Professional Ambulance & Oxygen Service, Inc.

Policies and Procedures

PRO EMS

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100 | Personnel and Staff Development

Pro Policy 100.1 – New Employees

Section:	Personnel and Staff Development
Policy #:	100.1
Modified:	04/15/2024
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1.1.A. Overview

New employees at PRO are in an extremely difficult situation. No matter how much training or orientation you receive, you will be unavoidably thrust into the world of EMS. With the high volume of emergency work here at PRO, a new employee must always be prepared to deal with situations that they have never come across. You must also be prepared to acclimate yourself to the different personalities and procedures that you will encounter.

All personnel with a significant amount of time here at PRO will be expected to assist and train new employees. This training will include paperwork, procedures, and driving among other things. All PRO "veterans" and new employees are expected to get along and work together. Leave all personality conflicts outside. We are a comparatively small company that does a high volume of work. The staff needs to function as a closely-knit group.

All new employees will be evaluated on paperwork, attitude, and overall performance. Use this manual and your common sense to consistently improve all aspects of your performance.

1.1.B. Pipeline

All new employees will be oriented to the operation of PRO by using FTEP and Pipeline.

Pro Policy 100.2 – Certification and Re-Certification

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1.2.A. Credentials, Ongoing Training and Continuing Medical Education (CME)

The Commonwealth of Massachusetts -Department of Public Health – Office of Emergency Medical Services (OEMS) will certify and re-certify all EMTs and Paramedics. Crew configurations will be in accordance with MDPH OEMS guidelines.

All field providers must meet Massachusetts OEMS re-certification requirements. Renewal of appropriate BLS CPR, ACLS/PALS (if ALS) certification. PRO requires all certification and re-certification training be conducted in house and will not accept any training conducted outside of PRO.

Additionally, all EMTs must be certified through PRO's Continuing Medical Education Program which has been developed with physician oversight by Medical Directors. A significant portion of PRO's CME is available online through Prodigy. Face-to-face and practical training is regularly available at PRO as stand-alone programs or in conjunction with Prodigy. PRO has a state-of-the-art human patient simulation lab that is utilized as an integral part of the CME program.

IT IS THE RESPONSIBILITY OF ALL EMPLOYEES TO MAINTAIN CURRENT CERTIFICATIONS. FAILURE TO MAINTAIN REQUIRED CERTIFICATIONS MAY RESULT IN IMMEDIATE DISMISSAL.

Pro Policy 100.3 – Staffing and Duties

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1.3.A. Staffing of Ambulances

All BLS ambulances will be staffed with a minimum of two (2) EMTs at all times.

All Paramedic/ALS ambulances will be staffed with a minimum of two (2) Paramedics at all times or by one (1) EMT and one (1) Paramedic when both crew members are specifically qualified by PRO to do so.

All ALS Intercept Units will be staffed by a minimum of one (1) Paramedic.

1.3.B. Duties

No matter what job or position you are hired for at PRO, always remember that there are times when you will be asked and required to perform duties that you may not like. There may be times when you are called upon to do transfers, sweep the garage, move ambulances, run errands, work as a driver, work as an attendant, teach EMS related subjects, and do other tasks as designated by a member of the Management Team or dispatcher. All personnel will be expected to accept this and cooperate.

Tasks should be equally divided as much as possible, but you must again realize and accept that it does not always work out that way. All types of duties are necessary to keep the company functioning at a high level. Afterward, if you have a reasonable question, by all means, address it to an appropriate person. We appreciate your help and understanding regarding this issue and this aspect of your employment.

Pro Policy 100.4 – Conduct Policy

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1.4.A. Guidelines for Appropriate Conduct

As an integral member of the PRO team, you are expected to accept certain responsibilities, adhere to high standards of personal conduct, and exhibit a high degree of personal integrity at all times. This not only involves showing sincere respect for the rights and feelings of others but also demands that you refrain from any behavior that might be harmful to you, your coworkers, PRO, or that might be viewed unfavorably by the people we service or by the public at large.

WHETHER YOU ARE ON OR OFF DUTY, YOUR CONDUCT REFLECTS ON PRO. YOU ARE, CONSEQUENTLY, REQUIRED TO OBSERVE THE HIGHEST STANDARDS OF PROFESSIONALISM AT ALL TIMES.

ANY TYPE OF BEHAVIOR AND/OR CONDUCT THAT PRO CONSIDERS INAPPROPRIATE COULD LEAD TO DISCIPLINARY ACTION UP TO AND INCLUDING TERMINATION OF EMPLOYMENT WITHOUT PRIOR WARNING, AT THE SOLE DISCRETION OF THE COMPANY.

Code of Conduct:

This list should not be viewed as being all- inclusive. Prohibited behaviors and/or conduct, include, but are not limited to, the following:

1. Falsifying employment or other PRO records;
2. Violating PRO's nondiscrimination and/or anti-harassment policy;
3. Soliciting gratuities from patients or the entities that we serve;
4. Establishing a pattern of excessive absenteeism or tardiness;
5. Reporting to work intoxicated or under the influence of non-prescribed drugs;
6. Illegally manufacturing, possessing, using, selling, distributing, or transporting illegal drugs;
7. Bringing or using alcoholic beverages on PRO property or using alcoholic beverages while engaged in PRO business off PRO's premises, except where authorized;
8. Fighting or using obscene, abusive, or threatening language or gestures;
9. Stealing property from coworkers, patients, entities that we serve, or PRO;
10. Having unauthorized firearms, weapons, or restraints such as handcuffs on PRO premises or while conducting PRO business;
11. Disregarding safety or security regulations;
12. Engaging in insubordination; and
13. Failing to maintain the confidentiality of patient information or PRO information.

IF YOUR PERFORMANCE, WORK HABITS, OVERALL ATTITUDE, CONDUCT, OR DEMEANOR BECOMES UNSATISFACTORY IN THE JUDGMENT OF PRO, BASED ON VIOLATIONS EITHER OF THE ABOVE OR OF ANY OTHER PRO POLICIES, RULES, OR REGULATIONS, YOU WILL BE SUBJECT TO DISCIPLINARY ACTION, UP TO AND INCLUDING DISMISSAL.

1.4.B. Courtesy and Politeness

Working in EMS is always a trying and testing position. When you are on the job or when you are wearing your uniform, you are seen as a representative of Professional Ambulance Service.

As a representative of the company, you must maintain a courteous, polite, and in control demeanor at all times.

Occasionally, you will be subject to verbal abuse, unsavory duties, and somewhat "difficult" people. When you find yourself in this position, remember that you are there for a reason. You are there to help a sick, injured, or infirm person. The people we serve depend on you and expect you to be neat, clean, courteous, polite, and in control of yourself and the situation you are dealing with.

Always be ready to work in concert with your partner and other people on the scene, not in conflict. If you lack any one of these attributes or if you disregard them, yourself, your patient, your coworkers, and the service will suffer. This is an unacceptable situation. You must always strive to be better and try harder for everyone concerned.

1.4.C. Discipline Process

(1) *Policy*
PRO, IN ITS SOLE DISCRETION, WILL DETERMINE WHEN TO WARN, REPRIMAND, OTHERWISE DISCIPLINE, OR DISCHARGE EMPLOYEES IN THE MANNER AND DEGREE PRO DEEMS APPROPRIATE.

(2) *Progressive Discipline*
Generally, PRO adheres to a progressive discipline policy; however, PRO may begin the discipline process at any step or advance to any step at PRO's sole discretion based on the circumstances at hand.

The levels of discipline are as follows:

1. Record of Conversation- documented and acknowledged via PRO's email.
2. Written Warning – documented on Corrective Action/Written Warning Form. A written warning could also be accompanied by a Decision Day.
3. Decision Day – documented on Decision Day Form and completed by the employee during paid time outside of PRO. A Decision Day is eight (8) hours paid time away from PRO to complete a form documenting the employee's decision as to whether they wish to remain employed at PRO. The employee must return for their next shift with either a letter of resignation; or the completed form that documents their acknowledgement and understanding of the inappropriate conduct, their commitment to absolutely correct the inappropriate conduct, and their acknowledgement and understanding that unless the inappropriate conduct is corrected, they will be discharged.
4. Discharge

(3) *Use of Disciplinary Action*
The Management Team is authorized to use disciplinary action in varying degrees.

- The Management Team is authorized to issue records of conversation, verbal warnings, written warnings, and relieve personnel from duty pending further action.
- The CEO or their designee is authorized to issue all levels of disciplinary action including Discharge.

(4) *Complaint/Conflict Resolution*
Employees may utilize the Complaint/Conflict Resolution Policy outlined in this handbook to dispute the administration of disciplinary action.

Pro Policy 100.5 – Uniform Policy

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1.5.A. Obtaining Uniforms

PRO provides every employee with uniforms. At the completion of your hiring process, you will complete a uniform survey indicating sizes and will receive your uniforms on your first day of employment.

Fulltime employees are credited $425.00 each calendar year (January – December) to purchase uniform items from the uniform store. Any unused credit will not be rolled over to the following calendar year.

Part-time employees are credited $250.00 to purchase uniform items from the uniform store each calendar year (January – December). Any unused credit will not be rolled over to the following calendar year. Please see a member of the Management Team with any questions.

1.5.B. Proper Uniform

All personnel are to wear their uniforms properly at all times when on duty. All employees must be in uniform for any training conducted at PRO unless otherwise authorized by management.

- Only PRO issued uniform items may be worn while on duty.
- A short sleeve or long sleeve t-shirt, issued by PRO, are the only items that may be visible under a uniform shirt, and they must remain as an under layer at all times. Only current PRO issued items may be visible as your top layer. Please plan accordingly for weather.
- One of the approved under-shirts listed above MUST be worn while on duty under the uniform shirt.
- You must wear your assigned radio and have it on at all times when on duty.
- Your uniform must remain clean, unwrinkled, neat, and in good repair. Uniform items that are faded, torn, or worn are not acceptable. If your uniform endures damage from anything other than natural wear and tear or your lack of care, please contact a member of the Management Team for direction of uniform piece replacement. This includes material or functional defects, fading or shrinkage.

Please note that some of your uniform pieces are covered with antimicrobial material that makes them safe for you and stain resistant, improper washing will reduce this feature for you, so please follow washing instructions on each care tag.

Uniform items include:

- PRO issued EMS pants with silver reflective striping;

- PRO issued Job shirt (embroidered);
- PRO issued blue polo shirt (embroidered);
- PRO issued t-shirt (short or long sleeve);
- PRO issued baseball hat (embroidered);
- PRO issued winter hat (embroidered);
- PRO issued Jacket with logo and patches;
- Any black boots with slip resistant traction;
- Any plain black belt;
- Appropriate radio clip/holster/harness.

You are responsible for the care and maintenance of your uniforms. *You should always have spare uniform items available. If for any reason your uniform becomes soiled during your shift, you are to return to quarters for your own spare uniform. If your uniform is damaged beyond cleaning or repair while working at a scene, please see a member of the Management Team for assistance in replacing it.*

YOU ARE REQUIRED TO WEAR YOUR UNIFORM IN A PROFESSIONAL MANNER AT ALL TIMES. THIS MEANS SHIRTS MUST HAVE A COLLAR AND BE TUCKED IN, NO BACKWARDS BASEBALL HATS, BOOTS LACED/ZIPPED, SHINED, AND NOT BLOUSED. YOUR PROFESSIONALISM WILL BE JUDGED BY THE PUBLIC BASED ON YOUR APPEARANCE.

1.5.C. Wearing Uniform When Not on Duty

No PRO employee shall wear an identifiable uniform item when not on duty. This particularly applies to wearing an identifiable uniform item in an establishment that serves alcohol. If it is your intention to go out after work, you should plan to have a change of clothes. ANY OFF-DUTY EMPLOYEE OBSERVED WEARING AN IDENTIFIABLE UNIFORM ITEM IN AN ESTABLISHMENT THAT SERVES ALCOHOL WILL BE SEVERELY DISCIPLINED UP TO AND INCLUDING DISCHARGE.

1.5.D. Personal Hygiene and Appearance

All personnel are required to present themselves at the beginning of their shift as someone proud to represent this organization and your profession. This presentation includes your personal hygiene. It is imperative that all employees are clean, showered, and presentable.

If an individual is emitting a malodorous air, from a uniform or his or her person, it is not fair to patients or partners. The offending party will be requested to shower or wash the uniforms at the base or asked to leave by a supervisor for the remainder of the shift. There will be no pay for this time lost. We are a professional organization and must present ourselves as such 24 hours per day 7 days a week.

Employees should wear their hair short or pinned back for their own safety. Unnaturally colored hair is not permitted, i.e. purple, blue, pink, etc.

Mustaches must be neat and trimmed. Facial hair that interferes with the seal of a respirator is not permitted.

Employees may not wear earrings that hang down. Generally, facial jewelry of any type is not permitted (a single stud in the nose is permitted). PRO discourages the wearing of large rings while on duty as they have the potential to cut through gloves, creating an environment of possible exposures.

Employees should not wear cologne or perfume while on duty. Your taste may not be that of another. Some patients may be allergic or made uncomfortable by these products.

Shoes and/or boots must be cleaned and shined. A shoeshine box is always available at the base. At no time are pants to be bloused into boots. At all times, boots must be zipped/laced and under PRO pants.

1.5.E. Professional Class B Uniform

All personnel will be issued a PRO Class B Uniform upon need:

- PRO issued navy blue button-down dress shirt;
- PRO issued black tie;
- PRO issued Pro EMS badge.

You will wear this uniform at events such as: Funerals, EMS Events, Court Dates, and any other time Management deems necessary. Uniforms must be returned for cleaning.

200 | Safety and Risk Management

Pro Policy 200.1 – Overview

Section:	Safety and Risk Management
Policy #:	200.1
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2.1.A. Introduction

Good safety risk management awareness and practice at all levels is a critical success factor for any EMS organization. Risk is inherent in everything that an EMS organization does including treating patients, determining service priorities, managing a project, purchasing new medical equipment, taking decisions about future strategies, or even deciding not to take any action at all. The PRO Risk Management Strategy provides the framework for the management of all risks, including organizational, financial, and clinical risks at every level of the organization. The aim of the strategy is to create a more coordinated, systematic, and focused approach to the management of risk.

2.1.B. Strategy objectives

1. Raise the quality of care provided by the PRO to patients, employees and others through the identification, control and elimination or reduction of all risks to an acceptable level.
2. Understand the underlying causes of adverse incidents and ensure that lessons are learned from the experience.
3. Ensure that managers and staff at all levels in the organization are clear of their personal responsibilities with regards to risk management.
4. Understand the many risks faced by PRO, their causes and cost and to transfer risks where unacceptable or unavoidable.
5. Provide a safe environment and facilities for patients, employees, and visitors.
6. Minimize the costs diverted to risk funding.
7. Maximize the resources available for patient services and care.

We have continued to revise and update our strategy and it now provides a system for evaluating the known or potential risks within PRO and then categorizing them into high, medium, low, or insignificant priorities.

Any areas that fall into the first three categories are entered onto a risk register with action plans to eliminate the risks, or at least reduce them to an acceptable level.

2.1.C. Risk Responsibilities

PRO splits its management of risk into financial and corporate, infrastructure, clinical, and health and safety. A number of individuals have specific management responsibilities:

(1) *Financial and Corporate Risk*

PRO has a responsibility to operate in line with GAAP and to ensure corporate risk is reduced through complying with all legal requirements related to tax, finance, and corporate structure. PRO regards as corporate, any risks that do not fall under the headings of financial, infrastructure, clinical or health and safety. The CEO and CFO have overall responsibility for all financial and corporate risk.

(2) *Infrastructure Risks*
The CEO is responsible for all risks arising out of the provision, use, operation and maintenance of PRO's vehicle fleet, its facility, and all its technology and communication systems.

(3) *Clinical Risk*
PRO has a duty of care to ensure its patients receive appropriate care in a safe environment and that all that can be done is done to minimize the risk of harm coming to its patients. This is done through learning lessons from complaints, claims, and from clinical incidents reported by staff. Additionally, PRO utilizes a formal CQI Plan that incorporates prospective, concurrent, and retrospective activities to track and address clinical risk. The PRO CQI Team has overall responsibility for clinical risk.

(4) *Health and Safety Risk*
As an employer, PRO has a specific responsibility to provide a safe working environment for its staff and any other individual (including patients) who are affected by the work of the organization. One way this is done is by learning lessons from incidents that are reported by staff and by proactively seeking to reduce health and safety risks. The COO has general responsibility for health and safety.

(5) *Infectious Disease Exposure*
This is found in its entirety in the Bloodborne Pathogen Exposure Control Plan, the Respiratory Protection Plan for TB, and the TB Exposure Control Plan.

(6) *Suspected Civil Risk*
Further information on PRO's plan to prevent any suspected civil risk can be found in PRO's CQI Plan, Health and Safety Plans, Policies and Procedure Manual, and Employee Handbook. Through the extensive in-house training and the continuing education of its employees, PRO hopes to minimize any civil risk associated with the company.

2.1.D. Overview

PRO is firmly committed to maintaining a safe and healthy work environment. To achieve this goal, PRO has implemented comprehensive safety policies. These policies are designed to prevent workplace injuries, accidents, and illnesses.

The success of any safety program depends on the safety consciousness and cooperation of everyone in the organization. Employees at every level are expected to assist PRO in the prevention of workplace accidents and injuries and are expected to follow all safety and health rules. It is the duty of each employee to adhere to all safety rules and to report any potential safety hazards to his or her supervisor immediately.

ANY INJURY THAT OCCURS ON THE JOB, EVEN A SLIGHT CUT OR STRAIN, MUST BE REPORTED IMMEDIATELY ON AN EMPLOYEE INCIDENT REPORT AND VERBALLY TO DISPATCH AND A MEMBER OF THE MANGEMENT TEAM, AS SOON AS POSSIBLE.

Workers' Compensation insurance is provided according to state law for occupational injuries or diseases. PRO pays for the cost of this insurance. Specific information regarding Workers' Compensation can be obtained from Human Resources.

More information regarding Employee Health and Safety can be found in Professional Ambulance's Health and Safety Plans.

ALL EMPLOYEES ARE RESPONSIBLE FOR WORKING SAFELY AND MAINTAINING A SAFE AND HEALTHY WORK ENVIRONMENT.

Pro Policy 200.2 – Duties of Employees

Section:	Safety and Risk Management
Policy #:	200.2
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2.2.A. Duties of the CEO

The CEO can be reached at 617-682-1808. The CEO is responsible for the overall implementation and maintenance of the organization's safety policies. The CEO's duties in regard to the safety policies include, but are not limited to the following:

1. Ensure that all members of the Management Team and supervisors are trained in workplace safety and are familiar with the safety and health hazards which employees under their immediate direction or control may be exposed to, as well as applicable laws, regulations and the organization's safety rules and policies;
2. Ensure that employees are trained in accordance with these safety policies and as required by federal, state, and local regulations;
3. Inspect, recognize, and evaluate work hazards on a continuing basis;
4. Develop methods for abating work hazards;
5. Ensure that work hazards are abated in a timely and effective manner;
6. Trace the cause of accidents, mishaps, and incidents;
7. Conduct periodic risk assessments within the organization; and
8. Conduct accident/illness investigations.
9. Chair the Safety Committee consisting of the Management Team and field providers. The CEO may assign some or all these tasks to other individuals.

2.2.B. Duties of Supervisors

All supervisors are responsible for the safety and health of the employees of PRO and for the safety and health of individuals who interact with PRO. To fulfill this duty, each supervisor must:

1. Become familiar with all applicable safety and health laws and regulations, and with the organization's rules and policies relating to workplace safety and health;
2. Ensure that all employees are properly trained in workplace safety and health. This includes training in general safe work practices, as well as specific instruction with respect to hazards specific to each employee's job assignment;
3. Ensure that all employees do, in fact, perform their work in a safe and healthy manner consistent with the organization's rules and policies;
4. Take all reasonable steps necessary to avoid unsafe working conditions, accidents, injuries, and illnesses;

5. Regularly inspect PRO offices and its equipment for workplace hazards and submit an Incident Report form to report any unsafe workplace conditions;
6. Ensure that unsafe and unhealthy working conditions are corrected promptly;
7. Immediately report all workplace accidents, injuries, illnesses, or “near misses”, to the CEO, using an Incident Report form; and
8. Serve on the Safety Committee as necessary and attend all required meetings.

2.2.C. Duties of Employees

All employees are required to conduct themselves in a manner consistent with PRO’s safety rules and policies. To fulfill this duty, each employee must:

1. Comply with all organizational safety rules, policies, and procedures;
2. Comply with all organizational operating rules, policies, and procedures;
3. Immediately report all workplace accidents, injuries or illnesses involving the employee, or to which the employee is a witness, to a supervisor or a member of the Management Team; and
4. Immediately report all unsafe conditions or hazards to a supervisor or a member of the Management Team by submitting an Incident Report form. Employees may report such conditions or hazards anonymously.

2.2.D. Contractors and Other Workers

In addition to all employees, this program covers all other workers who the organization contracts or directs and directly supervises on the job to the extent such workers are exposed to work site and job assignment specific hazards. All such workers must:

1. Attend all required meetings (including safety meetings);
2. Comply with all organizational safety rules, policies, and procedures;
3. Comply with all organizational operating rules, policies, and procedures;
4. Immediately report all workplace accidents, injuries or illnesses involving the employee, or to which the employee is a witness, to his or her supervisor or a member of the Management Team;
5. Immediately report all unsafe conditions or hazards to a supervisor or a member of the Management Team, using an Incident Report. Employees may report such conditions or hazards anonymously using this form; and
6. Such workers will receive appropriate training.

Pro Policy 200.3 – Hazard Assessment and Control

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2.3.A. Hazard Assessment and Control

PRO will conduct regularly scheduled safety and health inspections. These inspections will be performed as follows:

Office: Quarterly

Garage: Quarterly

Company Vehicles: Detailed Inspected – every 5,000 miles per vehicle recommendations
Daily upon use – visual spot check and cleaning

The purpose of these periodic inspections is to ensure that all identified hazards are corrected or controlled and to identify, correct and control any new hazards that have arisen in the workplace. A PRO Safety Inspection Report Form and/or Vehicle Checklists will be utilized during these inspections.

In addition to scheduled inspections and ongoing review, the Management Team may arrange for unscheduled, surprise inspections. The list of subjects for these inspections will be chosen randomly.

2.3.B. Employee Reporting of Hazards

Employees are required to immediately report any unsafe condition or hazard they discover in the workplace to a dispatcher and member of the Management Team. Submit an Incident Report Form for this purpose. No employee will be disciplined or discharged for reporting any workplace hazard or unsafe condition.

PRO takes all reports of unsafe conditions seriously. Prompt attention will be given to all actual and potential hazards that have been reported to the organization. PRO will inform the employee (if known to PRO) who reported the hazard of the action that was taken to correct the hazard or the reasons why the condition was determined not to be hazardous. There will be no discrimination against any employee who reports unsafe working conditions or workplace hazards. Indeed, employees are encouraged and required to do so.

2.3.C. Newly Discovered Safety and Health Concerns

PRO will respond to new workplace safety and health concerns as soon as they are discovered. All hazards will be corrected, controlled, or abated in a timely manner based on the severity of the hazard.

Any hazard that poses an imminent risk of harm to employees will be corrected immediately. All other hazards will be corrected as soon as feasible. If for any reason a hazard cannot be corrected, a member of the Management Team must be notified immediately, and a member of the Management Team will notify all exposed employees and follow all other notification requirements. Supervisors must report workplace safety and health concerns to a member of the Management Team immediately. The CEO or his designee will set a target date for correction of any hazards that cannot be abated immediately. Potentially affected employees will be notified of any newly identified hazard in a timely manner.

2.3.D. Hazards That Give Rise to a Risk of Imminent Harm

It is this organization's intent to immediately abate hazards which give rise to a risk of imminent harm. When a hazard exists that the organization cannot abate immediately without endangering employees and/or property, all exposed personnel will be removed from the area of potential exposure, except those necessary to correct the hazardous condition. All employees involved in correcting the hazardous condition will receive appropriate training and will be provided with necessary safeguards and personal protective equipment.

2.3.E. Correcting the Hazard and Preventing Recurrences

A member of the Management Team will ensure that the proper personnel are assigned responsibilities to take all steps necessary to correct the hazard and avoid similar accidents in the future. Preventive action will include, if necessary:

- Replacing all defective or broken tools and/or equipment.
- Revising or adding to the safety policies.
- Re-training Employees.
- Monitoring the hazard to ensure that it remains corrected or controlled.

2.3.F. Hazard Communication

(1) *Overview*

PRO believes communication with employees concerning workplace hazards and the methods used to control them will help create the safest possible work environment. PRO, therefore, places a great deal of importance on communicating with employees about health and safety issues.

PRO's system for communicating with employees on safety and health issues include:

- Providing a copy of the safety policies to every employee. Employees are required to read and be familiar with its terms.
- Safety Committee meetings will be held annually at a minimum and will be conducted by an employee designated by the CEO. The committee shall discuss issues such as:
    - New hazards that have been introduced or discovered in the workplace.
    - Causes of any recent accidents or injuries and the methods adopted by the organization to prevent similar incidents in the future.
    - Any health or safety issue deemed to be worthy of reinforcement.
- Minutes of all Safety Committee meetings will be documented.

(2) *Postings and Emails*

PRO will post and email safety or health information on a regular basis.

(3) *Company Memos*
PRO will regularly issue memos and health and safety information. Most often, these memos will be sent to all staff via email.

(4) *Training*
PRO has training requirements designed to instruct each employee on general safety procedures as well as on safety procedures specific to the employee's job. These training requirements are described in greater detail in the section entitled Safety and Health Training.

Pro Policy 200.4 – OSHA Regulations and Inspections

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2.4.A. Ongoing Workplace Review

Every member of the Management Team, supervisor, and employee must engage in daily, ongoing, safety and health monitoring and inspection of their work area. Any potential safety or health concerns should be reported to the dispatcher, a supervisor, or a member of the Management Team.

2.4.B. OSHA Regulations

The Occupational Safety and Health Act of 1970 requires employers to ensure, so far as possible, every working woman and man in the nation, safe working conditions. The Act also requires employees to comply with occupational safety and health standards, since the purpose of the Act cannot be obtained without the fullest cooperation of the employees.

The CEO will review and be familiar with the provisions of the OSHA regulations relevant to the organization's workplace. The Management Team must review, be familiar with, and train their employees with regard to the portions of the safety orders that apply to their particular function.

2.4.C. New Matters

The Management Team will arrange for an inspection/investigation of any new substance, process, procedure, or equipment introduced into the workplace. They will also arrange for an inspection and investigation whenever the organization is made aware of a new or previously unrecognized hazard.

2.4.D. Specific Health Care Concerns

The Management Team will ensure that all personnel in contact with patients are familiar with, and trained in, proper infection control and patient transfer procedures.

2.4.E. Documentation of Inspections

All scheduled or unscheduled inspections (except for the daily ongoing monitoring of work areas) will be documented on a Safety Inspection Report Form. If any item is rated as unsatisfactory, the person conducting the inspection must submit an Incident Report form. These reports will be retained by the organization forever electronically.

Pro Policy 200.5 – Safety Program and Training

Section:	Safety and Risk Management
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2.5.A. Enforcement of the Safety Program

VIOLATION OF PRO'S SAFETY POLICIES OR SAFETY RULES MAY RESULT IN DISCIPLINE UP TO AND INCLUDING TERMINATION.

2.5.B. Safety and Health Training

Awareness of potential health and safety hazards, as well as knowledge of how to control such hazards, is critical to maintaining a safe and healthy work environment and preventing injuries, illness, and accidents in the workplace. PRO is committed to instructing employees in safe and healthy work practices. To achieve this goal, the organization will provide training to employees on general safety procedures and on any specific safety procedures for each employee's job. Training will be provided as follows:

1. Upon hire;
2. Whenever an employee is given a new job assignment for which training has not previously been provided;
3. Whenever new substances, processes, procedures, or equipment that represents a new hazard are introduced into the workplace;
4. Whenever the organization is made aware of a new or previously unrecognized hazard; and
5. Whenever the organization, or the Management Team believes additional training is necessary.

2.5.C. Areas of Training for Employees

All employees will receive training on the following subjects:

- General Safe Work Practices
- Fire Procedures
- Safety Rules

In addition, employees will receive training on the specific hazards associated with their jobs.

2.5.D. Supervisor Training

Supervisors shall be apprised of, and provided with, appropriate training and instruction with regard to safety and health hazards to which employees may be exposed. To accomplish this task, the CEO or a designee will:

1. Conduct sessions for all supervisors informing them of any new substances, processes, procedures, or equipment that have been introduced into the workplace;
2. Distribute written safety and health communications to the supervisors whenever the CEO believes it necessary to inform them of particular hazards or concerns;
3. Update the organization's safety rules, procedures and policies on a regular basis, and distribute the updates to all supervisors; and
4. Take all other actions necessary to keep the organization's supervisors informed about workplace hazards that may affect their employees.

2.5.E. Documentation of Training

Training will be documented using attendance sheets and via Prodigy. This documentation will be retained forever electronically.

2.5.F. Safety Committee

A Safety Committee has been established at PRO; however, SAFETY IS EVERYONE'S RESPONSIBILITY. Safety will be discussed regularly at the Safety Committee Meeting. The Safety Committee is responsible for ensuring compliance with the requirements of the Act and Company policy by investigating and eliminating unsafe and unhealthy working conditions.

Pro Policy 200.6 – Patient Safety

Section:	Safety and Risk Management
Policy #:	200.6
Modified:	04/15/2024
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2.6.A. Transferring

All patients will be transferred to or from the ambulance on the stretcher when necessary. Patients, who are readily ambulatory, such as psychiatric patients who are not flight risks, can be walked under close supervision.

- STRETCHER PATIENTS WILL ALWAYS BE SECURED TO THE STRETCHER WITH THREE STRAPS AND THE SHOULDER HARNESS.
- When transporting a patient on a stretcher the patient will be turned on a level surface and brought headfirst to the waiting ambulance.
- When rolling a stretcher patient, the stretcher should be maintained at one-half height and must be carefully handled by both crew members.
- Never leave a stretcher patient unattended.
- Utilize Cot-Safe procedures.

These actions serve to prevent patient tipping injuries.

2.6.B. Carrying

When carrying a patient downstairs, the patient always travels feet first when sitting up, and feet first when lying flat.

WHENEVER AN EMPLOYEE DOES NOT THINK THAT HE OR SHE IS ABLE TO SAFELY LIFT OR CARRY A PATIENT, THE EMPLOYEE IS REQUIRED TO CALL FOR A LIFT ASSIST. ALWAYS ERR ON THE SIDE OF CAUTION AND CALL FOR A LIFT ASSIST IF YOU THINK THAT YOU MAY NEED ONE.

DO NOT SEEK ASSISTANCE FROM OR ALLOW ANY UNTRAINED BYSTANDER TO AID IN MOVING ANY PATIENT.

When transporting a patient on a scoop stretcher or backboard, at least three straps must be used to secure the patient. For patient and employee safety, the patient is transferred to the stretcher in a lowered position. The restraints from the stretcher are then used to secure the patient and backboard.

Pro Policy 200.7 – Employee Safety

Section:	Safety and Risk Management
Policy #:	200.7
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2.7.A. Overview

The key to employee safety regarding the use of lifting equipment and the movement of patients is proper body mechanics. Before lifting the patient, the employee evaluates the situation, makes certain they are aware of what needs to be done and assures they have the necessary equipment and assistance to accomplish the task.

The equipment is positioned by placing the wheelchair, stretcher, or other equipment, as close to the patient as possible and in proper alignment for the shortest and easiest transfer. Necessary adjustments are made by raising or lowering the equipment to bed level or vice versa, and by lowering any handrails or side rails. These steps minimize the amount of lowering or lifting required. The wheels on the chair or bed must be locked.

Transfer the patient by sliding them as far as possible on a draw sheet, then lifting them smoothly onto the stretcher or other equipment. Holding the patient close helps balance and reduces strain on the arms and back. Keeping the feet apart provides a stable base and helps maintain balance, leaving more energy for lifting. Employees should use their arms and legs in proper proportion. Bending the elbows to hold the patient close makes the lift easier.

Lifting is always done in unison. When working with others, everyone must know what to do in advance and move at the same time as a team. Counting out loud may help. Sudden, jerky movements are to be avoided.

2.7.B. Body Mechanics

Moving any object safely depends on knowledge and understanding of these basic guidelines:

(1) *Balance*
It takes a certain amount of effort just to balance the weight of one's own body. Keeping a low center of gravity over a stable base expends less energy by balancing the load, making more energy available for lifting and carrying.

(2) *Pull or Push When Possible*
Less energy is used to pull or push than to lift an object. When lifting or carrying, the force must be overcome, and the load balanced at the same time. By pulling or pushing, it is only necessary to overcome the friction between the object being moved and the surface on which it rests. The strongest muscles should be used.

(3) *Avoid Twisting*

If it is necessary to turn while lifting or moving something, it is better to change the position of the feet than to twist at the waist. By moving the feet, it is possible to balance the load being carried and minimize the strain on the back and abdominal muscles.

2.7.C. Common Lifting Techniques

The actual procedures used may vary slightly from those listed below, depending on the methods of training, the required movement, personnel, and materials available.

(1) From Stretcher

When transferring a patient from the stretcher, it is necessary to adjust the height, so it is even with the bed. The attendants should stand on either side of the patient and grasp the draw sheet at the patient's shoulders and hips. A third attendant may be needed to support a patient's legs. Pulling the draw sheet tight, the attendants move the patient across the stretcher to the bed. The same method should be utilized when transferring a patient from the bed to the stretcher.

(2) To Wheelchair

When helping a patient from a bed or stretcher to a wheelchair, the attendant should lift the patient, holding the patient around the waist. Holding the patient close, the attendant lifts, helping the patient rise to a standing position. The attendant then turns the patient and lowers him into the chair. Another method that is commonly used is where one attendant approaches the patient from behind, coming under the arms and grasping the patient's wrists. The second attendant takes the patient behind the knees and lifts the patient on a verbal count.

(3) *Think Ahead*

Attendants should always think ahead and be sure to assess each patient's medical condition, strength, mobility, etc. before attempting to lift or carry. The patient should be informed exactly as to what is going to happen, to calm any fears and encourage their cooperation.

(4) Don't Guess

Only those procedures with which the employee is familiar are to be used. Guessing what the procedure is, improvising, or failing to exercise proper judgment when lifting or moving a patient may be harmful to everyone.

2.7.D. Equipment

OPERATIONS GUIDELINES FOR POWER PRO XT STRETCHER

- Use the cot only as described in this manual.
- Read all labels and instructions on the cot before using the cot.
- Use a minimum of two (2) operators to manipulate the cot while a patient is on the cot. If additional assistance is needed.
- Do not adjust, roll, or load the cot into a vehicle without advising the patient. Stay with the patient and control the cot at all times.
- The ambulance cot can be transported in any position. Stryker recommends transporting the patient in as low a position as is comfortable for the operators to maneuver the cot.
- Only use the wheel lock(s) during patient transfer or without a patient on the ambulance cot.

- Always use the restraint straps.
- Use properly trained helpers when necessary to control the cot and patient.

WARNING

- Improper usage of the ambulance cot can cause injury to the patient or operator. Operate the ambulance cot only as described in this manual.
- Entanglement in powered ambulance cot mechanisms can cause serious injury. Operate the ambulance cot only when all persons are clear of the mechanisms.
- Practice changing height positions and loading the ambulance cot until operation of the product is fully understood. Improper use can cause injury.
- Do not allow untrained assistants to assist in the operation of the ambulance cot. Untrained technicians/assistants can cause injury to the patient or themselves.
- Do not ride on the base of the ambulance cot. Damage to the cot could occur, resulting in injury to the patient or operator.
- Transporting the cot sideways can cause the cot to tip, resulting in possible damage to the product and/or injury to the patient or operator. Transporting the cot in a lowered position, head, or foot end first, will minimize the potential of a cot tip.
- Grasping the cot improperly can cause injury. Keep hands, fingers, and feet away from moving parts. To avoid injury, use extreme caution when placing your hands and feet near the base tubes while raising and lowering the ambulance cot.

CAUTION
Before operating the cot, clear any obstacles that may interfere and cause injury to the operator or patient.

TRANSFERRING THE PATIENT TO THE COT

1. Roll the cot to the patient.
2. Place the cot beside the patient and raise/lower the cot to the level of the patient.
3. Lower the siderails and open the restraint straps.
4. Transfer the patient to the cot using accepted EMS procedures.
5. Use all the restraint straps to secure the patient to the cot.
6. Raise the siderails and adjust the backrest and leg rest as necessary.

WARNING

- Always use all restraint straps to secure the patient on the cot. An unrestrained patient may fall from the cot and be injured.
- Never leave a patient unattended on the ambulance cot or injury could result. Hold the ambulance cot securely while a patient is on the product.
- Never apply the optional wheel lock(s) while a patient is on the cot. Tipping could occur in the cot is moved while the wheel lock is applied, resulting in injury to the patient or operator and/or damage to the cot.
- Side rails are not intended to serve as a patient restraint device. Failure to utilize the side rails properly could result in patient injury.

- Hydraulically raising and lowering the cot may temporarily affect electronic patient monitoring equipment. For best results, patient monitoring should be conducted when the cot is idle.

USING THE SLIDE BOARD

When transferring large patients, use of the slide board is recommended.

AMBULANCE COT MOTION

1. Make sure all the restraint straps are securely buckled around the patient.
2. The cot shall be at designated rolling height.
3. When rolling the cot with a patient on it, position an operator at the foot end and one at the head end of the cot **at all times**.
4. During transport, approach door sills and/or other lower obstacles squarely and lift each set of wheels over the obstacle separately.

WARNING
High obstacles such as curbing, steps or rough terrain can cause the ambulance cot to tip, possibly causing injury to the patient or operator. Transporting the cot in lower positions can reduce the potential of a cot tip. If possible, obtain additional assistance or take an alternate route.

CAUTION
The ambulance cot can be set at any height position. Establish the required load height for the ambulance cot prior to placing the unit into service.

LOADING THE COT INTO A VEHICLE WITH TWO OPERATORS – POWERED METHOD

WARNING
Ensure proper hand placement on hand grips. Hands should be clear of red safety bar pivots while loading and unloading the cot.

Loading an occupied cot into the vehicle requires a minimum of **two (2) trained operators**.

When loading the cot into a vehicle, an operator should remember the following important issues:

- There must be a safety hook properly installed in the vehicle so that the bumper does not interfere with the front legs of the base frame.

WARNING
Failure to install and use the vehicle safety hook can result in injury to the patient or operator. Installed and use the hook as described in this manual.

- Cot operators must be able to lift the total weight of the patient, cot, and any items on the cot. The higher an operator must lift the cot, the more difficult it becomes to hold the weight. An operator may need help loading the cot if he is small or if the patient is too large to lift safely.

CAUTION

Loading, unloading, or changing the position of a loaded ambulance cot requires a minimum of **two (2) trained operators**. The operator (s) must be able to lift the total weight of the patient, cot, and any other items on the cot.

Place the cot in a loading position (any position where the loading wheels meet the vehicle floor height). Roll the cot to the open patient compartment. Lift the vehicle bumper to the raised position (if possible). Push the cot forward until the load wheels are on the patient compartment floor and the safety bar passes the safety hook.

For maximum clearance to lift the base, pull the cot to lift the base, pull the cot back until the safety bar engages the safety hook. Operator two should verify that the bar engages the safety hook.

Operator 1- Grasp the cot frame at the foot end and push the retract (-) button until the undercarriage of the cot retracts fully.

Operator 2- Securely grasp the cot outer rail to stabilize the cot during retraction.

Both Operators- Push the cot into the patient compartment, until the cot engages the cot fastener.

WARNING
When using a standard ambulance cot fastener, do not load the cot into the vehicle with the head section retracted. Loading the cot with the head section retracted may cause the product to tip or not engage properly in the cot fastener, possibly causing injury to the patient or operator and/or damage to the cot.

HIGH SPEED RETRACT/EXTEND

- The ambulance cot is equipped with a high-speed retract mode to expedite loading/unloading the cot into and out of a vehicle.
- The undercarriage rapidly retracts towards its uppermost position once the weight of the ambulance cot and patient is off the wheels. Press the retract (-) button to actuate the control switch.
- The undercarriage rapidly extends towards its lowermost position once the weight of the ambulance cot and patient is off the wheels. Press the extend (+) button to actuate the control switch.

WARNING
Whenever the weight of the ambulance cot and patient is off the wheels, the ambulance cot will automatically enter the high speed retract mode is the retract (-) button is pressed.

Once the weight is off the ground, the operator(s) must support the load of the patient, ambulance cot and any accessories. Failure to support the load properly may cause injury to the patient or operator.

LOADING THE COT (OCCUPIED) INTO A VEHICLE WITH TWO OPERATORS AT THE FOOT END

WARNING
Ensure proper hand placement on hand grips. Hands should be clear of red safety bar pivots while loading and unloading the cot.

1. Place the cot in a loading position (any position where the loading wheels meet the vehicle floor height). Roll the cot to the open patient compartment. Lift the vehicle bumper to the raised position (if possible).
2. Push the cot forward until the load wheels are on the patient compartment floor and the safety bar passes the safety hook.
3. For maximum clearance to lift the base, pull the cot back until the safety bar engages the safety hook. One operator should remain at the foot end while the second operator engages the safety hook as described above.
4. The second operator should return to the foot end both operators should lift the cot while one operator push the retract (-) button until the undercarriage of the cot retracts fully.
5. Both operators should push the cot into the patient compartment, until the cot engages the cot fastener (not included).

LOADING AN EMPTY COT INTO A VEHICLE (SINGLE OPERATOR) – POWERED METHOD

Loading an **unoccupied** cot into the emergency vehicle can be accomplished by a single operator.

WARNING
The one person loading and unloading procedures are for use only with an empty ambulance cot. Do not use the procedures when loading/unloading a patient. Injury to the patient or operator could result.

1. Place the ambulance cot into a loading position (any position where the load wheels of the head section meet the vehicle floor height).
2. Roll the ambulance cot to the open door of the patient compartment.
3. Lift the vehicle bumper to the raised position (if possible).
4. Push the ambulance cot forward until the load wheels are on the patient compartment floor and the safety bar passes the safety hook.
5. For maximum clearance to lift the base, pull the ambulance cot until the safety bar engages the safety hook. Operator two should verify that the bar engages the safety hook.
6. Grasp the ambulance cot frame at the foot-end and press the retract (-) button, until the undercarriage of the ambulance cot retracts into its uppermost position.
7. Push the ambulance cot into the patient compartment until the ambulance cot engages the cot fastener.

WARNING
When using a standard ambulance cot fastener, do not load the cot into the vehicle with the head section retracted. Loading the cot with the head section retracted may cause the cot to tip or not engage properly in the cot fastener, possibly causing injury to the patient or operator and/or damage to the cot.

<u>LOADING AND UNLOADING OF THE COT INTO AND OUT OF A VEHICLE WILL BE ACCOMPLISHED USING THE STRYKER POWERLOAD SYSTEM</u>

<u>ABSENT POWERLOAD SYSTEM FUNCTIONALITY THE FOLLOWING PROCEDURES WILL BE USED</u>:

UNLOADING THE COT FROM A VEHICLE- POWERED METHOD

Unloading the cot from the vehicle while a patient is on the cot requires a minimum of **two (2) operators**, positioned at each end of the ambulance cot. Each operator must grasp the ambulance cot frame securely.

Disengage the cot from the cot fastener.

Lift the vehicle bumper to the raised position (if possible).

WARNINGS
Do not press the extend (+) button until the safety bar engages the safety hook.

1. Operator 1- Grasp the ambulance cot out of the patient compartment until the safety bar engages the safety hook. Operator two should verify that the bar engages the safety hook.

To avoid injury, verify the safety bar has engaged the safety hook before removing the ambulance cot from the patient compartment.

2. Operator 2– Stabilize the cot during the unloading operation by securely grasping the outer rail.
3. Operator 1– Depress the extend (+) button to lower the undercarriage to its fully extended position.
4. Operator 2– Push the safety bar release lever forward to disengage the safety bar from the safety hook in the patient compartment.

Do not pull or lift on the safety bar when unloading the cot. Damage to the safety bar could result in injury to the patient or operator could occur.

5. Remove the load wheels from the patient compartment of the vehicle.

CAUTION
- When unloading the cot from the patient compartment, ensure the caster wheels are safely set on the ground or damage to the product may occur.
- Do not "jog" the cot past the load height while the safety bar is engaged.

LOADING THE COT INTO A VEHICLE- MANUAL METHOD

To load the cot with the manual release:

Place the cot in a loading position (any position where the loading wheels meet the vehicle floor height). Roll the cot to the open door of the patient compartment. Lift the vehicle bumper to the raised position (if possible).

Push the cot forward until the loading wheels are on the patient compartment floor and the safety bar passes the safety hook.

For maximum clearance to lift the base, pull the cot back until the safety bar engages the safety hook.

Operator 1 – Grasp the cot frame at the foot end. Lift the foot end of the cot until the weight is off the latching mechanism. Squeeze and hold the release handle.

Operator 2 – Stabilize the cot by placing your hand on the outer rail. Grasp he base frame, after the foot end operator has lifted the cot and squeezed the release handle, raise the undercarriage until it stops in the uppermost position and hold it there,

Both Operators – Push the cot into the patient compartment, engaging the cot fastener. NOTE – When operating the manual release, avoid rapid lifting or lowering of the base or movement may appear sluggish; lift with a slow constant motion.

UNLOADING THE COT FROM A VEHICLE WITH TWO OPERATORS– MANUAL METHOD

Unloading the cot from the vehicle while a patient is on the cot requires a minimum of **two (2) operators**, positioned at each end of the ambulance cot. Each operator must grasp the ambulance cot frame securely.

Disengage the cot from the cot fastener. Lift the vehicle bumper to the raised position (if equipped).

Operator 1 – Grasp the ambulance cot frame at the foot end. Pull the manual release lever to lower the undercarriage to its fully extended position. Pull the cot out of the patient compartment until the safety bar engages the safety hook. Operator two should verify that the bar engages the safety hook.

WARNINGS
To avoid injury, verify the safety bar has engaged the safety hook before removing the ambulance cot from the patient compartment.

1. Operator 2 – Stabilize the cot during the unloading operation by securely grasping the outer rail.
2. Operator 2 – Push the safety bar release lever forward to disengage the safety bar from the safety hook in the patient compartment.

Do not pull or lift on the safety bar when unloading the cot. Damage to the safety bar could result and injury to the patient or operator could occur.

Remove the load wheels from the patient compartment of the vehicle.

CAUTION
When unloading the cot from the patient compartment, ensure the caster wheels are safely set on the ground or damage to the product may occur.

UNLOADING THE COT FROM A VEHICLE WITH ONE OPERATOR– MANUAL METHOD

Unloading an **unoccupied** ambulance cot from a vehicle can be accomplished by a single operator.

WARNING
The one person loading and unloading procedures are for use only with an empty ambulance cot. Do not use the procedures when unloading a patient. Injury to the patient or operator could result.

1. Disengage the cot from the cot fastener.

2. Grasp the cot frame at the foot end. Pull the manual release lever to lower the undercarriage to its fully extended position. Pull the cot out of the patient compartment until the safety bar engages the safety hook. Operator two should verify that the bar engages the safety hook.
3. Push the safety bar release lever forward to disengage the safety bar from the safety hook in the patient compartment.

WARNING
Do not pull or lift on the safety bar when unloading the cot. Damage to the safety bar could result and injury to the patient or operator could occur.

4. Remove the load wheels from the patient compartment of the vehicle.

CAUTION
When unloading the ambulance cot from the patient compartment, ensure the caster wheels are safely set on the ground or damage to the product may occur.

Hydraulic fluid will become more viscous when the cot is used for extended periods in cold temperatures.

When using the manual release function to extend the base during unloading in cold weather conditions, hold the release lever engaged for approximately one second after the cot wheels touch the ground to minimize sagging of the litter as the cot is removed from the ambulance.

ADJUST THE COT HEIGHT

Changing height of the cot while a patient is on the cot requires a minimum of **two (2) operators**, positioned at each end of the ambulance cot.

Operator 1 – Grasp the ambulance cot frame at the foot-end. Actuate the control switch, depress either the (+) or (-) button depending on desired travel direction, and allow the littler to raise/lower to the desired position.

Operator 2 – Maintain a firm grip on the outer rail until the ambulance cot is securely in position.

WARNING
Grasping the ambulance cot improperly can cause injury. Keep hands, fingers and feet away from moving parts. To avoid injury, use extreme caution when placing your hands and feet near the base tubes while raising and lowering the ambulance cot.

NOTE: If the push button switch remains activated, the motor will remain halted until the operator releases the button. Once the push button is released, actuate the extend (+) button again to “jog” the cot height up further.

CAUTION
Do not “jog” the ambulance cot past the established load height of the product when the safety bar engages the vehicle safety hook or damage may occur to the product.

OPERATING THE RETRACTABLE HEAD SECTION

The head section telescopes from a first position suitable for loading the ambulance cot into an emergency vehicle to a second position retracted within the litter frame. When retracted, the ambulance cot can roll in any direction on the caster wheels even in the lowest position, allowing improved mobility and maneuverability.

To extend the head section:

1. Grasp the outer rail with one hand for support and release the lever, rotate the lever towards the head end of the cot to release the head section from the locked position.
2. While holding the handle in the released position, pull the head section away from the litter frame, lengthening the head section until it engages in the fully extended position.

To retract the head section:

1. Grasp the outer rail with one hand for support and release the lever, rotate the lever towards the head end of the cot to release the head section from the locked position.
2. While holding the handle in the released position, push the head section toward the litter frame, retracting the head section until it engages in the retracted position.

WARNING
To avoid injury, always verify that the head section is locked into place prior to operating the ambulance cot.

When using a standard ambulance cot fastener, do not attempt to load the ambulance cot into the patient compartment with the head section retracted. Loading the ambulance cot with the head section retracted may cause the cot to tip or not engage properly in the cot fastener, possibly causing injury to the patient or operator and/or damage to the cot.

BATTERY OPERATION

The ambulance cot is supplied with two removable 24-volt batteries as the power source. To install the battery, align the tabs in the battery enclosure and push the battery into the enclosure until the latch clicks into place.

To remove the battery, locate the **red** battery release along the patient left side of the foot end control enclosure. Push the battery release the latch. Slide the released battery out of the left.

To reinstall the battery, align the tabs in the battery enclosure and push the battery into the enclosure until the latch clicks into place. The indicator will light GREEN, if the battery is fully charged or has adequate battery power. If the indicator flashes red, the battery needs to be charged or replaced.

NOTE: Keep your spare battery on the charger at all times. Batteries slowly lose power when not on the charger.

WARNING

- To avoid risk of electric shock, never attempt to open the battery pack for any reason. If the battery pack case is cracked or damaged, do not insert it into the charger. Return damaged battery packs to a service center for recycling.
- Do not remove the battery when the ambulance cot is activated.
- Avoid contact with a wet battery enclosure. Contact may cause injury to the patient or operator.

CAUTION
Remove the battery if the cot is not going to be used for an extended period of time (over 24 hours).

CLEANING

The POWER PRO XT STRETCHER ambulance cot is designed to be power washable. The unit may show some signs of oxidation or discoloration from continuous washing; however, no degradation of the cot's performance characteristics or functionality will occur due to power washing as long as the proper procedures are forward.

Thoroughly clean the cot once a month. Clean Velcro AFTER EACH USE. Saturate Velcro with disinfectant and allow disinfectant to evaporate. (Appropriate disinfectant for nylon Velcro should be determined by the service.)

WASHING PROCEDURE

- **Remove the battery!** The battery and charger are not immersible or power washable.
- Follow the cleaning solution manufacturer's dilution recommendations exactly.
- The preferred method Stryker Medical recommends for power washing the ambulance cot is with the standard hospital surgical cart washer or handheld wand unit.

WASHING LIMITATIONS

WARNING
Use any appropriate personal safety equipment (goggles, respiratory, etc.) to avoid the risk of inhaling contagion. Use of power washing equipment can aerate contamination collected during the use of the cot.

CAUTION
- DO NOT STEAM CLEAN OR ULTRASONICALLY CLEAN THE UNIT.
- Maximum water temperature should not exceed 180Deg F / 82Deg C.
- Maximum air-dry temperature (cart washers) is 240Deg / 115Deg C.
- Maximum water pressure should not exceed 1500 psi / 130.5 bar. If a handheld wand is being used to wash the unit, the pressure nozzle must be kept a minimum of 24 inches (61 cm) from the unit.
- Towel dry all casters and interface points.
- Failure to comply with these instructions may invalidate any/all warranties.
- Remove the battery before washing the cot.

In general, when used in those concentrations recommended by the manufacturer, either phenolic type or quaternary type disinfectants can be used. Iodophor type disinfectants are not recommended for use because staining may result.

Suggested cleaners for the cot surfaces are:

- Quaternary Cleaners (active ingredient – ammonium chloride)
- Phenolic Cleaners (active ingredient – o-phenyl phenol)
- Chlorinated Bleach Solution (5.25% – less than 1 part bleach to 100 parts water)

Avoid over saturation and ensure the cot does not stay wet longer than the chemical manufacturer's guidelines for proper disinfecting.

WARNING
SOME CLEANING PRODUCTS ARE CORROSIVE AND MAY CAUSE DAMAGE TO THE COT IF USED IMPROPERLY. If the products above are used to clean the cots, measures must be taken to ensure the cots are wiped with clean water and thoroughly dried following cleaning. Failure to properly rinse and dry the cots will leave a corrosive residue on the surface of the cots, possibly causing premature corrosion of critical components.

NOTE: Failure to follow the above directions when using these types of cleaners may avoid this products warranty.

WARNING
Failure to properly clean or dispose of contaminated mattress or cot components will increase the risk of exposure to blood borne pathogens and may cause injury to the patient or the operator.

Use of the Stair Chair – STRYKER Chair Pro

These guidelines are based on a STRYKER Chair Pro stair chair. The STRYKER Chair Pro chair is designed to aid in the movement of a patient in a seated position either by rolling on the wheels or by carrying in situations where a larger device, such as a stretcher, cannot be maneuvered. These instructions are general. Attendants should secure the patient with restraints and should never leave the patient unattended.

(1) *Operational Features*
The maximum load on this specific piece of equipment is 500 pounds (159 kg). To open the chair, grasp the seat and back frame and separate them. The chair should be unfolded completely with the locks engaged. The locking of the chair should be confirmed visually by checking that both sides of the lock bar are engaged. The locking of the chair should also be confirmed visually by checking that both sides of the lock bar are engaged over the crossbar. To fold the chair, lift the lock bar, grasp the seat frame, and pull it toward the head frame.

(2) *Carrying Handles*
Handles are provided at the head and the foot of the chair. Handles should be used on all transports. A firm grip on the handles with the palms of the hands is necessary because the palms are stronger than the fingers alone. If you elect to not use the handles on the chair you must be certain that your grip is certain and sure.

(3) *Restraints*
The chair is equipped with two restraints for patient security. They should be used whenever there is a patient on the chair. The restraints support the patient's legs and feet, preventing them from swinging their legs from side to side. The other restraint is secured around the patient's chest to ensure that the patient does not fall off the side.

(4) *Placing the Patient*
A recognized patient handling technique should be used to place the patient on the chair.

(5) *Securing the Patient*
After placing the patient on the chair and fastening the restraints, the attendants move to positions at the front and rear of the chair. The rear attendant grasps the chair frame then tilts the chair back until the weight is balanced on the chair wheels. The chair can be rolled without lifting.

(6) *Carrying the Patient*
To carry the patient, the same tilt-back and balance procedures are used. The attendants grasp the front and rear carrying handles simultaneously, using the "3" count method. On level surfaces, the front carrying handles should be in the stored position. The front attendant may face either direction while carrying. When carrying on stairs, the front attendant should have the carrying handles in the up position and should face the patient.

2.7.E. Breaks and Rest Cycles

PRO allows all field providers who work shifts of more than four (4) consecutive hours, a reasonable rest period with pay. All employees shall be authorized and permitted to take rest periods which, insofar as practicable shall be in the middle of each work period. Employees are also afforded a rest period between the hours of 22:00 – 06:30. PRO may interrupt a rest period for emergency calls, non-emergency calls, stand-bys, and post coverage when necessary.

The personal use of any **hospital linens** is **strictly prohibited**.

Pro Policy 200.8 – Loss Control

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Policy #:	200.8
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It is the intent of PRO to provide a safe environment for all its employees. Accident and injury prevention is an important part of your job. By working together, we can achieve a safer workplace. Your ideas and safe working practices are extremely important to a successful safety program. PRO will endeavor to make safety everyone's responsibility. The purpose of a loss control program is to protect our employees, the patient, and the organization. Its main function is to eliminate or reduce hazards within our organization, which in turn decreases the probability of loss. When losses occur, they

adversely affect productivity, efficiency, and health. Loss Control's objective is to minimize the adverse effects of these factors in our workplace. A few individuals cannot accomplish this goal; it requires every employee to become involved in order for it to be successful. PRO's ongoing process to manage loss control and risk involves all aspects of PRO's safety policies and is predominantly focused on the work of the Safety Committee. The Safety Committee manages the ongoing process of assessing risk and mitigating hazards through observation and subsequent implementation of improved practices and/or safety measures. Safety Committee minutes will show assessed risks, the follow-up plan implemented to reduce risks and the results of these efforts.

Pro Policy 200.9 – Accidents

Section:	Safety and Risk Management
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2.9.A. Vehicle Contacts

When you consider the amount of time you spend driving, your chance of a vehicle contact certainly increases by virtue of being on the road all day. It is understandable that some vehicle contacts are avoidable while others are not.

As an employee of PRO, you have been instructed in the safe operation of an emergency vehicle. It is imperative to understand exactly what to do if you find yourself involved in a company vehicle contact.

2.9.B. General Guidelines

(1) *Vehicle Contact Information*

If you are involved in a vehicle contact with a company vehicle:

All vehicle contacts involving company vehicles will be reported immediately to the dispatcher who will notify a member of the Management Team. If you are injured and are able to visually assess the situation notify dispatch of what kind of help you require. If you are not injured, you are to assess the situation and instruct dispatch of the help you require. It is important to render medical assistance to any other party involved.

Dispatch must be notified immediately after the incident. An incident report form must be submitted, and the Insurance form must be filled out and sent to a member of the Management Team.

At a minimum the following information should be obtained:

- Name and address of operator;
- Name and address of owner;
- Make, model, and year of vehicle involved;
- Registration number of vehicle and validity of inspection sticker;
- Driver's license number/state of operator;
- Insurance company;
- Names and addresses of all passengers;
- Names and addresses of all injured parties;
- Location and time;
- Damage sustained to all vehicles;
- Name of responding police officer (if applicable);

- Photograph the ambulance with close ups of damaged areas;
- Photograph other vehicle(s) involved with close ups of any damage;
- The street behind and ahead of the vehicle contact; and
- Any stationary objects involved in the vehicle contact;

(2) *Vehicle contacts occurring with a patient on board.*

If the patient being transported is stable, there are no injuries, and damage is minimal, advise the other party or parties involved that police are en route and proceed to the hospital with your patient. Advise dispatch of the location of the accident

If the patient being transported is unstable, no serious injuries have been incurred, and damage is minimal, advise the other party involved that the police and another ambulance are en route and proceed to the hospital with your patient. Advise dispatch of the location of the accident.

In situations where the patient is stable and injuries have been incurred, notify dispatch to send any help that you require. If the patient being transported and crew are uninjured, you are to remain on scene until another ambulance arrives, then proceed to the hospital with your patient.

In situations where there is an unstable patient and serious injuries are incurred, the crew should exercise their best judgment and request assistance from dispatch.

(3) *Vehicle contacts occurring while responding to a call.*

If you are involved in a vehicle contact while responding to an emergency call you must notify dispatch immediately. If another ambulance is available to respond within a reasonable time frame the dispatcher will send another ambulance to the original call.

