Sierra – Sacramento Valley EMS Agency
Regional Emergency Medical Advisory Committee
(REMAC)

MEETING AGENDA

MEETING DATE & TIME INFORMATION

- **Tuesday, October 28, 2025, 9:00 am – 12:00 pm**

MEETING LOCATION & ALTERNATE ATTENDANCE INFORMATION

- **Primary Meeting Location:** 535 Menlo Drive, Suite A, Rocklin, CA 95675
- **Alternate Meeting Location:** 1255 East Street, 2nd Floor, Redding, CA 96001
- **Zoom:** Https://us02web.zoom.us/j/89420097820?pwd=s67WzS96jIEJS2M6Rzjpku5fPbBKJA.1
- **Telephone:** (669) 900-9128 **Meeting ID:** 894 2009 7820 **Passcode:** 1702

IMPORTANT NOTIFICATONS

- Public comments on proposed policy/protocol actions listed on this agenda will be taken during the review/discussion of the applicable item. Individuals unable to attend the meeting may provide written public comment on any item listed on this agenda, no later than seven (7) calendar days prior to the scheduled meeting date, by using the following comment form link: https://www.ssvems.com/s-sv-ems-remac-public-comment/.
- Policy/protocol actions listed on this agenda may be approved by a majority vote of the REMAC members present at the meeting. If necessary, proposed policy/protocol actions may be continued to subsequent REMAC meetings until consensus is reached by the committee.
- All REMAC approved policy/protocol actions shall also be approved by the S-SV EMS Medical Director and Regional Executive Director prior to implementation. S-SV EMS may make non-substantive corrections to approved policy/protocol actions to address any technical defect, error, irregularity, or omission prior to final publication.
- EMS system participants will be notified of approved policy/protocol actions a minimum of 30 calendar days prior to the effective implementation date. Policy/protocol action updates are routinely published on a bi-annual basis as follows:
  - October & January meeting approved policy actions: April 1st implementation date.
  - March & July meeting approved policy actions: October 1st implementation date.
- Some policy/protocol actions may require immediate action to maintain compliance with statutes/ regulations, or to preserve medical control/integrity of the EMS system. Policy/protocol actions of this type may be implemented by S-SV EMS as urgency measures and scheduled for discussion at the next regularly scheduled REMAC meeting, if necessary.

Sierra – Sacramento EMS Agency – REMAC Meeting Agenda

MEETING AGENDA		
ITEM	**TITLE**	**LEADER**
A	**Call to Order/Introductions**	**Chairperson**
B	**Approval of Previous Meeting Minutes**	**Chairperson**
C	**Approval of Meeting Agenda**	**Chairperson**
D	**Public Comment**	**Attendees**
E	**S-SV EMS Policy/Protocol Actions**	**S-SV EMS Staff**
	411: LALS/ALS Provider Agency Responsibilities	Trenton Quirk
	414: 911 Ground Ambulance Dispatch Requirements	Trenton Quirk
	504: Emergency Department Downgrade/Cessation	Trenton Quirk
	450: HEMS Aircraft Authorization, Classification & Operations	Michelle Moss
	621: HEMS Aircraft Quality Management	Michelle Moss
	862: HEMS Aircraft Requesting & Utilization	Michelle Moss
	710: Management of Controlled Substances *(Discussion: Narcotic Waste)*	John Poland
	S-SV EMS Drug Reference Guide	Brittany Pohley
F	**EMS Aircraft Provider Reports**	**Attendees**
G	**EMS Ground Provider Reports**	**Attendees**
H	**Hospital Provider Reports**	**Attendees**
I	**Quality Improvement (QI) Case Review**	**Brittany Pohley**
J	**S-SV EMS Agency Reports**	**S-SV EMS Staff**
	EMS Data System	Jeff McManus
	Regional Specialty Committees	Michelle Moss
	Operations	Patrick Comstock
	Regional Executive Director	John Poland
	2026 S-SV EMS Meeting Calendar	John Poland
	Medical Director	Troy Falck, MD
K	**Next Meeting/Adjournment: January 27, 2026**	**Chairperson**

Sierra – Sacramento Valley EMS Agency
Regional Emergency Medical Advisory Committee
(REMAC)

MEETING MINUTES

Meeting Date
Tuesday, July 22, 2025

A. Call to Order/Introductions

- Dr. Royer called the meeting to order at 9:02 am, and all attendees introduced themselves.

B. Approval of Previous Minutes: April 22, 2025

- The minutes were unanimously approved by the committee with no changes.

C. Approval of Agenda

- The committee approved the agenda with no changes.

D. Public Comment

- Sutter Roseville will have a Run Review at S-SV EMS, on August 27, from 9-11 am. It will be about the importance of GCS assessment in the pre-hospital setting. They will try and make it available by Zoom as well.

E. S-SV EMS Policy Actions

Policy Actions for Final Review & Approval:

Policy	Name	Motion	Second	Committee Vote
509	**Trauma Center Designation Criteria, Requirements & Responsibilities** • This policy is due for routine review. • On page 2, added 'Continuously' to number 5 and 6. • On page 3, added lines 17-25. • On page 4, Under Procedure, added language to A. Added 'Trauma PI RN' to A2. Line 35 removed 'The hospital' and added 'Hospitals seeking initial S-SV EMS Trauma Center designation'. • On page 5, added 'initial' to line 1, and 'or based on the trauma needs assessment for Trauma Centers seeking to change their designation level' to lines 2-3. And removed 'The hospital' from line 4 and added 'Hospitals seeking initial S-SV EMS Trauma Center designation'.	Dr. Iwai	Debbie Madding	Passed Unanimously

854	**Unsafe Scene** • This is a brand-new policy. • A survey was conducted, with many different responses. • The word 'patient' wasn't used intentionally in this policy. • John suggested using the language 'subject/patient'. • There was some discussion on this. • These will all be audited.	Dr. Iwai	Dr. Goldsmith	Passed Unanimously
1106	**Mechanical Chest Compression Devices (REMOVE)** • It was determined that this policy has outlived its usefulness. • At the next REMAC meeting there will be a new policy of general approved devices. • Once this is removed there will only be one policy left in the 1100s, so it will be moved to a different section.	Cindy Bergstrom	Chris Britton	Passed Unanimously
C-6	**Chest Discomfort/Suspected Acute Coronary Syndrome (ACS)** • Language was added to give crews direction on when it is appropriate to do a posterior 12 Lead. • If there's a reason why it's difficult, it needs to be documented by the crews. • Language was added regarding contacting a SRC. • Added to the 'STEMI pt Notes' box, at least 10 mins prior to arrival at SRC'.	Dr. Iwai	Debbie Madding	Passed Unanimously
M-5	**Ingestions & Overdoses** • This is due for routine review. • The PAC Committee suggested adding 'When possible, contact' to the 'Treatment Notes' box on page 1. • Instead of having specific doses listed, the policy will be referenced for the dosage instead. (this will occur in all policies/protocols going forward). • On page 2, direction is given when administering Narcan (see the Naloxone box) regarding providing BVM ventilation.	Dr. Iwai	Chris Britton	Passed Unanimously

