



Mountain-Valley

Emergency Medical Services Agency

PLEASE POST

REGIONAL ADVISORY COMMITTEE
Wednesday, September 15, 2010 at 1:00 P.M.

Saddle Creek Resort
1001 Saddle Creek Drive
Copperopolis, California
(Map Enclosed)

NOTICE: FOR MEMBERS ONLY, LUNCH WILL BE SERVED AT 12:00 P.M.
PLEASE RSVP TO TINA CASIAS AT (209)529-5085, OR, tcasias@mvemsa.com BY
SEPTEMBER 13, 2010

(No Subcommittee Meetings)

AGENDA

Any member of the audience desiring to address the committee on a matter on the agenda: Please raise your hand at the time the item is announced by the Committee Chairperson. In order that all interested parties have an opportunity to speak, any person addressing the Committee will be limited to a maximum of 5 minutes unless the Chairperson of the Committee grants a longer period of time.

Public comment periods: Matters under the jurisdiction of the Committee, and not on the posted agenda, may be addressed by the general public at the beginning of the regular agenda and any off-agenda matters before the Committee for consideration. However, California law prohibits the Committee from taking action on any matter which is not on the posted agenda unless it is determined to be an emergency by the Committee. Any member of the public wishing to address the Committee during the "Public Comment" period will be limited to a maximum of 5 minutes.

ACTION	1.	Call to Order
	2.	Welcome and Introduction of Members and Guests
INFO	3.	Conflict of Interest Statements/Fair Political Practices: <i>RAC members will be reminded that they should recuse themselves during any discussion concerning a topic of which they may have a conflict of interest.</i>
INFO	4.	Public Comment
ACTION	5.	Acceptance/Additions/Deletions to Agenda
INFO	6.	Correspondence/Information <i>No correspondence has been received this period.</i>

INFO/ACTION	7.	Approval of May 19, 2010 Minutes (Attachment #1) <i>July 15th Meeting Cancelled (No Minutes)</i>
INFO/ACTION	8.	Policy for Review: (Attachment #2) <ul style="list-style-type: none"> a. 256.00 Paramedic Scope of Practice b. 261.00 MICN Authorization c. 404.00 Response to Ground Ambulance Requests d. 405.00 Ground Ambulance Staffing e. 406.00 Cancellation or Reduction of EMS System Response f. 408.00 Mark 1 Provider Agency g. 418.00 AED Service Providers h. 431.00 ALS Ground Ambulance Authorization i. 511.00 Receiving Facility Criteria j. 543.00 Mutual Aid and Coordination k. 544.00 Trauma System Fees l. 546.00 Trauma Center Designation Process m. 546.10 Trauma Bypass Policy n. 549.10 Trauma Marketing and Advertising o. 552.64 Mark 1 Kit Administration p. 554.40 Poisoning/Ingestion/OD Adult q. 555.63 Frostbite – Pediatric r. 555.81 Burns – Pediatric s. 555.82 Traumatic Shock – Pediatric t. 555.83 Traumatic Cardiac Arrest – Pediatric u. 555.84 Head-Neck-Facial Trauma – Pediatric v. 555.85 Chest Trauma – Pediatric w. 555.86 Abdominal Trauma – Pediatric x. 555.87 Extremity Trauma – Pediatric y. 555.88 Medication Chart – Pediatric z. 570.30 Physician on Scene aa. 580.31 Trauma Patient Transfer and Transportation bb. 580.32 Coordination with HMOs and Other Managed Care Organizations cc. 850.00 MCI Field Ops dd. 853.00 Altered Standard of Care ee. 910.10 Alpine County Specific Emergency BLS Ambulance Policy ff. 922.20 Dispatch of First Responders in Amador County
INFO/ACTION	9.	2010 EMS Plan Recommendation for Board Approval (Attachment #3)
INFO	10.	Agency/County Reports
INFO/ACTION	11.	Next Meeting Date /Time <i>Wednesday, November 17, 2010</i>
ACTION	12.	Adjournment

REGIONAL ADVISORY COMMITTEE MEETING
May 19, 2010
Minutes

Location: Saddle Creek Resort
Copperopolis, California

Time: 1:00 p.m.

Committee Members Present William Schmielt, Calaveras County; Jesse Figueroa, Mariposa County; Suzanne Turpin, Mariposa County; Michael Skinner, Stanislaus County; Cindy Woolston, Stanislaus County

Committee Members Absent: Brian Kirk, Amador County; Alan McNany, Amador County; Drew Hood, Amador County; Don Zyski, Calaveras County; Mildred Zyski, Calaveras County;

Guests:

Staff: Richard Murdock – Interim Deputy Director; Patrick Murphy - Field Liaison

1. CALL TO ORDER

The meeting was called to order by Chairman Skinner at 1:00 p.m.

2. WELCOME AND INTRODUCTION OF MEMBERS AND GUESTS

Committee members and guests introduced themselves.

3. CONFLICT OF INTEREST STATEMENTS/FAIR POLITICAL PRACTICES

Chairman Skinner reminded Committee members to recuse themselves if they have a financial interest in matters before the Committee.

4. PUBLIC COMMENT

There were no comments from the public.

5. ACCEPTANCE/ADDITIONS DELETIONS TO AGENDA

M/S/C (S. Turpin/B. Schmeit) To approve agenda as submitted

VOTE: Unanimous

MOTION PASSED

6. CORRESPONDENCE/INFORMATION

Richard Murdock read the correspondence from the Mariposa County Board of Supervisors Clerk regarding reappointment of Jesse Figuero, Suzanne Turpin, and Nanette Wardle to the Regional Advisory Committee with a term that expires on January 5, 2012.

7. APPROVAL OF March 17, 2009 MINUTES

M/S/C (S. Turpin/J. Figueroa) To approve minutes of March 17, 2010

VOTE: Unanimous. Bill Schmeitt abstained for he was not in attendance at the March 17, 2010 Meeting

MOTION PASSED

8. POLICIES FOR REVIEW

Richard Murdock gave clarification on the following policies:

Policy 555.51 is a consolidated policy termed “Pediatric General Poisonings” therefore policies 555.53, 555.54, and 555.56 were consolidated into one policy.

Policy 938.50 (Calaveras Co. Fireline Paramedic Authorization/Procedures) was approved as an “emergency” policy by the Calaveras County Emergency Medical Oversight Committee in order to be implemented prior to fire season. Dr. Mackey approved.

M/S/C (C. Woolston/S. Turpin) To approve all policies, which are listed on the May 19, 2010 as “a-v, z, and aa”, with the deletion of Policies 555.53, 555.54, and 555.56, which are listed as “w, x, and y”.

VOTE: Unanimous

MOTION PASSED

9. EMS PLAN UPDATE (EMS Plan due to State EMSA by Oct. 21, 2010)

Richard Murdock informed Committee members of his intention to update the EMS Plan by October 21, 2010, as requested by the EMS Authority. He asked that Committee members bring a copy of the previous year’s EMS Plan back to the Counties they represent, if needed, in order to incorporate any changes that may be needed.

10. AGENCY/COUNTY REPORTS

EMS Agency

Richard Murdock reported that Dr. Mackey will not be renewing his contract with the EMS agency, which expires June 30, 2010. The agency will be recruiting for a new medical director.

Amador County

No report

Calaveras County

Richard Murdock reported that the contracts with American Legion Ambulance and Ebbetts Pass FD have been approved by the Board of Supervisors.

Mariposa County

Jesse Figueroa reported that Mercy Ambulance is getting on board with the 12-Lead EKG and on the first of the month, CPAP will be introduced.

Stanislaus County

Cindy Woolston reported that AMR has moved their operations to a newer facility located at 4846 Stratos Way, Modesto.

11. NEXT MEETING DATE/TIME

The next meeting is scheduled for July 21, 2010 at 1:00 pm.

12. ADJOURNMENT

M/S/C (B. Schmielt/S. Turpin) To adjourn the meeting

Vote: Unanimous

ATTACHMENT #2

The following policies are up for review/approval by RAC:

- a. 256.00 Paramedic Scope of Practice
- b. 261.00 MICN Authorization
- c. 404.00 Response to Ground Ambulance Requests
- d. 405.00 Ground Ambulance Staffing
- e. 406.00 Cancellation or Reduction of EMS System Response
- f. 408.00 Mark 1 Provider Agency
- g. 418.00 AED Service Providers
- h. 431.00 ALS Ground Ambulance Authorization
- i. 511.00 Receiving Facility Criteria
- j. 543.00 Mutual Aid and Coordination
- k. 544.00 Trauma System Fees
- l. 546.00 Trauma Center Designation Process
- m. 546.10 Trauma Bypass Policy
- n. 549.10 Trauma Marketing and Advertising
- o. 552.64 Mark 1 Kit Administration
- p. 554.40 Poisoning/Ingestion/OD Adult
- q. 555.63 Frostbite – Pediatric
- r. 555.81 Burns – Pediatric
- s. 555.82 Traumatic Shock – Pediatric
- t. 555.83 Traumatic Cardiac Arrest – Pediatric
- u. 555.84 Head-Neck-Facial Trauma – Pediatric
- v. 555.85 Chest Trauma – Pediatric
- w. 555.86 Abdominal Trauma – Pediatric
- x. 555.87 Extremity Trauma – Pediatric
- y. 555.88 Medication Chart – Pediatric
- z. 570.30 Physician on Scene
- aa. 580.31 Trauma Patient Transfer and Transportation
- bb. 580.32 Coordination with HMOs and Other Managed Care Organizations
- cc. 850.00 MCI Field Ops
- dd. 853.00 Altered Standard of Care
- ee. 910.10 Alpine County Specific Emergency BLS Ambulance Policy
- ff. 922.20 Dispatch of First Responders in Amador County

APPROVED: Signature On File In EMS Office
Executive Director

Signature On File In EMS Office
Medical Director

EFFECTIVE DATE 8/24/2009
SUPERSEDES:
REVISED: 07/2009
REVIEW DATE: 07/2014
PAGE: 1 of 4

EMERGENCY MEDICAL TECHNICIAN-PARAMEDIC SCOPE OF PRACTICE

I. AUTHORITY

Division 2.5, California Health and Safety Code, sections 1797.206; 1797.214; 1797.218; 1797.220 and; 1797.221. Title 22, California Code of Regulations, sections 100144 and 100145.

II. DEFINITIONS

A. "Emergency Medical Technician I" or "EMT-I" means a person who has successfully completed an EMT-I course which meets the requirements of Title 22, California Code of Regulations, Chapter 2, and who is certified as an EMT-I in the state of California.

~~B.~~ "Emergency Medical Technician Paramedic" or "EMT-P" or "Paramedic" or "Mobile Intensive Care Paramedic" means an individual who is educated and trained in all elements of prehospital advanced life support, who is licensed by the state of California as a paramedic and accredited by the Agency Medical Director.

~~B.~~ "Altered Standard of Care" means a level of medical care delivered to individuals under conditions of duress, such as after a disaster or when medical supplies are insufficient for demand for emergency care.

~~C.~~ "Medical/Health Operational Area Coordinator (MHOAC)" means the Public Health Officer and local EMS Agency Administrator or designee who is responsible, in the event of a disaster or major incident where mutual aid is requested, for obtaining and coordinating services and allocation of resources within the Operational Area (county) border.

III. PURPOSE

To define the Emergency Medical Technician-Paramedic scope of practice approved for use within the Mountain-Valley EMS Agency member counties.

IV. POLICY

A. An EMT-P may perform any activity identified in the scope of practice of an EMT-I or EMT-II.

B. As part of the State approved basic scope of practice, an EMT-P student or an accredited EMT-P, as part of the organized emergency medical services system in the region, while caring for patients in a hospital as part of his/her training or continuing education under direct supervision of a physician, registered nurse, or

physician assistant, or while at the scene of a medical emergency or during transport, or during interfacility transfer, may perform the following procedures or administer the following medications in accordance with the written policies and procedures of the Agency:

1. Perform defibrillation.
2. Perform synchronized cardioversion.
3. Visualize the airway by use of the laryngoscope and remove foreign body(ies) with forceps.
4. Perform pulmonary ventilation by use of lower airway multi-lumen adjuncts, the esophageal airway, stomal intubation, and adult oral endotracheal intubation.
5. Institute intravenous (IV) catheters, saline locks, needles, or other cannulae (IV lines) in peripheral veins; and monitor and administer medications through pre-existing vascular access.
6. Administer intravenous glucose solutions or isotonic balanced salt solutions, including Ringer's lactate solution.
7. Obtain venous blood samples.
8. Use glucose-measuring device.
9. Utilize Valsalva's maneuver.
10. Perform needle cricothyrotomy.
11. Perform needle thoracostomy.
12. Monitor thoracostomy tubes
13. Monitor and adjust IV solutions containing potassium equal to or less than 20 mEq/L.
14. Administer approved medications by the following routes: intravenous, intramuscular, subcutaneous, inhalation, transcutaneous, rectal, sublingual, endotracheal, oral or topical.
15. Administer, using prepackaged products when available, the following medications:
 - a. 25% and 50% Dextrose
 - b. Activated Charcoal
 - c. Adenosine
 - d. Aerosolized or Nebulized beta-2 specific bronchodilators;

- e. Aspirin
- f. Atropine Sulfate
- g. Calcium Chloride
- h. Diazepam
- i. Diphenhydramine Hydrochloride
- j. Dopamine Hydrochloride
- k. Epinephrine
- l. Furosemide
- m. Glucagon
- n. Midazolam
- o. Lidocaine Hydrochloride
- p. Morphine Sulfate
- q. Naloxone Hydrochloride
- r. Nitroglycerine Preparation
- s. Pralidoxime Chloride
- t. Sodium Bicarbonate

C. As part of the State approved expanded scope of practice, an EMT-P student or an accredited EMT-P, as part of the organized emergency medical services system in the region, while caring for patients in a hospital as part of his/her training or continuing education under direct supervision of a physician, registered nurse, or physician assistant, or while at the scene of a medical emergency or during transport, or during interfacility transfer, may perform the following procedures or administer the following medications in accordance with the written policies and procedures of the Agency:

- a. Perform pediatric oral endotracheal intubation.
- b. Perform intraosseous infusion and administer via intraosseous lines all medications listed for administration by IV.
- c. Perform transcutaneous pacing
- d. Intravenous infusion of Heparin and Nitroglycerine – (Inter-Facility Transfer only – requires prior approval pursuant to MVEMSA Policy #552.62)
- e. CPAP

~~D.~~ Base Hospital Physicians may order any medication or procedure within the local paramedic

scope of practice for any patient condition regardless of the treatment protocols.

D. Any skill that is not identified in this policy shall not be performed by paramedics, or paramedic students, even if they are directly supervised by a physician or registered nurse, except as specified in the Altered Standard of Care Pre-Planning Guide (Attachment A), during a declared emergency, and when Altered Standard of Care orders have been issued by the EMS Agency Medical Director and MHOAC..

E.

TITLE: **MICN AUTHORIZATION
AND RE-AUTHORIZATION**

APPROVED: <u>SIGNATURE ON FILE IN EMS OFFICE</u> Executive Director	CREATION DATE: <u>6-14-95</u>
<u>SIGNATURE ON FILE IN EMS OFFICE</u> Medical Director	EFFECTIVE DATE: <u>04-13-05</u> DRAFT
	SUPERSEDES:
	REVISED: <u>02/2005</u>
	REVIEW DATE: <u>04/2010</u> DRAFT
	PAGE <u>1</u> OF <u>3</u>

MICN AUTHORIZATION AND RE-AUTHORIZATION

I. AUTHORITY

Division 2.5, Health and Safety Code, Section 1797.56; Division 2, Business and Professions Code, Section 2725; and Title 22, California Code of Regulations, Section 100168, (b) (7).

II. DEFINITIONS

A. "Agency" - means the Mountain-Valley Emergency Medical Services Agency.

B. "Base Hospital" - means a hospital approved and designated by the Agency to provide immediate Medical Direction and supervision of Advanced Life Support care in accordance with policies and procedures established by the Agency.

C. "Mobile Intensive Care Nurse" ("MICN") - means a registered nurse who is functioning pursuant to Section 2725 of the Business and Professions Code, and who has been authorized by the Agency Medical Director to issue instructions to prehospital emergency medical care personnel within this region according to the Prehospital Treatment Guidelines developed by the Agency.

III. PURPOSE

The purpose of this policy is to establish a process for authorization and re-authorization of Mobile Intensive Care Nurses.

IV. POLICY FOR MICN AUTHORIZATION

A. Registered Nurses in good standing who possess a California MICN course completion certificate, and successfully fulfill MICN authorization requirements as established by the Agency, are eligible for authorization.

B. Candidate must successfully complete all requirements of this policy within six months of application.

V. PROCEDURE

A. The candidate must submit an MICN application, provided by the agency, which documents:

1. Current licensure as a California Registered Nurse.
2. Successful completion of an MICN course approved by the Agency or a course which meets or exceeds Agency requirements.
3. One year experience as a Registered Nurse.
4. Six months experience as a Registered Nurse working in a critical care setting such as the intensive care unit, critical care unit or emergency department, or six months experience working as a California licensed paramedic with 50 or more ALS patient contacts.
5. A copy of a valid Advanced Cardiac Life Support (ACLS) certificate from a training course which meets the standards established by the American Heart Association.
6. Region IV, Office of Emergency Services, four-hour Hospital Module, Multi-casualty Incident (MCI) Training

Candidates who do not document the MCI training will be issued authorization for six months only. Candidates must acquire the training within this six-month period to be eligible for continued authorization for the full two-year cycle.

B. The candidate shall:

1. Pay the established fee. The Agency shall not process applications until all related fees are paid.
2. Sign an affidavit that he/she is not precluded from authorization for any reasons defined in Section 1798.200 of the Health and Safety Code.
3. Pass a written MICN examination with a minimum score of 75% and a written protocol examination with a minimum score of 80%. A candidate who fails either the MICN exam or the protocols exam is eligible to retake the appropriate exam(s) within 60 days. A score of 80% or higher shall be required to pass the repeat exams. A candidate may not take the exam(s) a third time without completing additional criteria as required by the Agency Medical Director.
4. Provide a photograph for identification purposes.

5. Satisfactorily complete a pre-authorization Base Hospital evaluation which includes:

a. No less than 10 ALS radio calls supervised by a Mobile Intensive Care Nurse or Base Hospital Physician, with the following exception:

b. No less than 3 ALS radio calls if the applicant is currently an authorized MICN in good standing in Fresno, Kings, Madera, Merced or San Joaquin Counties, and submits a letter of reference from the MICN's most recent Base Hospital Medical Director or Nurse Liaison verifying the MICN's satisfactory performance in handling ALS radio calls within the last two-year period.

- C. Upon satisfactory completion and submission of the requirements of this policy, the candidate will be issued authorization for a maximum period of two (2) years. The effective date of authorization shall be the date the candidate satisfies all authorization requirements. The authorization expiration date will be the final day of the final month of the two (2) year period.

MICN RE-AUTHORIZATION

VI. PROCEDURE

A. Prior to expiration of current authorization, the candidate shall:

1. Submit a completed Agency application which includes:

a. Payment of established fee(s). The Agency shall not process applications until all required fees are paid.

b. A signed affidavit that the candidate is not precluded from authorization for any reason defined in Division 2.5, Health and Safety Code, Section 1798.200.

c. Documentation of current California Registered Nurse license.

d. A photo identification.

e. Verification of successful completion of all continuing education requirements during the authorization period. Continuing education for each MICN shall include, at a minimum:

(1) Sixteen (16) hours of formal education, relating specifically to ALS pre-hospital care.

(2) Any additional continuing education prescribed by the EMS Agency Medical Director.

B. Upon satisfactory completion of the requirements of this policy, The MICN will be issued authorization for a maximum period of two years. The new effective date of authorization shall be the day after their current authorization expires. The certification expiration date will be the final day of the final month of the two (2) year period.

1. If an MICN applies for reauthorization more than six (6) months before their current authorization expires, they will be issued a new beginning authorization date effective the day that they meet the reauthorization requirements.

C. Individuals applying for reauthorization, whose authorization has lapsed, shall be eligible for reauthorization upon submission of documents indicating:

1. For a lapse of less than one (1) year:

Completion of all of the above requirements, plus a prorated amount of continuing education based on the number of months since the last authorization, not to exceed a total of 36 hours.

2. For a lapse of one (1) to two (2) years: MOUNTAIN-VALLEY EMS AGENCY MICN REAUTHORIZATION POLICIES AND PROCEDURES Page 3 of 3

a. Completion of all of the above, including the prorated amount of continuing education and;

b. Successful evaluation by an authorized MICN or Base Hospital physician of ten (10) ALS radio calls.

3. For a lapse of more than two (2) years:

a. Completion of all the above and any additional training or evaluation required by the Agency Medical Director.

TITLE: RESPONSE TO GROUND AMBULANCE REQUESTS

APPROVED: <u>SIGNATURE ON FILE IN EMS OFFICE</u> Executive Director	CREATION DATE: <u>2-10-1999</u> EFFECTIVE DATE: <u>4-13-2005</u> SUPERSEDES: <u>432.00</u> REVISED: <u>04/2005</u> REVIEW DATE: <u>04/2010</u> PAGE <u>1</u> OF <u>2</u>
<u>SIGNATURE ON FILE IN EMS OFFICE</u> Medical Director	

RESPONSE TO GROUND AMBULANCE REQUESTS

I. AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1797.5~~26~~ and 1797.220; Title 13, California Code of Regulations, Chapter 5., Article 1., Section 1100.3, and the California State EMS Systems Guidelines, Sections 1.23, 2.08, 4.02, 4.06, 4.07, and 4.16.

II. DEFINITIONS

A. "Designated Emergency Medical Dispatch Center" An ambulance dispatch center that meets the requirements in Agency policy #311.00.

~~B. B.~~ "Medical Emergency" The term used to denote a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by a public safety agency, emergency medical personnel at the scene of an emergency or dispatch personnel at a Designated Emergency Medical Dispatch Center as used in the context of Division 2.5 of the Health and Safety Code, Section 1797.70.

C. "Emergency Medical Technician" or "EMT" means a person who has successfully completed an EMT course which meets the requirements of Title 22, California Code of Regulations, Chapter 2, and who is certified as an EMT in the state of California.

D. "Paramedic" means an individual who is educated and trained in all elements of prehospital advanced life support, who is licensed by the state of California as a paramedic and accredited by the Agency Medical Director.

III. PURPOSE

To establish the appropriate levels of ground ambulance response.

IV. POLICY

A The minimum response to a Medical Emergency dispatched by a Designated Emergency Medical Dispatch Center, except as outlined in Sections IV, B, C., and D., shall be an Advanced Life Support Ambulance staffed in accordance with EMS Agency policy # ~~405.0032.00~~.

- B. When an ambulance is requested by a transferring physician for an Interfacility Transfer, the ambulance shall meet the requirements for either a BLS Ambulance, ALS Ambulance, or CCT Ambulance as specified in Policy # 405.00.
- C. The EMS agency may establish county specific policies that deviate from the minimum response levels cited in IV. A. (e.g. per Level III Dispatch procedures).
- D. The requirements of this policy may be suspended by the Medical Director or his/her designee during declared disaster situations or multiple casualty situations.

V. PROCEDURE

- A. When a request for an emergency response is received by a Designated Emergency Medical Dispatch Center, that Dispatch Center will dispatch an Advanced Life Support Ambulance staffed with at least one (1) EMT-P and one EMT-I in accordance with Section IV, A.

B. B.—In the event that no ALS units are available for an emergency response in an ambulance service area, the closest appropriate adjacent service provider shall be notified to activate mutual aid move-up and/or posting. Should an emergency call occur, the closest ALS unit, appropriately staffed in accordance with this policy, shall be dispatched.

C. If ~~t~~he ALS ambulance service provider responsible for that service area in which the emergency call has occurred is able to staff and mobilize a BLS back-up unit with a minimum of two (2) EMT-Is, that BLS unit may be dispatched to the call.

a. The BLS crew shall follow BLS treatment guidelines, contact the local base hospital, advise them of their BLS status and follow base hospital direction.

b. Based upon the patient condition, length of transport time and the ETA of the responding ALS unit, the base hospital ~~shall direct~~shall direct the BLS unit to either wait on scene for the ALS unit, rendezvous with the ALS unit or transport to the closest appropriate hospital.

c. An Unusual Occurrence Report must be submitted to the EMS Agency following within 24 hours after the call.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 08/01/2008
SUPERSEDES:
REVISED: 07/2008
REVIEW DATE: 06/2013
PAGE: 1 OF 2

GROUND AMBULANCE STAFFING LEVELS

I. AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1797.56 and 1797.220, Title 13, California Code of Regulations, Chapter 5., Article 1., Section 1100.3; and, the California State EMS Systems Guidelines, Sections 1.23, 2.08, 4.02, 4.06, 4.16, 4.07.

II. DEFINITIONS

- A. BLS Ambulance - An ambulance equipped per the requirements of Agency Policy # 407.00 Equipment and Drug Inventory; and specifically constructed, modified, or equipped, and used for the purpose of transporting sick, injured, convalescent, infirm, or otherwise incapacitated persons.
- B. ALS Ambulance - An ambulance that meets the requirements of a BLS Ambulance and is equipped per the EMS Agency Policy # 407.00 Equipment and Drug Inventory
- C. Critical Care Transport Ambulance (CCT Ambulance) - An ambulance that meets all requirements of an ALS Ambulance and any equipment required by the transferring physician and EMS Agency policy.
- D. Agency – means the Mountain-Valley EMS Agency.

III. PURPOSE

To establish the appropriate staffing levels for ground ambulances.

IV. POLICY

- A. Ground ambulance minimum staffing requirements shall be as follows:
 - 1. BLS Ambulance - Two EMT-Is currently certified in the State of California.
 - 2. ALS Ambulance - One EMT-P accredited by the Agency and one EMT-I currently certified in the State of California.
 - 3. CCT Ambulance - One EMT-I currently certified in the State of California, and one attendant who must be either a Physician or a Registered Nurse, licensed by the State of California, with a minimum of two (2) years of critical care experience, and current certificate of completion from an Advanced Cardiac Life Support course. One attendant must be authorized to provide nasotracheal and orotracheal intubation.

B. During Interfacility Transfers, a transferring physician is responsible for determining the need for additional staff and equipment.

C. The requirements of this policy may be suspended by the Medical Director or his/her designee during declared disaster situations or multiple casualty situations [pursuant to the Altered Standard of Care Pre-Planning Guide \(see Policy 256.00, Attachment A: Altered Standard of Care Pre-Planning Guide\)](#).

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TITLE: CANCELLATION OR REDUCTION OF EMS SYSTEM RESPONSE

APPROVED: <u>SIGNATURE ON FILE IN EMS OFFICE</u> Executive Director	CREATION DATE: EFFECTIVE DATE: <u>4/2005</u> SUPERSEDES: REVISED: <u>3/2005</u> REVIEW DATE: <u>4/2010</u> PAGE <u>1</u> OF <u>3</u>
<u>SIGNATURE ON FILE IN EMS OFFICE</u> Medical Director	

CANCELLATION OR REDUCTION OF EMS SYSTEM RESPONSE

I. AUTHORITY

Division 2.5, California Health and Safety Code, Section 1797.220.

II. DEFINITIONS

- A. “EMS System Response” means the response by fire department first responders or ambulances to a request via 9-1-1.
- B. “Skilled Nursing Facilities” includes nursing homes, convalescent hospitals, rehabilitation centers, and rest homes where licensed personnel are present.
- C. “EMS Personnel” means first responders, ambulance personnel, or dispatchers at Primary and Secondary Public Safety Answering Points.
- D. “Medical Personnel” means physicians, RNsR-N-s, and any other medically trained personnel not part of the EMS System response.
- E. “First Responder” means a person who is trained to provide care and treatment to the sick and injured while part of the organized emergency medical services system.

III. PURPOSE

The purpose of this policy is to establish criteria and procedures to guide EMS Personnel for cancellation or reduction of an EMS System Response. This policy addresses this issue in the following categories:

- 1. Requests from Skilled Nursing Facilities.
- 2. Requests from Medical Personnel and the public.
- 3. Requests from On-scene EMS Personnel.

IV. POLICY

An EMS System Response may be canceled ~~only~~ by the requesting party who initiated the 911 call, ~~or~~ by on-scene EMS Personnel, ~~In the event no patient can be located at an incident, or~~ any on-scene public safety agency, ~~may cancel an EMS System Response.~~

V. PROCEDURE

A. Cancellation from Skilled Nursing Facilities

1. The requesting party at the Skilled Nursing Facility may cancel an EMS system response by:
 - a. re-contacting 9-1-1
 - b. asking on-scene first responders to cancel the EMS System Response
 - c. asking the on-scene ambulance to cancel the EMS System Response
2. Occasionally, residents of Skilled Nursing Facilities activate the EMS system without the knowledge of facility staff. Calls originated by a resident at a Skilled Nursing Facility and subsequently cancelled shall be reported to the EMS Agency by the Emergency Medical Dispatch Center within 72 hours.
3. The EMS Agency shall advise the office of the County Ombudsman (or appropriate County patient advocate) and the administrator of the Skilled Nursing Facility where the call took place within 72 hours of receiving notification.

B. Cancellation by Medical Personnel or members of the public

1. Medical Personnel or members of the public that request an EMS System Response may cancel said response by:
 - a. re-contacting 9-1-1
 - b. asking on-scene first responders to cancel the EMS System Response
 - c. asking the on-scene ambulance to cancel the EMS System Response

C. Cancellation of the EMS System Response by on-scene EMS Personnel

1. On-scene EMS Personnel may cancel an EMS System Response when:
 - a. requested by the original requesting party, or upon determination

that the incident does not involve an injury or illness.

- b. the criteria set forth in Policy # 570.20 (~~Determination of Death in the Prehospital Setting~~) or Policy # 570.~~2130~~ (~~Do Not Resuscitate Orders~~) for EMS System Response cancellation are met.

D. An EMS System Response may be reduced from Code 3 to Code 2:

1. When on-scene EMS Personnel determine that the illness and injury is not immediately life threatening or that the difference between Code 3 and Code 2 response times would not likely have an impact on patient outcome.

~~2.~~ 2. Upon determination that the requesting party is at an acute care facility.

~~3.~~ 3. Per EMD (Emergency Medical Dispatch)

TITLE: MARK I PROVIDER

AGENCY

CREATION DATE: _____

2/05

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: 06/08/05

SUPERCEDES: _____

REVISED: _____

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 06/2010

PAGE 1 OF 5

MARK I KIT PROVIDER AGENCY

I. AUTHORITY

California Code of Regulations, Title 22, Division 9, Chapters 2, Sections 100064(g), and 100144 (c,2,A)

II. DEFINITIONS

A. “Emergency Responder” means ~~a firea fire~~ services personnel firefighter, law enforcement officer, or emergency medical ~~services personnel~~ services personnel, including first responders, EMT-Is, and paramedics.

B. “Mark I Kit” means a Nerve Agent Antidote Kit containing autoinjectors of 2 mg Atropine and 600 mg Pralidoxime Choride (2-PAM)

C. “Mark I Provider Agency” means a public or private EMS Service Provider, recognized by the Mountain-Valley EMS Agency as being part of the local EMS ~~system, that~~ system, which meets the requirements of this policy.

III. PURPOSE

The purpose of this policy is to provide a mechanism for an EMS Service Provider to receive approval as a Mark I Provider Agency.

IV. POLICY

- A. The local EMS Agency may approve an EMS service provider as a Mark I Provider Agency, which will allow their personnel to administer the Mark I Kits to themselves, and other emergency responders in the event of an exposure to nerve agent.