Dispatch may determine that the circumstances dictate that the ambulance involved in the vehicle contact should continue on the original response based on the nature of the call or an inordinate delay in the response of another unit. If there are no injuries, and damage is minimal, advise the other parties involved that police are en route and proceed to the emergency call.

In situations where injuries have been incurred, notify dispatch to send any help that you require and render treatment and transport as necessary.

2.9.C. Accident Investigation and Review

All work-related accidents will be investigated in a timely manner. Minor incidents and near misses will be investigated as well as serious accidents. A near miss is an incident that, although not serious, could have resulted in a serious injury or significant property damage. Investigation of these instances may avoid serious accidents in the future.

(1) *Responsibility For Accident Investigation*

A member of the Management Team must investigate all work-related accidents. They will ensure that the investigation was thorough, and that proper action has been taken to avoid similar accidents in the future.

(2) *Procedures for Investigating Accidents*

All accidents shall be investigated as soon as possible. In conducting an inquiry, the member of the Management Team investigating the accident, at a minimum, shall (if applicable):

- Make contact with all employees involved.
- Interview witnesses to the accident either at the scene or as soon after the accident as possible.
- Ensure the employee(s) has submitted an Incident Report through ePro (ESO)
- Save or preserve all evidence including telematics (Samsara) and any physical evidence.

(3) *Reporting Procedures*

Accidents resulting in personal injury, or death shall be reported to the Office of Emergency Medical Services (OEMS) immediately following any accident involving an ambulance. Any accident with personal injury or significant property damage shall be reported to OEMS within five (5) days.

All Accident Reports and Incident Reports must be completed by both crew members prior to the end of your shift.

All employees will document any injuries sustained. Any employee involved in an accident will not make any statement to anyone on scene, aside from the responding officer and the Management Team.

2.9.D. Safety Committee

The Safety Committee will review selected accidents involving a PRO vehicle as determined by the CEO. Employees involved in a collision will be invited to attend the meeting in order to present the facts of the case. The Safety Committee will make a ruling based upon whether it could be deemed as a preventable accident. The employee will be notified of the ruling immediately following the meeting.

Pro Policy 200.10 – Infection Control Procedure

Section:	Safety and Risk Management
Policy #:	200.10
Modified:	04/15/2024
Reviewed:	04/15/2024

See Professional Ambulance Service Health and Safety Plans in ePro.

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Pro Policy 300.1 – Beginning of Shift Duties

Section:	Operations
Policy #:	300.1
Modified:	04/15/2024
Reviewed:	04/15/2024

3.1.A. Arriving on Time

Crews are encouraged to arrive at least 15 minutes prior to scheduled start time for a shift in Cambridge and encouraged to arrive 30 minutes early when working in the Emerson Service Area. It is your responsibility to determine ambulance assignment and prepare your vehicle for service by your scheduled start time.

3.1.B. Ambulance and Equipment Assignment

After punching in you should immediately:

- Alert the dispatcher you are in; and
- Determine your ambulance assignment.

3.1.C. Preparing Your Vehicle for Service

(1) *Cleanliness*

Vehicles should be cleaned (interior and exterior). Your assigned vehicle should have been cleaned by Support Services and have a Green Check Tag. If your vehicle does not have a Green Tag or is not clean it is your responsibility to notify a member of the Management Team. This will allow the Management Team to address the problem with Support Services. You may need to clean, check, and stock your unit.

(2) *Equipment Readiness*

Vehicle restocking should occur after every shift. The crew should ensure that there is a Green Tag in the unit they are assigned to before removing the unit from the garage. The Green Tag shows that the unit has been checked by a Support Services Technician.

If for any reason the Green Tag is not in the vehicle you should alert support services. Regardless, you should always do a walk around exterior inspection noting the following:

- Presence of fluids on ground under vehicle;
- Condition of tires (low pressure, cuts, bubbles, missing lug nuts, etc.); and
- Emergency light operations.

While the vehicle is checked regularly, it is good practice to walk around your ambulance prior to operating the vehicle.

Report any and all vehicle problems, broken equipment or damage to the dispatcher and a member of the Management Team. Submit an Incident Report form on ePro. The absence of an Incident Report signifies no damage/no repairs needed and that the vehicle, when assigned, was in perfect working order.

(3) *PSTrax*

See policy on Controlled Substances.

3.1.D. Placing Your Ambulance In-service

After preparing your vehicle for service, as outlined in the preceding section, you should carry out the following steps to place your vehicle in service:

1. Retrieve the appropriate radio and tablet from dispatch.
2. Gather your belongings (lunch bag, cooler, rain gear, backpack, etc.) and place them in your ambulance in such a way as to keep them from becoming projectiles in a crash i.e. secured behind seats.
3. Ensure that a Green Tag is on the dashboard.
4. If you are assigned to an ALS Unit, ALS crew members must complete the PSTrax Controlled Substances Check for each set of narcotics.
5. You should immediately leave the base and head to your posting location, appropriate facility as directed by the dispatcher, or a centralized location. Throughout your shift the dispatcher will assign you to a specific post. Assignments can come over the radio or by the paging system. It is your responsibility to proceed directly to the assigned post area once you have been instructed by the dispatcher.

Pro Policy 300.2 – During Shift Duties

Section:	Operations
Policy #:	300.2
Modified:	04/15/2024
Reviewed:	04/15/2024

3.2.A. Crew Member Responsibilities

(1) *Driver*

Responsible for mechanical aspects of vehicle and tools, clean-up, make-up and restocking following calls. The driver also has a responsibility to assist the attendant with paperwork and other duties when necessary or requested.

The driver is also primarily responsible for reporting the following events to dispatch for entry into Zoll RescueNet Dispatch - Billing:

- Vehicle in service and start of shift;
- Acknowledging call;
- En route to scene (“Responding”);
- On scene (“Out”);
- Pt contact;
- Delayed on scene/waiting;
- Transporting (“Occupied”);
- On arrival at destination/facility (with mileage);
- Delayed at destination/facility;
- Clear/in service; and
- Returning to/In the primary service area (“City”).

(2) *Attendant*

Primarily responsible for patient care when the unit is occupied. Responsible for completing paperwork (keep in mind both crew members are responsible for what is in the paperwork). The attendant is also responsible to assist the driver with clean-up, restocking, and other duties when necessary or requested.

Remember, these are the divisions of labor, but they should not prohibit crew members and crews from working together and assisting in proper completion of all duties.

If your partner or another crew needs and/or asks for assistance, and your duties are completed or not as pressing, step in and help.

Develop a good working relationship with your partner, not an adversarial or mechanical one. Without working together on a scene, be it a routine transfer or a life-threatening emergency, the

only people who suffer will be the patients. Personal disputes and individual personal problems are your own. Do not bring them to a scene and impose them on a patient's safety or comfort. Doing so is unacceptable and inexcusable.

3.2.B. Returning to Service Following a Call

Returning to service and getting ready to respond to the next call is critical. Once patient care is properly transferred to the receiving staff, the crew's primary focus must be on getting back in service and becoming ready to respond to the next call.

This means:

- Equipment cleaned and replaced;
- Ambulance cleaned and disinfected; and
- Stretcher made with a sheet, blanket, pillow, and towel.

Paramedic crews must pay particular attention to this due to the nature of their make-up, equipment replacement, and limited availability. With limited ALS resources in this and surrounding communities, paramedic crews must get ready to respond to the next call immediately and without delay. This means both members working to get in service first with the paperwork coming second.

PAPERWORK MUST BE COMPLETED WITH IN 45 MINUTES AFTER COMPLETING THE CALL.

If at all possible, paperwork should be completed after calling in service but prior to departing the receiving facility. A copy of the completed paperwork is faxed to the receiving facility staff upon completion of the ePCR.

Crews should be back in service, dispatch notified and the vehicle ready to respond as soon as possible after arrival to the drop-off facility. Occasionally you may be unavoidably delayed; however, all attempts should be made to return to service as soon as possible.

If upon arrival at the facility you anticipate a delay in returning to service, it's important to notify dispatch as soon as possible. This will provide the dispatcher with a more accurate idea as to when you'll become available and allows for an explanation of the exception into Zoll RescueNet Dispatch - Billing.

Pro Policy 300.3 – End of Shift Duties

Section:	Operations
Policy #:	300.3
Modified:	04/15/2024
Reviewed:	04/15/2024

3.3.A. End of Shift Duties

Crews are not permitted to return to base without permission from the dispatcher. No crews should return to base unannounced. The dispatcher, under normal circumstances, will attempt to return crews to base approximately thirty (30) minutes prior to end of shift. Upon being cleared to return to base, the following must be done:

(1) *Vehicle must be fueled.*

After you are cleared to return to base for shift you should head immediately to the gas station for fueling. All vehicles are to be returned at the end of shift "FULL". The vehicle is to be fueled at the end of every shift.

(2) *Place a Red Tag.*

Place a Red Tag in the windshield of the ambulance so the Support Services Technicians know to check and clean the vehicle and remove all trash from the vehicle. Red Tags can be found in the Garage at PRO Base next to the washing machines.

(3) *Paperwork*

Paperwork must be completed and synced immediately after completion of a call whenever possible. The Zoll RescueNet Dispatch - Billing system will send pages to each crew member with run numbers and times of all jobs at the completion of each run.

The patient demographic sheet and the physician necessity from should have a run number before it is turned into dispatch.

All paperwork must be completed and checked in by the dispatcher before either crew member punches out or departs upon completion of their shift. The dispatcher must clear you to leave.

(4) *Responsibilities*

Never, UNDER ANY CIRCUMSTANCES, leave any vehicle that you have worked in without the following:

- At least 1/2 tank of fuel (full tank unless special circumstances)
- Put a Red Tag on dashboard.

These things are imperative. Some are potentially life and death. Occasionally, a crew will have to immediately respond. We all must feel comfortable that the preceding items are always going to be present.

In this profession, it is probable that you will work later than your scheduled off time for a variety of reasons. RETURNING LATE TO THE BASE (PAST YOUR OFF TIME) DOES NOT RELIEVE YOU OF YOUR END OF SHIFT DUTIES.

3.3.B. Relief and Other Responders' Availability

Dispatchers and crews coming off shift must not punch out and leave unless there is adequate coverage available in the service area. If the only PRO ALS unit(s) is on a call, the ALS crew that is coming off shift must remain until a PRO ALS unit is available to cover the city. BLS crews who are coming off shift may also be required to remain on duty until there is adequate PRO coverage available.

Dispatchers and crews coming off shift must not punch out and leave unless scheduled relief is punched in. You are required to stay until adequate coverage can be attained.

Pro Policy 300.4 – Duties of Evening/Overnight Personnel (1500-0800)

Section:	Operations
Policy #:	300.4
Modified:	04/15/2024
Reviewed:	04/15/2024

PERSONNEL ARE NOT PERMITTED TO SLEEP IN ANY AREA EXCEPT THE BUNK ROOM BETWEEN THE HOURS OF 22:00 – 06:30.

ALL OF THE FOLLOWING TASKS MUST BE COMPLETED BEFORE GOING TO SLEEP.

- Cleaning the Crew Room, Offices, Kitchen, and designated areas within Cambridge Hospital
- Blankets, towels, pillows, sheets, etc. should be removed from the recliners;
- All Counters, Surfaces, and Recliners should be cleaned;
- Table and chairs should be cleaned;
- No garbage should be left in any area;
- Floors should be vacuumed;
- Debris should be removed from all areas; and
- Old food should be removed from the refrigerator (ask first).

While working in the Emerson Service Area, crews should clean up after themselves each time they leave the Base. Crews must clean the Base at the end of their shift, discarding of personal trash, emptying the garbage, sweeping, and mopping as needed.

EMERSON AREA UNITS

BOTH EMERSON PARAMEDIC UNITS WILL BE AT THEIR POSTS NO LATER THAN 0545 READY FOR SHIFT CHANGE.

Pro Policy 300.5 – Ancillary Duties

Section:	Operations
Policy #:	300.5
Modified:	04/15/2024
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At any time, you may be called upon to perform duties and tasks outside of those outlined in the "Duties" sections.

YOU ARE REQUIRED TO PERFORM ANY REASONABLE TASK ASSIGNED TO YOU BY ANY SUPERVISOR, MEMBER OF MANAGEMENT, OR DISPATCHER ACTING ON THEIR BEHALF.

These duties may include, but are not limited to:

- Cleaning/sweeping of the wash bay and garage;
- Cleaning of additional vehicles;
- Cleaning of a vehicle you are not assigned to;
- Cleaning the dispatch office;
- Emptying of the trash;
- Stocking of the supply room; and
- Cleaning of the crew room.

Pro Policy 300.6 – Non-Discrimination

Section:	Operations
Policy #:	300.6
Modified:	04/15/2024
Reviewed:	04/15/2024

IN ACCORDANCE WITH REQUIREMENTS OF FEDERAL AND STATE ANTI-DISCRIMINATION STATUTES, PROFESSIONAL AMBULANCE SERVICE, AND NO PERSON IN ITS EMPLOY, SHALL DISCRIMINATE ON THE GROUNDS OF RACE, COLOR, CREED, RELIGION, SEX, SEXUAL ORIENTATION, AGE, NATIONAL ORIGIN, ANCESTRY OR DISABILITY IN ANY ASPECT OF THE PROVISION OF AMBULANCE SERVICE OR IN EMPLOYMENT PRACTICES.

Pro Policy 300.7 – Employee Safety

Section:	Operations
Policy #:	300.7
Modified:	04/15/2024
Reviewed:	04/15/2024

3.7.A. Primary Service Area and Duties

PRO and all of its employees have the responsibility and duty to respond to all emergency calls in our regular operating areas. PRO's regular operating areas are defined as the geographic boundaries of the City of Cambridge, the property of Harvard University, and the property of the Massachusetts Institute of Technology, the Emerson Service Area, and contiguous communities. The dispatcher shall post units throughout the regular operating area to ensure the best "coverage" of the area.

In the case of an emergency, PRO and its EMS personnel shall not refuse to dispatch an available ambulance and to provide emergency response, assessment, and treatment, within its regular operating area, in accordance with the Statewide Treatment Protocols, at the scene or during transport, or to transport a patient to an appropriate health care facility.

1. Upon receipt of a call to respond to an emergency, PRO shall immediately dispatch the most appropriate resource available.
2. If the PRO dispatcher believes at the time a call is received that a Class I ambulance is not available for immediate dispatch, the dispatcher shall immediately contact the ambulance service's backup service pursuant to 105 CMR 170.385. If the ambulance service dispatcher believes that another ambulance service has an ambulance that can reach the scene in a significantly shorter period of time, the dispatcher shall immediately notify:
    - The other ambulance service, which shall immediately dispatch an ambulance, and
    - Police or fire in the town in which the emergency has occurred.

3.7.B. Duty to Treat and Transport to Closest Appropriate Facility

All patients must be delivered to the nearest appropriate facility at all times at a minimum. PRO will strive to honor specific patient requests for transport to a more distant facility based on the condition of the patient and current emergency loads and stresses on the EMS system in the area. The crew caring for the patient will make this determination with input from dispatch, a supervisor, and/or medical control if necessary.

3.7.C. Transport of a Deceased Person

No PRO vehicle shall transport a dead body, except in special circumstances when it is in the interest of public health and/or safety to do so or when ordered to do so by the senior official on scene.

3.7.D. Parent Rights

Any parent requesting to accompany a minor child in the ambulance shall be allowed to do so unless it is determined that this would hinder patient care (i.e. parent uncontrollably upset). If a parent is denied the right to accompany a child, the reasons must be completely and thoroughly documented on the trip report. Such determination shall be noted in the written report of said emergency medical technician and a copy of such report shall be sent to such parent or guardian within 30 days of such determination.

Pro Policy 300.8 – Hot and Cold Weather Operations

Section:	Operations
Policy #:	300.8
Modified:	04/15/2024
Reviewed:	04/15/2024

3.8.A. Hot Weather Operations

Hot weather can present problems for vehicle operations. The following procedures are necessary to ensure vehicles will operate at maximum performance.

- Shut unit down whenever possible when back at the base.
- Prior to shutting down or starting up, make sure all lights, master switch and A/C (front and back) are off and the windows up.
- When operating A/C units, walk thru door should be closed, and windows up.

3.8.B. Cold Weather Operations

Garage door will remain closed at all times day or night. The crews and dispatchers will operate the doors to keep heat loss to a minimum. Do not open the door then go and start the ambulance. This keeps the door open longer than necessary.

1. Employee vehicles should be parked in the garage or in designated spaces outside as close together as possible. Keys to employee vehicles must be left at the base on the keyboard every shift. This will allow for snow removal and plowing.
2. When storing ambulances for the overnight, snow should be cleaned off outside. Heavy snow and ice buildup around lower fenders, running boards, and mud flaps should be removed outside.
3. Excess snow, water, and sand on garage floor must be dispersed immediately. Puddles of water and debris are potential hazards and obviously slippery.
4. During winter months, vehicles are stock with shovels and road salt.
5. ALL ON DUTY PERSONNEL ARE RESPONSIBLE FOR SNOW AND ICE REMOVAL FROM IN AND AROUND THE BASE. WALKWAYS AND DOORWAYS ARE HIGH TRAFFIC AREAS AND MUST BE KEPT CLEAR AND DRY WITHOUT FAIL.

Pro Policy 300.9 – In the Field Patient Care

Section:	Operations
Policy #:	300.9
Modified:	04/15/2024
Reviewed:	04/15/2024

3.9.A. Equipment to Patient Side

BLS must always bring the BLS First-In, Oxygen Bag, and AED on all emergency calls. Additionally, depending on the type of call, stair chair, blanket, immobilization equipment and/or stretcher should be brought when necessary and possible.

ALS should always bring the first-in bag, airway bag, cardiac monitor, and other BLS and extrication equipment as circumstances warrant.

3.9.B. Continuity of Care

All PRO field providers will maintain the continuity of patient care by not discontinuing any treatment, or leaving any patient until care has been properly and completely turned over to the staff of the receiving facility. Oxygen, cardiac monitors, and your undivided attention to the patient must remain in place until care is transferred.

3.9.C. Handling a Stretcher and "Packaging" a Patient

All stretchers should always have a blanket (weight appropriate for the season) and sheet on them. Remember to utilize these items. Always cover your patients with the appropriate items to keep them warm and comfortable. If it is raining or very cold, wrap a towel around the patient's head. Keeping a patient warm and dry is one of the most basic and important things you can do.

Over the shoulder straps must be used in conjunction with the three (3) stretcher straps at all times. Do not store these straps under the mattress. They should always be accessible. When you have a patient on your stretcher, always do the following:

1. Blanket and cover the patient properly. During cold weather, utilize heavy blankets and cover the patient's head with a towel. ALWAYS PROTECT EVERY PATIENT'S PRIVACY.
2. Keep the patient as comfortable as possible.
3. When rolling the patient on a stretcher the stretcher should be maintained at one-half height to prevent tipping. Have two people attending the stretcher when it is raised at all.
4. Pull stretcher feet first whenever possible.
5. Put the head of the stretcher into an elevator first.
6. When using a stair chair, place a blanket down, then a sheet, and wrap the patient. Keep a blanket and sheet on the stair chair at all times. Store the stair chair with them so that they are always there.

7. Pay attention to patient's hands and feet when moving them through narrow spaces or downstairs.
8. NEVER LEAVE A PATIENT UNATTENDED
9. Always use Cot-Safe methods

All of these may seem like small and trivial points, but if you have ever been on a stretcher, you know how important these things are to the patient's safety, comfort, and state of mind.

3.9.D. Massachusetts Medical Orders for Life Sustaining Treatment (MOLST)

The MOLST and CC/DNR forms are statewide standardized forms issued by the Massachusetts Department of Public Health. Patients and their health care providers can use these to document the results of discussions they have had about appropriate life-sustaining treatment. These are the only documents that ambulance services and their EMTs and paramedics can immediately recognize and honor as an actionable order (in the case of MOLST) or verification of such an order (CC/DNR form) about the use, or limitation of use, of life-sustaining treatments for their patients. Massachusetts is currently transitioning to use of the MOLST form, but EMS personnel will continue to encounter patients with CC/DNR forms. At this time, patients may have either form, and as long as the form is current and valid, EMS personnel may honor either document.

EMS personnel at all levels are required to provide emergency care and transport patients to appropriate health care facilities. EMS personnel are further required to provide treatment to the fullest extent possible, subject to their level of certification and the level of licensure of the ambulance service for which they are working. However, more and more patients, where it is medically appropriate, are opting for limitations on life-sustaining treatments, such as cardiopulmonary resuscitation (CPR), in the event of cardiac arrest. Thus, EMS personnel may encounter a patient who has chosen such options and has either a Massachusetts Medical Orders for Life Sustaining Treatments (MOLST) or the Comfort Care/DNR Order Verification Form or bracelet (CC/DNR). These documents provide for a statewide, standardized form, approved by the Massachusetts Department of Public Health (DPH), Office of Emergency Medical Services (OEMS), that EMS personnel can instantly recognize as an actionable order (MOLST) or verification of such an order (CC/DNR) regarding the use of life sustaining treatments. This protocol governs EMS personnel response to a patient with a MOLST or CC/DNR form.

For current MOLST protocol, reference the Massachusetts DPH-OEMS Statewide Treatment Protocols.

As an initial introduction, there are three key differences between CC/DNR vs. MOLST:

1. Verification of an order vs. the actual order: A CC/DNR Order Verification Form does only what its name implies – it verifies that the patient has an existing DNR order and allows EMS personnel to honor the patient's preference for no resuscitation. In contrast, the MOLST form is the actual, actionable medical order to allow EMS personnel to either offer or withhold certain medical treatments, including but not limited to, not providing resuscitation.

2. For EMS only vs. for all health care settings: The Comfort Care/DNR Order Verification Form is designed to be honored by EMS personnel only, and there is no requirement that any other health care personnel honor the form. A MOLST form is designed to be honored by all clinicians across multiple treatment settings throughout the health care delivery system, including EMS personnel in out- of-hospital settings.

3. Scope limited to DNR vs. broader scope of life-sustaining treatments addressed: The CC/DNR Verification Form's scope is limited to addressing DNR only. The MOLST form is more comprehensive in scope: It may be used to specify the patient's preferences regarding accepting or withholding not just resuscitation, but other types of life sustaining treatments as well. EMTs must read the MOLST carefully to understand the patient's preferences and what the clinician has ordered.

3.9.E. Physician on Scene

Occasionally, you may respond to a call where a physician is on scene. If a physician who is on scene requests to be involved with patient care all of the following procedures must be followed.

1. The physician must show their identification indicating their credentials as a physician with this information being documented on the trip report.
2. The EMS provider should contact the medical control physician via radio or cellular phone to allow the physician on scene to speak directly to the medical control physician. The medical control physician will determine if the on-scene physician may assume responsibility for the patient.
3. The on-scene physician who assumes responsibility for the care of any patient must accompany the patient in the ambulance during transport to the receiving emergency department.

Printed cards with this policy are maintained in all ALS/BLS First-In bags and can be given to a physician who expresses interest in participating in patient care.

Pro Policy 300.10 – Special Circumstances

Section:	Operations
Policy #:	300.10
Modified:	06/25/2024
Reviewed:	06/25/2024

3.10.A. Safety Restraints – Adult and Pediatric (Seatbelts)

ALL EMPLOYEES, THIRD RIDERS, FAMILY MEMBERS AND PATIENTS RIDING IN ANY PRO VEHICLE ARE REQUIRED TO WEAR THEIR SEAT BELTS OR SAFETY RESTRAINTS. THE ONLY EXCEPTION TO THIS IS THE ATTENDANT WHO MAY BE UNRESTRAINED ONLY TO ADMINISTER PATIENT CARE. NO CHILDREN UNDER THE AGE OF 12 ARE PERMITTED TO RIDE IN THE CAB OF THE AMBULANCE AT ANY TIME.

There are two (2) safety restraints located in the cab of every ambulance, with four (4) in the patient compartment. Three (3) sets of safety restraints are mounted along the wall of the squad bench. The fourth is located at the technician seat.

All stretcher patients are to be secured to the stretcher at all times. An unrestrained patient can fall off causing injury. There are three (3) safety restraints that are required to be used in securing the patient. They are:

Lower Safety Restraint – Secure around the patient's lower legs. (mid tibia)

Upper Safety Restraint – Secure around the patient's upper legs. (mid femur)

Harness Restraints – Secure one shoulder restraint over each shoulder so they are resting over the chest area and secure each shoulder strap into the third restraint located just at the waist.

Adjust all the straps so they safely secure the patient without causing discomfort or impairing circulation.

To unfasten any of the above restraints, press the release button on the receiver end of the restraint.

It is important to keep the restraints fastened on the stretcher when not in use to prevent them from interfering with the stretcher's operational capabilities.

Worn, frayed, or soiled safety restraints should be reported immediately for replacement.

Pediatric patients will be secured in the ACR-4 and secured to the stretcher. The ACR-4 is designed for a 4lbs to 99lbs child. If you are called on to transport a child smaller than 4 pounds, utilize the Kangoo-Fix with any responsible adult as the base.

Children who are not patients, who must be transported, should be placed in an appropriate car seat.

3.10.B. Violent Patient Restraint Policy

The safety of the patient, community, and responding personnel is of paramount concern when following this policy.

Restraints are to be used only when necessary, in situations where the patient is potentially violent, and is exhibiting behavior that is dangerous to self or others. Pre-hospital personnel must consider that aggressive or violent behavior may be a symptom of medical conditions such as head trauma, alcohol, drug-related problems, metabolic disorders, stress, or psychiatric disorders.

The method of restraint used shall allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway or compromise neurological or vascular status.

If a patient is an immediate danger to self or others, a Section 12 ("pink paper") is not required for you to restrain them.

The police should be called whenever it appears that a patient may need to be restrained in the field or whenever a patient is being picked up in the community under a Section 12.

Restraints such as handcuffs that are applied by law enforcement require an officer to remain available at the scene and during transport to remove or adjust the restraints for patient safety.

This policy is not intended to negate the need for law enforcement personnel to use appropriate restraint equipment that is approved by their respective agency to establish scene management control.

The following procedures should guide pre-hospital personnel in the application of restraints and the monitoring of the restrained patient.

1. Restraint equipment applied by pre-hospital personnel must be either padded leather restraints or soft restraints (i.e., stretcher restraints, seat-belt type, or triangular bandages applied correctly). All methods must allow for quick release. Whenever possible, patients should be restrained using PRO's equipment and restraints. All PRO stretchers have separate restraints on the stretcher for arms and under the mattress for legs. It should not be necessary to transport patients in the hospital's restraints.
2. PRO personnel shall NOT apply any of the following forms of restraint:
    - Hard plastic ties or any restraint device requiring a key to remove.
    - Backboard or scoop stretcher as a "sandwich" restraint.
    - Restraining a patient's hands and feet behind the patient, i.e., hog-tying.
    - Methods or other materials applied in a manner that could cause vascular, neurological, or airway compromise.
3. Restraint equipment applied by law enforcement for example, handcuffs, plastic ties, or "hobble" restraints, must provide sufficient slack in the restraint device to allow the patient to straighten the abdomen and chest, and to take full tidal volume breaths.
4. Restraint devices applied by law enforcement require the officer's continued presence to ensure patient and scene management safety. The officer shall accompany the patient in the

ambulance or follow, by driving in tandem with the ambulance on a predetermined route. A method to alert the officer of any problems that may develop during transport should be discussed prior to leaving the scene.

5. Pre-hospital personnel must ensure that the patient's position does not compromise respiratory/circulatory systems or does not preclude any necessary medical intervention to protect the patient's airway should vomiting occur.
6. Restrained extremities should be evaluated for pulse quality, capillary refill, color, nerve, and motor function every 5 minutes. It is recognized that the evaluation of nerve and motor status requires patient cooperation, and thus may be difficult or impossible to monitor.
7. Restrained patients shall be transported to the closest appropriate emergency department except in the case of a "Section 12" where a direct admission to a psychiatric facility has been pre-arranged.
8. Restrained patients should not be carried downstairs in a stair chair. A violent patient cannot be properly restrained in a stair chair. Furthermore, a violent patient that is sitting in a stair chair could throw the rescuers off balance while carrying. Violent patients who must be carried downstairs should be restrained on a scoop stretcher.

3.10.C. Documentation of Restraint

Documentation on the Trip Sheet shall include:

1. The reason(s) restraints were necessary.
2. Which agency that applied the restraints (i.e., EMS, law enforcement, other).
3. Information and data regarding the monitoring of circulation to the restrained extremities.
4. Information and data regarding the monitoring of respiratory status while restrained.
5. What types of restraints were applied.

If at any time you need further clarification on the above, please contact a supervisor.

3.10.D. Transport of Psychiatric Patients

In most cases, psychiatric patients will be ambulatory. Psychiatric patients who are ambulatory and not a flight risk can be walked to the ambulance under close supervision. Often, the act of placing these patients on a stretcher could be counterproductive and a source of agitation. Ambulatory psychiatric patients should be transported on the stretcher whenever possible. At a minimum, these patients must be seated in the tech seat or on the squad bench with their seatbelt on.

YOU MUST ALWAYS SIT BETWEEN A SEAT-BELTED PSYCHIATRIC PATIENT AND THE BACK DOORS OF THE AMBULANCE. THE DOORS OF THE AMBULANCE MUST ALWAYS BE LOCKED. THESE PROCEDURES WILL SLOW A PSYCHIATRIC PATIENT WHO ATTEMPTS TO JUMP OUT OF A MOVING AMBULANCE.

These procedures will also provide the driver with an opportunity to bring the ambulance to a stop when dealing with a psychiatric patient who suddenly attempts to flee.

Upon arrival at the receiving facility, you are not relieved of responsibility for any patient until the staff of the receiving facility releases you. There is a common misconception that once the paperwork is

transferred that the patient is no longer your responsibility. This is not accurate. Every patient remains your responsibility until the patient is properly accepted and the staff of the receiving facility relieves you. All facilities are different. If you encounter a problem at a receiving facility, you should contact dispatch as soon as possible for assistance.

3.10.E. Transport of Disabled Person with No Medical Complaint

Whenever possible, attempt to contact a handicapped accessible taxicab as a first resort. The City of Cambridge has a contract to make these accessible taxis available 24/7. Dispatchers are authorized to commit PRO to pay for this service. Contact: **Accessible Cambridge Taxi (ACT) at 1-866-654-1003**.

Additionally, rideshare programs have wheelchair accessible options (see Lyft's WAV program https://help.lyft.com/hc/en-us/rider/articles/115013081668-Accessible-vehicle-dispatch).

Occasionally, you may be called on to transport a disabled person with no medical complaint to a location other than a hospital when there is no other safe and suitable means of transportation available. Even though the disabled person has no current medical complaint, their disability necessitates accessible transportation. These situations most often arise in the context of disabled persons who are police prisoners who cannot be safely transported in the police wagon. These situations also surface when a disabled person with no current medical complaint requires accessible transportation to a local shelter or to court.

For the patient to be taken to a location other than a hospital, the patient must not have any current medical complaint whatsoever. The Cambridge Police and local hospitals usually generate these calls.

Disabled persons must always be transferred to an ambulance cot and secured for transport.

3.10.F. Transporting of Patient with a Service Animal

Service animals, for example, guide dogs utilized by visually impaired persons, shall be permitted to accompany the patient in the ambulance or wheelchair van unless the presence of the service animal will disrupt emergency or urgent patient care or there is some basis for the crew members to believe that the safety of the crew, the patient or others would be compromised by the presence of the service animal in the ambulance or wheelchair van.

EMS personnel should assess the level of care required to provide competent medical attention to the patient.

When the presence of a service animal in the ambulance might interfere with patient care, jeopardize the safety of the crew, the patient or others, or cause damage to the ambulance or equipment, personnel should make other arrangements for simultaneous transport of the service animal to the receiving facility. Unless emergency conditions dictate otherwise, absolutely every effort must be made to reunite the patient with the service animal at the time of the patient’s arrival at the receiving facility or other destination.

Acceptable alternative methods of transporting a service animal to the receiving facility include, but are not necessarily limited to, family members, friends or neighbors of the patient, or a law enforcement official. Attempt to obtain and document the consent of the patient for transport of the service animal

by such person. If no such individuals are available, contact the service base or PSAP and request that additional manpower respond to transport the service animal.

Personnel should document on the patient care report instances where the patient utilizes a service animal and should document on the patient care report whether or not the service animal was transported with the patient. If the service animal is not transported with the patient, a separate incident report should be maintained by the ambulance service describing the reasons that the service animal was not transported with the patient.

3.10.G. Transporting of Municipal Police K-9

The following is taken directly from the Massachusetts Department of Public Health, Office of EMS, 2023 Statewide Treatment Protocols:

(1) *Overview*

Under Chapter 23 of the Acts of 2022 (known commonly as “Nero’s Law,”) EMS is required to assess, treat and transport police K9s who are injured in the line of duty. However, EMS shall not transport an injured police K9 if providing such transport would inhibit their ability to provide emergency medical attention or transport to a person requiring such services.

- This statute defines "police dog" as a dog owned by a police department or police agency of the Commonwealth, or any political subdivision thereof, and used by the department or agency for official duties. EMS is not authorized to treat and transport any other type of dog.
- EMS will require the assistance of the police dog’s police handler or backup handler, to approach the dog and ensure it is safe for EMS personnel to attend to the police dog. If neither police K9 handler or backup K9 handler are available, EMS may contact local Animal Control for assistance restraining and safely treating and transporting the police d o g . The Department is aware that Animal Control capabilities vary greatly across the state, and in some areas, this may not be appropriate. However, if transport by ambulance would impair EMS’ ability to respond to persons who need EMS care and transport, Animal Control may be considered an appropriate transport choice as long as Animal Control is available and appropriately equipped to transport the police dog. At no time shall EMS care of a police dog take priority over a person needing EMS care.
- This statute requires EMS personnel to provide police dogs only BLS-level first aid, cardiopulmonary resuscitation and life-saving interventions, including, but not limited to, administering naloxone. The statute does NOT authorize EMS to provide ALS-level care to a police dog.
- The statute protects EMS personnel from liability when they provide care to police dogs in accordance with the statute and these protocols. It also exempts EMS care provided in accordance with the statute and these protocols from being considered the practice of veterinary medicine.

- Ambulance services shall alert the receiving facility at the phone number listed in the Statewide Point-Of-Entry Plan for Police Dogs, using their Public Safety Access Point (PSAP) and/or cell phone.
- EMS shall document all responses to police dogs on a patient care report (PCR). In electronic PCRs, and for submission to MATRIS, EMTs shall document Police Dog transports by entering "K9" in the Patient Last Name Field (ePatient.02).
- Injured or ill humans always take priority over police dogs.
- These guidelines are reserved for use only on police dogs who are injured in the line of duty.
- In accordance with the statute, the Department consulted with veterinarians and with police dog handlers in the creation of these protocols, and thanks all these experts for their time and input.

(2) *Point of Entry*

Point of Entry (POE) for the Pro EMS service areas is as follows:

Service Area	Facility	Location	Number
Cambridge	MSPCA-Angell Animal Medical Center	350 S Huntington Ave., Boston, MA 02130	(617) 522-7282
	BluePearl Pet Hospital (Boston)	56 Roland St, Boston, MA 02129	(617) 284-9777
Emerson	MSPCA Angell-West	293 2nd Ave, Waltham, MA 02451	(781) 902-8400
	BluePearl Pet Hospital (Waltham)	180 Bear Hill Rd, Waltham, MA 02451	(781) 684-8387
	Westford Veterinary Emergency Referral Center	11 Cornerstone Square, Westford, MA 01886	(978) 577-6525
	Massachusetts Veterinary Referral Hospital	20 Cabot Rd, Woburn, MA 01801	(781) 932-5802

(3) *Decontamination*

After transportation of a Police K-9 unit, the ambulance and any associated equipment must be decontaminated in accordance with MDPH-OEMS A/R 1-522G.

Pro Policy 300.11 – Procedures at Hospital

Section:	Operations
Policy #:	300.11
Modified:	04/15/2024
Reviewed:	04/15/2024

3.11.A. Locking Ambulances and Equipment

YOUR AMBULANCE IS TO BE LOCKED AT ALL TIMES.

This includes all doors and outside compartments. One key FOB is provided to each crew member. Leave the ignition key in the vehicle at all times. Carry the key FOB on your person at all times. ALS must pay particular attention to this. The ALS drug box is to be sealed, inside of the locked ambulance.

For Emerson ALS Units: Crew members assigned to an Emerson ALS Unit must lock the vehicle manually upon exiting the vehicle. Crew members will still leave the key in the ignition at all times. The Emerson ALS Units are manually locked via the Keypad on the front doors. The code is given to crew members upon hire.

3.11.B. Shutting Down Ambulances at Hospitals

Your ambulance should be shut down and the batteries turned off upon arrival at a hospital. This procedure is necessary to cut down on vehicle exhaust fumes entering the facility. Ambulances should never be shut off at the scene of a call unless it is absolutely necessary.

Pro Policy 300.12 – Diversions, Delays, and Standbys

Section:	Operations
Policy #:	300.12
Modified:	04/15/2024
Reviewed:	04/15/2024

3.12.A. Hospital Code "BLACK" Status

Dispatch will monitor all Boston area hospital diversions. When a Boston area hospital goes on the diversion status of "Code BLACK" it will call the Dispatch Center as well as utilize the BAMA radio to notify Pro. The only recognized diversion status is "Code BLACK" status in MA. All diversions will be paged out to each on-duty crew member through Zoll RescueNet Dispatch - Billing.

If at all possible, a patient should not be transported to a facility that is on diversion. If a patient is unstable, requires cardiac cath, requires level 1 trauma care, or adamantly requesting transport to a facility that is on divert, you must notify the receiving facility and inform them that you are transporting the patient to them.

A hospital cannot refuse to accept you unless the facility is completely closed due to an event such as an internal disaster or a power outage (Code Black).

3.12.B. Delays

Any delay should be reported as soon as possible to the dispatcher and should be documented. Common delays that you may encounter include, but are not limited to, delays of longer than 15 minutes in a hospital triage area waiting for a bed, delays on the floor of a hospital for paperwork or a bed not being ready, delays in responding to a call due to a train, traffic, and extended extrications. Delays should be documented in CAD, trip sheets, and/or an Incident Report form in ePro (ESO) as necessary.

3.12.C. Fire Standbys

The following are requirements and considerations when on a fire standby:

1. Back down into fire scenes whenever possible to facilitate pulling out and away.
2. Position your vehicle on scene where it is out of the way and where additional arriving fire apparatus will not block it in. Leave your vehicle in a place where you can get out. YOU MUST CHECK YOUR VEHICLE CONTINUOUSLY TO ENSURE THAT IT DOES NOT GET BLOCKED IN. RELOCATE YOUR VEHICLE/S AS NECESSARY TO FACILITATE ACCESS TO, AND EGRESS FROM THE SCENE.
3. Update other crews and dispatcher as to the best access to the scene, standby location, and if the building is occupied.
4. Shut your emergency lights down if you are out of harm's way.

5. STAY WITH YOUR PARTNER IN AN APPROPRIATE LOCATION THAT CAN ALSO BE SET UP AS A TREATMENT AND REHAB AREA WITH IMMEDIATE ACCESS TO YOUR EQUIPMENT AND THE SCENE. POSITION YOURSELVES SO THAT YOU ARE READILY APPARENT TO THE INCIDENT COMMANDER AND/OR NOTIFY THEM OF YOUR LOCATION.
6. Periodically update the dispatcher of your status and needs.
7. Call for PRO ISU immediately if it appears that the incident will be extensive. The PRO ISU has equipment for rehab, additional supplies, and items for displaced fire victims.
8. All PRO personnel are required to wear High Visibility Vests for all standbys – including but not limited to fires, hazmat incidents, the Cambridge Festival, 4th of July and the Cambridge Half Marathon. See a member of the Management Team with any questions.

Pro Policy 300.13 – Details

Section:	Operations
Policy #:	300.13
Modified:	04/15/2024
Reviewed:	04/15/2024

3.13.A. Details

Occasionally, you may be assigned to a detail. Details sometimes require two crew members and an ambulance but usually, only one person is requested and assigned. When assigned to a detail, you are required to wear your uniform, have a jump bag, oxygen bag, an AED, and a portable radio at a minimum.

Always be aware of what the event is and who is in charge. You will be required to be aware of how to call for assistance and transporting resources. As each venue is different, you must be aware of procedures such as these before the detail. All paperwork requirements still apply when assigned to a detail. You must document care, treat and releases and AMA's. Basic patient information should be documented but be aware that PRO does not bill patients who are not transported.

Pro Policy 300.14 – Patient Confidentiality

Section:	Operations
Policy #:	300.14
Modified:	04/15/2024
Reviewed:	04/15/2024

All PRO staff members must be aware of patient confidentiality issues at all times. Discussing any information regarding the care or circumstances of any patient's care is strictly prohibited.

Trip reports are only released to the patient or to a person who has a signed waiver or other legal authority from the patient. Trip reports and specific case information will be used for QA/QI purposes as appropriate.

Do not discuss patient information in any public place such as an elevator or restaurant.

ALWAYS CONSIDER AND RESPECT THE PRIVACY OF EVERY PATIENT, NO MATTER WHAT HIS OR HER CONDITION. ALWAYS PROTECT A PATIENT'S MODESTY AS MUCH AS POSSIBLE, KEEP THE PATIENT COVERED, AND BE AWARE OF THEIR CIRCUMSTANCES AND FEELINGS.

Given the nature of our work, it is imperative that we maintain the confidence of patient information that we receive in the course of our work. PRO prohibits the release of any patient information to anyone outside the organization unless required for purposes of treatment, payment, or health care operations. Additionally, discussions of Protected Health Information (PHI) within PRO should be limited. Acceptable uses of PHI within the organization include, but are not limited to, exchange of patient information needed for the treatment of the patient, billing, and other essential health care operations, peer review, internal audits, and quality assurance activities.

PRO provides services to patients that are private and confidential, and you are a crucial step in respecting the privacy rights of PRO's patients. In the rendering of EMS, patients provide personal information and that such information may exist in a variety of forms such as electronic, oral, written, or photographic and that all such information is strictly confidential and protected by federal and state laws.

You must comply with all confidentiality policies and procedures set in place by PRO during your entire employment or association with PRO. If you, at any time, knowingly or inadvertently breach the patient confidentiality policies and procedures, you must notify PRO's Privacy Officer (CEO) immediately. In addition, a breach of patient confidentiality may result in disciplinary action, up to and including, discharge.

Pro Policy 300.15 – ALS Service Issues

Section:	Operations
Policy #:	300.15
Modified:	04/15/2024
Reviewed:	04/15/2024

3.15.A. Triage to BLS

On many calls, ALS will respond with BLS in a two-tiered response. This leads to issues surrounding the transfer of care, or both ALS and BLS staying with a patient. PRO paramedics will consider the following guidelines when on calls with any BLS (PRO, Rescue, Cataldo, etc.).

1. Do not apply a cardiac monitor or check the blood sugar of a patient who you think may be transferred to BLS care. These are ALS procedures that you should not be doing unless you have some doubt as to the patient's condition (i.e. Altered mental status, pleuritic chest pain). If you have some doubt as to the patient's condition you should be working-up and transporting the patient. Certainly, the thought behind this is that we do not treat monitors or glucometers but patients. Obtaining normal results from these procedures does not enable you to make the determination that a patient is clear for BLS transport.
2. IF ANY PROVIDER DOES NOT FEEL COMFORTABLE WITH A PATIENT'S CONDITION OR REQUESTS THAT ALS ASSUME CARE OF THE PATIENT, ALS WILL ASSUME CARE OF THE PATIENT.
3. Whenever ALS transfers patient care to BLS, ALS will document their evaluation of the patient on a BLS trip report.

3.15.B. Cardiac Monitor Procedures

Every ALS patient, emergency and transfer, will be transported with a cardiac monitor unless there is an extreme circumstance calling for the contrary.

Cardiac Monitor data for every ALS patient must be downloaded to TabletPCR immediately following completion of the call. Additionally, cardiac monitor data from CFD shall be downloaded into TabletPCR as soon as possible following the completion of the call.

Patients should be left on a cardiac monitor until care is transferred to the staff at the receiving facility.

3.15.C. SMEMS ALS Rounds

All personnel must complete all M&M's training via attending the training or completing the training posted on Prodigy of the M&M Rounds. There are limited exceptions to this policy, and it will be strictly enforced.

3.15.D. ALS Transfers

All ALS personnel must attend an OEMS approved ALS Inter-facility Training Program and all required refresher training.

Pro Policy 300.16 – BLS Service Issues

Section:	Operations
Policy #:	300.16
Modified:	04/15/2024
Reviewed:	04/15/2024

3.16.A. Calling for ALS

Many calls that you will respond to are triaged as a BLS response that will result in a patient requiring ALS treatment. BLS must evaluate situations quickly and call for ALS as soon as possible. This will allow an ALS crew to respond as you package and extricate the patient.

IF YOU ARE CONFRONTED WITH A PATIENT WHO YOU FEEL MAY NEED ALS YOU SHOULD REQUEST ALS FROM DISPATCH IMMEDIATELY. DO NOT ASSUME THAT ALS IS NOT AVAILABLE OR TOO FAR AWAY TO INTERCEPT YOU.

Always have an ALS unit start toward you and work to establish an intercept even after you have initiated transport. Update the ALS unit that is responding to your call as soon as you are able. An update for ALS should be short and concise including the patient's age and chief complaint.

Normally you will not wait on scene with a patient who is packaged and ready for transport. In most cases you will initiate transport and contact the responding ALS unit or dispatch by radio to set up an intercept.

KEEP IN MIND THAT THE ULTIMATE GOAL IS TO HAVE ALS REACH THE PATIENT IN THE SHORTEST AMOUNT OF TIME.

Every situation is different. Sometimes it might make sense to stop briefly or wait to allow ALS to reach you. This will sometimes be the fastest route to ALS rather than proceeding to the hospital when ALS is 30 seconds away from you. Communication will be critical in these situations.

3.16.B. BLS Triage to ALS

ANY BLS PROVIDER WHO IS NOT COMFORTABLE WITH ANY PATIENT CAN INSIST THAT ALS ASSUME CARE OF ANY PATIENT AND ALS WILL COMPLY.

Based on the situation, ALS will ideally transport the patient in the ALS unit or will ride with the BLS unit if necessary. ALS will document this transport no matter what level of care the patient receives. BLS will document the call as "ALS to handle".

ALS is expected to accommodate a BLS provider who requests that ALS assume care of any patient. The ALS provider should speak to the BLS after the call to discuss any issues or thoughts once care of the patient has been transferred to the receiving facility.

3.16.C. BLS Canceling ALS

After completing an appropriate patient assessment and having determined that a patient does not require the activation of an ALS intercept or ALS treatment in accordance with the Statewide Treatment Protocols; and there is no foreseeable need for ALS treatment based on the patient's condition or mechanism of injury, BLS may cancel responding ALS.

BLS may also cancel ALS if it is determined that the patient can be transported to an appropriate health care facility in less time than it would take ALS to arrive on scene or intercept BLS during transport.

Pro Policy 300.17 – Sanitary Practices

Section:	Operations
Policy #:	300.17
Modified:	04/15/2024
Reviewed:	04/15/2024

3.17.A. Care and Maintenance of Reusable Items

Proper technique in cleaning reusable ambulance equipment ensures that the equipment is safe for the next crew and patient and protects them from coming in contact with potentially infectious agents. Guidelines for cleaning reusable items are found in the PRO Health and Safety Plans.

All equipment is to be cleaned of obvious debris and fully cleaned and disinfected before being returned to service. All personnel shall wear gloves when cleaning reusable items. No one should be subjected to having soiled equipment in any company vehicle. Always utilize universal precautions when cleaning any item. Always assume all items are contaminated.

3.17.B. Disposable Items

The majority of the equipment used by PRO is disposable. If a disposable piece of equipment is contaminated it should be immediately disposed of in a red biohazard receptacle. Consult a supervisor or the dispatcher if there is any doubt in your mind as to whether an item is disposable or reusable.

All sheets and linen should be exchanged at and returned to the hospital. Do not leave dirty linen in an ambulance or bring it back to the base.

Pro Policy 300.18 – Drive Cam

Section:	Operations
Policy #:	300.18
Modified:	04/15/2024
Reviewed:	04/15/2024

3.18.A. Drive Cam Video System

Each PRO vehicle has a Drive Cam audio and video recording device installed. The Drive Cam camera is used to capture driving events that result in forward or side G force while driving. Events such as hard braking, traveling too fast around a turn, or an accident will be captured by Drive Cam. The cameras are downloaded on a regular basis and the events are reviewed by a member of the Management Team. PRO will provide positive and negative feedback to drivers based on the events and archive each notable event to a folder for each driver.

IT IS STRICTLY FORBIDDEN TO TAMPER WITH DRIVE CAM IN ANY FASHION. DISABLING OR TAMPERING WITH A DRIVE CAM COULD RESULT IN IMMEDIATE DISCIPLINARY ACTION UP TO AND INCLUDING TERMINATION.

Pro Policy 300.19 – Vehicle Operations

Section:	Operations
Policy #:	300.19
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Reviewed:	04/15/2024

3.19.A. Vehicle Operations Overview

Driving an emergency vehicle is an immense responsibility. Responding to a scene, then transporting a patient to the hospital are procedures that are often devalued in importance. Always remember that if you do not perform these two tasks with care, prudence, and professionalism, the worst will happen. You must get to a scene and safely transport the patient to the hospital to accomplish anything. There are many issues to be addressed relating to emergency vehicle operation. Both the driver and tech are responsible for safe and appropriate navigation to calls. Equipment and personal belongings in the front and back of the ambulance; including, but not limited to, items such as backpacks and portable radios should be secured at all times. Monitors, oxygen equipment and jump bags must be secured in equipment cabinets unless they are being used for patient care, at which time equipment should be secured in the patient compartment during use. This policy is in place to prevent items from falling on patients or crew and/or becoming projectiles if the vehicle is involved in an accident or sudden stop.

All new employees will complete the Driver Training Program as part of the FTEP.

3.19.B. Vehicle Locked at ALL Times

Your vehicle is to be locked at all times while unattended, all doors, windows and compartments included. One key FOB is provided to each crew member. Leave the ignition key in the vehicle and keep the key FOB on your person at all times. Your ambulance will lock automatically after 30 seconds of being unlocked. If you have any problems with the key FOB or the automatic lock function on an ambulance, please submit an Incident Report Form.

For Emerson ALS Units, crew members assigned must lock the vehicle manually upon exiting the vehicle. Crew members will still leave the key in the ignition at all times. The Emerson ALS Units are manually locked via the Keypad on the front doors. The code is given to crew members upon hire.

Personal vehicles parked at PRO base must be left with the keys in the ignition in case the vehicle must be moved. The garage is monitored continuously be a security camera system in the case that anything happens to your personal vehicle.

3.19.C. Seatbelts Required

ALL PERSONNEL ARE REQUIRED TO WEAR SEATBELTS WHILE IN THE FRONT SEATS OF A MOVING VEHICLE. ANY STAFF MEMBER FOUND NOT WEARING A SEATBELT WILL BE SUBJECT TO PROGRESSIVE DISCIPLINE.

All passengers must wear seatbelts whether they are in the front seat or in the patient compartment.

3.19.D. Call Information

When you are given a call, emergency or otherwise, make sure that you have the details correct. If you are not sure and you need help, ASK! Do not let your pride or embarrassment stand in the way of doing your job. You must get there to do any good.

GETTING LOST AND NOT ASKING FOR HELP IMMEDIATELY IS INEXCUSABLE.

3.19.E. Vehicle Idling

Turning off a vehicle is a simple and cost-effective way to reduce noise, reduce greenhouse gas emissions, protect health, and extend engine life. No PRO vehicle is to be idled while posting unless directed otherwise based on weather conditions. Crews operating company vehicles should turn them off if idling more than 30 seconds. Vehicles should not be left running while unattended.

This policy DOES NOT apply to vehicles at emergency scenes and/or while the unit has a patient on-board.

Pro Policy 300.20 – Safe Driving Guidelines and Updated Procedures

Section:	Operations
Policy #:	300.20
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Reviewed:	04/15/2024

3.20.A. General Ambulance Driving and Parking Guidelines

THE AMBULANCE OPERATOR'S PRIMARY RESPONSIBILITY IS THE SAFE TRANSPORT OF THE PATIENT. DO NOT RISK AN ACCIDENT OR INJURY.

Smooth driving refers to driving that will not stress or traumatize the patient, permitting the attendant to safely provide medical care to the patient. Your headlights should be on at all times for safety.

REMEMBER, YOU ARE THE PERSON WHO IS MOST IN CONTROL OF SAFETY WHEN RESPONDING OR TRANSPORTING ON A PRIORITY.

Drivers shall endeavor to enter rotaries from the far-left lane and exit rotaries from the far-right lane. Drivers should use the controlled intersection at Concord Ave and Moulton Street when returning to or leaving PRO base.

3.20.B. Transportation Considerations

No medical emergency, however severe, justifies driving in a manner that risks loss of control of the vehicle, or that relies on other drivers or pedestrians to react ideally.

A decision to transport emergently must be based upon reasonable cause to believe that the medical emergency justifies the risks incurred when demanding the right-of-way through traffic. However, any doubt as to the seriousness of the emergency must be resolved in favor of the patient.

All personnel should be aware that high-speed transportation of patients is often unnecessary, and sometimes harmful. A high-speed transport with its associated noise, sudden starts, stops, and sway can:

- Frighten the patient;
- Put a stabilized patient into shock;
- Disrupt ongoing medical treatment or injure personnel providing treatment; and
- Aggravate certain medical conditions sufficient to cause death or permanent disability to the patient; i.e., spinal injuries, serious fractures, and heart attacks.

'Smooth driving' principles should be observed at all times. Smooth driving refers to driving that will not stress or traumatize the patient, permitting the attendant to safely provide medical care.

Sufficient notice of the ambulance's approach must be given to allow other motorists and pedestrians to yield the right-of-way. Proper use of signaling equipment is, by itself, not enough. You should always

presume that other drivers do not hear the siren under most conditions, and particularly at an intersection. Be aware that other drivers often have difficulty in locating the source of the siren.

NEVER ASSUME THAT THE USE OF LIGHTS AND SIREN WILL CLEAR THE WAY THROUGH TRAFFIC OR THAT A MOTORIST OR PEDESTRIAN IN THE VICINITY WILL DO WHAT IS EXPECTED AFTER BECOMING AWARE OF THE AMBULANCE. WATCH FOR THE REACTION OF OTHER VEHICLES AND PEOPLE TO THE SIREN AND BE PREPARED TO MANEUVER ACCORDINGLY.

An ambulance operator must anticipate particular hazards during emergency operation, they include:

- Blind intersections
- Driveways
- Motorists with impaired hearing and;
- Inattentive drivers
- Pedestrians

An ambulance transporting a stable patient should never travel over the posted speed limit. Regardless of patient condition, never travel at a speed that does not permit complete control of the vehicle at all times.

3.20.C. Law of Due Regard

ALL DRIVERS MUST DRIVE WITH “DUE REGARD” FOR THE SAFETY OF OTHERS USING THE ROADWAYS.

State vehicle statutes provide special privileges to an operator of an emergency vehicle; however, this does not relieve the operator from the duty and responsibility to drive with “due regard” for the safety of others. A driver can be cited or held personally liable for damages if he/she exercises this privilege without justifiable cause, or in an imprudent manner. All emergency vehicle operators should be familiar with MGL Chapter 89, section 7B, “Operation of Emergency Vehicles”.

Due regard can be defined as driving in a manner to avoid any predictable collision.

As noted above, the emergency vehicle driver must provide adequate warning to others by using the warning devices, and by controlling their speed to allow other motorists time to react to their warning.

Pro Policy 300.21 – Driving Standards

Section:	Operations
Policy #:	300.21
Modified:	04/15/2024
Reviewed:	04/15/2024

3.21.A. Driving Standards

(1) *Use of Headlights*

Headlights are to remain on whenever vehicle is in motion. All lights must be turned off when vehicle is powered off.

(2) *Systematic Eye Movements*

Drivers should search for, identify, and anticipate potential hazards by scanning the near, middle and distant areas in front of, and to the sides of, the vehicle.

(3) *Constant Rate Acceleration*

Drivers should move their foot slowly from the brake to the accelerator, gradually rolling the vehicle forward, thereby overcoming inertia forces, gradually and smoothly.

(4) *Smooth Braking*

The driver should anticipate braking situations early and reduce speed ahead of time by releasing pressure from the accelerator. The engine compression will gradually slow the vehicle. The driver then applies the brake gradually, and just before the vehicle comes to a complete stop, reduces brake pressure so the vehicle does not jerk to a stop.

(5) *Following Distance*

When traveling at less than 40 MPH in ideal daytime conditions, the driver should maintain a four second following distance to maintain a cushion of safety in front of the vehicle. To measure an adequate distance, choose a vehicle in front of the ambulance and observe it passing a stationary object., The ambulance driver then counts, “1001, 1002, 1003, 1004” and should not pass the same object until four seconds have elapsed. When traveling at speeds above 40 MPH, increase the cushion of safety to five seconds.

Double the Distance: When you have a patient on board and when you are driving in darkness, rain, fog, smoke, or limited by other factors such as fatigue.

Triple the Distance: When the road surface has snow, packed snow, ice, or black ice.

This added cushion allows a driver additional reaction time to safely navigate any obstacle or hazard.

(6) *Ten-second Lane Change*

Drivers should anticipate and plan for lane changes in advance. They should signal in advance to advise other drivers of their intention. After signaling, the driver then drifts towards the centerline, and before entering the lane makes a second check of both mirrors and over their shoulder for vehicles in their blind spots. Sit forward in your seat while checking mirrors to minimize ambulance blind spot. Gradually and smoothly move to the next lane.

(7) *Rear and Side-Space Cushion*

Through systematic eye movements, a driver should remain aware of vehicles and objects surrounding their vehicle. By adjusting their speed or position, they maintain a cushion of space on all sides and to the rear of their vehicle.

(8) *Avoiding Rear-end Collisions*

Rear-end collisions can be avoided by maintaining a safe following distance, thinking, and looking far enough ahead so that you can anticipate the need to stop, controlling your speed, and not allowing your vehicle to roll backwards into another vehicle.

To avoid rear-end collisions the driver must practice the use of safe following and stopping distances. In order to understand the problem, and what the emergency vehicle driver must do to avoid rear-end collisions, they need a total understanding of the following:

- A driver must know the distance required to allow the vehicle to stop before, or steer around, an object that suddenly appears or another vehicle that suddenly stops in front of the vehicle.
- Following distances: To drive safely, the driver must maintain adequate following distances, and understand the three (3) factors that make up your total stopping distance.
    - Perception distance
    - Reaction distance
    - Braking distance

Stopping Distances at Various Speeds in Ideal Conditions

VEHICLE SPEED	STOPPING DISTANCE
10 MPH	18 Feet
20 MPH	52 Feet
30 MPH	100 Feet
40 MPH	169 Feet
50 MPH	280 Feet
60 MPH	426 Feet

- The Four Second Rule for Road Safety: Apply the principles outlined above in section 3.21.A.4.

(9) *Stopping at Intersections*

Stopping at Controlled Intersections:

Always stop your vehicle so that your front bumper does not extend into or over a “Pedestrian Lane” or the first “white line” in front of your vehicle. Stop your vehicle so that you can see a minimum of two feet of road surface between your vehicle and the first “white line” in front of your vehicle.

Stopping in Traffic at Controlled Intersections:

Use the “Rear Tire Concept”-

> Remain far enough behind (12-15 feet) a vehicle stopped in front of your vehicle to observe the front vehicle’s rear tires and a small amount of pavement. This provides adequate room to turn the vehicle around without backing up.

In either case, when stopped, keep your right foot on the brake pedal with pressure applied. Do not take your right foot off the brake pedal and start to accelerate until the vehicle in front of you has started to move and is accelerating. When starting in traffic, anticipate the vehicle in front of you will make a sudden stop.

(10) *Backing Policy*

While backing, one (1) individual is positioned eight to ten (8-10) feet behind the left rear of the vehicle and maintains visual and voice contact with the driver.

