

LEMSA DRAFT ADMINISTRATIVE POLICY MANUAL

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1001 EMS Plan Development and Update

I. Purpose

- A. This policy is issued pursuant to California Health and Safety Code and California Code of Regulations, to establish a standardized and transparent process for the development, annual update, and five-year comprehensive revision of the EMS Plan for the Local EMS Agency (LEMSA). This policy ensures alignment with California state EMS requirements and compliance with the Sonoma County EMS Ordinance, which mandates a comprehensive LEMSA assessment every five (5) years.

II. Policy

- A. LEMSA shall maintain and update an EMS Plan to include analysis of system performance, internal agency effectiveness, community needs, and system goals.

III. Procedure

- A. Annual EMS Plan Update
 - 1. The LEMSA shall submit an annual update to the EMS Authority
 - a. Annual update will include prior years accomplishments and next years goals.
- B. Five-Year EMS Plan Update
 - 1. System and LEMSA Assessment
 - a. Every five years, CVEMSA will conduct a comprehensive assessment that includes:
 - i. LEMSA assessment.
 - ii. EMS system assessment.
 - ii. Analysis of trends, gaps, and community needs.
 - iv. Recommendations for system development and improvement.
 - 2. Timeline
 - a. Begin preparation in October.
 - b. Submit finalized update to California EMS Authority (EMSA) by January 30th.
 - 3. Required Components
 - a. Summary of Prior Year Accomplishments: Documentation of initiatives completed, improvements achieved, and progress on strategic goals.
 - b. LEMSA Assessment: Review of the LEMSA operations, oversight activities, and regulatory compliance.
 - c. EMS System Assessment: Evaluation of EMS service delivery, provider performance, system integration, and community impact.
 - d. Goals and Objectives: Defined goals for the coming year with measurable outcomes and timelines.
 - 4. Stakeholder Engagement
 - a. Draft plan will be distributed to regional EMCCs as the advisory bodies to the LEMSA and BOS.
 - b. The LEMSA will conduct a minimum of two public stakeholder meetings and provide a 60 day public comment period.

Effective Date

5. Consultant Support

- a. LEMSA may perform the assessment internally with stakeholder input or engage external consultants to support system analysis or facilitate the planning process.

IV. Roles and Responsibilities

- A. LEMSA: Ensures compliance with all state and local mandates and oversees the EMS Plan process.
- B. EMCC: Serves as an advisory body and provides recommendations to the LEMSA
- C. System Stakeholders: Participate in assessments, contribute data, and provide input.

1002 Medical Control

I. PURPOSE

- A. To define the role of the Medical Director of the Local EMS Agency (LEMSA) with respect to EMS medical control.

II. DEFINITION

- A. "Medical control" means the medical management of the EMS System, pursuant to the provisions of Chapter 5, Division 2.5 of the California Health and Safety Code.

III. POLICY

- A. The Medical Director of the LEMSA shall establish and maintain medical control in the following manner:
 - 1. Approve and regularly review the EMS Agency policies and procedures to assure medical control of the EMS System. These shall include at a minimum:
 - a. Readily accessible treatment protocols that encompass EMS scope of practice.
 - b. The development of, and ongoing monitoring of, a comprehensive, system-wide Continuous Quality Improvement and Assurance Program and its Incident Event Review Process.
 - c. Transport and transfer policies (air and ground).
 - 2. Certification and recertification of EMT personnel and local accreditation of paramedics.
 - 3. Administration of due process standards established by the California EMS Authority regarding the suspension and revocation of EMT and paramedic certificates/accreditation.
 - 4. Evaluate and authorize EMS training programs.
 - 5. Evaluate and authorize EMS dispatch centers.
 - 6. Evaluate and authorize EMS service providers.
 - 7. Evaluate and authorize EMS receiving facilities, EMS base hospitals and specialty care centers.

1003 SCENE MANAGEMENT AND AUTHORITY

I. POLICY

- A. At the scene of a non-disaster medical emergency the following will occur per Health and Safety Code.

II. AUTHORITY FOR MEDICAL EMERGENCY SCENE MANAGEMENT

- A. Authority for patient health care management in an emergency shall be vested in that licensed and/or certified health care professional, which may include any paramedic or other prehospital emergency medical personnel, at the scene of an emergency who is most medically qualified specific to the provision of rendering emergency medical care. If no licensed or certified health care professional is available, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency.
- B. EMS personnel shall properly identify, when operating within the scope of their employment to deliver patient care, to ensure;
 - 1. Patients right to identify their caregivers
 - 2. Coordinated multi agency operations on scene.
 - 3. Minimum requirements for personnel identification
 - 4. Organization
 - 5. Level of certification/licensure
 - 6. Name or certification/license number

III. CONTINUUM OF PATIENT CARE

- A. First responders, when first on-scene, should transfer patient care authority to the transport paramedic or EMT as soon as feasible.
- B. A paramedic may transfer patient care authority to a transport EMT per Administrative Policy 4008-Turnover of Patient Care and / or Administrative Policy 4010 EMT Transport of Emergent Patients.
- C. The individual with patient care authority is responsible for the patient until care is turned over to other prehospital personnel or receiving hospital staff.
- D. Medical management at the scene of a medical emergency includes:
 - 1. Medical Assessment.
 - 2. Medical aspects of extrication and all movement of the patient(s).
 - 3. Medical care.
 - 4. Patient destination decisions per LEMSA Treatment Regulation 7007- Point of Entry.
 - 5. Transport code.
- E. The assignment of responsibility for patient care management in the LEMSA System is based on resources available on scene, listed below, from the lowest level to highest level, with the emergency ambulance service transport provider paramedic having the highest level of responsibility for patient care management (medical):
 - 1. Public Safety First Aid
 - 2. Non-transport EMT
 - 3. Transport EMT
 - 4. Non-transport Paramedic
 - 5. Transport Paramedic

IV. PHYSICIAN ON-SCENE

- A. A paramedic may not accept direction from any source except the base hospital physician, except under the following circumstances:
 - 1. A qualified physician on-scene agrees to direct patient care and accompany the patient to the hospital; and
 - 2. Physician direction is within the paramedic scope of practice.
- B. A qualified physician is any physician licensed in the State of California.
- C. Procedure for physician on-scene of a pre-hospital call
 - 1. The paramedic shall:
 - a. Verify identity and credentials of the on-scene physician. A physician must produce a current California medical license and show it to the paramedic with a valid photo ID demonstrating that they are the person who's name is on the medical license.
 - b. Advise the physician of the options as described below;
 - i. Assist and offer advice regarding patient care, but allow the paramedic(s) to remain in control of the scene and transport the patient according to LEMSA policy; or,
 - ii. Consult with the Base Hospital Physician and offer advice on the care of the patient, allowing the Base Hospital Physician to direct care and transport; or
 - iii. Accompany the patient to the hospital and assume total responsibility for patient care until responsibility is assumed by the receiving physician.
 - 1. In this case, the paramedics will assist the physician as requested provided they operate within local scope of practice.
 - 2. Paramedics will advise the Base Hospital of the situation.
 - 3. All orders given by the on-scene physician shall be documented on the PCR and the physician's name and contact information will be documented on the PCR.
- D. Contact the Base Hospital Physician for consultation or conflict resolution as needed.

V. Personnel Identification

- A. Purpose – EMS personnel shall properly identify, when operating within the scope of their employment to deliver patient care, to ensure;
 - 1. Patients right to identify their caregivers
 - 2. Coordinated multi agency operations on scene.
- B. Minimum requirements for personnel identification
 - 1. Organization
 - 2. Level of certification/licensure
 - 3. Name or certification/license number

1004 Emergency Medical Service Committees

I. LEMSA COMMITTEES

- A. The following committees meet on a routine basis, and their input is instrumental to the LEMSA. For information on committee meetings contact the EMS Agency.
- B. Emergency Medical Care Committee (EMCC) – Each county may have an EMCC established in accordance with the provisions of the Health and Safety Code and/or local ordinance and/or committee bylaws.
- C. Medical Advisory Committee (MAC) - Comprised of representatives from EMS providers. This committee advises the LEMSA and the EMS Medical Director on prehospital medical care.
- D. Policy Advisory Committee (PAC) – Comprised of representatives from EMS providers. This committee advises the LEMSA and the EMS Medical Director on development, implementation, and revision of EMS treatment guidelines.
- E. Continuous Quality Improvement (CQI) - Comprised of representatives from EMS providers. This committee oversees the quality of prehospital medical services in the LEMSA and monitors, reviews and evaluates prehospital care delivery and efficacy.
- F. Specialty Care Advisory Committees (SCACs)- Comprised of pre-hospital and hospital representatives. This committee oversees the quality of specialty care provided throughout the system and reviews patient outcomes to evaluate specialty care delivery and efficacy.
- G. EMS Aircraft - Comprised of representatives from EMS air ambulance, air rescue and dispatch providers. This committee oversees the quality and evaluates EMS aircraft services throughout the system and advises on response, staffing, coordination and medical care.

1005 Policy Development Process

I. PURPOSE

- A. To provide a mechanism for policy development including treatment guideline and administrative policies.

II. POLICY

- A. The development of EMS policies, procedures, standards and guidelines, hereafter referred to as policies, shall:
 - 1. Include a mechanism for the initiation of a draft document.
 - 2. Provide a mechanism for adequate internal staff review and input on draft document(s).
 - 3. Provide a mechanism for review and input of the draft document by the impacted external groups and EMCC members.
 - 4. Receive final approval from the EMS Administrator and Medical Director.
 - 5. Allow for the development of emergency policies/Special Memos by the EMS Medical Director for the immediate protection of the public health and safety.

B. Format

- 1. A standard policy format shall be maintained.

C. Process

- 1. Prehospital care policies will routinely be reviewed and revised as needed. This process will be initiated by the LEMSA following the steps outlined in this policy. Suggestions for new policies or revisions will be considered from any interested agency or individual.
- 2. A LEMSA staff member will draft policy and submit to all staff for internal review. LEMSA staff will review and make comments and submit revised content.
- 3. The draft policy and LEMSA public-comment form will be made available to County EMCC members and posted on the LEMSA website for stakeholder review for a sixty day (60) external comment period. Extension of the public comment period can occur as needed to ensure adequate participation.
- 4. All public comment must be submitted with the LEMSA public-comment form per instructions provided in the public comment release.
- 5. After the close of the external review period, the policy author will review and make appropriate revisions to the draft policy.
- 6. The revised draft policy will be re-submitted to LEMSA staff for final review. If necessary, an internal or external workshop will be scheduled to discuss the proposed policy.
- 7. Approved policies and public comment matrix shall be distributed to EMCC members and posted on the LEMSA website at least thirty (30) days prior to the effective date.

D. Administrative Policy Development/Revision Process

- 1. A meeting of the stakeholders will be held to introduce the policy being developed/revised. The LEMSA will notice all stakeholders via the MAC distribution list at least 15 days in advance of the meeting. The meeting may also take place during a regularly schedule MAC meeting if it falls within the time frame. A draft of the policy/s being developed/revised will also be provided at the time of the meeting invite.
- 2. Following the stakeholder meeting the policy will be released for an additional 30-day stakeholder input period along with notice of a final meeting at closure of the input process. This meeting may also be a regularly scheduled MAC meeting if it falls within the time frame.

3. Upon closure of the stakeholder input period, it will be determined whether the policy has no comment and is prepared for publishing or if an additional meeting is required.
 4. Following the second meeting the policy shall be subject to a final 15-day public comment period prior to publishing.
 5. The final policies will be reported out at each of the following EMCC meetings in each County.
- E. EMS Special Memorandum
1. The LEMSA medical director may issue EMS special memoranda to address immediate issues that require temporary or interim guidance. EMS special memoranda have the same authority as policy or treatment guidelines but are limited in duration to one (1) year. Interim guidance within special memoranda must be subject to formal policy development or revision to remain in effect as properly promulgated regulations.
- F. Provider Policies
1. No EMS service provider shall develop or institute a patient care policy/protocol that conflicts with any LEMSA policy/protocol.
- F. Hearing Process
1. Following final adoption of a policy or procedure any EMS system provider agency effected by the policy may request a hearing as provided in EMS Ordinance.

1006 ON-VIEWING MEDICAL EMERGENCIES

I. PURPOSE

- A. To coordinate the utilization of emergency medical service resources when responding to and coming upon the scene of medical and/or traumatic emergencies.

II. DEFINITIONS

- A. On View: When a pre-hospital care provider either comes upon the scene of a medical/ traumatic emergency or is flagged down by bystanders requesting assistance for a medical/ traumatic emergency for which that provider has not been dispatched.

III. POLICY

- A. When a pre-hospital care provider comes upon the scene of a medical emergency without being dispatched to that emergency, the crew of that unit shall immediately notify EMS Dispatch of the location and nature of that emergency.
- B. If no pre-hospital care responders are on scene and the on-viewing unit is not enroute to another medical emergency, or not transporting a patient, the crew of that unit must stop and render aid including transport, if appropriate, or wait until other EMS resources arrive.
- C. If enroute to another emergency or transporting a patient notify dispatch and if appropriate the on-viewing unit may stop to render aid.
- D. If other EMS resources are on scene the provider may stop and ask if assistance is needed.
- E. If the incident is within an identified EOA, and a contracted ambulance has been dispatched, the on-view ambulance should not transport unless the delay might jeopardize the patient. The decision to transport should be made based upon the patient's condition and estimated time of arrival of the contracted ambulance.

1007 LEMSA SYSTEM OBSERVATION POLICY

I. Purpose

- A. System Oversight: LEMSA uses the ride-along program to ensure that the EMS system is operating in accordance with established protocols and standards.
- B. Quality Assurance and Improvement: LEMSA representatives can observe real-world interactions with patients, ensuring that the system is delivering safe, effective, and compassionate care.
- C. Education and Training: The program provides valuable insight into the operational realities of EMS work and provides an educational opportunity for field providers and LEMSA personnel.
- D. Regulatory Compliance: By monitoring field practices, LEMSA ensures compliance with state and local regulations and the standards set by the state EMS authority.

II. Program Structure and Participation

- A. Eligibility: Ride-along participants will be limited to LEMSA staff.
- B. Accountability: LEMSA staff will be clearly identifiable as LEMSA personnel including field-appropriate agency clothing while in the field.
- C. Field Operations: LEMSA may assign staff to accompany field personnel during their shifts, observing emergency calls, patient assessments, treatments, and transports.
- D. Supervision: LEMSA staff may not directly intervene in patient care unless there is an immediate risk to public safety and health.

III. Key Areas of Review

- A. Clinical Competence: Assessing whether personnel are correctly applying medical procedures, diagnosing conditions, and performing advanced life support.
- B. Communication Skills: Reviewing abilities to communicate clearly with patients, family members, and other healthcare providers (e.g., during hand-offs to the hospital).
- C. Adherence to Protocols: Ensuring that personnel follow LEMSA treatment guidelines and administrative policies for medical treatment, transport, and documentation.
- D. Decision-Making: Reviewing the decision-making processes for on-scene assessments, determining the level of care required, and evaluating the appropriateness of transports or interventions.

IV. Feedback and Continuous Improvement

- A. Performance Feedback: After the ride-along, LEMSA provides feedback to the EMS provider agencies helping them identify strengths and areas for improvement.
- B. Incident Review: If any concerns arise during a ride-along (e.g., deviation from protocols or patient care issues), the LEMSA team may review specific cases and recommend corrective actions.
- C. Educational Enhancements: Based on observations, LEMSA may suggest targeted training or professional development for personnel to improve care quality.

V. Benefits of the Program

- A. For Personnel: Opportunity to interact with their LEMSA.
- B. For LEMSA: It helps the agency maintain a high standard of care and ensures that EMS agencies are compliant with regulations and guidelines.
- C. For Patients: Ultimately, the ride-along program ensures that patients receive the best possible care in emergency situations.

1008 EXCLUSIVE OPERATING AREAS

I. EXCLUSIVE OPERATING AREAS (EOA)

- A. The local EMS Agency shall provide for Emergency and ALS ambulance services under a local plan, which may create one or more exclusive operating areas. The LEMSA may establish exclusive operating areas in accordance with health and safety code and California code of regulations.

2001 Paramedic Accreditation

I. PURPOSE

- A. To establish requirements and process for the accreditation of paramedics within the LEMSA jurisdiction.

II. INTERIM ACCREDITATION

- A. The following requirements must be met to obtain interim paramedic accreditation in the Local EMS Agency jurisdiction.
 - 1. Complete the EMS Agency's electronic application form, including submission of a current and valid California paramedic license, government issued identification and payment of the established non-refundable application fee.
 - 2. Provide proof of employment with an authorized paramedic service provider within the LEMSA jurisdiction (Service Affiliation through the LEMSA License Management System).
- B. After meeting the requirements in section II (A) the LEMSA will issue an interim accreditation authorization that will expire on the last day of the month no less than 90 days from date of issue.
- C. Interim accredited paramedics may practice under the supervision of a LEMSA approved Evaluator/Preceptor while completing the LEMSA ALS Field Evaluation.

III. INITIAL ACCREDITATION

- A. Interim accredited paramedics must complete the following within the term of interim accreditation to receive a full accreditation:
 - 1. Successfully complete the pre-accreditation system orientation including:
 - a. Base Hospital/medical control orientation through the local base hospital.
 - b. EMS communications/dispatch orientation provided by the employer or EMS Communications Center.
 - c. 5 ALS patient contacts meeting LEMSA criteria, performed under the supervision of a LEMSA approved evaluator. Contacts shall be documented on the LEMSA form and approved by a designated LEMSA EMS Coordinator under the direction of the LEMSA medical director.
 - d. Successful completion of the LEMSA ALS Update class.
 - 2. After steps III A, 1(a) through 1(c) have been completed, and proof of completion submitted to the LEMSA, the LEMSA may authorize the interim accredited paramedic to work independently. Authorization will be in writing to the paramedic's employer.
 - 3. Upon proof of completion of all accreditation requirements above, validated by submission of an Initial Accreditation Application in the LEMSA License Management System, the EMS Agency shall review the application and if satisfactory issue a local paramedic accreditation which shall be valid for a period consistent with and not to exceed the period for which their current California paramedic license is valid.
 - 4. Applicants must complete the accreditation application and field evaluation process outlined above prior to the expiration of their Interim Accreditation Authorization.
 - 5. Failure to complete the local accreditation requirements within the term of Interim Accreditation Authorization shall constitute an abandoned application. Individuals with abandoned applications may repeat the application process if desired.

IV. MAINTAINING ACCREDITATION

- A. Maintaining continuous accreditation as a Paramedic shall be contingent upon:
 - 1. Submission of the EMS Agency's paramedic accreditation electronic renewal form for the purpose of updating information and verifying license status, completion of required training and current service affiliation within 30 days prior to the expiration of current paramedic license.
 - 2. Continuous employment with an approved ALS provider in the LEMSA region.
 - a. An employment lapse greater than 90 days requires reaccreditation.
 - 3. Possession of a current and valid California paramedic license.
 - 4. Completion of the ALS update course within 24 months prior to submission of electronic renewal form.

Effective Date

5. Upon receipt and review of an electronic renewal form indicating the paramedic continues to meet accreditation requirements, the LEMSA shall issue an accreditation card with a renewal date concurrent with applicant's California paramedic license.
6. Paramedics failing to maintain the requirements specified above are not authorized to provide paramedic level care under LEMSA medical control.

V. DISCRETIONARY AUTHORITY OF EMS MEDICAL DIRECTOR

- A. Local accreditation requirements are created for the purpose of ensuring the EMS Medical Director can establish and maintain medical control over the care delivered within the EMS system. Local accreditation is not a health care certificate or license but represents the EMS Medical Director's approval for a specific individual to practice within the system at the ALS level.
- B. The requirements within this policy for training and evaluation of paramedics to obtain and maintain continuous accreditation are subject to modification at the sole discretion of the EMS Medical Director.
- C. Temporary modifications to accreditation requirements will be communicated to EMS System partners.

VI. NON-ACCREDITED PRACTICE OF ADVANCED LIFE SUPPORT

- A. Any paramedic practicing without a valid local accreditation issued by the LEMSA shall be deemed as practicing outside of medical control for the purpose of professional license action.
- B. Any ALS care delivered by non-accredited paramedics shall be considered as care practiced without a physician order, and ineligible for medical billing reimbursement.

2002 Training Programs

I. PURPOSE

- A. Establish standards for the approval of Public Safety First Aid (PSFA), Emergency Medical Technician and Paramedic Training Programs and EMS Continuing Education Provider authorization by the LEMSA
- B. Comply with California Code of Regulations procedures for PSFA, EMT and Paramedic Training Program Approval.

II. PUBLIC SAFETY FIRST AID TRAINING PROGRAM

- A. Training institutions that wish to be approved as a Public Safety Training Program in the LEMSA region must complete a course approval application and provide required course approval documents.
 - 1. The following public safety personnel shall be trained to administer first aid, Cardiopulmonary Resuscitation (CPR), and the use of an Automated External Defibrillator (AED):
 - a. Lifeguard
 - b. Firefighter
 - c. Peace Officer
 - 2. Program approval or disapproval shall be made in writing by the LEMSA to the requesting training program within thirty (30) days after receipt of all required documentation.
 - 3. Training Program approval will be for four (4) years.
 - 4. All program materials are subject to periodic reviews.
 - 5. All programs are subject to periodic on-site evaluation.
- B. Scope of practice and PSFA Training Program Requirements
 - 1. The Scope of practice shall not exceed those activities, while at the scene of an emergency, as authorized by California Code of Regulations.
 - 2. Optional Skills under Title 22, Division 9 may be utilized if approved by the LEMSA Medical Director.
 - 3. Initial PSFA training course shall comply with hourly training requirements identified in CCR Title 22.
 - 4. Course content shall include all topics under Title 22, Division 9.
 - 5. Each certificate or written verification of course completion shall include the following information:
 - a. Indicate initial or refresher training and number of training hours completed.
 - b. Date of issue.
 - c. Date of expiration; expiration of training company shall be two (2) years from the date of course completion.
 - 6. Course refresher requirements shall be satisfied every two years by an authorized LEMSA training program.
- C. Changes in PSFA training program
 - 1. Persons or agencies conducting an approved first responder training program must notify the Agency in writing, in advance when possible and in all cases within thirty (30) days of any change in course content, hours of instruction, program director or program clinical coordinator.

III. EMERGENCY MEDICAL TECHNICIAN TRAINING PROGRAM

- A. Training institutions that wish to be approved as an Emergency Medical Technician (EMT) Training Program in the LEMSA region must complete a course approval application on the LEMSA data portal and provide required course approval documents.
- B. Approval
 - 1. Program approval or disapproval shall be made in writing by the LEMSA to the requesting training program within thirty (30) days after receipt of all required documentation.

Effective Date:

2. Program approval shall be for four (4) years following the effective date of program approval and may be renewed every four (4) years by following the procedure outlined above for initial program approval.
 3. All programs and program materials shall be subject to on-site review by the LEMSA.
 4. The LEMSA shall be notified of all course offerings thirty (30) days before the starting date of the course.
- C. Scope of practice and EMT training program requirements
1. The Scope of practice shall not exceed those activities, while at the scene of an emergency, as authorized by Title 22, Division 9.
 2. Optional Skills under Title 22, Division 9 may be utilized if approved by the LEMSA Medical Director.
 3. Initial EMT training course shall comply with hourly training requirements identified in CCR Title 22.
 4. Course content shall include all topics under Title 22, Division 9.
 5. Each trainee who successfully completes an approved course of instruction shall be issued a Certificate of Completion identifying:
 - a. The name of the individual.
 - b. The date of course completion.
 - c. Type of EMT course completed (i.e., EMT refresher, or challenge), and the number of hours completed.
 - d. The EMT approving authority.
 - e. The signature of the Program Director.
 - f. The name and location of the training program issuing the record.
 - g. The following statement in bold print “This is not an EMT certificate”.
 6. Expiration date shall be 2 years from the date of course completion.
 7. Each training program provider shall maintain a record of the names of trainees and the date(s) on which training courses have been completed for at least four (4) years.
 8. Provisions for a twenty-four (24) hour refresher course shall be satisfied every two years by an authorized LEMSA training program.
- D. Changes in EMT training program
1. Persons or agencies conducting an approved EMT training program must notify the Agency in writing, in advance when possible and in all cases within thirty (30) days of any change in course content, hours of instruction, program director or program clinical coordinator.

IV. PARAMEDIC TRAINING PROGRAM

- A. Training institutions that wish to be approved as a Paramedic Training Program in the LEMSA region must complete the course approval application on the LEMSA data portal and provide required course approval documents.
- B. Approval
 1. Program approval or disapproval shall be made in writing by the LEMSA to the requesting training program within thirty (30) days after receipt of all required documentation.
 2. Program approval shall be for four (4) years following the effective date of program approval and may be renewed every four (4) years by following the procedure outlined above for initial program approval.
 3. All programs and program materials shall be subject to on-site review by the LEMSA.
 4. The LEMSA shall be notified of all course offerings thirty (30) days before the starting date of the course.
 5. The LEMSA shall be notified in writing, in advance when possible and in all cases within thirty (30) days of any change in course content, hours of instruction, program director, program clinical coordinator or principal instructor(s).
- C. Scope of Practice and Paramedic Training Program Requirements

Effective Date:

1. The Scope of practice shall not exceed those activities, while at the scene of an emergency, as authorized by Title 22, Division 9.
 2. Initial Paramedic training course shall comply with hourly training requirements identified in CCR Title 22.
 3. Course content shall include all topics under Title 22, Division 9.
- D. Changes in Paramedic Training Program
1. Persons or agencies conducting an approved paramedic training program must notify the Agency in writing, in advance when possible and in all cases within thirty (30) days of any change in course content, hours of instruction, program director or program clinical coordinator.