B. Training

1. A Mark I Provider Agency, shall provide initial Mark I ~~Kit~~ training ~~Kit training~~ to all of their field response personnel. A bBasic weapons of mass destruction training is also recommended.
2. Mark I Kit training shall consist of no less than 2 hours of didactic and skills laboratory training in the appropriate utilization of the Mark I Kit, including, but not be limited to:
 - a. Indications
 - b. Contraindications
 - c. Side/ adverse effects
 - d. Routes of administration
 - e. Dosages
 - f. Mechanisms of drug action
 - g. Disposal of contaminated items and sharps
 - h. Medication administration.
3. At the completion of this training, the student shall complete a competency based written and skills examination for the administration of Mark I Kits, which shall include:
 - a. Assessment of when to administer these medications,
 - b. Managing an emergency responder patient before and after administering these medications,
 - c. Using universal precautions and body substance isolation procedures during medication administration,
 - d. Demonstrating aseptic technique during medication administration,
 - e. Demonstrate the preparation and administration of medications by the intramuscular route,
 - f. Proper disposal of contaminated items and sharps.
4. Once field personnel have successfully completed the training and testing, the Mark I Kit Provider Agency shall issue a certificate of completion which shall include, at a minimum:
 - a. Name of Issuing Agency
 - b. Course Title

- c. Name of Personnel Completing the Training
- d. Date of Course Completion
- e. Number of Course Hours Completed

5. The Mark I Kit Provider Agency shall establish internal policies for skills competency demonstration that requires EMT-~~I~~ and First Responder personnel to demonstrate skills competency every ~~six months~~ two years or more frequently as determined by EMS QI provider after initial accreditation. ~~These policies shall include a mechanism to document continued competency. Documentation of skills competency is the responsibility of the Mark I Kit Provider Agency.~~

C. EMT-~~I~~ Optional Scope Accreditation

EMT-~~I~~ personnel who receive Mark I Kit certification shall be considered to be accredited in this optional scope by Mountain Valley EMS Agency pursuant to Section 100064 (a) of the California Code of Regulations (Optional Skills). This accreditation shall be continuous as long as the accredited EMT-~~I~~ maintains all continuing education requirements of this policy.

D. First Responder Authorization

First Responder personnel not currently certified or licensed as an EMT-~~I~~, or ~~EMT-PP~~ Paramedic must obtain authorization from their prescribing physician to participate in the Mark I administration program.

E. Equipment

It is recommended that all response vehicles carry a minimum of three Mark I kits for each on duty crew member assigned to that vehicle. Mark I Kits should be carried and stored per manufacturers recommendations.

V. PROCEDURE

- A. In order to receive and maintain approval as a Mark I Provider Agency, an EMS provider shall submit an application to the local EMS Agency which shall include the following:
 1. Name of Agency
 2. A written commitment to comply with the terms of this policy and ensure the

applying agency will provide the following:

- a. Training to personnel in the use of a Mark I Injector Kit, utilizing an approved Mark I training program.
 - b. Ensure appropriate storage and replacement of Mark I Injector Kits.
 - c. Ensure that all field personnel meet the Mark I Kit training requirements.
 - d. Verification that physician authorization is obtained for field personnel with less than EMT-I certification.
 - e. Maintain a listing of all Mark I Provider Agency authorized personnel and provide listings upon request to the local EMS agency or the EMS Authority.
- B. Upon review and approval of a Mark I Provider Agency application, the Mountain-Valley EMS Agency will grant approval to an ~~Organization~~ EMS provider to utilize Mark I Injector Kits for self-administration by their personnel and administration to other emergency responders.
- C. A Mark I Provider Agency's approval to utilize Mark I Injector Kits maybe revoked or suspended for failure to maintain the requirements of this policy.

Mark I Kit Provider Application

Provider Certification	
Provider Name:	
Address:	
Telephone:	
Provider agrees to:	
<ul style="list-style-type: none">• provide initial Mark I Kit training to <u>all</u> of their field response personnel• ensure that Mark I Kit training shall consist of no less than 2 hours of didactic and skills laboratory training in the appropriate utilization of the Mark I Kit• ensure that students shall complete a competency-based written and skills examination for the administration of Mark I Kits• issue a certificate of completion which shall include, at a minimum: Name of Issuing Agency, Course Title, Name of Personnel Completing the Training, Date of Course Completion, and Number of Course Hours Completed• establish internal policies for skills competency demonstration that requires EMT-I and First Responder personnel to demonstrate skills competency every six months <u>two years or more often as determined by EMS QI</u> after initial accreditation; and shall include a mechanism to document continued competency• obtain physician authorization for all First Responder personnel not currently certified <u>or licensed</u> as an EMT-I, or <u>Paramedic, EMT-P</u>• equip each response vehicle with a minimum of three Mark I kits for each on duty crew member assigned to that vehicle (estimated number of Mark I kits needed: _____)• carry and store Mark I Kits per manufacturers recommendations• maintain a listing of all Mark I Provider Agency authorized personnel and provide listings upon request to the local EMS agency, Public Health Department, or the EMS Authority	
On behalf of the above named Provider, I certify that the above is true and correct.	
_____ (_____)	_____
Management Representative	Title
_____	_____
Signature	Date

EMS Agency Authorization	
The above-named provider is approved by the Mountain-Valley EMS Agency to utilize Mark I Injector Kits for self-administration by their personnel and administration to other emergency responders	
_____	_____
EMS Agency Medical Director	Date

TITLE: AED SERVICE PROVIDERS

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: 01/89

SUPERCEDES: _____

REVISED: 8/2004

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 8/2009

PAGE 1 OF 2

AED SERVICE PROVIDERS

I. AUTHORITY

California Code of Regulations, Title 22, Division 9, Chapters 1.5 and 2, Sections 100021 and 100063.1

II. DEFINITIONS

A. "Automated External Defibrillator" means an external defibrillator capable of cardiac rhythm analysis which will charge and deliver a shock either automatically or by user interaction after electronically detecting ventricular fibrillation or rapid ventricular tachycardia.

B. "EMS Service Provider" means a public or private entity recognized by the Mountain-Valley EMS Agency as being part of the local EMS system.

C. "Public Safety AED Service Provider" means an EMS Service Provider agency or organization which is responsible for, and is approved to operate, an AED that employs individuals as defined in Title 22, Chapter 1.5 Section 100015 of the California Code of Regulations.

D. "EMT AED Service Provider" means an EMS Service Provider agency or organization that employs individuals as defined in Title 22, Chapter 2.0, Section 100060, which is responsible for, and is approved to operate, an AED.

III. PURPOSE

The purpose of this policy is to provide a mechanism for EMS Service Providers to receive approval as AED Service Providers.

IV. POLICY

The local EMS Agency may approve a Public Safety Agency or an EMT AED Service Provider who meets the requirements of this policy.

V. PROCEDURE

- A. In order to receive and maintain approval as a Public Safety AED Service Provider or EMT AED Service Provider, a Public Safety Agency or EMT AED Service Provider shall submit an application to the local EMS Agency which addresses their plan to meet the following requirements:
1. Provide orientation of AED authorized personnel to the AED;
 2. Ensure maintenance of AED equipment;
 3. Ensure continued competency of AED authorized personnel.
 34. Collect and report to the Mountain-Valley EMS Agency, on an annual basis, data that includes, but is not limited to:
 - a. The number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care,
 - b. The total number of patients on whom defibrillatory shocks were administered, when cardiac arrest was witnessed and not witnessed; and
 - c. The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation.
 45. Authorize personnel and maintain a listing of all AED service provider authorized personnel and provide listings upon request to the local EMS agency or the EMS Authority.
 56. Provide a description of the AED service area.
 67. Provide the name of the AED Service Provider.
 78. Provide the date beginning to offer AED services.
- B. Upon review and approval of an AED Service Provider application, the Mountain-Valley EMS Agency will grant approval to a Public Safety Agency or EMT AED Service Provider to provide AED service.
- C. An AED Service Provider's approval to provide AED service may be revoked or suspended for failure to maintain the requirements of this policy.

TITLE: ALS GROUND AMBULANCE AUTHORIZATION

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

CREATION DATE: March 1, 1993

EFFECTIVE DATE: 04/13/05

SUPERSEDES:

REVISED: 03/2005

REVIEW DATE: 04/2010

PAGE 1 OF 4

ALS GROUND AMBULANCE AUTHORIZATION

I. AUTHORITY

Division 2.5, California Health and Safety Code, sections 17~~89~~7.52, 1797.78, 1797.85, 1797.178, 1797.206, 1797.218, 1797.220, 1797.224, and Title 22, California Code of Regulations, sections 100167.

II. DEFINITIONS

- A. "Region" means the geographic jurisdiction of the Mountain-Valley Emergency Medical Services Agency.
- B. "County" means any of the counties that are part of the joint powers agreement that forms the Mountain-Valley EMS Agency.
- C. "Exclusive Operating Area" is an area or sub-area defined by the emergency medical services plan for the local EMS Agency, upon the recommendation of a county, -which limits operations to one or more providers of advanced life support service.
- D. "Non-Exclusive Operating Area" is an area defined by the local EMS agency which does not limit the operations to specific providers of advanced life support services.
- E. "Request for Proposal" or "R.F.P." is the document that specifies the requirements for all respondents that wish to bid to provide ALS service to an exclusive operating area.

III. PURPOSE

To establish standards and procedures for the authorization of ground ambulance providers to provide advanced life support ground ambulance services within the Region.

IV. POLICY

- A. ALS ground ambulance providers that wish to provide advanced life support services within the Region must satisfy all requirements and adhere to the process listed in the Procedure section of this policy.
- B. When an operating area has been designated as a "Non-exclusive Operating Area" in a County, the local EMS Agency shall require that ALS ground ambulance providers who wish to provide ALS ground ambulance service in that area complete the application process

as outlined in V. A.

- C. When an exclusive operating area has been designated in a County, the local EMS Agency shall develop a Request for Proposal which describes the competitive process for awarding the operating area to an ALS provider except in those cases in which an ALS provider may be exempted from the RFP process according to Section 1797.224, Division 2.5, of the California Health and Safety Code.
- D. An ambulance provider may be designated to service an exclusive operating area without an RFP process when there has been no change in manner and scope of ambulance service within said area since January 1, 1981. If there has been an upgrade of service by said ambulance provider that was voluntary, this shall not be considered as a change in manner or scope and does not require a "Request for Proposal."

V. PROCEDURE

A. Non-exclusive Operating Areas

- 1. When an ALS ground ambulance provider wishes to provide service in a non-exclusive operating area, the provider must:
 - a. Complete an application as provided by the local EMS Agency.
 - b. Pay the required processing fee.
- 2. Upon the receipt of the completed application, the local EMS agency shall:
 - a. make, or cause to be made, an investigation to determine if the applicant meets all requirements as outlined in applicable laws, ordinances, policies, and regulations.
 - b. Within ninety (90) days of receipt of the application make a determination to issue, or decline to issue, an Advanced Life Support Provider Agreement based upon the outcome of the above investigation.
 - c. If the local EMS agency determines that the provider meets all of the specified requirements, the local EMS agency and the applicant shall attempt to negotiate the terms of an Advanced Life Support Provider Agreement.
 - d. If the ALS provider agreement is being negotiated to provide ALS ambulance services in a County that has an ambulance ordinance that specifies a mechanism to resolve an ALS provider agreement impasse between the above parties, the mechanism available in the specific County shall be utilized. If no such mechanism exists, the following shall apply: The Regional Advisory Committee (RAC) shall create a review panel made up of five (5) persons knowledgeable in EMS and/or the provision of ALS ambulance services. A maximum of two persons for this review panel may be from the affected county. The chairperson of the RAC shall ensure that no conflict of interest exists for those persons selected for this review panel.

This review panel shall either serve as an arbitration board to resolve issues between the EMS Agency and the applicant or recommend to the EMS Agency Board of Directors that such an agreement cannot be reached. The EMS Agency Board of Directors shall have the final decision to either award or disqualify the applicant for an ALS Provider Agreement.

3. The Advanced Life Support Provider Agreement shall, at a minimum, address the following areas:
 - a. geographic area to be served
 - b. emergency response procedures and standards
 - c. level of service standards, quality improvement, and disputes
 - d. communication and dispatch standards
 - e. equipment and supply standards
 - f. personnel standards
 - g. crew quarters
 - h. records and reports
 - i. insurance and indemnification
 - j. compensation and fees
 - k. contract performance, breach, and default
 - l. coordination with ALS ground ambulance companies
 - m. mutual aid
 - n. additional issues as required in local ordinances

B. Exclusive Operating Areas

1. When a county develops an exclusive operating area, the Request for Proposal process must include the following:
 - a. Formal advertising of the opportunity to compete for the area.
 - b. The R.F.P. document must specify the requirements and standards of the county which shall include the EMS capability and fiscal status of all respondents.
 - c. A responder's conference to provide a forum for answering questions.
 - d. Specific instructions for:
 1. submission of responses
 2. receiving responses
 3. response evaluation
 4. response rejection
 5. award notification
 6. protests and appeals
 7. contract cancellation
 - e. Upon completion of the R.F.P. process, the local EMS Agency and the successful bidder shall attempt to negotiate the terms of an Advanced Life Support Provider Agreement which shall address the areas as outlined in section V. A. 3. of this policy. If an agreement cannot be negotiated by the

above parties, the Regional Advisory Committee shall address this as described in section V. A. 2. d. of this policy.

2. If it is determined that an ALS ground ambulance provider may be granted an exclusive operating area without an RFP process as per Section 1797.224, Division 2.5, Health and Safety Code, the provider must follow the procedure listed in V.(A).

TITLE: RECEIVING FACILITY CRITERIA

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: 12-9-92

SUPERSEDES: _____

REVISED: 4/2002

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 4/2007

PAGE 1 OF 5

RECEIVING FACILITY CRITERIA

I. AUTHORITY

California Health and Safety Code, Division 2.5, sections 1797.220, 1798., 1798.101, 1798.170

II. DEFINITIONS

- A. "Receiving Facility" means an acute care facility authorized pursuant to Agency policy to receive emergency patients treated and/or transported by an ambulance service provider.
- B. "Emergency Patient" means a person requiring emergency medical care who is treated and/or transported by an authorized ambulance service provider.
- C. "Ambulance service provider" means a company or organization authorized to provide emergency ambulance service by the Mountain-Valley EMS Agency.

III. PURPOSE

To establish standards for the designation, utilization, and evaluation of facilities receiving emergency patients; to develop a mechanism for collecting and evaluating patient care information for patients transported to a receiving facility; and to ensure receiving facilities are included in emergency medical services planning activities.

IV. POLICY

- A. The EMS Agency shall approve and designate receiving facilities.
- B. Receiving facilities shall have a written agreement with the EMS Agency which indicates that hospital administration, medical staff and emergency department staff will meet the requirements for participation in the EMS system as specified in the EMS Agency's policies and procedures.
- C. The EMS Agency shall have the authority to deny, suspend or revoke Receiving Facility Designation for a facility's failure to comply with any applicable policy, procedure, regulation or agreement.
- D. Hospitals that have current agreements with the EMS Agency, which designates them as a Base Hospital or Specialty Care Receiving Facility shall be considered as meeting the requirements of this policy.
- E. The EMS Agency Medical Director may waive all or some of the requirements of this policy

for acute care facilities operated by or for the United States National Park Service, the United States Armed Forces or the United States Department of Veterans Affairs.

- F. Emergency patients shall only be transported to designated receiving facilities, except in cases of actual or declared disasters when adopted contingency plans call for the utilization of non-designated facilities.
- G. A facility shall meet or exceed the following criteria to be eligible for designation as a Receiving Facility:

1. General

- a. Be licensed by the State Department of Health Services as a general acute care hospital with a permit for basic or comprehensive emergency service or an out-of-state acute care hospital which substantially meets the requirements of licensing as determined by the EMS Agency and is licensed in the state in which it is located.
- b. Agree to adhere to all applicable EMS Agency policies and procedures and to participate in EMS system planning activities.
- c. Agree to accept for treatment any patient who has been treated or transported by ~~prehospital-pre~~ hospital personnel.
- d. Have interfacility transfer agreements in place with hospitals and specialty care facilities for the provision of higher levels of care.
- e. Agree to be formally evaluated ~~at least every two years~~ periodically by the EMS Agency for the purpose of ensuring compliance with this policy.
- f. Agree to participate in ~~on-going~~ facility assessment activities.
- g. Agree to participate in EMS education programs, including clinical internships.

2. Communications

- a. Have and agree to utilize and maintain communications equipment, as specified by the EMS Agency, capable of direct two-way communication with EMS field units, specified base hospitals, the county disaster control facility and other specified receiving facilities for their service area.

~~b.~~ Utilization of EMS Systems

- ~~b.c.~~ — Have a dedicated, non-operator, telephone line into the emergency department for communication between the county disaster control facility, EMS field units, specified base hospitals, and other specified receiving hospitals for their service area.

3. Staffing

- ~~a.~~ ~~Designate a person who shall be responsible for the overall supervision of the EMS program within the hospital and for assuring that the facility's responsibilities specified by agreement and EMS Agency policy are met.~~
- ~~b.a.~~ Identify an RN with experience in and knowledge of hospital radio operations and EMS Agency policies and procedures as a Receiving Facility Nurse Liaison to be responsible for the completion of all required Receiving Facility documentation and submitting such documentation to the EMS Agency and appropriate Base Hospitals.
- ~~e.b.~~ Agree to staff the emergency department at all times with a physician trained and experienced in emergency medical services and whose practice includes emergency medical care in the hospital, and who shall assume responsibility for physician coverage of the service as follows:
 - (1) In-house 24-hour coverage with primary assignment to the emergency department and immediate availability. Physicians assigned to the emergency department may not be called from the area to treat patients of other physicians except in case of an emergency.
 - (2) All emergency department physicians shall have, at a minimum, current American Heart Association Advanced Cardiac Life Support provider certification or Emergency Medicine Board certification..
 - (3) All emergency department physicians shall be credentialed by the medical staff, according to current medical staff bylaws, and meet current community standards.
- ~~d.c.~~ The nursing service operating within the emergency department shall operate under the following guidelines:
 - (1) A registered nurse qualified by education and/or training in emergency medical services shall be responsible for nursing care within the emergency department.
 - (2) A registered nurse trained and/or experienced in emergency medical care shall be on duty at all times with primary assignment to the emergency department.
 - (3) At least one registered nurse scheduled in the emergency department on each shift shall maintain, at a minimum, current American Heart Association ACLS provider certification. All remaining patient care providers shall maintain current Basic Life Support certification.
 - (4) Sufficient licensed nurses and skilled support personnel shall be utilized as required to support the services offered.
 - (5) Assure that all Emergency Department personnel are oriented to the receiving hospital role and pertinent EMS Agency policies and

procedures.

~~e.d.~~ To have physician consultation available in accordance with hospital bylaws or pre-established patient transfer arrangements.

4. Record Keeping

Agree to maintain and make available to the EMS Agency all relevant records for program monitoring and evaluation of the EMS system in an electronic format approved by the EMS Agency.

5. ~~Medical Supplies and Equipment~~

~~Replace narcotics and other controlled substances used by advanced life support personnel during treatment of patients according to the EMS Agency Controlled Substances policy #439.00.~~

6. Facility

- a. Maintain 24 hour in-house physician and emergency department registered nurse coverage.
- b. Maintain 24 hour laboratory coverage by a licensed medical technologist.
- c. Maintain 24 hour radiology coverage by a licensed radiologic technologist capable of performing basic x-ray service.

7. Quality Improvement

Ensure participation of Receiving Facility staff in EMS Agency quality improvement processes, according to the EMS Agency Quality Improvement policy # ~~420620~~.10.

H. In remote areas when the transport of a patient to a designated receiving hospital is precluded because of geographic or other extenuating circumstances, the EMS Agency Medical Director, with the approval of the State Emergency Medical Services Authority, may authorize patients to be transported to a facility which does not meet the requirements of a receiving facility, if the facility has adequate staff and equipment to provide emergency medical services, as determined by the EMS Agency Medical Director.

1. If the EMS Agency utilizes any facility which does not meet the requirements of a receiving facility, the EMS Agency shall submit to the State Emergency Medical Services Authority, as part of its EMS plan, protocols approved by the EMS Agency Medical Director to ensure that the use of that facility is in the best interest of patient care. The protocols which govern the use of the facility shall take into account, but not be limited to the following:

- a. The medical staff, and availability of the staff at various times to care for patients requiring emergency medical services.

- b. The ability of the staff to care for the degree and severity of patient injuries.
 - c. The equipment and services available at the facility necessary to care for patients requiring emergency medical services and the severity of their injuries.
 - d. The availability of more comprehensive emergency medical services and the distance and travel time necessary to make the alternative emergency medical services available.
 - e. The time of day and any limitations which may apply for the facility to treat patients requiring emergency medical services.
- I. Any change in the status of a receiving facility, authorized to care for patients requiring emergency medical services, with respect to protocols and the facility's ability to care for patients shall be reported by the facility to the EMS Agency.

V. PROCEDURE

- A. Applications for designation as a Receiving Facility shall be accepted from the Administration of all interested facilities.
- B. The EMS Agency will review all applications to determine if a facility meets the minimum requirements for designation as a Receiving Facility.
- 1. Facilities will be notified by the EMS Agency if any requirement is not met according to their application.
 - 2. Facilities that do not meet the requirements for designation as a Receiving Facility may request in writing, from the EMS Agency Medical Director, an exemption from requirements as described in paragraph IV, H.
- C. ~~If the facility meets the requirements~~~~Facilities which meet the requirements~~ for Receiving Facility designation, MVEMSA will develop a contract with them according to their application, shall be contacted by the EMS Agency for the purpose of formalizing and signing a Receiving Facility agreement. The EMS Agency may conduct a site survey of the facility prior to signing an agreement.
- D. The agreement shall include but not be limited to all of the requirements contained in this policy.

TITLE: Trauma Mutual Aid and Coordination with Neighboring Systems

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: 01/01/2004DRAFT

SUPERSEDES: _____

REVISED: _____

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 01/01/2009DRAFT

PAGE 1 OF 2

TRAUMA MUTUAL AID AND COORDINATION WITH NEIGHBORING SYSTEMS

I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1798.162, 1798.163, 1798.170
California Code of Regulations Section 100255.

II. DEFINITIONS

A. "Service area" means that geographic area defined by the local EMS agency in its trauma care system plan as the area served by a designated trauma center.

III. PURPOSE

To ensure that major trauma patients are treated at an appropriate facility, regardless of geopolitical boundaries and to facilitate coordination with neighboring systems.

IV. POLICY

A. Extraneous factors, such as geopolitical boundaries, will not be considered in the development of service areas. Mountain-Valley EMS Agency will coordinate its trauma care system with those in neighboring EMS systems - both in California and in other states - in order to ensure that patients are transported to the closest appropriate facility. Written mutual aid agreements will be executed as necessary to ensure coordination with neighboring systems.

1. Mountain-Valley EMS Agency will maintain contact with neighboring EMS agencies in order to monitor the status of trauma care systems in surrounding jurisdictions.

2. Where it appears that a service area within the Mountain-Valley EMS region is closer to a designated trauma center in another EMS system, Mountain-Valley EMS Agency staff will contact the appropriate EMS agency to seek an appropriate trauma service area boundary. This will include trauma centers, which are outside of California.

3. Where it appears that patients in another EMS system are closer to the Mountain-Valley EMS Agency designated trauma center, Mountain-Valley EMS Agency will contact the appropriate EMS agency.

- B. Where patients from the Mountain-Valley EMS Agency region are transported to a trauma center in another EMS system, Mountain-Valley EMS Agency will seek patient information which is equivalent to that provided ~~by~~ the Mountain-Valley EMS Agency by trauma centers within MVEMSA region.
- C. Where patients from another EMS system are transported to a Mountain-Valley EMS Agency designated trauma center, Mountain-Valley EMS Agency will attempt to provide patient information which is equivalent to that provided by that system's designated trauma center.
- D. Hospital and ambulance providers within the Mountain-Valley EMS Agency region are encouraged to cooperate with other EMS agencies in data collection and evaluation efforts of patients who are served by the Mountain-Valley EMS Agency's system.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: 01/01/2004
SUPERSEDES: _____

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVISED: _____
REVIEW DATE: 01/01/2009
PAGE 1 OF 2

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TRAUMA SYSTEM FEES

I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1798.162, 1798.163, 1798.164
California Code of Regulations Section 100255.

II. DEFINITIONS

A. "Trauma Center" or "designated trauma center" means a licensed hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV trauma center and/or Level I or II pediatric trauma center by the local EMS agency, in accordance with California Trauma Care System Regulations.

III. PURPOSE

To mitigate the expense to Mountain Valley EMS for implementation and managing the trauma system.

IV. POLICY

A. Trauma Center Application Fee: A trauma center application fee will be established. This fee will cover the costs associated with the designated process. These costs may include contract costs for plan development, Requests for Proposal development, review of proposals, out of area site team costs, legal reviews and agency costs in excess of the costs associated with the day to day trauma system regulation. The trauma center application fee will be assessed for hospitals applying for trauma center designation. Fees paid that are in excess of actual costs will be returned to applicants.

B. Trauma Center Designation Fee:

1. The Mountain-Valley EMS Agency Board of Directors will establish a trauma center designation fee. This fee covers the cost of monitoring the operation of the trauma care system in compliance with state trauma care systems regulations and regional policies. The fee will be based on the time requirements of the trauma medical director, trauma coordinator, and other staff time dedicated to trauma issues as well as associated overhead and program support costs.

2. Mountain-Valley EMS Agency will provide contractor written notice of any increase in the designated fee at least 90 days (three (3) months) prior to the effective date of the increase with an explanation for the increase and the basis on which it was calculated.

3. If the amount is not agreeable to the contractor and resolution of the amount cannot be reached prior to the effective date of the charge, or any later date as mutually agreed upon in writing by the parties, then either party may terminate the agreement without penalty. A written notice of 180 days must be made to other party to terminate the agreement. If the agreement is terminated, the designated fee in existence at the time notice is given will be prorated until termination.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director
SIGNATURE ON FILE IN EMS OFFICE
Medical Director

TITLE: Trauma Center Designation Process
EFFECTIVE DATE: 01/01/04
SUPERSEDES : _____
REVISED: _____
REVIEW DATE: 01/2009
PAGE 1 OF 2

TRAUMA CENTER DESIGNATION PROCESS

I. **AUTHORITY**

Division 2.5, California Health and Safety Code, Sections 1798.162, 1798.163, 1798.165.
California Code of Regulations Section 100255.

II. **DEFINITIONS**

A. "Trauma Center" or "designated trauma center" means a licensed hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV trauma center and/or Level I or II pediatric trauma center by the local EMS agency, in accordance with California Trauma Care System Regulations

III. **PURPOSE**

To define the process by which hospitals will be designated as trauma centers.

IV. **POLICY**

A. Level II trauma centers

1. Mountain Valley EMS will use a request for proposal(s) process for designation of level II trauma centers. The process will be structured to allow an application by any interested Receiving Facility in the area for which a Level II trauma center is to be designated.
2. Submitted proposals will be reviewed by Mountain-Valley EMS Agency staff for completeness and compliance with minimum requirements. Mountain-Valley EMS Agency will offer applicants whose proposals are incomplete or not fully compliant an opportunity to revise the proposal prior to its review by the Trauma Proposal Review Team.
3. The Trauma Proposal Review Team, which reviews the written proposals and conducts site visits, will include a trauma surgeon(s), emergency physicians(s), trauma nurse coordinator(s), and/or hospital administrator(s), EMS agency administrator(s), and/or similar experts as necessary. It will consist of individuals who:
 - * Have previous expertise in trauma center and trauma care system operation.
 - * Understand the multi-disciplinary nature of trauma care.
 - * Have no known conflicts of interest.
 - * Are from outside of Mountain-Valley EMS Agency region.
4. Based on the recommendation(s) of the Trauma Proposal Review Team, the

Board of Directors will designate the Level II trauma center(s). The Board's preliminary decision may be appealed to an appeal committee consisting of the Health Officers of the counties in the service area. The committee will review the appeal and make recommendation to the Board of Directors whose decisions will be final. Grounds for appeals are limited to alleged failure to follow the RFP process and criteria and conflicts of interest.

5. Mountain-Valley EMS Agency will execute a contract with the designated facility based on the proposal. If Mountain-Valley EMS Agency and the facility are unable to mutually agree on a contract, the designation may be withdrawn and offered to another Receiving Facility.

B. Level III and Level IV trauma centers

1. Mountain-Valley EMS Agency will use an application process for designation of level III and Level IV trauma centers. The process will be structured to allow an application by any interested receiving facility in the Mountain-Valley EMS Agency area.
2. Submitted application will be reviewed by Mountain-Valley EMS Agency staff for completeness and compliance with minimum requirements. Mountain-Valley EMS Agency will offer applicants whose proposals are incomplete or not fully compliant an opportunity to revise the proposal prior to its review by the Trauma Proposal Review Team. The goal of this process to promote participation in the system by all interested facilities.
3. The Trauma Proposal Review Team, which reviews the written proposals and conducts site visits, will include a trauma surgeon(s), emergency physicians(s), trauma nurse coordinator(s), and/or hospital administrator(s), EMS agency administrator(s), and/or similar experts as necessary. It will consist of individuals who:
 - * Have previous expertise in trauma center and trauma care system operation.
 - * Understand the multi-disciplinary nature of trauma care.
 - * Have no known conflicts of interest.
4. Based on the recommendation(s) of the Trauma Proposal Review Team, the Board of Directors will designate the Level III and Level IV trauma center(s). The Board's preliminary decision may be appealed to an appeal committee consisting of the Health Officers of the counties in the service areas. The committee will review the appeal and make recommendation to the Board of Directors whose decisions will be final. Grounds for appeals are limited to alleged failure to follow the RFP process and criteria and conflicts of interest.
5. Mountain-Valley EMS Agency will execute a contract with the designated facility based on the proposal.

TITLE: **TRAUMA CENTER BYPASS**

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

CREATION DATE: 01/19/2005

EFFECTIVE DATE: 06/08/2005

SUPERSEDES: _____

REVISED: _____

SIGNATURE ON FILE IN EMS OFFICE

REVIEW DATE: 06/2010

Medical Director

PAGE 1 OF 2

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TRAUMA CENTER BYPASS

I. AUTHORITY

Division 2.5 of the California Health and Safety Code, section 1798.163

II. DEFINITIONS

- A. "Trauma Center" means a licensed hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or Level II Pediatric Trauma Center by the local EMS Agency, in accordance with California Trauma Care System Regulations.
- B. "Disaster Control Facility" or "DCF" means a facility designated by the EMS Agency as having primary responsibility for patient disbursement decisions during a multiple casualty incident.
- C. "Trauma bypass" means all Tier I and Tier II trauma patients are redirected to the next closest level I or level II trauma facility.

III. PURPOSE:

To establish standards and procedures for Trauma Center bypass.

IV. POLICY

- A. The on-call trauma surgeon is responsible for determining the bypass status of his/her Trauma Center and will utilize the following criteria for making this determination. The Trauma Center must go on bypass status if one of the following criteria is met:
 - 1) More than 30 minutes is needed to obtain a backup trauma surgeon, neurosurgeon, orthopedist, or anesthesiologist because the primary physician is occupied with another trauma patient, or is unavailable.
 - 2) More than 1 hour is needed to identify a second operating room because the primary room is being utilized and another is not readily available.

- 3) Two or more trauma patients with major injuries are being resuscitated in the trauma room.
- 4) The hospital is closed due to an internal disaster.
- 5) The CT scanner(s) is being serviced or is broken.

V. PROCEDURE

- A. Once a Trauma Center determines that they must go on Trauma Bypass, the on-duty Trauma Nurse is responsible for ensuring that:
 - a. all trauma patients are redirected to another trauma center, taking into consideration transport time, the patient's medical needs, and the institution's available resources.
 - b. Trauma Center personnel immediately notify the appropriate resources at the time of initiation with reasons/conditions for the bypass and estimated time of bypass. Notifications will include:
 - i. Submission of an unusual occurrence report to the Mountain-Valley EMS Agency by fax at the initiation and discontinuation of the bypass.
 - ii. Update of the Trauma Center status in EMSytem:
 1. upon initiation of Trauma Bypass to Advisory Status, indicating the activation of Trauma Bypass and reason for the bypass (e.g. "TRAUMA BYPASS: CT down")
 2. upon termination of Trauma Bypass, removal of the Trauma Bypass status and text.
 - iii. DCF will be notified by telephone at the initiation and termination of the bypass. The DCF shall notify the ground ambulance dispatch center(s).
- B. In the event that both Level II Trauma Centers are requesting trauma bypass, both facilities shall remain open to trauma patients. The EMS Agency will consult with both Trauma Medical Directors and take appropriate action to ensure the safety and welfare of the public.
- C. All occurrences of Trauma Bypass greater than (60) sixty minutes, or more than (5) five hours in a (30) thirty day period, shall be referred to the Administrative Trauma Committee for review of contract compliance.

TITLE: Trauma Marketing and Advertising

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE: 01/01/2004

SUPERSEDES: _____

REVISED: _____

REVIEW DATE: 01/01/2009

PAGE 1 OF 2

TRAUMA MARKETING AND ADVERTISING

I. AUTHORITY

Division 2.5, California Health and Safety Code, Section 1798.162, 1798.163, 1798.165. (c)
California Code of Regulations Section 100255.

II. DEFINITIONS

A. "Trauma Center" or "designated trauma center" means a licensed hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV trauma center and/or Level I or II pediatric trauma center by the local EMS agency, in accordance with California Trauma Care System Regulations.