The driver of any company vehicle is responsible for the safe backing of the unit. The driver shall not place the unit in the reverse gear and start backing until the following procedures have been completed:

- The unit has come to a complete stop.
- A spotter is in place eight (8) to ten (10) feet at the left rear of the unit. Eye contact has been made with the spotter through the left-hand side rear-view mirror and voice and hand communications have been established with the spotter. The spotter helps guide the driver to slowly back the vehicle. This practice greatly reduces the possibility of backing mishaps.

Spotters must get out of the unit and survey the right side and rear area for obstacles that would damage the unit, or be damaged by the unit, if contact were made during the backing process.

Drivers are cautioned never to be in a hurry when backing up or parking. They are instructed not to start to back up or park when they are unsure of the area behind the vehicle. When no employee is available to be a spotter, the driver must visually survey the area and back slowly using extreme caution, with the back-up alarm on.

(11) *Parking the Ambulance*

The driver of any company vehicle is responsible for the safe and prudent parking of any company vehicle. Always park the vehicle in a safe area to protect the crew, patient, and the unit. When parking to the operator’s blind side, use a spotter. Do not pull forward into a parking space or driveway. Always back into the parking area, so that you have a safe and efficient exit. Nose in

parking is strongly discouraged unless no other option exists. Always be aware of overhangs and low clearances when operating or parking any vehicle.

Use caution when parking at scenes with multiple responding vehicles (fire, police), assuring that the ambulance is not "parked in" by others. It is the responsibility of the driver to park in a location that will allow prompt patient transport. If you are unsure of the best place to park at a scene, consult fire alarm or dispatch as needed.

3.21.B. Emergency Driving Standards

The following standards should be utilized as a guideline to follow in addition to the driving standards found above.

REMEMBER, YOU ARE THE PERSON WHO IS MOST IN CONTROL OF SAFETY WHEN RESPONDING OR TRANSPORTING ON A PRIORITY.

(1) *Use of Warning Devices*

Your headlights should be on at all times. When driving on an emergency, the driver activates all emergency lights (excluding the four-way flashers) and the siren. It is better to use the siren too much rather than not enough. The siren must be sounded and sustained for several seconds to enable other drivers and other responding emergency vehicles to hear you.

DO NOT "CHIRP" THE SIREN. THIS WARNING IS NOT ADEQUATE FOR OTHERS TO HEAR YOU AND REACT.

The driver must always balance the factors of location, time of day or night, and the need to provide adequate warning and notice to other drivers. The driver should maintain a four-second following distance to allow other drivers adequate time to react and reduce the intimidating effects of an emergency vehicle's warning devices.

(2) *Passing Vehicles*

When an ambulance approaches another vehicle traveling in the same direction as the ambulance, the driver positions the ambulance three (3) to four (4) feet further to the left and advises motorists of their intention to pass them on the left, using the siren.

(3) *Approaching an Intersection Facing a Red Light*

When the ambulance is located 150 feet before an intersection, the driver lifts his foot off the accelerator and transfers it to the brake pedal. Even with the siren on, the driver must bring the ambulance to a complete stop before entering the crosswalk and intersection. When the driver can see every lane with either, a vehicle stopped and eye contact made with its driver, or the ambulance crew can see far enough down a vacant lane (usually 150 feet) to eliminate any threat from approaching traffic, the ambulance operator can proceed with extreme caution.

(4) *Lane Control Under Emergency Operation*

When driving on an emergency, the ambulance should be in the far-left lane of traffic in the direction you are traveling. An exception to this guideline is one-way streets and avenues. In these

cases, you should travel in the center lane as it provides the most space for you to maneuver and to allow other vehicles to move out of your way.

The general public is required by law to pull to the right, nearest curb on one-way streets and avenues, when they see or hear an emergency vehicle approaching from the front or rear of their vehicle and the emergency vehicle is on an emergency response.

The left turn lane should not be used as a response lane. The only exceptions are:

- Clearing an intersection, before proceeding through under the law of “due regard”;
- Heavily congested traffic; or
- Directed by a police officer.

You should never pass on the right unless necessary or directed to do so by a law enforcement officer. When passing on the right, use the following guidelines:

- When you have no choice but to pass on the right, it shall be done with the utmost caution, and under the law of “due regard”.
- Expect and anticipate other vehicles will move to the right when you are passing on the right. They will!

When approaching an intersection under emergency operation, do not attempt a right turn from the left lane until other vehicles have stopped and acknowledged that you are taking a right turn. Stay in the left lane and use your partner to clear you on the right and stop traffic as you cautiously make the right turn. This procedure will reduce the chance that the other driver will drive into your side as you turn to the right in front of their path.

When stopped in traffic, attempt to leave one or two vehicle lengths between your vehicle and the vehicle in front of you in case you are dispatched to an emergency call.

(5) *Transporting Relatives and Friends in the Ambulance*

When it is necessary for a friend or relative to be a passenger in the ambulance, they shall sit in the front right seat and be secured with a seat belt before the vehicle is placed in motion. Only one passenger should accompany the patient in the ambulance, unless absolutely necessary.

A family member of a child may be permitted to ride in the patient compartment if the situation warrants, i.e., the child is upset, and the family member is able to calm them.

Individual circumstances will dictate whether the child of an injured adult should be allowed to ride in the patient compartment. All children of “car seat” age must be secured in the ambulance in a car seat, ACR-4 or Kangoo-Fix. If there are more children needing transport with an injured adult than car seats available, contact dispatch or fire alarm as appropriate for additional response to transport children.

DO NOT TRANSPORT CHILDREN IN REGULAR “ADULT” SEATBELTS. NEVER TRANSPORT A CHILD “IN THE ARMS” OF AN ADULT THAT IS SECURED TO THE STRETCHER.

When transporting an ill or injured patient and they do not speak or understand English, you may allow a passenger in the patient compartment to assist in translating and communicating with the patient.

When it is necessary for a passenger to ride in the patient compartment, he or she must be seated in the seat, at the head of the stretcher, and secured with a seat belt.

Only PRO personnel and authorized medical personnel are permitted in the patient compartment when a critical patient is being transported.

(6) *Safe Following Distances for Emergency Vehicles Following Other Emergency Vehicles*

When operating on an emergency, the operator of the vehicle will stay back a minimum of 300 feet or allow a buffer zone of 300 feet between their vehicle and other emergency vehicles in front of their vehicle. When approaching an intersection other drivers may hear only one siren, not both. Most drivers will enter the intersection as soon as the first emergency vehicle clears not realizing that there is another emergency vehicle right behind.

A significant following distance will also provide the operator of the following vehicle more time to react if the first emergency vehicle is involved in an accident going through the intersection. There could be other emergency vehicles responding from your left or right, and you may not be able to hear or distinguish their siren from the emergency vehicle in front of you. Try to utilize a different tone on your siren from the vehicle in front of you to help other drivers discern the presence of a second emergency vehicle.

The law mandates that no vehicle shall follow an emergency vehicle closer than 300 feet.

If you are involved in an intersection accident and you are the second emergency vehicle, you could be found negligent and guilty of failure to use “due regard.” Remember the following:

- Other drivers must be able to hear and see you; and
- You must give sufficient warning to other drivers, so they are able to stop in time.

YOU DO NOT HAVE THE RIGHT OF WAY, YOU CAN ONLY REQUEST OTHER VEHICLES YIELD TO YOU, ALLOWING YOU TO PROCEED WITH “DUE REGARD”.

(7) *Maximum Speed*

When traveling in the emergency mode, the ambulance driver must not exceed speeds greater than reasonable and prudent with due regard for weather, visibility, the traffic on, and the surface of the roadway. In no event should a Pro EMS vehicle be driven at a speed which endangers the safety of persons or property. At no time may a vehicle be driven at a speed greater than that needed to maintain constant control of the vehicle (i.e., speeds much less than the posted speed limit may be warranted for inclement weather, traffic, and other restrictive conditions).

(8) *Route of Travel*

Before leaving on an emergency response, the driver must first establish the most appropriate route of travel. Drivers consider factors such as street conditions, time of day, one-way versus two-way streets, traffic patterns, height restrictions, and pedestrian traffic.

(9) *Pre-call Preparation*

Emergency vehicle drivers must make every effort to assure that they maintain a constant state of readiness. Every detail must be attended to, from backing the vehicle into its parking spot, to having every aspect of the vehicle and equipment inspected, to being able to get to the vehicle rapidly.

(10) *Reducing Distractions*

When driving in the emergency mode, particularly at intersections, the driver should try to avoid using the radio or allowing other distractions to affect his/her ability to maintain constant control and awareness of the ambulance. Always try to give the hospital notification prior to leaving the scene of a call so that you can devote your full attention to driving to the hospital.

DRIVERS SHOULD NOT BE TALKING ON A CELL PHONE WHILE DRIVING UNLESS ABSOLUTELY NECESSARY. UNDER NO CIRCUMSTANCE SHOULD DRIVERS SEND OR READ EMAIL OR TEXT MESSAGES WHILE OPERATING ANY PRO VEHICLE.

FAILURE TO MEET ONE OR MORE OF THE ABOVE COULD BE CONSIDERED AS SHOWING A LACK OF "DUE REGARD" FOR THE SAFETY OF OTHERS AND A VIOLATION OF THE LAW AND COMPANY POLICY.

Pro Policy 300.22 – Handling and Storage of Medication & Controlled Substances

Section:	Operations
Policy #:	300.22
Modified:	04/15/2024
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3.22.A. Inventory Control

(1) *Storage*

When an ambulance is in service as a BLS Unit the Drug Box will be stored in the locked curbside cabinet and access by non-authorized individuals is prohibited. Paramedics are the only authorized personnel to access the Drug Box.

The Controlled Substances must be removed from the ambulance if it is out of the control of PRO. When removed from the ambulances the controlled substances must be locked securely in the Support Services secure supply room and the ambulance should have a "NO ALS GEAR" sign. This should be done by either a Supervisor or Support Services Technician.

All PRO vehicles are to be sealed and locked at all times. Medications are kept in sealed boxes, bags, and/or compartments inside the locked vehicle.

- The ALS drug box is to be sealed inside of the locked vehicle.
- The ALS First in bag has a compartment containing the Schedule II III, and IV drug box (900mcg Fentanyl, 1000mg Ketamine, and 12 mg Midazolam) that is to be sealed at all times inside of the locked vehicle.
- The narcotics box is sealed with numbered tags and is inside of a secured compartment in the ALS first in bag, inside of the locked vehicle.

(2) *Daily Vehicle Check*

Prior to the start of shift the Support Services Technician(s) will complete a daily check. The seal numbers on the narcotics box should be recorded by the paramedic crew member. If the seal is missing or broken a supervisor should be notified, a seal replaced, and the new seal number recorded in PSTrax and on the DVC.

(3) *Narcotics Checks*

PRO utilizes an online program (PSTrax) to document all narcotic related activities. An Arriving (or Start of Shift) Check must be completed by an ALS crew member and witnessed by the partner (ALS or BLS). Logs must be kept reflecting when an ALS vehicle is either out of service or was being used by a BLS crew to ensure that all shifts are documented. A supervisor shall reconcile this list weekly to

ensure ALS crews are in compliance with this policy. PSTrax will be audited on a regular basis to ensure compliance to this policy.

3.22.B. Re-Stocking

PRO maintains an agreement to replace used, expired and/or damaged medications with the Cambridge Hospital, the Mount Auburn Hospital, and the Emerson Hospital. Procedures for replacement at each facility vary.

(1) *Re-stocking of Controlled Substances in Emerson Service Area*

The controlled substances in the secondary narcotics box (located in the Orange ALS 1st In Bag) should be used to re-stock the primary narcotics box. An inventory control tag shall be replaced on both the primary and secondary narcotics boxes. The primary narcotics box should be re-stocked, returned to a full complement (Fentanyl 900mcg, 1000mg Ketamine, Midazolam 12mg), and resealed as soon as practicable after each patient encounter. The secondary narcotics box should be resealed.

A Supervisor will re-stock the secondary narcotics box as soon as possible. Paramedics are not responsible for re-stocking the secondary narcotics box. It is not uncommon that the secondary narcotics box may not be re-stocked to a full complement until the completion of your shift and the vehicle is returned to Cambridge. NO CONTROLLED SUBSTANCES WILL BE EXCHANGED OR REPLACED AT ANY HOSPITAL. ONLY SUPEVISORS AND/OR AUTHORIZED PERSONNEL MAY TRANSPORT ANY CONTROLLED SUBSTANCE THAT IS NOT IN A NARCOTICS BOX AND SEALED WITH AN INVENTORY CONTROL TAG. SUPERVISORS WILL FACILITATE THE REPLACEMENT OF ALL CONTROLLED SUBSTANCES.

(2) *Documenting the Administration and Re-stocking of Controlled Substances*

The paramedic will document the administration of a controlled substance in the PCR as an intervention and document the amount used in PSTrax. Any unused portion of the medication that has been wasted requires the Paramedic to document the facility name, name of the RN or Paramedic witness and the amount wasted in the narrative section of the PCR. The amount wasted and facility name are also documented in PSTrax. The paramedic will re-inventory, restock and document the recount in PSTrax for both narcotics boxes prior to sealing both with inventory control tags.

3.22.C. Accountability

Access, care, and handling of the drug box (orange Pelican case), first-line drug case (ALS First-In Bag), narcotics box (ALS First-In Bag) and ultimately all medications, are the responsibility of the paramedic(s) on the assigned ALS unit on each shift. Liability for the loss of drug boxes, medications, and controlled substances rests with the paramedic(s) on the assigned ALS unit on each shift.

3.22.D. Loss

Loss of any controlled substances will be cause for submission of an Incident Report Form. In addition, the following agencies shall be notified within twenty-four (24) hours of any related loss:

- Massachusetts Office of Emergency Medical Services;
- Massachusetts Drug Control Program (Drug Incident Report Faxed to Program);
- PRO's affiliate Hospital Medical Director; and
- Police department with jurisdiction where the loss occurred.

3.22.E. Temperature Sensitive Supplies

Temperature sensitive ALS supplies, including but not limited to medications and IV solutions, must be monitored, and maintained in the temperature-controlled environment inside the ambulance. If an ambulance and/or its medications and IV solutions cannot be maintained in a properly controlled environment, temperature sensitive supplies must be removed and stored in a climate-controlled environment at PRO.

PRO monitors all Units' Drug boxes for temperature variations at all times. PRO utilizes Samsara Environmental Monitor temperature tags to monitor the temperature. This Bluetooth device automatically connects to the Samsara gateway. The unit automatically notifies designated supervisors when temperature goes out of the set range as determined by the manufacturer of the medications.

Any temperature sensitive ALS supplies that have been exposed to temperatures outside of manufacturers recommendations for a significant period of time are to be placed out of service, disposed of and replaced by the Support Services Technicians or Supervisor.

3.22.F. Administrative Audits

On a monthly basis, Supervisors shall conduct a physical (hands-on) audit and inventory of all controlled substances in possession. This inventory must consist of an inspection of packages and vials to identify potential signs of tampering and include breaking (and inspection) of the existing seals. An audit log in PSTrax shall be completed by the Supervisor participating in the inventory. The administrative audit shall be conducted within 10 (ten) business days of 1st of the month.

Any temperature sensitive ALS supplies that have been exposed to extreme temperatures for a significant period of time are to be placed out of service, disposed of, and replaced by the Support Services Technician (with the exception of narcotics) or Supervisor.

Pro Policy 300.23 – Vehicle Types

Section:	Operations
Policy #:	300.23
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Vehicles should be assigned to specific call types based on the nature of the call. The following are the types of vehicles available for assignment:

- Advanced Life Support (P)
- Radio/CAD designation: P1, P2, P3, P4, etc.
- Basic Life Support (A)
- Radio/CAD designation: Ex. – A1, A2, A3, A4, etc.
- ALS Intercept Unit (ALS)
- Radio/CAD designation: ALS2, ALS3, ALS4, ALS5
- Field Provider (EMT, MEDIC)
- Radio/CAD designation: Corresponding Employee I.D. Number
- Incident Support Unit (ISU)
- Radio/CAD designation: ISU

Pro Policy 300.24 – Response Policies

Section:	Operations
Policy #:	300.24
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3.24.A. Emergency

1. The most appropriate unit when dispatching a Priority 1 or Priority 2 call is the appropriate unit that can be on scene in the least amount of time.
2. If a hailed and paged unit does not respond within one (1) minute the dispatcher should assign the response to the next most appropriate unit.
3. If a unit advises they are closer to a call than the assigned unit the dispatcher should utilize GPS (request an ETA of both units if GPS is down), assess the information and make a determination, reassigning the call if necessary.
4. Units assigned to Priority 3 and Priority 4 calls should be reassigned to Priority 1 or Priority 2 calls when necessary. Emergency calls take precedence even if it results in a late arrival to a scheduled non- emergency call.
5. If a unit is at a destination, on arrival for pick-up or drop-off, and that unit is the only appropriate unit that could respond to a call, the dispatcher should ask the unit if they can come on the air or come out for a response. If the unit acknowledges they can handle the call and call “on the air” the response should be assigned to that unit.
6. All emergency calls involving psychiatric patients should have the appropriate law enforcement agency dispatched simultaneously. Crews should be reminded to enter the scene only after it is deemed safe by law enforcement. Information regarding calls that come in privately should be relayed to ECC for law enforcement dispatch.
7. Dispatchers are required to take all emergency calls and ascertain all relevant information from any source, location or area and dispatch the appropriate resources and outside agencies if necessary. Dispatchers must not make callers with an emergency access the EMS system twice.
8. A unit assigned to an emergency call that on-sites another emergency call or has a mechanical failure should be removed from the original response. The next most appropriate unit should be immediately assigned to the cover original response. The original unit may be reassigned if the unit clears the on-site and is still the most appropriate unit to respond to the original call. Vehicles experiencing mechanical problems should not be reassigned to another call.
9. Dispatchers may assign units to an emergency response outside of the regular operating area if mutual aid or “coverage” is requested by a respective outside agency.

3.24.B. Non-Emergency

1. Under normal circumstances, a unit should not be assigned a Priority 3 or Priority 4 call that will cause them to work past their off time. This will not always be possible as call volume can dictate that units come in early and/or stay late.
2. Non-emergency calls should be assigned and dispatched so that the scheduled pick-up time can be met.

Pro Policy 300.25 – Response Priorities and Response Time Guidelines

Section:	Operations
Policy #:	300.25
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A specific response priority must be assigned to every call. Only certain vehicles can be assigned to specific response priorities/types, (e.g., a chair car cannot be assigned to an Emergency or Priority 1 response). The following are the response priorities in descending order from highest to lowest priority:

3.25.A. Emergency

Priority 1 – Life Threatening or Potentially Life-Threatening Emergency Response

- 911 or privately generated emergency call.
- Compliant response time is < 8:59 / 90% of the time from the call started time in Zoll RescueNet Dispatch - Billing Dispatch, until the time the wheels of the ambulance stop at the scene of the call.
- Unit should clear/become available as soon as possible after arrival at destination.

Priority 2- Non-Life-Threatening Emergency Response

- 911 or privately generated emergency call.
- Compliant response time for Cambridge is < 8:59 / 90% of the time; compliant response time for Emerson Service Area is <14:59 / 90% of the time from the call started time in Zoll RescueNet Dispatch - Billing Dispatch, until the time the wheels of the ambulance stop at the scene of the call.
- Unit should clear/become available as soon as possible after arrival at destination.

Fire/Hazmat Stand-by

- Medical coverage stand-by requested by 911 or another public safety entity.
- Compliant response time is < 8:59 / 90% of the time from the call started time in Zoll RescueNet Dispatch - Billing Dispatch, until the time the wheels of the ambulance stop at the scene of the call.
- Unit clears when released by the public safety entity assuming Incident Command.

3.25.B. Non-Emergency

Priority 3 – Non-Emergency Response – Pick up on arrival.

- Non-emergency call. Pick-up is ASAP.
- Compliant response time is < 29:59 minutes 90% of the time from receipt of request.
- Unit should clear/become available as soon as possible after arrival at destination.

Priority 4 – Non-emergency Response – Scheduled transfer

- Non-emergency call. Pick-up at a scheduled time requested.
- Compliant response time is within 9:59 minutes 90% of the time of scheduled pick-up time.
- Unit should clear/become available as soon as possible after arrival at destination.

Detail / Stand-by

- Football game, parade, outdoor event.
- Compliant response is a unit/field provider at the stand-by prior to the scheduled start of coverage.
- Unit/field provider should clear/become available as soon as possible after the scheduled end of coverage time.

Pro Policy 300.26 – Appropriate Receiving Facilities

Section:	Operations
Policy #:	300.26
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3.26.A. Receiving Facilities

Every patient transported should be transported to the closest appropriate facility. There are some circumstances in which a patient may need to be transported to a facility better equipped to deal with a specific illnesses or injuries. In the event of a trauma patient or burn patient it is advised to deliver the patient to a Level 1 Trauma Center or a Burn Center. Additionally, patient requests can be honored depending on the patient's condition and call volume.

If field units are unsure as to what destination may best suit the patient's needs, they are directed to contact medical control or the dispatcher for assistance.

Trauma Centers
Beth Israel Hospital (no pediatrics)
Massachusetts General Hospital
Brigham & Women's Hospital (no pediatrics)
Boston Medical Center
Children's Hospital (pediatrics only)
NEMC Floating Hospital (pediatrics only)
UMASS Worcester
Tufts Medical Center
Lahey Clinic

Burn Centers
Massachusetts General Hospital
Brigham & Women's Hospital
UMASS Worcester

Cardiac Cath Facilities for STEMI
Mount Auburn Hospital
Massachusetts General Hospital
Brigham & Women's Hospital
Boston Medical Center
Beth Israel Hospital
St. Elizabeth's Hospital
Lahey Clinic
Metro-West Framingham
Lowell General Hospital
Saints Memorial Hospital

Stroke Centers
All Boston area Facilities

3.26.B. Receiving Facilities – Emerson Service Area

Every patient transported should be transported to the closest appropriate facility. There are some circumstances in which a patient may need to be transported to a facility better equipped to deal with a specific illnesses or injuries. In the event of a critical patient (i.e. STEMI, trauma, or burn patient) it is advised to transport the patient based on the Statewide Trauma Field Triage Criteria and Point of Entry Plan for Adult and Pediatric. Additionally, patient requests can be honored depending on the patient's condition and call volume.

If field units are unsure as to what destination may best suit the patient's needs, they are directed to contact medical control or the dispatcher for assistance.

3.26.C. Hospital Diversion Status

Code Black diversions should also be entered into Zoll RescueNet Dispatch - Billing for immediate crew notification. To enter diversion information while in Zoll RescueNet Dispatch - Billing, go to the VIEW drop down menu and select "Diversions". The diversion window will open. Click the "Add" button. Add the facility. Be certain to include/exclude the appropriate department(s). e.g. TCH L&D only.

The only Diversion status a hospital in MA may have is Code BLACK, meaning the Emergency Department is closed to all ambulances. Under no circumstances can this diversion status be ignored. No patients will be transported to a hospital that is Code BLACK

3.26.D. Hospital Notification

Cambridge Service Area

At times it may be necessary for the dispatcher to notify a receiving facility of the status of an incoming patient. All entry notes to TCH and MAH will be done directly by the Unit on scene through the appropriate CFD portable Channel 7. Entry notes can also be done by the Unit on scene through C-Med. If necessary, entry notes to facilities can be relayed through the dispatcher. The dispatch phone has a ring down or speed dials to all local emergency departments.

Entry notifications should be concise and include the patient's age, sex, chief complaint, treatment, and ETA. Entry notifications are not necessary for Boston hospitals unless the patient presents with a life-threatening condition. After the hospital has been notified by a dispatcher, the dispatcher should inform the unit that the transfer of information is complete, and the receiving facility is awaiting their arrival.

Emerson Service Area

Emerson Hospital for Medical Control and/or Entry Notes phone number is 617-575-9991.

Boston CMED is also available for entry notes to the Emerson Hospital.

This telephone number should be used for ALL MEDICAL CONTROL AND ENTRY NOTE conversations with the Emerson Hospital. No other telephone numbers are to be used, you are no longer required to be transferred through Dispatch in Cambridge, nor should you call the hospital directly on their published numbers.

617-575-9991 is the ONLY AUTHORIZED TELEPHONE NUMBER FOR COMMUNICATION WITH THE EMERSON HOSPITAL.

3.26.E. Point of Entry Plans

All patients meeting the designated criteria for trauma should be transported to an appropriate facility per the Region IV Trauma Point of Entry Plan and in conjunction with the MDPH Statewide Point of Entry Plan.

All patients with stroke symptoms should be transported to the closest appropriate facility per the Region IV Stroke Point of Entry Plan.

PRO utilizes a specific point of entry plan that requires all patients with >1mm of ST elevation be transported to a facility with cardiac cath capability.

PRO also uses a specific point of entry plan for patients requesting transport to MIT Medical or Harvard University Health Services.

If you ever have any question or doubt regarding where to transport a patient always contact Medical Control or a supervisor.

Pro Policy 300.27 – Compliance With Protocols

Section:	Operations
Policy #:	300.27
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3.27.A. Clinical Standards

PRO is dedicated to providing the highest level of patient care. We will endeavor to ensure that every patient receives personalized, compassionate, and professional care. Specific established quality improvement procedures must be followed. PRO reviews 100% of our calls to have an accurate evaluation of the operational, administrative, and procedural activities of the system as it relates to the delivery of patient care. The Management Team evaluates trip sheets in an effort to objectively track performance of both individuals and the overall system.

The Management Team will work with the Medical Directors and their designees to take an active role in the evaluation of protocols, procedures, and patient care standards with constant re-evaluation based on events and progressions made within the system. The Management Team will tabulate a monthly statistical analysis on individual compliance.

M&M Rounds are held on a monthly basis and mandatory for all field providers. Issues that involve protocol changes in patient care will require participation of all levels of the system.

3.27.B. Clinical and Response Time Non-Compliance

All employees who have been found operating out of compliance with the Statewide Treatment Protocols will be subject to immediate remediation with the Management Team. In the event of a serious issue, it will be brought to the attention of the Medical Director's designee or the Medical Director of the protocol violation. The employee may be orally counseled and/or be disciplined up to and including termination.

Any deviation from the Statewide Treatment Protocols will subject the employee to remediation with the Management Team. The employee may also be required to ride with a member of the Management Team when deemed necessary.

Any employee who has repeated paperwork problems will be orally counseled and may be required to ride with a member of the Management Team. Repeated paperwork problems will be dealt with as a disciplinary problem and will subject the employee to further disciplinary action up to and including termination.

Response time compliance will be monitored on a daily, weekly, monthly, and annual basis for trends and to develop procedures to continuously improve performance.

Pro Policy 300.28 – Patient's Property

Section:	Operations
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PRO employees are instructed to properly transport patient's personal belongings when requested to do so. Various items may include clothes, flowers, personal belongings, etc. Crew members will account for these items upon arrival at the receiving facility. In the event crews find items that were not left with the patient upon delivery, notify Dispatch immediately.

Dispatch will make every attempt to:

- Allow the ambulance to immediately return to the receiving facility to return these items.
- Notify another ambulance crew to facilitate return.
- If neither option is possible due to ambulance traffic, the patient's items will be secure in the Dispatch office for return by administration at the earliest possible time.

The patient and/or facility will be notified as to the events and expected time of delivery of the items.

In the event of missing patient belongings, an incident report should be submitted.

Pro Policy 300.29 – Affiliate Hospital Medical Director (AHMD)

Section:	Operations
Policy #:	300.29
Modified:	04/15/2024
Reviewed:	04/15/2024

This policy is issued pursuant to the requirement set forth by the Massachusetts Department of Public Health, Office of EMS in the Statewide Treatment Protocol (version 2024.1, section 6.0) that all (Affiliate Hospital) Medical Director Options shall have "The service must have a written policy adopting use of the procedure, in accordance with the terms of [MA DPH OEMS STP 2024.1], and such policy is signed by the service's Affiliate Hospital Medical Director".

This policy documents PRO's AHMD authorization for PRO employees to utilize all protocols listed under the Medical Director Option section (6.0-6.4) of the STP version 2024.1 in accordance with all MA DPH requirements.

The following STP-MDOs are hereby authorized for use at Pro EMS:

Basic Life Support providers:

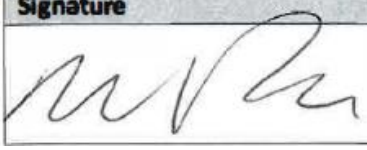
- BLS Bronchodilators
- Check & Inject Epinephrine by BLS Providers

Advanced Life Support providers:

- Needle Cricothyrotomy
- Tranexamic Acid
- Surgical Cricothyrotomy
- Withholding and Cessation of Resuscitation by Paramedic

Training for the above approved MDOs is approved to be conducted in accordance with outlined requirements and occur during initial and ongoing HALO (High Acuity, Low Occurrence) training sessions.

By signature below, the PRO AHMD hereby authorizes PRO employees to perform the above listed protocols as listed and documented in STP version 2024.1 under section 6.0. The AHMD also requires and authorizes PRO to oversee, provide, and document all required training for these protocols to all PRO employees at the level of their certification.

Name	Title
William Porcaro MD, MPH, FACEP	Affiliate Hospital EMS Medical Director and Physician Liaison to the Emergency Preparedness Committee Instructor in Emergency Medicine, Harvard Medical School Department of Emergency Medicine, Mount Auburn Hospital - Beth Israel Lahey Health
Signature	**Dated**
	7/12/23

Pro Policy 300.30 – PB Staffing and Deployment

Section:	Operations
Policy #:	300.30
Modified:	04/15/2024
Reviewed:	04/15/2024

(1) *Staffing*

BLS resources will be staffed with two (2) EMTs. ALS resources will be staffed with two (2) paramedics or one paramedic and one EMT.

(2) *EMD*

Emergency Medical Dispatch with prearrival instructions and QA/Oversight is the standard. When ALS is required, 2 paramedics will be dispatched except during times of extraordinary system demand.

(3) *Paramedic Deployment*

Two paramedics will respond and/or transport patients with the following medical conditions:

- Anyone who (during transport) needs, or may need, ventilatory or circulatory support.
- Suspected STEMI
- Multisystem trauma (Mass trauma point of entry definitions).
- Pregnant patients with imminent delivery or 3rd trimester bleeding.

Medically necessary treatment and transport will NOT be delayed waiting for the arrival of the 2nd paramedic.

(4) *Second Paramedic Cancellations and Requests*

A second paramedic may be cancelled by the first paramedic if not needed. This scenario will not occur in the vast majority of cases as two paramedics will respond and be on scene in the same vehicle or in separate vehicles.

Every system field provider, ALS and BLS, may request and commit the resources that the field provider feels are needed. All system field providers may request an ALS response or a second paramedic for ALS transport of any patient.

(5) *Training Related to Single Paramedic Deployment*

Every system field provider, ALS and BLS, will be trained in accordance with Massachusetts OEMS requirements and the requirements approved by the affiliate hospital medical director.

(6) *CQI Related to Single Paramedic Deployment*

Cambridge EMS conducts 100% case review of all patient care reports.

Whenever a patient who would have ideally called for the presence of two paramedics is treated and/or transported by one paramedic, SMEMS will receive the patient care report and all associated documentation to provide an additional level of case review.

400 | Communications and Dispatch

Pro Policy 400.1 – Overview and Qualifications of Dispatch

Section:	Communications and Dispatch
Policy #:	400.1
Modified:	04/15/2024
Reviewed:	04/15/2024

4.1.A. Overview

Under normal circumstances dispatch is a relatively stress-free position but at times, it can be extremely demanding. The dispatcher must always know the status of all units and crew members.

THE DISPATCHER SHOULD SATELLITE UNITS IN PARTICULAR AREAS TO MAXIMIZE COVERAGE AND MINIMIZE RESPONSE TIMES.

It is imperative that all dispatchers have a thorough knowledge of our service area/surrounding area to assign the most appropriate unit in a rapid and safe manner. Overall, the dispatcher must be prepared for anything and capable of routinely handling multiple tasks simultaneously.

DISPATCHERS MUST BE PREPARED FOR FIELD SERVICE AT ALL TIMES. TO THAT END, ALL DISPATCHERS MUST BE IN UNIFORM AT ALL TIMES.

4.1.B. Employment Qualifications

All employees assigned to dispatch must meet the requirements and qualifications outlined in the Dispatcher job description. All dispatchers are required to have and maintain the following certifications and training:

- American Heart Association CPR (BLS)
- Complete the PRO Dispatch FTEP

Pro Policy 400.2 – Dispatch

Section:	Communications and Dispatch
Policy #:	400.2
Modified:	04/15/2024
Reviewed:	04/15/2024

4.2.A. Dispatch Priorities

A specific response priority is assigned to every call by the Dispatcher. The following are the response priorities in descending order from highest to lowest priority:

- Priority 1 – EMERGENCY, (Emergency lights and siren are used)
- Priority 1 Emerson – EMERGENCY in the Emerson Service Area for ALS Intercept (Emergency lights and siren are used)
- Priority 3 – ASAP, NON-EMERGENCY (Any non-emergency call requesting a pick-up ASAP)
- Priority 4 – SCHEDULED, NON-EMERGENCY (Any non-emergency call that has a scheduled pick-up time)
- Standby/Detail – Events (football standby, parade, fire standby, etc.) Detail is any scheduled or unscheduled event medical coverage.

4.2.B. Dispatch Format

The following format will be used to dispatch:

(1) ***Emergency***

- Unit number/ID being hailed;
    - Unit acknowledges;
- Dispatch priority;
- Exact location of the call (business name or landmark if known);
- Nature of the call;
- Sex/age of patient and additional info on call if known;
- Additional responders;
- Repeat Unit number/ID; and
- Additional information, landmarks, or presence of danger shall be given as it becomes available.

Unit will acknowledge receipt of the call and confirm accuracy of such information by repeating it back to the dispatcher.

Example:
Dispatch: "Pro Base calling Paramedic 2"

Paramedic 2: "Paramedic 2 answering"

Dispatch: "Paramedic 2, Cambridge Family Health, 2067 Mass Ave, Suite #2, 84-year-old female, Difficulty Breathing, with Engine 4 and Rescue 1, Paramedic 2"

Paramedic 2: "Paramedic 2, received, 2067 Mass Ave."

Simultaneously, Zoll RescueNet Dispatch - Billing will send a page to the assigned crew in the following format:

- Response Priority
- Call Type
- Pick-Up Location (Including department and apt/ste/rm number)
- Pick-Up City
- Complaint
- Run Number
- Pick-Up Time
- Dispatch Comments

Example:
Page: P1, ALS, 2067 MASS AVE, SUITE 2, CAMBRIDGE, DIFFICULTY BREATHING, Run#1731, 11:58, 84 YOF

(2) **Emerson Service Area Emergency**

- Unit number/ID being hailed over the Radio with name of Town the response is in;
    - Unit Acknowledges
- Exact Location of the call (business name or landmark if known);
- Repeat location of the call;
- Sex and age of the patient and Nature of the call;
- Repeat Unit number/ID; and
- Additional information, landmarks, or presence of danger shall be given as it becomes available.

The call should be dispatched as follows: ***If you are able to get Business Name (MCI Concord), Cross streets (Rt.2 between Commonwealth Ave and Baker Ave Ext), Major Intersections (East of the Concord MCI Rotary) or a numerical location (i.e., "xxx block of Rt2 Eastbound") that information can be added at your discretion. It is unnecessary for you to state extraneous information such as the caller "feels ill" and was "recently released from the hospital". The key is a succinct radio transmission containing only the pertinent information for the crew to NAVIGATE to the call and bring in the proper equipment (i.e., Pedi bag, Lucas, etc.). The TOWN NAME MUST COME FIRST***

Dispatch should first attempt to reach the Unit utilizing the Emerson Radio or if the Unit is at one of the bases they can be reached using the recorded landline phone at the base.

Format: "Unit ID, Priority, TOWN NAME, Numerical and Street Address (say the address again) TOWN NAME, Numerical and Street Address; MPDS Determinant Language, (say the Unit ID again)"

Example 1: "ALS2, Priority 1, In Concord, 965 Elm Street; In Concord, 9-6-5 ELM Street; 50 y/o Male, Breathing Problems; ALS2."

Example 2: "ALS2, Priority 1, In Concord, 965 Elm Street, MCI Concord; In Concord, 9-6-5 ELM Street, MCI Concord; 50 y/o Male, Breathing Problems; ALS2."

The crew should verify the Dispatch information as follows:
"In Concord, 9-6-5 Elm Street, MCI Concord, responding" (if they are in the unit)
"In Concord, 9-6-5 Elm Street, MCI Concord" (if they are away from the vehicle)

The crew (if they were out of the vehicle) will alert Dispatch once they are responding:
"ALS2, responding in Concord, 965 Elm Street."

The crew should then hail the appropriate Town FD as follows:
"ALS2 calling Concord Fire."

After the Town acknowledges the unit, the crew should then tell the FD where they are responding from:
"ALS2 responding to 965 Elm Street, Concord, from Lincoln Road and Codman in Lincoln."

(3) **Non-Emergency**

- Unit number/ID being hailed
- Unit Acknowledges
- Dispatch priority
- Pick-Up Location/Floor number (if private residence, obtain call back number)
- Drop-Off Location
- Special equipment considerations (IV, cardiac monitor, meds, oxygen, extra attendant, etc.)
- Pick-Up time
- Repeat unit number /ID

Example:
Dispatch: "Pro Base calling Ambulance 1"
Ambulance 1: "Ambulance 1 answering"

Dispatch: "Ambulance 1, Priority 3, Mount Auburn Hospital, Cath Lab, returning to the Cambridge Hospital 4W, bring in your 02, patient is ready now, Ambulance 1"

Ambulance 1: "We have it, Mount Auburn Cath Lab"

Simultaneously, Zoll RescueNet Dispatch - Billing will send a page to the assigned crew in the following format:

- Response Priority
- Call Type
- Pick-Up Location (Including department and Apt/Ste/Rm number)
- Run Number
- Pick-Up Time
- Patient Name
- Drop-Off Location (Including Apt #, etc.)
- Dispatch Comments

Example:
Page: P3, BLS, MT AUBURN HOSPITAL, CATH LAB, CAMBRIDGE, Run#1731, 11:58, DOE, JOHN, BEAR HILL NURSING CENTER, BRING IN YOUR O2.

Pro Policy 400.3 – Dispatch Responsibilities

Section:	Communications and Dispatch
Policy #:	400.3
Modified:	04/15/2024
Reviewed:	04/15/2024

4.3.A. Responsibility to Dispatch

The Massachusetts Department of Public Health – Office of Emergency Medical Services Responsibility to Dispatch, Treat, and Transport (105 CMR 170.355)

A. No service, or agent thereof, including but not limited to its EMS personnel, shall refuse in the case of an emergency to dispatch an available EMS vehicle and to provide emergency response, assessment and treatment, within the service's regular operating area, in accordance with the Statewide Treatment Protocols, at the scene or during transport, or to transport a patient to an appropriate health care facility in accordance with the applicable service zone plan.

B. Primary Ambulance Response.

   1) Upon receipt of a call to respond to an emergency, the service zone's primary ambulance service, or a service operating pursuant to a service zone agreement, and the closest appropriate designated EFR service(s), if any, shall be immediately notified and dispatched in accordance with the applicable service zone plan and 105 CMR 170.510(I)(3)(f).

   2) When the primary ambulance service receives a call, it shall ensure that the closest ambulance is immediately dispatched, in accordance with the service zone plan. If the primary ambulance service dispatcher believes at the time the call is received that an ambulance is not available for immediate dispatch or believes that another ambulance service has the capacity to reach the scene in a significantly shorter period of time, the dispatcher shall immediately contact the ambulance service with the closest ambulance, in accordance with the service zone plan.

   3) When an ambulance service with a provider contract providing primary ambulance response pursuant to a service zone agreement receives a call for primary ambulance response, if it believes at the time the call is received that it cannot meet the service zone standards for primary ambulance response, the ambulance service must immediately refer the call to the primary ambulance service, unless otherwise provided in the service zone plan.

   4) When an ambulance service other than the primary ambulance service receives a call to provide primary ambulance response that is not pursuant to a provider contract and a service zone agreement, it must immediately refer the call to the primary ambulance service.

C. Prior to the approval of a service zone plan.

1) No service, or agent thereof, including but not limited to its EMS personnel, shall refuse in the case of an emergency to dispatch an available ambulance and to provide emergency response, assessment, and treatment, within the service's regular operating area, in accordance with the Statewide Treatment Protocols, at the scene or during transport, or to transport a patient to an appropriate health care facility.

2) Upon receipt of a call to respond to an emergency, the ambulance service shall immediately dispatch a Class I ambulance.

3) If the ambulance service dispatcher believes at the time a call is received that a Class I ambulance is not available for immediate dispatch, the dispatcher shall immediately contact the ambulance service's backup service pursuant to 105 CMR 170.385. If the ambulance service dispatcher believes that another ambulance service has an ambulance that can reach the scene in a significantly shorter period of time, the dispatcher shall immediately notify:

    (a) The other ambulance service, which shall immediately dispatch an ambulance, and
    (b) Police or fire in the town in which the emergency has occurred.

D. As soon as there is a Department-approved service zone plan, no ambulance service shall provide primary ambulance response in a service zone, unless:

1) It is the designated primary ambulance service; or

2) It is acting pursuant to a service zone agreement, in accordance with a department-approved service zone plan and 105 CMR 170.249.

E. Each service whose regular operating area includes all or part of the service zone in which a mass casualty incident occurs must immediately dispatch available EMS resources upon request by the primary ambulance service.

4.3.B. Primary Dispatch Responsibilities

1) Provide professional and courteous service while receiving incoming calls from the public or other public safety entities requesting emergency and non-emergency assistance; achieve and maintain control of call and provide proper interrogation to obtain necessary information to determine the appropriate response and priority by using the MPDS Protocols.

2) Dispatch appropriate unit(s) according to the acuity and location of the call and provide appropriate information as required while simultaneously maintaining radio contact with and monitoring the status of all field units.

3) Prioritize requests for, and dispatch appropriate resources to, non-emergency transports based on customer relationship.

4) Utilize Zoll RescueNet Dispatch - Billing, maintain accurate record and log of all incidents including address of incident, times, type of response, unit number, crew names, patient name, and disposition.

5) Maintain awareness of all field units' status and location through Zoll RescueNet Dispatch – Billing, GPS/AVL, radio communication, and any other means available and assist in coordinating the activities of all field units.

6) Monitor multiple public safety radio frequencies, hospital diversions and video surveillance screens; operate a variety of communications equipment, including radio consoles, paging systems, telephones, computer aided dispatch systems and multiple computer programs/systems.

7) Communicate with other public safety agencies, hospitals, public works departments, support services and any other entity as needed to request or forward necessary information.

8) Serve as shift supervisor in the absence of a supervisory staff member or member of the Management Team.

9) Monitor the ePCR Sync Status screen to ensure all PCRs are synced prior to crew leaving.

10) Collect patient demographic sheets from crews at the end of each shift then scan and attach the paperwork to the corresponding run number.

Pro Policy 400.4 – Primary Service Area and Posts

Section:	Communications and Dispatch
Policy #:	400.4
Modified:	04/15/2024
Reviewed:	04/15/2024

4.4.A. METRO CAMBRIDGE SERVICE AREA

PRO's regular operating area is defined as the geographic boundaries of the City of Cambridge, the property of Harvard University, and the property of the Massachusetts Institute of Technology, and all jurisdictions contiguous to Cambridge. Pro also provides mutual aid service to the towns of Watertown, Belmont, and other surrounding communities upon request. The dispatcher shall post units throughout the regular operating area to ensure the best "coverage" of the area. Posts are not meant to require units to be parked in a set location. Posts are flexible coverage areas designed to focus available units on a specific portion of the city. Assigning units to a Post allows the dispatcher to assure that calls are given to the closest appropriate unit and response times are reduced. PRO uses five (5) posts:

1. *Harvard Square*: any centralized location in or around Harvard Square
2. *Uptown*: any location north or west of Harvard Square including Harvard Square. Ex. – Fresh Pond, Porter Sq., North Cambridge.
3. *Downtown*: any location south or east of Harvard Square including Harvard Square. Ex. – Central Square, East Cambridge, Kendall Square, Magazine Beach.
4. *The Cambridge Hospital*
5. *Mount Auburn Hospital (WATERTOWN/BELMONT)*

Units will be posted at the discretion of the dispatcher; however, it is generally accepted to post as follows:

From 06:00 to 22:00:

# of Units Available	Post	Post	Post
3	Uptown	Downtown	Harvard Sq. or TCH
2		Downtown	Harvard Sq. or TCH
1			Harvard Sq.

From 22:00 to 06:00:
At least 1 available unit @ Harvard Sq. or TCH

4.4.B. EMERSON SERVICE AREA

PRO's primary service area consists of the geographic boundaries of the Towns of: Boxborough, Carlisle, Concord, Lincoln, Maynard, Stow, and Weston. This area includes the four major highways: Route 2, Interstate 95, Interstate 90, and Interstate 495. The dispatcher shall post units throughout the regular operating area to ensure the best "coverage" of the area.

Posts are not meant to require units to be parked in a set location. Posts are flexible coverage areas designed to focus available units on a specific portion of the service area. Assigning units to a Post allows the dispatcher to assure that calls are given to the closest appropriate unit and response times are reduced.

PRO uses three (3) posts in the Emerson Area:

1. *Tracy's Corner*: in the close proximity to the intersection of the Cambridge Turnpike (Route 2) and the Concord Turnpike (Route 2A) in the Town of Lincoln. This is a centralized post used when only one unit is available in the service area.
2. *Acton*: any location in or around Acton, including the Acton Base (25 Maple St) or Kelly's corner (the intersection of Routes 27 and 111). The Acton unit generally responds to calls in Boxborough, West Concord, Maynard, Stow, and Carlisle.
3. *Lincoln*: any location in or around Lincoln, including the Lincoln Base (11 Lewis St), the Lincoln-Weston line (The Dairy Joy on Route 117), or Nine Acre Corner (Route 117 and Sudbury Road). The Lincoln unit generally responds to calls in Lincoln, Concord, and Weston.

The units will be posted at the dispatcher's discretion; however, the following policies apply to posting in the Emerson Area:

- Crews will be posted at the discretion of a Supervisor or Dispatcher.
- If both crews are posted at Bases and one crew is assigned a run, the available crew will immediately move toward their vehicle and request a posting location if not already assigned by Dispatch. No crew shall be at any Base if they are the only resource available (unless making shift change).
- Dispatchers will post crews at specific bases/posts, based on system status and operational demands. Dispatchers may deviate from the aforementioned plan at any time in an attempt to better manage their available resources.

Pro Policy 400.5 – Local Response Plan

Section:	Communications and Dispatch
Policy #:	400.5
Modified:	04/15/2024
Reviewed:	04/15/2024

PRO Communications Center will maintain the most current EMS response assignment plan, using response assignments for each of the MPDS determinant descriptors (sub-determinant codes) approved by the EMD Steering Committee in conjunction with the Cambridge Emergency Communications Center. The EMD Medical Director will review the EMS response assignment plan annually and recommend any proposed changes to the EMD Steering Committee. The EMD Steering Committee will make any changes to the EMS response assignment plan.

PRO seeks to ensure the EMS response assignment plan is maintained and kept current with any changes in EMS law, policy, procedures, research, and standards. In order to meet the needs of the local community, the MPDS response assignment will be subject to annual review and revision.

Procedure

- The EMD system Medical Director will evaluate the EMS response assignment plan annually, by comparing response assignments for each MPDS determinant descriptor to available data, including patient outcome information, local EMS policies and procedures, and the availability of system resources.
- The EMD system Medical Director will make recommendations for any proposed changes to the EMS response assignment plan. He/she will list specific MPDS codes for which response changes are proposed, with a written rational for each proposed change.
- The EMD Steering Committee will approve and make final any proposed changes to the EMD response assignment plan.
- All agency personnel will be notified in writing of response plan changes no later than seven (7) days before actual implementation of the new plan.

Pro Policy 400.6 – Calls

Section:	Communications and Dispatch
Policy #:	400.6
Modified:	04/15/2024
Reviewed:	04/15/2024

4.6.A. Origin of Call (Ordering Facility)

Emergency and non-emergency calls can originate from a variety of sources. On both emergency and non-emergency calls originating from a healthcare facility you must record the department or floor as well as the calling party's name. Zoll RescueNet Dispatch - Billing populates (fills in) most of this information for you on known facilities and residences of patients in our database. Regardless of if the information is automatically populated by Zoll RescueNet Dispatch - Billing or not, the caller shall ask the caller to state the information to ensure its accuracy.

(1) *Emergency Calls*

Dispatchers should document the origin of all emergency calls (P1) by entering the most appropriate caller using the "SOURCE" field in the Emergency Call Taking Screen. Zoll RescueNet Dispatch - Billing automatically populates the ordering facility field under Tab 2, "Medical" based off the "SOURCE" field. The caller's telephone number must be ascertained and entered on all emergency calls received from a source other than Cambridge 9-1-1.

(2) *Emerson Service Area Emergency Calls*

Dispatchers should document the origin of all P1-Emerson emergency calls by entering the Fire Department requesting the ALS resource in the "SOURCE" field in the Emergency Call Taking Screen. Zoll RescueNet Dispatch - Billing automatically populates the ordering facility field under Tab 2, "Medical" based off the "SOURCE" field. The caller's phone number does NOT need to be ascertained since the call is originating from an agency within the CAD.

(3) *Non-Emergency Calls*

Dispatchers should document the origin of all non-emergency calls (P3 & P4) by entering the most appropriate caller using the "ORDERING FACILITY" drop down box (located under Tab 2). Zoll RescueNet Dispatch - Billing automatically populates the ordering facility field with the pick-up facility name. This should be verified and changed as necessary. Ex.- patient traveling from MGH to MIT may have been ordered by MIT, not MGH. "ORDERING FACILITY" will occasionally have new callers and entities added. Please pay attention to these changes and enter the correct caller as this information is vital.

4.6.B. Call Type

A specific call type must be assigned to every incident. Vehicles should be assigned call types based on the nature of the call. The following are the call types:

(1) *Advanced Life Support (ALS)*

Based on the complaint or request; any emergency or non-emergency call requiring ALS assessment, skills, procedures, or monitoring. (e.g., chest pain, shortness of breath, etc.)

(2) *Basic Life Support (BLS)*

Based on the complaint or request; any emergency or non-emergency call requiring only BLS skills, procedures, or monitoring. BLS calls can be assigned to an ALS or BLS vehicle. (e.g., Lifeline alarm, man down, etc.)

(3) *Detail*

Any scheduled or unscheduled emergency medical coverage provided to an event, entity, incident, or area. A detail should be assigned the type of response that was requested. (e.g., football stand-by, Harvard Graduation, fire stand-by, etc.)

Pro Policy 400.7 – Call Taking

Section:	Communications and Dispatch
Policy #:	400.7
Modified:	04/15/2024
Reviewed:	04/15/2024

4.7.A. Emergency

THE DISPATCH OF EMERGENCY CALLS SHOULD TAKE PLACE WITHIN THIRTY (30) SECONDS FROM THE TIME THE CALL IS RECEIVED.

The dispatcher is to make every effort to ascertain, at the earliest possibility, whether a potential for danger exists. If there is a question of danger to a crew on any call such as weapons or Hazmat, the dispatcher will alert the police department and/or fire department. It is important to remember that responding units are not to enter a potentially dangerous situation until it has been determined that the scene is safe and secure.

All dispatchers are required to obtain and enter the following information into Zoll RescueNet Dispatch - Billing on private (non-911/ECC) emergency callers:

- Location/Street Address/Apartment number/Inside or Outside
- City (enter zip code)
- Nature of the call (Transport Reason)
- Origin of Call
- Phone number that caller is calling from (Ordering Facility Phone)
- Any relevant information for the crew's knowledge or documentation purposes (Dispatch Comments)

Dispatchers should document the origin of all emergency calls by entering the most appropriate caller using the "SOURCE" field in the Emergency Call Taking screen.

ALL DISPATCHERS ARE REQUIRED TO TAKE ALL EMERGENCY CALLS AND ASCERTAIN THE ABOVE INFORMATION FROM ANY AND EVERY SOURCE OR LOCATION AND DISPATCH THE APPROPRIATE RESOURCES AND OUTSIDE AGENCIES IF NECESSARY. DISPATCHERS MUST NOT MAKE CALLERS WITH AN EMERGENCY ACCESS THE EMS SYSTEM TWICE. *e.g., - if a patient or facility calls for an emergency in Dedham the dispatcher should take all information and inform the patient that the local EMS will be notified. The dispatcher will then immediately notify the fire department in that locale. Local fire department phone numbers are located in the Mitel Phone System.*

4.7.B. Emerson Paramedics ALS Intercept

Dispatchers should document the origin of all P1-Emerson emergency calls by entering the Fire Department requesting the ALS resource in the "SOURCE" field in the Emergency Call Taking Screen. Zoll RescueNet Dispatch - Billing automatically populates the ordering facility field based off the SOURCE

field. The caller's phone number does NOT need to be ascertained since the call is originating from an agency within the CAD.

All dispatchers are required to obtain and enter the following information into Zoll RescueNet Dispatch - Billing for calls in the Emerson Service Area:

- Location of the emergency (Street address, apartment, and business name if applicable)
- Nature of the call
- Age of patient (if available)

4.7.C. Non-Emergency

The dispatch of non-emergency calls should take place as soon as possible/feasible to ensure a timely response to both Priority 3 and Priority 4 responses. All dispatchers will be required to obtain the following information on non-emergent callers and enter required information into Zoll RescueNet Dispatch - Billing.

- Patient's name*
- Pick-up Location/Street Address/Floor number (if private residence, obtain call back number)*
- Pickup time*
- Drop-off Location/Street Address/Floor number*
- Ordering Facility*
- Ordering Facility Caller's Name*
- Insurance information and medical necessity information for calls originating from a private residence or a facility that we do not regularly service. Ask a supervisor or the billing office if you are unsure of whether the patient's insurance will cover a particular service.

**In order to assign a non-emergency response to an appropriate unit, Zoll RescueNet Dispatch - Billing requires data be entered into these fields along with Call Type and Priority.*

Dispatchers should document the origin of all non-emergency calls (P3 & P4) by entering the most appropriate caller using the "ORDERING FACILITY" drop down box (located under Tab 2). Zoll RescueNet Dispatch - Billing automatically populates the ordering facility field with the pick-up facility name. This should be verified and changed as necessary. *e.g.- patient traveling from MGH to MIT may have been ordered by MIT, not MGH.*

All information should be verified by the dispatcher by verbally repeating all pertinent information back to the caller.

If a Priority 3 or Priority 4 call cannot be dispatched so that a unit can be on scene in accordance with the compliant response times the facility should be notified by telephone and a note should be entered in Tab 6.

4.7.D. ALS Inter-facility Transport – Specialty Care Transport (SCT)

Specialty Care Transport can be an Emergency or Non-Emergency transport in which the patient is transferred from facility to another facility, who requires specialized care by a paramedic with additional training and/or physicians/nurses during transport.

- Patient's name*
- Pick-up Location/Street Address/Floor number (if private residence, obtain call back number)*
- Pickup time*
- Drop-off Location/Street Address/Floor number*
- Ordering Facility*
- Ordering Facility Caller's Name*
- Is the patient unstable?
- What are the current medications or procedures?
- How many IV drips are they currently receiving?
- Is this patient intubated?

**In order to assign a non-emergency response to an appropriate unit, Zoll RescueNet Dispatch - Billing requires data be entered into these fields along with Call Type and Priority.*

4.7.E. Incident Address Verification

Address verification shall be completed in a standardized manner following approved practices and procedures as contained in this policy.

PRO will provide all Emergency Medical Dispatchers (EMDs) with approved procedures and practices for obtaining and verifying an accurate and complete address and phone number.

Procedure

(1) *Answering the Phone-line*

All emergency phone lines will be answered in the following manner:

"Professional Ambulance. This call is recorded."

(2) *CAD System Entry and Verification*

- The call taker will enter the source of the call into the "SOURCE" field in the Emergency Call Taking screen.
- The call taker will enter the address or location provided by the caller into the CAD system using the most accurate information available from the caller (This could be a numeric address, intersection, business, landmark, etc.)
- The call taker will verify the address (or location) by stating the following: "Please repeat the address/location for confirmation."
- For all residential (or suspected residential) locations, the call taker will ask "Is there a specific floor or apartment number?" and correctly enter this information into the CAD incident.
- For all non-residential locations, the call taker will obtain all necessary access information, which may include building name, business name, floor number, office or suite number, specific entrance instructions, and intersection or street segment (for roadway incidents).
- Once the call taker has entered the address/location into the CAD system, he/she will geo-verify the entered address/location by ensuring that CAD returns a valid address or location AND it matches the initial information by the caller.

- The call taker will then ask for and verify the phone number and enter it into Zoll RescueNet Dispatch - Billing (excluding calls originating from a town agency in the Emerson Service Area).

Pro Policy 400.8 – Caller Management and Customer Service

Section:	Communications and Dispatch
Policy #:	400.8
Modified:	04/15/2024
Reviewed:	04/15/2024

PRO Dispatchers shall handle all calls for emergency ambulance assistance using established caller management and customer service practices. It is understood that not all callers will be calm and/or cooperative. PRO Dispatchers will anticipate those situations and respond as trained professionals, following the call taking guidelines to the best of their ability and providing emotional care and comfort to callers. PRO's goal is to provide all PRO Dispatchers with a well-defined procedure for managing callers and providing those callers with sufficient reassurance, emotional comfort, and customer service.

Procedure

(1) *Caller Reassurance and Explanations*

- Politely but firmly focus the caller on answering all questions *as you ask them*. If callers lose their focus, get agitated or uncooperative, say, "**Sir/Madam, it's important I get this information so I can tell you exactly what to do to help."** Repeat this as often as necessary *using exactly the same phrasing*.

(2) *Coping with Distressed, Hysterical, Aggressive and Abusive Callers*

- It is recognized that some callers will be highly distressed, uncooperative and, at times, abusive. All of these callers behave this way because they are frightened and feel helpless. When faced with these callers, the PRO Dispatcher will maintain a professional demeanor and caring approach.
- The PRO Dispatcher will remain calm and courteous at all times.
- The PRO Dispatcher will maintain normal speaking volume and a professional, caring voice tone, avoid yelling and any display of anger or contempt.
- Whenever possible, the PRO Dispatcher will give clear, brief explanations as to what he/she is doing and why. For example, explain to the caller why they will be put on hold (so that you can get the ambulance on the way to them).
- The PRO Dispatcher will continually reassure callers that he/she is there to help. It may be necessary to repeat this. The PRO Dispatcher will explain that trained help is on the way and repeat it when necessary.
- The PRO Dispatcher will, when necessary, obtain and use a callers first name or title (Jane, Bill, Mr. Jones, Mrs. Stevens, etc.)
- The PRO Dispatcher will use 'REPETITIVE PERSISTENCE.' *Give the caller an action, followed by a reason for complying with the action.* Repeat this, using exactly the same phrasing, and in a calm level voice, as often as is necessary until the caller listens and cooperates.

- The PRO Dispatcher will, when necessary, use 'POSITIVE AMBIGUITY.' Do not 'lie' to the caller, even if motivated by kindness. Do not make promises or create unrealistic expectations for the caller.
- The PRO Dispatcher will never make any statements that foster or create feelings of helplessness, guilt, or panic in a caller.
- The PRO Dispatcher will never threaten a caller in any way, or engage in any discriminatory, derogatory, or demeaning behavior toward the callers, patients, family members or bystanders, explicitly or implicitly, through language, attitude, or voice intonation.

Pro Policy 400.9 – Monitoring/Recording the Status of Units

Section:	Communications and Dispatch
Policy #:	400.9
Modified:	04/15/2024
Reviewed:	04/15/2024

From the moment a call is received the dispatcher has several events that must be recorded. Zoll RescueNet Dispatch - Billing will automatically record and timestamp each unit's progress when data is entered by the dispatcher. The following is a list of all events that must be recorded:

(1) *Dispatched / Assigned*:

Unit has been assigned a call by the dispatcher prior to acknowledging they are en route.

