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**EMS Resources**
- R01 Hospital Decision Matrix for Acute Care Interfacility Transport
- R02 Multi-Casualty Incident (MCI) Plan
9-1-1 ambulance provider: An ambulance provider holding a valid Contra Costa County emergency ambulance permit or contracting with the County to provide ALS ambulance response to 9-1-1 requests.

Abuse or Neglect: Refers to physical injury or death inflicted by other than accidental means on a child by any other person. It includes willful harm or injury; sexual abuse, assault, and exploitation; endangerment; deprivation of food, water or healthcare, and unlawful corporal punishment or injury. With respect to adults or dependents, it also includes abandonment, isolation, abduction, treatment resulting in physical harm or mental suffering, deprivation of goods or services by a custodian that are necessary to avoid physical harm or mental suffering, and financial abuse.

Accredited Center of Excellence Accreditation or ACE: The International Academies of Emergency Dispatch, through its College of Fellows, has established a high standard of excellence for emergency dispatch, providing the tools to achieve this high standard at both the dispatcher level through certification, and at the communication center level through the accreditation program.

Advanced Health Care Directive (AHCD): A legal written document that allows an individual to provide health care instructions or designate an agent to make health care decisions for that person. AHCD is the current legal format for a living will or Durable Power of Attorney for Health Care (DPAHC).

Advanced Life Support or ALS: Special services designed to provide definitive pre-hospital emergency medical care, including, but not limited to cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a Base Hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital.

Agent: An individual, eighteen years of age or older, designated in a power of attorney for health care to make health care decisions for the patient, also known as “attorney-in-fact.”

Air Ambulance 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 at a minimum two (2) attendants certified or licensed in advanced life support.

Ambulance: An emergency basic life support (BLS) or advanced life support (ALS) ambulance.

Ambulance Parking: The practice of having patients arriving by 9-1-1 ambulance wait on the ambulance gurney for greater than thirty (30) minutes 90% of the time after arrival on hospital grounds.

Ambulance Provider: An entity properly permitted to operate an emergency ALS ambulance service in Contra Costa County.

Ambulance Stacking: Two or more 9-1-1 ambulances waiting for more than thirty (30) minutes at a single hospital.

Automated External Defibrillator or AED: Refers to an external defibrillator capable of cardiac rhythm analysis, which will charge and, with or without further operator action, deliver a shock after
electronically detecting and assessing ventricular fibrillation or rapid ventricular tachycardia. These devices are known as fully or semi-automatic defibrillators.

**Basic Life Support or BLS:** Emergency first aid and cardiopulmonary resuscitation procedures which, as a minimum, include recognizing respiratory and cardiac arrest and starting the proper application of cardiopulmonary resuscitation to maintain life without invasive techniques until the victim may be transported or until advanced life support is available.

**Base Hospital:** A hospital which, upon designation by the local EMS agency and upon the completion of a written contractual agreement with the local EMS agency, is responsible for directing the advanced life support system or limited advanced life support system and pre-hospital care system assigned to it by the local EMS agency.

**Best Practices:** Processes that, through experience and research, have proven to be the best method to achieve a desired result.

**Bi-directional Data Exchange:** A health information sharing project that builds on the previously established Federal Health Information Exchange program. Allows for two-way sharing of PHI data between prehospital providers and hospitals.

**California EMS Data Set:** The California approved list of core and elective data elements to be collected for EMS calls and transmitted to the local EMS agency for submission to the state data system.

**Cardiopulmonary Resuscitation or CPR:** The manual opening and maintaining of an airway, providing artificial ventilation by rescue breathing and providing artificial circulation by means of external cardiac compression.

**CEMSIS:** The California Emergency Medical Services Information System, which is the state repository that stores data from participating EMS systems.

**CCCEMSIS:** The Contra Costa County Emergency Medical Services Information System, which is a multi-system, multi-disciplinary data collection and management system.

**Child:** A person under the age of 18 years. The term “child” includes students who are under the age of 18.

**Competency:** The ability to understand and to demonstrate an understanding of the nature of the illness/injury and the consequence of declining medical care.

**Computer Interpretation of STEMI:** With printout of P12ECG done, a patient with a STEMI is identified distinctly with ***Acute MI Suspected*** (LP12) or ***MEETS ST ELEVATION MI CRITERIA*** (LP15) by a computerized algorithm present in the monitor-defibrillator unit (wording varies by manufacturer). Other abnormalities of P12ECG do not signify STEMI.

**Conservator:** Court-appointed authority to make health care decisions for a patient.

**Contamination:** When a hazardous material is physically present on a person’s skin, clothing or hair (external) or has been inhaled or ingested (internal).

**Decision Making Capacity:** The term used when determining whether or not a patient or subject is psychologically or legally capable of adequate decision-making. Decision making capacity relates to the specific medical decision at hand and does not imply a global ability to make any or all decisions.
about health care or other matters.

**Definitive Care**: A level of therapeutic intervention capable of providing comprehensive health care services for a specific condition.

**Delayed Patient Care Transfer**: Patient care transfer between ambulance personnel and ED staff in excess of thirty (30) minutes.

**Dependent adult**: Anyone aged 18-64 who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights. These include persons with physical or developmental disabilities or whose physical or mental abilities have diminished with age.

**Do Not Resuscitate (DNR)**: A legal written document that expresses the patient’s wishes to withhold cardiopulmonary resuscitation or advanced cardiac lift support.

**Donate Life California**: A donor registry (internet-based, accessible by hospital personnel involved in transplant or tissue donation decisions) also contains the information on donor status that is present on driver’s licenses or identification cards issued since 2006.

**Dual Power of Attorney for Health Care (DPAHC)**: A legal written document that gives a person(s) designated by the patient the power to make health care decisions in the event the patient is unable to do so on their own. See Advanced Health Care Directive

**Elder**: Anyone age 65 or older.

**Electronic Health Record or EHR**: A legal record completed by prehospital personnel that includes the systematic documentation of a patient’s medical history, assessment, and care.

**Emergency Department or ED**: The area of licensed general acute care hospital that customarily receives patients in need of emergent medical evaluation and care.

**Emergency Medical Dispatch or EMD**: The reception, evaluation, processing and provision of dispatch life support, management of requests for emergency medical assistance, and ongoing evaluation and improvement of the emergency medical dispatch process.

**Emergency Medical Dispatch Center**: Any dispatching center receiving and dispatching calls for EMS, which provide pre-arrival medical care instructions and/or tiered response resource management.

**Emergency Medical Dispatcher**: An individual certified by the International Academies of Emergency Dispatch (IAED) providing pre-arrival instructions (PAIs) and/or tiered response management.

**Emergency Medical Services or EMS**: The services utilized in responding to a medical emergency.

**Emergency Medical Technician or EMT**: An individual trained in all facets of basic life support according to standard prescribed by this part and who has a valid certificate issued pursuant to this part. This definition shall include but not be limited to, EMT and A-EMT.

**Emergency Trauma Re-Triage**: The movement of patients meeting specific high-acuity criteria to a trauma center for trauma care. Timeliness of evaluation and intervention at the trauma center is critical.

**EMS Quality Improvement Program (EQIP)**: An integrated, multidisciplinary program that focuses on system improvement. Methods of evaluation are composed of structure, process and outcome measurements.
EMS Provider: First responder and/or ambulance provider participating in the Contra Costa County EMS System.

First Responder Provider: An organization authorized by Contra Costa County EMS to participate in the EMS system as the initial contact for patients in the pre-hospital setting.

Hospital: An acute care hospital licensed under Chapter 2 (commencing with Section 1250) of Division 2, with a permit for basic emergency service.

Immediate Family: The spouse, domestic partner, adult child(ren) or adult sibling(s) of the patient.

Imminent Death: A condition wherein illness or injuries are of such severity that in the professional opinion of emergency medical personnel, death will probably occur before the patient arrives at the receiving hospital. This definition does not include any conscious patient regardless of the severity of illness or injury.

Incident Command System or ICS: A standardized on-scene emergency management system.

International Academies of Emergency Dispatch or IAED: The IAED is a non-profit standard-setting organization promoting safe and effective emergency dispatch services world-wide.

Local EMS Agency or LEMSA: The agency, department or office having primary responsibility for administration of emergency medical services in a county.

Mandated Reporter: Any healthcare practitioner, childcare custodian or employee of a child protective agency. This includes EMTs and paramedics.

Medical Arrest: Cardiac arrest with total absence of observers or witness information OR cardiac arrest in which arrest occurred greater than fifteen (15) minutes prior to arrival of prehospital personnel without resuscitative measures taken.

Medical Control: Physician responsibility for the development, implementation and evaluation of the clinical aspects of an EMS system.

Mobile Intensive Care Nurse or MICN or Authorized Registered Nurse: A registered nurse who is functioning pursuant to Section 2725 of the Business and Professions Code and who has been authorized by the medical director of the local EMS agency as qualified to provide pre-hospital advanced life support or to issue instructions to pre-hospital emergency medical care personnel within an EMS system according to standardized procedures developed by the local EMS agency consistent with statewide guidelines established by the authority.

Multi-casualty Incident or MCI: A natural or human caused event that may overwhelm the medical resources within a system and may result in multiple injuries or deaths. It is characterized by a limited geographic scope and can be managed by an on-scene command system.

NEMSIS: The National Emergency Medical Services Information System, which is the national repository that standardized and stores data from all participating EMS systems.

Never Event: Never events are serious, largely preventable, patient safety incidents. Patient transfer of care delays of greater than sixty (60) minutes shall be considered a “Never Event” within the Contra Costa EMS System.
Newborn Safe Surrender Kits: These kits are used by Safely Surrender Site personnel and contain all written procedures and materials necessary to accept a safely surrendered baby.

Non-emergency ambulance provider: An ambulance provider holding a valid Contra Costa County non-emergency ambulance permit.

Optimal Patient Care Transfer: Patient care transfer between ambulance personnel and ED staff in fifteen (15) minutes or less.

Paramedic or EMT-P or Mobile Intensive Care Paramedic: An individual whose scope of practice to provide advanced life support is according to standards prescribed by this division and who has a valid certificate issued pursuant to this division.

Paramedic Preceptor: “Paramedic Preceptor” or “Preceptor” means a licensed California and Contra Costa County accredited paramedic that is authorized to supervise and instruct paramedic students during their field internship.

Paramedic Intern: “Paramedic Intern” or “Intern” means a paramedic student that has completed didactic and clinical portions of paramedic training and is eligible for and who is in the process of completing the field internship portion of paramedic training and who has been authorized as a paramedic intern in Contra Costa County.

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.

Patient Care Transfer Time: The time when the patient is removed from the ambulance gurney and transferred into the care of ED staff. This period includes EMS patient care verbal report to ED receiving staff.

Prehospital 12-Lead ECG: A 12-lead electrocardiogram obtained by EMS crews or in rare circumstances by a medical facility or office other than a hospital.

Prehospital Provider: EMS and Fire First Responders and/or Transport Providers.

Protected Health Information (PHI): Individually identifiable health information, including demographic information collected from an individual.

Psychiatric Detention: Refers to a patient who is held under the authority of Welfare and Institutions Code, Section 5150, because the patient is a danger to himself/herself, a danger to others, or gravely disabled (e.g., unable to care for self). This written order may be placed by a law enforcement officer, County mental health worker or an emergency physician certified by the County to place an individual on a 5150 hold.

Qualified Person: A competent person making a decision for him/herself or another who is qualified by one of the following:
1. An adult patient defined as a person who is at least eighteen (18) years old; OR
2. A minor (under eighteen [18] years old) who qualifies based on one of the following conditions:
   a. A legally married minor;
   b. A minor on active duty with the U.S. military;
c. A minor seeking prevention or treatment of pregnancy or treatment related to sexual assault;

d. A minor, twelve (12) years of age or older, seeking treatment of contact with an infectious, contagious or communicable disease or sexually transmitted disease;

e. A self-sufficient minor at least fifteen (15) years of age, living apart from parents and managing his/her own financial affairs;

f. An emancipated minor (must provide proof); OR

3. The parent of a minor child or a legal representative of the patient (of any age). Spouses or relatives cannot consent to or decline care for the patient unless they are legally designated representatives.

Quality Improvement or QI: A method of evaluation of services provided, which includes defined standards, evaluation methodologies and utilization of evaluation results for continued system improvement.

Reasonable Search: A brief attempt by emergency medical personnel to locate documentation that may identify a patient as a potential organ donor, or one who has refused to make an anatomical gift. This search shall be limited to a wallet or purse that is on or near the individual to locate a driver’s license or other identification card with this information. A purse or wallet search by emergency medical personnel must be done in the presence of a witness.

Safely Surrendered Baby Program: The local program that includes county-wide policies and procedures for the training of personnel responsible for safe surrender of infants. This program is administered jointly by the Employment and Human Services’ Children and Family Services and Contra Costa Health Services (CCHS) Family, Maternal and Child Health Programs Division. CCHS Emergency Medical Services (EMS) Division supports this program as part of its EMS for Children efforts.

Safely Surrender Site: Contra Costa Safely Surrender Sites include hospitals, fire stations, County Health Centers and Kaiser medical offices.

ST-Segment Elevation Myocardial Infarction or STEMI: A specific finding on P12ECG showing ST-segment elevation of 1 mm or greater in anatomically contiguous leads, indicating this specific type of myocardial infarction.

Standardized Patient-Designated Directives:

1. DNR: Statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form. A DNR may also present as a standard DNR medallion/bracelet (e.g., Medi-Alert).

2. POLST: Physician Orders for Life Sustaining Treatments a standardized and signed designated-physician order that addresses a patient’s wishes about a specific set of medical issues related to end-of-life care.

STEMI Alert: Notification to STEMI Receiving Center that a patient is inbound with possible myocardial infarction. Notification should be given as soon as a STEMI is identified.

STEMI Receiving Center or SRC: Hospitals designated by Contra Costa EMS as those to which patients with identified STEMI on P12ECG will be transported based on the center’s prompt availability of
invasive cardiac care.

**Stroke Alert**: Notification to Stroke Receiving Center that a patient is inbound with stroke like symptoms. Notification should be given as soon as symptoms are identified.

**Trauma Transfer**: The movement of other patients with traumatic injuries to a trauma center (those not meeting “Emergency Trauma Re-Triage criteria”) whose needs may be addressed in a prompt fashion but are less likely to require immediate intervention.

**Traumatic Arrest**: Cardiac arrest resulting from blunt or penetrating trauma.

**Unusual Level of Demand**: Periods of unanticipated high levels of ED demand that are unable to be addressed by internal protocols for ED saturation (e.g., multi-casualty incidents or hospital internal disaster). Unusual level of demand does not include predictable high utilization periods associated with normal EMS system operations (e.g., seasonal influenza, time of day or day of week).

**Unstable**: A patient who has a life- or limb-threatening condition requiring immediate and definitive care. An unstable patient may have chest discomfort, blood pressure less than 90mmHg, respiratory distress, pulmonary edema, airway compromise, neurological changes from baseline, signs of actual or impending shock or may meet criteria for transport directly to a trauma center. Refer to EMS Administrative Policy #1003 for additional information regarding patients with valid DNR or POLST orders.

**Whole Person Care (WPC)**: An EMS/health care system quality initiative designed to provide a high level of the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved outcomes and more efficient and effective use of resources.
I. PURPOSE
Emergency Medical Services (EMS) rendered by Contra Costa County EMS system provider agencies, both emergency and non-emergency, are accomplished under the medical direction of the EMS Medical Director. This policy defines the scope of medical direction and oversight provided in the EMS system.

II. SCOPE OF OVERSIGHT AND DIRECTION
Medical direction applies to all events involving emergency medical care for patients from the initial request for service to the delivery of patients to receiving facilities. Dispatch, first response, transport provider care and Base Hospital direction fall under the auspices of the EMS Agency Medical Director or his/her designee. In addition to emergency and non-emergency scene responses, medical direction also applies to paramedic (and in some situations to EMT) interfacility transports (IFTs).

Medical direction is provided prospectively through written policies and procedures, approved by the EMS Medical Director, and immediately through on-line communications with the Base Hospital. Oversight is also provided retrospectively through quality improvement activities and continuing education of providers.

Medical direction also includes oversight of EMS personnel credentialed by the county. These include EMTs, paramedics and MICNs.

III. PROSPECTIVE, IMMEDIATE, AND RETROSPECTIVE MEDICAL DIRECTION AND OVERSIGHT
Below is a listing of examples that describe individual facets of prospective, immediate, and retrospective medical direction and oversight. This list is not all-inclusive.

A. Prospective medical direction and oversight:
   1. Credentialing of EMT, paramedic and MICN personnel
   2. Designation of continuing education and prehospital training program providers;
   3. Designation of Base Hospitals and trauma center
   4. Review and approval of medical dispatch protocols, including pre-arrival and post-dispatch instructions
   5. Provision of the Prehospital Care Manual, which guides EMTs, paramedics and MICNs in the care provided in the field
   6. Continuing education activities
   7. Provision of the Multicasualty Incident Plan (MCI)
   8. EMS Agency policies

B. Immediate (concurrent) medical direction and oversight:
   1. Provision for guidance by MICNs following treatment guidelines from the Prehospital Care Manual
   2. Provision for guidance by Base Hospital physicians (including situations defined in the Prehospital Care Manual)
3. Provision for guidance by Base Hospital MICNs and physicians concerning IFTs with regard to scope issues for EMT and paramedic personnel

C. Retrospective medical direction and oversight:
   1. Quality assurance and improvement activities, coordinated at the LEMSA level;
   2. Specific incident review and action by the Base Hospital and LEMSA personnel;
   3. Continuing education prompted by QI data review.

IV. INPUT AND MODIFICATION OF MEDICAL DIRECTION
System participants, including provider agencies and personnel, participate in regular meetings of the Medical Advisory Committee (MAC). This committee is open to the public for input. Requests for changes in treatment guidelines or policy and procedure changes that impact medical care are discussed and recommendations are made. The recommendations of MAC are advisory to the LEMSA Medical Director and the LEMSA Director. Formal requests for changes are to be made in writing to the LEMSA Medical Director.

Proposals for utilization of paramedic personnel in settings other than 9-1-1 ground response (e.g., bicycle-based units, tactical paramedics, etc.) must be submitted to the LEMSA Medical Director and the LEMSA Director for review and authorization. Any approval must include policies and procedures that maintain prospective, immediate, and retrospective medical direction and oversight of paramedic personnel.

V. OPTIONAL SCOPE PROCEDURES AND MEDICATIONS
Most procedures or medications outside of the basic scope of practice require additional authorization from the LEMSA Medical Director and Emergency Medical Services Authority (EMSA). Proposals for optional procedures, medications or trial studies shall be submitted to the LEMSA Medical Director for consideration as part of the treatment guidelines, policy and procedure update process. The LEMSA Medical Director is responsible for submission of requests for optional scope procedures and medications and for trial studies to the EMSA.
I. PURPOSE
This policy provides guidelines for the transfer of care from non-transport to transport personnel in the prehospital setting, and to provide guidelines for the transfer of care from an on-scene paramedic to an EMT staffed transport ambulance.

II. SCOPE OF DIRECTION AND OVERSIGHT
A. Patient Care Authority
1. The most medically qualified pre-hospital personnel, first on-scene at a medical emergency, shall have patient care management authority.
2. The individual with patient care authority is responsible for the patient until care is turned over to other prehospital personnel or receiving hospital staff.

III. CONTINUUM OF PATIENT CARE
A. First Responder Paramedics
1. First Responder paramedics, when first on scene, should transfer patient care authority and provide a verbal report to the transport paramedics as soon as feasible.
2. The non-transport paramedic shall provide a verbal report of patient assessment and treatment provided, to ensure the continuum of patient care.
3. An electronic health record (EHR) shall be completed and sent with the patient if time permits. If the EHR cannot be completed prior to patient transport, the non-transport paramedic shall complete the EHR and forward it to the Emergency Department (ED) of the receiving facility as soon as possible.

B. Paramedic/EMT Ambulances
1. The paramedic assigned to the ambulance is ultimately responsible for all patient assessment and care.
2. The EMT may accompany the patient in the patient compartment of the ambulance, if:
   a. In the paramedic's best judgment, the patient does not currently require ALS care and there is no reasonable possibility of the patient requiring ALS care throughout the transport.

IV. TURN OVER OF PATIENT CARE AUTHORITY
A. First Responders, when first on-scene, should transfer patient care authority to the transport paramedics as soon as feasible.

B. A paramedic may transfer patient care authority to BLS transport ambulance, when all of the following circumstances exist:
   1. The BLS ambulance is available within a reasonable time.
   2. ALS care has not been initiated.
   3. It has been determined that ALS care is unneeded during transport.

C. First Responder paramedics or ALS transport ambulances may transfer care of stable patients to BLS transport ambulances within the following guidelines:
1. Patients must be stable with medical complaints that can be cared for at the BLS level. Before transferring care to the BLS transport ambulance, the examining paramedic will reasonably determine that there are no anticipated changes in the patients' present condition. No patient will be turned over once ALS or advanced scope interventions have been initiated.

2. ALS assessment tools may be utilized (i.e. ECG 3- and 12-Lead cardiac monitor, and blood glucose level) in order to fully assess the patient and determine eligibility for turnover to BLS.

3. Patient airway, maintained without assistance or adjuncts.

4. The patient must be hemodynamically stable. Vital signs should be steady and commensurate with the patients' condition.

5. The patient must be of their normal mental status and not impaired because of alcohol or substances.

6. No mechanism or injury that would warrant a trauma alert or activation.

7. No cardiac, respiratory, or neurological complaints that may warrant ALS intervention.

8. 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.

9. The EMT who will be transporting is comfortable with the patients' condition.

D. 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.

V. DOCUMENTATION

Documentation of transfer of care shall be made by both transferring and receiving crews, (e.g., “Patient care transferred to AMR paramedic 56 at 0900,” and “Patient care accepted from CCC Fire paramedic 115 at 0900”).
I. PURPOSE
The EMS system believes in respect for patient autonomy. A patient with decision-making capacity has the right to accept or refuse medical intervention. This includes the right to specify, in advance, patient preferences when the person is no longer able to communicate wishes.

II. DNR ORDERS HONORED BY PREHOSPITAL PERSONNEL
A patient or patient’s Durable Power of Attorney for Health Care (DPAHC) may verbally rescind the DNR order at any time. Prehospital personnel shall honor the following types of DNR orders:
A. A California Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR form.
B. A California EMSA POLST form where Section A – DNR has been chosen.
C. A Final Attestation form for patients that have chosen to utilize the Aid-in-Dying drugs.
D. An Advanced Health Care Directive (AHCD), living will or Durable Power of Attorney for Health Care (DPAHC) presented by an agent of the patient empowered to make health care decisions for the patient.
E. An approved DNR medallion/bracelet (e.g., Medi-Alert or Caring Advocates)
F. A DNR order in the medical record of a licensed healthcare facility (e.g., acute care hospital, skilled nursing facilities, hospices, intermediate care facilities) signed by a physician. Electronic physician’s orders are considered signed and shall be honored.
G. A verbal DNR order given by the patient’s physician.

III. PROCEDURE FOR COMPLYING WITH AN HONORED DNR ORDER
A. Do not attempt resuscitation:
   1. If the pulseless and apneic patient does not meet the criteria of Policy 1004 (Determination of Death) but is suspected to be a candidate for withholding resuscitation, BLS resuscitative measures shall be performed until one of the following occurs:
      a. The EMS provider sees a written DNR/POLST order, which should be honored and resuscitation stopped.
      b. The patient’s physician is contacted and directs EMS providers to discontinue resuscitation.
      c. The EMS provider sees a valid AHCD or DPAHC which yields decision making authority to a representative who is present, who the EMS Provider verifies the identity of and who verbally specifies the level of care they wish for the patient.
      d. If a person who is terminally ill appears to have ingested medication under the provisions of the California End of Life Act.
   2. DNRs do not expire and photocopies are considered valid.
B. If presented with a DNR:
   1. Verify the identity of the patient.
   2. Confirm validity of DNR/POLST.
3. If deemed valid, perform no life saving measures.

4. Provide supportive care to family members.

C. End of Life Act:
If a person who is terminally ill and appears to have ingested medication under the provisions of the California End of Life Option Act, EMS providers shall:
1. Provide comfort care as indicated. Comfort care includes oxygen administration, opening and maintaining the airway using non-invasive means only (chin life or jaw thrust), and suctioning as necessary.

2. Determine who called 9-1-1 and why.

3. Determine whether there are DNR orders or a Final Attestation form available.

4. If a Final Attestation form is present and the family objects, provide comfort care to the patient and contact the Base Hospital to have a physician speak with the family. Do not start resuscitation if the patient is in cardiopulmonary arrest.

D. Complying with a DNR/POLST form when patient is not in cardiac arrest:
DNR orders only apply to patients in cardiac arrest. A patient with a DNR order that is not in cardiac arrest shall be provided treatment as appropriate for their complaint unless a POLST is in place that directs care differently.

If a patient or representative presents EMS with a POLST form, the prehospital provider shall:
1. Verify the identity of the patient.

2. Review “Section B” of the POLST form:
   a. “Full treatment” indicates the patient should be treated as appropriate pursuant to EMS protocols and no treatment should be withheld.
   b. “Limited Additional Measures” or “Selective Treatment” indicates a patient who should not be intubated. Other airways adjuncts (e.g., NPA/OPA) and positive pressure ventilation are permitted.
   c. “Comfort Focused Treatment” or “Comfort Measures Only” indicates a patient whose care should be followed as outlined on this section of the form.
   d. The additional orders section does not apply to the prehospital setting.

3. “Section C” of the POLST form does not apply in the prehospital setting.

4. Contact the Base Hospital if there are any questions or concerns about treatment.

IV. SPECIAL CONSIDERATIONS
A. An approved DNR order is presented, but on-scene relatives object to the order or the validity of the order is in question:
1. Provide all appropriate care/resuscitation measures for the patient. Although a patient’s instructions should remain paramount; resuscitation is to be done until the situation is clarified. Base Hospital contact may be initiated if necessary.
B. A patient presents with advanced or terminal disease and an incomplete approved DNR order (e.g., no signature) is presented or no order is presented and an immediate family member, agent or conservator at the scene requests no resuscitation:
   1. With complete agreement of family and providers on scene, resuscitative efforts may be withheld.
   2. Base Hospital contact is not necessary.
   3. Resuscitation should be initiated if there is any question of the circumstances or any disagreement of family or providers on scene.