V. EMS CONTINUING EDUCATION PROVIDER

- A. Continuing education providers shall comply with the requirements of Title 22 of the California Code of Regulations.
- B. The LEMSA shall grant or deny approval of CE providers whose training sites are located within the LEMSA.
- C. The LEMSA may audit the records of or visit the site of any CE provider program for the purposes of compliance monitoring.
- D. Approval Process
1. Interested organization or individuals shall submit an application to the LEMSA, which may consist of access to the LEMSA electronic application, or a LEMSA-approved alternative.
 2. The application shall be considered for approval if it is complete, if all supplemental material requested is submitted, and if it meets requirements of California Code of Regulations
 3. The LEMSA will review the materials for compliance with CCR Title 22 Div.9 and issue a "CE provider number" in accordance with State regulations and guidelines if found compliant.
 4. EMS CE provider approvals will be valid for a four-year period expiring on the last day of the month in which the CE application was approved. CE Provider Responsibilities and Requirements
 5. Approved CE providers are responsible for maintaining competent understanding of and adherence to all requirements for EMS CE programs as outlined in CCR Title 22, and LEMSA policy and procedure.
- E. Requirements for CE Providers
1. CE provider shall ensure, at a minimum, the following:
 - a. Relevant EMS or prehospital content of all CE.
 - b. The LEMSA is notified of any changes in program name, address, phone, program director, and/or clinical director.
 - c. All records are made available to the LEMSA upon request, and classes and courses are open to the LEMSA for scheduled or unscheduled visits.
 - d. Training program staff meet requirements as specified in the CCR Title 22 Div.9 requirements for EMS CE programs.
 - e. Award of CE hours, record keeping, certificates and documents, advertising and sponsorship are done in accordance with the CCR Title 22 Div.9 requirements for EMS CE programs.
- F. CE Provider Renewal
1. The LEMSA shall renew CE provider approval if all provisions of the State of California Guidelines for Prehospital Continuing Education, local policy, and Title 22 are continuously met and application with required materials has been submitted.
 2. Applications for renewal shall be submitted to the LEMSA at least 60 calendar days before the date of program expiration in order to maintain continuous approval.
 3. All CE provider requirements must be met and maintained for renewal.
 4. CE Providers are solely responsible for tracking expiration date of their program.

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VI. CONTINUING EDUCATION COURSE APPROVAL

- A. EMS CE programs may only issue continuing education hours within the limitations and delivery methods specified in CCR Title 22 Div.9.
- B. Authorized providers may only issue a certificate for the actual hours spent on a given topic as allowed in CCR Title 22 Div. 9.
- C. EMS CE issued in violation of relevant regulations may be deemed invalid by the LEMSA.
- D. EMS CE Programs are subject to action up to revocation of authorization for issuing non-compliant EMS CE certificates in accordance with LEMSA policy

VII. Unified Enforcement Language for EMS Training Programs Compliant with CCR Title 22

- A. Failure to comply with all applicable provisions of California Code of Regulations (CCR) or LEMSA policy for an EMS training program may result in denial, probation, suspension or revocation of EMS program approval.
- B. The requirements for training program noncompliance notification and actions are as follows:
 - 1. The LEMSA shall provide notification of noncompliance, including the specific provision(s) of CCR the LEMSA has found noncompliant to the EMS training program provider found in violation. The notification shall be in writing and sent by certified mail to the EMS training program director specified in CCR for the type of EMS training program.
 - 2. Within fifteen (15) working days from receipt of the noncompliance notification the approved EMS training program shall submit in writing, by certified mail, to LEMSA one of the following:
 - a. Evidence of compliance with the provisions of CCR, or
 - b. A plan to comply with the provisions of CCR within sixty (60) calendar days from the day of receipt of the notification of noncompliance.
 - 3. Within fifteen (15) working days from receipt of the EMS training program's response, or within thirty (30) calendar days from the mailing date of the noncompliance notification if no response is received from the approved EMS training program, the LEMSA shall issue a decision letter by certified mail to the EMS training program and if required by CCR to the California EMS Authority. The letter shall identify the LEMSA's decision to take one or more of the following actions:
 - a. Accept the evidence of compliance provided.
 - b. Accept the plan for meeting compliance.
 - c. Place the training program on probation.
 - d. Suspend or revoke the training program approval.
 - 4. The decision letter shall also include, but not be limited to, the following:
 - a. Date of the LEMSA decision.
 - b. Specific provisions found noncompliant by the LEMSA, if applicable.
 - c. The probation or suspension effective and ending date, if applicable.
 - d. The terms and conditions of the probation or suspension, if applicable.
 - e. The revocation effective date, if applicable.
 - 5. If the training program found noncompliant with CCR does not comply with subsection (2) of this section, the LEMSA may uphold the noncompliance finding and initiate a probation, suspension, or revocation action as described in subsection (3) of this Section.
 - 6. LEMSA shall establish the probation, suspension, or revocation effective dates no sooner than sixty (60) days after the date of the decision letter, as described in subsection (3) of this Section.
 - 7. If EMS training program status is suspended or revoked, approval for any course completion certificate issued or CE credit shall be withdrawn for all training activity scheduled after the date of action.

Effective Date:

2003 EMT CERTIFICATION REVIEW/DISCIPLINE PROCESS

I. PURPOSE

- A. To establish a policy for administration of the process for EMT disciplinary action as required by California Code of Regulations (CCR) Title 22.

II. DEFINITIONS

- A. Certificate - a valid Emergency Medical Technician (EMT) certificate issued pursuant to Division 2.5 of the California Health and Safety Code.
- B. Medical Director - as used in this policy, means the medical director of the Local EMS Agency (LEMSA).
- C. Certification Action - those actions that may be taken by the LEMSAs medical director that include denial, suspension, revocation of a certificate, or placing a certificate holder on probation.
- D. Certificate Holder – for the purpose of this policy, shall mean the holder of a certificate, as that term is described above.
- E. CCR – the California Code of Regulations, Title 22, Division 9.
- F. Discipline - either a disciplinary plan taken by a relevant employer pursuant to Section 100206.2 of the CCR or certification action taken by the medical director pursuant to Section 100204 of the CCR, or both a disciplinary plan and certification action.
- G. Disciplinary Cause -an act that is substantially related to the qualifications, functions, and duties of an EMT and is evidence of a threat to the public health and safety, per Health and Safety Code Section 1798.200.
- H. Model Disciplinary Orders (MDO) - the Recommended Guidelines for Disciplinary Orders and Conditions of Probation (EMSA document #134) which were developed to provide consistent and equitable discipline in cases dealing with disciplinary cause.
- I. Disciplinary Plan -a written plan of action that can be taken by a relevant employer as a consequence of any action listed in Section 1798.200 (c). The Disciplinary Plan shall be submitted to the medical director and may include recommended certification action consistent with the Recommended Guidelines for Disciplinary Orders and Conditions of Probation for EMT (MDOs).
- J. Relevant employer(s) - those ambulance services permitted by the Department of the California Highway Patrol or a public safety agency that the certificate holder works for or was working for at the time of the incident under review, as an EMT either as a paid employee or a volunteer.
- K. Valid, Validate or Validated – for the purpose of this policy means to determine by preliminary investigation, within reasonable certainty, that a violation of Health and Safety Code §1798.200 may have occurred and that said violation may be reason for disciplinary cause.

III. POLICY

- A. Any information received from any source, including discovery through medical audit or routine follow-up on complaints, which purports a violation of, or deviation from, state or LEMSAs laws, regulations, policies, procedures or protocols will be evaluated pursuant to this policy and consistent with the CCR, Title 22, Division 9.

IV. RESPONSIBILITIES OF RELEVANT EMPLOYER

- A. Under the provisions of the CCR and this policy, relevant employers:
 - 1. May conduct investigations to determine disciplinary cause.
 - 2. Shall notify the medical director within three (3) working days after an allegation has been validated as potential for disciplinary cause.
 - 3. Upon determination of disciplinary cause, the relevant employer may develop and implement a disciplinary plan, in accordance with the MDOs.

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4. The relevant employer shall submit that disciplinary plan to the LEMSA along with the relevant findings of the investigation related to disciplinary cause, within three (3) working days of adoption of the disciplinary plan.
 5. The employer's disciplinary plan may include a recommendation that the medical director consider taking action against the holder's certificate to include denial of certification, suspension of certification, revocation of certification, or placing a certificate on probation.
- B. Relevant Employers shall notify the medical director within three (3) working days of the occurrence of any of following:
1. The employee is terminated or suspended for a disciplinary cause,
 2. The employee resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause, or the employee is removed from employment-related duties for a disciplinary cause after the completion of the employer's investigation.

V. JURISDICTION OF LEMSA MEDICAL DIRECTOR

- A. The medical director shall conduct investigations to validate allegations for disciplinary cause when the EMT is not an employee of a relevant employer, or the relevant employer does not conduct an investigation. Upon determination of disciplinary cause, the medical director may take certification action as necessary against a certificate holder.
- B. The medical director may, upon determination of disciplinary cause and according to the provisions of this policy, take certification action against an EMT to deny, suspend, or revoke, or place a certificate holder on probation, upon the findings by the medical director of the occurrence of any of the actions listed in Health and Safety Code, and for which any of the following conditions are true:
1. The relevant employer, after conducting an investigation, failed to impose discipline for the conduct under investigation, or the medical director makes a determination that discipline imposed by the relevant employer was not in accordance with the MDOs and the conduct of the certificate holder constitutes grounds for certification action.
 2. The medical director determines, following an investigation conducted in accordance with this policy, that the conduct requires certification action.
- C. The medical director, after consultation with the relevant employer or without consultation when no relevant employer exists, may temporarily suspend, prior to a hearing, a certificate holder upon a determination of the following:
1. The EMT has engaged in acts or omissions that constitute grounds for revocation of the certificate; and
 2. Permitting the EMT to continue to engage in certified activity without restriction poses an imminent threat to the public health and safety.
- D. If the medical director takes any certification action the medical director shall notify the State EMS Authority of the findings of the investigation and the certification action taken by entering said information into the state registry.
- E. The medical director may designate LEMSA staff to perform all of the functions and duties specified in this policy with the exception of the final determination of certification action.

VI. EVALUATION OF INFORMATION

- A. A relevant employer who receives an allegation of conduct listed in Section 1798.200 (c) of the Health and Safety Code against a certificate holder and once the allegation is validated, shall notify the medical director, within three (3) working days, of the certificate holder's name, certification number, and the allegation(s).
- B. When the LEMSA receives a complaint against a certificate holder, the LEMSA shall forward the original complaint and any supporting documentation to the relevant employer for investigation, if there is a relevant employer, within three (3) working days of receipt of the information. If there is no relevant employer or the relevant employer does not wish to investigate the complaint, the medical director shall evaluate the

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information received from a credible source, including but not limited to, information obtained from an application, medical audit, or public complaint, alleging or indicating the possibility of a threat to the public health and safety by the action of an applicant for, or holder of, a certificate issued by the LEMSA or pursuant to Division 2.5, Health and Safety Code.

- C. The relevant employer or medical director shall conduct an investigation of the allegations in accordance with the provisions of this policy, if warranted.

VII. INVESTIGATIONS INVOLVING FIREFIGHTERS

- A. The rights and protections described in Chapter 9.6 of the Government Code shall only apply to a firefighter during events and circumstances involving the performance of his or her official duties.
- B. All investigations involving certificate holders who are employed by a public safety agency as a firefighter shall be conducted in accordance with Chapter 9.6 of the Government Code, Section 3250 et. seq.

VIII. DUE PROCESS

- A. The certification action process shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

IX. DETERMINATION OF ACTION

- A. Upon determining the disciplinary or certification action to be taken, the relevant employer or medical director shall complete and place in the personnel file or any other file used for any personnel purposes by the relevant employer or the LEMSA, a statement certifying the decision made and the date the decision was made. The decision must contain findings of fact and a determination of issues, together with the disciplinary plan and the date the disciplinary plan shall take effect.
- B. In the case of a temporary suspension order pursuant to Section 100209 (c) of the CCR, it shall take effect upon the date the notice required by Section 100213 of the CCR is mailed to the certificate holder.
- C. For all other certification actions, the effective date shall be thirty days from the date the notice is mailed to the applicant for, or holder of, a certificate unless another time is specified or an appeal is made.

X. TEMPORARY SUSPENSION ORDER

- A. The medical director may temporarily suspend a certificate prior to hearing if there is a valid complaint that the certificate holder has engaged in acts or omissions that constitute grounds for denial or revocation according to Section 100216(c) of the CCR and, if in the opinion of the medical director, permitting the certificate holder to continue to engage in certified activity would pose an imminent threat to the public health and safety.
- B. Prior to, or concurrent with, initiation of a temporary suspension order of a certificate pending hearing, the medical director shall consult with the relevant employer of the certificate holder.
- C. The notice of temporary suspension pending hearing shall be served by registered mail or by personal service to the certificate holder immediately, but no longer than three (3) working days from making the decision to issue the temporary suspension. The notice shall include the allegations that allowing the certificate holder to continue to engage in certified activities would pose an imminent threat to the public health and safety.
- D. Within three (3) working days of the initiation of the temporary suspension by the medical director, the medical director and relevant employer shall jointly investigate the allegation in order for the medical director to make a determination of the continuation of the temporary suspension.
- E. All investigatory information, not otherwise protected by the law, held by the LEMSA and the relevant employer shall be shared between the parties via facsimile transmission or overnight mail relative to the decision to temporarily suspend.

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- F. The medical director shall serve within fifteen (15) calendar days an accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code (Administrative Procedures Act).
- G. If the certificate holder files a Notice of Defense, the administrative hearing shall be held within thirty (30) calendar days of the LEMSA's receipt of the Notice of Defense.
- H. The temporary suspension order shall be deemed vacated if the LEMSA fails to serve an accusation within fifteen (15) calendar days or fails to make a final determination on the merits within fifteen (15) calendar days after the Administrative Law Judge (ALJ) renders a proposed decision.

XI. FINAL DETERMINATION OF SUSPENSION ACTION BY MEDICAL DIRECTOR

- A. Upon determination of certification action following an investigation, and appeal of certification action pursuant to Section 100211.1 of the CCR, if the respondent so chooses, the medical director may take the following final actions on an EMT certificate:
 - 1. Place the certificate holder on probation
 - 2. Suspension
 - 3. Denial
 - 4. Revocation

XII. PLACEMENT OF A CERTIFICATE HOLDER ON PROBATION

- A. The medical director may place a certificate holder on probation any time an infraction or performance deficiency occurs which indicates a need to monitor the certificate holder's conduct in the EMS system, in order to protect the public health and safety. The term of the probation and any conditions shall be in accordance with the MDOs. The medical director may revoke the EMT certificate if the certificate holder fails to successfully complete the terms of probation.

XIII. SUSPENSION OF A CERTIFICATE

- A. The medical director may suspend an individual's EMT certificate for a specified period of time for disciplinary cause in order to protect the public health and safety.
- B. The term of the suspension and any conditions for reinstatement shall be in accordance with the MDOs.
- C. Upon the expiration of the term of suspension, the individual's certificate shall be reinstated only when all conditions for reinstatement have been met. The medical director shall continue the suspension until all conditions for reinstatement have been met.
- D. If the suspension period will run past the expiration date of the certificate, the EMT shall meet the recertification requirements for certificate renewal prior to the expiration date of the certificate.

XIV. DENIAL OR REVOCATION OF A CERTIFICATE

- A. The medical director may deny or revoke any EMT certificate for disciplinary cause that has been investigated and verified by application of this policy.
- B. The medical director shall deny or revoke an EMT certificate if any of the following apply to the applicant:
 - 1. Has committed any sexually related offense specified under Section 290 of the Penal Code.
 - 2. Has been convicted of murder, attempted murder, or murder for hire.
 - 3. Has been convicted of two (2) or more felonies.
 - 4. Is on parole or probation for any felony.
 - 5. Has been convicted and released from incarceration for said offense during the preceding fifteen (15) years for the crime of manslaughter or involuntary manslaughter.

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6. Has been convicted and released from incarceration for said offense during the preceding ten (10) years for any offense punishable as a felony.
 7. Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to the use, sale, possession, or transportation of narcotics or addictive or dangerous drugs.
 8. Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to force, threat, violence, or intimidation.
 9. Has been convicted within the preceding five (5) years of any theft related misdemeanor.
- C. The medical director may deny or revoke an EMT certificate if any of the following apply to the applicant:
1. Has committed any act involving fraud or intentional dishonesty for personal gain within the preceding seven (7) years.
 2. Is required to register pursuant to Section 11590 of the Health and Safety Code.
- D. Subsection 3. (b) shall not apply to convictions that have been pardoned by the Governor and shall only apply to convictions where the applicant/certificate holder was prosecuted as an adult. Equivalent convictions from other states shall apply to the type of offenses listed in (b). As used in this Section, "felony" or "offense punishable as a felony" refers to an offense for which the law prescribes imprisonment in the state prison as either an alternative or the sole penalty, regardless of the sentence the particular defendant received.
- E. This Section shall not apply to those EMTs who obtain their California certificate prior to July 1, 2010; unless:
1. The certificate holder is convicted of any misdemeanor or felony after July 1, 2010.
 2. The certificate holder committed any sexually related offense specified under Section 290 of the Penal Code.
 3. The certificate holder failed to disclose to the certifying entity any prior convictions when completing his/her application for initial EMT certification or certification renewal.
- F. Nothing in this Section shall negate an individual's right to appeal a denial of an EMT certificate pursuant to this policy.
- G. Certification action by the medical director shall be valid for a period of at least twelve (12) months from the effective date of the certification action. An EMT whose application was denied or an EMT whose certification was revoked by another LEMSA medical director shall not be eligible for EMT application through the LEMSA for a period of at least twelve (12) months from the effective date of the certification action. EMT whose certification is placed on probation must complete their probationary requirements with the LEMSA that imposed the probation.

XV. NOTIFICATION OF FINAL DECISION OF CERTIFICATION ACTION

- A. For the final decision of certification action, the medical director shall notify the applicant/certificate holder and his/her relevant employer(s) of the certification action within ten (10) working days after making the final determination.
- B. The notification of final decision shall be served by registered mail or personal service and shall include the following information:
1. The specific allegations or evidence which resulted in the certification action;
 2. The certification action(s) to be taken, and the effective date(s) of the certification action(s), including the duration of the action(s);
 3. A statement that the certificate holder must report the certification action within ten (10) working days to any other LEMSA and relevant employer in whose jurisdiction s/he uses the certificate.

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2004 PARAMEDIC EVALUATORS AND PRECEPTORS

I. REQUIREMENTS

- A. Evaluators for paramedic accreditation applicants and preceptors for paramedic students must meet LEMSA criteria. Minimum requirements for consideration are as follows:
 - 1. Current paramedic licensure in California, with at least two years full time experience working as a paramedic.
 - 2. At least one year full time experience as a paramedic in the LEMSA region.
 - 3. Successful completion of a LEMSA-approved preceptor workshop.
 - 4. Recommendation by the paramedic provider agency.
 - 5. Approval by the LEMSA Medical Director or designee.
 - 6. Exceptions to any of these minimum requirements will be considered on an individual basis and must be approved by the provider agency, and the LEMSA.

II. OTHER CONSIDERATIONS

- A. All preceptors and evaluators require approval by the LEMSA. Preceptors, evaluators and provider agencies will receive written notification of approval or denial.
- B. Preceptor and/or Evaluator status is subject to revocation for cause after a review by LEMSA Medical Director.

2005 Special Event

I. PURPOSE

- A. The ALS Special Use Medic Program:
 - 1. Is an optional prehospital advanced life support program administered by the LEMSA through authorized local ALS providers. The program functions as an extension to State and LEMSA rules, regulations, policies, protocols, and operates under medical control and authority of the LEMSA Medical Director.
 - 2. Is intended to provide expedient ALS response to incidents that may occur at special events within the LEMSA region prior to ALS transport unit scene arrival.
 - 3. Shall not be construed, interpreted or allowed to replace or modify in any way ALS transportation resources required by contract between the LEMSA and ALS providers.
 - 4. Shall coordinate appropriate notification, response, communications, and utilization of local EMS resources.

II. SCOPE OF PRACTICE

- A. The ALS Special Use Medic:
 - 1. Is authorized to provide prehospital ALS within the scope of practice allowed by the State of California and the LEMSA.

III. PROVIDER REQUIREMENTS

- A. To be an ALS Special Use Medic provider the following requirements shall be met:
 - 1. Existing ALS provider authorized by the LEMSA;
 - 2. Have and maintain an ALS Special Use Medic training program which complies with the provisions of these policies and procedures;
 - 3. Have and maintain the appropriate equipment and supplies;
 - 4. Have and maintain a quality improvement program
 - 5. Have and maintain records and reports per LEMSA policy

IV. QUALIFICATIONS, CERTIFICATION AND TRAINING

- A. The ALS Special Use Medic shall have and maintain active Coastal Valleys EMS paramedic accreditation.
- B. An ALS Special Use Medic shall receive training in ALS Special Use Medic policies and procedures, ALS Special Use Medic scope of practice, communications systems and EMS resource utilization before being authorized to operate in an ALS Special Use Medic capacity. The ALS Special Use Medic provider must provide the training.
- C. The ALS Special Use Medic provider shall maintain records of personnel that have completed ALS Special Use Medic training.

V. PLANNING AND DEVELOPMENT

- A. The ALS Special Use Medic provider shall ensure appropriate deployment and utilization of ALS Special Use Medic Program.
- B. The ALS Special Use Medic provider shall develop a pre-event plan, based on the specific special event, which defines ALS Special Use Medic staffing, transportation method to be used, hours of coverage, communications, area resources, incident reporting, and procedures for requesting additional resources. All assigned Special Use Medic personnel shall be provided a briefing in the pre-event plan for the special event.
- C. Non-emergent activity, movement and positioning of an ALS Special Use Medic shall be at the discretion of the ALS Special Use Medic provider.
- D. An ALS Special Use Medic provider shall only provide the ALS Special Use Medic Program for special events where area crowds, roadways, and general access would significantly delay response time of a conventional ambulance.

VI. SCENE OPERATIONS

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- A. ALS first responder capacity (meaning the ALS Special Use Medic) is the first medical unit or first ALS level personnel arriving at scene:
- B. In a first responder capacity, the ALS Special Use Medic is expected to assume patient health care responsibility and/or medical group operations responsibility. Under normal conditions, if the ALS Special Use Medic is the first unit arriving at the scene of an emergency incident involving a multi-agency response, the ALS Special Use Medic would assume incident commander responsibility until a public agency arrives, then the ALS Special Use Medic would automatically transition into medical group supervisor responsibility.
- C. The ALS Special Use Medic is expected to establish medical control, complete scene and patient assessment and initiate BLS/ALS patient treatment intervention according to LEMSA policies, procedures, and protocols, as the patient condition necessitates.
- D. The ALS Special Use Medic continues providing on scene patient care and maintains patient health care authority until an ALS ambulance arrives and transfers patient care responsibility to the ALS ambulance paramedic.
- E. The ALS Special Use Medic Program shall be inclusive of, but not limited to, the use of bicycles (mountain bikes), all terrain vehicles, motorcycles, med-carts, and horseback.
- F. The ALS Special Use Medic provider shall be responsible to provide all equipment and supplies in accordance with these policies that are mechanically sound, properly configured, and safe to operate within the ALS Special Use Medic role.

VII. EMS RESOURCE UTILIZATION

- A. The ALS Special Use Medic shall be responsible for prudent notification, response and efficient utilization of all EMS resources to be used at the scene of an incident at which the paramedic was the first responder.

VII. DOCUMENTATION AND QUALITY IMPROVEMENT

- A. The ALS Special Use Medic provider shall develop a pre-event plan based on the specific special event, which defines ALS Special Use Medic staffing, transportation method to be used, hours of coverage, communications, area resources, incident reporting, and procedures for requesting additional resources. All assigned Special Use Medic personnel shall be provided a briefing in the pre-event plan for the special event.
- B. The ALS Special Use Medic shall complete a Patient Care Record for every patient contact.
- C. The ALS Special Use Medic provider shall provide ALS Special Use Medic pre-event plans, related data and/or ALS Special Use Medic program evaluations to the LEMSA upon request.

VIII. REQUIRED ALS SPECIAL USE MEDIC EQUIPMENT AND SUPPLIES

- A. The ALS Special Use Medic and ALS Special Use Medic provider shall be responsible for the care and maintenance of all ALS Special Use Medic inventory. ALS Special Use Medic inventory shall also be subject to inspection by the LEMSA.
- B. The ALS Special Use Medic shall have, at the minimum, the entire ALS Special Use Medic inventory items listed in the Response and Transport policies.
- C. "Special Event" for the purposes of this policy is any planned and organized event where an ALS service provider utilizes its personnel and resources to provide stand-by dedicated EMS services to the participants and attendees of the event.
- D. To define the process by which a paramedic service provider may utilize paramedics under this policy and obtain special event accreditation.
- E. "Stand-by EMS" Services for the purposes of this policy is the utilization of personnel and resources to provide EMS services above regular staffing levels which are dedicated to the event and not expected to be available to respond to incidents unrelated to the event.

IX. Special Event Paramedic Accreditation

- A. Requirements for accreditation under this policy
 1. Paramedics seeking accreditation under this policy shall:

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2. Be currently employed by an ALS service provider in another LEMSA jurisdiction
 3. Be employed by the approved LEMSA service provider during the special event.
 4. Hold a current and valid California paramedic license and valid accreditation issued by a LEMSA.
 5. Have completed all employer agency training requirements with current ALS service provider employer
- B. Application process
1. The ALS service provider will notify the LEMSA via the approved application process, at least 10 business days prior to the event. The application shall provide the following information at a minimum:
 - a. The name of the special event
 - b. Dates of the special event
 - c. Description of event and geographic area involved
 - d. Name and license number of special event paramedic applicant.
 - e. Attestation of completion of employer agency training requirements.
 - f. LEMSA Special Event Paramedic fee will apply to the Special Event Limited Accreditation credential per applicant and shall be due at the time of paramedic application.
- C. Approval of temporary accreditation paramedics by the LEMSA
1. The LEMSA will provide verification of approval to the paramedic service provider for all staff authorized to serve as a special event paramedic.
 2. Effective accreditation dates shall not exceed thirty (30) consecutive calendar days.
- D. Scope of practice under this policy
1. Paramedics accredited under this policy shall be limited to the paramedic basic scope of practice outlined in Title 22, CCR.
 2. Paramedics accredited under this policy shall not use optional scope of practice skills or medications.
- E. Orientation and deployment criteria
1. The service provider shall provide orientation to temporary accredited personnel appropriate to the needs of the work environment and deployment. Orientation should include, at a minimum, the following topics:
 - a. LEMSA medical control policy
 - b. Limitation to providing basic scope of practice as outlined in Title 22, CCR
 - c. Location of hospitals
 - d. Base hospital contact procedures and means of hospital contact including 12-Lead transmission
 - e. MCI Plan overview
 - f. Access to LEMSA Treatment Guidelines
 - g. Patient Care Report requirements and utilization of the provider's e-PCR system
 - h. Radio frequencies and radio procedures
 - i. Equipment orientation
 2. Paramedics utilized under this policy shall be assigned to work with either an EMT who has completed any probationary period or a regularly accredited LEMSA paramedic.
 3. A paramedic utilized under this policy shall be assigned to work at the special event and shall not be assigned to work on a unit with 911 system responsibilities.
 4. The paramedic service provider shall provide a report to the LEMSA within five (5) business days outlining the number of paramedics actually used at the event, patient care provided by the temporary paramedic, and any concerns raised related to use of this policy.