(2) *En route*:

Unit is physically underway or moving toward a call. A unit cannot be "en route" if the crew is not physically in their unit, responding.

(3) *At Scene*:

Unit has arrived at the address of their call. Commonly referred to as "out". (e.g., "Ambulance 1 out at the Mount Auburn", "Paramedic 2 out with Rescue")

(4) *Transporting*:

Unit is occupied with a patient that is en route to a facility to drop off a patient.

(5) *At Destination (The dispatcher will be prompted for a transporting mileage)*:

Unit has reached the destination of their transport.

(6) *Available*:

Unit is clear and available for assignment to the next call.

(7) *Checking the Well-being of a Crew*

Every effort should be made to contact a crew that does not respond to radio traffic or has been on scene for an extended period of time to establish their well-being.

If a crew contacts dispatch to report a violent or disruptive situation, the dispatcher should immediately contact the local police department to respond. It is the dispatcher's responsibility to be aware of ALL crew's whereabouts, status, and well-being at all times.

Pro Policy 400.10 – Canceling, Re/Un-Assigning, Running Late for a Call

Section:	Communications and Dispatch
Policy #:	400.10
Modified:	04/15/2024
Reviewed:	04/15/2024

On occasion it will be necessary for dispatchers to cancel units from a response, to exchange units, or reassign a call to another unit. Dispatchers are strongly cautioned that once a unit is responding to a call, assigning another unit that appears physically closer may not always be appropriate. Consider the time of day, time needed to look up the call and plan a route, and actual response time. During a response or transport, a unit may get cancelled or become delayed for several reasons that need to be documented. Details to document unusual circumstances should be entered in the comment section of the call.

Dispatchers should document all cancellations and assignments by entering the most appropriate reason on all “Cancelled”, “Unassigned” or “Reassigned” calls by using the various drop-down boxes that will automatically prompt the Zoll RescueNet Dispatch - Billing user. Take the time to pick the most accurate reason.

Dispatchers should also make notes and add comments as appropriate to best document the circumstances and provide additional information on the cancellation.

Pro Policy 400.11 – Utilization of Outside Resources

Section:	Communications and Dispatch
Policy #:	400.11
Modified:	04/15/2024
Reviewed:	04/15/2024

4.11.A. Cambridge Service Area

The dispatcher may utilize an outside agency for emergency calls if the response time of a PRO unit will be significantly greater than that of the outside resource. Another agency or fire department may be significantly closer or there may be no PRO units available for response. The following resources should be considered based on the location and nature of the call:

(1) *For BLS or ALS calls:*

- Cataldo Ambulance Service 617-625-0042
- Armstrong Ambulance Service 781-648-0612
- MIT EMS (if in service) – dispatch directly on MIT-EMS channel 617-253-1212
- Coastal Medical Transportation 617-745-9999
- Belmont Fire 617-484-1300
- Watertown Fire 617-972-6567
- Arlington Fire 781-643-1212

(2) *Belmont/Watertown Service Area*

If a PRO unit is not available for a response in Belmont or Watertown, it is the responsibility of the PRO dispatcher to find an outside agency to respond to the call. Another agency or fire department may be significantly closer or there may be no PRO units available for response. The Pro dispatcher shall determine the level of response and resource required (ALS/BLS, transporting/non-transporting). The following resources should be considered based on the location and nature of the call:

- Watertown Fire Department 617-972-6567 or Belmont Fire Department 617-484-1300
- Armstrong Ambulance 781-648-0612
- Waltham (Use for Watertown or Belmont) 781-893-4100
- Newton (Use for Watertown only) 617-796-2123
- Lexington Fire Department (Use for Belmont only) 781-862-0271
- Arlington Fire Department (Use for Belmont Only) 781-643-1212
- Cambridge Fire Department (Non-transporting ALS only) 617-349-4900

After finding the appropriate resource to respond to the call, the Pro dispatcher shall notify the Belmont/Watertown dispatcher of which unit is responding and where they are responding from if known.

4.11.B. Emerson Service Area

It is the responsibility of the community requesting ALS intercept service to request this service from another source if PRO does not have an ALS vehicle available. The dispatcher shall enter the call into Zoll RescueNet Dispatch - Billing and leave it pending in open work until an ALS unit becomes available. At this time, the dispatcher shall call the community that requested ALS intercept service to see if the service is still needed. If service is still needed, the closest ALS resource will be sent. If service is no longer needed, the call will be canceled with the reason “ALS not available from any source.”

For ALS Backup:

- Acton Fire Department 978-264-9645
- Littleton Fire Department 978-540-2302
- Sudbury Fire Department 978-443-2239

4.11.C. Review Process

The Management Team will receive a First Watch Alert anytime a call is given away to a mutual aid agency. These calls will be audited to ensure compliance to the above policy. A report of all calls given away to other agencies will be generated regularly.

Pro Policy 400.12 – Operation and Familiarization with Dispatch Equipment

Section:	Communications and Dispatch
Policy #:	400.12
Modified:	04/15/2024
Reviewed:	04/15/2024

All equipment is to be used in accordance with its operating instructions and is not to be abused in any manner. If you don't know, ASK! Any out-of-service equipment or any questions regarding equipment should be reported to a supervisor as soon as possible.

4.12.A. Zoll RescueNet Dispatch - Billing Dispatching

PRO utilizes Zoll RescueNet Dispatch - Billing by Zoll Data Systems to monitor, track and record all data regarding incidents. All dispatchers must input all required data for EVERY incident. Procedures for documenting incidents have been thoroughly outlined in the preceding sections.

Logging In/Out of the Network:

When taking over responsibility for dispatch, the dispatcher is required to log in to the network and then Zoll RescueNet Dispatch - Billing. Personalization of the Zoll RescueNet Dispatch - Billing desktop is permitted. When releasing the desk to another dispatcher, the dispatcher should first log out of Zoll RescueNet Dispatch - Billing, then log out of the network.

4.12.B. Zoll RescueNet Dispatch - Billing Paging

Paging is done through the Zoll RescueNet Dispatch - Billing interface and is used for the dispatcher to communicate information to field staff that have provided their cell phone as a paging device.

The Zoll RescueNet Dispatch - Billing system will automatically deliver pages to crews assigned to ambulances detailing call information and times.

The procedure for manually paging an employee is as follows:

While in Zoll RescueNet Dispatch - Billing, go to the paging icon on the toolbar. The paging window will open. Highlight and select the name or group on the left, adding it to the paging box to the right. Type your message. Click on the "Send" button on the bottom of the window.

When paging an individual, be as specific as possible with messages. *i.e. "Merg, call PRO. ALS open shift tonight 4-12"*

In the event you would like to page multiple employees, groups are set up in Zoll RescueNet Dispatch - Billing for this purpose. The groups you can page are ALL, ALS full-time, ALS part-time, BLS full-time, BLS part-time, and Dispatchers. *For example, if you are trying to fill an open ALS shift, select the group name(s), which in this case would be ALS full-time and ALS part-time, type your message and send.* You

have just paged every paramedic employed by PRO with your message. You can also select more than one employee by holding the “Ctrl” key and clicking on the name of each person that you want to page.

4.12.C. RescueNET Dispatch Log

The Dispatch Log, which can be accessed through the Zoll RescueNet Dispatch - Billing interface by going to the VIEW drop down menu and selecting “RescueNet Dispatch Log”, is to be used as a daily log of the following activities/events:

(1) *Sick Calls*:

When an employee calls in sick the following information should be documented:

SICKOUT, Employee name, shifts out for, time of call, who called, and reason for sickout (if provided)
Example: SICKOUT/Mergendahl/8-4, 4-12/7:50/Ben Mergendahl/Flu

(2) *Late for Shift*:

LATE, Employee name, how late, time of call, start time, who called, reason for tardy.
Example: LATE/Mergendahl/running 30 mins late/8:02/8:00/Mergendahl/overslept

(3) *Unit involved in an MVA*:

MVA, Unit number, driver name, passenger name, injuries (if applicable), damage assessment, and supervisor incident was reported to.

(4) *Complaints/Compliments*:

All complaints and/or compliments should be logged, and an Incident Report must be submitted. Provide a brief summary including crew member/members involved and party reporting the incident.

(5) *Unrecovered Equipment*:

Any equipment reportedly left at a hospital or facility should be noted.

(6) *Critical Vehicle Failures*:

A critical vehicle failure (CVF) is any time a vehicle is unable to complete a response or a transport because of some failure. This includes a flat tire, overheating, electrical failure.

The dispatcher should document all CVFs in the Dispatch Log including the unit/vehicle ID, crew members, a brief description of the problem/situation and outcome, if applicable and an Incident Report Form must be submitted by the crew.

(7) *Vehicle Failures*:

A vehicle failure is any failure resulting in the vehicle being placed out of service for any period of time.

The dispatcher should document vehicle failures in the Dispatch Log including the unit/vehicle ID, crew members, a brief description of the problem/situation and outcome (if applicable), and an Incident Report Form must be submitted.

(8) *Other Information*:

In addition, the Log can be used to pass along any relevant information to the next dispatcher as well as to convey information to the Management Team. The Log will be reviewed every morning by the Management Team. The Log is a permanent record – you cannot erase an entry once it has been saved.

4.12.D. Zoll RescueNet Dispatch - Billing Reminders

On occasion it will be necessary to enter information about an upcoming event into Zoll RescueNet Dispatch - Billing. This is not a standing order or recurring transport, this would be an unusual circumstance requiring the notification of a dispatcher in the future *e.g., NSTAR calls to say they will be cutting power for 15-minute periods on December 19, 2023, starting at 2100*.

Use the following procedure to enter Reminders:

- Ctrl "T" as if you were entering a call.
- Enter "Reminder" as the last name. Choose "Reminder, this is a" as the patient.
- Enter PRO in the pick-up facility field.
- Choose REMINDER! As the Call Type.
- Choose REMINDER as the Priority.
- Choose REMINDER as the Transport Priority.
- Enter the message/reminder in the notes area.

To acknowledge the reminder, after review, right click the REMINDER! In Open Work and cancel the REMINDER. Use "REMINDER ACKNOWLEDGED" as the cancel reason. If the reminder requires follow-up, recreate a new reminder, or add the information to the RescueNet Dispatch Log.

4.12.E. Motorola Radio Console

The Motorola Radio Console is located at the Dispatch 1 position. From this console, we have the ability to communicate on and monitor several frequencies including: channel 1 (Cambridge FD), channel 3 (Emerson), channel 4 (Pro EMS), channel 5 (Cambridge EMS), channel 7C (TCH-ER), channel 7M (MAH-ER), channel 11 (EMS Ops-1), channel 12 (EMS Ops 2), channel 14 (CFD Fireground), channel 16 (CFD Fireground), the MIT EMS channel and a Pro UHF frequency.

4.12.F. Cambridge ECC Computer Monitors

There is a monitor located at dispatch to check emergency vehicle status and call information for emergencies in Cambridge. The monitor is linked to Cambridge Emergency Communications Center via a fiber connection and is set up to automatically import calls from their CAD into our CAD. The monitor will provide real-time call taker updates that can then be conveyed to the responding crew. Software of any type shall not be loaded into the computer at any time.

4.12.G. Telephone/Radio Recordings

The Mitel Phone system records all telephone traffic on every phone line in the building as well as internal extensions. These recordings can be accessed by clicking on the "Voice Recordings" folder on the desktop and choosing the appropriate extension. Radio traffic is recorded at ECC.

4.12.H. Telephone Etiquette

The telephone should be answered as quickly as possible. The following script should be used when answering the phone: “Professional Ambulance, your call is recorded.”

The dispatcher should be able to maintain multiple calls if necessary. Routine and non-emergency calls should be placed on hold if multiple lines are ringing. Emergency requests take precedence over non-emergency and routine business calls.

The dispatcher shall know how to direct incoming phone calls to appropriate extensions or voice mailboxes, transfer calls to inside and outside lines and conference 3rd parties into our phone system.

4.12.I. ePro

The dispatcher should have a working knowledge of ePro.

Access to ePro is gained by directing your web browser to ePro at:
https://scheduling.esosuite.net/Default.aspx?DB=proems

The User ID is typically your first initial and last name in lowercase letters and the password is case sensitive.

4.12.J. RangeCast

RangeCast is a web-based audio management system that receives, stores, and sends audio clips of radio traffic over the internet. PRO utilizes RangeCast to scan and monitor radio traffic for the Emerson Paramedic service area and several surrounding communities that we provide mutual aid for. It is the dispatchers’ responsibility to monitor radio traffic and satellite units as necessary for coverage.

Pro Policy 400.13 – End of Shift

Section:	Communications and Dispatch
Policy #:	400.13
Modified:	04/15/2024
Reviewed:	04/15/2024

4.13.A. End of Shift/Hand-off to On-coming Dispatcher

The dispatch area should be free of debris at all times. At the end of your shift before handing off to the on-coming dispatcher the following should be done:

- Remove all trash, food, beverages from work area;
- Empty the desk trash can; and
- Clean counter.

Any required information should be noted in the RescueNet Dispatch Log, if not already done.

All open tasks/applications/windows on the PC should be closed. The off-going dispatcher should log out of Zoll RescueNet Dispatch - Billing and the network.

The off-going dispatcher should pass along any information regarding status of crews, equipment in need of recovery at facilities and any other relevant information. All information should be documented in the RescueNet Dispatch log. The icon for the log is located on the toolbar next to the question mark.

All paperwork from crew will be scanned prior to leaving at the end of your shift.

Pro Policy 400.14 – Management Notification

Section:	Communications and Dispatch
Policy #:	400.14
Modified:	04/15/2024
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The dispatcher is responsible for notifying the Management Team:

- Multiple Alarm Fires
- Mass Casualty Incidents
- Any Power Failures
- Complaints requiring immediate action/response.
- Company Vehicle Accidents with severe damage and/or injury or death
- On-duty employee injury, illness, or death

If you find yourself in a situation where you are unsure whether to notify management of some type of event, you should make the notification.

Notifications can be made using the paging system, text, or phone call.

Pro Policy 400.15 – Emergency Procedures for Equipment Failure

Section:	Communications and Dispatch
Policy #:	400.15
Modified:	04/15/2024
Reviewed:	04/15/2024

4.15.A. Phone Failure

In the event you lose the power to the telephones, immediately plug in the backup phones (located in the dispatch cabinet). The phones will be plugged into the jacks on the wall behind the dispatch printer. Immediately notify IT, the Management Team, and submit a Support Ticket to support@proems.com.

4.15.B. Zoll RescueNet Dispatch - Billing Failure

In the event of the failure of Zoll RescueNet Dispatch - Billing the dispatcher should immediately begin to dispatch using the paper log system. Paper logs can be found in the red binder in the Dispatch Cabinet. Alert all units via radio that pages, run numbers and ePCRs will not be generated for calls. At the end of the event, all calls should be entered and updated in Zoll RescueNet Dispatch - Billing. A page should be generated alerting all crews that the CAD is back up and running.

4.15.C. Radio Failures

Failure of the Motorola Radio Console – Use the backup radios at the Dispatch 2 position and notify ECC and PRO IT Department of the console failure.

In the event that Channel 4 is not functioning, the dispatcher shall utilize the PRO UHF frequency which will allow crews to communicate via the truck radio. Notify ECC of the issue so they can troubleshoot.

Dispatcher should send pages frequently to update crews as to the status of the radio failure. When service has been restored to normal, all crews should be notified via pager and over the radio.

4.15.D. Pager Failure

In the event of failure of the paging system, all units will be advised over the radio that pages will not be generated for any calls. A page should be sent when the system returns to normal. Dispatcher must notify the IT Department as soon as possible of the Pager Failure via the support@proems.com email.

Pro Policy 400.16 – Emergency Procedures for Power and Communications Failure

Section:	Communications and Dispatch
Policy #:	400.16
Modified:	04/15/2024
Reviewed:	04/15/2024

4.16.A. Power Failure Procedures

IN THE EVENT ALL POWER IS LOST IN THE BUILDING, THE EMERGENCY LIGHTS WILL AUTOMATICALLY ILLUMINATE WITHIN A FEW SECONDS. WHEN POWER IS RESTORED, THE GENERATOR WILL SHUT OFF AUTOMATICALLY.

4.16.B. Communications Center Failure Procedures

PRO maintains a diesel generator capable of providing nearly instantaneous emergency power automatically to our building and all of its systems within five (5) seconds of a power failure. Additionally, all mission critical PRO computers have battery back-up/UPS in place to protect against power surges and prevent data loss.

In the event of telephone service interruption in the building, Barry Communications must be immediately contacted to resolve the issue. Additionally, PRO can operate both radio frequencies for vehicle and portable radio communications in the event of generator failure by utilizing portable radios in dispatch.

Should the PRO Communications Center need to be evacuated, all dispatch and communications center operations could continue by moving to the Harvard University Police Station located at 1033 Mass Ave in Cambridge. A PRO dispatcher can utilize the cubicle provided by HUPD. The Dispatcher will bring an Emerson Area portable radio and a Cambridge portable radio with them to HUPD. If you are not familiar with where the Pro Backup Communications Center is at HUPD ask the Officer at the Front Desk of HUPD. All PRO and Emerson Paramedics phone lines are set up as off-premise extensions, so no forwarding is needed in the event of a failure.

The Pro Backup Communications Center has internet access that can be used by the PRO dispatcher to sign onto Parallels and log onto Zoll RescueNet Dispatch - Billing.

Paper logs are available if access to CAD is not possible or unsuccessful.

Pro Policy 400.17 – Radios

Section:	Communications and Dispatch
Policy #:	400.17
Modified:	04/15/2024
Reviewed:	04/15/2024

4.17.A. Radio Etiquette

The conduct of employees using PRO radios must be professional at all times. Speak slowly, clearly, and concisely. There should be no inappropriate, profane, or personal remarks at any time. Your radio traffic should be well thought out and succinct and you should "echo" or repeat instructions back to the dispatcher. If at any time you are unsure or did not clearly understand the message, ask for it to be repeated. Do not acknowledge a message if you are unsure what was said.

Keep the microphone 1-3 inches away from your mouth. Depress and hold the push-to-talk button on the microphone for 1 second before and after transmitting to prevent "clipping" your message.

4.17.B. Radio Equipment

It is your responsibility to ensure you have your radio on you before your scheduled start time. Make absolutely sure that you have an appropriately charged battery and that your radio remains on throughout your shift. The volume should be turned up. You must keep your portable radio on your person at all times when not in your vehicle.

(1) *Portable "Fire" Radio*

This is a portable radio. **Each** member of the crew will carry a "Fire" Portable. This radio is to remain on channel 4 and in the "scan" mode. This radio is to be utilized for all communication when out of the vehicle.

- Utilize channel 14 for communications in the MBTA stations.
- Utilize channel 5 for communications directly with Fire Alarm and CFD units assigned to EMS calls.

(2) *Mobile "Company" Radio*

This is a mobile radio installed in the cab of each ambulance. This radio is to remain on channel 4, being utilized when crews are in the ambulance. Utilize the mobile "Company" radio to notify C-MED.

4.17.C. Radio Traffic

When communicating via the radio, identify yourself, then continue with your message:

"Paramedic 2, out at 237 Franklin with Rescue 1"

Typical response: “Paramedic 2, you’re out with Rescue 1 at 15:32”

When hailing Dispatch/another unit, identify yourself, then the party you’re calling:

“Paramedic 2 calling PRO Base.”
Typical response: “PRO Base answering Paramedic 2.”

When hailing the Mt. Auburn or Cambridge Hospitals, state the facility name, identify yourself, then continue with your message:

“Cambridge Hospital, Paramedic 2 with a BLS entry note.”
Typical Response: “Cambridge Hospital online, go ahead PRO.”

If you believe you have emergency traffic (e.g., you are in a life-threatening situation, MVA, etc.) hail dispatch and state you have emergency traffic. The dispatcher will inform all other units to stand-by.

“Paramedic 1 calling PRO Base with emergency traffic.”
Typical Response: “All units, stand-by with your traffic, go ahead Paramedic 1”

Pro Policy 400.18 – Transmissions

Section:	Communications and Dispatch
Policy #:	400.18
Modified:	04/15/2024
Reviewed:	04/15/2024

4.18.A. Required Transmissions

From the moment a call is assigned there are several events that must be verbalized to the dispatcher over the air. They are:

(1) *En route*:

Unit is physically underway or moving toward a call. A unit cannot be “en route” if you are not physically in the unit, responding.

Example: “Paramedic 1, en route to 237 Franklin”

(2) *At Scene*:

Unit has arrived at the address of their call. Commonly referred to as “out”.

Example: “Paramedic 1, out at 237 Franklin with Rescue 1”

(3) *Transporting*:

Unit is occupied with a patient and is underway or en route to a facility to drop off a patient. *Note: Reset the trip odometer to zero

Example: “Paramedic 1, transporting 1, Paramedic 1-ALS to the Cambridge”

(4) *At Destination with Mileage*:

Unit has reached the destination of their transport.

Example: “Paramedic 1, on arrival at the Cambridge, 1.1”

(5) *Available*:

Unit is clear and available for assignment to the next call.

Example: “Paramedic 1, clear and available at the Cambridge”

Pro Policy 400.19 – Hospital Notification

Section:	Communications and Dispatch
Policy #:	400.19
Modified:	04/15/2024
Reviewed:	04/15/2024

4.19.A. Overview

Dispatch is equipped with ring down lines or speed dial capability to all area emergency rooms. For ALS or BLS calls going to TCH ER or MAH ER, your entry note can go through fire portable Channel 7 TCH or 7 MAH respectively.

When contacting the Emerson Hospital for Medical Control and/or Entry Notes, call **617-575-9991**. Boston CMED is also available for entry notes to the Emerson Hospital.

This telephone number should be used for ALL MEDICAL CONTROL AND ENTRY NOTE conversations with the Emerson Hospital. No other telephone numbers are to be used, nor should you call the hospital directly on their published numbers.

Entry notifications should be concise and include the patient's age, sex, chief complaint, treatment, and ETA. Please note that entry notifications are not required to Boston hospitals unless the patient presents with a life-threatening condition.

Attempt to hail the receiving facility two (2) times. If the facility does not answer, contact dispatch to relay your entry notification. Relay all pertinent patient information to the dispatcher so they can give an appropriate entry note to the receiving facility. The dispatcher will then inform you that the transfer of information is complete, and the facility is awaiting your arrival.

4.19.B. C-Med Entry Notes

If you must notify C-Med for medical control or for entry notifications, the following procedure should be followed:

1. Switch to channel C-Med 4 on your vehicle radio-this is Med-4. Here you will contact Boston C-Med. Ex.- *"Boston C-Med, Boston C-Med, PRO Paramedic 3 calling with an ALS entry note for MGH coming from Cambridge"* they will answer. You then can request your hospital patch along with your location so they can determine which tower to utilize. Ex.- *"Requesting medical control from the Cambridge Hospital – we are in Cambridge."*
2. Boston C-Med will then assign you a Med channel. This will usually be Med2, Med 5, or Med7. Switch your radio accordingly. The hospital will meet you on the assigned channel. You can then give your notification or request for medical control.

4.19.C. Medical Control by Telephone

Medical control is also available by telephone.

- TCH: 617.682.9235
- MAH: 617.684.4744
- Emerson: 617.575.9991

Pro Policy 400.20 – Status Checks

Section:	Communications and Dispatch
Policy #:	400.20
Modified:	04/15/2024
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It is important that dispatchers occasionally check the status of crews at all call locations when a unit has been on scene for an extended period of time. Your only communication link outside of the ambulance is your portable radio. Every effort will be made to contact a crew that does not respond to radio traffic or has been on scene for an extended period of time to establish their well-being. If the dispatcher cannot confirm your safety, the dispatcher will initiate a police response.

If you find yourself in a violent or disruptive situation alert the ECC dispatcher on Channel 5 with your Unit Number, location and nature of the emergency and they will in turn notify the police.

Pro Policy 400.21 – Vehicle Operations

Section:	Communications and Dispatch
Policy #:	400.21
Modified:	04/15/2024
Reviewed:	04/15/2024

4.21.A. Cellular Telephones

Except for an emergency, cellular telephone communication is prohibited when operating any PRO vehicle.

4.21.B. Telephone Calls to Dispatch

Any unit concerned with the dispatch or assignment of a call can contact the dispatcher or a supervisor after handling the call. You should not call dispatch prior to completing your assigned run. There should be no confrontations over the telephone.

Pro Policy 400.22 – Addressing Language Diversity

Section:	Communications and Dispatch
Policy #:	400.22
Modified:	04/15/2024
Reviewed:	04/15/2024

4.22.A. Language Line

Any time that a PRO employee encounters a Language Diversity problem, PRO has the ability to utilize the Language Line service for both emergency and non-emergency situations. In each of the First In (ALS & BLS) bags in all Pro vehicles there is a packet with information of how to use the Language Line service and a backup copy will also be held in Dispatch. PRO has access to over-the-phone interpretation 24 hours a day and 7 seven days a week with this service. Instructions on how to use the service are on the cards and proper training will be provided to all PRO employees.

Language Line 800.523.1786 – ID# 126018

Pro Policy 400.23 – Communication Equipment Preventative Maintenance

Section:	Communications and Dispatch
Policy #:	400.23
Modified:	04/15/2024
Reviewed:	04/15/2024

4.23.A. Communication Equipment Preventative Maintenance

All PRO communication equipment will receive Preventative Maintenance annually through an outside vendor who will provide documentation of the process.

500 | Support Sevices

Pro Policy 500.1 – Disposable Medical Equipment and Supplies

Section:	Support Services
Policy #:	500.1
Modified:	04/15/2024
Reviewed:	04/15/2024

5.1.A. Overview

Disposable medical equipment and supplies serve a medical purpose, are not useful to an individual in the absence of an illness or injury and are intended for one-time or single patient use. Disposable items are discarded after their intended use. Consult a Supervisor if there is any doubt in your mind as to whether an item is disposable or reusable. The following are examples of disposable medical equipment and supplies:

- Suction Canister/Tubing
- Bandaging
- Sterile Water / Normal Saline
- All other equipment not listed under Durable Medical Equipment and not intended for repeated medical use.

5.1.B. Use

All employees should be totally familiar with the use of all equipment and supplies within the vehicle in which you are working. All equipment and supplies are to be used based on the manufacturer's recommendations. Instruction on the use of equipment and supplies will be provided by any Supervisor or Field Training Officer (FTO). IF YOU DON'T KNOW HOW TO USE IT, ASK.

5.1.C. Disposal

Any disposable item that has been opened or removed from its original packaging is considered "used" and should be discarded and not considered for future patient use. Used, but not contaminated disposable waste can be discarded in any waste receptacle. Any disposable item that has come in contact with body fluid must be considered contaminated. All contaminated, disposable materials must be considered potentially infectious and placed in impervious red plastic bags clearly marked with the bio-hazardous waste symbol and sealed prior to disposal. Grossly contaminated or wet, dripping waste must be doubled bagged. Red bio-hazard waste bags should be disposed of at the receiving facility in bio-hazard waste containers after patient care has been terminated, prior to returning your unit to service.

ALWAYS UTILIZE UNIVERSAL PRECAUTIONS WHEN CLEANING ANY ITEM – ASSUME ALL ITEMS ARE CONTAMINATED. NO ONE SHOULD BE SUBJECT TO HAVING SOILED OR CONTAMINATED EQUIPMENT IN ANY COMPANY VEHICLE.

5.1.D. Restocking

PRO's equipment and supplies exceed the minimum requirements set forth by state guidelines for all Class I ambulances. A properly stocked ambulance should be more than sufficient to get you through most shifts. In the event that you need to re-stock before your shift is complete, attempt to do so at the receiving facility prior to returning to service. If you are unable to re-supply at the facility, contact the Dispatcher for permission to return to PRO Base to re-supply your ambulance. All disposable medical equipment and supplies are located in the Supply Room. If it appears the equipment/supplies you need are not available in the supply room, or that we are running low, alert a Support Service Technician, the Dispatcher, or a Supervisor. It is expected that your ambulance be sufficiently stocked at all times.

5.1.E. Linen

All dirty sheets and linen should be exchanged at and returned to the receiving facilities. Do not leave dirty linen in the ambulance or bring it back to base.

5.1.F. Expired and Expiring Meds/Equipment

Certain disposable medical equipment and most medications have expiration dates. Any disposable medical equipment or medication that has expired should be placed out of service and/or discarded of and replaced immediately.

Pro Policy 500.2 – Durable Medical Equipment and Supplies

Section:	Support Services
Policy #:	500.2
Modified:	04/15/2024
Reviewed:	04/15/2024

5.2.A. Overview

Durable medical equipment and supplies primarily serve a medical purpose, are not useful to an individual in the absence of an illness or injury and are intended to withstand repeated use. Durable items are cleaned, sanitized, and placed back in service after their intended use. Consult a Supervisor if there is any doubt in your mind as to whether an item is disposable or durable (reusable). The following are examples of durable medical equipment and supplies:

- Onboard Suction
- Portable Suction
- Monitor / Defibrillator
- Ambulance Stretcher
- Stair Chair
- Scoop Stretcher
- Glucometer*
- Oxygen Delivery Device*
- Backboards*
- Padded Board Splint*
- Traction Splint*
- Stethoscope*
- B/P cuff*
- Thermometer
- Lactate Meter
- Pumps

**Some "reusable" equipment should be considered "disposable" if it is grossly contaminated, or cleaning/sanitizing would require exuberant effort. Such items should be replaced rather than cleaned.*

5.2.B. Use

All employees should be totally familiar with the use of all equipment and supplies within the vehicle in which he or she is working. All equipment and supplies are to be used based on the manufacturer's recommendations. Instruction on the use of equipment and supplies will be provided by any Supervisor. If you don't know how to use it, ASK.

5.2.C. Cleaning and Sanitizing

Proper technique in cleaning and sanitizing reusable ambulance equipment ensures that the equipment is safe for the next crew and patient, protecting them from potentially infectious agents. All equipment is to be cleaned of obvious debris and fully cleaned and disinfected before being returned to service.

Always utilize Universal Precautions when cleaning any item – assume all items are contaminated. No one should be subject to having soiled or contaminated equipment in any company vehicle.

(1) *Suction Unit – Onboard*

Disassemble the suction unit. Remove the disposable canister. Remove the disposable tubing and catheter. Place both the disposable canister and the disposable tubing/catheter in a red bio-hazard bag and discard. Replace the canister and the tubing/catheter. Care should be taken that no liquid enters the vacuum gauge. After cleaning, the components should be thoroughly disinfected. After inspection for any worn, broken, or defective parts, the portable suction unit will be reassembled and checked for proper function.

(2) *Suction Unit – Portable*

Remove the disposable canister. Remove the disposable tubing and catheter. Place both the disposable canister and the disposable tubing/catheter in a red bio-hazard bag and discard. Replace the canister and the tubing/catheter. Wipe the unit housing with disinfectant wipes following manufactures recommendations. After inspection for any worn, broken, or defective parts, the portable suction unit will be reassembled and checked for proper function.

(3) *Monitor / Defibrillator Cardiac Monitor*:

Clean the Cardiac Monitor defibrillator/monitor, cables, and accessories with disinfectant wipes following manufactures recommendations. Do not clean any part of this device or accessories with bleach, bleach dilution, or phenolic compounds. Do not use abrasive or flammable cleaning agents. Use only cleaning solutions that are non-abrasive, non-staining and are diluted with water. Rinse accordingly with a damp clean cloth.

(4) *Med Infusion Pump*

Clean the Pump by first turning it off and unplugging the device, then wipe the device and all of its components with a disinfectant wipe following manufactures recommendations. Do not clean any part of this device or accessories with bleach, bleach dilution, or phenolic compounds. Do not use abrasive or flammable cleaning agents. Use only cleaning solutions that are non-abrasive, non-staining and are diluted with water. Avoid using any spray cleaners to ensure fluid does not enter pump housing, speaker holes, or battery chamber. Disconnect the power cord from the external power connector, on the side of the pump. Inspect the pumps outside surfaces for damage (any cracks or punctures may allow fluid to enter).

(5) *Glucometer*

Clean the Glucometer with disinfectant wipes following manufactures recommendations. Do not clean any part of this device or accessories with bleach, bleach dilution, or phenolic compounds. Do

not use abrasive or flammable cleaning agents. Use only cleaning solutions that are non- abrasive, non-staining and are diluted with water. Do not immerse the glucometer in liquid.

(6) *Oxygen Delivery Device*

A flowmeter that has been contaminated with any patient secretions/excretions, i.e. blood, sputum, urine, feces, bile, etc., shall be cleaned and disinfected by the crew. The exterior surface of the flowmeter will be cleaned with disinfectant wipes following manufactures recommendations. If contaminant has entered the internal part of the flowmeter, it is to be placed in a red bio-hazard bag, disposed of, and replaced.

(7) *Stretchers*

Any stretcher, wheelchair or stair chair that has been contaminated with any patient excretions/secretions shall be cleaned and disinfected by the crew. The stretcher, wheelchair or stair chair will be thoroughly cleaned by washing with warm water and disinfectant and then wiped down with a clean rag or with disinfectants wipes following manufactures recommendations. Be sure to dry thoroughly. If the straps of these devices become contaminated follow the procedures outlined under "Straps" for cleaning. If the straps are grossly contaminated, consider their replacement. Batteries should always be removed before cleaning.

(8) *Stretcher Mattresses*

All mattresses shall be inspected for any cuts, tears, or worn areas on their covers and immediately replaced or repaired if any defects are noted. Any mattress that has become contaminated with any patient excretions/secretions shall be cleaned and disinfected by the crew using a disinfectant cleaning product and a clean rag.

(9) *Stair chairs*

Any stretcher, wheelchair or stair chair that has been contaminated with any patient excretions/secretions shall be cleaned and disinfected by the crew. The stretcher, wheelchair or stair chair will be thoroughly cleaned by washing with warm water and disinfectant and then wiped down with a clean rag. Be sure to dry thoroughly. If the straps of these devices become contaminated follow the procedures outlined under "Straps" for cleaning. If the straps are grossly contaminated, consider their replacement.

(10) *Backboard, Scoop Stretcher*

The crew shall clean any backboard and/or scoop stretcher that has been contaminated with any patient excretion/secretions. The backboard and/or scoop stretcher will be thoroughly cleaned by washing with warm water and disinfectant and then wiping it down with a clean rag.

(11) Padded Board Splints and Traction Splints,

The crew shall clean any splint that has been contaminated with any patient excretion/secretions. The splint will be thoroughly cleaned by washing with warm water and disinfectant and then wiping it down with a clean rag. Some "reusable" equipment should be considered "disposable" if it is grossly contaminated, or cleaning/sanitizing would require exuberant effort. Such items should be replaced rather than cleaned.

(12) *Straps*

The crew shall clean any strap that is contaminated. The strap will be placed in a red biohazard bag and returned to quarters. Straps should be buckled prior to entering the washing machine. Launder the strap in the washing machine on a "Hot" setting with detergent and disinfectant added. Do not use bleach. Remove the strap and hang to dry. Do not put straps in dryer. Some "reusable" equipment, including straps, should be considered "disposable" if it is grossly contaminated or cleaning/sanitizing would require exuberant effort. Such items should be replaced rather than cleaned.

(13) *Stethoscopes and B/P Cuffs*

Stethoscopes and B/P cuffs should be cleaned between each patient use. The crew shall thoroughly clean any stethoscope and/or B/P cuff that has been contaminated with any patient excretion/secretions. The stethoscope and/or B/P cuff will be thoroughly cleaned with disinfectant wipes following manufacturers recommendations. Some "reusable" equipment, including a stethoscope or B/P cuff, should be considered "disposable" if it is grossly contaminated or cleaning/sanitizing would require exuberant effort. Such items should be replaced rather than cleaned.

Note: The above is a short list of examples. Please keep in mind that items such as stethoscopes, trauma shears, floors, seats, and steering wheels are often contaminated and must be cleaned and disinfected.

5.2.D. Inspection and Maintenance

All durable medical equipment shall be inspected by a Supervisor or Support Services Technician for proper operation prior to being placed in service. All durable medical equipment will be inspected after each shift,

All patient handling equipment (i.e., stretchers, scoops, stair chairs) shall be inspected and lubricated on a regular schedule by an outside vendor per the manufacturer's maintenance guide. Any outside manufacturer or contracted, licensed and insured technician providing service to PRO is responsible for maintaining and submitting maintenance records upon request.

(1) *Suction Unit – Onboard*

A Support Service Technician will check the Suction Units after every shift.

(2) *Suction Unit – Portable*

A Support Service Technician will check the Suction Units after every shift. Support Service Technician will initial the device documenting that it has been inspected.

(3) *Monitor / Defibrillator*

Cardiac Monitor:

PRO maintains a service agreement with Zoll for the preventive maintenance and repair of our Zoll X- Series Monitors. During the Vehicle Audit the Supervisor or Support Services Officer should visually inspect the patient cable, therapy cable, limb leads and other associated cables/accessories,

ensuring all cables, cords and connectors are in good condition and void of any cuts, cracks, frays, or bent pins. Verify the batteries are fully charged and ensure that the unit is clean and void of any cracks or other signs of damage. Any problems or discrepancies should be reported to dispatch, through an Incident Report form, and a member of the Management Team. Monitor should be placed OOS and replaced with another unit. All necessary repairs shall be handled by an authorized Zoll technician.

(4) *Med Infusion Pump*

Repairs and programming will be completed by a certified in-house technician. Preventative maintenance is contracted yearly based on product guidelines.

(5) *Glucometer*

Other than replacing the battery, there is no repair of the glucometer. Any problems or discrepancies should result in the glucometer being placed OOS and replaced with another unit. These are considered disposable if they are inoperable. Glucometers will be calibrated routinely by Support Services Technicians based on manufacturers recommendations.

(6) *Oxygen Delivery Device*

There is no repair of the oxygen delivery device. Any problems or discrepancies should result in the oxygen delivery device placed OOS and replaced with another unit. These are considered disposable if they are inoperable.

(7) *Stretchers*

A Support Service Technician will check the Stretchers at the end of every shift.

PRO maintains a service agreement with STRYKER for the preventive maintenance and repair of our STRYKER PRO POWER COTS (stretchers). Any problems or discrepancies should be reported to the Supervisor, the stretcher placed OOS and replaced with a spare. All necessary repairs shall be handled by STRYKER.

(8) *Stretcher Mattresses*

The stretcher mattresses should be inspected for any rips, tears, punctures, or degradation of any kind. Mattresses in any of the above conditions should be repaired or replaced.

(9) *Stair Chairs*

A Support Service Technician will check the Stair Chairs at the end of every shift.

PRO maintains a service agreement with STRYKER for the preventive maintenance and repair of all our stair chairs. Any problems or discrepancies should be reported to a Supervisor or the Support Services Technician, the stair chair placed OOS and replaced with a spare. All necessary repairs shall be handled by STRYKER.

(10) *Backboard, Scoop Stretcher, Reeves Stretcher*

There is no repair of backboards, scoop stretchers, or Reeves stretcher. Any problems or discrepancies should result in the backboard being placed OOS and replaced with another unit.

(11) *Padded Board Splints, Traction Splint*

A Support Services Technician will check the Splints at the end of every shift.

There is no repair of these items. Any problems or discrepancies should result in the equipment being replaced. These are considered disposable if they are inoperable or grossly contaminated. Follow the directions outlined previously in the "Cleaning" section of this policy.

(12) *Straps/Restraints*

There is no repair of straps/restraints. Any problems or discrepancies must result in the straps/restraints being replaced. These are considered disposable if they are inoperable or grossly contaminated. Follow the directions outlined previously in the "Cleaning" section of this policy.

(13) *Stethoscopes and B/P Cuffs*

There is no repair of stethoscopes and/or B/P cuffs. Any problems or discrepancies should result in the stethoscope or B/P cuff being replaced with another unit. These are considered disposable if they are inoperable or grossly contaminated.

5.2.E. Rechargeable or Battery-Operated Equipment

(1) *Portable Suctions*

The LCSU portable suction units have a "Low Battery" light, when this occurs, the battery is removed and placed into an external charger. At the end of every shift, the device is tested by a Support Services Technician. The battery is removed monthly to be charged for a minimum of 5-hours per product guidelines.

If you use the unit during your shift, it should be cleaned.

(2) *Monitor / Defibrillator*

Monitor Batteries

Monitor batteries have LED lights that indicate the amount of charge each battery is holding. All batteries (both those in the monitor and spares in the ambulance) should be checked at the beginning of each shift. No battery should be placed into service without ALL LEDs green, indicating a full charge. Batteries that are not fully charged should be returned to Support Services. Any faulty battery should be taken out of-service and turned over to a Support Services Technician for replacement. Monitor batteries are calibrated per manufacturers recommendations.

(3) *Glucometer Batteries*

If a small battery icon is displayed on the screen the glucometer battery should be replaced. See a Support Service Technician for replacement.

(4) *DL Laryngoscope Batteries*

During the Daily Vehicle Check, if a DL laryngoscope light is not “white, tight, and bright”, the battery must be replaced. See a Support Service Technician for replacement.

(5) *Video Laryngoscope Batteries*

During the Daily Vehicle Check, if a video laryngoscope has under 90% battery, it must be charged. See a Support Service Technician for replacement.

(6) *Flashlights*

Flashlights have a charger incorporated into the mount that holds them in the vehicle and they are constantly charging. If the flashlight is not working, submit an incident report so it can be replaced.

5.2.F. Placing Equipment Out of Service

Any employee can place a piece of equipment out of service at any time if the employee feels as though utilizing the equipment is a safety hazard. In this case a Supervisor/Dispatcher or Support Services Technician must be notified immediately and submit an Incident Report. It may be common for you to place equipment out of service for replacement, repairs, routine maintenance, and other safety concerns.

In the event an in-service piece of equipment needs to be repaired, do the following:

1. Take equipment out of service.
2. Notify a Supervisor / Dispatcher / Support Services Technician.
3. Submit an incident report form.
4. Attempt to replace the equipment.

At no time should anyone un-tag a piece of equipment and return it to service. Any equipment taken out of service will be evaluated by a Supervisor or the Support Services Technician to determine the course of action for repair and/or replacement.

5.2.G. Laundry Procedures

PRO has implemented the following procedures for laundry:

1. The only personnel who are permitted to do laundry are Supervisors and Support Services Technicians.
2. All laundry must be done in accordance with manufacturers recommendations.

Pro Policy 500.3 – Washing Vehicles

Section:	Support Services
Policy #:	500.3
Modified:	04/15/2024
Reviewed:	04/15/2024

Vehicles are to be washed at the end of every use. Vehicles may additionally be washed mid-shift during severe weather storms. Vehicles are to be washed in the wash bay. Vehicles are to be washed based on manufacturers recommendations.

600 | Fleet Management

Pro Policy 600.1 – Preventative Maintenance

Section:	Fleet Management
Policy #:	600.1
Modified:	04/15/2024
Reviewed:	04/15/2024

6.1.A. Preventative Maintenance

PRO adheres to Ford Motor Company's 5,000-mile Severe Duty Schedule in maintaining all ambulances in its fleet. PRO employs an onsite mechanic to address all vehicle preventative maintenance and repairs. Records of all fleet maintenance are kept by PRO.

6.1.B. Tracking Vehicle Preventative Maintenance

Vehicle mileage is automatically uploaded from the telematics system (Samsara) directly to the Fleet Management Information Software (FMIS). At the manufactures recommended mileage, the Fleet Maintenace department is automatically notified, and preventative maintenance appointments are made based on availability. Additional maintenance may be performed on a regular schedule based on risk analysis. All preventative maintenance tracking and records are hosted on RTA.

Pro Policy 600.2 – Mechanical Failures- Ambulances and Damage to Vehicle

Section:	Fleet Management
Policy #:	600.2
Modified:	04/15/2024
Reviewed:	04/15/2024

6.2.A. Mechanical Failures – Ambulances

If you experience a mechanical failure in an ambulance, you must do the following:

1. Stop the vehicle and attempt to park the vehicle in a place out of the traffic flow that is safe and proper. (parking space, side of road, etc.)
2. Notify Dispatch
3. If you are occupied with a patient, the dispatcher will send you help in getting the patient to their destination.
4. The dispatcher will contact the mechanic. If the dispatcher is unable to do so, the dispatcher will contact a tow truck.
5. Problems of a non-debilitating nature must be reported to the dispatcher or a Supervisor, documented in an Incident Report Form. The incident report is then automatically sent to appropriate staff.

BE CERTAIN TO ALWAYS COMPLETE AN INCIDENT REPORT NO MATTER HOW MANY TIMES YOU BELIEVE THE PROBLEM HAS BEEN REPORTED.

CRITICAL VEHICLE FAILURES MUST BE DOCUMENTED USING AN INCIDENT REPORT FORM AS SOON AS PRACTICABLE. SEE THE INCIDENT REPORTING SECTION OF THIS MANUAL FOR FURTHER DETAIL.

Do not risk severe or permanent damage to a vehicle by not adhering to the above.

6.2.B. Damage to Vehicles

If a stain or scratch exists on any unit, do not attempt to remove, or touch it up yourself. Please submit an Incident Report Form.

Pro Policy 600.3 – Request for Vehicle Maintenance

Section:	Fleet Management
Policy #:	600.3
Modified:	04/15/2024
Reviewed:	04/15/2024

As a prudent practice to protect PRO employees, patients, and passengers, identified, or suspected vehicle malfunctions must be documented.

An Incident Report Form must be completed when a vehicle problem is identified or suspected. This form will be submitted to Fleet Services.

A copy may be retained by the crew member for his/her record.

If the mechanical problem is of the nature that prevents the vehicle being available for field use, the driver is responsible for notifying Dispatch of the unavailable status and ensuring an Incident Report is completed.

700 | Billing and Collections

Pro Policy 700.1 – Billing and Collections

Section:	Billing and Collections
Policy #:	700.1
Modified:	04/15/2024
Reviewed:	04/15/2024

PRO prides itself on its billing staff and policies. PRO's billing office is a vital aspect of providing customer service. PRO has always been dedicated to compassionate billing and collection policies. FIELD PERSONNEL SHOULD NEVER COMMENT OR SPECULATE ON BILLING OR PAYMENT ISSUES. ALL QUESTIONS ON CHARGES, INSURANCE COVERAGE, AND BILLING ISSUES SHOULD BE REFERRED TO THE BILLING OFFICE OR A SUPERVISOR.

PRO utilizes Zoll Data System's RescueNet Billing software. This software assists our billing staff in providing timely response to patient and third-party payer inquiries regarding the submission of insurance claims, dates and types of payments made, itemized charges and other inquiries. The billing staff is available at our offices to answer questions regarding patient bills. All invoices are itemized so that all charges are clearly explained, and all services and supplies charged to the patient are listed separately.

PRO will not engage in on-scene collections for services at scene, en route, or upon delivery of the patient. PRO accepts assignment from Medicare, Medicaid, and most third-party payers for patients meeting applicable medical necessity requirements.

The following are the basic billing and collection policies of PRO:

1. PRO accepts assignment from most third-party payers.
2. PRO will make every effort to bill, and collect payment from, patient insurance companies directly.
3. PRO will not utilize threatening letters, billing tactics, or telephone collection methods to collect payment for services rendered.
4. The primary focus of all billing messages and telephone contacts will be to secure patient insurance information.
5. PRO utilizes an outside collection agency only when all efforts fail in contacting a patient for insurance information or to arrange for payment.
6. Any outside collection agency utilized by PRO will be held to the highest standard of accountability for its customer service and collection tactics. PRO has a long-standing relationship with First Financial Resources, Inc. and has received no significant complaints from any patient regarding their collection tactics.
7. PRO will address all cases of financial hardship on an individual basis.

PRO'S ONLY BASIC REQUIREMENT OF A PATIENT WITH A FINANCIAL HARDSHIP IS THAT THEY CONTACT OUR OFFICE AND WORK WITH US COOPERATIVELY BEFORE THEIR BILL IS SENT TO THE OUTSIDE COLLECTION AGENCY.

- Any patient who contacts our billing office and states that they have a financial hardship will be offered a payment plan to meet their individual needs.
- Any patient that states that they are unable to meet the terms of a payment plan for the full amount of the bill will be offered a reduction in the bill to the current Medicaid rate of reimbursement with the balance written off as a "financial hardship." A payment plan for the balance due will be arranged if necessary.
- Any patient who contacts PRO and states that they are unable to pay any amount of the bill may qualify to have their entire bill written off as a "financial hardship."

All such requests and determinations of financial hardship are considered on an individual case-by-case basis. PRO may request documentation of the financial hardship in the form of hospital free care documentation, a letter from a third party such as a social worker, or a letter from the patient himself or herself stating that they have a financial hardship.

Pro Policy 700.2 – Credit Balances/Overpayments

Section:	Billing and Collections
Policy #:	700.2
Modified:	04/15/2024
Reviewed:	04/15/2024

7.2.A. Background

Credit balances generally occur when reimbursement for services provided to a patient exceeds the charges billed. When we receive a duplicate payment from the Medicaid or Medicare program, receive payment from another payer after Medicaid or Medicare reimbursement has been received, or receive excess payment from a patient or other financially responsible party, an overpayment exists and should be paid back to the insurer or the patient as applicable.

Credit balances may also occur from errors in calculating contractual allowances, errors in calculating coinsurance and other accounting errors.

The law requires that we promptly identify any credit balances and, when applicable, make a refund payment to the Medicare or Medicaid programs as soon as possible. As an example of the significance of this responsibility on our part, Title 42 of the Code of Federal Regulations Part 489.20 (h) states that if a provider receives payment for the same services from Medicare and another payer that is primary to Medicare, the provider must "reimburse Medicare any overpaid amount within 60 days."

The purpose of this policy is to ensure that we reduce the time between the discovery of a credit balance and actual repayment to Medicare or other payor.

7.2.B. Procedures

1. When an account goes into a "Refund" status (i.e., overpayments have been received, the payment received exceeds the charges or amount due, including the effect of mandatory assignment, when applicable) it should appear in the designated Workflow.
2. Specified billing staff will review the monthly account statements, particularly the credit balances to verify the validity of the statements, reconciling the account statements with the individual remittance advice for each account.
3. Adjustments to the accounts should promptly be made to the payor or patient, as applicable. When Medicare is the recipient of the overpayment, refunds shall be done in accordance with the procedure identified by the Carrier and utilizing the appropriate overpayment form.

Pro Policy 700.3 – Financial Hardship Determination Policy

Section:	Billing and Collections
Policy #:	700.3
Modified:	04/15/2024
Reviewed:	04/15/2024

7.3.A. Purpose

To develop guidelines to objectively evaluate the financial ability of patients to make payments for their emergency medical services.

7.3.B. Overview

PRO provides emergency services to patients without regard to their ability to pay. We recognize that a patient's illness can create large medical bills that inhibit the patient's ability to make payment. Our billing procedures allow for billing of all possible insurance carriers to maximize recovery from these sources. A follow-up should be performed, when necessary, which includes statements and phone calls to the patient to keep him or her informed as to the progress of payment for the emergency medical service rendered.

When a patient has Medicare, he or she is required to pay the deductible and co-payment. However, Medicare will allow the balance due by the patient to be written off if the patient is unable to pay due to financial or income restrictions. Indigent patients may be determined to be financially unable to pay their portions of the bill in advance. Hardship declaration is the exception, not the rule.

A patient with no insurance, or an unpaid balance after insurance options have been exhausted can seek eligibility for discounts under this policy. If a patient does not meet eligibility requirements, and he refuses to render payment, he will be turned over to a collection agency.

7.3.C. Procedures

Before any discounts for services are granted, the first option is to attempt to arrange for the patient to make regular monthly payments in a dollar amount that is financially convenient and affordable. Should this attempt fail, the following guidelines will be used:

Option 1	Ensure that insurance benefits have been maximized.
Option 2	Payment plan – offer again
Option 3	Provide discount to the current Medicaid rates and payment plan (immediate payment is preferred)
Option 4	Financial Hardship consideration – guidelines listed below
Option 5	Collection Agency

If a patient claims financial hardship, the patient will be requested to complete, or provide the information required by, the Patient Questionnaire for Financial Hardship Determinations.

Only an authorized PRO official may approve a financial hardship case. Under no circumstances may personnel disclose our hardship criteria to the patient. If the patient exceeds the income criteria, he or she will be billed in accordance with the directions of his insurance company, if any. Status can change at any time. Income status must be renewed every six (6) months when a patient claims financial hardship.

800 | Administration

Pro Policy 800.1 – Chain of Command

Section:	Administration
Policy #:	800.1
Modified:	04/15/2024
Reviewed:	04/15/2024

The chain of command will be governed by PRO's Organizational Chart and will determine links of responsibility and authority. Under special circumstances, special command structures may be designated by company management.

Pro Policy 800.2 – Policies and Procedures Accessibility and Dissemination

Section:	Administration
Policy #:	800.2
Modified:	04/15/2024
Reviewed:	04/15/2024

All Policies and Procedures Manuals are available to be accessed at any time online at the PRO EMS website: www.proems.com. Changes to the Policies and Procedures Manuals will be disseminated via email to all employees within the organization. All Health and Safety Plans are available for access through ePRO. All changes to PRO's Health and Safety Plans will be disseminated via email to all employees within the organization.

Pro Policy 800.3 – Community Volunteerism and Corporate Contributions

Section:	Administration
Policy #:	800.3
Modified:	04/15/2024
Reviewed:	04/15/2024

PRO recognizes the community benefits and good spirits of those involved in worthwhile volunteer projects. PRO encourages and promotes such voluntary involvement by employees. From time to time, PRO may elect to provide monetary or in-kind support to volunteer projects. Such support shall be at the discretion of company management.

PRO and its employees are involved in many community service activities throughout the year including food drives and events sponsored by a variety of charitable organizations. We encourage your participation in such organizations and welcome your suggestions as well as your involvement in these activities. Please contact a member of the Management Team if you are interested in any of these activities or if you have ideas and recommendations to help make PRO an even better corporate citizen.

Pro Policy 800.4 – Information/Incident Reporting

Section:	Administration
Policy #:	800.4
Modified:	04/15/2024
Reviewed:	04/15/2024

PRO utilizes a web-based system called Smartsheet for all incident reporting, which can be accessed directly through ePro (ESO). When submitting an incident report, the reporter designates an incident type, facilitating the categorization of all incident reports. Following submission, the report is automatically emailed to the relevant admin groups within PRO, ensuring a prompt follow up to each incident. The admin team regularly examines the uploaded incidents, looking for trends that indicate an increase in any particular type of incident. Incident trends are tracked by running a monthly report in Smartsheet that can be sorted by Incident Type. If any trend develops with a certain Incident Type they can be easily seen and addressed. The incident report is categorized by incident type, which consists of:

Child Abuse / Neglect	Elder Abuse / Neglect	Navigation Issue
Clinical Issue / Concern	Employee Injury/Illness/Exposure	Patient Injury
Commendation	General Complaint	Policy Issue
Communication Issue	General Issue	Safety Issue / Concern
Conflict - External	Medical Equipment Failure/Damage	Uniform & Appearance Issue
Conflict - Internal	Medication Error	Vehicle Contact
Documentation Issue	Missing Patient Belongings	Vehicle Issue

The following are types of incidents that require immediate verbal notification to a member of the Management Team:

- Any serious incident that must be reported pursuant to OEMS Regulation 105 CMR 170.350(B);
- Any accident involving an Ambulance with injuries or that warranted a police response;
- Any accident including substantial personal/property damage to/by a member while on duty, on the premises, or on official business;
- Any occurrence of possible negligent care of a patient; and
- Any inappropriate behavior of a crew member.

Pro Policy 800.5 – Management Development Program

Section:	Administration
Policy #:	800.5
Modified:	04/15/2024
Reviewed:	04/15/2024

PRO encourages ongoing education for its management level employees.

In the past, PRO has utilized a multilevel approach to education and training. PRO utilizes the following approaches to management training.

- Encouragement of personnel to seek or continue higher education (college and college level courses)
- Providing financial assistance to management personnel seeking local courses in pre-approved management training programs, such as courses offered by the following agencies and organizations: Office of Emergency Medical Services, Massachusetts Ambulance Association, and the American Ambulance Association.
- PRO will supplement this training with a bi-annual in-house training specialty course.

Pro Policy 800.6 – Financial Responsibility & Financial Performance Monitoring

Section:	Administration
Policy #:	800.6
Modified:	04/15/2024
Reviewed:	04/15/2024

8.6.A. Financial Responsibility & Performance Monitoring

Certain managers have the responsibility of the procurement of all goods and services, the processing and sale of goods and services, and to either provide the services for such procurement and processing or give functional directions to others delegating the authority to perform such services.

Only those persons designated by the CEO and or members of the Executive Team are authorized to commit PRO for materials, equipment, supplies, and services. The CEO has the final authorization for payment of purchases.

These individuals or their designees have the responsibility for obligating PRO and for making the final determination of the source of supply, quantities purchased, and delivery schedule and price negotiations.

These decisions will be made in conjunction with Operations, Communications, CQI, Administration, and other departments as appropriate.

All individuals designated by the CEO are responsible for procurement of goods and services are responsible for initiating and maintaining effective and professional relationships with suppliers, actual and potential.

These individuals are to serve as the exclusive channel through which all requests regarding prices and products are handled. They conduct all correspondence with suppliers involving prices or quotations. In cases where technical details are necessary, the affected department may correspond with suppliers. In such cases, the individual/individuals designated with the purchase responsibilities should be provided with copies of all such correspondence.

When supplier sales representatives make personal sales calls, they are to be directed to the staff member responsible for such procurement. All employees involved in purchasing activities will work to maintain and enhance PRO's image by their personal conduct and methods of doing business. All employees engaged in purchasing activities will recognize and practice good public relations by giving all callers and visitors courteous treatment.

Vendor selection and products purchased are to meet the basic policies and standard practices of PRO. The orderly replacement "by attrition" is to occur when cost-effective and operating commitments can be met.

In accordance with all GAAP (Generally Accepted Accounting Principles) rules and regulations, all financial records will be kept with PRO's Certified Public Accountant for a minimum of seven years.

It is the policy of PRO that all purchases over $500 or that have a material financial impact, must have received prior written authorization from the CEO unless the purchase is for a normal supply order.

Financial Monitoring is consistently performed on an ongoing basis by utilizing Intuit QuickBooks Enterprise Solutions Accounting software and ZDS RescueNet Billing Software. Performance is monitored by regularly measuring cash, budget vs. actual for receivables and payables, specific payor billings and payments, and comparing all to previous time frames. PRO also utilizes the accounting firm of Nardella & Taylor LLP to monitor financial performance, review financial statements, and address tax issues.

Pro Policy 800.7 – Media Relations

Section:	Administration
Policy #:	800.7
Modified:	04/15/2024
Reviewed:	04/15/2024

8.7.A. Media Relations

News is defined as those events that occur outside the parameters of normal circumstance and behavior. In EMS, you will frequently be called to scenes that fall into these categories. You may be asked to answer questions or give an opinion on a topic or a call that you have responded to.

The policy of PRO is to not publicize or release any information that may be construed as confidential to any source.

When asked a question by any media personnel, you are to refrain from stating “no comment” as a response. This could only end up as a lead-in for the six o’clock news broadcast. Never tell any media personnel something “off the record” as it could subsequently become a front-page story. PRO endeavors to retain a favorable position with some media outlets and looks forward to developing more contacts as time goes on. Until that time, requests for information shall be referred to a member of the Management Team.

The following information shall **not** be discussed with the media:

1. Any information concerning a patient, including assessment of injuries and treatment provided;
2. Any information prejudicial to law enforcement investigations;
3. Information not based on fact; or
4. Information that might be an invasion of privacy, such as a suicide, AIDS, HIV status, overdose, psychiatric, etc. In cases of death, only the medical examiner shall give the exact cause.

The following information may be released to the media:

1. Location of the call; and/or
2. The patient’s receiving hospital.

Any articles, advertisements, or other written materials developed for publication in local, state, internet, national, or international publications on any matter involving PRO, or referencing PRO directly or indirectly, must be approved by the CEO.