M-8	**Pain Management** • There was some concern that because this was a 'top down' protocol that medics may get confused and start with the non-trauma chronic pain and keep working down through the acute pain. For clarity, these were separated out.	Dr. Goldsmith	Josh Sher	Passed Unanimously
M-8P	**Non-Traumatic Pulseless Arrest** • There was some concern that because this was a 'top down' protocol that medics may get confused and start with the non-trauma chronic pain and keep working down through the acute pain. To make this clearer, these were separated out. • In addition, when the Ketamine contraindications were removed, they weren't taken out of this protocol, so this has been updated.	Dr. Goldsmith	Josh Sher	Passed Unanimously
M-9	**CO Exposure/Poisoning** • There are some formatting changes. • The PAC committee suggested adding the two bullet points in the top box. • Perform a 12Lead was added to the ALS box, and the language was updated. • The BLS box was reworded, with the addition of 'Measure SpCO if CO-Oximeter is available'.	Dr. Goldsmith	Dr. Iwai	Passed Unanimously
N-1	**Altered Level of Consciousness** • There was some language clean-up to make this match other protocols with regard to Cardiac and End-tidal CO^2 monitoring. • Instead of giving specific direction on how to handle these situations with altered state, the appropriate protocols are referenced.	Dr. Iwai	Dr. Goldsmith	Passed Unanimously
N-2	**Seizure** • The PAC committee suggested direction to the crews to refer to the OBG-2 protocol rather than following this in the case of 3rd trimester pregnancies – in the top box. • In the ALS box – language was cleaned-up to be consistent with the other protocols.	Dr. Goldsmith	Dr. Iwai	Passed Unanimously

	• The PAC committee suggested differentiating 'Status epilepticus'. • It was suggested to reference T-3 in this as well.			
PR-1	**12 Lead EKG** • This is just making clear how to do the procedure with 12 Leads.	Dr. Iwai	Chris Britton	Passed Unanimously
PR-2	**Airway & Ventilation Management** • iGel information was added to the Indications box, the last bullet point. • This is really duplicating the information to make sure it's seen.	Dr. Iwai	Dr. Goldsmith	Passed Unanimously
R-2	**Respiratory Arrest** • 'as needed' was removed from the BLS box. • It was suggested, in the ALS box, to have it read 'Consider Cardiac monitor and $EtCo_2$ monitoring' to match the other protocols.	Dr. Goldsmith	Dr. Iwai	Passed Unanimously
T-2	**Crush Injuries** • This is a brand-new protocol. • Most of the other LEMSAs have a protocol for this, and some of the language was taken from those.	Dr. Iwai	Dr. Goldsmith	Passed Unanimously
T-3	**Suspected Moderate/Severe Traumatic Brain Injury (TBI)** • Added the 'Seizures present' box, and if there are seizures, then go to 'N-2'.	Dr. Iwai	Dr. Goldsmith	Passed Unanimously
T-4	**Hemorrhage** • At the request of UC Davis, they wanted an exclusive criterion for extremity hemorrhage controlled by a tourniquet. This was added to page 2, in the TXA Exclusion Criteria box. • Under TXA, the dose was made 2g.	Dr. Goldsmith	Dr. Iwai	Passed Unanimously
N/A	**New: Advanced Airway Utilization Form** • A checklist will be required for every intubation attempt. • Online form for consistent data. • These will all be reviewed and will help educate the paramedics. • If everyone likes the form, it should be available by October 1st. • All feedback on the form should be sent to Brittany.	N/A	N/A	No Vote was called for

F. EMS Aircraft Provider Updates

- No reports.

G. Ground EMS Provider Updates

- Etna:
  - PHTLS Class on 11/1-2, in person and hybrid.
  - Working on TCC pro.

H. Hospital Provider Reports

- No reports.

I. Quality Improvement (QI) Case Review

- The case was presented by Devon Ellsworth (CalFire), Jason Swan (Mercy Redding) and Cindy Bergstrom (Mercy Redding).

J. S-SV EMS Agency Reports

- **EMS Data System**
  - The procedure/medication list has been released -many won't apply to the providers though. Anyone using the S-SV regional schematron should stop at this point.
  - EMSA is actively sending S-SV monthly reports regarding data quality or performance issues.
  - No new updates for D3 5.1.

- **Clinical Quality Dashboards**
  - A live pdf of the dashboards can be sent to anyone, and it can be narrowed down to a date range. Eventually, these will be available on the website.
  - The dashboards are automatically updated every morning at 1 am.
  - 95% of the dashboard data comes from PCRs. Documentation is key.

- **Regional Specialty Committees**
  - The Trauma QI Committee met in May. They reviewed a Trauma triage criteria audit, and an audit on hemorrhage control management.
  - There is a new Trauma registry that was recently deployed.

- **Operations**
  - Policy 462 was implemented this year; seems to be working well.
  - Starting with Placer County, Patrick is shadowing their Behavioral Crisis Team to become more involved with the 911 system. This will expand to other areas in the S-SV region.
  - Ambulance Inspections are starting to be scheduled.

- **Regional Executive Director's Report**
  - Working on finalizing the EOA extension for AMR in Placer County. The current agreement expires 11/30/25. The extension will be a 2-year agreement.
  - S-SV EMS is working with Health Strategists on a system assessment of the Western Placer County EMS System.
  - APOT Emergency regulations were approved by the EMS Commission about a month ago. This will include an audit tool for hospitals and LEMSAs.

- S-SV may reach out to providers for additional information on calls – due to the State looking closely at this data. It needs to be complete, accurate and timely in the system.
- All but one of the hospitals in the S-SV Region are compliant with the APOT standard. S-SV has been working closely with this hospital.

- Chapter 1 – the EMS Authority is finalizing the initial draft of those regulations. These are still likely 9-12 months out.
- Chapter 6 Regulations – have been published for a second 45-day public comment period.
- AB645 – is close to the end of its legislative process. This will require all PSAPs in California that do medical dispatching to have at least a limited prearrival instruction capability. The six items all 911 dispatch centers that dispatch medical resources are:
  - Airway/choking instructions for infants, children and adults
  - AED/CPR instructions for children and adults
  - Childbirth
  - Bleeding control/Hemorrhage
  - Administration of EPI auto injector
  - Administration of Naloxone
- SB582 – would require the disaster and evacuation plan that skilled nursing facilities are required to have in place to share those with the MHOAC program in each county. It would give an opportunity to the MHOACs to provide input on those plans to make sure they line up with the County's evacuation plans and make sure they're realistic.

