MIDSTATE EMERGENCY MEDICAL SERVICES

Basic EMT Blood Glucose Packet

☐ *Midstate Blood Glucose Policy / Procedure*

☐ *Midstate Application for Blood Glucose Monitoring*

☐ *Midstate EMT Blood Glucose Skill Sheet*

☐ *Agency Medical Director Verification (DOH 4362)*

☐ *Wadsworth Lab Application (DOH 4081)*

☐ *NYS DOH Policy Statement 12-01*

MIDSTATE REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL

PROUDLY SERVING ONEDIA HERKIMER AND MADISON COUNTIES

New York State Department of Health Bureau of Emergency Medical Services (NYS DOH BEMS) Policy Statement 05-04 allows the use of Glucometers by Basic Life Support Agencies and Providers to check patient blood glucose levels. This approval was given under the conditions that the EMS service wishing to use a glucometer at the BLS level, be granted approval by the local REMAC., each EMT complete an approved training program and the service apply and be granted a Limited Laboratory Registration. To provide this additional care, a BLS Agency must complete the following items and be approved by the REMAC before allowing BLS providers to perform this skill.

1. **Complete the Limited Laboratory Registration form (DOH-4081), Send DOH-4081 including registration fee to:**

NYS DOH
Wadsworth Center
Clinical Laboratory Evaluation Program
PO Box 509
Albany, NY 12201-0509

Develop written Agency Policies and Procedures to include:

i. **Didactic and psychomotor objectives for training of authorized users including who will be authorized to conduct this training.**
ii. **ii. Notice to the EMS Agency Physician of the use of the glucometer.**
iii. **Quality Assurance program, to include appropriateness review by Agency Medical Director.**
iv. **Documentation of control testing process.**
v. **Storage and proper disposal of sharps.**
vi. **Training documentation and attendance records of authorized users.**

2. **Submit to the Midstate REMAC**
    1. **Completed *Midstate REMAC Application for BLS Agency to Perform Blood Glucose Monitoring Agency***
    2. **Limited Service Laboratory Registration DOH-4081 and authorization number received from DOH**
    3. **Copy of Policies and Procedures as outlined above**
    4. **Letter of recommendation from Agency Medical Director**
    5. **Medical Director Verification form (DOH-4362)**

PURPOSE:
Establish a uniformed procedure to determine a safe and effective manner for Basic EMT's to determine Blood Glucose levels in the Pre-Hospital Setting

EDUCATION

All Basic EMT's will be required to attend Agency specific training sessions utilizing glucometer used by the Agency. The provider complete and the Agency maintain records of didactic and skills completion.

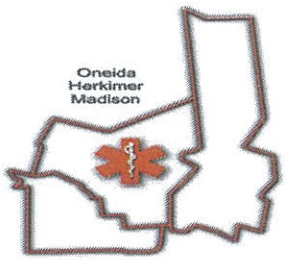
QUALITY

The Agency will designate an individual who will complete and maintain records of quality control testing.

PROCEDURE

- **When a Patient presents with an altered mental status request ALS intercept.**
- **Follow NYS DOH BEMS protocol for the General Approach to Medical Emergencies prioritizing and managing Airway, Breathing, Circulation.**
- **Obtain a complete set of vital signs**
- **Check Blood Glucose and place lancet in an approved sharps container.**
- **If Blood Glucose is greater than 80 mg/dl and the patient has an altered mental status, confirm ALS is enroute and monitor A, B, C's.**
- **If hypoglycemic (blood glucose less than 80 mg/dl) and awake (A or V on AVPU) with the ability to maintain their airway; administer oral glucose consistent with NYS BLS Protocol. Repeat vital signs and AVPU after 5 minutes.**
- **If completely alert and oriented, request medical control approval to cancel ALS.**
- **Continue going assessment consistent with current BLS protocols.**

DO NOT DELAY TRANSPORT!