C. If CPR is initiated prior to the presentation of an approved DNR order, CPR may be discontinued upon presentation of a valid DNR order without Base Hospital contact.

D. If multiple forms are presented follow the order with the most current date.

NOTE: EMS personnel shall document all relevant information in the Electronic Health Record (EHR) for all patients. Approved DNR orders/POLST forms (copies acceptable) shall be attached to the EHR if a patient is not transported.
I. PURPOSE
This policy provides criteria to aid prehospital personnel in determining death in the field and to identify criteria to determine the termination or withdrawal of resuscitative efforts.

II. DETERMINATION OF DEATH
A. Prehospital personnel do not pronounce death, but may determine death in certain situations.
B. The body of a patient who has been determined to be dead from any of the reasons identified in the “Coroner” section of this policy shall not be disturbed or moved from the position or place of death without permission of the Coroner or his/her appointed deputy.
C. If any questions exist about the application of this policy, Base Hospital direction should be utilized.

III. OBVIOUS DEATH
A. Definition: Pulseless, non-breathing patients with any of the following:
   1. Decapitation
   2. Total incineration
   3. Decomposition
   4. Total destruction of the heart, lungs, or brain, or separation of these organs from the body
   5. Rigor mortis or post-mortem lividity without evidence of hypothermia, drug ingestion or poisoning
   6. Mass casualty situations: pulseless, apneic or agonal patient where triage principles are available resources preclude initiation of resuscitation.
B. Procedure:
   1. Do not initiate resuscitative efforts.
   2. In patients with rigor mortis or post-mortem lividity:
      a. Attempt to open airway.
      b. Assess for breathing and circulation.
      c. Rigor, if present, should be noted in jaw and/or upper extremities.
      d. If any doubt exists, utilize cardiac monitor to ensure asystole in two (2) leads for one (1) minute.
   3. Ensure notification of County Coroner and any other appropriate investigative agencies.
   4. Complete an Electronic Health Record (EHR).

IV. TRAUMATIC ARREST
If a trauma patient (blunt or penetrating) is in cardiopulmonary arrest upon arrival of a paramedic, the paramedic may discontinue CPR without Base Hospital contact after confirming the following:
A. The patient is not breathing for a period of one (1) minute.
B. The patient is pulselessness (no heart tones or carotid or femoral pulses).
C. The patient’s cardiac rhythm is confirmed to be asystole or PEA with a wide QRS at a rate of 40 bpm or less in two (2) leads for one (1) minute.
D. Ensure notification of County Coroner and any other appropriate investigative agencies.
E. Complete an EHR that includes the observed cardiac rhythms, time in rhythms, and the approximate time death was determined.

V. DISCONTINUING CPR (Does not apply if hypothermia, suspected drug ingestion, or poisoning is suspected)
   A. Paramedics may discontinue CPR without Base Hospital contact in the following situations:
      1. If an approved DNR order or POLST is produced for the patient after initiation of resuscitative efforts; or
      2. If an AHCD, Living Will or DPAHC is produced and the responsible party is present and makes the request; or
      3. If an immediate family member is present and make the request to discontinue resuscitation efforts, in the absence of a DNR, AHCD, Living Will, or DPAHC document. Full agreement of prehospital personnel and family present to discontinue efforts is required; or
      4. If a patient presents with advanced or terminal disease and an incomplete approved DNR order (e.g., no signature) is presented or no form is presented and an immediate family member, agent, or conservator at the scene requests no resuscitation. Full agreement of prehospital personnel and family present to discontinue efforts is required; or
      5. If a non-shockable rhythm persists for thirty (30) minutes despite aggressive resuscitative efforts, consider discontinuation of CPR.
   B. Prehospital personnel should attempt resuscitation and consider transport in patients with multiple rhythms, intermittent perfusing rhythms (e.g., bradycardia or V-Tach), or where scene conditions warrant transport (i.e., safety issues).
   C. Early transport to a STEMI Receiving Center is indicated under the following circumstances:
      1. Witnessed arrest with strong suspicion of pulmonary embolism; or
      2. V-Fib arrest resistant to four (4) shocks.
   D. CPR shall not be discontinued during transport.
   E. If a patient does not meet the criteria listed in Section V(A), consider contacting the Base Hospital for an order to discontinue efforts.
   F. Unless in the presence of obvious death, only ALS personnel shall discontinue resuscitative efforts.
   G. Notify Coroner and any other appropriate investigative agency.
   H. Complete an EHR that includes the observed cardiac rhythms, time in rhythms, and the approximate time death was determined.

VI. CORONER INVESTIGATION
The Coroner is responsible for investigating all deaths listed in California Government Code Section 27491. The deceased should not be disturbed or moved from the position or place of death without permission of the Coroner or his/her appointed deputy.
I. PURPOSE
This policy provides direction for prehospital personnel, when at the scene of injury or illness, a bystander identifies him/herself as a physician.

II. PROCEDURE FOR PHYSICIAN INVOLVEMENT
A. If bystander at an emergency scene identifies him / herself as a physician and wishes to direct patient care, prehospital personnel should show the card issued by the State of California entitled “Note to Physician on Involvement with EMTs / Paramedics” (attached).

B. Then endorsed alternatives for physician involvement include:
   “After identifying yourself by name as a physician licensed in the State of California, and, if requested, showing proof of identity, you may choose to do one of the following:
   1. Offer your assistance with another pair of eyes, hands or suggestions, but let the life support team remain under Base Hospital control.
   2. Request to talk to the Base Hospital physician and directly offer your medical advise and/or assistance.
   3. Take responsibility for the care given by the life support team and physically accompany the patient until the patient arrives at the hospital and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedure. (Whenever possible, remain in contact with the Base Hospital physician.)”

C. If the physician on scene desires option one (1), the Base Hospital will retain medical control if Base Hospital contact was established.

D. If the physician on scene desires option two (2) or three (3), the paramedics will:
   1. Ask to see the physician’s valid California medical license, unless the paramedics know the physician.
   2. Immediately contact the Base Hospital and speak to the Base Hospital Physician.
   3. Paramedics will make ALS equipment and supplies available to the physician and offer assistance.
   4. Ensure the physician accompanies the patient to the receiving hospital in the ambulance.
   5. Ensure the physician signs for all instructions and medical care given on the EMS patient care report.
NOTE TO PHYSICIAN ON INVOLVEMENT WITH PARAMEDICS (PARAMEDIC)

A life support team (PARAMEDIC) operates under standard policies and procedures developed by the local EMS agency and approved by their Medical Director under the Authority of Division 2.5 of the California Health and Safety Code. The drugs they carry and procedures they can do are restricted by law and local policy.

If you want to assist, this can only be done through one of the alternatives listed on the back of this card. CMA, State EMS Authority, CCLHO, and BMQA have endorsed these alternatives.

Assistance rendered in the endorsed fashion, without compensation, is covered by the protection of the "Good Samaritan Code" (see Business and Professions Code, Sections 2144, 2395-2398 and Health and Safety Code, Section 1799.104).

ENDORSED ALTERNATIVES FOR PHYSICIAN INVOLVEMENT

After identifying yourself by name as a physician licensed in the State of California, and, if requested, showing proof of identity, you may choose to do one of the following:

1. Offer your assistance with another pair of eyes, hands, or suggestions, but let the life support team remain under base hospital control; or,
2. Request to talk to the base station physician and directly offer your medical advice and assistance; or,
3. Take total responsibility for the care given by the life support team and physically accompany the patient until the patient arrives at a hospital and the receiving physician assumes responsibility. In addition, you must sign for all instructions given in accordance with local policy and procedures. (Whenever possible, remain in contact with the base station physician).
I. PURPOSE
A. Section 7150.55 of the Health and Safety Code requires emergency medical personnel to make a reasonable search for a document of anatomical gift, other information identifying the patient as a donor, or an individual who has declined to make an anatomical gift, “upon providing emergency medical services to an individual, when it appears that the death of that individual may be imminent. This requirement shall be secondary to the requirement that ambulance or emergency medical personnel provide emergency medical services to the patient.”

B. No search is to be made by emergency medical personnel after the patient has expired.

II. PROCEDURE
Emergency medical treatment and transport of the patient remains the highest priority for field personnel. This search shall not interfere with patient care or transport.

A. If a document of anatomical gift or evidence of declination to make an anatomical gift is located by emergency medical personnel, and that individual is taken to a hospital, the hospital shall be provided with the documentation. In situations where the investigating law enforcement officer has requested the card, hospital notification of documentation found will meet this requirement. Verification of documentation can be made through the “Donate Life California” registry.

B. If emergency medical personnel are unable to perform a search due to overriding medical care priorities or sensitivity concerns at the scene or during transport, the hospital shall be notified that the search has not been performed along with surrounding circumstances.

C. Details of any search including witnesses, what was found and who was notified shall be documented in the Electronic Health Record (EHR) completed for the patient.

D. Most importantly, a completed EHR that describes the circumstances and timing of events leading to the patient’s condition as well as prehospital patient care delivered are critical to hospital personnel responsible for anatomical gift decisions.
I. PURPOSE
Healthcare providers are mandated reporters. Regardless of whether or not another mandated reporter agrees to make the report or if law enforcement is on-scene, it is the responsibility of every and all healthcare providers to report child, dependent adult and elder abuse and/or neglect.

II. MANDATORY REPORTING
If a prehospital care provider reasonably suspects child, elder or dependent abuse or neglect:
A. Notify the appropriate law enforcement agency immediately if it is suspected that abuse or neglect has occurred, whether or not the person that is suspected to have been abused or neglected is a patient.

B. If the person who is reasonably suspected to have been abused or neglected is a patient and is suffering from a medical emergency, make reasonable efforts to transport the patient to a receiving hospital for evaluation. Provide the receiving hospital staff with the basis for the abuse/neglect suspicions.

C. Document observations and findings of suspected abuse or neglect if it relates to the medical complaint or condition, in addition to the other required information concerning the patient’s medical complaint, on the prehospital care report.

D. Contact the appropriate reporting agency by telephone immediately, or as soon as practically possible, to provide a verbal report.

E. File a written report on the California Child Abuse Report form or the California Suspected Elder/Dependent Abuse Report form or use the online reporting tool for Elder/Dependent abuse with the appropriate reporting agency within two (2) business days.

F. Reporting under this policy is an individual requirement. Reporting is required even if law enforcement is on scene, or if there are other mandated reporter(s) on scene who also reasonably suspect abuse or neglect and whether or not the other mandated reporter(s) indicate he/she will make the report. Supervisors and managers shall not prevent or otherwise instruct a subordinate not to file a report required by this policy.

G. Reporting suspected abuse or neglect to the receiving hospital does not relieve a prehospital care provider of their obligation to report suspected abuse or neglect to the reporting agencies by telephone and in writing.

H. A prehospital care provider is not required to prove, or have substantial evidence of, abuse or neglect before making a report of suspected abuse or neglect pursuant to this policy. If a reasonable person under the circumstances would suspect the possibility of elder, dependent adult or child abuse or neglect, then the prehospital care provider is mandated to make a report pursuant to this policy.

Effective January 2019
III. REPORTING AGENCIES

A. Child Abuse/Neglect
   Call: Children and Family Services  (877)881-1116
   File a written report: Employment and Human Services Department
                          Children and Family Services Screening Unit
                          400 Ellinwood Way
                          Pleasant Hill, California 94523

B. Dependent Adult or Elder Abuse/Neglect
   Call: Adult Protective Services  (925)602-4179 or
         (877)839-4347
   File a written report: Employment and Human Services Department
                          Adult Protective Services
                          500 Ellinwood Way, 3rd Floor
                          Pleasant Hill, California 94523

RESOURCES:
- Suspected Child Abuse Report (SS Form 8572)
- Report of Suspected Adult/Elder Abuse (SOC Form 341)
- Report Elder and/or Dependent Abuse Online
- Elder and Dependent Abuse Reporting Act, Welfare and Institutions Code §§ 15630
I. PURPOSE
This policy provides guidance on managing patients with assaultive behavior and direction on the authorized use of patient restraints.

II. APPROACH TO ASSAULTIVE PATIENTS
A. Assaultive behavior may be a manifestation of a medical condition such as head injury, drug or alcohol intoxication, metabolic disorders, hypoxia, or postictal state. Field personnel should consider these conditions along with psychiatric disorders in their differential diagnosis.
B. Prehospital personnel should obtain a detailed history from family members, bystanders, and law enforcement personnel, and make particular note of patient surroundings for clues to the cause of the behavior (e.g., drug paraphernalia, medication bottles, and alcoholic beverage containers).
C. Prehospital personnel should attempt to de-escalate aggressive behavior with a calm and reassuring approach and manner.

III. RESPONSIBILITY OF LAW ENFORCEMENT
A. Law enforcement personnel are responsible for the capture and restraint of assaultive or potentially assaultive patients. Prehospital personnel should obtain assistance from law enforcement to prepare patients for ambulance transport. Request law enforcement assistance if not already on scene.
B. Law enforcement agencies retain primary responsibility for safe transport of patients under arrest or on a psychiatric detention (Welfare and Institutions Code § 5150).
C. Patients under arrest or on a psychiatric detention shall be searched thoroughly by law enforcement for weapons and contraband prior to placement in the ambulance.
D. Patients under arrest must always be accompanied in the ambulance by law enforcement personnel.
E. Prehospital personnel and law enforcement officers should mutually agree on the need for law enforcement assistance during transport of patients on a psychiatric detention.

IV. USE OF RESTRAINTS
A. Restraints should only be utilized when necessary and in situations in which the patient is exhibiting behavior that presents an immediate danger to themselves or others. Providers must appropriately document the reasons for the use of restraints.
B. Leather or cloth restraints are the only authorized method of restraining patients.
C. Handcuffs may only be applied by law enforcement personnel. Handcuffs should be replaced with leather or cloth restraints prior to transport. Handcuffs may only be used for restraint during transport when law enforcement personnel accompany the patient in the ambulance and no other safe alternative exists. A patient in handcuffs shall not be handcuffed to the gurney or ambulance.
D. Before restraining any patient, prehospital personnel must ensure there are sufficient properly trained personnel available to physically restrain the patient safely.
E. Restrained patients shall be placed in a supine, semi-Fowler’s, or Fowler's position. Patients shall never be transported in a prone or "hog-tied" position.

F. The method of restraint must allow for adequate monitoring of pulse and respiration, and should not restrict the patient or rescuer’s ability to protect the airway should vomiting occur.

G. Restrained extremities should be assessed for circulation, motor function, and sensory function every fifteen (15) minutes and documented in the EHR.

H. Prehospital documentation must include a specifically articulable reason for the use of restraints such as an immediate threat to the patient, prehospital provider or the public.

I. Patients with medical conditions that appear to compromise their ability to consent for care, or where a life threatening emergency exists or potentially exists, may be restrained when indicated and transported without law enforcement authority.

V. TRANSPORT
   A. If an unrestrained patient becomes assaultive during transport, prehospital personnel shall request law enforcement assistance and make reasonable efforts to calm and reassure the patient.
   
   B. Prehospital personnel should not physically inhibit a patient’s attempt to leave the ambulance. However, every effort shall be made to release the patient into a safe environment.
   
   C. If a patient does leave the ambulance, prehospital personnel are to remain on scene, or at a safe staging location, until law enforcement arrives.
I. PURPOSE
A. This policy identifies the local resources and training materials to be used to support Contra Costa County’s Safely Surrendered Baby Program. California’s Safely Surrendered Baby Law (SB1368) requires all California Emergency Departments and designated sites, such as fire stations, to accept safely surrendered infants.

B. The Safely Surrendered Baby Law (SB1368) was created to encourage parents who might otherwise abandon their infants in unsafe places to bring their newborns to a safe place without fear of legal consequences. The law creates legal immunity from criminal liability for child abandonment so long as the child is voluntarily surrendered by a parent or person with legal custody at a designated “Safely Surrendered Site.”

II. POLICY
A. All EMS personnel will be trained in the roles and responsibilities of the Contra Costa County Safely Surrendered Baby Program using the standardized county-wide training.
   1. The standardized curriculum supports Fire-EMS, Emergency Department and Labor and Delivery personnel in the proper intake and notification procedures during a Safe Surrender.

B. Designated Safely Surrender Sites will have appropriate signage and a reliable process to store and replace newborn safe surrender kits.
I. PURPOSE
This policy outlines the fee structure for various programs administered by the Contra Costa County EMS Agency.

II. FEES

Certification Verification – Fee for completion of forms required by other entities for verification of certification. $25 Fee

EMT Initial Certification ($85\(^1\) local fee/$75 State Registry Fee) $160 Application Fee
EMT Recertification ($85\(^1\) local fee/$37 State Registry Fee) $122 Application Fee
Replacement Card (if lost/stolen/damaged) $25 Fee

Paramedic Accreditation $90 Application Fee
MICN Authorization/Reauthorization $90 Application Fee

Continuing Education (CE) Provider Authorization/Reauthorization – Four (4) year approval $2,500 Application Fee

EMT Training Program – Four (4) year approval (public safety agencies and community colleges pay 50\% of fee) $3,500 Application Fee
Paramedic Training Program – Four (4) year approval (public safety agencies and community colleges pay 50\% of fee) $20,000 Application Fee

Public Safety First Aid/CPR Training Program Approval – Four (4) year approval $1,400 Application Fee

Non-Emergency Ambulance Service Permit – Three (3) year county-wide permit $8,000 Permit Fee
Emergency Ambulance Service Permit – Three (3) year permit per Emergency Response Area (ERA) $8,000 Fee per ERA
Ambulance Re-inspection Fee – Fee assessed for re-inspection after prior failed inspection $125 Fee per Ambulance

\(^1\)Fee waived for volunteer and reserve fire personnel affiliated with a public fire agency located within Contra Costa County.

\(^2\)Fees are non-refundable. Cashier Check or money order only made payable to Contra Costa Health Services. Major credit cards accepted. Cash and personal checks will NOT be accepted.

\(^3\)One-time fee.
II. FEES (continued)

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<th>Service Description</th>
<th>Fee</th>
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<tr>
<td>EMS Aircraft Classification</td>
<td>$300 Fee per Aircraft</td>
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<tr>
<td>Tactical EMS Program Authorization</td>
<td>$250 Application Fee</td>
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<tr>
<td>Public Safety Narcan Program Authorization</td>
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<tr>
<td>Non-Emergency Paramedic Transfer Program Authorization</td>
<td>$10 Fee Per Transfer</td>
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<td>Critical Care Paramedic Program Authorization</td>
<td>$10,000 Annual Fee</td>
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<tr>
<td>EMS Air Ambulance Authorization – Two (2) year approval</td>
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III. DESIGNATION FEES (as specified by contracts)

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<tr>
<td>Stroke Center Designation</td>
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<td>Comprehensive Stroke Center Designation</td>
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<td>Pediatric Center Designation</td>
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<td>Emergency Department Approval for Pediatrics</td>
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I. Purpose
To describe criteria and process for BLS First Responder and Public Safety agencies applying for “Optional Scope” interventions as defined in Title 22, Division 9, Chapter 1.5.

II. Participant Criteria
A. BLS agencies must meet Title 22 Optional scope requirements including, but not limited to, LEMSA approved: Curriculum, skills training, testing, mandatory reporting to LEMSA, minimum 2-year training cycle for any approved optional scope(s) of practice.

B. Public Safety agencies must be POST certified and meet optional scope requirements including but not limited to the LEMSA approved: Curriculum, skills training, testing, mandatory reporting to LEMSA, minimum 2-year training cycle for any approved optional scope(s) of practice.

C. Any participating agency MUST train and approve every field provider to same level, maintain, and submit training records to the LEMSA at initial training and every 2 years thereafter.

III. Notification
A. Upon optional scope approval (or revocation) of a public safety or BLS agency, the LEMSA shall notify all EMS responders and the Base Hospital.

IV. Revocation
A. The LEMSA and LEMSA Medical Director reserve the right to revoke any Optional Skills or programs at any time if any LEMSA or Title 22 criteria are not met.
   1. Revocable criteria includes but is not limited to:
      a. Completion, documentation, and submission of minimum two year training cycle for all employees.
      b. Documentation submitted to the LEMSA for each intervention/deployment applicable to patient care within 24 hours.
      c. Annual agency reporting for total number of deployments/interventions
      d. Fulfill any ad-hoc reporting request within 2 business days.

V. STEPS OF OPTIONAL SKILL/PROGRAM APPLICATION
A. Agency Chief or Director to submit formal letter of application for specific skill and supporting documentation that includes:
   1. Proposed training curriculum that meets Title 22 criteria.
   2. Test material for didactic portion of curriculum.
   3. Testing parameters and sign off sheet for skills testing.
   4. Plan to maintain optional scope education and skills testing at minimum 2 year training cycle.
   6. Documentation plan for skill/intervention(s).
   7. Plan and format for ad-hoc and annual reporting.
I. PURPOSE
This policy establishes the requirements for initial certification and recertification as a California Emergency Medical Technician (EMT) by the Contra Costa County EMS Agency (LEMSA).

II. REQUIREMENTS FOR EMT CERTIFICATION
A. The following requirements apply to all applicants who have never been certified as an EMT in California:
   1. Be eighteen (18) years of age or older.
   2. Provide a current government-issued photo ID (e.g., driver license or identification card issued by any State of the United States, United States military ID card, or United States issued passport).
   3. Provide documentation of successful completion of the National Registry of Emergency Medical Technicians (NREMT) written and skills examination and have either:
      a. A valid EMT course completion record from an approved U.S. DOT EMT training program dated within the last two (2) years; OR,
      b. Documentation of successful completion of an approved out-of-state initial U.S. DOT approved EMT training course within the past two (2) years; OR,
      c. Possess a current and valid out-of-state EMT certificate; OR,
      d. Possess a valid California Advanced EMT (AEMT) certificate or paramedic license.
   4. Complete an electronic application for an initial EMT certificate through Contra Costa County’s online license management system (https://cccems.imagetrendlicense.com/public/contracosta/).
   5. Disclose whether the applicant has ever been convicted of a felony or misdemeanor in California, or any other state or place, or convicted of any crime punishable under the Uniform Code of Military Justice, including entering a plea of no contest, or any conviction which has been set aside pursuant to Penal Code § 1203.4 or expunged; or whether the applicant has ever had a certification, accreditation, or professional healing arts license suspended or revoked; or whether the applicant is currently under investigation by any law enforcement, health care or regulatory agency. For any disclosure, the applicant must provide the following documents at the time of application, if applicable:
      a. Misdemeanor Arrests/Convictions
         i. Police report(s), arrest record(s), and if applicable, judgment of conviction, probation or restitution orders for each arrest and/or conviction within the preceding 5 years.
      b. Felony Arrests/Convictions
         i. Police report(s), arrest record(s), and if applicable, judgment of conviction, probation or restitution orders for each arrest and/or conviction within the preceding 10 years, unless said felony was a capital offense, in which case the applicant shall provide each police report(s), arrest record(s), and if applicable, judgment of conviction, probation or restitution orders for each arrest and/or conviction within the preceding 75 years.

Effective January 2019
c. Administrative/Licensure Actions
   i. Administrative records including the allegation(s) or accusation(s) and final decisions or orders relating to any prior certification or licensure action.

6. Complete a Department of Justice (DOJ) Criminal Offender Record Information (CORI) background check (Live Scan) after completing your online EMT certificate application. Live Scans completed prior to submission of an EMT certificate application will not be retained by the Agency and will require the applicant to provide a new Live Scan.

7. Pay the established Contra Costa certification application fee and the applicable California EMT Registry fee.

III. WITHDRAWAL OF APPLICATION/ABANDONED APPLICATION
   A. A completed application that has been submitted to the LEMSA may not be withdrawn.
   B. An incomplete application that has not been completed within 30 days will be deemed abandoned and any fees paid will be forfeited. An applicant who has had a prior abandoned application will be required to start the application process again, including payment of applicable fees.

IV. ISSUANCE OF CERTIFICATION
   A. Upon completion of Items 1 through 8 above, and upon confirmation that the applicant is not precluded from certification for reasons defined in § 1798.200(c)(1) through (11) of the Health & Safety Code or the provisions of § 100214.3(c)(1) through (9) or (d)(1) through (2) of Title 22 of the Code of Regulations, the applicant shall be certified as a California EMT. A permanent California EMT card will be issued by the LEMSA and mailed to the applicant within thirty (30) days of approval of the application by the LEMSA. Applicants who disclose criminal history, criminal convictions, pending criminal charges, or administrative or disciplinary actions against a healthcare related license or certificate may be delayed for up to 60 days.

   B. The effective date of the initial EMT certificate will be the date the EMT certificate is issued by the LEMSA.

   C. The expiration date of the EMT certificate shall be the lesser of:
      1. The last day of the month two (2) years from the effective date of the initial certification; or
      2. The expiration date of the certificate or license used to establish eligibility.

V. REQUIREMENTS FOR EMT CERTIFICATE RENEWAL
   A. To maintain a California EMT certificate, applicants shall meet the following requirements:
      1. Possess a valid and current California EMT certificate.
      2. Provide a current government-issued photo ID (e.g., state driver license, state ID card, military ID card or passport).
      3. Successfully complete an approved EMT twenty-four (24) hour refresher course within the two (2) year certification period; OR,
         Obtain a minimum of twenty-four (24) hours of approved prehospital continuing education (CE) from an approved CE provider within the two (2) year certification period.
4. Submit a completed skills competency verification form (EMSA-SCV 01/17), verifying skills competency has been verified only by a licensed or certified California EMT, AEMT, paramedic, Registered Nurse (RN), Physician’s Assistant (PA), or Physician who has been designated by an EMS approved training program (EMT training program, AEMT training program, Paramedic training program or CE provider) or an EMS service provider. The skills to be verified shall be those skills set forth on form EMSA-SCV 01/17 and shall be demonstrated by performance of the psychomotor skills on a live or simulated patient.

5. Complete an electronic application for renewal of an EMT certificate through Contra Costa County’s online license management system (https://cccems.imagetrendlicense.com/public/contracosta/).

