246-976-920.pdf> is a secure document that has been embedded in this document. Double click the pushpin to view.

