### Summary of Changes
#### 2020 Policies

<table>
<thead>
<tr>
<th>Treatment Guideline Number</th>
<th>Treatment Guideline Name</th>
<th>Requested changes</th>
<th>Changes/Updates</th>
</tr>
</thead>
</table>
| 4002                      | Patient Destination Determination                 | o VIII. B.1. – Contact base for burn bed availability, remove?  
  o Two sections called XI  
  o Incomplete sentence in second section XI  
  o Change title of XII | o VIII.B.1 removed. Regardless of bed availability, patients with significant burns should be transported to a burn center for specialty care  
  o Section numbers changed  
  o Sentence corrected  
  o XII – Renamed to “Out of County ReddiNet Status” |
| 4006                      | Activation Criteria for Non-Emergency Providers    | o I. Add “for an unstable patient”  
  o II.B – Remove “and the time from arrival on scene to arrival at the hospital is less than ten minutes” | o Added for more clarity to Purpose section  
  o II.B. Removed. Other subsections renumbered.  
  • Added II.D. “911 shall be activated for any patient that receives Epinephrine or Narcan administered by an EMS operating on a non-emergency ambulance”  
  • Added II.E. “An EMS Event shall be submitted for any event where a BLS or CCT ambulances activates 911 for a patient in their care” |
| 4007                      | AMA/RAS                                           | o Algorithm confusing  
  o Change “Individual” to “Patient” | o Page 5 – Removed algorithm  
  o Added the word “Patient” to allow the completion of an RAS on a person or individual who may meet the criteria of being a patient, but both the EMT or Paramedic AND the person/patient agree they do not need to be treated and transported by EMS |
| 4010                      | EMS Emergency Department Transfer of Care Standards | o Remove III.F. “Never Events” must be reported as an EMS Event” | o 4010 or “Never Events” will no longer need to be completed for patients that are at hospitals longer than an hour. This information is being captured elsewhere. If the patient falls into the category of 4010 or Never Event and there are other issues such as medicated on gurney, issues with hospital personnel, etc. please submit an EMS Event |
| 6002                      | EMS Event Reporting                               | o IV. 1. – Do we want to define or give examples of an “unusual event/occurrence”?  
  o IV. 6. - Data being captured elsewhere | o IV. 1. - Removed “(e.g. MCI, abnormal patient condition, Base Hospital communication failure).” No examples needed  
  o IV. 6 – Changed to “Any event where a non-911 BLS or CCT ambulance activates 911 for a patient in their care” |
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. Contra Costa County EMS system recognizes hospital internal disaster or specialty service closure (e.g., CT, STEMI, Trauma) and does NOT recognize “diversion” or “bypass” status for Emergency Departments located within or outside of Contra Costa 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. 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).

E. 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. Consider Base contact 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.

XII. OUT-OF-COUNTY REDDINET STATUS
A. Out-of-county “internal disaster,” when captured in the ReddiNet “STATUS” screen, should be immediately disseminated to field providers via radio, pager, message, etc.
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.

XIII. 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:

1. Pertaining to Kaiser Richmond “Red” Status:
   a. Kaiser Richmond will be limited to two – two hour periods per calendar day with at least four hours between “Red” Statuses.

<table>
<thead>
<tr>
<th>Green Status</th>
<th>Operating normally and available for all patient transports appropriate to that hospital.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yellow Status</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 Status</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:
### XIV. RESOURCE:
Approved Kaiser Richmond Status Scripts:

#### Directed Destination Scripts for Stable Patients

<table>
<thead>
<tr>
<th>Status</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yellow</td>
<td><strong>If a patient or family requests transport to Kaiser Richmond, please explain:</strong></td>
</tr>
</tbody>
</table>
|          | "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                              |

<table>
<thead>
<tr>
<th>Red</th>
<th><strong>If a patient or family requests transport to Kaiser Richmond, please explain:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&quot;Kaiser Richmond is currently unavailable due to patient overload. We can transport you to another hospital of your choice.&quot;</td>
</tr>
<tr>
<td></td>
<td>&quot;Which of these hospitals would you like to be transported to?&quot;</td>
</tr>
<tr>
<td></td>
<td>Other nearby hospitals:</td>
</tr>
<tr>
<td></td>
<td>*Contra Costa Regional Medical Center – Martinez</td>
</tr>
<tr>
<td></td>
<td>*John Muir Medical Centers – Concord and Walnut Creek</td>
</tr>
<tr>
<td></td>
<td>Kaiser Permanente – Walnut Creek</td>
</tr>
<tr>
<td></td>
<td>Highland Hospital – Oakland</td>
</tr>
<tr>
<td></td>
<td>*Alta Bates Medical Center – Berkeley</td>
</tr>
<tr>
<td></td>
<td>Kaiser Permanente – Oakland</td>
</tr>
<tr>
<td></td>
<td>*Summit Medical Center – Oakland</td>
</tr>
<tr>
<td></td>
<td>Kaiser Permanente – Vallejo</td>
</tr>
<tr>
<td></td>
<td>Sutter Solano – Vallejo</td>
</tr>
<tr>
<td></td>
<td>Kaiser Permanente – San Rafael</td>
</tr>
<tr>
<td></td>
<td>Marin General – Greenbrae</td>
</tr>
<tr>
<td></td>
<td>*Contra Costa Health Plan and MediCal hospital</td>
</tr>
</tbody>
</table>
I. PURPOSE
This policy defines the criteria for upgrade to advanced life support (ALS) for non-emergency transport providers who are not dispatched by 9-1-1 response for an unstable patient.

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. Any non-emergency ambulance provider transporting a patient that becomes unstable during transport should divert to the closest/appropriate ED.

C. 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.

D. 911 shall be activated for any patient that receives Epinephrine or Narcan administered by an EMT operating on a non-emergency ambulance.

E. An EMS event shall be submitted for any event where BLS or CCT ambulance activates 911 for a patient in their care.
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 patients 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).
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

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.

*Emergency Medical Treatment and Labor Act (EMTALA)
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.
      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. Any event where BLS or CCT ambulance activates 911 for a patient in their care.

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 confidentiality 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.