BERRIEN COUNTY FIRE CHIEFS MEETING MINUTES

Call to order: 0830-1020 Date: March 18, 2020

Old Minutes: Motion to accept old minutes and seconded. Motion passed. None opposed

Treasure Report: For March 2020: Starting $3838.29/ Ending $3838.29. Dues check received and will be deposited. Motion to accept Treasures report, and Seconded.
Motion passed. None opposed.

Communications/Bills:
COVID-19 Protocol
(See attached)

Special Guest: Brandi Narragan from Medic-1.

Committee Reports:

Sherriff: As of this morning no COVID-19 positive cases in Berrien County. COVID-19 will only be given if person meets the criteria . EOC will be activated at 1000 today in response to COVID-19. EOC will be working with Spectrum-Lakeland/Fire Departments/EMS/the state to get the PPE needed for the
COVID-19 response. Courthouse still open with limited access. No finger printing will be taking place. Deputies taking many reports by phone to reduce potential COVID-19 contamination. Jail doing initial acceptance in salyport. Asking three questions if answer no to questions proceeding into jail. If yes to any one of the questions nurse evaluation follows.

Red Cross: No one present

911: Due to COVID-19 there has been a change in response. 911 has worked with Med Control to develop a set of questions to ask of potential flu/COVID-19 calls into 911. If answer yes to any one of the questions ems will be advised over radio to wear PPE. Some fire departments have advised dispatch they will not respond to lift assist requests. Request that dispatch pass on COVID-19 PPE information to fire departments that are are not MFR and are sent to assist EMS agencies…lift assist/cardiac arrests/etc…. Dave stated this should already be done but will make sure that information is going to all agency's that are responding to incident. Question on if that information could be inputed into Active911. Several felt over radio would be better. Potential COVID-19 incident in Chikaming discussed. Crew responded to fire alarm call and at the end of incident resident informed the Fire Crew he was in quarantine due to returning from Europe.
Unication pager implementation had been significantly slowed down. MPSCS extremely low on staff and due to COVID-19/system upgrades/7 new counties coming on to MPSCS/state facilities shutting down/ pagers are on indefinite hold. MPSCS system upgrades will further delay projects. Chief Davidson stated he has reached out to Rep. LaSata's office for assistance on getting our pagers completed. Gabe and LaSata's office to talk. Pager footprint has been completed and waiting on MPSCS to create the HEXcodes for department paging talkgroups. Gabe has a possible solution…Pagers can be programed minus department paging talkgroup HEX codes and handed out. Since we are not able to move to MPSCS paging the departments that purchased the Unication G5 pagers can use the pagers in VHF mode as we wait for MPSCS to create the HEX codes and program the dispatch consoles.
All felt this is a viable solution for the time being. SGT. Bush was able to get the pager foot pring expanded with the addition of towers in Van Buren and Cass counties. When Gabe has the pagers programed minus the department page talkgroups pagers can be dispersed to

departments. Pagers that have already ben dispersed will need to be updated with new pager footprint. Spectrum-Lakeland Watervliet site moving forward. Equiptment delivery to site has been approved.

DNR: No one

Funeral: In Berrien Springs

Emergency Management: EOC will be operational at 1000 today.

EMPTF: None

EMS:
Medic-1- Brandi from Medic-1 gave presentation on COVID-19. COVID-19 hotline 269-391-2380 there is a 24-36 hr wait for return call. If you have symptoms/exposure/thing you may have flu/COVID-19 need to self quarantine contact your PCP and if PCP advised you to then contact the COVID-19 hot line. The COPS center on Hollywood road is only COVID-19 testing center in county. If responding to anyone with flu like symptoms/cough/fever over 100.4/trouble breathing/ use of PPE N-95 mask/gown/gloves/eye protection must be warn. Wash hands and all equipment used immediately. Hand sanitizer can only be used up to five times, then MUST wash hands with warm soap and water. ALL PPE N-95masks/gloves/gowns/eye protection is either on back order or not available to purchase. EMS agencies have limited supply and will help fire departments if possible.
As long as first responders are wearing appropriate PPE N-95 mask/gown/gloves/eye protection it is NOT considered an exposure by first responders if come in contact with COOVID-19 positive patient. Wash hands with soap and water often/try not to touch eyes/nose/face/no facial hair except for mustache allowed. Three types of exposure risk:
Low-self quarantine
Medium-Need check up with PCP
High-14 day in hospital quarantine
Department need to consider daily/shift medical evaluations: no flu like symptoms/no temp over 100.4/no cough/no breathing issues. If yes to any of these send to PCP/ER for evaluation.
If any questions feel free to contact the following Medic-1 personnel:
Jason Wiley/Nichole Smith/Brandi Narragan
S.M.C.A.S.- Nothing to report.
MedFlight-Not Present
Med Control-Not present