MIDSTATE REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL

PROUDLY SERVING ONEDIA HERKIMER AND MADISON COUNTIES

Midstate REMAC
BLS Agency Blood Glucose Application

Agency Name _____ Agency Code _____

Address _____
Mailing Address City Zip

Contact _____ Title _____ Limited Lab Reg # _____

Representative responsible for BLS Glucose Testing Care:

Name _____ Contact Phone # _____

Agency QA/QI Coordinator:

Name _____ Phone / email _____

_____ request authorization from the Midstate REMAC to permit
Agency

BLS providers to perform Blood Glucose testing in compliance with NYS BLS Protocol and Midstate Policy Statement. Attached to this application are the following items;

- Agency Medical Director request
- Completed NYS Department of Health Clinical Laboratory Limited Laboratory Registration application for blood testing licensure (DOH-4081) ○ Copies of written Policies and Procedures for the operation of the glucometer that are consistent with local protocols and as described in NYS DOH BEMS Policy 09-13.

As CEO of the above agency, I agree to the requirements set forth in the Midstate REMAC Policy Statement on blood glucose monitoring and will be responsible to assure that Agency providers follow the Regional protocols. I also agree that all Blood Glucose monitor operators will successfully complete the required training with and approved instructor and that documentation of this training will be submitted to the Regional QA/QI Coordinator at least yearly.

Name _____
Print Name

_____ _____
Signature Date

Date submitted _____

REMAC _____ Approval

MIDSTATE EMS BLOOD GLUCOMETRY

BASIC EMT SKILL SHEET

PASS	*FAIL*

EMT Name	*EMT #*	*EMS Agency*
Evaluator (Print)	*Date*	*Evaluator Signature*

Takes or describes body substance isolation precautions	C	
Able to identify all equipment used	1	
Prepares equipment according to manufacturer's recommendations	C	
Safely obtains blood sample	1	
Applies blood to glucometer per manufactures recommendations	C	
Places direct pressure over finger site	1	
Reads and record glucometer results	C	
Disposes of sharps appropriately	C	
Provides appropriate treatment based	C	
Assess patient's response to interventions	1	

NOTE: Provider must complete all critical criteria and receive at least 3 points to pass

4	

New YORK STATE DEPARTMENT OF HEALTH Bureau of Emergency Medical Services and Trauma Systems

Medical Director Verification

Please identify the physician providing Quality Assurance oversight to your individual agency. If your agency provides Defibrillation, Epi-Pen,
Blood Glucometry, Albuterol or Advance Life Support (ALS), you must have specific approval from your Regional EMS Council's Medical Advisory Committee (REMAC) and oversight by a NY state licensed physician. If you change your level of care to a higher ALS level, you must provide the NYS DOH Bureau of EMS a copy of your REMAC's written approval notice.

If your service wishes to change to a lower level of care, provide written notice of the change and the level of care to be provided, and the effective date of implementation, to your REMAC with a copy to the NYS DOH Bureau of EMS.

If your agency has more than one Medical Director, please use copies of this verification and indicate which of your operations or REMAC approvals apply to the oversight provided by each physician. Please send this form to your DOH EMS Central Office for filing with your service records.

☐ Defibrillation / PAD ☐ Epi Autoinject ☐ Albuterol ☐ Blood Glucometry ☐ Naloxone

☐ CPAP ☐ Check and Inject ☐ 12 Lead ☐ Ambulance Transfusion Service (ATS)

☐ EMT Level of Care ☐ AEMT Level of Care ☐ Critical Care Level of Care ☐ Paramedic Level of Care ☐ Controlled Substances (BNE License on File)

Agency Name _____

Agency Code Number _____ Agency Type: ☐ Ambulance ☐ ALSFR ☐ BLSFR

Agency CEO Name _____

Medical Director Name _____

NYS Physician's License Number _____

Ambulance/ALSFR Agency Controlled Substance License # if Applicable: 03C – _____

Ambulance/ALSFR Agency Controlled Substance License Expiration Date: _____

I affirm that I am the Physician Medical Director for the above listed EMS Agency. I am responsible for oversight of the pre-hospital Quality Assurance/Quality Improvement program for this agency. This includes medical oversight on a regular and on-going basis, in-service training and review of Agency policies that are directly related to medical care.