6. Disclose whether the applicant has ever been convicted of a felony or misdemeanor in California, or any other state or place, or convicted of any crime punishable under the Uniform Code of Military Justice, including entering a plea of no contest, or any conviction which has been set aside pursuant to Penal Code § 1203.4 or expunged; or whether the applicant has ever had a certification, accreditation, or professional healing arts license suspended or revoked; or whether the applicant is currently under investigation by any law enforcement, health care or regulatory agency. For any disclosure, the applicant must provide the following documents at the time of application, if applicable:
   a. Misdemeanor Arrests/Convictions
      i. Police report(s), arrest record(s), and if applicable, judgment of conviction, probation or restitution orders for each arrest and/or conviction within the preceding 5 years.
   b. Felony Arrests/Convictions
      i. Police report(s), arrest record(s), and if applicable, judgment of conviction, probation or restitution orders for each arrest and/or conviction within the preceding 10 years, unless said felony was a capital offense, in which case the applicant shall provide each police report(s), arrest record(s), and if applicable, judgment of conviction, probation or restitution orders for each arrest and/or conviction within the preceding 75 years.
   c. Administrative/Licensure Actions
      i. Administrative records including the allegation(s) or accusation(s) and final decisions or orders relating to any certification or licensure action.

7. Applicants for renewal who are not currently certified through Contra Costa EMS must complete a Department of Justice background check (Live Scan) after submitting an application for EMT certificate renewal.

8. Pay the established Contra Costa certification application fee and the California EMT Registry fee.

B. Upon completion of Items one (1) – nine (9) above, and confirmation that the applicant is not precluded from certification for reasons defined in § 1798.200 of the Health and Safety Code or the provisions of §§ 100214.3(c)(1)-(9) or (d)(1)-(2) of Title 22 of the Code of Regulations an individual shall be recertified as an EMT.

C. A permanent California EMT card will be issued by the LEMSA and mailed to the applicant within
thirty (30) days of approval of the EMT certificate renewal application by the LEMSA.

D. If the renewal requirements are met within six (6) months prior to the current expiration date, the effective date of the EMT certification shall be the first day after the expiration date of the current certification and the expiration date shall be the final day of the final month of the two (2) year period.

E. If the renewal requirements are met greater than six (6) months prior to the current expiration date, the effective date of the EMT certificate shall be the date all certification requirements are completed and the expiration date shall be the final day of the final month of the two (2) year period.

VI. EXPIRATION WHILE ON ACTIVE DUTY IN MILITARY
A. A California EMT certificate that expires while an applicant is deployed on active duty or within six (6) months from the date they return from active duty shall have six (6) months from the date they return from active duty deployment to complete the recertification requirements.

B. An applicant who claims exemption under this provision shall submit proof of their membership in the Armed Forces of the United States and documentation of their deployment starting and ending dates.

VII. EMT CERTIFICATE RENEWAL AFTER LAPSE IN CERTIFICATION
A. For a lapse of less than six (6) months:
   1. Meet the requirements for California EMT renewal set forth in Section IV above.

B. For a lapse of six (6) months or more, but less than twelve (12) months:
   1. Meet the requirements for EMT renewal set forth in Section IV above and complete an additional twelve (12) hours of approved prehospital CE from an approved CE provider for a total of thirty-six (36) hours.

C. For a lapse of twelve (12) months or more, but less than twenty-four (24) months:
   1. Meet the requirements for EMT renewal set forth in Section IV and:
      a. Complete an additional twenty-four (24) hours of approved prehospital CE from an approved CE provider for a total of forty-eight (48) hours; AND,
      b. Provide documentation of successful completion of the NREMT written and skills exams within the past two (2) years.

D. For a lapse of twenty-four (24) months or more, applicants must meet the criteria in Section II for initial certification.

VIII. CONTINUING EDUCATION (CE) HOURS
A. The LEMSA randomly audits CE used for EMT certificate renewal. Failure to respond to an audit request may result in disciplinary action against the EMT certificate, up to and including suspension or revocation. In the event the LEMSA requires an applicant to submit verification of CE used for as basis for eligibility for EMT certificate renewal, the renewal application will not be processed until the documents requested have been received and verified by the LEMSA.
B. When requested by the LEMSA, photocopies of CE certificates for those courses used for completing the required CE must be submitted and must meet the criteria set forth in 22 CCR § 100395(m).
I. PURPOSE
The policy provides licensed California paramedics accreditation to practice in Contra Costa County and sets forth the prerequisites for accreditation.

II. ACCREDITATION ELIGIBILITY
A. All applicants for paramedic accreditation shall:
1. Possess a current California paramedic license.
2. Complete an American Heart Association (AHA) Basic Life Support for Prehospital Providers (BLS PHP) CPR course that has not exceeded the recommended date for renewal.
3. Be employed as a paramedic with a designated advanced life support (ALS) service provider or the Contra Costa County EMS Agency (LEMSA).
4. Attend a Contra Costa EMS system orientation provided by the LEMSA within six (6) months of applying for accreditation.
5. Pass the LEMSA’s paramedic accreditation examination with a score of at least 80%. The results of the examination are valid for six (6) months. Examination attempts are limited to three (3) attempts in any twelve (12) month period.
6. Successfully complete the Contra Costa County EMS Optional Scope Skills Session provided by the provider agency, if applicable.
7. Provide documentation from an ALS employer recommending the applicant for accreditation.
8. Pay the established LEMSA accreditation application fee.
9. Complete an electronic application for paramedic accreditation through Contra Costa County’s online license management system.
10. The applicant must disclose whether they have ever been convicted of a felony or misdemeanor in California, or any other state or place, or convicted of any crime punishable under the Uniform Code of Military Justice, including entering a plea of no contest, or any conviction which has been set aside pursuant to Penal Code section 1203.4 or expunged, or whether they have ever had a certification, accreditation, or professional healing arts license suspended or revoked, or whether they are currently under investigation by any law enforcement, health care or regulatory agency.

III. MAINTAINING ACCREDITATION
A. Paramedic accreditation to practice shall be continuous if the accredited paramedic meets the following requirements:
1. Continuously possesses a valid California paramedic license.
2. Maintains continuous employment as a paramedic with an approved Contra Costa ALS service provider or the LEMSA.
3. Submits a completed electronic application verifying eligibility for continuous accreditation:
a. Possesses proof of completion of an AHA BLS PHP CPR course that has not exceeded the recommended date for renewal.
b. Possesses proof of completion of an AHA course in ACLS that has not exceeded the recommended date for renewal.

c. Has met the requirements of the LEMSA’s local EMS quality improvement plan and has had the skills identified in the quality improvement plan verified.

d. Has attended the required annual EMS training on policy and treatment guideline updates.

IV. TRANSFER OF ACCREDITATION

A. Paramedic accreditation ceases upon termination of employment or when the paramedic no longer meets the eligibility for continuous accreditation.

B. EMS accreditation is not automatically transferable. Transfer of accreditation is permissible if the paramedic:
   1. Submits an application for transfer of accreditation with the new employer’s recommendation for continued accreditation to the LEMSA.
   2. Meets the eligibility requirements for continuous accreditation under Section III.
I. PURPOSE
This policy identifies the process for Mobile Intensive Care Nurse (MICN) authorization in Contra Costa County.

II. AUTHORIZATION
A. All candidates shall meet the following requirements for MICN authorization:
   1. Submit an electronic MICN application to the EMS Agency.
   2. Provide documentation of valid and current licensure as a Registered Nurse (RN) in the State of California.
   3. Provide proof of completion in Advanced Cardiac Life Support (ACLS) according to the American Heart Association (AHA) standards.
   4. Provide documentation of a minimum of twelve (12) months full-time work experience in critical care as a RN in an acute care hospital within the past three (3) years, including six (6) months of emergency department (ED) experience within the past one (1) year.
   5. Provide evidence of successful completion of a Contra Costa EMS approved MICN course within the previous twelve (12) months.
   6. Provide documentation of completion of an Advanced Life Support (ALS) emergency ambulance observation experience consisting of a minimum of eight (8) hours of direct observation to include at least 4 (four) ALS patient contacts. The ALS emergency ambulance observation experience shall be completed with a ground or air based Contra Costa County LEMSA designated ALS provider. An ALS patient contact is defined as any procedure performed on a patient as defined in Section 100159(b) of the California Code of Regulations.
   7. Submit documentation of satisfactorily completing at least ten (10) proctored ALS radio calls.

B. Upon successful completion of section (A)(1) through (7) above, the EMS Agency shall authorize the candidate as a “Provisional” MICN for a period of no more than six (6) months.

C. The Provisional MICN must successfully complete the following additional requirements within six (6) months in order to obtain permanent MICN authorization.
   1. EMS Agency approved Base Hospital orientation;
   2. EMS Agency approved prehospital communications system orientation;
   3. California State EMS Authority (EMSA)/Local Paramedic scope of practice orientation;
   4. EMSA/Local EMT scope of practice orientation;
   5. Attend an EMS system orientation; and
   6. Pass a Contra Costa County EMS protocol examination with a score of not less than eighty percent (80%) that has been proctored by the EMS Agency.

Upon successful completion of (C)(1) through (6) above, the EMS Agency shall authorize the candidate as a Base Hospital MICN for a period of two (2) years from the last day of the month in which the candidate completes all requirements.
III. REAUTHORIZATION
To maintain MICN authorization all applicants shall meet the following requirements:
A. Submit an electronic MICN re-authorization application.
B. Provide documentation of valid and current licensure as a RN in the State of California.
C. Provide proof of completion in ACLS according to the AHA standards.
D. Obtain a minimum of twelve (12) hours of continuing education (CE) relating specifically to prehospital care. Six (6) hours of the twelve (12) hour requirement shall be obtained from BH tape review.
E. Provide documentation of having had direct contact with EMS field crews via the Base Hospital telephone or radio system no less than twelve (12) times within the past two (2) years.
F. Although required for initial authorization, MICNs are strongly encouraged to participate in an ALS emergency ambulance direct observation experience for reauthorization. A minimum of eight (8) hours of direct observation to include at least 4 (four) ALS patient contacts is recommended. The ALS emergency ambulance observation experience may be completed with a ground or air based Contra Costa County LEMSA designated ALS provider. An ALS patient contact is defined as any procedure performed on a patient as defined in Section 100159(b) of the California Code of Regulations.

Upon fulfillment of (A)(1) through (6) above, the EMS Agency shall reauthorize the candidate as an MICN for a period of two (2) years from the expiration date on the candidate’s current authorization card.

IV. DENIAL, SUSPENSION, PROBATION OR REVOCATION
An MICN who has not completed the reauthorization process prior to the expiration of their current authorization is not permitted to act in the capacity of an MICN and shall not provide field guidance to ALS service providers. Candidates must complete all of the requirements of this policy prior to being authorized to function as an MICN.
A. The EMS Agency Medical Director may, for good cause, deny, suspend, revoke, or place on probation any MICN authorization. The administrative procedure for any disciplinary actions will be the same used for EMT certificate actions as defined in EMS Agency policy and the California Health and Safety Code.
B. Any action taken against MICN authorization is independent of any action taken by any Board of Registered Nursing for investigation and/or licensure action.
I. PURPOSE
This policy identifies the process for prehospital credential review. Any proceedings by the Contra Costa County EMS Agency (LEMSA) to deny, suspend or revoke an EMT/Advanced EMT (AEMT) certification or MICN authorization, or place any EMT/AEMT or MICN certificate holder on probation pursuant to Section 1798.200 of the Health and Safety Code (H&SC) shall be conducted in accordance with California Code of Regulations (CCRs), Title 22, Division 9, Chapter 6.

II. EMT
Negative action against any EMT or AEMT certificate may be instituted by the LEMSA Medical Director based upon the finding(s) of an imminent threat to the public's health and safety as evidenced by the occurrence of any of the items listed in H&SC, Division 2.5, Chapter 7, Section 1798.200(c). All investigations and disciplinary actions shall be conducted in accordance with H&SC, Title 22, Division 9, Chapter 6 and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

III. PARAMEDIC
Paramedic licensure actions taken by the LEMSA Medical Director (e.g., immediate suspension) shall be performed according to the California H&SC 1798.202.

IV. MICN
Negative action against any MICN authorization may be instituted by the LEMSA Medical Director based upon the finding of an imminent threat to the public's health and safety as evidenced by the occurrence of any of the items listed in H&SC, Division 2.5, Chapter 7, Section 1798.200(c).

V. BASE HOSPITAL OR PROVIDER AGENCY REPORTING OF EMS EVENTS
In compliance with LEMSA Administrative Policy 6002 (EMS Event Reporting), EMS events (patient/provider safety events) involving EMS personnel, which may constitute a threat to the public's health and safety under California H&SC, section 1798.200 (listed on the back of each EMS Event Report Form), should be reported to the LEMSA. If, in the judgment of the Base Hospital Liaison Physician or other physician designee, immediate action must be taken by the LEMSA after normal business hours to protect the public's health and safety, the on-call EMS Duty Officer may be contacted through the Sheriff's Dispatch Center at (925) 646-2441.

RESOURCES: EMS Event reporting forms are available at http://cchealth.org/ems/event-reporting/
I. PURPOSE
This policy establishes the criteria for authorization to perform as a Paramedic Preceptor in Contra Costa County.

II. REQUIREMENTS
A. No person shall precept or otherwise supervise or evaluate a Paramedic Intern unless that individual has been authorized as a Paramedic Preceptor by the Contra Costa County EMS Agency (EMS Agency) in accordance with this policy.

B. All Paramedic Preceptor candidates shall meet the following requirements:
1. Submit an application on the approved form to the EMS Agency.
2. Submit proof of licensure as a California paramedic with at least two (2) years full-time field experience within the previous two (2) years.
3. Submit proof of current full-time paramedic experience within the Contra County EMS System for the previous twelve (12) months.
4. Submit approval to perform as a Paramedic Preceptor by a Contra Costa County ALS EMS system provider.
5. Submit approval to perform as a Paramedic Preceptor by an approved paramedic training program.
6. Submit proof of attendance of an EMS Agency approved paramedic preceptor training course within six (6) months preceding the date of application.
7. Candidate shall have no clinical corrective action, clinical performance improvement plan(s) or clinical education assignment(s); no violations of EMS Agency policy or protocol; and no violations of the EMS regulations as codified in the Emergency Medical Services System and Prehospital Emergency Medical Personnel Act within the preceding twenty-four (24) months.

The candidate may petition the EMS Agency in writing for a waiver related to the criteria described above (Section II.B.7) if the following criteria is met:
- Candidate has successfully completed any/all assigned clinical performance improvement plan(s) or clinical education assignment(s);
- A minimum of six (6) months have lapsed from the date of completion; and,
- The candidates’ clinical manager(s) endorses the petition to the EMS Agency and recommends the candidate for preceptor approval.

III. PRECEPTOR RESPONSIBILITIES
The Paramedic Preceptor is responsible:
A. For direct supervision, instruction and evaluation of the Paramedic Intern at all times while the Paramedic Intern is assigned to the Paramedic Preceptor.
B. To intercede and assume patient care whenever a Paramedic Intern’s performance or clinical care falls below the standard of care and/or may cause patient harm.
C. For completing the documentation and evaluations of the Paramedic Intern as required by the employer, training institution and the regulations pertaining to paramedic internships.

D. To report to the EMS Agency and the paramedic training program any clinical deficiencies, incompetency, negligence or conduct that may or did result in patient harm or that would or did have an adverse operational impact on the EMS system.

E. To comply with all employer rules and policies, state, federal and county laws, EMS system policies, protocols and state regulations pertaining to prehospital personnel at all times, whether or not precepting a Paramedic Intern.

F. For disclosing to the EMS Agency, the employer and the approved training program any conflict of interest with any Paramedic Intern or approved training program.

G. For having no more than one (1) Paramedic Intern assigned to him/her at any time.

IV. APPROVAL PROCESS
A. The EMS Agency will undertake a review of all applications for Paramedic Preceptor to determine that the prerequisites for authorization have been met.

B. Upon proof of compliance with this policy, the EMS Agency will issue documentation of authorization to perform as a Paramedic Preceptor.

V. CONTINUOUS AUTHORIZATION
A. Paramedic preceptor authorization shall be continuous if the following conditions are met:
   1. The paramedic preceptor attends an EMS Agency approved preceptor refresher course every two (2) years.
   2. The paramedic preceptor precepts at least one (1) paramedic intern every eighteen (18) months.
   3. The paramedic preceptor attends at least one (1) paramedic preceptor meeting every six (6) months.
   4. The paramedic preceptor maintains continuous paramedic accreditation in Contra Costa County.

VI. DEAUTHORIZATION PROCESS
A. The EMS Agency, after an administrative investigation, will take enforcement action to de-authorize a Paramedic Preceptor for violations of state, federal or county laws; EMS system policies and protocols; state regulations pertaining to prehospital personnel; or, for other misconduct which affects the integrity or trust associated to a Paramedic Preceptor.

B. Upon a determination that the Paramedic Preceptor should be de-authorized for a violation of this policy, the EMS Agency will notify the Paramedic Preceptor in writing by U.S. certified mail. The EMS Agency will also provide notice of the de-authorization to the paramedic training program who approved the paramedic preceptor and to the paramedic preceptor’s employer.
C. Outside of the written waiver related to the criteria described in (Section II.B.7) of this policy, there is no right of appeal or to a hearing on any decision to de-authorize a Paramedic Preceptor.

D. Paramedic preceptors who have been de-authorized may apply for Paramedic Preceptor authorization and accreditation upon the expiration of twenty-four (24) months from the date of the de-authorization.
I. PURPOSE
This policy establishes the criteria for authorization to perform as a Paramedic Intern in Contra Costa County.

II. REQUIREMENTS
A. No person shall precept or otherwise identify themselves as a Paramedic Intern unless that person has been authorized as a Paramedic Intern by the Contra Costa County EMS Agency (LEMSA) in accordance with this policy.

B. The requirements for authorization to perform as a Paramedic Intern are:
   1. Submit an application on the approved form to the LEMSA with payment of the established fee and with a copy of a government issued photo identification.
   2. Submit a current unrestricted California EMT certificate.
   3. Submit proof of completion of a course in an American Heart Association (AHA) Basic Life Support for Prehospital Providers (BLS PHP) CPR course that has not exceeded the recommended date for renewal.
   4. Submit proof of Advanced Cardiovascular Life Support (ACLS) certification by an approved AHA ACLS training program.
   5. Submit proof of Pediatric Advanced Life Support (PALS) certification by an approved AHA PALS training program.
   6. Submit proof of International Trauma Life Support or Prehospital Trauma Life Support certification by an approved training program.
   7. Attend a Contra Costa County EMS system orientation within 6 months preceding the application.
   8. Pass a Contra Costa County paramedic internship competency based written examination on the LEMSA’s optional scope of practice, policies and protocols with a minimum score of 80%. A paramedic intern shall not be permitted to take the examination more than three (3) times in a twelve (12) month period.

C. Existing Paramedic Interns that have been placed into a paramedic internship in Contra Costa County prior to implementation of this policy shall be required to comply with this policy within twelve (12) months of its effective date.

III. OPERATIONAL RESPONSIBILITIES
The Paramedic Intern shall:
   A. Maintain proof of authorization to perform as a Paramedic Intern issued by the LEMSA at all times while acting or performing as a Paramedic Intern.
   B. Comply with all instructions and direction of the Paramedic Preceptor for the clinical care and operation of the EMS system while performing as a Paramedic Intern.
   C. Report any conduct of the Paramedic Preceptor or the Paramedic Intern that may or did result in patient harm or that would or did have an adverse operational impact on the EMS system.

Effective January 2019
D. Not retain or otherwise duplicate any patient care records or identifying patient information.

E. Complete a student evaluation of the Paramedic Preceptor and paramedic training program to the LEMSA upon completion of the paramedic internship.

IV. APPROVAL PROCESS

A. The LEMSA will undertake a review of all applications for Paramedic Intern to determine that the prerequisites for authorization are met.

B. Upon proof of compliance with this policy, the LEMSA will issue documentation of authorization to perform as a Paramedic Intern.

V. DEAUTHORIZATION PROCESS

A. The LEMSA, after an administrative investigation, will take enforcement action to de-authorize a Paramedic Intern for violations of state, federal or county laws; EMS system policies and protocols; state regulations pertaining to prehospital personnel; or, for other misconduct which affects the integrity or trust associated to a Paramedic Intern.

B. Upon a determination that the Paramedic Intern should be de-authorized for a violation of this policy, the LEMSA will notify the Paramedic Intern in writing by U.S. certified mail. The LEMSA will also provide notice of the de-authorization to the paramedic training program that approved the Paramedic Intern and to the ALS service provider.

C. There is no right of appeal or to a hearing on any decision to de-authorize a Paramedic Intern.
I. PURPOSE
This purpose of this policy is to establish the requirements and standardized criteria for the registration and orientation of EMS providers (e.g., EMTs, paramedics, flight paramedics, and MICNs) functioning in the Contra Costa County EMS system.

II. EMS ORIENTATION
A. EMS providers shall apply to the LEMSA to attend a Contra Costa County EMS System Orientation within thirty (30) days of employment in Contra Costa County.

B. EMS providers who apply to the LEMSA to attend a Contra Costa County EMS System Orientation shall have a valid California EMT certificate number or license number and shall provide proof of completion of an American Heart Association (AHA) Basic Life Support for Prehospital Providers (BLS PHP) CPR course that has not exceeded the recommended date for renewal at the time of application.

C. EMS providers who apply and attend a Contra Costa County EMS System Orientation shall pass a policy and protocol examination with a score of no less than 80%. EMS providers that do not pass the examination will be required to attend another Contra Costa County EMS System Orientation before being permitted to take the examination again.

D. EMS providers who have not met the requirements of this policy but have applied to the LEMSA to attend a Contra Costa County EMS System Orientation may work with an accredited or certified provider who has met the requirements of this policy for no more than 30 days.

E. If an EMS provider is not employed at the time they attend an EMS system orientation, a certificate of completion for the EMS system orientation is valid for 6 months from the time it is issued.

F. EMS providers who have no more than a six month lapse in employment between Contra Costa County EMS service providers and who attended an EMS system orientation while they were previously employed need not attend an additional EMS system orientation.

III. REGISTRATION REQUIREMENTS
A. EMS providers must be registered by their employer with the LEMSA prior to working. Registration must include the following information:
   1. First and last name
   2. Date of hire
   3. Certification/license number
   4. Certification/license expiration date

B. Employers shall, as soon as practical, notify the LEMSA of any change of employment status with an EMS provider, but in no event shall the notification be made more than thirty (30) days from the day of the change of the EMTs employment status.

IV. ENFORCEMENT
A. EMS providers not in compliance with this policy will be immediately removed from service in Contra Costa County and their EMT certificate may be subject to discipline.
B. Employer ambulance providers not in compliance with this policy may be subject to revocation of their ambulance permit.
I. PURPOSE
This policy outlines the process for approval of prehospital continuing education (CE) providers in Contra Costa County. The California Code of Regulations (CCRs) authorizes local EMS Agencies to approve Advanced Life Support (ALS) and Basic Life Support (BLS) prehospital CE providers. Approved CE providers shall approve individual courses, assign course identification numbers, and specify the category, number of hours, and level of training for each course authorized.

II. PROCEDURE FOR APPROVAL AS CE PROVIDER
A. All applicants shall meet the following requirements:
   1. Complete a CE Provider application.
   2. Provide documentation and resumes demonstrating the applicant’s Program Director and Clinical Director experience and qualifications in prehospital care/education as outlined in Title 22, Division 9, Chapter 11, Article 6, Section 100395(g) and (i).
   3. Provide a sample course completion certificate, containing all information listed in Title 22, Division 9, Chapter 11, Article 6, Section 100395(m) of the California Code of Regulations (CCR). Course completion certificates must be tamper resistant.
   4. Provide an overview of the applicant’s recordkeeping system.
   5. Provide other course information requested by the Contra Costa County EMS Agency (LEMSA).
   6. Pay the established LEMSA CE Provider application fee.
   7. Applications must be received at least sixty (60) days before the first scheduled course of instruction.

B. The LEMSA will notify the applicant within thirty (30) days that the application was received and shall notify the applicant within thirty (30) days of its decision to approve or deny.

C. Approval shall be good for four (4) years from the last day of the month in which the application is approved. It shall be the responsibility of the CE provider to submit an application for renewal at least sixty (60) days in advance of the expiration date, in order to maintain continuous approval.

D. CE providers shall ensure that each CE activity or course meets the criteria outlined in the CCRs, Title 22, Division 9, Chapter 11.

E. All records shall be available to the LEMSA upon request, or during scheduled or unscheduled site visits by LEMSA staff.

F. The LEMSA shall be notified in writing within thirty (30) days, of any change in CE provider names, address, telephone number, Program Director or Clinical Director.
I. PURPOSE
This policy defines the role of the Base Hospital and to define the procedure when Base Hospital contact is required and/or communication is disrupted.

II. BASE HOSPITAL ROLE
A. Contra Costa County EMS Agency (LEMSA) Policies and Procedures, including the Prehospital Care Manual, are guidance documents that direct the actions of prehospital personnel. The Base Hospital is available at all times to provide medical direction and advice. Base Hospital contact may be necessary to address any of the following issues:
   1. Orders for medical care as required by Field Treatment Guidelines;
   2. Orders for care not outlined in the Field Treatment Guidelines;
   3. Patient destination concerns;
   4. Determination of death or cessation of resuscitative efforts;
   5. Other policy concerns that may need additional input, direction and guidance (e.g., patient refusal of care, physician on scene, variation order, etc.).
B. Prehospital personnel are encouraged to contact the Base Hospital if they have any questions regarding patient treatment or disposition.

III. DISRUPTED COMMUNICATION
When a paramedic is directed by a field treatment guideline to contact the Base Hospital and he/she is unable to establish or maintain contact and determines that a delay in treatment may jeopardize the patient, the paramedic may initiate indicated ALS care as specified in the Field Treatment Guidelines until Base Hospital contact can be established or until the patient is delivered to the closest appropriate receiving hospital. The paramedic shall transport the patient as soon as possible while providing necessary treatment en-route.