LEPC- None

BCFA- March meeting was at Michiana Shores. Presentation on Hazmat incident in LaPorte county. Continue to Working to update front of Fire Education Building at fair grounds for this years Fair. April meeting cancelled. Next meeting May 06 New Buffalo Twp.

Training- Berrienn County FF1/2 clas suspended until April 06, 2020 due to COVID-19. No classes/testing/training allowed per the state Fire Marshals office.

HAZMAT- None

MITRT-5- None

MABAS- Tabletop exercise planned for April will be taskforce boxcard. Future exercises will be taskforce to POD/tanker/tender boxcard tabletop/tanker/tender to POD. There was a miscommunication on MABAS radios. There was no desktop sets available to MI MABAS. We had requested 2 MPSCS portable and 3 MPSCS desktop sets. Due to no desktop sets available we took three MPSCS 800 portables for Division 3501.

Due to the extreme potential of COVID-19 knocking out a fire department/EMS agency MI MABAS had discussion on ems strike team and/or taskforce boxcards being implemented on a standby notice due to COVID-19. Most felt that was not needed at this time but is being monitored by MI MABAS Leaders.

Old Business: Discussion on grant. Grant sumited on Thursday March 12, 2020. Dave Agens rewrote dispatch narrative and new MOU for the grant. Chief Stover thanked everyone for all the needed information and for those that made adjustments to requested radios. Chief Stover stated he changed base radios to mobile with AC/DC power supply. If left in as base station the grant would of required a 12 page environmental report for each base station. Question on department share. Department share of grant will be around $178,000.00. and we will have 1 year from acceptance of grant to spend money. Therefore match amount would possible fall into most department 2021 budget years. Grant was reworked and summited under both Berrien Springs and New Buffalo Twp Fire Departments in hope of doubling our chance to receive grant this time around. All thanked Chief Stover/Chief Jamie Flick for all the work on grant.

New Business: Discussion on BC Chiefs active911 account. Capt. DeLaTorre explained and active911 account was created for the BC Chiefs in order to get information out in a timely manor..Capt. DeLaTorre explained that he has had many chiefs state that due to their jobs they do not read/check emails on a regular basis some only a couple times a month. With the BC Chiefs active911 information/drills/activations can be sent out to chiefs/and representative immediately. As of this meeting today only the following departments have responded to the request for chiefs and/or department representative active911 code so they can by put into BC Chiefs active911 account: Niles City/Baroda/SJPS/Berrien MCA/New Buffalo City/Watervliet/Three Oaks/North Berrien/ST Joe Twp. 1/Lake Twp/New Buffalo Twp./Bridgman/Chikaming/BHDPS/Wesaw/Buchanan Twp.Sodus/S.M.C.A.S./
Capt. DeLaTorre advised all that the active911 codes will not be shared with anyone and that Chief Davidson/Chief Mattix/Capt. DeLaTorre all have access to send active911 messzages and that ths BC Chiefs active911 email will be given to dispatch so that dispatch can send active911 as well.

Discussion on if departments lose personnel due to COVID-19 to let BC Chiefs/dispatch/EOC know as soon as possible so neighboring coverage can be established immediately. Question asked about county MA agreement has been updated. Chief Davidson stated he does not believe it has been updated recently and we may need to look into that. Capt. DeLaTorre stated that the MABAS agreement serves as mutual aid agreement for all departments that sign it both in county and across the state. MABAS agreement also recognized by the state as EMS mutual aid agreement. Capt DeLaTorre stated if going to look into updating county mutual aid agreement we should just use the MABAS agreement as the county mutual aid agreement.

Discussion on if dispatch/EOC has capabilities for video/tele conference if needed for future BC Chiefs meetings. Dave Agens stated he would look into it and let Chief Davidson know.