I am familiar with applicable State and Regional Emergency Medical Advisory Committee treatment protocols, policies and applicable state regulations concerning the level of care provided by this Agency.

If the service I provide oversight to is not certified EMS agency and provides AED level care, the service has filed a Notice of Intent to Provide Public Access Defibrillation (DOH-4135) and a completed Collaborative Agreement with its Regional EMS Council.

Medical Director

Signature _____

Date of Signature _____

NEW YORK STATE DEPARTMENT OF HEALTH Wadsworth Center
Clinical Laboratory Evaluation Program
Empire State Plaza, P.O. Box 509
Albany, New York 12201-0509
Telephone: (518) 402-4253 Fax: (518) 449-6902
E-mail: CLEPLtd@health.ny.gov
Web: www.wadsworth.org/regulatory/clep/limited-service-lab-certs

FOR OFFICE USE ONLY: I____ R____
*Rec'd.*_____
*Fee No.*_____
PFI: _____ *Gaz Code:* _____
CLIA No:
_____

INITIAL LIMITED SERVICE LABORATORY REGISTRATION APPLICATION

Please follow the instructions carefully since the submission of incomplete applications will delay the processing and issuance of the registration. **NOTE: You must enclose a $200.00 application fee payment with your application. Your check or money order should be made payable to:** New York State Department of Health. **This fee is non-refundable.**

1. CLIA STATUS AND APPLICATION TYPE:

If your laboratory already has a CLIA number, please indicate here:
_____

Type of Limited Service Laboratory Registration Requested (Select One):
Single-Site Registration
Multi-Site Registration (if you wish to add secondary testing sites, please complete form, DOH-4081MS)

If this is a new facility, indicate the projected opening date:
_____

2. GENERAL INFORMATION: ***(Note: If applying for a multi-site registration, complete this information for the primary site).***

Laboratory Name (Limited to 70 Characters):	*Federal Employer ID Number:*
	County/Borough:

Laboratory Address (Physical Location of Laboratory):

City:	*State:*	*ZIP Code:*

Mailing Address (If Different From Physical Location):

City:	*State:*	*ZIP Code:*

Telephone Number:	*FAX Number:*	*Contact Person Name (If Not the Laboratory Director):*
Laboratory E-mail Address:		*Telephone Number:* *E-mail Address:*

Indicate the Days & Hours when testing will be performed (Please clarify hours as AM and/or PM):

MO _____ *to* _____ *TU* _____ *to* _____ *WE* _____ *to* _____ *TH* _____ *to* _____

FR _____ *to* _____ *SA* _____ *to* _____ *SU* _____ *to* _____

Indicate whether your laboratory or laboratory network will perform off-site community screening events: *No* *Yes*

3. LABORATORY TYPE: *Select one from the list below that best describes your laboratory.*

01-24 Ambulance	14-01 Hospital
02-3B Ambulatory Surgery Center	15-11 Independent
03-02 Ancillary Testing Site in Health Care Facility/ Hospital Extension Clinic	16-12 Industrial* (Indicate Bureau License Number: _____)
04-25 Assisted Living Facility	17-13 Insurance
05-26 Blood Bank	18-14 Intermediate Care Facility for the Mentally Retarded
06-3A Community Clinic	19-15 Mobile Laboratory
07-04 Comprehensive Outpatient Rehabilitation Facility	20-16 Pharmacy
23-06 Correctional Facilities	21-19 Physician Office
08-3C End Stage Renal Disease Dialysis Facility	22-20 Practitioner Other
09-3D Federally Qualified Health Center	24-27 Public Health Laboratory
10-08 Health Fair	25-3D Rural Health Clinic
11-07 Health Maintenance Organization	26-17 School/Student Health Service
12-08 Home Health Agency	27-18 Skilled Nursing Facility or Nursing Facility
13-09 Hospice	28-28 Tissue Bank/Repositories
	29-99 Other (Indicate): _____