2006 EMT CERTIFICATION POLICY

I. PURPOSE

- A. The purpose of this policy is to establish requirements for issuing Emergency Medical Technician (EMT) certification by the Local Emergency Medical Services Agency (LEMSA)

II. POLICY

A. Initial Certification:

1. To be eligible for EMT certification by the LEMSA an individual shall meet one of the following criteria:
 - a. Possess documented proof of passing the National Registry of Emergency Medical Technician EMT Cognitive Examination and Psychomotor Examination within the last two (2) years and have either:
 - b. A valid EMT course completion record dated within the last two (2) years of the date of application; or
 - c. Documentation of successful completion of an approved out-of-state EMT training course within the last two (2) years of the date of application; or,
 - d. A current and valid out-of-state EMT certificate.
 - e. Possess a current and valid National Registry EMT, Advanced EMT or Paramedic registration certificate; or
 - f. Possess a current and valid out-of-state Advanced EMT or Paramedic certificate; or
 - g. Possess a current and valid California Advanced EMT certification or current and valid California Paramedic license.
2. In addition to meeting one of the criteria listed in subdivision 1, to be eligible for initial certification, an individual shall:
 - a. Be eighteen (18) years of age or older;
 - b. Submit a completed EMT certification application that includes this statement: "I hereby certify under penalty of perjury that all information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to EMT certification in the state of California. I understand all information on this application is subject to verification, and I hereby give my express permission for this certifying entity to contact any person or agency for information related to my role and function as an EMT in California.";
 - c. Disclose any prior and/or current certification, licensure, or accreditation actions:
 - (i) Against an EMT, Advanced EMT certificate, or any denial of certification by a Local EMS Agency (LEMSA), including any active investigations;
 - (ii) Against a Paramedic license, or any denial of licensure by the Authority, including any active investigations;
 - (iii) Against any EMS-related certification or license of another state or other issuing entity, including denials and any active investigations; or
 - (iv) Against any health-related license.
 - d. Disclose any pending or current criminal investigations;
 - e. Disclose any pending criminal charges;
 - f. Disclose any prior convictions;
 - g. Disclose each certifying entity or LEMSA to which the applicant has applied for certification in the previous 12 months;
 - h. Submit copies of the following:
 - (i) A valid state identification card (i.e., driver's license) or valid federal identification (i.e., military identification).
 - (ii) A current and valid certification in cardiopulmonary resuscitation (CPR) equivalent to the American Heart Association or American Red Cross standards of CPR for the Professional Rescuer or Healthcare Provider.
 - i. And one of the following:

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- (i) A valid EMT course completion certificate within 2 years from the date of the application and proof of passing the National Registry EMT cognitive examination and psychomotor examination within 2 years from the date of the application.
 - (ii) A current and valid National Registry EMT certificate.
 - (iii) A current and valid out-of-state EMT certificate and proof of passing the National Registry EMT cognitive examination and psychomotor examination within 2 years from the date of the application.
 - (iv) A current and valid out-of-state National Registry Advanced EMT or Paramedic certificate.
 - (v) A current and valid California Advanced EMT certification or current and valid California Paramedic license.
- j. Complete a live scan criminal background check by the State of California Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI) for this LEMSA.
- (i) Live scan results older than twelve (12) months from the date of submission of an application shall not be accepted and the live scan must be repeated at the applicant's cost.
- k. Pay the application fees established by the Board of Supervisors and the State of California EMS Authority. All fees are non-refundable and non-transferable.
- l. Upon receiving and reviewing DOJ and FBI live scan criminal background check results, and validating for non-disciplinary or disqualifying events, and after all certification requirements have been met in Section A 1-6 of this policy:
- (i) The LEMSA will issue an EMT certification.
 - (ii) The effective date of initial certification shall be the day the certificate is issued.
 - (iii) The expiration date for an initial EMT certificate shall be the last day of the month two (2) years from the effective date of the initial certification.
 - (iv) The EMT shall be responsible for notifying the LEMSA of their proper and current mailing address and shall notify the LEMSA within thirty (30) calendar days of any and all changes of the mailing address, giving both the old and the new address, and EMT certification number.
 - (v) An EMT shall only be certified by one (1) certifying entity during a certification period.

B. EMT Certification Renewal:

1. In order to renew certification, an EMT shall:
 - a. Submit a completed EMT application no later than thirty (30) days prior to expiration of their certification.
 - b. Possess current EMT certification in the State of California.
 - c. Submit proof of obtaining at least twenty-four (24) hours of EMS continuing education (CE) from an approved EMS continuing education provider or successfully complete a twenty-four (24) hour EMT refresher course from an approved EMT training program.
 - (i). CE hours may be used to renew multiple licensure/certification types as long as they are earned within the licensure/certification cycle being renewed and were not used in a previous cycle.
 - d. Submit the completed EMT skills competency verification form (EMSA-SCV (01/17)).
 - (i) Skills competency shall be verified by direct observation of an actual or simulated patient contact.
 - (ii) Skills competency shall be verified by an individual who is currently certified or licensed as an EMT, AEMT, Paramedic, Registered Nurse, Physician's Assistant, or Physician and who shall be designated by an EMS approved training program or an EMS service provider (EMS service providers include, but not limited to, public safety agencies, private ambulance providers and other EMS providers).
 - (iii) Verification of skills competency shall be valid for a maximum of two (2) years for the purpose of applying for recertification.
 - e. Submit copies of the following:
 - (i) Valid state identification card (i.e., driver's license) or valid federal identification (i.e., military identification).
 - (ii) A current and valid certification in cardiopulmonary resuscitation (CPR) equivalent to the American Heart Association or American Red Cross standards of CPR for the Professional Rescuer or

Effective Date

Healthcare Provider.

- f. If renewing an EMT certificate issued by another LEMSA, complete a live scan criminal background check by the State of California Department of Justice and the Federal Bureau of Investigation (FBI) for this LEMSA.
 - g. Pay the application fees established by the Board of Supervisors and the State of California EMS Authority. All fees are non-refundable and non-transferable.
2. The LEMSA will issue an EMT certification.
- a. If the renewal requirements are met within six (6) months prior to the current certification expiration date, the effective date of the renewal will be the date immediately following the expiration date of the current certificate. The certification will expire the last day of the month, two (2) years from the day prior to the effective date.
 - b. If the EMT renewal requirements are met greater than six (6) months prior to the expiration date, the effective date of the renewal will be the day the certificate is issued. The certification expiration date will be the last day of the month two (2) years from the effective date.
 - c. A California certified EMT who is a member of the Armed Forces of the United States and whose EMT certification expires while deployed on active duty, or whose certification expires less than six (6) months from the date they return from active duty deployment with the Armed Forces of the United States, shall have six (6) months from the date they return from active duty deployment to complete the requirements of subsections A.1-7 of this section. In order to qualify for this exception, the individual shall:
 - (i). Submit proof of their membership in the Armed Forces of the United States, and
 - (ii). Submit documentation of their deployment start and end dates.
 - (iii). Continuing education credit may be given for documented training that meets the requirements while the individual was deployed on active duty.
 - (iv). The continuing education documentation shall include verification from the individual's Commanding Officer attesting to the training attended.
- C. Reinstatement of an Expired California EMT Certificate:
1. Applicants who have allowed their certification to expire less than six (6) months shall complete the requirements of Section B. 1-2. The CE shall be completed within the 24 months prior to applying for reinstatement.
 2. Applicants who have allowed their certification to expire beyond six (6) months but less than twelve (12) months shall be required to:
 - a. Complete the requirements of Section B. 1-2.
 - b. Complete twelve (12) additional hours of approved EMS continuing education for a total of thirty-six (36) hours of continuing education within the 24 months prior to applying for reinstatement.
 3. Applicants who have allowed their certification to expire beyond twelve (12) months, shall be required to:
 - a. Complete the requirements of Section B. 1-2.
 - b. Complete an additional twenty-four (24) hours of EMS continuing education, for a total of forty-eight (48) hours of continuing education within the 24 months prior to applying for reinstatement; and
 - c. Shall pass the cognitive and psychomotor skills examinations required for initial certification within two (2) years of the date of application for EMT AEMT or paramedic National Registry Certificate or a current and valid AEMT certificate or paramedic license.
 - d. Complete live scan criminal background check by the DOJ and FBI for this LEMSA.
 - (i) The LEMSA shall send a notice of non-interest to the DOJ for lapse in certification after twelve (12) months. EMT reinstatements that require a live scan must pay the fee as required by CCR, Title 22, Division 9.
 4. Pay the application fees established by the Board of Supervisors and the State of California EMS Authority. All fees are non-refundable and non-transferable.
 5. For individuals who meet the requirements of Section C., the effective date of reinstatement shall be the day the certificate is issued. The certification expiration date will be the last day of the month two (2) years

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from the effective date.

D. Requirements of any and all applications:

1. All EMT applications shall be submitted via the LEMSA License Management System accessed through the LEMSA EMS Agency website.
2. The LEMSA will not accept applications from individuals with current negative certification action against their EMT certificate (e.g. revocation, suspension, denial, probation) until the negative certification action has been cleared by the LEMSA that took such action.
3. Falsification of any of the certification/recertification documents may result in the denial/revocation of the application.
4. In accordance with the requirements of H&SC § 1797.229 (AB2293/Reyes), the LEMSA shall collect and report to the EMS Authority ethnicity and other demographic data for all applicants.

2007 Flight Paramedic

I. LOCAL ACCREDITATION REQUIREMENTS

- A. Any individual practicing as a flight paramedic under the medical control of the Local EMS Agency (LEMSA) must be accredited by the LEMSA
- B. LEMSA flight paramedics accredited per the provisions of this policy are permitted to provide Advanced Life Support (ALS) as directed by the relevant Local EMS Agency policy, procedures and guidelines while on duty with an approved air ambulance provider agency authorized by the LEMSA.
- C. Flight paramedics practicing on duty with an ALS first response (non-transport), ground ambulance provider agency or ALS Air Rescue agency must comply with the LEMSA policy, "Paramedic Accreditation."
- D. The following requirements must be met to obtain accreditation as a flight paramedic:
 - 1. Complete the LEMSA electronic application form including the statement that the individual is not precluded from accreditation for reasons defined by California Code of Regulations.
 - 2. Pay the LEMSA flight paramedic accreditation fee, which is non-refundable.
 - 3. Successfully complete an orientation to the response area served including:
 - a. Base Hospital/medical control orientation.
 - b. EMS communications/dispatch orientation.
 - c. LEMSA's policy and procedures.

II. LOCAL ACCREDITATION PROCESS

- A. Upon satisfactory completion of items 1-2 as outlined in Section I (D) above, LEMSA shall issue an interim flight paramedic authorization, which shall be valid for not more than ninety (90) days.
- B. Flight Paramedics holding an interim flight paramedic authorization may be released to independent duty upon completion of item 3 as outlined in Section I (D) above, and when deemed competent to practice independently by the air ambulance provider agency.
- C. Upon submission of proof of completion of item 3 as outlined in Section I (D) above, the LEMSA will issue a flight paramedic accreditation with a renewal date concurrent with the applicant's California paramedic license.
- D. Applicants must complete the accreditation application and air ambulance provider agency response area orientation process outlined above within ninety (90) calendar days of the initial date of application. Applicants not completing the process within ninety (90) days of initial application shall be required to complete a new application, including non-refundable application fee.
- E. Failure to complete the local accreditation requirements shall result in suspension or revocation of accreditation to practice as a flight paramedic.

III. MAINTAINING ACCREDITATION

- A. Maintaining valid accreditation as a flight paramedic shall be contingent upon maintenance of current, valid California paramedic licensure, employment with a LEMSA-approved air ambulance provider agency and timely submission of renewal documentation including a complete LEMSA application form thirty (30) calendar days prior to the renewal date of the accreditation.
- B. Paramedics failing to maintain the requirements specified above shall be required to complete a new application, including non-refundable application fee.
- C. Individuals functioning as a flight paramedic without current valid accreditation will be reported as functioning outside of medical control to the California EMS Authority and may be subject to criminal and civil penalties.

Effective Date:

3001 DISPATCH CENTER STANDARDS

I. PURPOSE

- A. To establish minimum standards for Emergency Medical Service (EMS) Communication Centers in the LEMSA.

II. POLICY

- A. This policy authorizes the EMS communication centers for emergency medical dispatch. Eligibility for authorization will require that the EMS communication centers comply with all requirements contained in this policy.

III. REQUIREMENTS

- A. EMS Communication centers shall:
 - 1. operate in compliance with the standards of the Federal Communications Commission;
 - 2. meet minimum requirements to function as an Emergency Medical Dispatch (EMD) center consistent with the California Emergency Medical Services Authority (EMSA) requirements;
 - 3. abide by the policies, regulations and standards approved and mandated by State and Federal agencies, and the local EMS Agency;
 - 4. immediately notify the EMS Agency when the Center anticipates operational down time, defined as the inability to meet their obligation as a dispatch center being able to receive calls or dispatch resources;
 - 5. allow announced audit and on-site inspections, depending on call load, by the LEMSA Medical Director or designee.
 - 6. use a priority dispatch assignment system approved by the LEMSA Medical Director;
 - 7. ensure all calls handled by a designated communication center will be recorded and maintained in an electronic format as required by relevant law and provided to the EMS Agency upon request.

IV. DISPATCH PERSONNEL

- A. EMS Communication Centers shall provide appropriately qualified personnel to staff the center.
- B. An EMS Dispatcher shall be defined as a person who has met all requirements of the EMS Dispatcher certification. This person has:
 - 1. Completed an EMS Agency approved Emergency Medical Dispatcher course.
 - 2. Current CPR certification.
 - 3. Successfully completed written and skills certification testing.
 - 4. Completed continuing education requirements and mandatory in-service as required by the EMS Agency.
 - 5. Other requirements as determined by the EMS Agency.
- C. EMS Communication Centers shall be staff at all times with the following personnel:
 - 1. A dispatch supervisor or relief supervisor assigned specific duties to assist in the management of the EMS Communication Center.
 - 2. Appropriate level of dispatch personnel to meet accreditation standards and system demand.
- D. EMS Communication Center Quality Improvement Coordinator
 - 1. A Physician, Registered Nurse, EMT-P, EMD Instructor or Communications Manager-Supervisor shall be appointed by the EMS Communication Center and approved by the EMS Agency.
 - 2. The dispatch center shall have a CQI policy approved by the Agency.

V. SUPPLIES, EQUIPMENT AND COMMUNICATIONS

- A. EMS Communication Centers shall have available appropriate supplies and equipment to accomplish system duties including, but not limited to, adequate computer hardware and software for data collection and analysis

to meet reporting requirements.

- B. EMS Communication Centers shall have communications equipment necessary to function as an EMS Communication Center and ensure the equipment is maintained and updated to reflect current technology as follows:
 - 1. Computers and Software
 - a. EMS Communication Centers shall maintain and upgrade all computer hardware and software, as necessary.
 - 2. Telephone Systems
 - a. Telephone Systems shall have 9-1-1 primary or secondary PSAP capabilities and/or one speed dial or dedicated ring down line to primary PSAP's, each private ambulance dispatch, and Designated Fire Dispatch Centers.
 - b. EMS Communication Centers shall either be a primary or secondary PSAP unless otherwise approved by the Agency.
 - 3. Radio Equipment
 - a. Radio equipment shall have the capability of direct voice communication for all emergent calls.
 - 4. Recording Equipment
 - a. Equipment shall be capable of continuously recording all elements of dispatching. (Phone calls, radio traffic, etc.) with the capability for emergency playback.
 - b. Retention of digital records shall be for 180 days unless an unusual occurrence has occurred. In this case, the recordings should be held for a period designated by the Communication Manager.
 - 5. Backup Power
 - a. Backup power supply generator and fuel shall be available on site and adequate to continue operations for 24 hours.

VI. EDUCATION

- A. The EMS Communication Center(s) shall provide on-going education of its staff in new technology and advances in prehospital care as they relate to dispatch.



VII. DATA REQUIREMENTS

- A. At a minimum, the following data shall be collected on every call, as appropriate, by the dispatching agency responsible for tracking the units dispatched. Unless otherwise required by the Agency.
 - 1. Time of call receipt at the EMS Communication Center
 - 2. Time of dispatch of units
 - 3. Time of Units en route to call
 - 4. Time of units on scene of incident
 - 5. Time of ambulance en route to hospital or other destination.
 - 6. Time of ambulance arrived at hospital ED area or other destination.
 - 7. Time of ambulance clearing hospital or other destination.
 - 8. Time of cancellation, if applicable

IX. DESIGNATION PROCESS

- A. Initial and continuing designation, as an EMS Communication Center is contingent upon compliance with State and Federal regulations and EMS policies and procedures. Must maintain continuous accreditation as an EMD-certified communication center by a nationally recognized organization as approved by the LEMSA.



REDWOOD DISPATCH COMMUNICATIONS AUTHORITY
STANDARD OPERATING POLICY

<p>RADIO CHANNEL LINE-UP AND USE</p> <p style="text-align: center; color: green;">Green denotes most recent changes.</p> <p>Page 1 of 3</p> <p>Approvals  Spencer Andreis DOAG Chairperson</p>	<p>Policy 5</p> <p style="color: green;">Updated Date March 20, 2025 Effective Dates: ,2025</p> <p> Evonne Stevens REDCOM Executive Director</p>
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5.0 RADIO CHANNEL LINE-UP AND USE

NAME	PRIMARY ZONE/SECONDARY TAC	TX	PL	RX	PL
REDCOM	ALL ZONES	159.915	146.2	154.310	146.2
CONTROL 2	4,5,6,8	159.4575	123.0	155.265	123.0
CONTROL 3	7	158.985	146.2	154.145	146.2
CONTROL 4	3,9	159.4125	156.7	154.175	156.7
CONTROL 9	ZONE 9 BASIN	154.025	107.0	154.025	107.2
CDF WEST	COMMAND	159.390	Multi	151.460	156.7
CDF CMD 6	COMMAND	159.360	Multi	151.250	103.5
CDF CMD 2	COMMAND	159.330	Multi	151.265	103.5
CDF TAC 6	SRA/MTZ	151.325	192.8	151.325	192.8
CDF TAC 10	CDF TACTICAL	151.400	192.8	151.400	192.8
CALCORD	EMS AIR/GROUND	156.075	156.7	156.075	156.7
COAST BLUE	ZONE 4 COMMAND AND TAC	159.4425	103.5	154.1525	103.5
MEDCOM	STATEWIDE EMS OPS (BLUE1)	155.835	MULTI	155.100	192.8
ROHNERT PARK	RPDPS FIRE	156.045	103.5	154.100	103.5
XSN TAC 1	Z3 =1 + Z4/9 =2	153.770	146.2	153.770	146.2
XSN TAC 2	Z4/ =1 + Z3 = 2	154.010	146.2	154.010	146.2
XSN TAC 3	Z5 = 1	154.445	146.2	154.445	146.2
XSN TAC 5	ZONE 7 ONLY	154.250	146.2	154.250	146.2
XSN TAC 7	Zone 6 = 2	154.010	146.2	154.010	146.2
XSN TAC 8	Zone 6 = 1	154.995	146.2	154.995	146.2
XSN TAC 9	Zone 7 = 2	154.070	146.2	154.070	146.2
CDF TAC 10	CDF Tactical	151.400	192.8	151.400	192.8

REDWOOD DISPATCH COMMUNICATIONS AUTHORITY
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XSN TAC 11	RESERVE/TRAINING	154.430	146.2	154.430	146.2
XSN TAC 12	LRA FIRE AR/GROUND	153.995	192.8	153.995	192.8
XSN TAC 13	RESERVE/TRAINING	154.385	131.8	154.385	131.8
XSN TAC 14	RESERVE/TRAINING	155.895	131.8	155.895	131.8
VICTOR 6 JACKSON/T15	MA XSN TAC/Special event cmd	159.150	162.2	155.3775	156.7
VICTOR 6 BODEGA/T8	MA Tactical Coastal Only	159.150	103.5	155.3775	156.7
VICTOR 6 RACEWAY/T5	MA Tactical/Raceway CMD	159.150	146.2	155.3775	156.7
TACTICAL INFO >	1= PRIMARY AND 2 = SECONDARY				
INTEROPERABILITY STATE OF CALIFORNIA					
COMM WEST	CAL OES INTEROP RPT/Associated w/vtac11 requires OES approval	156.210	162.2	151.1375	156.7
COMM EAST	CAL OES INTEROP RPT/Associated w/vtac12 requires OES approval	156.0675	162.2	154.4525	156.7
COMM NORTH	CAL OES INTEROP RPT/Associated w/vtac13 requires OES approval	156.1500	162.2	158.7375	156.7
COMM COAST	CAL OES INTEROP RPT/Associated w/vtac14 requires OES approval	158.8725	162.2	154.4000	156.7
VFIRE 21	CAL OES MA TAC	156.2800	156.7	156.2800	156.7
VFIRE 22	CAL OES MA TAC	154.265	157.7	154.265	157.7
VFIRE 26	CAL OES MA TAC	154.3025	157.7	154.3025	157.7
VCALL10	Ntl Interop Calling	155.7525	157.7	155.7525	None
VTAC11	Ntl Interop Tac	151.1375	157.7	151.1375	157.7
VTAC12	Ntl Interop Tac	154.4525	157.7	154.4525	157.7
VTAC13	Ntl Interop Tac	158.7375	157.7	158.7375	157.7
VTAC14	Ntl Interop Tac	159.4725	157.7	159.4725	157.7

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Effective Dates: ,2025

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Spencer Andreis
DOAG Chairperson


Evonne Stevens
REDCOM Executive Director

5.3 A tactical frequency shall be assigned by the CRO after the supplemental information is provided to the responding units. On first alarm assignments inclusive of (Structure Fires, vegetation Fires, TC-EX and Rescue) the assigned tactical channel for that zone shall be assigned if not in use. If unavailable due to another incident utilizing the primary tactical channel, the secondary tactical channel assigned to that zone shall be utilized as noted in ***above.

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DOAG Chairperson


Evonne Stevens
REDCOM Executive Director

5.3.1 Once incident command has been established, arriving resources shall switch to the assigned Tactical Channel after placing themselves ON SCENE by radio or MDC. All radio traffic between incident management personnel (such as division and group supervisors) and resources operating on the incident shall be conducted on the tactical channel.

5.3.2 The Assignment of the Tactical Channel is not necessary for normal routine incidents such as Medical Aids, Traffic Collisions without extrication, or single engine fire responses.

5.4 A secondary tactical will be assigned for all structure and vegetation fire in addition to the primary tactical. The secondary tactical (VFIRE 22) will be designated for all zones and strictly used only for the “Incident within the Incident” (IWI). If an incident commander requires an additional frequency for an expanding incident, he/she must request such through the CRO.

5.5 Assignment of Control 9 (Formerly Petaluma Red) as an incident control channel is an option for the REDCOM dispatcher to consider. Its use shall be limited to southern Sonoma County agencies only.

5.6 An agency requesting a tactical channel for non-emergency use (e.g. training, parades, etc.) shall be assigned a surplus frequency that is unassigned (XSN tactical 11-13).

3002 Dispatch Channels

I. LEMSA DESIGNATION

- A. As the FCC license holder, the individual counties within the LEMSA Region may designate or grant permission to ambulance providers to operate on the radio system.

II. EQUIPMENT

- A. All ambulances operating within the LEMSA Region shall have the appropriate equipment capable of communicating with the designated EMS Dispatch center in their assigned county of operation.

III. CELLULAR

- A. Alternate communications technologies such as cellular telephone and EMS approved "trunked radio" may be used as an adjunct to the communication system outlined within this policy.

IV. UHF CAPABILITY

- A. Each ALS ambulance shall have UHF capability Med channels 1-10.

V. MENDOCINO COUNTY EMERGENCY DISPATCH CHANNELS

- A. All Mendocino County ambulance providers must have these primary Mendocino County Fire frequencies:
 - 1. 153.950/154.385
 - 2. CTTS PL=s 123.0, 110.9, 192.8, 131.8, 151.4
 - 3. Also, MED 9 + 10 for dispatch
 - 4. UAS - MED 9
 - 5. Willits- MED 10
 - 6. Ukiah Fire - 154.010/154.010 PL3

VI. EMERGENCY DISPATCH CHANNELS

- A. The LEMSA authorizes all approved EMS providers to operate on EMS frequencies as published by designated dispatch centers.

3003 Availability of Ambulances

I. RESPONSIBILITY

- A. Ambulance provider shall keep EMS Dispatch advised at all times of any circumstances which may change the level of service or capability of the ambulance provider to deliver emergency service within its designated response zone.

II. AVAILABILITY OF AMBULANCES

- A. An emergency service ambulance is considered available once staffed with a crew of at least two (2) qualified provider agency personnel and is ready to be dispatched.
- B. An ambulance which is occupied by a patient is not considered available.

III. AVAILABILITY STATUS

- A. Within the LEMSA region, EMS system designated ambulances shall inform EMS Dispatch of their movements and status including response to emergency calls, pre-arranged calls, post moves and routine movements.

IV. AMBULANCE ZONES

- A. Ambulance Zones are defined within the EMS Plan.
- B. Any changes to ambulance zones shall be in accordance with statute, regulation, and relevant county ordinance.