III. PURPOSE

To establish limitations on direct-to-consumer advertising by trauma centers that is intended to influence patient flow.

IV. POLICY

A. Level II Trauma Centers:

1. Marketing /Advertising - This policy encourages public information and educational activity regarding the inclusive trauma system and how it is accessed. The following shall guide the approval of the term "trauma" in marketing and advertising for Level II Trauma Centers:
 - a. Shall provide accurate information.
 - b. Shall not include false claims.
 - c. Shall not be critical of other providers.
 - d. Shall not include financial inducements to any provider or third parties.
2. Titles may include the word "trauma" in staff position titles.
3. The request to advertise and/or incorporate the term "trauma center" in promotional materials shall be made in writing to the Mountain Valley EMS

Agency. The agency shall respond within 30 days of receipt of the written request.

B. Level III and IV Trauma Centers:

1. May NOT advertise/market using the term "trauma."
2. May include the word "trauma" in staff position titles.

TITLE: MARK I KIT ADMINISTRATION

APPROVED: SIGNATURE ON FILE IN EMS OFFICE

Executive Director

SIGNATURE ON FILE IN EMS OFFICE

Medical Director

CREATION DATE: 2/05

EFFECTIVE DATE: 6/08/05

SUPERSEDES: _____

REVISED: _____

REVIEW DATE: 6/2010

PAGE 1 OF 3

MARK I KIT ADMINISTRATION FOR EMERGENCY RESPONDERS

I. AUTHORITY

Health & Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9. California Code of Regulations, Title 19, Division 2, Articles 1-8, Sections 2400et seq., Standardized Emergency Management System (SEMS) Regulations.

II. DEFINITIONS

- “Emergency Responder” means a fire fighter, law enforcement officer, or emergency medical services personnel, including first responders, EMT-Is, and paramedics.
- “Mark I Kit” means a Nerve Agent Antidote Kit containing autoinjectors of 2 mg Atropine and 600 mg Pralidoxime Choride (2-PAM).

III. PURPOSE

The purpose of this policy to establish standards for Emergency Responders in the administration of Mark I Kit Auto-injectors in treating Emergency Responders with nerve agent exposures.

IV. POLICY

- A. Mark I Kits shall only be utilized by individuals who are current employees or volunteers of an approved Mark I Provider Agency.
- B. Mark I Kits will be used only by approved Mark I Provider Agency personnel that have been trained in their use and have them available. Atropine may be administered IM/IV only by EMT-Ps in situations where MARK I Kits are not available.
- C. **Mark I Kits may only be administered to emergency responders. They are not to be utilized for the general public.**
- D. Nerve agent antidote medications are only given if an emergency responder is showing signs and symptoms of nerve agent poisoning. **THEY ARE NOT TO BE GIVEN**

PROPHYLACTICALLY.

This policy is to be used in conjunction with policy # 570.40 (Haz/Mat Incidents).

V. PROCEDURE

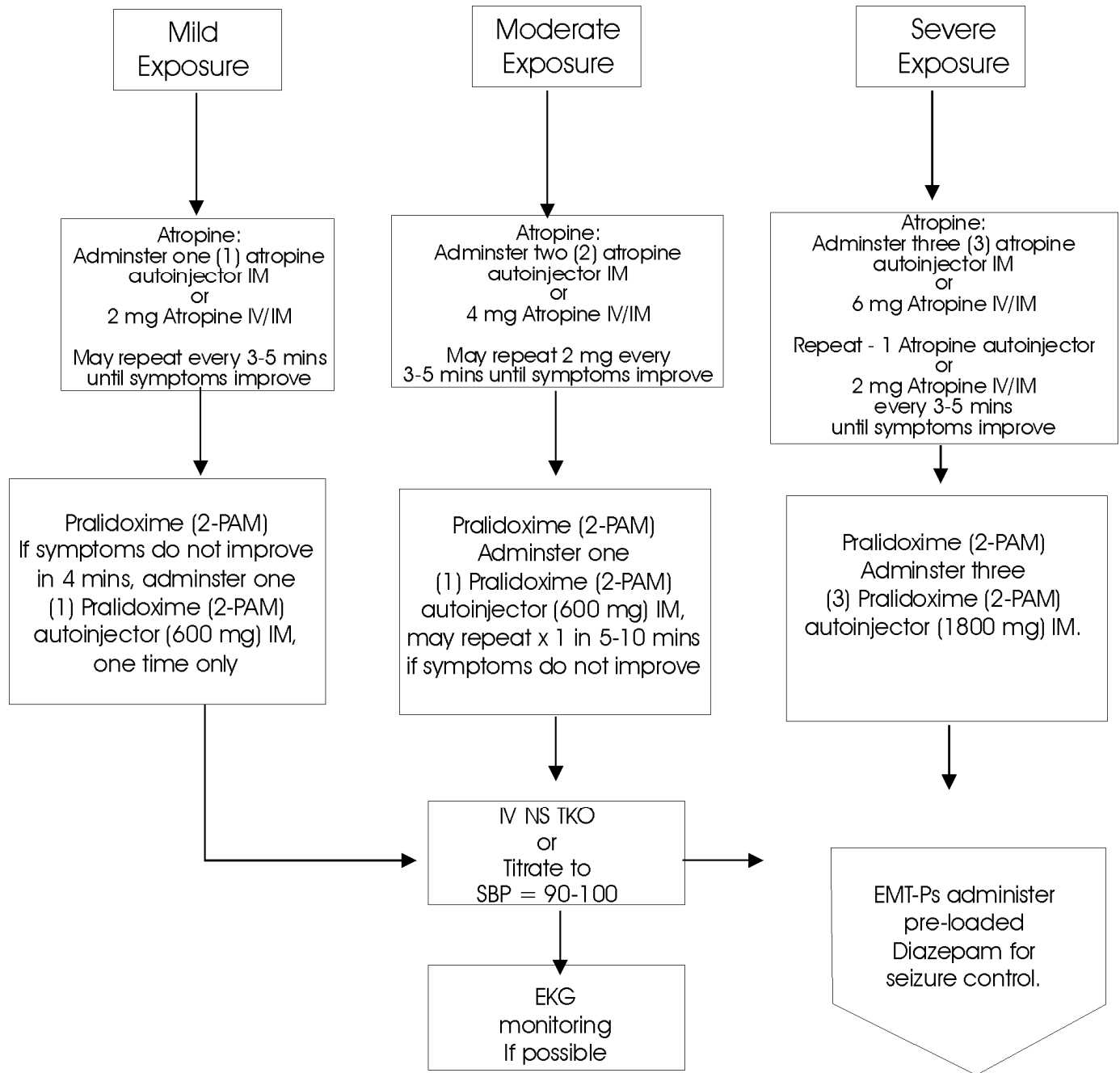
A. If exposure to nerve agents is suspected, evaluate emergency responders for signs and symptoms to determine severity of exposure using the following chart:

Signs and Symptoms of Nerve Agent Exposure

<u>EXPOSURE</u>	<u>SIGNS & SYMPTOMS</u>
Mild	<ul style="list-style-type: none">• Unexplained runny nose• Tightness in the chest• Difficulty breathing
Moderate	<ul style="list-style-type: none">• Bronchospasm• Pinpoint pupils resulting in blurred vision• Drooling• Excessive sweating• Nausea and/or vomiting• Abdominal cramps
Severe	<ul style="list-style-type: none">• Involuntary urination and/or defecation• Jerking, twitching and staggering• Headache• Drowsiness• Coma• Convulsions• Apnea

***Mnemonic for Nerve Agent
Exposure
S alivation
L acrimation
U rination
D efecation
G astrointestinal pain & gas
E mesis***

B. Administer the Mark I Kits using the following guide.



C. Submit an Unusual Occurrence report within 24 hours to Mountain-Valley EMS Agency.

**MOUNTAIN-VALLEY EMS AGENCY
POLICIES AND PROCEDURES**

POLICY: **554.50**
TITLE: **POISONING/INGESTION/OVERDOSE
(ADULT)**

APPROVED: Signature On File In EMS Office
Executive Director

Signature On File In EMS Office
Medical Director

EFFECTIVE DATE DRAFT
SUPERSEDES: _____
REVISED: _____
REVIEW DATE: _____
PAGE: 1 of 2

Poisoning/Ingestion/Overdose

- I. Authority: Health and Safety Code, Division 2.5, CA. Code of Regulation, Title 22, Division 9.
- II. | Purpose: To serve as treatment Standard of EMT-4s and ParamedicEMTPs in treating patients.
- III: Protocol:

Be careful not to contaminate yourself and others, remove contaminated clothing, brush off powders and wash off liquids. Bring in the container or label.

Contact Base Hospital if any questions or if additional therapy /treatment is required. Any Poison Control Center consultation must be coordinated with Base Hospital.

<u>Standing Orders</u>	
ABCs	
Secure airway	As appropriate. Confirm EET placement if intubated with ETCO2 detector. Continuous waveform capnography shall be used in all intubated patients, if available.
Oxygen	
IV/IO access	Rate as indicated. If systolic BP is < 90mmHg, give 250cc boluses until systolic BP is 90 – 100mmHg. Reassess patient after each bolus.
*** If patient present ALOC, refer to ALOC Treatment Guideline.***	
General Ingestion	
If non-acid, non-caustic, non-petroleum consider:	
Activated Charcoal:	Consider 1g/kg PO, maximum dose of 50gms if transport time exceeds 30 minutes. Charcoal is contraindicated if patient is not completely awake, uncooperative, lacks gag reflex, cannot self administer.
Narcotics/Opioids	
Naloxone:	Only if Respirations are < 10/min or systolic BP is < 90mmHg: 2 mg SQ, IM, IV, IN. May repeat once in 3 minutes if inadequate response.

Tricyclic Antidepressants

Sodium Bicarbonate: 1mEq/kg IVP for:
GCS < 15
HR > 100
Systolic BP < 90mmHg
QRS widening >0.12

Repeat 0.5mEq/kg every 5 minutes
for persistent signs and symptoms.

*** Do not give Activated Charcoal due to potential for rapid deterioration of LOC ***

Beta/Calcium Channel Blockers

Atropine: 0.5 – 1mg IV if BP < 90mmHg AND HR < 50/min with serious signs/symptoms.
May repeat once in 5 minutes.

Glucagon: 1 mg IM for serious signs and symptoms.

Calcium Chloride: If Calcium Channel Blocker ingestion is suspected, give 100mg (slowly) for BP < 90 AND HR < 50 AND serious signs and symptoms. May repeat in 5 minutes.

Caustics/Corrosives/Petroleum Distillates

Remove Agent. If agent is dry, brush off then flush with copious amounts of water. If agent is liquid, flush with copious amounts of water. If eyes are contaminated, flush with water for a minimum of 20 minutes.

DO NOT INDUCE VOMITING OR GIVE ACTIVATED CHARCOAL

Organophosphates

Atropine: 2mg slow IV or IM. Repeat every 3 minutes as needed to control secretions, bronchorrhea, and dysrhythmias

Amphetamine or Cocaine Intoxication with Acute Agitation

Do not approach patient unless safe. Consider employing law enforcement personnel for patient restraint.
Four point ~~restraints, restraints~~ left lateral position if possible.

Midazolam: 2mg IV. ~~Titrate~~Titrate 1mg increments to control agitation or psychosis (max dose of 6mg).
If unable to establish IV access (after one attempt), give 5mg IM. May repeat IM dose once in 10 minutes if uncontrollable behavior continues.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: 011/01/201004

SUPERSEDES: _____

REVISED: _____

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 011/01/201509

PAGE: 1 OF 1

FROSTBITE - PEDIATRIC

I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II. PURPOSE: To serve as a patient treatment standard of EMTs and Paramedics within their scope of practice. To serve as the treatment standard for EMT-Is and EMT-Ps in treating patients.

III. PROTOCOL:

Skin is white or cyanotic, numb or burning, and does not re-color with touch.

STANDING ORDERS	
EVALUATE	All exposed at-risk body parts.
WARMING PROCEDURES:	Move patient to warm environment and wrap affected extremity with thick, unwarmed blanket or clothing. <u>Do not rub affected extremity. Avoid chemical heat packs, radiant heat, or forced-air heating.</u>
IV/IO ACCESS:	Warm IV fluid, TKO with microdrip tubing and volume control chamber. Avoid cold fluids.
MORPHINE PAIN MANAGEMENT:	1-2 mg IV slow push (if systolic BP above Broselow Tape target), then 1.0 mg increments slow IV, to relieve pain. May give up to 20 mg MS without Base Physician order. Refer to Pain Management Protocol 555.43
BASE PHYSICIAN ORDERS	
MORPHINE:	Additional Morphine per Base Physician order.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: ~~01/01/2004~~11/01/2010

SUPERSEDES: _____

REVISED: _____

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 011/01/201509

PAGE: 1 OF 2

BURNS - PEDIATRIC

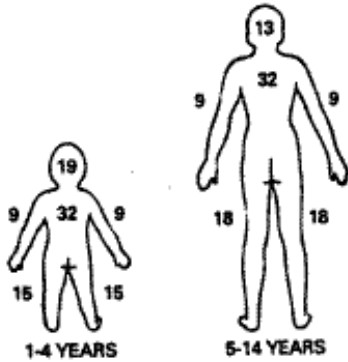
I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II. PURPOSE: ~~To serve as the treatment standard for EMT-Is and EMT-Ps in treating patients.~~ To serve as a patient treatment standard of EMTs and Paramedics within their scope of practice.

III. PROTOCOL:

STANDING ORDERS	
ABC's	
MOVE PATIENT	To a safe environment
ABC's COOLING PROCESS	For decontamination instructions and transport with patient. <u>Tar Burns:</u> Cool with water and transport. Do not attempt to remove tar. <u>Thermal Burns:</u> Cool with water for up to 5 minutes to stop the burning process.
OXYGEN	<u>Oxygen delivery as appropriate</u>
SECURE AIRWAY/ INTUBATE	<u>Consider EARLY intubation if ineffective ventilation/oxygenation, or if patient is unconscious. Otherwise, use the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable.</u> If facial or oral swelling and respiratory depression are present, especially if the patient has a history of smoke exposure in a confined space. Ventilate with bag-valve or approved ventilator with 100% oxygen. Confirm placement with end-tidal CO₂ detector & esophageal detector device. Continuous waveform capnography should be used in all intubated patients, if available.
IV/IO ACCESS	<input type="checkbox"/> <u>Superficial burns:</u> Consider Normal Saline TKO. <input type="checkbox"/> <u>Partial and full-thickness burns:</u> 0.5 ml x patient weight in kg x % burn = IV fluid per hour. If systolic BP less than Broselow Tape target, give 20 ml/kg boluses until SBP reaches target. <u>Reassess patient after each bolus.</u> <input type="checkbox"/> Reassess patient after each bolus.
MONITOR:	IV site in order of preference: 1. unburned upper extremity, or external jugular 2. unburned lower extremity 3. burned upper extremity 4. burned lower extremity
DRESS BURNS	Treat rhythm as appropriate. Cover with dry dressing and keep patient warm.
MORPHINE:	<u>Refer to Pain Management Protocol 555.431-2 mg IV slow push (if systolic BP above Broselow Tape target), then 1.0 mg increments slow IV, to relieve pain. May give up to 20 mg MS without Base Physician order.</u>
TRANSPORT	To nearest facility if patient is unstable (airway difficulty, hypotension) or according to Trauma Triage and Patient Destination Policy 553.25 if stable.
BASE PHYSICIAN ORDERS	

Body Surface Area Chart Follows



<u>Burn Area</u>	<u>Age in years</u>				
	<u>1</u>	<u>1-4</u>	<u>5-9</u>	<u>10-14</u>	<u>15</u>
Head	19	17	13	11	9
Neck	2	2	2	2	2
Anterior Trunk	13	13	13	13	13
Posterior Trunk	18	18	18	18	18
Genitalia	1	1	1	1	1
Upper Extremity (each)	9	9	9	9	9
Lower Extremity (each)	14.5	15.5	17.5	18.5	19.5

The patient's palm (hand minus fingers) is about 1% of the patient's body surface area.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: 011/01/201004

SUPERSEDES: _____

REVISED: _____

| SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 01 11/01/201509

PAGE: 1 OF 1

PEDIATRIC TRAUMATIC SHOCK

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard of EMTs and Paramedics within their scope of practice. ~~the treatment standard for EMT-Is and EMT-Ps in treating patients.~~
- III. PROTOCOL:

STANDING ORDERS

ABC's

SECURE AIRWAY

Using the simplest effective method while maintaining c-spine. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider intubation/perilaryngeal airway while en route. Confirm placement, ~~if intubated, with end-tidal CO₂ detector and esophageal detector device.~~ **Continuous waveform capnography should be used in all intubated patients, with advanced airways, if available.**

OXYGEN

Oxygen delivery as appropriate

SPINE IMMOBILIZATION

If indicated, refer to General Protocols ALS Intro-554.00

CONTROL OBVIOUS BLEEDING

Consider tourniquet for uncontrolled extremity hemorrhage

OXYGEN

IV/IO ACCESS

Start two large-bore cannulas with volume control chambers. Give 20 ml/kg fluid boluses. Repeat x 2. Reassess the patient after each bolus administration.

DRESS & SPLINT

As needed.

CONSIDER

MORPHINE

Refer to Pain Management Protocol 555.431-0 mg increments slow IV, to relieve pain. May give up to 20 mg MS without Base Physician order. Beware of respiratory depression or worsening of hypotension.

NEEDLE THORACOSTOMY TENSION PNEUMOTHORAX

For tension pneumothorax, on affected side in second intercostal space in midclavicular line. Perform on other side if no response to treatment and tension pneumothorax physiology persists. Secure catheter to chest.

DRAW BLOOD SAMPLE TEST FOR GLUCOSE

Test for glucose-Finger Stick

BASE PHYSICIAN ORDERS

MORPHINE:

Additional morphine per Base Physician order.

DECLARATION OF DEATH Refer to Determination of Death policy 570.20 for obvious death criteria.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE 01/01/2010

SUPERSEDES: _____

REVISED: _____

| SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 01/01/2015

PAGE: 1 of 1

PEDIATRIC HEAD – NECK – FACIAL TRAUMA

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: ~~To serve as a patient treatment standard for EMTs and Paramedics within their scope of practice~~
To serve as the treatment standard for EMTs and EMT-Ps in treating patients.
- III. PROTOCOL:

STANDING ORDERS

ABC's

SECURE AIRWAY/INTUBATE Use simplest effective method, while maintaining c-spine. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider intubating while en route. Confirm tube placement, if intubated, with end-tidal CO₂ detector and esophageal detector device. **Continuous waveform capnography should be used in all intubated patients, if available.**

NOTE: Medicate brain injury patients with Lidocaine 1.5 mg/kg IV prior to intubating, when time allows.

C-SPINE IMMOBILIZATION: If indicated, refer to ~~ALS Intro~~ General Protocols 554.00

OXYGEN: ~~Hyperventilate only if neurologic status is deteriorating.~~ Oxygen deliver as appropriate

POSITION: Elevate the heads of brain injured patients, if patient exhibits no signs of shock.

IV/IO ACCESS: TKO ~~with microdrip tubing and volume control chamber.~~

DRESS & SPLINT As needed.

MORPHINE: ~~Refer to Pain Management Protocol 555.431 – 2 mg IV slow push (if systolic BP above Broselow Tape target), then 1.0 mg increments slow IV, to relieve pain. May give up to 20 mg MS without Base Physician order.~~

CONSIDERATIONS

- **Avulsed Tooth** Place tooth in milk, normal saline, saline soaked gauze or a commercial "tooth saver."
- **Eye Injuries** Cover with a non-contact dressing, such as a paper cup. Do not apply direct pressure to eye and do not attempt to replace partially torn globe.
- **Impaled Object** Immobilize and leave in place. Remove object only if it interferes with CPR, extrication or ventilation.

BASE PHYSICIAN ORDERS

MORPHINE: Additional morphine per Base Physician order

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: 1102/012/201004

SUPERSEDES: _____

REVISED: _____

| SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 1102/01/201509

PAGE: 1 OF 1

PEDIATRIC CHEST TRAUMA

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: ~~To serve as the treatment standard for EMT-Is and EMT-Ps in treating patients.~~ To serve as a patient treatment standard for EMTs and Paramedics within their scope of practice
- III. PROTOCOL:

STANDING ORDERS

ABC's

SECURE AIRWAY/INTUBATE Use simplest effective method while maintaining c-spine. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider intubating while en route. Confirm tube placement, if intubated, with end-tidal CO₂ detector and esophageal detector device. **Continuous waveform capnography should be used in all intubated patients, if available.**

SPINE IMMOBILIZATION If indicated, refer to ~~ALS Intro~~ General Protocols 554.00

OXYGEN Oxygen delivery as appropriate

IV/IO ACCESS TKO ~~with microdrip tubing and volume control chamber.~~
If signs of shock, 20 ml/kg fluid bolus until Broselow Tape systolic BP target. Reassess patient after each bolus.

DRESS & SPLINT As needed.

CONSIDERATIONS

- ~~●~~ **Impaled Object** Immobilize and leave in place. Remove object only if it interferes with CPR, extrication, or ventilation
- ~~●~~ **Flail Chest** Stabilize chest. Observe for tension pneumothorax. Consider assisted ventilation.
- ~~●~~ **Open Chest Wound** Cover wound. Dress wound loosely (do not seal). Continuously re-evaluate patient for tension pneumothorax.
- ~~●~~ **Tension Pneumothorax** Perform needle thoracostomy or remove any occlusive dressing on an open chest wound. Refer to the Traumatic Shock Protocol Policy 555.82
- ~~●~~ **Cardiac Tamponade** If systolic BP below Broselow Tape target, give 20 ml/kg fluid boluses until systolic BP reaches target. Reassess the patient after each bolus. Refer to the Traumatic Shock Policy 555.82
- ~~●~~ **Cardiac Contusion** Monitor for dysrhythmias. Refer to Cardiac Protocols (Policy 555.11, 555.12, 555.13, 555.14, and 555.15)

BASE PHYSICIAN ORDERS

MORPHINE: ~~1-2 mg IV slow push (if systolic BP above Broselow Tape target), then 1.0 mg increments slow IV, to relieve pain. May repeat as needed.~~ Refer to Pain Management Protocol 555.43

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: 02/02/2004

SUPERSEDES: _____

REVISED: _____

SIGNATURE ON FILE IN EMS OFFICE

REVIEW DATE: 02/2009

Medical Director

PAGE: 1 OF 1

PEDIATRIC ABDOMINAL TRAUMA

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: ~~To serve as the treatment standard for EMT-Is and EMT-Ps in treating patients.~~ To serve as a patient treatment standard for EMTs and Paramedics within their scope of practice
- III. PROTOCOL:

STANDING ORDERS	
ABC's	
SECURE AIRWAY	Use simplest effective method while maintaining c-spine. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider intubating while en route <u>intubation/perilaryngeal airway</u> . Confirm tube placement, if intubated, with end-tidal CO₂ detector and esophageal detector device. Continuous waveform capnography should be used in all intubated patients, if available.
SPINE IMMOBILIZATION	If indicated, refer to ALS Intro <u>General Protocols</u> 554.00
OXYGEN	<u>Oxygen delivery as appropriate</u>
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber. If signs of shock, give 20 ml/kg fluid bolus until Broselow Tape systolic BP target. Reassess patient after each bolus.
DRESS & SPLINT	As needed.
CONSIDERATIONS	
● Impaled Object	Immobilize and leave in place. Remove object only if object interferes with CPR, extrication, or ventilation.
● Eviscerating Trauma	Cover eviscerated bowels and organs with saline soaked gauze. <u>Do not</u> attempt to replace bowels or organs into the abdominal cavity.
● Genital Injuries	Cover genitalia with saline soaked gauze. If necessary apply direct pressure to control bleeding. Treat amputation the same as extremity amputation, refer to Extremity Trauma Policy 555.87.
BASE PHYSICIAN ORDERS	
MORPHINE:	1-2 mg IV slow push (if systolic BP above Broselow Tape target), then 1.0 mg increments slow IV, to relieve pain. May repeat as needed. <u>Refer to Pain Management Protocol 555.43</u>

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE: 1102/012/201004

SUPERSEDES: _____

REVISED: _____

REVIEW DATE: 1102/01/201509

PAGE: 1 OF 1

PEDIATRIC EXTREMITY TRAUMA

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: ~~To serve as the treatment standard for EMT-Is and EMT-Ps in treating patients.~~ To serve as a patient treatment standard for EMTs and Paramedics within their scope of practice
- III. PROTOCOL:

STANDING ORDERS

ABC's

SECURE AIRWAY: Use simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider intubation/perilaryngeal airway. Confirm placement. Continuous waveform capnography should be used in all patients with advanced airways. As appropriate. Confirm tube placement, if intubated, with end-tidal CO₂ detector and esophageal detector device. **Monitor intubated patients with continuous waveform capnography if available.**

SPINE IMMOBILIZATION: If indicated, refer to ~~ALS Intro~~ General Protocols 554.00

OXYGEN: Oxygen delivery as appropriate

DRESS & SPLINT:

- Splint dislocations in position found.
- Check neurovascular status prior to and after each extremity manipulation.
- Control bleeding with direct pressure.
- Cover exposed bone with saline soaked gauze.
- Angulated long bone fractures may be realigned with gentle axial traction for splinting.
- In cases involving major multi-system trauma, consider "splinting the whole body" by strapping the patient to a back board, rather than splinting each ~~individually~~ individual extremity.

IV/IO ACCESS: TKO ~~with microdrip tubing and volume control chamber.~~

If signs of shock, give 20 ml/kg fluid bolus until Broselow Tape systolic BP target. Reassess patient after each bolus.

MORPHINE: Refer to Pain Management Protocol 555.431-2 mg IV slow push (if systolic BP above Broselow Tape target), then 1.0 mg increments slow IV, to relieve pain. May give up to 20 mg MS without Base Physician order. May give 0.2 mg/kg IM.

CONSIDERATIONS

Amputations If partial amputation, splint in anatomic position and elevate the extremity. Wrap completely amputated parts in dry sterile gauze, then place in a sealed, dry container. Place container in ice, if possible.

BASE PHYSICIAN ORDERS

MORPHINE:

Additional Morphine per Base Physician order

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 02/02/2004
SUPERSEDES: _____
REVISED: 01/2008
REVIEW DATE: 02/2009
PAGE: 1 of 2

PEDIATRIC MEDICATION CHART

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard for EMTs and Paramedics within their scope of practice
~~serve as the treatment standard for EMT-Is and EMT-Ps in treating patients.~~
- III. PROTOCOL:

DO NOT EXCEED ADULT TOTALS
c = concentration

	Premie	NB	3 Mos.	6 Mos.	1 Year	2 year	4 Year	6 Year	8 Year	10 Year	12 Year
Body Length Range (centimeters)	0 to 53	54 to 58	59 to 65	66 to 74	75 to 80	81 to 86	87 to 99	100 to 113	114 to 132	133 to 158	159 to 189
Average Body Weight (kilograms)	< 2.5	2.5 - 4	6	7	10	12	16	20	25	34	41
Activated Charcoal c=6.25 g/oz- dose = 1 g/kg	-	-	-	-	-	12-g	16-g	20-g	25-g	34-g	41-g
Adenosine c = 3 mg/ml dose = 0.1 mg/kg	-	0.25 - 0.4 mg	0.6 mg	0.7 mg	1 mg	1.2 mg	1.6 mg	2.0 mg	2.5 mg	3.4 mg	4.1 mg
Albuterol 1 unit dose (3 ml of 0.083% nebulizer solution)	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit
Atropine IV c = 0.1 mg/ml dose = 0.02 mg/kg (cardiac dose)	-	.1 mg	0.12 mg	0.14 mg	0.2 mg	0.24 mg	0.32 mg	0.4 mg	0.5 mg	0.68 mg	0.82 mg
Dextrose (D50W diluted to D25W) dose = 2 ml/kg	2 - 5 ml	5 - 8 ml	12 ml	14 ml	20 ml	24 ml	-	-	-	-	-
Dextrose (D50W) dose = 1 ml/kg	-	-	-	-	-	-	16 ml	20 ml	25 ml	34 ml	41 ml
Midazolam IV c = 5 mg/ml dose = 0.1 mg/kg	0.1 - 0.25 mg	0.25 - 0.4 mg	0.6 mg	0.7 mg	1 mg	1.2 mg	1.6 mg	2 mg	2 mg	2 mg	2 mg
Diphenhydramine c = 10 mg/ml dose = 1 mg/kg	1 - 2.5 mg	2.5 - 4 mg	6 mg	7 mg	10 mg	12 mg	16 mg	20 mg	25 mg	34 mg	41 mg

	Premie	NB	3 Mos.	6 Mos.	1 Year	2 year	4 Year	6 Year	8 Year	10 Year	12 Year
Body Length Range (centimeters)	0 to 53	54 to 58	59 to 65	66 to 74	75 to 80	81 to 86	87 to 99	100 to 113	114 to 132	133 to 158	159 to 189
Average Body Weight (kilograms)	< 2.5	2.5 - 4	6	7	10	12	16	20	25	34	41
Dopamine	FOR A CONCENTRATION OF 800 µg of DOPAMINE PER MILLILITER SOLUTION: One 5 ml ampule of Dopamine (200 mg of dopamine per ampule) mixed in 250 ml of NS										
10µg IV/IO	1	3	4	5	7	9	12	15	19	25	31
15µg IV/IO	2	4	7	8	11	13	18	22	28	38	46
20µg IV/IO	3	6	9	10	15	18	24	30	37	51	61
Epinephrine 1:10,000 IV/IO dose = 0.01 mg/kg	0.01 - 0.025 mg	0.025 - .04 mg	0.06 mg	0.07 mg	0.1 mg	0.12 mg	0.16 mg	0.2 mg	0.25 mg	0.34 mg	0.41 mg
Epinephrine 1:1000 ET dose =0.1 mg/kg	-	-	0.6 mg	0.7 mg	1 mg	1.2 mg	1.6 mg	2 mg	2.5 mg	3.4 mg	4.1 mg
Epinephrine 1:1000 SQ dose = 0.01 mg/kg	-	-	0.06 mg	0.07 mg	0.1 mg	0.12 mg	0.16 mg	0.2 mg	0.25 mg	0.34 mg	0.41 mg
Fluid Challenge dose = 20 ml/kg	20 - 50 ml	50 - 80 ml	120 ml	140 ml	200 ml	240 ml	320 ml	400 ml	500 ml	680 ml	820 ml
Glucagon c = 1 mg/ml or 1 unit/ml dose = 0.05 mg/kg (up to 1 mg)	0.3 mg	0.3 mg	0.3 mg	0.35 mg	0.5 mg	0.6 mg	0.8 mg	1 mg	1 mg	1 mg	1 mg
Lidocaine IV c = 20 mg/ml dose = 1 mg/kg	-	2.5 - 4 mg	6 mg	7 mg	10 mg	12 mg	16 mg	20 mg	25 mg	34 mg	41 mg
Lidocaine ET c = 20 mg/ml dose = 3 mg/kg	-	7.5 - 12 mg	18 mg	21 mg	30 mg	36 mg	48 mg	60 mg	75 mg	102 mg	123 mg
Morphine c = 10 mg/ml dose = 0.1 mg/kg	-	0.25 - 0.4 mg	0.6 mg	0.7 mg	1 mg	1.2 mg	1.6 mg	2 mg	2 mg	2 mg	2 mg
Naloxone c = 1 mg/ml dose = 0.1 mg/kg (up to 2 mg)	0.1 - 0.25 mg	0.25 - 0.4 mg	0.6 mg	0.7 mg	1 mg	1.2 mg	1.6 mg	2 mg	2 mg	2 mg	2 mg
Sodium Bicarbonate c = 1 mEq/ml dose = 1 mEq/kg	1 - 2.5 mEq	2.5 - 4 mEq	6 mEq	7 mEq	10 mEq	12 mEq	16 mEq	20 mEq	25 mEq	34 mEq	41 mEq

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 4/13/2005DRAFT
SUPERSEDES: _____
REVISED: 03/2005DRAFT
REVIEW DATE: DRAFT04/2010
PAGE: 1 of 3

PHYSICIAN ON SCENE

I. AUTHORITY

Health and Safety Code, Section 1797.220, and Title 22, California Code of Regulations, Section 100169.

II. PURPOSE

To provide direction for prehospital personnel when a physician is present on the scene of an EMS call.

III. POLICY


Prehospital ALS personnel shall accept direction from a physician at the scene of an EMS call only under the circumstances described below.