K. Medical Director's Report

- Recognized 2 members of the EMS community. EMSA had their statewide EMS awards on June 4th. Chris Britton, from Kaiser Roseville, and Rose Colangelo from Sutter Roseville both received awards not only for the APOT work but all their work to improve care for EMS patients.
- Mr. Poland attended the awards ceremony and encouraged nominations from the S-SV Region.

L. Next Meeting Date & Adjournment

- The next meeting will be on October 28, 2025, at 9:00 am.
- The meeting was adjourned at 11:15 am.

Sierra – Sacramento Valley EMS Agency Program Policy			
LALS/ALS Provider Agency Responsibilities			
	Effective: DRAFT	Next Review: DRAFT	**411**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish LALS/ALS prehospital service provider agency responsibilities.

AUTHORITY:

A. HSC, Division 2.5.

B. CCR, Title 22, Division 9, Chapters 3.2 and ~~4~~ 3.3.

POLICY:

A. An S-SV EMS approved LALS/ALS prehospital service provider agency shall:

1. Provide LALS/ALS prehospital emergency medical services on a continuous twenty-four (24) hours per day basis unless otherwise approved by S-SV EMS, in which case there shall be adequate justification for the exemption.

2. Maintain and utilize telecommunications as specified in S-SV EMS policies.

3. Maintain medical equipment and supplies as specified in S-SV EMS policies.

4. Ensure that security mechanisms and procedures are established for storage and administration of controlled substances as required by S-SV EMS policies.

5. Have a written agreement with S-SV EMS to participate in the EMS system, and comply with all applicable EMS laws, regulations, and policies, including participation in the S-SV EMS Emergency Medical Services Quality Improvement Program (EMSQIP).

6. Participate in S-SV EMS regional committee meetings and other EMS activities that affect the region.

7. Participate in the S-SV EMS data collection program.

8. Be responsible for training and assessing the knowledge/skills of their prehospital personnel in S-SV EMS policies/protocols.

9. Maintain approval as an EMS continuing education (CE) provider and provide training deemed necessary by S-SV EMS.

10. Provide supervised field internship experience for prehospital students in accordance with CCR Title 22 and S-SV EMS policies.

11. Provide remedial education/training for prehospital personnel as needed.

12. Actively participate in local/regional disaster planning efforts, and reasonably participate in local/regional MCI and disaster drills.

13. Follow the procedures specified in regional plans and S-SV EMS policies during an MCI or disaster response.

B. If, through the EMSQIP the relevant employer or S-SV EMS Medical Director determines that an AEMT or paramedic requires additional training, observation, or testing, the relevant employer and the S-SV EMS Medical Director may create a remediation program based on the identified need. If there is disagreement between the relevant employer and the S-SV EMS Medical Director regarding remediation matters, the decision of the S-SV EMS Medical Director shall prevail.

C. No organization or responding unit shall advertise itself as providing LALS/ALS services unless they are approved by S-SV EMS and staffed with appropriately credentialed AEMT and/or paramedic personnel.

D. S-SV EMS may deny, suspend, or revoke LALS/ALS prehospital service provider agency approval for failure to comply with applicable EMS policies, procedures, laws or regulations.

Sierra – Sacramento Valley EMS Agency Program Policy			
911 Ground Ambulance Dispatch Requirements			
	Effective: DRAFT	Next Review: DRAFT	**414**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish minimum 911 ground ambulance dispatch requirements.

AUTHORITY:

A. HSC, Division 2.5, Chapter 4, Article 1, § 1797.223.

B. CCR, Title 22, Division 9, Chapter 4.

C. GC, Title 5, Division 2, Part 1, Chapter 1, Article 6, § 53110.

POLICY:

A. A public agency shall not delegate, assign, or enter into a contract for 911 call processing services for the dispatch of emergency response resources except if the delegation or assignment is to, or the contract or agreement is with, another public agency.

B. If applicable, a public safety agency that provides 911 call processing services for emergency medical response shall make a connection available from the public safety agency dispatch center to an emergency medical services (EMS) provider's dispatch center for the timely transmission of emergency response information.

1. For purposes of this policy, "connection" means either a direct computer aided dispatch (CAD) to CAD link, where permissible under law, between the public safety agency and an EMS provider or an indirect connection, including, but not limited to, a ring-down line, intercom, radio, or other electronic means for timely notification of caller data and the location of the emergency response.

2. A public safety agency shall be entitled to recover from an EMS provider the actual costs incurred in establishing and maintaining this connection.

3. An EMS provider that elects not to use this connection shall be dispatched by the appropriate public safety agency and charged a rate negotiated by the parties.

C. Any dispatch center (including non-emergency providers) receiving a request for emergency medical assistance from any member of the public, either through the 911 system or a non-emergency number, shall promptly notify the applicable dispatch center for the first responder and/or 911 ambulance provider of the call.

D. All 911 ambulance providers shall operate their own dispatch center, contract with an existing dispatch center, or join with other providers to operate a dispatch center. If a 911 ambulance provider utilizes dispatch services provided by another organization, it must have a written contract for those services.

E. All 911 ambulance providers shall maintain dispatch services necessary to receive and respond to requests for emergency ambulance services. The 911 ambulance provider's dispatch center shall:

1. Receive calls for emergency medical assistance from applicable public safety answering points (PSAPs) and non-emergency telephone lines.

2. Identify and dispatch the closest available 911 ambulance to the scene of the emergency in accordance with current EOA and non-EOA agreements/permits.

3. Only dispatch the number of ambulances appropriate for the type of incident or as requested by the Incident Commander (IC).

4. Notify responding personnel and agencies of pertinent incident information.

5. Monitor and track responding resources.

6. Coordinate with law enforcement, first responders and other EMS providers.

7. Provide required dispatch data to S-SV EMS.

F. To maintain the integrity of EOA's within the S-SV EMS region, the exclusive 911 ambulance provider for the service area where the call is located shall be dispatched to all emergency medical incidents within that service area, unless a closer authorized provider is requested through automatic/mutual aid.

G. If the dispatch center utilizes an S-SV EMS approved MPDS, the dispatcher shall follow the protocols associated with that system.

H. Ambulances shall not at any time proceed at a level of response other than as directed by the applicable PSAP or ambulance provider dispatch center.

I. 911 ambulance providers shall have a written policy and shall make all reasonable efforts to immediately notify the jurisdictional PSAP, if applicable, of the location from where the ambulance is responding from.

J. The dispatch center shall be staffed with sufficient properly trained personnel to accomplish all applicable dispatch functions.

K. A computer-aided dispatch (CAD) system shall be utilized to record dispatch information for all 911 ambulance requests. CAD system information shall include a minimum of caller, incident date, incident location, assigned unit ID, reason for cancellation (if applicable), and all appropriate incident times (hours, minutes, and seconds).

L. The dispatch center shall have capabilities for 24-hour real time recordings of all emergency telephone lines and radio frequencies. All radio and telephone communications shall be recorded on tape or other digital recording medium and maintained for a minimum of 90 days.