V. PROHIBITED DISPATCH

- A. A provider shall not dispatch an ambulance as a result of information obtained by monitoring a radio frequency assigned to a public safety agency unless directed to do so by EMS Dispatch.
- B. Field units shall not initiate a Code 3 response to a call as a result of information obtained by monitoring a radio frequency assigned to a public safety agency unless directed to do so by EMS Dispatch.

3004 Medical Dispatch Standards

I. PURPOSE

This policy applies to all EMS dispatch personnel, emergency call centers, and EMS providers operating under the medical control of the LEMSA Medical Director. This policy establishes the standards and protocols for Emergency Medical Services (EMS) medical dispatch in compliance with:

- A. State of California statutes and regulations
- B. International Academies of Emergency Dispatch (IAED) standards.
- C. Medical Priority Dispatch System (MPDS)
- D. California Vehicle Code

II. MEDICAL DISPATCH PROTOCOLS

- A. Call Triage and Prioritization
 1. Upon receipt of an emergency medical call, the dispatcher shall follow the IAED Medical Priority Dispatch System (MPDS), which utilizes a structured, protocol-based approach to categorize and prioritize emergency calls based on the severity of the medical situation.
- B. Priority for dispatch shall be determined based on the criteria established in the IAED standards and local EMS medical direction.
- C. If EMD cannot be performed the dispatch center retains the authority to dispatch all resources at the CHARLIE priority level.

III. PRIORITIZATION CATEGORIES ARE DESIGNATED AS:

- A. OMEGA = eligible for referral to alternate medical resources as determined by the LEMSA Medical Director. Without specific direction, all OMEGA determinant calls shall be dispatched as ALPHA priority EMS assignments.
- B. ALPHA = Code 2 all units
- C. BRAVO = Code 3 first due resource, Code 2 second due resource
- D. CHARLIE = Code 3 first ALS resource, Code 2 Second ALS resource
- E. DELTA = Code 3 all units
- F. ECHO = Code 3 all units

IV. PRE-ARRIVAL INSTRUCTIONS (PAIS)

In accordance with IAED standards, and as approved by the LEMSA Medical Director, dispatchers must provide appropriate Pre-Arrival Instructions (PAIs) to callers based on the symptoms or situation described. These instructions are designed to help stabilize the patient before EMS units arrive.

4001 ALS FIRST RESPONDER AUTHORIZATION AND APPROVAL PROCESS

I. PURPOSE

- A. To outline the criteria and process for Public Safety Agencies to receive Local EMS Agency (LEMSA) authorization to become Advanced Life Support (ALS) Service Providers within the LEMSA jurisdiction.

II. POLICY

- A. Cities, Special Districts and County Departments within LEMSA jurisdiction are eligible to receive approval to provide ALS services if authorized by the public agency governing board and approved by the Medical Director of the LEMSA to do so.

III. APPLICATION PROCESS

- A. The applicant shall submit a written request for approval of ALS Provider status to the LEMSA Administrator. The request shall include the following:
 - 1. The desired implementation dates.
 - 2. Geographic area to be served.
 - 3. Emergency response procedures and standards.
 - 4. The number of ALS units desired and the proposed location for each unit.
 - 5. The preferred Base Hospital assignment (subject to LEMSA approval).
 - 6. Other information pertinent to the proposed ALS program (e.g. the number of personnel licensed and accredited as Paramedics, the number of personnel requiring Paramedic training, and the name and contact information of the EMS Education Paramedic Coordinator).
 - 7. The name and contact information of the Provider Agency Medical Director/Drug Authoring Physician, under whose license the Provider Agency will procure equipment, pharmaceuticals (both scheduled and non-scheduled), and medical devices.
 - 8. Provision of emergency medical service response on a continuous twenty-four (24) hour per day basis or submission of a justification for consideration to waive the 24-hour/day requirement. Waivers shall be granted on a case-by-case basis for provision of services such as:
 - a. Law Enforcement Special Weapons or Tactical Squads; or
 - b. County-approved Search and Rescue Services; or
 - c. County-approved Hazardous Materials Services; or Public Boat Patrol Services; or
 - d. Public Lifeguard; or
 - e. Otherwise specified by the EMS Agency.
 - 9. Submission of a Continuous Quality Improvement (CQI) Plan.
 - 10. A plan and process to provide designated quality improvement reports to the LEMSA
 - 11. A plan to coordinate with ALS ground ambulance companies and response to mutual aid requests.
 - 12. Disclosure of any compensation and fees for services.
 - 13. Designation of an individual to serve as the liaison for training and quality improvement that will work with and participate with the LEMSA for the provider-based quality improvement, training issues, and will attend continuous quality improvement committee meetings.
 - 14. A plan to respond to emergency medical requests with a minimum staffing level of at least one (1) person who shall be a locally accredited Paramedic.
 - 15. Description of the communication equipment that will be used by the ALS Service Provider

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16. A controlled substance policy that outlines how scheduled pharmaceuticals will be procured, stored, secured, and distributed. The policy shall include procedures for handling any lost or tampered scheduled pharmaceuticals.
 17. A supply/resupply policy that outlines the method for purchasing and storing non-scheduled pharmaceuticals and medical devices.
 18. A policy/procedure to ensure that all ALS units and Paramedic personnel are visibly identified (only for 24-7 operations).
 19. Implementation and use of a compliant Electronic Patient Care Record (ePCR) system that meets all state and local requirements.
 20. A list of all the ALS units, numerical description, physical address, and contact number for the location of each unit.
- B. The information listed above that is required for approval is due to the LEMSA as a completed packet.

IV. PROVIDER AGENCY REQUIREMENTS

- A. Utilize and maintain communications as specified by the LEMSA.
- B. Ensure all ALS personnel maintain competency in paramedic scope of practice including any local optional scope of practice approved for the LEMSA.
- C. Procure and maintain equipment, supplies, and pharmaceuticals for each ALS unit, as outlined in the applicable policies. Ensure that all deployed unit(s) are fully stocked.
- D. Complete an MOU for the provision of Medical Control by the LEMSA Medical Director to the ALS Service Provider to include provision for cost recovery related to Provider Agency oversight.
 1. MOUs signed for the purpose of ALS Service Provider Medical Control shall not be construed by the Provider Agency or the LEMSA as an agreement to relieve or vacate any rights or obligations a City or District may hold as described in Health and Safety Code.
- E. Appoint a Paramedic Coordinator to act as the liaison between the LEMSA and the assigned Base Hospital.
- F. Utilize the ePCR system to document all patient responses and ensure all personnel comply with LEMSA documentation requirements. If ALS Provider will not use LEMSA ePCR system for such reporting, Providers' ePCR system must be integrated both initially and on an ongoing basis, at Provider's cost with LEMSA data system and must meet state and local requirements for data submission.
- G. Staff each approved ALS response unit with a minimum of one (1) licensed and locally accredited Paramedic.

V. LEMSA REQUIREMENTS

- A. Acknowledgement of the applicant's request in writing and furnish a generic template copy of the applicable ALS Service Provider MOU. A finalized Agreement will be mailed under a separate cover for execution. A fully executed Agreement must be in place prior to program implementation.
- B. Approval or rejection of the request for ALS Provider status based on the LEMSA review of the documents submitted by the applicant no later than 90 days from submission of a completed application.
- C. Periodic performance review, including field observations, to ensure compliance with state laws and regulations, local policy, medical control, and the ALS Service Provider MOU.
- D. Provide a collaborative problem-solving approach to address any issues in a non-punitive manner prior to taking any negative actions described in this policy.
- E. Protect public health and safety through denial, suspension, or revocation of the approval of ALS Provider upon failure to comply with applicable policies, procedures, and regulations.
- F. Public Safety agencies may appeal any denial or revocation of ALS Provider approval in accordance with California Health and Safety Code.

Effective Date:

4002 VEHICLE STANDARDS

I. PURPOSE

- A. To establish minimum ambulance standards.

II. Vehicle Requirements

- A. Ambulances shall meet standards specified in Title 13, Chapter 2, California Vehicle Code, and each shall possess a valid emergency vehicle permit issued by the California Highway Patrol (CHP). Agencies exempt from the above standard must still comply with LEMSA requirements for equipment, medication and contractual standards. All ambulances shall be maintained in good working order.

III. SAFETY EQUIPMENT

- A. Safety equipment as required per CHP specifications will be carried on all ambulances and maintained in good working order.
- B. A child safety restraint shall be incorporated/available in each transport vehicle.

IV. EQUIPMENT AND SUPPLIES

- A. All vehicles shall meet the requirements listed in LEMSA policy for minimum equipment and supplies inventory.

V. SPECIALTY IDENTIFICATION

- A. No ambulance shall display specialty service(s) on the unit unless that unit is staffed, licensed and equipped to provide that level of service.

VI. RIGHT TO INSPECT

- A. The LEMSA reserves the right to inspect all ambulances within its LEMSA jurisdiction at any time.

4003 Supplies and Medication

I. MINIMUM EQUIPMENT

- A. All Transport or 1st Response will be equipped with at least the equipment described in the Administrative Guideline # 4004 Addendum List. Providers are expected to maintain quantities sufficient for historical daily patient contact volume.

II. REMOVAL OF SUPPLIES FROM ALS UNIT

- A. If a Transport or 1st Response unit is not staffed or available for response at the ALS level, the provider shall ensure all ALS equipment and medications will be secured from use or removed from the unit.

III. EQUIPMENT AND SUPPLY INSPECTION

- A. LEMSA personnel may inspect Transport or 1st Response units at any time for compliance with the identified minimum standards for equipment and personnel. Deficiencies may result in the unit's removal from service until the deficiencies are remedied.
- B. The LEMSA will notify the Provider's designated management representative immediately of the infraction.

IV. DRUGS AND MEDICATIONS

- A. The list of drugs, medications, solutions and supplies as listed in the addendum is the minimum number to be carried on each Transport or 1st Response unit. Requests for exemptions to this section will be considered by the LEMSA on an individual basis.
- B. Use of any drug, medication, needle, catheter or specialized ALS equipment outside the scope of the ALS program or personnel certification or licensure is cause for immediate suspension and for revocation of certification/licensure as well as potential criminal and civil liability.
- C. All controlled substances will be kept in a secure manner at all times. Controlled substances will be secured properly and appropriately to prevent losses by any means. The ALS provider agency is responsible for ensuring that this security occurs, as well as supervising adequate record keeping as described below or required by the Authority cited.

V. CONTROLLED SUBSTANCES INVENTORY LOG

- A. An inventory of controlled substances assigned to an ALS Ambulance or ALS 1st Response unit will be complete and a record maintained. Controlled substances will be accounted for, attained, stored and administered in compliance with the intent of DEA - Controlled Substance Manual Standard.
- B. The ALS provider agency is responsible for ensuring that this security occurs, as well as supervising adequate record keeping as required by the Authority cited. The LEMSA requires all controlled substances to be kept in a secure manner at all times, properly and appropriately to prevent losses by any means.

VI. CONTROLLED SUBSTANCES TRACKING MECHANISM

- A. A record of any use of controlled drugs by an ALS Ambulance or ALS 1st Response unit will be maintained.
- B. If theft or unusual occurrences are suspected a LEMSA Event form will be completed along with reporting per the provider internal policy for reporting discrepancies.

VII. Medication Shortages and Substitutions:

- A. EMS service providers may face critical drug shortages from time to time. The LEMSA is requesting ALS Providers regularly update the EMS Agency on medication supply problems. The EMS Agency is also providing the following direction in regard to the shortages:

Effective Date:

1. Designated shortage medications should be limited to truly critical situations (Midazolam for seizures, not anxiety).
2. It may become necessary to use medications that have different packaging and/or concentrations. This creates the potential for dosing errors and changes must be accompanied by training.
3. Expired drugs shall be stored and monitored in a separate, clearly designated area according to manufacturer's recommendations. If medications cannot be procured, despite extensive efforts including using alternative sources, drugs can be used up to 6 months after their expiration date.
4. Providers using medications past manufacturer's expiration date shall advise the EMS agency weekly in writing of:
 - a. efforts made to resupply with non-expired medications
 - b. total volume and type of expired medications administered
5. Providers using medications past manufacturer's expiration date shall maintain a log documenting instances such medications were administered.
6. Refer to current medications and currently approved medication substitutions list located on the LEMSA website. [\(Add hotlink\)](#)

Please contact the LEMSA for any needed clarification.

Effective Date:

4004 Ambulance Service Provider Permits

I. PURPOSE

- A. Provide structure for the regulation of private ambulance providers within the Local EMS Agency (LEMSA) jurisdiction.

II. POLICY

- A. Any entity (either as an owner, agent or otherwise) who wishes to furnish, operate, conduct, maintain, or otherwise engage in, or offer, or profess to engage in providing ambulance service within the jurisdiction of the LEMSA shall have a valid ambulance service provider permit in accordance with County ordinance and this policy.
- B. Permits are required for the provision of:
 - 1. 911 and/or emergency ambulance services
 - 2. Advanced Life Support (ALS) interfacility ambulance transportation services
 - 3. Basic Life Support (BLS) ambulance transportation services
 - 4. Critical Care Transport (CCT) ambulance transportation services
 - 5. Air ambulance services
- C. Exceptions
 - 1. Public agencies, including, but not limited to, cities, special districts or county public service providers providing the services in subsection B., above, are exempt from the requirement to obtain an ambulance provider permit per Sonoma County Ordinance Sec 28-6 and Mendocino County Code Sec 9.05.210 (the County Ambulance Ordinances).
 - a. Any privately organized or not-for-profit ambulance service provider contractor providing services to a governmental agency shall be subject to all permitting requirements.
 - i. Contract language between government agency and ambulance contractor will be reviewed by the LEMSA designated staff for roles and responsibilities related to patient care, certification, certification/license disciplinary action, and safety provisions within the relationship and subject to comment or clarification as a condition of the ambulance provider permit approval process.
 - ii. Nothing in this Policy shall be construed to allow a public agency or private entity to independently authorize a third party to provide the services in subsection B., above, within Sonoma or Mendocino Counties.
 - b. Those entities not subject to permitting are subject to the equipment, requirements, and standards for ambulance providers specified in the LEMSA Administrative Policy and Treatment Guidelines and relevant County Ambulance Ordinances and are subject to an attestation agreement regarding medical control with the LEMSA affirming an intention to comply with each.
 - 2. A permit shall not be required for vehicles operated as ambulances at the request of local authorities during any "state of war emergency," duly proclaimed "state of emergency," or "local emergency" as defined in the California Emergency Services Act (Chapter 7 of Division 1 of Title 2 of the Government Code) as amended.
 - 3. Ambulances based and properly licensed outside of the LEMSA area may transport patients within the LEMSA area without compliance with this chapter provided:
 - a. The patient is being transported to a residence or facility within the LEMSA area from a residence or facility outside of the area; or,
 - b. The patient is being transported through the LEMSA area to a destination outside the area; or,
 - c. The patient was transported into the LEMSA area by the same operator and is to be transported back to the county of origin by the same ambulance unit; or,
 - d. An agreement exists between contiguous counties for emergency medical services by ambulances.

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4. Nothing in this Policy should be read to exempt any ALS ambulance service provider (including exempt public agency providers such as cities, special districts, or county public service providers) from compliance with the Administrative Policies and Treatment guidelines, respective County Ambulance Ordinances, and California Code of Regulations.
5. All ambulance service providers delivering BLS and/or CCT services within the LEMSA jurisdiction (including exempt public agency providers, which include, but are not limited to, cities, special districts, or county public service providers), shall comply with the Administrative Policies and Treatment guidelines and respective County Ambulance Ordinances and be subject to a provider agreement specific to the services provided in accordance with the County Ambulance Ordinances.

III. PERMIT APPLICATION REQUIREMENTS AND PROCESS

- A. Permit applicants shall submit in writing, on a form(s) provided by the LEMSA, the following minimum information:
 1. Name and description of the applicant.
 2. Business address and resident address of record of the applicant.
 3. Location of each ambulance station and number and level of ambulances therein stationed.
 4. Trade or firm name or Doing Business As (DBA) as recorded.
 5. If a corporation, a joint venture, or a partnership or a limited partnership, the names of all partners or the names of corporate officers, their permanent addresses, and their percentage of participation in the business.
 6. An organizational chart, including the applicant's parent or subsidiary entities or agencies, if any.
 7. A statement identifying the services to be provided.
 8. A general description of the geographic area in which the applicant proposes to provide the service.
 9. A statement that the applicant shall comply with all applicable federal, state, and local laws and regulations, and LEMSA policies, procedures, protocols, and guidelines.
 10. For prospective emergency ambulance service providers only:
 - a. A statement of facts showing the experience or capability of the applicant to provide emergency ambulance service and that the applicant is qualified to render efficient twenty-four (24) hour ambulance service.
 - b. A statement that the applicant shall not:
 - i. Provide emergency ambulance services within any ambulance response zone assigned to another provider pursuant to County ordinance and current EMS plan.
 - ii. Provide any services that are designated as exclusive within an EOA designated by the LEMSA in the current EMS plan, unless expressly authorized by the LEMSA to provide such services pursuant to this Policy, the County Ambulance Ordinances, and state law.
 - iii. Exceptions: Subsection 10(b), above, shall not apply:
 - (a) During any proclaimed "state of emergency" or "local emergency".
 - (b) With specific written permission of the LEMSA; or
 - (c) As Mutual Aid pursuant to a written mutual aid agreement with the provider assigned to the response zone.

(1) "Mutual Aid" means resource sharing in which similar organizations assist each other during emergencies and day-to-day operations pursuant to a written mutual aid agreement.

"Mutual aid" includes the following:

- Auto/Instant Aid: Agreements between two or more jurisdictions where the nearest available resource is dispatched to an emergency irrespective of jurisdictional boundaries or where two or more agencies are automatically dispatched simultaneously to predetermined types of emergencies or in predetermined

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situations. This type of mutual aid agreement is typically utilized on a day-to-day basis.

- Mutual Aid: Agreements between two or more jurisdictions to provide assistance across jurisdictional boundaries, when requested, as a result of the circumstances of an emergency exceeding local resources.
- Disaster Assistance: Similar to mutual aid but are requests for assistance in the event that a disaster overwhelms local resources. These requests may be under existing mutual aid agreements or the result of unforeseen needs arising from a particularly large-scale disaster.

(2) One defining element of mutual aid is that it is initiated by an agreement with or request from the response zone provider. Here, such a request or agreement may be operationalized in the form of instructions to a LEMSA approved dispatch center from the response zone provider and the mutual aid provider. There may be a standing agreement between both agencies to activate mutual aid when certain conditions exist, or mutual aid may be provided on an ad-hoc basis when unforeseen circumstances arise. In no case may one provider unilaterally respond into another response zone without the expressed permission of the designated response zone provider.

- c. A statement that the applicant shall pay all applicable EMS dispatch fees which may be a direct charge from the designated 911 dispatch center.
- d. A background and need study including:
 - i. A description of the prehospital care system currently in place in the area(s) wherein the applicant proposes to provider services;
 - ii. An explanation and supporting documentation of prehospital care services that provider desires to bring to the affected area;
 - iii. A description and documentation (in numerical terms where possible) of the anticipated improvement in prehospital care achieved by adding provider to the area described.
 - iv. Evidence of community support within the affected area;
 - v. The background and need study requirement shall not apply to any EOA providers to the extent the services for which a permit is sought are authorized and regulated by an EOA Agreement.
11. A statement that the applicant owns or has under its control the required equipment to conduct an ambulance service that meets the requirements established by the California Vehicle Code, California Code of Regulations, the LEMSA Administrative Policies and Treatment Guidelines, the appropriate County Ordinances and regulations adopted pursuant thereto, and that the applicant owns or has access to suitable and safe facilities for maintaining services ambulance in a clean, sanitary, and good mechanical condition.
12. A statement giving a complete description of each ambulance vehicle operated by the applicant, including the patient capacity thereof and a copy of the most recent Ambulance Inspection Report and license issued by the California Highway Patrol for each vehicle. If the applicant is exempted by statute or regulation from CHP permitting, the applicant may substitute an attestation that the applicant is aware that compliance with the applicable CHP regulations is required by law, and applicant agrees to comply with such applicable CHP regulations.
13. A statement that the applicant employs sufficient certified, licensed and accredited personnel adequately trained to deliver emergency medical services of good quality at all times.
14. A list of currently accredited and certified personnel associated with the provider will be provided and the provider agrees to update the personnel list as needed within the LEMSA License Management System and shall be provided to the LEMSA before the start or renewal date of ambulance permits.
15. A schedule of rates including any special rates to be charged by the permittee for ambulance services provided.
16. An attestation to agree to the following:

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- a. Private service ambulance dispatch centers may dispatch ambulances within the LEMSA area if approved by the LEMSA.
 - b. Such approval must include a requirement that the LEMSA approved system of call triage, including a process to refer urgent calls received on any phone line to EMS dispatch.
 - c. An acknowledgment that the LEMSA can audit the dispatch of records of dispatched ambulances as a condition of permitting. Ambulance dispatch centers other than the approved EMS dispatch center are not authorized to receive calls from Public Safety Answering Points (PSAPs).
17. A statement that the applicant shall pay all applicable fees as determined by the applicable County Board of Supervisors.
 18. A statement acknowledging the right of the LEMSA staff to inspect vehicles, medications, equipment, business, and staff records for compliance related to any policy, regulation, or laws related to the permit process or delivery of ambulance service.
 19. A Statement that the applicant agrees to use an electronic health record system that exports data in a format that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements that are required by the LEMSA.
- B. In addition to complying with permitting requirements, if applicable, prospective 911 ambulance providers for areas within the LEMSA jurisdiction that are currently designated emergency response zones must conform to the process outlined within County Ordinance.
 - C. Applicants for permits to operate ALS ambulance service are required to enter into a Memorandum of Understanding, Statement of Acknowledgment or Contract as required under any applicable policy of the LEMSA to comply with California Code of Regulations.
 - D. Upon the receipt of a completed application, the LEMSA shall review to determine whether the application is complete as to form and whether the applicant is eligible for consideration of a permit in accordance with local Ordinance(s) and EMS policies.
 - E. The LEMSA shall notify the applicant within 30 calendar days of application receipt that the application is complete as to form or provide a list of missing requirements.

IV. PERMIT APPLICATION FEES AND REVIEW

- A. County shall have the ability to recover the reasonable regulatory costs for issuing licenses and permits, performing investigations, inspections, and audits, enforcing orders, and the administrative enforcement and adjudication thereof through the establishment of fees in accordance with the relevant County Board of Supervisors fee schedule.
- B. The LEMSA staff may issue a written decision on the permit application within 30 days from notification that the application is complete as to form and eligible for consideration of permit. The LEMSA shall notify the applicant if the permit consideration will require more than 30 days.
- C. The LEMSA shall issue a written decision on a completed permit application within 60 days from notification that the application is complete.
- D. The LEMSA may include conditions in an ambulance service provider permit as necessary to ensure an applicant's operations are consistent with public health, safety, and welfare, the EMS system, applicable laws, regulations, and the LEMSA policy.
- E. Renewal of any Ambulance Service Provider Permit shall be conditioned on the permit applicant or holder remitting any established fees that are approved by the County.

V. INSURANCE

- A. Permit holders shall obtain and keep in force during the term of said permit,
 1. General liability for vehicle operation which shall be public liability and bodily injury insurance issued by a company authorized to do business in the State of California, insuring the owner and also naming the

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County as an additional insured of such ambulance against loss by reason of injury or damage that may result to persons or property from negligent operation or defective construction of such ambulance, or violation of the respective County ordinance and/or EMS policies and procedures or of any other law of the State of California or the United States. Said policy shall be for not less than one million dollars (\$1,000,000) combined single limit for personal injury and property damage for each vehicle in any one accident.

2. Workers Compensation Insurance shall be carried covering all employees of the permit holder.
 3. Medical Liability - The permittee shall defend, indemnify and hold harmless the County, its agents, and employees, from and against any and all claims and actions for damages or losses to persons or property arising out of or in connection with the activities of the permittee, his/her agencies or employees in which the claim or action against the County is in any way derived from or vicariously based upon the activities of the permittee, his/her agencies or employees. Said defense and indemnification shall include, but not be limited to, any and all costs, expenses, attorneys' fees, any liability incurred in defense of such claims or actions whether the same proceeds to judgment or not. The permittee shall maintain comprehensive medical liability insurance in the amount of one million dollars (\$1,000,000) and shall furnish the LEMSA with a certificate of insurance before issuance or renewal of an operational permit. Said policy shall name the County as coinsured and shall require a minimum of 15 calendar days' notice to be given to the County prior to cancellation, modification, or reduction in limits.
- B. Copies of the policies or certificates evidencing such policies shall be filed with the LEMSA before a permit is issued. All policies shall contain a provision requiring a minimum of 15-calendar days' notice to be given to the County prior to cancellation, modification, or reduction in limits. The amounts of public liability insurance for bodily injury or property damage and medical liability shall be subject to review and adjustment annually at the LEMSA's option.

VI. PERMIT TERMS AND AMENDMENTS AND VARIANCES

- A. The Policy is effective **date to be determined** (the Effective Date) for any new providers entering into LEMSA's jurisdiction.
- B. Providers operating as of the Effective Date may continue for six (6) months, when permit applications will be due for providers that were operating as of the Effective Date. These existing providers may continue to provide the same type of service while their application is pending; provided, however, that nothing in this Policy shall be construed to allow an existing provider to continue to provide any services designated as exclusive within an EOA unless the existing provider is the EOA's designated provider or the subcontractor of EOA's designated provider.
- C. Any rights under sub-section (B) above are terminated 6 months from effective date, if no application is submitted, or upon LEMSA's initial determination to grant or deny the permit, whichever happens sooner.
- D. Nothing in the Policy overrules stricter standards in an agreement with the LEMSA.
- E. The terms and conditions in a permit issued to an EOA provider or its subcontractor regarding exclusive services in an EOA shall be the same as the terms and conditions in the corresponding EOA Agreement for the EOA between the respective County and the EOA provider.
- F. In the event of a conflict between an EOA Agreement and this Policy and the permits issued hereunder, the EOA Agreement shall govern.
- G. Initial permits issued under this Policy shall be effective for one (1) calendar year from the date the permit is issued. Renewal permits issued under this Policy shall be effective for three (3) years from the date the permit is issued.
- H. Permits may be renewed upon application of the permittee if it is determined that the permit holder has during the period of the expiring permit operated in conformity with this Policy, County Ambulance Ordinances, laws, regulations, policies, and procedures and that the permittee is capable of continuous operation in conformity. Requests for renewal shall be submitted no later than 45 days before the expiration on the LEMSA Permit Renewal Application.