4. OWNERSHIP INFORMATION: *List the name and address of the individual, partnership or corporation owning or operating the laboratory or laboratory network. "Address of Principal Office" refers to the address of the principal office of the corporation, partnership or government entity, which owns or operates the laboratory or laboratory network.*

Type of Control/Ownership (Check Only One Box From the List Below):

For-Profit (indicate):	Individual	Partnership	Corporation	
Not-For-Profit (indicate):	Religious Affiliation	Private		
Government (indicate):	City	County	State	Federal

Name of Owner (if Sole Proprietorship) or Corporation:

Street Address of Principal Office of Owner (if Sole Proprietorship) or Corporation:

City:	State:	ZIP Code:

This Facility: A small business is defined as one, which is located in New York State, independently owned and operated, and employs 100 or fewer individuals. This includes all employees, both technical and non-technical.

Is a small business *Is not a small business*

5. AFFILIATION: *If your laboratory is affiliated with a laboratory holding a NYS laboratory permit, provide the name, address, and NYS laboratory permit PFI Number (if known). Do not provide the name and PFI Number of your reference laboratory.*

PFI Number:	Name of Affiliated Laboratory:

Street Address:

City:	State:	ZIP Code:

6. MANAGEMENT: *If the laboratory testing performed on-site in your facility is provided under a management or consulting contract, indicate the name, and address of the company you contract with to perform this testing. Do not provide the name and PFI Number of your reference laboratory.*

Name of Management/Consulting Company:

Street Address:

City:	State:	ZIP Code:

7. LABORATORY DIRECTORSHIP: *Complete this section in its entirety for the individual providing technical and clinical direction of your laboratory testing.*

First Name:	M.I.:	Last Name:

Do you currently hold a NYS Laboratory Director Certificate of Qualification?

Yes (Indicate CQ Code): _____ *No*

Check Degree(s) and License(s) Held (Include a Copy of Current New York State Professional License):

M.D. *D.O.* *D.D.S.* *Ph.D.* *O.D.* *D.Sc.* *NP* *PA* *CNM*

Indicate New York State Professional License Number: _____

Indicate whether the Laboratory Director is employed at the laboratory on a full-time or part-time basis (Select One):

Director Status: *Full-Time* *Part-Time*

8. WAIVED TEST PROCEDURES REQUESTED: *Check off all waived tests that you intend to perform and indicate the estimated annual test volume for all waived tests to be performed.*

Adenovirus *Erythrocyte Sedimentation Rate (ESR)* *Occult Blood* *Aerobic/Anaerobic Organisms-Vaginal*
Ethanol *Ovulation Tests*

Alanine Aminotransferase (ALT)	*Follicle Stimulating Hormone (FSH)*	*pH*
Albumin	*Fructosamine*	*Phosphorous*
Alkaline Phoshatase (ALP)	*Gamma Glutamyl Transferace (GGT)*	*Platelet Aggregation*
Amylase	*Glucose*	*Potassium*
Aspartate Aminotransferase (AST)	*Glycosylated Hemoglobin*	*Pregnancy Test (Urine)*
B-Type Natriuretic Peptide (BNP)	*HDL Cholesterol*	*Protime*
Bacterial Vaginosis, Rapid	*Helicobacter Pylori*	*RSV (Respiratory Syncytial Virus)*
Bladder Tumor Associated Antigen	*Hematocrit*	*Saliva Alcohol*
Blood Urea Nitrogen (BUN)	*Hemoglobin*	*Sodium*
Breath Alcohol (FDA OTC Devices Only)	*HCV, Rapid*	*Strep Antigen Test (Rapid)*
Calcium	*HIV, Rapid*	*Thyroid-Stimulating Hormone (TSH)*
Calcium, Ionized	*Influenza*	*Total Bilirubin*
Carbon Dioxide	*Ketones*	*Total Protein*
Catalase (Urine)	*Lactic Acid (Lactate)*	*Trichomonas, Rapid*
Chloride	*LDL Cholesterol*	*Triglycerides*
Cholesterol	*Lead (*Submit Protocol w/App.)*	*Urinalysis*
Creatine Kinase (CK)	*Microalbumin*	*Other:* _____
Creatinine	*Mononucleosis*	
Drugs of Abuse	*Nicotine*	