M. 911 ambulance providers shall have a plan to provide ambulance dispatch services during any period of primary dispatch failure. The plan shall ensure that an equivalent dispatch center or dispatch system is able to serve as a backup within five (5) minutes of failure of the primary dispatch center.

Sierra – Sacramento Valley EMS Agency Program Policy			
Emergency Department Downgrade/Cessation			
	Effective: DRAFT	Next Review: DRAFT	**504**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish procedures for evaluation of potential EMS system impacts due to the downgrade/cessation of emergency medical services in hospitals.

AUTHORITY:

HSC, Division 2, Chapter 2, § 1255 and 1300.

POLICY:

A. Any hospital proposing a reduction or elimination of emergency medical services in their facility shall notify the State Department of Health Services, the County Department of Public Health, S-SV EMS, and all health service plans under contract with the hospital, no later than 90 days prior to any such change.

B. The hospital implementing a change shall provide for public notification of the proposed changes no less than 90 days prior to implementing any changes. The notification shall be of such magnitude as to inform a significant number of residents within the hospital's service area and be in terms likely to be understood by a layperson.

C. Upon notification, S-SV EMS shall proceed with an impact evaluation in collaboration with the California Healthcare Association and the local Public Health Department. The report shall include, but is not limited to, the following:

1. Geography: service area population density, travel time and distance to the next nearest facility, number and type of other available emergency services and availability of prehospital resources.

2. Base hospital designation: number of calls; impact on patients, prehospital personnel, and other base hospitals.

3. Level of care: assessment of level of emergency services provided, i.e., basic, standby, and next nearest availability.

4. Trauma care: number of trauma patients; impact on other hospitals, trauma centers and trauma patients.

5. Specialty services provided: neurosurgery, obstetrics, burn center, pediatric critical care, stroke, STEMI, etc. and the next nearest availability.

6. Patient volume: number of emergency department patients annually, both 911 transports and walk-ins.

7. Notification of the public: process to be used: public hearing, advertising, etc.; ensure that all appropriate health care providers are consulted with.

8. Availability of prehospital care: availability and level of prehospital care and EMS aircraft resources.

9. Public and emergency provider comments: obtained through local EMS committees and public hearing.

10. ~~Recommendations: shall include a determination of whether the request for reduction or elimination of emergency services should be approved or denied.~~

D. Within 45 days of notification, S-SV EMS shall:

1. Ensure planning or zoning authorities have been notified.

2. Conduct, in conjunction with the local Department of Public Health, at least one public hearing on the proposed changes.

3. Distribute a draft of the impact evaluation report to the local County Department of Public Health, the S-SV EMS Regional Medical Control Advisory Committee, the affected county's Emergency Medical Control Committee (or similar county EMS committee), the S-SV EMS JPA Governing Board, and any other emergency care provider affected by the changes.

E. No more than 60 days after notification, S-SV EMS shall submit the final impact evaluation report to the local County Department of Public Health, the State Department of Health Services, the State EMS Authority, the S-SV Regional Medical Control Advisory Committee, the affected county's Emergency Medical Care Committee (or similar county EMS committee), and the S-SV EMS JPA Governing Board.

Sierra – Sacramento Valley EMS Agency Program Policy			
HEMS Aircraft Authorization, Classification & Operations			
	Effective: 12/01/2022	Next Review: 09/2025	**450**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish standards for the authorization, classification, and operations of HEMS aircraft/personnel.

AUTHORITY:

A. HSC, Division 2.5, § 1797.200 – 1797.276, 1798 – 1798.8 & 1798.170.

B. CCR, Title 22, Chapter ~~8~~ 7.

C. Federal Aviation Regulations, § 91~~.3, 91.11 and 91.12.~~

DEFINITIONS:

A. **Helicopter Emergency Medical Services (HEMS) Aircraft –** Rotor wing aircraft utilized for the purpose of prehospital emergency response and patient transport. HEMS aircraft include air ambulances and all ALS/BLS rescue aircraft.

B. **Air Ambulance –** Any aircraft specially constructed, modified or equipped and used for the primary purpose of responding to emergency incidents and transporting critically ill and/or injured (life or limb) patients, whose medical flight crew has, at a minimum, two (2) attendants certified or licensed in advanced life support.

C. **Rescue Aircraft –** Aircraft whose usual function is not patient transport but may be used for patient transport when the use of an air or ground ambulance is inappropriate or not readily available. Rescue aircraft are classified as one of the following:

1. **Advanced Life Support (ALS) Rescue Aircraft –** A rescue aircraft whose medical flight crew has, at a minimum, one (1) attendant licensed as a paramedic.

2. **Basic Life Support (BLS) Rescue Aircraft –** A rescue aircraft whose medical flight crew has, at a minimum, one (1) attendant certified as an EMT.

3. **Auxiliary Rescue Aircraft –** A rescue aircraft that does not have a medical flight crew, or whose flight crew does not meet ALS/BLS rescue aircraft requirements.

POLICY:

A. S-SV EMS is responsible for classifying/authorizing HEMS aircraft based within the S-SV EMS region, except that the California EMS Authority (EMSA) is responsible for classifying aircraft of the California Highway Patrol, CAL FIRE, and California National Guard. S-SV EMS classification/authorization will be provided by written agreements with HEMS aircraft providers.

B. No person or organization shall provide or hold themselves out as providing HEMS aircraft services unless that organization has aircraft which have been classified/ authorized by a local EMS agency (LEMSA) or, in the case of the California Highway Patrol, CAL FIRE, and California National Guard, by EMSA.

C. Except for mutual aid requests, HEMS aircraft must be classified/authorized by S-SV EMS and possess a current/valid S-SV EMS air ambulance service provider permit to operate within the S-SV EMS region. A request from a designated dispatch center shall be deemed as authorization of aircraft operated by the California Highway Patrol, CAL FIRE, California National Guard, or the Federal Government.

D. HEMS aircraft providers, owners, operators, or any hospital where a HEMS aircraft is based, housed, or stationed permanently or temporarily shall adhere to all federal, state, and local statues, ordinances, policies, and procedures related to HEMS aircraft operations, including qualifications of flight crews and aircraft maintenance.

E. All ALS HEMS aircraft shall employ a provider medical director who is a physician licensed in the State of California who by training and experience, is qualified in emergency medicine. The medical director shall be responsible for the supervision of the quality assurance/improvement program of air medical transport patient care.

F. Medical Control:

1. The medical direction/management of the EMS system shall be under the medical control of the S-SV EMS medical director.

2. Flight paramedics shall operate under S-SV EMS policies/protocols. Paramedics employed by S-SV EMS authorized air ambulance providers who have been approved for Unified Paramedic Optional Scope of Practice may perform skills and administer medications in accordance with applicable S-SV EMS and/or HEMS aircraft provider approved policies/protocols.