Next meeting planned for April 15, 2020 at Lincoln Twp at 0830

Motion to adjourn.
Motion seconded.
Meeting adjourned 1010

Minutes submitted by Captain DeLaTorre

Berrien County Fire Chief's Association
Attendance Sheet
March 18th, 2020

	Print	Signature	Dept.
1.	Mike Davidson	Mike Davidson	CTFD
2.	Jamie Flick	J. F	NBTFD
3.	Garry Bendix	Garry Bendix	MSUFD
4.	DAVE AGENS		BC911
5.	Larry Lauk		NFD
6.	BRUCE A STOVER		13 SOFD
7.	Tim Jesswein		Buch. Twp.
8.	Bill Boyd JR	Bill Boyd	MEDIC 1
9.	Brandi Narregan		Medic 1
10.	Mike Phelps		BIADPS
11.	LARRY KLUG		BARODA
12.	DAN JONE		Watervliet
13.	MIKE IAVALACCI	Mike Iavalacci	BCTFD
14.	Frank DeloTore		SMCAS
15.	Matt Remmel		Bertrand
16.	Ted Chase		GALIEN
17.	Gerry Kabelman		S.J.C.T.F.D. 1
18.	Brandon Chiarelli		LTFD
19.	Donnie Johnson II		Weesaw
20.	Mike Mattson		NBFR
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Destination and Transport for Patients at Risk for Coronavirus Disease (COVID-19)

Purpose: To direct patient transport and destination for patients that are triaged medium or high-risk for Coronavirus Disease (COVID-19).

I. Applicable patients – triaged by Center for Disease Control (CDC) quarantine station, through the local health department, or utilizing CDC triage criteria
   a. High-Risk –
      i. Have traveled from locations with current CDC travel restrictions related to COVID-19 within 14 days (current restrictions can be found at www.cdc.gov/travel)
      ii. Those who share the same household as, are an intimate partner of, or provided care to symptomatic patients with laboratory-confirmed COVID-19 (or clinically diagnosed outside of the United States who did not have laboratory testing).
   b. Medium-Risk –
      i. Had close contact with a person with symptomatic laboratory-confirmed COVID-19 infection, and not having any exposures that meet a high-risk definition.
         1. The same risk assessment applies for close contact with a person diagnosed clinically with COVID-19 infection outside of the United States who did not have laboratory testing.
         2. On an aircraft, being seated within 6 feet of a traveler with symptomatic laboratory-confirmed COVID-19 infection
      ii. Are living in the same household as, an intimate partner of, or caring for a person in a nonhealthcare setting (such as a home) to a person with symptomatic laboratory-confirmed COVID-19 infection while consistently using recommended precautions for home care and home isolation
      iii. Have traveled from locations with current CDC travel restrictions related to COVID-19 AND not having any exposures that meet a high-risk definition.
   c. Low-Risk –
      i. Being in the same indoor environment (e.g., a classroom, a hospital waiting room) as a person with symptomatic laboratory-confirmed COVID-19 infection for a prolonged period of time but not meeting the definition of close contact
      ii. On an aircraft, being seated within two rows of a traveler with symptomatic laboratory-confirmed COVID-19 infection but not within 6 feet AND not having any exposures that meet a medium- or a high-risk definition
   d. No identifiable risk –
      i. Interactions with a person with symptomatic laboratory-confirmed COVID-19 infection that do not meet any of the high-, medium- or low-risk conditions above, such as walking by the person or being briefly in the same room.

II. High-risk patients – Transported by Emergency Medical Services
   a. Transported by EMS, utilizing standard, contact, and airborne precautions, to the closest facility with inpatient monitoring capability.
   b. If patient is being transferred from a CDC quarantine station, the destination facility may be identified by the CDC.
   c. Treat symptoms according to clinical protocols.
   d. Any receiving facility should be notified of the incoming patient immediately when known to be a high-risk patient.

III. Medium-risk patients
   a. Patients deemed to be at medium risk may be allowed to continue to their destination with instructions to report to their respective local health department for monitoring under voluntary quarantine.
   b. In the instance that these patients need EMS transport, they should be transported using standard, contact, and airborne precautions and may be transported to alternate destinations which may include residences, hotels, or other housing facilities.
   c. The destination for these patients will be coordinated by the local health department.