If ALS procedures normally requiring Base Hospital contact are performed under disrupted communications, the paramedic shall:
A. Immediately following delivery of the patient to the receiving hospital:
   1. Complete the EHR documenting the ALS skills performed;
   2. Notify, or request that the agency dispatcher notifies Sheriff’s Dispatch of the communication problem, if the paramedic suspects that any radio problem was due to a situation other than geographical location.
B. Within twenty-four (24) hours, send a copy of the completed EHR and a written report explaining the reason(s) or suspected reason(s) for communication failure to the paramedic provider agency QI coordinator. The paramedic shall be prepared to demonstrate that the treatment delivered was appropriate.
I. PURPOSE
This policy establishes countywide minimum standards for authorized Emergency Medical Dispatch (EMD) Centers to dispatch emergency medical services (EMS) resources and establish the minimum response levels of those resources.

Medical Priority Dispatch System™ (MPDS) is the approved EMD program utilized in Contra Costa County.

II. DISPATCH OPERATIONS
A. EMD Centers are strongly encouraged to achieve and maintain Accredited Center of Excellence (ACE) accreditation through the International Academies of Emergency Dispatch (IAED).

B. At a minimum, EMD Centers shall:
1. Provide dispatch services necessary to receive and respond to requests for emergency and advanced life support (ALS) ambulance service requests.
2. Be approved by the State of California as a public safety answering point (PSAP).
3. Receive and process calls for emergency medical assistance from primary 9-1-1 PSAPs.

C. Emergency Medical Dispatchers shall:
1. Determine the nature and severity of medical incidents consistent with MPDS protocols.
2. Dispatch appropriate EMS resources and forward requests for transporting ambulance providers when indicated.
3. Provide post-dispatch instructions (PDIs) and pre-arrival instructions (PAIs) to callers.
4. Notify responding personnel and provider agencies of pertinent information.
5. Monitor and track responding resources of their agency.
6. Coordinate with law enforcement and other EMS providers as needed and provide education to enhance cooperation between agencies.
7. Participate in the Contra Costa County EMS Quality Improvement (QI) process.

III. STAFFING
A. The EMD Center shall be staffed with sufficient trained dispatchers.
B. All dispatchers interrogating callers shall be certified by the IAED.
C. All emergency medical dispatchers shall receive the required amount of continuing dispatch education to meet IAED training and certification standards.

IV. PROCEDURE
A. All EMD Centers that dispatch 9-1-1 medical responses shall follow medical priority dispatch procedures that are compliant with IAED guidelines.
B. All EMS providers using tiered response shall adhere to minimum response requirements set forth by the LEMSA Medical Director.
C. The Contra Costa County EMS Agency (LEMSA) Medical Director shall review & approve modification requests prior to implementation.

V. QI PLAN
A. EMD Centers shall participate on the Contra Costa EMD review committee (CCERC).
B. Meetings will be held bi-annually or as needed to review the QI data and will include communication center directors, dispatch supervisors, dispatch representatives and Contra Costa EMS representatives.
C. Each EMD Center shall establish and maintain a continuous QI plan.
D. Updates approved by the LEMSA Medical Director to the MPDS shall be implemented in a timely manner as soon as the education is completed and hardware is compatible. Documentation of the training must be sent to LEMSA once complete.
E. Each EMD Center shall submit monthly QI reports to LEMSA. Indicators and education that were reviewed and completed will be documented in this report. Specific additional indicators may be requested by the LEMSA as needed.
I. PURPOSE

This policy establishes approved Medical Priority Dispatch System™ (MPDS) response and mode assignments for use by authorized Emergency Medical Dispatch (EMD) Centers in Contra Costa County.

II. POLICY

A. EMD Centers shall dispatch EMS resources to medical emergencies and manage their response in accordance with the response level established by this policy.

B. First Responder and ambulance resources shall comply with instructions from an authorized EMD Center to upgrade, cancel, or reduce their response mode.

C. Contra Costa County EMS approved MPDS response and mode assignments for use by authorized EMD Centers are as follows:

<table>
<thead>
<tr>
<th>MPDS Card</th>
<th>Protocol</th>
<th>Dispatch Levels</th>
<th>First Responder Minimum Response Requirement*</th>
<th>Ambulance Minimum Response Requirement**</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Abdominal pain/Problems</td>
<td>A, C, D</td>
<td>No response</td>
<td>No lights and siren</td>
</tr>
<tr>
<td>2</td>
<td>Allergies/Envenomations</td>
<td>A, B, C, D, E</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>3</td>
<td>Animal bites/Attack</td>
<td>A, B, D</td>
<td>No response</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>4</td>
<td>Assault/Sexual assault</td>
<td>A, B, D</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>5</td>
<td>Back Pain</td>
<td>A, C, D</td>
<td>No response</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>6</td>
<td>Breathing problems</td>
<td>C, D, E</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
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<td>7</td>
<td>Burns/Explosion</td>
<td>A, B, C, D, E</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>8</td>
<td>Carbon monoxide/Inhalation/</td>
<td>B, C, D</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
</tr>
<tr>
<td></td>
<td>Hazmat/ CBRN</td>
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<td></td>
</tr>
<tr>
<td>9</td>
<td>Cardiac or respiratory arrest/</td>
<td>B, D, E</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
</tr>
<tr>
<td></td>
<td>Death</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Chest pain</td>
<td>A, C, D</td>
<td>No response</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>11</td>
<td>Choking</td>
<td>A, D, E</td>
<td>No response</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>12</td>
<td>Convulsions/Seizures</td>
<td>A, B, C, D</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>13</td>
<td>Diabetic problems</td>
<td>A, C, D</td>
<td>No response</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>14</td>
<td>Drowning/Diving/Scuba accident</td>
<td>A, B, C, D</td>
<td>No response</td>
<td>Lights and siren</td>
</tr>
</tbody>
</table>

* First responder minimum response requirements – changes require approval of the LEMSA Medical Director.

** Ambulance minimum response requirement – changes require approval of LEMSA Medical Director.
## Dispatch Requirements for 9-1-1 Resources

<table>
<thead>
<tr>
<th>MPDS Card</th>
<th>Protocol</th>
<th>Dispatch Levels</th>
<th>First Responder Minimum Response Requirement</th>
<th>Ambulance Minimum Response Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Electrocution/Lightning</td>
<td>C, D, E</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>16</td>
<td>Eye problems</td>
<td>A, B, D</td>
<td>No response</td>
<td>No lights and siren</td>
</tr>
<tr>
<td>17</td>
<td>Falls</td>
<td>A-1, A-2</td>
<td>No response</td>
<td>No lights and siren</td>
</tr>
<tr>
<td>18</td>
<td>Headache</td>
<td>A, B, C</td>
<td>No response</td>
<td>No lights and siren</td>
</tr>
<tr>
<td>19</td>
<td>Heart problems/AICD</td>
<td>A, C, D</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>20</td>
<td>Heat/Cold exposure</td>
<td>A, B, C, D</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>21</td>
<td>Hemorrhage/Laceration</td>
<td>A, B, C, D</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>22</td>
<td>Inaccessible incident/Other entrapment</td>
<td>A, C, D</td>
<td>No response</td>
<td>No lights and siren</td>
</tr>
<tr>
<td>23</td>
<td>Overdose/Poisoning</td>
<td>A, B, C, D</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>24</td>
<td>Pregnancy/Childbirth/ Miscarriage</td>
<td>A, B, C, D</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>25</td>
<td>Psychiatric/Abnormal behavior/ Suicide attempt</td>
<td>A, B, C, D</td>
<td>No response</td>
<td>No lights and siren</td>
</tr>
<tr>
<td>26</td>
<td>Sick person</td>
<td>A, B, C, D</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>27</td>
<td>Stabbing/Gunshot/ Penetrating trauma</td>
<td>A, B, C, D</td>
<td>No response</td>
<td>No lights and siren</td>
</tr>
<tr>
<td>28</td>
<td>Stroke (CVA)/Transient Ischemic Attach (TIA)</td>
<td>A, B, C, D</td>
<td>No response</td>
<td>No lights and siren</td>
</tr>
<tr>
<td>29</td>
<td>Traffic/Transportation incidents</td>
<td>A, B, C, D</td>
<td>No response</td>
<td>No lights and siren</td>
</tr>
<tr>
<td>30</td>
<td>Traumatic injuries</td>
<td>A, B, D</td>
<td>No response</td>
<td>No lights and siren</td>
</tr>
<tr>
<td>31</td>
<td>Unconscious/Fainting</td>
<td>A, C, D, E</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>32</td>
<td>Unknown problem</td>
<td>B, D</td>
<td>Lights and siren</td>
<td>Lights and siren</td>
</tr>
<tr>
<td>33</td>
<td>Transfer/Interfacility/Palliative care</td>
<td>A, B, C, D</td>
<td>No response</td>
<td>No lights and siren</td>
</tr>
</tbody>
</table>

*First responder minimum response requirement – changes require approval of the LEMSA Medical Director.

**Ambulance minimum response requirement – changes require approval of LEMSA Medical Director.
I. PURPOSE
This policy is to establish guidelines for essential communication between EMS field providers and receiving facilities. These guidelines pertain to communication prior to arrival at an approved receiving hospital, during communication with the Base Hospital, or during patient care turnover.

II. POLICY
A. The person with the most knowledge of the patient’s complaint and current condition will communicate with the receiving hospital or Base Hospital. This will usually be the provider with primary patient care responsibilities. During multi-patient events, this may be the transportation group supervisor or the Incident Commander designee.

B. Receiving hospital reports, including Base Hospital contact, allow the receiving hospital to prepare the appropriate bed, equipment, and personnel to care for the needs of the patient.

C. There are many different formats for giving report including SOAP, SAMPLE, MIVT and SBAR. This policy addresses the minimum acceptable information to be communicated, regardless of the report format utilized.

D. When possible, it is important to keep pre-arrival reports brief and concise.

III. PROCEDURE
A. Receiving Hospital Report:
Receiving hospital communication reports are designed to inform the receiving hospital (Base Hospital or otherwise) of incoming patients. Receiving hospital communication reports should contain:
1. EMS unit identifier, nature/type of call, and if applicable specialty alert notification (i.e. STEMI/Stroke/Sepsis);
2. State urgent concerns/level of concern up front;
3. Patient’s age, sex, chief complaint, and level of consciousness/GCS;
4. Brief history of current complaint;
5. Medical history, medications, allergies, and physical findings pertinent to the patient’s current medical complaint;
6. Vital signs;
7. Any treatment and response; and
8. ETA to receiving hospital.

B. Base Hospital/Trauma Report:
The Base Hospital may be contacted for a variety of reasons including treatment guideline variation, cessation of efforts and high risk patient refusals. When contacting the Base Hospital, the report should include everything outlined in the receiving hospital report in addition to the following:

Trauma Patients:
1. Mechanism of injury, including either highway or surface street speed, seatbelt use/airbag deployment, and if extrication required;
2. Injuries;
3. Vital Signs, including GCS; and
4. Treatment, including any spinal motion restriction including, tourniquets placed and estimated blood loss.
5. 5-minute Update:
   The five (5) minute update call should be made when the ambulance is five (5) minutes from the trauma center and should include expanded patient information, including significant changes in vital signs, mental status, physical findings or symptoms.

C. For all other Base Hospital communication, utilize the receiving hospital report format and include the following when applicable:
1. Reason for call (e.g., AMA, additional orders, field treatment guideline variation, Physician on Scene, etc.);
2. Level of Concern; and
3. Destination if other than the Base Hospital.
## V. SBAR REPORT

### Adult Patients

#### Agency, Unit, Age, Gender, Type of Call

 *(This is Medic 1 with a Twenty-Six, 2-6 year old Male trauma activation)*

#### Pediatric Patients

#### Agency, Unit, Age, Gender, Type of Call

 *(This is Medic 1 with a Pediatric Six, 0-6 year old Female requesting trauma destination)*

<table>
<thead>
<tr>
<th>Situation (Mechanism)</th>
<th>Activation or Destination</th>
<th>Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MVA:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Speed (Known MPH and/or Freeway or City Streets)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Type of Impact (roll over, head on, rear end, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Type of vehicle (Newer model or older model)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Patient Compartment Intrusion/steering wheel intact/ Airbags deployment/restrained driver</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Motorcycle:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Speed (Known MPH and/or Freeway or City Streets)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Protective Clothing (Helmet, Jacket, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fall:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Distance, surface, Blood thinners?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assault:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Object</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Impact area</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- What is the situation?
- State urgent issues and immediate needs up front!

| Background (Injuries) | | |
|-----------------------| |         |
| **Physical Assessment** | |         |
| **EXPOSE AND PALPATE!** | |         |
| **Kill Zones:** Head, Neck, Chest (Anterior & Posterior) |
| Abdomen, Pelvis, Femurs. | |         |

- What has happened up to this point?
- What past history would be important to know for further patient treatment?

| Assessment (Vital Signs) | | |
|--------------------------| |         |
| **Activation:** ABC’s, GCS, Pulse, Respiration, Skin signs, Pupils. | |         |
| **Destination:** Full Set of Vitals including: Blood pressure, pulse, respirations, GCS, SpO₂, skin signs, BGL, ECG, lungs and pupils | |         |

- How is the patient now?
- Full Set of Vitals including any ECGs
- Stable or unstable?

| Rx/Tx Recap (Treatment) | | |
|-------------------------| |         |
| **Key Treatments** | |         |
| (SMR, medication administered, advance airway, tourniquets, splints, etc.) | |         |

- Treatment the outcome?
- Concerns?

| ETA | | |
|-----| |         |
| **ETA to the closest, most appropriate trauma center** | |         |
| **or** |
| **Destination decision should be made by MD based on information given. Provide requested hospital during report** | |         |

- ETA to the appropriate receiving hospital

---

**Standard Policies**

**Policy 3004**

**Effective January 2019**
I. PURPOSE
Defibrillation, utilizing an automated external defibrillator (AED) according to policies and procedures established by the Contra Costa County EMS Agency (LEMSA), is included in the EMT scope of practice and has been approved as an optional skill for use by personnel trained to Public Safety First Responder standards.

II. AED SERVICE PROVIDER
An AED service provider is an agency or organization that employs individuals as Public Safety Fire Responders or EMT personnel and who obtain AEDs for the purpose of providing AED services to the general public.
A. An AED service provider shall be approved by the LEMSA. In order to receive and maintain AED service provider approval, an AED service provider shall comply with the requirements of this policy and/or applicable state regulations.
B. AED service provider approval may be revoked or suspended for failure to maintain the requirements of this policy and/or applicable state regulations.
C. An AED service provider shall be approved if it meets and provides the following:
   1. Completes an application available from the LEMSA.
   2. Provides orientation of AED authorized personnel to the AED.
   3. Ensures maintenance of the AED equipment.
   4. Ensures initial training and continued competency of AED authorized personnel.
   5. Notification to the LEMSA when an AED has been utilized on a patient using form (Public Safety/EMT AED Service Provider “AED Use Report”).
   6. Collects and reports to the LEMSA annually, data that includes:
      a. Number of patients with sudden cardiac arrest receiving CPR prior to arrival of AED service provider personnel.
      b. Total number of patients the AED was applied to.
      c. Total number of patients on whom defibrillatory shocks were administered.
      d. Total number of patients on whom defibrillatory shocks were administered, who suffered a witnessed cardiac arrest.
      e. Annual data shall be submitted to the LEMSA using the attached form (Public Safety/EMT AED Service Provider “AED Annual Report”).
   7. Authorizes personnel to use an AED and maintains a list of all authorized personnel and provides the list to the LEMSA annually or upon request.
D. An approved AED service provider and its authorized personnel shall be recognized statewide.

III. PUBLIC SAFETY AED SERVICE PROVIDER TRAINING PROGRAM REQUIREMENTS
A. A public safety agency wishing to implement an AED training program must be approved by the LEMSA. This program shall include:
   1. A minimum of four (4) hours of initial instruction and testing.
2. A course outline which includes the topics and skills listed in the current Public Safety regulations, for the optional skill of AED.

3. A final written and practical evaluation.

B. The public safety agency shall implement a quality improvement (QI) program as outlined in the EMS QI plan (EQIP) established by the LEMSA.

C. The public safety agency shall follow the policies and procedures issued by the LEMSA Medical Director.

D. Defibrillators and defibrillator trainers shall be maintained in accordance with manufacturer's recommendations.

IV. PUBLIC SAFETY AED INSTRUCTOR REQUIREMENTS

To be authorized to instruct public safety personnel in the use of an AED, an AED instructor shall either:

A. Complete an American Heart Association (AHA) recognized instructor course (or equivalent) including instruction and training in the use of an AED, or;
I. PURPOSE
This policy identifies the procedure for determining the appropriate receiving facility for patients transported by ground ambulance to the Emergency Department (ED) of an acute care hospital.

II. POLICY
A. Patients transported as part of an EMS response shall be taken to the closest Emergency Department staffed and equipped to provide care appropriate to the needs of the patient.

B. Patients may be transported to any acute care hospital in Contra Costa County or any contiguous county.

C. Patients transported by a non-emergency ambulance as part of a 911 system response and who meet the criteria set forth Section IV of Policy 1002, shall be transported as directed in this policy.

D. Out-of-County ED “diversion” or “bypass” is not recognized by the Contra Costa County EMS system.

E. Prehospital providers are responsible for the decision to transport with or without red lights and sirens (RLS). Consideration should be given to whether there are reasonable grounds to believe there is a life threatening emergency and whether RLS is necessary or appropriate based on travel time, distance, patient, weather and road conditions. The decision to transport with RLS should not be based solely on the destination decision or whether the patient meets specialty care criteria (e.g., stroke, STEMI, trauma).

F. For destination requests not addressed in this policy, consider contacting an EMS Field Supervisor for guidance.

III. PROCEDURE FOR DETERMINING DESTINATION
A. Prehospital personnel shall assess a patient to determine whether the patient is stable or unstable.

B. Patient stability must be considered along with a number of additional factors in making destination and transport mode decisions. Additional factors to be considered include:
   1. Patient or family’s choice of receiving hospital and ETA to that facility.
   2. Recommendations from a physician familiar with the patient’s current condition.
   3. Patient’s regular source of hospitalization or health care.
   4. Ability of field personnel to provide field stabilization or emergency intervention.
   5. ETA to the closest basic emergency department (ED).
   6. Traffic and weather conditions.
   7. Hospitals with specialized resources.
   8. Hospital status.

IV. UNSTABLE PATIENTS
A. An unstable patient should be transported to the closest, appropriate ED.

B. Patients meeting trauma, STEMI or stroke criteria, or when there is a high index of suspicion that a
patient meets such criteria, should be transported to the most appropriate ED with trauma, STEMI or stroke specialty services.

C. Field crews should contact the Base Hospital for guidance in situations where the appropriate choice of receiving facility is unclear to transport personnel.

V. STABLE PATIENTS

A. Stable patients are to be transported to an acute care hospital based on patient/family preference.

B. If a patient does not express a preference, the hospital where the patient normally receives care should be considered.

VI. PATIENTS ON PSYCHIATRIC DETENTION

A. A patient placed on a legal detention (e.g., a hold pursuant to W&I Code § 5150) in the field by a legally authorized person shall be assessed for the presence of a medical emergency. Based on the history and physical examination of the patient, prehospital personnel shall determine whether the patient is stable or unstable.

B. Medically stable patients shall be transported to Contra Costa Regional Medical Center.

C. Medically unstable patients shall be transported to the closest ED.

D. A patient with a current history of overdose of medications shall be transported to the closest ED.

E. A patient with history of ingestion of alcohol or illicit street drugs shall be transported to the closest ED if there is any of the following:

F. Altered mental status (e.g., decreased level of consciousness or extreme agitation).

G. Significantly abnormal vital signs.

H. Any other history or physical findings that suggest instability (e.g., chest pain, shortness of breath, hypotension, diaphoresis).

VII. OBSTETRICAL PATIENTS

A. A patient is considered “obstetric” if pregnancy is estimated to be twenty (20) weeks or greater.

B. Obstetric patients should be transported to a hospital with in-patient obstetrical services in the following circumstances:

1. Patients in labor.

2. Patients whose chief complaint appears to be related to the pregnancy, or who potentially have complications related to the pregnancy.

3. Injured patients who do not meet trauma criteria or guidelines.

4. Obstetric patients meeting trauma triage criteria shall be transported to a trauma center.

5. Obstetric patients with impending delivery or unstable conditions where imminent treatment appears necessary to preserve the mother’s life should be transported to the nearest basic ED.
6. Stable obstetric patients should be transported to the ED of choice if their complaints are unrelated to the pregnancy.

VIII. PATIENTS WITH BURNS
A. Hospital Selection:
   1. Burn patients with unmanageable airways should be transported to the closest facility.
   2. Patients with burns to < 20% total body surface area (TBSA) can be cared for at any hospital.
   3. Adult and pediatric patients with burns and significant trauma should be transported to the closest appropriate trauma center.
   4. Patients with major burns should be transported directly to a designated Burn Center, including:
      a. ≥ 20% TBSA partial or full thickness burns
      b. Burns with suspected inhalation injury
      c. High voltage electrical burns
   5. Consider transporting patients with burns to the face, hands, perineum or feet to a burn center.

B. Procedure for Burn Center destination:
   1. Contact the Base Hospital prior to transport to confirm bed availability.
   2. Consult the Base Hospital for any questions regarding destination decision.

IX. CARDIAC ARREST WITH RETURN OF SPONTANEOUS CIRCULATION
A. Patients who have had ROSC at any time during their course of care or are in persistent V-Fib/pulseless V-Tach should be transported to an STC when transport is deemed appropriate.

X. STEMI/ACUTE STROKE
A. Suspected STEMI/acute stroke patients shall be transported to the closest specialty center (STEMI Receiving Center/Primary Stroke Center) unless another facility is requested.

B. A specialty center that is not the closest facility is acceptable but only if the estimated additional transport time does not exceed fifteen (15) minutes.

C. If the closest specialty center is on CT or STEMI diversion the patient shall be taken to the next closest appropriate specialty center.

D. Patients may request an out-of-county receiving center if all above conditions are met and EMS personnel have verified the out-of-county receiving center is not on diversion for CT or STEMI.

XI. OTHER TRANSPORT CONSIDERATIONS
A. Patients with other specialty care needs (e.g., patients with LVADs, disease/illness specific treatments) should be transported to their facility of choice. Specialty care patients meeting the definition of unstable shall be transported to the closest ED.

XI. OUT-OF-COUNTY SPECIALTY CENTER AND ED DIVERSION OR “BYPASS”
A. Out-of-county “internal disaster,” when captured in the ReddiNet “STATUS” screen, should be
B. Out-of-county specialty services closure (e.g., CT, STEMI, trauma), when captured in the ReddiNet “STATUS” screen, should be immediately disseminated to field providers via radio, pager, message, etc.

XII. DIRECTED DESTINATION FOR WEST CONTRA COSTA COUNTY PATIENTS

A. Kaiser Richmond is the only ambulance receiving facility in the western part of Contra Costa County. To mitigate the impact to the West County community, patients requiring transport will be informed of Kaiser Richmond’s ED status as part of the destination decision.

B. ReddiNet is the only method approved to determine Kaiser Hospital – Richmond ED status. Prehospital providers shall not make transport destination decisions based on information received from other sources (e.g., EMS supervisors or hospital staff). Only Contra Costa EMS Agency staff may override ReddiNet status.

C. The following ED status designations will be used by Kaiser Hospital – Richmond and communicated via ReddiNet:

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>Operating normally and available for all patient transports appropriate to that hospital.</td>
</tr>
<tr>
<td>Yellow</td>
<td>Stable patients will be informed that Kaiser Richmond is significantly impacted by patient volume. Stable patients choosing Kaiser Richmond should be advised of significant delays and will be asked to choose another hospital. The patient may still choose Kaiser Richmond. Unstable patients (lights and sirens transports) will continue to be transported to the closest hospital, which includes Kaiser Richmond.</td>
</tr>
<tr>
<td>Red</td>
<td>Stable patients will be informed that Kaiser Richmond is severely impacted and will be requested to choose another hospital. Stable patients may not be transported to Kaiser Richmond. Unstable patients (lights and sirens transports) will continue to be transported to the closest hospital, including Kaiser Richmond.</td>
</tr>
</tbody>
</table>

D. Prehospital personnel should utilize approved scripts that address Yellow and Red Status procedures to assist in choice of hospital destination:
XIII. RESOURCE:
Approved Kaiser Richmond Status Scripts:

Directed Destination Scripts for Stable Patients

Yellow Status - If a patient or family requests transport to Kaiser Richmond, please explain:

“Kaiser Richmond is currently experiencing very long wait times for care. There is a high likelihood that your care could be delayed by more than two hours.”

“Would you still like to be transported to Kaiser Richmond?”
If the answer is yes, proceed to Kaiser Richmond and notify the hospital accordingly.
If the answer is no, ask, “Which hospital would you like to be transported to?”

Other nearby hospitals:
*Contra Costa Regional Medical Center – Martinez
*John Muir Medical Centers – Concord and Walnut Creek
Kaiser Permanente – Walnut Creek
Highland Hospital – Oakland
*Alta Bates Medical Center – Berkeley
Kaiser Permanente – Oakland
*Summit Medical Center – Oakland
Kaiser Permanente – Vallejo
Sutter Solano – Vallejo
Kaiser Permanente – San Rafael
Marin General – Greenbrae
*Contra Costa Health Plan and MediCal hospital

Red Status - If a patient or family requests transport to Kaiser Richmond, please explain:

“Kaiser Richmond is currently unavailable due to patient overload. We can transport you to another hospital of your choice.”

“Which of these hospitals would you like to be transported to?”

Other nearby hospitals:
*Contra Costa Regional Medical Center – Martinez
*John Muir Medical Centers – Concord and Walnut Creek
Kaiser Permanente – Walnut Creek
Highland Hospital – Oakland
*Alta Bates Medical Center – Berkeley
Kaiser Permanente – Oakland
*Summit Medical Center – Oakland
Kaiser Permanente – Vallejo
Sutter Solano – Vallejo
Kaiser Permanente – San Rafael
Marin General – Greenbrae
*Contra Costa Health Plan and MediCal hospital

Effective January 2019
I. PURPOSE
This policy identifies the most frequented receiving hospitals and specialty centers for patients transported by 9-1-1 ground ambulance or interfacility patients who become unstable during transport. This is not an inclusive list of all receiving hospitals.

