BACKUS HOSPITAL POLICY
OBTAINING PARAMEDIC MEDICAL CONTROL AUTHORIZATION

Purpose:
Provide a defined process for individual EMS providers to obtain medical authorization to practice independently at the paramedic level.

Scope:
Connecticut licensed paramedics requesting authorization to practice at the paramedic level as an employee of an EMS organization sponsored by Backus Hospital.

Procedure:
Step 1 - Application:
Email Backus Hospital's EMS Coordinator the following documents. It is preferred that all required documents be sent together as a single submission in .pdf format.
  • Application for Medical Authorization at the paramedic level (at the end of the policy).
  • Letter or email from the candidate's sponsored service, verifying the candidate's status as an employee and the EMS organization’s request that the candidate be authorized by the EMS Sponsor Hospital to precept at the paramedic level.
  • Written recommendation from the candidate's most recent sponsor hospital EMS Coordinator or Medical Director attesting the candidate has (or had) medical authorization to practice at the paramedic level, is (or left) in good standing and when the authorization was granted/terminated. Acceptable forms of documentation include a signed recommendation on hospital letterhead or email directly from the sponsor hospital EMS Coordinator or Medical Director to the Backus Hospital EMS Coordinator.
  • Continuing Education log demonstrating at least 24 hours of EMS continuing medical education in the last calendar year. This requirement may be waived or modified for newly licensed (within the last year) paramedics.
  • Copies of current certification cards to include:
    ▪ Connecticut Paramedic License
    ▪ ACLS
    ▪ PALS
    ▪ PHTLS
    ▪ BLS (CPR)
    ▪ NREMT (if applicable and recommended)
    ▪ CCEMT, CCP-C, or FP-C (if applicable)
    ▪ Results of a State and Federal criminal background check of the candidate. This must be submitted directly from the sponsored EMS Organization.
Step 2 – Meet with EMS Coordinator:
Upon submission of all required documents, the EMS Coordinator will schedule a meeting with the candidate to:

- Review expectations, policies and procedures.
- Review focused areas of clinical concern.
- Successfully complete the Protocol Exam. This exam tests knowledge of the Connecticut EMS Patient Care Protocols (which may be accessed at: http://portal.ct.gov/DPH/Emergency-Medical-Services/EMS/Statewide-EMS-Protocols). In addition, questions may address clinical knowledge, appropriate medical decision making, medication calculations, ECG rhythm interpretation and 12 lead ECG interpretations.
  - A score of 80% or better defines successful completion.
  - Candidates who fail will be allowed to retake a different version of the exam at a later date.
  - Candidates who fail the exam a second time may be required to complete remedial education prior to a third and final attempt at the exam.

- Demonstrate competency in the following skills:
  - Difficult airway management including decision making, basic adjuncts and ventilation, orotracheal intubation and supraglottic airways.
  - Other practical skills assessment at the discretion of the EMS Coordinator/EMS Medical Director

Step 3 – Service-Specific Equipment Training and Competency Validation
The candidate will successfully complete training and competency validation on all service-specific equipment and clinical procedures prior to start of precepting. The EMS organization will maintain records of this competency validation and submit copies to the EMS Coordinator. Service-specific equipment and clinical procedures may include but is not limited to:

- Monitor/Defibrillator/External Pacer/12 Lead ECG transmission
- Ventilator operation
- Continuous positive airway pressure device unit
- Intraosseous insertion device (both tibia and humeral head insertion sites)
- ‘Safety’ needles/catheters
- Intravenous infusion pumps (service devices and common hospital pumps)
- Mechanical CPR devices
- Commercially manufactured tourniquets
- Supraglottic airways
- Video laryngoscopes
- Quicktrach (adult, pediatric)
- e-Bridge
Step 4 – Field Clinical Performance Evaluation:
Having successfully met the requirements of steps 1 & 2, the paramedic may be issued provisional authorization to practice as a paramedic. This authorization will be on Backus Hospital EMS letterhead and signed by the EMS Coordinator. Copies will be sent to both the paramedic and his or her employer. With this provisional authorization, the paramedic may only perform ALS assessment and treatment under the supervision of a Backus Hospital authorized preceptor who will provide education on service-specific equipment and procedures, evaluate his or her performance, offer guidance for improvement and submit written reports to the EMS Coordinator. Provisionally authorized paramedics must consistently demonstrate competence in all evaluated aspects of their performance prior to being considered for full authorization to practice as a paramedic. Performance should be evaluated in the management of a variety of clinical conditions and acuities. The following are guidelines for minimum precepted field clinical time. Precepting requirements may be waived, modified or extended by the EMS Medical Director and/or EMS Coordinator in consultation with the preceptor and EMS agency management.

- Newly Graduated (≤6 months paramedic field practice)
  - 5 observation calls. Minimum 30 ALS calls
- Minimally Experienced (>6 months but less than 1 year recent, active paramedic field practice)
  - 5 observation calls. Minimum 20 ALS calls
- Experienced (>1 year recent, active paramedic field practice)
  - Minimum 5 ALS calls
- Following absence (>90 days, <6 months)
  - Minimum 5 ALS calls
- Following absence (>6 months)
  - Minimum 10 ALS Calls
- Any candidate who has not been actively practicing (at least 32 hours per month) as a paramedic for greater than 180 days immediately preceding the submission of their application will be assigned the field performance evaluation requirements of the next lower experience category than they would otherwise be eligible for.