IV. Low-risk patients will not be tracked or placed under quarantine. These patients will be under self-observation according to CDC or local health department instruction.

V. Types of precautions
   a. Standard precautions - The principle that all blood, body fluids, secretions, excretions except sweat, nonintact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered.
   b. Contact precautions - intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment. Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment.
   c. Airborne precautions – intended to prevent transmission of infectious agents that remain infectious over long distances when suspended in the air. Healthcare personnel caring for patients on Airborne Precautions wear an N95 or higher-level respirator or mask that is donned prior to room entry.
   d. Contact with these patients should include the use of eye protection.

Person Protection During Treatment of Patients at Risk for Coronavirus Disease (COVID-19) and Decontamination of Equipment after Use

Purpose: To outline precautions when providing treatments for patients who are at risk for COVID-19. To outline the appropriate decontamination for people, equipment, and vehicles utilized in treatment and transport of patients at risk for COVID-19.

I. Applicable patients –
   a. Patients who have been identified prior to arrival as at risk for COVID-19 by a 911 Public Safety Answering Point (PSAP) and/or Emergency Medical Dispatch Center (EMDC), local health department, or CDC quarantine station.
   b. Patients encountered by EMS personnel who have signs and symptoms of respiratory illness (fever, cough, shortness of breath) AND meet (or are suspected to meet) current CDC travel or exposure risks. (current travel restrictions can be found at www.cdc.gov/travel)

II. Initial assessment –
   a. Standard, contact, and airborne precautions, per **Destination and Transport for Patients at Risk for Coronavirus Disease Protocol** must be observed if within six feet of the patient.
   b. The number of responders within six feet of the patient should be limited to the fewest number to provide essential patient care.
   c. A (surgical type) facemask should be placed on the patient for source control, if tolerated. Do not place N-95 or similar masks on patients as these increase the work of breathing.
   d. Assess the patient for travel to areas of concern as defined by the CDC (e.g. mainland China) or has exposure to a confirmed COVID-19 in the previous 14 days in addition to respiratory symptoms (e.g., dyspnea, cough) and fever:
      i. If patient has travel or exposure risks AND respiratory symptoms, continue utilizing this protocol, performing interventions while maintaining source control and PPE.
      ii. If COVID-19 is not suspected, responders should use PPE appropriate for the clinical condition.

III. Treatment –
   a. Oxygen administration
      i. Nasal cannulas may be worn by the patient **under** a facemask as clinically indicated.
      ii. Non-rebreather masks should be used when clinically indicated (e.g., moderate to severe respiratory distress, significant hypoxia, failure to improve with nasal oxygen).

b. Aerosol Generating Procedures
    i. In addition to PPE, there should be increased caution in aerosol-generating procedures (BVM, suctioning, emergency airways, nebulizers, etc)
    ii. Perform aerosol-generating procedures only when clinically indicated.
    iii. Keep patient and aerosolization away from others without PPE (e.g., bystanders, EMS personnel not in PPE, etc).
    iv. When treating patient in the ambulance, activate patient compartment exhaust fan at maximum level.
    v. When possible, consider using HEPA filtration to expired air from the patient. (Ventilators, CPAP, biPAP, BVM)

IV. Patient Compartment –
a. When practical, utilize a vehicle with an isolated driver and patient compartment.
b. Only necessary personnel should be in the patient compartment with the patient.
c. All compartments should have ventilation maintained, with outside air vents open and set to non-recirculated mode.

V. Patient Transfer and Documentation
a. Whenever possible, friends and family of the patient should not ride in the transport vehicle with the patient. If they must accompany the patient, they should have respiratory precautions applied and be in the driver compartment of the vehicle.
b. Personnel driving the transport vehicle should doff PPE (with the exception of respirator) and perform hand hygiene before entering the driver's compartment. Respirator (N95) should be maintained throughout.
c. Notification of infectious risk should be made to receiving facility as soon as feasible and on a secure channel.
d. Maintain mask on patient and filtered exhaust while transporting patient to room.
e. Avoid transporting the patient within 6 feet of others (e.g., unprotected hospital staff, patients, bystanders, etc.)
f. Transfer patient care via verbal report.
g. Doff PPE after leaving patient room and perform hand hygiene before touching documentation tools.