II. POLICY
A. A patient, transported as part of an EMS response, shall be taken to the most appropriate hospital staffed and equipped to provide care appropriate to the needs of the patient, despite County boundaries.

B. Field transport personnel should refer to LEMSA Administrative Policy 4002 (Patient Destination Determination) for destination determination.

III. RECEIVING CENTERS

<table>
<thead>
<tr>
<th>Contra Costa County Hospitals</th>
<th>Specialty Services</th>
<th>ED Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Muir Medical Center – Walnut Creek (Base)</td>
<td>Trauma</td>
<td>(925) 939-5804 (Base)</td>
</tr>
<tr>
<td>1601 Ygnacio Valley Road</td>
<td>STEMI</td>
<td>(925) 939-5800 (ED)</td>
</tr>
<tr>
<td>Walnut Creek, California 94598</td>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OB/Neonatal</td>
<td></td>
</tr>
<tr>
<td>Contra Costa Regional Medical Center</td>
<td>OB/Neonatal</td>
<td>(925) 370-5971</td>
</tr>
<tr>
<td>2500 Alhambra Avenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Martinez, California 94553</td>
<td></td>
<td></td>
</tr>
<tr>
<td>John Muir Medical Center – Concord</td>
<td>STEMI</td>
<td>(925) 689-0553</td>
</tr>
<tr>
<td>2540 East Street</td>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Concord, California 94520</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Medical Center – Antioch</td>
<td>Stroke</td>
<td>(925) 813-6099</td>
</tr>
<tr>
<td>5001 Deer Valley Road</td>
<td>OB/Neonatal</td>
<td></td>
</tr>
<tr>
<td>Antioch, California 94531</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Medical Center – Richmond</td>
<td>Stroke</td>
<td>(925) 307-1758</td>
</tr>
<tr>
<td>901 Nevin Avenue</td>
<td></td>
<td></td>
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<tr>
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<tr>
<td>Kaiser Medical Center – Walnut Creek</td>
<td>STEMI</td>
<td>(925) 939-1788</td>
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<tr>
<td>1411 East 31st Street</td>
<td>Trauma</td>
<td>(510) 535-6000</td>
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<tr>
<td><strong>Alta Bates Medical Center – Berkeley</strong></td>
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<tr>
<td>2450 Ashby Avenue</td>
<td>OB/Neonatal</td>
<td>(510) 204-2500</td>
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<td>350 Hawthorne Avenue</td>
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<td>(510) 869-8700</td>
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<td><strong>Eden Medical Center</strong></td>
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<tr>
<td>20103 Lake Chabot Road</td>
<td>Trauma</td>
<td>(510) 727-3015</td>
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<td>3600 Broadway</td>
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<td>(925) 307-1758</td>
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<td>5565 West Las Positas Boulevard</td>
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<td>(925) 416-6585</td>
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<td>700 Lawrence Expressway</td>
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<td>975 Serena Drive</td>
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Effective January 2019
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<td>(415) 925-7203</td>
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<td>Northbay Medical Center</td>
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<td>751 South Bascom Avenue</td>
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<tr>
<td>St. Francis Burn Center</td>
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<tr>
<td>Sutter Solano Medical Center</td>
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<td>(707) 642-7080</td>
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<td>300 Hospital Drive</td>
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<td>Sutter Tracy Community Hospital</td>
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<td>(209) 832-6018</td>
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<td>1420 North Tracy Boulevard</td>
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<tr>
<td>UC Davis Medical Center</td>
<td>Trauma</td>
<td>(916) 734-3892 (Trauma)</td>
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<td>2315 Stockton Boulevard</td>
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<td>Sacramento, California</td>
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I. PURPOSE
This policy specifies the classification/authorization requirements for EMS aircraft providers who provide services within Contra Costa County.

II. CLASSIFICATION
The Contra Costa County EMS Agency (LEMSA) is responsible for classifying EMS aircraft based within its jurisdiction, except that the California EMS Authority (EMSA) is responsible for classifying aircraft of the California Highway Patrol (CHP H-30/32 Napa), CAL FIRE, and California National Guard.

A. Classification Categories
An EMS aircraft will be classified as either an air ambulance or a rescue aircraft. Rescue aircraft will be further classified as advanced life support (ALS), basic life support (BLS) or auxiliary based on level of medical flight crew credentials.

1. Air Ambulance: Any aircraft that is:
   a. constructed, modified, equipped, and used to respond to emergency requests and to transport critically ill or injured patients, and
   b. staffed with a minimum of two (2) attendants credentialed in advanced life support.

2. Rescue Aircraft: An aircraft whose usual function is not prehospital emergency patient transport but which may be used, in compliance with EMS policy, for prehospital emergency patient transport when use of an air or ground ambulance is unsuitable or unavailable.
   a. Advanced Life Support (ALS) Rescue Aircraft: A rescue aircraft whose medical flight crew has a minimum of one (1) attendant credentialed in advanced life support.
   b. Basic Life Support (BLS) Rescue Aircraft: A rescue aircraft whose medical flight crew has at a minimum one (1) attendant certified as an EMT or AEMT.
   c. Auxiliary Rescue Aircraft: A rescue aircraft which does not have a medical flight crew, or whose medical flight crew does not meet minimum requirements established for BLS Rescue Aircraft.

B. Medical Helicopter
The term “medical helicopter” shall mean a rotary wing aircraft that has been classified as an “air ambulance.”

III. CLASSIFICATION PROCEDURE
A. To become classified in Contra Costa County, an EMS aircraft provider is required to:
   1. Submit a completed Contra Costa County EMS Aircraft Classification form
   2. Submit all required attachments
   3. Pay the current EMS Aircraft Classification fee.

B. Prior to classification, LEMSA staff may visually inspect the aircraft, equipment and radios.

C. An EMS aircraft provider shall apply for re-classification whenever there is a:
   1. Transfer of ownership, or
2. Change in any factor that applies to or affects its classification category.

D. No person or organization shall provide or hold itself out as providing prehospital air ambulance or air rescue services unless that person or organization has been classified by a local LEMSA, or in the case of the CHP, CAL FIRE, and California National Guard, by the EMSA.

IV. AUTHORIZATION
The LEMSA is responsible for authorizing EMS aircraft used for EMS response within its jurisdiction. Typically, only EMS aircraft that meet the “air ambulance” classification standard shall be authorized by the LEMSA to respond in Contra Costa County. However, any request by a public safety agency dispatch center shall constitute “authorization” to respond to that request only.

V. AUTHORIZATION PROCEDURE
To become authorized in Contra Costa County, an EMS aircraft provider is required to:
A. Submit a completed EMS Aircraft authorization form
B. Enter into a written agreement with the County, and
C. Pay the current EMS Aircraft Authorization fee.

VI. PERFORMANCE STANDARDS
A. Services
1. Only an “air ambulance” may be dispatched in response to an emergency medical aircraft request.
2. Aircraft may respond to emergency requests when requested by a local public safety dispatch center.
3. A seamless “one (1) contact number system,” approved by the LEMSA, is to be used by local public safety dispatch centers when requesting EMS aircraft assistance.
4. An authorized provider shall assure that its dispatch center provides an accurate “estimated time of arrival” (ETA) in minutes and clock hours to the requester of each air ambulance request.
5. An authorized provider shall comply with all applicable Federal, State and local laws and regulations, and County EMS policies, procedures and protocols.

B. Dispatch and Communications
1. EMS aircraft dispatch centers shall be staffed and equipped to receive and process requests for EMS aircraft.
2. Dispatchers shall be adequately trained and prepared to process emergency medical requests.
3. Aircraft shall be capable of communicating with Sheriff’s Dispatch, on-scene ambulances, public safety agencies, and local Base and receiving hospitals.

C. Staffing
1. Air ambulance staffing shall include a medical flight crew consisting of a minimum of two (2) attendants licensed in advanced life support, at least one (1) of which is a registered nurse or physician.
2. Air medical flight crewmembers and pilots shall maintain all required professional licensure.

D. Training and Orientation
   1. Medical flight crewmembers shall be trained in aeromedical transportation as specified in Section 100302, California Code of Regulations, and maintain current professional licenses.
   2. Medical flight crews and pilots shall be oriented and familiar with the local EMS system prior to responding to local emergency medical requests. Orientation shall include the following topics:
      a. Terrain and weather considerations specific to the geographic area of the County.
      b. Local EMS and public safety agencies.
      c. Locations of and special operational information related to local hospitals and medical specialty centers, helipads, airports and pre-determined emergency landing sites.
      d. Comprehensive communications inventory including frequency numbers, agency names and identifiers, PL codes, and any special communications procedures.
      e. (Medical crew) Local medical control policies and procedures.

E. Medical Control
   1. Local Medical Control Agreements shall be in place for paramedic crewmembers.
   2. Providers shall assure compliance with local policies and procedures for medical control.
   3. Registered Nurse (RN) crewmembers function within the Nurse Practice Act and shall be trained qualified to provide ALS care within the local paramedic scope of practice at a minimum.

F. Documentation and Reporting
   1. Electronic Health Records (EHR) shall be completed for all patient transports regardless of location of receiving hospital. EHRs shall include required patient care data elements, requesting party/agency and times necessary to determine aircraft response time from initial notification, on-scene time, and transport time. Copies of EHRs shall be left with the patient at the receiving hospital. Response data for each call that originated within Contra Costa County shall be submitted to the LEMSA by the tenth (10th) of the following month in a format specified by the LEMSA. Submitted data shall include, but not be limited to, all data points specified in the “Contra Costa County Helicopter Minimum Dataset”. Individual EHRs will be submitted to the LEMSA when requested.

G. Quality Improvement (QI)
   1. Medical treatment guidelines for medical flight crew shall be in place and shall have been approved by the County EMS Medical Director.
   2. A comprehensive continuous quality improvement (QI) program approved by the EMS Medical Director shall be in place and shall be overseen by a physician or a registered nurse.
   3. QI information shall be supplied to the County upon request.
   4. County shall be notified of any events that could impact the credentials of air medical crewmembers.
   5. Provider shall participate in QI activities.

Effective January 2019
H. Equipment and Supplies
   1. EMS aircraft shall meet configuration and restraint standards for “air ambulance” according to Section 100306, California Code of Regulations.
   2. Aircraft shall be stocked with full drug and solution inventories, and with BLS/ALS and related specialty medical equipment and supplies at all times.

VII. MAINTENANCE OF AUTHORIZATION
   A. County may inspect aircraft, facilities, equipment, policies and records relating to aircraft maintenance, dispatch, patient care, and personnel qualifications as pertain to local operations.
   B. Provider shall adhere to all applicable FARs including FAR Part 91 and 135 (or their equivalent).
   C. County may deny, suspend, or revoke an air ambulance authorization for failure to comply with applicable policies, procedures and regulations.
I. PURPOSE
   A. To identify procedures for use by public safety agencies when requesting an air ambulance or rescue aircraft for an EMS system response.
   B. To specify criteria for patient transport by air ambulance and to outline coordination of field operations at incidents involving air ambulance response.
   C. To assure the safest, most appropriate, and cost effective method of transport based on the needs of the patient.

II. REQUEST FOR AIR AMBULANCE OR RESCUE AIRCRAFT
   A. The Incident Commander (IC) or designee is responsible for initiating an air ambulance or rescue aircraft response through the IC’s fire/medical dispatch center after consultation with the primary paramedic on-scene.
   B. Requests should include if known:
      1. Number of patients requiring helicopter transport;
      2. Current weather conditions; and
      3. Haz-Mat information if pertinent.

III. EMS AIRCRAFT UTILIZATION CRITERIA
   A. Air ambulance transport should be used when it provides a significant advantage over ground transport in terms of timely delivery of the patient from the scene to the emergency department.
   B. The helicopter estimated time of arrival, the time it takes to ground transport a patient to a helicopter rendezvous site, the helicopter scene time, and the helicopter off-load time are factors to be considered when determining whether or not a helicopter is the most expeditious and appropriate method of transport.
   C. Clinical Criteria
      1. Patients who meet the following clinical criteria may benefit from air ambulance transport:
         a. Trauma patients who meet trauma activation criteria according to EMS trauma triage policy except for:
            i. Stable patients with isolated extremity trauma
            ii. Patients with mechanism but no significant physical exam findings.
         b. Trauma patients who do not meet trauma activation criteria but by evaluation of mechanism and physical exam findings, appear to have potential significant injuries that merit rapid transport.
         c. Patients with specialized needs available only at a remote hospital such as major burn victims or critical pediatric patients.
         d. Critically ill or injured patients whose conditions may be aggravated or endangered by ground transport (e.g., limited access via ground ambulance or unsafe roadway) may be appropriate for helicopter transport.

Effective January 2019
IV. ALS RESCUE AIRCRAFT (CHP) PARAMETERS
   A. If a patient meets below criteria, consider using CHP ALS Aircraft for patient transport to receiving hospital:
      1. Primary Care paramedic believes patient will be adequately and effectively cared for by a single paramedic resource; and
      2. Time savings must be ≥ 10 minutes in favor of CHP versus Air Ambulance asset.

V. HELICOPTER UTILIZATION AND CANCELLATION DECISION
   A. The IC shall cancel the helicopter response when air ambulance transport criteria is not met. The following information is important for the IC to consider in making the best possible decision regarding mode of transport:
      1. Patient need: The paramedic with primary patient care responsibility will have the best information regarding the patient meeting clinical criteria.
      2. Estimated ground transport time versus air response and transport: The ground transport crew will be the best resource for determining whether or not there will be a transport time savings based on the travel time considering current traffic/weather conditions particularly when time savings by helicopter is minimal.
      3. Proximity of a helispot or need for a helicopter/ambulance rendezvous site: A significant amount of time may be added to overall transport time if a helicopter is unable to land in proximity to the patient.
      4. ETA of the helicopter: If the patient is packaged and ready for transport, ground transport may be the fastest mode of transport overall if a helicopter has not arrived on-scene.
   B. The ground ambulance responding to, or at the scene, should not be canceled until:
      1. The helicopter has left the scene with the patient aboard, or
      2. The senior medical personnel with primary patient care responsibility on-scene have determined that no patient transport is required.

VI. COMMUNICATIONS
   A. CALCORD should be utilized for air-to-ground communication. The IC or designee, in conjunction with the fire/medical dispatch will designate an alternate frequency if necessary.
   B. The IC or designee may cancel a helicopter response at any time prior to patient transport through the fire/medical dispatch center or by direct communication to the responding helicopter.

VII. GROUND PROVIDER RESPONSIBILITIES
   A. The IC or designee shall assure Base Hospital contact is made as soon as possible to provide early notification of patient arrival.
   B. A ground ambulance paramedic who accompanies a patient in a rescue aircraft must assure the presence of appropriate medical equipment and must obtain orientation to the aircraft and to medical air transport procedures prior to transport.
VIII. HELICOPTER RENDEZVOUS
   A. If a helicopter rendezvous is deemed appropriate, including the consideration of added transport time, a helispot (rendezvous site) as close as possible to the scene should be established.
   B. A first-responder paramedic may elect to maintain primary patient care responsibility by accompanying the patient in transport to the helispot in order to facilitate communication with the treating helicopter crew.

IX. MULTICASUALTY INCIDENT (MCI) RESPONSES
Detailed roles and responsibilities for EMS helicopter providers during MCI are specified in the County MCI Plan. Helicopters:
   A. Respond to an incident only when requested.
   B. Prepare to stage at closest airport or location designed by the IC.

X. INCIDENT REVIEW AND QUALITY IMPROVEMENT (QI)
   A. Helicopter providers shall participate in LEMSA QI activities.
   B. The LEMSA maintains oversight of helicopter utilization and works with helicopter provider agencies in assuring appropriate use of helicopter resources.
Optimal Air Ambulance and Ground Transport Timeline

10:05 – 10:50
Target Time = 45 minutes

10:00
Call received

10:02
Auto launch air request

10:04
Fire Department on scene

10:05
Air ambulance dispatched

10:08
EMS on scene

10:18
EMS transport OR transport to LZ

10:46
Air ambulance arrival at hospital

10:48
EMS arrival at hospital

10:50
EMS transfer of care

10:50
Air ambulance transfer of care

**Weather/traffic/geography conditions should be taken into consideration for estimated ground transport time**

CHP ALS Rescue Aircraft Parameters

If patient meeting the following criteria, consider using CHP ALS aircraft for patient transport to a hospital:

1. **Primary care paramedic** believe the patient will be adequately and effectively cared for by a single paramedic resource; AND

2. Time savings must be **≥ 10 minutes** in favor of CHP versus air ambulance asset.
I. PURPOSE
This policy defines the criteria for upgrade to advanced life support (ALS) for non-emergency transport providers who are not dispatched to a 9-1-1 response.

II. 9-1-1 ACTIVATION CRITERIA
A. An unstable patient shall be transported by a 9-1-1 ambulance unless otherwise authorized by this policy.
B. Non-emergency ambulance providers may transport an unstable patient to the closest/appropriate hospital, if they can do so safely, and the time from arrival on scene to arrival at the hospital is less than ten (10) minutes. In all other cases, the non-emergency ambulance crew shall activate the 9-1-1 system and request an ALS response.
C. Any non-emergency ambulance provider transporting a patient that becomes unstable during transport should divert to the closest/appropriate ED.
D. Prehospital providers working on a non-emergency ambulance arrives on the scene of a collision, illness, or injury shall provide appropriate care and immediately activate the 9-1-1 system.
I. PURPOSE
This policy defines the requirements for patients with decision making capacity to decline medical care/transport. This policy is applicable to all EMS providers.

Providers should recognize these situations as high risk. When patients insist on refusing care/ambulance transport or insist on leaving the scene; careful discussion with the patient and specific documentation may improve outcomes. In addition, this policy is intended to empower providers to ensure appropriate utilization of transportation resources.

Against Medical Advice (AMA): To provide a procedure for ALS personnel to follow when an individual identified as a “patient” refuses medical treatment/ambulance transportation or when a parent(s) or legal guardian refuses medical treatment/ambulance transport for a minor identified as a patient. Only ALS personnel may complete an AMA.

Release at Scene (RAS): To provide a procedure for BLS and ALS personnel to follow when both a person with decision making capacity AND the provider feel that no further EMS treatment and/or ambulance transport is warranted. The individual must meet all criteria set forth in Section 4007.VII.

II. AMA CRITERIA AND ACTIONS

Against Medical Advice (AMA)

A. AMA applies to patients who refuse medical care or ambulance transport. Only ALS personnel may complete an AMA.

B. In order to refuse care, a patient must be legally and mentally capable of doing so by meeting the following criteria:
   1. Is an adult (> 18 years of age), or if a minor meets the criteria set forth in Section 4007.V; and
   2. Understands the nature of the medical condition or injury and the risks and consequences of refusing care;
   3. Exhibits no evidence of altered mental status, including suspected alcohol or drug ingestion that impairs one’s ability to make a sound decision regarding medical care/transport.

C. Actions:
   1. If the patient is legally and mentally capable of refusing care:
      a. Honor the patient’s request and complete the refusal;
      b. Document the Electronic Health Record (EHR) thoroughly; and
      c. Complete an “AMA/Release at Scene” (AMA/RAS-Form 4007) Form Section II.
   2. If the patient cannot legally refuse care or is mentally incapable of refusing care AND requires medical care/transport:
      a. Document in the EHR to reflect that the patient required immediate treatment/transport and lacked the mental capacity to understand the risks/consequences of refusal (implied consent). Assessment findings should also be documented to support a decision to treat/transport.
      b. Treat and transport only as necessary to prevent death or serious disability.
c. The law presumes that an individual is competent to consent or refuse care. The party alleging a lack of capacity has the legal burden of proving it. Document accordingly; anyone forcing treatment on an unwilling patient must be able to prove both the necessity of the treatment and the incapacity of the patient.

III. BASE HOSPITAL CONTACT
A. For patients with acute conditions that pose a threat to the life or health of the patient, every effort should be made to convince the patient to be transported. Be persuasive – get help from family members, friends, or a Base Hospital MICN/Physician.

B. Paramedics must contact the Base Hospital:
   1. For any patient determined to require involuntary treatment or transport;
   2. Whenever the refusal of care or transport poses a threat to the patient’s well-being;
   3. In trauma triage when criteria is met for base contact and the patient wishes to AMA; or
   4. Any other situation in which, in the prehospital personnel’s opinion, Base Hospital contact would be beneficial in resolving treatment or transport issues.
   5. When required by field treatment guideline (e.g., Syncope, BRUE, etc.).

IV. REQUIRED DOCUMENTATION FOR THE PATIENT REFUSING CARE:
A. Document thoroughly as outlined in LEMSA Administrative Policy 6001 (Documentation of the Electronic Health Record).

B. The phrase “decision making capacity” shall be documented in the EHR narrative to reflect that the patient had the mental capacity to make a sound decision when refusing care/transport. This phrase is a quality assurance marker used for auditing purposes.

C. Specific AMA documentation may include:
   1. Indications that there were no signs of impairment due to drugs, alcohol, organic causes, or mental illness that affected the patient’s ability to make a sound decision regarding medical care/transport.
   2. Anything that caused the prehospital provider to believe the patient was mentally capable.
   3. The indications that the patient understood the risks.
   4. What the patient specifically said about why he/she is refusing treatment/transport (use “quotes” as appropriate).
   5. The prehospital provider’s efforts to encourage the patient to seek care.
   6. The person(s), if any, who agreed to look after the patient.
V. MINORS

A. Minors who may consent include:
   1. A legally married minor;
   2. A minor on active duty with the U.S. military;
   3. A minor seeking prevention or treatment of pregnancy or treatment related to sexual assault;
   4. A minor seeking treatment of contact with an infectious, contagious or communicable disease or sexually transmitted disease;
   5. A self-sufficient minor of at least 15 years of age, living apart from parents and managing his/her own financial affairs;
   6. An emancipated minor (must provide proof); or
   7. The parent of a minor child or a legal representative of the patient (of any age)

B. If the parent/guardian or conservator is not at the scene, consent/refusal of care may be obtained over the telephone. Document exactly as if the parent/guardian or conservator was present on scene. Verify the name and relationship of the individual to the patient. Attempt to have another person validate the consent/refusal with the parent/guardian or conservator. Document exactly what was said (use “quotes” as appropriate).
   1. Do not release the child to the custody of a relative or friend unless the individual has been authorized by the parent/guardian or conservator to make medical decisions for the child.

C. If the patient is 18 years of age or older, but there is a reason to suspect that the patient has been judged incompetent by a court and placed under a legal conservatorship, seek consent from the designated guardian.

D. If the parent/guardian or conservator is unavailable and treatment can be safely delayed:
   1. Document thoroughly.
   2. Attempt to reach the parent/guardian or conservator by telephone. Do not release the child to the custody of a relative or friend unless the individual has been authorized by the parent/guardian or conservator to make medical decisions for the child.

E. If the parent/guardian or conservator is unavailable and treatment cannot be safely delayed:
   1. Treat and transport as necessary to prevent death or serious disability (implied consent).

F. If the parent/guardian or conservator is available but refuses to consent for necessary, emergency treatment:
   1. Explain the risks of refusal;
   2. Be persuasive – get help from family members, friends, or a Base Hospital MICN/Physician.
   3. Involve law enforcement.

VI. ARREST AND 5150

An individual under arrest, incarcerated, or on a 5150 is legally capable of consenting or refusing medical care.

VII. RELEASE AT SCENE (RAS)

A. Release at scene applies to all individuals. Both BLS AND ALS personnel may complete a RAS.
   1. The individual must meet ALL of the following criteria:
a. Exhibits no evidence of altered mental status, including suspected alcohol or drug ingestion that impairs one’s ability to make a sound decision regarding medical care/transport;
b. Does not have a complaint suggestive of potential illness or injury that indicates a need for EMS treatment/transport;
c. Does not have obvious evidence of illness or injury that indicates a need for EMS treatment/transport;
d. Has not experienced an acute event that could reasonably lead to illness or injury; and
e. Is not in a circumstance or situation that could reasonably lead to illness or injury that indicates a need for EMS treatment/transport.

B. Actions:
1. Complete the release;
   a. Enter the individual’s name on the “AMA/Release at Scene” (AMA/RAS-Form 4007) Form Section I and obtain a signature; and
2. Complete a narrative detailing the circumstances of the RAS.
3. In an event where multiple people sign a “Multi-Person/Pt. Release at Scene” (RAS-Log 4007) Log, complete one narrative detailing the circumstances of that event (not one for each individual).
DOES THE PATIENT HAVE ANY ONE OF THE FOLLOWING?

- Exhibits evidence of altered mental status that impairs one’s ability to make a sound decision regarding medical care/transport;
- Has a complaint suggestive of potential illness or injury that indicates a need for EMS treatment/transport;
- Has an obvious evidence of illness or injury that indicates a need for EMS treatment/transport;
- Has experienced an acute event that could reasonably lead to illness or injury; or
- Is in a circumstance or situation that could reasonably lead to illness or injury that indicates a need for EMS treatment/transport.

**NOTE TO BLS PERSONNEL:** If the individual does not meet Release at Scene (RAS) criteria and is refusing care, the patient requires an assessment by ALS provider. Treat as necessary while awaiting the arrival of ALS personnel.

**LEGAL CAPACITY**

a. 18 or over
b. Emancipated minor:
   - Declaration of emancipation
   - Married
   - On active military duty
   - Other (4007 Section V)

**MENTAL CAPACITY**

a. Understands:
   - Nature of the medical condition
   - Risks and consequences of refusing care
b. Exhibits no evidence of:
   - ALOC
   - Alcohol or drug ingestion that impairs judgment

**DISPOSITION OF MINORS**

a. Minors must be left in the custody of a parent, guardian, conservator or law enforcement
b. Consent to leave a minor on-scene can be obtained from a parent, guardian or conservator via telephone

**Make base contact if appropriate**

- Complete the AMA/RAS Form 4007
- Thoroughly document the conversation and circumstances of the encounter on the PCR. Pay special attention to include minimum documentation requirements such including the phrase “decisional capacity”.