IV. PROCEDURE

- A. If a physician wishes to direct the ALS care of a patient in the field and they are not recognized as a physician by EMS personnel, identification shall be requested. Identification should include a valid California Medical License and some form of identification that includes a picture (e.g. drivers license, hospital I.D.). Identification will not be required for calls originating at a physician's office, hospital or clinic.
- B. For calls originating at a private physician's office, clinic, emergency department, or when a patient's own private physician is on-scene, ALS personnel may follow the attending physician's written direction and will not be required to make base hospital contact unless: 1) the physician's orders do not comply with Regionally approved policies or treatment guidelines, or 2) the physician's orders do not comply with Regionally approved ALS/BLS scope of practice, or 3) there is an unexpected development in route which would require base hospital contact. Any written directions given by the physician shall accompany the patient and a copy shall be attached to the Patient Care Record.

- C. For calls originating at the scene of a medical emergency in which a physician is present who is not the patient's private physician, or if the attending physician's orders described in paragraph B, do not comply with approved treatment guidelines or scope of practice, the physician shall either be 1) advised that prehospital personnel function under the direction of a base hospital physician and place them in contact with the base physician; or 2) presented with a "Note to Physician on Involvement with EMT IIs and EMT-P (Paramedic)" card endorsed by the California Medical Association and the State EMS Authority (see page 3 of 3); or 3) informed that he/she may assume medical direction if they are also willing to accompany the patient in the ambulance to the receiving hospital.
- D. If the physician is not willing to accompany the patient and still wishes to direct the care, EMS personnel shall establish radio or telephone contact with the appropriate base hospital and explain the situation to the base hospital physician.
- E. If the base hospital physician so directs, the ALS personnel may take medical direction from the private physician as long as that direction is consistent with their scope of practice. In this situation, the base hospital physician shall assume medical control upon the initiation of transport.
- F. ALS personnel accepting appropriate direction from a private physician shall continue to follow Regional EMS policies, Treatment Guidelines, and Scope of Practice.
- G. The private physician may choose to offer assistance with another pair of eyes, hands, or suggestions; but allow the ALS personnel to operate under the direction of the base hospital, or the appropriate policies and procedures.
- H. At all times the private physician is to be treated with respect and courtesy. Utilize the base hospital physician to resolve any challenges that arise and file an Unusual Occurrence report with your employer liaison.

V. State of California - California Medical Association, Note To Physician on Involvement With EMT-IIs and EMT-Ps (Paramedic):

 <p>STATE OF CALIFORNIA EMSA &</p> <p>CALIFORNIA MEDICAL ASSOCIATION</p> <p>NOTE TO PHYSICIANS ON INVOLVEMENT WITH EMT-Is AND PARAMEDICS</p> <p>A life support team (EMT-II or Paramedic) operates under standard policies and procedures developed by the local EMS agency and approved by their Medical Director under Authority of Division 2.5 of the California Health and Safety Code. The drugs they carry and procedures they can do are restricted by law and local policy. If you want to assist, this can only be done through one of the alternatives listed on the back of this card. These alternatives have been endorsed by CMA, State EMS Authority, CCLHO and BMQA.</p> <p>Assistance rendered in the endorsed fashion, without compensation, is covered by the protection of the Good Samaritan Code@ (see Business and Professional Code, Sections 2144, 2395-2298 and Health and Safety Code, Section 1799.104). (over)</p>	<p><u>ENDORSED ALTERNATIVES FOR PHYSICIAN INVOLVEMENT</u></p> <p>After identifying yourself by name as a physician licensed in the State of California, and, if requested, showing proof of identity, you may choose one of the following:</p> <ol style="list-style-type: none">1. Offer your assistance with another pair of eyes, hands or suggestions, but let the life support team remain under base hospital control; or,2. Request to talk to the base station physician and directly offer your medical advice and assistance; or,3. Take total responsibility for the care given by the life support team and physically accompany the patient until the patient arrives at a hospital and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedures. <p>(Whenever possible, remain in contact with the base station physician)</p> <p>(REV. 7/88) 88 49638 Provided by the Emergency Medical Services Authority</p>
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TITLE: Trauma Patient Transfer and Transportation

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: 1102/0102/201004

SUPERSEDES: _____

REVISED: _____

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 02/200911/01/2015

PAGE 1 OF 2

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TRAUMA PATIENT TRANSFER AND TRANSPORTATION

I. AUTHORITY:

Division 2.5, California Health and Safety Code, Sections 1798.162, 1798.163,
California Code of Regulations Section 100255, 100266.

II. DEFINITIONS:

- A. "Pediatric" or "pediatric patient" means an individual, age 14 and under who meets trauma triage criteria.
- B. "Trauma Center" or "designated trauma center" means a licensed hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV trauma center and/or Level I or II pediatric trauma center by the local EMS agency, in accordance with California Trauma Care System Regulations.

III. PURPOSE:

To establish standards for trauma patient flow among levels of trauma centers and receiving hospitals.

IV. POLICY

A. Interfacility

Patient transfers between Level II trauma centers within Mountain Valley EMS system shall only be conducted by mutual agreement of the transferring and receiving hospitals. The receiving hospital shall ensure that an appropriate member of its medical staff is available to take responsibility for the patient.

B. Level III or Level IV Trauma Center to Level I or Level II Trauma Center

Each Level III or Level IV trauma center, as a condition of designation, shall have:

- 1. ~~A-w~~Written transfer agreements with, at least, the nearest designated Level

II trauma center.

2. Guidelines for identification of those patients who should be transferred to the trauma center which are based on the American College of Surgeons' High-Risk Criteria for Consideration of Early Transfer.
3. A procedure for arranging for transfer of appropriate patients, including, but not limited to:
 - a. Notification of the receiving trauma center physician
 - b. Arranging for transport, either ground or air
 - c. Accompanying of the patient by hospital staff, if appropriate

C. Level II Trauma Center to Level I Trauma Center

Each Level II trauma center, as a condition of designation, shall have:

1. ~~A~~written transfer agreements with, at least, the nearest designated Level I trauma center and with specialty centers providing tertiary level care for burn and spinal cord injury patients.
2. Guidelines for identification of those patients who should be transferred to the trauma center which are based on the American College of Surgeons' High-Risk Criteria for Consideration of Early Transfer.
3. A procedure for arranging for transfer of appropriate patients, including, but not limited to:
 - a. Notification of the receiving trauma center physician
 - b. Arranging for transport, either ground or air
 - c. Accompanying of the patient by hospital staff, if appropriate

D. Pediatric Transfers

Each Level II trauma center, as a condition of designation, shall have:

1. A written transfer agreements with, at least, the nearest designated pediatric trauma center.
2. Guidelines for identification of those patients who should be transferred to the trauma center
3. A procedure for arranging for transfer of appropriate patients, including, but not limited to:
 - a. Notification of the receiving trauma center physician
 - b. Arranging for transport, either ground or air
 - c. Accompanying of the patient by hospital staff, if appropriate

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: 01/01/2004

SUPERSEDES: _____

REVISED: _____

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 01/01/2009

PAGE 1 OF 2

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COORDINATION WITH HMOS AND OTHER MANAGED CARE ORGANIZATIONS

I. AUTHORITY:

Division 2.5, California Health and Safety Code, Sections 1798.162, 1798.163
California Code of Regulations Section 100255.

II. DEFINITIONS:

- A. "Health maintenance organization" (HMO) means an organization authorized under the Knox-Keene Health Care Service Plan Act of 1975
- B. "Trauma center" or "designated trauma center" means a licensed hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV trauma center and/or Level I or II pediatric trauma center by the local EMS agency, in accordance with California Trauma Care System Regulations

III. PURPOSE:

To promote patient flow in a manner than meets patients clinical needs while considering the economic impact of patient flow decisions.

IV. POLICY

- A. The Mountain-Valley EMS Agency trauma triage policy (Policy #553.25) does not consider the patient's insurance status in determining the destination of patients who meet the triage criteria. Since patients who require trauma center level services may not require this level once they have been stabilized, trauma centers should consider the need to return patients who are insured by health maintenance and other managed health care organizations to their payer's network at a medically appropriate time.
- B. Trauma centers shall make a good faith effort to negotiate agreements with health maintenance and other managed health care organizations regarding payment, repatriation of patients, and other related factors.

APPROVED: DRAFT
 Executive Director

DRAFT
 Medical Director

EFFECTIVE DATE 00/00/0000
 SUPERSEDES:
 REVISED:
 REVIEW DATE:
 PAGE: 1 of 9

MULTI-CASUALTY INCIDENT (MCI) FIELD OPERATIONS GUIDE

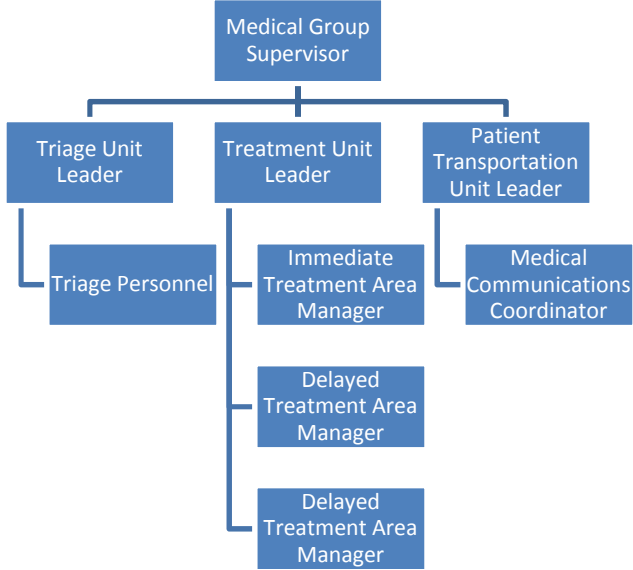
- I. **AUTHORITY:** Division 2.5, Health and Safety Code, Section 1797.220
- II. **PURPOSE:** To direct EMS responders regarding the response organization, personnel, equipment, resources, and procedures for field operations during a multiple casualty incident. This policy and procedures are intended to supplement the Cal-EMA Mutual Aid Region IV MCI Plan.
- III. **POLICY:** Field EMS responders shall use the following procedures when the corresponding triggers are met at each stage, during response to a multiple casualty incident.
- IV. **PROCEDURE:**

STAGE 1 MCI	
ACTIVATION TRIGGERS:	Incident conditions significantly impact or overwhelm hospital or pre-hospital resources, which may include one or more of the following: <ul style="list-style-type: none"> ➤ More than 6 patients at a single incident, or ➤ More than 2 Immediate/Delayed patients being sent to a single receiving facility, or ➤ More than 2 receiving facilities are needed, or ➤ The IC or MGS determined that Stage 1 MCI protocols are necessary
COMMAND & CONTROL:	<ol style="list-style-type: none"> 1. The Incident Commander (IC) shall be that individual present on scene representing the public service agency having primary investigatory authority or responsibility. 2. The IC may directly supervise operations or appoint an Operations Section Chief. 3. The first-in medical responders should be appointed Medical Group Supervisor (MGS) and Triage Unit Leader.
INITIAL RESPONDERS:	<p>The first medical unit enroute shall notify the Control Facility of a possible MCI. Once on scene, report to the IC and get permission to establish the medical group (or temporarily assume IC and establish the ICS), including:</p> <ul style="list-style-type: none"> ➤ Resources: Ensure adequate resources have been ordered (Equipment, Manpower, Transportation), and clarify with IC the ordering process (i.e. can MGS order additional medical resources). Update ambulance dispatch and the Control Facility as soon as possible upon arrival. ➤ Assignments: Assign Triage Unit Leader to begin triage. ➤ Communications: Determine medical tactical channel, command net, air ops (if any), etc. in cooperation with the IC. ➤ Ingress / Egress: Determine the best routes in and out of the incident with IC, and notify dispatch. ➤ Name: Clarify incident name with IC, and notify dispatch. ➤ Geography: Quickly determine with the IC where incoming resources will stage, establish triage, treatment, transport areas. <p>Note: The first in ambulance should generally be the last ambulance to leave</p>

	the scene. Additionally, medical supplies from the first in ambulance should be used by triage/treatment units.
RECOMMENDED NIMS / SEMS STRUCTURE	<p>Initial Multi-Casualty Organization:</p> <pre> graph TD MGS[Medical Group Supervisor] --- TUL[Triage Unit Leader] MGS --- TUL_Leader[Treatment Unit Leader*] MGS --- PTUL[Patient Transportation Unit Leader*] </pre> <p>*Treatment /Transport Unit Leader positions may be performed by the MGS.</p>
TRIAGE	<ol style="list-style-type: none"> 1. The S.T.A.R.T. method of triage shall be used. Triage tags should be applied to each victim. 2. Personnel should spend no more than 30-60 seconds per victim triaging. 3. Treatment rendered will initially be confined to airway positioning and major hemorrhage control.
TREATMENT	<ol style="list-style-type: none"> 1. Designate Treatment Areas as needed: Immediate (Red), Delayed (Yellow), and Minor (Green). These areas should be located in safe areas, large enough to handle the number of victims, easily accessible to rescue vehicles, and away from the Morgue Area (Black). 2. Once they have been triaged, patients may be sent to the appropriate treatment area. Continuous re-triage and patient evaluation should occur in these areas until the patient is transported. 3. Personnel assigned to the treatment areas shall only function within their scope of practice and under medical control. 4. Any on-scene MD's and RN's should be assigned to the treatment areas.
TRANSPORTATION	<ol style="list-style-type: none"> 1. The Patient Transportation (Transport) Unit Leader in cooperation with the Control Facility will arrange transport of patients to the most appropriate facilities. 2. At all times the most immediate patients should be transported first to the most appropriate available medical facility. Patients may be transported by a lower level of trained personnel as determined by the Transport Unit Leader in cooperation with Treatment Area Managers based on available resources and personnel. 3. The Transport Unit Leader will contact the Control Facility and provide patient information, and total number of transport resources available. Patient information will be limited to age, gender, triage category, tag number, and major injury. 4. Control Facility relays patient information to receiving facilities. 5. Transport units shall not contact receiving facilities on the Med-Net radio.
COMMUNICATIONS	<ol style="list-style-type: none"> 1. On-scene coordination/car-to-car communications may occur on an EMS Tactical Channel. 2. If authorized by the IC, the MGS will request ambulance resources directly through Ambulance Dispatch and notify the IC or designee. 3. The Control Facility shall be notified: <ul style="list-style-type: none"> • enroute by first-in ambulance to known or suspected MCI; • after initial scene size-up, and after triage is completed, • when patients are ready for transport (to obtain destinations), • when units depart scene (with Unit #/ETA), and • when scene is clear.
DOCUMENTATION	<ol style="list-style-type: none"> 1. Patient Care Report shall be completed for each patient.

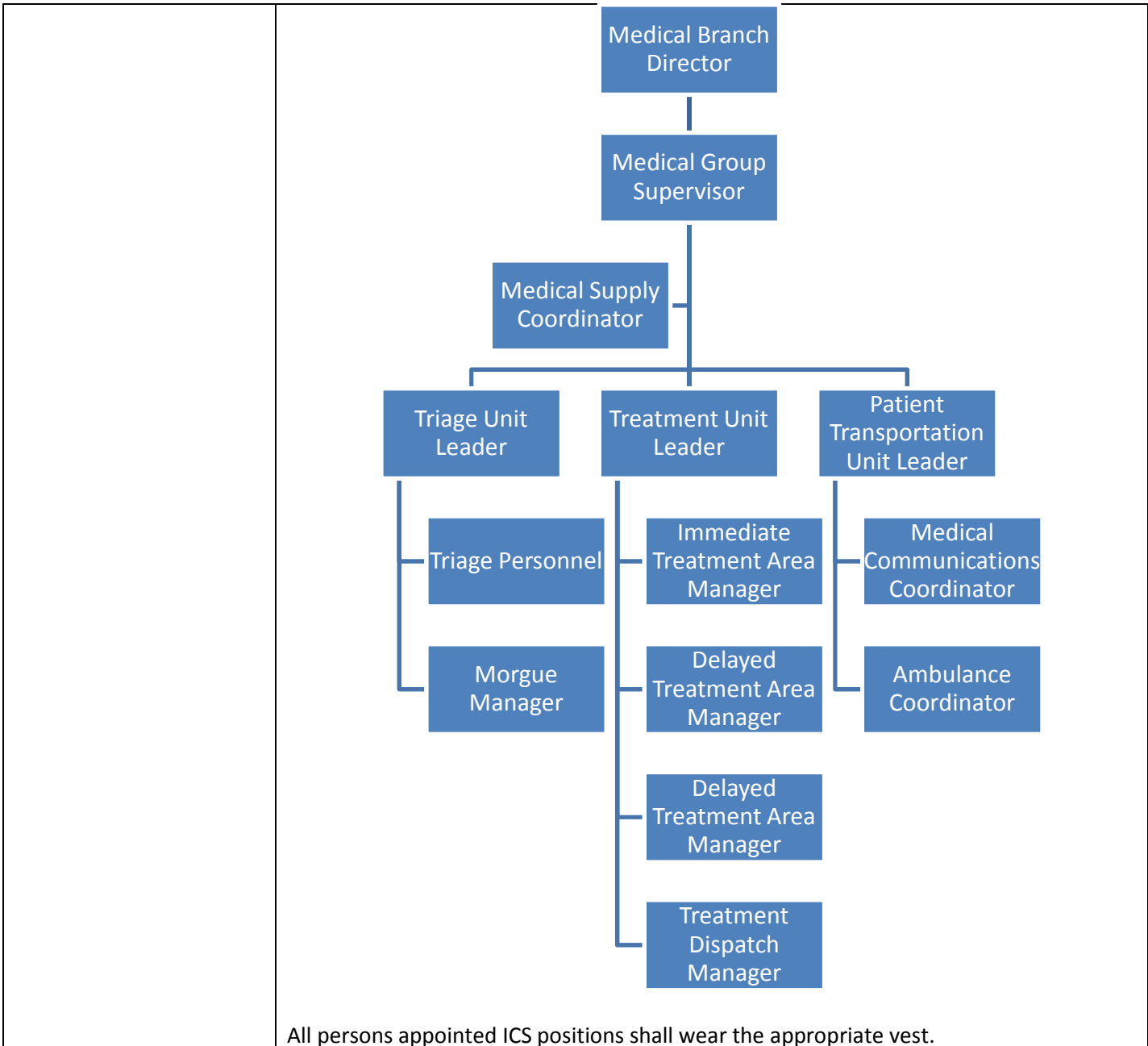
	2. Patient Transportation Worksheet completed by Transport Unit Leader. 3. MGS is responsible to ensure all paperwork is complete (coordinate with Control Facility) and copies submitted to the EMS Agency.
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STAGE 2 MCI	
ACTIVATION TRIGGERS:	Incident conditions significantly impact or overwhelm hospital or pre-hospital resources, which may include: <ul style="list-style-type: none"> ➤ More than 10 patients at a single incident, ➤ More than 4 Immediate/Delayed patients being sent to a single receiving facility, ➤ Receiving facilities are needed in more than 2 counties, or ➤ The IC or MGS determine that Stage 2 MCI protocols are necessary
COMMAND & CONTROL:	<ol style="list-style-type: none"> 1. The Incident Commander (IC) shall be that individual present on scene representing the public service agency having primary investigatory authority or responsibility. 2. The IC may directly supervise operations or appoint an Operations Section Chief. 3. The first in medical responders should be appointed MGS and Triage Unit Leader
INITIAL RESPONDERS:	The first medical unit enroute shall notify the Control Facility of a possible MCI. Once on scene, report to the IC and get permission to establish the medical group (or temporarily assume IC and establish the ICS), including: <ul style="list-style-type: none"> ➤ Resources: Ensure adequate resources have been ordered (Equipment, Manpower, Transportation), and clarify with IC the ordering process (i.e. can MGS order additional medical resources). Update ambulance dispatch and the Control Facility as soon as possible upon arrival. ➤ Assignments: Get approval to establish Medical post and begin Triage. ➤ Communications: Determine medical tactical channel, command net, air ops (if any), etc. ➤ Ingress / Egress: Determine the best routes in and out of the incident and notify dispatch. ➤ Name: Clarify incident name with IC, and notify dispatch. ➤ Geography: Quickly determine where incoming resources will stage, establish triage, treatment, transport, and morgue areas. <p>Note: The first in ambulance should generally be the last ambulance to leave the scene. Additionally, medical supplies from the first in ambulance should be used by triage/treatment units.</p>
RECOMMENDED NIMS / SEMS STRUCTURE	Re-inforced Multi-Casualty Organization:

	 <pre> graph TD MGS[Medical Group Supervisor] --> TUL[Triage Unit Leader] MGS --> TOL[Treatment Unit Leader] MGS --> PTUL[Patient Transportation Unit Leader] TUL --> TP[Triage Personnel] TOL --> ITAM[Immediate Treatment Area Manager] TOL --> D1TAM[Delayed Treatment Area Manager] TOL --> D2TAM[Delayed Treatment Area Manager] PTUL --> MCC[Medical Communications Coordinator] </pre> <p>All persons appointed ICS positions shall wear the appropriate vest.</p>
<p>TRIAGE</p>	<ol style="list-style-type: none"> 1. The S.T.A.R.T. method of triage shall be used. Triage tags should be applied to each victim. 2. Personnel will spend no more than 30-60 seconds per patient triaging. 3. Treatment rendered will initially be confined to airway positioning and major hemorrhage control. 4. CPR should not be initiated for cardiac arrest victims.
<p>TREATMENT</p>	<ol style="list-style-type: none"> 1. Designate Treatment Areas as needed: Immediate (Red), Delayed (Yellow), and Minor (Green). These areas should be located in safe areas, large enough to handle the number of victims, easily accessible to rescue vehicles, and away from the Morgue Area (Black), if established. 2. Once they have been triaged, patients shall be moved to the appropriate treatment area. Continuous re-triage and patient evaluation should occur in these areas until the patient is transported. 3. Personnel assigned to the treatment areas shall only function within their scope of practice using Standing Orders. 4. Any on scene MD's and RN's should be assigned to the treatment areas.
<p>TRANSPORTATION</p>	<ol style="list-style-type: none"> 1. The Transport Unit Leader, in cooperation with the Control Facility will arrange transport of patients to the most appropriate available facilities. 2. At all times the most immediate patients should be transported first to the most appropriate available medical facility. Patients may be transported by a lower level of trained personnel as determined by the Medical Transportation Unit Leader in cooperation with the managers of the treatment areas based on available resources and personnel. 3. Transport crews will remain with their vehicle in the staging area until called up by the Transport Unit Leader. 4. The Transport Unit Leader will contact the Control Facility and provide patient information, and total number of transport resources available. Patient information will be limited to age, gender, triage category, tag number, and major injury. 5. Control Facility relays patient information to receiving facilities. 6. Transport units shall not contact receiving facilities on the Med-Net radio.
<p>COMMUNICATIONS</p>	<ol style="list-style-type: none"> 4. On-scene coordination/car-to-car communications may occur on an EMS Tactical Channel. 5. If authorized by the IC, the Transport Unit Leader will request ambulance resources through Ambulance Dispatch and notify the IC or designee. 6. The Control Facility shall be notified:

	<ul style="list-style-type: none"> • enroute by first-in ambulance to known or suspected MCI; • after initial scene size-up, and after triage is completed, • when patients are ready for transport (to obtain destinations), • when units depart scene (with Unit #/ETA), and • when scene is clear.
DOCUMENTATION	<ol style="list-style-type: none"> 1. Triage tags used, and followed by Patient Care Report for each patient. 2. Patient Transportation Worksheet completed by Transport Unit Leader. 3. MGS is responsible to ensure all paperwork is complete (coordinate with Control Facility) and copies submitted to the EMS Agency.

STAGE 3 MCI	
ACTIVATION TRIGGERS:	<p>Incident conditions significantly impact or overwhelm hospital or pre-hospital resources, which may include:</p> <ul style="list-style-type: none"> ➤ More than 50 patients at a single incident, ➤ Receiving facilities are needed outside of mutual-aid region capabilities ➤ The IC or MGS determine that Stage 3 MCI protocols are necessary
COMMAND & CONTROL:	<ol style="list-style-type: none"> 1. The Incident Commander (IC) shall be that individual present on scene representing the public service agency having primary investigatory authority or responsibility. 2. The IC may directly supervise operations or appoint an Operations Section Chief. 3. The first in medical responders should be appointed MGS and Triage Unit Leader
INITIAL RESPONDERS:	<p>The first medical unit enroute shall notify the Control Facility of a possible MCI. Once on scene, report to the IC and get permission to establish the medical group (or temporarily assume IC and establish the ICS), including:</p> <ul style="list-style-type: none"> ➤ Resources: Ensure adequate resources have been ordered (Equipment, Manpower, Transportation), and clarify with IC the ordering process (i.e. can MGS order additional medical resources). Update ambulance dispatch and the Control Facility as soon as possible upon arrival. ➤ Assignments: Get approval to establish Medical post and begin Triage. ➤ Communications: Determine medical tactical channel, command net, air ops (if any), etc. ➤ Ingress / Egress: Determine the best routes in and out of the incident and notify dispatch. ➤ Name: Clarify incident name with IC, and notify dispatch. ➤ Geography: Quickly determine where incoming resources will stage, establish triage, treatment, transport, and morgue areas. <p>Note: The first in ambulance should generally be the last ambulance to leave the scene. Additionally, medical supplies from the first in ambulance should be used by triage/treatment units.</p>
RECOMMENDED NIMS / SEMS STRUCTURE	Full Multi-Casualty Organization:



All persons appointed ICS positions shall wear the appropriate vest.

<p>TRIAGE</p>	<ol style="list-style-type: none"> 1. The S.T.A.R.T. method of triage will be used. Triage tags shall be applied to each victim. 2. Personnel will spend no more than 30-60 seconds per patient triaging. 3. Treatment rendered will initially be confined to airway positioning and major hemorrhage control. 4. CPR shall not be initiated for cardiac arrest victims.
<p>TREATMENT</p>	<ol style="list-style-type: none"> 1. Designate Treatment Areas as needed: Immediate (Red), Delayed (Yellow), and Minor (Green). These areas should be located in safe areas, large enough to handle the number of victims, easily accessible to rescue vehicles, and away from the Morgue Area (Black). 2. Once they have been triaged, patients shall be moved to the appropriate treatment area. Continuous re-triage and patient evaluation should occur in these areas until the patient is transported. 3. Personnel assigned to the treatment areas shall only function within their scope of practice using Standing Orders. 4. Any on scene MD's and RN's should be assigned to the treatment areas.

	<ol style="list-style-type: none"> 5. Medical Supply Coordinator shall coordinate needed medical supplies with Logistics Section.
TRANSPORTATION	<ol style="list-style-type: none"> 1. Transport crews will remain with their vehicle in the staging area until called up by the Transport Unit Leader. 2. The Medical Communications Coordinator will contact the Control Facility and provide patient information, and total number of transport resources available. Patient information will be limited to age, gender, triage category, tag number, and major injury. 3. The Control Facility will provide patient destinations to the Medical Communications Coordinator. 4. Patients may be transported by a lower level of trained personnel as determined by the Transportation Unit Leader in cooperation with the MGS based on available resources and personnel. 5. The Control Facility relays patient information to receiving facilities. 6. Transport units shall not contact receiving facilities on the Med-Net radio. 7. Non-traditional transport resources may be used (e.g. buses, vans)
COMMUNICATIONS	<ol style="list-style-type: none"> 7. On-scene coordination/car-to-car communications may occur on an EMS Tactical Channel. 8. The IC or Logistics Section shall coordinate all resource ordering. 9. The Control Facility shall be notified: <ul style="list-style-type: none"> • enroute by first-in ambulance to known or suspected MCI; • after initial scene size-up, and after triage is completed, • when patients are ready for transport (to obtain destinations), • when units depart scene (with Unit #/ETA), and • when scene is clear.
DOCUMENTATION	<ol style="list-style-type: none"> 1. Triage tags used, followed by Patient Care Reports (PCR) for each patient (The PCR requirement may be waived by the EMS Agency). 2. The Patient Transportation Worksheet shall be completed by the Transport Unit Leader. 3. The MGS shall complete the Medical Branch Worksheet. 4. Ambulance Staging Log shall be completed by the Ambulance Coordinator. 5. ICS 214 logs shall be completed by each position as requested by the IC. 6. MGS is responsible to ensure all paperwork is complete (coordinate with Control Facility) and copies submitted to the EMS Agency.

<p style="text-align: center;">MEDICAL GROUP SUPERVISOR (MGS)</p> <ul style="list-style-type: none"> • <u>Resources</u>: assess need for additional resources: <ul style="list-style-type: none"> ○ Equipment: medical supplies (e.g. medical caches, backboards, litters, cots). ○ Manpower: FRs, EMTs, paramedics ○ Transportation: air/ground, vans, buses • <u>Assignments</u>: <ul style="list-style-type: none"> ○ Establish Medical Group, assign personnel. ○ Direct and/or supervise on-scene personnel from agencies such as Coroner's Office, Red Cross, law enforcement, ambulance, etc. • <u>Communications</u>: <ul style="list-style-type: none"> ○ Participate in Medical Branch/Operations Section planning activities. ○ Ensure notification of the Control Facility. • <u>Ingress/Egress</u>: Report staging area and transport routes to dispatch. • <u>Name</u>: Confer with IC/Ops Chief to determine incident name, report to dispatch / Control Facility. • <u>Geography</u>: Designate Treatment Area locations. <ul style="list-style-type: none"> ○ Isolate Morgue and Minor Treatment Area from Immediate/ Delayed Treatment Areas. ○ Request proper security, traffic control, and access for the Medical Group work areas. <p>• Maintain Unit/Activity Log (ICS Form 214).</p>	<p style="text-align: center;">TRIAGE UNIT LEADER</p> <ul style="list-style-type: none"> • Develop organization sufficient to handle assignment. • Inform Medical Group Supervisor of resource needs. • Implement triage process. <ul style="list-style-type: none"> ○ Ensure triage tags are properly applied to each victim. • Coordinate movement of patients from the Triage Area to the appropriate Treatment Area. • Give periodic status reports to Medical Group Supervisor, including total victims counts by triage category. • Maintain security and control of the Triage Area. • Establish Morgue. • Maintain Unit/Activity Log (ICS Form 214).
<p style="text-align: center;">TREATMENT UNIT LEADER</p> <ul style="list-style-type: none"> • Develop organization sufficient to handle assignment. • Direct and supervise Treatment Dispatch, Immediate, Delayed, & Minor Treatment Areas. • Coordinate movement of patients from Triage Area to Treatment Areas with Triage Unit Leader. • Request sufficient medical caches and supplies as necessary. • Establish communications and coordination with Patient Transportation Unit Leader. • Ensure continual triage of patients throughout Treatment Areas. • Direct movement of patients to ambulance loading area(s). • Give periodic status reports to Medical Group Supervisor. • Maintain Unit/Activity Log (ICS Form 214) 	<p style="text-align: center;">PATIENT TRANSPORTATION UNIT LEADER</p> <ul style="list-style-type: none"> • Ensure the establishment of communications with the Control Facility. • Designate Ambulance Staging Area(s). • Direct patient destinations as reported by the Medical Communications Coordinator and Control Facility. • Ensure patient information and destination are recorded on the Patient Transport Worksheet. • Establish communications with the Ambulance Coordinator. • Request additional ambulances as required. • Notify Ambulance Coordinator of ambulance requests. • Coordinate requests for air ambulance transportation through the Air Operations Branch Director. • Coordinate the establishment of the Air Ambulance Helispots with the Medical Branch Director and Air Operations Branch Director. • Maintain Unit/Activity Log (ICS Form 214).