3. Flight RNs may perform skills and administer medications beyond the S-SV EMS paramedic scope of practice, in accordance with RN specific policies/protocols developed/approved by the provider's medical director and agreed to by the S-SV EMS medical director. HEMS aircraft provider patient care policies/protocols shall be submitted to S-SV EMS initially and upon subsequent revision.

G. Personnel:

1. Air ambulances shall be staffed with a minimum of two (2) ALS medical flight crew members. Staffing can be achieved with any combination of:

   - S-SV EMS accredited paramedic.
   - Registered nurse (RN) who has successfully completed an S-SV EMS paramedic accreditation course or similar S-SV EMS approved training.

2. Rescue aircraft shall be staffed with a minimum of one (1) S-SV EMS accredited paramedic or EMT medical flight crew member, based on their classification level.

3. The medical flight crew of HEMS aircraft shall have training in aeromedical transportation equivalent to DOT Air Medical Crew National Standard Curriculum.

4. Medical flight crews shall participate in such continuing education requirements as required by their license/certification.

5. In situations where the flight crew is less medically qualified than the ground personnel from whom they receive patients, they may only assume patient care responsibility in accordance with applicable S-SV EMS policies/protocols.

H. Communications:

1. HEMS aircraft providers shall be honest, open, ethical, and responsible for accurately informing the air ambulance coordination center and/or requesting PSAP of any changes in availability or response status. This shall include any circumstance and/or activity that will delay their ability to respond (maintenance, training flights, interfacility transports, need for refueling, etc.).

2. HEMS aircraft shall provide an updated ETA to the air ambulance coordination center, requesting PSAP and/or designated LZ contact when enroute.

3. All communications between HEMS aircraft and the designated LZ contact should be done using CALCORD operational frequency of 156.075.

4. HEMS aircraft shall have the capability of communicating directly, while in flight, with the following entities:

   - Required FAA facilities.
   - Air ambulance coordination center and/or requesting PSAP.
   - Ground units.
   - Base, modified base and receiving hospitals.
   - S-SV EMS air to air EMS aircraft on frequency 123.025.

5. Air ambulance providers shall notify the applicable air ambulance coordination center when entering/flying through their geographical area. The air ambulance coordination center will inform air ambulance personnel of any other known aircraft activities in the area (fire suppression, other responding aircraft, etc.).

6. Air ambulance coordination centers will not routinely perform flight-following operations with HEMS aircraft. This will remain the responsibility of the requesting PSAP and/or the HEMS aircraft provider's dispatch center.

7. ~~Air ambulance providers shall maintain and update their availability on EMResource a minimum of once per pilot shift. EMResource will not be used as a primary method of determining HEMS aircraft availability by the air ambulance coordination centers.~~ Each permitted HEMS resource is responsible for maintaining current availability status in EMResource.

I. Air Ambulance Coordination Center Data Recording and Reporting:

1. Air ambulance coordination centers shall adequately record all air ambulance resource request activities.

2. Air ambulance coordination centers shall provide air ambulance coordination data to S-SV EMS upon request.

J. Space & Equipment:

1. HEMS aircraft shall be configured so that:

   - There is sufficient space to accommodate one (1) patient on a stretcher and one (1) patient attendant. Air ambulances shall have space to accommodate one (1) patient and two (2) patient attendants, at a minimum.
   - There is sufficient space for medical personnel to have adequate patient access to carry out necessary procedures on the ground and in the air.
   - There is sufficient space for medical equipment and supplies required by applicable regulations and S-SV EMS policies.

2. HEMS aircraft shall have adequate safety belts and tie-downs for all personnel, patients, stretchers, and equipment to prevent inadvertent movement.

3. HEMS aircraft shall have onboard equipment and supplies commensurate with the scope of practice of the medical flight crew, as approved by S-SV EMS.

4. HEMS aircraft shall be equipped with a radio headset for each crew member, ride along and patient. Each crew member headset should allow for communications with ground stations, base/modified base and receiving hospitals.

Sierra – Sacramento Valley EMS Agency Program Policy			
HEMS Aircraft Quality Management			
	Effective: 12/01/2022	Next Review: 09/2025	**621**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish HEMS aircraft quality management requirements.

AUTHORITY:

A. HSC, Division 2.5, § 1797.204, 1797.220 and 1798.

B. CCR, Title 22, Chapters 4, ~~8~~ 7 & ~~12~~ 10.

POLICY:

A. Records

1. HEMS aircraft providers shall submit patient care data as required by S-SV EMS policies.

2. HEMS aircraft providers shall submit dispatch/flight records to S-SV EMS for quality management and/or investigative purposes upon request.

B. Emergency Medical Services Quality Improvement Program (EMSQIP):

1. HEMS aircraft providers shall develop, implement, and maintain an EMSQIP, which is approved by S-SV EMS.

2. The EMSQIP shall be designed to objectively, systematically and continuously monitor, assess and improve the quality and appropriateness of patient care and safety. The EMSQIP indicators should be tracked and trended to determine compliance with established thresholds as well as reviewed for potential issues.

3. When the EMSQIP identifies a need for improvement, the HEMS aircraft provider shall develop, in cooperation with other EMS system participants when applicable, a performance improvement action plan. If the area identified as needing improvement includes system clinical issues, collaboration is required with the provider's medical director and the S-SV EMS medical director.

4. The EMSQIP shall be reviewed annually for appropriateness to the operation of the HEMS aircraft provider. A summary of this review, including how the provider's EMSQIP addressed the program indicators, shall be provided to S-SV EMS.

5. HEMS aircraft providers are responsible for conducting initial and recurring planned/structured safety training to public safety agencies and hospital personnel who interface with their medical services. This training at a minimum shall include:

   - Identifying, designating, and preparing an appropriate landing zone (LZ).
   - Personal safety in and around the helicopter for all ground personnel.
   - Procedures for day/night operations, conducted by the medical team, specific to the aircraft.
   - High and low reconnaissance.
   - Two-way communications between helicopter and ground personnel to identify approach and departure obstacles and wind direction.
   - Approach and departure path selection.
   - Procedures for the pilot to ensure safety during ground operations in a LZ with or without engines running.
   - Crash recovery procedures specific to the aircraft make and model must minimally include:
     - Location of fuel tanks.
     - Oxygen shut-offs in cockpit and cabin.
     - Emergency egress procedures.
     - Aircraft battery – stay away from it.
     - Emergency shut-down procedures.
   - Education regarding "weather shopping" must be included.

   Safety training records shall be submitted to S-SV EMS as part of the annual EMSQIP update.

6. Appropriate HEMS aircraft provider management and clinical representatives shall participate in S-SV EMS regional committee meetings and other EMS activities that affect the region.

C. HEMS Aircraft Utilization Review:

1. HEMS aircraft scene calls will be routinely reviewed by S-SV EMS staff to evaluate appropriate utilization, deviation from applicable policies/protocols, dispatch trends and to assess EMS system management.

2. S-SV EMS may select a committee to systematically review HEMS aircraft scene incidents for appropriate utilization and adherence to applicable policies/protocols.