**Standard Policies**

**Policy 4007**

**Page 5 of 5**

**Effective January 2019**
I. PURPOSE
This policy provides guidelines aimed to reduce the risk of exposure/transmission of infectious and communicable diseases to prehospital personnel and patients.

II. EXPOSURE RISK REDUCTION
A. Prehospital Personnel Shall:
   1. Follow employer’s policies/procedures for infection control to protect both patients and themselves.

B. Provider Agencies Shall:
   1. Comply with all federal, state, and local regulations regarding infectious disease precautions.
   2. Establish and maintain a written exposure control plan designed to eliminate or minimize employee exposure. This plan shall include a procedure to be used if an employee is possibly exposed to a communicable disease and this plan shall be made easily accessible.
   3. Designate an infection control officer (Designated Officer or DO) to evaluate and respond to possible infectious disease exposure of provider agency’s prehospital personnel. Providers shall ensure current DO contact information is on file with the LEMSA.
   4. Make available equipment, supplies and training necessary for prehospital personnel to reasonably protect themselves and their patients against infectious disease exposure.
   5. Develop and implement policies regarding the prompt reporting and follow-up of exposures to infectious diseases.
I. PURPOSE
Utilizing prehospital 12-Lead electrocardiograms (ECG), patients presenting ST-segment elevation myocardial infarction (STEMI) shall be triaged and transported, with patient consent, directly to STEMI centers for rapid intervention. This policy outlines the process of triage and transport of STEMI patients.

II. TRIAGE
A. Patients with chest pain or other symptoms suggestive of Acute Coronary Syndrome (ACS) and those patients who have Return of Spontaneous Circulation (ROSC) following Sudden Cardiac Arrest (SCA) should have a 12-Lead ECG performed.
   1. Exceptions include patients who are not cooperative with the procedure, or patients in whom the need for critical resuscitative measures, preclude performance of the 12-Lead ECG.
B. Paramedic personnel should review the 12-Lead ECG tracing in all instances to assure that little or no artifact exists. Repeat 12-Lead ECG may be necessary to obtain an accurate tracing. If computerized interpretation of accurately performed 12-Lead ECG indicates ***Meets ST Elevation Criteria*** the patient qualifies as a candidate for transport to an SRC. Patients without these findings should be transported in accordance with Policy 4002 – Patient Destination Determination.

III. DESTINATION
A. STEMI patients
   1. Patients with an identified STEMI shall be transported to a STEMI Receiving Center (SRC).
      a. Patients shall be transported to the closest SRC unless they request another hospital.
      b. Patient request and condition must be considered when determining destination.
      c. An SRC that is not the closest SRC hospital is an acceptable destination if estimated additional transport time does not exceed 15 minutes.
      d. If the nearest SRC is on STEMI diversion the patient should be transported to the next closest accepting SRC.
B. Once transport has been deemed appropriate and the patient has experienced a return of spontaneous circulation (ROSC) at any time throughout the resuscitation or remains in persistent V-Fib, transport to a SRC.
C. Patients with unmanageable airway enroute shall be transported to the closest basic emergency department.
D. If a SRC is on STEMI Diversion, the patient should be transported to the next closest accepting SRC.

IV. TRANSFER OF CARE REPORT
A full SBAR report will be given at receiving hospital, including any ECG changes or changes in patient condition.

V. DOCUMENTATION
A. A copy of the 12-Lead ECG (multiple if performed) shall be delivered to the nurse caring for the
patient at arrival in the Emergency Department.

B. A copy of the 12-Lead ECG (multiple if performed) shall be generated for inclusion in the prehospital Patient Care Record or incorporated via electronic means into the record. The finding of STEMI on 12-Lead ECG and confirmation of the STEMI Alert shall also be recorded in the Patient Care Record.
I. PURPOSE
This policy establishes standards for transfer of patient care for 9-1-1 ambulance personnel to Emergency Department (ED) staff in Contra Costa County. These standards are essential to public safety.

II. POLICY
Hospitals designated as an EMS receiving hospital in Contra Costa County shall be prepared to receive patients transported by 9-1-1 ambulance providers and accept these patients upon arrival. The patient transfer process performance expectations for the EMS System is twenty (20) minutes or less 90% of the time.

III. EMS AMBULANCE PROVIDER RESPONSIBILITIES
A. Prehospital personnel will notify ED staff of their estimated time of arrival as soon as practical, once patient destination has been established.
B. Prehospital personnel shall provide continuity in their treatments upon arrival at the hospital, which typically may involve oxygen, IV fluids and nebulizer treatments, which have been started prior to patient arrival in the ED.
C. During periods of unusual level of demand, prehospital personnel may provide the stable patient with information on hospital delays to assist the patient in their choice of destination.
D. Prehospital personnel will promptly notify ED supervisory staff of ambulance parking, stacking conditions and “Never Events” when they occur. Ambulance supervisory personnel will assist with the resolution of parking and stacking issues and follow up with the Contra Costa County EMS Agency (LEMSA) and hospital.
E. Notification of the need to release ambulance resources shall be communicated by the ambulance supervisor using the following chain of command:
   1. ED charge nurse and physician in charge
   2. Hospital House Nursing Supervisor
F. “Never Events” must be reported as an EMS Event.

IV. RECEIVING HOSPITAL 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.*
B. Hospital staff shall provide ongoing care beyond oxygen and IV fluids once the patient has arrived in the ED.
C. ED staff will work with ambulance personnel to ensure optimal patient care handoff and resolve any instances or delayed patient care handoff.
D. During periods of unusual level of demand, hospitals shall activate internal protocols for ED saturation using the hospital incident command system.
E. Predictable 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.
F. Hospital staff will work with LEMSA staff to ensure internal policies and procedures are in place to prioritize patients arriving by EMS ambulance and effectively manage ambulance parking and stacking issues. Examples include:
   1. Rapid response teams to support ED patient care flow.
   2. Communication protocols with appropriate personnel to support rapid patient transfer of care decisions (e.g., Hospital Nurse Supervisor, Hospital Administrator on call, the EMS Duty Officer, etc.)

V. EMS AGENCY RESPONSIBILITIES
   A. Provide hospitals and ED leadership with reliable patient handoff performance reports.
   B. Post countywide EMS-hospital offload reports including “Never Events” on the LEMSA website at appropriate intervals.
   C. All “Never Events” will be referred to the hospital patient safety manager and will be subject to appropriate action upon review.

*Emergency Medical Treatment and Labor Act (EMTALA)
I. PURPOSE
This policy provides guidance for prehospital management of patients with pre-existing medical devices & equipment during routine, emergency or interfacility transport; including intravenous lines and devices, home ventilators, and other patient care equipment.

II. PROCEDURE
A. Peripheral IV Lines
1. EMTs may:
   a. Monitor IV lines delivering glucose solutions or isotonic balanced salt solutions including Ringer’s Lactate for volume replacement.
   b. Monitor, maintain and adjust if necessary in order to maintain a preset rate of flow and turn off the flow of IV fluid.
   c. They may not monitor an IV if any medication has been added to the solution.

2. Paramedics may:
   a. Administer intravenous glucose solutions or isotonic balanced salt solutions including Ringer’s lactate solution.
   b. Monitor and adjust IV flow rates of existing IV(s) with solutions containing potassium chloride (KCl) equal to or less than 20 mEq/L.
   c. Monitor, maintain and adjust approved IV solutions with medications that are allowed as part of the local paramedic scope of practice.

B. Special Populations
1. For dialysis patients whose peripheral access site (fistula/graft) has already been accessed, the existing IV line may be used by a paramedic for administration of fluids or medications.

C. Central Lines/Central Venous Access Device/Infusion Devices
1. EMTs may transport patients with existing central lines or central venous access devices (e.g., Heparin or saline locked central lines), but may not transport patients if any fluid or medications are being administered through these devices.
   a. Exceptions: In the case where a patient has a physician-prescribed infusion device that is being controlled/monitored by either the patient or a family member (e.g., patient controlled analgesia (PCA) pump); or
   b. If any question exists, base contact should be made for further clarification.

2. Paramedics may transport a patient that has fluid or medication running through a central line or other central venous access device as long as the medications are within the paramedic scope of practice.
   a. Exception: In the case where a patient has a physician-prescribed infusion device that is being controlled/monitored by either the patient or a family member; or
   b. Exception: Paramedics may access a dialysis fistula if the patient is in cardiac arrest and attempts at IV and IO access have failed.
c. If any question exists, base contact should be made for further clarification.

3. Central venous access devices that require the penetration of skin, such as internal subcutaneous infusion ports or fistulas/graffs, may not be used.

4. When handling a central line paramedics should:
   a. Use strict aseptic technique,
   b. Not remove injection caps from catheters,
      i. Not allow IV fluids to run dry,
      ii. Always expel air from preloads/syringes prior to medication administration,
      iii. In the event of damage to the central line immediately clamp the external catheter between the site of the catheter damage and the patient.

D. Thoracostomy Tubes
   1. Paramedics may monitor thoracostomy tubes.
   2. EMTs are not permitted to transport patients with thoracostomy tubes.

E. Foley Catheters, Nasogastric Tubes, Gastrostomy Tubes, Tracheostomy Tubes
   1. EMT and paramedic personnel may transport these patients, however, these devices are not to be manipulated, removed, or discontinued.
   2. If any question exists, Base Hospital contact should be made for further clarification.

F. Home Ventilators
   1. EMTs may transport patients with home ventilators but these patients should ideally be transported via ALS-level ambulance.
   2. In an emergency situation requiring immediate transport (cardiac arrest, respiratory distress or extremis due to shock), patients may be transported to the closest hospital via EMT ambulance and ventilation should be supported via bag-valve-mask device.

G. Other Devices
   1. If other equipment is encountered by EMT or paramedic personnel, a patient may be transported with the equipment provided that the prehospital providers are not required to discontinue or alter the functioning of the equipment.
   2. If the patient cannot be moved without disrupting the function of the equipment, base consultation should be obtained.
I. PURPOSE
This policy defines the criteria, which shall be met by acute care hospitals in Contra Costa County for Base Hospital designation.

II. FUNCTION
The Base Hospital functions within the local EMS system to provide destination and prehospital on-line decision making support without interruption, twenty-four (24) hours per day, seven (7) days a week. The Base Hospital works in partnership with local EMS stakeholders in accordance with the California Emergency Medical Services Authority (EMSA) and LEMSA requirements.

III. DESIGNATION PROCESS
A. The LEMSA designates Base Hospitals.
B. Application and agreement process is defined by the LEMSA in compliance with EMSA requirements.
C. The designation period will coincide with the period covered in a written agreement between the Base Hospital and the LEMSA.

IV. DESIGNATION CRITERIA
A. Current California Licensure as an acute care hospital providing Basic EMS and Joint Commission Accreditation.
B. Ability to enter into a written agreement as Base Hospital with the LEMSA.
C. Continuous availability of Base Hospital service without interruption twenty-four (24) hours per day, seven (7) days a week.
D. Ability to provide immediate response to each and every request by prehospital personnel for medical consultation or trauma destination.
E. Commitment to collaborate with the LEMSA to provide and maintain function of communication equipment for the purposes of communicating with prehospital personnel without interruption.
F. Ability to promptly notify receiving hospital of every patient for whom there is Base Hospital direction.
G. Ability to provide audio and written documentation of radio and telephone consultations with prehospital personnel including trauma destination determinations.
H. Commitment to assist the county in implementing new policies and procedures issued by the county.
I. Designate appropriate personnel to support and oversee Base Hospital functions including:
   1. Base Hospital Liaison Physician: responsible for providing oversight and leadership to the Base Hospital EMS QI program. This key position must have the following qualifications:
      a. Licensed physician on the hospital staff experienced in emergency medicine and regularly assigned to the ED.
b. Experienced in Base Hospital radio operations and LEMSA policies and procedures.

c. Maintains Base Hospital physician requirements.

d. Participates on Medical Advisory Committee (MAC), Pre-Trauma Audit Committee (Pre-TAC) and other appropriate prehospital committees or advisory groups.

2. **Base Hospital Nurse Coordinator**: responsible for providing overall support for base station operations and assists the Base Hospital Liaison Physician in the medical supervision of prehospital and hospital personnel within the Base Hospital's area of responsibility.

   a. MICN authorized California licensed Registered Nurse (RN) experienced in emergency nursing.

   b. Experienced in Base Hospital radio operations and LEMSA policies and procedures.

   c. Participates on MAC and other appropriate prehospital committees or advisory groups.

   d. Acts as liaison between receiving facilities and LEMSA supporting identification and resolution of Base Hospital issues.

   e. Coordinates the Base Hospital data collection and QI program.

3. Base Hospital physicians must be knowledgeable and capable of issuing advice and instructions to MICNs and prehospital personnel consistent with the standards established by EMSA and the LEMSA.

   a. Maintain current certification in Advanced Cardiac Life Support (ACLS). This requirement may be waived if the physician is Board certified in Emergency Medicine.

   b. Board certified or eligible in Emergency Medicine.

   c. Completes radio communications preparation and Base Hospital orientation to the local EMS system prior to acting as EMS Base Hospital physician including:

      i. State legislation and regulations governing EMS and prehospital providers.

      ii. Base Hospital physician role and responsibilities.

      iii. County field treatment guidelines and Electronic Health Record (EHR).

      iv. Policies and procedures pertinent to Base Hospital function and medical control, (e.g., interfacility transfers, disrupted communications).

   d. Acts as a resource in QI activities to Base Hospital Nurse Coordinator and Base Hospital Liaison Physician.

4. MICNs knowledgeable and capable of issuing advice and instructions in consultation with the Base Hospital physician to prehospital personnel consistent with the standards established by the State of California and the LEMSA.

   a. Maintain current certification in ACLS.

   b. Maintain MICN authorization in compliance with LEMSA policies and procedures.
c. Completes radio communications preparation and Base Hospital orientation to EMS prior to acting as a MICN including:
   i. State legislation and regulations governing EMS and prehospital providers.
   ii. MICN role and responsibilities.
   iii. County field treatment guidelines and EHR forms.
   iv. Policies and procedures pertinent to Base Hospital function and medical control, (e.g., interfacility transfers, disrupted communications).

d. Acts as a resource in QI activities to Base Hospital Nurse Coordinator and Base Hospital Liaison Physician.

V. PERFORMANCE IMPROVEMENT
A. Base Hospital staff maintains a written Base Hospital QI policy or plan.
B. Assures EMS quality improvement plan (EQIP) shall interface with the LEMSQA EQIP.
C. Participates in LEMSQA QI process.
D. Participates in the LEMSQA EMS event reporting process.
E. Provides in a timely manner data and statistical reports as may reasonably be required by the LEMSQA and as allowed under HIPPAA.
F. Maintains and oversees Base Hospital physician and MICN authorization and continuing education tracking system.

VI. BASIS FOR LOSS OF DESIGNATION
Base Hospital designation may be denied, suspended or revoked by the LEMSQA Medical Director for failure to comply with state and LEMSQA policies, procedures or regulations.
I. PURPOSE
This policy outlines the processes required to ensure prompt notification of diversion status throughout the EMS system so that emergency patients are transported to the closest most appropriate hospital that is staffed, equipped, and prepared to administer emergency or specialty care appropriate to the needs of the patient.

II. TYPES OF DIVERSION
A. CT Divert – Inoperable CT scanner
B. STEMI Divert – Inoperative Cardiac Catheterization (Cath) Lab
C. INT Divert – Internal Disaster

III. REDDINET NOTIFICATION OF DIVERSION STATUS
ReddiNet is the only accepted notification method for reporting CT, STEMI and INT diversion. Once the appropriate ReddiNet status field has been changed, the diversion status will be automatically relayed to ambulances. Emergency Department (ED) personnel should note that using the ReddiNet “message” feature alone will not result in ambulance diversion. Messaging about diversion status should only to be used to provide additional information after the appropriate change has been made in the ReddiNet status field.

IV. HOSPITAL ELIGIBILITY FOR DIVERSION
A. CT Divert – CT scanner inoperative: If a hospital’s CT scanner is inoperative, diversion of specific ambulance patients as specified in the LEMSA Administrative Policy 4002 (Patient Destination Determination) shall be considered. These patients may include those with:
   1. Suspected stroke – duration of signs and symptoms four (4) hours or less.
   2. New onset of altered level of consciousness for traumatic or medical reasons.
B. STEMI Divert – Cardiac Cath Lab Inoperative: If a STEMI Receiving Center’s (SRCs) cardiac cath lab becomes inoperative due to maintenance or equipment failure, diversion of STEMI alert patients shall be considered.
C. INT Divert – Internal Disaster: A hospital shall be eligible for internal disaster diversion whenever a “physical plant” internal disaster has occurred that has rendered ED services unavailable to the public (e.g., bomb threat, fire, power outage, explosion or internal systems failures that compromise the ability of the hospital to provide safe patient care).

V. PROCEDURE FOR IMPLEMENTING AND CANCELLING CT and/or STEMI DIVERT STATUS
A. Obtain authorization from hospital administration according to hospital’s internal procedures.
B. Update appropriate diversion status in the ReddiNet Hospital Status section. If ReddiNet is unavailable, contact Sheriff’s dispatch at (925) 646-2441, and request that they notify all ambulance providers and the EMS Duty Officer of the change in diversion status.
C. If diversion is anticipated to be prolonged, notify the EMS Duty officer at (925) 570-9708.
D. To re-establish normal ambulance traffic, update the appropriate diversion status field on ReddiNet. If ReddiNet is unavailable, contact Sheriff’s dispatch at (925) 646-2441, and request that they notify all ambulance providers and the EMS Duty Officer of the change in diversion status.

VI. PROCEDURE FOR REQUESTING, IMPLEMENTING AND CANCELLING INTERNAL DISASTER DIVERST STATUS
A. Obtain authorization from hospital administration according to hospital’s internal procedures.
B. Place hospital on applicable specialty care diversion via ReddiNet, if not already done.
C. Hospital administrator on-call or designee shall contact the EMS Duty Officer at (925) 570-9708 to evaluate current status and determine need for total diversion of 9-1-1 system ambulances.
D. If determined appropriate after consultation with the EMS Duty Officer, place hospital on internal disaster diversion via ReddiNet.
E. Maintain contact with the EMS Duty Officer as agreed in initial contact.
F. Re-establish ambulance traffic as soon as possible by updating internal disaster status via ReddiNet. If ReddiNet is unavailable, contact Sheriff’s dispatch at (925) 646-2441 and request that they notify all ambulance providers.
G. Notify the EMS Duty Officer that the hospital is no longer on internal disaster diversion.
H. In a countywide catastrophic event, emergency ambulance traffic may continue to facilities requesting internal disaster diversion, depending on the nature of the issue causing diversion.
I. PURPOSE
This policy defines the requirements for designation as a Contra Costa County STEMI Receiving Center (SRC) for patients transported via the 9-1-1- system with ST-elevation myocardial infarction (STEMI) who may benefit by rapid assessment and percutaneous coronary intervention (PCI).

II. APPLICATION PROCESS
To apply for designation as an EMS SRC for Contra Costa County patients, an interested hospital shall:
A. Submit a Contra Costa EMS designation application to the Contra Costa EMS Agency (LEMSA).
B. Pay applicable initial application fee and annual designation fee to cover initial and ongoing County costs to support the STEMI program.

III. DESIGNATION CRITERIA
A. Current California licensure as an acute care hospital providing basic emergency medical services.
B. Ability to enter into a written agreement with Contra Costa County identifying SRC and County roles and responsibilities.
C. Meets SRC designation criteria as defined in the STEMI designation application. The criteria include:
   1. Hospital Services
      a. Special permit for cardiac catheterization (cath) laboratory.
      b. Intra-aortic balloon pump capability.
      c. Special permit for cardiovascular surgery service.
         i. The LEMSA Medical Director may waive this requirement for patient or system needs.
         ii. Conformance with the American College of Cardiology/American Heart Association/Society for Cardiovascular Angiography and Intervention (ACC/AHA/SCAI) guidelines for centers without backup cardiovascular surgery will be evaluated in consideration of the waiver.
      d. Continuous availability of PCI resources twenty-four (24) hours/seven (7) days a week.
   2. Hospital-Personnel
      a. SRC Medical Director
      b. SRC Program Manager
      c. Cardiac Cath Lab Manager/Coordinator
      d. Intra-aortic balloon pump technician(s)
      e. Appropriate cardiac cath nursing and support personnel
f. Physician Consultants
   i. Cardiology Interventionalist
   ii. CV Surgeon

3. Clinical Capabilities
   a. ACC/AHA/SCAI guidelines for activity levels of facilities and practitioners for both primary PCI and total PCI events are optimal benchmarks.
   b. Performance (timeliness) and outcome measures will be assessed initially in the survey process, and will be monitored closely on an ongoing basis.

D. Appropriate internal (hospital) policies including:
   1. Cardiac Interventionalist activation
   2. Cardiac cath lab team activation
   3. STEMI contingency plans for personnel and equipment
   4. Coronary angiography
   5. PCI and use of fibrinolytic
   6. Interfacility transfer STEMI policies/protocols

E. Performance Improvement Program
   1. Participation in EMS system SRC QI Committee
      a. LEMS A Medical Director
      b. LEMS A Quality Improvement (QI) Coordinator
      c. Designated cardiologist from each SRC
      d. Designated QI representative from each SRC
   2. Meetings to be held at the discretion of the LEMS A and at the request of the SRCs.
   3. Written internal quality QI/program description for STEMI patients shall include appropriate evidence of an internal review process. The plan/program description is made available to the LEMS A as requested.
   4. Participation in prehospital STEMI-related educational activities.

F. Data Collection, Submission and Analysis
   1. Participation in National Cardiac Data Registry (NCDR)
   2. Participation in EMS system data collection.

IV. DESIGNATION
A. SRC designation will be awarded to a hospital following satisfactory review of written documentation and an initial site survey by LEMS A staff.

B. SRC designation period will coincide with the period covered in the written agreement between the SRC and the County.
V. BASIS FOR LOSS OF DESIGNATION
   A. Inability to meet and maintain SRC designation criteria
   B. Failure to provide required data
   C. Failure to participate in STEMI system QI activities
   D. Other criteria as defined and reviewed by the SRC QI Committee

VI. LIST OF STEMI CENTERS

<table>
<thead>
<tr>
<th>Contra Costa County STEMI Centers</th>
<th>Out-of-County STEMI Centers</th>
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<tbody>
<tr>
<td>John Muir Medical Center – Concord</td>
<td>Kaiser Permanente Medical Center - Oakland</td>
</tr>
<tr>
<td>John Muir Medical Center – Walnut Creek</td>
<td>Summit Medical Center - Oakland</td>
</tr>
<tr>
<td>Kaiser Permanente Medical Center – Walnut Creek</td>
<td>Kaiser Permanente Medical Center - Vallejo</td>
</tr>
<tr>
<td>San Ramon Regional Medical Center – San Ramon</td>
<td>Kaiser Permanente Medical Center – San Rafael</td>
</tr>
<tr>
<td>Sutter Delta Medical Center - Antioch</td>
<td>Marin General - Greenbrae</td>
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<tr>
<td></td>
<td>ValleyCare Medical Center - Pleasanton</td>
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Effective January 2019
I. PURPOSE
This policy defines the designation process and criteria for Primary Stroke Center (PSC) in Contra Costa County. PSCs are facilities that have been designated by the Contra Costa County EMS Agency (LEMSA) as appropriate care centers for patients with suspected stroke. The PSCs work collaboratively with emergency medical services (EMS) system partners to establish and support an optimal system of stroke care in the community.

II. APPLICATION PROCESS
To apply for designation as an EMS PSC in Contra Costa County, the hospital shall:
A. Submit a designation application to the LEMSA.
B. Submit applicable designation fees to support stroke system of care activities.
C. Meet PSC designation criteria and contractual requirements.

III. WRITTEN AGREEMENT
All PSCs must enter into a written agreement with the LEMSA prior to designation. The written agreement details the specific obligations of all parties responsible for the management of stroke patient care within the LEMSA.

IV. PSC DESIGNATION CRITERIA
Designation criteria for an EMS PSC in Contra Costa County shall require documentation of the following:
A. The hospital is a 9-1-1 receiving hospital, licensed in the State of California.
B. Certified as a Joint Commission or equivalent National Primary Stroke Center as approved by the LEMSA.
C. Designation of the PSC Medical Director and PSC Nurse Program Manager.
D. Hospitals may qualify for PSC designation as a Telestroke Center using telemedicine.
E. A written commitment to fully participate in the Contra Costa County EMS Quality Improvement (QI) and data collection program.
F. Participation in California Stroke Registry (CSR).
G. Internal policies and procedures to assure reliable use of ReddiNet to communicate CT diversion in compliance with EMS Policy 5002 (Hospital CT / STEMI - Cardiac Cath Lab And Internal Disaster Diversion).
H. A Community Stroke Reduction Plan including participation in outreach programs to reduce cardiovascular disease and stroke.

V. DESIGNATION PROCESS AND TERM
A. Initial PSC designation will be awarded to a hospital following satisfactory review of all evidence to show compliance with this policy and upon completion of an informational site survey conducted by the Contra Costa EMS PSC designation review team.
B. The PSC designation term shall be not more than three (3) years, as specified in the written agreement between the PSC and the County.

VI. RENEWAL PROCESS AND TERM
A. PSCs who maintain compliance with PSC designation criteria will be eligible for automatic renewal of designation.
B. Renewal requires maintaining a written agreement and submission of annual designation fees.

VII. OUT-OF-COUNTY DESIGNATION
A. PSCs that are located out-of-the county qualify for recognition as designated PSCs within Contra Costa County under the following conditions:
   1. Certified by the Joint Commission as a PSC or equivalent accrediting organization as approved by the LEMSA.
   2. Designated by their county’s LEMSA as a PSC.
   3. If the Hospital is located in a county that does not have a stroke system, the hospital must enter into a written agreement to be qualified for PSC designation in the Contra Costa Stroke System.

VIII. LOSS OF DESIGNATION
The inability to meet and maintain PSC designation as defined in this policy and the written agreement is criteria for loss of designation.