Preceptees will meet with the EMS Coordinator to receive feedback at 15 call intervals throughout the precepting process. Meetings may be held earlier than the 15 call interval, as needed, at the request of the EMS Medical Director, EMS Coordinator, or sponsored service.

The EMS Coordinator, in consultation with the EMS Medical Director, will review the candidate’s performance evaluations and patient care reports during the field clinical performance evaluation period. If the Candidate’s evaluations have received favorable review by the EMS Coordinator and EMS Medical Director, the EMS Coordinator or EMS Medical Director may schedule and conduct a final field evaluation of the candidate.
Step 5 - Review and Full Authorization to Practice

Once all applicable preceding steps have been completed to the satisfaction of the EMS Medical Director / EMS Coordinator, the paramedic may be issued full authorization to practice as a paramedic. This authorization will be on Backus Hospital letterhead and signed by the EMS Medical Director and EMS Coordinator. Copies will be sent to both the paramedic and his or her employer. With this full authorization, the paramedic may only perform ALS assessment and treatment while acting in his or her official capacity as an employee of the specified Backus Hospital sponsored EMS agency.

Once granted medical control, 100% QA by sponsored service is required for the first 30 days. Any deviations from protocol or generally accepted care standards must be reported to the EMS Coordinator.

Authorization to practice may be suspended or withdrawn by the EMS Medical Director or EMS Coordinator at any time through notice to the paramedic’s EMS Organization. Authorization to practice immediately terminates upon the paramedic’s separation from employment with the sponsored EMS organization.

The Backus Hospital EMS Medical Director has the sole discretion to grant, deny, or revoke medical control authorization.
APPLICATION FOR PARAMEDIC MEDICAL CONTROL AUTHORIZATION

Name: ___________________________ Date: ___/___/_____

Street Address: ____________________________

City, State, Zip: ____________________________

Phone (circle: mobile or home): (___) ___________ Email: ____________________________

Certifications/Licenses (attach copies to this application):

CT Paramedic #: _______ Exp. Date: ___/___/______ BLS CPR Exp. Date: ___/___/______

ACLS Exp. Date: ___/___/______ PALS Exp. Date: ___/___/______ PHTLS Exp. Date: ___/___/______

NREMT #: ________ Exp. Date: ___/___/______ CCEMTP#: ________ Exp. Date: ___/___/______

CCP-C/FP-C#: ________ Exp. Date: ___/___/______ EMS-I#: ________ Exp. Date: ___/___/______

List all hospitals with which you presently have paramedic practice authorization:

__________________________________________________________________________

Service Affiliation(s) for which you are requesting paramedic authorization:

☐ American Ambulance Service, Inc. ☐ Mohegan Tribal Fire Department

Has your medical control or license/certification ever been suspended or revoked?

NO / YES If yes, explain:

__________________________________________________________________________

Are you presently under investigation by a State or professional licensing agency?

NO  YES If yes, explain:

__________________________________________________________________________

__________________________________________________________________________

Backus Hospital EMS 

August 2018
Healthcare Employment History

Beginning with the most recent, list all employment (including volunteer membership) in which your role included direct patient contact. Attach additional sheets if needed.

1) Employer name: __________________________________________________________

Address: _____________________________________________________________________

Employed from: ___/____ to___/_____    Average hours per week_________________________

Positions held with dates: ______________________________________________________

Sponsor Hospital (if applicable): _______________________________________________

Name of EMS Coordinator or Medical Director (specify): _____________________________

Phone: (     ) ________________    Email:________________________________________

2) Employer name: __________________________________________________________

Address: _____________________________________________________________________

Employed from: ___/____ to___/_____    Average hours per week_________________________

Positions held with dates: ______________________________________________________

Sponsor Hospital (if applicable): _______________________________________________

Name of EMS Coordinator or Medical Director (specify): _____________________________

Phone: (     ) ________________    Email:________________________________________

3) Employer name: __________________________________________________________

Address: _____________________________________________________________________

Employed from: ___/____ to___/_____    Average hours per week_________________________

Positions held with dates: ______________________________________________________

Sponsor Hospital (if applicable): _______________________________________________

Name of EMS Coordinator or Medical Director (specify): _____________________________

Phone: (     ) ________________    Email:________________________________________
ATTESTATION

I, ________________________________, attest that the information provided in this application is accurate and truthful. I understand that false or misleading information may result in loss of medical control, notification to the CT Department of Health, and other sponsor hospitals with which I have medical control.

I understand that continued authorization to practice is contingent on my adherence to the approved EMS patient care protocols, as well as all policies, procedures and clinical guidance issued by the Backus Hospital EMS Medical Director and his or her designee.

Printed Name of Paramedic: __________________________________________________________

Signature of Paramedic: _____________________________________________________________

Date: ___________________________________________________________________________