VI. Cleaning of Transport Vehicle
a. Leave patient compartment open for ventilation while patient is taken into receiving facility.
b. Personnel should wear disposable gown and gloves for decontamination of the vehicle. A face shield or facemask and goggles should be worn if there is a potential for splashing or sprays.
c. Maintain doors open during cleaning.
d. Disinfect after cleaning using EPA-registered, hospital-grade disinfectant to all surfaces that were touched, or all surfaces if aerosol-generating procedures were performed. Products with statements for emerging viral pathogens should be used.

Protocol Source/References: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html,
https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html,

Conventional Response to Potential COVID-19 Outbreak

Purpose: To reduce risk of exposure of EMS personnel during the conventional response phase of a COVID-19 outbreak.

I. Requests for EMS should be screened for risks for COVID-19:
   a. Respiratory distress and/or cough AND
   b. Fever
   c. Those calls who screen positive for both of the above will be treated as a possible COVID-19 patient and responding EMS should be advised.

II. Priority one and two responses* who screen for potential COVID-19:
   a. Normal agency response
   b. First unit on scene:
      i. Initial responder(s) enter at minimum level of personnel (if non-transporting and transporting units arrive at the same time, transporting personnel enter scene wearing appropriate PPE, while non-transporting personnel provide support as needed).
      ii. After initial assessment, personnel who have made patient contact request additional (specific) resources, as indicated.

III. Priority three** patients who screen for possible COVID-19:
   a. Initial response by transporting agency ONLY, unless transporting agency delayed by more than 30 minutes.
   b. Transporting personnel make contact wearing appropriate PPE.
   c. After initial assessment, if more resources are needed, personnel request specific necessary resources (e.g., lift assist).

IV. Responses to health facilities (those with licensed health care staff present) with a patient who screens positive for possible COVID-19:
   a. Initial response by transporting agency only.
   b. Minimal personnel enter the scene and assess the patient.
   c. After initial assessment, if more resources are needed, personnel request specific necessary resources.

*Priority one includes patients with potential life-threatening emergencies including, but not limited to, shortness of breath, chest pain, and/or altered mental status.

**Priority three includes patients with fever and cough but without other Priority one symptoms.

Telehealth and Stationary Treatment of Low Acuity Patients During Covid-19 Outbreak

Purpose: To reduce unnecessary EMS transport to hospital emergency departments during the COVID-19 outbreak while assuring delivery of appropriate healthcare services.

I. Description:
This Emergency System Protocol describes the process to be followed by Paramedics when, following an appropriate clinical assessment including a telemedicine medical control consultation with an authorized physician, it is determined that the patient is not experiencing a medical emergency and will not likely benefit from transport by EMS to the hospital emergency department.

II. Definitions:
A. Emergency Patient: means an individual with a physical or mental condition that manifests itself by acute symptoms of sufficient severity, including, but not limited to, pain such that a prudent layperson, possessing average knowledge of health and medicine, could reasonably expect to result in 1 or all of the following:
1. Placing the health of the individual or, in the case of a pregnant woman, the health of the patient or the unborn child, or both, in serious jeopardy.
2. Serious impairment of bodily function.
3. Serious dysfunction of a body organ or part.

B. Non-Emergency Patient: For the purposes of this protocol, a non-emergency patient means an individual who has been **jointly** assessed by both EMS and an authorized medical control telemedicine physician and has been determined to not meet the definition of an emergency patient as defined above.

C. EMS Telemedicine Application: means a telecommunication application that is HIPPA-compliant and provides for remote medical control between the treating paramedic and the supervising authorized medical control physician and has been approved by the local medical control authority.

D. Medical Control Telemedicine Physician: means a physician authorized by the local medical control authority Medical Director and serving as a representative of the local medical control authority.

E. Alternate Destination: means a healthcare facility other than a hospital emergency department approved by the local medical control authority Medical Director to which a non-emergency patient may be transported. This may include physician offices, clinics, urgent care centers, and other approved alternate care centers.

F. Alternate Transport: means a vehicle, other than a licensed ambulance, used to safely transport a non-emergency patient to a hospital emergency department or approved alternate destination. This may include wheelchair van, private vehicle, ride share vehicle, licensed non-transporting EMS vehicle, non-licensed public safety vehicle, or other type of vehicle type approved by the local medical control authority Medical Director.