IX. LIST OF DESIGNATED PRIMARY STROKE CENTERS

<table>
<thead>
<tr>
<th>Contra Costa County Stroke Centers</th>
<th>Out-of-County Stroke Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Muir Medical Center – Concord</td>
<td>Summit Medical Center - Oakland</td>
</tr>
<tr>
<td>John Muir Medical Center – Walnut Creek</td>
<td>Kaiser Permanente Medical Center – Oakland</td>
</tr>
<tr>
<td>Kaiser Permanente Medical Center – Antioch</td>
<td>Kaiser Permanente Medical Center – Vallejo</td>
</tr>
<tr>
<td>Kaiser Permanente Medical Center – Richmond</td>
<td>Sutter Medical Center - Solano</td>
</tr>
<tr>
<td>Kaiser Permanente Medical Center – Walnut Creek</td>
<td>Marin General - Greenbrae</td>
</tr>
<tr>
<td>San Ramon Regional Medical Center – San Ramon</td>
<td>Kaiser Permanente Medical Center – San Rafael</td>
</tr>
</tbody>
</table>
I. PURPOSE
   A. To outline the criteria and process for re- triage of patients needing trauma care from non-trauma facilities to appropriate trauma centers.

   B. Patients meeting the criteria for Emergency “Rapid” Trauma Re-Triage shall be transferred using 9-1-1 Paramedic IFT emergency transport guidelines. Refer to EMS Administrative Policy 5006 (Hospital Guidelines for Acute Care IFT).

II. EMERGENCY TRAUMA RE-TRIAGE CRITERIA
   A. Adult patients (≥ fifteen [15] years of age) appropriate for Emergency Trauma Re-Triage to a trauma center include:
      1. Patients with abnormal blood pressure/perfusion as evidenced by:
         a. Systolic blood pressure under (<) 90 mmHg;
         b. Need for high-volume fluid resuscitation (> 2 L NS) or immediate blood replacement.
      2. Patients with significant neurological findings or injuries, including:
         a. GCS < 9 or deteriorating by two (2) or more during observation;
         b. Blown pupil;
         c. Obvious open skull fracture.
      3. Patients meeting anatomic criteria:
         a. Penetrating injury to head, neck, chest, or abdomen;
         b. Extremity injury with evident ischemia or loss of pulses.
      4. Patients, who in the judgment of the evaluating emergency physician, are anticipated to have a high likelihood for emergent life or limb-saving surgery or other intervention within two (2) hours.

   B. Pediatric Patients (< fifteen [15] years of age) appropriate for Emergency Trauma Re-Triage to a Pediatric Trauma Center (UCSF Benioff Children’s Hospital Oakland (CHO)) include:
      1. Hemodynamic criteria:
         a. Patients with abnormal blood pressure or poor perfusion. Pediatric clinical signs of poor perfusion include: cool, mottled, pale or cyanotic skin or prolonged capillary refill, low urine output, or lethargy;
         b. Requirement of more than two (2) crystalloid boluses (20 mL/kg each) or requirement of blood transfusion (10 mL/kg).

      2. Neurologic criteria:
         a. GCS < 12 (pediatric scale – or deteriorating by two (2) or more during observation;
         b. Blown pupil;
         c. Obvious open skull fracture;
         d. Cervical spine injury with neurologic deficit.

      3. Respiratory criteria:
         a. Respiratory failure resultant from injury;
         b. Intubation required resultant from injury.

Effective January 2019
4. Anatomic criteria:
   a. Penetrating wound to the head, neck, chest, or abdomen.

5. Patients, who in the judgment of the evaluating emergency physician, are anticipated to have a high likelihood for emergent life or limb saving surgery or other intervention within two (2) hours.

6. Exceptions
   a. Pregnant pediatric patients may be transferred to an adult trauma center;
   b. Pediatric patients with significant/major burns without traumatic injuries should be transferred to a burn center instead of a trauma center;
   c. Contact the trauma center to discuss patients with suspected vascular injuries.

III. RE-TRIAGE PROCEDURE
   A. Once the patient has been identified as qualifying for Emergency Trauma Re-triage, the trauma center should be contacted (see contact list and phone numbers below) as soon as possible and the patient should be specifically identified as an “Emergency Trauma Re-Triage.” Based on that notification (and if the specialty center is not on trauma bypass), the patient will be accepted for transfer.

   B. Have records (and staff and equipment, if necessary) prepared for transport. The ambulance will generally arrive within ten (10) minutes of request and patient should be ready for transport. If delays occur, the 9-1-1 ambulance may be reassigned for other emergency needs. Availability of records should never delay transport.

IV. TRANSFER PROCEDURE (if not Emergency Trauma Re-Triage)
   A. Contact the trauma center to discuss patient status and request transfer. See list of hospitals and phone numbers below.

   B. If transfer is accepted, arrange for transport, appropriate to patient condition or potential need.

   C. Patient records and diagnostic imaging disks (if available) should be readied for transport ambulance. Records that are not ready at time of transport departure can be faxed. Availability of records should never delay transport.

V. TRAUMA CENTERS
   A. John Muir Health Medical Center (JMMC) – Walnut Creek is the designated trauma center for adults (≥ fifteen [15] years of age) in Contra Costa County.

   B. CHO is the closest designated trauma center for pediatric patients (< fifteen [15] years of age).

   C. When JMMC is on trauma bypass status, it is unable to accept patients with emergent need for transfer or field triages because critical hospital resources (e.g., surgeons and operating rooms) are not available. Location and helipad availability are items to consider in choice of other trauma center destinations.

   D. When not on trauma bypass status, trauma centers may also be impacted by bed availability issues and may not be able to accept non-emergent transfers.
E. Alternate pediatric trauma centers include UC Davis Medical Center in Sacramento and Santa Clara Valley Medical Center in San Jose. Emergency Re-Triage Criteria as addressed in this policy are not utilized at these two (2) facilities.

Other local adult trauma centers include:

**LOCAL TRAUMA CENTER CONTACT PERSONS/PHONE NUMBERS**

<table>
<thead>
<tr>
<th>Adult Trauma Centers</th>
<th>Contact Person</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Alameda County Medical Center (Highand) - Oakland</td>
<td>Re-Triage only: ED Physician</td>
<td>(510) 535-6000</td>
</tr>
<tr>
<td></td>
<td>Other transfers: On-call Trauma Surgeon</td>
<td>(510) 437-4800 ext. 0</td>
</tr>
<tr>
<td><strong>San Francisco General Hospital</strong></td>
<td>Attending Physician</td>
<td>(415) 206-8111</td>
</tr>
<tr>
<td>John Muir Medical Center – Walnut Creek</td>
<td>Transfer Center</td>
<td>(925) 947-4488</td>
</tr>
<tr>
<td>Santa Clara Valley Medical Center – San Jose</td>
<td>ED Physician</td>
<td>(408) 885-3228</td>
</tr>
<tr>
<td>Sutter Eden Medical Center – Castro Valley</td>
<td>On-call Trauma Surgeon</td>
<td>(510) 898-6805</td>
</tr>
<tr>
<td>UC Davis Medical Center - Sacramento</td>
<td>ED Physician</td>
<td>(916) 734-5669</td>
</tr>
<tr>
<td>Kaiser Permanente Medical Center - Vacaville</td>
<td>ED Physician</td>
<td>(707) 624-1161</td>
</tr>
<tr>
<td>Stanford Medical Center – Palo Alto</td>
<td>ED Physician</td>
<td>(650) 723-7337</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatric Trauma Centers</th>
<th>Contact Person</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCSF Benioff Children’s Hospital of Oakland</td>
<td>Transfer Center</td>
<td>(510) 428-3240</td>
</tr>
<tr>
<td>UC Davis Medical Center - Sacramento</td>
<td>ED Physician</td>
<td>(916) 734-5669</td>
</tr>
<tr>
<td>Santa Clara Valley Medical Center – San Jose</td>
<td>ED Physician</td>
<td>(408) 885-3228</td>
</tr>
<tr>
<td>Stanford Medical Center – Palo Alto</td>
<td>ED Physician</td>
<td>(650) 723-7337</td>
</tr>
</tbody>
</table>

** Indicates no helipad on site
I. PURPOSE
This policy describes options for interfacility transfer (IFT) between acute care hospitals and the procedures required to arrange transport. Transport options vary in terms of accompanying personnel, scope of practice provided and timeliness of availability.

II. PROCEDURES TO ARRANGE 9-1-1 PARAMEDIC IFT EMERGENCY TRANSPORT
A. For a patient who requires emergency transfer (needing immediate care or intervention at the receiving hospital – e.g., critical trauma or STEMI):
   1. Assure appropriate indication for use. Emergency ambulance transport utilizes 9-1-1 resources and is reserved for truly emergent cases;
   2. Activate 9-1-1 to request Interfacility Emergency Response. Exception: For San Ramon Medical Center, contact San Ramon Valley Fire Protection District Communication Center;
   3. Arrange for transfer with receiving hospital personnel;
   4. Assess patient needs in transport to determine if patient needs exceed paramedic scope of care. If beyond paramedic scope hospital will need to provide personnel and equipment to accompany patient (e.g., if IV pump needed, blood transfusion in progress, management of paralytic agents for intubated patient);
   5. Have records (and staff and equipment, if necessary) prepared for transport. The ambulance will generally arrive within ten (10) minutes of request and patient should be ready for transport. If delays occur, the 9-1-1 ambulance may be reassigned for other emergency needs. If additional records are not available, they can be faxed or transported separately.

Guideline Table:

<table>
<thead>
<tr>
<th>Type of Transport</th>
<th>Patient Needs</th>
<th>Scope of Practice</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-1-1 Advanced Life Support (Paramedic) IFT Emergency Transport</td>
<td>Emergent intervention or evaluation not available at the sending hospital (e.g., trauma, STEMI, obstetric care for active labor where birth is not imminent). May include neuro and vascular patients transported directly to OR/intervention.</td>
<td>- Advanced airway (ETT and King);&lt;br&gt;- Administer and adjust IV fluids including: Glucose, isotonic saline and those containing potassium;&lt;br&gt;- ECG monitoring;&lt;br&gt;- Defibrillation and synchronized cardioversion;&lt;br&gt;- Monitoring of a water sealed chest tube;&lt;br&gt;- Administration of ACLS medications. See 22 CCR § 100146(c)1</td>
<td>9-1-1</td>
</tr>
</tbody>
</table>
### III. ARRANGING NON-EMERGENCY INTERFACILITY TRANSPORT

It is the responsibility of the transferring hospital to determine the transport option appropriate for the patient’s condition based on the table below.

**Guideline Table:**

<table>
<thead>
<tr>
<th>Type of Transport</th>
<th>Patient Needs</th>
<th>Scope of Practice</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care Transport with RN</td>
<td>Advanced care for patients with complex medical care needs as determined by the transferring physician and the ambulance agency. May include pediatric and obstetric patients.</td>
<td>Critical Care RN</td>
<td>Contact ambulance service directly</td>
</tr>
<tr>
<td>Air Ambulance</td>
<td>RN/Paramedic level of care for patients with complex medical care needs when receiving is distant and time is a critical factor. May include pediatric and obstetric patients.</td>
<td>Critical Care RN/Paramedic</td>
<td>Contact air ambulance service directly</td>
</tr>
<tr>
<td>Non-emergency Advanced Life Support (Paramedic)</td>
<td>Scheduled transport for patients who require advanced level of care. Patient does not require emergent intervention.</td>
<td></td>
<td>Contact Contra Costa County Fire Protection District (925) 941-3377</td>
</tr>
<tr>
<td>Non-emergency Basic Life Support (EMT)</td>
<td>Needs transport for procedure or to another facility. May include pediatric and obstetric patients.</td>
<td>EMT scope of practice See 22 CCR § 100063(a)</td>
<td>Contact ambulance service directly</td>
</tr>
</tbody>
</table>
I. PURPOSE
This policy defines the requirements for patient care documentation and the procedure for completion, distribution and retention of the electronic health record (EHR) applicable to all EMS transport providers, ALS first responders, and EMT first responders.

II. POLICY
A. EMS personnel shall complete an EHR on all EMS responses regardless of outcome. This includes responses where a unit responded and there was no patient contact.

B. All available and relevant information shall be accurately documented in the EHR.

III. EHR AVAILABILITY
The timely delivery of a completed EHR to the receiving facility is a high priority. An EHR for each transported patient must be left with receiving facility staff prior to clearing the receiving facility.

A. Transporting agencies shall leave a partially completed or preliminary EHR, marked as such, with receiving facility staff if an EHR cannot be completed prior to clearing the receiving facility. If the EHR cannot be completed and a copy left with receiving facility staff before departing the facility, the narrative section of the call report should explain the delay.

B. Non-transporting agencies that have turned over patient care to transporting personnel may send a partially completed or preliminary EHR, marked as such, with the patient. Non-transporting agencies are not required to transmit EHRs to receiving facilities.

C. Except as outlined in III(A) above, all EHRs shall be completed, delivered to the receiving facility as applicable and posted to the EHR server within twenty-four (24) hours of patient contact.

IV. EHR PROCEDURES
A. Personnel providing patient care are responsible for accurately documenting all available and relevant patient information on the EHR. This requirement includes transport and first responder personnel.

B. Use of usual and customary abbreviations is permitted in the narrative section of the record or as defined in automated EHR pre-designated pick lists.

C. An EMS provider’s EHR should include, at a minimum the following information:
   1. Complete demographic information.
   2. A clear history of the present illness with chief complaint, onset time, associated complaints, pertinent negatives, mechanism of injury, etc. The information should accurately reflect the patient’s chief complaint as stated by the patient to the EMS provider and should be sufficient to refresh the clinical situation after it has faded from memory.
   3. An appropriate physical assessment that includes all relevant portions of a head-to-toe physical exam. When appropriate, this information may be supplemented in the narrative section of the EHR.
   4. At least two (2) complete sets of vital signs for every patient including: pulse, respirations, blood pressure and pulse oximetry. These vital signs should be repeated and documented after drug administration, prior to patient transfer and as needed during transport. For children < three (3)
years of age, blood pressure measurement is not required for all patients, but should be measured if possible, especially in critically ill patients in whom blood pressure measurement may guide treatment decisions.

5. A pain scale shall be documented for all patients with a GCS > 14.

6. Only approved medical abbreviations may be used – see appendix.

7. The CAD to EHR interface embedded within the EHR system should be used to populate all EHR data fields it supplies. When 9-1-1 center times were improperly recorded, these may be properly edited.

8. When the cardiac monitor is applied, data will be transferred to the EHR from the device. If transferred automated vital sign values do not correlate with manually obtained values, or are not consistent with the patient’s clinical condition, providers should manually check vitals and record manual results.

9. For drug administrations, the drug dosage, route, administration time and response shall be documented.

10. A complete list of treatments in chronological order. Response to treatments should also be listed.

11. For patients with extremity injury, neurovascular status must be noted before and after immobilization.

12. For patients with spinal motion restriction, document motor function before and after motion restriction.

13. For IV administration or saline lock placement, the catheter size, site, number of attempts, type of fluid, and flow rate.

14. A cardiac monitor strip should be attached for all patients placed on the cardiac monitor. All 12-Leads should also be included. Any significant rhythm changes should be documented. For cardiac arrests, the initial strip, ending strip, pre and post defibrillation, and pacing attempts, should be attached.

15. Any requested medical control orders, whether approved or denied, should be documented clearly.

16. Any waste of controlled medications should include the quantity wasted, where wasted and name of the person who witnessed the waste. Only agency approved personnel should be utilized to witness controlled substance waste.

17. All personnel information, including signatures.

18. ALL crew members are responsible for, and should review, the content of the EHR for accuracy.

19. Completing the record includes marking the record “complete” in the EHR system and uploading the record to the EHR server.

D. The EHR shall be completed and distributed in accordance with this policy.
E. Once the EHR is completed and posted, the EHR may not be modified for any reason. Corrections or additions should be in the form of an addendum to the EHR.

F. If a paper EHR is used, or a change is made on a hard copy of an automated EHR, documentation errors shall be lined through (e.g., Like this), and the correction shall have the patient attendant’s initials beside it.

G. Any changes made to an electronic EHR shall have documentation of those changes retained in the EHR record database.

V. ELECTRONIC SYSTEM FAILURE
   A. Back-up systems to provide for paper EHR documentation must be in place for use should an electronic documentation system fail. Electronic documentation system failure is NOT an exception for providing the required EHR documentation.
   B. The LEMSA shall be notified of downtime or transmission difficulties lasting more than twenty-four (24) hours for all electronic EHR system outages.

VI. MULTI-CASUALTY (MCI) INCIDENTS
   A. EHRs shall be completed for all patients in MCI unless requirements have been shifted to documentation on triage tags per MCI plan directives.
   B. In incidents with large numbers of persons refusing treatment or transport, efforts should be made to document as much information as possible. For persons not meeting patient criteria, a Release at Scene Log may be completed and attached to an EHR for the incident.
I. PURPOSE
   A. To establish a system of patient safety and EMS response-related reporting requirements for the purposes of review, data analysis, patient safety and EMS system performance;
   B. To define reporting requirements for events which may have the potential to cause community concern or represent a threat to public health and safety;
   C. To define the reporting and monitoring responsibilities of all EMS system participants; and
   D. To recognize exemplary prehospital care in the EMS system.

II. REPORTING RESPONSIBILITY
   A. The reporting requirements established by this policy apply to prehospital care providers, EMS service providers, and hospitals.
   B. Providers shall directly report to the Contra Costa EMS Agency (LEMSA) any event that is “required to be reported” by this policy.

III. IMMEDIATE POLICY REPORTING REQUIREMENTS
   The following EMS events shall be reported immediately to the LEMSA by telephone to the EMS Duty Officer at (925) 570-9708. The telephone report shall be followed by the submission of a written EMS event report:
   A. Any event that has resulted in or has the potential to lead to an adverse patient outcome;
   B. Any deviation from a LEMSA policy or protocol that resulted in patient harm or a threat to public safety;
   C. Medication, treatment or clinical errors that resulted in patient harm;
   D. Equipment failure or malfunction that resulted in patient harm;
   E. Technology or communications systems errors or malfunctions that resulted in patient harm;
   F. The on-duty death of any pre-hospital personnel;
   G. The on-duty arrest of any pre-hospital personnel either working in Contra Costa County or certified or accredited through the LEMSA; or
   H. The collision of any ambulance or EMS response vehicle that results in injury.

IV. URGENT POLICY REPORTING REQUIREMENTS
   A. The following EMS events shall be reported to the LEMSA within twenty-four (24) hours:
      1. Any unusual event/occurrence (e.g., MCI, abnormal patient condition, Base Hospital communication failure);
      2. Any deviation from LEMSA policy or treatment guideline that had the potential to result in patient harm or a threat to public safety;
      3. Medication, treatment or clinical errors that had the potential to result in patient harm;
      4. Equipment failure or malfunction that had the potential to result in patient harm;
5. Any event or circumstance that is or shall be reported to another regulatory or enforcement agency, including but not limited to any law enforcement agency, the California Emergency Medical Services Authority (EMSA), California Occupational Health and Safety Administration (Cal-OSHA), the State or County Department of Public Health (CDPH), or the Centers for Disease Control and Prevention;

6. Whenever the operator of an interfacility basic life support (BLS) or critical care transport (CCT) ambulance operates with lights and siren whether responding to or from a location in Contra Costa County or upgrades mode of transport to lights and siren; or

7. Knowledge of or the commission of any event or circumstance that represents a threat to public health and safety as defined by Health and Safety Code Section 1798.200(c)(1) through 11):
   a. Fraud in the procurement of any certificate or license under this division;
   b. Gross negligence;
   c. Repeated negligent acts;
   d. Incompetence;
   e. The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of prehospital personnel;
   f. Conviction of any crime which is substantially related to the qualifications, functions, and duties of prehospital personnel;
   g. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel;
   h. Violating or attempting to violate any federal or state statute or regulation that regulates narcotics, dangerous drugs, or controlled substances;
   i. Addiction to, the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances;
   j. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification;
   k. Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired;
   l. Unprofessional conduct exhibited by any of the following:
      i. The mistreatment or physical abuse of any patient resulting from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties would use if confronted with a similar circumstance. Nothing in this section shall be deemed to prohibit an EMT or paramedic from assisting a peace officer, or a peace officer who is acting in the dual capacity of peace officer and EMT or paramedic, from using that force that is reasonably necessary to affect a lawful arrest or detention.
ii. The failure to maintain confidentiality of patient medical information, except as disclosure is otherwise permitted or required by law in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

iii. The commission of any sexually related offense specified under Section 290 of the Penal Code.

V. GENERAL POLICY REPORTING REQUIREMENT
Timely reporting of the following types of events is strongly encouraged:
A. Great Catches: Events that are recognized and prevented before they actually occur. A “great catch” includes recognition of provider action that contributes to the prevention of negative or adverse patient outcomes. Near miss events are included in this category.

B. Community events that may cause public concern, either positive or negative (e.g., bomb threats, multi casualty incidents and EMS system operational issues).

C. Exemplary care in the field deserving of recognition and/or commendation.

D. Any event in which the provider agency determines a case review would be beneficial (e.g., educational component; unusual/abnormal component).

VI. PARAMEDIC REPORTING REQUIREMENTS
A. The employer or supervisor of a paramedic shall report the commission of any event or circumstance described in Section IV(A)(7)(a) through (l) herein, involving a paramedic to EMSA within 72 hours of the discovery of such circumstance or event. The report shall be made to EMSA on the Paramedic Complaint Investigation Request form no later than the following business day and shall include any applicable supporting documents (e.g., internal investigation report, witness statements, EHR).

B. The employer or supervisor of a paramedic who makes a report to EMSA under this section must provide the LEMSA with a copy of the completed paramedic investigation request form and supporting documents and attachments no later than the following business day.
I. PURPOSE
This policy identifies the primary responsibilities of all participants in the Contra Costa County EMS Quality Improvement (QI) Program and to ensure optimal quality of care for all patients who access the EMS system.

II. REQUIREMENTS
A. EQIP includes all Contra Costa County EMS provider agencies participating in patient care and delivery.

B. EQIP shall be compliant with the California Code of Regulations, Title XXII, Division 9, Chapter 12 and modeled after the State of California Emergency Medical Services Authority (EMSA) Publication: Emergency Medical Services System QI Program Model Guidelines.

C. The oversight for EQIP will be the responsibility of the LEMSA Medical Director, who will solicit input from stakeholders participating in the Prehospital Quality Improvement (QI) Committee.

D. All proceedings, documents and discussions of the Prehospital QI Committee are confidential pursuant to section 1157.7 of the Evidence Code of the State of California.
   1. Each member of the Prehospital QI Committee shall sign a confidentially agreement.
   2. Each agency shall maintain all records in a confidential manner consistent with current patient privacy laws (HIPAA).

E. Appropriate QI indicators shall be reviewed at the EMS provider agency level on a monthly basis and a report of findings shall be made to the LEMSA at agreed upon intervals. Aggregate data for the EMS System will be maintained by the LEMSA and reported annually to all system stakeholders.

F. Each provider agency shall submit an annual report of QI activities to the LEMSA.

G. The LEMSA shall provide an annual report of QI activities to the California EMSA. This information may be incorporated as part of the LEMSA Annual Report.
I. PURPOSE
This policy defines the requirements for transmission of cardiac monitor data and is applicable to all ALS EMS transport providers and ALS first responders. The collection of data is used to improve patient care and is crucial to the progression of the EMS system.

II. POLICY
A. EMS personnel shall transmit cardiac monitor data in accordance with this policy for EMS patient responses regardless of patient outcome. This includes calls where a unit responded and a patient was not transported.

B. Optimally, a single cardiac monitor should be used to gather data, particularly with regard to cardiac arrest or continuous monitoring of patients with advanced airways.

III. 12-LEAD ECG TRANSMISSION
A. A 12-Lead ECG that indicates that a patient is experiencing a STEMI should be transmitted to the identified STEMI receiving center where the patient is to be transported.

B. For all other 12-Lead ECGs, at least one 12-Lead should be transmitted to the receiving hospital the patient is to be transported to, as well as other monitoring site(s) identified by the provider’s agency.

C. At a minimum, 12-Lead ECGs should be electronically labeled with the incident number and initials of the first and last name of the patient. Provider agencies may require additional labeling.

D. Once a STEMI 12-Lead has been transmitted to a STEMI receiving center, the receiving hospital should be notified as soon as possible following the 12-Lead transmission to verify receipt and to provide a STEMI alert.

E. A physical copy of 12-Lead ECGs must be provided to the receiving hospital.

IV. CARDIAC ARREST AND OTHER CARDIAC MONITOR DATA TRANSMISSION
A. Cardiac monitor data must be transmitted for the following types of patients:
   1. Cardiac arrests. All patients in cardiac arrest must be monitored in “paddles mode” to ensure vital data is captured/transmitted.

   2. Any patient that is identified to have and/or is treated for a cardiac dysrhythmia.

   3. Any patient who is treated using a treatment guideline that requires an advanced airway and/or EtCO2 monitoring.

   4. At a minimum, cardiac arrest and other cardiac monitor data transmission should be electronically labeled with the incident number and initials of the first and last name of the patient. Provider agencies may require additional labeling.
I. PURPOSE
This policy establishes the requirements for data collection and submission for ambulance providers and first responder agencies to ensure appropriate quality improvement of the EMS system.

II. REQUIREMENTS
A. Ambulance providers and first responder agencies shall implement and utilize an electronic health record (EHR) system that is compliant a current version of NEMSIS. Additional requirements include:
   1. EHR systems shall provide the prehospital provider with the ability to complete and transmit an EHR at the patient’s side.
   2. EHR systems shall be capable of bi-directional data exchange as required by the Contra Costa County EMS Information System and EMS/healthcare quality initiatives (e.g., Whole Person Care).
B. Ambulance providers and first responder agencies shall provide the LEMSA electronic access to their EHR system.
C. Ambulance providers and first responder agencies shall connect their EHR system to the LEMSA designated comprehensive data analytic tool. Data reporting from the EHR system to the designated comprehensive data analytic tool shall be unrestricted and include Protected Health Information.
D. EHR systems shall meet the data field requirements contained within the EQIP approved by the LEMSA Medical Director. The EHR system must be able to accommodate the addition or modification of data elements which may be specific to the Contra Costa County EMS System or NEMSIS/CEMSIS data sets. Data reporting shall be consistent with NEMSIS, CEMSIS and any local modification requirements.
   1. For non-urgent alterations, each EHR system, ambulance provider and first responder agency must implement modifications or additions to data elements within 30 calendar days of written request by the LEMSA.
   2. For urgent alterations, each EHR system, ambulance provider and first responder agency must implement modifications or additions to data elements within 15 calendar days of written request by the LEMSA.