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- I. Annually, or more often if requested by the EMS Medical Director, each permittee shall submit compiled patient and ambulance operation information.
- J. Permits may be amended during the renewal process provided that such amendments shall continue to conform to all applicable provisions of the respective ordinance and this Policy.
 - 1. Upon request by the permittee, the LEMSA may amend the conditions specified in the permit if such changes are in substantial compliance with the provisions of the respective ordinance and any policies or procedures.
 - 2. Such amendments shall not affect the expiration date of the existing permit. Such amendments shall not authorize a change in ownership from that specified in the original permit.
 - 3. Change in the level of service shall not be allowed unless in substantial compliance with the LEMSA EMS Plan.
 - 4. A permittee must conform to the requirements of the permit unless a revision is approved by LEMSA.
- K. At the discretion of the LEMSA, a temporary operating permit may be authorized for an ambulance service based outside the county and properly licensed by the California Highway Patrol for up to thirty (30) days for special activities.
- L. Permits issued under this Policy are non-transferable.
 - 1. In the event of a change in ownership of any kind or nature, any interruption of service of more than twenty-four (24) hours duration for 911 providers, or any substantial change in staffing, location, or equipment of the ambulance service which causes the ambulance service to be carried out differently than specified in the current operating permit, the permittee shall notify the LEMSA immediately in writing stating the facts of such change.
 - 2. Upon request by the permittee, the LEMSA may grant a temporary variance from the condition so specified in the original permit if the LEMSA finds that such change is in substantial compliance with the provision of the relevant County Ordinance, EMS policies and procedures, and any applicable law.
 - 3. In all cases when a change of ownership occurs in an ambulance service, an application for a new permit shall be filed with the LEMSA within thirty (30) days. In no case shall any temporary variance be valid for more than sixty (60) days without the written approval of the LEMSA.
- M. Permittee shall notify the LEMSA in writing within thirty (30) days of any other changes in the information outlined in any application or certification document required by the LEMSA.
- N. Permittees that provide 911 and/or emergency ground ambulance services shall render services required under the respective ordinance and/or EMS policies and procedures on a twenty-four (24) hour-a-day basis unless specifically exempted by the LEMSA. Such service shall commence five (5) days after the issuance of a permit unless the LEMSA grants the time limitation.

VII. INTERRUPTIONS OR DISCONTINUATION OF SERVICE FOR 911 PROVIDERS

- A. Permit holders shall immediately notify the LEMSA and other affected public safety agencies beforehand of any known or foreseeable interruptions, suspensions, or delays in services that may endanger the health, safety, and welfare of the residents of the area covered by the ambulance service.
- B. Ambulance services shall not discontinue any services to any area without first providing written notice to the LEMSA at least ninety (90) days before the proposed discontinuance. Failure to do so may result in revocation of any permit issued under this Policy.

VIII. RIGHT OF INSPECTION

- A. The LEMSA shall inspect the records, facilities, vehicles, equipment, and methods of operation whenever such inspections are deemed necessary. Each permitted ambulance service, its equipment and premises, vehicle maintenance records, and records of calls shall be open to inspection by the LEMSA during usual hours of operation.

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IX. NOTIFICATION OF ACTIONS BY GOVERNMENT AGENCIES

- A. Permit holders shall notify the LEMSA within five (5) days after the receipt of the results of all vehicle inspections conducted by the State and of any disciplinary action taken by any Federal, State or County agency regarding any ambulance license or related to the provision of ambulance services.

X. DENIAL, SUSPENSION AND REVOCATION OF PERMITS

- A. A permit may be denied if the applicant or its employees, partners, officers, or directors commits or has committed any of the actions listed in the California Health and Safety Code. In addition, a permit may be revoked or suspended for the following:
 1. Applicant or permit holder knowingly makes any false statement or fails to disclose or suppresses another from disclosing material facts in an application, report, or other document furnished to the LEMSA.
 2. Applicant was previously the holder of a permit issued under the local Ordinance in which a permit has been revoked or not reissued and the terms or conditions of the suspension have not been fulfilled or corrected.
 3. Applicant is committing any act which, if committed by any permittee would be grounds for denial of a permit issued pursuant to the local Ordinance.
 4. Applicant has acted in the capacity of a permitted person or firm under the local ordinance without having a valid permit,
 5. Applicant or permit holder has entered a plea of guilty to, or been found guilty of, or been convicted of a felony or a crime involving moral turpitude, and the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal irrespective of an order granting probation following such conviction suspending the imposition of sentence, or of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such person to withdraw his plea of guilty and to enter a plea of not guilty, or setting aside the plea or verdict of guilty, or dismissing the accusation of information.in the case of an applicant,
 6. Applicant or permit holder is not the real party in interest in the business.
 7. Applicant or permit holder operates ambulance service in violation of any provision of the local ordinances or any other law, regulation, or policy of the County, State, or Federal government pertaining to the operation of an ambulance or ambulance service.
 8. Applicant or permit holder has breached an agreement with a local government regarding the provision of ambulance services.
 9. Applicant or permit holder knew or should have known of falsified data supplied to the LEMSA, or another governmental entity, local, state, or federal, during the course of operations, including, but not limited to, dispatch data, patient report data, response time data, financial data, or falsification of any other data permittee is required to submit to the above-named agencies.
 10. Failure to pay permit or other fees as required by a respective ordinance and/or assessed by the LEMSA.
 11. Applicant or permit holder provided emergency ambulance and/or advanced life support ambulance services within an EOA designated by the LEMSA without specific written permission of the LEMSA or in the absence of a written Mutual Aid agreement with the designated EOA provider.
 12. Failure to obtain or maintain appropriate state, county, or federal permits or licenses.
 13. Applicant or permit holder director or representative and/or staff is required to register as a sex offender under the provisions of Section 290 of the California Penal Code and continues to be involved in the operation of ambulance service.
 14. Applicant or permit holder director or representative habitually or excessively uses or is addicted to the use of narcotics or dangerous drugs.
 15. Applicant or permit holder director or representative habitually or excessively uses intoxicating beverages. In the case of a driver has been culpably involved during the preceding year in any motor vehicle accident, causing death or bodily injury or in three or more motor vehicle accidents.

16. Applicant or permit holder director or representative has been convicted during the previous seven years of any offense involving moral turpitude, including fraud or intentional dishonesty for personal gain.
17. Applicant or permit holder director or representative has been convicted during the preceding seven years of theft or any felony involving force, violence, threat, or intimidation.
18. Applicant or permit holder director or representative and/or staff aids or abets an unlicensed person to evade compliance with provisions of this chapter.
19. Failure to maintain equipment in accordance with safe industry standards.
20. Failure of permittee's employees to conduct themselves professionally and courteously, where reasonable remedial action has not been taken by the permittee.
21. Failure to comply with any applicable service response time standards. "Failure" is defined as failure to meet or exceed such standards according to the terms outlined in any agreement for service with the LEMSA.
22. Failure to meet insurance requirements as provided within this Policy
23. Provision of emergency ambulance services within any other ambulance service zone in violation of Section III (A)(10)(b) of this policy.
24. Any other willful acts or reckless or negligent acts or omissions of permittee which endanger the public's health and safety.

XI. CORRECTIVE ACTION

- A. Any permit issued may be suspended or revoked for good cause by an enforcement officer. "Good cause" for the purpose of this section, means a violation of state law, a violation of any of the provisions of this chapter, a violation of LEMSA policy, a violation of any condition of such permit or agreement, or failure to make payment of the required fee to the department.
- B. The following practices will be utilized before and during permit revocation or suspension:
 1. Whenever an enforcement officer finds that a permittee is not operating in compliance with their permit, a written notice to comply shall be issued to the permit holder. If the permittee fails to comply within fifteen (15) days of the notice, the enforcement officer shall issue a second written notice to comply describing the acts or omissions with which the permittee is charged and informing them of their right to request a hearing.
 2. At any time within a fifteen-day period after service of such notice, the EMS entity may request a hearing before the hearing officer to show cause why the permit or should not be suspended or revoked.
 3. A failure to request a hearing within fifteen (15) days shall be deemed a waiver of a right to such a hearing.
 4. Any hearing provided for in this section shall be conducted in accordance with Section XII of this Policy.
 5. A permit may be reinstated or a new one issued if the LEMSA determines that the conditions that prompted the suspension or revocation no longer exist.

XII. APPEALS

- A. Permit applications denied for reasons other than failure to submit a complete application or permit holders that have had a permit revoked may appeal the LEMSA decision through a hearing process conducted in accordance with this section.
- B. Upon receipt of a written request for a hearing, the hearing officer shall set a hearing date at the earliest practicable time. The hearing shall be held no later than fifteen (15) calendar days after receipt of the request for a hearing. Upon written request of one (1) of the parties, the hearing officer may postpone a hearing date, if circumstances warrant the action. The hearing officer shall give notice of the hearing to the parties at least ten (10) calendar days before the date of the hearing.
- C. When circumstances warrant, the hearing officer may order a hearing at any reasonable time within this fifteen-day period to expedite permit or provider agreement suspension or revocation process.

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- D. Neither the provisions of the Administrative Procedure Act (Government Code Section 11500 et seq.) nor the formal rules of evidence in civil or criminal judicial hearings shall apply to such hearing. At the hearing, the hearing officer may admit any evidence, including witness testimony, relevant to the determination of the matter, except as otherwise provided in this chapter. A record of the hearing shall be made by any means, including electronic recording, so long as a reasonably accurate and complete written transcription of the proceedings can be made.
- E. The hearing officer shall issue a written notice of decision within five (5) working days following the hearing. Notice of the written decision, including findings of facts, conclusions of law, and notification of the time period in which judicial review may be sought pursuant to Code of Civil Procedure Section 1094.6 shall be served on all parties. If the hearing was held to appeal an action against a permit or provider agreement, the notice of decision shall also specify the acts or omissions with which the permitted EMS entity or permit applicant is charged and shall state the terms of any applicable suspension or notice that a permit has been revoked. Any decision rendered by the hearing officer shall be a final administrative decision.
- F. Judicial Review. Hearing officer decisions shall be final, subject to judicial review under the provisions of California Code of Civil Procedure.
- G. For the purposes of this policy, "hearing officer" means an administrative law judge from the California Office of Administrative Hearings.

4005 EMS Aircraft

I. DEFINITIONS

- A. Air Ambulance: Any aircraft specifically constructed, modified, or equipped, and used for the primary purpose of responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has a minimum of two (2) attendants licensed in Advanced Life Support (ALS). One of the attendants must be a registered nurse. All air ambulance aircraft must maintain Commission on Accreditation of Medical Transport System (CAMTS) certification.
- B. Rescue Aircraft: An aircraft which does not have a medical flight crew that meets minimum requirements established in regulations for classification as an air ambulance. Also, an aircraft that does not primarily function as prehospital emergency patient transport but which may be utilized, in compliance with local EMS policy, for prehospital emergency patient transport, when use of an air or ground ambulance is inappropriate or unavailable. Rescue aircraft include ALS rescue aircraft, Basic Life Support (BLS) rescue aircraft and auxiliary rescue aircraft.
- C. EMS Aircraft: Any aircraft utilized for the purpose of prehospital emergency patient response and transport. EMS aircraft includes air ambulances and all categories of rescue aircraft.
- D. Air Medical Resource Management: A management system which makes optimum use of all resources, including but not limited to equipment, procedures, and personnel to promote safety and enhance the efficiency of flight operations.
- E. Authorizing Agency: Local EMS agency which approves utilization of specific prehospital EMS aircraft within its jurisdiction.
- F. Classifying Agency: Entity which categorizes the prehospital EMS aircraft into the groups identified in California Code of Regulations. This shall be the local EMS agency in the jurisdiction of origin except for aircraft operated by the California Highway Patrol (CHP), the California Department of Forestry (Cal Fire) or the California National Guard which shall be classified by the EMS Authority.
- G. Emergency Landing Zone: the term used to designate an "emergency landing site" of an EMS aircraft by a public safety official.
- H. ED: Emergency Dispatch
- I. Flight Paramedic: California-licensed paramedic accredited by Local EMS Agency as an approved paramedic to transport patients with an RN and operate to include flight paramedic optional scope. All terms not specifically defined in this section are provided in the California Code of Regulations.

II. AUTHORIZATION OF EMS AIRCRAFT

- A. All EMS aircraft providing prehospital patient transport within the jurisdiction of the LEMSA must be authorized by the LEMSA. Authorization will be provided by written agreements between the LEMSA and EMS Aircraft provider.
- B. Notwithstanding the requirement for a written agreement set forth above, aircraft operated by California Highway Patrol, California Department of Forestry and California National Guard may be authorized to operate as an EMS aircraft by a designated dispatch center.
- C. A request to out of area EMS aircraft providers by a designated dispatch center shall constitute authorization to respond to that emergency only and does not provide ongoing authorization for operation within the LEMSA jurisdiction.

III. COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS, ORDINANCES, POLICIES & PROCEDURES

- A. All EMS aircraft shall adhere to all federal, state and local statutes, ordinances, policies and procedures related to EMS aircraft operations, including the qualifications of flight crews, aircraft maintenance and equipment standards per California Code of Regulations.

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IV. MEDICAL STAFFING REQUIREMENTS

- A. In accordance with state and local requirements- EMS aircraft shall be staffed at all times with medical personnel accredited by the appropriate LEMSA Policy as follows:
 - 1. Air Ambulance – Minimum of two (2) attendants licensed in advanced life support, e.g., accredited flight paramedic, registered nurse, and physician.
 - 2. ALS Rescue – Minimum of one (1) attendant licensed in advanced life support, e.g., paramedic.
 - 3. BLS Rescue – Minimum of one (1) attendant certified as an EMT.

V. MEDICAL CONTROL

- A. Medical control for patients cared for and transported by EMS Aircraft from the scene shall be under the direction of the LEMSA Medical Director.
- B. EMS aircraft medical crew members are subject to LEMSA Administrative Guidelines.
- C. The LEMSA Medical Director may provide medical direction in coordination with the EMS aircraft provider agency Medical Director through provider's LEMSA approved treatment guidelines and operational protocols for Inter-Facility Transfers.

VI. AUTHORIZED EMS AIRCRAFT DISPATCH CENTERS

- A. EMS aircraft may respond to a prehospital scene emergency only upon the request and direction of the authorized EMS aircraft dispatch centers:
 - 1. Sonoma County – LEMSA Authorized Dispatch Center
 - 2. Mendocino County – LEMSA Authorized Dispatch Center

VII. DISPATCH OF EMS AIRCRAFT

- A. Authorized dispatch centers will simultaneously dispatch the appropriate EMS air ambulance along with the ground ambulance. In addition, rescue aircraft will also be dispatched when scene information indicates the need for rescue capabilities. Dispatch of EMS aircraft will occur for all scene locations greater than 30 minutes ground transport time to the closest receiving facility, in accordance with emergency dispatch determinate codes as defined by Medical Direction. All air resources responding to an incident must be dispatched by the authorized dispatch center.
 - 1. EMS aircraft shall remain enroute to an incident until an on-scene evaluation is conducted by highest level of medical personnel at scene and determines appropriate transport.
 - 2. An air resource cannot cancel another air resource unless there is a safety concern.
 - 3. All air resources, air ambulance and air rescue, entering and exiting Mendocino or Sonoma Counties shall notify the LEMSA -Authorized Dispatch Center for that County. Advisement shall include their intent and area of the county that they will be available to respond from.

VIII. REQUESTING EMS AIRCRAFT BY RESPONDING UNITS

- A. Emergency personnel that have knowledge of the scene or additional information beyond that provided by the dispatch center may request an EMS aircraft be dispatched. After assessing the scene the emergency personnel may cancel or ask for a continued response by the EMS aircraft.
- B. The patient(s) meets the LEMSA prehospital trauma triage criteria and /or on-scene personnel determine the use of the prehospital EMS Aircraft will provide a significant reduction in transport time to a receiving facility capable of providing definitive care

IX. DETERMINING TYPE OF AIRCRAFT RESPONSE

Effective Date

- A. Authorized dispatch centers will request from an authorized air resource dispatch center to dispatch the closest most appropriate available air ambulance resource to the scene.
- B. In the event the primary aircraft is not available, the authorized air dispatch center shall send the next closest air ambulance.
- C. In the event that an ALS air rescue has a time savings of greater than 10 minutes that air rescue should be dispatched in addition to the air ambulance.
 - 1. The primary care paramedic at scene upon assessment (ground) will make the determination as to which aircraft to cancel based on the medical care needed and destination requirements of the patient.
- D. A rescue aircraft should be dispatched to any rescue incident.
- E. Dispatch centers shall advise EMS aircraft and field personnel when multiple aircraft are responding

X. SCENE SAFETY & COORDINATION

- A. The responsibility for scene management and safety shall be under the control of the Incident Commander (the appropriate public safety agency having primary investigative authority; Health & Safety Code)
- B. Management of the scene shall be conducted in a manner that minimizes the risks to the patient and other persons while recognizing the importance of ensuring appropriate medical care and transportation.
- C. The Incident Commander shall consult with on-scene emergency medical personnel in making decisions regarding the use of or landing of an EMS aircraft. (HSC § 1798.6).
- D. The Incident Commander (or designee) shall have the authority for allowing an EMS aircraft to land. Notwithstanding this authority, the pilot of any EMS aircraft has the final discretion regarding the decision to respond to any incident if in his/her judgment such flight imposes undue risk or danger.
- E. If the EMS aircraft pilot questions safety, they shall have the final authority in the decision to continue or cancel the response. Air medical crew resource management and/or the pilot in command may deviate from the LEMSA destination policy based on safety concerns.

XI. DESTINATION OF SCENE PATIENTS TRANSPORTED BY EMS AIRCRAFT

- A. The patient should be transported to the closest appropriate hospital per the LEMSA Point of Entry Guidelines with an Emergency Department that has an approved helipad or emergency landing site. Emergency Landing Sites (ELS) or heliport stops are acceptable landing locations when required by patient or weather conditions. If a patient is requesting to be transported outside of the LEMSA region and the flight team believes there would be benefit, the base hospital should be contacted for a consultation.

XII. CANCELLATION OF EMS AIRCRAFT

- A. After a complete patient assessment, qualified on-scene personnel may cancel the aircraft if they determine that ground transport is more appropriate, through Incident Command.

XIII. COMMUNICATIONS

- A. EMS aircraft shall have the capability of communicating with:
 - 1. The approved dispatch centers
 - 2. EMS ground units and first responders
 - 3. Designated base hospitals
 - 4. Receiving hospitals
 - 5. Other aircraft on air to air frequency 123.025mhz
 - 6. Other appropriate facilities and/or agencies as may be necessary

Effective Date

XIV. TRANSPORTATION OF EMERGENCY PERSONNEL

- A. When appropriate and necessary, EMS aircraft may be used to transport first responders, EMS personnel, or equipment/supplies to the scene of an emergency or other location.

XV. UNUSUAL OCCURRENCE REQUEST DOCUMENTATION

- A. When an EMS aircraft is requested for situations not meeting accepted criteria, the designated dispatch center receiving the request shall report the occurrence to the LEMSA via the LEMSA EMS Event Reporting policy within 72 hours of the incident.

XVI. CQI

- A. All EMS aircraft scene calls will be reviewed by the LEMSA to evaluate appropriate utilization, deviation from protocol, dispatch trends and to assess EMS system management.
- B. The LEMSA may select a special review committee that will systematically review each EMS aircraft flight for appropriate utilization and adherence to policy standards.
- C. Consistent with the California Code of Regulation, EMS aircraft service providers are to develop and participate in a CQI program in cooperation with the LEMSA as outlined in LEMSA Administrative Policy.

SPECIAL CIRCUMSTANCES

XVII. ON-SITE LANDING ZONE

- A. Field personnel may use on-site hospital helipads as landing zones for aircraft rendezvous when patient's condition requires transport to a specialty care center.
- B. The hospital with the helipad has no Emergency Medical Treatment and Active Labor Act (EMTALA) obligations to the patient as long as:
 - 1. The hospital is not the receiving facility.
 - 2. Neither the ground or air crew requests assistance, with patient care, from hospital staff. Hospital staff do not need to make contact with crew or patient.
- C. The incident commander (IC) or designee shall notify the hospital of the intended use of their helipad for transporting a patient to another receiving facility.

XVIII. LANDING SITE FOR INTER-FACILITY TRANSFER FLIGHTS

- A. Off-site landing determination for inter-facility transfers applies to Providence Santa Rosa Memorial Hospital only. This determination is required pursuant to impacts and mitigation measures established in the Environmental Impact Report (EIR) for the Level II Trauma Center Designation at the hospital. In consultation with the sending physician, EMS Aircraft will use the following criteria to determine the appropriate on-site vs. off-site landing location for inter-facility transfer patients being transported by helicopter:
 - 1. Is the patient intubated and /or requiring ventilatory assistance?
 - 2. Does the patient have an unstable cervical spine fracture?
- B. Does the patient require any of the following emergent interventions:
 - 1. Active titration of cardiovascular or tocolytic agents
 - 2. Active treatment of cardiac related pain
 - 3. Active fluid resuscitation
 - 4. Emergent diagnostic and/or surgical interventions

- C. If the answer is “yes” to any of the above questions, the helicopter should land at Providence Santa Rosa Memorial Hospital. If the answer is “no” to all of the above questions, the helicopter should land at an appropriate off-site landing location.
- D. The medical flight crew should discuss the decision regarding use of on-site vs. off-site landing as per the above criteria with the transferring physician prior to initiating transport. The medical flight crew may include the receiving physician at the destination hospital in that discussion.
- E. The helicopter flight crew shall contact the appropriate ground ambulance communications center to request a ground unit whenever an off-site landing location is utilized. Such contact will be initiated in a timely manner to ensure the availability and response of the ground unit to meet the helicopter at the off-site location.
- F. The transfer of care, if occurring, will be conducted in accordance with EMS policy and procedures. If at any time during transport of patient’s condition deteriorates such that it poses a threat to life or limb, the flight crew may cancel the off-site landing and transport to the on-site location.
- G. In the event that a flight does not result in an off-site landing as specified above, an EMS Event Report documenting the circumstances, along with an electronic PCR shall be submitted by the flight crew to the LEMSA within 72 hours of the incident.

4006 Procedures for Paramedics Outside LEMSA Region

I. PURPOSE

- A. To provide guidelines for LEMSA paramedics when providing care during authorized transports, auto aid, mutual aid and disaster responses outside of the LEMSA area. This includes responses for officially requested Fireline Paramedic Programs and Ambulance Strike Teams, along with State/Federal Agencies need requests or contract fulfillment requests.
- B. With the exception of on-view incidents, this policy does not authorize ALS operation within another LEMSA area without a mutual-aid request from that area and approval from LEMSA or LEMSA-Approved EMS Communications Centers.

II. POLICY

- A. This policy is intended to permit the provision of ALS level care during emergency operations/situations and inter-facility transportation. It is not intended to replace existing emergency medical services or circumvent the established response of emergency medical services in locations outside of the LEMSA.
- B. A paramedic who is on-duty with an approved ALS provider is authorized to practice paramedic level skills in compliance with all LEMSA prehospital care policies during the treatment or transportation of patients from within the LEMSA area to destinations outside of the LEMSA area. A paramedic who is on-duty with an approved LEMSA ALS provider on authorized mutual aid, Fireline Paramedic assignment or auto aid deployment may perform paramedic level skills during emergency operations outside the LEMSA in compliance with LEMSA policies and treatment guidelines.
- C. A paramedic who is on duty with an approved LEMSA ALS provider is authorized to provide paramedic level care in compliance with all LEMSA policies and treatment guidelines if presented with a patient contact while outside the LEMSA area (on-view) until patient care can be handed over to the local EMS ALS Ambulance provider.
- D. Provider Agency EQIP will be completed as indicated in the LEMSA quality improvement program.
- E. The paramedic must have access to the Advanced Life Support equipment as required by the LEMSA minimum equipment supply list., except as defined in the following sections.

III. FIRELINE PARAMEDICS (EMPFs):

- A. ALS Provider Agencies shall develop and submit to the LEMSA, policies and procedures for the deployment of EMPF resources. At minimum these policies will include:
 - 1. Narcotics shall be stored and handled in accordance with LEMSA policy and in compliance with any additional ALS Provider Agency procedure developed for EMPF operations.
 - 2. Procedures for Continuous Quality Improvement and Clinical Quality Assurance of the care delivered by paramedics deployed in the EMPF role.
 - 3. Documentation practices to comply with LEMSA policy. As electronic documentation of patient care may be impossible, EMPFs may utilize the LEMSA "Field Notes" form; with later entry in to the electronic format.
- B. ALS Provider Agencies must obtain approval from the LEMSA prior to deploying personnel under this policy.
- C. Designation by an ALS Provider Agency as a EMPF must include verification the paramedic has completed standard FIRESCOPE training and meets requirements mandated for that position.
- D. Paramedics operating during emergency operations as a Fireline Paramedic (EMPF) shall be subject to the provisions of California OES/FIRESCOPE Position Manual specific to EMPF operations.
- E. The EMPF shall present their credentials (paramedic license and department identification) to the Medical Unit Leader at the incident.
- F. The complement of required equipment, medication and supplies may be varied for special assignments or circumstances) by the LEMSA Medical Director. EMPF minimum inventory link ([add hotlink](#))

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- G. All ALS equipment and supplies are to remain under the direct control of a paramedic at all times. If a paramedic is on an extended assignment, is relieved of duty, and another paramedic does not assume control of the ALS equipment and supplies, all such equipment and supplies must be secured in such a manner as to prevent access by non-paramedic personnel.
- H. Paramedics shall follow the directions of the Incident Commander or other designated ICS official, as appropriate.