G. Alternate Treatment Plan: This means a treatment plan for the non-emergency patient that involves home care, transport to an alternate destination, or transport using and alternate vehicle.

III. Qualifying Patients:
This protocol is intended for patients who, following patient assessment and medical control telemedicine consultation, are determined to not be an emergency patient as defined above and are in not in need of EMS transport to a hospital emergency department. Examples include, but are not limited to:

A. Mild respiratory infection findings including sore throat, cough, muscle pain
B. Mild respiratory illness with bronchospasm without signs of infection
C. Vomiting and diarrhea without signs of significant dehydration or circulatory shock
D. Mild exacerbations of chronic medical conditions
E. Mild soft tissue injuries such as superficial abrasions, lacerations, and minor burns
F. Minor orthopedic injuries such as sprains, strains, and contusions
G. Minor medical complaints such as urinary tract infection or minor skin infection without fevers or other comorbid factors
H. Other clinical conditions appearing to be of low acuity associated with stable vital signs.

IV. Excluded Patients:
This protocol does not apply to patients who, following paramedic assessment are felt to reasonably have a clinical condition consistent with an emergency patient as defined above. Examples include, but are not limited to:

A. Significantly abnormal vital signs (excluding fever and mild tachycardia) that fail to resolve with initial treatment
B. Hypoxia, defined as a room air SPO2 less than 92% that does not promptly improve with EMS treatment
C. Chest pain suggestive of an acute cardiopulmonary condition, regardless of EKG finding
D. Labored breathing following EMS treatment
E. Acutely altered level of consciousness
F. Significant acute pain of known or unknown etiology
G. Other conditions that may otherwise be consistent with an emergency patient

V. Process:

A. Paramedic dons appropriate PPE and limits EMS personnel contact, as appropriate
B. Paramedic completes assessment in accordance with appropriate protocols, including complete vital signs (BP, HR, RR), temperature, and SPO2.
C. Paramedic initiates treatment per appropriate protocols
D. If patient clinically appears to be an emergency patient continue with treatment and transport per appropriate protocols
E. If patient clinically appears to be a non-emergency patient, contact Medical Control Telemedicine Physician for consultation using MCA-approved EMS telemedicine application.
F. Paramedic provides appropriate clinical presentation to Medical Control Telemedicine Physician and provides for telemedicine video consultation between the physician and patient.
G. If physician determines the patient continues to represent an emergency patient, the paramedic continues treatment and transports to hospital emergency department per appropriate protocol.

H. If physician determines the patient's condition is consistent with a non-emergency patient, the patient is advised of the clinical justification for the determination.
I. An alternate treatment plan will be collaboratively developed with the patient, paramedic, and physician as described below.
J. When alternate transportation is indicated, the paramedic may clear the scene prior to arrival of the alternate transport vehicle.
K. Initiate alternate treatment plan and document the encounter electronically utilizing an MCA approved documentation vendor.

VI. Alternate Treatment Plan Options:
A. At home treatment and follow-up with outpatient medical provider. Treatment may include:
a. Common over-the-counter supportive self/family care and/or
b. Medical Control Telemedicine Physician provided prescription (optional), as appropriate
B. Transport to an alternate destination using alternate transport (or licensed ambulance)
C. Transport to the emergency department using alternate transport

VII. Non-911 Requests for Evaluation:
A. Local public health and/or healthcare communities, outside of 911 EMS activation process
B. EMS will attempt to honor non-emergent requests for evaluation originating from public health and healthcare sources, contingent upon the availability of EMS resources. Paramedics should remind patients, public health, and healthcare personnel to contact 911 if the patient's condition worsens.

VIII. If physician determines an emergency does not exist and the patient insists on Transport by Licensed Ambulance to Hospital Emergency Department:
A. Advise Physician.
B. Physician consults with patient and family.
C. Ambulance transport denied by physician
a. Collaborate with Physician and Family for alternate treatment plan
b. If patient continues to insist on EMS transport, contact MCA Medical Director or on call designee.

IX. Mandatory Review:
The use of this protocol requires notification within 24 hours and review by the local medical control authority Medical Director (or designee).