References:
Disclosure of Medical Information by Providers – California’s Confidentiality of Medical Information Act (See Civil Code § 56.10(c)(14).) http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=CIV&sectionNum=56.10.
<table>
<thead>
<tr>
<th>Type of Transport</th>
<th>Patient Needs</th>
<th>Scope of Practice</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>9-1-1 Advanced Life Support (Paramedic) IFT Emergency Transport</strong></td>
<td>Emergent intervention or evaluation not available at the sending hospital (e.g., trauma, STEMI, obstetric care for active labor where birth is not imminent). May include neuro and vascular patients transported directly to OR/intervention.</td>
<td>• Advanced airway (ETT and King); • Administer and adjust IV fluids including: Glucose, isotonic saline and those containing potassium; • ECG monitoring; • Defibrillation and synchronized cardioversion; • Monitoring of a water sealed chest tube; • Administration of ACLS medications. See 22 CCR § 100146(c)1</td>
<td>9-1-1</td>
</tr>
<tr>
<td><strong>Critical Care Transport with RN</strong></td>
<td>Advanced care for patients with complex medical care needs as determined by the transferring physician and the ambulance agency. May include pediatric and obstetric patients.</td>
<td>Critical Care RN</td>
<td>Contact ambulance service directly</td>
</tr>
<tr>
<td><strong>Air Ambulance</strong></td>
<td>RN/Paramedic level of care for patients with complex medical care needs when receiving is distant and time is a critical factor. May include pediatric and obstetric patients.</td>
<td>Critical Care RN/Paramedic</td>
<td>Contact air ambulance service directly</td>
</tr>
<tr>
<td><strong>Non-emergency Advanced Life Support (Paramedic)</strong></td>
<td>Scheduled transport for patients who require advanced level of care. Patient does not require emergent intervention.</td>
<td>• Advanced airway (ETT and King); • Administer and adjust IV fluids including: Glucose, isotonic saline and those containing potassium; • ECG monitoring; • Defibrillation and synchronized cardioversion; • Monitoring of a water sealed chest tube; • Administration of ACLS medications. See 22 CCR § 100146(c)1</td>
<td>Contact Contra Costa County Fire Protection District (925) 941-3377</td>
</tr>
<tr>
<td><strong>Non-emergency Basic Life Support (EMT)</strong></td>
<td>Needs transport for procedure or to another facility. May include pediatric and obstetric patients.</td>
<td>EMT scope of practice</td>
<td>Contact ambulance service directly</td>
</tr>
</tbody>
</table>

*Note: 22 CCR § 100063(a) and 22 CCR § 100146(c)1 refer to specific regulations for the scope of practice.*
## Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Section</th>
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<tr>
<td>July 1, 2007</td>
<td>All</td>
<td>Initial plan released</td>
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<tr>
<td>July 15, 2011</td>
<td>Appendix E</td>
<td>Addition of Appendix E – Contra Costa County CHEMPACK Mobilization Plan</td>
</tr>
<tr>
<td>April 19, 2012</td>
<td>Appendix F</td>
<td>Addition of Appendix F – Field Treatment Sites</td>
</tr>
<tr>
<td>January 15, 2018</td>
<td>All appendices</td>
<td>Stricken and/or moved to corresponding policy</td>
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<tr>
<td>January 15, 2018</td>
<td>All</td>
<td>Edited and distributed for stakeholder feedback</td>
</tr>
<tr>
<td>July 27, 2018</td>
<td>All</td>
<td>Updates Finalized and MCI Plan Posted</td>
</tr>
<tr>
<td>January 1, 2019</td>
<td>All</td>
<td>MCI Plan incorporated into policy manual as EMS resource document R02</td>
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<td>EMS Transport Resource Ordering Overview</td>
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<td>Communications Plan</td>
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</table>
I. MULTI-CASUALTY INCIDENT PLAN SCOPE
A. The Contra Costa County Multi-Casualty Incident Plan was developed by a multi-disciplinary task force of personnel comprehensively representing the entire emergency response to a multi-casualty incident (MCI). This Plan is a component of the Contra Costa County Emergency Medical Services Agency (LEMSA) System Plan, and represents the response to all MCI’s that occur within the Contra Costa County Operational Area.

II. MULTI-CASUALTY INCIDENT PLAN OBJECTIVES
A. Establish and sustain standardized organization, management, and communication structure to coordinate emergency response to MCI’s.
B. Establish methods of triage and transportation that will provide the best medical outcome possible for the greatest number of casualties.
C. Establish pre-defined responsibilities for key entities to achieve successful activation of the plan.
D. This Plan will be drilled regularly and reviewed annually.
E. Following significant activations of the Plan and as directed by the EMS Director, incidents will be reviewed case by case.

III. MULTI-CASUALTY INCIDENT OPERATIONAL CONCEPTS
A. Incident organization will be based on the principles and practices of the National Incident Management System (NIMS), including the use of the Incident Command System (ICS).
   1. The organizational structure will expand and contract as the dynamics of the incident warrant.
   2. Requests for resources from the incident will be ordered utilizing the Incident Command System and single point ordering.
   3. Incident information will be transferred between organizational elements, the field Incident Commander (IC) or designee, and supporting communications centers in a timely fashion.
B. First responders may utilize the triage tape system.
   1. Patients will be assigned a Simple Triage and Rapid Transport (START) tag at designated Casualty Collection Point (CCP) or upon transport.
C. Triaged patients will be referred to as RED, YELLOW, GREEN, or DECEASED.
D. First responders should not delay in sending patients to hospitals. All Contra Costa County receiving hospitals are prepared to accept a minimum of two (2) RED (immediate) and four (4) YELLOW (delayed) patients.
   1. When making patient destination/distribution decisions, consider:
      a. Patients self-transporting to nearby facilities.
      b. Using out of county hospitals when appropriate.
      c. In the event of an earthquake or other infrastructure event some facilities may be offline or operating with reduced service capabilities.
E. Incident Command should be established at a fixed location.
   1. Unified Command should be established when appropriate.
IV. MULTI-CASUALTY INCIDENT OPERATIONAL POLICIES

A. Authority and Scope

1. The MCI Plan may be initiated on the authority of:
   a. The Incident Commander (e.g., a fire officer, law enforcement officer, or ambulance crew);
   b. A supervisor from the Sheriff’s Communications Center;
   c. A supervisor from the Contra Costa Regional Fire Communications Center;
   d. Director of Contra Costa County Emergency Medical Services Agency, or designee.

2. The Sheriff’s Communications Center, as the Emergency Medical Services Operational Area Communications Center (EMSOACC), will be responsible for initiating activation of the Plan in Reddinet.

3. All requests for activation should include the following information, when available (do not allow incomplete information to delay initiation):
   a. Multi-Casualty Incident Tier
   b. Type of incident
   c. Location
   d. Approximate number of injured
   e. HAZMAT: Rule out or identify potential threat

4. Authority for escalation to a higher tier MCI, de-escalation to a lower tier MCI, and deactivation of the MCI will rest with the Incident Commander. The Incident Commander must take into account the potential for AMA patients to self-transport and create surges at local facilities.

5. When in doubt as to the appropriate MCI tier, the Incident Commander should consider the higher tier for incidents that may still be evolving. For incidents where there is no further significant medical threat and where most or all of the injuries are relatively minor, the Incident Commander may consider the lower MCI tier.

B. Incident Command and Control

1. Command and incident management authority should be established under unified command with the jurisdictional law enforcement agency, the jurisdictional fire agency, and other entities as appropriate.

2. The Incident Commander is expected to make the following notifications to their respective communication center:
   a. Name of the incident
   b. Location of Incident Command Post
   c. Location of Staging Area.

3. Incident operations should be established by the jurisdictional fire agency.
   a. A Deputy Operations Section Chief position may be assumed by the jurisdictional law enforcement agency.
4. Positions within the incident command structure should be assigned based on responder’s discipline (EMS/fire/law) and experience.

5. The Incident Commander or designee shall specify a heli-spot for EMS helicopters.

6. The Incident Commander of a multi-casualty incident will request additional resources utilizing their normal procedures.

7. Whenever possible, mutual aid ambulances will be dispatched directly to the ambulance staging area of the incident and not used for zone coverage.

C. Medical Transportation Management

1. The Medical Group Supervisor (MGS) position is integral to patient distribution and tracking. The role of MGS shall be assigned to a paramedic supervisor unless none are available, in which case it shall be assigned to the most qualified responder on scene.
   a. MGS or designee shall be responsible for transmitting the following info in real time commensurate with the MCI COMS Plan:
      i. Patient count
      ii. Patient acuity
      iii. Patient triage tag – last 4 numbers
      iv. Unit transporting
      v. Destination

2. Destination information and hospital availability, including out-of-county receiving hospital availability, will be available in Reddinet and via all com centers via radio or phone.

3. When there are a limited number of available ambulances for the magnitude of the incident, patients with minor injuries may be transported by other (non-ambulance) means.

4. Ambulances transporting patients from Tier 2 and Tier 3 MCIs shall not communicate with the receiving hospital. As time and workload permits, information received from the Transportation Group Supervisor/Unit Leader regarding the nature and extent of injuries on board an ambulance may be relayed by the EMSOACC to the receiving hospital via Reddinet.

5. An electronic health record (EHR) is to be completed on each casualty transported if it can be accomplished taking into consideration the situation and the resources:
   a. EHRs for patients who refuse transport shall be included if possible.
   b. During Tier 3 incidents, the EMS Branch Director, or designee, is authorized to suspend standard EHR protocol and direct that triage tags be used as the immediate and minimal level documentation of field assessment and treatment.
### Tier Definitions

<table>
<thead>
<tr>
<th></th>
<th>Pre-Alert</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Alert</strong></td>
<td>Official notification of an incident that has the POTENTIAL to result in an activation of the plan at a higher tier (≥6 patients) even when the number of known victims is zero, in order to provide situational awareness for hospitals). “PRE-ALERT” activation is required for a Community Warning System Level II incident or any Emergency Department closure or evacuation.</td>
<td>An incident involving 6-10 patients when the scene is contained and the number of patients is not expected to rise significantly.</td>
<td>An incident involving more than 10 patients OR an incident involving less than 10 patients when there is a substantial chance that the number of patients may rise.</td>
<td>Any incident involving more than 50 patients; any incident involving mass casualties, or a reasonable expectation of mass casualties.</td>
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</table>

### Tier Examples

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<tr>
<th></th>
<th>Pre-Alert</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
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</thead>
<tbody>
<tr>
<td><strong>Pre-Alert</strong></td>
<td>Report of an active shooter incident where the number of victims is not known or cannot be confirmed; passenger aircraft attempting emergency landing; evacuation of a facility due to potential threat to public safety; actual or potential significant hazardous materials incident, including transportation incidents.</td>
<td>Multi-vehicle traffic collision; multiple shooting victims at a contained scene and no ongoing active shooter threat.</td>
<td>Petrochemical incident involving dispersal cloud moving over populated area; passenger train derailment; an active shooter incident with an uncontained scene.</td>
<td>Actual or suspected WMD incident; significant explosion in or around occupied commercial or multi-unit residential structure or any significant explosion in a heavily populated area. Large-scale evacuation of a hospital or skilled nursing facility.</td>
</tr>
</tbody>
</table>
## Hospital Responsibilities

<table>
<thead>
<tr>
<th>Pre-Alert</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
</table>
| • Make internal notifications and institute appropriate ED procedures as per facility protocol  
• Respond to ED capacity poll from EMSOACC, when initiated  
• Monitor Reddinet | • All Pre-Alert responsibilities  
• Immediately prepare to accept 2 RED (immediate) patients and 4 YELLOW (delayed) patients  
• Assess ability to handle additional | • All Pre-Alert responsibilities  
• Immediately prepare to accept 2 RED (immediate) patients and 4 YELLOW (delayed) patients  
• Assess ability to handle additional | • All Pre-Alert responsibilities  
• Immediately prepare to accept 2 RED (immediate) patients and 4 YELLOW (delayed) patients  
• Assess ability to handle additional  
• If applicable: Conduct damage assessment and report results to EMSOACC/EMS, VIA Reddinet |
<table>
<thead>
<tr>
<th>LEMSA Responsibilities</th>
<th>Pre-Alert</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor incident</td>
<td>Monitor incident</td>
<td>Monitor incident</td>
<td>Monitor incident</td>
<td>All Tier Two responsibilities</td>
</tr>
<tr>
<td>Consider activation of the EMS Operations Center if the incident has potential for escalation</td>
<td>Consider activation of the EMS Operations Center if the incident has potential for escalation</td>
<td>Consider activation of the EMS Operations Center if the incident has potential for escalation</td>
<td>Activate MHOAC Program and EMS Branch Operations Center</td>
<td></td>
</tr>
<tr>
<td>If appropriate, based on scenario: Create entry in WEBEOC or Health Services Incident Response Information System (IRIS) and post updates as needed</td>
<td>If appropriate, based on scenario: Create entry in WEBEOC or Health Services Incident Response Information System (IRIS) and post updates as needed</td>
<td>If applicable, provide updates on nature of exposure and recommended treatments</td>
<td>Provide SitStat for Health Officer</td>
<td></td>
</tr>
<tr>
<td>Respond staff to Sheriff’s Communications to assist with patient distribution and hospital notification</td>
<td>Provide ongoing updates to hospitals on status of incident</td>
<td>Consider activation MHOAC program and LEMSA Branch Operations Center</td>
<td>Activate Med/Health Surge Plan</td>
<td></td>
</tr>
<tr>
<td>Staff at outside meetings contact office to determine need for additional personnel</td>
<td>If applicable, provide updates on nature of exposure and recommended treatments</td>
<td></td>
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</table>
## Emergency Ambulance Zone Provider Responsibilities

<table>
<thead>
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<th>Tier 3</th>
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</thead>
<tbody>
<tr>
<td>- Paramedic Supervisor response</td>
<td>- Paramedic Supervisor response</td>
<td>- Paramedic Supervisor response</td>
<td>- Paramedic Supervisor response</td>
</tr>
<tr>
<td>- Notification of Communication Center</td>
<td>- Notification of Communication Center</td>
<td>- Notification of Communication Center</td>
<td>- Notification of Communication Center</td>
</tr>
<tr>
<td>- Notification of all on-duty administration</td>
<td>- Notification of all on-duty administration</td>
<td>- Notification of all on-duty administration</td>
<td>- Notification of all on-duty administration</td>
</tr>
<tr>
<td>- Monitor Reddinet</td>
<td>- Monitor Reddinet</td>
<td>- Monitor Reddinet</td>
<td>- Monitor Reddinet</td>
</tr>
<tr>
<td>- Notification of management personnel as per organization’s policy</td>
<td></td>
<td>- Consider recall of employees to staff additional units</td>
<td></td>
</tr>
</tbody>
</table>

## Permitted Non-Emergency Ambulance Provider Responsibilities

<table>
<thead>
<tr>
<th>Pre-Alert</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Monitor Reddinet</td>
<td>- Monitor Reddinet</td>
<td>- Monitor Reddinet</td>
<td>- Monitor Reddinet</td>
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<tr>
<td></td>
<td>- Monitor Reddinet</td>
<td>- Monitor Reddinet</td>
<td>- Monitor Reddinet</td>
</tr>
<tr>
<td></td>
<td>- Assess capability to respond to requests from EMSOACC</td>
<td>- Respond to ReddiNet polling</td>
<td>- Consider recall of personnel to support resource requests</td>
</tr>
<tr>
<td></td>
<td>- Respond to ReddiNet polling</td>
<td>- Respond to incident ONLY when requested</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Respond to incident ONLY when requested</td>
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</tbody>
</table>
### EMS Helicopter Provider Responsibilities

<table>
<thead>
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<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Monitor incident</td>
<td>• All Pre-Alert responsibilities</td>
<td>• All Tier One responsibilities</td>
<td>• All Tier Two responsibilities</td>
</tr>
<tr>
<td>• Provide aircraft availability information if requested</td>
<td>• Cancel non-emergency flight activity</td>
<td>• Ascertain availability of EMS aircraft in other counties if formally requested by Contra Costa County designated Communications Center</td>
<td>• Initiate internal disaster plans for extended operations</td>
</tr>
<tr>
<td></td>
<td>• Respond only when requested</td>
<td>• Facilitate declaration of restricted airspace if directed by IC or Op Area Law Enforcement Coordinator</td>
<td>• Consider recall of personnel to support air medical operations and to staff additional aircraft</td>
</tr>
<tr>
<td></td>
<td>• Prepare to stage at closest airport or location designated by the Incident</td>
<td></td>
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<tr>
<td></td>
<td>• Notify requesting agency when responding</td>
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<tr>
<td></td>
<td>• Ascertain status of hospitals outside of Contra Costa County</td>
<td></td>
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<tr>
<td></td>
<td>• Maintain air-to-air contact with all aircraft responding to the MCI</td>
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<tr>
<td></td>
<td>• Contact heli-spot manager on assigned air-to-ground frequency</td>
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<tr>
<td></td>
<td>• Coordinate patient destination with Incident personnel</td>
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</tr>
<tr>
<td></td>
<td>• Notify EMSOACC of patient destination</td>
<td></td>
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<tr>
<td></td>
<td>• Report back to EMSOACC after transport</td>
<td></td>
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<tr>
<td></td>
<td>• Remain assigned to the incident until released by the IC or designee</td>
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## Jurisdictional Fire Agency Responsibilities

<table>
<thead>
<tr>
<th>Pre-Alert</th>
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</thead>
<tbody>
<tr>
<td>- Establish IC – (Consider Unified Command)</td>
</tr>
<tr>
<td>- Consult FOG (MCI section – Initial Response Organization)</td>
</tr>
<tr>
<td>- Keep dispatch informed of situation.</td>
</tr>
<tr>
<td>- Recon potential locations for expanded incident needs</td>
</tr>
<tr>
<td>- Consider what resources might be needed if situation escalates</td>
</tr>
<tr>
<td>- At any time, patient numbers are a guideline, not a hard and fast rule. Do not hesitate to raise the Tier rating if SITSTAT is incomplete or the incident can easily grow</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>- All Pre-Alert responsibilities</td>
</tr>
<tr>
<td>- Scale ICS positions according to size of incident – Consider moving to Reinforced Response Organization (FOG – MCI)</td>
</tr>
<tr>
<td>- Consult with EMSOACC as necessary</td>
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<table>
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<tr>
<th>Tier 2</th>
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<tbody>
<tr>
<td>- All Tier One responsibilities</td>
</tr>
<tr>
<td>- Establish Reinforced Organization (FOG – MCI) and consider establishing Multi-Group Response Organization</td>
</tr>
<tr>
<td>- Consider special calling for MCI caches or trailers</td>
</tr>
<tr>
<td>- Consider requesting Temporary Flight Restrictions via the Op Area Law Enforcement Coordinator</td>
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<tr>
<th>Tier 3</th>
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<tbody>
<tr>
<td>- All Tier Two responsibilities</td>
</tr>
<tr>
<td>- Establish Multi-Group Organization (FOG – MCI) and consider establishing Multi-Branch Response Organization</td>
</tr>
<tr>
<td>- Call for MCI caches and trailers if not already dispatched</td>
</tr>
<tr>
<td>- Confirm Temporary Flight Restrictions have been requested</td>
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## San Ramon and Richmond Fire Communications Center Responsibilities

<table>
<thead>
<tr>
<th>Pre-Alert</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Notify EMSOACC via XCCEMS1</td>
<td>- All PRE-ALERT responsibilities</td>
<td>- All PRE-ALERT responsibilities</td>
<td>- All PRE-ALERT responsibilities</td>
</tr>
<tr>
<td>- Notify supervisory or management personnel as per agency policy</td>
<td>- If an environmental hazard is involved or suspected, contact appropriate Hazardous Materials Incident Response Team: CCCHazmat, Richmond Fire, and/or San Ramon Valley Fire</td>
<td>- If an environmental hazard is involved or suspected, contact appropriate Hazardous Materials Incident Response Team: CCCHazmat, Richmond Fire, and/or San Ramon Valley Fire</td>
<td>- If an environmental hazard is involved or suspected, contact appropriate Hazardous Materials Incident Response Team: CCCHazmat, Richmond Fire, and/or San Ramon Valley Fire</td>
</tr>
<tr>
<td>- Make additional notifications as necessary or requested</td>
<td>- Monitor ReddiNet</td>
<td>- Notify EMSOACC via XCCEMS1 and transmit incident pertinent info</td>
<td>- Notify EMSOACC via XCCEMS1 and transmit incident pertinent info</td>
</tr>
<tr>
<td>- Monitor ReddiNet</td>
<td></td>
<td>- Notify EMSOACC via XCCEMS1 and transmit incident pertinent info</td>
<td>- Notify EMSOACC via XCCEMS1 and transmit incident pertinent info</td>
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## Contra Costa Regional Fire Communications Center

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<tr>
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<tbody>
<tr>
<td>- Notify EMSOACC via XCCEMS1 and transmit incident pertinent info</td>
<td>- Notify EMSOACC via XCCEMS1 and transmit incident pertinent info</td>
<td>- Notify EMSOACC via XCCEMS1 and transmit incident pertinent info</td>
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<tr>
<td>- Notify EMSOACC via XCCEMS1 and transmit incident pertinent info</td>
<td>- Monitor ReddiNet</td>
<td>- Notify EMSOACC via XCCEMS1 and transmit incident pertinent info</td>
<td>- Notify EMSOACC via XCCEMS1 and transmit incident pertinent info</td>
</tr>
<tr>
<td>- Page agency MGMT paging group for agency with fire jurisdiction</td>
<td>- Monitor ReddiNet</td>
<td>- Notify EMSOACC via XCCEMS1 and transmit incident pertinent info</td>
<td>- Notify EMSOACC via XCCEMS1 and transmit incident pertinent info</td>
</tr>
<tr>
<td>- Page agency MGMT paging group for agency with fire jurisdiction</td>
<td>- Page agency MGMT paging group for agency with fire jurisdiction</td>
<td>- Notify SRVFPD Communications, MOFD BC</td>
<td>- Notify SRVFPD Communications, MOFD BC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Page FIRE MGMT paging group</td>
<td>- Page FIRE MGMT paging group</td>
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<td></td>
<td>- Notify OES Region II Fire/Rescue</td>
<td>- Notify OES Region II Fire/Rescue</td>
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<td></td>
<td></td>
<td></td>
<td>- Consider dispatch of Incident Management Team (IMT)</td>
</tr>
</tbody>
</table>
### Jurisdictional Law Enforcement Agency Responsibilities

<table>
<thead>
<tr>
<th>Pre-Alert</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Broadcast information to field units</td>
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</tr>
<tr>
<td>• Make supervisory and command notifications as per department policy</td>
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<tr>
<td>• If not already responding, respond to the scene</td>
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<td>• If not already responding, respond to the scene</td>
<td>• If not already responding, respond to the scene</td>
</tr>
<tr>
<td>• When appropriate consider establishing unified command or assume</td>
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</tr>
<tr>
<td>appropriate position within ICS structure</td>
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<tr>
<td>• Determine need for additional police resources</td>
<td>• Determine need for additional police resources</td>
<td>• Determine need for additional police resources</td>
<td>• Determine need for additional police resources</td>
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<tr>
<td>• Handle traffic control and/or crowd control as needed</td>
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<tr>
<td>• Consider immediate activation of mutual aid resources, including the</td>
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<tr>
<td>Mutual Aid Mobile Field Force (MAMFF)</td>
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<tr>
<td>EMS Operational Area Communications Center (EMSOACC) Tasks</td>
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<td>----------------------------------------------------------</td>
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<td><strong>Pre-Alert</strong></td>
<td><strong>Tier 1</strong></td>
<td><strong>Tier 2</strong></td>
<td><strong>Tier 3</strong></td>
</tr>
<tr>
<td>• Broadcast incident on XCCEMS1</td>
<td>• Broadcast incident on XCCEMS1</td>
<td>• All Tier One responsibilities</td>
<td>• All Tier Two responsibilities</td>
</tr>
<tr>
<td>• Advise hospitals and ambulance zone providers via Reddinet MCI Activation</td>
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<td>• Notify the Alameda/Contra Costa blood bank via telephone</td>
<td>• Coordinate with LEMSA Duty Officer on the activation of facility damage assessment poll</td>
</tr>
<tr>
<td>• Notify LEMSA Duty Officer</td>
<td>• Notify LEMSA Duty Officer</td>
<td>• Notify on-call Health Officer</td>
<td></td>
</tr>
<tr>
<td>• Ensure jurisdictional fire agency is aware of MCI status</td>
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<td>• Establish communications with adjoining county EMS dispatch centers. Request mutual aid ambulances if requested by the Incident Commander or EMS Branch Director</td>
<td></td>
</tr>
<tr>
<td>• Make additional notifications as necessary or requested</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Make telephone contact with any hospital not responding to Reddinet MCI function</td>
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<td></td>
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</tr>
<tr>
<td>• If an environmental hazard is involved or suspected, contact the Environmental Health Hazardous Materials Incident Response Team, Contra Costa Fire, Richmond Fire and San Ramon Valley Fire</td>
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</table>
EMS Transport Resource Ordering Overview

PSAP

EMS OACC (CCC Sheriff’s Dispatch)

Fire Coms Center

EMSOACC

(OUTSIDE CCC)
Immediate Need
Mutual Aid –
RDMHC via MHOAC
(ALS/BLS)

(WITHIN CCC)
All Zone Providers
(BLS)

EMS Helicopter Providers

Request(s) for EMS resources should be made through requesting agency’s normal ordering process.

Police
Field

Fire
Field

Ambulance
Field
MCI Communications Plan

CCRFC (or) SRVFD

Medical Group Supervisor or Transport Unit Leader

EMSOACC (Sheriff’s Dispatch)

Reddinet