<p style="text-align: center;">MEDICAL BRANCH DIRECTOR</p> <p>The Medical Branch Director is responsible for the implementation of the Incident Action Plan within the Medical Branch. The Branch Director reports to the Operations Section Chief and supervises the Medical Group(s) and the Patient Transportation function (Unit or Group). Patient Transportation may be upgraded from a Unit to a Group based on the size and complexity of the incident.</p> <ul style="list-style-type: none"> • Review Group Assignments for effectiveness of current operations and modify as needed. • Provide input to Operations Section Chief for the Incident Action Plan. • Supervise Branch activities. • Report to Operations Section Chief on Branch activities. • Maintain Unit/Activity Log (ICS Form 214). 	<p style="text-align: center;">TREATMENT AREA MANAGER</p> <ul style="list-style-type: none"> • Request or establish Medical Teams as necessary. • Assign treatment personnel to patients received in the Treatment Area. • Ensure treatment of patients triaged to the Treatment Area. • Assure that patients are prioritized for transportation. • Coordinate transportation of patients with Treatment Dispatch Manager. • Notify Treatment Dispatch Manager of patient readiness and priority for transportation. • Ensure that appropriate patient information is recorded. • Maintain Unit/Activity Log (ICS Form 214)
<p style="text-align: center;">MEDICAL COMMUNICATIONS COORDINATOR</p> <ul style="list-style-type: none"> • Establish communications with the Control Facility. • Determine and maintain current status of hospital/medical facility availability and capability. • Receive basic patient information and condition from Treatment Dispatch Manager. • Coordinate patient destination with the hospital alert system. • Communicate patient transportation needs to Ambulance Coordinators based upon requests from Treatment Dispatch Manager. • Communicate patient air ambulance transportation needs to the Air Operations Branch Director based on requests from the treatment area managers or Treatment Dispatch Manager. • Maintain Patient Transport Worksheet. • Maintain Unit/Activity Log (ICS Form 214) 	<p style="text-align: center;">AMBULANCE COORDINATOR</p> <ul style="list-style-type: none"> • Establish appropriate staging area for ambulances. • Establish routes of travel for ambulances for incident operations. • Establish and maintain communications with the Air Operations Branch Director regarding Air Ambulance Transportation assignments. • Establish and maintain communications with the Medical Communications Coordinator and Treatment Dispatch Manager. • Provide ambulances upon request from the Medical Communications Coordinator. • Assure that necessary equipment is available in the ambulance for patient needs during transportation. • Establish contact with ambulance providers at the scene. • Request additional transportation resources as appropriate. • Provide an inventory of medical supplies available at ambulance staging area for use at the scene. • Maintain records as required and Unit/Activity Log (ICS Form 214)

<p style="text-align: center;">MEDICAL SUPPLY COORDINATOR</p> <ul style="list-style-type: none"> • Acquire, distribute and maintain status of medical equipment and supplies within the Medical Group*. • Request additional medical supplies* • Distribute medical supplies to Treatment and Triage Units. • Maintain Unit/Activity Log (ICS Form 214). <p>*If the Logistics Section is established, this position would coordinate with the Logistics Section Chief or Supply Unit Leader.</p>	<p style="text-align: center;">TREATMENT DISPATCH MANAGER</p> <ul style="list-style-type: none"> • Establish communications with the Immediate, Delayed, and Minor Treatment Managers. • Establish communications with the Patient Transportation Unit Leader. • Verify that patients are prioritized for transportation. • Advise Medical Communications Coordinator of patient readiness and priority for transport. • Coordinate transportation of patients with Medical Communications Coordinator. • Assure that appropriate patient tracking information is recorded. • Coordinate ambulance loading with the Treatment Managers and ambulance personnel. • Maintain Unit/Activity Log (ICS Form 214)
<p style="text-align: center;">MORGUE MANAGER</p> <ul style="list-style-type: none"> • Assess resource/supply needs and order as needed. • Coordinate all Morgue Area activities. • Keep area off limits to all but authorized personnel. • Coordinate with law enforcement and assist the Coroner or Medical Examiner representative. • Keep identity of deceased persons confidential. • Maintain appropriate records. 	

ALTERED STANDARD OF CARE PRE-PLANNING GUIDE

I. PURPOSE

- A. The purpose of the Altered Standard of Care Pre-Planning Guide is designed to provide a mechanism to alter the EMS delivery system in response to an increased demand for medical aid services, beyond the capacity of the current system providers.

II. ASSUMPTIONS

- A. The Medical/Health Branch of the OA EOC (MHOAC) has established collaboration with the EMS Agency Medical Director and other affected agencies to coordinate changes to the EMS response.
- B. Mutual-aid resources are scarce or unavailable.
- C. Appropriate waivers, proclamations, or declarations required to implement specific system changes have been identified and secured.

III. WAIVERS/AUTHORITIES

A. Altered Treatment Protocols / Scope of Practice

- MVEMSA Policy 256.00 EMT-P Scope of Practice
- H&SC, Division 2.5, Section 1797.172 (b) The approval of the director, in consultation with a committee of local EMS medical directors named by the EMS Medical Directors Association of California, is required prior to implementation of any addition to a local optional scope of practice for EMT-Ps proposed by the medical director of a local EMS agency.
- CCR Title 22 Division 9, Ch 4, Art. 2. Section 100145 (2) Local Optional Scope of Practice: (A) Perform or monitor other procedure(s) or administer any other medication(s) determined to be appropriate for paramedic use, in the professional judgement of the medical director of the local EMS agency, that have been approved by the Director of the Emergency Medical Services Authority when the paramedic has been trained and tested to demonstrate competence in performing the additional procedures and administering the additional medications.
- HSC § 101040 Authority to take preventive measures during emergency. "The county health officer may take any preventive measure that may be necessary to protect and preserve the public health from any public health hazard during any "state of war emergency," "state of emergency," or "local emergency," as defined by Section 8558 of the Government Code, within his or her jurisdiction.

B. Ambulance Transport

- MVEMSA Policy 405.00 - Ground Ambulance Staffing Levels
- CCR Title 13, Div.2, Ch. 5, Art 1, Section 1100.3 (b) Medical Training Prerequisite. Ambulances shall not respond to emergency calls or transport patients unless the attendant -or the driver, if the service has been exempted from the requirement to have an attendant -possesses a certificate or license evidencing compliance with the emergency medical training and educational standards for ambulance personnel established by the State Emergency Medical Service Authority in

title 22 of this code. This requirement shall not apply during a "state of war emergency," duly proclaimed "state of emergency," or "local emergency," as defined in Government Code section 8558, when it is necessary to fully utilize all available Search Term Begin ambulances Search Term End in an area and it is not possible to have such Search Term Begin ambulances Search Term End operated or attended by persons with the qualifications required by this section.

- VC Div. 2, Ch. 2.5, Art. 2, Section 2512. (a) The commissioner, after consultation with, and pursuant to the recommendations of, the Emergency Medical Service Authority and the department, shall adopt and enforce reasonable regulations as the commissioner determines are necessary for the public health and safety regarding the operation, equipment, and certification of drivers of all ambulances used for emergency services. The regulations shall not conflict with standards established by the Emergency Medical Service Authority pursuant to Section 1797.170 of the Health and Safety Code. **The commissioner shall exempt, upon request of the county board of supervisors that an exemption is necessary for public health and safety,** noncommercial ambulances operated within the county from the regulations adopted under this section as are specified in the board of supervisors' request. The Emergency Medical Service Authority shall be notified by the county boards of supervisors of any exemptions.

IV. DEFINITIONS

- A. **"Altered Standard of Care"** means a level of medical care delivered to individuals under conditions of duress, such as after a disaster or when medical supplies are insufficient for demand for emergency care.
- B. **"Medical/Health Operational Area Coordinator (MHOAC)"** means the Public Health Officer and local EMS Agency Administrator or designee who is responsible, in the event of a disaster or major incident where mutual aid is requested, for obtaining and coordinating services and allocation of resources within the Operational Area (county) border.
- C. **"OA EOC"** means the Operational Area Emergency Operations Center for any of the member counties within the Mountain-Valley EMS Agency Region.
- D. **"QRV"** means a Quick Response Vehicle that is staffed with at least one paramedic, and equipped with advanced life support (ALS) equipment/supplies per local EMS Agency protocol.

V. PROCEDURE

- A. MHOAC / EMS Agency Collaboration
 - 1. During a locally declared emergency, the MHOAC or Medical/Health Branch Director of the OA EOC shall collaborate with the EMS Agency Medical Director, and other appropriate agencies, to modify the EMS delivery system in order to meet increased demand on the EMS system.
 - 2. During a significant incident, and prior to a locally declared emergency, the EMS Agency Medical Director shall collaborate with the Public Health Officer, Office of Emergency Services, and other appropriate agencies, to modify the EMS delivery system in order to meet increased demand on the EMS system

B. SYSTEM ACCESS

1. The MHOAC and EMS Agency shall collaborate with the OA EOC to establish priorities for 911 medical-aid response based upon available system resources.
2. The MHOAC and EMS Agency shall collaborate to complete the Standard Dispatch Order (Appendix A) to ensure the stability of the EMS system, and inform all Public Safety Answering Points (PSAPs), ambulance dispatch centers, Disaster Control Facilities, hospitals, and EMS providers of these orders.
3. **Public Access Number**
The MHOAC and EMS Agency shall collaborate to ensure notification of all provider agencies in the event that a Public Access telephone number (e.g. 2-1-1) or web-based information for the public seeking minor medical care, social services, and other non-urgent needs has been established by the OA EOC.
4. **Field Treatment Sites**
The MHOAC and EMS Agency shall consider establishing Field Treatment Sites for rapid triage, treatment, and referral, in cooperation with the OA EOC.
5. **911 Medical-Aid Requests**
The MHOAC and EMS Agency shall collaborate to authorize altered triage and response protocols for the 911 system. The MHOAC and EMS Agency shall consider:
 - a. Suspension of Pre-Arrival Instructions
 - b. Implementation of symptom-specific triage (e.g. Pandemic Outbreak EMD)
 - c. Implementation of austere triage protocol (see Appendix B- Altered 911 Triage)
6. **Scheduled Transport Center**
In cooperation with the OA EOC, the MHOAC and EMS Agency shall consider establishing a Scheduled Transport Center for all medical transport requests from all System Access Points (i.e. hospitals, health facilities, Public Access Number, 911, and field). The Scheduled Transport Center shall consider:
 - a. Augmenting medical transportation with alternative vehicles: buses, taxis, etc.
 - b. Developing and implementing a medical transportation scheduling process
 - c. Working with Disaster Control Facilities to direct destinations of transport resources, including possible Alternate Care Sites, clinics, etc.

EXAMPLE OF ALTERED 911 TRIAGE

Access Point	Symptom-Specific	Immediate	Delayed	Minor	Deceased
Public Access #	Refer to (symptom-specific) Alternate Care Site	Refer to 911	Refer to Scheduled Transport Center	TBD	TBD
911 / Ambulance Dispatch	Dispatch Specialty Unit/Team	ALS Response	Refer to Scheduled Transport Center	Refer to Public Access #	Refer to Public Access #
Scheduled Transport	Dispatch Specialty	ALS Response	Schedule Transport	Refer to Public	Refer to Public Access #

Center (Ambl. Dispatch)	Unit/Team			Access #	
Field EMS	Transport to (symptom-specific) Alternate Care Site	Treat and Transport	Treat &Release or Refer	Refer to Public Access #	Witnessed = shock X3, unwitnessed = refer to Public Access #

C. FIELD RESPONSE

1. In cooperation with the OA EOC, the MHOAC and EMS Agency shall consider:
 - a. Establishing EMS staging area to consolidate personnel, equipment, supplies, and emergency response vehicles.
 - b. Converting all ALS ambulances to BLS transport units (allowing use of paramedics on QRVs), thereby expanding available EMS resources.
 - c. Implementing Quick Response Vehicles (QRVs) with available paramedics, thereby expanding available EMS resources.
 - d. Securing vehicles for QRVs (consider ALS supervisor vehicles, shared resources from other emergency response agencies, company cars, rental cars, private cars, etc.)
 - e. Equipping QRVs with ALS equipment/supplies, communications, etc.
 - f. Developing additional Disaster Caches, as needed, to augment ALS supplies (e.g. Flu Cache of: powdered Gatorade, compazine suppositories, ibuprofen, pepcid, etc.)
 - g. Developing, equipping, and deploying a specialty response team (e.g. Pandemic Flu Team) to respond to specific patient types

EXAMPLE OF ALTERED EMS SYSTEM RESPONSE

- All paramedics are re-assigned to QRVs to respond to patients with immediate medical needs (paramedics may be placed in supervisor vehicles, on fire apparatus, or deployed in other non-traditional vehicles).
- After providing on-scene medical care/intervention, patients are handed off to a BLS transport unit, freeing the QRV to respond to the next call in need of ALS intervention.
- Other options include: Treat/Release on-scene with home care instructions; referral to Public Access Number; referral to Transport Center for scheduled transport to hospital or other medical agency.

2. The MHOAC and EMS Agency shall work collaboratively with the OA EOC to develop a Family/Patient brochure to be distributed by EMS personnel to include:
 - Development of home care/home treatment documents (e.g. Flu Care).
 - Explanation of current healthcare situation and altered system standards currently being implemented.
 - Preventative measures to avoid exposure to health threat.
 - Available community resources (e.g. Public Access Number, website, etc.)

D. JUST-IN-TIME TRAINING

In cooperation with the OA EOC, the MHOAC and EMS Agency shall collaborate to develop Just-in-Time Training for ambulance dispatch and field personnel to include:

- A. Altered System Standard Orders (Appendix A)
- B. Altered 911/EMD/Triage Algorithm (Appendix B)
- C. Altered Treatment Orders (Appendix C)
- D. Family/Patient Brochure
- E. Grief Support Principles

Altered System Standard Orders

Date: _____ Time: _____ Effective Period: _____ Until Further Notice

NOTICE

The following actions shall be implemented immediately in order to ensure the stability of the Emergency Medical Services system. All EMS providers, ambulance dispatch centers, and EMS field units shall be informed of these orders. If it is not possible to electronically transmit a copy of this form, these orders may be relayed verbally to all affected agencies.

Authority: Division 2.5, Health and Safety Code, Sections 1797.170, 1797.220, 1798.101; California Code of Regulations, Title 22, Division 9, Chapters 4 through 9

EMERGENCY ORDERS

Operating as an agent of the Medical Health Operational Area Coordinator or EMS Agency Medical Director, I hereby authorize the following altered system standard orders.

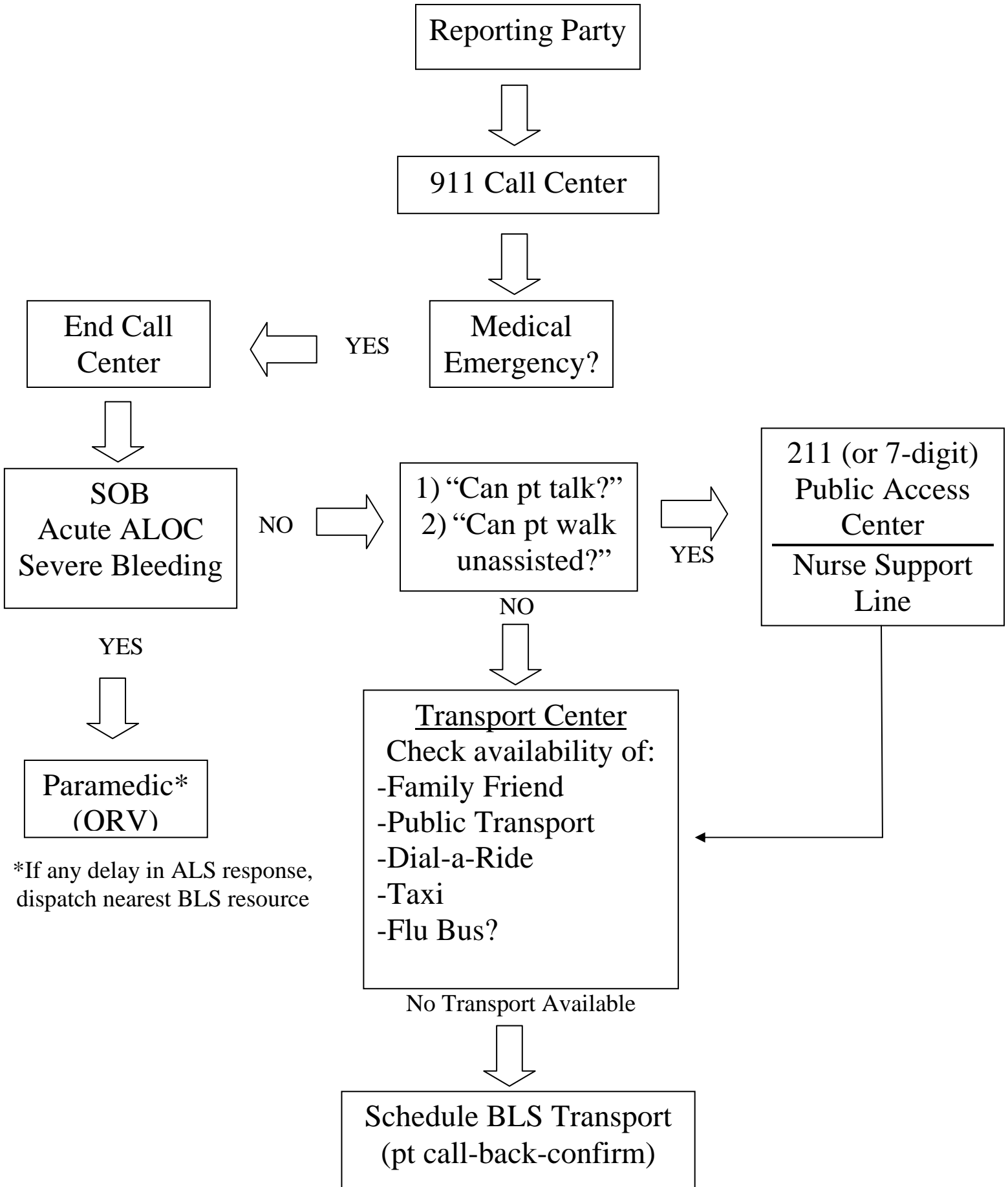
Name: _____ Title: _____

Signature: _____ Date / Time: _____

ACTIONS

	Order Number	Initial to Execute	Description
DISPATCH	ASSO-1		Notify All Dispatch Center personnel of ASOs
	ASSO-2		Notify All EMS Field Units and personnel of ASOs
	ASSO-3		Place All Available Ambulances in Service Place all available ambulances in service. Once attached to an event, a BLS unit shall not be canceled because of ALS availability.
	ASSO-4		Dispatch BLS to Alpha, Bravo, and Code 2 EMS Events Once attached to an event, the BLS ambulance shall remain on the event even if the call is upgraded. If ALS is required, the first responder agency or QRV shall provide this service (if available) and follow up to the hospital if needed.
	ASSO-5		Automatic Ambulance Dispatches are Suspended Until Verified by First Responder Ambulances shall only be sent to calls for services when a patient has been identified and is in need of EMERGENCY transportation by ambulance. <u>Patients not in immediate need will not be transported.</u>
	ASSO-6		Ambulance Dispatches to Alpha, Bravo, and Code 2 EMS Calls are Suspended
	ASSO-7		Implement Pandemic Outbreak EMD Protocol Card
	ASSO-8		Discontinue Use of Emergency Medical Dispatching (EMD) Procedures Implement Altered Triage Algorithm
	ASSO-9		Discontinue Use of Pre-Arrival Instructions (PAI)
	ASSO-10		Shelter-in-Place Implement Shelter-in-Place protocols in response to external threat.
CONTROL FACILITY	ASSO-11		Notify All DCF personnel and Hospitals of ASOs
	ASSO-12		Suspend System Communications on _____ radio frequency Notify all hospitals that use of the _____ radio frequency is suspended and allocated for EMS Command Net communications.

Appendix B: Altered 911/EMD Triage



Appendix:C

Altered Treatment Orders

Data: _____ Time: _____ Effective Period: _____ UFN

NOTICE

The following orders shall be implemented immediately in order to ensure the stability of the Emergency Medical Services system. All EMS providers shall be informed of these orders. If it is not possible to electronically transmit a copy of this form, these orders may be relayed verbally to all affected agencies.

Authority: Division 2.5, Health and Safety Code, Sections 1797.170, 1797.220, 1798.101; California Code of Regulations, Title 22, Division 9, Chapters 4 through 9

EMERGENCY ORDERS

Operating as an agent of the Medical Health Operational Area Coordinator or EMS Agency Medical Director, I hereby authorize the following altered treatment orders.

Name: _____ Title: _____

Signature: _____ Date / Time: _____

ACTIONS

Initial to Execute	ALS Guideline	Altered Treatment	Altered Disposition
ADULTS			
	Implement Changes to accommodate BLS Transport: <ul style="list-style-type: none"> - No cardiac monitoring / pacing - No continuous drug therapy (during transport) - No ALS airway 		
	554.01 - V-Fib PVT	No treatment	Refer to Public Access #
	554.02 - PEA	No treatment	Refer to Public Access #
	554.03 - Asystole	No treatment	Refer to Public Access #
✓	554.04 - Bradycardia	No change	Schedule BLS Transport
✓	554.05 - V-Tach with Pulses	No change	Schedule BLS Transport
✓	554.06 - PSVT	No change	Schedule BLS Transport
✓	554.07 - Wide Complex Tach	No change	Schedule BLS Transport
✓	554.08 - Atrial Fib - Flutter	No change	Schedule BLS Transport
✓	554.09 - Coronary Ischemic Chest Discomfort	No change	Schedule BLS Transport
✓	554.10 - Acute CHF	No change	Schedule BLS Transport
✓	554.21 - Airway Obstruction - Stridor	No change	Schedule BLS Transport
✓	554.22 - COPD - Asthma - Bronchospasm	No change	Schedule BLS Transport
✓	554.23 - Tension Pneumothorax	No change	Schedule BLS Transport

✓	554.31 - ALOC	No change	<i>Competent adults with normal vital signs, blood sugar, and mental status 10 minutes after ALS intervention, may be released if a cause of their condition and its solution has been identified.</i>
	554.32 - Acute CVA	Aspirin	Schedule BLS Transport
✓	554.33 - Status Seizures	No change	<i>Competent adults with normal vital signs, blood sugar, and mental status 10 minutes after ALS intervention, may be released if a cause of their condition and its solution has been identified.</i>
	554.41 - Non-Traumatic Shock	Oral rehydration solutions (Gatorade, sports juices, water, etc.)	Schedule BLS Transport
✓	554.42 - Blood Sugar Emergencies	No change	<i>Competent adults with normal vital signs, blood sugar, and mental status 10 minutes after ALS intervention, may be released if a cause of their condition and its solution has been identified.</i>
✓	554.43 - Allergic Reaction	No change	Schedule BLS Transport
	554.44 - Pain Management	Consider over-the-counter pain control as necessary: Aspirin: 325mg orally or rectally, (contraindications: pregnancy, child, ALOC, allergy. OTC Tylenol/Motrin (follow instructions on label)	Schedule BLS Transport
	554.45 - Abdominal Pain	Treat for shock if indicated. Trial of p.o. fluids. Trial of over-the-counter antacid, if available (follow label instructions).	Schedule BLS Transport
✓	554.51 - Beta Blocker and Calcium Channel Blocker OD	No change	Schedule BLS Transport
	554.52 - Caustics - Corrosives	Irrigate	Schedule BLS Transport
✓	554.53 - Cyclic Antidepressants	No change	Schedule BLS Transport
✓	554.54 - Dystonic Reactions to Phenothiazines	No change	Schedule BLS Transport
✓	554.55 - Narcotics - Sedatives	No change	Schedule BLS Transport
✓	554.56 - Organophosphates	No change	Schedule BLS Transport
✓	554.57 - Petroleum Distillates	No change	Schedule BLS Transport
✓	554.58 - Amphetamine or Cocaine OD or Psychosis	No change	Schedule BLS Transport
✓	554.61 - Envenomation	No change	Schedule BLS Transport
✓	554.62 - Hypothermia	No change	Schedule BLS Transport
✓	554.63 - Frostbite	No change	Schedule BLS Transport
✓	554.64 - Heat Illness	No change	Schedule BLS Transport
	554.71 - Childbirth	Oxygen and IV fluid. Deliver baby.	Schedule BLS Transport
✓	554.81 - Burns	No change	Schedule BLS Transport
✓	554.82 - Traumatic Shock	No change	Schedule BLS Transport
	554.83 - Traumatic Cardiac Arrest	No Treatment	Coroner

	554.84 - Head Neck Face Trauma	If shock develops, and does not respond to initial IV infusion of 2 liters, provide palliative care only. Provide immobilization, ice pack, and pain control (morphine or over-the-counter pain meds). Clean wounds with soap and water. Remove foreign bodies and debris. Irrigate with normal saline or clean water as available. Apply dressings. Signs of infection require higher level care.	Schedule BLS Transport
	554.85 - Chest Trauma		Schedule BLS Transport
	554.86 - Abdominal Trauma		Schedule BLS Transport
	554.87 - Extremity Trauma		Schedule BLS Transport
PEDIATRICS			
	555.10 - Newborn Resuscitation	No Treatment	Refer to Public Access #
	555.11 - V-Fib - Pulseless V-Tach	No Treatment	Refer to Public Access #
	555.12 - PEA	No Treatment	Refer to Public Access #
	555.13 - Asystole	No Treatment	Refer to Public Access #
✓	555.14 - Bradycardia	No change	Schedule BLS Transport
✓	555.15 - Tachycardia	No change	Schedule BLS Transport
	555.21 - Airway Obstruction	BLS care	Schedule BLS Transport
	555.22 - Respiratory Arrest	Attempt to open airway Establish BLS Airway	Refer to Public Access # for deceased Schedule BLS Transport all others
✓	555.23 - Respiratory Distress	No change	Schedule BLS Transport
✓	555.31 - ALOC	No change	Schedule BLS Transport
✓	555.32 - Status Seizure	No change	Schedule BLS Transport
	555.41 - Non-traumatic Shock	Oral hydration	Schedule BLS Transport
✓	555.42 - Allergic Reaction	No change	Schedule BLS Transport
	555.43 - Pain Management	Tylenol (15mg/kg, max.650mg)	Schedule BLS Transport
	555.51 - Caustic - Corrosives	Irrigate	Schedule BLS Transport
✓	555.52 - Cyclic Antidepressants	No change	Schedule BLS Transport
✓	555.53 - Dystonic Reactions to Phenothiazines	No change	Schedule BLS Transport
	555.54 - Narcotics - Sedatives	Contact Poison Control	Schedule BLS Transport
	555.55 - Organophosphates	Contact Poison Control	Schedule BLS Transport

	555.56 - Petroleum Distillates	Contact Poison Control	Schedule BLS Transport
✓	555.61 - Envenomation	No change	Schedule BLS Transport
	555.62 - Hypothermia	Rectal Temp- Temp >32: warming blanket/ warm fluids	If temp <32 transport
✓	555.63 - Frostbite	No change	Schedule BLS Transport
	555.64 - Heat Illness	Rectal temp Temp <40: cool, oral hydration	If temp >40- transport
✓	555.81 - Burns	No change	Schedule BLS Transport
✓	555.82 - Traumatic Shock	No change	Schedule BLS Transport
	555.83 - Traumatic Arrest	No Treatment	Refer to Public Access #

Additions/Notes

Discontinue the Following Orders

Total Number of Actions to Execute _____ Total Number of Actions to Discontinue _____

TITLE: ALPINE COUNTY SPECIFIC
EMERGENCY BLS AMBULANCE
POLICY

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE: 06-11-98

SUPERSEDES:

REVISSED: 12/2003

REVIEW DATE: 12/2008

PAGE 1 OF 3

ALPINE COUNTY SPECIFIC EMERGENCY BLS AMBULANCE POLICY

I. AUTHORITY

Division 2.5, California Health and Safety Code, sections 1797.70, 1797.204, 1797.220, 1798(a), 1798.6; and Title 22, California Code of Regulations, Division 9, Chapter 2, section 100063.

II. DEFINITIONS

- A. "Alpine County EMS Response Area" means the areas of Hwy 88 (Carson Pass) from the California/Nevada State border to the Alpine/Amador County line; Hwy 89 from the Alpine/Mono county line to the Alpine/El Dorado county line; Hwy 4 (Ebbetts Pass) from Markleeville to the top of Ebbetts Pass, and all residential, public and private lands serviced by the above mentioned highway routes.
- B. "Agency" means the Mountain-Valley EMS Agency
- C. "Base Hospital" means a hospital designated by the Agency, that is contracted to the Agency to direct the advanced life support system and pre_hospital care system assigned to it by the Agency.
- D. "Emergency" means a condition or situation in which an individual has a need for immediate medical attention or where the potential for such need is perceived by emergency medical personnel or a public safety agency. (HSC 1797.70)
- E. "Hospital" means an acute care hospital licensed under Chapter 2 (commencing with Section 1250) of Division 2, with a permit for basic emergency service or an out-of state acute care hospital which substantially meets the requirements of Chapter 2 as determined by the local EMS agency which is utilizing the hospital in the emergency medical services system, and is licensed in the state in which it is located.
- F. "MCI" means a Multi-Casualty Incident as defined in Agency policy #810 and the ~~June 1993~~ current edition of the California Office of Emergency Services Region IV Multi-Casualty Incident Plan.
- G. "Mutual Aid ALS Ambulance" means any ALS ambulance not based within Alpine

County that responds to emergency requests within Alpine County.

II. PURPOSE

To establish criteria and procedures for utilization of ambulance services within Alpine County and for those cases in which Alpine County EMS ambulance responds to Amador County for the care and transport of Emergency patients.

III. POLICY

- A. —Alpine County Emergency Medical Services shall respond an ambulance to areas within the Alpine County EMS Response Area, and to areas within Amador County when dispatched by an Authorized EMS Dispatch Center.
- B. In order to reduce ambulance response times and minimize patient transport delays, Alpine County EMS will respond a BLS ambulance to EMS calls, and the appropriate ALS ambulance will be simultaneously dispatched .
- C. Patients in Alpine County EMS Response Area shall may be transported toward the closest appropriate acute care facility and rendezvous with ~~an~~ Mutual Aid ALS ambulance.
- D. Patients in Amador County shall-may be transported by Alpine County EMS ambulance: to rendezvous with a ground ALS ambulance, an air ambulance, or to an acute care facility only:
 1. upon direction provided by an authorized dispatch agency for Alpine County following direction from Amador County S.O. Dispatch, directly from Amador County S.O. Dispatch, or
 2. upon direction provided by ~~an American Legion Ambulance Paramedic~~ the authorized Amador County emergency ambulance provider .

IV. PROCEDURE

- A. Ambulance Response to Alpine County EMS Response Area
 1. Ambulance response to Emergencies in the Alpine County EMS Response ~~Area—shall~~Area shall consist of a combination of Mutual Aid ALS Ambulance response and Alpine County's BLS ambulance response.

2. Alpine County EMS Ambulance shall cancel Mutual Aid ambulance services upon determining that no ambulance services are required.

B. Alpine County Mutual Aid Ambulance Response to Amador County

1. Ambulance Response to Emergencies in Amador County shall consist of a combination of Mutual Aid from Alpine County's BLS ambulance and ALS response from American Legion Ambulance.

32. ALS Ambulance response shall not be canceled unless on-scene emergency personnel have determined that no ground ambulance is necessary to transport a patient to an acute care facility or rendezvous with air or ground ambulance resources.

C. ~~Patient Transport~~Patient Transport from Alpine County

1. The Alpine County EMS ambulance staff shall assess and treat patients per Agency protocols on the scene of every Emergency and may transport to rendezvous with the appropriate ALS ambulance per this policy.

D. Patient Transport from Amador County

1. The Alpine County EMS ambulance staff shall assess and treat patients per Agency protocols on the scene of every Emergency.
2. Alpine County EMS ambulance staff shall contact Amador County S.O. and receive direction concerning whether to:
 - a. wait on scene for an ~~American Legion Ambulance~~ambulance from the authorized Amador County emergency ambulance provider, or
 - b. transport the patient to rendezvous with the and ambulance from the authorized Amador County emergency ambulance provider, American Legion Ambulance, or
 - c. whether to transport the patient to rendezvous with an alternate ALS ground ambulance or Air Ambulance.

E. Exceptions

1. Any decisions concerning patient treatment, ambulance transport, and rendezvous between ALS and BLS ambulances made by a Base Hospital

shall take precedence over the rules set forth in this policy.

2. During an MCI, the requirements set forth in Agency MCI policies shall take precedence over the requirements in the Alpine County Specific Emergency BLS Ambulance Policy.

F. Quality Improvement

1. The Alpine County BLS ambulance service shall conduct a quality improvement program approved by the Agency.

TITLE: DISPATCH OF FIRST RESPONDERS IN AMADOR COUNTY

APPROVED:	<u>SIGNATURE ON FILE IN EMS OFFICE</u>	CREATION DATE:	<u>3/31/94</u>
	Executive Director	EFFECTIVE DATE:	<u>4/2005</u>
	<u>SIGNATURE ON FILE IN EMS OFFICE</u>	SUPERSEDES:	<u>5/98</u>
	Medical Director	REVISED:	<u>4/2005</u>
		REVIEW DATE:	<u>4/2010</u>
		PAGE	<u>1 OF 1</u>

DISPATCH OF FIRST RESPONDERS IN AMADOR COUNTY

I. AUTHORITY AND DEFINITION

California Health and Safety Code, Division 2.5, Section 1797.220

II. PURPOSE

To establish criteria for the dispatch of Medical First Responders within Amador County

III. POLICY

Amador County S.O. will interrogate callers accessing the EMS system utilizing Emergency Medical Dispatch. Based on responses to this interrogation, a dispatch level will be determined and appropriate resources dispatched.

IV. PROCEDURE

A. Amador County Sheriff's Office (ACSO) will interrogate callers utilizing Emergency Medical Dispatch (EMD). Based on the information received:

1. When an advanced life support unit is dispatched code 2 or code 3, ACSO will notify Camino Dispatch who will determine whether to send Medical First Responders.
2. Independent of ambulance requests received at ACSO as described in IV. A. 1., anytime on-scene emergency personnel determine that Medical First Responders are needed, ACSO will request Camino Dispatch to send Medical First Responders.

TITLE: SIGNIFICANT EXPOSURE REPORTING FOR AMADOR COUNTY

APPROVED: <u>SIGNATURE ON FILE IN EMS OFFICE</u> Executive Director	CREATION DATE: <u>10/01/94</u> EFFECTIVE DATE: <u>4/2005</u> SUPERSEDES: <u>5/1998</u> REVISED: <u>4/2005</u>
<u>SIGNATURE ON FILE IN EMS OFFICE</u> Medical Director	REVIEW DATE: <u>4/2010</u> PAGE <u>1</u> OF <u>3</u>

SIGNIFICANT EXPOSURE REPORTING FOR AMADOR COUNTY

1. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1797.186, 1797.188, 1797.189, 1797.200.

2. DEFINITION

- A. "Prehospital Emergency Medical Care Personnel" means any First Responder, EMTs, Paramedics, RNs, or Physicians who functions as a part of the EMS system. those persons who have been certified as qualified to provide prehospital emergency medical care pursuant to Division 2.5, California Health and Safety Code.
- B. "Reportable disease or condition" or "a disease or condition listed as reportable" means those diseases prescribed by Subchapter 1 (commencing with Section 2500) of Chapter 4 of Title 17 of the California Administrative Code, as may be amended from time to time.
- C. "Exposed" means at risk for contracting a disease, as defined by regulations of the State Department of Health Services.
- D. "Health Facility" means a health facility, as defined in Section 1250, California Health and Safety Code, including a publicly operated facility.
- E. "Provider Agency" means an Agency that provides Prehospital Emergency Medical Care.
- F. Significant Exposure is defined as an unprotected exposure to blood or; body fluid secretions or airborne or droplet contact.s or secretions.

3. PURPOSE

To provide a procedure by which the above sections of the law can be fulfilled, should a prehospital emergency medical care personnel be exposed to a reportable communicable disease.

4. POLICY

- A. Each health facility shall develop and implement a policy for notifying the county health officer of significant exposures to prehospital emergency medical care personnel.

5. PROCEDURE

- A. Prehospital emergency medical care personnel who suspect that they have been significantly exposed to a patient shall immediately notify their appropriate provider agency representative and shall complete and submit a "Significant Exposure Report Form" (See example of Form attached to this policy). A separate form must be completed for each exposed person.

1. To determine if a Prehospital Emergency Medical Care Provider has had an unprotected exposure ask:

- a) If disease is airborne; was the responder near the patient without a mask; or
- b) If bloodborne or body fluid; did the fluid enter the responders body by:
- 1) needlestick,
 - 2) laceration by contaminated object,
 - 3) mucus membrane or eyes, or
 - 4) open wound

- B. The Significant Exposure Report Form shall be submitted to the health facility or Chief Medical Examiner/Coroner (if the patient is deceased) at the time of delivery of the patient. The transporting ambulance personnel shall assure that this form is delivered to the receiving facility in a timely manner. The completion of this form is the responsibility of the person/agency requesting notification.

- C. A physician at the receiving facility shall determine whether there has been significant exposure to the prehospital personnel and shall document his certification on the Significant Exposure Report form. If it is determined that the patient has a communicable disease, the receiving facility and/or the health department will notify the prehospital personnel of the exposure.

1. Prehospital personnel should contact the Amador County health department within forty-eight (48) hours of the incident to ensure that the process has been started.

- D. Upon certifying a significant exposure, the receiving facility shall submit the designated completed copy of the "Significant Exposure Report Form" to the county health officer or

his/her designee.

- E. Prehospital personnel may seek prophylactic medical treatment and/or advice per their employer's policy. PAYMENT FOR ANY TREATMENT/TESTS IS THE RESPONSIBILITY OF THE EMPLOYING AGENCY. PAYMENT FOR MEDICAL EXPENSES SHOULD BE AVAILABLE THROUGH WORKERS' COMPENSATION INSURANCE.

~~F. F.~~—Nothing in this policy shall be construed to authorize the further disclosure of confidential medical information by the health facility or any of the prehospital emergency medical care personnel except as otherwise authorized by law.

ED: Please forward (fax) to Infection Control Immediately
Coroner: Please forward (fax) to Public Health

Reporting Agency: _____ Unit #: _____

Agency Contact Person (Designated Officer): _____ Telephone #: _____

Agency Address: _____

Form completed by: _____ Date submitted: _____

Date exposure took place: _____

Individuals exposed: _____ Nature of Exposure: (airborne or droplet or body fluid contamination)

Details of exposure: _____

Source Patient name: _____ Transported to: _____

For Hospital Use Only

No infectious disease documented as identified or suspected

Recommendations/Comments: _____

Follow-up with Public Health Department required: YES _____ NO _____

=====

Initial follow-up with reporting agency

Name of person notified: _____ Date: _____ Time: _____

Hospital Infection Control Practitioner (signature): _____ Date: _____

Deputy Coroner * (signature): _____ Date: _____

* If patient is deceased and not transported to health care facility.

*Mountain-Valley
Emergency Medical Services Agency*

EMERGENCY MEDICAL SERVICES SYSTEM PLAN

Annual Update



~~2008 / 2009~~ 2009/2010

Table of Contents

INTRODUCTION3

TABLE 1: CHANGES MADE ON A STANDARD.....5

SUMMARY OF CHANGES.....10

TABLE 2: SYSTEM RESOURCES AND OPERATIONS12

System Organization and Management12

County: Alpine12

County: Amador12

County: Calaveras.....12

County: Mariposa12

County: Stanislaus12

TABLE 3: SYSTEM RESOURCES AND OPERATIONS - Personnel/Training.....18

TABLE 4: SYSTEM RESOURCES AND OPERATIONS - Communications.....18

County: Alpine County18

County: Amador County.....19

County: Calaveras County20

County: Mariposa County.....21

County: Stanislaus County22

TABLE 5: SYSTEM RESOURCES AND OPERATIONS - Response/Transportation23

Alpine County23

Amador County23

Calaveras County.....24

Mariposa County24

Stanislaus County25

TABLE 6: SYSTEM RESOURCES AND OPERATIONS - Facilities/Critical Care.....26

TABLE 7: SYSTEM RESOURCES AND OPERATIONS -- Disaster Medical.....27

County: Alpine27

County: Amador29

County: Calaveras.....31

County: Mariposa33

County: Stanislaus35

TABLE 8: RESOURCES DIRECTORY -- Approved Training Programs37

TABLE 9: RESOURCES DIRECTORY -- Dispatch Agency45

EMS Plan56

Ambulance Zone Summary Form56

Mountain-Valley EMS Agency – Alpine County.....56

Mountain-Valley EMS Agency – Amador County57

Mountain-Valley EMS Agency – Calaveras County59

South Zone.....59

East Zone62

Mountain-Valley EMS Agency – Mariposa County.....67

Mountain-Valley EMS Agency – Stanislaus County68

Zone One68

Zone Three.....68

Zone Four68

Zone Five.....68

Zone Eight68

Zone A68

Zone B68

Zone C68

Zone D.....68

INTRODUCTION

The Mountain-Valley EMS Agency (MVEMSA) was formed through a joint powers agreement in 1981 and currently serves the counties of Alpine, Amador, Calaveras, Mariposa, and Stanislaus. The MVEMSA's primary responsibility is to plan, implement, and evaluate an emergency medical services (EMS) system which meets the minimum standards developed by the California EMS Authority.

State law requires EMS agencies to develop plans for the delivery of emergency medical services (paramedic treatment, ambulance transport, trauma services, etc.) to the victims of sudden illness or injury within the geographic area served by the EMS agency. These plans must be consistent with state standards and address the following components: manpower and training, communications, transportation, assessment of hospitals and critical care centers, system organization and management, data collection and evaluation, public information and education, and disaster response.

Major changes have taken place in the EMS system since the MVEMSA first adopted an EMS plan in 1985. Among these changes are: the availability of advanced life support (paramedic) and 9-1-1 services in all parts of the EMS system, the development of specialized policies and services for critically ill and injured children, the formation of exclusive operating areas (EOAs) for ambulance service in Amador, Calaveras, and Stanislaus Counties, the implementation of Emergency Medical Dispatch in all counties, the implementation of first response AEDs region wide, the adoption of a regional Policy and Procedure Manual, and the designation of a formal trauma care system designed to triage and transport major trauma victims to designated trauma care hospitals.

The process of assessing system needs and developing plan objectives revealed that although major improvements have been made in EMS system since 1985, some components of the EMS system still remain underdeveloped. The Mountain-Valley EMS system currently meets or exceeds 117 of the State's 121 minimum standards and recommended guidelines Those sections of the State EMS System Guidelines (EMSA 101) which require attention and upgrade include:

1.22 Reporting of Abuse (*Abuse policy targeting the reporting of suspected child, elderly, and sexual abuse*).

3.01 Communication Plan (*Update to MVEMSA communication plan/directory*)

4.05 Response Time Standards (*Measured from recite of call at the Primary PSAP*)

5.02 Triage Transfer Protocols (*STEMI PatientTriage*)

5.04 Specialty Care Facilities (*Designation of STEMI Centers*)

6.05 Data Management Systems (*Data Repository Software Implementation*)

8.07 Disaster Communication (*Interoperability*)

~~The Mountain Valley EMS system currently meets or exceeds 117 of the State's 121 minimum standards and recommended guidelines.~~

SUMMARY OF SYSTEM STATUS

TABLE 1: CHANGES MADE ON A STANDARD

Standard	EMSA objective	Meets Minimum Req.	Short Range (one year or less)	Long Range (more than one year)	Progress	Objective
1.22	Reporting of Abuse			√	Currently EMS personnel are required by law to report suspected abuse to the receiving facility and the EMS Agency receives reports via our incident reporting process. Have not had staff time resources to develop policies.	Specific policy, including definitions of abuse, need to be developed. Currently there is insufficient resource and staff to dedicate to this project.
3.01	<u>Communication Plan</u>	√	√		<u>Currently MVEMSA has a communication plan in place that specifies the medical communication capabilities of emergency medical transport vehicles, non-transporting advanced life support responders, and acute care facilities and shall coordinate the use of frequencies with other users</u>	<u>Need to make updates to communication plan</u>
4.05	Response Time Standards <i>(Measured from recite of call at primary PSAP)</i>			√	<u>Stanislaus County - CAD to CAD advisory committee established by PSAP, SPSAP, and Agency with directive to establish procedure to accomplish objectives. The Stanislaus CAD project is currently on hold because of PSAP CAD upgrade implementation by end of 2010. Calaveras County – Limited data due to current CAD system. Calaveras will upgrade CAD by end of 2010 and MVEMSA will continue to work with Calaveras Co. Amador County - Discussions continue with Amador County regarding data requirements. Alpine County - No Progress. Response data difficult to obtain due to numerous PSAP's in County, SPSAP information comes from providers outside of this agency's jurisdiction</u> Stanislaus County – CAD to CAD advisory	Need to create a mechanism, based on current activity, to measure response times from each county PSAP to arrival on scene.

				<p>committee established by PSAP, SPSAP, and Agency with directive to establish procedure to accomplish objectives. Calaveras County—No Progress. Communications infrastructure limitations and a recent catastrophic event caused the ability for the PSAP to provide data to temporarily stop. Agency continues to monitor response time, obtaining data from provider PCRs. Amador County—Discussions regarding agreement between Sheriff's Office and Agency that will include language to meet objectives. Alpine County—No Progress. Response data difficult to obtain due to numerous PSAP's in County; SPSAP information comes from providers outside of this agency's jurisdiction. Mariposa County - Currently receiving data from both PSAP and SPSAP. No linkage. Receiving separate reports.</p>	
--	--	--	--	--	--

Standard	EMSA objective	Meets Minimum Req.	Short Range (one year or less)	Long Range (more than one year)	Progress	Objective
5.02	Triage & Transfer Protocols (STEMI Patient Policy Development)	√	√		<p><u>Ongoing development of STEMI program in the Mountain-Valley EMS Region. Discussion has been initiated between MVEMSA, Doctor's Medical Center, and Memorial Medical Center to identify STEMI Receiving Center within the region and surrounding communities. MVEMSA representative meets monthly with DMC and MMC PCI committees. Ongoing development of STEMI program in the Mountain-Valley EMS Region. Discussion has been initiated between MVEMSA, Doctor's Medical Center, and Memorial Medical Center to identify STEMI Receiving Center within the region and surrounding communities, equipment availability, and costs to include equipment and training, and policy revision.</u></p>	<p><u>MVEMSA STEMI Pilot Study ends December 31, 2010. STEMI policy will be developed by Medical Director after study ends. Continue to develop MVEMSA STEMI Pilot Study Proposal, provide training to pre-hospital providers on 12 lead ekg use, work with DMC and MMC regarding receiving STEMI patients during study period.</u></p>

Standard	EMSA objective	Meets Minimum Req.	Short Range (one year or less)	Long Range (more than one year)	Progress	Objective
5.04	Specialty Care Facility (STEMI Center Designation)	√		√	<p><u>Establish an RFP (Request for Proposal) process to formally designate STEMI centers or facility assessment and designation process within the MVEMSA area of responsibility. STEMI trial study will be completed 12/31/2010</u> Establish a RFP (Request for Proposal) process to formally designate STEMI centers within the MVEMSA area of responsibility</p>	Designate qualified STEMI Centers within the EMS Region
6.05	Data Management System		√	√	<p>Legacy data collection system is unsupported & does not meet NEMSIS/CEMSIS data standards. RFI extended to ePCR vendors; responses are being evaluated. System providers and Agency to evaluate and select an ePCR platform option that meets local, state, and federal standards. All providers to implement an ePCR platform. CAD data to be linked to the ePCR. Agency will collect data and manage the repository of system data. CEMSIS Data Dictionary released. MVEMSA to implement a Regional Repository "WEBCUR" of PCR data as Providers</p>	<p><u>Create & maintain</u> <u>Maintain & Enhance an ePCR Data management</u> system that supports system wide planning & evaluation; to include system response and clinical (both prehospital and hospital) data.</p>

Standard	EMSA objective	Meets Minimum Req.	Short Range (one year or less)	Long Range (more than one year)	Progress	Objective
					submit ePCR files	
8.07	Disaster Communications <i>(Interoperability)</i>		√	√	Calaveras County: County-wide interoperability project in progress. Stanislaus County: Purchased cache of portable radios. Continued working with local communications groups to integrate medical communications priorities with overall county planning.	Continue to work with local Fire, OES, and Public Health toward an integrated/interoperable communications system.

SUMMARY OF CHANGES

This section summarizes the progress made to the State's minimum standards and recommended guidelines since FY 2007/2008. The EMS Agency is:

§ Working towards the completion of a draft policy (560.10) for reporting child abuse, elder abuse, and suspected SIDS deaths.

~~§ Developing a mechanism for reporting child abuse, elder abuse, and suspected SIDS deaths.~~

§ Continuing to develop a mechanism to measure response times from each county PSAP to arrival on scene ~~§ Developing a mechanism to measure response times from each county PSAP to arrival on scene.~~

§ Near completion of a one year STEMI Pilot Study that started December 1, 2009 targeting the Mountain-Valley EMS Region.

~~§ Drafting a STEMI Pilot Proposal to be used within the Mountain-Valley EMS Region.~~

§ Beginning the process of data collection and meetings with local hospitals to establish a STEMI Center(s) within the EMS Region.

~~§ Beginning the process to establish a STEMI Center(s) within the EMS Region.~~

§ Purchase of WEBCURE ePCR data repository, July 2010 that supports current NEMSIS/CEMSIS data standards. Implementation expected to be completed by September 2010.

~~§ Working to replace its outdated EMS data collection system to be compliant with state and national standards~~

§ Continue to work with local Fire, OES, and Public Health agencies toward an integrated/interoperable communications system.

The following personnel, funding, and provider changes have occurred in the MVEMS System since the last update.

Staffing

§ In August, 2009 Jim Worobe resigned his position as Deputy Director.

§ In September 2009, Richard Murdock accepted the position of Interim Deputy Director.

§ Effective June 30, 2010, Dr. Mackey resigned his position as Medical Director. Dr.

Mackey will extend his contract until a replacement is hired.

~~§ In May 2009, Tom Morton was hired as Quality Improvement and Facilities Coordinator,~~

~~§ In August, 2009 Jim Worobe resigned his position as Deputy Director and the position remains unfilled.~~

§ The Agency still maintains two additional staff vacancies which we were unable to fill due to fiscal constraints.

Funding

§ Attempts to make progress on State General Fund augmentation for EMS regions in California during the year have again yielded no additional funding.

ALS Service Providers

~~§ In November of 2008, Pro Transport One Ambulance began to provide service as a second ALS 911 ambulance service within Hughson Zone C.~~

~~§ In April 2009 Cal Star Air Ambulance began providing service in Amador County.~~

TABLE 2: SYSTEM RESOURCES AND OPERATIONS**System Organization and Management**EMS System: Mountain-Valley EMS AgencyReporting Year: 2008

NOTE: Number (1) below is to be completed for each county. The balance of Table 2 refers to each agency.

1) County Reports**County: Alpine**

- | | |
|---|-------|
| A. Basic Life Support (BLS) | |
| B. Limited Advanced Life Support (LALS) | |
| C. Advanced Life Support (ALS) | 100 % |

County: Amador

- | | |
|---|-------|
| A. Basic Life Support (BLS) | |
| B. Limited Advanced Life Support (LALS) | |
| C. Advanced Life Support (ALS) | 100 % |

County: Calaveras

- | | |
|---|-------|
| A. Basic Life Support (BLS) | |
| B. Limited Advanced Life Support (LALS) | |
| C. Advanced Life Support (ALS) | 100 % |

County: Mariposa

- | | |
|---|-------|
| A. Basic Life Support (BLS) | |
| B. Limited Advanced Life Support (LALS) | |
| C. Advanced Life Support (ALS) | 100 % |

County: Stanislaus

- | | |
|---|-------|
| A. Basic Life Support (BLS) | |
| B. Limited Advanced Life Support (LALS) | |
| C. Advanced Life Support (ALS) | 100 % |

2. Type of agency

- a - Public Health Department
- b - County Health Services Agency
- c - Other (non-health) County Department

d - Joint Powers Agency

e - Private Non-Profit Entity

f - Other: _____

3. **The person responsible for day-to-day activities of the EMS agency reports to**

- a - Public Health Officer
- b- Health Services Agency Director/Administrator
- c - **Board of Directors**
- d - Other: _____

4. **Indicate the non-required functions which are performed by the agency:**

- Implementation of exclusive operating areas (ambulance franchising) X
- Designation of trauma centers/trauma care system planning X
- Designation/approval of pediatric facilities X
- Designation of other critical care centers X
- Development of transfer agreements X
- Enforcement of local ambulance ordinance X
- Enforcement of ambulance service contracts X
- Operation of ambulance service
- Continuing education X
- Personnel training X
- Operation of oversight of EMS dispatch center
- Non-medical disaster planning
- Administration of critical incident stress debriefing team (CISD)
- Administration of disaster medical assistance team (DMAT)
- Administration of EMS Fund [Senate Bill (SB) 12/612] Other: _____

5. **EMS agency budget for FY 201009-201110**

EXPENSES

Salaries and benefits (All but contract personnel)	\$ <u>794,562,778,563</u>
Contract Services (e.g. medical director)	<u>183,482,230,066</u>
Operations (e.g. copying, postage, facilities)	<u>163,836,138,025</u>
Travel	<u>28,900,24,900</u>
Fixed assets	<u>12,8390</u>
Indirect expenses (overhead)	_____
Ambulance subsidy	_____
EMS Fund payments to physicians/hospital	_____
Dispatch center operations (non-staff)	_____
Training program operations	_____
Other: <u>Pass Through</u>	<u>64,000</u>
TOTAL EXPENSES	\$ <u>1,183,619,1,235,554</u>

Table 2 - System Organization & Management (cont.)**SOURCES OF REVENUE**

Special project grant(s) [from EMSA]	
Preventive Health and Health Services (PHHS) Block Grant	\$ _____
Office of Traffic Safety (OTS)	<u>12,833,17,288</u>
State general fund	<u>311,612,314,731</u>
County general fund	_____
Other local tax funds (e.g., EMS district)	_____
County contracts (e.g. multi-county agencies)	<u>284,003,285,851</u>
Certification fees	<u>25,000</u>
Training program approval fees	<u>1,980</u>
Training program tuition/Average daily attendance funds (ADA)	_____
Job Training Partnership ACT (JTPA) funds/other payments	_____
Base hospital application fees	_____
Trauma center application fees	_____
Trauma center designation fees	<u>147,464</u>
Pediatric facility approval fees	_____
Pediatric facility designation fees	_____
Other critical care center application fees	_____
Other critical care center designation fees	_____
Ambulance service/vehicle fees	<u>305,994</u>
Contributions	_____
EMS Fund (SB 12/612)	_____
Other grants: _____	_____
Other fees: <u>Workshops/Misc</u>	<u>2623,450</u>
Other (specify): <u>Pass Thru</u>	<u>2064,000</u>
Other (specify): <u>Fund Interest</u>	<u>19,000</u>
SUBTOTAL	\$ <u>1,154,336,1,204,758</u>
Net Income (Amount of Operating Reserve Required to Balance Budget)	<u>(29,283,30,796)</u>
TOTAL REVENUE	\$ <u>1,183,619,1,235,554</u>

Due to multiple reductions in the State General Fund contribution over the past several years and rising operational costs, the deficit between revenue and expenses in the Fiscal Year 2008/2009 budget will be covered through a one time draw down of operational reserves in the amount of \$29,283.

08/09.

Table 2 - System Organization & Management (cont.)EMS System: Mountain-Valley EMS AgencyReporting year 2009

*Salaries as of June 30, 2009

CATEGORY	ACTUAL TITLE	FTE POSITIONS (EMS ONLY)	TOP SALARY BY HOURLY EQUIVALENT	BENEFITS (%of Salary)	COMMENTS
EMS Admin./Coord./Director	Executive Director	1 FTE	43.88 <u>46.07</u>	37.5%	
Asst. Admin./Admin. Asst./Admin. Mgr.	Deputy Director	1 FTE	29.66 <u>28.82</u>	37.5%	*As of August 7, 2009 Vacant
ALS Coord./Field Coord./ Training Coordinator	Certification and Training /Communications Coordinator	1 FTE	25.24 <u>27.04</u>	37.5%	
Program Coordinator (Non-clinical)	Transportation Coordinator	1 FTE	29.56 <u>31.05</u>	37.5%	
Trauma Coordinator	Trauma/Medical Coordinator	0.3 FTE	40.99 <u>43.63</u>	N/A	
Medical Director	Medical Director	0.2 FTE	77.89 80.23	N/A	July 2008—June 2009 July 2009-2010 – June 2010 <u>2011</u>
Disaster Medical Planner	Disaster Coordinator	0.47 FTE	42.00 43.26 <u>45.43</u>	N/A	July 2008—June 2009 July 2009-2010 – June 2010 <u>2011</u>
Field Liaison (Non-Clinical)	Field Liaison	1 FTE	23.10 <u>16.00</u>	37.5% <u>N/A</u>	

Include an organizational chart of the local EMS agency and a county organization chart(s) indicating how the LEMSA fits within the county/multi-county structure.

Table 2 - System Organization & Management (cont.)

CATEGORY	ACTUAL TITLE	FTE POSITIONS (EMS ONLY)	TOP SALARY BY HOURLY EQUIVALENT	BENEFITS (%of Salary)	COMMENTS
Data Evaluator/Analyst	Information Systems Analyst	1 FTE	21.76 <u>22.87</u>	37.5%	
QA/QI Coordinator	Quality Improvement and Facilities Coordinator	1 FTE	23.79 <u>25.26</u>	37.5%	
Public Info. & Education Coordinator					
Executive Secretary	Executive Secretary	0.8 FTE	17.32 <u>18.38</u>	37.5%	
Other Clerical	Receptionist/Secretary 1	1 FTE	16.30 <u>17.13</u>	37.5%	
Data Entry Clerk	Data Registrar	1 FTE	19.11 <u>20.28</u>	37.5%	
Management Services Assistant	Financial Services Assistant	0.5 FTE	18.51 <u>19.84</u>	37.5%	

Include an organizational chart of the local EMS agency and a county organization chart(s) indicating how the LEMSA fits within the county/multi-county structure.

Mountain Valley Emergency Medical Services Agency Organizational Chart

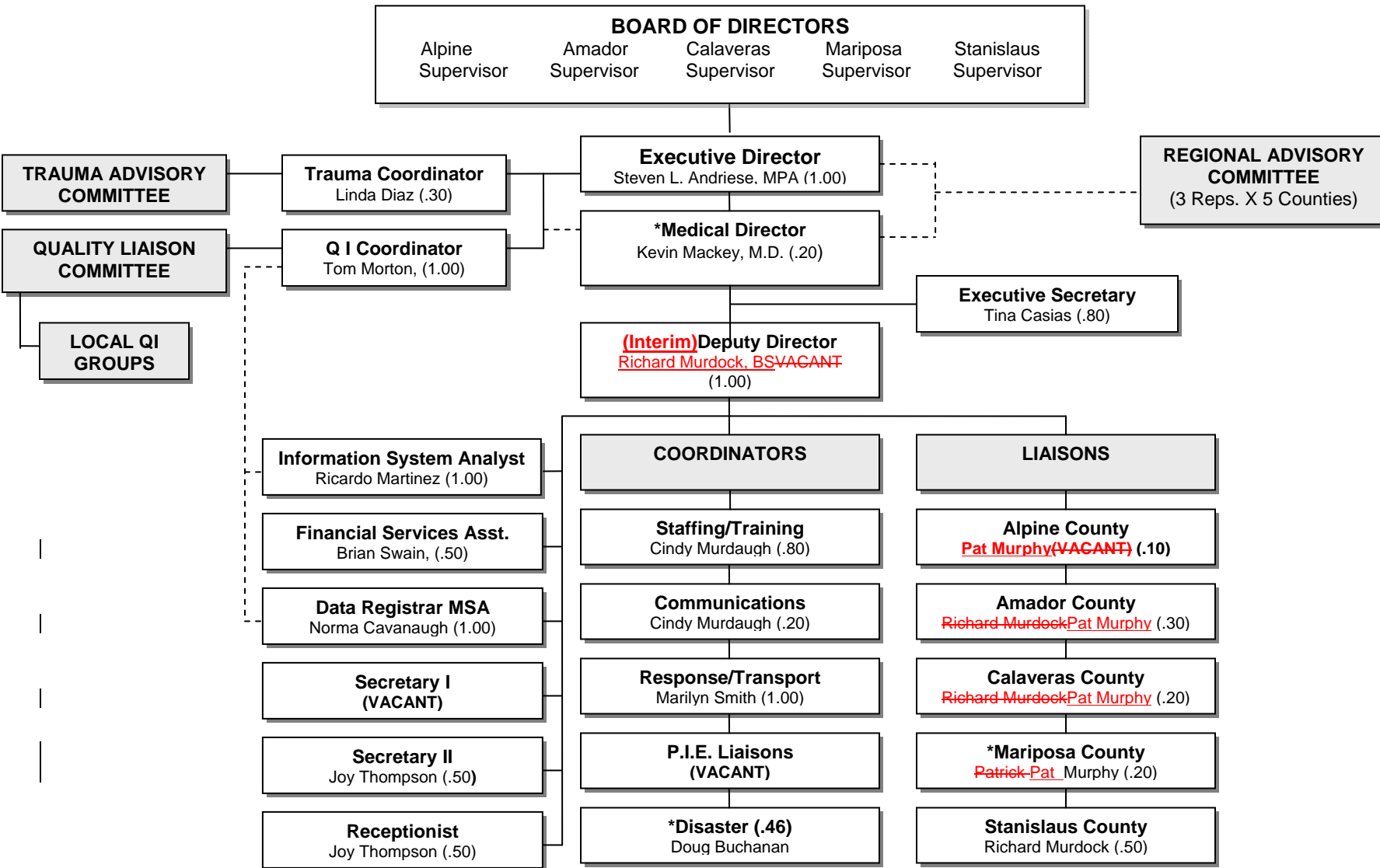


TABLE 3: SYSTEM RESOURCES AND OPERATIONS - Personnel/Training

EMS System: Mountain-Valley EMS Agency

Reporting Year: FY 2008/2009/2009/2010

NOTE: Table 3 is to be reported by agency.

	EMT - Is	EMT - IIs	EMT - Ps	MICN
Total Certified	1058 <u>1256</u>	0	284	240 <u>269</u>
Number newly certified this year	180 <u>233</u>	0	24	39 <u>37</u>
Number recertified this year	412 <u>458</u>	0	127	110
Total number of accredited personnel on July 1 of the reporting year			305	
Number of certification reviews resulting in:				
a) formal investigations	10	0		0
b) probation	0	0	0	0
c) suspensions	1	0	0	0
d) revocations	10	0		0
e) denials	0 <u>1</u>	0		0
f) denials of renewal	0	0		0
g) no action taken	0	0	0	0

1. Number of EMS dispatch agencies utilizing EMD Guidelines: 4
2. Early defibrillation:
 - a) Number of EMT=I (defib) certified _____
 - b) Number of public safety (defib) certified (non-EMT-I) _____

3. Do you have a first responder training program yes no

TABLE 4: SYSTEM RESOURCES AND OPERATIONS - Communications

EMS System: Mountain-Valley EMS Agency

County: Alpine County

Reporting Year: FY ~~2008/09~~2009/10

Note: Table 4 is to be answered for each county.

1. Number of primary Public Service Answering Points (PSAP) 1
2. Number of secondary PSAPs 0
3. Number of dispatch centers directly dispatching ambulances 0
4. Number of designated dispatch centers for EMS Aircraft 0
5. Do you have an operational area disaster communication system? Yes No
 - a. Radio primary frequency: 153.800154.100/153.800
 - b. Other methods: RACES
 - c. Can all medical response units communicate on the same disaster communications system?
Yes No
 - d. Do you participate in OASIS? Yes No
 - e. Do you have a plan to utilize RACES as a back-up communication system?
Yes No
 - 1) Within the operational area? Yes No
 - 2) Between the operational area and the region and/or state? Yes No
6. Who is your primary dispatch agency for day-to-day emergencies? Alpine County Sheriff
7. Who is your primary dispatch agency for a disaster? Alpine County Sheriff

EMS System: Mountain-Valley EMS AgencyCounty: Amador CountyReporting Year: FY ~~2008/09~~2009/10**Note:** Table 4 is to be answered for each county.

- | | | |
|----|--|------------------------------|
| 1. | Number of primary Public Service Answering Points (PSAP) | <u>1</u> |
| 2. | Number of secondary PSAPs | <u>0</u> |
| 3. | Number of dispatch centers directly dispatching ambulances | <u>1</u> |
| 4. | Number of designated dispatch centers for EMS Aircraft | <u>0</u> |
| 5. | Do you have an operational area disaster communication system? Yes <u>X</u> No | |
| | a. Radio primary frequency: | <u>467.975/462.975</u> |
| | b. Other methods: | <u>RACES</u> |
| | c. Can all medical response units communicate on the same disaster communications system?
Yes <u>X</u> No | |
| | d. Do you participate in OASIS? Yes <u>X</u> No | |
| | e. Do you have a plan to utilize RACES as a back-up communication system?
Yes <u>X</u> No | |
| | 1) Within the operational area? Yes <u>X</u> No | |
| | 2) Between the operational area and the region and/or state? Yes <u>X</u> No | |
| 6. | Who is your primary dispatch agency for day-to-day emergencies? | <u>Amador County Sheriff</u> |
| 7. | Who is your primary dispatch agency for a disaster? | <u>Amador County Sheriff</u> |

EMS System: Mountain-Valley EMS Agency

County: Calaveras County

Reporting Year: FY ~~2008/09~~2009/10

Note: Table 4 is to be answered for each county.