Sierra – Sacramento Valley EMS Agency Program Policy			
HEMS Aircraft Requesting & Utilization			
	Effective: DRAFT	Next Review: DRAFT	**862**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish criteria for the requesting and utilization of HEMS aircraft on 911 incidents.

AUTHORITY:

A. HSC, Division 2.5, § 1797.200 – 1797.276, 1798 – 1798.8 & 1798.170.

B. CCR, Title 22, Division 9, Chapters 4 & ~~8~~ 7.

DEFINITIONS:

A. **Air Ambulance Coordination Center –** An emergency dispatch center designated by S-SV EMS for the purpose of coordinating air ambulance requests within the S-SV EMS region. The following EMS Aircraft Coordination Centers have been designated by S-SV EMS:

1. CAL FIRE Grass Valley Emergency Command Center: Colusa, Nevada, Placer, Sutter, and Yuba counties.

2. CAL FIRE Oroville Emergency Command Center: Butte, Glenn, Shasta, and Tehama counties.

3. CAL FIRE Yreka Interagency Command Center: Siskiyou County

B. **Public Safety Answering Point (PSAP) –** A public safety dispatch center where a 911 call is first received (primary PSAP) or where a 911 call is transferred/relayed for the purpose of dispatching resources (secondary PSAP).

C. **Helicopter Emergency Medical Services Aircraft (HEMS Aircraft) –** Rotor wing aircraft utilized for the purpose of prehospital emergency response and patient transport. HEMS aircraft include air ambulances and all ALS/BLS rescue aircraft.

D. **Air Ambulance –** Any aircraft specially constructed, modified or equipped and used for the primary purpose of responding to emergency incidents and transporting critically ill and/or injured (life or limb) patients, whose medical flight crew has, at a minimum, two (2) attendants certified or licensed in advanced life support.

E. **Rescue Aircraft –** Aircraft whose usual function is not patient transport but may be used for patient transport when the use of an air or ground ambulance is inappropriate or not readily available. Rescue aircraft are classified as one of the following:

1. **Advanced Life Support (ALS) Rescue Aircraft –** A rescue aircraft whose medical flight crew has, at a minimum, one (1) attendant licensed as a paramedic.

2. **Basic Life Support (BLS) Rescue Aircraft –** A rescue aircraft whose medical flight crew has, at a minimum, one (1) attendant certified as an EMT.

3. **Auxiliary Rescue Aircraft –** A rescue aircraft that does not have a medical flight crew, or whose flight crew does not meet ALS/BLS rescue aircraft requirements.

POLICY:

A. Medical Control

1. Treatment rendered in all prehospital care situations, including HEMS transport, shall be in accordance with current S-SV EMS protocols.

2. Flight nurse protocols must be approved in writing by the S-SV EMS Medical Director.

B. After assessing the incident location, conditions and patient needs, the most medically qualified provider on scene shall be responsible for determining if the patient/event meets HEMS aircraft utilization criteria and shall advise the Incident Commander (IC)/ designee regarding the need for HEMS aircraft. The final authority to request or cancel HEMS aircraft is at the discretion of the IC/designee.

C. The use of HEMS aircraft should provide a significant reduction (≥20 minutes) in arrival time to a receiving facility capable of providing definitive care, including designated specialty care centers.

1. The flight crew should limit on-scene treatment as much as possible to ensure that the advantages of rapid air transport are not diminished.

2. Prehospital providers must consider delays associated with the utilization of HEMS aircraft (e.g. flight planning, time to lift-off, safe-landing operations) when making transport decisions. Providers must ensure that the shortest and most appropriate transportation method is utilized. See table on the next page for average HEMS response times by county.

COUNTY	GENERAL AREA	AVG. PSAP REQUEST TO ARRIVAL AT SCENE
Butte		
Central	Chico, Magalia, Oroville, Gridley	25 mins
Eastern	Forbestown	28 mins
Northeastern	Butte Meadows	27 mins
Colusa		
Central	Colusa, Williams	23 mins
Eastern	Stonyford, Fouts Springs	31 mins
Glenn		24 mins
Nevada		28 mins
Placer		25 mins
Shasta		
Central	Redding, Igo, French Gulch, Montgomery Creek, Lakehead, Shingletown, Round Mountain, Igo	32 mins
Northeastern	Burney, Fall River Mills, Hat Creek, Old Station, Big Bend	37 mins
Southern	Platina	43 mins
Siskiyou		49 mins
Sutter		22 mins
Tehama		30 mins
Yuba		
Eastern	Brownsville, Camptonville, Dobbins, Oregon House, Oak Valley	38 mins
Western	Marysville, Olivehurst, Browns Valley, Loma Rica	22 mins

D. HEMS aircraft utilization criteria:

1. Trauma patients who meet RED Field Trauma Triage Criteria, and transport time to an appropriate level trauma center is ≥30 minutes by ground.

2. Prolonged extrication of an entrapped patient.

3. Multi-casualty incidents with a need for additional resources or distribution of patients to facilities ≥30 minutes by ground from the incident location.

4. Time-sensitive conditions where a decrease in transport time may reduce the risk of long-term disability or death.

5. Significantly reduced transport time for patients with specialty resource needs (significant burns, pediatric trauma, etc.).

6. Patients who are likely to require advanced procedures/medications/*blood* ~~beyond the scope of practice~~ *not available on* ground ~~providers~~ *ambulances*.

7. Delayed accessibility to the scene by ground personnel and/or transport resources.

~~8. Initial dispatch for significant trauma mechanism or time-sensitive medical condition with ground transport provider time to scene ≥20 minutes.~~

E. HEMS aircraft transportation should not be used for the following patients:

1. Trauma patients meeting only mechanism of injury criteria

2. Patients with CPR in progress.

3. Patients contaminated by hazardous materials who cannot be completely decontaminated prior to transport.

4. Patients who are combative, uncooperative, or have behavioral emergencies. However, a patient may be transported at the discretion of the flight crew.

F. The most medically qualified provider on scene has the authority/obligation to ensure that the patient meets HEMS aircraft utilization criteria. If the patient does not meet HEMS aircraft utilization criteria, the flight crew may transfer care to the ground ambulance for transport to the most appropriate facility.

G. HEMS Aircraft Requesting and Coordination:

1. For incidents likely meeting HEMS utilization criteria, appropriate HEMS resources should be requested early by applicable dispatch or ground EMS personnel, and may be cancelled prior to lift off, overhead or at scene when appropriate.

2. An air ambulance should be utilized for any incident that does not require the need for air rescue operations. Rescue aircraft may be utilized when, in the opinion of the most medically qualified provider at scene, the patient's condition warrants immediate transport and/or air ambulance resources are not readily available. Consideration should be given to airway stabilization and/or the need for higher level medical procedures.

3. No air ambulance shall respond to an EMS incident in the S-SV EMS region without the request of a designated air ambulance coordination center.