Indicate the combined estimated annual test volume for <u>all</u> Waived Test Procedures indicated above:

9. PROVIDER-PERFORMED MICROSCOPY (PPM) PROCEDURES REQUESTED: *Check off all PPM Procedures that you intend to perform. NOTE: Only providers (physicians, nurse practitioners, nurse midwives and physician assistants) may perform testing.*

Direct wet mount preparations for the presence or absence of cervical bacteria, fungi, parasites, and human cellular elements

Fecal Leukocyte examinations

Fern tests

Nasal smears for granulocytes

Pinworm examinations

Post-coital direct, qualitative examinations of vaginal or mucous

Potassium hydroxide (KOH) preparations

Qualitative semen analysis (limited to the presence/absence of sperm and detection of motility)

Urine sediment examinations

	Indicate the combined estimated annual test volume for <u>all</u> PPM Procedures indicated above:

10. CERTIFICATION. ***I understand that by signing this application form, I agree to any investigation made by the Department of Health to verify or confirm the information provided herein or adjunctive to this application, and any investigation in connection with my laboratory registration, a complaint or incident report made known to the Department. Registration under this subdivision may be denied, limited, suspended, revoked or annulled by the Department upon a determination that a laboratory services registrant: (i) failed to comply with the requirements of this subdivision; (ii) provided services that constitute an unwarranted risk to human health; (iii) intentionally provided any false or misleading information to the Department relating to registration or performing laboratory services; or (iv) has demonstrated incompetence or shown consistent errors in the performance of examinations or procedures. If additional information is requested, I will provide it. Further, I understand that, should this application or my status be investigated at any time, I agree to cooperate in such an investigation.***

Laboratory test registrants shall: (i) provide only the tests and services listed on the registration issued by the Department hereunder; (ii) advise the Department of any change in the registrant's name, ownership, location or qualified health care professional or laboratory director designated to supervise testing within thirty days of such change; (iii) provide the department with immediate access to all facilities, equipment, records, and personnel as required by the Department to determine compliance with this subdivision; (iv) comply with all public health law and federal requirements for reporting reportable diseases and conditions to the same extent and in the same manner as a clinical laboratory; (v) perform one or more tests as required by the department to determine the proficiency of the persons performing such tests; and (vi) designate a qualified health care professional or qualified individual holding a certificate of qualification pursuant to section five hundred seventy-three of this title, who shall be jointly and severally responsible for the testing performed.

By signing this application, I hereby attest that the information I have given the Department of Health as a basis for obtaining a Limited Service Laboratory Registration is true and correct, that I have read the relevant rules and regulations, and that I accept responsibility for the tests indicated in Section(s) 8. Waived Test Procedures Requested and/or 9. Provider-Performed Microscopy (PPM) Procedures Requested of this application.

Print Name of Laboratory Director	***Signature of Laboratory Director***	***Date***
Print Name of Person Completing this Form	***Signature of Person Completing this Form***	***Date***

SPECIAL NOTICE

The submission of incomplete and/or incorrect application materials will delay processing. Required information includes, but is not limited to the following:

- $200.00 Application Fee (*Volunteer Ambulances Services Refer to Page - 1 of the Instructions*);
- A Working E-Mail Address;
- A Copy of Laboratory Director's Current New York State Professional License;
- Estimated Annual Test Volumes for Waived and/or PPM Procedures;
- Name & Original Signature of Laboratory Director and Individual Completing Application. Signature stamps will <u>not</u> be accepted.