IV. EMPF CONTROLLED SUBSTANCE INVENTORY

- A. ALS Provider Agencies shall carry a minimum controlled substance inventory to meet the expected need, secured in the vehicle to act as a resupply cache. In circumstances requiring the paramedic to deploy to the fire line on foot, the following controlled substance inventory shall be allowable in the EMPF backpack:
 - 1. Midazolam: up to 20 mg
 - 2. Fentanyl: up to 600 mcg or 60 mg Morphine Sulfate as a substitute medication per Alternate Medications [\(add hotlink to alternate medications list\)](#).
 - 3. EMPF paramedic backpack must be in constant possession of assigned paramedic with controlled substances secured per DEA and CVEMSA locking requirements.

Effective Date:

4007 Public Safety Defibrillation

I. PURPOSE

- A. To develop minimum standards for Public Safety AED Service Providers and Personnel as authorized in California Code of Regulations (CCR).

II. DEFINITIONS

- A. Public Safety AED Service Provider is an agency or organization that is responsible for and is approved to operate AEDs.

III. REQUESTS FOR AUTHORIZATION AND PROGRAM AUTHORIZATION

- A. Public safety AED service providers shall be approved by the LEMSA, or in the case of state or federal agencies, the California EMS Authority, prior to beginning service.
- B. Any Public Safety AED Service Provider wishing to utilize AEDs within the LEMSA area will be approved if they meet the following requirements in conformity with CCR
 1. Submission of CVEMSA Public Safety AED Service Provider Authorization form.
 2. Provide an orientation to the AED for authorized personnel.
 3. Ensure maintenance of AED equipment.
 4. Ensure initial training and continued competency of AED-authorized personnel.
 5. Maintain a list of all Public Safety AED Service Provider authorized personnel and provide upon request to the LEMSA.
- C. Public Safety AED Service Provider approval may be revoked or suspended for failure to maintain the requirements.

4008 TURNOVER OF PATIENT CARE

I. POLICY and INTENT

- A. The purpose of this policy is to define the process for the transfer of care between prehospital care providers.

II. DEFINITIONS

- A. BLS: EMT level of care
- B. ALS: Paramedic level of care
- C. First Response: Non-ambulance EMS response
- D. Transport: EMS ambulance
- E. IC: Incident Commander

III. TRANSFER OF RESPONSIBILITY - PATIENT TURNOVERS

- A. Patients under the care of a First Responder or transport provider may be transferred to another provider or transport unit, if the level of care is appropriate for the patient's condition.
- B. Providers transferring care will provide the transport care provider with a complete report on the patient's condition, treatment provided and properly document the transfer of responsibility and care per Administrative Guideline #6001 ePCR Completion
- C. Transition of patient care may be affected by scene hazards such as SWAT operations, heavy rescue, crash-fire-rescue, confined space rescue or hazardous materials incidents. In such hazardous situations, the Incident Commander (IC) shall determine when the patient can be safely accessed by transport care providers.
- D. The care provider with patient health care authority shall comply with all IC decisions regarding scene safety. The care provider with patient health care authority shall keep IC informed of resource needs and medical decisions.
- E. ALS First Response or ALS transport personnel may transfer care of patients to BLS transport units if an assessment on scene has been completed, the patient is deemed stable, and does not meet the following BLS Exclusion Criteria:
 - 1. BLS Exclusion Criteria:
 - a. Airway emergencies
 - b. Respiratory distress that has received any ALS intervention
 - c. Unresolved hypotension for any reason
 - d. Cardiac-related working primary impression
 - e. Suspected stroke, regardless of time of onset
 - f. Acute change in mental status
 - g. Severe acute pain where complaints of pain and physical exam are consistent
 - h. Anaphylaxis. This is defined as systemic symptoms characterized by respiratory findings and shock, usually within 30 minutes of exposure. This does not include localized swelling and itching at site of exposure.
 - i. Obstetric complaint with reported gestational age of 20 weeks or later
 - j. Hypoglycemia when the patient cannot safely take oral glucose during transport
 - k. Paramedic Discretion: Any condition where the complaint, or extent of a known problem is unclear. Examples include multiple trauma, severe abdominal pain in a patient with comorbid conditions of age and complex medical history, etc.

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- I. Meets Specialty Care destination/activation/alert criteria
- F. The process to ensure patient transport safety will include:
 1. Patients must be stable with medical complaints that can be cared for at the BLS level. Before transferring care to the BLS transport unit, the examining paramedic will reasonably determine that there are no anticipated changes in the patients' present condition.
 2. ALS assessment tools may be utilized (such as EKG monitoring and blood glucose determination) in order to fully assess the patient and determine eligibility for turnover to BLS. Saline locks are permissible.
 3. All administration of ALS medications requires the patient to remain under the care of ALS personnel with the exception of Ondansetron-PO.
 4. Except during a declared MCI or when no other ALS transport alternative exists, patients meeting trauma criteria will be considered ALS patients and treated accordingly.
 5. The EMT who will be in attendance is comfortable with the patients' condition and fully accepts responsibility for the patient and ongoing care.

IV. TRANSFER BETWEEN SPECIALTY UNITS AND CIRCUMSTANCES

- A. Flight nurses may turn patients over to paramedics. These patients must not have or require any medications or therapies that are outside the paramedic scope of practice, and the transporting paramedic must agree to accept responsibility for the patient.
- B. These same procedures should be utilized for turnovers from, or to, specialized transport vehicles or other modality as long as the delay caused by the turnover is offset by a safer or more rapid transport overall.
- C. These procedures will also apply when providers caring for patients in a standby capacity at a special event or mass gathering and require another unit to transport from the event location.

V. MEASURABLE INDICATORS

- A. A patient status change resulting in the BLS transport unit upgrading to an emergent transport or requesting emergent ALS assistance or intercept will be a sentinel event requiring investigation. All sentinel events will be reviewed by the provider Medical Director.
- B. Medical decisions or actions of the care provider, at the time of occurrence, that seem to be non-compliant with LEMSA policies and procedures should be brought to the attention of the IC, when present. The IC may intervene by advising the involved medical care provider of such concerns. If concerns persist after consultation and communication with the care provider, the Base Hospital should be contacted. The Base Hospital Physician has final authority over patient care decisions. The IC will submit a written incident report detailing the concerns via the LEMSA Event Reporting system per Administrative Guideline #6003 EMS Event Reporting.
- C. Any significant problem which poses a potential or actual threat to patient care or public health and safety that requires immediate attention should be brought to the attention of the IC, or Incident Safety Officer, if one is appointed. Care providers should follow up by preparing an incident report which provides a factual summary of the incident, actions, results and incident outcome. Incident reports shall be submitted through the organization, agency or department chain of command, with referral to the LEMSA

4009 AMBULANCE PATIENT OFFLOAD TIME EMERGENCY DEPARTMENT TRANSFER OF CARE STANDARDS

I. PURPOSE

- A. To provide guidelines and standards for the transfer of care of patients arriving via the 911 system to Local EMS Agency (LEMSA) approved receiving facilities. The establishment and review of the standards are essential to public safety, EMS system oversight and for implementing standardized methodologies for Ambulance Patient Offload Time data collection for reporting to the LEMSA and to the California EMSA.

II. POLICY

- A. Receiving facilities designated by the LEMSA shall be prepared to receive patients transported by 911 ambulance providers and accept these patients upon arrival. The ambulance patient offload time performance standard is set at twenty (20) minutes or less 90% of the time.

III. DEFINITIONS

- A. **Ambulance arrival at the Emergency Department (ED)** - the time the ambulance arrives at the location outside the hospital ED where the patient will be unloaded from the ambulance.
- B. **Ambulance Patient Offload Time** - the time interval between the arrival of an ambulance patient at an ED and the time the patient is transferred to the ED gurney, bed, chair or other acceptable location, for example Triage and the emergency department assumes the responsibility for care of the patient 1,2, (Reference- NEMSIS eTimes.11 and eTime.12)
- C. **Ambulance Patient Offload Delay** – the ambulance patient offload time for a patient exceeds a period of time designated by the LEMSA.³ For purposes of this policy and for LEMSA system oversight review, all transfer of care timestamps over 20 minutes and up to 60 minutes will be considered an offload delay.
- D. **Ambulance Patient Offload Delay Sentinel Event** – the occurrence of a patient remaining on the ambulance gurney and/or the emergency department has not assumed responsibility for patient care beyond the LEMSA maximum delay time-over 60 minutes.
- E. **Emergency Department (ED) Medical Personnel** – an ED physician, mid-level practitioner (e.g. Physician Assistant, Nurse Practitioner) or Registered Nurse (RN).

IV. 911 TRANSPORT PROVIDER RESPONSIBILITIES

- A. Transportation units will notify ED staff of their estimated time of arrival as soon as practical, once patient destination has been established.
- B. EMS caregivers shall provide continuity in their treatments upon arrival at the hospital
- C. During periods of unusual levels of demand, EMS personnel may provide the stable patient with information on hospital delays to assist the patient in their choice of destination. Transportation providers should consider the patient's historical location of medical care when considering advising a patient of offload delays.
- D. Transportation units will promptly notify ED, LEMSA contracted dispatch centers and any provider agency supervisory staff of ambulance patient offload issues past the twenty minute (20 mins) standard. If able EMS supervisory staff will assist with the resolution of the availability issues and follow up with the LEMSA and hospital.
- E. Notification of the need to release ambulance resources will be communicated by EMS personnel using the following chain of command:
 - 1. ED charge nurse and physician in charge
 - 2. Hospital House Nursing Supervisor
- F. The EMS Duty Officer should be notified of all "Sentinel Events."

Effective Date

V. RECEIVING FACILITY RESPONSIBILITIES

- A. The hospital responsibility for the care of a patient begins when the patient or ambulance arrives on hospital grounds and requires an initial assessment and triage of the patient without delay as defined by Emergency Medical Treatment and Labor Act (EMTALA).
- B. ED staff will work with ambulance personnel to ensure optimal patient transfer of care and resolve any instances of delay past the time standard.
- C. During periods of unusual level of demand, hospitals shall activate internal protocols for ED saturation.
- D. Predictable daily and seasonal high utilization periods are considered normal EMS System operations that should be included in hospital planning and are not considered unusual level of demand episodes.
- E. Hospital staff will work with the LEMSA to ensure internal policies and procedures are in place to prioritize patients arriving by 911 transport providers.
- F. Hospital staff shall sign patient care report at the transfer of care, as required by California Health and Safety code.

VI. LEMSA RESPONSIBILITIES

- A. Provide hospitals and ED leadership with reliable patient transfer of care performance reports.
- B. Post publically EMS to ED patient transfer of care reports including "Sentinel Events" on the LEMSA website.
- C. All "Sentinel Events" will be referred to the ED supervisor for the appropriate review and action. Review by the LEMSA CQI process per Administrative Guideline #6002 Quality Improvement Program will occur.

VII. METRICS

- A. Clock start: Time stamp when the 911 transport provider stops outside the receiving facility ED. Data collection can be made by:
 - 1. Transport provider CAD systems, with two-way radio voice communication or MDC;
 - 2. Automated systems with AVL/GPS capability;
 - 3. ePCR or other commercial data collection systems.
- B. Clock stop: California Health and Safety code defines the criteria for transfer of patientcare:
 - 1. When the patient is transferred to the emergency department gurney, bed, chair or other acceptable location and
 - 2. The emergency department has assumed the responsibility for care of the patient.
- C. Ambulance patient offload time: Will be defined as an event, recorded as a clock timestamp to be inserted on all ePCR platforms, occurring when:
 - 1. The patient is off of the ambulance gurney and the verbal patient report is given by transporting EMS personnel and acknowledged by ED medical personnel 2

Note: Completion of the ePCR and/or removal of equipment is not required for transfer of care to occur.
- D. Sentinel Events: In addition to offload delays in excess of LEMSA standard as defined in 4012.3 (d), reportable Sentinel Events include:
 - 1. Occurrence of Ambulance Patient Offload Delay with the patient decompensating or worsening in condition
 - 2. Occurrence of Ambulance Patient Offload Delay with associated delayed 911 system ambulance response(s) within the LEMSA.
 - 3. Continued facility or system performance below established fractal (e.g. 90%) for compliance to the LEMSA's APOT standard

Effective Date

4010 EMT Transport of Emergent Patients

I. POLICY AND INTENT

- A. The purpose of this policy is to provide direction for EMTs making transport decisions for emergent patients in their care. While in general patients meeting criteria for ALS transport should be turned over to ALS personnel, in certain circumstances, the rapid BLS transport of an emergent patient is preferable to waiting for ALS response or intercept.

II. BLS IMMEDIATE TRANSPORT

- A. EMTs with emergent patients in their care must determine the ETA of ALS unit to their location. In cases where the time to the arrival of an ALS unit to the scene is longer than the combination of patient extrication and transport time to an appropriate ED, the BLS unit should transport the patient without delay. If EMT personnel determine immediate transport is appropriate, any ALS response to the scene should not be canceled until the BLS ambulance is enroute to the closest hospital.

III. ALS INTERCEPT

- A. In some circumstances, EMTs should rendezvous with an ALS ambulance or first responders to access ALS care.
Rendezvous Procedure:
 1. EMTs shall contact the dispatch center as soon as possible to request an ALS rendezvous if an ALS ambulance is not responding to the incident., The request for ALS intercept should be made as early as possible.
 2. The BLS transporting unit shall not wait at the scene for a rendezvous.
 3. Once a rendezvous location has been identified and if the BLS transporting unit arrives to that location prior to the ALS ambulance, the BLS transporting unit shall not wait at the initial rendezvous site if there is extended wait time for the ALS ambulance arrival. If the ALS rendezvous unit has not arrived at the rendezvous site, the BLS transporting unit should proceed to the next best rendezvous location or to the closest hospital without delay.
 4. The EMS dispatch center will monitor and support communication for the rendezvous; however, EMS units may also communicate directly to provide a report on patient condition and/or additional rendezvous information if appropriate.
 5. When the rendezvous occurs, paramedic personnel shall join the patient in the back of the BLS ambulance transporting the patient. Good pre-rendezvous communications are essential to allow the paramedics to prepare the proper equipment for transfer into the transporting unit.

Effective Date:

4011 LEAVE BEHIND NARCAN AUTHORIZATION

I. PURPOSE

- A. To authorize EMS prehospital personnel to distribute Naloxone and provide training material to patients with suspected opioid misuse, or family and/or friends of these patients. The opioid crisis has had a profound impact on communities across the United States. This policy is part of a broader harm reduction strategy that attempts to mitigate the impact of the crisis by increasing the availability of Naloxone to the public.

II. POLICY

- A. This policy will authorize prehospital EMS personnel to distribute Naloxone and approved training materials to patients with suspected opiate misuse, or to the friends and/or family of these patients.
- B. Indications:
 1. Suspected opioid misuse or self-reported dependence

III. PROCESS

- A. The Leave Behind Narcan Program is an optional initiative – EMS and fire agencies are not mandated to participate. EMS and fire agencies that choose to participate in the program are required to ensure CQI oversight and comply with the following program specifications within their agency Leave Behind Narcan Program guidelines.
 1. Provide all appropriate patient care in accordance with the LEMSA treatment guidelines.
 2. Once determined that a patient will refuse transport for a suspected overdose, AMA shall be completed in accordance with CVEMSA policy 8003 – Patient Refusal of Treatment or Transport.
 3. Provide Naloxone and approved training materials to patient directly or a friend and/or family member at scene. Approved training material can be printed or provided through an electronic format through this link: <https://bridgettotreatment.org/resource/naloxone-what-you-need-to-know/>
 4. If unable to resuscitate or patient meets Determination of Death policy due to suspected overdose, friends and/or family can be offered Naloxone if they appear to be at risk for opioid misuse. Example, if they were using drugs with the patient, identify a self-dependence or drug paraphernalia is found on scene.
 5. If the patient is treated with Naloxone for a suspected overdose and transported to the hospital, but the patient's friends and/or family at scene express concern that they may need Naloxone because of identified self-dependence or financial limitations to access a prescription, Naloxone may be left on scene. Efforts should be made to ensure patients, friends and/or family understand resources that are available related to overdose prevention. Agencies within Coastal Valleys shall provide local area resources to staff.
 6. The maximum dose to be left on scene is one package of Naloxone. One package contains two, 4 mg Intra-nasal doses.
 7. Provide documentation of any Naloxone distribution through the EMS data system.
 - a. EMS and fire agencies who wish to participate in the Leave Behind Narcan program shall notify the EMS Agency.
 - b. Once the EMS Agency receives notification, reportable Leave Behind Narcan data fields will be uploaded to the agency's patient care report.
 - c. Field providers who Leave Behind Narcan are required to complete the applicable data fields when completing the patient care report. If Leave Behind Narcan is left on scene with a family member or friend and not the patient, the field provider does not need to create a new patient care report as it is applicable to the emergency scene of the initial 911 response.

IV. SPECIAL CONSIDERATIONS

Effective Date:

- A. Leave Behind Narcan may be provided when a patient refuses transport after a naloxone field reversal, a suspected opioid-related overdose, or if friends and/or family at scene identify a potential need due to self-identified dependence. It is not to be used as an alternative to transporting a patient to the hospital.
- B. The Leave Behind Narcan Program is an important component in improving outreach to a vulnerable patient population by increasing opportunities for access to care and treatment and recovery from opioid addiction. Agencies who participate in this program shall provide field personnel access to information about local support and recovery services to better inform our patient care population and the public.

Effective Date:

5001 Receiving Hospital

I. PURPOSE

- A. To establish the minimum requirements for a Receiving Hospital within the LEMSA region, integrate Receiving Hospitals into the EMS system for planning, design, and delivery of Emergency Medical Services and provide a mechanism for collecting and evaluating patient care information for patients transported to a Receiving Hospital.

II. DEFINITION

- A. A Receiving Hospital is a hospital designated by the LEMSA with a written contractual agreement.

III. PROCESS FOR APPROVAL

- A. Submit a written request to be designated as a Receiving Hospital. The request shall contain, at a minimum, the following:
 - 1. Hospital name, addresses, and phone number.
 - 2. Owner's name and address (List all names if more than one or if there is a Board of Directors)
 - 3. Copy of State Hospital license.
 - 4. Copy of accreditation by a Centers for Medicare and Medicaid Services (CMS) recognized hospital accreditation organization.
 - 5. Copy of Special Permit for Standby/Basic/Comprehensive Emergency Medical Services.
 - 6. Tentative schedule date to begin operations.
- B. Submitted requests will be reviewed by LEMSA staff for completeness and compliance with minimum requirements.
- C. Receiving Hospital approval or disapproval shall be made in writing by LEMSA to the applicant after receipt and review of all required documentation.
- D. LEMSA will establish the effective date of Receiving Hospital approval upon satisfactory documentation of compliance with all requirements. The Receiving Hospital approval shall be formalized by the signing of a written agreement with the County of Sonoma.

IV. FEES

- A. Hospital shall reimburse County for reasonable costs incurred as a result of designating and regulating Hospital as a receiving facility in accordance with the Health and Safety Code.

V. REQUIREMENTS

- A. All Receiving Hospitals shall have a written agreement with the LEMSA to be recognized as an approved destination for ambulances transporting prehospital patients.
- B. All Receiving Hospitals must be licensed by the State Department of Health Services as a general acute care hospital and have a special permit for Standby/Basic or Comprehensive Emergency Medical Services. Receiving Hospitals must comply with all city, county, state and federal laws/regulations.
- C. The Receiving Hospital shall:
 - 1. Provide Receiving Hospital and Emergency services routinely, on a continuous twenty-four (24) hours per day basis, follow all policies and medical protocols established by the LEMSA and agree to accept for treatment any patient who has been treated or transported by prehospital personnel.
 - 2. Maintain 24-hour in-house emergency physician and ED registered nurse coverage and ensure that all effected personnel receive the appropriate training and continued retraining as necessary.

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3. Admit ED patients to the hospital if appropriate, if the patient accepts admission and space is available. If transfer to another facility is appropriate, the patient shall be transferred according to the LEMSA Interfaculty Transfer policy.
 4. Participate and cooperate with any and all LEMSA quality assurance/improvement programs as currently exist or as may be adopted pursuant to LEMSA policies and procedures
 5. Cooperate with the LEMSA in the collection and analysis of patient care and other data necessary to an ongoing evaluation of prehospital care
 6. Provide a clinical experience program approved by the LEMSA, for Prehospital and emergency ambulance personnel and document any training provided under this program
 7. Maintain a radio report record and document a brief description of all communications received or transmitted.
 8. Ensure all ED personnel are oriented to the Receiving Hospital roles and pertinent LEMSA policies and procedures.
 9. Have a process to ensure that all patients transported via ambulance are offloaded in a timely manner and transfer of care to hospital staff meets the current ambulance patient offload time (APOT) in accordance with EMSA regulation.
 10. Hospital shall participate in healthcare coalition activities including steering committee, MCI/Disaster exercises, redundant communication drills and hospital preparedness program development.
- D. Staffing Requirements:
1. Medical Director
 - a. Designate a Receiving Hospital Emergency Department Medical Director who shall be a physician on the hospital staff and have experience in emergency medical care.
 - b. Shall be regularly assigned to the emergency department.
 - c. Shall have knowledge of the LEMSA Policies and Procedures.
 - d. Be responsible for reporting known deficiencies in patient care regardless of personnel involved, to the LEMSA.
 - e. Represent the Receiving Hospital at appropriate LEMSA meetings.
 2. Emergency Department Nursing Representation
 - a. Shall be an individual licensed by the State of California as a Registered Nurse.
 - b. Shall have experience in and knowledge of hospital operations and LEMSA policies and procedures.
 - c. Works with the LEMSA to identify hospital problems/needs and to develop plans for solutions.
 - d. Participates in the process of reviewing and revising LEMSA policies and procedures.
 - e. Attends and participates at appropriate LEMSA Meetings.
 - f. Identifies and reports Prehospital care problems to the LEMSA.
- E. Receiving Hospital Continuous Quality Improvement Program (CQI)
1. Establish a CQI program, which shall identify methods of improving the quality of patient care provided. The Receiving Hospital CQI program shall operate in conjunction with the LEMSA CQI program.
 2. Any change in the operational status of a Receiving Hospital shall be reported through the EMS data system or directly through EMS Duty Officer program.
- F. Data Collection and Sharing of Information
1. The ED shall maintain a medical record for each patient in accordance with accreditation standards (e.g. JCAHO, CMS) and shall include the ePCR if applicable.
 2. All records relevant to Prehospital care and Receiving Hospital operation shall be made available when requested by the LEMSA; to include the following:
 - a. Hospital shall actively participate in an approved Health Information Exchange (HIE) to enable bidirectional patient data exchange. This participation shall include, but is not limited to, the receipt of

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prehospital electronic patient care reports (ePCR) from EMS providers and the provision of patient outcome data to the LEMSA. The Hospital shall maintain compliance with all applicable standards and interoperability requirements to facilitate seamless data exchange.

- b. Records or pertinent materials that may be required in the course of audit, inquiries, investigations or statistical analysis. Representatives of the LEMSA shall comply with all applicable state and federal laws relating to confidentiality and shall maintain the confidentiality of all records, tapes and logs submitted.

- c. CQI records

G. Communication equipment

1. Equip facility and agree to utilize and maintain communications equipment in accordance with the Federal Communications Commission, California State EMSA requirements, including LEMSA designated inter-hospital communications systems.
2. Be financially responsible for installation, purchase/rental and maintenance of radio/phones.
3. Maintain a radio report record documenting a brief description of communication with field personnel.

H. Trauma System

1. Participate in the trauma system evaluation and data collection program
2. Participate in the LEMSA Trauma Audit Committee (TAC). Attend or send designee to scheduled meetings and provide patient information for case presentations when requested.

I. EMS Agency shall:

1. Maintain program criteria, operational policies and medical protocols in conformity with applicable Federal, State, and local laws and regulations.
2. Monitor the receiving hospital for adequacy of services and medical quality improvement in cooperation with hospital in an ongoing evaluation of the EMS system.
3. Maintain confidentiality of all patient specific information, quality improvement information, records provided for review and audit purposes in accordance with HIPAA (Health Insurance Portability and Accountability Act).
4. Designate a physician to function as the EMS Medical Director.
5. Provide support and education to the hospital for the designated EMS data and communication systems.
6. Manage any state funded programs for uncompensated care and distribute funds accordingly.

J. Designation Review

1. Periodic on-site evaluations by the LEMSA shall be scheduled.
2. Allow inspection at any time by the LEMSA with or without notice, for the purpose of verifying Receiving Hospital agreement, regulation, policy and procedure compliance.

K. Withdrawal of Receiving Hospital Designation

1. The EMS Agency may deny, suspend or revoke the approval of a receiving hospital for failure to comply with any applicable policies, procedures, and regulations.

5002 Base Hospital

I. PURPOSE

- A. To establish the minimum requirements for a Base Hospital designated by the LEMSA.

II. DEFINITION

- A. A Base Hospital directs prehospital care and emergency medical services in a given area and shall provide basic and advanced life support medical direction to pre-hospital care providers.

III. PROCESS FOR APPROVAL

- A. Applicants shall submit a written request to be designated as a Base hospital. The request shall contain, at a minimum, the following:
 - 1. Hospital name, addresses, and phone number.
 - 2. Owner's name and address (List all names if more than one or if there is a Board of Directors)
 - 3. Copy of State Hospital license.
 - 4. Copy of accreditation by a Centers for Medicare and Medicaid Services (CMS) recognized hospital accreditation organization.
 - 5. Copy of Special Permit for Basic/Comprehensive Emergency Medical Services.
 - 6. Tentative schedule date to begin operations.
 - 7. Other information as deemed necessary by the applicant or the LEMSA.
- B. Submissions will be reviewed by LEMSA staff for completeness and compliance with minimum requirements.
- C. Additional information may be requested of the applicant prior to granting approval.
- D. Base Hospital approval or disapproval shall be made in writing by the LEMSA after receipt and review of all required documentation.
- E. The LEMSA will establish the effective date of Base Hospital approval upon satisfactory documentation of compliance with all requirements. The Base Hospital approval shall be formalized by the signing of a written agreement with the LEMSA and/or County.
- F. The LEMSA shall approve and designate Base Hospitals. No Base Hospital shall advertise itself as providing these services until it has completed the LEMSA approval process.

IV. FEES

- A. The hospital shall reimburse the County for its reasonable costs incurred as a result of designating and regulating a base hospital in accordance with the California Code of Regulations.