4. HEMS aircraft shall be requested by the IC/designee on scene, through the PSAP of the agency having jurisdiction over the incident. A responding ground EMS provider may request appropriate HEMS resources while enroute to an incident ('rolling request'), if they believe the patient/event meets HEMS utilization criteria.

    - If communication with the IC is not possible or practical, HEMS aircraft shall be requested through the applicable PSAP.
    - If a private ambulance arrives on scene before the arrival of public safety personnel, HEMS aircraft shall be requested through the applicable PSAP. If unable to contact the PSAP directly from the field, the private ambulance dispatch center may be used to relay the request to the PSAP.

5. HEMS aircraft requests received from providers still enroute may be overridden by the IC/designee on scene. Excluding safety reasons, the IC/designee shall consult with the most medically qualified provider on scene to determine the necessity for HEMS aircraft.

6. The PSAP shall utilize the following procedures, based on the type and availability of HEMS aircraft resource requested:

    - Air ambulance resource request:
        - Contact the designated air ambulance coordination center for air ambulance resource requesting.
    - Rescue aircraft resource request:
        - The PSAP is responsible for contacting the applicable air rescue provider directly for resource requests.

7. PSAPs are required to provide the following information to the air ambulance coordination center or air rescue provider for all HEMS aircraft resource requests:

- Incident or LZ location: the general geographic location will suffice.
- Nature of call: type of incident and severity of injuries, if known.
- The designated LZ contact – as follows:
  - Identified by incident name (i.e., 'Jones Road LZ'), if HEMS aircraft is being requested to respond directly to the incident scene; or
  - Identified by LZ name (i.e., 'Rood Center LZ'), if HEMS aircraft is being requested to respond to a pre-established local/regional LZ location.
- Any known aircraft hazards in the area, including hazardous materials, other aircraft, or inclement weather conditions at the scene.

8. The air ambulance coordination center will complete the following for all air ambulance resource requests:

- Verify the incident/LZ location and identify the closest air ambulance.
- Contact the closest air ambulance provider to obtain their availability to respond to the incident.
  - If the air ambulance resource is available and accepts the request, they will be assigned to the incident by the air ambulance coordination center.
  - If the air ambulance resource is unavailable/declines the request, the air ambulance coordination center will contact the next closest air ambulance provider to obtain their availability to respond to the incident. This process will continue until an air ambulance is assigned, or it is determined that no timely air ambulance resources are available to respond to the incident.
  - Air ambulance coordination centers shall consider the location of an available airborne air ambulance in determining the closest resource to the incident when this information is known to the coordination center.
  - Air ambulance providers who have multiple aircraft shall accept/decline the request based on the availability of the specific aircraft resource requested.
  - The air ambulance provider will be allowed up to five (5) minutes to check weather. If the air ambulance provider does not accept/decline the assignment within five (5) minutes, the air ambulance coordination center will re-contact the air ambulance provider to confirm their status prior to contacting the next closest air ambulance provider.
    - If an air ambulance provider declines due to inclement weather at the incident/LZ location, it is unlikely that an alternate air ambulance provider will subsequently accept the request. The IC/designee shall be notified of this information as soon as possible. Personnel on scene may consider appropriate alternatives (utilizing an alternate LZ/rendezvous location; requesting the availability of rescue aircraft which are allowed to operate under different weather minimums; initiating ground ambulance transport; etc.).
- Relay the assigned air ambulance resource identifier and initial ETA to the requesting PSAP.

9. The requesting PSAP shall notify all responding agencies when a HEMS aircraft has been requested/assigned and shall keep responding agencies updated as to the HEMS aircraft status (delays, aborts, etc.).

10. HEMS aircraft personnel are responsible for communicating to the requesting PSAP any response delays or aborts in a timely manner.

11. Once assigned to an incident, HEMS aircraft shall not commit/respond to another assignment unless cancelled by the initial incident requestor.

12. *HEMS aircraft shall remain enroute to an incident until one of the following events has occurred:*

    - *No patients are found at scene or the responders are unable to locate the incident.*
    - *The highest-level medical provider on scene has completed a comprehensive physical assessment of the patient(s). Following assessment, the highest-level medical provider may, through the IC/designee, cancel the aircraft if it is determined that ground transport would be more appropriate.*

13. If multiple aircraft are responding to or in the area of the incident, the air ambulance coordination center and/or the requesting PSAP shall notify all agencies of multiple aircraft responders.

14. All parties are responsible for informing HEMS aircraft providers of inclement weather related to the response, including previous HEMS aircraft providers who declined the flight due to weather conditions (at base, enroute, or at scene).

15. CALCORD operational frequency (156.075) should be utilized for air-to-ground communication. The IC/designee will communicate to all responding agencies if an alternate frequency will be utilized for the event.

H. Ground Provider Responsibilities:

1. If the event is a declared MCI, the IC/designee is responsible for notifying all responding HEMS aircraft of such.

2. If required by S-SV EMS policies/protocols, the most medically qualified provider on scene shall contact the appropriate facility for patient destination consultation prior to EMS aircraft arrival (when possible).

3. ~~If ground personnel are at scene,~~ The IC/designee shall assign appropriate personnel to establish/prepare a landing zone (LZ) and assure scene safety during landing. The LZ should meet the following criteria:

    - 100' x 100' open area, clear of hazards, obstacles, sloped terrain, loose surface materials, animals, overhead wires, foreign object debris (FOD).
    - If the LZ is on a dirt surface, assure that the area is watered down to reduce the risk of brown out upon aircraft landing.
    - Locate the LZ upwind from any incident with known hazardous materials.

4. *The IC/designee shall have the authority for allowing a HEMS aircraft to land at scene. Notwithstanding,* the pilot has final authority to determine if a landing is appropriate, including instances when no ground personnel are at scene.

5. Ground personnel shall not approach the aircraft under a running/hot rotor unless accompanied by HEMS personnel.

6. If requested, ground EMS personnel may accompany a patient in a rescue aircraft if the appropriate medical equipment is available and they have received an adequate safety briefing prior to transport.

7. S-SV EMS Transfer of Patient Care policy shall be followed, and a verbal patient care report shall be provided to HEMS aircraft personnel.

I. HEMS Aircraft Provider Responsibilities:

1. *Each permitted HEMS resource is responsible for reporting to and maintaining current availability status with the S-SV EMS web-based communications and resource management platform.*

2. HEMS aircraft providers are expected be enroute within 15 minutes of incident acceptance. Response delays shall be documented in the PCR.

3. HEMS aircraft providers are expected to transport within 15 minutes from *at* ~~the time~~ patient ~~contact is made~~. Scene delays shall be documented in the PCR.

4. The pilot in command shall have the final authority in decisions to continue or abort the response. The pilot may also dictate the need to identify an alternate LZ/ rendezvous location.