Blood Glucometry and Nebulized Albuterol

Bureau of EMS Policy Statement	
Policy Statement #	12-01
Date	January 10, 2012
Subject	Blood Glucometry and Nebulized Albuterol
Supercedes/Updates	09-13

BACKGROUND

The New York State Emergency Medical Advisory Committee (SEMAC) has approved the use of glucometers and nebulized albuterol by Emergency Medical Technicians (EMT) who are employees/volunteers of an EMS agency (i.e. ambulance service, ALS-FR, BLS-FR). The SEMAC approval was granted with the specific condition that the EMS agency wishing to use a glucometer or nebulized albuterol, be granted approval by the Regional Emergency Medical Advisory Committee (REMAC), that each EMT from that EMS agency complete a REMAC approved training program, and that the EMS agency be granted a Limited Service Laboratory Registration (for blood glucometry only).

The purpose of this policy is to explain the approval process for EMS agencies wishing to implement a nebulized albuterol and/or blood glucometry program.

- Prehospital blood sugar evaluation is intended to assist in the recognition of hypoglycemia and improve the speed with which proper treatment is received.
- Nebulized albuterol, when administered under the Statewide BLS Adult and Pediatric Treatment Protocols has been shown to decrease respiratory distress in patients between one and sixty-five years of age who are experiencing an exacerbation of their previously diagnosed asthma.

AUTHORIZATION FOR BLOOD GLUCOMETRY AND/OR NEBULIZED ALBUTEROL

Each REMAC will adopt protocols which will allow an EMT to obtain a blood sample, using a lancet device or equivalent, and test the blood sample in a commercially manufactured electronic glucometer. The REMAC will determine the type and level of record keeping and quality assurance required for both blood glucometry and/or nebulized albuterol. Please note that a protocol for nebulized albuterol has been approved by SEMAC and is included in the Statewide BLS Adult and Pediatric Treatment Protocols for EMT-B and AEMT.

To be authorized to use an electronic glucometer or nebulized albuterol, the EMS agency must make written request to the appropriate REMAC. The request must include, but not necessarily be limited to, the following items:

- A letter from the EMS agency physician medical director supporting the request and indicating an understanding of their role in the Clinical Laboratory requirements (blood glucometry only) and quality assurance process.
- A completed NYS Department of Health Clinical Laboratory Evaluation Program Limited Service Laboratory Registration Application (form DOH-4081) for blood testing licensure (blood glucometry only).

- Written policies and procedures for the operation of the glucometer and storage and maintenance of nebulized albuterol that are consistent with applicable Regional and State protocols. These policies and procedures shall include, but not necessarily be limited to the following:
    - didactic and psychomotor objectives for training of authorized users including who will be authorized to conduct this training;
    - documentation and attendance records of the training of authorized users;
    - a defined quality assurance program, including appropriateness review by the EMS agency physician medical director;
    - documentation of control testing process (blood glucometry only);
    - written policies and procedures for storage of the glucometer and/or nebulized albuterol, and proper disposal of sharps devices (blood glucometry only);
    - notice to the EMS agency physician medical director of the use of the glucometer and/or nebulized albuterol, and;
    - requirements for documentation when the glucometer and/or nebulized albuterol is used for patient care.

LIMITED LABORATORY REGISTRATION FOR BLOOD GLUCOMETRY

New York State Public Health Law requires that any EMS agency testing blood glucose, whether by electronic glucometer or chemstrip, be required to possess a **Limited Service Laboratory Registration**. In order to obtain the Registration, EMS agencies must complete and submit the following document:

- Limited Service Laboratory Registration Application (form DOH-4081)

Information and application materials are available at:

- http://www.wadsworth.org/labcert/limited/index.htm

No EMS agency may engage in the testing of blood glucose without a Limited Service Laboratory Registration Certificate.

NOTIFICATION

Once the EMS agency has received written approval for blood glucometry and/or nebulized albuterol from the REMAC, the EMS agency must provide BEMS with an updated and signed Medical Director Verification Form (form DOH-4362), indicating the Limited Laboratory Registration permit number (if applicable) and authorization by the EMS agency physician medical director.

Issued and authorized by the Bureau of EMS Acting Director