V. REQUIREMENTS

- A. All Base Hospitals shall have a written agreement with the LEMSA to be recognized as an approved destination for ambulances transporting Prehospital patients. .
- B. All Base Hospitals must be licensed by the State Department of Health Services as a general acute care hospital and have a special permit for Basic or Comprehensive Emergency Medical Services pursuant to the California Code of Regulations.
- C. The Base Hospital shall:
 - 1. Provide Base Hospital and Emergency services on a continuous twenty-four (24) hours per day basis and follow all policies and medical protocols established by the EMS Agency.
 - 2. Maintain 24 hour in-house emergency physician and ED registered nurse coverage and ensure that all effected personnel receive the appropriate training and continued retraining as necessary.

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3. Admit ED patients to the hospital if appropriate, if the patient accepts admission and space is available. If transfer to another facility is appropriate, the patient shall be transferred according to Coastal Valleys EMS Interfaculty Transfer policy.
 4. Direct patient transports based entirely on objective analysis of patient needs and point of entry protocols and shall make no effort to obtain institutional or commercial advantage through use of transport instructions and hospital assignments.
 5. Actively participate in the Emergency Medical Care Committee for which the base hospital is located.
 6. Participate and cooperate with any and all local EMS quality assurance/improvement programs as currently exist or as may be adopted pursuant to local EMS policies and procedures
 7. Completely and accurately complete all appropriate forms and records of the advanced life support and emergency ambulance program, cooperate with the EMS Agency in the collection and analysis of patient care and other data necessary to an ongoing evaluation of Prehospital care and emergency ambulance operations, and provide records and other necessary information to the EMS Agency for assessment of emergency ambulance services
 8. Conduct continuing education sessions, supervise and, when necessary immediately critique Prehospital runs, develop and schedule base hospital training programs in accordance with EMS Agency requirements
 9. Provide a continuing education and clinical experience program approved by the EMS Agency, for Prehospital and emergency ambulance personnel and document any training provided under this program
 10. Record all Prehospital communications requiring medical direction from EMS field units and maintain for a period of not less than twelve (12) months
 11. Have a process to ensure that all patients transported via ambulance are offloaded in a timely manner and transfer of care to hospital staff meets the current ambulance patient offload time (APOT) in accordance with EMSA regulation.
- D. Staffing Requirements:
1. Medical Director
 - a. Shall be a physician who is licensed in the State of California and certified by the American Board of Emergency Medicine.
 - b. Shall be regularly assigned to the emergency department
 - c. Shall have experience in and knowledge of Base Hospital radio operations and Coastal Valleys EMS Policies and Procedures
 - d. Shall be responsible for overall medical supervision, direction, and operation of the Base Hospital as it applies to the provisions of the Base Hospital Agreement, including audit of Prehospital care patient records and critique with base/and/or Prehospital care personnel involved
 - e. Ensure that all emergency department physicians at the hospital wherein the base hospital is located, and who may direct Prehospital patient care in the EMS system, are oriented to the local EMS system and are familiar with the scope of practice, role and function of Prehospital EMS personnel, including paramedics, EMT's, first responders and Mobile Intensive Care Nurses (MICN's)
 - f. Be responsible for reporting known deficiencies in patient care regardless of personnel involved, to the EMS Agency
 - g. Approve all continuing education for Prehospital care personnel offered by the base hospital consistent with EMS Agency policies and procedures
 - h. Represent the base hospital at appropriate Coastal Valleys EMS meetings
 - i. Perform an on-going evaluation of certified Prehospital care personnel employed by agencies assigned to the base hospital and identify problems and weaknesses and recommend specific remediation as needed
 2. Prehospital Liaison Nurse
 - a. Shall be an individual licensed by the state of California as a Registered Nurse

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- b. Shall have experience in and knowledge of hospital operations and Coastal Valleys EMS Agency policies and procedures
 - c. Shall work in conjunction the Base Hospital Medical Director to ensure appropriate planning, organization, implementation, supervision, and evaluation of Prehospital care operations of the base hospital and the assigned field units
 - d. Supervised hospital operations with particular regard to ensure that operations are in accordance with California laws and regulation, and Coastal Valleys EMS Agency policies and procedures.
 - e. Ensures that field-hospital communication reflect the requirements set forth by the Federal Communications Commission and the Coastal Valleys EMS Agency
 - f. Ensures the maintenance of a medically and legally proper system for documentation, storage and maintenance pf Prehospital taped transmission of field runs and all Prehospital care written records
 - g. Works with the Coastal Valleys EMS Agency to identify hospital problems/needs and to develop plans to solutions
 - h. Establish and implement base hospital orientation for emergency department staff and physicians, and other appropriate personnel
 - i. Participates in process of reviewing and revising Coastal Valleys EMS policies and procedures
 - j. Coordinates and provides regularly scheduled run reviews
 - k. Schedules and coordinated clinical experience for Prehospital EMS personnel
 - l. Attends and participates at appropriate Coastal Valleys EMS Meetings
 - m. Maintains records and submits statistics related to the Prehospital care program as requested by the EMS Agency and State EMS Authority
 - n. Identifies and reports Prehospital care problems to the EMS Agency
3. Base Hospital Physicians
- a. Must be oriented to the local EMS system including policies and procedures and be familiar with the scope of practice, role and function of Prehospital EMS personnel, including paramedics, EMT's, first responders and Mobile Intensive Care Nurses (MICN's)
 - b. Must provide immediate on –line medical direction to Prehospital personnel
 - c. Physicians assigned to the emergency department may not be called from the area to treat patients for other physicians, except in case of an emergency.
4. Base Hospital Continuous Quality Improvement Program (CQI)
- a. Establish a CQI program, which shall identify methods of improving the quality of patient care provided. The Base Hospital CQI program shall operate in conjunction with the Coastal Valleys EMS CQI program.
 - b. Any change in the status of a Base Hospital, authorized to care for patients requiring EMS, with respect to protocols and the facility's ability to care for patients shall be reported by the facility to Coastal Valleys EMS within 24 hours and repeated in writing within 72 hours.
5. Data Collection and Sharing of Information –
- a. The ED shall maintain a medical record for each patient in accordance with licensure standards:
 - i. Record shall include the PCR, if applicable
 - ii. Appropriate documentation/form must be completed when ALS direction or orders to field providers are given and shall become a part of the patient chart.
 - b. All records relevant to Prehospital care and Base Hospital operation shall be made available when requested by Coastal Valleys EMS; to include the following:
 - i. Cooperate with Coastal Valleys EMS in providing follow-up information regarding patient diagnosis, disposition and outcome.
 - ii. Records or pertinent materials that may be required in the course of audit, inquiries, investigations or statistical analysis. Representatives of Coastal Valleys EMS shall comply with all applicable state

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and federal laws relating to confidentiality and shall maintain the confidentiality of all records, tapes and logs submitted

- iii. Record of Hospital Prehospital care meetings and attendance records of all such meetings, tape reviews, and continuing education classes
 - iv. CQI records
 - c. Report any change in Base Hospital Director or Prehospital Liaison Nurse within 10 days.
 - d. Maintain a current copy and incorporate any updates of the Coastal Valleys EMS Policy and Procedure Manual. Employees shall know the location of the policy manual and it shall be readily accessible for reference during Prehospital communications.
 - e. Hospital shall actively participate in an approved Health Information Exchange (HIE) to enable bidirectional patient data exchange. This participation shall include, but is not limited to, the receipt of prehospital electronic patient care reports (ePCR) from EMS providers and the provision of patient outcome data to the LEMSA. The Hospital shall maintain compliance with all applicable standards and interoperability requirements to facilitate seamless data exchange.
6. Communication Equipment
- a. Equip facility with, and agree to utilize and maintain communications equipment in accordance with Coastal Valleys EMS, Federal Communications Commission, and California State EMSA requirements, including EMS Agency designated inter-hospital communications systems.
 - b. Be financially responsible for installation, purchase/rental and maintenance of radio/phones with 24 hour recording capability.
 - c. Maintain a radio log documenting a brief description of communication with field personnel as well as identify which call received on-line medical direction from the Base Hospital physician.
7. Trauma System
- a. Participate in the trauma system evaluation and data collection program. Base Hospitals will submit data quarterly to the EMS Agency when a trauma patient meeting the following criteria is treated in a non-trauma receiving facility;
 - i. Local EMS Field Trauma Triage Criteria
 - ii. All patients who go to the operating room from the emergency department or are admitted as an inpatient for a major head, neck, chest, vascular or abdominal injury (i.e., an isolated liver or spleen injury requiring surgical intervention, including ICD-9's 850.2-869.1 and 900.0-903.9)
 - iii. Spinal cord injury patients with an ICD-9 code range of 806.0-806.0
 - iv. All trauma-related deaths in the emergency department or after admission (excluding traumatic cardiac arrests prior to ED arrival)
 - b. Participate in the Coastal Valleys EMS Trauma Audit Committee (TAC). Attend or send designee to scheduled quarterly meetings and provide patient information for case presentations when requested.
8. Designation Review
- a. Periodic on-site evaluations by Coastal valleys EMS shall be scheduled
 - b. Allow inspection at any time by Coastal Valleys EMS with or without notice, for the purpose of verifying Base Hospital agreement, regulation, and policy and procedure compliance.
9. Withdrawal of Base Hospital Designation
- a. The EMS Agency may deny, suspend or revoke the approval of a base hospital for failure to comply with any applicable policies, procedures, and regulations.

Effective Date

5003 STEMI RECEIVING CENTER

I. DEFINITION

- A. A STEMI Receiving Center (SRC) is a hospital that is designated as such by the EMS Agency and shall have a cardiac catheterization facility and cardiovascular surgical services.

II. CRITERIA

A. Hospital

- 1. The hospital will have a special permit for percutaneous coronary intervention (PCI) in accordance with the requirements of Title 22 of the California Health & Safety Code.
- 2. The hospital will have a special permit for cardiovascular surgical services.
- 3. The hospital shall maintain 24 hour a day / 7 days a week / 365 days a year availability.
- 4. The hospital Emergency Department must have EKG transmission capabilities.

B. Personnel

- 1. Physician Liaison – The hospital shall designate a physician to serve as a liaison to the Local EMS Agency (LEMSA) on behalf of the SRC. Ideally the physician should also serve as the director of the cardiac catheterization laboratory.
- 2. Nursing Liaison – The hospital shall designate a registered nurse to serve as a liaison to the LEMSAs on behalf of the SRC. Ideally the nurse liaison should be a staff member of the cardiac catheterization laboratory.
- 3. Physician Consultants – The hospital shall maintain a roster of available interventional cardiologists and cardiovascular surgeons for cardiovascular surgery.

C. Policies

- 1. The hospital must have internal policies developed for the following:
 - a. Emergency department policies pertaining to the care of acute STEMI patients as identified in the prehospital setting.
 - b. Cardiac catheterization laboratory policies pertaining to the care of the acute STEMI patients as identified in the prehospital setting.
 - c. Policy for reporting cardiac catheterization laboratory unavailability.

D. Data Collection

- 1. The following data shall be collected on an on-going basis and submitted to or made available to LEMSAs in accordance with CCR Title 22.

E. Quality Assurance and Improvement

- 1. Participation by key personnel in the LEMSAs STEMI committee.
 - a. Hospital shall participate in a QA/QI program consistent with CCR Title 22.

III. EMS AGENCY RESPONSIBILITIES

- A. The EMS Agency shall continue to maintain program criteria, operational policies and medical protocols in conformity with applicable Federal, State, and local laws and regulations, and accepted EMS system standards
- B. The EMS Agency shall meet and consult with SRC prior to the adoption of any policies or procedure that concerns the administration of the STEMI Care System, or the triage, transport, and treatment of STEMI patients.
- C. The EMS Agency shall monitor the SRC for adequacy of services and medical quality improvement in cooperation with SRC in an ongoing evaluation of the EMS STEMI System.
- D. The EMS Agency shall maintain confidentiality of all patient specific information and quality improvement information and records provided for review and audit purposes to the fullest extent available under the law.

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- E. The EMS Agency shall designate a physician to function as the EMS Medical Director.
- F. The EMS Agency will provide Prehospital data related to STEMI care.

IV. DESIGNATION

- A. The SRC shall be designated after satisfactory review of written documentation and an initial site survey by the LEMSA.
- B. The SRC shall have a written agreement with the LEMSA to be recognized as an approved destination for ambulances transporting STEMI patients.
- C. The SRC shall notify the LEMSA by telephone followed by a letter or email within 48 hours of changes in program compliance or performance

5004: Trauma Receiving Hospitals

I. Purpose

- A. To establish criteria, responsibilities, and oversight expectations for designated Trauma Receiving Hospitals within the Local EMS Agency (LEMSA) jurisdiction. This policy outlines the standards for participation in the regional trauma system, consistent with state regulatory requirements and local ordinances governing EMS and ambulance operations.

II. Scope

- A. This policy applies to all hospitals designated by the LEMSA as Trauma Receiving Centers (TRCs) and to all EMS providers participating in the regional trauma system within the counties served by the LEMSA.

III. Policy Statement

- A. Trauma Receiving Hospitals play a critical role in the coordinated delivery of trauma care. Each designated facility must maintain compliance with LEMSA requirements, applicable California statutes and regulations, and local ambulance ordinances. The designation process ensures that patients meeting trauma triage criteria are transported to the most appropriate facility capable of providing definitive care.

IV. Designation

- A. Authority and Approval:
 - 1. The LEMSA has authority, under state law and local ordinance, to designate hospitals as Trauma Receiving Centers. Designation is contingent upon compliance with applicable trauma system standards and LEMSA verification processes.
 - 2. Designation Levels:
The LEMSA recognizes trauma centers as defined in state regulations (Level I through Level IV). The specific level of designation will be determined through evaluation of hospital resources, capabilities, and performance within the regional trauma system.
 - 3. Duration and Renewal:
Trauma center designation is granted for a finite term, subject to periodic review and re-verification by the LEMSA or its designee. Continued participation requires evidence of ongoing compliance with system requirements and quality performance standards.

V. Roles and Responsibilities

- A. Trauma Receiving Hospitals Shall:
 - 1. Provide 24-hour trauma care coverage with qualified personnel and resources consistent with state trauma system standards.
 - 2. Maintain active participation in the regional trauma system, including submission of data to the LEMSA-approved trauma registry.
 - 3. Participate in the LEMSA Continuous Quality Improvement (CQI) and Performance Improvement (PI) programs.
 - 4. Participate in the Regional Trauma Advisory Committee and related multidisciplinary reviews.

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5. Ensure trauma care policies, procedures, and staffing are consistent with current evidence-based standards and LEMSA guidance.
 6. Comply with all applicable elements of relevant County Ordinance regarding patient transport, interfacility transfer, and coordination with prehospital providers.
- B. The LEMSA Shall:
1. Establish and maintain a regional trauma system plan approved by the State EMS Authority.
 2. Conduct initial and ongoing verification and designation of trauma hospitals.
 3. Collect and analyze trauma data for system evaluation and quality improvement.
 4. Facilitate multidisciplinary review of trauma cases and trends through advisory committees.
 5. Ensure coordination between EMS providers, non-designated hospitals, and trauma receiving centers to promote optimal patient outcomes.

VI. Data Submission and Reporting

- A. Trauma Receiving Hospitals must submit trauma registry data to the LEMSA in a format and frequency prescribed by the Agency. Data must include, but are not limited to:
1. Demographic, clinical, and outcome information for all trauma patients meeting inclusion criteria.
 2. Time-sensitive performance indicators and quality metrics as defined in the LEMSA CQI plan.
 3. Reports supporting system-level performance monitoring and state reporting requirements.

VII. Performance Improvement and System Oversight

- A. The LEMSA will oversee a regional trauma quality improvement process consistent with Just Culture principles and the statewide Trauma Quality Improvement Program framework. Hospitals must participate in system-level reviews, peer case discussions, and corrective action planning when indicated.

VIII. Suspension or Revocation of Designation

- A. Designation may be suspended or revoked if a hospital fails to maintain compliance with LEMSA standards, data submission requirements, or performance expectations. The LEMSA will provide written notice and an opportunity for corrective action prior to final determination.

5005 Trauma Receiving Centers

I. PURPOSE

- A. The following standards define Trauma Centers for the LEMSA Region.

II. DEFINITION

- A. A Trauma Center is a licensed receiving facility, which has met the State requirements and has successfully been designated as a Trauma Center by the LEMSA.

III. TRAUMA PROGRAM

- A. Trauma Centers are committed to resuscitate patients based on ATLS guidelines. The Level IV Trauma Center will include equipment, resources, and personnel knowledgeable in the treatment of trauma patients necessary for initial stabilization and transfer of the major trauma patient. The goal of the Level IV Trauma Center is to stabilize and facilitate transfer of the trauma patient to a higher level Trauma Center with the capabilities to meet the patient's needs.
- B. The Level IV trauma program shall include the following:
 - 1. Facility:
 - a. Basic/stand by license
 - b. Accreditation by JCAHO (Joint Commission on Accreditation of Healthcare Organization)
 - c. Maintain status as a base hospital
 - d. Approved helicopter landing site
 - e. Designated trauma resuscitation area of adequate size to accommodate multi-system-injured patient and necessary equipment.
 - f. Drugs and supplies necessary for usual emergency medical care and the initial resuscitation of major trauma patients.
 - 2. Trauma Program Medical Director who is a qualified specialist whose responsibilities include, but are not limited to, factors that affect all aspects of trauma care, including pediatric trauma care, such as:
 - a. Recommending trauma team physician privileges;
 - b. Working with nursing administration to support the nursing needs of trauma patients;
 - c. Developing trauma treatment protocols;
 - d. Having authority and accountability for the quality improvement peer review process, attends and participates in the LEMSA Trauma Audit Committee meetings as scheduled
 - e. Correcting deficiencies in trauma care or excluding from trauma call those trauma team members who no longer meet the standards of the quality improvement program;
 - f. Assisting in the coordination for the budgetary process for the trauma program.
 - 3. Trauma Program Manager who is a registered nurse with qualifications including evidence of educational preparation and clinical experience in the care of adult and/or pediatric trauma patients, administrative ability, and responsibilities that include, but are not limited to:
 - a. Organizing services and systems necessary for the multidisciplinary approach to the care of the injured patient;
 - b. Coordinating day-to-day clinical process and performance improvement as it pertains to nursing and ancillary personnel; and
 - c. Collaborating with the trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the trauma program.

- d. Trauma Program Manager will have current ACLS and PALS as well as TNCC (Trauma Nurse Core Curriculum) verification within 6 months of appointment.
4. The capability of providing prompt assessment, resuscitation and stabilization to trauma patients.
5. The ability to provide treatment and arrange transportation to higher level trauma center as appropriate.
6. An emergency department, division, service, or section staffed and equipped so that trauma patients are assured of immediate and appropriate initial care. A Qualified Emergency Medicine Specialist shall be immediately available at all times, 24 hours a day. The emergency physician directs the resuscitation team until the patient is transferred out or (if available) until the trauma surgeon arrives.
7. A multidisciplinary trauma resuscitation team shall be promptly available and responsible for the initial resuscitation and management of the trauma patient.
8. Trauma team: If available, may have a trauma team that consist of a trauma surgeon, anesthesiologist, and operating room crew and if team is available, shall be promptly available and respond as clinically indicated. If and when the trauma surgeon is available on call, but not present in the Trauma Resuscitation Area on patient arrival, a Qualified Emergency Medicine Specialist shall direct the team until the arrival of the trauma surgeon. If applicable or when a trauma team is available at the Level IV Trauma Center:
 - a. Trauma Surgeon: A general surgeon is available and capable of evaluating and treating adult and pediatric patients, s/he may be on call from outside of the facility provided that s/he is promptly available and responds as clinically indicated from the time the Trauma Notification is made.
 - b. Anesthesiologist: A mechanism will be established to ensure that the anesthesiologist is in the operating room when the patient arrives in the surgical suite.
 - c. Surgical Service: An operating room must be adequately staffed and readily available in a timely manner. The criterion can be met by a team on call from outside the hospital. If an on-call team is used, availability of the operating room personnel and the timeliness of starting operations must be documented.
9. The following service capabilities:
 - a. Radiological service: The radiological service will have a radiological technician promptly available.
 - b. Clinical laboratory service: A clinical laboratory service will be promptly available and have a comprehensive blood bank or access to a community central blood bank and clinical laboratory services.
10. Written transfer agreements with Level I, II Trauma Centers, pediatric Trauma Centers, or other specialty care centers, for the immediate transfer of those patients for whom stabilization and the most appropriate medical care requires additional resources.
11. Outreach Program:
 - a. The capability to provide both telephone and on-site consultations with physicians in the community and outlying areas.
 - b. This program shall include Trauma Prevention for the general public.
12. Trauma Center Response Policies and Procedures
 - a. Identification of appropriate staff/team(s) to be activated for trauma patients. Call schedules will identify individuals by name and will be date and time specific.
 - b. If applicable, individual (by position) responsible for notification of the resuscitation team and the trauma team.
 - c. Procedure for activation (notification) of the resuscitation team and if applicable, the trauma team.
 - d. Determining appropriate equipment and supplies for trauma care.
 - e. If applicable, tiered levels of response to trauma patients
 - f. If applicable, making a surgical suite available for Critical Trauma Patients.
 - g. Notification of other surgical or non-surgical specialties
 - h. Documentation of compliance with this policy and the response times of other trauma team members, and if applicable, the time surgeon paged and time of arrival of trauma surgeon to the patient's bedside.

Effective Date

- i. Identification guidelines of patients who should be transferred out to a higher level trauma center or specialty care center.

13. Trauma Registry and Data Collection

- a. Participate as requested by EMS Agency in approved Trauma Registry and in research and/or evaluative studies designed to determine the effectiveness of Hospital services or to provide information about Hospital's services to Major Trauma Persons. Hospital will participate in the integration and transmission of electronic data to the State EMSA CEMISIS-Trauma database. Hospital is responsible for all costs related to the implementation, operation, and maintenance of the Trauma Registry.
- b. Submit reports reasonably requested by EMS Agency, in a format to be determined by the Agency. The timely submission of these reports is a material condition of ongoing trauma center designation, and material or repeated failure to meet specified deadlines may be grounds for suspension or revocation of trauma center designation, at EMS Agency's discretion.

14. Trauma Education:

- a. Successful completion and current ATLS status is an optimal standard for emergency physicians who participate in the initial assessment and resuscitation of injured patients
- b. A minimum of 4 hours per year of trauma related CME/CE will be provided for staff physicians, staff nurses, staff allied health personnel, EMS personnel and other community physicians and health care personnel.
- c. All ED nursing staff will have current ACLS and PALS certification and TNCC verification within 1 year of hire.

15. Quality Improvement: Medical and Nursing Care Evaluation

- a. Written plan of quality improvement, including the monitoring of structure, process, outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:
 - 1. Detailed audit for trauma deaths, major complications/delays and transfers
 - 2. Internal Trauma Committee that is multidisciplinary and includes medical records and utilization review.
 - 3. Disaster Planning and rehearsal
 - 4. Participation in the local EMS Trauma Audit Committee
 - 5. Participation in regional trauma data collection, evaluation and reporting.

16. Trauma Marketing and Advertising

- a. In accordance with California Health and Safety Code, Division 2.5, Section 1798.165©, no healthcare provider shall use the terms "trauma facility", "trauma hospital", "trauma center", "trauma care provider", "trauma vehicle" or similar terminology in signs or advertisements, or printed materials and information furnished to the general public unless authorized by the local EMS Agency.
- b. All marketing and promotional plans, with respect to trauma center designation, shall be submitted to the EMS Agency for review and approval prior to implementation. Such plans shall be reviewed by the EMS Agency based on the following guidelines:
 - 1. Provision of accurate information
 - 2. Does not include false claims
 - 3. Not critical of other healthcare providers
 - 4. Does not include financial inducements to any providers or third parties
- c. In addition to the above, all healthcare providers shall comply with all existing applicable consumer protection laws and regulations related to advertising and marketing.

IV. TRAUMA CENTER FEES

Effective Date

- A. Trauma Center Designation Fee: The EMS Agency will establish an annual fee for trauma center designation which is intended to cover the direct costs of monitoring the operation of the Trauma Care System and ensuring compliance with State Trauma Care System Regulation. For each consecutive fiscal year during the term of this Agreement, Hospital shall issue payment to County in the amount of the previous fiscal year's fee plus the Consumer Price Index for December of the invoiced fiscal year for the San Francisco-Oakland-San Jose, California area.

V. TRAUMA CENTER DESIGNATION/REDESIGNATION

- A. The Level IV Trauma Designation will be awarded for up to a 10 year period. The LEMSA shall have the right at all times to monitor, assess, or evaluate the performance as a Level IV Trauma Center. Such monitoring, assessments, or evaluations may include, without limitations:
 - 1. Audits and inspections of premises, reports and patient records
 - 2. Interviews of Trauma Center staff and participants
- B. At a minimum of every 3 years after the designation has been awarded, a site review shall be conducted by a Site Review Committee which may include:
 - 1. Trauma surgeon
 - 2. Emergency physician
 - 3. Trauma nurse coordinator
 - 4. EMS Agency representatives
- C. If requested by the Trauma Center, a trauma center review conducted by the American College of Surgeons, paid for by Hospital in lieu of an outside review conducted by the EMS Agency.
- D. Failure of a trauma center to comply with applicable State and local trauma requirements or to provide adequate quality of medical care, as identified through medical audit and quality audit procedures may result in suspension or revocation of that hospital's trauma center designation.
- E. Redesignation/continuing trauma center designation shall be contingent upon multiple factors including, but not limited to:
 - a. Maximum term of initial designation of the facility, if applicable;
 - b. Continued compliance of the trauma center with all applicable requirements including appropriate state and local laws, regulations, EMS policies and procedures and trauma center designation agreements;
 - c. Demonstration of continued need for trauma center services.
- F. The EMS Agency shall be responsible for conducting appropriate Redesignation/continuing designation functions as necessary to ensure continuity of the regional trauma care system. The EMS Agency may incorporate on-site reviews of any trauma center as a component of its evaluation of qualifications for Redesignation/continuing designation.