- 1. Number of primary Public Service Answering Points (PSAP) 1
- 2. Number of secondary PSAPs 0
- 3. Number of dispatch centers directly dispatching ambulances 1
- 4. Number of designated dispatch centers for EMS Aircraft 0
- 5. Do you have an operational area disaster communication system? Yes No
 - a. Radio primary frequency: 468.950/-and-462.950
 - b. Other methods: RACES
 - c. Can all medical response units communicate on the same disaster communications system?
Yes No
 - d. Do you participate in OASIS? Yes No
 - e. Do you have a plan to utilize RACES as a back-up communication system?
Yes No
 - 1) Within the operational area? Yes No
 - 2) Between the operational area and the region and/or state? Yes No
- 6. Who is your primary dispatch agency for day-to-day emergencies? Calaveras County Sheriff
- 7. Who is your primary dispatch agency for a disaster? Calaveras County Sheriff

EMS System: Mountain-Valley EMS Agency

County: Mariposa County

Reporting Year: FY ~~2008/09~~2009/10

Note: Table 4 is to be answered for each county.

1. Number of primary Public Service Answering Points (PSAP) 1
2. Number of secondary PSAPs 1
3. Number of dispatch centers directly dispatching ambulances 1
4. Number of designated dispatch centers for EMS Aircraft 1
5. Do you have an operational area disaster communication system? Yes X No
 - a. Radio primary frequency: 159.390 / 151.460
 - b. Other methods: NONE
 - c. Can all medical response units communicate on the same disaster communications system?
Yes X No
 - d. Do you participate in OASIS? Yes X No
 - e. Do you have a plan to utilize RACES as a back-up communication system?
Yes X No
 - 1) Within the operational area? Yes X No
 - 2) Between the operational area and the region and/or state? Yes X No
6. Who is your primary dispatch agency for day-to-day emergencies? California Dept. of Forestry, Mariposa
7. Who is your primary dispatch agency for a disaster? California Dept. of Forestry, Mariposa

EMS System: Mountain-Valley EMS Agency

County: Stanislaus County

Reporting Year: FY ~~2008/09~~2009/10

Note: Table 4 is to be answered for each county.

- 1. Number of primary Public Service Answering Points (PSAP) 4
- 2. Number of secondary PSAPs 1
- 3. Number of dispatch centers directly dispatching ambulances 1
- 4. Number of designated dispatch centers for EMS Aircraft 1
- 5. Do you have an operational area disaster communication system? Yes No
 - a. Radio primary frequency: 467.975 and
154.145157.6125/463.00
 - b. Other methods: RACES
 - c. Can all medical response units communicate on the same disaster communications system?
Yes No
 - d. Do you participate in OASIS? Yes No
 - e. Do you have a plan to utilize RACES as a back-up communication system?
Yes No
 - 1) Within the operational area? Yes No
 - 2) Between the operational area and the region and/or state? Yes No
- 6. Who is your primary dispatch agency for day-to-day emergencies? LifeCom Fire/EMS Dispatch
- 7. Who is your primary dispatch agency for a disaster? LifeCom Fire/EMS Dispatch

TABLE 5: SYSTEM RESOURCES AND OPERATIONS - Response/Transportation

EMS System: Mountain-Valley EMS Agency

Reporting Year: FY 2007/20082009/10

Note: Table 5 is to be reported by agency.

Early Defibrillation Providers

1. Number of EMT-Defibrillation providers 36

SYSTEM STANDARD RESPONSE TIMES IN MINUTES (90TH PERCENTILE)

Information provided is broken down by county. Each county has established slightly different response time requirements for each zone.

Alpine County	METRO/URBAN	SUBURBAN/RURAL	WILDERNESS	SYSTEMWIDE
BLS and CPR capable first responder	ASAP	ASAP	ASAP	ASAP
Early defibrillation responder	ASAP	ASAP	ASAP	ASAP
Advanced life support responder	N/A	N/A	N/A	N/A
Transport Ambulance	ASAP	ASAP	ASAP	ASAP

Amador County	METRO/URBAN	SUBURBAN/RURAL	WILDERNESS	SYSTEMWIDE
BLS and CPR capable first responder	ASAP	ASAP	ASAP	ASAP
Early defibrillation responder	ASAP	ASAP	ASAP	ASAP
Advanced life support responder	N/A	N/A	N/A	N/A

Transport Ambulance	12/16	20/30	ASAP	N/A
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TABLE 5: SYSTEM RESOURCES AND OPERATIONS (Cont)

Calaveras County	METRO/URBAN	SUBURBAN/RURAL	WILDERNESS	SYSTEMWIDE
BLS and CPR capable first responder	ASAP	ASAP	ASAP	ASAP
Early defibrillation responder	ASAP	ASAP	ASAP	ASAP
Advanced life support responder	ASAP	ASAP	ASAP	ASAP
Transport Ambulance	-	-	-	20

Mariposa County	METRO/URBAN	SUBURBAN/RURAL	WILDERNESS	SYSTEMWIDE
BLS and CPR capable first responder	ASAP	ASAP	ASAP	ASAP
Early defibrillation responder	ASAP	ASAP	ASAP	ASAP
Advanced life support responder	ASAP	ASAP	ASAP	ASAP
Transport Ambulance	8	12/20	ASAP	N/A

TABLE 5: SYSTEM RESOURCES AND OPERATIONS (Cont)

Stanislaus County	METRO/URBAN	SUBURBAN/RURAL	WILDERNESS	SYSTEMWIDE
BLS and CPR capable first responder	ASAP	ASAP	ASAP	ASAP
Early defibrillation responder	ASAP	ASAP	ASAP	ASAP
Advanced life support responder	ASAP	ASAP	ASAP	ASAP
Transport Ambulance	7:30	11:30/19:30	ASAP	N/A

TABLE 6: SYSTEM RESOURCES AND OPERATIONS - Facilities/Critical CareEMS System: Mountain-Valley EMS AgencyReporting Year: ~~2008~~2009**NOTE:** Table 6 is to be reported by agency.**Trauma**

Trauma patients:

a) Number of patients meeting trauma triage criteria	1785 <u>1850</u>
b) Number of major trauma victims transported directly to a trauma center by ambulance	<u>1727</u>
c) Number of major trauma patients transferred to a trauma center	175 <u>171</u>
d) Number of patients meeting triage criteria who weren't treated at a trauma center	<u>Unknown</u>

Emergency Departments

Total number of emergency departments	<u>7</u>
a) Number of referral emergency services	<u>0</u>
b) Number of standby emergency services	<u>1</u>
c) Number of basic emergency services	<u>6</u>
d) Number of comprehensive emergency services	1 <u>0</u>

Receiving Hospitals

1. Number of receiving hospitals with written agreements	<u>1</u>
2. Number of base hospitals with written agreements	<u>7</u>

TABLE 7: SYSTEM RESOURCES AND OPERATIONS -- Disaster Medical

EMS System: Mountain-Valley EMS Agency

County: Alpine

Reporting Year: ~~07/08~~09/10

NOTE: Table 7 is to be answered for each county.

SYSTEM RESOURCES

1. Casualty Collections Points (CCP)
 - a. Where are your CCPs located? N/A
 - b. How are they staffed? N/A
 - c. Do you have a supply system for supporting them for 72 hours? Yes ___ No X

2. CISD

Do you have a CISD provider with 24 hour capability? Yes ___ No X

3. Medical Response Team
 - a. Do you have any team medical response capability? Yes ___ No X
 - b. For each team, are they incorporated into your local response plan? Yes X No ___
 - c. Are they available for statewide response? Yes ___ No X
 - d. Are they part of a formal out-of-state response system? Yes ___ No X

4. Hazardous Materials
 - a. Do you have any HazMat trained medical response teams? Yes ___ No X
 - b. At what HazMat level are they trained? N/A
 - c. Do you have the ability to do decontamination in an emergency room? Yes ___ no X
 - d. Do you have the ability to do decontamination in the field? Yes X no ___

OPERATIONS

1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? Yes X no ___

2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? 1

3. Have you tested your MCI Plan this year in a:
 - a. real event? Yes ___ no X
 - b. exercise? Yes X no ___

4. List all counties with which you have a written medical mutual aid agreement.

El Dorado, Douglas County, NV

5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response? Yes ___ No X
6. Do you have a formal agreements with community clinics in your operational areas to participate in disaster planning and response? Yes ___ No X
7. Are you part of a multi-county EMS system for disaster response? Yes X No ___
8. Are you a separate department or agency? Yes X No ___
9. If not, to whom do you report? _____
8. If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department? Yes X No ___

TABLE 7: SYSTEM RESOURCES AND OPERATIONS -- Disaster Medical

EMS System: Mountain-Valley EMS Agency

County: Amador

Reporting Year: 07/0809/10

NOTE: Table 7 is to be answered for each county.

SYSTEM RESOURCES

- 1. Casualty Collections Points (CCP)
 - a. Where are your CCPs located? Ione
 - b. How are they staffed? County staff/ mutual-aid
 - c. Do you have a supply system for supporting them for 72 hours? Yes No

- 2. CISD
 - Do you have a CISD provider with 24 hour capability? Yes No

- 3. Medical Response Team
 - a. Do you have any team medical response capability? Yes No
 - b. For each team, are they incorporated into your local response plan? Yes No
 - c. Are they available for statewide response? Yes No
 - d. Are they part of a formal out-of-state response system? Yes No

- 4. Hazardous Materials
 - a. Do you have any HazMat trained medical response teams? Yes No
 - b. At what HazMat level are they trained? N/A
 - c. Do you have the ability to do decontamination in an emergency room? Yes No
 - d. Do you have the ability to do decontamination in the field? Yes No

OPERATIONS

- 1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? Yes No

- 2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? 2

- 3. Have you tested your MCI Plan this year in a:
 - a. real event? Yes No
 - b. exercise? Yes No

4. List all counties with which you have a written medical mutual aid agreement.

5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response? Yes No
6. Do you have a formal agreements with community clinics in your operational areas to participate in disaster planning and response? Yes No
7. Are you part of a multi-county EMS system for disaster response? Yes No
8. Are you a separate department or agency? Yes No
9. If not, to whom do you report? _____
8. If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department? Yes No

TABLE 7: SYSTEM RESOURCES AND OPERATIONS -- Disaster MedicalEMS System: Mountain-Valley EMS AgencyCounty: CalaverasReporting Year: 07/0809/10

NOTE: Table 7 is to be answered for each county.

SYSTEM RESOURCES

1. Casualty Collections Points (CCP)
 - a. Where are your CCPs located? N/A
 - b. How are they staffed? N/A
 - c. Do you have a supply system for supporting them for 72 hours? Yes No

2. CISD

Do you have a CISD provider with 24 hour capability? Yes No

3. Medical Response Team
 - a. Do you have any team medical response capability? Yes No
 - b. For each team, are they incorporated into your local response plan? Yes No
 - c. Are they available for statewide response? Yes No
 - d. Are they part of a formal out-of-state response system? Yes No

4. Hazardous Materials
 - a. Do you have any HazMat trained medical response teams? Yes No
 - b. At what HazMat level are they trained? N/A
 - c. Do you have the ability to do decontamination in an emergency room? Yes No
 - d. Do you have the ability to do decontamination in the field? Yes No

OPERATIONS

1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? Yes No

2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? 2

3. Have you tested your MCI Plan this year in a:
 - a. real event? Yes No
 - b. exercise? Yes No

4. List all counties with which you have a written medical mutual aid agreement.

5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response? Yes No
6. Do you have a formal agreements with community clinics in your operational areas to participate in disaster planning and response? Yes No
7. Are you part of a multi-county EMS system for disaster response? Yes no
8. Are you a separate department or agency? Yes no
9. If not, to whom do you report? _____
8. If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department? Yes no

TABLE 7: SYSTEM RESOURCES AND OPERATIONS -- Disaster Medical

EMS System: Mountain-Valley EMS Agency

County: Mariposa

Reporting Year: 07/0809/10

NOTE: Table 7 is to be answered for each county.

SYSTEM RESOURCES

1. Casualty Collections Points (CCP)
 - a. Where are your CCPs located? N/A
 - b. How are they staffed? N/A
 - c. Do you have a supply system for supporting them for 72 hours? Yes No

2. CISD

Do you have a CISD provider with 24 hour capability? Yes No

3. Medical Response Team
 - a. Do you have any team medical response capability? Yes No
 - b. For each team, are they incorporated into your local response plan? Yes No
 - c. Are they available for statewide response? Yes No
 - d. Are they part of a formal out-of-state response system? Yes No

4. Hazardous Materials
 - a. Do you have any HazMat trained medical response teams? Yes No
 - b. At what HazMat level are they trained? N/A
 - c. Do you have the ability to do decontamination in an emergency room? Yes No
 - d. Do you have the ability to do decontamination in the field? Yes No

OPERATIONS

1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? Yes No

2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? 2

3. Have you tested your MCI Plan this year in a:
 - a. real event? Yes No
 - b. exercise? Yes No

4. List all counties with which you have a written medical mutual aid agreement.

5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response? Yes X No ____
6. Do you have a formal agreements with community clinics in your operational areas to participate in disaster planning and response? Yes ____ No X
7. Are you part of a multi-county EMS system for disaster response? Yes X No ____
8. Are you a separate department or agency? Yes X No ____
9. If not, to whom do you report? _____
8. If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department? Yes X No ____

TABLE 7: SYSTEM RESOURCES AND OPERATIONS -- Disaster Medical

EMS System: Mountain-Valley EMS Agency

County: Stanislaus

Reporting Year: 08/0909/10

NOTE: Table 7 is to be answered for each county.

SYSTEM RESOURCES

- 1. Casualty Collections Points (CCP)
 - a. Where are your CCPs located? N/A
 - b. How are they staffed? N/A
 - c. Do you have a supply system for supporting them for 72 hours? Yes ___ No X

- 2. CISD
 - Do you have a CISD provider with 24 hour capability? Yes ___ No X

- 3. Medical Response Team
 - a. Do you have any team medical response capability? Yes X No ___
 - b. For each team, are they incorporated into your local response plan? Yes X No ___
 - c. Are they available for statewide response? Yes X No ___
 - d. Are they part of a formal out-of-state response system? Yes ___ No X

- 4. Hazardous Materials
 - a. Do you have any HazMat trained medical response teams? Yes ___ No X
 - b. At what HazMat level are they trained? N/A
 - c. Do you have the ability to do decontamination in an emergency room? Yes X No ___
 - d. Do you have the ability to do decontamination in the field? Yes X No ___

OPERATIONS

- 1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? Yes X No ___

- 2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? **8**

- 3. Have you tested your MCI Plan this year in a:
 - a. real event? Yes X No ___
 - b. exercise? Yes X No ___

4. List all counties with which you have a written medical mutual aid agreement.

5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response? Yes No
6. Do you have a formal agreements with community clinics in your operational areas to participate in disaster planning and response? Yes No
7. Are you part of a multi-county EMS system for disaster response? Yes No
8. Are you a separate department or agency? Yes No
9. If not, to whom do you report? _____
8. If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department? Yes No

TABLE 8: RESOURCES DIRECTORY -- Approved Training Programs

EMS System: Mountain-Valley EMS Agency County: Amador Reporting Year: FY ~~2008/09~~2009/10

Training Institution Name Cosumnes River College **Contact Person telephone no.** Matthew McHugh (916) 691-7906
Address - 11350 American Legion Drive
Sutter Creek, CA. 95

Student Eligibility: * OPEN	Cost of Program Basic <u>Varies</u> Refresher _____	**Program Level: <u>EMT-I</u> Number of students completing training per year: Initial training: <u>5365</u> Refresher: <u>0</u> Cont. Education <u>1526</u> Expiration Date: <u>12/31/2011</u> Number of courses: <u>2</u> Initial training: <u>2</u> Refresher: <u>0</u> Cont. Education: <u>1</u>
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Training Institution Name Jackson Rancheria Fire Department **Contact Person telephone no.** Bryan Smith (209) 304-1159
Address - 12222 New York Ranch Road
Jackson, CA. 95642

Student Eligibility: * Restricted to Fire Department personnel only	Cost of Program Basic _____ Refresher _____	**Program Level: <u>EMT-I</u> Number of students completing training per year: Initial training: <u>03</u> Refresher: _____ Cont. Education <u>n/a</u> Expiration Date: <u>12/2011</u> Number of courses: <u>01</u> Initial training: <u>01</u> Refresher: _____ Cont. Education: <u>n/a</u>
---	--	--

Open to general public or restricted to certain personnel only.** Indicate whether EMT-I, EMT-II, EMT-P, or MICN; if there is a training program that offers more than one level

complete all information for each level.

EMS System: Mountain-Valley EMS Agency **County:** Calaveras **Reporting Year:** FY ~~2008/2009~~2009/10

Training Institution Name Murphys Fire Protection District **Contact Person telephone no.** Steve Kovaks (209)

Address - 37 Jones Street, PO Box 1260
Murphys, CA. 95247

Student Eligibility: * OPEN	Cost of Program Basic Refresher _____	**Program Level: <u>EMT-I</u> Number of students completing training per year: Initial training: <u>350</u> Refresher: <u>0</u> Cont. Education <u>40</u> Expiration Date: <u>10/31/2012</u> Number of courses: <u>20</u> Initial training: <u>20</u> Refresher: <u>0</u> Cont. Education: <u>20</u>
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Open to general public or restricted to certain personnel only.** Indicate whether EMT-I, EMT-II, EMT-P, or MICN; if there is a training program that offers more than one level complete all information for each level.

TABLE 8: RESOURCES DIRECTORY -- Approved Training Programs

EMS System: Mountain-Valley EMS Agency County: Mariposa Reporting Year: FY ~~2008/09~~2009/10

Training Institution Name Mountain-Valley EMS Agency – Mariposa County **Contact Person telephone no.** Cindy Murdaugh – 209-529-5085
Address – 1101 Standiford Ave. Suite D-1 Modesto, CA. 95350

Student Eligibility: * OPEN	Cost of Program Basic \$325.00 Refresher \$20.00	**Program Level: <u>EMT-I</u> Number of students completing training per year: Initial training: <u>230</u> Refresher: <u>0</u> Cont. Education <u>80</u> Expiration Date: <u>11/30/2011</u> Number of courses: <u>10</u> Initial training: _____ Refresher: _____ Cont. Education: <u>100</u>
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Training Institution Name Mountain-Valley EMS Agency – Yosemite **Contact Person telephone no.** Cindy Murdaugh – 209-529-5085
Address 1101 Standiford Ave. Suite D-1 Modesto, CA. 95350

Student Eligibility: *	Cost of Program Basic \$325.00 Refresher \$20.00	**Program Level: <u>EMT-I</u> Number of students completing training per year: Initial training: <u>0</u> Refresher: _____ Cont. Education _____ Expiration Date: <u>11/30/2011</u> Number of courses: <u>0</u> Initial training: _____ Refresher: _____ Cont. Education: _____
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Training Institution Name Fresno Regional Occupational Program – Mariposa County **Contact Person telephone no.** Phil Whitson – 209-966-4880
Address 1318 Shaw Ave.,
 Fresno, CA. 93710

<u>Student Eligibility: *</u>	<u>Cost of Program</u> <u>Basic \$325.00</u> <u>Refresher</u>	<u>**Program Level: EMT-I</u> <u>Number of students completing training per year:</u> <u>Initial training: 53</u> <u>Refresher: _____</u> <u>Cont. Education _____</u> <u>Expiration Date: 07/31/2013</u> <u>Number of courses: 0</u> <u>Initial training: 2</u> <u>Refresher: _____</u> <u>Cont. Education: _____</u>
--------------------------------------	--	--

Open to general public or restricted to certain personnel only.** Indicate whether EMT-I, EMT-II, EMT-P, or MICN; if there is a training program that offers more than one level complete all information for each level.

TABLE 8: RESOURCES DIRECTORY -- Approved Training Programs

EMS System: Mountain-Valley EMS Agency **County:** Stanislaus **Reporting Year:** FY 2008/092009/10

Training Institution Name Abrams College **Contact Person telephone no.** Dan Lucky 209-527-7777
Address 201 E. Rumble Rd.
 Modesto, CA. 95350

<u>Student Eligibility: *</u> OPEN	<u>Cost of Program</u> <u>Basic \$775.00</u> <u>Refresher _____</u>	<u>**Program Level: EMT-I</u> <u>Number of students completing training per year:</u> <u>Initial training: 201256</u> <u>Refresher: 2538</u> <u>Cont. Education 28</u> <u>Expiration Date: 06/60/2012</u>
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Training Institution Name Hughson Fire District

Address 2315 Charles Ave.
 Hughson, CA. 95326

Contact Person telephone no. Michael Crabtree or Ron Callahan – 209-883-2863

Student Eligibility: * OPEN	Cost of Program Basic Unknown Refresher _____	**Program Level: <u>EMT-I</u> Number of students completing training per year: Initial training: <u>016</u> Refresher: ____ Cont. Education ____ Expiration Date: <u>06/30/201204/30/2013</u> Number of courses: <u>1</u> Initial training: <u>16</u> Refresher: ____ Cont. Education: ____
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Training Institution Name Modesto Junior College

Address 1220 Fire Science Lane
 Modesto, CA. 95351

Contact Person telephone no. John Sola 209-549-7030

Student Eligibility: * OPEN	Cost of Program Basic <u>Varies -\$150.00\$250-\$450</u> Refresher _____	**Program Level: <u>EMT-I</u> Number of students completing training per year: Initial training: <u>7784</u> Refresher: <u>1724</u> Cont. Education ____ Expiration Date: <u>11/302010</u> Number of courses: <u>4</u> Initial training: <u>3</u> Refresher: <u>1</u> Cont. Education: ____
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Training Institution Name Oakdale Rural Fire Department

Address 1398 East F Street
 Oakdale, CA. 95361

Contact Person telephone no. Jered Eckle – 209-847-6898

Student Eligibility: * OPEN	Cost of Program Basic Unknown Refresher _____	**Program Level: <u>EMT-I</u> Number of students completing training per year: Initial training: <u> 0 </u> Refresher: <u> </u> Cont. Education <u> </u> Expiration Date: <u>08/31/2009</u> Number of courses: <u> </u> Initial training: <u> 0 </u> Refresher: <u> </u> Cont. Education: <u> </u>
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Open to general public or restricted to certain personnel only.** Indicate whether EMT-I, EMT-II, EMT-P, or MICN; if there is a training program that offers more than one level complete all information for each level.

TABLE 9: RESOURCES DIRECTORY -- Dispatch Agency

EMS System: Mountain-Valley EMS Agency County: Amador Reporting Year: FY 2008/092009/10

Name, address & telephone: Amador County Sheriff Department, Communications Center		Primary Contact: Lt. Charles Ray 209-223-6672 or 209-223-6284	
Written Contract: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Medical Director: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	<input checked="" type="checkbox"/> Day-to-day <input checked="" type="checkbox"/> Disaster	Number of Personnel providing services: ___12___ EMD Training ___ EMT-D ___ ALS ___ BLS ___ LALS ___ Other
Ownership: <input checked="" type="checkbox"/> Public <input type="checkbox"/> Private		If public: <input type="checkbox"/> Fire <input checked="" type="checkbox"/> Law <input type="checkbox"/> Other explain: _____	If public: <input type="checkbox"/> city; <input checked="" type="checkbox"/> county; <input type="checkbox"/> state; <input type="checkbox"/> fire district; <input type="checkbox"/> Federal

EMS System: Mountain-Valley EMS Agency County: Calaveras

Reporting Year: FY 2008/092009/10

Name, address & telephone: Calaveras County Sheriff Department, Communications Center Government Center, San Andreas, CA. 95249		Primary Contact: Dave Seawell <u>Rochelle Whiting</u> 209-754-6500	
Written Contract: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Medical Director: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	<input checked="" type="checkbox"/> Day-to-day <input checked="" type="checkbox"/> Disaster	Number of Personnel providing services: __12__ EMD Training _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other
Ownership: <input checked="" type="checkbox"/> Public <input type="checkbox"/> Private		If public: <input type="checkbox"/> Fire <input checked="" type="checkbox"/> Law <input type="checkbox"/> Other explain: _____	If public: <input type="checkbox"/> city; <input checked="" type="checkbox"/> county; <input type="checkbox"/> state; <input type="checkbox"/> fire district; <input type="checkbox"/> Federal

EMS System: Mountain-Valley EMS Agency County: Mariposa

Reporting Year: FY 2008/092009/10

Name, address & telephone: California Department of Forestry, Emergency Comm. Center 5366 Highway 49 North, Mariposa, CA. 95338		Primary Contact: James Forga 209-966-3803	
Written Contract: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Medical Director: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	<input checked="" type="checkbox"/> Day-to-day <input checked="" type="checkbox"/> Disaster	Number of Personnel providing services: __15__ EMD Training _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other
Ownership: <input checked="" type="checkbox"/> Public <input type="checkbox"/> Private		If public: <input checked="" type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other explain: _____	If public: <input type="checkbox"/> city; <input type="checkbox"/> county; <input checked="" type="checkbox"/> state; <input type="checkbox"/> fire district; <input type="checkbox"/> Federal

EMS System: Mountain-Valley EMS Agency County: Stanislaus

Reporting Year: FY 2008/092009/10

Name, address & telephone: LifeCom Fire & EMS Communications 4701 Stoddard Rd. Modesto, CA. 95367		Primary Contact: Jared Bagwell 209-236-8302	
Written Contract: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Medical Director: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	<input checked="" type="checkbox"/> Day-to-day <input checked="" type="checkbox"/> Disaster	Number of Personnel providing services: __72__ EMD Training _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other
Ownership: <input type="checkbox"/> Public <input checked="" type="checkbox"/> Private		If public: <input type="checkbox"/> Fire <input type="checkbox"/> Law <input checked="" type="checkbox"/> Other explain: _____	If public: <input type="checkbox"/> city; <input type="checkbox"/> county; <input type="checkbox"/> state; <input type="checkbox"/> fire district; <input type="checkbox"/> Federal

Mountain-Valley EMS Agency



EMS Transportation Plan

**Approved by the Board of Directors
October 2005
Revised October 2009**

The EMS Transportation Plan has been developed to comply with the State EMS Authority's Minimum Standards and Recommended Guidelines 4.01 through 4.22. The plan is divided into three categories:

- ALS Ground Transport Services
- ALS Ground Non-Transport Services
- Air Transportation Services

All policies adopted by the Mountain-Valley EMS Agency are developed in a manner that encourages public input through local EMCC meetings, a sixty-day public comment period, and Regional Advisory Committee and Board of Directors meetings.

I. ALS Ground Ambulance Services

A. Standards for Provision of Service

The Mountain-Valley EMS Agency Policies that ALS Ground Ambulance Services must meet are:

431.00 ALS GROUND AMBULANCE AUTHORIZATION

407.00 EQUIPMENT AND DRUG INVENTORY

404.00 RESPONSE TO GROUND AMBULANCE REQUESTS

405.00 GROUND AMBULANCE STAFFING LEVELS

412.20 ALS TRANSFER OF PATIENT CARE

256.00 PARAMEDIC SCOPE OF PRACTICE

236.00 EMERGENCY MEDICAL TECHNICIAN SCOPE OF PRACTICE

Additionally, ALS Ground Ambulance Service Providers must meet requirements set forth in their ambulance provider agreements.

B. System Design

The optimal EMS system model suggests that each county in the region have a single exclusive provider of all ambulance services in the county. This system would ensure system-wide coordination and a predictable EMS response in areas that contain a variety of population densities and the financial survival of ambulance providers required to respond to 911 requests. 911 providers must serve the public, regardless of expectation of being paid for providing ambulance services. Therefore, in order to be consistent with the desire to ensure the viability of the 911 system, exclusivity should also include interfacility transports.

Some of the benefits derived from a "single ambulance provider" per county are as follows:

- The coordination of resources through a single ambulance dispatch center in each county. A single ambulance dispatch center is better able to send the closest ambulance to an emergency call;
- A more coordinated "system status" response of ambulance resources;
- A greater efficiency derived from economies of scale that should lead to lower ambulance fees and contribute to the financial viability of the provider;
- Areas of lower population density are at less risk of receiving ambulance response below EMSA standards because appropriate standards can be imposed upon a single provider that benefits financially from the areas of higher population in a single county.

- Ease of contract coordination for managed care providers.

However, the EMS agency recognizes that the five counties within the region are comprised of a unique combination of political, geographical and financial features that may make the realization of this "optimal model" for ground ambulance services impractical in every county. Because the development of a single ambulance provider system per county may be optimal, the development of such a system shall be explored in each county as ambulance provider agreements are due to expire. A single ambulance provider system shall only be pursued if evidence indicates that the county would benefit from a single provider system. In those counties in which the ideal (single ambulance provider per county model) is not achieved, exclusive operating areas shall be developed that ensure the following:

- An adequate mix of urban and suburban/rural population areas to provide a balanced support necessary for the financial viability of the ambulance providers.
- That the agreements with those providers ensure optimal coverage for the entire county.
- 9-1-1/PSAP requests
- Requests for immediate ambulance service transmitted through an authorized 9-1-1/PSAP
- Requests for emergency ambulance service made directly to the ambulance service from a seven-digit telephone call without going through an authorized 9-1-1/PSAP
- All ground interfacility transports requiring the services of an ALS, BLS or Critical Care Transport (CCT) ambulance.
- Any other request for service requiring a ground ambulance response
- Response time standards shall be developed on a county-specific basis for urban, suburban, rural, and wilderness response areas.

In those counties with a single provider of ambulance services, exclusivity should be defined in a manner that protects the provider's financial viability to the extent allowed by law during the contract period. Therefore, the MVEMSA shall endeavor to define exclusivity language for single provider counties as for all "ground ambulance services"

Mountain Valley EMS Agency Policy 431.00 - ALS Ground Ambulance Authorization requires that a competitive process be utilized for the development of ALS ground exclusive operating areas (except when "grandfathering" is allowed per H&SC, 1797.224). This policy also outlines some of the minimum components that must be included in an Request for Proposal (R.F.P.) document. It is the plan of the MVEMSA to develop "Emergency Ambulance" exclusive operating areas. The process described in Policy #431 -ALS Ground Ambulance Authorization shall be used as a model to be followed in each of these cases. The MVEMSA will also utilize guidelines provided by the State EMS Authority (i.e. EMSA #141 "Competitive Process for Creating Exclusive Operating Areas") and seek approval by the EMSA as it pertains to following EMSA's guidelines and processes for the development of EOAs.

To ensure the continuation of system optimization, at the end of each ambulance contract cycle of the exclusive operating area Ambulance Provider Agreements, the performance of the provider and the needs of the EMS system shall be assessed and a decision made whether greater system optimization could be achieved if the exclusive operating area was made subject to a competitive R.F.P. process.

Pursuant to Section 1797.224 of the Health and Safety Code, the following companies have been awarded an EOA in Calaveras County through a competitive bid process:

- American Legion Post#108 Ambulance – North and South Zones
- Ebbetts Pass Fire District – East Zone

Pursuant to Section 1797.224 H&SC, the following ambulance companies have been determined to have provided emergency ambulance services in the same manner and scope (in the areas named below and identified on the attached map) without interruption since January 1, 1981:

1. Patterson District Ambulance - Zone 5, Stanislaus County
2. American Medical Response (formerly "911 Emergency Medical Services, Inc." and Doctors Ambulance of Modesto) - Zone 1, Stanislaus County
3. American Medical Response (formerly "911 Emergency Medical Services, Inc.") - Zone 3, Stanislaus County
4. American Medical Response (Formerly Turlock Ambulance Service) - Zone 8, Stanislaus County
5. Oak Valley Hospital District - Zone 4, Stanislaus County
6. American Legion Ambulance Service - all of Amador County

System participants shall be assigned roles in the exclusive operating areas and non-exclusive operating areas pursuant to MVEMSA policies and procedures and agreements between the MVEMSA and the system participant agencies.

II. ALS Ground Non-Transport Services

A. Standards for Provision of Service

The Mountain-Valley EMS Agency Policies that ALS Ground Non-Transport Services must meet are:

412.00 FIRST RESPONDER - ALS AUTHORIZATION

407.00 EQUIPMENT AND DRUG INVENTORY

412.20 ALS TRANSFER OF PATIENT CARE

Additionally, ALS Ground Ambulance Service Providers must meet requirements set forth in their ALS First Responder agreements.

III. Air Transportation Services

A. Standards for Provision of Service

The Mountain-Valley EMS Agency Policies that ALS Ground Non-Transport Services must meet are:

441.00 EMS AIRCRAFT POLICY DEFINITIONS

442.00 EMS AIRCRAFT PROVIDER AUTHORIZATION

444.00 EMS AIRCRAFT ON-LINE MEDICAL CONTROL

445.00 EMS AIRCRAFT REQUEST/CANCELLATION

446.00 EMS AIRCRAFT PROVIDER DISPATCH

447.00 EMS AIRCRAFT LANDING SITE

B. System Design

Currently, air ambulance transport services are approved on a non-exclusive operating basis. Should system coordination issues between air ambulance providers have a negative impact on the EMS system, an R.F.P. (as specified in the California H.S. Code, Division 2.5, Section 1797.224) may be developed to allow a competitive process in the selection of an exclusive provider or providers of air ambulance services in the region. The development and acceptance of the R.F.P. that defines the details of this document shall be reviewed and approved at a public hearing during a scheduled EMS Agency Board of Directors meeting. The EMS agency recognizes that there are financial, legal and political considerations that make the realization of this "optimal model" for air ambulance services a serious challenge. Despite these difficulties, the EMS air transportation system discussed herein has been adopted by the MVEMSA as a model for all future system development.

The components of an optimal air ambulance transportation system would include the:

- Designation of an exclusive air ambulance transport service to provide care within the boundaries of the Mountain-Valley EMS region:
- Establishment of one or more bases of operation in strategic locations throughout the five-county region.
- Reliance on air ambulance transport services, based outside the five-county region, to be accessed for either mutual aid or when out-of-region based services have the shortest response to a field emergency
- Establishment of a single Regional Air Resource Center to coordinate emergency air ambulance resources and ensure that the closest air ambulance is sent to the scene.
- Appropriate utilization of air ambulance providers (whether based within or outside the region) is maintained.
- Exclusivity for the region-based provider furnishes some measure of protection for the financial viability of the region's exclusive provider (which increases the likelihood that air ambulance services will continue).
- Greater efficiency through "economics of scale" that should lead to lower air ambulance costs and potentially air ambulance fees.
- Ease of contract coordination for managed care providers.

**EMS Plan
Ambulance Zone Summary Form**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Mountain-Valley EMS Agency – Alpine County

Area or subarea (Zone) Name or Title:

Alpine County

Name of Current Provider(s):

Alpine County continues to depend upon mutual aid response for ALS ambulance services. ALS ambulances are dispatched from surrounding counties and either rendezvous with the Alpine County EMS BLS ambulance on the eastern slope of the County, arrive on scene, or be canceled. Currently Lake Valley Fire District based in El Dorado County or East Fork Fire Department based in Minden, Nevada provides ALS ambulance service into the eastern slope of the County. Ebbetts Pass Fire District provides ALS ambulance service into the western portion of Alpine County.

Statement of Exclusivity, Exclusive or non-Exclusive (HS1797.6):

There is no ALS or emergency ambulance service exclusivity in Alpine County.

Type of Exclusivity, “Emergency Ambulance”, “ALS”, or “LALS” (HS1797.85):

None

Method to achieve Exclusivity, if applicable (HS1797.224):

Not applicable.

**EMS Plan
Ambulance Zone Summary Form**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Mountain-Valley EMS Agency – Amador County

Area or subarea (Zone) Name or Title:

Amador County

Name of Current Provider(s):

The current provider of emergency ground ambulance services in this zone is American Legion Ambulance Service. This provider has provided emergency ambulance services without interruption since 1929.

Statement of Exclusivity, Exclusive or non-Exclusive (HS1797.6):

The ambulance provider agreement between the LEMSA and American Legion Ambulance Service specifies that American Legion Ambulance Service is the exclusive operator of ALS ground ambulance and emergency ground ambulance services for that County.

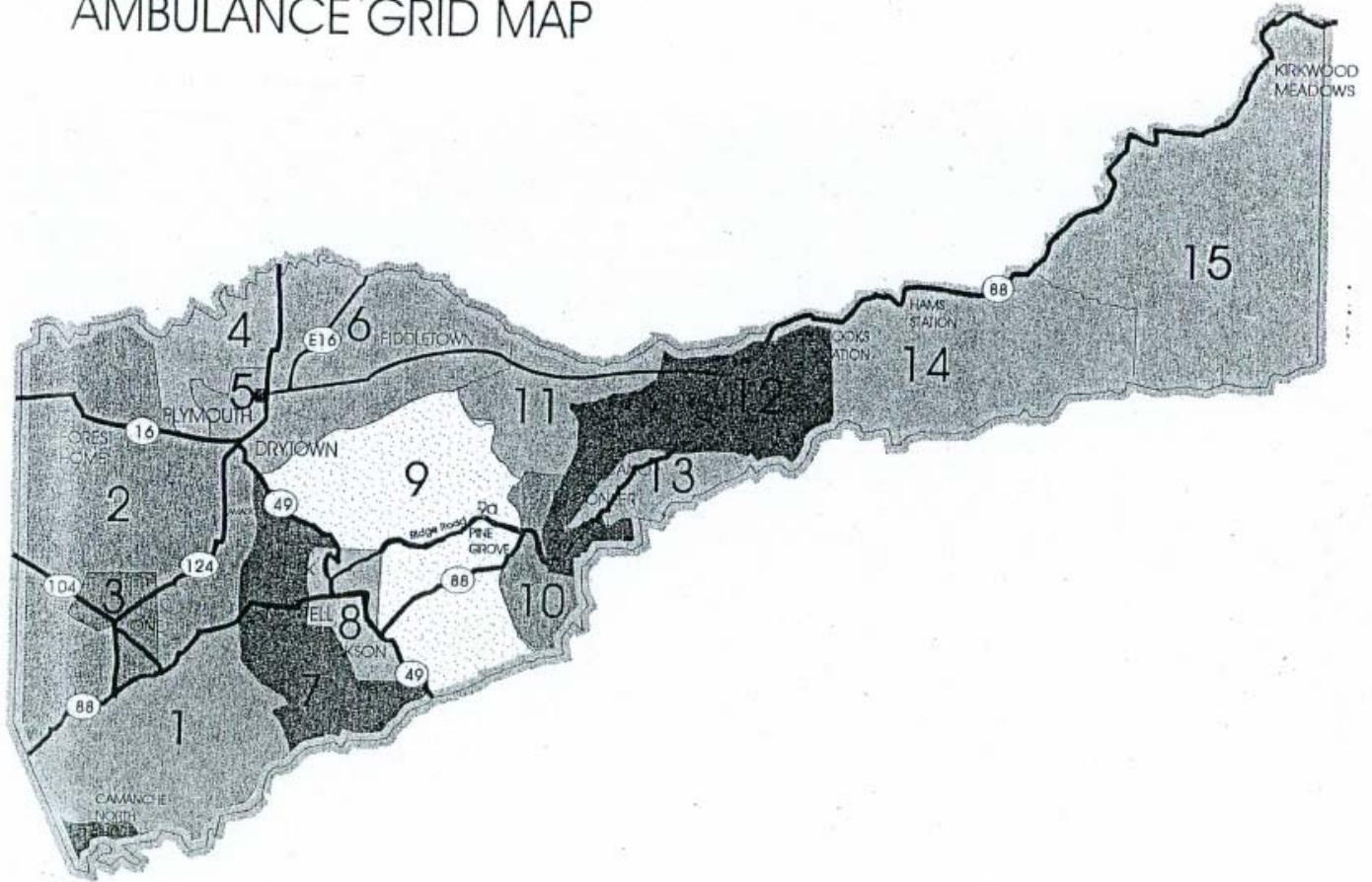
Type of Exclusivity, “Emergency Ambulance”, “ALS”, or “LALS” (HS1797.85):

All emergency ground ambulance services and Advanced Life Support ground ambulance services. “Emergency ground ambulance services” shall mean all services originating in Amador County that require the use of an ambulance, including but not limited to interfacility transfers or scene calls whether Advanced Life Support, Basic Life Support, or Critical Care Transports as defined in the Amador County Ambulance Ordinance. The term “emergency ground ambulance services” is used to differentiate between air and ground ambulance services, and its meaning is equivalent to “emergency ambulance services” as found in the Health and Safety Code, Division 2.5, Section 1797.85.

Method to achieve Exclusivity, if applicable (HS1797.224):

American Legion Ambulance was "Grandfathered" into Amador County as the sole provider of ALS and emergency ground ambulance services due to no changes in manner and scope of service to the area other than upgrading to LALS and then ALS services in the early 1990s. In November, 1999, the Amador County Board of Supervisors approved a county ambulance ordinance that further defined “emergency ground ambulance services” to reflect the maximum level of exclusivity allowed according recent court decisions. These court cases, “Schaefer v. San Bernadino County” and “Redwood Empire v Sonoma County” define “emergency ambulance services” as found in the Health and Safety Code, Division 2.5, Section 1797.85, to include all ambulance services.

AMADOR COUNTY AMBULANCE GRID MAP



**EMS Plan
Ambulance Zone Summary Form**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Mountain-Valley EMS Agency – Calaveras County

Area or subarea (Zone) Name or Title:

South Zone

Name of Current Provider(s):

American Legion Post Number 108 began providing service in the South Zone on July 1, 2005, after winning a competitive bid process.

Statement of Exclusivity, Exclusive or non-Exclusive (HS1797.6):

The Mountain-Valley EMS Agency has adopted exclusive operating areas for ambulance services as defined below. Approval was received from the State of California EMS Authority in 2004 to establish EOAs in Calaveras County.

Type of Exclusivity, “Emergency Ambulance”, “ALS”, or “LALS” (HS1797.85):

Definition of Terms

“All Ambulance Services” is defined as the activity, business or service; for hire, profit, or otherwise; of transporting one or more persons by ambulance on or in any of the streets, roads, highways, alleys, or any public ways or places in Calaveras County. This definition adopts the premise that Ambulance Services are considered to be “emergency ambulance services” as defined in Section 1797.85, Division 2.5 of the Health and Safety Code. Ambulance Services include all services requiring the use of a ground Ambulance in Calaveras County during any of the following circumstances: (1) All requests for ambulance services transmitted through the Authorized EMS Dispatch Center; (2) Requests for Ambulance Service made directly to the ambulance service from a seven digit telephone call without going through an authorized 9-1-1/PSAP; (3) All ground Interfacility Transfers requiring the services of an ALS, BLS, or Critical Care Transport (CCT) ambulance; or (4) Any other request for service requiring a ground ambulance response, including Basic Life Support, Advanced Life Support, or Critical Care Transport. This definition shall not apply to Ambulance Services that transport patients to or through Calaveras County from an area outside Calaveras County.

“Interfacility Transfer” is defined as all ambulance transports originating from an Acute Care Facility in Calaveras County.

“Scene Call” is defined as All Ambulance Services originating within Calaveras County not defined as Interfacility Transfers.

Types of Exclusivity Adopted for Calaveras County EOAs

1. Interfacility Transfers - The right to provide All Ambulance Services for all types of Interfacility Transfers originating from the Acute Care Facility (or any future Acute Care Facility) in Calaveras County is a right that is

shared amongst the providers awarded exclusive rights to provide Ambulance Services within a Zone or Zones within Calaveras County. This shared right is independent of the Ambulance Zone within which the Acute Care Facility is geographically located.

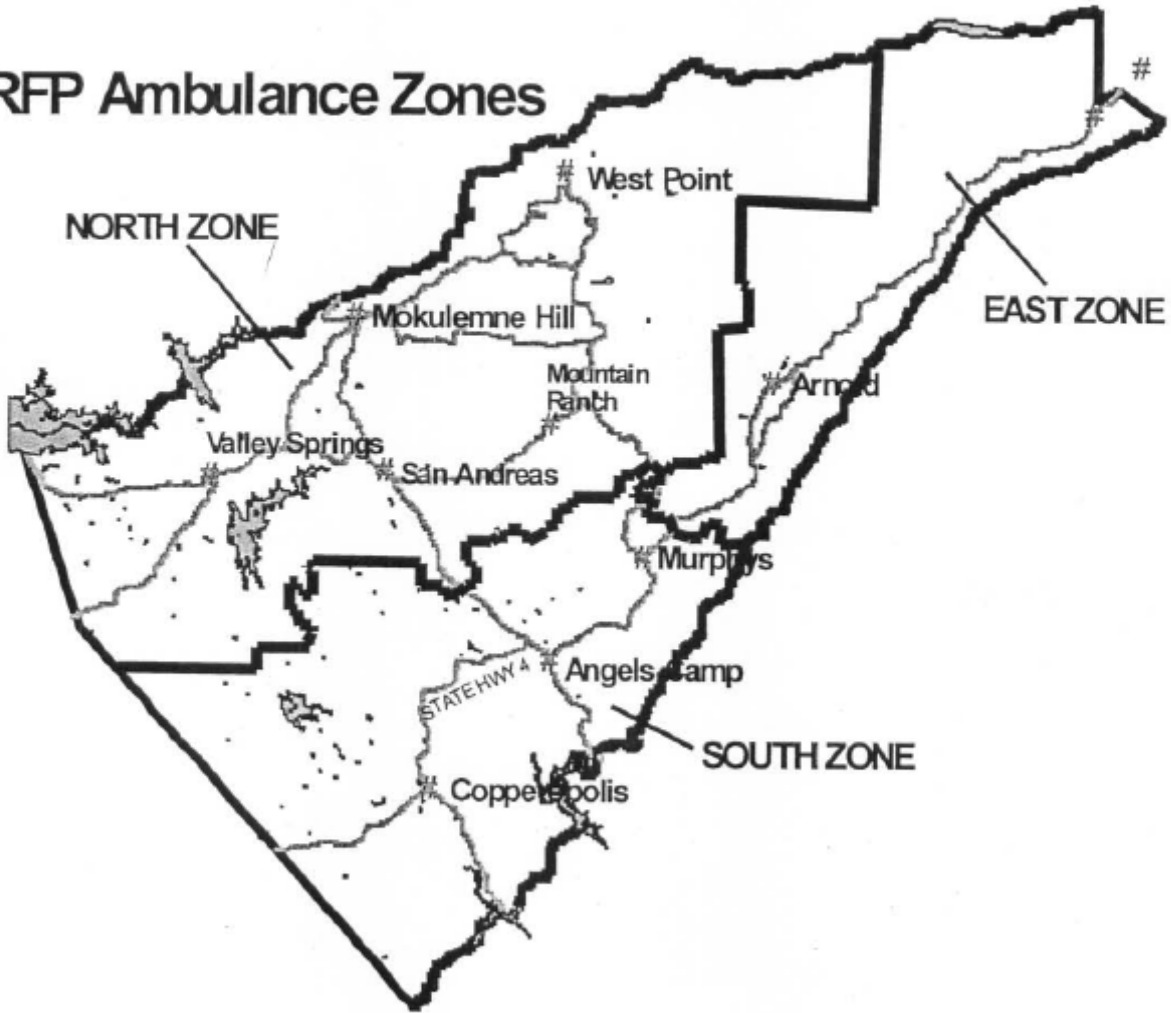
2. Scene Calls - The right to provide All Ambulance Services for scene calls is awarded to providers for a specific Ambulance Zone. Exceptions to this exclusivity include air ambulance services; the conditions specified in the AGENCY Special Events Policy #570.71; and during declared disasters, or events requiring Medical Mutual Aid Coordination authorized by the Authorized EMS Dispatch Center, MHOAC, or AGENCY, with the exception of Interfacility Transfers within their respective zones. The second level of exclusivity is for all Authorized Ambulance Providers to be eligible to share Interfacility Transfers originating from Mark Twain St. Joseph's Hospital.

Method to achieve Exclusivity, if applicable (HS1797.224):

Competitive Bid Process

CALAVERAS COUNTY

RFP Ambulance Zones



**EMS Plan
Ambulance Zone Summary Form**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Mountain-Valley EMS Agency – Calaveras County

Area or subarea (Zone) Name or Title:

East Zone

Name of Current Provider(s):

As of July 1, 2005, the provider of ALS service in the east zone is Ebbetts Pass Fire District. They earned the right to provide service through a competitive bid process.

Statement of Exclusivity, Exclusive or non-Exclusive (HS1797.6):

The Mountain-Valley EMS Agency has adopted exclusive operating areas for ambulance services as defined below. Approval was received from the State of California EMS Authority in 2004 to establish EOAs in Calaveras County

Type of Exclusivity, “Emergency Ambulance”, “ALS”, or “LALS” (HS1797.85):

Definition of Terms

“All Ambulance Services” is defined as the activity, business or service; for hire, profit, or otherwise; of transporting one or more persons by ambulance on or in any of the streets, roads, highways, alleys, or any public ways or places in Calaveras County. This definition adopts the premise that Ambulance Services are considered to be “emergency ambulance services” as defined in Section 1797.85, Division 2.5 of the Health and Safety Code. Ambulance Services include all services requiring the use of a ground Ambulance in Calaveras County during any of the following circumstances: (1) All requests for ambulance services transmitted through the Authorized EMS Dispatch Center; (2) Requests for Ambulance Service made directly to the ambulance service from a seven digit telephone call without going through an authorized 9-1-1/PSAP; (3) All ground Interfacility Transfers requiring the services of an ALS, BLS, or Critical Care Transport (CCT) ambulance; or (4) Any other request for service requiring a ground ambulance response, including Basic Life Support, Advanced Life Support, or Critical Care Transport. This definition shall not apply to Ambulance Services that transport patients to or through Calaveras County from an area outside Calaveras County.

“Interfacility Transfer” is defined as all ambulance transports originating from an Acute Care Facility in Calaveras County.

“Scene Call” is defined as All Ambulance Services originating within Calaveras County not defined as Interfacility Transfers.

Types of Exclusivity Adopted for Calaveras County EOAs

1. Interfacility Transfers - The right to provide All Ambulance Services for all types of Interfacility Transfers originating from the Acute Care Facility (or any future Acute Care Facility) in Calaveras County is a right that is shared amongst the providers awarded exclusive rights to provide Ambulance Services within a Zone or Zones within Calaveras County. This shared right is independent of the Ambulance Zone within which the Acute Care Facility is

geographically located.

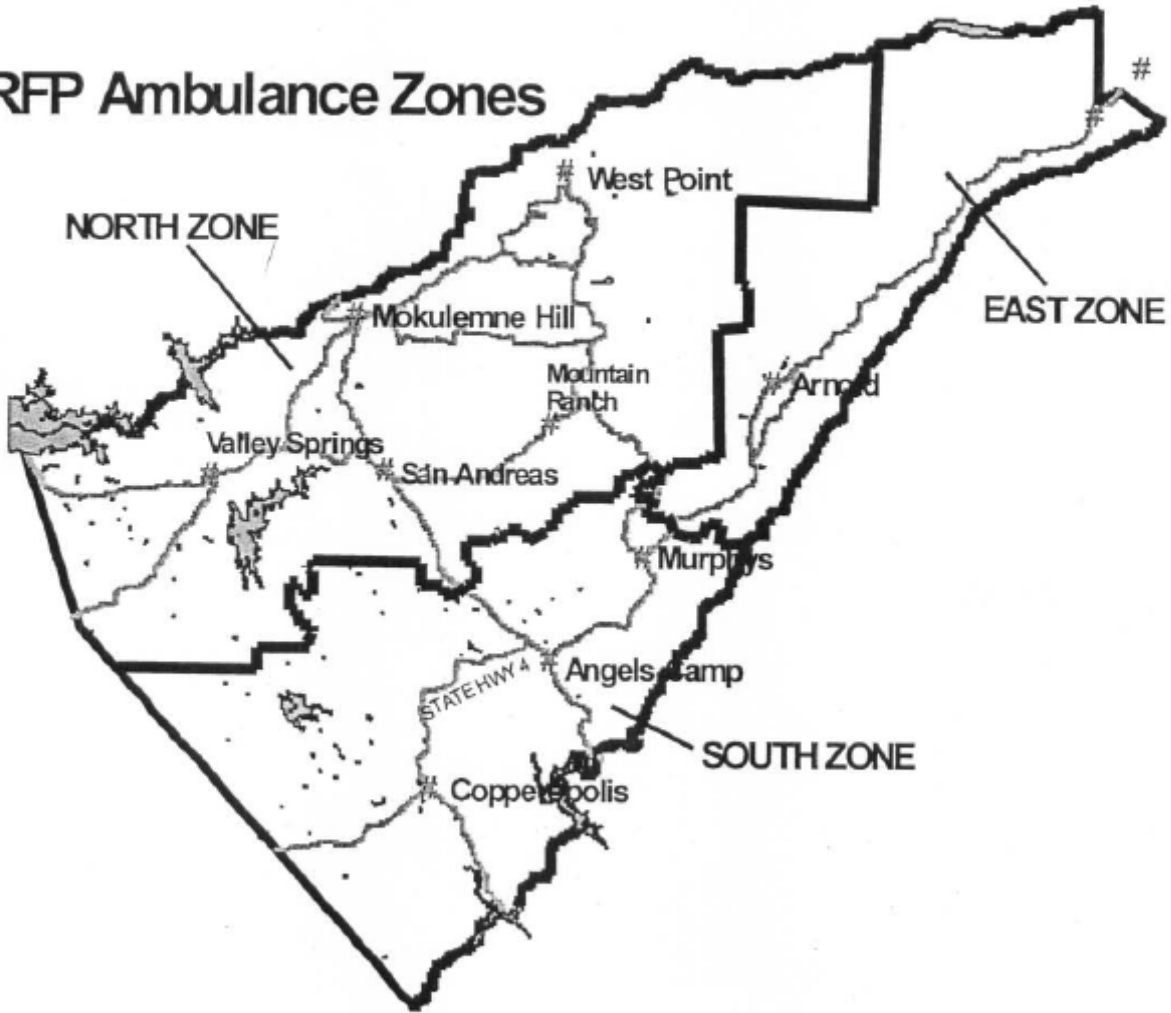
2. Scene Calls - The right to provide All Ambulance Services for scene calls is awarded to providers for a specific Ambulance Zone. Exceptions to this exclusivity include air ambulance services; the conditions specified in the AGENCY Special Events Policy #570.71; and during declared disasters, or events requiring Medical Mutual Aid Coordination authorized by the Authorized EMS Dispatch Center, MHOAC, or AGENCY, with the exception of Interfacility Transfers within their respective zones. The second level of exclusivity is for all Authorized Ambulance Providers to be eligible to share Interfacility Transfers originating from Mark Twain St. Joseph's Hospital.

Method to achieve Exclusivity, if applicable (HS1797.224):

Competitive bid process.

CALAVERAS COUNTY

RFP Ambulance Zones



**EMS Plan
Ambulance Zone Summary Form**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Mountain-Valley EMS Agency – Calaveras County

Area or subarea (Zone) Name or Title:

North Zone.

Name of Current Provider(s):

American Legion Ambulance begins providing service in the north zone on July 1, 2005. They obtained the right to provide exclusive service by being the winning bidder in a competitive bid process.

Statement of Exclusivity, Exclusive or non-Exclusive (HS1797.6):

The Mountain-Valley EMS Agency has adopted exclusive operating areas for ambulance services as defined below. Approval was received from the State of California EMS Authority in 2004 to establish EOAs in Calaveras County.

Type of Exclusivity, “Emergency Ambulance”, “ALS”, or “LALS” (HS1797.85):

Definition of Terms

“All Ambulance Services” is defined as the activity, business or service; for hire, profit, or otherwise; of transporting one or more persons by ambulance on or in any of the streets, roads, highways, alleys, or any public ways or places in Calaveras County. This definition adopts the premise that Ambulance Services are considered to be “emergency ambulance services” as defined in Section 1797.85, Division 2.5 of the Health and Safety Code. Ambulance Services include all services requiring the use of a ground Ambulance in Calaveras County during any of the following circumstances: (1) All requests for ambulance services transmitted through the Authorized EMS Dispatch Center; (2) Requests for Ambulance Service made directly to the ambulance service from a seven digit telephone call without going through an authorized 9-1-1/PSAP; (3) All ground Interfacility Transfers requiring the services of an ALS, BLS, or Critical Care Transport (CCT) ambulance; or (4) Any other request for service requiring a ground ambulance response, including Basic Life Support, Advanced Life Support, or Critical Care Transport. This definition shall not apply to Ambulance Services that transport patients to or through Calaveras County from an area outside Calaveras County.

“Interfacility Transfer” is defined as all ambulance transports originating from an Acute Care Facility in Calaveras County.

“Scene Call” is defined as All Ambulance Services originating within Calaveras County not defined as Interfacility Transfers.

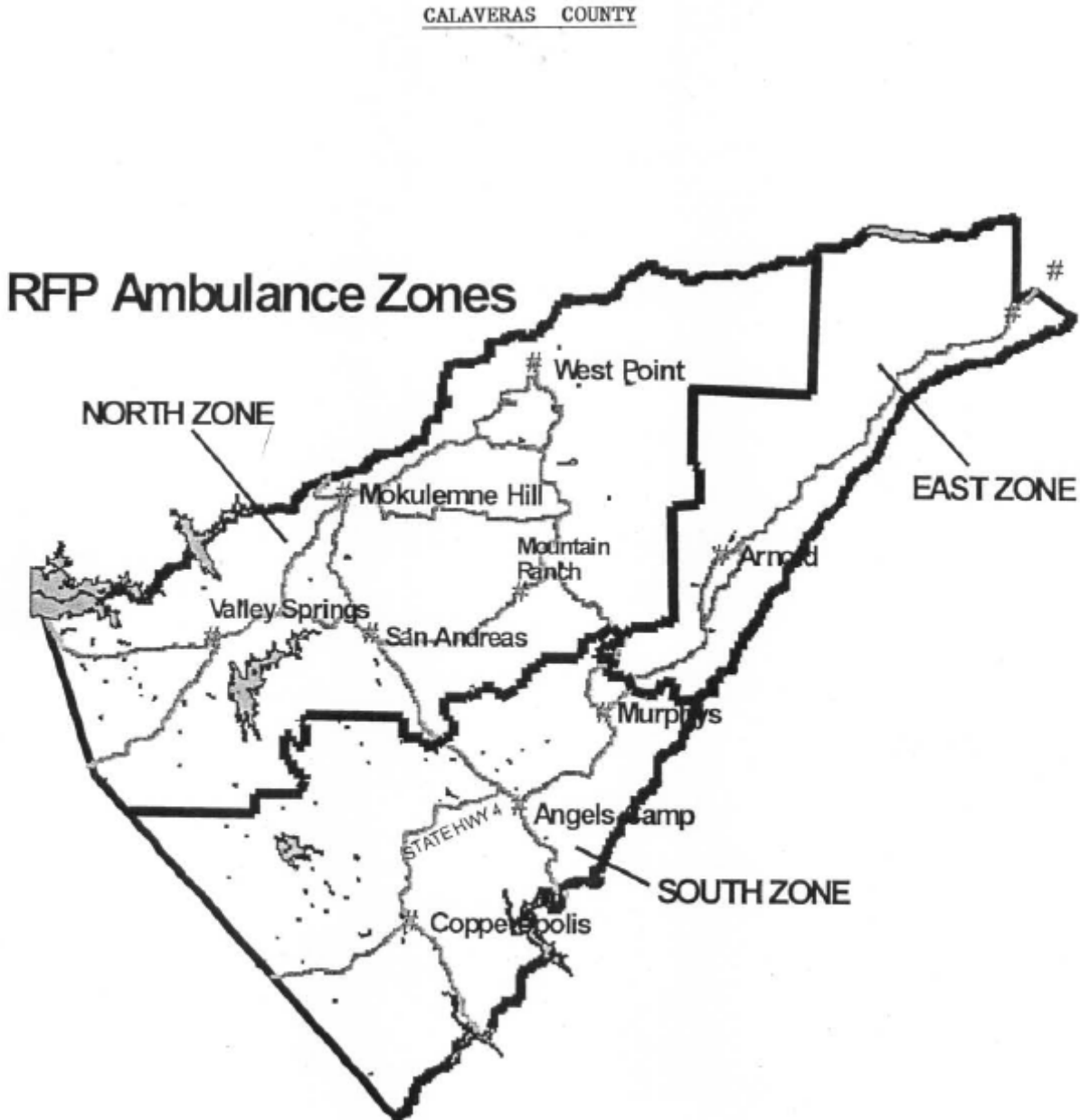
Types of Exclusivity Adopted for Calaveras County EOAs

1. Interfacility Transfers - The right to provide All Ambulance Services for all types of Interfacility Transfers originating from the Acute Care Facility (or any future Acute Care Facility) in Calaveras County is a right that is shared amongst the providers awarded exclusive rights to provide Ambulance Services within a Zone or Zones within Calaveras County. This shared right is independent of the Ambulance Zone within which the Acute Care Facility is geographically located.

2. Scene Calls - The right to provide All Ambulance Services for scene calls is awarded to providers for a specific Ambulance Zone. Exceptions to this exclusivity include air ambulance services; the conditions specified in the AGENCY Special Events Policy #570.71; and during declared disasters, or events requiring Medical Mutual Aid Coordination authorized by the Authorized EMS Dispatch Center, MHOAC, or AGENCY, with the exception of Interfacility Transfers within their respective zones. The second level of exclusivity is for all Authorized Ambulance Providers to be eligible to share Interfacility Transfers originating from Mark Twain St. Joseph's Hospital.

Method to achieve Exclusivity, if applicable (HS1797.224):

Competitive bid process.



**EMS Plan
Ambulance Zone Summary Form**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Mountain-Valley EMS Agency – Mariposa County

Area or subarea (Zone) Name or Title:

All of Mariposa County.

Name of Current Provider(s):

The current provider of emergency ground ambulance services and Advanced Life Support Services in Mariposa County is Mercy Medical Transport (MMT). MMT has provided ambulance services in Mariposa County since January 1, 1994.

Statement of Exclusivity, Exclusive or non-Exclusive (HS1797.6):

There is no ALS or emergency ambulance service exclusivity in Mariposa County.

Type of Exclusivity, “Emergency Ambulance”, “ALS”, or “LALS” (HS1797.85):

None

**EMS Plan
Ambulance Zone Summary Form**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Mountain-Valley EMS Agency – Stanislaus County

Area or subarea (Zone) Name or Title:

Zone One

Zone 1 is in north central Stanislaus County encircling the City of Modesto. It is depicted on the map attached and is specifically described as follows:

Commencing at a point directly north of Oakdale Road on the border of Stanislaus County adjacent to San Joaquin County northwest of the City of Riverbank, the line proceeds west southwesterly along the county line to the confluence of the San Joaquin River and the Tuolumne River; southeasterly along the Tuolumne River and continuing east northeasterly along the Tuolumne River to a point south of Goodwin Road; northerly to Yosemite Blvd; westerly along Yosemite Blvd to Wellsford Road; northerly along Wellsford Road to Milnes Road; northwesterly along the Santa Fe tracks to Claribel Road; westerly along Claribel Road to Oakdale Road; then northerly along Oakdale Road to the Stanislaus County Line adjacent to San Joaquin County northwest of the City of Riverbank at a point directly north of Oakdale Road.

Name of Current Provider(s):

The current provider of emergency ground ambulance services in this zone is American Medical Response, Inc. 911 Emergency Medical Services, Inc provided emergency ambulance services without interruption from 1958 through 1994. American Medical Response became the controlling corporation of 911 Emergency Medical Services Inc. pursuant to a reverse merger which left 911 Emergency Medical Services Inc. technically intact but with American Medical Response as the lead company.

Statement of Exclusivity, Exclusive or non-Exclusive (HS1797.6):

On October 23, 1990, the Stanislaus County Ambulance Ordinance (C.S. 410) was enacted. Section 6.70.030, B. of this ordinance states, "The number and boundaries of ambulance response zones in Stanislaus County, and their designations as exclusive and non-exclusive operating areas, will be determined by the Board of Supervisors of Stanislaus county at the time of the enactment of this ordinance." Pursuant to this ordinance, the Stanislaus County Board of Supervisors designated the entire County to be exclusive operating areas divided into zones shown on the attached map entitled "Ambulance Response Zones." The Board also specified the areas that were to be "grandfathered" into exclusive operating areas and those that were to be developed only through a competitive bid process (as shown on the same map).

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS1797.85):

All emergency ground ambulance and Advanced Life Support ground ambulance requests.

Method to achieve Exclusivity, if applicable (HS1797.224):

911 Emergency Medical Services, Inc. and Doctors Ambulance of Modesto were "Grandfathered" into Zone One as providers of emergency ground ambulance services pursuant to a shared ambulance provider agreement for Zone One with an agreement start date of July 1, 1992. 911 Emergency Medical Services, Inc. has provided uninterrupted emergency ground ambulance services in this zone since 1958. The company provided Advanced Life Support ambulance services from 1973 to the present. Doctors Ambulance Company of Modesto began providing emergency ground ambulance service in Zone One in 1970 and began providing ALS ambulance services in 1973. Doctors Ambulance Company was dissolved as a corporate entity in July of 1995 and pursuant to the Zone One ambulance agreement that agreement reverted entirely to American Medical Response. American Medical Response absorbed the corporate entity, "911 Emergency Medical Services, Inc.," in September, 1994, and has provided ALS ambulance services in Zone One through the present.

