FIELD TO HOSPITAL COMMUNICATION

I. **Offline Medical Control:** These are the written Region XI Standing Medical Orders (SMOs)/Policies & Procedures that establish guidelines for prehospital patient care.

A. EMS providers will initiate care in accordance with these guidelines

B. EMS providers should determine the appropriate hospital to contact for each patient encounter as defined below

II. **Field to Hospital Communication:** For each patient encounter as defined below, EMS providers should provide a field to hospital communication report. Reports shall be categorized as:

A. "**Online Medical Control**" for medical, trauma, or refusal calls requiring Base Station contact and/or medical direction, or

B. "**Pre-notification**" for calls that do not require Base Station contact.

III. **Online Medical Control (OLMC)**: Base Station contact is required for: 1) Medical direction in Regionalized Systems of Care patients or complex patient care situations or 2) Situations not clearly defined by the Region XI Policies & Procedures as needed by the EMS provider.

A. Goal: To provide immediate medical direction to the EMS provider for situations where patient care or destination may be impacted.

B. Hospital staffing requirements: OLMC calls will only be answered by trained ECRNs or ECPs at Region XI Resource or Associate Hospitals

C. Communication method: OLMC calls will be made through the MED Channels or cellular lines and all contact will be recorded

D. Report format: The radio report should follow the Online Medical Control Report (OLMC) format (See Outline for Radio Report A.4) and be presented in a clear and concise manner.

E. OLMC Assignments: Providers should directly contact the receiving hospital if it is a Region XI Base Station or contact their assigned Resource or Associate Hospital. If the contact is unsuccessful:

1. Attempt to contact the next closest Resource/Associate Hospital.

2. All attempts at contact must be documented in the patient care report.

3. Notification of a communication problem must be made to the Resource/Associate Hospital and the ambulance service provider's supervisor on duty after arriving at the receiving hospital.

F. Situations requiring OLMC contact include, but are not limited to:

1. Regionalized Systems of Care transports including patients with:
   a. Acute coronary syndrome and STEMI criteria
   b. Suspected acute stroke
   c. Trauma Field Triage Criteria (Steps 1-4)
   d. Ventricular Assist Device (VAD)
   e. Obstetric related complaint

2. Cardiac Arrest
   a. For patients in whom resuscitation is initiated, OLMC should be consulted before moving the patient. OLMC is required in making the decision to continue on-scene resuscitation, transport, or terminate resuscitation.
   b. Patients that meet criteria for withholding resuscitation (see Initiation or Withholding of Resuscitative Measures Policy B.5) do not require OLMC consultation (i.e. DOA).

3. Complex patient care situations and/or questions regarding the appropriate destination. For example:
   a. Any patient potentially requiring a Level 1 Trauma Center, but not clearly meeting Trauma Field Triage Criteria
   b. Patients with possible acute coronary syndrome or stroke symptoms that may not meet defined criteria for specialty center transport
   c. Patients potentially requiring diversion for critical airway stabilization

4. Refusals of care (as defined in the Consent/Refusal of Service Policy B.12)

5. Bypass: Transportation to a hospital on bypass

6. Multiple Patient Incidents: For situations with multiple patients such as an EMS Plan response, EMS may request assistance with patient distribution from the Resource Hospital.

7. Pediatric patients: Pediatric ALS transports should be called in to OLMC, all other pediatric transports require pre-notification.

8. Patient care situations not defined by protocols: Advanced life support (ALS) patients where EMS providers encounter a situation not clearly defined by the Region XI Protocols and Policies.

The base station is an available resource for any situation as requested by the EMS provider

IV. **Pre-Notification**: EMS should contact the receiving hospital directly for ALS transports in situations where the Region XI Standing Medical Orders/Protocols have been followed.

A. Goal: To provide direct communication between EMS providers and the receiving hospital for straightforward BLS or ALS patient transports.

B. Hospital staffing requirements: All pre-notification calls shall be answered by receiving hospital personnel trained at minimum of Registered Nurse (RN).