8.7.B. Requesting Media Coverage

When an incident or event happens that PRO feels will generate positive media coverage, the CEO will call a specified list of media contacts.

8.7.C. Media Inquiries

From time to time, as an employee of PRO, you may receive inquiries from the media (e.g., newspapers, television stations, radio stations, magazines, or other periodicals). To ensure that PRO maintains the appropriate public image and that communications to the media are accurate and in line with applicable company policy, if you are contacted by the media, you should refer the individual making the inquiry to the CEO or direct them to the Public Information Officer on scene at an event (usually a member of the Cambridge Fire or Police Departments). No other employees are authorized to give statements to any representative of the media.

Pro Policy 800.8 – Inspection Authority

Section:	Administration
Policy #:	800.8
Modified:	04/15/2024
Reviewed:	04/15/2024

Massachusetts OEMS has the right to stop and inspect an ambulance at any time.

If you are signaled to stop by a police officer or OEMS official, immediately pull over to a complete stop and notify the dispatcher. If you are on an emergency call, advise the police officer or OEMS official of the situation and ask the officer to contact the dispatcher. If the officer refuses to allow you to proceed on the call, inform them that they must take full responsibility for the patient. You must note the officer's name, badge number, location and time and document this incident on your run sheet and on an incident report.

PRO operates Class I ambulances. These vehicles conform to the United States Department of Transportation General Services Administration, Ambulance Design and Construction Specifications (KKK-A-1822, KKK-A-1822A as amended, revised, or replaced) that are in effect at the date of vehicle production.

The inspector will be looking at the cleanliness of the vehicle and checking medical supplies and equipment. They could also inspect the undercarriage for any fluid leaks. It is important to maintain the cleanliness of your assigned vehicle throughout your shift.

THE INSPECTOR WILL ALSO BE CHECKING TO SEE THAT YOU HAVE YOUR DRIVER'S LICENSE, EMT, CPR, AND ACLS (IF APPLICABLE) CARDS ON YOUR PERSON. YOU ARE REQUIRED TO CARRY ALL OF THESE CARDS WHENEVER YOU ARE ON DUTY.

Pro Policy 800.9 – Releasing Information to Outside Agencies and the Media

Section:	Administration
Policy #:	800.9
Modified:	04/15/2024
Reviewed:	04/15/2024

Dispatchers should not release ANY information to the media. All media inquiries should be directed to the CEO.

Dispatchers may release pertinent information to other ambulance companies/outside public safety departments if they requested our service. Such information may include facility patient was transported to, nature of illness, etc. Patient confidentiality should be considered in each case. No information is to be released to other outside agencies. All requests for such information should be directed to the CEO.

Pro Policy 800.10 – Backup Services and Disaster Coordination

Section:	Administration
Policy #:	800.10
Modified:	04/15/2024
Reviewed:	04/15/2024

8.10.A. Backup Agreements

PRO currently maintains several active backup agreements in the form of written letters and "gentleman's agreements". PRO currently maintains reciprocal written backup agreements with Cataldo Ambulance Service, Armstrong Ambulance Service, Boston EMS, and Coastal Medical Transportation Systems for all ALS and BLS services. PRO also maintains a verbal agreement with Boston EMS to provide reciprocal backup coverage in certain areas and during certain extreme incidents.

In the event that PRO does not have an ALS Intercept Unit available, it is the responsibility of the requesting agency to obtain another resource.

In the event PRO is unable to immediately respond to a priority emergency call or an MCI exists requiring additional resources, all dispatchers are directed to contact the previously listed backup services and request their response in the following order:

For ALS Responses:

CAMBRIDGE FIRE	CFD Ringdown Line
CATALDO	(617) 625 0042
ARMSTRONG	(781) 648 0612
COASTAL	(617) 745 9999
BOSTON EMS	(617) 343 4510

For BLS Responses:

CATALDO	(617) 625 0042
ARMSTRONG	(781) 648 0612
CAMBRIDGE FIRE	CFD Ringdown Line
COASTAL	(617) 745 9999
BOSTON EMS	(617) 343 4510

8.10.B. Disaster Coordination

PRO utilizes a disaster plan approved by the South Middlesex Emergency Medical Service (SMEMS) and the Cambridge Fire Department (CFD), as well as the metro-Boston UASI Region and Cambridge Emergency Operations Center (EOC). The disaster plan is also modeled after a national plan and is predicated on the Incident Command System (ICS) and the National Incident Management System (NIMS). This plan is located in every company vehicle and in the Help section of TabletPCR and provides step-by-step instructions to each responder and outlines their responsibilities. Annual training in disaster coordination utilizing multiple agencies and participation in a disaster drill will be mandatory for all employees. Please familiarize yourself with the disaster plans.

Pro Policy 800.11 – Code of Conduct Policy

Section:	Administration
Policy #:	800.11
Modified:	04/15/2024
Reviewed:	04/15/2024

8.11.A. Statement of Commitment

PRO has been, and continues to be, committed to conducting our activities in full compliance with all federal, state, and local laws. Our reputation for quality service and excellent care has been achieved by the personal integrity, good judgment, and common sense of our staff members. Staff members are expected to demonstrate appropriate ethical behavior when conducting activities with patients and their families, fellow staff members, suppliers, vendors, consultants, and those with whom we do business. We commit to provide each staff member the policies, procedures, and guidelines to be aware of his/her responsibility in ensuring compliance with this Code of Conduct.

8.11.B. Purpose of the Compliance Plan

The Compliance Plan provides the approach to guide our conduct in all that we do. It is intended to provide overall guidance for us in providing EMS and medical transportation services in a legal, ethical, and appropriate manner; however, it does not supersede the more specific policies of PRO. The Compliance Plan is a supplement to the standards of conduct as presented our Policies and Procedures Manual and Employee Handbook, where applicable and is found with the Health and Safety Plans through PRO's Learning Management System. Each staff member and all supervisory and administrative personnel should read and understand the Code and subscribe to its standards and procedures.

This Code of Conduct does not address every aspect of PRO's activities and the applicable legal issues they may entail. Because of changes in PRO's structure and operations or changes in regulatory requirements, the document is inherently subject to change.

Each staff member, supervisor, and member of the Management Team will participate in an initial training program explaining the Code. New staff members should receive compliance training during new staff member orientation. Annually, each staff member will receive a minimum of one hour of compliance training. Upon completion of each training session or orientation, staff members will be required to successfully complete a quiz to document their participation and attendance.

Each staff member is expected to be familiar with the applicable laws and regulations that govern the matters set forth in the Code of Conduct as it pertains to his or her duties. That familiarity should be part of every staff member's job performance and a regular part of that staff member's review.

8.11.C. Standard of Compliance with Laws

PRO personnel, including, where applicable, managers, staff members, agents, consultants, and other representatives, should conduct their activities in compliance with applicable laws, rules, and

regulations. If there is reasonable doubt as to the appropriateness of an activity, staff members should seek advice within the PRO chain of command. Staff members may also contact the Chief Compliance Officer at any time if they have questions about the appropriateness of any particular action or course of conduct.

Policies and procedures regarding certain laws and regulations important to the provision of health care services are a part of the Compliance Plan.

(1) *Patient Rights*

PRO is dedicated to protecting its patients' personal privacy and confidentiality of information consistent with PRO's mission, applicable laws (including HIPAA, where applicable) and quality standards.

(2) *Disclosure*

PRO and its agents will deal honestly and fairly with patients, community members, vendors, competitors, mutual aid companies, payors, and other outside contractors. Communication and disclosure information should be clear, accurate and sufficiently complete.

Financial and operational reports should be prepared in accordance with applicable rules and regulations and prepared within PRO's normal system of accountability.

(3) *Patient Billing*

PRO will deal honestly with all payors (e.g., self-pay, insurance companies, HMOs, Medicare, Medicaid, etc.). Claims submitted to Medicare and other governmental and private payors should be complete and accurately reflect the services rendered. PRO should submit claims for services that are supported by the necessary documentation, while maintaining prompt and proper billing practices.

Billing issues should be resolved according to applicable laws, regulations, organizational policies and, where applicable, payor contracts. Questions regarding patient billing should be resolved expeditiously. If staff members are unsure of the proper response to a question or inquiry, the staff member should contact the Compliance Officer or other responsible person in the organizational chain of command.

(4) *Integrity of Workforce*

We recognize that the personal integrity, good judgment, and common sense of our staff members is responsible for our reputation of quality service. To maintain that reputation, prior to entering into a relationship with PRO, all staff members, contractors, vendors, and others will be subject to a reasonable and prudent background investigation, including a reference check.

Applicants (career and/or volunteer, as applicable) will be asked to disclose any criminal convictions, (as defined by 42 U.S.C. 1320a-7(i) and state law) or any action taken by the government to exclude the individual from participation in federal health care programs. Individuals who have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded or otherwise ineligible for participation in federal health care programs (as defined in 42

U.S.C. 1320a- 7b(f)) may not be considered for employment or a volunteer position with PRO. Additionally, applicants will be required to divulge their driving record, particularly if their work involves the operation of PRO vehicles.

(5) *Conflict of Interest*

Staff members are to conduct themselves in a manner that encourages and preserves the trust of those we serve. Staff members should not have financial relationships with parties with which PRO does business. Prompt disclosure of conflicts of interest should be made to PRO administration. Violations should be handled in accordance with applicable PRO disciplinary procedures.

(6) *Confidentiality*

No member of the organization should use confidential or proprietary information for his or her own personal gain or for the benefit of another person or entity, while associated with PRO or at any time thereafter.

Information concerning a patient is confidential. PRO personnel should not obtain or divulge details of a patient's condition without a specific professional reason, except as required by law. Violations should be handled in accordance with PRO disciplinary policies, and/or our HIPAA policies, where applicable.

All new personnel, prior to performing any substantial duties with PRO that involve patient interaction or information, shall undergo the mandatory privacy training as required under the HIPAA Privacy Regulations (where PRO is a "covered entity" in accordance with HIPAA).

(7) *Compliance with Federal, State and Local Laws and Regulations*

PRO will take all actions necessary to ensure compliance with all applicable federal, state and/or local laws and regulations, as well as with the public policies they represent.

(8) *Anti-Kickback Laws*

PRO will take all actions necessary to ensure compliance with Federal and State anti-kickback laws regarding the acceptance or payment of any remuneration for the inducement of referrals of services or the generation of other business and shall comply with all applicable regulations regarding self-referrals and kickbacks. Staff members should not give or receive kickbacks, rebates, or anything of value to a vendor, patient, physician, or other health care provider in exchange for a referral for services or the generation of other business.

(9) *Business Arrangements with Physicians or other Referral Sources*

PRO will take all actions necessary to ensure compliance with federal and state laws regarding self-referral and business arrangements. Business arrangements with any referral sources should be set forth in a written contract and should be in accordance with applicable federal and state laws. Payments by PRO to any referral source should be equal to the fair market value of the services rendered or items being purchased by PRO and should not be based on the volume of transports, or the value of referrals generated by the referral source.

(10) *Environment*

PRO strives to manage and operate in ways to ensure there is minimal risk to patients, staff members, visitors, and the community environment within the confines of PRO. Every staff member should comply with the safety, hazardous waste and other environmental care policies established by PRO.

(11) *PRO Transactions*

PRO transactions should be completed at fair market value and should not result in a direct or indirect monetary benefit to a staff member. PRO assets should not be used for the benefit of private individuals or staff members.

(12) *Anti-Competitive Practices*

PRO will take all actions necessary to ensure compliance with federal, state, and/or local laws and regulations that prohibit price-fixing and other anti-competitive practices. This includes compliance with all laws and regulations related to the procurement of EMS or ambulance service for a municipality or other government entity.

(13) *Gifts to Government Representatives*

Staff members should not provide gifts or pay for meals, refreshments travel or lodging expenses for government or public agency representatives, with the intent to influence an official action or decision in an illegal, unethical, or unlawful manner.

(14) *Government Investigation*

Information disclosed without proper authorization jeopardizes the rights of our patients. We also do not want to hinder in any way a legitimate government investigation. If federal or state law enforcement officials request information from a PRO staff member, the staff member should direct the federal or state law official to contact the PRO Compliance Officer. The PRO Compliance Officer should then communicate with the staff member to ensure that the appropriate documents are provided.

Whenever there is any indication that a government investigation may be underway, under no circumstances will any records or documents that could have a bearing on that investigation be destroyed or altered in any way. Any question about disposition of documents or records should be directed to the Compliance Officer.

(15) *Individual Judgment*

Staff members are often faced with making critical decisions based on activities in the workplace. Remember to always respect others and use good judgment and common sense. If anything within this Code of Conduct goes against your own good judgment, you are encouraged to discuss it with the Compliance Officer or other member of PRO management.

8.11.D. Compliance Officer

The Compliance Officer's responsibilities are to develop, implement and maintain the plan, oversee the staff member education, and investigate issues in a confidential manner.

PRO's CEO shall serve as the Compliance Officer.

Designation of a Compliance Officer does not lessen each staff member's responsibility to comply with the Code and related policies and procedures.

8.11.E. Reporting of Violations

It is important to first attempt to resolve issues within the area of responsibility in which they arise. If the staff member knows of a violation or possible violation of the Code or related policies and procedures, it is the staff member's responsibility to report that information immediately to the Compliance Officer.

Supervisory staff should report potential violations to the Compliance Officer. If the staff member cannot report a possible violation to the Supervisory staff, the staff member may report such violations anonymously by submitting an Incident Report form in ePro (ESO). Information on Incident Reports shall be disseminated to all personnel. Reported violations should be logged, assigned a tracking number, and investigated by the Compliance Officer.

In reporting violations to the Compliance Officer, if staff members wish to remain anonymous, they may do so by either not disclosing identifying information or by requesting that their confidentiality be protected. The Compliance Officer should make an effort not to identify an individual making an anonymous report, unless it is subsequently determined that the person engaged in improper conduct. Reasonable efforts shall be expended to assure confidentiality of anonymity requests; however, there may be a point where the individual's identity may become known in connection with the investigation or may have to be revealed if governmental authorities become involved.

8.11.F. Disciplinary Actions

Failure to comply with the standards established by the Code may have severe consequences. Appropriate discipline for violations of the Code, up to and including suspension or termination, may be imposed. Personnel will be subject to disciplinary action if they authorize or participate directly or indirectly in actions that constitute a violation of the law, the Code or related policies and procedures.

8.11.G. No Retaliation for Good Faith Reporting of Violations

The success of any compliance policy, including this Code, depends on the prompt and accurate reporting of violations and suspected violations without fear of retaliation. PRO's policy, as well as both federal and state law, does not condone retaliation against a staff member for reporting, in good faith, an actual or suspected violation of the law. Reports should remain confidential except when the nature of the complaint requires disclosure and then should be disclosed only to the extent necessary or advisable to resolve the complaint.

8.11.H. Monitoring of Compliance Efforts

An integral component of the Compliance Code and Compliance Plan is the continual monitoring, auditing, and evaluation of PRO's compliance efforts. An initial audit of compliance should be conducted to determine the areas in which area-specific compliance programs should be focused. Thereafter, audits may be authorized by the Compliance Officer in response to reports received through the compliance reporting system or through other means. In addition, overall compliance efforts should be reviewed on an annual basis.

8.11.I. Questions Regarding the Code

PRO wants to provide timely guidance to its staff members with respect to the Code. If staff members have a question concerning the Code or related policies or feel the need to seek guidance with respect to a particular issue, staff members should consult a member of the Management Team or the Compliance Officer.

Pro Policy 800.12 – Compliance Policy

Section:	Administration
Policy #:	800.12
Modified:	04/15/2024
Reviewed:	04/15/2024

8.12.A. Compliance Policy

We are committed to providing ambulance services and conducting our business practices with the highest level of skill, integrity, honesty, and compassion, and in compliance with the laws and regulations that govern our operations. In order to achieve this commitment, we have periodically adopted policies and procedures that are intended to guide our actions and protect against unlawful activity. Our Code of Conduct has been specifically designed to provide the necessary guidance that will allow each of us to perform our jobs with the highest level of integrity, and thereby avoid even the appearance of unlawful behavior.

However, we all must make personal commitments to adhere to these guiding principles and to comply with our policies, procedures, and regulatory requirements, including the Professional Ambulance Service Code of Conduct. If you have questions or concerns about what appropriate conduct is, or if you become aware of any situation that may jeopardize the ethical integrity of our organization, we ask that you please refer to the Code of Conduct, or promptly contact your supervisor, a member of the Management Team, or our Compliance Officer. However, if you feel that your concern has not been addressed to your satisfaction you can submit an inquiry through an Incident Report.

PRO depends on everyone to carry out its values and achieve its mission of responding to the health care needs of our patients. We must all commit ourselves to conducting business ethically and in accordance with applicable laws, rules, and regulations.

Pro Policy 800.13 – Corporate Credit Card

Section:	Administration
Policy #:	800.13
Modified:	04/15/2024
Reviewed:	04/15/2024

Corporate Credit Card Policy

Pro EMS has taken the step to issue many corporate cards to numerous personnel to provide flexibility to make necessary purchases. Please keep in mind that having a corporate credit carries with it responsibilities related to record keeping for accounting purposes.

Completing an accurate and detailed Suti expense report in a timely fashion is required for accurate accounting.

Please keep the following in mind when completing your Suti expense reports.

- All Suti reports must be completed by the 4th of the following month. For example, March purchases should be included on the expense report and submitted by April 4th without fail.
- When attaching receipts, the image must include the details of what was purchased and the total. During accounting reviews or government audits, it is required by law that we can identify both the items purchased and the amount paid, **including any taxes or tips**.
- Explanations must be included listing "**who, what, when, where, and why**" for the corporate expense
- Any purchase over $500 must be pre-approved by your immediate supervisor and documented via e-mail.
    - Please include your immediate supervisor's pre-approval e-mail as an additional attachment on the transaction in Suti.

The number one guide to using the corporate card is common sense and the need for the purchase. Please keep in mind the following:

- The corporate credit card is not meant to purchase meals and coffee in the normal course of work. We provide food, coffee, and drinks in the crew room next to dispatch for easy grab and go options while working.
- All purchases for meals and coffee for staff, students, and guests must be approved by your immediate supervisor. Purchases of food and drinks for all crews will be approved by Directors as operational circumstances may require.
- Tips on food orders will not exceed 20% of the total.
- If you are on a business trip, Pro EMS expects to cover all travel, hotel, and reasonable meal expenses. All receipts must be submitted with required details completed.
- When making purchases, every effort should be made to utilize current invoicing arrangements with the vendors that we have relationships with.

- The corporate credit card should not be used for personal purchases. Mistakes can happen. If personal purchases are inadvertently made select “Personal Charge to be Repaid” as the Expense Type in Suti. Within one week of the purchase, you are required to write a check to ‘Pro EMS’ and give it to either the CFO or their designee.

Failure to comply with any of these rules/guidelines may result in a deactivation of your card.

900 | Documentation

Pro Policy 900.1 – Mandated Reporting

Section:	Documentation
Policy #:	900.1
Modified:	04/15/2024
Reviewed:	04/15/2024

EMTs are required by law to report all cases of suspected or actual abuse and/or neglect of children, the elderly, and the disabled.

An oral report must be made immediately by telephone and a written report must be made within 48 hours.

Child abuse cases must be reported to the Department of Social Services. Elder abuse must be reported to the Executive Office of Elder Affairs. Abuse of disabled persons must be reported to the Disabled Persons Protection Commission.

24 Hour Child Abuse Hotline – (800) 792-5200

24 Hour Elder Abuse Hotline – (800) 922-2275

24 Hour Disabled Person Abuse Hotline – (800) 426-9009

Report forms are available on ePro in the documents section. Completed forms must be turned into dispatch and attached to job as soon as possible and before leaving at the end of your shift. Failure to report cases involving children is punishable by a fine of up to one thousand dollars ($1000). All EMTs must attest that they are aware of this law upon re-certification.

An Incident Report Form must also be completed.

For further information contact PRO management staff, the Department of Social Services, the Executive Office of Elder Affairs, or the Disabled Persons Protection Commission.

Pro Policy 900.2 – Vehicle Checklist

Section:	Documentation
Policy #:	900.2
Modified:	04/15/2024
Reviewed:	04/15/2024

A daily check must be completed by a Support Services Technician prior to leaving the base. There will be a Green Tag in the windshield of the unit when a Support Services Technician has cleared the vehicle for use. You must return the Green Tag to the Support Services Technician's area prior to putting the unit into service. Only remove the Green Tag from the unit you are assigned to and only when you are ready to take over responsibility for the vehicle.

Pro Policy 900.3 – Receiving Absence and Late Reports

Section:	Documentation
Policy #:	900.3
Modified:	04/15/2024
Reviewed:	04/15/2024

A supervisor or the on-duty dispatcher is the only person authorized to receive late or absence calls from the staff. Upon receipt of notification that an employee will be absent or late, the dispatcher will log the event in the RescueNet Dispatch Log.

The dispatcher should attempt to fill the shift by utilizing the Emergency Overtime Policy.

Pro Policy 900.4 – Complaints/Compliments

Section:	Documentation
Policy #:	900.4
Modified:	04/15/2024
Reviewed:	04/15/2024

The dispatchers first attempt should be to contact a member of the Management Team. If unable to do so, the dispatcher should log complaints/compliments by submitting an Incident Report form. The dispatcher will ensure that a supervisor is aware of the incident. The dispatcher is to notify an available supervisor of any complaints, no matter how minor in nature, as they are received. Where follow-up needs to occur, the supervisor is to inform the complainant of when they shall receive a call to report the outcome. Information shall be obtained including:

- Date;
- Caller Comments in Detail;
- Complaint/Compliment Taken By; and
- Caller's name and phone number if they are willing to give it.

PRO will utilize the Smartsheet webform to record Incident Reports where they will be tracked for trends by management. These reports will be used as a tool to assist in measuring satisfaction with the company. They are a means of determining strengths and weaknesses within the organization to be used for CQI.

Pro Policy 900.5 – Information/Incident Reporting

Section:	Documentation
Policy #:	900.5
Modified:	04/15/2024
Reviewed:	04/15/2024

It is the dispatcher's responsibility to ensure appropriate employees have submitted an incident Report form on Smartsheet. Dispatcher should also ensure that the appropriate onsite supervisor or support service technician has been notified, when applicable.

Pro Policy 900.6 – Records Management

Section:	Documentation
Policy #:	900.6
Modified:	04/15/2024
Reviewed:	04/15/2024

9.6.A. Record Falsification/ Patient Confidentiality/ Records Maintenance

Policy

Employees must accurately complete all personnel records, incident reports, patient information, and communications information as required by federal, state, county, local and/or PRO policies. Inaccurate or untimely completion of records will not be tolerated.

The information in these records may not be inspected, amended, or removed without the express written permission of the CEO. Furthermore, this information is confidential and will not be relayed to other employees or the public without written permission of management in accordance with HIPAA.

Records are to be completed ASAP after call completion and submitted no later than the end of the employee's assigned shift. At no time shall official records of any kind be removed from company property. Official records include but are not limited to: Patient Care Records, billing information, face sheets, transportation prescriptions, or other information related to any given patient or employee.

Patients receiving care, employees, and the general public have a definite right to expect that the confidential nature of identifiable medical and personal information obtained by PRO be reasonably preserved.

1. No person employed by PRO shall disclose medical or personal information regarding a patient, fellow employee, or member of the general public without first obtaining an authorization from the party or party's legally authorized representative except when such disclosure is permitted and/or required by law.
2. Radio communications shall be limited to that information which is relevant to the field care of the patient. If the patient's name is necessary, the paramedic shall landline the hospital with the required information.

Pre-hospital care providers transporting patients to hospitals shall disclose all relevant information to health care professionals at the hospital as required by our local governing medical authorities.

Medical information refers to any patient-identifiable information possessed by a health care provider regarding a patient's medical history, mental or physical condition, or treatment, or the specific circumstances surrounding a specific patient-identifiable incident, (e.g. suspected child/elder abuse).

All records will be maintained forever electronically. The following chart will detail how/where records are stored and whose responsibility it is for maintaining the records:

Record Type	Location Stored	Responsibility to Store
Dispatch Record	RescueNet Server	Dispatcher
Patient Care Report	RescueNet Server	Field Provider/Billing Personnel
Financial Record	RescueNet/QuickBooks	CEO and CFO
Vehicle & Equipment Maintenance	Network Server/ Smartsheet/RTA	Director, Support Services
Quality Improvement	RescueNet/FirstWatch	Pro CQI Team
Unusual Incidents	Smartsheet	COO
Safety Officer	Smartsheet/Safety Culture	COO
Compliance Program Documentation	Network Server/Prodigy	COO and CCO
Employee Health	Network Server	HR
Customer Comments	Feedback Innovations/ Paycom	HR
Training	Prodigy/Pipeline	Operations Manager
Certification & Credentialing	Prodigy	Operations Manager

(1) *Records Maintenance-Patient Records*

All employees shall maintain strict confidence on all patient records.

Patient records are retained for a period of seven years. Patient care reports are stored in secured filing cabinets in the Billing Office for the current year and past calendar years.

Records are destroyed by a "shredding service." The service shreds the records at our facility on a yearly basis or as needed.

(2) *Release of EMS Report Forms*:

PRO shall utilize the following policy related to Release of EMS Reports:

Copies of Records, to include medical or billing information, shall only be released by PRO in accordance with HIPAA regulations.

(3) *HIPAA Compliance for Electronic data back-up*:

Systems containing Electronic Protected Health Information (ePHI) have backups performed on them on an hourly basis. The backups are then continuously replicated offsite for Disaster Recovery/Continuity of Operations purposes. Backups of ePHI are retained for six (6) years. Backups are taken and transmitted using encryption. Backups are only stored on systems that encrypt the data at rest.

(4) *Retention of Pre-hospital Records*:

PRO shall store records related to patient care and transports for seven (7) years following the date of service:

Records affected by this policy are:

- Copies of the original EMS Report Form.
- Patient Information Sheet/ Run Ticket
- Copies of medical insurance cards or authorizations.

All records are stored virtually or on PRO property.

9.6.B. Personnel Records

Policy

PRO maintains accurate and current information on each employee for purposes of salary administration, operation of employee benefit plans, and in cases of emergency.

(1) *Accuracy of Information*

Personal information is recorded in each employee's personnel file at the time the employee is hired. It is a condition of employment for each employee to ensure that this information is accurate, current, and up to date at all times.

(2) *All Employees will have a Method of Contact*

The current telephone number or method of contact will be provided to the Management Team. If a change in the telephone number or the method of contact occurs, the employee must immediately notify the Management Team.

(3) *Database*

An employee must notify the Management Team in writing of any changes in:

- Name;
- Address;
- Telephone Number;
- Marital Status;
- Number of Dependents;
- Beneficiary Designations for PRO's Insurance Plan;
- Expiration, suspension or revocation of any license or certificate required for employment; and/or
- Persons to be notified in case of an emergency.

(4) *Income Tax Withholding*

When a change in a number of dependents or marital status occurs, employees should complete a new Form W-4 for income tax withholding purposes. These forms may be obtained from the CEO.

(5) *Access to the File*

While employee's personnel file is property of PRO, employees have the right to review anything contained within their personnel file. Requests for this material should be made to the CEO.

Pro Policy 900.7 – Documentation

Section:	Documentation
Policy #:	900.7
Modified:	04/15/2024
Reviewed:	04/15/2024

9.7.A. Overview

It goes without saying that paperwork is vital to our operation and your duties. The attendant on the call is responsible for completing the paperwork; however, both crew members are always responsible for its content. Please keep in mind that a driver should not sit back, do nothing, and watch the attendant write up all of the day's paperwork. If you have paperwork problems or questions, do not hesitate in asking for help from your partner or the office. Proper paperwork is essential for billing purposes and for proper patient care and follow up.

Your paperwork must be completed before the end of your shift. Your paperwork should be completed during or immediately after returning to service after each and every call. This is the best time to write your narrative and document what occurred on the call.

REMEMBER, IF YOU DO NOT DOCUMENT IT, IT DID NOT HAPPEN OR YOU DID NOT DO IT.

If you are pulled out of the hospital for another call, you must have the patient's name and, hopefully, the required signatures.

9.7.B. Documentation

The following pages provide the basic instructions necessary to complete the various forms that you will encounter at PRO.

Proper documentation will clearly explain what you did for the patient and why. It will also include pertinent negatives to show that you looked for and did not find certain things. Your documentation serves as the justification for the services provided or not provided by you. Properly documenting a call can discourage or defeat charges made against you before they begin. It is your first line of defense if issues or questions arise at a later date.

Complete, precise documentation is essential in order for PRO to be paid for the quality services that we provide. Insurance companies and HMOs are setting stringent policies regarding reimbursement for ambulance transportation making documentation that much more important. The determination of whether an ambulance was medically necessary is predominately based on your documentation.

When completing any paperwork, please print the information clearly and take an extra minute to double check the spelling. Use common and simple abbreviations. You are expected to complete all of the appropriate documentation. If you cannot obtain certain information, be sure to explain why on the

BLS trip sheet. It is just as important to document what you did not do as it is to document what you did do.

All BLS trip sheets and forms you complete become legal medical records. Document facts only, don't add assumptions, personal beliefs, or editorial comments.

DOCUMENT EVERYTHING EXACTLY AS IT HAPPENED ON THE CALL.

ALL INFORMATION CONTAINED IN THESE RECORDS IS STRICTLY CONFIDENTIAL.

Any requests by outside sources for release of any information shall be referred to the CEO.

The completion of paperwork is the responsibility of both crew members, regardless of who was driving. Normally, the EMT who "teched" the call is primarily responsible for the paperwork, however, both members are equally responsible for its accuracy, completeness, and submission. All paperwork must be completed and turned in at the end of your shift or whenever requested by a supervisor or member of the Management Team.

Pro Policy 900.8 – Patient Care Reports

Section:	Documentation
Policy #:	900.8
Modified:	04/15/2024
Reviewed:	04/15/2024

9.8.A. Patient Care Reports

Any employee of PRO must complete a patient care report for all calls where a patient has been contacted.

ALL INFORMATION AND COMMENTS MUST BE DOCUMENTED. ALL FIELDS REQUIRED BY TABLETPCR MUST BE COMPLETED.

Signature of Patient – Every patient should sign TabletPCR where appropriate. If a relative or family member accompanies the patient, they should be asked to sign for the patient. *If you cannot obtain a signature, you must document that the patient was unable to sign and document why. Ex.-PUTS/Cardiac disorder.*

ALL CREWS MUST PROVIDE AT LEAST A VERBAL REPORT TO THE RECEIVING FACILITY WHILE TRANSFERRING PATIENT CARE INCLUDING THE FOLLOWING ELEMENTS AT A MINIMUM:

- Age
- Gender
- Chief Complaint
- History of present illness
- Meds, PMH, Allergies
- Treatments Provided

UNDER NO CIRCUMSTANCES WILL A CREW LEAVE A PATIENT WITHOUT PROVIDING AT LEAST A VERBAL REPORT WITH ESSENTIAL MEDICAL INFORMATION TO THE RECEIVING FACILITY.

ALL CREWS MUST COMPLETE THEIR FINAL EPCR ON TABLETPCR AS SOON AS POSSIBLE AFTER PATIENT TRANSPORT IS COMPLETE. RUN SHEETS ARE DELIVERED BY SYNCING THE COMPLETED PCR WHICH IS SUBSEQUENTLY FAXED TO THE RECEIVING FACILITY.

LAW REQUIRES THIS PROCEDURE. THIS IS FOR YOUR OWN BENEFIT AND PROTECTION AS IT ENABLES RECEIVING FACILITIES TO CONTACT THE RESPONDERS IF A PATIENT HAS AN INFECTIOUS DISEASE.

If you have any additional questions or need further review, please see a supervisor.

9.8.B. Amendment of Patient Care Reports

<u>Background</u>

Patient Care Reports (PCRs) or "tripsheets" create a legal record of an ambulance call. It is the responsibility of each staff person to ensure that their PCRs accurately reflect patient information, care given and the medical condition of the patient. This policy outlines the role and responsibility of each staff member in accurately documenting patient care. Additionally, this policy allows PRO to fulfill its legal obligation to ensure the integrity of its operations and the confidentiality of patient information and ensure that it is in compliance with all state and federal regulations.

A supervisor or member of the Management Team may request that staff members modify, amend or fully complete PCRs for a given call when PCR reviews suggest that the information documented may be incorrect or incomplete. Information for each patient call must be complete, accurate, honest, and wholly based on the patient's condition. It is legally permissible for staff members to amend PCRs for reasons of completeness, correction, and clarity, and in compliance with the procedures outlined below. PRO does not endorse, nor will it tolerate any staff member who embellishes or falsifies medical necessity, mileage, services rendered, supplies used or any other information for the purpose of obtaining or enhancing reimbursement.

Proper reasons for modifying a patient care report may include correcting erroneous information, such as the patient's name, address, insurance numbers, or patient care-related information. For example, a non-emergency PCR must include accurate information on the patient's condition, the crew members' observations of a change in the patient's condition, how the patient was moved to the litter, whether the patient required additional care such that transportation by any other means would be contraindicated, etc.

In addition, a PCR that fails to document how a non-emergency patient was found and moved it may be returned for being incomplete. Staff members must accurately document how the patient was moved to the stretcher, whether the patient walked to the stretcher, walked with assistance, was carried by two-person sheet lift/total assist, etc.

Procedures

1. Original PCRs must be fully and accurately documented to reflect the patient's condition, ambulatory status, treatment given and patient disposition.
2. Medical information on PCRs should only be modified by the original author.
3. Other personnel (billing, QA, etc.) may only amend patient demographic information (name, address, insurance numbers, etc.), correct spelling errors and make other changes not related to patient care documentation.
4. Incorrect information should be crossed out, initialed, and dated, or clearly indicated as "amended" on electronic PCR.
5. New or revised information added to the PCR should be initialed and dated.
6. A copy of the revised PCR will be provided to the member of the Management Team who initiated the PCR review.
7. All amended PHI (Protected Health Information) will be maintained and disseminated as required by the HIPAA Privacy Rule and in accordance with PRO's HIPAA compliance policies.

Pro Policy 900.9 – Patient Refusals and Sick Assists

Section:	Documentation
Policy #:	900.9
Modified:	04/15/2024
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To properly document a patient refusal, you must first understand what constitutes a patient refusal. Just as the consent to receive treatment must be informed, the refusal for treatment must also be informed. A sick assist is a similar situation that should involve similar documentation and patient interaction.

FOR THE PURPOSES OF DOCUMENTATION, A REFUSAL AND A SICK ASSIST SHOULD BE TREATED EXACTLY THE SAME WAY. BOTH OF THESE SITUATIONS REQUIRE THAT THE PATIENT BE EXAMINED AND SIGN THE PATIENT REFUSAL SECTION OF TABLETPCR.

You must do an adequate examination of the patient. You cannot just take their word that they are fine. Often, the patient is the least qualified person to assess his or her own medical condition, and, if the patient's judgment proves to be wrong, you could be held liable. If the patient refuses to let you touch them, evaluate the patient as best you can visually and gather as much information as possible.

After completing the examination, clearly advise the patient of your findings and explain why you recommend that they be transported. Even when the medical problem is minor, your best protection is to recommend that the patient seek treatment.

ADVISE THE PATIENT OF THE POSSIBLE CONSEQUENCES OF NOT SEEKING MEDICAL ATTENTION. THESE CONSEQUENCES MAY INCLUDE DETERIORATION OF THEIR CONDITION OR DEATH.

You must determine whether the patient has the capacity to refuse treatment. The patient's competency to refuse treatment should be questioned if head trauma, alcohol, or drugs could be affecting the patient's mental status. The questionable mental capacity of a patient to refuse treatment is the biggest reason why, when you are in doubt, to decide in favor of treatment and transport.

In sick assist situations, try to evaluate the situation to feel comfortable that the patient will be able to care for him or herself after you have assisted them, and you have departed. We have seen instances where a patient has been assisted into a chair only to return the next day to find them in the same chair from the night before. You must carefully evaluate the patient and the patient's surroundings in an effort to prevent this scenario.

Once you are satisfied that the patient's mental capacity is not impaired, ensure that their understanding of the refusal is clear and absolute. If you believe the patient could change their mind, you should continue to urge the patient to consent to transport. Seek the assistance of others present to encourage the patient to consent. Many patients will refuse at first and then consent to treatment. When this occurs, document it.

You must document the names of witnesses for all patient refusals and sick assists. The witness should be an independent third party, preferably a friend or relative, who has witnessed your attempts to obtain consent and the patient's subsequent refusal. You should request an available witness to sign the trip report. This witness can be a police officer or a firefighter. If the person is a minor (anyone under the age of eighteen), enter the name of the parent/legal guardian who is signing under the "Comments" section. If no parent/legal guardian is present, and the minor has a complaint of pain or illness, you are required to transport that person to the hospital under the implied consent rule, as a minor is unable to make decisions himself. Implied consent does not apply to any individual who has no complaint of injury or illness. You must request assistance from dispatch or a supervisor if you are unsure of this procedure.

When you have exhausted all possibilities of performing a patient transport, you need to document the refusal in TabletPCR with a complete, detailed narrative. Enter the date, time, and incident location. You are documenting this incident the same way you would document an actual transport. Explain to the person that this form is to document their refusal of treatment and transport and they will not be billed. Furthermore, inform the patient that if they change their mind after they sign the refusal, you will gladly take them to the hospital.

If the person required ALS treatment such as D50 and subsequently refuses transport, medical control must be contacted to document the refusal.

Again, it cannot be stressed enough that you must document everything that you have said and done. Clearly explain what you found in your assessment, what you told the patient, and the patient's response. Remember, if you do not properly document the steps you went through for the refusal, it could be embarrassing trying to remember the call in a court of law three years later.

Pro Policy 900.10 – Police to Handle and No EMS

Section:	Documentation
Policy #:	900.10
Modified:	04/15/2024
Reviewed:	04/15/2024

You will respond to many calls where the situation is more of a police matter or where EMS is not needed. These calls must be well documented to protect you from the myriad of scenarios that could arise resulting in your actions and your release of a patient being questioned. Whenever a patient is turned over to the police for transport to a location other than a hospital, you must carefully document your observations of the patient and the circumstances of the call.

YOU SHOULD DOCUMENT THE PATIENT'S NAME WHENEVER POSSIBLE. BY DOCUMENTING THE PATIENT'S NAME, WE WILL BE ABLE TO KEEP STATISTICS AND TRACK PATIENTS THAT WE ENCOUNTER ON A REGULAR BASIS.

Pro Policy 900.11 – No Patient Contact/Cancellations

Section:	Documentation
Policy #:	900.11
Modified:	04/15/2024
Reviewed:	04/15/2024

When you are dispatched to a call that results in a cancellation or no visible patient, you are required to fill out TabletPCR. TabletPCR must be completed to document your response, your efforts to find a patient, or who cancelled you and the circumstances surrounding the cancellation. This PCR also provides us with statistical information vital to daily operations.

Pro Policy 900.12 – Obvious Death

Section:	Documentation
Policy #:	900.12
Modified:	04/15/2024
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There are occasions when you will encounter a patient who you will not transport due to obvious death. Obvious death can be defined as a patient who is unresponsive, apneic, and pulseless; with at least one of the following criteria present:

- Decomposition of the body;
- Rigor mortis (stiffening of the body after death);
- Dependent lividity (discoloration to skin due to pooling of blood);
- Decapitation/brain matter visible;
- Incineration (third degree burns to 100% of the body);
- DNR/Comfort Care; and/or
- MOLST Form.

Documenting the reason that you did not treat and transport a patient who is obviously dead can be more difficult than when you do transport. You need to complete TabletPCR containing all information as if this were a transport. Special attention should be paid to the biographical information, the medical history, and the circumstances of the call.

It is much more difficult to defend yourself when you did not do anything for the patient. Be sure to include details of the above criteria that you found. You must also include a description of the scene, including the position of the patient, the state of dress, any visible wounds or contusions, and an estimated length of time the patient may have been deceased if known.

This PCR may become vital to the police department and/or medical examiner. It must be completed prior to your leaving the scene. Do not assume that you can obtain the information or that you will remember crucial details at a later time.

All personnel are prohibited from applying a cardiac monitor or an AED to a patient who is obviously dead. A strip of asystole is meaningless and actually indicates that there is doubt in your mind that the patient is obviously dead.

Pro Policy 900.13 – Physician Certification Statement (Medical Necessity)

Section:	Documentation
Policy #:	900.13
Modified:	04/15/2024
Reviewed:	04/15/2024

A PHYSICIAN CERTIFICATION STATEMENT (PCS) MEDICAL NECESSITY FORM MUST BE COMPLETED FOR THE NON-EMERGENCY TRANSPORT OF A MEDICARE OR MEDICAID PATIENT. The billing office or the dispatcher may also request that the crew obtain this form for other insurance types based on the circumstances of the call.

YOU MUST BE SURE THAT A DOCTOR OR NURSE SIGNS THE FORM AND THAT IT IS FILLED OUT APPROPRIATELY. SECTION 12 FORMS AND SIGNED ALS NECESSITIES ARE ACCEPTABLE.

PREFERABLY, A DOCTOR OR A NURSE WILL FILL OUT AND SIGN THE MEDICAL NECESSITY FORM AT THE TIME OF TRANSPORT. The floor of the sending facility often completes these forms on their own but there may be occasions when you will need to ask the staff to complete the form. If hospital staff refuses to fill out a medical necessity form you are to contact the dispatcher for advice.

IF THE STAFF OF THE SENDING FACILITY IS NOT ABLE TO SIGN THE FORM, PLEASE MAKE SURE THAT YOU HAVE THE FIRST AND LAST NAME OF THE PATIENT'S PRIMARY CARE DOCTOR ON THE TRIP REPORT.

This information is needed on all non-emergency transports to enable the billing office to contact the patient's doctor to have the medical necessity completed. Please refer people to the billing office or a supervisor if more information is needed.

1000 | Continuous Quality Improvement

Pro Policy 1000.1 – CQI Introduction

Section:	Continuous Quality Improvement Policies
Policy #:	1000.1
Modified:	04/15/2024
Reviewed:	04/15/2024

10.1.A Continuous Quality Improvement (CQI) Introduction

The nature of the services provided by PRO requires that public confidence in the professionalism of our staff be maintained. Therefore, it is the responsibility of PRO and each employee to continually strive to make the service provided of the highest possible quality. Accordingly, oversight of clinical care is handled in collaboration between the PRO CQI Team, Pro EMS Solutions, the South Middlesex EMS Medical Peer Review Committee, and affiliate hospital medical direction from both Mount Auburn Hospital and Emerson Hospital. This collaboration is knowns as the PRO Continuous Quality Improvement Program (PRO CQI Program).

The PRO CQI Team is comprised of an Operations Manager, a clinical provider with experience in critical care, and PRO's Affiliate Hospital Medical Director. The PRO CQI Team works closely in conjunction with the Pro EMS Solutions team.

Pro Policy 1000.2 – PRO CQI Program Purpose

Section:	Continuous Quality Improvement Policies
Policy #:	1000.2
Modified:	04/15/2024
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The PRO CQI Program is a protected function and element of the South Middlesex EMS (SMEMS) Medical Peer Review Committee. The purpose of the PRO CQI Program is to promote, enhance, and ensure the highest quality of patient centered EMS care through information analysis, education, and coordination utilizing the principles of CQI.

CQI is a never-ending process in which all participants in the EMS system are encouraged to work together, without fear of repercussion, to develop and enhance the system they work in. By developing and implementing a thorough and inclusive CQI Program, the goal of achieving higher quality patient centered care with efficiency and cost effectiveness may be realized. The elements of prospective, concurrent, and retrospective analysis and activities will all be included.

CQI takes on the responsibility of continuously examining system performance to determine how the system and personnel within the system can improve. The overall concept of quality improvement is based on the premise that each EMS provider strives to perform appropriately, and that failures are most often related to system defects requiring an analysis of the system to determine how it can be structured to achieve the highest quality. The process of CQI is to examine all actions; both appropriate and inappropriate so that all members can learn from both.

PRO is committed to CQI and recognizes that optimum care and outcomes can be achieved through process analysis and improvement rather than reactively attributing blame to individuals when best results are not achieved. We also understand that a CQI Program is an on-going, dynamic process that takes time to develop and is always evolving.

Pro Policy 1000.3 – CQI Authority

Section:	Continuous Quality Improvement Policies
Policy #:	1000.3
Modified:	04/15/2024
Reviewed:	04/15/2024

The SMEMS Medical Peer Review Committee (the "Committee") creates and administers Continuous Quality Improvement (CQI) Programs including the PRO CQI Program. The Committee is established in accordance with G.L. 111C s 12 and is subject to the reporting requirements of the state medical director and the Region IV medical director.

The SMEMS Affiliate Hospital Medical Director (AHMD) chairs the Committee. The AHMD may appoint and remove members of the Committee at any time at his or her sole discretion.

Pursuant to G.L. c. 111 s 203(f) all EMS providers are required to participate in all CQI activities as required by the Committee.

All PRO CQI Program activities are carried out under the authority and direction of the Committee. All PRO CQI Program activities are performed, and all records are created, by and for the Committee.

Pro Policy 1000.4 – CQI Confidentiality

Section:	Continuous Quality Improvement Policies
Policy #:	1000.4
Modified:	04/15/2024
Reviewed:	04/15/2024

In accordance with G.L. c. 111 s 204, all proceedings, reports, records, and all material created by, for, or otherwise as a result of the activities of the Committee and its participants shall be confidential and shall be exempt from the disclosure of public records under Section 10 of G. L. c. 66, shall not be subject to subpoena or discovery prior to the initiation of a formal administrative proceeding pursuant to G. L. c. 30A, and shall not be subject to subpoena or discovery, or introduced into evidence, in any judicial or administrative proceeding, except proceedings held by the boards of registration in medicine, social work, or psychology or by the Department of Public Health pursuant to G. L. c. 111C.

No person who attends a meeting of the Committee shall be permitted or required to testify in any such judicial or administrative proceeding, except proceedings held by the boards of registration in medicine, social work, or psychology or by the Department of Public Health pursuant to G. L. c. 111C, as to the proceedings of such committee or as to any findings, recommendations, evaluations, opinions, deliberations, or other actions of such committee or any members thereof.

No person participating in any Committee activity including, but not limited to, meetings, recordkeeping, interviews, statements, findings, viewing recorded presentations, training, remediation, rounds, case reviews, reporting, and data collection shall disclose any information concerning these activities. Any disclosure is strictly prohibited unless authorized by the Committee Chair or as required by law. All participating services and hospitals will adhere to the strict protection of peer review material in accordance with this policy. Unauthorized disclosure shall be grounds for disciplinary action, up to and including termination of authorization to practice and termination of employment.

The “minimum necessary” standard is required for all activities related to this policy. This standard essentially limits the information disclosed to the minimum necessary information needed to accomplish the task.

Encrypted email and/or other approved secure means must be utilized when using electronic communications for all Committee activities.

All employees may be required to sign a confidentiality agreement at the time of hire.

Pro Policy 1000.5 – PRO CQI Program Objectives

Section:	Continuous Quality Improvement Policies
Policy #:	1000.5
Modified:	04/15/2024
Reviewed:	04/15/2024

10.5.A. PRO CQI Program Objectives

- To ensure the highest level of patient centered care.
- To identify trends and implement best practices in prehospital care.
- To set performance standards related to prehospital care.
- To collect and organize data in an attempt to obtain outcome-based information.

Pro Policy 1000.6 – PRO CQI Program Activities

Section:	Continuous Quality Improvement Policies
Policy #:	1000.6
Modified:	04/15/2024
Reviewed:	04/15/2024

10.6.A. Patient Care Record Review

A retrospective review of 100% of all Patient Care Records (PCRs) will be performed by the PRO CQI Team or their designee using Committee approved PCR audit criteria. The PRO CQI Team shall follow the direction of the Committee to carry out the activities of providing feedback and reports to providers, participants, and the Committee. All documentation, communications, and material are created by, for, or otherwise as a result of the activities of the Committee.

10.6.B. Discipline Related to CQI

The CQI process is designed to be an educational tool. Discipline will only arise from the CQI process in limited circumstances. Therefore, any recommendation for discipline that arises out of this process shall be referred to the CEO or COO.

10.6.C. Continuing Education

The information obtained and lessons learned through the PRO CQI Program shall be incorporated into the education process and provided to providers where indicated in order to appropriately complete the CQI feedback loop. Continuing education resulting from this process may be done individually or system wide, depending on the needs as identified by the PRO CQI Team, the AHMD, and/or the Committee. Only continuing education provided and/or approved by PRO will be accepted.

10.6.D. Rounds and Case Reviews

Rounds and case reviews are always held during a meeting of the Committee. All attendees at Rounds and case review sessions will be required to sign a roster which contains an acknowledgement of the confidentiality requirements of the meeting and all Pro EMS CQI Program activities. Rounds and case reviews during the Committee meetings are video recorded and must be completed online by all PRO personnel who are unable to attend in person. Completion of rounds and case reviews online requires use of a password protected learning management system platform as well as an acknowledgement of the confidentiality of the online materials. Online materials may only be accessed and viewed by authorized personnel. These materials and videos are created by, for, or otherwise as a result of the activities of the Committee and are strictly confidential.

10.6.E. High Acuity Low Occurrence Training (HALO)

HALO is a specific program of training and skill retention approved and required by the Committee. All field providers are required to participate in scheduled HALO training.

Pro Policy 1000.7 – PRO CQI Program Responsibilities

Section:	Continuous Quality Improvement Policies
Policy #:	1000.7
Modified:	04/15/2024
Reviewed:	04/15/2024

10.7.A. PRO CQI Team

The PRO CQI Team will coordinate the PRO CQI Program. The PRO CQI Team can delegate program responsibilities and duties as needed. Duties will include, but not be limited to, performing audits of 100% of PCRs; tracking all data and reporting to the Committee; meeting with providers to discuss specific case issues; providing feedback, direction, and guidance to all personnel regarding clinical matters; participating in prehospital research activities; and analyzing needs based on problem identification, scope of practice, and industry trends. Educational duties will include, but not be limited to, the creation of educational programs as directed by the Committee; tracking all educational activities and reporting activities to the Committee; seeking out and proposing best practices for system implementation; coordinating HALO and FTEP training activities; and conducting remediation activities as required. All documentation, communications, and material are created by, for, or otherwise as a result of the activities of the Committee.

10.7.B. Pro EMS Solutions

Pro EMS Solutions will support the efforts of the PRO CQI Program. They can delegate program responsibilities and duties as needed. Duties will include, but not limited to, assisting with automated CQI process management, CQI alerting, compliance with state and national standards, and submission of data to national databases such as CARES. All documentation, communications, and material are created by, for, or otherwise as a result of the activities of the Committee.

10.7.C. SMEMS

SMEMS will be responsible for the coordination, training, and evaluation of medical control physicians. Duties will include, but not be limited to, orientation of medical control physicians; designing standardized corrective action plans for individual medical control physician deficiencies; establishing procedures for informing the Medical Control personnel of system changes; and developing performance standards for evaluating medical control physicians. All documentation, communications, and material are created by, for, or otherwise as a result of the activities of the Committee.

Pro Policy 1000.8 – Progression of PRO Field Providers

Section:	Continuous Quality Improvement Policies
Policy #:	1000.8
Modified:	04/15/2024
Reviewed:	04/15/2024

10.8.A. Paramedics

All PRO paramedics must complete each of the following steps in order to serve on a 2P resource with an FTO:

1. Successful completion of hiring process;
2. Successful completion of PRO FTEP (Field Training Evaluation Program) – Phases 1 and 2;
3. Completion of all OEMS recertification requirements if coming from outside entity;
4. Successful completion of ALS IFT training or FCCS;
5. Successful completion of ACLS/PALS;
6. Successful completion of Massachusetts Statewide Treatment Protocol test; and
7. Successful completion of HALO training.

All paramedics must complete the following additional steps to serve on a 1P or P/B resource:

1. Successful Completion of PRO FTEP – Phase3

10.8.B. EMTs

All PRO BLS personnel must complete each of the following steps in order to serve on a resource with an FTO:

1. Successful completion of hiring process;
2. Successful completion of PRO FTEP Phases 1 and 2; and
3. Completion of all OEMS recertification requirements if coming from outside entity.

All EMTs must complete the following additional steps to serve on a P/B resource with a non-FTO:

1. Successful completion of PRO FTEP Phase 3

Pro Policy 1000.9 – PRO CQI Program Performance Measures

Section:	Continuous Quality Improvement Policies
Policy #:	1000.9
Modified:	04/15/2024
Reviewed:	04/15/2024

The PRO CQI Program, as directed by the Committee, will track, measure, and report the following parameters:

- Statewide Treatment Protocol compliance
- ALS Assessment and Care Initiated Upon Patient Contact
- All required and completed follow-up information with field providers.
- All requested and completed patient outcome follow-up information.
- Internal or external customer feedback (e.g., patient, family members, emergency responders, co-workers, managers, hospital staff etc.) including results from formal Patient Satisfaction Surveys. Every patient contacted will receive a formal Patient Satisfaction Survey.
- Tracking and success of advanced airway procedures
- Waveform ETCO2 Monitoring When Indicated (100% compliance)
- STEMI: Review all ECG interpretations and POE determination.
- Stroke: Complete and submit all parameters to MDPH Coverdell Program
- Trauma: Transport to appropriate facility; limit non-entrapment scene time to < 10 minutes.
- Seizure: When Benzodiazepine was administered, did seizure stop; Patients where blood glucose level was taken.
- Asthma: Patients that received beta agonist with improved condition.
- CPAP: Total Pulmonary Edema patients with Nitro and CPAP administered.
- Sudden Cardiac Arrest (SCA): Complete CARES data submission
- Information regarding Special Projects

Pro Policy 1000.10 – Mandatory Review Requirements

Section:	Continuous Quality Improvement Policies
Policy #:	1000.10
Modified:	04/15/2024
Reviewed:	04/15/2024

The following is a list of the call events which may trigger review by the Committee. The current list of events includes, but is not limited to, the following:

- Complaints or grievances filed by the patient or their families;
- Equipment failure;
- Incidents that are injurious or potentially injurious to patients;
- All calls requiring Online Medical Control requests; and
- Any medication errors.

Pro Policy 1000.11 – SMEMS Medical Peer Review Committee Meetings – Cambridge Fire Department and PRO

Section:	Continuous Quality Improvement Policies
Policy #:	1000.11
Modified:	04/15/2024
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The evaluation of the EMS system as a whole is crucial to ensuring patient centered care. The overall evaluation takes into consideration all system aspects including emergency medical dispatch, field operations, education, equipment, and the receiving hospital and staff capability. The Committee will normally be scheduled to meet on a monthly basis, and additionally as needed, to discuss and evaluate issues touching the Cambridge EMS System and the Emerson Paramedics System.

The Committee will meet to evaluate information concerning compliance with standard of care procedures and protocols, complaints, patient feedback, and unusual incidents. The Committee will evaluate and recommend continuing education programs to continuously improve protocol compliance and the provision of patient centered care.

The Cambridge Fire Department (CFD) and PRO representatives who will regularly participate in Committee meetings and activities will include, but not be limited to, the following:

- SMEMS Executive Director
- SMEMS Medical Control Physicians
- PRO CQI Team
- PRO CEO
- PRO COO
- PRO Operations Managers
- CFD Chief or designee
- CFD EMS Deputy Chief
- CFD EMS Captain
- CFD representatives as designated by CFD Chief
- Pro EMS Solutions representative

1100 | Compliance

Pro Policy 1100.1 – Introduction & Code of Conduct

Section:	Compliance
Policy #:	1100.1
Modified:	04/15/2024
Reviewed:	04/15/2024

11.1.A. Introduction

The following policies and forms are part of our Compliance Program. The policies are to be followed and the forms are to be used to foster our organization's compliance with statutes, regulations and policies relating to compliance. Some of these policies deal exclusively with the Medicare Program.

11.1.B. Definitions

When used in our policies and forms, the following words and abbreviations shall have the following meanings unless the context clearly indicates otherwise:

Term	Definition
Assignment of Benefits (AOB)	The assignment by or on behalf of the patient, to the ambulance service provider, of the patient's insurance benefit for the service provided by the ambulance service provider.
Attending Physician	The physician who coordinates the care and treatment of a patient.
Benefit	The health services that may be covered under Medicare or other insurance.
Coinsurance/Copayment	The percentage of the "allowed amount" that is not paid by the insurer for which the patient is responsible. For Medicare, the patient is responsible for 20% of the Medicare allowed amount.
Coordination of Benefits (COB)	Ensuring that insurance claims are coordinated between insurers when an individual is covered by two insurance plans for the same item or service so that the claim is paid first by the primary insurer according to the insurance benefit of the individual provided by that insurer.
Cost Sharing Amount	The amount that the patient is responsible for, including both the coinsurance ("co-payment") and the annual deductible.
Deductible	An amount that must be paid by the patient on an annual basis before benefits are paid.

Emergency Response	Responding immediately at the BLS or ALS-1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance service provider begins as quickly as possible to take the steps necessary to respond to the call.
Federal Health Care Program	Any plan or program that provides health benefits, whether directly or indirectly, through insurance, or otherwise, that is funded directly, in whole or in part by the United States government (except for the Federal Employees Health Benefits Program) or a state health care program (as defined in 42 U.S.C. § 1320-7(h)
Loaded Mileage	The number of miles traveled while a patient was actually in the ambulance. Only "loaded" miles are reimbursed by Medicare.
Medicare Administrative Contractor (MAC)	Medicare contractor that processes Medicare Part B claims by an ambulance service provider.
Medicare	A federally funded health insurance program for people that meet certain conditions.
Medicare Beneficiary	A person who is enrolled in the Medicare Program and is entitled to Medicare benefits.
Medicare Part B	Voluntary healthcare coverage for persons who are not in an inpatient stay, or otherwise considered to be in an "outpatient" status. Ambulance services are a Part B benefit.
OIG	Office of Inspector General, United States Department of Health and Human Services.
Patient Care Report (PCR)	Also called the "trip sheet," "run report," "incident report," or "pre-hospital care report." The PCR is the "official record" of the ambulance service completed by the ambulance crew to record information about the call. The information on the PCR becomes the basis for billing.
Payer	A person or entity that makes or is responsible for making payment for the ambulance service.
Physician Certification Statement (PCS)	This form is used for most non-emergency transports to verify, by an authorized person with knowledge of the patient's condition at the time of the transport or when the transport was ordered, that ambulance service is required, and that forms of transport other than by ambulance would be harmful or risky to the patient's well-being.
Primary Insurer	The insurer that should be billed first for coverage of a service rendered to a patient.

Remittance Advice	Notice sent by a Medicare Administrative Contractor after the claim for healthcare services has been processed. It details, among other information, the amount billed, allowed amount, approved amount, contractual allowance, and amount owed by the patient (cost-sharing).
Repetitive Transport	Transport of a patient three or more times in a span of 10 days, or once per week for a span of three weeks.
Secondary Payer	The insurer that should be billed for coverage of a service rendered to a patient after the primary insurer pays if an insurance benefit remains for the service provided after payment by the primary insurer.
Subscriber	An individual who has paid an ambulance service provider a membership fee as part of a "membership" or "subscription" drive in advance of receiving actual services.

11.1.C. CODE OF CONDUCT

CODE OF CONDUCT

PURPOSE

Professional Ambulance Service (PRO) continually strives to provide high quality emergency care and medical transportation services to our patients, and to maintain high standards of integrity in our dealings with our patients' families, as well as our own staff members and those with whom we do business. It is our philosophy that we provide all of our services in full compliance with all laws and regulations. This requires the highest standard of conduct from all of our staff members. This philosophy of total compliance is the foundation of all that we do, and consistent with that philosophy, PRO has approved and adopted this Code of Conduct.

POLICY

(1) *STATEMENT OF COMMITMENT*

PRO has been, and continues to be, committed to conducting our activities in full compliance with all federal, state, and local laws. Our reputation for quality service and excellent care has been achieved by the personal integrity, good judgment, and common sense of our staff members. Staff members are expected to demonstrate appropriate ethical behavior when conducting activities with patients and their families, fellow staff members, suppliers, vendors, consultants, and those with whom we do business. We commit to provide each staff member the policies, procedures, and guidelines to be aware of his/her responsibility in ensuring compliance with this Code of Conduct.

(2) *PURPOSE OF THE COMPLIANCE PLAN*

The Compliance Plan provides the approach to guide our conduct in all that we do. It is intended to provide overall guidance for us in providing EMS and medical transportation services in a legal, ethical, and appropriate manner; however, it does not supersede the more specific policies of PRO.

The Compliance Plan is a supplement to the standards of conduct as presented our Policies and Procedures Manual and Employee Handbook, where applicable. Each staff member, administrative personnel, and all members of the Management Team should read and understand the Code and subscribe to its standards and procedures.

This Code of Conduct does not address every aspect of PRO's activities and the applicable legal issues they may entail. Because of changes in PRO's structure and operations or changes in regulatory requirements, the document is inherently subject to change.

Each staff member, supervisor, and member of the Management Team should participate in an initial training program explaining the Code. New staff members should receive compliance training during new staff member orientation. Annually, each staff member may receive a minimum of one hour of compliance training. Upon completion of each training session or orientation, staff members should be required to sign a statement of participation and attendance.

Each staff member is expected to be familiar with the applicable laws and regulations that govern the matters set forth in the Code of Conduct as it pertains to his or her duties. That familiarity should be part of every staff member's job performance and a regular part of that staff member's review.

(3) *STANDARD OF COMPLIANCE WITH LAWS*

PRO personnel, including, where applicable, managers, staff members, agents, consultants, and other representatives, should conduct their activities in compliance with applicable laws, rules, and regulations. If there is reasonable doubt as to the appropriateness of an activity, staff members should seek advice within the PRO chain of command. Staff members may also contact the PRO Compliance Officer at any time if they have questions about the appropriateness of any particular action or course of conduct.

Policies and procedures regarding certain laws and regulations important to the provision of health care services are a part of the Compliance Plan.

(1) *Patient Rights*

PRO is dedicated to protecting its patients' personal privacy and confidentiality of information consistent with PRO's mission, applicable laws (including HIPAA, where applicable) and quality standards.

(2) *Disclosure*

PRO and its agents will deal honestly and fairly with patients, community members, vendors, competitors, mutual aid companies, payors, and other outside contractors. Communication and disclosure information should be clear, accurate and sufficiently complete.

Financial and operational reports should be prepared in accordance with applicable rules and regulations and prepared within PRO's normal system of accountability.

(3) *Patient Billing*

PRO will deal honestly with all payors (e.g., self-pay, insurance companies, HMOs, Medicare, Medicaid, etc.). Claims submitted to Medicare and other governmental and private payors should be complete and accurately reflect the services rendered. PRO should submit claims for services that are supported by the necessary documentation, while maintaining prompt and proper billing practices.

Billing issues should be resolved according to applicable laws, regulations, organizational policies and, where applicable, payor contracts. Questions regarding patient billing should be resolved expeditiously. If staff members are unsure of the proper response to a question or inquiry, the staff member should contact the Compliance Officer or other responsible person in the organizational chain of command.

(4) *Integrity of Workforce*

We recognize that the personal integrity, good judgment, and common sense of our staff members are responsible for our reputation of quality service. To maintain that reputation, prior to entering into a relationship with PRO, all staff members, contractors, vendors, and others will be subject to a reasonable and prudent background investigation, including a reference check.

Applicants (career and/or volunteer, as applicable) will be asked to disclose any criminal convictions, (as defined by 42 U.S.C. 1320a-7(i) and state law) or any action taken by the government to exclude the individual from participation in federal health care programs. Individuals who have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded or otherwise ineligible for participation in federal health care programs (as defined in 42 U.S.C. 1320a- 7b(f)) may not be considered for employment or a volunteer position with PRO. Additionally, applicants will be required to divulge their driving record, particularly if their work involves the operation of PRO vehicles.

(5) *Conflict of Interest*

Staff members are to conduct themselves in a manner that encourages and preserves the trust of those we serve. Staff members should not have financial relationships with parties with which PRO does business. Prompt disclosure of conflicts of interest should be made to PRO administration. Violations should be handled in accordance with applicable PRO disciplinary procedures.

(6) *Confidentiality*

No member of the organization should use confidential or proprietary information for his or her own personal gain or for the benefit of another person or entity, while associated with PRO or at any time thereafter.

Information concerning a patient is confidential. PRO personnel should not obtain or divulge details of a patient's condition without a specific professional reason, except as required by law. Violations should be handled in accordance with PRO disciplinary policies, and/or our HIPAA policies, where applicable.

All new personnel, prior to performing any substantial duties with PRO that involve patient interaction or information, shall undergo the mandatory privacy training as required under the HIPAA Privacy Regulations (where PRO is a "covered entity" in accordance with HIPAA).

(7) *Compliance with Federal, State and Local Laws and Regulations*

PRO will take all actions necessary to ensure compliance with all applicable federal, state and/or local laws and regulations, as well as with the public policies they represent.

(8) *Anti-Kickback Laws*

PRO will take all actions necessary to ensure compliance with Federal and State anti-kickback laws regarding the acceptance or payment of any remuneration for the inducement of referrals of services or the generation of other business and shall comply with all applicable regulations regarding self-referrals and kickbacks. Staff members should not give or receive kickbacks, rebates, or anything of value to a vendor, patient, physician, or other health care provider in exchange for a referral for services or the generation of other business.

(9) *Business Arrangements with Physicians or other Referral Sources*

PRO will take all actions necessary to ensure compliance with federal and state laws regarding self-referral and business arrangements. Business arrangements with any referral sources should be set forth in a written contract and should be in accordance with applicable federal and state laws. Payments by PRO to any referral source should be equal to the fair market value of the services rendered or items being purchased by PRO and should not be based on the volume of transports, or the value of referrals generated by the referral source.

(10) *Environment*

PRO strives to manage and operate in ways to ensure there is minimal risk to patients, staff members, visitors, and the community environment within the confines of PRO. Every staff member should comply with the safety, hazardous waste and other environmental care policies established by PRO.

(11) *PRO Transactions*

PRO transactions should be completed at fair market value and should not result in a direct or indirect monetary benefit to a staff member. PRO assets should not be used for the benefit of private individuals or staff members.

(12) *Anti-Competitive Practices*

PRO will take all actions necessary to ensure compliance with federal, state and/or local laws and regulations that prohibit price-fixing and other anti-competitive practices. This includes compliance with all laws and regulations related to the procurement of EMS or ambulance service for a municipality or other government entity.

(13) *Gifts to Government Representatives*

Staff members should not provide gifts or pay for meals, refreshments travel or lodging expenses for government or public agency representatives, with the intent to influence an official action or decision in an illegal, unethical, or unlawful manner.

(14) *Government Investigation*

Information disclosed without proper authorization jeopardizes the rights of our patients. We also do not want to hinder in any way a legitimate government investigation. If federal or state law enforcement officials request information from a PRO staff member, the staff member should direct the federal or state law official to contact the PRO Compliance Officer. The PRO Compliance Officer should then communicate with the staff member to ensure that the appropriate documents are provided.

Whenever there is any indication that a government investigation may be underway, under no circumstances will any records or documents that could have a bearing on that investigation be destroyed or altered in any way. Any question about disposition of documents or records should be directed to the Compliance Officer.

(15) *Individual Judgment*

Staff members are often faced with making critical decisions based on activities in the workplace. Remember to always respect others and use good judgment and common sense. If anything within this Code of Conduct goes against your own good judgment, you are encouraged to discuss it with the Compliance Officer or other member of PRO management.

Pro Policy 1100.2 – Patient Care Report Documentation

Section:	Compliance
Policy #:	1100.2
Modified:	04/15/2024
Reviewed:	04/15/2024

11.2.A. Purpose

To capture a complete picture of the ambulance service provided for a patient, ensure appropriate billing, and prevent False Claims Act and other federal violations.

11.2.B. Policy

All PCRs must be complete and thorough and must accurately and objectively address the patient's condition at the time of transport. Documentation must cover all key elements necessary to fully document the patient assessment and care provided, as well as to allow the billing staff to make appropriate determinations as to the medically necessity and other requirements needed to ensure proper reimbursement for the services we provide.

11.2.C. Procedure

The PCR should contain the information necessary to accurately describe the services provided. The PCR should be concise, thorough, and accurate and include an unbiased, objective description of information received, observations, and the care provided. The information contained in the PCR must be complete, accurate and never misrepresent the patient's actual condition. There must be sufficient documentation in the PCR to determine if the patient's medical or physical condition was such that means of transportation other than an ambulance was appropriate for the patient.

All sections of the PCR must be completed in their entirety and should include information such as: dispatch instructions, the patient's condition and chief complaint, the patient's relevant medical history, the services provided to the patient, the pick-up and destination location, and the loaded mileage.

The PCR should not be used as a medium to express concerns or otherwise document potential problems to management and others. The PCR should document the objective findings related to patient assessment, patient care, and the ambulance services provided. Other forms and documents should be used (e.g., incident report, complaint reporting form, etc.) to document concerns, risks, issues, or complaints.

Pro Policy 1100.3 – Review & Amendment of PCRs

Section:	Compliance
Policy #:	1100.3
Modified:	04/15/2024
Reviewed:	04/15/2024

11.3.A. Purpose

PRO shall maintain a strict quality assurance procedure to ensure that the accuracy and clarity of our patient care documentation is at the highest possible level.

11.3.B. Policy

Substantive amendments to the PCR shall be made only by the original author of the PCR or another member of the crew that provided the ambulance service. Demographic information (e.g., patient name, Social Security Number, address, health insurance information) may be corrected or added by billing personnel.

11.3.C. Procedure

An ambulance crew shall complete a PCR as promptly as possible following completion of the call (and prior to the completion of the shift). The PCR should be completed by the primary caregiver. A PCR may not be completed by personnel other than the crew that participated in the call. Amendments may be made as set forth in this policy.

Crewmembers who provided the ambulance service shall check the PCR for accuracy prior to submitting the PCR and other paperwork for billing.

PCRs will undergo quality assurance review as part of the billing process and prompt feedback shall be given to the author of the PCR where it is apparent that there is an error, or missing information on a PCR.

Addenda and corrections will be requested by returning the PCR to the author for any substantive amendments. Requests for addenda and corrections shall be made only to ensure completeness and accuracy of the medical record, or to correct clearly erroneous or conflicting information.

A crew member may make corrections or additions to the PCR after submitting if information was inadvertently omitted prior to submission or additional information regarding the patient's care or condition was acquired after submission.

All amendments must be truthful and initialed and dated by the crewmember who makes the amendment. That crewmember must have direct knowledge of the matter addressed by the amendment.

Pro Policy 1100.4 – Physician Certification Statements

Section:	Compliance
Policy #:	1100.4
Modified:	04/15/2024
Reviewed:	04/15/2024

11.4.A. Purpose

To satisfy a regulatory requirement that requires a properly completed Physician's Certification Statement (PCS) for most non-emergency transports of Medicare beneficiaries.

11.4.B. Policy

PRO personnel (dispatch or field crews) will obtain a properly completed and signed PCS for any non-emergency transport for which a PCS is required. Billing personnel will confirm that a PCS is obtained and properly completed and signed by an authorized signer before billing Medicare for any non-emergency transport for which a PCS is required to support the claim, or the appropriate steps are taken to verify an attempt to obtain a PCS.

11.4.C. Procedure

1. Billing personnel will ensure that there is a PCS for a non-emergency ambulance service unless other documentation reviewed by them establishes that the ambulance transport was an unscheduled transport of a beneficiary who at the time of the transport was residing either at home or in a facility and who was not under the direct care of a physician.
2. Billing personnel will ensure that the PCS includes:
    a) Identification of the beneficiary, and date of transport or notation that the PCS is for scheduled repetitive transports and dated within 60 days of the date of transport.
    b) Specific information regarding the patient's condition which substantiates the certified medical necessity for an ambulance transport.
    c) A certification by a qualified person that other means of transportation were medically contraindicated.
    d) Signature of a qualified person. A qualified person is the attending physician for scheduled, repetitive transports. For all other transports for which a PCS is required, a qualified person includes the attending physician or where the physician is unavailable, a physician assistant (PA), registered nurse (RN), discharge planner, clinical nurse specialist, or nurse practitioner (NP) as long as that person is employed by either the attending physician or the facility from which the beneficiary is being transported and has personal knowledge of the beneficiary's condition at the time the ambulance transport is ordered or the ambulance service is furnished.

e) The date the document is signed by the qualified person and that the person signing the PCS is identified, in accordance with the signature verification requirements as outlined in Medicare Transmittal 327 of 2010, and the Medicare Program Integrity Manual, Chapter 3, Section 3.2.2.4.

3. In the event a PCS was not obtained prior to or at the time of transport, or if the PCS is incomplete, efforts can be made to obtain a signed PCS for 21 days after the date of transport for unscheduled, non-repetitive transports. A PCS obtained after the date of service can still be valid, as long as the PCS relates to the patient's condition on the actual date of service.

    a) If a PCS is not obtained within 21 calendar days following the date of the service, billing personnel will document the attempts to obtain the PCS with either a signed return receipt from the U.S. Postal Service or other similar service or the U.S. Postal Service Certificate of Mailing form approved by CMS, and then submit the claim to Medicare using the certified mailing record in lieu of the signature on the PCS.

4. Billing personnel will review the PCS form submitted with the PCR and other documentation to ensure that the above requirements have been satisfied.

Pro Policy 1100.5 – Internal Audits

Section:	Compliance
Policy #:	1100.5
Modified:	04/15/2024
Reviewed:	04/15/2024

11.5.A. Purpose

To verify that claims are properly coded to be submitted for payment or that proper payment was made for submitted claims, and to determine if appeals for denials or refunding of overpayments may be required.

11.5.B. Policy

In accordance with the auditing and monitoring standards, to promote a positive compliance atmosphere, and to detect and prevent violations of the law, Medicare Program requirements, and our policies and procedures, PRO will conduct periodic audits and reviews of claims and other Medicare requirements to ensure that proper coding and billing of services are being performed and that proper reimbursement is being pursued and received. Samples of pre- and/or post-submission claims will be audited to verify accuracy, check for any possible errors, and ensure that all Medicare coverage criteria are met.

11.5.C. Procedure

1. On a monthly basis, thirty (30) claims will be selected and internally reviewed and audited for accuracy ("self-audit"). Claims will be chosen randomly.

    a) Upon review of claims that have not yet been billed, a determination will be made as to whether each claim can be submitted for payment as prepared, or whether additional documentation is required, corrections must be made to address errors, or it cannot be billed at all. In each case, compliance with all Medicare coverage criteria should be evaluated.
    b) Upon review of claims which have been paid, a determination will be made as to whether the claim was appropriately billed and paid, and whether an overpayment or underpayment exists. In each case, compliance with all Medicare coverage criteria should be evaluated. A denied or "downcoded" claim will be further reviewed and a decision made as to whether the claim should be appealed.
    c) Information for each claim shall be reviewed (including a review of the CMS 1500 claim form (or its electronic equivalent), the electronic remittance advice, the PCR, the PCS (if applicable), the CAD notes (or other dispatch instructions or information) if available, and all other available and relevant information.
    d) The self-audit process shall ensure that claims for ambulance transports of Medicare beneficiaries meet the requirements for a "covered transport" in accordance with CMS Manual 100-02 ("Medicare Benefit Policy Manual"), Chapter 10 ("Ambulance Services"), CMS Manual

100-04 (“Medicare Claims Processing Manual”), Chapter 15 (“Ambulance”), 42 CFR 410.40, 42 CFR 410.41, and 42 CFR 414.605 et seq.

2. We will utilize an audit tool to perform self-audits, which will be able to concisely demonstrate problem areas, and provide input for future corrective actions.

3. In order to assess these criteria, we will use our Ambulance Claims Review Spreadsheet to assist us in performing a thorough review. Below is a table further describing the general categories on the spreadsheet and a brief explanation as to what to consider when assessing each area.

Documentation *on PCR*	**Things to look for**
Patient Name	Verify that patient’s name is spelled correctly and will be/was recognized by Medicare.
Date of Service	Ensure that the dates reported on the various forms (PCR, PCS, dispatch records, claim, etc.) are consistent and correct.
Was Medical Necessity Met?	Determine if the documentation reveals the medical or physical reason the patient needed an ambulance transport, and that other forms of transport were contraindicated.
Was the Transport Reasonable?	Determine if the patient required transport from the origin point to the destination point. Ensure that the service could not have been provided at less cost at the point of origin and that the destination was the closest appropriate destination.
Was There an Immediate Response?	For emergency transports, verify that there was a 911 dispatch or equivalent and that there was minimal delay between the dispatched and en route times. If the time between dispatch and arrival is lengthy, verify that the PCR contains information explaining the delay and how the crew acted as quickly as possible to respond.
Are Modifiers Correct?	Verify that proper modifiers were used, including origin and destination modifiers, and possible payment related modifiers (GY, GA, GZ, etc.).
Does Destination Appear Appropriate?	Confirm that the destination facility is a covered destination, appropriate (to meet reasonableness standards) and that it is the closest appropriate facility to meet the patient’s needs.
Was Mileage Recorded?	Check to make sure that mileage was recorded on the PCR (from the point of pickup to the destination in tenths), and that only loaded mileage was billed on the claim form.
Was Patient Signature Obtained?	Confirm that a patient signature has been captured, or, where appropriate and permitted, that a representative signature has been obtained, or a lifetime signature is on file (only if no other alternative).

Was Zip Code Recorded?	Verify that the zip code of the point of pick–up is recorded. This is relevant for both obtaining rural payment bonuses and determining the proper MAC to bill.
What Service Level was Billed?	Determine whether the service level (base rate HCPCS code) was appropriately recorded, based on the information available, and was based upon the totality of facts and circumstances.
Does the Service Level Billed Appear Correct?	If the claim is not yet paid, verify that the level of service to be billed is proper. If already paid, make sure that the right service level code was used, and that payment is consistent with the trip documentation. Verify coding based upon both the level of service billed considering dispatch type (E or NE) and services provided (ALS, BLS, etc.)
Is the Crew Appropriate for Level of Service?	Verify that the composition of the crew is adequate for the level of service billed or to be billed. The legible name of each crew member, accompanied by their certification level should appear on the PCR and, if billed or to be billed ALS, the crew member who assessed the patient or provided interventions needs to be identified.
Comments	For completeness in the self-audit, insert relevant comments, related to any of the review areas, or any other issues that may arise, including whether an overpayment or underpayment may exist.

Pro Policy 1100.6 – Identifying & Refunding Overpayments

Section:	Compliance
Policy #:	1100.6
Modified:	04/15/2024
Reviewed:	04/15/2024

11.6.A. Purpose

To prevent retention of improper payments, and to avoid fraud and abuse or the appearance of improper payments.

11.6.B. Policy

All improper or inadvertent overpayments that are self-identified will be promptly returned upon identification of the overpayment, but in no case shall an overpayment be refunded more than 60 days after the date it was identified. Overpayments identified by payers will be investigated internally and responded to in an appropriate manner.

11.6.C. Procedure

1. Remittance advice and payments will be reconciled with submitted claims to determine whether payment was made in accordance with how the claim was billed. All patient accounts will be reconciled.

    a) Billing personnel (other than the person that prepared and submitted the claim) will compare the billed amounts with the received amount to fully reconcile all claims. This helps prevent overpayments, underpayments, and the accumulation of large amounts of accounts receivable.
    b) Accounts that have been properly paid in full may be considered "closed."
    c) If a duplicate payment is made upon any account, an assessment will be made to determine which payer is "primary." Payments made by a secondary payer for which the payer is not responsible will be reimbursed.
    d) Upon discovery of payment from any payer that is not responsible for payment, the overpayment (or improper payment) will be refunded, and an appropriate payer will be subsequently billed.

2. Where overpayments are discovered, and where overpayment forms exist, appropriate repayment forms and explanatory letters (where required) will be utilized to explain the reason for the repayment. For example:

    a) Payment may have been made at the wrong level of service.
    b) Payment may have been made where it was improper (e.g., medical necessity not met, no proper assignment of benefits, etc.)

3. If a payer identifies an overpayment and issues a demand notice, billing personnel in coordination with the Compliance Officer, if necessary, will review the request to determine if an overpayment does indeed exist. PRO will contest the overpayment demand or initiate a refund promptly in accordance with the timeframe established in the letter or with typical payer practices.
4. In the case of an overpayment demand or self-identified overpayment that involves a federal health care program and that could potentially be large in scale or implicate the need for the OIG Self Disclosure Protocol, the Compliance Officer will consult with legal counsel and make a decision on how to proceed on a case-by-case basis.

Pro Policy 1100.7 – Cost-Sharing Exceptions

Section:	Compliance
Policy #:	1100.7
Modified:	04/15/2024
Reviewed:	04/15/2024

11.7.A. Purpose

To objectively evaluate the financial ability of patients to make payments for their ambulance services and make appropriate decisions as to when a discount or waiver may be appropriate.

11.7.B. Policy

Write-offs, waivers of payments, and other discounts will be made on a discretionary basis, taking such considerations as financial hardship and ability to pay into account.

11.7.C. Procedure

1. Patients will be billed promptly for any balance due, including legally required cost-sharing amounts.
2. Departure from our standard attempts to collect co-payments or deductible amounts or payment in full from the patient may occur, as follows, if the patient or patient representative advises us that the patient is suffering a financial hardship and is unable to make payment:
    a) If the patient or patient representative advises us that the patient is suffering a financial hardship and is unable to make payments, we will ensure that insurance benefits have been maximized and offer a payment installment plan.
    b) If the patient claims financial hardship and also claims inability to satisfy a payment installment plan, we will conduct a Financial Hardship Assessment by asking the patient to provide the information requested on our Financial Hardship Request Form.
    c) We will grant a waiver of payment or a discount if the assessment yields evidence of financial hardship sufficient to a grant a waiver or discount.
    d) A patient is eligible to be declared a “Financial Hardship” case and may be eligible for a waiver or discounted services if the patient’s household income is at or below the income levels in the annual poverty guidelines published by United States Department of Health and Human Services.
    e) Personnel shall gather as much information as possible from the patient and present this information to the Billing Manager for processing. Personnel shall use the attached Financial Hardship Request Form.
    f) Under no circumstance may any personnel disclose hardship criteria to the patient or the patient’s representative.
    g) Only the personnel designated by management may approve a financial hardship case.

h) If financial hardship does not apply, the patient must make routine installment payments on their account. If installment payments are not made, the patient's account will be referred to a collection agency.

3. A patient's financial and insurance status is subject to change. The fact that a patient qualifies for financial hardship treatment at one time does not mean that the patient will qualify for financial hardship treatment in the future. Past showing of financial hardship sufficient to justify a waiver of payment shall not preclude attempts to collect full payment on future transports if financial hardship ceases to exist or patient discounted payments if diminished financial hardship so warrants.

4. For Medicare beneficiaries, the attached Financial Hardship Form shall be used.

Pro Policy 1100.8 – Excluded Parties/Background Checks

Section:	Compliance
Policy #:	1100.8
Modified:	04/15/2024
Reviewed:	04/15/2024

11.8.A. Purpose

To collect exclusion and other background information about individuals and entities who provide or seek to provide services for PRO to enable PRO to comply with federal health care program requirements and otherwise make employment and contract decisions.

11.8.B. Policy

All personnel and contractors shall be subject to background screening. PRO will not employ or do business with individuals or entities who have been convicted of health care fraud or listed by a federal agency as excluded, debarred or otherwise ineligible to participate in federal health care programs.

11.8.C. Procedure

1. We will utilize the Office of Inspector General's List of Excluded Individuals/Entities ("LEIE") to determine if an individual or entity has been excluded from participation in federal health care programs. For individuals, both current and maiden names or any other prior legal names will be checked.
2. Individuals seeking to work for us and entities seeking to contract with us will be required to disclose exclusion from a federal health care program, debarment by a federal agency, any criminal conviction, and any civil monetary penalty assessed against the individual or entity for conduct involving a federal health care program.
3. We will screen all individuals seeking to work for us and entities seeking to contract with us against the LEIE prior to making an employment or contract decision.
4. Our personnel and contractors, upon receiving notice of being excluded from a federal health care program, debarred by a federal agency, convicted of a criminal offense, or assessed a civil money penalty for conduct involving a federal health care program, will be required to immediately disclose that information to us.
5. We shall check the LEIE on a quarterly basis to determine whether any of our personnel or entities with which we contract have been excluded from a federal health care program.
6. We shall require our contractors to check the LEIE on a monthly basis to determine whether any of their personnel have been excluded from a federal health care program and to alert us promptly if an excluded individual is involved in any way with providing services (directly or indirectly) for us under the contract.

7. We shall not allow an individual who is excluded from a federal health care program to work for us in any capacity that directly or indirectly involves the provision of service payable by a federal health care program. This includes, without limitation, field personnel, billers, coders, and administrative and management personnel.
8. We will take disciplinary action against any of our personnel who fail to immediately notify us of exclusion from a federal health care program, debarment by a federal agency, a criminal conviction or a civil monetary penalty assessed against the individual for conduct involving a federal health care program.

Pro Policy 1100.9 – Licensure/Certification Checks

Section:	Compliance
Policy #:	1100.9
Modified:	04/15/2024
Reviewed:	04/15/2024

11.9.A. Purpose

To ensure compliance with Medicare and state ambulance staffing requirements, including Medicare crew and vehicle requirements.

11.9.B. Policy

All personnel who serve as EMS provider members of our ambulance crews shall have their licensure/certification (hereafter "licensure") status verified to ensure current licensure at the EMS provider level for which they are being used by us.

11.9.C. Procedure

1. We will verify the licensure status of all personnel who serve as EMS provider members of our ambulance crews as follows:
    a) All individuals who apply to work for us as an EMS provider will be required to produce an original document issued by the licensing authority identifying their licensure level and the status of their license.
    b) Before making a hiring decision regarding an EMS provider applicant, we will communicate with the licensing authority to verify the applicant's licensure status.
    c) Personnel who are serving as EMS providers for us will be required to immediately inform us of any change in their licensure status and display an original document issued by the licensing authority demonstrating that change in status.
    d) We will maintain in each EMS provider's personnel file a copy of current and past documents issued by the licensing authority identifying their licensure level and the status of their license.
    e) We will maintain a record of the scheduled expiration date of each EMS provider's license, and will require the EMS provider to display, prior to that date, an original document issued by the licensing authority verifying the timely renewal of the license. If the EMS provider advises that the license has been timely renewed but is unable to secure written documentation from the licensing authority as proof, we will contact the licensing authority to determine whether the license has been timely renewed.
2. An individual who does not have a current active license as an EMS provider may not serve as an EMS provider on an ambulance operated by our organization or as a member of an ambulance crew on behalf of PRO.

3. We will not permit any of our personnel to serve as an EMS provider on an ambulance for whom either of the following apply:

    a) We have evidence that the individual does not have a current active license.
    b) The expiration date of the individual's license has arrived, the individual has not produced original documentation from the licensing authority to prove renewal, and we have not otherwise confirmed renewal of the license with the licensing authority.

4. We will take disciplinary action against any of our personnel whose EMS provider license has been revoked, suspended, downgraded, restricted, or sanctioned in any manner by the licensing or any other regulatory authority, who fails to immediately notify us of such action upon the EMS provider receiving notification of such action.

Pro Policy 1100.10 – Risk Identification & Response

Section:	Compliance
Policy #:	1100.10
Modified:	04/15/2024
Reviewed:	04/15/2024

11.10.A. Purpose

To identify possible compliance risk areas and ensure proper controls are in place to prevent compliance problems in an effort to avoid a government investigation or other negative consequences for PRO.

11.10.B. Policy

On a routine basis, we will perform a risk assessment which will include a review of potential risk areas identified by the OIG as well as other potential risks identified by the Compliance Officer as relevant to the organization in order to ensure that we are maintaining compliance with statutes, regulations and other requirements applicable to our ambulance service operations and that our compliance efforts are properly focused and effective.

11.10.C. Procedure

1. During the initial development of the Compliance Program, and at least annually thereafter, the Compliance Officer will conduct a risk assessment of PRO. The risk assessment may be conducted with the assistance of legal counsel or consultants who have experience with compliance risks impacting ambulance services.
2. The risk assessment will include an evaluation of the risk areas identified by the OIG in its Compliance Program Guidance as well as other OIG publications and any other risk areas impacting PRO as identified by the Compliance Officer. The Compliance Officer may consider laws, regulations, policies and conduct as well as complaints or concerns reported by personnel, prior audits or lawsuits, and external audits and reviews among other factors when identifying areas of risk.
3. As part of the risk assessment, the Compliance Officer may evaluate PRO's policies and procedures, employee training, employee knowledge, the claims submission process, documentation practices, management structure and commitment to compliance, contractual arrangements, and technology relied upon in the claims submission process to identify areas where PRO may be exposed to compliance risk.
4. After identifying potential risks, the Compliance Officer will evaluate all of the identified potential risks along with the systems and controls PRO currently has in place to combat those risks. Compliance program efforts will be focused on the areas with greatest potential risk to PRO and those areas where PRO needs to improve systems and controls.

5. The Compliance Officer may choose to implement a Corrective Action Plan to address some of the identified risks to ensure risks are properly mitigated.

Pro Policy 1100.11 – Government Investigation

Section:	Compliance
Policy #:	1100.11
Modified:	04/15/2024
Reviewed:	04/15/2024

11.11.A. Background

Government attorneys, agents, and investigators ("government representatives") frequently conduct investigations and inquiries in order to monitor compliance with government regulations and laws. As a result, PRO personnel may be contacted by a government representative in the course of an investigation. This does not mean that any laws have been violated or that the government representative believes that any laws have been violated; it could simply be part of a routine inquiry.

Personnel may be contacted either at work or away from work during off hours, or be visited at home, at work, or at some other location.

11.11.B. Purpose

To ensure that personnel understand their rights and their responsibilities to PRO when approached by a government representative during an investigation and to ensure that the information and documents PRO provides during an investigation are honest and accurate.

11.11.C. Policy

All personnel are expected to understand their rights in a government investigation and to deal with a government investigation in accordance with the procedures set forth in this policy.

11.11.D. Procedure

1. Personnel have certain rights and obligations of which they should be aware in the event they are contacted by a government representative during the course of an investigation. Personnel have the following rights:

    a) While personnel are free to talk with government representatives, they are under no obligation to do so.
    b) Personnel have a right to decline to be interviewed by a government representative.
    c) Government representatives cannot require personnel to be interviewed or make a statement.
    d) Unless given permission, government representatives cannot enter the homes of personnel without a search warrant.
    e) Just as personnel are free to decline to speak with a government representative, they also have a right to choose to speak with a government representative. If personnel choose to be interviewed or make a statement, they are to respond to questions truthfully.

f) If personnel are contacted by a government representative who wants to conduct an interview, they may inform the government representative that they wish to have an attorney present for any interviews or statements (if that is in fact their wish), or that they wish to first confer with PRO's Compliance Officer or management, and it is their right to do so.
g) If the government representative seeks to interview personnel, they have the right to inform the government representative to contact PRO's Compliance Officer for the purpose of scheduling the interview at a mutually convenient time when legal counsel can be present.

2. If a government representative asks to see or make copies of any PRO documents, including call records, PCRs, computer disks, hard drives, printouts, faxes, PCSs, etc., personnel should understand that these are PRO records and inform the government representative that he or she must contact our Compliance Officer. If the representative refuses to do so, personnel should immediately contact the Compliance Officer and so advise.

3. In the event the government representative has a search warrant, the representative is permitted to enter and inspect the premises described in the warrant and obtain all documents or other evidence within the scope of the search warrant. Personnel should advise the government representative that they want to contact the Compliance Officer before the representative executes the search warrant and do the following:

   a) IMMEDIATELY contact the Compliance Officer.
   b) DO NOT interfere or prevent the person from executing the warrant if the representative elects to execute the search warrant without waiting but advise the Compliance Officer that the representative is executing the search warrant.
   c) DO NOT make any statements to the government representative while the government representative is executing the warrant.
   d) DO monitor the government representative while the representative is performing the search or executing the warrant.
   e) DO take notes as to the areas searched and documents or other evidence seized by the government representative during the course of their visit.
   f) DO attempt to make copies of any documents that are seized. Personnel may not have a right to copy documents being taken in response to a warrant but should make a request of the government representative to permit you to do this. If the request is refused, allow the representative to continue to do their work uninterrupted.
   g) DO NOT lie or make a false statement to a government representative at any time.

4. In the event personnel are served with a subpoena duces tecum for records for PRO (this is a subpoena for PRO documents or other records or items), that is not the same as a search warrant and does not entitle the representative to immediate access to the records covered by the subpoena. The subpoena should specify a date by which the covered items are to be produced. Advise the government representative the subpoena will be provided to management for processing. If personnel receive the subpoena by mail, provide it to the Compliance Officer. In either event, immediately apprise the Compliance Officer of the service of the subpoena and provide the subpoena to the Compliance Officer.

5. After a government investigation has been initiated, and while it is ongoing, DO NOT destroy or dispose of any documents or records in any form that may have any relationship to a government investigation.

Pro Policy 1100.12 – Complaint & Concern Reporting

Section:	Compliance
Policy #:	1100.12
Modified:	04/15/2024
Reviewed:	04/15/2024

11.12.A. Purpose

To promote the reporting of compliance concerns or potential violations of the law to the Compliance Officer as soon as possible so that the matter can be promptly considered and addressed.

11.12.B. Policy

All personnel shall report good faith compliance concerns or suspected compliance violations without fear of retaliation.

11.12.C. Procedure

Personnel shall report any concern about conduct they believe to be improper including, but not limited to, conduct in violation of our Code of Conduct or any conduct that could be seen as violating the principles or standards of our Compliance Program.

1. Concerns are to be brought to the Compliance Officer's attention as soon as possible after the incident or behavior occurs that causes concern or constitutes the perceived improper conduct.
2. As a general rule, personnel should bring concerns to their immediate supervisor. If the concern is compliance related or personnel do not feel comfortable in reporting the concern to an immediate supervisor, for whatever reason, report the concern to the Compliance Officer instead. Personnel have the discretion to report any concern about our operations or personnel conduct to the Compliance Officer, whether or not they also report the concern to an immediate supervisor.
    - Reports may be made in writing, but it is not required that concerns be placed in writing to be treated seriously. Any concern that could affect our compliance with the law will be investigated, even if it is not put in writing.
    - Reports can be made directly to the Compliance Officer by emailing kcook@proems.com or calling 617.682.1837.

The anonymous reporting process we have in place may also be used to anonymously report compliance concerns. Any compliance concern can be reported anonymously through Lighthouse by calling toll-free 844-990-0002; on the web https://report.syntrio.com/proems or by fax (215) 689-3885 (must include company name with report when faxed).

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Pro Policy 1200.1 – HIPAA Risk Analysis

Section:	HIPAA Policy
Policy #:	1200.1
Modified:	04/15/2024
Reviewed:	04/15/2024

12.1.A. Purpose

PRO is responsible, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), to ensure the privacy and security of all protected health information ("PHI") that we use or disclose. The foundation of compliance with the HIPAA is the completion of a "Risk Analysis" to identify existing risks and vulnerabilities in the way we create, receive, maintain, or transmit our PHI. This policy describes our general approach to our HIPAA Risk Analysis.

12.1.B. Scope

PRO's HIPAA Risk Analysis includes an assessment of potential risks and vulnerabilities to the confidentiality, availability, and integrity of all PHI that PRO creates, receives, maintains, or transmits. This includes assessing any risks and vulnerabilities to the confidentiality, integrity, and availability of non- electronic PHI (such as papers and documents) and electronic protected health information (e-PHI). At a minimum, the risk analysis will include a review of PRO's:

- General security hardware and procedures to protect our facility, vehicles, and electronic assets;
- Computer servers (on or off-site) that store PHI;
- Computer network (including any local and wide area networks, communications servers and bandwidth connections, and storage devices and hardware);
- Databases where patient information is created, stored, and accessed by PRO, whether on or off-site;
- Electronic media that store e-PHI such as hard drives, disks, CDs, DVDs, USB drives or other storage devices, transmission media, or portable electronic media;
- Electronic devices used for processing patient information (such as laptops and field data collection devices);
- Workstations and access points where PHI is created, accessed, and used;
- Policies and procedures (written and unwritten) that involve the creation, use, or access to e-PHI; and
- Vendors, billing companies, clearinghouses and others who create, receive, maintain, or transmit PHI for PRO.

12.1.C. Procedure

The HIPAA Compliance Officer will utilize PRO's HIPAA Risk Analysis Tool to identify all current and potential risks and vulnerabilities to PHI at PRO and to develop a plan to manage those risks.

(1) *Annual Risk Analysis*

PRO will, on an annual basis, undertake a risk analysis that includes the following:

- Identifying and documenting all places where the physical (paper) PHI and e-PHI is stored, received, maintained, or transmitted at PRO (e., all sources of PHI at PRO whether on or off-site).
- Identifying and documenting all current and potential risks to the confidentiality, security, integrity, and availability of all PHI sources identified at PRO.
- Assessing the likelihood of each identified risk and assigning the risk to a "risk level" and "potential impact" category.
- Identifying and documenting any measures that PRO currently has in place to address each identified risk, including any policies, procedures, hardware/software, security devices, etc. Then, identifying any methods that are not currently in place that may eliminate or mitigate the risk.
- Providing recommendations to PRO that might remedy identified risks and vulnerabilities and improve the security, integrity and availability of all PHI sources identified at PRO.
- Implementing methods that might remedy identified risks and vulnerabilities and improve the security, integrity and availability of all PHI sources identified at PRO.

(2) *Implementation Specifications*

Implementation specifications under HIPAA that are "required" must be implemented and documented that they were in fact implemented, including how the specification was implemented. Implementation specifications under HIPAA that are "addressable" will be implemented as follows:

- If the implementation specification is reasonable and appropriate, PRO will implement it.
- If the implementation specification is determined to be inappropriate and/or unreasonable, but the security standard cannot be met without implementation of an additional security safeguard, PRO may implement an alternative measure that achieves the addressable specification.
- If PRO meets the standard through alternative measures, the decision not to implement the specification will be documented, including the reason for the decision, the rationale, and a description of the alternative safeguard that was implemented.

Pro Policy 1200.2 – Patient Requests for Access to PHI

Section:	HIPAA Policy
Policy #:	1200.2
Modified:	04/15/2024
Reviewed:	04/15/2024

12.2.A. Purpose

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") grants individuals the right to access their protected health information ("PHI") contained in a designated records set ("DRS"). (See, Policy on Designated Records Sets). PRO must afford individuals this right of access in accordance with federal and state law. To ensure that PRO complies with its obligations, this policy outlines our procedures for handling requests for patient access and establishes the procedures by which patients or authorized representatives may request access to PHI.

12.2.B. Scope

This policy applies to all PRO staff members who receive requests from patients for access to PHI. Generally, all access requests will be directed to the HIPAA Compliance Officer, and it shall be the responsibility of the HIPAA Compliance Officer to handle all access requests.

12.2.C. Procedure

Requests for Access from the Patient or the Patient's Personal Representative

Patients and their authorized representatives shall be granted a right of access to inspect and obtain a copy of their PHI contained in a DRS maintained by PRO.

If a patient or their authorized representative requests access to or a copy of a patient's PHI, the requestor shall be referred to the HIPAA Compliance Officer. The HIPAA Compliance Officer shall request that the patient or authorized representative complete PRO's "Request for Access to Protected Health Information" Form.

The HIPAA Compliance Officer must verify the patient's identity, or, if the requestor is not the patient, the name and identity of the representative and whether the representative has the authority to act on the patient's behalf. The use of a driver's license, social security card, or other form of government-issued identification is acceptable for this purpose. If it is impossible for the requestor to physically come in to make the request and verify this information, the HIPAA Compliance Officer shall ask the requestor to verify the patient's name, date of birth, SSN, address, and telephone number over the phone and ask the requestor to submit the "Request for Access to Protected Health Information Form" via email, mail, or fax.

Upon receipt of the completed "Request for Access to Protected Health Information Form" and verification of the requestor's identity, the HIPAA Compliance Officer will act upon the request within 30

days, preferably sooner. Generally, PRO must respond to requests for access to PHI within 30 days of receipt of the access request.

If PRO is unable to respond to the request within these time frames, the requestor must be given a written notice no later than the initial due date for a response, explaining why PRO could not respond within the time frame, and in that case, PRO may extend the response time by an additional 30 days.

(1) *Requests for Access from the Patient's Attorney*

If PRO receives a request for a patient's PHI from the patient's attorney, the HIPAA Compliance Officer shall verify that the patient has authorized the release of PHI. Generally, the request should be accompanied by a form or letter, signed by the patient, stating that the patient authorizes the release of the requested PHI to the attorney. If there is a signed form or letter from the patient authorizing the release of the PHI requested (or some other valid authorization from the patient), then the HIPAA Compliance Officer may release the PHI to the attorney in accordance with what the authorization states.

If the request from the patient's attorney is not accompanied by a signed request form or letter from the patient (or some other valid patient authorization), the HIPAA Compliance Officer shall contact the attorney and inform the attorney that PRO will not release the information without valid authorization from the patient. PRO shall not release any PHI to the attorney until the patient authorizes the release.

(2) *Approval of a Request for Access*

Upon approval of access, the patient or authorized representative should generally be provided the right of access in the manner requested on the Form. PRO will either provide a copy of the PHI to the requestor in the format requested or arrange for a convenient time for the patient to come into PRO to copy their PHI. If PRO uses or maintains the PHI requested electronically, PRO will provide a copy of the PHI in an electronic format if the patient or authorized representative requests an electronic copy. PRO will also transmit a copy of the PHI directly to an entity or person designated by the patient or authorized representative, provided that the written direction is signed and clearly identifies the designated party.

PRO will establish a reasonable charge for copying PHI for the patient or authorized representative in accordance with federal and state laws. The fee for providing an electronic copy of PHI shall not be greater than PRO's labor costs in responding to the request for the copy. The HIPAA Compliance Officer shall consult with legal counsel regarding applicable laws regarding fee limitations.

The requestor will not be given access to the actual files or systems that contain the DRS. Rather, copies of the records shall be provided for the patient or requestor to view in a confidential area under the direct supervision of a designated Company staff member. UNDER NO CIRCUMSTANCES SHOULD ORIGINALS OF PHI LEAVE THE PREMISES.

Whenever a patient or requestor accesses a DRS, a note should be maintained in a logbook indicating the time and date of the request, the date access was provided, what specific records were provided for review, and what copies were left with the patient or requestor.

(3) *Denial of a Request for Access*

If the request for access is denied, the HIPAA Compliance Officer shall send the requestor a "Denial of Request for Access to Protected Health Information Form," outlining the reason for the denial and explaining the individual's rights regarding the denial. Patient access may be denied for the reasons listed below:

a) If the information the patient requested was compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding;
b) If the information the patient requested was obtained from someone other than a healthcare provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information;
c) If a licensed healthcare professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person;
d) If the PHI makes reference to another person (other than a healthcare provider) and a licensed health professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to that person; or
e) If the request for access is made by a requestor as a personal representative of the individual and a licensed health professional has determined, in the exercise of professional judgment, that access is reasonably likely to cause harm to the individual or another person.

If the denial of the request for access to PHI is for reasons c, d, or e above, then the patient may request a review of the denial of access by sending a written request to the HIPAA Compliance Officer.

- PRO will designate a licensed health professional, who was not directly involved in the denial, to review the decision to deny the patient access. PRO will promptly refer the request to this designated review official. The review official will determine within a reasonable period of time whether the denial is appropriate. PRO will provide the patient with written notice of the determination of the designated reviewing official.
- The patient may also file a complaint in accordance with PRO's "Procedure for Filing Complaints About Privacy Practices" if the patient is not satisfied with PRO's determination.

Pro Policy 1200.3 – Patient Requests for Amendment of PHI

Section:	HIPAA Policy
Policy #:	1200.3
Modified:	04/15/2024
Reviewed:	04/15/2024

12.3.A. Purpose

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") grants individuals the right to request that PRO amend their protected health information ("PHI") contained in a Designated Record Set ("DRS"). (See, Policy on Designated Record Sets). PRO has an obligation to afford individuals the right to request an amendment to their PHI in accordance with federal and state law. To ensure that PRO complies with its obligations, this policy outlines procedures for handling patient requests for amendment of their PHI and establishes the procedures by which patients or authorized representatives may make a request for an amendment to PHI.

12.3.B. Scope

This policy applies to all PRO staff members who handle requests from patients for amendment to PHI. Generally, all requests will be directed to the HIPAA Compliance Officer, and it shall be the responsibility of the HIPAA Compliance Officer to handle all requests for amendment of PHI.

12.3.C. Procedure

(1) *Requests for Amendment of PHI*

- Patients or their authorized representatives shall be granted the right to request an amendment to a patient's PHI contained in the DRS.
- If a patient or authorized representative requests an amendment to PHI, the requestor shall be referred to the HIPAA Compliance Officer. The HIPAA Compliance Officer shall request that the patient or authorized representative complete PRO's "Patient Request for Amendment of Protected Health Information" Form.
- The HIPAA Compliance Officer must verify the patient's identity, or, if the requestor is not the patient, the name and identity of the representative and whether the representative has the authority to act on the patient's behalf. The use of a driver's license, social security card, or other form of government-issued identification is acceptable for this purpose. If it is impossible for the requestor to physically come in to make the request and verify this information, the HIPAA Compliance Officer shall ask the requestor to verify the patient's name, date of birth, SSN, address, and telephone number over the phone and ask the requestor to submit the "Request for Amendment of Protected Health Information Form" via email, mail, or fax.

- PRO must act upon a request for amendment of PHI within 60 days of the request. If PRO is unable to act upon the request within 60 days, it must provide the requestor with a written statement of the reasons for the delay, and in that case may extend the time period in which to comply by an additional 30 days.

(2) *Granting the Request for Amendment of PHI*

- If the HIPAA Compliance Officer grants the request for amendment, then the requestor will receive a letter (See, "Acceptance of Patient Request for Amendment" Form), indicating that the appropriate amendment to the PHI or record that was the subject of the request has been made.
- The letter will contain a form for the patient to complete, sign, and return to PRO. On the form, the patient must identify individuals who may need the amended PHI and sign the statement giving PRO permission to provide them with the updated PHI.
- PRO must provide the amended information to individuals identified by the patient as well as persons or business associates that have such information and who may have relied on or could be reasonably expected to rely on the amended PHI.

(3) *Denying the Request for Amendment of PHI*

PRO may deny a request to amend PHI for the following reasons:

1. If PRO did not create the PHI at issue:
    - The information is not part of the DRS;
    - The PHI is accurate and complete;
    - The information would not be available for inspection as provided by law; or
    - The information was received from someone else under a promise of confidentiality.
2. PRO must provide a written denial (See, "Denial of Patient Request for Amendment" Form), and the denial must be written in plain language and contain the following information:
    - The reason for the denial;
    - The individual's right to submit a statement disagreeing with the denial and how the individual may file such a statement;
    - A statement that, if the individual does not submit a statement of disagreement, the individual may request that PRO provide the request for amendment and the denial with any future disclosures of the PHI; and
    - A statement that the individual may file a complaint with PRO or with the Office for Civil Rights of the Department of Health and Human Services.
3. PRO shall provide a copy of our "Procedure for Filing Complaints About Privacy Practices" if the requestor indicates that he or she wants to file a complaint against PRO.
4. If the individual submits a "statement of disagreement," PRO may prepare a written rebuttal statement to the patient's statement of disagreement. The statement of disagreement will be

appended to the PHI, or at PRO's option, a summary of the disagreement will be appended, along with the rebuttal statement of PRO.

(4) *Administrative Obligations*

- If PRO receives a notice from another covered entity, such as a hospital, that the other covered entity has amended its own PHI in relation to a particular patient, PRO must amend its own PHI that may be affected by the amendments. The HIPAA Compliance Officer shall be responsible for performing this task.
- PRO will add the "Patient Request for Amendment of Protected Health Information Form," the denial or granting of the request, as well as any statement of disagreement by the patient and any rebuttal statement by PRO to the DRS. The HIPAA Compliance Officer shall be responsible for performing this task.

Pro Policy 1200.4 –Patient Requests for Restriction of PHI

Section:	HIPAA Policy
Policy #:	1200.4
Modified:	04/15/2024
Reviewed:	04/15/2024

12.4.A. Purpose

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") grant individuals the right to request that PRO restrict its use of PHI contained in a Designated Record Set ("DRS"). (See, Policy on Designated Record Sets). PRO has an obligation to abide by a requested restriction in accordance with federal and state law. To ensure that PRO complies with its obligations under HIPAA and the HITECH Act, this policy outlines procedures for handling requests for restrictions on the use of PHI and establishes the procedures by which patients or their authorized representatives may request a restriction on the use of PHI.

12.4.B. Scope

This policy applies to all PRO staff members who handle requests from patients for a restriction on the use of their PHI. Generally, all requests will be directed to the HIPAA Compliance Officer, and it shall be the responsibility of the HIPAA Compliance Officer to handle all requests for restrictions on the use of PHI.

12.4.C. Procedure

(1) *Requests for Restriction*

- PRO will permit patients to request restrictions on the use and disclosure of their PHI:

  a) To carry out treatment, payment, or health care operations and/or
  b) To people involved in their care or for notification purposes.

- All requests for restriction on the use and disclosure of PHI shall be referred to the HIPAA Compliance Officer who shall request that the patient or authorized representative complete and submit PRO's "Patient Request for Restriction of Protected Health Information" Form. All requests will be reviewed and denied or approved by the HIPAA Compliance Officer in accordance with this policy. The HIPAA Compliance Officer shall utilize the "Review of Patient Request for Restriction of Protected Health Information" Form when reviewing restriction requests.

- The HIPAA Compliance Officer must verify the patient's identity, or, if the requestor is not the patient, the name and identify of the representative and whether the representative has the authority to act on the patient's behalf. The use of a driver's license, social security card, or

other form of government-issued identification is acceptable for this purpose. If it is impossible for the requestor to physically come in to make the request and verify this information, the HIPAA Compliance Officer shall ask the requestor to verify the patient's name, date of birth, SSN, address, and telephone number over the phone and ask the requestor to submit the "Patient Request for Restriction of Protected Health Information" Form via email, mail, or fax.

- Under most circumstances, PRO is not legally required to agree to any request to restrict the use and disclosure of PHI, and given the emergent nature of our operation, PRO generally will not agree to a restriction unless required by law to do so. However, PRO is required to abide by any restrictions that it agrees to.

(2) *Granting a Request for Restriction*

- PRO will and must comply with a requested restriction if:

  a) The request concerns the disclosure of PHI to a health plan for purposes of carrying out payment or healthcare operations; and
  b) The request pertains to a service for which PRO has been paid out-of-pocket in full. In other words, PRO must grant patients the right to pay for a service out-of-pocket and abide by a request not to submit a claim to the insurer for that service.

- If PRO receives a request from a patient or authorized representative asking PRO to refrain from submitting PHI to a health plan and the HIPAA Compliance Officer determines that PRO has either been paid in full, or that PRO has received reasonable assurances that it will be paid in full for that service, then PRO will grant the request for restriction and not submit a claim to insurance for that service. Patients must make a new request for all subsequent services.

- If PRO agrees to a requested restriction, the HIPAA Compliance Officer shall inform the patient of that fact in writing, by sending an "Acceptance of Request for Restriction of Protected Health Information" letter to the patient. The HIPAA Compliance Officer shall also note on the "Review of Patient Request for Restriction of Protected Health Information" Form that the request was accepted and document all pertinent information regarding the request and acceptance (date, payment received, etc.).

- PRO may not use or disclose PHI in violation of the agreed upon restriction. Notwithstanding, if the individual who requested the restriction is in need of an emergency service, and the restricted PHI is needed to provide the emergency service, then PRO may use the restricted PHI or may disclose such PHI to another healthcare provider to provide treatment to the individual.

- The HIPAA Compliance Officer shall also inform all other necessary parties at PRO and its business associates, such as its billing company, about the accepted restriction and take all appropriate steps to ensure that those parties abide by the restriction.

- The HIPAA Compliance Officer shall add the "Patient Request for Restriction of Protected Health Information" Form, the Acceptance letter and documentation regarding the acceptance of the request to the DRS.

(3) *Denying the Request for Restriction*

- Unless PRO is required by law to agree to a request for restriction of PHI, the HIPAA Compliance Officer shall deny the request in writing, by dispatching a "Denial of Patient Request for Restriction of PHI" letter to the patient.
- The HIPAA Compliance Officer shall also note on the "Patient Request for Restriction of Protected Health Information" Form that the request was denied and document all pertinent information regarding the request and denial (date, reason for denial, etc.).

(4) *Termination of Restrictions*

- A restriction may be terminated if the individual agrees to or requests the termination.
- Oral agreements to terminate restrictions must be documented.
- Most restrictions may also be terminated by PRO as long as PRO notifies the patient that PHI created or received after the restriction is removed is no longer restricted. PHI that was restricted prior to the notice voiding the restriction must continue to be treated as restricted PHI.
- PRO should not terminate a restriction regarding PHI that pertains to a service for which PRO has been paid in full and where a patient has requested that such PHI not be disclosed to the patient's health plan. Such restriction will only apply with respect to that service and not to subsequent services. The patient must make another request and pay out-of-pocket for each service.

Pro Policy 1200.5 – Patient Requests for Accounting of Disclosures of PHI

Section:	HIPAA Policy
Policy #:	1200.5
Modified:	04/15/2024
Reviewed:	04/15/2024

12.5.A. Purpose

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") grants individuals the right to an accounting of disclosures of their protected health information ("PHI") from paper and electronic records. PRO has an obligation to render an accounting to individuals in accordance with federal and state law. To ensure that PRO complies with its obligations, this policy outlines our procedures for handling requests for an accounting and establishes the procedures by which patients or their authorized representatives may request an accounting of disclosures of PHI from PRO.

12.5.B. Scope

This policy applies to all PRO staff members who receive requests from patients for an accounting of disclosures of PHI. Generally, all requests will be directed to the HIPAA Compliance Officer, and it shall be the responsibility of the HIPAA Compliance Officer to handle all accounting requests.

12.5.C. Procedure

(1) *Requests for an Accounting*

Patients and their authorized representatives shall have a right to request an accounting of certain disclosures of PHI made by PRO.

- If a patient or their authorized representative requests an accounting of disclosures of PHI, the requestor shall be referred to the HIPAA Compliance Officer. The HIPAA Compliance Officer shall request that the patient or authorized representative complete PRO's "Patient Request for Accounting of Disclosures Protected Health Information" Form.
- The HIPAA Compliance Officer must verify the patient's identity, or, if the requestor is not the patient, the name and identity of the representative and whether the representative has the authority to act on the patient's behalf. The use of a driver's license, social security card, or other form of government-issued identification is acceptable for this purpose. If it is impossible for the requestor to physically come in to make the request and verify this information, the HIPAA Compliance Officer shall ask the requestor to verify the patient's name, date of birth, SSN, address, and telephone number over the phone and ask the requestor to submit the "Patient Request for Accounting of Disclosures of Protected Health Information" Form via email, mail or fax.

- Upon receipt of the completed "Patient Request for Accounting of Disclosures of Protected Health Information" Form and verification of the requestor's identity, the HIPAA Compliance Officer will respond to a request for an accounting of disclosures within 60 calendar days of receipt of a request, preferably sooner.
- If PRO is unable to provide the accounting within 60 calendar days, PRO may extend the time for responding to the request by no more than 30 calendar days, provided that within the 60-day period PRO provides a written statement to the individual explaining the reasons for delay and the date by which the accounting will be provided. Only one 30-day extension may be exercised per accounting request.

(2) *Fulfilling an Accounting Request*

1. PRO will provide the patient or their authorized representative with a written or electronic accounting of disclosures of their PHI made by PRO or its business associates on PRO's behalf, as required by HIPAA. PRO will render an accounting of all disclosures of PHI during the period requested by the patient or other requestor. If the requestor does not specify a time period for the accounting, PRO will render an accounting of disclosures of PHI made during the past six (6) years. The following disclosures are excluded from the HIPAA accounting requirement:

    a) Disclosures to carry out treatment, payment, or health care operations;
    b) Disclosures made to the patient or to the patient's authorized representative;
    c) Disclosures incident to a use or disclosure otherwise permitted or required by HIPAA;
    d) Disclosures pursuant to the patient's authorization;
    e) Disclosures for a facility directory or to persons involved in the patient's care;
    f) Disclosures for national security or intelligence purposes;
    g) Disclosures to correctional institutions or law enforcement officials to provide them with information about a person in their custody; and
    h) Disclosure made as part of a limited data set.

    PRO will not render an accounting for disclosures that are exempt from the HIPAA accounting requirement.

2. All accountings shall include the following information regarding each disclosure of PHI addressed in the accounting:

    a) The date of the disclosure;
    b) The name of the entity or person who received the PHI and, if known, the address of such entity or person;
    c) A brief description of the PHI disclosed; and
    d) A brief statement of the purpose of the disclosure that reasonably informs the patient of the basis for the disclosure.

(3) *Tracking Disclosures of PHI*

1. In order to fulfill its obligations to render an accounting of disclosures of PHI under HIPAA, PRO shall track all necessary disclosures of PHI. The HIPAA Compliance Officer is responsible to ensure PRO is tracking disclosures when required by HIPAA to do so.

2. Generally PRO shall track all disclosures for or pursuant to:

    a) Research purposes, unless authorized by the patient;
    b) Subpoenas, court orders or discovery requests;
    c) Abuse and neglect reporting;
    d) Communicable disease reporting; and
    e) Other reports to a Department of Health.

    The HIPAA Compliance Officer may utilize the "Accounting Log for Disclosures of PHI" Form for this purpose and track all information required on the Form.

(4) *Administrative Requirements*

PRO shall retain the following documentation, in either written or electronic form, for 6 years:

- Written requests by an individual for an accounting of disclosures;
- Accountings of disclosures that have been provided to an individual, including the titles of the persons and offices responsible for receiving and processing the request for accounting; and
- Copies of any notices to the individual explaining that PRO requires an extension of time to prepare the requested accounting.

Pro Policy 1200.6 – Patient Requests for Confidential Communications

Section:	HIPAA Policy
Policy #:	1200.6
Modified:	04/15/2024
Reviewed:	04/15/2024

12.6.A. Purpose

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") grants individuals the right to request that PRO send PHI to an alternate location (e.g., somewhere other than a home address), or through alternate means (e.g., by email rather than regular mail). This is called the right to "confidential communications." PRO has an obligation to grant patients this right and it must abide by a request for confidential communications of PHI in accordance with federal and state law. To ensure that PRO complies with its obligations, this policy outlines procedures for handling requests for confidential communications of PHI and establishes the procedures by which patients or their authorized representatives may request confidential communications.

12.6.B. Scope

This policy applies to all PRO staff members who handle requests from patients for confidential communications of their PHI. Generally, all requests will be directed to the HIPAA Compliance Officer, and it shall be the responsibility of the HIPAA Compliance Officer to handle all requests for confidential communications.

12.6.C. Procedure

(1) *Requests for Confidential Communications*

- PRO will permit patients to request that PRO send PHI to individuals at an alternate location (g., somewhere other than a home address), or in a specific manner (e.g., by email rather than regular mail).
- All requests for confidential communications PHI shall be referred to the HIPAA Compliance Officer who shall request that the patient or authorized representative complete and submit PRO's "Patient Request for Confidential Communications of Protected Health Information" Form. All requests will be reviewed and denied or approved by the HIPAA Compliance Officer in accordance with this policy. The HIPAA Compliance Officer shall utilize the "Review of Patient Request for Confidential Communications of Protected Health Information" Form when reviewing requests for confidential communications of PHI.
- The HIPAA Compliance Officer must verify the patient's identity, or, if the requestor is not the patient, the name and identify of the representative and whether the representative has the authority to act on the patient's behalf. The use of a driver's license, social security card, or other form of government-issued identification is acceptable for this purpose. If it is impossible

for the requestor to physically come in to make the request and verify this information, the HIPAA Compliance Officer shall ask the requestor to verify the patient's name, date of birth, SSN, address, and telephone number over the phone and ask the requestor to submit the "Patient Request for Confidential Communications of Protected Health Information" Form via email, mail, or fax.

- PRO is required to and will agree to any "reasonable requests" for confidential communications.

(2) *Granting a Request for Confidential Communications*

- PRO will and must comply with a confidential communications request if the request is "reasonable." The HIPAA Compliance Officer shall take into account logistical reasons and other factors, such as the cost of making the alternate confidential communications, when determining whether the request is reasonable.

- If PRO receives a request from a patient or authorized representative asking PRO to communicate PHI in an alternate manner and PRO determines that the request is reasonable, it will agree to the request and the HIPAA Compliance Officer shall inform the patient of that fact, in writing, by sending an "Acceptance of Request for Confidential Communications of Protected Health Information" letter to the patient. The HIPAA Compliance Officer shall also note on the "Review of Patient Request for Confidential Communications of Protected Health Information" Form that the request was accepted and document all pertinent information regarding the request and acceptance.

(3) *Denying the Request for Confidential Communications*

- If the HIPAA Compliance Officer determines, after taking into account logistical reasons and other factors, that the request is not reasonable, the HIPAA Compliance Officer shall deny the request, in writing, by dispatching a "Denial of Patient Request for Confidential Communications of PHI" letter to the patient.

- The HIPAA Compliance Officer shall also note on the "Review of Patient Request for Confidential Communications of Protected Health Information" Form that the request was denied and document all pertinent information regarding the request and denial.

Pro Policy 1200.7 – HIPAA Compliance Officer Action Plan for Patient Requests Relating to PHI

Section:	HIPAA Policy
Policy #:	1200.7
Modified:	04/15/2024
Reviewed:	04/15/2024

Step 1: Whenever a request is made regarding a patient's PHI, the HIPAA Compliance Officer must first verify that the requestor is the patient. Or, if the requestor is not the patient, the HIPAA Compliance Officer must verify the name and identity of the requestor and verify whether the requestor has the authority to act on the patient's behalf as a personal representative. The use of a driver's license, social security card, or other form of government-issued identification is acceptable for making this verification. If it is impossible for the requestor to physically come in to make the request and verify this information, the HIPAA Compliance Officer shall ask the requestor to verify the patient's name, date of birth, SSN, address, and telephone number over the phone and ask the requestor to submit the appropriate request form via email, mail, or fax.

Step 2: The HIPAA Compliance Officer will ask the requestor what type of request is being made, provide the requestor with the appropriate request form, and handle the request in accordance with the appropriate policy. The general process for handling patient requests regarding PHI is outlined in this Action Plan.

(1) *Request for Access to PHI*

- Request Form: The HIPAA Compliance Officer shall request that the patient or authorized representative complete PRO's "Request for Access to Protected Health Information" Form.
- General Procedure: Upon receipt of the completed "Request for Access to Protected Health Information" Form, the HIPAA Compliance Officer will act upon the access request within 30 days, preferably sooner. The HIPAA Compliance Officer will proceed to handle the request in accordance with PRO's "Policy on Patient Requests for Access to Protected Health Information." Most access requests must be granted within 30 days.

(2) *Request for Amendment of PHI*

- Request Form: The HIPAA Compliance Officer shall request that the patient or authorized representative complete PRO's "Patient Request for Amendment of Protected Health Information" Form.
- General Procedure: Upon receipt of the completed "Patient Request for Amendment of Protected Health Information" Form, the HIPAA Compliance Officer must either grant or deny the patient's amendment request within 60 days in accordance with PRO's "Policy on Patient Requests for Amendment of Protected Health Information." Many requests for amendment will

be denied if PRO determines that the current record that the requestor is asking PRO to amend is true and correct.

(3) *Request for Restriction of PHI*

- Request Form: The HIPAA Compliance Officer shall request that the patient or authorized representative complete and submit PRO's "Patient Request for Restriction of Protected Health Information" Form.

- General Procedure: Upon receipt of the completed "Patient Request for Restriction of Protected Health Information" Form, the request will be reviewed and denied or approved by the HIPAA Compliance Officer in accordance with PRO's "Policy on Patient Requests for Restriction of Protected Health Information," as soon as possible. The HIPAA Compliance Officer shall utilize PRO's "Review of Patient Request for Restriction of Protected Health Information" Form when reviewing restriction requests. Under most circumstances, PRO is not legally required to agree to any request to restrict the use and disclosure of PHI and PRO generally will not agree to a restriction unless required by law to do so. PRO is required to agree to a restriction if a patient pays PRO in full for a service and requests that PRO not to submit a claim to the patient's insurer for that service.

(4) *Request for Accounting of Disclosures of PHI*

- Request Form: The HIPAA Compliance Officer shall request that the patient or authorized representative complete PRO's "Patient Request for Accounting of Disclosures Protected Health Information" Form.

- General Procedure: Upon receipt of the completed "Patient Request for Accounting of Disclosures of Protected Health Information" Form, the HIPAA Compliance Officer will respond to a request for an accounting of disclosures within 60 calendar days of receipt of a request in accordance with PRO's "Policy on Requests for Accounting of Disclosures of Protected Health Information." PRO will render an accounting of certain disclosures of PHI during the period requested, or, if the requestor does not specify a time period for the accounting, PRO will render an accounting for certain disclosures of PHI made during the past six (6) years. However, most disclosures are excluded from the HIPAA accounting requirement, including disclosures related to treatment, payment, or health care operations. PRO will not render an accounting for disclosures that are exempt from the HIPAA accounting requirement.

(5) *Requests for Confidential Communications*

- Request Form: Individuals can request that PRO send PHI to an alternate location (e.g., somewhere other than a home address), or through alternate means (e.g., by email rather than regular mail). This is called the right to "confidential communications." Upon receipt of a request for confidential communication of PHI, the HIPAA Compliance Officer shall request that the patient or authorized representative complete and submit PRO's "Patient Request for Confidential Communications of Protected Health Information" Form.

- General Procedure: All requests for confidential communications of PHI will be reviewed and denied or approved by the HIPAA Compliance Officer in accordance with PRO's "Policy on

Patient Requests for Confidential Communications of Protected Health Information." The HIPAA Compliance Officer shall utilize the "Review of Patient Request for Confidential Communications of Protected Health Information" Form when reviewing these requests. PRO will and must comply with a requested confidential communications request if the request is "reasonable." If PRO agrees to the request, the HIPAA Compliance Officer shall inform the patient of that fact in writing, by sending a version of PRO's "Acceptance of Request for Confidential Communications of Protected Health Information" letter to the patient.

Pro Policy 1200.8 – HIPAA Training

Section:	HIPAA Policy
Policy #:	1200.8
Modified:	04/15/2024
Reviewed:	04/15/2024

12.8.A. Purpose

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that all members of PRO's workforce be trained on our policies and procedures regarding privacy and security. This policy is meant to ensure that all of PRO staff – including all employees, volunteers, students, and trainees (collectively referred to as "staff members") – who have access to protected health information ("PHI") understand and are trained regarding PRO's HIPAA policies and procedures.

12.8.B. Scope

This policy applies to all PRO staff members. This includes those who have access to PHI in any form.

12.8.C. Procedure

- All current staff members must be trained on PRO's HIPAA policies and procedures in accordance with HIPAA.
- All new staff members will be required to undergo privacy training within a reasonable time upon association with PRO.
- All staff members who have undergone initial HIPAA training will be required to undergo HIPAA training within a reasonable time after there is a material change to PRO's HIPAA policies and procedures.
- The HIPAA training will be coordinated and tracked on the "HIPAA Training Log" Form by the HIPAA Compliance Officer or his or her designee. Training documentation will be maintained for six (6) years.
- All staff members will receive copies of PRO's HIPAA policies and procedures.
- All staff members must personally complete the HIPAA training and verify completion and agree to adhere to PRO's HIPAA policies and procedures.
- Training will be conducted through the following method: PWW HIPAA TV.
- All staff members shall sign the "HIPAA Training Log" after completing HIPAA training.

Pro Policy 1200.9 – Updating HIPAA Policies, Procedures & Training

Section:	HIPAA Policy
Policy #:	1200.9
Modified:	04/15/2024
Reviewed:	04/15/2024

12.9.A. Purpose

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires PRO to ensure that its HIPAA policies, procedures, and training materials are up to date and effective in safeguarding the confidentiality, integrity, and availability of protected health information ("PHI"). This policy outlines our commitment to adjust and update our policies and procedures, accordingly, based on periodic reviews and evaluations of our existing practices and in light of new and changing risks to PHI. PRO will also evaluate and consider new technologies and methodologies for securing PHI, as specified by guidance from the Secretary of Health and Human Services ("HHS").

12.9.B. Scope

This policy applies to all PRO staff members who are responsible for evaluating and updating current HIPAA policies and procedures and providing the updates to staff members. The HIPAA Compliance Officer will have the overall responsibility for monitoring all new developments in patient privacy and security of PHI and will recommend updates to our HIPAA Compliance Program, as necessary. The HIPAA Compliance Officer should perform these duties in consultation with PRO management and solicit the input of appropriate PRO staff members, when appropriate.

12.9.C. Procedure

(1) *Maintaining Knowledge*

- The HIPAA Compliance Officer will strive to keep current with all changes in the law and regulations that address the privacy and security of PHI.
- The HIPAA Compliance Officer will review journals and newsletters on the subject of HIPAA and will sign up for appropriate list-serves to obtain current information.
- The HIPAA Compliance Officer will monitor HIPAA websites, such as the site for the Office of Civil Rights, for new information on HIPAA compliance.
- The HIPAA Compliance Officer will participate in seminars and conferences on HIPAA as needed and as the budget allows.
- The HIPAA Compliance Officer will consult with legal counsel as necessary to learn of new legal developments that could affect PRO with respect to HIPAA issues.

(2) *Evaluation of HIPAA Policies and Procedures*

- On at least an annual basis, the HIPAA Compliance Officer will convene a committee of managers and/or appropriate staff members to identify and review all existing HIPAA policies and procedures for compliance with current HIPAA laws and regulations.
- Any member of the review committee or any other staff member may suggest changes to our HIPAA Policies or Procedures by submitting the suggestion to the HIPAA Compliance Officer for consideration.
- The annual policy and procedure review will identify all changes that need to be made to our policies, based on the experience of staff and management, technological developments, and changes in the regulatory environment during the prior year.
- Any critical changes in the law or regulations that require a change in our privacy practices will be addressed immediately and incorporated into our privacy compliance program.
- All complaints and concerns regarding the safeguarding of patient information will be evaluated by the HIPAA Compliance Officer to determine if policy or procedure changes need to be implemented.
- Unwritten procedures and practices will also be reviewed to ensure compliance with HIPAA regulations.

(3) *Evaluating and Updating HIPAA Training Programs*

- The HIPAA Compliance Officer annually reviews all HIPAA-related training materials and will update those materials and keep them current with recent changes in privacy practices as necessary.
- Additional in-service training will be scheduled as necessary to ensure that all current staff members are kept up to date on our current HIPAA policies and procedures.

Pro Policy 1200.10 – Contracting with Business Associates

Section:	HIPAA Policy
Policy #:	1200.10
Modified:	04/15/2024
Reviewed:	04/15/2024

12.10.A. Purpose

PRO is responsible for ensuring the privacy and security of all protected health information ("PHI") that we create, receive, maintain, or transmit under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA requires that PRO ensure that those persons and entities that perform services on our behalf using PHI agree to protect that PHI as we would by requiring those parties to sign a "business associate agreement" ("BAA") with PRO. This policy describes our approach to entering into business associate agreements with persons and organizations that perform services on our behalf involving the use of PHI.

12.10.B. Scope

This policy applies to all PRO staff members who are responsible for entering into agreements with outside vendors or persons who might have access to PHI. Generally, the HIPAA Compliance Officer of PRO is responsible to initiate a business associate agreement with any person or entity that performs a service on behalf of PRO that involves the use or disclosure of PHI.

12.10.C. Procedure

- The HIPAA Compliance Officer is responsible for identifying persons and organizations that perform services on our behalf and who in any manner create, receive, maintain, or transmit PHI about our patients. All such persons or entities are called "business associates" ("BAs") of PRO. For example, our business associates include, but are not limited to, our outside billing company, our outside consultants, and our outside attorney. Workforce members are not business associates, nor are organizations that share a direct treatment relationship with patients to whom PRO provides services. When in doubt, the HIPAA Compliance Officer should consult qualified legal counsel when determining whether an entity meets the legal definition of a BA.
- All identified BAs of PRO must enter into a BAA if they wish to do business with us. Even if we do not have a written services contract with a party, HIPAA requires that we have a written business associate agreement with all BAs. No disclosures of PHI will be made by PRO to a BA until the BAA has been signed.
- Whenever possible, PRO will use its standard business associate agreement. If the BA insists on using its own business associate agreement, the HIPAA Compliance Officer must ensure that the agreement proposed by the BA conforms to HIPAA's requirements.

- Whenever PRO modifies its existing business associate agreement, the HIPAA Compliance Officer shall ensure that we enter into a new business associate agreement with our current BAs.
- Whenever possible, all contracts and service agreements between PRO and any BA should include the relevant business associate language directly in the contract or service agreement. Otherwise, a stand-alone business associate agreement is required. If there is a business associate agreement separate from the main contract or service agreement, then the main agreement must specifically refer to the business associate agreement.
- The HIPAA Compliance Officer will maintain a current list of business associates.
- At times, PRO may be asked to enter into business associate agreements. The HIPAA Compliance Officer shall evaluate the appropriateness of the business associate agreement under the circumstances and enter into the agreement only when required by law and if the agreement meets the legal requirements under HIPAA.
- The HIPAA Compliance Officer is responsible for maintaining BA agreements on file for periodic review and inspection.
- With respect to a person or entity that is not a BA, but which may potentially come into contact with PHI, such as janitorial services or information technology service providers, the HIPAA Compliance Officer should seek to have a “Confidentiality Agreement” in place with the entity.

Pro Policy 1200.11 – Workforce Sanctions for Violations of HIPAA Policies and Procedures

Section:	HIPAA Policy
Policy #:	1200.11
Modified:	04/15/2024
Reviewed:	04/15/2024

12.11.A. Purpose

PRO is responsible under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to administer appropriate sanctions to its workforce members who violate the HIPAA policies and procedures of the organization. This policy outlines our approach to violations of our HIPAA policies and procedures and emphasizes the fact that PRO takes any breach of our policies and procedures very seriously.

12.11.B. Scope

This policy applies to all PRO staff members, including those staff members who may learn of patient information indirectly, and even if use of this information is not part of the staff member's responsibilities with PRO.

NOTE: Any sanctions under this policy or any other policy will not apply to staff members who:

1. File a complaint with the federal government about potential HIPAA violations,
2. Testify, assist, or participate in an investigation or compliance review proceeding or official government proceeding investigating HIPAA issues, and
3. Oppose any actions by PRO that are unlawful under HIPAA, when that opposition is made with the good faith belief that PRO was violating HIPAA (as long as any opposition or filing of a complaint did not result in improper disclosure of PHI).

12.11.C. Procedure

1. PRO will implement sanctions that are to be used when any staff member fails to comply with or violates our HIPAA policies and procedures.

2. Sanctions will be administered in a progressive manner, wherever possible. PRO will administer sanctions to the degree necessary to correct improper behavior and to ensure the protection of patient privacy. The nature of the PHI involved in the incident will be considered.

   (EXAMPLE: A first time violation where an employee revealed PHI to another staff member without any need to know may receive a verbal counseling or written warning, but if a first violation resulted in revealing PHI to someone who was not a staff member or business associate, a suspension may be warranted.)

3. Progressive sanctions may include the following:

    a) Remedial HIPAA training and education;
    b) Informal verbal counseling;
    c) Formal verbal counseling with written documentation of the counseling;
    d) Written warning;
    e) Suspension; and/or
    f) Termination or expulsion from PRO.

4. Staff members have an affirmative duty to report to management or the HIPAA Compliance Officer any suspected violation of our HIPAA policies and procedures.

5. Staff members shall be educated about this policy and the serious nature of violating our HIPAA policies. Staff members will be made aware of the potential sanctions that may occur and will be made aware of any changes to this sanction policy.

6. A record of individual staff member sanctions will be kept in the respective staff member's file. Adherence to our HIPAA policies may also be considered as part of the staff member's performance evaluation.

7. In the event of a suspected or reported violation of our HIPAA policies, the HIPAA Compliance Officer will initiate an objective and comprehensive investigation that will include:

    a) Interviews of potential witnesses
    b) Interviews of the alleged violator
    c) Preparation of an investigative report
    d) Presentation of the report to management with recommendations for sanctions (if any) or changes in our policies or practices

8. At all times, whenever there is a suspected violation of our HIPAA policies or other breach of privacy, the HIPAA Compliance Officer will recommend immediate action to be taken to mitigate the violation and its impact on PRO and any other parties.

Pro Policy 1200.12 – Minimum Necessary Requirement & Role-Based Access to PHI

Section:	HIPAA Policy
Policy #:	1200.12
Modified:	04/15/2024
Reviewed:	04/15/2024

12.12.A. Purpose

Generally, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that PRO only use or disclose the minimum amount of protected health information ("PHI") that is needed to accomplish the intended purpose for which the use or disclosure is made. This policy outlines PRO's commitment to adhere to HIPAA's "minimum necessary requirement." In order to effectively meet our obligations, this policy outlines the appropriate levels of access to PHI that specific staff members of PRO should have – "Role Based Access." This policy does not in any way limit the amount of PHI that may be exchanged between PRO staff members or between PRO staff members and other individuals during the course of treating patients.

12.12.B. Scope

This policy applies to all PRO staff members who have any degree of access to PHI at PRO.

12.12.C. Procedure

PRO retains strict requirements on the security, access, disclosure, and use of PHI. Access, disclosure, and use of PHI will be based on the role of the individual staff member in the organization, and only to the extent that the person needs to access and use the PHI to complete necessary responsibilities for PRO. When PHI is accessed, disclosed, and used, the individuals involved will make every effort, except in patient care situations, to only access, use, and disclose the minimum necessary amount of information needed to accomplish the intended purpose.

(1) *Role Based Access*

Access to PHI will be limited to those who need access to carry out their duties. The following table describes the specific categories or types of PHI to which identified persons need access, and any conditions that would apply to such access.

Job Title	Description of PHI to be Accessed	Conditions of Access to PHI
EMT	Intake information from dispatch, patient care reports, QA, and QI reports	May access only as part of completion of a patient event and post-event activities and only while actually on duty.
Paramedic	Intake information from dispatch, patient care reports, QA, and QI reports	May access only as part of completion of a patient event and post-event activities and only while actually on duty.
Billing Clerk	Intake information from dispatch, patient care reports, billing claim information, remittance advice, other patient information from facilities necessary for billing	May access only as part of duties to complete patient billing and follow up and only while actually on duty.
Field Supervisor	Intake information from dispatch, patient care reports, QA, and QI reports	May access only as part of completion of a patient event and post-event activities, as well as for quality assurance checks and corrective counseling of staff.
Dispatcher	Intake information, preplanned CAD information on patient address	May access only as part of completion of an incident, from receipt of information necessary to dispatch a call, to the closing out of the incident and only while on duty.
Training Coordinator	Intake information from dispatch, patient care reports, QA, and QI reports	May access only as a part of training and quality assurance activities. All individually identifiable patient information should be redacted prior to use in training and quality assurance activities.
Members of the Management Team	Intake information from dispatch, patient care reports, QA and QI reports, billing claim forms, remittance advice, other patient information necessary for oversight	May access only to the extent necessary to monitor compliance and to accomplish appropriate supervision and management of personnel and compliance with the law.

Access to a patient's entire file will not be allowed except when necessary for a legitimate treatment, payment, or healthcare operations-related reason.

(2) *Disclosures to and Authorizations from the Patient*

PRO may freely disclose PHI to patients who are the subject of the information, and we may freely use and disclose PHI to the extent authorized by a patient. PRO is required to limit disclosure to the

minimum amount of information necessary when releasing it pursuant to a patient request or formal Authorization.

(3) *PRO Requests for PHI from Other Parties*

If PRO needs to request PHI from another party on a routine or recurring basis, we must limit our requests to only the minimum amount of information needed for the intended purpose, as described in the table below. For requests not addressed in the table below, PRO must make this determination individually for each request, and this determination should be made by the HIPAA Compliance Officer. For example, if the request is non-recurring or non-routine, like making a request for documents pursuant to an audit request, we must make sure our request covers only the minimum necessary amount of information needed to accomplish the purpose of the request.

Holder of PHI	Purpose of Request	Information Reasonably Necessary
Skilled Nursing Facilities	To have adequate patient records to treat the patient, determine medical necessity for service, and to properly bill for services provided	Patient face sheets, discharge summaries, Physician Certification Statements and Statements of Medical Necessity, Mobility Assessments
Hospitals	To have adequate patient records to treat the patient, determine medical necessity for service, and to properly bill for services provided	Patient face sheets, discharge summaries, Physician Certification Statements and Statements of Medical Necessity, Mobility Assessments
Mutual Aid Ambulance or Paramedic Services	To have adequate patient records to treat the patient, conduct joint billing operations for patients mutually treated/transported by the Company	Patient care reports

(4) *PHI Requests to PRO from Other Parties*

PRO will make reasonable efforts to release only the minimum amount of PHI that is necessary to accomplish the actual purpose of a request from a third party.

(5) Incidental Disclosures

PRO understands that there will be times when there are incidental disclosures about PHI in the context of caring for a patient. HIPAA was not intended to impede common healthcare practices that are essential in providing healthcare to the individual. Incidental disclosures are inevitable, but these will typically occur in radio or face-to-face conversations between healthcare providers, or when PHI is able to be viewed by others, despite reasonable efforts to protect the PHI from view.

But all personnel must be sensitive to avoiding incidental disclosures to other healthcare providers and others who do not have a need to know the information. PRO staff should be attentive to who is within earshot when making verbal statements about a patient's health information, and follow some of these common sense procedures for avoiding accidental or inadvertent disclosures:

(6) *Measures to Protect PHI*

1. Verbal PHI: Staff members should only discuss PHI with those who are involved in the care of the patient, regardless of physical location. When discussing PHI with patients, staff members should make sure that there are no other persons (including other PRO staff members) in the area that could overhear the discussion. If so, the patient should be brought into a screened area before engaging in discussion.

2. Hard Copy PHI: All paper patient care reports should be stored in safe and secure areas when not in use. No paper records concerning a patient should be left in open bins or on desktops or other surfaces. Only those with a need to have the information for the completion of their job duties should have access to any paper records. Additionally, billing records, including all notes, remittance advices, charge slips or claim forms should not be left out in the open and should be stored in files or boxes that are secure and in an area with access limited to those who need access to the information for the completion of their job duties.

3. E-PHI: Computer access terminals and other mobile devices should be kept secure. Staff members should be sensitive to who may be in viewing range of the monitor screen and take simple steps to shield viewing of the screen by unauthorized persons. All mobile devices such as laptops, ePCRs and cell phones should remain in the physical possession of the individual to whom they are assigned at all times.

Pro Policy 1200.13 – Designated Record Sets

Section:	HIPAA Policy
Policy #:	1200.13
Modified:	04/15/2024
Reviewed:	04/15/2024

12.13.A. Purpose

To ensure that PRO patients and their authorized representatives are granted rights regarding Protected Health Information ("PHI") in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), this policy establishes what protected health information ("PHI") at PRO should be accessible to patients as part of a Designated Record Set ("DRS"). Under HIPAA, a DRS includes medical records that are created or used by PRO to make decisions about the patient.

12.13.B. Scope

This policy applies to all PRO staff members responsible for the designation of PHI into designated record sets and those responsible for fulfilling patient requests pertaining to PHI. All staff members should be familiar with the types of information that will be part of a DRS. Generally, the HIPAA Compliance Officer will be responsible for fulfilling patient requests related to PHI and for ensuring that the correct information is made part of the DRS.

12.13.C. Procedure

The DRS should only include PHI as defined under HIPAA and should be comprised of individually identifiable healthcare and billing information created, received, maintained or transmitted by or on behalf of PRO that is used, in whole or in part, by PRO to make decisions about individuals. The HIPAA Compliance Officer shall be the party in charge of designating what information is part of a DRS at PRO and for ensuring that appropriate information is being maintained by PRO in its designated record sets.

(1) The Designated Record Set at PRO

1. The DRS at PRO for any requests regarding PHI includes the following records:

    a) Paper or electronic patient care reports ("PCR" or "ePCR") created or received by PRO and supplementary information regarding the patient's condition. This includes any photos, videos, monitor strips, Physician Certification Statements, Refusal of Care forms, Advance Beneficiary Notice of Noncoverage forms, or information from other source used by PRO to treat patients or bill for services.
    b) The electronic claims records or other paper records of submission of actual claims to Medicare or other insurance companies.
    c) Any patient-specific claim and billing information, including responses from insurance payers, such as remittance advice statements, Explanation of Medicare Benefits

(EOMBs), charge screens, patient account statements, and signature authorization and agreement to pay documents.

d) Notices from insurance companies indicating coverage determinations, documentation submitted by the patient, and copies of the patient's insurance card or policy coverage summary, that relate directly to the care of the patient or payment for that care.
e) Amendments to PHI, or statements of disagreement by the patient requesting the amendment when PHI is not amended upon request, or an accurate summary of the statement of disagreement.

2. The DRS should also include treatment related records created by other parties such as first responder units, assisting ambulance services, air medical services, nursing homes, hospitals, police departments, coroner's offices, etc., that are used by PRO for treatment and payment related purposes.

3. A designated record set should not include:

    a) Quality assurance data collected and maintained for peer review purposes;
    b) Accident reports;
    c) Incident reports;
    d) Duplicate information maintained in other systems;
    e) Data collected and maintained for research;
    f) Information compiled in reasonable anticipation of litigation or administrative action;
    g) Employment records; or
    h) Student records.

Pro Policy 1200.14 – News Media Interaction

Section:	HIPAA Policy
Policy #:	1200.14
Modified:	04/15/2024
Reviewed:	04/15/2024

12.14.A. Purpose

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") establishes the circumstances under which individuals' protected health information ("PHI") can be disclosed. Generally, PRO may not disclose PHI to the news media without the patient's written express authorization. In addition, state laws may also grant patients additional privacy protections and may enable parties to bring legal action for invasion of privacy or other related causes of action for improper releases of patient information to the news media – sometimes even information that might not qualify as PHI under HIPAA.

This policy establishes consistent guidelines for PRO to follow when dealing with requests from the media so that PRO respects individual privacy rights and complies with applicable federal and state law. This policy is meant to work in conjunction with PRO's "Action Plan on News Media Interaction." PRO fully respects the right of the public to know about events, but we will provide information to the news media only to the extent that the law allows us and only when it would not infringe on the privacy rights of our patients.

12.14.B. Scope

This policy applies to all PRO staff members who might come into contact with or who may be contacted by various media outlets. Generally, all requests from the media for any information about an incident involving PRO will be directed to our Public Information Officer to handle. Or, if PRO does not have a designated Public Information Officer, all requests should be directed to our HIPAA Compliance Officer.

12.14.C. Procedure

(1) *Requests from the News Media*

1. PRO staff members will at all times treat members of the media in a professional manner when a request for information is made.

2. All information requests from the news media received by any PRO staff members shall be directed to the Public Information Officer. Or, if PRO does not have a designated Public Information Officer, all requests from the news media shall be directed to the HIPAA Compliance Officer. Upon receipt of a request for information from the news media, staff members should inform the news media requestor that it is the policy of PRO that all media requests be handled by one official and staff members should provide the media requestor contact information for the Public Information Officer or HIPAA Compliance Officer, as appropriate. Or the staff member may contact the Public Information Officer or HIPAA

Compliance Officer to inform the Officer of the request and request authorization to release information to the media.

3. Staff members other than PRO's Public Information Officer or HIPAA Compliance Officer are not permitted to release information to the news media, unless authorized or directed by the appropriate Officer to do so.

4. The Public Information Officer or HIPAA Compliance Officer shall use discretion in handling requests from the news media and when deciding whether to release (or permit the release) of information to the media. The Public Information Officer or HIPAA Compliance Officer should only release information to the media when such release would not violate federal or state laws and when release would not infringe a patient's reasonable expectation to privacy. For example, if PRO transported a high-profile member of the community, PRO should probably decline to disclose even general information that does identify the individual to the media since it is likely the patient's identity would be known to anyone hearing the report.

(2) *Releasing Information to the News Media*

1. PRO may not release any PHI to the news media, absent a patient's written, signed authorization. In the event that the patient or the patient's authorized representative signs a HIPAA-compliant authorization form, disclosures of information, including PHI, may be made so long as they are done in accordance with the express terms of the written Authorization. PRO's "Authorization to Use and Disclose Protected Health Information" Form should be used for this purpose.

2. If there is no written authorization from the patient, PRO may only release information that is "de-identified." De-identified information is information that does not identify an individual and there is no reasonable basis to believe that the information can be used to identify a specific individual. PRO may only release the following types of "de-identified" information to members of the media where appropriate:

    a) Name of hospital: PRO may provide the name of the hospital to which patients have been transported. *(Example: The media calls about "the accident at Third and Main earlier this afternoon." PRO may inform the media that "a patient was transported from the accident scene to ABC Hospital.")*
    b) Number of patients: PRO may provide the total number of patients involved in an incident or transported to a facility. PRO may not indicate specifics, such as the type of vehicle a patient was driving, or which patient went to a particular facility. *(Example: PRO may inform the media that "four patients were transported from the fire at the Chemical Factory. Two were taken to County General and two were taken to the Regional Medical Center.")*
    c) Age & Gender: PRO may provide the age of a patient and the gender of the patient unless it could reasonably be used to identify the patient. *(Example: PRO may inform the media that "a 39 y/o male was transported from the accident on the Interstate.")*
    d) Designation of crew members: PRO may state, for example, that one paramedic and two EMTs were involved in caring for the patients involved in a motor vehicle accident. PRO may identify the names of the personnel who responded. *(Example: PRO may inform the*

media that "PRO personnel on the scene of the incident included two paramedics and a supervisor and advanced life support was administered.")

e) Type of Transport: PRO may indicate that a particular call was an emergency, and that transportation was facilitated by ambulance or helicopter. *(Example: "Of the 3 patients on the scene of the incident, one was transported by helicopter to the Trauma Center and two were transported as non-emergency patients to the local hospital emergency department.")*

Pro Policy 1200.15 – Action Plan on News Media Interaction

Section:	HIPAA Policy
Policy #:	1200.15
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Step 1: Is the request asking PRO to disclose PHI?

Upon receipt of a request for information from the news media, the Public Information Officer or HIPAA Compliance Officer shall determine whether the request is asking PRO to disclose PHI.

- YES: Go to Step 2
- NO: Go to Step 3

Step 2: PRO will not release any PHI to the news media absent a patient's written, signed authorization. The Public Information Officer or HIPAA Compliance Officer may consider asking the patient, or the patient's personal representative, whether they would agree to allow PRO to release the requested PHI to the news media. In the event that the patient or the patient's authorized representative does agree to permit PRO to make the disclosure, the Public Information Officer or HIPAA Compliance Officer shall require the individual to complete and sign PRO's "Authorization to Use and Disclose Protected Health Information" Form to permit the disclosure. PRO may only disclose PHI to the media in strict compliance with what the Authorization states.

Step 3: PRO may release the following types of "de-identified" information to members of the media in accordance with PRO's "Policy on News Media Interaction":

- Name of hospital
- Number of patients
- Age and gender of patients
- Designation of crew members
- Type of transport

Pro Policy 1200.16 – Release of PHI to Law Enforcement Without Legal Process

Section:	HIPAA Policy
Policy #:	1200.16
Modified:	04/15/2024
Reviewed:	04/15/2024

12.16.A. Purpose

Protected health information ("PHI") may only be released to law enforcement officials under specific and limited circumstances under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This policy provides consistent guidelines for PRO staff members to follow regarding the release of PHI to law enforcement when the law enforcement official does not serve some type of legal process, such as a summons, subpoena, or warrant, so that staff only release PHI in accordance with HIPAA. This policy will work in conjunction with PRO's "Staff Member Action Plan for Release of PHI to Law Enforcement Without Legal Process."

12.16.B. Scope

This policy applies to all PRO staff members who may come in contact with law enforcement including field personnel who may encounter law enforcement officials at the scene of an incident and other staff who may be approached by law enforcement directly after an incident. This policy applies to situations where law enforcement is seeking PHI from a staff member and the law enforcement official does not present PRO with legal process, such as a subpoena, summons, or warrant. PRO's Policy on Release of Protected Information Pursuant to Warrant, Subpoena, Summons or Administrative Request applies to situations where law enforcement or other parties are seeking information pursuant to legal process.

12.16.C. Procedure

(1) *General Procedure for Handling Requests*

1. If a staff member of PRO is approached by a law enforcement official and the official makes requests a request for PHI about a patient from the staff member, the staff member should verify the identity of the law enforcement official and ask the official what is the purpose for which the request is being made.

2. If the request is being made for one of the purposes listed in this policy, then the staff member may release the PHI to the law enforcement official, in accordance with this policy. Formal written patient authorization is not required when releasing PHI pursuant to one of the purposes listed in this policy; however, where the patient is readily available and able to consent to the disclosure, verbal consent should be obtained and documented by the staff member before disclosure of PHI is made to the law enforcement official.

3. If the staff member is unsure about whether the release of PHI is proper, the staff member should contact PRO's HIPAA Compliance Officer or an immediate supervisor for guidance. Under no circumstance should any staff member release PHI to law enforcement if the staff member is unsure about the appropriateness of the disclosure.

4. If the request for PHI does not fall under one of the purposes listed in this policy, the staff member should inform the law enforcement officer that s/he is not permitted under HIPAA to release the information. The staff member may inform the law enforcement official of the following two options:

    a) The law enforcement official may obtain legal process, such as a warrant, summons, or subpoena, to obtain the information from PRO.
    b) The law enforcement official may obtain the information directly from the patient if the patient is stable and willing to speak with the official. Staff members should only provide this option to a law enforcement official when doing so would not impede patient care and where the patient is willing to speak with the official. For a stable patient, the staff member should first consult with the patient to determine whether the patient is willing to speak with the official. If the patient declines to speak with the official, the staff member should inform the enforcement official.

5. Staff members should record, at a minimum, the following information about all law enforcement requests that are unaccompanied by legal process:

    - The name of the law enforcement official;
    - The date and time of the request;
    - The purposes for which the request was made (if provided);
    - What information the law enforcement official requested;
    - Whether the patient was consulted about the request and the patient's response;
    - Whether the HIPAA Compliance Officer or other individual at PRO was consulted about the request;
    - Whether the law enforcement official made any representations to PRO;
    - Whether PHI was released and what PHI was released; and
    - The reason(s) why the PHI was released.

<u>Purposes for Which Disclosure Can Be Made to Law Enforcement Without Legal Process</u>

(2) *Disclosures of PHI Required by State Reporting Law*

1. Massachusetts law requires that PRO staff members report the following types of incidents to law enforcement agencies in Massachusetts: Child Abuse or neglect, elder abuse or at-risk, and Disabled abuse or neglect.
2. If there is any doubt regarding whether or not Massachusetts requires reporting of a particular injury or incident, the staff member should contact a supervisor for a list of incidents that must reported under Massachusetts law.

(3) *Disclosures of PHI to Locate or Identify a Suspect, Material Witness, Fugitive, or Missing Person*

1. PHI may be disclosed to law enforcement for purpose of locating or identifying a ***suspect***, ***material witness***, ***fugitive***, or ***missing person*** only upon request of a law enforcement official. The disclosure may not be initiated by PRO.

2. If a law enforcement official indicates to a staff member that they need PHI about an individual to identify or locate a ***suspect***, ***material witness***, ***fugitive*** or ***missing person***, the staff member should ask the law enforcement official to confirm that the sole purpose of the request is to locate or identify one of the listed individuals. If the law enforcement official already knows who the individual is and where the individual is located, then the staff member should not proceed to disclose PHI for this purpose.

3. Although no formal written request is required from law enforcement, the staff member should ask that the PHI request be documented in writing, preferably on the law enforcement department's letterhead. In the absence of a written request from the law enforcement agency, the staff member should, at a minimum, document that the law enforcement officer verified that the PHI was needed to identify or locate a ***suspect***, ***material witness***, ***fugitive***, or ***missing person***.

4. If the staff member is satisfied that law enforcement has made a good faith representation that the information requested is needed to locate or identify a ***suspect***, ***fugitive***, ***material witness***, or ***missing person***, then the staff member may disclose only the following PHI about that individual to the official:
    - Name
    - Address
    - Date of birth
    - Place of birth
    - Social Security Number
    - Blood type
    - Type of injury
    - Date of treatment
    - Time of treatment
    - Description of distinguishing physical characteristics (i.e. weight, hair color, eye color, gender, facial hair, scars, and tattoos)

(4) *Disclosing PHI About Crime Victims*

1. PHI about crime victims may be disclosed to law enforcement only upon request of a law enforcement official. The disclosure may not be initiated by PRO.

2. If a law enforcement officer requests PHI about an individual who may be the victim of a crime, PRO staff members should first discern whether the individual is in fact a victim of a crime. Victims of a crime may include motor accident victims because often a summary or misdemeanor offense is involved (like when the accident is the result of the driver of another vehicle violating traffic laws). In many cases, the determination that a patient is or may be a crime victim can be inferred from the circumstances and the presence of law enforcement at the scene.

3. PRO may disclose PHI about a crime victim to a law enforcement official if the individual agrees to the disclosure. If the patient is conscious and alert, and it would not impede the provision of care, the staff member should ask the patient if it is acceptable to disclose the PHI to law enforcement. If the patient does not consent to the disclosure, then PHI should not be disclosed, and law enforcement should be informed of that fact. If the victim does consent to the disclosure, the PHI may be released in accordance with the patient's wishes. The consent may be verbal, but it should be documented on a patient care report or other document.

4. If the patient is unable to consent, due to incapacity or other reason, the staff member should ask law enforcement if they can wait until the patient is able to consent to the release of the PHI. If the law enforcement official represents that waiting until the patient is capable of agreeing to the disclosure would compromise an immediate law enforcement activity, then PHI may be disclosed to law enforcement provided the following conditions are met:

    a) The staff member, in the exercise of professional judgment, determines that disclosure would be in the best interests of the crime victim;
    b) The law enforcement officer needs the information to determine whether a violation of law has occurred; and
    c) The law enforcement officer represents that the information requested is not intended to be used against the crime victim.

    Representations from law enforcement may be verbal and should be documented in a patient care report or other document.

(5) *Disclosing PHI Regarding Victims of Abuse, Neglect, or Domestic Violence*

1. If law enforcement makes a request for PHI regarding someone who a PRO staff member reasonably believes to be the victim of violence or abuse, PRO may release PHI to law enforcement if the patient agrees to the disclosures. The staff member should first ask the patient for his/her consent to release the information. If the patient does not consent to the disclosure, no PHI should be provided to law enforcement and law enforcement should be informed of this fact. If the individual agrees to the disclosure of PHI, the staff member may give the PHI to law enforcement in accordance with the patient's consent. This consent can be verbal, but it should be documented on the patient care report.

2. If the individual is unable to consent to the disclosures due to incapacity, mental condition, etc., and the laws of Massachusetts expressly authorize reporting of this type of information to law enforcement, PRO staff members may release PHI to law enforcement provided that either of the following conditions are met:

    a) The staff member, in the exercise of professional judgment, believes that the disclosure is necessary to prevent serious harm to the patient or other potential victims; or
    b) Law enforcement assures the staff member that the PHI will not be used against the victim and represents that an immediate law enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

3. Representations from law enforcement may be verbal and should be documented in a patient care report by the staff member along with all details regarding the disclosure including the identity of the requestor, the purpose of the request, the date and time of the request, and the PHI released about the victim.

4. If PRO discloses PHI without the patient's consent because the patient was unable to consent, the HIPAA Compliance Officer must contact the patient and alert them of the disclosure, unless PRO believes contacting the patient will only put the patient at greater risk.

(6) *Disclosing PHI Regarding Decedents*

1. PHI can be released to law enforcement about decedents without a request for PHI from a law enforcement official (i.e., PRO may initiate this type of disclosure).

2. PRO staff members may disclose limited PHI to law enforcement about an individual who has died when staff members have a reasonable, good faith belief that the death may have resulted from criminal conduct. The staff member does not necessarily have to come to a legal conclusion, or know with complete certainty, that the death resulted from a crime. This includes any type of crime.

3. Disclosure regarding suspected victims of a crime should be limited to basic facts about the victim and the circumstances of the death.

(7) *Disclosing PHI to Report a Crime on PRO's Premises*

1. PRO may initiate this type of disclosure to law enforcement absent a request from a law enforcement official.

2. PRO staff members may disclose to law enforcement any PHI that staff members in good faith believe constitutes evidence of a crime committed on PRO's premises. PRO's premises include the station house, headquarters, parking lot, the ambulance, etc.

3. Disclosure of PHI to report a crime on the premises should be limited to information that is necessary to alert law enforcement about the crime and to describe the crime to law enforcement.

(8) *Disclosing PHI to Report a Crime in an Emergency*

1. PRO may initiate this type of disclosure to law enforcement absent a request from a law enforcement official.

2. PRO staff members may disclose PHI to law enforcement when they believe it is necessary to alert law enforcement to:

    a) The commission of a crime- The nature of a crime;
    b) The location of the crime;
    c) The location of a crime victim; and
    d) The identity, description, and location of the perpetrator of a crime.

3. Disclosures of PHI to report a crime in an emergency should be limited to necessary information about the nature of the crime and information about the suspect(s).

(9) *Disclosure of PHI to Avert a Serious Threat to Health or Safety*

1. PRO may initiate this type of disclosure to law enforcement absent a request from a law enforcement official.
2. PRO staff members may disclose PHI to avert a serious threat to health or safety so long as a staff member believes that the disclosure is necessary to:
    a) Avert a serious and imminent threat to a person's safety or the public at large;
    b) Identify or apprehend an individual because that individual admitted to participating in a violent crime that may have caused serious harm to someone; or
    c) Identify or apprehend someone who escaped from a correctional institution or from lawful custody.
3. Disclosures of PHI to prevent or lessen a serious and imminent threat to the health or safety should only be made to alert persons who are reasonably able to prevent or lessen the threat.
4. Disclosures of PHI to prevent or lessen a serious threat to health or safety should be limited to necessary information to prevent or lessen the threat, and necessary information about the individual who poses the threat.

Pro Policy 1200.17 – Staff Member Action Plan for Release of PHI to Law Enforcement Without Legal Process

Section:	HIPAA Policy
Policy #:	1200.17
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Step 1:

If the request comes from law enforcement, verify the identity of the law enforcement official and ask the official what is the purpose for which the request is being made.

Step 2:

Is the law enforcement officer requesting information for one of the law enforcement purposes listed in this action plan?

- NO: *Go to Step 3*
- YES: You may release the PHI in accordance with the corresponding guidance for each purpose, listed in the column directly across from the stated purpose. Formal written patient authorization is not required when releasing PHI pursuant to one of the purposes listed in this policy. But, if the patient is readily available and able to consent to the disclosure, verbal consent should be obtained and documented before disclosure of PHI is made to the law enforcement official. In addition, you should record, at a minimum, the following information about all law enforcement requests that are unaccompanied by legal process:

    a) The name of the law enforcement official;
    b) The date and time of the request;
    c) The purposes for which the request was made (if provided);
    d) What information the law enforcement official requested;
    e) Whether the patient was consulted about the request and the patient's response;
    f) Whether the HIPAA Compliance Officer or other individual at PRO was consulted about the request;
    g) Whether the law enforcement official made any representations to PRO;
    h) Whether PHI was released and what PHI was released; and
    i) The reason(s) why the PHI was released.

(1) *Required by State Reporting Law*

- The information that the law enforcement officer is asking for is required to be reported to law enforcement under state law (e.g., animal bites, gunshot wounds, burn injuries, out of hospital deaths, vehicle accidents, etc.).

- You may release any PHI that is necessary to comply with state reporting law and should track the disclosure on a patient care report or other form and inform the patient about the disclosure, whenever possible.

(2) *Identify or Locate a Suspect, Material Witness, Fugitive, or Missing Person*

- The information is needed by law enforcement for the sole purpose of identifying or locating a suspect, material witness, fugitive, or missing person.
- You may release only the following types of PHI about the individual to law enforcement:

    a) Name;
    b) Address;
    c) Date of Birth;
    d) Place of Birth;
    e) Social Security Number;
    f) Blood Type;
    g) Type of Injury;
    h) Date of Treatment;
    i) Time of Treatment; and
    j) A Description of Distinguishing Physical Characteristics.

(3) *Crime Victims*

- The information is needed by law enforcement about a person who is or who is suspected by the law enforcement officer to be the victim of a crime.
- You should first ask whether the victim agrees to the disclosure and if the victim refuses, the PHI should not be released, and the officer should be informed that s/he may speak with the victim directly. If the patient agrees, information may be disclosed pursuant to the patient's wishes and the agreement should be documented along with the disclosure. If the patient is unable to agree to the disclosure because he/she is incapacitated or some other reason and the law enforcement official represents that waiting until the patient is capable of agreeing to the disclosure would compromise an immediate law enforcement activity, then you may release the PHI requested provided all the following conditions are met:

    a) You determine that disclosure would be in the best interests of the victim;
    b) The officer needs the information to determine whether a violation of law has occurred; and
    c) The law enforcement officer represents that the information requested is not intended to be used against the crime victim and you document that representation.

(4) *Crime on Premises*

- You need to disclose PHI to report a crime that occurred on the premises of PRO or in one of our vehicles.
- You may disclose PHI to law enforcement if you believe in good faith the PHI constitutes evidence of criminal conduct on the premises of PRO's station house, headquarters, parking lot,

or any vehicle. The information should be limited to basic information about the patient and circumstances about the crime.

(5) *Reporting Crime in Emergency*

- You need to disclose PHI to report a crime in an emergency.
- You may disclose PHI to a law enforcement official if such disclosure appears necessary to alert law enforcement to:

    a) The commission and nature of a crime;
    b) The location of the crime; and
    c) The identity, description, and location of the perpetrator of such crime.

(6) *To Avert a Serious Threat to Health or Safety*

- You need to disclose PHI to someone who is able to prevent or lessen a serious threat to health or safety.
- You may disclose PHI to someone who is able to prevent or lessen a threat to health or safety if you believe it is necessary to do so in order to:

    a) Avert a serious and imminent threat to a person's safety or the public at large;
    b) Identify or apprehend an individual because that individual admitted to participating in a violent crime that may have caused serious harm to someone; or
    c) Identify or apprehend someone who escaped from a correctional institution or from lawful custody.

- Disclosures of PHI to prevent or lessen a serious threat to health or safety should be limited to necessary information to prevent or lessen the threat, and necessary information about the individual who poses the threat.

Step 3:

If the request for PHI does <u>not</u> fall under one of the purposes listed in this action plan, you should inform the law enforcement official you are not permitted under HIPAA to release the information. You may inform the law enforcement official of the following two options:

- The law enforcement official may obtain legal process, such as a warrant, summons, subpoena, or administrative request to obtain the information from PRO.
- The law enforcement official may obtain the information directly from the patient if the patient is stable and willing to speak with the official. You should only provide this option to a law enforcement official when doing so would not impede patient care and where the patient is willing to speak with the official. You should first consult with the patient to determine whether the patient is willing to speak with the official. If the patient declines to speak with the official, you should inform the enforcement official.

Pro Policy 1200.18 – Release of PHI to Law Enforcement with Legal Process

Section:	HIPAA Policy
Policy #:	1200.18
Modified:	04/15/2024
Reviewed:	04/15/2024

12.18.A. Purpose

Protected health information ("PHI") may be released pursuant to valid legal process under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This policy provides guidelines for PRO regarding the release of PHI pursuant to court orders, summonses, subpoenas, warrants, administrative requests, and discovery requests (collectively referred to in this policy as "legal process"), so that PRO only releases PHI in accordance with HIPAA and as required by state law. This policy will work in conjunction with PRO's HIPAA Compliance Officer Action Plans on "Requests for PHI from Attorneys," "Administrative Requests for PHI from Government Agencies," and "Court-Ordered Requests for PHI."

12.18.B. Scope

This policy applies to all PRO staff members who may receive or respond to requests for PHI accompanied by legal process. These requests typically occur after a call is completed and are generally served on staff at PRO's station in person or through the mail. Generally, all such requests will be directed to and handled by the HIPAA Compliance Officer.

12.18.C. Procedure

(1) *General Procedure for Handling Requests*

- PRO is permitted by HIPAA and may be required by Massachusetts law and federal law, to furnish requested PHI to certain parties pursuant to a valid legal process.
- If PRO receives a request for PHI accompanied by legal process, the request shall be directed to the HIPAA Compliance Officer.
- The HIPAA Compliance Officer shall first determine whether the request is:
    a) a court order or a court- ordered subpoena, summons, or warrant ("SSW");
    b) an administrative request; or
    c) a subpoena, discovery request, or other legal process issued by an attorney.
- When determining what type of request has been received, the HIPAA Compliance Officer shall look to the issuer of the request (i.e., who the requesting party is) and keep in mind the following guidelines:

a) Court orders and court-ordered SSWs are issued by courts, grand juries, and administrative tribunals and signed by a judge or other judicial officer.
b) Administrative requests are issued by a federal, state, or local administrative agency such as a department of health, a law enforcement agency, or other similar type of agency. Administrative agencies are permitted to issue "administrative" warrants, subpoenas, summonses, or other similar type requests for information. These documents are likely to be signed by a high-level official from the requesting administrative agency.
c) Attorneys may issue subpoenas and discovery requests. These requests can usually be distinguished from other types of "official" court-ordered or administrative requests because they are signed by an attorney, not a judge, judicial officer, or administrative official.

When in doubt, the HIPAA Compliance Officer should solicit the assistance of legal counsel in determining what type of request was received.

Patient authorization is not required when releasing PHI pursuant to a request for PHI accompanied by legal process. However, patients may need to be notified about certain requests in accordance with this policy before PHI is released.

All disclosures of PHI pursuant to requests accompanied by legal process must be documented by the HIPAA Compliance Officer in PRO's "Accounting Log for Disclosures of PHI" and a copy of the request shall be maintained with that log in the patient file, along with other information required by this policy.

(2) *Responding to Court-Ordered Requests*

If the HIPAA Compliance Officer determines that the request is a court order or a court-ordered SSW, the HIPAA Compliance Officer shall first verify that the request has been signed by a judge or other judicial officer of a court, grand jury, or administrative tribunal. If the request has not been signed by a judge or judicial officer, the HIPAA Compliance Officer shall send the requestor a letter stating that PRO will not disclose any PHI until PRO receives a court order or court-ordered SSW that is signed by the appropriate party.

If the request is signed by a judge or judicial officer, PRO may disclose ONLY the information that is specifically requested by the court order or court-ordered SSW. For example, the HIPAA Compliance Officer should not simply turn over a copy of all records (including records relating to prior transports and billing records) if the request asks PRO to "provide any treatment records about John Smith from April 15, 2013." However, if the request asks PRO to provide "any and all records pertaining to John Smith," then PRO must generally provide all PCRs, all billing records, and any other information maintained about the patient. The HIPAA Compliance Officer shall also contact the issuer of the request whenever it is unclear what PHI PRO is required to disclose. If necessary, the HIPAA Compliance Officer shall ask that the requester re-issue a more specific request.

The HIPAA Compliance Officer shall retain a copy of the court-ordered request and document the name of the requesting party, the date of the request, the date of disclosure, and the PHI that was disclosed.

(3) *Responding to Administrative Requests from Government Agencies*

If the HIPAA Compliance Officer determines that a request for PHI qualifies as an administrative request (including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process) issued by a federal, state, or local government agency, the HIPAA Compliance Officer should first determine whether the agency has the authority to make the request and to receive the PHI requested. The HIPAA Compliance Officer should look to any statutory or regulatory authority cited in the request and consult with legal counsel when making this determination. If the HIPAA Compliance Officer determines that the agency does not have the legal authority to request and receive the PHI requested, the HIPAA Compliance Officer shall send the requestor a letter stating that PRO will not disclose any PHI until the agency provides PRO with a statement citing appropriate legal authority to request and receive the PHI requested.

If the HIPAA Compliance Officer determines that the agency is authorized by law to make the request, the HIPAA Compliance Officer must then verify that:

a) The PHI sought by the request is relevant and material to a legitimate law enforcement inquiry;
b) The request is specific and limited in scope to the extent reasonable and practicable in light of the purpose for which the PHI is sought; and
c) De-identified information could not reasonably be used.

The HIPAA Compliance Officer should look to the administrative request to determine whether these conditions are clearly met. If it is not clear from the administrative request that all three of the above- listed conditions are met, then the HIPAA Compliance Officer shall contact the administrative agency who issued the request and inform the agency that PHI will not be released until PRO receives written assurances from the requestor that the conditions are met.

If the HIPAA Compliance Officer determines that the above-listed conditions are met, the HIPAA Compliance Officer may release ONLY the PHI that the administrative request asks for. The HIPAA Compliance Officer shall also contact the issuer of the request whenever it is unclear what PHI PRO is required to disclose. If necessary, the HIPAA Compliance Officer shall ask that the requester re-issue a more specific request.

The HIPAA Compliance Officer shall retain a copy of the administrative request as well as any assurances, and document: the name of requesting party; the date of the request; the date of disclosure; and the PHI that was disclosed.

(4) *Responding to Requests from Attorneys*

If the HIPAA Compliance Officer determines that the request is a subpoena, discovery request, or other legal process from an attorney (that is not accompanied by an official order from a court, grand jury, or administrative tribunal), the HIPAA Compliance Officer shall first verify that the original subpoena, discovery request, or other legal process is enclosed with the request. References to a subpoena or other document in the request are not sufficient. If the original legal process has not been provided to PRO, the HIPAA Compliance Officer shall send the requestor a letter stating that PRO will not disclose any PHI until the original process has been provided.

Then, the HIPAA Compliance Officer shall verify that "satisfactory written assurances" have been provided to PRO by the requestor. This means that PRO must receive written documentation from the attorney requesting the PHI that demonstrates either of the following:

1. The attorney requesting the PHI made a good faith attempt to provide written notice to the patient that included information about the litigation or proceeding and the PHI request and such notice was sufficient to permit the individual the opportunity to raise an objection to the court or administrative tribunal. Additionally, the time for the patient to raise objections to the court or administrative tribunal has elapsed, and either:

    a) No objections were filed; or
    b) All objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution. Documentation may include, for example, a copy of the notice mailed to the individual that includes instructions for raising an objection with the court and the deadline for doing so, and a written statement or other documentation demonstrating that no objections were raised, or all objections raised were resolved and the request is consistent with the resolution. To the extent that the subpoena or other request itself demonstrates the above elements, no additional documentation is required;

OR

2. The parties to the dispute giving rise to the request for PHI have agreed to a "qualified protective order" and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or the attorney seeking the PHI has requested a qualified protective order from such court or administrative tribunal. A "qualified protective order" is an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that:

    a) Prohibits the parties from using or disclosing the PHI for any purpose other than the litigation or proceeding for which such information was requested; and
    b) Requires the return of the PHI or destruction of the PHI (including all copies made) at the end of the litigation or proceeding. Documentation may include, for example, a copy of the qualified protective order that the parties have agreed to and documentation or a statement that the order was presented to the court, or a copy of the motion to the court requesting a qualified protective order.

If all written assurances have not been provided to PRO, the HIPAA Compliance Officer shall send the requestor a letter stating that PRO will not disclose any PHI until the proper written assurances have been provided.

If the required satisfactory written assurances have been provided to PRO, then the HIPAA Compliance Officer may disclose PHI as requested in the subpoena or other legal process. The HIPAA Compliance Officer shall ONLY disclose the PHI that has been requested in the document. The HIPAA Compliance Officer shall also contact the issuer of the request whenever it is unclear what PHI PRO is required to disclose. If necessary, the HIPAA Compliance Officer shall ask that the requester re-issue a more specific request.

The HIPAA Compliance Officer shall retain a copy of the request from the attorney as well as the satisfactory written assurances from the attorney in the patient file. The HIPAA Compliance Officer shall also document the name of requesting party, the date of the request, the date of disclosure, and the PHI that was disclosed.

Pro Policy 1200.19 – HIPAA Compliance Officer Action Plan for Court-Ordered Requests for PHI

Section:	HIPAA Policy
Policy #:	1200.19
Modified:	04/15/2024
Reviewed:	04/15/2024

Step 1:

Is the court order or a court-ordered subpoena, summons, or warrant ("SSW") signed by a judge or other judicial officer of a court, grand jury, or administrative tribunal?

- YES: Go to Step 2
- NO: The HIPAA Compliance Officer should deny the request in writing stating that a court order or court- ordered SSW signed by a judge or judicial officer must be provided to PRO before the request will be considered.

Step 2:

If the request is signed by a judge or judicial officer, PRO may disclose ONLY the information that is specifically requested by the court order or court-ordered SSW. The HIPAA Compliance Officer shall also contact the issuer of the request whenever it is unclear what PHI PRO is required to disclose. If necessary, the HIPAA Compliance Officer shall ask that the court, grand jury, or administrative tribunal re-issue a more specific request. The HIPAA Compliance Officer shall retain a copy of the court-ordered request in the patient file, track the disclosure in an accounting log, and document: the name of requesting entity; the date of the request; the date of disclosure and the PHI that was disclosed.

Pro Policy 1200.20 – HIPAA Compliance Officer Action Plan for Administrative Requests for PHI from Government Agencies

Section:	HIPAA Policy
Policy #:	1200.20
Modified:	04/15/2024
Reviewed:	04/15/2024

Step 1:

Does the federal, state, or local government agency have the authority to make the administrative request (an administrative request can include an administrative subpoena, summons, civil or other authorized investigative demand or similar process)? The HIPAA Compliance Officer should look to any statutory or regulatory authority cited in the request and consult with legal counsel when making this determination.

- YES: Go to Step 2
- NO: The HIPAA Compliance Officer should deny the request in writing stating that proper legal authority, demonstrating that the agency has the right to request and receive the PHI, must be provided to PRO by the administrative agency before the request will be considered.

Step 2:

Is it clear from the request that all 3 conditions below are satisfied?

1. The PHI sought by the request is relevant and material to a legitimate law enforcement inquiry;
2. The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the PHI is sought; and
3. De-identified information could not reasonably be used?

- YES: Go to Step 3
- NO: The HIPAA Compliance Officer should send the requestor a letter stating that PRO will not disclose any PHI until the administrative agency certifies in writing that the three conditions have been met.

Step 3:

The HIPAA Compliance Officer shall ONLY disclose the PHI that has been requested in the administrative request. The HIPAA Compliance Officer shall also contact the issuer of the request whenever it is unclear what PHI PRO is required to disclose. If necessary, the HIPAA Compliance Officer shall ask the requesting agency to re-issue a more specific request. The HIPAA Compliance Officer shall retain a copy of the administrative request as well as any written assurances in the patient file. The HIPAA Compliance

Officer shall also track the disclosure in an accounting log and document: the name of requesting agency; the date of the request; the date of disclosure and the PHI that was disclosed.

Pro Policy 1200.21 – HIPAA Compliance Officer Action Plan for Attorney-Issued Subpoenas and Discovery Requests

Section:	HIPAA Policy
Policy #:	1200.21
Modified:	04/15/2024
Reviewed:	04/15/2024

Step 1:

Does the request contain the original subpoena, discovery request, or other legal process? *References to a subpoena or other document in the request letter are not sufficient.*

- YES: Go to Step 2
- NO: The HIPAA Compliance Officer should deny the request in writing stating that the original subpoena, discovery request, or other legal process must be provided to PRO before PRO will consider the request.