5. S-SV EMS Patient Destination policies/protocols shall be followed for ~~all~~ patients requiring HEMS aircraft transport. Patients shall be transported to the closest/most appropriate hospital with an approved helipad or HEMS aircraft landing site. The pilot in command has the authority to deviate from S-SV EMS patient destination policies.

6. HEMS aircraft providers are required to submit an abort report to S-SV EMS anytime a flight request has been accepted and the provider is unable to arrive at the incident or complete the requested transport due to any reason other than being cancelled by the requestor or if it is determined that HEMS transport is not needed. These reports must be submitted through the following link within 48 hours of the event. https://www.ssvems.com/hems-aircraft-aborted-flight-reporting-form/

Sierra – Sacramento Valley EMS Agency Program Policy			
Management Of Controlled Substances			
	Effective: DRAFT	Next Review: DRAFT	**710**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To ensure accountability in the management of controlled substances utilized by ALS/ LALS prehospital service provider agencies/personnel.

AUTHORITY:

A. Code of Federal Regulations, Title 21.

B. HSC, Div. 2.5 & Div. 10.

C. CCR, Title 22, Div. 9.

POLICY:

A. S-SV EMS Approved Controlled Substances:

1. Fentanyl.

2. Ketamine.

3. Midazolam.

B. Obtaining Controlled Substances:

Prehospital service provider agencies shall obtain controlled substances through one of the following methods:

1. The medical director of the prehospital service provider agency.

2. The base/modified base hospital shall ensure that a mechanism exists for prehospital service provider agencies to contract for the provision of controlled substances.

C. Prehospital Service Provider Agency Controlled Substances Policies/Procedures:

1. Prehospital service provider agencies shall ensure that security mechanisms and procedures are established for controlled substances, including, but not limited to:

   - Controlled substance ordering & order tracking.
   - Controlled substance receipt & accountability.
   - Controlled substance master supply storage, security & documentation.
   - Controlled substance labeling & tracking.
   - Controlled substance vehicle storage & security.
   - Controlled substance usage procedures & documentation.
   - Controlled substance reverse distribution.
   - Controlled substance disposal.
   - Controlled substance re-stocking procedures.

2. Prehospital service provider agencies shall ensure that mechanisms for investigation and mitigation of suspected controlled substance tampering or diversion are established, including, but not limited to:

   - Controlled substance testing.
   - Controlled substance discrepancy reporting.
   - Controlled substance tampering, theft & diversion prevention/detection.
   - Controlled substance usage audits.

D. Controlled Substance Security:

1. AEMT II and paramedic personnel are responsible for maintaining the correct inventory of controlled substances at all times.

2. All controlled substances shall be stored/secured in one of the following manners:

   - Preferred: Secured in a commercially developed drug locker specifically designed for controlled substance storage. The drug locker shall be securely mounted to the vehicle to prevent theft and shall have an electronic access keypad with an individual PIN code assigned to each individual authorized to access/utilize controlled substances. The drug locker shall be able to produce an electronic audit trail showing the date, time and PIN code of each instance the locker was opened. The double lock requirement does not apply to providers storing their controlled substance utilizing this method.
   - Alternative: Secured in the vehicle under double lock, in an appropriate manner to prevent theft. The outside driver/passenger/patient access door(s) of the vehicle shall not be considered one of the two locks.

3. Prehospital service provider agencies shall abide by all State and Federal laws/ regulations related to the storage/security of controlled substances.

4. Each unit shall maintain a standardized written record of the controlled substance inventory. Controlled substance inventory and administration records shall be maintained in accordance with all applicable State and Federal laws/regulations.

5. Controlled substances shall be inventoried any time there is a change in personnel. The key to access the controlled substances, if applicable, shall be in the custody of the individual who performed the inventory.

6. Any discrepancies in the controlled substance count shall be reported as soon as possible to an appropriate supervisor and the issuing agent. A discrepancy report must be appropriately documented.

E. Controlled Substances Administered to Patients:

1. Controlled substances shall be administered in accordance with applicable S-SV EMS policies/protocols.

2. The following information must be documented on a controlled substance administration record:

- Date & time administered.
- Unit number.
- Patient name.
- Drug administered.
- Amount administered.
- AEMT II or paramedic signature & number.

3. If only a portion of the controlled substance was administered to the patient, the remainder shall be wasted *in accordance with the prehospital service provider agency's policy/procedure. At a minimum, this policy/procedure shall require that unused controlled substance wastage be done in the presence of another EMS or receiving hospital provider (EMT or above), and that both individuals document this action on the applicable controlled substance administration form.* ~~in the presence of a registered nurse or physician at the receiving hospital, or the provider's immediate supervisor. Both parties shall document this action on the controlled substance administration form.~~

4. Controlled substance inventories/logs are subject to inspection by the California Board of Pharmacy, Bureau of Narcotic Enforcement Administration of the Justice Department, Federal Drug Enforcement Administration, S-SV EMS, the issuing agent, and/or officers of the prehospital service provider agency.

Sierra - Sacramento Valley EMS Agency 2026 Calendar

January						
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S-SV EMS Holidays - Office Closed

S-SV EMS Agency Public & RDMHS/MHOAC Meetings

JPA Board of Directors Meeting 1:00 pm - 3:00 pm
• Feb. 13, 2026
• Apr. 10, 2026
• Jun. 12, 2026
• Aug. 14, 2026
• Oct. 9, 2026
• Dec. 11, 2026

REMAC Meeting 9:00 am - 12:00 pm
• Jan. 14, 2026
• Apr. 8, 2026
• Jul. 8, 2026
• Oct. 14, 2026

S-SV EMS Agency Non-Public QA/QI Meetings

Prehospital Advisory Committee 9:00 am - 12:00 pm
• Jan. 21, 2026
• Apr. 15, 2026
• Jul. 15, 2026
• Oct. 21, 2026

STEMI QI Committee 9:00 am - 11:00 am
• Mar. 10, 2026
• Sep. 8, 2026

Stroke QI Committee 9:00 am - 11:00 am
• Mar. 11, 2026
• Sep. 9, 2026

Trauma QI Committee 11:00 am - 3:00 pm
• May 7, 2026
• Dec. 3, 2026

S-SV EMS Agency Accreditation/ Orientation Classes

Paramedic, Flight Nurse, & MICN Accreditation/Orientation 9:00 am - 1:00 pm	
• Jan. 7, 2026	• Jul. 1, 2026
• Feb. 4, 2026	• Aug. 5, 2026
• Mar. 4, 2026	• Sep. 2, 2026
• Apr. 1, 2026	• Oct. 7, 2026
• May 6, 2026	• Nov. 4, 2026
• Jun. 3, 2026	• Dec. 2, 2026

S-SV EMS Agency Office/Meeting Locations

Rocklin (Open to the Public)
535 Menlo Drive, Suite A
Rocklin, CA 95765

Redding (Meetings/Classes Only)
1255 East Street, Second Floor
Redding, CA 96001

Telephone Number: (916) 625-1702
Email Addess: info@ssvems.com