C. Communication method: Pre-notification reports should be given through a hospital's dedicated telemetry line if the hospital is a Resource/Associate Hospital within Region XI (or another Region). Contact may also be through a dedicated EMS telephone line or MERCI radio if the participating hospital does not have a telemetry line.

D. Report format: The radio report should follow the 'Pre-Notification Report' format (see Outline for Radio Report A.4) and be presented as a brief, clear report that provides pertinent information to the receiving hospital staff.

E. If there is a concern about patient treatment and/or transport, a non-Region XI Base Station receiving hospital may ask the EMS provider to call their assigned base station for online medical control direction.

F. No medical direction will be given by non-Region XI Base Station hospitals receiving pre-notification reports.

G. EMS should provide a pre-notification call for any BLS patient that may require an immediate bed upon Emergency Department arrival (for example: patients with spinal immobilization or who are unable to sit in a wheelchair or chair).

H. Any concern about patient care or transport destination should be reported to the Resource Hospital through a Request for Clarification (RFC) form.

Attachment 1: Outline for Radio Report

Written: 1988
Reviewed: 10/92; 10/94; 11/2/95; 1/96; 3/00; 12/06; 4/07; 3/10; 5/11; 8/15; 9/17
Revised: 10/92; 10/94; 1/96; 3/00; 12/06; 4/07; 6/10; 8/15; 11/17
MDC Approval: 1988; 11/5/92; 11/03/94, 11/2/95; 6/13/96; 3/00; 12/4/07; 6/1/10; 11/21/17
IDPH Approval: 1988; 11/16/92; 11/18/94; 9/17/96; 5/00; 10/24/08; 11/24/10; 2/25/16; 12/21/17
Implementation: 1/1/89; 9/1/93; 3/1/95; 12/1/96; 10/00; 3/1/11; 3/1/16; 8/1/18

OUTLINE FOR RADIO REPORT

I. Pre-Notification Report

A. Identify agency and number
B. State "This is a pre-notification report."
C. Age and sex
D. Chief complaint
E. Vital signs
F. "Routine protocols followed"
G. Additional details that may be needed for the receiving hospital to prepare for the patient
H. Destination and ETA

II. Online Medical Control (OLMC) Report

A. Use the I-SBAR mnemonic

B. **Identify**
   1. Agency
   2. Number
   3. Level of care (BLS, ALS, Critical Care)

C. Situation
   1. State primary reason for call (For example: "*We have a STEMI, Stroke, Trauma, Cardiac Arrest, or Refusal call for Online Medical Control*")

D. Background
   1. Age and sex
   2. History including:
      a. Medical: brief history of present illness, including time of onset of symptoms for patients with suspected acute stroke
      b. Trauma: description of the mechanism of injury
      c. Pertinent past medical history
      d. Medications applicable to circumstance
   3. Allergies, if applicable to circumstance

E. Assessment
   1. Vital signs including:
      a. Level of consciousness and orientation
      b. Blood pressure
      c. Pulse and rhythm
      d. Respiratory rate and degree of distress
      e. Pulse oximeter
   2. Pertinent physical findings
      a. Medical assessment including Cincinnati Stroke Scale (CSS) for patients with suspected acute stroke
      b. Trauma assessment findings

F. Rx(Treatment)/Response/Request

1. Treatment initiated
    a. Procedures performed
    b. Medications given
    c. ETCO2 if advanced airway/cardiac arrest
    d. Computer interpretation of 12-lead ECG (when obtained)
2. Patient response to treatment and reassessment
3. Request medical direction from ECRN/ECP as needed
4. Destination and ETA

Written: 7/86
Reviewed: 1/92; 10/95; 1/01; 6/07; 3/10; 5/11; 3/12; 10/14; 8/15; 9/17
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IDPH Approval: 8/86; 11/16/92; 2/20/96; 4/01; 10/24/08; 11/24/10; 5/4/12; 5/20/15; 12/21/17
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