Step 2:

Does the request seeking PHI also contain "satisfactory written assurances?" In order to contain satisfactory written assurances, the request must include documentation that demonstrates either of the following:

1. The attorney requesting the PHI made a good faith attempt to provide written notice to the patient that included information about the litigation or proceeding and the PHI request, and such notice was sufficient to permit the individual the opportunity to raise an objection to the court or administrative tribunal. Additionally, the time for the patient to raise objections to the court or administrative tribunal has elapsed, and either:

    a) No objections were filed; or
    b) All objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.

    Documentation may include, for example, a copy of the notice mailed to the individual that includes instructions for raising an objection with the court and the deadline for doing so, and a written statement or other documentation demonstrating that no objections were raised, or all objections raised were resolved and the request is consistent with the resolution. To the extent that the subpoena or other request itself demonstrates the above elements, no additional documentation is required;

OR

2. The parties to the dispute giving rise to the request for PHI have agreed to a "qualified protective order" and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or the attorney seeking the PHI has requested a qualified protective order from such court or administrative tribunal. A "qualified protective order" is an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that:

    a) Prohibits the parties from using or disclosing the PHI for any purpose other than the litigation or proceeding for which such information was requested; and
    b) Requires the return of the PHI or destruction of the PHI (including all copies made) at the end of the litigation or proceeding.

    Documentation may include, for example, a copy of the qualified protective order that the parties have agreed to and documentation or a statement that the order was presented to the court, or a copy of the motion to the court requesting a qualified protective order.

- YES: Go to Step 3
- NO: The HIPAA Compliance Officer should send the requestor a letter stating that PRO will not disclose any PHI until the proper satisfactory written assurances have been provided to PRO.

Step 3:

The HIPAA Compliance Officer shall ONLY disclose the PHI that has been requested in the subpoena. The HIPAA Compliance Officer shall also contact the issuer of the request whenever it is unclear what PHI PRO is required to disclose. If necessary, the HIPAA Compliance Officer shall ask the requesting agency to re-issue a more specific request. The HIPAA Compliance Officer shall retain a copy of the request from the attorney as well as the satisfactory written assurances in the patient file. The HIPAA Compliance Officer shall also track the disclosure in an accounting log and document: the name of requesting party; the date of the request; the date of disclosure and the PHI that was disclosed.

Pro Policy 1200.22 – Breaches of Unsecured PHI

Section:	HIPAA Policy
Policy #:	1200.22
Modified:	04/15/2024
Reviewed:	04/15/2024

12.22.A. Purpose

Under the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act") PRO has an obligation, following the discovery of a breach of unsecured protected health information ("PHI"), to notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, used, or disclosed. PRO also has an obligation to notify the Department of Health and Human Services ("HHS") of all breaches. In some cases, PRO must notify media outlets about breaches of unsecured PHI. This policy details how PRO will handle and respond to suspected and actual breaches of unsecured PHI.

12.22.B. Scope

This Policy applies to all PRO staff members who come into contact with PHI. All suspected breach incidents shall be brought to the attention of the HIPAA Compliance Officer and the HIPAA Compliance Officer shall investigate each incident and initiate the appropriate response to the incident.

12.22.C. Procedure

(1) *Breach Defined*

A breach is the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of the PHI.

An acquisition, access, use, or disclosure of PHI created, received, maintained, or transmitted by PRO that is not permitted by HIPAA is presumed to be a breach unless PRO demonstrates that there is a low probability that the PHI has been compromised based on a "risk assessment" of at least the following factors:

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person who used the PHI or to whom the disclosure was made;
- Whether the PHI was actually acquired or viewed; and
- The extent to which the risk to the PHI has been mitigated.

"Unsecured protected health Information" is PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by HHS for securing PHI – available on HHS's website at: http://www.hhs.gov/ocr/privacy.

Generally, PHI is "unsecured" if it is not encrypted by strong encryption technology or if it has not been properly destroyed. If the PHI is able to be used, read, or deciphered it is "unsecured."

A breach does not include any of the following:

- Unintentional acquisition, access, or use of unsecured PHI by a staff member at PRO or someone acting under the authority of PRO if the acquisition, access, or use was made in good faith and within that individual's scope of authority, so long as the information was not further used or disclosed in violation of HIPAA.
- Any inadvertent disclosure of PHI by a PRO staff member who is generally authorized to access PHI to another person at PRO who is generally authorized to access PHI, so long as the information received as a result of such disclosure was not further used or disclosed in violation of HIPAA.
- A disclosure of PHI where PRO has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain the information.

(2) *Reporting a Suspected Breach Incident*

All PRO staff members are responsible for immediately reporting a suspected breach incident to a supervisor or the HIPAA Compliance Officer. PRO staff members shall report all known and suspected HIPAA violations.

The HIPAA Compliance Officer will notify management about the suspected incident.

The HIPAA Compliance Officer shall document the date that the suspected breach of unsecured PHI occurred (if known) and the date(s) on which the supervisor and the HIPAA Compliance Officer were notified about the incident.

(3) *Investigating a Suspected Breach Incident*

The HIPAA Compliance Officer shall then initiate an investigation to determine whether an actual breach has occurred and what actions, if any, are necessary.

The HIPAA Compliance Officer shall interview all necessary parties who may have information about the incident. The staff member who reported the suspected incident and other members with knowledge of the incident should be asked to complete PRO's "Internal Breach Incident Reporting Form." Staff members should be required to convey all information that they know about the incident and to cooperate in any subsequent investigation regarding the incident.

After gathering all available information about the incident, the HIPAA Compliance Officer shall conduct an analysis to determine whether an actual breach of unsecured PHI occurred. PRO shall consult with legal counsel whenever necessary in making this determination. The HIPAA Compliance Officer shall utilize PRO's "HIPAA Compliance Officer Action Plan: Breach Analysis Steps" in making this determination.

If the Compliance Officer determines that a breach of unsecured PHI has not occurred, the reasons behind that conclusion shall be thoroughly documented.

If the HIPAA Compliance Officer determines that a breach of unsecured PHI has occurred, the reasons behind that conclusion shall be thoroughly documented and the HIPAA Compliance Officer shall proceed to notify all necessary parties in accordance with this policy.

(4) *Breach Notification to Affected Individuals*

Following the discovery of a breach of unsecured PHI, PRO will notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, used, or disclosed as a result of such breach. The HIPAA Compliance Officer shall be the party who is primarily responsible to make proper notice, in consultation with PRO management.

A breach shall be treated as discovered by PRO as of the first day on which the breach is known, or, by exercising reasonable diligence would have been known to PRO or any person, other than the person committing the breach, who is a staff member or agent of PRO.

PRO shall provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of a breach.

If a law enforcement official states to PRO that a notification, notice, or posting would impede a criminal investigation or cause damage to national security, PRO shall:

- Delay notification for the time period specified by the official if the statement is in writing and specifies the time for which a delay is required; or
- If the notice is a verbal statement, delay notification temporarily, and no longer than 30 days from the date of the oral statement, unless a written statement is submitted during that time. If the statement is made orally, the HIPAA Compliance Officer shall document the statement, including the identity of the official making the statement.
- PRO shall provide written notification, in plain language, by first-class mail to each affected individual at the last known address of each individual. If the affected individual agreed to receive electronic notice of breaches, PRO may provide notice by electronic mail. The notification may be provided in one or more mailings as information becomes available.
- The HIPAA Compliance Officer shall utilize PRO's "Individual Notice of Breach of Unsecured PHI" when sending notice to affected parties. The Notice shall include, to the extent possible:
- A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;
- A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, or other types of information were involved);
- Any steps individuals should take to protect themselves from potential harm resulting from the breach;
- A brief description of what PRO is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and
- Contact procedures for individuals to ask questions or learn additional information about the incident from PRO. These contract procedures shall include a toll-free telephone number and an e-mail address to reach PRO's HIPAA Compliance Officer.

If the HIPAA Compliance Officer determines that affected individuals need to be contacted immediately to protect them from potential harm, the HIPAA Compliance Officer shall contact those individuals by telephone or other means as soon as possible. PRO shall still send written notice to these individuals about the incident.

If PRO knows that any affected individual is deceased and PRO has the address of the next of kin or personal representative of the individual, PRO shall provide written notification by first class mail to either the next of kin or personal representative.

If PRO has insufficient or out-of-date contact information for any affected individuals, PRO shall use a substitute form of notice that, in the informed opinion of the HIPAA Compliance Officer, will reach the individual. Substitute notice is not required in cases where there is insufficient or out-of-date contact information for the next of kin or personal representative of a deceased individual. Substitute notice will be provided in the following manner:

- If there is insufficient or out-of-date contact information for fewer than 10 affected individuals, then substitute notice may be provided by an alternative form of written notice such as placing a notice in the newspaper, calling the patient, or other means.
- If there is insufficient or out-of-date contact information for 10 or more individuals, then the substitute notice shall:
    a) Be conspicuously posted on PRO's home page of its website for 90 days, or conspicuous notice in major print or broadcast media in geographic areas where each affected individual likely resides; and
    b) Include a toll-free phone number for PRO that remains active for at least 90 days where individuals can learn whether their unsecured PHI may be included in the breach.

(5) *Breach Notification to the Media*

For a breach of unsecured PHI involving more than 500 residents of a single state or jurisdiction, PRO shall notify prominent media outlets serving the state or jurisdiction about the breach. The HIPAA Compliance Officer shall be the party in charge of making such notice and shall make such notification in consultation with PRO management and legal counsel.

Notification to the media shall be made without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.

Notification to the media shall include all information that must be included in individual notice.

(6) *Breach Notification to HHS*

PRO shall notify HHS of all breaches of unsecured PHI in accordance with this policy.

For breaches of unsecured PHI involving 500 or more individuals, PRO shall provide notice to HHS when it provides notice to affected individuals. Notice must be provided in the manner specified on the HHS Website at: https://www.hhs.gov/hipaa/for-professionals/breach-notification/index.html/. The HIPAA Compliance Officer shall be responsible for ensuring that such notice is submitted to HHS and must consult management before submitting the information to HHS.

For breaches of unsecured PHI involving less than 500 individuals, PRO shall maintain a log of such breaches and report them to HHS on an annual basis. The HIPAA Compliance Officer shall track these breaches on PRO's "Log for Tracking Breach Incidents." The HIPAA Compliance Officer shall report these breaches to HHS annually, no later than 60 days after the end of the calendar year in which these breaches were discovered. This shall be done in the manner specified on the HHS Website at: https://www.hhs.gov/hipaa/for-professionals/breach-notification/index.html/. The HIPAA Compliance Officer shall ensure that the information is submitted to HHS by March 1 of each year and must consult with management before submitting the information to HHS.

(7) *Breach Notification in Accordance with State Law*

The HIPAA Compliance Officer shall also determine, in consultation with legal counsel, whether PRO has any additional breach notification obligations under applicable Massachusetts laws or other state laws.

PRO must look to each state in which an affected individual resides when making this determination and shall consult legal counsel licensed to practice in those states.

(8) *Administrative Requirements*

The HIPAA Compliance Officer shall record and maintain thorough records of all activities related to suspected and actual breach incidents.

In the event of a suspected crime, or other unlawful activity, local, state, or federal law enforcement may need to be notified. That determination will be made by management with recommendation from the HIPAA Compliance Officer. The HIPAA Compliance Officer shall coordinate communications with outside organizations and law enforcement.

PRO will train all members of its staff so that they are able to identify suspected breaches of unsecured PHI and know to report all suspected breaches to the appropriate party immediately.

Staff members who violate this policy will be subject to disciplinary action, up to and including termination.

Pro Policy 1200.23 – HIPAA Compliance Officer Action Plan: Breach Analysis Steps

Section:	HIPAA Policy
Policy #:	1200.23
Modified:	04/15/2024
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Step 1:

Was there an acquisition, access, use or disclosure of PHI that was created, received, maintained, or transmitted by PRO? The HIPAA Compliance Officer shall determine whether PHI was actually involved in the incident, keeping in mind that PHI only includes individually identifiable information that relates to an individual's healthcare or payment for healthcare.

- YES: Go to Step 2
- NO: There has been no breach of unsecured PHI and breach notification is unnecessary.

Step 2:

Was the PHI involved in the incident "unsecured?" PHI involved in an incident will be considered to be "unsecured" when it is in electronic form, and it is not encrypted in accordance with PRO's "Policy on Encryption and Decryption of e-PHI."

- YES: Go to Step 3
- NO: If the HIPAA Compliance Officer determines that the PHI involved in the incident was secured in accordance with PRO's policies on securing hard copy and electronic PHI, then there has been no breach of unsecured PHI and breach notification is unnecessary.

Step 3:

Was there a HIPAA violation? The HIPAA Compliance Officer must make a determination that there was a violation of the HIPAA Privacy Rule. The incident must involve a use or disclosure that is not permitted by HIPAA.

- YES: Go to Step 4
- NO: There has been no breach of unsecured PHI and breach notification is unnecessary.

Step 4:

Did the incident compromise the security or privacy of the PHI involved? To determine whether the incident compromised the security or privacy of the PHI that was potentially breached, the HIPAA Compliance Officer must look to the 4-factors outlined below:

1. The nature and extent of the PHI involved.
   Consider the type and amount of PHI involved and whether the incident involved sensitive information. For example, credit card numbers, social security numbers, or other information that could be used for identity theft or financial fraud more likely compromises the security of information. The same is true for clinical information, especially detailed clinical information (e.g., treatment, medication, medical history information, etc.).

2. The person who used the PHI or to whom the disclosure was made.
   Consider whether the person who received the information has obligations to protect the information. For example, other covered entities are obligated to protect PHI that they receive in the same manner as PRO.

3. Whether the PHI was actually acquired or viewed.
   Determine whether the improperly disclosed PHI was returned before being accessed for an improper purpose.

4. The extent to which the risk to the PHI has been mitigated.
   Consider whether immediate steps were taken to mitigate the potential harm from the improper use or disclosure of the PHI.

- YES: Go to Step 5
- NO: There has been no breach of unsecured PHI and breach notification is unnecessary.

Step Five:

Does a breach exception apply? The HIPAA Compliance Officer must also determine whether one of the breach exceptions outlined in the Breach Notification Rule applies to the incident. If so, there is no reportable breach. The three breach exceptions are:

1. Unintentional Access, Acquisition or Use of PHI.
   The incident involved *unintentional* access, acquisition, or use of PHI by a workforce member of PRO or someone acting under the authority of PRO. The unintentional incident must:
   a) be made in good faith;
   b) made within the scope of employment; and
   c) not result in further improper use or disclosure of PHI.

2. Inadvertent Disclosure to an Authorized Party.
   Inadvertent disclosure between parties at PRO who are authorized to access PHI is **not** a breach if the PHI is not further used or disclosed in violation of HIPAA. "Authorized to access PHI" means that the two parties involved in the incident are authorized to access PHI *in general* – not necessarily that they are authorized to access the same type of PHI.

3. Disclosure Where Retention Was Not Possible.
   If the HIPAA Compliance Officer can demonstrate that an unauthorized recipient of the improperly disclosed PHI would not reasonably have been able to retain the PHI, this breach exception applies.

- YES: PRO does not have to make breach notification.

- NO: PRO must make breach notification in accordance with PRO's "Policy on Breaches of Unsecured Protected Health Information."

Pro Policy 1200.24 – Staff Member Access to e-PHI

Section:	HIPAA Policy
Policy #:	1200.24
Modified:	04/15/2024
Reviewed:	04/15/2024

12.24.A. Purpose

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") PRO is required to ensure that all staff members have appropriate access to e-PHI, and that his or her identity is properly verified before access to PRO's networks, systems and applications containing e-PHI can be obtained. This policy establishes procedures to prevent staff members (including former staff members) who should not have access to e-PHI from obtaining it and ensures that those who are authorized to have access to e-PHI obtain access in a secure fashion.

12.24.B. Scope

This policy applies to all PRO staff members who have access to any e-PHI that is created, received, maintained, or transmitted by PRO. The HIPAA Compliance Officer shall be responsible for ensuring proper administration of this policy.

12.24.C. Procedure

(1) *Authority to Access e-PHI*

Staff members seeking access to any network, system, or application that contains e-PHI must satisfy a user authentication mechanism such as unique user identification and password, biometric input, or a user identification smart card to verify their identity and authority to access e-PHI.

Staff members seeking access to any network, system, or application must not misrepresent themselves by using another person's User ID and password, or other authentication information.

Staff members should take reasonable steps to ensure that they verify the identity and correct address (digital or physical) of the receiving person or entity prior to transmitting e-PHI. This might include sending a "test email" or calling a party before a fax is sent.

(2) Unique User Identification

Any staff member or authorized user that requires access to any network, system, or application that creates, receives, maintains, or transmits e-PHI at PRO must be provided with a Unique User Identification Number.

When requesting access to any network, system, or application that creates, receives, maintains or transmits e-PHI at PRO, a staff member or authorized user must supply their assigned Unique User Identification in conjunction with a secure password.

If a staff member or authorized user believes their User Identification has been comprised, they must report that incident to the appropriate supervisor or the HIPAA Compliance Officer immediately.

(3) *Security Password Management*

All staff members must create a password in conjunction with their Unique User Identification to gain access to any network, system or application used to create, receive, maintain, or transmit e-PHI at PRO.

A generic User Identification and password may be utilized for access to shared or common area workstations so long as the login provides no access to e-PHI. An additional Unique User Identification and password must be supplied to access networks, systems applications and database systems containing e-PHI at PRO.

Managers of networks, systems, or applications used to create, receive, maintain, or transmit e-PHI at PRO must ensure that passwords set by staff members meet the minimum level of complexity described in this policy.

Managers of networks, systems, or applications used to create, receive, maintain or e-PHI are responsible for educating staff members about all password related policies and procedures, and any changes to those policies and procedures.

Password “aging times” (i.e., the period of time a password may be used before it must be changed) must be implemented in a manner commensurate with the criticality and sensitivity of the e-PHI contained within each network, system, application, or database.

Staff members are responsible for the proper use and protection of their passwords and must adhere to the following guidelines:

- Passwords are only to be used for legitimate access to networks, systems, or applications.
- Passwords must not be disclosed to other staff members or individuals.
- Staff members must not allow other staff members or individuals to use their password.
- Passwords must not be written down, posted, or exposed in an insecure manner such as on a notepad or posted on the workstation.
- All passwords used to gain access to any network, system, or application used to access, transmit, receive, or store e-PHI must be of sufficient complexity to ensure that it is not easily guessable.
- Passwords should be a minimum of eight characters in length.

Passwords should incorporate three of the following characteristics:

- Any lower-case letters (a-z)
- Any upper-case letters (A-Z)
- Any numbers (0-9)
- Any punctuation or non-alphanumeric characters found on a standard ASCII keyboard (! @ # $ % ^ & * ( ) _ – + = { } [ ] : ; “ ‘ | \ / ? < > , . ~ `).
- Passwords must not include easily guessed information such as personal information, names, pets, birth dates, etc.

- Passwords must not be words found in a dictionary.

(4) *Emergency Access to e-PHI and PHI*

If a system, network, or application contains e-PHI used to provide patient treatment, and the denial or strict access to that e-PHI could inhibit or negatively affect patient care, staff members responsible for electronic information systems must ensure that access to that system is made available to any caregiver in case of an emergency.

(5) *Termination of Access*

1. All supervisors will immediately notify the HIPAA Compliance Officer when a staff member has been separated from service with PRO or when the person no longer is permitted to access e-PHI on PRO's systems, networks, or applications.
2. Staff members' access to PRO's systems, networks and applications containing e-PHI will immediately be disabled on the effective date of the separation or, if still on the staff, the effective date when authorization for access to e-PHI has ended.
3. The staff member will be removed from all information system access lists.
4. The staff member will be removed from all user accounts.
5. The staff member will turn in all keys, tokens, or access cards that allow access to the information system.
6. The "Staff Member Termination Checklist" will be completed by a member of the Management Team on the last day of the staff member's authorized access.

Pro Policy 1200.25 – Contingency Planning

Section:	HIPAA Policy
Policy #:	1200.25
Modified:	04/15/2024
Reviewed:	04/15/2024

12.25.A. Purpose

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires PRO to implement a policy to ensure that we effectively protect the integrity of protected health information ("PHI") that we hold in the event of an emergency. This policy ensures that our response to an emergency or other occurrence that threatens or damages our computer, electronic, or other information systems is appropriate and provides for the contingencies necessary to protect and preserve PHI in accordance with the HIPAA.

12.25.B. Scope

This policy contains procedures for protecting the integrity of PHI (including e-PHI) and other essential patient information, billing and business information, and confidential information in the event of an emergency or other occurrence (i.e., fire, vandalism, system failure and natural disaster). The HIPAA Compliance Officer shall oversee the implementation of these procedures.

12.25.C. Procedure

(1) *Applications and Data Criticality Analysis*

PRO will assess the relative criticality of specific applications and data within the company for purposes of developing its Data Backup Plan, its Disaster Recovery Plan, and its Emergency Mode Operation Plan.

The assessment of data and application criticality should be conducted periodically and at least annually as part of the Security Risk Analysis to ensure that appropriate procedures are in place for data and applications at each level of risk.

(2) Data Backup Plan

Each functional area of PRO (Operations, Billing, Administration, etc.) will establish and implement a Data Backup Plan that ensures that each area of PRO will create and maintain retrievable exact copies of all PHI and other essential business information that is at a medium to high risk for destruction or disruption.

The Data Backup Plan must apply to all medium and high-risk files, records, images, voice, or video files that may contain PHI and other essential business information.

The Data Backup Plan must require that all media used for backing up PHI and other essential business information be stored in a physically secure environment such as a secure, off-site storage facility or cloud server. Where backup media remains on site, it will be kept in a physically secure location, different from the location of the computer systems have been backed up.

If an off-site storage facility or backup service is used, a written Business Associate Agreement must be entered into with the outside party maintaining the data to ensure that the Business Associate will safeguard any PHI and other essential business information in an appropriate manner.

Data backup procedures and contingency plan shall be tested on a periodic basis to ensure that exact copies of PHI and other essential business information can be retrieved and made available whenever it is needed.

The HIPAA Compliance Officer will ensure that each functional area of the Company with medium and high risk to PHI has an appropriate Data Backup Plan in place.

(3) *Disaster Recovery Plan*

To ensure that each functional area of PRO can recover from the loss of data due to an emergency or disaster such as fire, vandalism, terrorism, system failure, or natural disaster affecting information systems containing PHI or other essential business information, each functional area will establish and implement a Disaster Recovery Plan.

The Plan must ensure that each area can restore or recover any loss of this information and the systems needed to make that information available in a timely manner.

The Disaster Recovery Plan will include procedures to restore PHI and other essential business information from data backups in the case of a disaster causing data loss.

The Disaster Recovery Plan will include procedures to log system outages, failures, and data loss to critical systems, and procedures to train the appropriate personnel to implement the disaster recovery plan.

The Disaster Recovery Plan must be documented and easily available to the necessary personnel at all times, who should be trained to implement the Disaster Recovery Plan.

The disaster recovery procedures outlined in the Disaster Recovery Plan must be tested on a periodic basis to ensure that PHI and other essential business information and the systems needed to make e-PHI available can be fully restored or recovered.

The HIPAA Compliance Officer will ensure that each functional area of the Company with medium and high risk to PHI has an appropriate Disaster Recovery Plan in place.

(4) *Emergency Mode Operation Plan*

Each functional area of PRO must establish and implement (as needed) procedures to enable continuation of administrative, patient care, and billing and business processes for protection of the security of PHI and other essential business information while operating in emergency mode.

Emergency mode operation procedures outlined in the Emergency Mode Operation Plan must be tested periodically to ensure that critical business processes can continue in a satisfactory manner while operating in emergency mode.

The HIPAA Compliance Officer will ensure that each functional area of the Company with medium and high risk to PHI has an appropriate Emergency Mode Operation Plan in place.

Pro Policy 1200.26 – Disaster Management and Recovery of e-PHI

Section:	HIPAA Policy
Policy #:	1200.26
Modified:	04/15/2024
Reviewed:	04/15/2024

12.26.A. Purpose

PRO is responsible under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") for ensuring that we have a process in place to ensure that we can recover from the catastrophic disruption of our information system and loss of any data or information, especially electronic protected health information ("e-PHI"), which may be stored on that system. This policy will be followed in an emergency situation such as or disaster such as fire, vandalism, terrorism, system failure, or natural disaster.

12.26.B. Scope

This policy applies to all PRO staff members who create, receive, or use PHI and e-PHI, and any other confidential patient or business information. It is intended to cover all information system hardware, software, and operational procedures. The HIPAA Compliance Officer shall be the primary party in charge of disaster management and recovery.

12.26.C. Procedure

To ensure that PRO will be able to recover from a serious information system disruption, including situations that could lead to the loss of data in the event of an emergency or disaster (such as fire, vandalism, terrorism, system failure, or natural disaster) the following procedures are established:

1. A disaster recovery plan will be established and implemented to restore or recover any loss of e-PHI and any loss or disruption to the systems required to make e-PHI available.
2. The disaster recovery plan will be developed by staff members responsible for the maintenance of the security and integrity of the information system and will be reviewed and approved by the HIPAA Compliance Officer and senior management.
3. The disaster recovery plan must include:
    a) A data backup plan including the storage location of backup media.
    b) Procedures to restore e-PHI from data backups in the case of an emergency or disaster that results in a loss of critical data.
    c) Procedures to ensure the continuation of business-critical functions and processes for the protection of e-PHI during emergency or disaster situations.
    d) Procedures to periodically test data backup and disaster recovery plans.

e) Procedures to periodically perform an application and data criticality analysis establishing the specific applications and e-PHI that is necessary to maintain operation in an emergency mode.
f) Procedures to log system outages, failures, and data loss to critical systems.
g) Procedures to train the appropriate personnel to implement the disaster recovery plan.

4. The disaster recovery plan must be documented and easily available to the necessary personnel at all times.

Pro Policy 1200.27 – Physical Security of PHI and e-PHI

Section:	HIPAA Policy
Policy #:	1200.27
Modified:	04/15/2024
Reviewed:	04/15/2024

12.27.A. Purpose

PRO is obligated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to establish physical safeguards to protect electronic protected health information ("e-PHI") and other PHI. This policy establishes our security measures to protect our electronic information systems, networks and applications and as well as buildings and equipment from natural and environmental hazards, and unauthorized intrusion.

12.27.B. Scope

This policy applies to all PRO staff members. All staff members should be on the lookout for any potential problems that could jeopardize the security of electronically stored information, especially e-PHI. This policy describes our general approach to facility security and the steps necessary to prevent a breach in the physical security system in place. It also describes our general procedures to limit physical access to electronic information systems and the buildings and rooms in which they are housed, and our general procedures on disposal or reissuance of equipment containing e-PHI.

12.27.C. Procedure

(1) *Facility Access Controls*

Access to areas of our facility that contain our information system with e-PHI will be granted only to those with a verifiable and approved business need to have access.

All PRO staff members will be issued identification cards or badges for security purposes. These badges and identification must be displayed at all times while on the premises.

Access control will be established with physical hardware that prevents improper or inadvertent entry into a secure area. This hardware may include combination locks, swipe cards, smart cards and other devices on all doors housing our information system equipment.

Any space in a building that we share with another entity that contains PHI that we create, receive, maintain, or transmit will be maintained at the same level of security as if we owned the space. Specifically, we will protect that area from access by others in the building who are not part of PRO.

Disabling or circumventing any of the physical security protections is strictly prohibited. Any problems with physical security measures must be reported to the HIPAA Compliance Officer immediately.

(2) *Facility Security Plan*

The HIPAA Compliance Officer will be responsible for developing a facility security plan that protects our buildings from unauthorized physical access, tampering, and theft.

The plan will incorporate hardware to limit access to our buildings to only those persons with proper keys and/or access codes.

PRO will maintain a current list of all staff members who have authorization to access our facilities with PHI. Where appropriate, PRO will install security systems including video surveillance to protect PHI and to ensure the security of our information systems.

(3) *Access Control and Validation Procedures*

PRO has established procedures for controlling and validating a staff member's access to our facilities. Access to various areas of the facilities will be based on the role of the staff person and their need to access a particular area.

Access to locations that house our systems, networks, or applications with PHI that we create, receive, maintain, or transmit will have the greatest limitations on access, and access to these critical areas will be reviewed frequently by management and the HIPAA Compliance Officer.

(4) *Maintenance Records*

To help ensure that our physical security systems are in continuous operation, PRO has developed a maintenance program for all security devices, including locks, keypads, and other access devices.

Any repairs or change outs of any security devices will be recorded.

(5) *Workstation Security and Use*

A "workstation" is defined as any electronic computing device, such as a desktop computer, laptop computer, mobile electronic device or any other device that is used to create, receive, maintain, or transmit PHI.

All workstations (including fixed locations such as in our billing or business office and mobile workstations such as with portable electronic devices for field use) should be password protected so that they may not be accessed without authentication by an authorized user.

All workstations are set up to lock out after a set time period so that if the staff member is no longer using the workstation for a set period of time, access will not be permitted without the proper password.

Procedures are established for each work area, depending on the nature of the work area to limit viewing of workstation device screens to only those operating the workstation wherever possible.

- In office areas, all screens should be pointed away from hallways and open areas. The screens should be pointed away from chairs or other locations where non staff members, such as patients, may be.
- In field operations, ambulance personnel will need to follow procedures to ensure that the devices are not left in an open area, such as a countertop in the Emergency Department.

Workstations will be set so that staff members may not inadvertently change or disable security settings or access areas of the information system they are not authorized to access.

Only those authorized to access and use the workstation will be permitted to use the workstation.

No software may be downloaded or installed on the workstation in any manner without prior authorization. (This prohibition includes computer games, screen savers, and anti-virus or anti-spam programs).

All staff members will log out or lock workstations whenever they are left unattended or will not be in use for an extended period of time.

All portable workstation devices will be physically secured wherever possible when not in use. Laptops will be locked with security cables and other mobile devices will be locked physical locations or in an appropriate storage compartment when not in use.

Remote access to access e-PHI on our information system must be approved by PRO.

(6) *Disposal of Hardware and Electronic Media Devices and Media Controls*

PRO carefully monitors and regulates the receipt and removal of hardware and electronic media that contain PHI and other patient and business information into and out of our stations and other facilities.

As a general rule, simple deletion of files or folders is not sufficient to ensure removal of the file or data. This simply removes the directional "pointers" that allow a user to find the file or folder more readily. Deleted files are usually completely retrievable with special software and computer system expertise.

PRO has in place the following procedures governing the disposal of hardware, electronic media, and e- PHI stored on hardware and other electronic media:

- Sanitizing Hard Disk Drives. All hard disk drives that have been approved by the HIPAA Compliance Officer for removal and disposal (or taken out of active use) shall be sanitized so that all programs and data have been removed from the drive. PRO will follow industry best practices (such as the U.S. Department of Defense clearing and sanitizing standard – DoD 5220.22-M) when cleaning off hard drives.

Proper sanitizing usually involves a reformatting of the hard drive in a secure manner with an approved wipeout utility program. Degaussing software may need to be used to ensure total removal of files.

No hard drive will be reissued, sold, or otherwise discarded until the drive has been sanitized.

- Media Re-Use. All e-PHI and other patient and business information shall be removed from any media devices before they are made available for reuse.

- Accountability. PRO tracks the movement of all computer hardware, workstations, and data storage devices. Movement both within the organization and outside the organization is tracked.

- Data Backup and Storage. Each information system area will create an exact copy of all e-PHI, when necessary, immediately prior to any movement or disposal. This procedure is in addition to the standard routine backup protocol to ensure that all e-PHI is preserved before potential compromise.

- Destruction of Paper and Electronic PHI. When destroying and/or permanently removing PHI from electronic media for any purpose, PRO shall adhere to HHS's "Guidance Specifying the Technologies and Methodologies That Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals." In accordance with that Guidance, paper, film, or other hard copy media shall be shredded or destroyed such that the PHI cannot be read or otherwise reconstructed. Electronic PHI is considered to be destroyed or permanently removed from electronic media when the media that contain the PHI have been cleared, purged, or destroyed consistent with "NIST Special Publication 800–88, Guidelines for Media Sanitization," such that the electronic PHI cannot be retrieved. (NIST Special Publication available at: nist.gov).

Pro Policy 1200.28 – Electronic Information System Activity Review and Auditing

Section:	HIPAA Policy
Policy #:	1200.28
Modified:	04/15/2024
Reviewed:	04/15/2024

12.28.A. Purpose

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires PRO to monitor and audit its electronic information system used to create, receive, maintain, or transmit electronic protected health information ("e-PHI") so that quality assurance procedures will detect and address problems with the system. PRO needs to identify the specific actions that have taken place such as timing and completion of back-up procedures, tracking server file access, and tracking power interruptions and other unusual events that could compromise our system and threaten the integrity of e-PHI.

12.28.B. Scope

This policy applies to all PRO staff members who are responsible for monitoring and maintaining our electronic information system or are responsible for its security. The policy also applies to staff members assisting with the audit and review process. The HIPAA Compliance Officer shall have overall responsibility for monitoring, maintaining, and overseeing the security of our electronic information system and conducting audits.

12.28.C. Procedure

The HIPAA Compliance Officer will develop procedures to document the creation, receipt, maintenance, and transmission of e-PHI within the information system.

The HIPAA Compliance Officer will review the records of information system activities, including a review of audit logs, security incident tracking reports, back-up records, etc., as necessary.

Uses and disclosures need not be documented for purposes of an audit trail if the use is made entirely within the internal information system and the use did not involve any outside parties.

Disclosures that are required to be accounted for under HIPAA shall be recorded and tracked. Generally, all non-patient authorized disclosures that are not related to treatment, payment and healthcare operations will be accounted for. An accounting of these disclosures must include:

1. The date of the disclosure;
2. The name and address of the organization or person receiving the disclosure (if known);
3. A brief description of the PHI disclosed; and

4. A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure.

Pro Policy 1200.29 – Third Party Access to e-PHI

Section:	HIPAA Policy
Policy #:	1200.29
Modified:	04/15/2024
Reviewed:	04/15/2024

12.29.A. Purpose

PRO is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to control access to our physical locations, such as stations, buildings, garages and offices, vehicles, and secured areas where our electronic protected health information ("e-PHI") is stored as well as system hardware, software, or other mobile electronic devices that are used to create, receive, maintain, or transmit e-PHI. This policy outlines our approach to limiting third party access to our e-PHI while at the same time, permitting authorized access in the event that our contingency plan is operation.

12.29.B. Scope

This policy applies to all PRO staff members who control third party access to our e-PHI and systems, hardware and mobile electronic devices used to create, receive, maintain, or transmit e-PHI. It is intended to cover all physical locations that house our information system hardware, software and related devices and equipment that are utilized to create, receive, maintain, or transmit e-PHI at PRO.

12.29.C. Procedure

(1) *Access During Contingency Operations*

The HIPAA Compliance Officer will work with individuals who manage electronic information systems to determine contingency plans and procedures that should be implemented in the event of the need to restore lost data and to maintain uninterrupted access to e-PHI.

The HIPAA Compliance Officer will identify outside parties who have permission to access our electronic systems and secured areas in the event that restoration and preservation of data is necessary.

The HIPAA Compliance Officer will work with management to develop a "call list" of persons who need immediate notification when the contingency plan is in operation.

(2) *Facility Security*

The HIPAA Compliance Officer will work with management to determine what outside parties, in general, should have access to e-PHI and the electronic information system and determine the extent of that access.

The HIPAA Compliance Officer will maintain an inventory of all software, hardware and mobile electronic devices used to create, receive, maintain, or transmit e-PHI at PRO. That inventory should include:

- A unique identification number for hardware and other devices that are part of the electronic information system.
- A file to catalog all software, hardware, and mobile electronic devices with their unique identification numbers.

Any discrepancies in the current inventory of software, hardware and mobile electronic devices will be reported to management and will be investigated to ensure that there is a proper accounting of all items and to determine whether further action may need to be taken in response to the loss of an item (*e.g., breach notification in the event of a breach of unsecured PHI*).

If PRO implements keypad access to physical facilities, the HIPAA Compliance Officer will ensure that access codes are changed or disabled when staff members leave.

There will be measures at the entrance to PRO's facility and at key access points that require personal identification, so that only authorized parties gain access to areas where e-PHI can be accessed. These procedures will be reviewed periodically to ensure only authorized persons with a legitimate purpose for access actually have access to the facility or secured area.

(3) *Access Control and Validation*

The HIPAA Compliance Officer will maintain a list of all third parties with approved access to e-PHI and the electronic information system. This list will include names of approved vendors and other outside parties who have permission to access our facilities and secure areas.

Software testing and other maintenance or service of the electronic information system will be carefully monitored by the HIPAA Compliance Officer to ensure that only necessary e-PHI is accessed and that e- PHI is not being improperly used or disclosed.

PRO will ensure that only approved parties with a legitimate need to access our electronic information system are granted access. If outside parties need physical access to an area with e-PHI, they must present valid credentials (such as a driver's license and business card or badge).

(4) *Maintenance Records*

The HIPAA Compliance Officer will ensure that all repairs and maintenance to the electronic information system hardware, software and mobile electronic devices is properly logged and documented.

The repair or maintenance records will contain, at a minimum:

- Name of person completing the maintenance or repair;
- Purpose of the maintenance or repair;
- Name of person at PRO authorizing the maintenance or repair;
- Date and time the work started and ended; and
- Brief description of the work completed and the outcome of it (more work required, alternative procedure to put in place, etc.)

The HIPAA Compliance Officer will periodically review the documentation of maintenance and repairs to determine trends or changes in procedures to e-PHI security that should be made.

(5) *Accountability*

PRO shall have a way to record the addition or removal of any hardware, software, or mobile electronic devices to or from our electronic information system.

No hardware, software or mobile electronic devices will be added to the electronic information system without notifying the HIPAA Compliance Officer. The HIPAA Compliance Officer shall review any additions and ensure that any addition will comply with PRO's HIPAA Policies and Procedures.

To maintain security and to help prevent viruses from attacking our information system, no downloads or software additions are permitted without approval of management and only after consultation with the HIPAA Compliance Officer.

Pro Policy 1200.30 – Creating Backups of e-PHI

Section:	HIPAA Policy
Policy #:	1200.30
Modified:	04/15/2024
Reviewed:	04/15/2024

12.30.A. Purpose

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires PRO to back up and preserve all e-PHI created, received, used, and stored by PRO in the event of an emergency or disaster. This policy outlines the procedures for preserving and protecting e-PHI and other important business information from tampering, theft, fire, flood, and other physical damage. Key to this process is the proper replication of exact copies of data in a secondary system so that if the primary system fails, the data will be completely preserved and accessible.

12.30.B. Scope

This policy applies to all e-PHI created, received, maintained, or transmitted by PRO. Creating backups will be the responsibility of the manager in charge of the particular electronic equipment for his/her area of responsibility, in close coordination with the HIPAA Compliance Officer. This policy applies to all electronic equipment and devices that are used to create, receive, maintain, or transmit e-PHI at PRO. This policy applies to all staff members and vendors or contracted parties who are responsible for completing backups of PRO's e-PHI.

12.30.C. Procedure

(1) *Physical Access Controls*

All backup systems will be located in a secure area, with limited access so that only those with responsibility for the backup system will have access to it.

Servers, backup drives and other data and information saving hardware will be located in a locked room.

Only authorized parties will have access to a physical location where backup devices are stored.

(2) *Backup Schedule*

Data and information stored on any computers or electronic devices will, at a minimum, be backed up at sufficient intervals to ensure that critical data (especially PHI) can be restored and recovered immediately. A full system backup will be completed at least monthly.

PRO will verify that the backups are successfully completed at the end of each backup process to ensure that a complete replication of the data and information backed up has actually been created.

(3) *Backup Schedule Logs*

The backup software will capture a list of all files and directories encountered and saved. Logs will be maintained and will contain information about successful backups, unsuccessful backups, backup media that was left in place and overwritten, when and where the media was sent or transmitted off-site, the success or failure of restore tests and bad media encountered which may affect our ability to obtain files from a previous backup.

A primary and secondary staff member will be assigned to rotate the media used for backups if PRO backs up e-PHI with physical media. This staff member will track the following information:

- Whether the backup was successful;
- Date and time the backup began and the date and time it was completed;
- Description of any problems encountered during the backup; and
- Verification that a check was made to ensure that the backup was complete.

(4) *Marking and Storage of Backup Media*

All backup disks, drives, tapes, or other physical backup media will be legibly and clearly marked that it is a backup, the date and time the backup was completed, and the initials of the staff member who completed the backup.

All backup tapes, drives and other physical storage media should be stored at a secure off-site location to ensure the preservation of all but the most recent data and information in the event of a catastrophic fire, flood, or other damage to the primary backup location. The media must be transported in a secure manner by a supervisor or other official. PRO may contract with a reputable vendor to manage its backup process and media storage. The vendor must execute a business associate agreement with PRO to ensure that the vendor will, among other things, protect the integrity of the data stored and protect it from improper use or disclosure. Security access controls implemented at the off-site backup and storage location must meet or exceed the security access controls of the source systems. In other words, information security at the backup storage location must equal or exceed the security where the primary computers and servers are located.

PRO may electronically backup PHI to a cloud server if PRO obtains a business associate agreement from the server agency and all PHI is maintained in a manner that enables PRO to meet is HIPAA compliance obligations.

(5) *Data Retention*

Full system backups will be copied and/or archived.

Archived backups must be periodically tested to ensure that they are recoverable.

(6) *Documentation*

The backup restore and recovery processes must be documented by the HIPAA Compliance Officer.

(7) *Storage of Media Other Than Backups*

Old hard drives or other media storage devices that have been removed from the information system will be handled as follows:

- If the device is to retain PHI, it will be stored in the same fashion as the backup devices.
- If the device is to be taken out of service and no longer used to store PHI, it shall be "sanitized" and erased prior to disposal in accordance with PRO's "Policy on Physical Security of PHI and e- PHI."

(8) *Emergency Contact Information*

PRO will maintain a list of designated staff to be contacted in an emergency. A copy of this list will be kept in a secure location at the main facility and the off-site backup location (if applicable). The list must be kept up to date and readily accessible in case of an emergency. The list will also include vendor contact and support information and contacts for the off-site media storage location.

Pro Policy 1200.31 – Encryption of e-PHI

Section:	HIPAA Policy
Policy #:	1200.31
Modified:	04/15/2024
Reviewed:	04/15/2024

12.31.A. Purpose

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires PRO to consider encryption as a method for securing our electronic protected health information ("e-PHI") and to implement a mechanism to encrypt and decrypt e-PHI if PRO determines that doing so is reasonable and appropriate. Further, encrypting e-PHI consistent with the Department of Health and Human Services' ("HHS") "Guidance Specifying the Technologies and Methodologies That Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals" will create the equivalent of a "safe harbor" for PRO in the event that there is a breach of PRO's PHI. It is the policy of

PRO to use encryption consistent with HHS's Guidance wherever possible, as outlined in this policy.

12.31.B. Scope

This policy applies to all PRO staff members who are responsible for the manner in which e-PHI is created, received, maintained, or transmitted by PRO. The HIPAA Compliance Officer, in conjunction with appropriate information technology professionals, shall be responsible for implementing appropriate mechanisms to encrypt e-PHI consistent with this policy.

12.31.C. Procedure

The HIPAA Compliance Officer shall, on a periodic basis, meet with appropriate parties, such as management, information technology professionals, software vendors, and others, to discuss the steps necessary to encrypt all e-PHI that PRO creates, receives, maintains, or transmits consistent with HHS's Guidance at: http://www.hhs.gov/ocr/privacy.

The HIPAA Compliance Officer shall review or refer appropriate parties to the National Institute of Standards and Technology ("NIST") Special Publications referenced in this policy (available at: www.nist.gov) so that PRO implements appropriate technologies and methodologies to secure e-PHI as prescribed in the Publications.

The HIPAA Compliance Officer shall also annually review HHS's updated Guidance (available at: http://www.hhs.gov/ocr/privacy) for any additional resources referenced by HHS and ensure that those resources are furnished to appropriate parties.

Whenever possible, PRO shall convert all paper and hard copy PHI into electronic format and then secure it consistent with encryption methods outlined in this policy. Paper or other hard copy PHI should be scanned or otherwise converted into digital format and then the original hard copy should be

shredded or destroyed in a manner that ensures that the PHI can no longer be read or otherwise reconstructed. If PRO utilizes an outside agency to shred, destroy or digitize paper and hard copy PHI, PRO shall enter into a business associate agreement with that outside party.

All e-PHI created, received, maintained, or transmitted by PRO must be encrypted through the use of an algorithmic process that transforms data into a form in which there is a low probability of assigning meaning without use of a confidential process or key. All encryption keys must be stored in a different location than the data which it is meant to decrypt. PRO shall adhere to the following guidelines when encrypting PHI data in various forms:

- PHI at Rest. For PHI data that is "at rest," (*i.e.,* PHI in databases, file systems, stored on flash drives, electronic device memory, and other structured storage methods), PRO shall utilize encryption processes that are consistent with NIST Special Publication 800-111, "*Guide to Storage Encryption Technologies for End User Devices*." (available at www.nist.gov)
- PHI in Motion. For PHI data "in motion," (*i.e.,* PHI that is being transmitted through a network, wireless transmission, email, or other electronic transmission), PRO shall utilize encryption processes that comply with the requirements of Federal Information Processing Standards ("FIPS") 140–2. These include standards described in NIST Special Publications 800–52, "*Guidelines for the Selection and Use of Transport Layer Security (TLS) Implementations*;" Special Publication 800–77, "*Guide to IPsec VPNs*;" or Special Publication 800–113, "*Guide to SSL VPNs*," and may include others which are FIPS 140–2 validated. (NIST Special Publications available at: www.nist.gov).

Pro Policy 1200.32 – Security Incident Management

Section:	HIPAA Policy
Policy #:	1200.32
Modified:	04/15/2024
Reviewed:	04/15/2024

12.32.A. Purpose

The Health Insurance Portability and Accountability Act ("HIPAA") requires PRO to track and appropriately respond to all incidents that could compromise our electronic protected health information ("e-PHI"). This policy establishes PRO's procedures for reporting a security incident and the steps that will be taken by PRO to investigate and take action when a potential or actual security incident occurs.

12.32.B. Scope

This policy applies to all PRO staff members who utilize the electronic information system. Everyone at PRO is responsible to know what to do when confronted with a security incident. The Security/Breach Incident Reporting Form should be used in conjunction with this policy.

12.32.C. Procedure

(1) *Security Incident Defined*

A "security incident" is an attempted or successful unauthorized entry, breach, or attack on the electronic information system that we use to create, receive, maintain or transmit e-PHI. Security incidents include unauthorized probing and browsing of the files, a disruption of service in our information system and incidents where e-PHI has been improperly altered or destroyed. Security incidents also include things such as a virus, hacking attempt or incident, "phishing" incident, malware installation, corrupt data or other similar incident involving PRO's information system.

(2) *Reporting a Security Incident*

All staff members are responsible for immediately reporting a suspected security incident immediately to the HIPAA Compliance Officer or an immediate supervisor.

When a suspected security incident occurs, the HIPAA Compliance Officer shall have the reporting staff member and other members with knowledge of the incident complete PRO's "Internal Breach/Security Incident Reporting Form."

The HIPAA Compliance Officer will be responsible for initiating an immediate investigation to isolate the problem and take whatever action is necessary to protect the information system and e-PHI and other vital electronic information.

The HIPAA Compliance Officer will notify management immediately in the event the incident cannot be immediately corrected, or if any e-PHI or other vital information is altered or destroyed. Management will also be notified of any completed investigation and the outcome of the investigation.

In the event of unlawful activity via the use of PRO's information system, local, state, or federal law enforcement may be notified. That determination will be made by management with recommendation from the HIPAA Compliance Officer. The HIPAA Compliance Officer is responsible for coordinating communications with outside organizations and law enforcement.

Whenever a security incident is suspected or confirmed to have occurred, remedial action will be taken, including action against any individual staff members when it has been confirmed that they caused or contributed to the incident.

(3) *HIPAA Compliance Officer Responsibility*

The HIPAA Compliance Officer is responsible for the following:

1. Initiating the appropriate incident management action, including restoration.
2. Determining the physical and electronic evidence to be gathered as part of the incident investigation.
3. Monitoring that any damage from a security incident is repaired or mitigated and that the vulnerability is eliminated or minimized where possible.
4. Determining if a widespread communication is required, the content of the communication, and how best to distribute the communication.
5. Communicating new issues or vulnerabilities to the system vendor and working with the vendor to eliminate or mitigate the vulnerability.
6. Initiating, completing, and documenting the incident investigation.
7. Determining whether the incident may qualify as a breach of unsecured PHI requiring breach notification under PRO's "Policy on Breaches of Unsecured Protected Health Information."

Pro Policy 1200.33 – Staff Member Electronic Communications

Section:	HIPAA Policy
Policy #:	1200.33
Modified:	04/15/2024
Reviewed:	04/15/2024

12.33.A. Purpose

PRO is required under the Health Information Portability and Accountability Act of 1996 ("HIPAA") to ensure that protected health information ("PHI") that we create, receive, maintain, or transmit is not improperly disclosed through any means, including electronic means. The purpose of this policy is to prevent the improper use or disclosure of PHI through electronic means, while staff members are on and off-duty.

12.33.B. Scope

This policy covers any and all electronic communications of PRO staff members when those communications involve the use or disclosure of PHI created, received, maintained, or transmitted by PRO. This policy applies to all staff members both on and off duty, whether using company or personal equipment.

12.33.C. Procedure

(1) *General Rules Regarding Company Equipment*

All PHI created, received, maintained, or transmitted using any "Company Equipment" is at all times the property of PRO and may be considered to be part of the official records of PRO. "Company Equipment" is any electronic device that is owned, leased, controlled, or used for the benefit of PRO. This includes, but is not limited to computers, cell phones, cameras, USB drives, and other devices that are capable of creating, capturing, storing, and/or transmitting electronic information.

All Company Equipment shall remain at all times the property of PRO, even if being used for personal use.

PRO cannot guarantee the confidentiality of information stored on any Company Equipment, except that it will take all steps necessary to secure the privacy of all PHI in accordance with all applicable laws. Information stored on Company Equipment is subject to disclosure to law enforcement or other third parties at the sole discretion of PRO.

PRO may monitor activity on Company Equipment, our information systems, and our network(s) at any time for the purpose of ensuring that PHI is not being improperly used or disclosed. This includes the ability to monitor internet activity and email, as permitted by law.

All internet activity (browsing, email, etc.) using Company Equipment must comport with PRO's HIPAA Policies and Procedures and staff members may not disclose PHI on the internet using

Company Equipment unless the disclosure is authorized by PRO, would not violate HIPAA or other applicable federal and state laws, and the disclosure is for a legitimate, business-related purpose. For example, emailing demographic information about a patient to a patient's insurer for purposes of billing may be a permissible use.

(2) *General Rules Regarding Personal Equipment*

Staff members must comply with PRO's HIPAA Policies and Procedures when engaging in internet activity on "Personal Equipment," both on and off-duty. "Personal Equipment" includes any internet- capable device that is not owned, leased, or otherwise controlled or used for the benefit of PRO.

Where permitted by law to do so, PRO will investigate internet activity, whether on or off-duty, and take appropriate disciplinary action against staff members whenever PRO learns about a possible or actual violation of our HIPAA Policies and Procedures.

Staff members should consult with the HIPAA Compliance Officer whenever there is a question regarding whether an internet posting, or internet activity might violate our HIPAA Policies and Procedures.

The following types of activities are prohibited at all times and can result in disciplinary action:

- Posting, sharing, or otherwise disseminating any PHI relating to PRO patients without authorization from PRO.
- Posting, sharing or otherwise disseminating information that could potentially identify a patient, including photos, videos or other images of a scene or patient; a description of patient injuries, or; other scene activities that could be identified with a specific scene without authorization from PRO.

(3) *Use of Company Electronic Mail*

PRO's email is intended to be used as a tool to facilitate communications on behalf of PRO.

All email transmissions that originate from PRO staff members on Company email must contain, at a minimum, a signature section that contains the following information:

- The sender's full name;
- PRO's name;
- The telephone number of PRO; and
- An approved notice and disclaimer.

Below the signature section, the following notice and disclaimer must appear on all transmissions from PRO staff members in at least 10-point font:

CONFIDENTIALITY NOTICE: This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential, proprietary, and/or privileged information protected by law. If you are not the intended recipient, you may not use, copy, or distribute this e-mail message or its attachments. If you believe you have received this e-mail message in error, please contact the sender by reply e-mail and telephone immediately and destroy all copies of the original message.

(4) *Facsimile Transmissions Using Company Fax Machine*

PRO's fax machine is intended to be used as a tool to facilitate communications and the exchange of information, including patient information that is needed to perform our services.

All outgoing facsimile transmissions using the Company fax machine must contain a cover sheet that includes at a minimum, the following information:

- The name of PRO;
- The name of the intended recipient;
- The name of the sender;
- Facsimile number of the recipient;
- Telephone number of the sender;
- Date of the transmission;
- The number of pages in the transmission; and
- An approved notice and disclaimer.

At the bottom of the facsimile cover sheet, the following notice and disclaimer must appear in at least 10-point font:

Confidentiality Notice: This facsimile transmission is confidential and is intended only for the review of the party to whom it is addressed. It may contain proprietary and/or privileged information protected by law. If you are not the intended recipient, you may not use, copy, or distribute this facsimile message or its attachments. If you have received this transmission in error, please immediately telephone the sender above to arrange for its return.

(5) *Images and Videos That May Contain PHI*

Staff members are strictly prohibited from capturing any images or videos that could potentially identify a patient PHI while on duty without the express permission of a supervisor. Staff members may carry a personal electronic device (such as a cell phone) that is capable of capturing images; but staff members must adhere to our HIPAA Policies and Procedures when using the device and the device may never be used to capture PHI (unless expressly permitted by a supervisor). No other personal electronic devices that function as a camera and/or video recorder shall be carried by staff members while engaged in any work activities.

Staff members may only capture images or video while on-duty with a company-issued device and only for legitimate business-related purposes. Staff members must be authorized by PRO to capture images or video while on duty.

Images or videos taken with Company Equipment may only be disseminated in accordance with PRO's HIPAA Policies and Procedures and all such images and videos are the sole property of PRO.

Any images or videos that might identify a patient may not be posted on the internet without the express approval of PRO.

Pro Policy 1200.34 – Staff Member Medical Records

Section:	HIPAA Policy
Policy #:	1200.34
Modified:	04/15/2024
Reviewed:	04/15/2024

12.34.A. Purpose

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires PRO to treat protected health information ("PHI") contained in the medical records of our staff members with the same degree of protection as the PHI of our other patients. This policy provides guidance to management and staff concerning the privacy and security of PRO staff member medical records.

12.34.B. Scope

This policy applies to PHI of all staff members, and it applies equally to management and non-management staff members.

12.34.C. Procedure

(1) *Distinguishing PHI and Employment Records*

Health information that is obtained about staff members in the course of providing ambulance or other medical services directly to them is considered to be PHI under HIPAA.

Health information that PRO receives in its role as an employer is not considered to be PHI. Rather, the information is an employment record to which PRO does not have an obligation to extend HIPAA protections. For example, if a staff member submits a doctor's statement to a member of the Management Team to document an absence or tardiness from work, PRO does not need to treat that statement as PHI. Other health information that could be treated as an employment record, and not PHI, includes:

- Medical information that is needed for PRO to carry out its obligations under the FMLA, ADA and similar laws;
- Information related to occupational injury, disability insurance eligibility, drug screening results, workplace medical surveillance, and fitness-for-duty-tests of employees.

(2) *General Policy Regarding Staff Member's PHI*

1. PRO will, to the extent required by law, protect, use, and disclose PHI it receives about staff members in accordance with HIPAA and our HIPAA Policies and Procedures.

2. Only those with a legitimate need to use or disclose PHI about staff members will have access to that information.

3. In accordance laws concerning disability discrimination, all medical records of staff will be kept in separate files apart from the employee's general employment file. These records will be secured, used, and disclosed in accordance with applicable laws.

(3) *General Policy Regarding Employment Records*

1. Employment records are not considered to be PHI. As such, PRO is not required to protect, use and disclose employment records in accordance with HIPAA.
2. Employment records that are not covered under HIPAA include, but are not limited to:
3. Information obtained to determine suitability to perform the job duties (such as physical examination reports);
4. Drug and alcohol tests obtained in the course of employment;
5. Doctor's excuses provided in accordance with the attendance policy;
6. Work-related injury and occupational exposure reports; and
7. Medical and laboratory reports related to such injuries or exposures, especially to the extent necessary to determine workers' compensation coverage.
8. Despite the fact that PRO is not required to protect, use and disclose employment records in accordance with HIPAA, PRO will limit the use and disclosure of these records to only those necessary to perform business-related functions authorized by law. PRO will also secure all employment records of staff members and ensure that only staff members with a legitimate need to have access to them, such as certain management staff, PRO's designated physician and state agencies pursuant to state law, have access to employment records.

Pro Policy 1200.35 – Releasing PHI to Family Members and Others

Section:	HIPAA Policy
Policy #:	1200.35
Modified:	04/15/2024
Reviewed:	04/15/2024

12.35.A. Purpose

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") permits PRO to release protected health information ("PHI") about patients to family members, friends and others involved in the treatment of the patient or payment for that treatment. This policy outlines our procedures for releasing PHI to family members and others involved in our patients' care.

12.35.B. Scope

This policy applies to all PRO staff members who receive requests from family members, friends and others for PHI of patients of PRO. This policy does not apply to formal requests from patients or their personal representatives for: access to PHI; amendment of PHI; restriction of PHI; accounting of disclosures of PHI; or confidential communications. This policy shall apply to requests for PHI from family members of the patient or others who do not qualify as the patient's personal representative, but who are involved in the patient's care or payment for that care.

12.35.C. Procedure

(1) General Procedure for Releasing PHI to Family Members and Others

HIPAA permits PRO staff members to release PHI that is directly relevant to the patient's care or payment for care to family members, friends and others involved in a patient's care, or payment for that care, whenever releasing PHI to that individual would be in the best interest of a patient. PRO may also use or disclose PHI to notify family members or others about a patient's location, general condition, or death.

If an individual other than the patient or the patient's personal representative makes a request for PHI from a PRO staff member, the staff member shall first determine whether the patient about whom the request pertains to is present, competent, and able to make healthcare decisions.

If the patient is present, competent, and able to make healthcare decisions, the staff member should obtain the patient's agreement to share the requested PHI with the individual or give the patient an opportunity to object. The staff member may ask the patient whether it is okay to talk to the individual and release PHI to them. Or the staff member can simply infer from the circumstances that the patient does not object to sharing the information with the individual. For example, if the patient's neighbor asks to ride along in the ambulance and the patient smiles, the staff member could infer that the patient is fine with the neighbor riding along and overhearing any PHI that is discussed. Or, if the staff member starts asking the patient about his or her medical history and the

patient motions for a family member to come over, the staff member can infer that the patient wants the staff member to speak with the family member about his or her medical history.

If the patient is unavailable or unable to make medical decisions because of a physical or mental reason at the time of the request, then the staff member may only disclose PHI to the requestor if the requestor is involved with the patient's treatment or payment for the patient's treatment and the staff member believes that releasing PHI to the requestor is in the best interests of the patient. First, the staff member should ask the requestor what his or her relationship is to the patient. Then, the staff member should determine whether disclosure of PHI to the requestor would be in the best interest of the patient. In making this determination, the staff member should consider things such as:

- Who the requestor is and what the requestor's relationship is to the patient;
- Whether the requestor appears to have a legitimate interest in the patient's care or payment for that care; and
- Whether the staff member believes that the patient would want that requestor to know the PHI or whether the patient would benefit from the requestor knowing the PHI.

If the patient is deceased, a staff member may release relevant PHI to family members and others who were involved in the deceased patient's care prior to death or payment for care, unless doing so would be inconsistent with any prior expressed preference of the patient. The staff member should only disclose PHI that is relevant to the requestor's involvement with the patient's care prior to death or payment for that care.