5006 Stroke Receiving Centers

I. Purpose

- A. To establish criteria, responsibilities, and oversight expectations for designated Stroke Receiving Centers within the Local EMS Agency (LEMSA) jurisdiction. This policy outlines the standards for participation in the regional stroke system, consistent with state regulatory requirements and local ordinances governing EMS and ambulance operations.

II. Scope

- A. This policy applies to all hospitals designated by the LEMSA as Stroke Receiving Centers and to all EMS providers participating in the regional stroke system within the counties served by the LEMSA.

III. Policy Statement

- A. Stroke Receiving Centers play a critical role in the coordinated delivery of stroke care. Each designated facility must maintain compliance with LEMSA requirements, applicable California statutes and regulations, and local ambulance ordinances. The designation process ensures that patients meeting stroke triage criteria are transported to the most appropriate facility capable of providing definitive care.

IV. Designation

- A. Authority and Approval:
 - 1. The LEMSA has authority, under state law and local ordinance, to designate hospitals as Stroke Receiving Centers. Designation is contingent upon compliance with applicable stroke system standards and LEMSA verification processes.
 - 2. Designation Levels:
The LEMSA recognizes Stroke Receiving Centers as defined in state regulations. The specific level of designation will be determined through evaluation of hospital resources, capabilities, and performance within the regional stroke system.
 - 3. Duration and Renewal:
Stroke Receiving Center designation is granted for a finite term, subject to periodic review and re-verification by the LEMSA or its designee. Continued participation requires evidence of ongoing compliance with system requirements and quality performance standards.

V. Roles and Responsibilities

- A. Stroke Receiving Centers Shall:
 - 1. Provide 24-hour stroke care coverage with qualified personnel and resources consistent with state stroke system standards.
 - 2. Maintain active participation in the regional stroke system, including submission of data to the LEMSA-approved registry.
 - 3. Participate in the LEMSA Continuous Quality Improvement (CQI) and Performance Improvement (PI) programs.
 - 4. Participate in the Regional Stroke Advisory Committee and related multidisciplinary reviews.

5. Ensure stroke care policies, procedures, and staffing are consistent with current evidence-based standards and LEMSA guidance.
 6. Comply with all applicable elements of relevant County Ordinance regarding patient transport, interfacility transfer, and coordination with prehospital providers.
- B. The LEMSA Shall:
1. Establish and maintain a regional stroke system plan approved by the State EMS Authority.
 2. Conduct initial and ongoing verification and designation of Stroke Receiving Centers.
 3. Collect and analyze stroke data for system evaluation and quality improvement.
 4. Facilitate multidisciplinary review of stroke cases and trends through advisory committees.
 5. Ensure coordination between EMS providers, non-designated hospitals, and Stroke Receiving Centers to promote optimal patient outcomes.

VI. Data Submission and Reporting

- A. Stroke Receiving Centers must submit stroke registry data to the LEMSA in a format and frequency prescribed by the Agency. Data must include, but are not limited to:
1. Demographic, clinical, and outcome information for all stroke patients meeting inclusion criteria.
 2. Time-sensitive performance indicators and quality metrics as defined in the LEMSA CQI plan.
 3. Reports supporting system-level performance monitoring and state reporting requirements.

VII. Performance Improvement and System Oversight

- A. The LEMSA will oversee a regional stroke quality improvement process consistent with Just Culture principles and the statewide Stroke Quality Improvement Program framework. Hospitals must participate in system-level reviews, peer case discussions, and corrective action planning when indicated.

VIII. Suspension or Revocation of Designation

- A. Designation may be suspended or revoked if a hospital fails to maintain compliance with LEMSA standards, data submission requirements, or performance expectations. The LEMSA will provide written notice and an opportunity for corrective action prior to final determination.

5007 Hospital Emergency Service Downgrade

I. PURPOSE

- A. The establishment of this policy ensures that the LEMSA and its respective member counties meet relevant statutory requirements concerning the downgrading or closure of hospital emergency services. The downgrading or closure of a facilities emergency service can impact a community and its access to those services. This impact can also affect other entities and the emergency services that they provide in their hospitals. How to evaluate and report on these impacts to the affected communities and overall Emergency Medical Services system is the purpose of this policy.

II. POLICY

- A. To establish a methodical process for the evaluation of the potential impact on the Emergency Medical Services system due to the downgrade or closure of emergency medical services in hospitals.
- B. Procedure for Hospitals:
 - 1. Any hospital proposing a reduction or elimination of emergency medical services in their facility shall notify the LEMSA no later than 90 days prior to any such change. The notification must include:
 - a. Itemization of the services currently provided and the exact nature of the proposed change(s).
 - b. Reason for the proposed change(s).
 - c. Description of the local geography, surrounding services, and average number of visits
 - d. Description of potential impact on the EMS community regarding patient volume and type of Prehospital and emergency department services available, including a pre/post comparison
 - e. Description of potential impact on the public regarding an accessibility of comparable alternative facilities or services, including a pre/post comparison
- C. Procedure for LEMSA
 - 1. Within 30 days of notification, the LEMSA will complete and distribute a draft EMS Impact Evaluation of the proposed changes per the requirements within California Health and Safety Code.
- D. Public Hearings for hospital closure
 - 1. Within 7 days of completing the preliminary Impact Evaluation, the LEMSA, in cooperation with the affected county's health department, will conduct at least 1 public hearing, and incorporate the results of those hearings in the final Impact Evaluation. These public hearings may be incorporated with other public meetings held by the EMS Agency, the Board of Supervisors of the affected county, and/or other government agencies, commissions, or committees.
- E. Final Action for hospital closure
 - 1. Within 60 days of receiving notice, the LEMSA will prepare the final Impact Evaluation and final LEMSA recommendations, including a summary of comments received during the public hearing, and submit those findings to the California Department of Public Health Services, the Emergency Medical Care Committee(s), and the Board of Supervisors of the affected county.

6001 EMS PROVIDER DATA REQUIREMENTS

I. PURPOSE

- A. To define the use of standardized records and data sets or fields to be used by all Emergency Medical Service providers for documentation of prehospital care. This policy defines the minimum documentation sets and defines the structure for computer aided dispatch and patient care records maintained by prehospital care providers and submitted to the LEMSA as outlined in State regulations.

II. POLICY

- A. Patient Care Reporting- Requires an emergency medical care provider (Transport or First Response Agencies) to, when collecting and submitting data to the LEMSA, use a system that exports data in a format that is compatible with the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements required by the LEMSA. The LEMSA will not mandate that a provider use a specified system to collect and share data with the LEMSA. Providers must use a system that can be integrated with the LEMSA's system, as specified. Providers shall ensure compatibility with the LEMSA's system.
 1. Electronic Patient Care Report (ePCR)- Transport of First Response Agency Providers shall create patient care records in an electronic format acceptable to the LEMSA. EMS providers not utilizing the LEMSA selected ePCR system shall establish a process with the LEMSA ePCR vendor to allow for EMS data submission.
 2. Data shall be submitted to the LEMSA data system on a schedule agreed to by the provider and the LEMSA
 3. Patient care record data shall include records for all EMS incidents and patient contacts.
- B. Computer Aided Dispatch (CAD)- Dispatch Providers (or their Contractor) shall submit computer aided dispatch data to the LEMSA, in an electronic format acceptable to the LEMSA, a near real-time basis is optimal, in very limited cases time is NOT TO EXCEED 5 MINUTES. Computer aided dispatch data shall include records for all emergency and nonemergency ambulance or medical aid requests received at the provider's dispatch center.
 1. Each CAD record submitted to the LEMSA shall contain the following fields, as a minimum:
 - a. Call Date.
 - b. Incident Number.
 - c. Scene County.
 - d. Call Type (e.g. scene, interfacility transfer).
 - e. Emergency Medical Dispatch (EMD) determinant code.
 - f. Code of Response.
 - g. Updated Code of Response.
 - h. Code of Transport.
 - i. Updated Code of Transport.
 - j. Time Public Service Answering Point (PSAP)
 - k. Vehicle/Unit ID Number.
 - l. Time Call Entered.
 - m. Time Dispatched.
 - n. Time En Route.
 - o. Time Arrived Scene.
 - p. Time Departed Scene.
 - q. Time Arrived at Hospital
 - r. Time Available
 - s. Time Canceled, if applicable
 - t. Call disposition
 - u. GIS Map Page information

III. PROVISION OF ACCESS AND PROGRAM

- A. The LEMSA will provide access to the approved Electronic Patient Care Report system and software to EMS system participants required to enter, edit, or analyze data.

Effective Date:

IV. TECHNICAL PROBLEMS/RECOVERY PROCEDURES

- A. Device Failure - In the event of a device failure, contact your agency's support person. Document all pertinent information on paper and enter the information in the ePCR when the device issue is resolved or on another working device. Electronic documentation device failure is NOT an exception for providing the required PCR documentation. Device failures will be resolved within 48 hours. Any issues affecting more than one device or all agency devices will be reported to the LEMSA within 24 hours.
- B. Connectivity Failure – If there is connectivity failure, document all patient information on your device and save. Post your ePCR to the server as soon as connectivity returns.
- C. System Failure – In the event of system failure document all patient information on your device and save. Post/Sync to the server as soon as the system is rebooted.
- D. The LEMSA shall be notified of downtime or transmission difficulties lasting more than 24 hours.
- E. Any system upgrades or system maintenance must be reviewed and approved in writing by the LEMSA prior to implementation. Any planned issue that could cause a delay in data transmission will be notified to the LEMSA at least 24 hours in advance.
- F. Agencies not using the LEMSA's ePCR system will be required to ensure that their data is being sent to the LEMSA in the agreed upon amount of time. Data uploads should be monitored and checked by the sending agency (or software vendor) to ensure the data is being sent without interruption. The LEMSA shall be notified within 48 hours of any data interruption. Should the LEMSA identify a data flow issue it will notify the Agency as soon as the issue is identified. The Agency will then work on resolving the issue as soon as possible and will provide updates to the LEMSA.

V. GENERAL INSTRUCTIONS AND CONDITIONS

- A. The ePCR is a part of the patient's permanent medical record and is used for, but not limited to, the following purposes:
 - 1. Transfer of information to other healthcare providers
 - 2. Medical legal documentation
 - 3. Billing for services
 - 4. Development of aggregate data reports for Continuous Quality Improvement (CQI) including specific quality indicators and identification of educational needs
 - 5. LEMSA case investigation
- B. The EMS Medical Director is the final authority for determination of all aggregate data reports that are to be maintained confidential or distributed.
- C. Willful omission, misuse, tampering or falsification of documentation of patient care records is cause for formal investigative action under section 1978.200 of the California Health and Safety Code.

VI. PRIVACY

- A. Maintaining confidentiality is an essential part of all health care, including prehospital care. The confidentiality of personal health information (PHI) is covered by numerous State and Federal Statutes, Policies, Rules and Regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), California Civil Code and California Health and Safety Code. All EMS Providers are responsible to enact policies which ensure patient privacy by restricting access and implementing electronic protections. Any ePCR not completed on the LEMSA data system shall be made available to the LEMSA upon request.

VII. ePCR DOCUMENTATION REQUIREMENTS

- A. Definitions
 - 1. Incident: An incident is any response involving EMS, Transport or First Response agency personnel to any event in which there is an actual patient or the potential for a patient, regardless of whether the responding unit was cancelled en route. This includes all emergency responses, nonemergency responses, walk-in contacts, responses that are cancelled before scene arrival, any pre-arranged ambulance standby and any ambulance transfers originating in region.

Effective Date:

2. Patient: any person encountered by prehospital personnel who demonstrates any known or suspected illness or injury OR is involved in an event with significant mechanism that could cause illness or injury OR who requests care or evaluation.
 3. Patient Contact: A patient contact is defined as any contact between an EMT or Paramedic and a potential patient, including contacts which fall into the Determination of Death Policy, is considered a patient contact and requires completion of an ePCR.
 4. Patient Response: An incident with any NEMSIS patient-care disposition (e.g., treated/transported, treated/released, refused, deceased at scene, or cancelled on scene after patient contact).
 5. Non-Patient Event: An EMS incident with a non-patient contact disposition (e.g., Cancelled Prior to Arrival, Cancelled on Scene—No Patient Contact, No Patient Found, Standby—No Services Provided).
- B. Electronic PCR's shall be completed and submitted electronically.
- C. EMS personnel shall complete ePCR's as follows:
1. ePCR for patient responses. All ALS/BLS and ambulance transport providers shall complete and submit a NEMSIS-compliant ePCR for every Patient Response, consistent with CCR Title 22 §100096.03 and HSC §1797.227.
 2. Minimal documentation for non-patient events. For Non-Patient Events, providers may satisfy documentation with a minimal incident record containing dispatch, times, unit, location, and disposition. This may be an auto-generated NEMSIS "no-patient" record (CAD-populated; no narrative required)
 3. NERIS vs. ePCR. NERIS is not accepted in lieu of a NEMSIS-compliant ePCR for Patient Responses (HSC §1797.227). NERIS remains acceptable for agency fire reporting; for Non-Patient Events the minimal incident record in 6001 VII C (2) fulfills the LEMSA EMS data need.
 - a. Documentation matrix (new):

Scenario	Requirement
Arrived, no patient found / standby only or cancelled prior to arrival	Minimal incident record (CAD-information); no ePCR narrative required
Any patient contact (incl. treat/no-transport, refusal, deceased at scene)	Full NEMSIS ePCR

- D. All available and relevant information shall be accurately documented on the ePCR.
- E. Intentional failure to complete an ePCR when required, or fraudulent or false documentation on an ePCR, may result in formal investigative action under the California Health and Safety Code.
- F. Patient care documentation management is to be compliant with HIPAA and medical record retention requirements.
- G. The LEMSA may request specific documentation elements related to CQI, field study or trials and other emergency management data collection requirements.
- H. ePCR Availability
 1. First Responder agencies should migrate to electronic ePCR documentation when feasible
 2. All. incident ePCR's shall be fully completed and submitted within 4 hours
- I. ePCR Procedures
 1. Personnel providing patient care are responsible for accurately documenting all available and relevant patient information on the ePCR. Provider agencies may set documentation standards which are more specific than required by regulation.
 2. Care given prior to arrival, by bystanders or first responder personnel, shall be documented on an ePCR.
 3. Receiving facility signature is required for all patients arriving by ambulance at transfer of care time. Transfer of care time is at the time when the patient is removed from the gurney and turnover of care report has been given.
 4. Use of usual and customary abbreviations is permitted in the narrative section of the record or as defined in automated ePCR pre-designated pick lists.

Effective Date:

5. The PCR shall contain the following Basic Data Elements, when available:
 - a. Initial Response Information
 - i. Incident Number
 - ii. Agency Case Number
 - iii. unit number
 - iv. Date and estimated time of incident
 - v. Time of receipt of call
 - vi. Time of dispatch to the scene
 - vii. Time responding
 - viii. Time of arrival at the scene
 - ix. Incident location
 - b. Patient Information:
 - i. Name
 - ii. Age or date of birth
 - iii. Gender
 - iv. Weight, if necessary for treatment
 - v. Address
 - vi. Chief complaint
 - vii. Patient history
 - viii. Vital signs
 - ix. Appropriate physical assessment
 - x. Emergency care rendered and patient's response to such treatment
 - c. Complete any Agency defined/ required electronic data element fields
 - i. Patient disposition
 - ii. time of departure from scene (if transported)
 - iii. Time of arrival at receiving facility (if transported)
 - iv. Name of receiving facility (if transported)
 - v. Turnover of care receiving hospital signature
 - vi. Name and unique identifier number(s) of EMS personnel on the call
 - vii. Signature of EMS personnel on the call
6. The ePCR shall be completed and distributed in accordance with this policy.
7. A completed ePCR shall not be altered or changed except by the individual who completed the ePCR. Exceptions are permitted to add or change billing information or add a name or other pertinent demographics unknown at the time of the call.
8. Any changes made to an ePCR shall have documentation of those changes retained in the computer database.
9. In situations where the patient or their legal representative declines medical care or transport when care is recommended and felt to be necessary by the prehospital personnel attending that patient, documentation should include all available basic data elements.
10. Receiving facility signature is required for all patients arriving by ambulance at transfer of care time. Transfer of care time is at the time when the patient is removed from the gurney and turnover of care report has been given.

VIII. CORE MEASURES DATA ELEMENTS

Effective Date:

- A. California Emergency Medical Services Authority has developed outcome-based Core Measures. Data elements for these core measures should be addressed in any provider agency documentation standards. some of those elements may include, but are not limited to, and are subject to change as state requirements are revised
1. Trauma - Times, Destination decisions
 2. Acute Coronary Syndrome (ACS) - ASA, 12-lead, destination decisions
 3. Cardiac Arrest - AED use, bystander involvement
 4. Stroke- use stroke screening, destination decisions, times, blood glucose testing
 5. Respiratory - CPAP use, Beta2 use
 6. Pediatric - Bronchodilator use and Trauma Center Diversion
 7. Pain –Pain level assessed
 8. Endotracheal Intubation - Success and ETCO2
 9. Response and Transport - Times

Effective Date:

6002 EMS System Continuous Quality & Performance Improvement Framework

I. PURPOSE

- A. This policy establishes a unified framework for the development, oversight, and implementation of the Local EMS Agency's (LEMSA) Continuous Quality Improvement (CQI) system. It integrates the agency's policy, program expectations, and improvement plan into a single operational document. The framework advances a culture of learning, accountability, and evidence-based performance improvement throughout the EMS system.

II. GUIDING PRINCIPLES

- A. This framework is built on:
 - 1. A systems-oriented accountability model that aligns with modern high-reliability practices
 - 2. Human Factors and System Science philosophies
- B. Deming's Model for Improvement (Plan-Do-Study-Act)
- C. The EMS Agenda for the Future 2050, including goals around provider wellness, innovation, and data-driven service delivery

III. IMPROVEMENT CONCEPTS

- A. Quality Improvement (QI): A structured, data-informed, cyclical process used to identify, analyze, and improve system performance and patient outcomes. The Structure, Process, Outcome Model: An improvement model to evaluate performance using.
 - 1. structural metrics (resources, staff, equipment),
 - 2. process metrics (care delivery and system function),
 - 3. outcome metrics (patient and system results).
- B. Human Error: An unintentional action or decision inconsistent with established procedures, standards, or expectations.
- C. At-Risk Behavior: Behavioral drift or shortcuts taken in belief they are justified; typically driven by system design, habits, or perceived benefit.
- D. Reckless Behavior: A conscious disregard of substantial and unjustifiable risk.
- E. Performance Indicator: A quantifiable measure used to assess specific elements of clinical care or system performance.

IV. SYSTEM-WIDE QI FRAMEWORK

- A. LEMSA shall implement a region-wide Quality & Performance Improvement System that:
 - 1. Includes prospective, concurrent, and retrospective components
 - 2. Uses standardized data from ImageTrend, FirstWatch/FirstPass, and stakeholder input
 - 3. Benchmarks performance against national standards (e.g., NEMSQA, EMSA Core Measures)
 - 4. Incorporates multi-level stakeholder feedback
 - 5. Applies systems-based cause analysis (e.g., review of human/system contributions)
 - 6. Establishes and maintains a multidisciplinary CQI Committee

7. Collects, analyzes, and reports aggregate data across system domains (e.g., response,
8. time-sensitive conditions, documentation)
9. Coordinates improvement activities with EMS providers and hospital partners

V. EMS PROVIDER EXPECTATIONS

- A. All EMS providers shall:
 1. Submit an annual Provider CQI Plan to the LEMSA for approval per Title 22
 2. Actively participate in system CQI efforts and data submission
 3. Use the Plan-Do-Study-Act cycle, or preferred model to address internal performance gaps
 4. Participate in regionally coordinated improvement projects (e.g., stroke care bundle)
 5. Submit reports or respond to data requests related to system indicators
 6. Providers shall maintain internal review processes that address:
 - a. Event and trend review
 - b. Documentation accuracy and compliance
 - c. High-risk/high-frequency incidents
 - d. Clinical care variances
 - e. Crew performance and education

VI. CQI COMMITTEE STRUCTURE

- A. The LEMSA shall facilitate a standing CQI Committee with quarterly meetings, membership will include:
 1. EMS Agency Medical Director and staff
 2. ALS/BLS provider representatives
 3. Base hospital and receiving hospital clinical stakeholders
- B. The committee shall:
 1. Review performance metrics and improvement projects
 2. Support implementation of system-wide improvement efforts
 3. Recommend policy or protocol revisions based on QI findings
 4. Share best practices in quality improvement activities

VII. PERFORMANCE MEASUREMENT & DATA SOURCES

- A. Data for evaluation will include but not be limited to:
 1. EMS Data system alerts, dashboards and reports
 2. National EMS Quality Alliance (NEMSQA) and EMSA Core Measures
 3. Base Hospital audits and clinical feedback
 4. Patient experience or complaint reports
 5. Training evaluations

VIII. IMPROVEMENT METHODS

Effective Date

- A. The LEMSA and its providers will use structured approaches for performance improvement such as:
 - 1. System cause and behavioral review (human error, at-risk, reckless behaviors)
 - 2. Contributing factor analysis
 - 3. Focused education, protocol revisions, or equipment/process changes
 - 4. Plan-Do-Study-Act (PDSA) <https://deming.org/explore/fourteen-points/>

IX. COMMUNICATION AND COLLABORATION

- A. Improvement activities shall be shared through:
 - 1. CQI Committee discussions
 - 2. Provider-specific feedback
 - 3. Data System bulletins, special memo or updates when protocol/policy changes are needed,'
 - 4. Coordination with specialty care system advisory groups (Stroke, STEMI, Trauma)
 - 5. Provider agency recognition of outstanding patient care

X. REPORTING

- A. LEMSA responsibility:
 - 1. Submit an annual CQI Plan to the California EMS Authority
 - 2. Maintain documentation of CQI activities and data review processes
 - 3. Provide internal and external reports / dashboard to drive transparency, collaboration, and accountability as well as celebrating successes

*This document replaces all prior QI program and policy documents within Policy 6000 series. *

6003 EMS Event Reporting

I. PURPOSE

- A. To establish a clear and consistent system of EMS event reporting across the LEMSA system for the purpose of improving patient safety, mitigating risk, and supporting system-wide quality improvement through non-punitive, good-faith reporting and evaluation.

II. DEFINITIONS

- A. EMS Event/Unusual Occurrence: Any atypical or unexpected event that poses or could pose a risk to patient safety, including but not limited to protocol deviations, medication errors, delayed responses, equipment failure, or behavior inconsistent with accepted scope or standards of care.
- B. Human Error: An unintentional act that deviates from expected performance, often due to slips, lapses, or cognitive mistakes, despite the intent to act correctly.
- C. At-Risk Behavior: A behavioral choice that increases risk, where the risk is not recognized or is mistakenly believed to be justified.
- D. Reckless Behavior: A conscious disregard of a substantial and unjustifiable risk that constitutes a gross deviation from standard practice.
- E. Good-Faith CQI Report: A report submitted with the intent of improving care and understanding system vulnerabilities, not assigning blame.

III. POLICY

- A. All EMS providers, base hospitals, and receiving hospitals participating in the LEMSA system shall:
 - 1. Promptly identify, report, and respond to EMS events that pose actual or potential threats to patient safety or public trust.
 - 2. Submit initial notification of the event to the LEMSA within 48 hours using the EMS Event/Unusual Occurrence Reporting Form available on the LEMSA website. Will add link to form when revised with new email address.
 - 3. Complete an internal review and submit a good-faith CQI report to the LEMSA within 14 calendar days of discovery or request an extension from the LEMSA if additional time is needed.
- B. Events may include but are not limited to:
 - 1. Protocol or scope of practice deviations
 - 2. Incorrect medication administration (drug, dose, route, or patient)
 - 3. Equipment failures impacting patient care or crew safety
 - 4. Delays in care that may contribute to adverse outcomes
 - 5. Suspected patient neglect, abuse, or inappropriate behavior by EMS personnel
 - 6. Situations that may cause significant community concern or media attention
- C. Exemplary care and positive clinical events may also be reported to recognize success and promote learning.

IV. REPORTING RESPONSIBILITIES

- A. EMS Field Personnel:
 - 1. Ensure patient safety and notify receiving hospital staff if an event has or could impact the patient.

Effective Date:

2. Report the event promptly to the on-duty supervisor or designated agency reviewer.
 3. EMS personnel may report directly to the LEMSA if desired
- B. Provider Agency:
1. Maintain an internal EMS event reporting and review process integrated into the agency's CQI program.
 2. Submit initial event notification to the LEMSA within 48 hours.
 3. Conduct a fact-based internal review and submit a CQI event summary within 14 days or request an extension.
 4. Take appropriate action to address contributing factors, such as training, equipment, or policy changes.
- C. Base Hospitals:
1. Notify the Paramedic Liaison Nurse (PLN) of EMS events.
 2. Ensure completion and forwarding of the reporting form to the LEMSA and involved provider agency.
- D. Receiving Hospitals:
1. Report identified EMS events to the provider agency supervisor or PLN and/or complete the EMS Event Reporting Form available via the LEMSA website.
- E. LEMSA:
1. Acknowledge receipt of reports.
 2. Review reports for system-level concerns, trends, or learning opportunities.
 3. Facilitate interagency communication and collaborative response where needed.
 4. Support agencies in applying system science to identify and resolve human and system factors contributing to events.
 5. Promote recognition of exemplary care or actions

V. INTERNAL REVIEW PROCESS

- A. All agencies must:
1. Gather a clear timeline of the event.
 2. Interview involved personnel in a supportive, non-punitive manner.
 3. Identify whether the event involved human error, at-risk behavior, or reckless behavior.
 4. Determine contributing system issues (e.g., communication gaps, unclear protocols, inadequate equipment).
 5. Take appropriate mitigation actions: support, coaching, retraining, or system redesign.

VI. LEMSA PRINCIPLES

- A. The LEMSA fosters a safety-oriented culture in which EMS events are:
1. Viewed as opportunities to improve safety and system performance
 2. Analyzed for learning, not blame
 3. Protected under California Evidence Code as part of the QI process when possible
 4. Addressed as enforcement or disciplinary matters only when QI measures are ineffective or inappropriate.

Providers are expected to participate in this process with integrity and transparency, knowing that early identification and honest reporting are vital to improving outcomes and trust across the EMS system.

Effective Date: