Sierra – Sacramento Valley EMS Agency

Regional Emergency Medical Advisory Committee (REMAC)

MEETING AGENDA

MEETING DATE & TIME INFORMATION

- **Wednesday, January 14, 2026, 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 sending an email to Jared.Gunter@ssvems.com.

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 Consent Policy/Protocol Action Items** These policies/protocols items are due for routine review, with no substantive changes recommended by S-SV EMS staff or the S-SV EMS Medical Director. All Consent Policy/Protocol Actions will be approved by a single vote. Anyone may ask to address specific Consent Policy/Protocol Action items prior to the committee acting, and the item(s) may be removed for additional discussion.	**Chairperson**
	211: S-SV EMS Prehospital Advisory Committee	
	416: Alternate Transport Vehicles	
	812: Base/Modified Base/Receiving Hospital Contact	
	838: Crisis Standard of Care Procedures (including addendums A, B, C, D)	
F	**S-SV EMS Discussion Policy/Protocol Action Items**	**S-SV EMS Staff**
	307: Ambulance Patient Offload Time (APOT) (Including addendum A)	Poland
	462: Temporary Recognition of EMS Personnel	Quirk
	605: EMS Documentation	Moss/Pohley
	848: Reduction/Cancellation of ALS Response	Quirk
	C-1: Non-Traumatic Pulseless Arrest	Pohley
	C-1P: Pediatric Pulseless Arrest	Pohley
	C-4: Tachycardia With Pulses	Pohley
	G-2: Determination Of Death	Moss/Pohley
	M-2P: Newborn Care/Neonatal Resuscitation	Pohley
	R-3P: Pediatric Respiratory Distress	Pohley
	T-6: Traumatic Pulseless Arrest	Moss/Pohley
	G-1: Multiple Patient Incidents & Regional Multiple Casualty Incident (MCI) Plan	Pohley
G	**EMS Aircraft Provider Reports**	**Attendees**

Sierra – Sacramento EMS Agency – REMAC Meeting Agenda

ITEM	TITLE	LEADER
H	**EMS Ground Provider Reports**	**Attendees**
I	**Hospital Provider Reports**	**Attendees**
J	**Quality Improvement (QI) & Case Review**	**Pohley**
K	**S-SV EMS Agency Reports**	**S-SV EMS Staff**
	EMS Data System	McManus
	Regional Specialty Committees	Moss
	S-SV EMS Drug Reference Guide	Moss
	S-SV EMS Regional Training Module	Pohley
	Operations	Comstock
	Regional Executive Director	Poland
	Medical Director	Falck, MD
	Next Meeting/Adjournment: April 15, 2026	**Chairperson**

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

MEETING MINUTES

Meeting Date
Tuesday, October 28, 2025

A. Call to Order/Introductions

- Dr. Royer called the meeting to order at 9:00 am, and all attendees introduced themselves.

B. Approval of Previous Minutes: July 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 its annual EMS-A-Palooza on December 8. This will be posted on the S-SV EMS website.

E. S-SV EMS Policy Actions

Policy Actions for Final Review & Approval:

Policy	Name	Motion	Second	Committee Vote
411	**LALS/ALS Provider Agency Responsibilities** • There were no proposed changes.	Dr. Iwai	Dr. Morris	Passed Unanimously
414	**911 Ground Ambulance Dispatch Requirements** • There were no proposed changes.	Dr. Iwai	Dr. Morris	Passed Unanimously
504	**Emergency Department Downgrade/Cessation** • The only change is on page 2, lines 19-20 (Item 10) were removed.	Dr. Iwai	Clayton Thomas	Passed Unanimously

450	**HEMS Aircraft Authorization, Classification & Operations** • On page 4, Item 7, lines 10-13 removed. Added "Each permitted HEMS resource is responsible for maintaining current availability status in EMResource." • No other changes.	Dr. Iwai	Clayton Thomas	Passed Unanimously
621	**HEMS Aircraft Quality Management** • No suggested changes, except to update the regulations.	Dr. Iwai	Clayton Thomas	Passed Unanimously
862	**HEMS Aircraft Requesting & Utilization** • On page 1, the regulations were updated. • On page 2, under Policy, added Item 'A' Medical Control. Under Item A, added items 1 and 2. Under Item C, added items 1 and 2. • On page 4, item 6, added '/blood', and removed 'beyond the scope of practice', and added 'not available on', and 'ambulances'. Item E, line 27, added number 1, 'Trauma patients meeting only mechanism of injury criteria'. • On page 7, added item 12. • On page 8, removed the first sentence of line 1. On line 11, added 'The IC/designee shall have the authority for allowing a HEMS aircraft to land at scene. Notwithstanding,'. Under Item I, added number 1, lines 27-29. On line 34, added 'at' and removed 'the'. Line 35 removed 'time', and 'contact is made'. Line 41 removed the word 'all'. • On page 9, added Item 6. • It was suggested, on page 4, Item 6, to replace the back slashes with commas, and to add 'and/or' before 'blood'. • It was suggested to replace any bullet points, in any policy/protocol, with letters and/or numbers to denote items. • On page 7, item 12, line 17, it was recommended to replace 'comprehensive' with 'appropriate'.	Dr. Iwai	Josh Vicars	Passed Unanimously

710	**Management of Controlled Substances** • This was brought back to talk about wastage of controlled substances. • Sutter Roseville will no longer be wasting controlled substances for EMS. • S-SV EMS is an outlier in the State as far as this goes. • Page 3, Item 3, lines 32-36 were added, lines 37-39 were removed. This modification allows providers to modify their own policies. • The National Association of EMS Physicians recently had a webinar, managed by the DEA, regarding EMS agencies to obtain DEA registration. This is not allowed in California currently. This is being worked on at a state level.	Dr. Iwai	Clayton Thomas	Passed Unanimously
	S-SV EMS Drug Reference Guide • This is not a policy/protocol at this point. • A drug reference guide is a fantastic tool that some agencies use. • It's a reference guide for all drugs used for ALS. It includes reactions, contra-indications, dosages, etc., within the scope. • This was created by PAC members. • This would remove all drug info, other than the name of the drug, and would clean up the protocols/policies. Paramedics would reference the drug reference guide for details. • Other LEMSAs are using this. Paramedics really like having this tool. • If this committee is interested, Brittany will bring samples of what that would look like to the next meeting.			

F. EMS Aircraft Provider Updates

- REACH – For the last few weeks they've been supporting the Redding area. REACH 50 fixed wing aircraft is back in service this week. REACH 5 should go back in service tomorrow.

G. Ground EMS Provider Updates

- Dignity Health:
  - Wrapping up the end of the year trainings/requirements.
  - Moving to tablet command in Tehama and Shasta counties. This should improve call responses/times.

- Roseville FD
  - Josh Vicars introduced himself. He is replacing Rochelle Gregory.

H. Hospital Provider Reports

- No reports.

I. Quality Improvement (QI) Case Review

- The case was presented by Kristin Hammond (Sierra College), Chris Wade (Rocklin Fire), (AMR) and Debbie Madding (Sutter Roseville).
- There was a lot of good discussion.
- The next case was presented by Kelly Craig (Placer Hills FD), and Debbie Madding (Sutter Roseville).
- There was some discussion regarding Code-2 vs Code-3 and documentation.

J. S-SV EMS Agency Reports

- **EMS Data System**
  - Recent communication regarding the State's transition from NEMSIS 3.5 to 3.5.1.
  - Initially there was a big push by the State to get everyone transitioned by January 1, 2026.
  - The State has now moved the date back to summer of 2026.
  - S-SV providers have all been transitioned by Jeff McManus.
- **Regional Specialty Committees**
  - Jared Gunter conducted the most recent STEMI meeting. STEMI QI committee members received an email recently regarding dates/times for next year's meetings. The October STEMI meeting was the first time a virtual option was offered and went well.
  - The next Trauma QI meeting is on December 4. These meetings will remain in-person meetings.
- **Operations**
  - Whitney Sullivan, the Certification Specialist, recently left S-SV EMS for a job with Sierra College. Please be patient while S-SV transitions to the new Certification Specialist who starts on 11/10.
  - S-SV EMS is finishing up all the provider ambulance inspections and will finish by the end of the year.
- **Regional Executive Director's Report**
  - Glenn Medical Center Hospital closure has occurred. S-SV EMS has been motoring the EMS data for their county on a weekly basis and has been producing a weekly report for the EMS providers in that area.
    - For the first few weeks of October there wasn't a significant negative impact on the EMS system. The response times, on average, are almost the same as they were last year.
    - The average transport times are significantly increased due to the next hospital being much farther away.
    - Almost all the patients are going to Enloe Medical Center.
    - S-SV will continue to monitor this.
    - The system seems stable so far.

- APOT – the state audit tool went into effect in July. July/August were learning months for everyone. The State asked S-SV to trial the tool. S-SV gave the state a lot of feedback- that they didn't take.
  - There are opportunities to clean-up the data.
  - Make sure crews are documenting as accurately as possible.
  - Jeff McManus has developed a Power BI tool that is on the website and updates itself every day at 8am. Providers can look at specifics.
  - If anyone is seeing duplicates in the audit tool, let Mr. Poland know.
- The EMS Authority had several high-level staff come out for the tour of the Sutter Roseville and Kaiser Roseville facilities. Mr. Poland attended this as well.
  - There were a lot of good conversations.
- The AMR/Placer County EOA agreement has been finalized and signed.
  - This is a 2-year EOA agreement.
  - This was approved by the JPA Board a couple weeks ago.
  - The First Watch online compliance utility is being utilized for this. AMR is already using this tool in Yolo County.
- Consultants for S-SV have finished the Western Placer County EMS System Assessment. S-SV is working with them on the final document. This should be available in the next 2 weeks. A formal presentation will be made to the JPA Board in December. This meeting likely will not be in the Rocklin building but close by – and this information will be distributed to everyone.
- EOA Agreements – Within the last 2 weeks, Mr. Poland has received direction from Nevada, Yuba and Sutter Counties to move forward with renewal agreements for Sierra Nevada Ambulance, and Bi-County Ambulance in those counties. All three agreements expire 12/31/26. In January, S-SV will begin meeting with all stakeholders to begin the process.
- 2026 Meeting Calendar
  - REMAC meetings – starting in January, the meetings would move to the second Wednesday of each month (quarterly).
  - Accreditation classes will be on the first Wednesday of each month in 2026.
  - Once all meeting dates are finalized, the 2026 calendar will be distributed.
- Legislation
  - There wasn't a lot of EMS legislation this year.
  - AB645 – requires that by 1/31/27, every 911 PSAP in the state of California to at least provide some minimal pre-arrival instructions. There are six specific items: airway and choking, medical instructions for infants, children and adults, AED and CPR instructions for children and adults, childbirth bleeding control and hemorrhage, administration of epi and administration of naloxone for overdose.
    - Most of the S-SV 911 dispatch centers at least provide these services or have a process in place to transfer certain calls for those services. But for those that don't, they have until January of 2027 to implement those. S-SV will be working with a few of those PSAPs as appropriate.
  - The Governor's office has made it clear that he does not want to see any more EMS legislation for the rest of his term.
- Regulations
  - Chapter 1 - is a new chapter of EMS regulations regarding EMS administration. It has to do with LEMSA responsibilities, RFPs, 201, 224, and things that have been somewhat nebulous for a long time. These are regulations that should have been implemented 40 years ago when the EMS Act was done, but they never

were. The EMS authority is working through feedback provided by partners and experts to start the formal OAL rulemaking process within the next couple months – in early 2026.

- Chapter 3, which are the professional standards, are the new EMT, Advanced EMT and Paramedics. The state is potentially going to add EMR into those regulations when they update them as well. EMSA is reviewing the current regulations to identify areas that need updating. EMSA has already agreed that they need to be updated to more closely match the national standards and the national scope of practice.
- Chapter 4 - EMS personnel discipline. EMSA is also reviewing those to identify areas that need updating and will move forward with that.
- Chapter 5 is the community paramedicine triage alternate destination. EMSA is reviewing the current regulations to identify areas that need updating. There was a law that was passed last year that was supposed to update those regulations.
- Chapter 6 - these ones are moving forward. These are the trauma STEMI, Stroke and EMS for children. They've already gone through two public comment periods and they're going to have a two-week public comment period sometime within the next couple of months, and then those will move forward to the EMS commission for final review and approval and implementation.
    - Most of the S-SV STEMI, Stroke, and Trauma systems are already set up to match what's already in there. One of the things that's being added to the traumas is the requirement that every trauma center will have to be ACS verified. All S-SV Trauma Centers (Levels 1-3) are already ACS verified.

K. Medical Director's Report

- S-SV is starting to discuss the 2026 mandatory training. There will likely be a strong emphasis on pediatric training.
- There are a lot of providers that haven't completed the 2025 training. Please encourage everyone to get this done before the end of the year.
    - There was a Medic with a question regarding Protocol M-8. His question was answered off-line.

L. Next Meeting Date & Adjournment

- The next meeting will be on January 14, 2026, at 9:00 am.
- The meeting was adjourned at 11:28 am.

Sierra – Sacramento Valley EMS Agency Program Policy			
S-SV EMS Prehospital Advisory Committee			
	Effective: DRAFT	Next Review: DRAFT	**211**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish a Prehospital Advisory Committee for the continuous quality assessment/ improvement of prehospital care in the S-SV EMS region, and to assist the S-SV EMS Agency in ensuring prehospital medical care is consistent with best practices and evidence-based medicine.

AUTHORITY:

A. HSC, Division 2.5, § 1797.

B. CCR, Title 22, Div. 9, ~~Chapters 3, 4, 8, & 12~~ *Ch. 3.2, Ch. 3.2, Ch. 3.3, Ch. 7, Ch. 10.*

C. California Evidence Code § 1157.7

DESCRIPTION:

A. The S-SV EMS Prehospital Advisory Committee is a multi-disciplinary peer-review committee composed of representatives from public and private ALS ground and HEMS providers within the S-SV EMS region.

B. The committee process will be based on review of prehospital cases and S-SV EMS policies/protocols, selected by S-SV EMS staff, or requested by committee members.

C. The committee is responsible for the following:

1. Providing EMS system quality improvement and policy/protocol recommendations to S-SV EMS.
2. Assisting S-SV EMS in monitoring/evaluating EMS system performance metrics.
3. Discussing current EMS trends/research and collaborating to share experiences and best practices for optimal prehospital care.
4. Providing standardized ongoing review of prehospital medical care.
5. Assisting the S-SV EMS Medical Director in identifying and monitoring trends related to prehospital care in the S-SV EMS region.

COMMITTEE MEMBERSHIP:

A. The committee will be comprised of the following members, who are actively working in the field and are in good standing with S-SV EMS:

1. Two (2) Paramedic or RN representatives from S-SV EMS authorized air ambulance providers.
2. One (1) Paramedic representative from an S-SV EMS authorized air rescue provider.
3. Six (6) Paramedic/AEMT/EMT representatives from S-SV EMS authorized public ALS service provider agencies.
4. Six (6) Paramedic/AEMT/EMT representatives from S-SV EMS authorized private ALS service provider agencies.
5. S-SV EMS will maintain a list of alternate members from the above provider disciplines to serve on the committee in the absence of a primary member(s).

B. S-SV EMS committee representatives will include the following:

1. EMS Specialist – Quality Management.
2. Deputy Director – Specialty Programs/Clinical Quality Management.
3. Other S-SV EMS personnel as appropriate/required.

C. Member nominations will be solicited from S-SV EMS authorized prehospital provider agencies and committee members will be selected/appointed by S-SV EMS.

D. Committee members must remain in good standing in the S-SV EMS system, and will serve until removed for cause, resign, or are replaced by S-SV EMS.

E. At the discretion of S-SV EMS, other professionals may be invited to participate in committee activities when their expertise is essential to the quality improvement process and confidentiality requirements are met.

MEETINGS/ATTENDANCE:

A. The committee will meet on a regular basis, as determined by S-SV EMS.

B. S-SV EMS staff will facilitate committee meetings, set the meeting agenda, and ensure committee decisions are acted upon.

C. Committee members should attend a minimum of 75% of meetings per year. S-SV EMS may replace members who are not meeting minimum attendance expectations.

D. Committee members should notify S-SV EMS in advance of the meeting if unable to attend.

E. Resignation from the committee shall be submitted to S-SV EMS in writing.

VOTING:

Occasionally the committee may need to resolve committee matters by vote. S-SV EMS staff will decide when to call a vote. Each member of the committee who is present at the meeting shall have one (1) vote, and a simple majority shall determine the resolution.

MINUTES:

S-SV EMS staff will record and maintain confidential minutes of all meetings. Previous meeting minutes will be distributed to committee members at the beginning of the next meeting for review/comment. Due to the confidential nature of meeting materials, all copies of minutes and other confidential materials shall be collected at the end of each meeting.

CONFIDENTIALITY:

A. To the extent California Evidence Code § 1157.7 is applicable, closed meetings will occur when business addressed under 1157.7 is being transacted. The committee's 1157.7 business, records and minutes shall be considered confidential, and all members are prohibited from any unauthorized disclosures.

B. Members and attendees will sign a statement of confidentiality as a condition of participation.

Sierra – Sacramento Valley EMS Agency Program Policy			
Alternate Transport Vehicles			
	Effective: DRAFT	Next Review: DRAFT	**416**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish requirements for the utilization of alternate transport vehicles in the S-SV EMS region.

AUTHORITY:

A. HSC, Division 2.5, § 1797.

B. CCR, Title 13, § 1100.2 and 1108.

C. CCR, Title 22, Div. 9, *Ch. 3.1, Ch. 3.2, Ch. 3.3*.

DEFINITIONS:

A. **Alternate Transport Vehicle –** An S-SV EMS approved vehicle utilized by a non-transport EMS ground provider that has been specially constructed, modified or equipped for transporting sick, injured, or otherwise incapacitated persons.

B. **Authorized Transport Provider –** An S-SV EMS authorized helicopter EMS (HEMS) aircraft or ground ambulance transport provider.

C. **Landing Zone –** A location where a HEMS aircraft can land to allow for expeditious and safe transfer of a patient from EMS ground to HEMS aircraft personnel.

D. **Rendezvous Point –** A location, mutually agreed to by on-scene EMS personnel and responding authorized transport provider personnel, which will allow for expeditious and safe transfer of a patient from alternate transport vehicle to authorized ground transport provider personnel.

POLICY:

On limited occasions, alternate transport vehicles may be utilized to transport patients to rendezvous with an authorized HEMS aircraft or ground transport provider at a landing zone or rendezvous point, rather than waiting for the authorized transport provider to arrive on scene.

PROCEDURE:

A. A risk/benefit assessment, including consideration of the following items, shall be completed prior to transporting a patient utilizing an alternate transport vehicle:

1. Is the transport in the best interest of the patient?
2. What is the alternate transport vehicle's ETA to the landing zone or rendezvous point?
3. What is the ETA of the responding authorized transport provider to the scene, landing zone and/or rendezvous point?
4. If transporting to a landing zone, would the alternate transport vehicle be waiting at the landing zone for HEMS aircraft to arrive or would it be more appropriate to remain on scene for an approved ground transport provider without significantly delaying transfer of patient care to HEMS aircraft personnel?

B. The following criteria shall be met prior to transporting a patient utilizing an alternate transport vehicle:

1. Utilization of the alternate transport vehicle is expected to result in a shorter total transport time from the scene to the most appropriate acute care hospital.
2. The alternate transport vehicle can provide for safe patient transportation in accordance with S-SV EMS policies.

C. If the alternate transport vehicle can provide a higher level of care than the closest authorized transport provider, and the patient requires this higher level of care, the alternate transport vehicle may rendezvous directly with the closest authorized transport provider able to provide a similar or higher level of care.

D. An alternate transport vehicle shall not transport a patient directly to the hospital unless specifically approved by an S-SV EMS authorized base/modified base hospital.

E. An S-SV EMS approved patient care report (PCR) shall be completed for any patient transported in an alternate transport vehicle.

Sierra – Sacramento Valley EMS Agency Program Policy			
Base/Modified Base/Receiving Hospital Contact			
	Effective: DRAFT	Next Review: DRAFT	**812**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To define the circumstances under which prehospital personnel shall establish base, modified base, and/or receiving hospital contact for medical control, patient destination and/or patient notification purposes.

AUTHORITY:

A. HSC, Division 2.5, § 1797.220, 1798, 1798.2, 1798.102.

B. CCR, Title 22, Div. 9, ~~Chapters 2, 3 and 4~~ *Ch. 3.1, Ch. 3.2, Ch. 3.3*.

POLICY:

A. Prehospital personnel shall make appropriate hospital contact in a timely manner according to the requirements contained in this policy.

B. Base/modified base hospital contact is required by prehospital personnel to perform procedure(s) and/or administer medications(s) that are identified in S-SV EMS policies/protocols as 'Base/Modified Base Hospital Order Only'. In the event of communication failure, those procedures/medications may still be utilized if the patient's condition warrants such treatment.

C. Base/modified base hospital contact is required by prehospital personnel to perform procedure(s) and/or administer medications(s) that are identified in S-SV EMS policies/protocols as 'Base/Modified Base Hospital Physician Order Only'. In the event of communication failure those procedures/medications shall not be utilized.

D. When requesting to speak directly to a base/modified base hospital physician, prehospital personnel shall advise the hospital staff member who initially answers the telephone or radio of the reason for the request.

E. Prehospital personnel may provide minimum necessary patient identifying information (name, DOB, MR#, etc.) when requested by the receiving hospital. A secured communication line (e.g. landline, cellular telephone) shall be used for these purposes if available.

PROCEDURE:

A. Prehospital personnel shall contact the base/modified base hospital that is in closest proximity to the incident for any of the following circumstances:

1. For authorization to perform procedures and/or administer medications that are indicated in S-SV EMS policies/protocols as 'Base/Modified Base Hospital Order Only' or 'Base/Modified Base Hospital Physician Order Only'.

2. For patients refusing assessment, treatment and/or transportation as required by S-SV EMS Refusal Of EMS Care Policy (Reference No. 850).

3. For destination consultation on the following types of patients:

   a. Burn patients who require destination consultation as required by S-SV EMS Burns Treatment Protocol (Reference No. T-5).

   b. When there is initiation of an ALS/LALS protocol and transport to a facility other than the most accessible is being considered, except for the following types of patients meeting criteria for transport directly to a designated specialty care facility:

      i. STEMI patients as defined in S-SV EMS Chest Discomfort/Suspected Acute Coronary Syndrome (ACS) Protocol (Reference No. C-6): If a STEMI patient is within the authorized catchment area of a designated STEMI receiving center, contact shall be made directly with the designated STEMI receiving center.

      ii. Stroke patients as defined in S-SV EMS Stroke Protocol (N-3): If a suspected stroke patient is within the authorized catchment area of a designated stroke receiving center, contact shall be made directly with the stroke receiving center.

      iii. Patients who meet Field Trauma Triage Criteria, when required/directed by S-SV EMS General Trauma Management Protocol (Reference No. T-1).

      Note: These exceptions do not apply to patients who require transport to the closest facility (i.e. – unable to establish an airway, CPR in progress).

4. For any patient who, in the opinion of the prehospital provider, requires the additional input or judgment of the base/modified base hospital for appropriate management.

B. Prehospital personnel shall make contact directly with the destination facility, in a timely manner, for any patient who does not meet the above criteria or when base/modified base contact is made and the patient is authorized/directed to be transported to a facility other than the base/modified base hospital initially contacted.

Sierra – Sacramento Valley EMS Agency Program Policy			
Crisis Standard Of Care Procedures			
	Effective: DRAFT	Next Review: DRAFT	**838**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To provide a mechanism for altering the EMS system in response to an unprecedented demand for medical/health services beyond the capacity of current system providers and resources available through local, regional, state, and/or federal mutual aid.

AUTHORITY:

A. HSC, Article 1, § 101040.

B. HSC, Div. 2.5, § 1797.172.

C. CCR, Title 13, Div. 2, Ch. 5, Art. 1, § 1100.3.

D. CCR, Title 22, Div. 9.

DEFINITIONS:

A. **Operational Area (OA) –** An intermediate level of the State of California emergency organization, consisting of a county and all political subdivisions within the geographical boundaries of the county.

B. **Medical/Health Operational Area Coordinator (MHOAC) –** The public health officer/designee who is responsible for obtaining and coordinating services and allocation of resources within the OA in the event of a disaster or major incident where mutual aid is requested. The MHOAC role is shared between the public health officer/designee and S-SV EMS administrator/designee in some counties and assumed by the public health officer/designee alone in other counties (838-D).

C. **OA EOC –** The OA (county) Emergency Operations Center.

D. **Crisis Standard of Care –** A level of medical care delivered to individuals under conditions of duress (disaster, pandemic, etc.), or when medical/health resources are insufficient for demand.

E. **Quick Response Vehicle (QRV) –** A non-transport vehicle staffed with at least one AEMT or Paramedic and equipped with appropriate medical equipment/supplies.

F. **Field Treatment Site (FTS) –** A site activated to manage casualties/medical evacuees when the local area capacity to rapidly treat/place these individuals at an established medical facility is overwhelmed. A FTS is used for the assembly, triage, medical stabilization and subsequent evacuation of casualties to an established

medical facility when necessary/available. An FTS provides medical care for a period of up to 72 hours, or until patients are no longer arriving at the site. FTS activation, coordination, and support is managed from the Medical/Health Branch of the OA EOC and supported by the public health department and S-SV EMS.

G. **Alternate Care Site (ACS) –** A location that is not currently providing healthcare services and will be converted to enable the provision of healthcare services to support inpatient and/or outpatient care required after a declared catastrophic emergency. These specific sites are not part of the expansion of an existing healthcare facility but rather are designated under the authority of the local government. ACSs are established by the public health department with support from the OA EOC and S-SV EMS. Activation of an ACS usually requires a minimum of 72 hours. ACSs may also be activated to provide on-going treatment to injured patients when a FTS is demobilized and hospital capacity is still overwhelmed.

ASSUMPTIONS:

A. The Medical/Health Branch of the OA EOC or MHOAC has established collaboration with the S-SV EMS medical director and other affected agencies to coordinate EMS system response changes.

B. Mutual-aid resources are scarce or unavailable.

C. Appropriate waivers, proclamations, and/or declarations required to implement specific medical/health system changes have been identified and secured.

PROCEDURE:

A. MHOAC and S-SV EMS Collaboration:

1. During a significant incident, prior to a locally declared emergency, the S-SV EMS medical director should collaborate with the affected county public health officer, Office of Emergency Services (OES), and other appropriate agencies to modify the EMS delivery system to meet increased demand.

2. During a locally declared emergency, the MHOAC or Medical/Health Branch Director of the OA EOC should collaborate with the S-SV EMS medical director, and other appropriate agencies, to modify the EMS delivery system to meet increased demand.

B. System Access:

1. The MHOAC and S-SV EMS should collaborate with the OA EOC to establish priorities for 911 medical-aid response based upon available system resources.

2. The MHOAC and S-SV EMS should collaborate to complete the Crisis Standard Of Care EMS System Orders (838-B) and inform all public safety answering points (PSAPs), ambulance dispatch centers, control facilities (CFs), hospitals, and EMS providers of these orders to maintain the stability of the EMS system.

3. The MHOAC and S-SV EMS should collaborate to ensure notification of all medical/health system providers that a public access telephone number (e.g. 211) and/or website for individuals seeking minor medical care, social services and/or other non-emergent needs has been established.
4. The OA EOC, in cooperation with the MHOAC and S-SV EMS, should consider establishing FTSs for rapid triage, treatment and referral.
5. The MHOAC and S-SV EMS should collaborate to authorize altered triage and response protocols for the 911 system, including consideration of the following:
    a. Suspension of emergency medical dispatch (EMD) pre-arrival instructions.
    b. Implementation of symptom-specific triage (i.e., specialized EMD specific to a pandemic outbreak).
    c. Implementation of the Altered 911/EMD Triage Algorithm (838-A).
6. The OA EOC, in cooperation with the MHOAC and S-SV EMS, should consider establishing a transport center for medical transport requests from all system access points (public access numbers, PSAPs, EMS providers, FTSs, ACSs, hospitals, other healthcare facilities), including consideration of the following:
    a. Augmenting medical transportation with alternative vehicles (buses, taxis, etc.).
    b. Developing and implementing a medical transportation scheduling process.
    c. Working with designated CFs to direct destinations of transport resources (including ACSs, clinics, etc.).

C. EMS Response:

1. The OA EOC, in cooperation with the MHOAC and S-SV EMS, should consider:
    a. Establishing EMS muster stations to consolidate personnel, equipment, supplies, and emergency response/transport vehicles.
    b. Expanding available EMS resources by converting all ambulances to BLS transport units (EMR/EMT staffing) and implementing QRVs with available AEMT or Paramedic personnel.
        i. QRVs may consist of supervisor vehicles, other company vehicles, shared resources from other emergency response agencies, rental vehicles, private vehicles, etc.
        ii. QRVs will be equipped with appropriate communications equipment, LALS/ALS equipment and supplies, etc.
    c. Implementation of Crisis Standard Of Care Prehospital Treatment Orders (838-C) to establish alternative treatment and transport of patients in the prehospital setting.

d. Developing additional disaster caches to augment EMS supplies (i.e., flu cache of electrolyte replacement fluids, ibuprofen, Pepcid, etc.).

e. Developing, equipping and deploying a specialty response team to respond to specific types of patients.

2. The OA EOC should work collaboratively with the MHOAC and S-SV EMS to develop a family/patient brochure for distribution by EMS personnel to the public, which may include the following:

a. Explanation of the current healthcare situation and the crisis standard of care directions currently being implemented.

b. Preventive measures to avoid exposure to the applicable health threat(s).

c. Available community resources (public access telephone number, website, etc.).

D. Just-In-Time Training:

EMS provider agencies, in cooperation with the OA EOC, MHOAC and S-SV EMS, should develop just-in-time training for prehospital personnel to include:

1. Altered 911/EMD Triage Algorithm (838-A).
2. Crisis Standard Of Care EMS System Orders (838-B).
3. Crisis Standard Of Care Prehospital Treatment Orders (838-C).
4. Family/patient brochure.
5. Consideration of other appropriate just-in-time training (grief support, etc.).

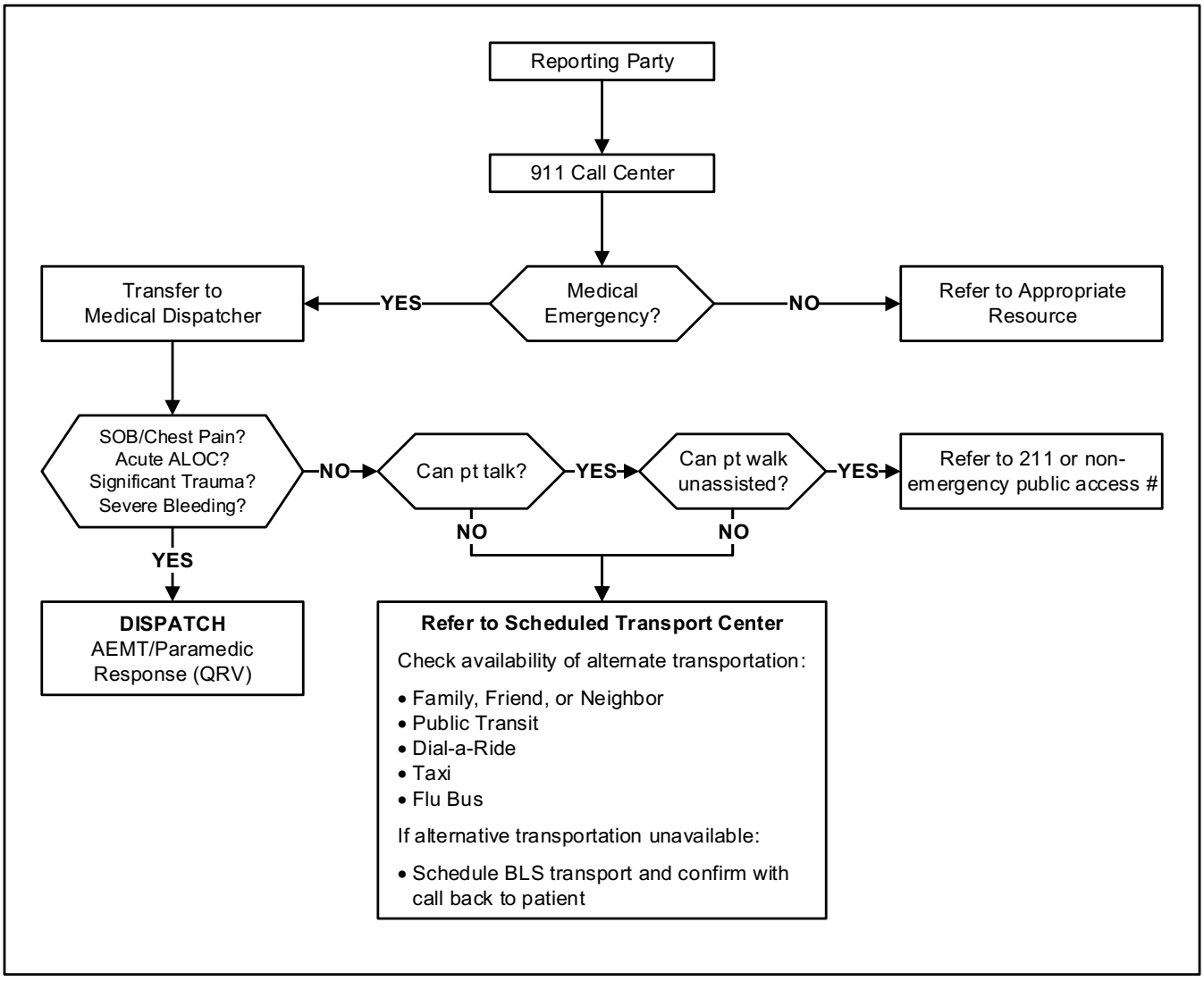
EXAMPLES:

Example of Altered 911/EMD Triage

Access Point	Symptom Specific	Immediate	Delayed	Minor	Deceased
Public Access #	Refer to Symptom Specific ACS	Refer to 911	Refer to Scheduled Transport Center	TBD	TBD
PSAP/ Ambulance Dispatch	Dispatch Specialty Unit/Team	ALS Response	Refer to Scheduled Transport Center	Refer to Public Access #	Refer to Public Access #
Scheduled Transport Center	Dispatch Specialty Unit/Team	ALS Response	Schedule Transport	Refer to Public Access #	Refer to Public Access #
Prehospital EMS	Transport to Symptom Specific ACS	Treat & Transport	Treat & Release or Refer	Refer to Public Access #	Witnessed: Attempt resuscitation Unwitnessed: Refer to Public Access #

Example of Altered EMS System Response

- All ambulances staffed with BLS personnel (EMR/EMT).
- All AEMT and Paramedic personnel assigned to QRVs to respond to patients with immediate medical needs (AEMT/Paramedic personnel may be placed on supervisor vehicles, fire apparatus, or deployed in other non-traditional EMS response vehicles).
- After providing on-scene medical care/intervention, patients are handed off to a BLS transport unit, making the QRV available to respond to the next call in need of ALS intervention.
- Other options may include treat & release, referral to public access telephone number, referral to transport center for scheduled transport to hospital or other medical facility, etc.


Reporting Party
911 Call Center
Medical Emergency?
YES
Transfer to Medical Dispatcher
NO
Refer to Appropriate Resource
SOB/Chest Pain? Acute ALOC? Significant Trauma? Severe Bleeding?
NO
Can pt talk?
YES
Can pt walk unassisted?
YES
Refer to 211 or non-emergency public access #
YES
NO
NO
DISPATCH AEMT/Paramedic Response (QRV)
Refer to Scheduled Transport Center
Check availability of alternate transportation:
• Family, Friend, or Neighbor
• Public Transit
• Dial-a-Ride
• Taxi
• Flu Bus
If alternative transportation unavailable:
• Schedule BLS transport and confirm with call back to patient

	Crisis Standard Of Care EMS System Orders	838-B

NOTICE

ORDERS MUST BE CONFIRMED VERBALLY WITH AN S-SV EMS REPRESENTITIVE

The following actions shall be implemented immediately to maintain the stability of the EMS delivery system. All PSAPs, ambulance dispatch centers, EMS provider agencies and personnel shall be informed of these orders. If it is not possible to provide a copy of this form electronically, these orders may be relayed verbally to all affected agencies and personnel.

Effective Date/Time:	End Date/Time:

Affected OA(s): ☐ Butte ☐ Colusa ☐ Glenn ☐ Nevada ☐ Placer ☐ Shasta ☐ Siskiyou ☐ Sutter ☐ Tehama ☐ Yuba

CRISIS STANDARD OF CARE EMS SYSTEM ORDERS

Name:	Title:
Signature:	Date/Time:

Operating as an agent of the S-SV EMS Agency, I hereby authorize the following orders

	Order #	Initial to Execute	DESCRIPTION
DISPATCH	CSO-1		**Notify all on-duty dispatch personnel of Crisis Standard of Care EMS System Orders**
	CSO-2		**Notify all on-duty EMS units/personnel of Crisis Standard of Care EMS System Orders**
	CSO-3		**Conduct a roll call to determine status and welfare of on-duty units** Contact each unit to determine status and ability to respond. This may be used following an incident when ambulance resources may have been compromised.
	CSO-4		**Place all available ambulances in service** Place all available ambulances in service and make them available for 911 system response. Dispatchers shall assign BLS ambulances to any appropriate event. Once assigned to an event, the BLS ambulance should not be canceled because of ALS availability.
	CSO-5		**Dispatch BLS ambulances to Alpha, Bravo and code 2 EMS calls** Once assigned, the BLS ambulance should remain on the event even if the call is upgraded. If ALS is required, first responder (FR)/Quick Response Vehicle (QRV) personnel should provide this service (if available).
	CSO-6		**Automatic ambulance dispatches suspended until verified by FR/QRV personnel** Ambulances should only be dispatched to calls when a patient has been identified to need immediate transportation by FR/QRV personnel. Patients not in immediate need will not be transported.
	CSO-7		**Ambulance dispatches to Alpha, Bravo and code 2 EMS calls are suspended**
	CSO-8		**PSAPs may discontinue use of emergency medical dispatching (EMD) procedures** Implement Altered Triage Algorithm (Reference No. 838-A)
	CSO-9		**Implement Pandemic EMD Triage Card**

	Crisis Standard Of Care EMS System Orders	838-B

	Order #	Initial to Execute	DESCRIPTION
CONTROL FACILITY	CSO-10		**Use of non-traditional patient transport resources (buses, taxis, etc.) are authorized**
	CSO-11		**Notify all hospitals of Crisis Standard of Care System Orders**
	CSO-12		**Suspend system communications on _____ radio frequency** Notify all hospitals that use of the _____ radio frequency is suspended and allocated for EMS command net communications.
	CSO-13		**Direct all ambulance patient destinations (including alternate care sites, clinics, etc.)**
EMS PROVIDERS	CSO-14		**Implement/continue ambulance system surge actions**
	CSO-15		**Alert all EMS command staff (managers, supervisors, etc.)**
	CSO-16		**Activity Suspension** Announce to all on-duty units that the following activities have been suspended: ☐ Off-duty times ☐ Meal breaks ☐ Inter-facility transports.
	CSO-17		**Ambulances shall transport to the closest open emergency department**
	CSO-18		**Ambulances shall contact the control facility for all patient destinations**
	CSO-19		**Replace ePCRs with interim patient care reports or triage tags** Discontinue use of ePCRs and replace with written interim patient care reports or triage tags for patient care documentation purposes.
	CSO-20		**Move all ambulances to muster stations** All available ambulances shall be staged at the following muster locations: **RESOURCE** **LOCATION** #1 _____ _____ #2 _____ _____

Notes:

Discontinue the following orders:

Total number of actions to execute:	**Total number of actions to discontinue:**

	Crisis Standard Of Care Prehospital Treatment Orders	838-C

NOTICE

ORDERS MUST BE CONFIRMED VERBALLY WITH AN S-SV EMS REPRESENTITIVE

The following actions shall be implemented immediately to maintain the stability of the EMS delivery system. All PSAPs, ambulance dispatch centers, EMS provider agencies and personnel shall be informed of these orders. If it is not possible to provide a copy of this form electronically, these orders may be relayed verbally to all affected agencies and personnel.

Effective Date/Time:	End Date/Time:

Affected OA(s): ☐ Butte ☐ Colusa ☐ Glenn ☐ Nevada ☐ Placer ☐ Shasta ☐ Siskiyou ☐ Sutter ☐ Tehama ☐ Yuba

CRISIS STANDARD OF CARE PREHOSPITAL TREATMENT ORDERS

Name:	Title:
Signature:	Date/Time:

Operating as an agent of the S-SV EMS Agency, I hereby authorize the following orders:

Initial to Execute	General Prehospital EMS Directions
	Implement changes to accommodate BLS transport

Adult Treatment Protocols

Initial to Execute	Treatment Protocol	Altered Treatment	Altered Disposition
	C-1 Non-Traumatic Pulseless Arrest	No treatment	Refer to Public Access #
	C-2 Return of Spontaneous Circulation	No change	Schedule BLS transport
	C-3 Bradycardia With Pulses	No change	Schedule BLS transport
	C-4 Tachycardia With Pulses	No change	Schedule BLS transport
	C-5 Ventricular Assist Device	No change	Schedule BLS transport
	C-6 Chest Discomfort/Suspected ACS	No change	Schedule BLS transport
	R-1 Airway Obstruction	No change	Schedule BLS transport
	R-2 Respiratory Arrest	Attempt to open & establish airway if appropriate	Refer to public access # for deceased - schedule BLS transport for all others
	R-3 Acute Respiratory Distress	No change	Schedule BLS transport
	M-1 Allergic Reaction/Anaphylaxis	No change	Schedule BLS transport

Adult Treatment Protocols (continued)			
Initial to Execute	**Treatment Protocol**	**Altered Treatment**	**Altered Disposition**
	M-3 Phenothiazine/Dystonic Reaction	No change	Schedule BLS transport
	M-5 Ingestions & Overdoses	No change	Schedule BLS transport
	M-6 General Medical Treatment	Treat for shock if indicated - trial of PO fluids & OTC antiemetic	Schedule BLS transport
	M-8 Pain Management	No change	Schedule BLS transport
	M-9 CO Exposure/Poisoning	No change	Schedule BLS transport
	M-11 Behavioral Emergencies	No change	Schedule BLS transport
	N-1 Altered Level of Consciousness	No change	Competent adults with normal V/S, blood glucose & mental status 10 min after ALS intervention may be released-at-scene if their condition cause & solution have been identified
	N-2 Seizure	No change	Competent adults with normal V/S, blood glucose & mental status 10 min after ALS intervention may be released-at-scene if their condition cause & solution have been identified
	N-3 Suspected Stroke	No change	Schedule BLS transport
	OB/G-1 Childbirth	No change	Schedule BLS transport
	OB/G-2 Obstetric Emergencies	No change	Schedule BLS transport
	E-1 Hyperthermia	No change	Schedule BLS transport
	E-2 Hypothermia & Avalanche Resus.	No change	Schedule BLS transport
	E-3 Frostbite	No change	Schedule BLS transport
	E-4 Bites/Envenomations	No change	Schedule BLS transport
	E-7 Hazardous Materials Exposure	No change	Schedule BLS transport
	E-8 Nerve Agent Treatment	No change	Schedule BLS transport

Adult Treatment Protocols (continued)			
Initial to Execute	**Treatment Protocol**	**Altered Treatment**	**Altered Disposition**
	T-1 General Trauma Management	If shock develops & does not respond to IV bolus of 2000 ml, provide palliative care only - provide immobilization, ice packs and pain control (EMS or OTC pain meds as appropriate) - clean wounds with soap and water, remove foreign bodies/debris, irrigate with NS or clean water as available & apply dressings - signs of infection require a higher level of care	Schedule BLS transport
	T-2 Crush Injury/Crush Syndrome	No change	Schedule BLS transport
	T-3 Suspected Moderate/Severe TBI	No change	Schedule BLS transport
	T-4 Hemorrhage	No change	Schedule BLS transport
	T-5 Burns	No change	Schedule BLS transport
	T-6 Traumatic Pulseless Arrest	No treatment	Refer to Public Access #
Pediatric Treatment Protocols			
	C-1P Pediatric Pulseless Arrest	No treatment	Refer to public access #
	C-3P Pediatric Bradycardia – With Pulses	No change	Schedule BLS transport
	C-4P Pediatric Tachycardia – With Pulses	No change	Schedule BLS transport
	R-1P Pediatric Foreign Body Airway Obstruction	No change	Schedule BLS transport
	R-2P Pediatric Respiratory Arrest	Attempt to open & establish airway if appropriate	Refer to public access # for deceased - schedule BLS transport for all others
	R-3P Pediatric Respiratory Distress	No change	Schedule BLS transport
	M-1P Pediatric Allergic Reaction/ Anaphylaxis	No change	Schedule BLS transport
	M-2P Newborn Care/Neonatal Resuscitation	No change	Schedule BLS transport
	M-5P Pediatric Overdose/Poisoning	No change	Schedule BLS transport
	M-6P Pediatric General Medical Treatment	No change	Schedule BLS transport
	M-8P Pediatric Pain Management	No Change	Schedule BLS transport

Pediatric Treatment Protocols (continued)			
Initial to Execute	**Treatment Protocol**	**Altered Treatment**	**Altered Disposition**
	M-11P Pediatric Behavioral Emergencies	No change	Schedule BLS transport
	N-1P Pediatric Altered Level of Consciousness	No change	Schedule BLS transport
	N-2P Pediatric Seizure	No change	Schedule BLS transport
	T-3P Pediatric Suspected Moderate/ Severe TBI	No change	Schedule BLS transport

Additions/Notes:

Medical & Health Disaster Responsibilities By Primary Entity

838-D

PHD = Public Health Department (Primary)					SSV = Sierra-Sacramento EMS Agency (Primary)						
PREPAREDNESS	**Butte**	**Colusa**	**Glenn**	**Nevada**	**Placer**	**Shasta**	**Siskiyou**	**Sutter**	**Tehama**	**Yuba**	**COMMENT**
1. OA medical/health disaster plan development	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	*SSV responsible for MCI Plan
2. Ensure 24-hour MHOAC contact for RDMHC/S	**PHD**	**PHD**	**PHD**	**PHD**	**SHARED PHD/SSV**	**SHARED PHD/SSV**	**SHARED PHD/SSV**	**SHARED PHD/SSV**	**PHD**	**SHARED PHD/SSV**	Contact MHOAC thru PHD or PSAP
RESPONSE	**Butte**	**Colusa**	**Glenn**	**Nevada**	**Placer**	**Shasta**	**Siskiyou**	**Sutter**	**Tehama**	**Yuba**	**COMMENT**
1. Assessment of immediate medical needs	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	*Prehospital EMS **Other medical/ health providers
2. Coordination of disaster medical/health resources	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	*SSV coordinates prehospital EMS
• Approve medical/health mutual-aid requests	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	***SSV **PHD**	*Prehospital EMS **Other medical/ health providers
• Assist in coordination of medical/health disaster resources in OA	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	*In coordination with EOC when activated (SSV to liaison with prehospital EMS)
• Authorize release of medical/health caches to be used by field	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	According to local plans/procedures
• Authorize release of medical/health caches to be used by hospital	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	According to local plans/procedures
• Coordinate reception of medical mutual aid	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	***PHD**	*In coordination with EOC when activated (SSV to liaison with prehospital EMS)

This matrix outlines medical & health disaster planning/response responsibilities within the Operational Area (County). Please refer to individual County Emergency Operations plans to identify lead agencies for specific types of incidents.

RESPONSE (cont.)	Butte	Colusa	Glenn	Nevada	Placer	Shasta	Siskiyou	Sutter	Tehama	Yuba	COMMENT
3. Coordination of patient distribution/evaluations	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	*Prehospital EMS **All other
4. Coordination with inpatient and emergency providers	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	***SSV ****PHD**	*Prehospital EMS **All other
5. Coordination of out of hospital medical care providers (facilities)	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	**PHD**	
6. Coordination/integration with FD and FD EMS	**Local Provider**	**Local Provider**	**Local Provider**	**Local Provider**	**Local Provider**	**Local Provider**	**Local Provider**	**Local Provider**	**Local Provider**	**Local Provider**	
• Plan automatic & mutual aid	**Local Provider**	**Local Provider**	**Local Provider**	**Local Provider**	**Local Provider**	**Local Provider**	**Local Provider**	**Local Provider**	**Local Provider**	**Local Provider**	
• Authorize EMS system austere care/alternate treatment standards	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	*In coordination with PHD & local providers
• Authorize modified EMD &/or deviation from unit dispatch standards	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	*In coordination with PHD & local providers
• Authorize non-standard patient transport (buses, private vehicles etc.)	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	*In coordination with PHD & local providers
7. Coordination of non-fire based prehospital EMS	**SSV**	**SSV**	**SSV**	**SSV**	**SSV**	**SSV**	**SSV**	**SSV**	**SSV**	**SSV**	
• Plan automatic & mutual aid	***Local Provider**	***Local Provider**	***Local Provider**	***Local Provider**	***Local Provider**	***Local Provider**	***Local Provider**	***Local Provider**	***Local Provider**	***Local Provider**	*In coordination with SSV
• Authorize EMS system austere care/alternate treatment standards	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	*In coordination with PHD & local providers
• Authorize modified EMD &/or deviation from unit dispatch standards	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	***SSV**	*In coordination with PHD & local providers

This matrix outlines medical & health disaster planning/response responsibilities within the Operational Area (County). Please refer to individual County Emergency Operations plans to identify lead agencies for specific types of incidents.

RESPONSE (cont.)	Butte	Colusa	Glenn	Nevada	Placer	Shasta	Siskiyou	Sutter	Tehama	Yuba	COMMENT
• Authorize non-standard patient transport (buses, private vehicles etc.)	*SSV	*SSV	*SSV	*SSV	*SSV	*SSV	*SSV	*SSV	*SSV	*SSV	*In coordination with PHD & local providers
8. (A) Coordinate establishment of field treatment sites	*PHD	*PHD	*PHD	*PHD	*PHD	*PHD	*PHD	*PHD	*PHD	*PHD	*SSV coordinates prehospital EMS
(B) Coordinate establishment of alternate care sites	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	
9. Health surveillance and epidemiological analysis of community health status	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	
10. Assurance of food safety	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	
11. Management of exposure to hazardous agents	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	
12. Provision or coordination of mental health services	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	
13. Provision of medical/health public information protective action recommendations	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	
14. Provision or coordination of vector control services	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	
15. Assurance of drinking water safety	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	
16. Assurance of the safe management of liquid, solid, and hazardous wastes	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	
17. Investigation and control of communicable diseases	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	PHD	

This matrix outlines medical & health disaster planning/response responsibilities within the Operational Area (County). Please refer to individual County Emergency Operations plans to identify lead agencies for specific types of incidents.

Sierra – Sacramento Valley EMS Agency Program Policy			
Ambulance Patient Offload Time (APOT)			
	Effective: DRAFT	Next Review: DRAFT	**307**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

A. To establish standards for the timely and efficient transfer of patient care from EMS prehospital personnel to *receiving* hospital emergency department (ED) personnel.

B. To establish standardized methodologies for collecting, calculating, and reporting Ambulance Patient Offload Time (APOT).

AUTHORITY:

A. HSC, Div. 2.5, Chapter 4, Article 1, § 1797.120.5, § 1797.120.6, § 1797.120.7, § 1787.225, § 1797.227 & § 1797.228.

B. CCR Title 22, Div. 9, Ch. 1.2, Ch. 3.1, Ch. 3.2, Ch. 3.3 ~~Chapter 3 & Chapter 4~~.

DEFINITIONS:

A. ***Ambulance Patient Offload Delay (APOD)*** *– An APOT, measured from the arrival of an ambulance patient at an ED ambulance bay (NEMSIS data element eTimes.11) to the time that patient care is transferred to an ED gurney, bed, chair, or other acceptable location and the ED assumes responsibility for the patient (NEMSIS data element eTimes.12), which exceeds the APOT standard established by this policy.*

B. **Ambulance Patient Offload Time (APOT) –** The time interval between the arrival of ~~a 911~~ an ambulance patient at a hospital ED ambulance bay *(NEMSIS data element eTimes.11)* and the time that patient is transferred ~~from the ambulance cot~~ to ~~the~~ *an* ED gurney, bed, chair or other acceptable location, and *the* ED ~~medical personnel~~ assume*s* ~~complete~~ responsibility for care of the patient *(NEMSIS data element eTimes.12)*.

C. **APOT 1.1** – An APOT time interval measure. This metric is a continuous variable measured in minutes, aggregated, and reported as a median.

D. **APOT 1.2** – An APOT interval measure. This metric is a continuous variable measured in minutes, aggregated, and reported as a 90th percentile. *The 90th percentile means 90% of the applicable patient population had an APOT at or below the reported time and 10% of the applicable patient population had an APOT above the reported time.*

E. **APOT 2** – An APOT time interval process measure. This metric demonstrates the incidence of ambulance patient offload times expressed as a percentage of total EMS patient transports within a thirty (30) minute target, and exceeding that time in reference to 60-, 120- and 180-minute intervals.

POLICY:

~~A. APOT Documentation and Standards:~~

~~1. EMS prehospital personnel shall adequately document APOT on all incidents.~~

~~a. All incident times, including 'Patient Arrived at Destination Date/Time' and 'Destination Patient Transfer of Care Date/Time' shall be accurately documented in the electronic patient care report.~~

~~b. Any misrepresentation of APOT documentation in the electronic patient care report is a serious infraction, which may result in disciplinary action.~~

~~2. The expectation is that all ambulance patients are transferred from the ambulance cot/equipment to the ED gurney, bed, chair or other acceptable location, and ED medical personnel assume complete responsibility for care of the patient as soon as possible after ED arrival. The standard APOT for the S-SV EMS region is 30 minutes, and 911 ambulance patients shall have an APOT time of 30 minutes or less, 90% of the time. The following time measurements exceed/significantly exceed S-SV EMS APOT standards:~~

~~c. Exceeds APOT Standard:~~

~~o APOT 1.1: 31 – 40 minutes~~

~~o APOT 1.2: 31 – 40 minutes~~

~~o APOT 2: 31 – 60 minutes~~

~~d. Significantly Exceeds APOT Standard:~~

~~o APOT 1.1: Greater than 40 minutes~~

~~o APOT 1.2: Greater than 40 minutes~~

~~o APOT 2: Greater than 60 minutes~~

~~B. APOT Calculations/Reporting:~~

~~1. APOT calculations will be completed by S-SV EMS staff on a monthly basis, utilizing electronic patient care report data from the S-SV EMS data system.~~

~~a. Incidents with obvious data errors, that cannot be subsequently resolved/ verified, will be excluded from APOT calculations and reporting.~~

~~2. S-SV EMS will produce/publish a system-wide APOT report on a monthly basis. This APOT report will be available to all EMS system participants as well as the general public.~~

~~3. S-SV EMS will provide APOT data to the California EMS Authority, as required by current statutes and regulations.~~

~~4. S-SV EMS will utilize the following National Emergency Medical Services Information System (NEMSIS) Version 3.5 (V3.5) data codes, descriptions, and criteria to calculate, evaluate and report APOT measures:~~

~~NEMSIS V3.5 Data Code~~	~~NEMSIS V3.5 Data Description~~	~~Criteria/ Calculation~~
~~dAgency.03~~	~~EMS Agency Name~~	~~All S-SV EMS Authorized Emergency Transport Providers~~
~~eResponse.05~~	~~Type of Service Requested~~	~~Emergency Response (Primary Response Area)~~
~~eDisposition.30~~	~~Transport Disposition~~	~~Transport by This EMS Unit (This Crew Only); or Transport by This EMS Unit, with a Member of Another Crew~~
~~eDisposition.21~~	~~Type of Destination~~	~~Hospital-Emergency Department~~
~~eDisposition.01~~	~~Destination/Transferred To, Name~~	~~Hospitals receiving emergency pts transported by ambulance~~
~~eTimes.11 eTimes.12~~	~~Patient Arrived at Destination Date/Time Destination Patient Transfer of Care Date/Time~~	~~Calculation = Difference (in minutes) between eTimes.11 & eTimes.12~~

A. APOT Standard:

1. The S-SV EMS APOT 1.2 (90th percentile) standard is as follows:

a. Effective 4/1/2026: 25 Minutes

b. Effective 10/1/2026: 23 Minutes

c. Effective 4/1/2027: 20 Minutes

B. *Prehospital EMS Provider APOT Documentation Requirements:*

1. *The prehospital EMS provider electronic patient care record (ePCR) shall serve as the legal record for all APOT data within the S-SV EMS and California Emergency Medical Services Information System (CEMSIS) data collection systems.*

2. *Prehospital EMS provider agencies/personnel shall:*

   a. *Be permitted to use GPS vehicle tracking technology or automatic vehicle location (AVL) technology to automatically populate or retrospectively verify the 'patient arrived at destination date/time' (NEMSIS data element eTimes.11) documented within the ePCR.*

   b. *Collect an electronic signature within the ePCR (NEMSIS data element eOther.19) from ED personnel at the time of transfer of care for each patient transported to an ED.*

   c. *Ensure the date and time entered within the ePCR for the "destination transfer of care" time (NEMSIS data element eTimes.12) is viewable to ED personnel upon collection of the transfer of care electronic signature.*

   d. *Ensure that the 'patient arrived at destination date/time' (NEMSIS data element eTimes.11) and 'destination patient transfer of care date/time' (NEMSIS data element.12) are accurately documented within the ePCR for all patients transported to an ED.*

   e. *Adequately investigate identified possible APOD data discrepancies within 10 business days of a notification from a receiving hospital or S-SV EMS.*

      i. *If the EMS prehospital provider agency agrees with the identified possible discrepancy, they shall correct the relevant data field(s) within the applicable ePCR and resubmit the revised record within five (5) business days of confirming the discrepancy. An ePCR addendum is not a sufficient method of correcting APOD data discrepancies.*

      ii. *If the EMS prehospital provider agency disagrees with the identified possible discrepancy, they shall notify the reporting entity of such and the original ePCR documented time(s) will not be changed.*

C. *Receiving Hospital Facility/Personnel Requirements:*

1. *Receiving hospitals are responsible for developing, implementing and maintaining policies and procedures that facilitate the timely and efficient transfer of patient care from EMS prehospital personnel to ED personnel upon ED arrival.*

2. *At the time ED personnel receive the physical transfer of patient care and report from EMS personnel, they shall provide an electronic signature within the ePCR that confirms the transfer of care.*

3. *Receiving hospitals may utilize the California EMS Authority (EMSA) PHI-secure electronic portal to review applicable CEMSIS APOT data for patients transported by ambulance to their ED. As is reasonable, S-SV EMS may also provide additional APOT data reports to receiving hospitals upon request.*

    a. *If the receiving hospital identifies a possible discrepancy between the EMS prehospital provider agency ePCR reported patient arrival (NEMSIS data element eTimes.11) or transfer of care time (NEMSIS data element eTimes.12) and their records, and the reported APOT exceeds the standard established by this policy, they shall notify the relevant EMS transport provider agency and/or S-SV EMS of the possible discrepancy in a timely manner. Possible discrepancies identified in the EMSA PHI-secure electronic portal must be identified/reported no later than the 15th calendar day of the month for data submitted in the preceding calendar month.*

4. *Receiving hospitals shall develop and submit an APOT reduction protocol electronically to EMSA (apot@emsa.ca.gov) with the subject line: "APOT Reduction Protocol – [Hospital Name]" in a PDF or Microsoft Word format. The APOT reduction protocol shall be submitted to EMSA annually on or before June 30th and shall include all required data elements and action plans defined in the Receiving Hospital Ambulance Patient Offload Time (APOT) Reduction Protocol Checklist (307-A).*

5. *If a receiving hospital has exceeded the S-SV EMS APOT standard for one month, they shall:*

    a. *Implement their APOT reduction protocol within 10 business days of receiving email notification/direction from EMSA to do so.*

    b. *Notify EMSA by email (apot@emsa.ca.gov) no later than twenty-four (24) hours after implementing their APOT reduction protocol to confirm compliance.*

    c. *When directed by EMSA, participate in EMSA-hosted bi-weekly calls to update and discuss implementation of the APOT reduction protocol and outcomes.*

D. S-SV EMS Agency Requirements:

1. *S-SV EMS will publish and regularly update APOT 1.1, APOT 1.2 and APOT 2 data on its agency website. As is reasonable, S-SV EMS will also provide additional APOT data reports to receiving hospitals upon request.*

2. *In coordination with applicable receiving hospitals and EMS prehospital provider agencies, S-SV EMS will review and validate APOT data and assist in resolving any identified discrepancies.*

3. *When directed by EMSA, S-SV EMS will participate in EMSA-hosted bi-weekly APOT coordination calls involving non-compliant hospitals, as referenced in this policy.*

	Receiving Hospital Ambulance Patient Offload Time (APOT) Reduction Protocol Checklist	**307-A**

PURPOSE

The purpose of this document is to establish requirements for the development and implementation of the APOT Reduction Protocol by hospitals. This protocol aims to ensure timely and efficient transfer of care for patients arriving by ambulance to improve operational efficiency and reduce APOT, in accordance with S-SV EMS standards. The information contained herein is intended to assist hospitals in meeting regulatory requirements, enhancing coordination, and improving patient outcomes through improved APOT practices.

HOSPITAL INFORMATION

Hospital Name:	
CDPH Hospital Licensing #:	
Hospital ED Address:	
CEO/President:	
CEO/President Email Address:	
CEO/President Phone Number:	
Primary Contact (ED Director/Manager):	
ED Director/Manager Email Address:	
ED Director/Manager Phone Number:	

APOT REDUCTION PROTOCOL CHECKLIST

The APOT reduction protocol was developed in consultation with ED staff and employee representatives.	☐
The APOT reduction protocol includes a process to notify hospital administrators, nursing staff, medical staff, & ancillary services if the S-SV EMS APOT standard has been exceeded for one month.	☐
The APOT reduction protocol includes mechanisms to improve hospital operations to reduce APOT. These may include, but are not limited to: 1) Activating the hospital's surge plan, 2) Transferring patients to other hospitals, 3) Suspending elective admissions, 4) Discharging patients, 5) Using alternate care sites, 6) Increasing supplies, 7) Improving triage and transfer systems, 8) Adding additional staffing.	☐
The APOT reduction protocol includes systems to improve coordination between the ED and other hospital departments, including consults for ED patients.	☐
The APOT reduction protocol includes direct operational changes designed to facilitate the rapid reduction of APOT to meet the S-SV EMS standard.	☐
The hospital shall submit its APOT reduction protocol to EMSA and report any revisions annually on or before June 30th. All updates should include required data elements and action plans.	☐

	Receiving Hospital Ambulance Patient Offload Time (APOT) Reduction Protocol Checklist	**307-A**

BASELINE HOSPITAL DATA	
Please provide the following baseline data for your hospital within your APOT reduction protocol.	
Total # of Licensed Beds:	
Average # of Staffed Hospital Beds (as a % of total licensed beds):	
% of Occupied Staffed Beds:	
% of Occupied Licensed Beds:	
Total # of Licensed ED Beds:	
Average # of Staffed ED Beds (as a % of total licensed ED Beds):	
Total Annual ED Visits:	
Average # of Daily ED Visits:	
Average # of Patients Arrived by EMS Daily:	
Average # of Patients with Behavioral Health Diagnosis Boarding Daily:	
Average # of Admitted Patients Boarding Daily:	
Average Number of Patients Pending Transfer Boarding Daily:	

APOT REDUCTION PROTOCOL ACTION PLAN
The APOT reduction protocol action plan must include strategies to manage APOT, including activation of hospital surge plans, utilization of hospital capacity tools, transferring patients, suspending elective admissions, discharging patients, using alternative care sites, increasing supplies, improving triage systems, and adding staff.

	Receiving Hospital Ambulance Patient Offload Time (APOT) Reduction Protocol Checklist	307-A

CAPACITY TOOL INFORMATION	
Please provide the following information regarding the use of a hospital capacity tool within your APOT reduction protocol.	
Does your hospital utilize a hospital capacity tool (e.g., NEDOCS)?	Yes ☐ No ☐
If yes, please provide the name of the hospital capacity tool used:	
If yes, summarize actions for each phase of the capacity tool:	
Level 1 or Green: Normal Operations:	
Level 2 or Yellow: Daily Operations:	
Level 3 or Orange: Overcrowded:	
Level 4 or Red: Overcapacity:	
Level 5 or Black: Critical Overcapacity:	
If your hospital does not use a hospital capacity tool, please describe your objective overcrowded assessment methods and associated action plans:	

Sierra – Sacramento Valley EMS Agency Program Policy			
Temporary Recognition Of EMS Personnel			
	Effective: DRAFT	Next Review: DRAFT	**462**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish a process for temporary recognition of EMS personnel on mutual aid/disaster incidents within the S-SV EMS region, to allow the S-SV EMS Medical Director to maintain adequate medical control of the EMS system and protect the public health and safety.

AUTHORITY:

A. HSC § 1797.202, § 1797.204, § 1797.206, § 1797.218, § 1797.220, 1797.227, § 1798.

B. CCR, Title 22, Div. 9, Ch. 3.1, Ch. 3.2, Ch. 3.3.

POLICY:

A. California Credentialed EMS Personnel

1. California Certified EMT Personnel:

   a. During a mutual aid/disaster response into the S-SV EMS region, a California certified EMT may utilize the scope of practice for which they are trained/ authorized according to the policies and procedures of the local EMS agency (LEMSA) where they are certified and/or employed as part of an organized EMS system.

2. California Certified Advanced EMT (AEMT) Personnel:

   a. During a mutual aid/disaster response into the S-SV EMS region, a California certified AEMT may utilize the scope of practice for which they are trained/ authorized according to the policies and procedures of the LEMSA within the jurisdiction where the AEMT is employed as part of an organized EMS system.

3. California Licensed/LEMSA Accredited Paramedic Personnel:

   a. A California licensed paramedic shall be affiliated with a LEMSA approved paramedic service provider to provide EMS care in the S-SV EMS region.

   b. During a mutual aid/disaster response into the S-SV EMS region, a California licensed/accredited paramedic employed by a LEMSA approved paramedic service provider may utilize the scope of practice for which they are trained/ accredited according to the policies and procedures of the accrediting LEMSA.

B. EMS Personnel not Credentialed in California

1. EMT/paramedic personnel not credentialed in California must obtain temporary recognition from S-SV EMS before they may provide EMS care within the S-SV EMS region. AEMT personnel not credentialed in California may only be granted temporary recognition to function as an EMT within the S-SV EMS region.

2. EMT/paramedic personnel not credentialed in California who have received temporary recognition from S-SV EMS may utilize the scope of practice for which they have been trained/authorized by a recognized EMS credentialling entity.

3. For the S-SV EMS Medical Director to maintain adequate medical control of the EMS system, and to protect the public health and safety, the following information/ documentation shall be submitted *by a Provider Organization* ~~to~~ and *be* approved by S-SV EMS prior to authorizing temporary recognition of EMT/paramedic personnel not credentialed in California.

Public EMS Provider Organization Requirements:

a. The public EMS provider organization, incident Medical Unit Leader (MEDL), or authorized designee shall submit the following EMS personnel documents to S-SV EMS at the time of incident assignment, which will be valid for the applicable incident assignment only:

i. Copies of current/valid EMS credentials for each EMT/paramedic.

ii. Confirmation that the EMT/paramedic is employed by and in good standing with the public EMS provider organization.

b. By requesting temporary recognition to provide EMS care within the S-SV EMS region, the public EMS provider organization agrees to submit all incident related patient care reports (PCRs) to S-SV EMS within 7 calendar days of incident demobilization, or within 24-hours of a request from an authorized S-SV EMS representative in response to an EMS complaint/ investigation related to an incident.

Private EMS Provider Organization Requirements:

a. A private EMS provider organization not authorized/permitted by a California LEMSA shall submit the following documents to S-SV EMS prior to operating within the S-SV EMS region (attachment 462-A):

i. Name, telephone number, and email address of the EMS provider organization's management contact and medical director.

ii. Copies of applicable EMS business license(s)/permit(s).

iii. A letter from the entity/state where the organization is authorized to provide EMS services, stating they are an authorized EMS provider in good standing.

iv. Identification of which patient care protocols will be utilized by the organization's EMS personnel (State EMS protocols, EMS provider organization protocols, etc.).

v. The organization's EMS documentation & data collection policy/process and an explanation of how the organization will submit incident PCRs to S-SV EMS.

vi. Attestation that the organization agrees to submit all incident related PCRs to S-SV EMS within 7 calendar days of incident demobilization, or within 24-hours of a request from an authorized S-SV EMS representative in response to an EMS complaint/investigation related to an incident.

vii. Copy of the organization's policy/process ensuring secure storage/ handling of controlled substances (if applicable).

viii. Copy of the organization's quality improvement plan/process.

ix. Attestation that any patient transport vehicle used in the provision of EMS services within the S-SV EMS region is mechanically sound and that the organization's personnel agree not to transport any patient from the incident directly to an acute care hospital without the direction/ approval of the IC, MEDL, or authorized designee.

b. A private EMS provider organization shall submit the following EMS personnel documents to S-SV EMS at the time of incident assignment, which will be valid for the applicable incident assignment only:

i. Copies of current/valid EMS credentials for each EMT/paramedic.

ii. A brief resume for each EMT/paramedic verifying a minimum of 1 year EMS experience.

iii. Confirmation that the EMT/paramedic is not under investigation by the employer or any applicable EMS personnel credentialling entity. If applicable, a summary of any open investigations shall also be included.

Incident Command/Management Requirements:

a. Confirmation from the incident Medical Unit Leader (MEDL), or authorized designee, that there is a need to utilize EMT/paramedic personnel not credentialed in California to meet the medical needs of the incident.

b. Submission of the California Emergency Medical Services Authority's 'REQUEST FOR TEMPORARY RECOGNITION OF OUT-OF-STATE EMS PERSONNEL RESPONDING ON MUTUAL AID IN CALIFORNIA' (EMSA-920) or equivalent form listing all applicable EMT/paramedic personnel and their relevant credentialing information (minimum of EMS provider level, certifying/ licensing entity & certification/license number).

PROCEDURE:

A. The incident MEDL, or authorized designee, shall notify S-SV EMS of any incident within the S-SV EMS region where an incident action plan (IAP) and incident medical plan involving the utilization of EMS personnel to provide incident related medical care has been established. The MEDL, or authorized designee, shall provide appropriate incident related medical system updates to S-SV EMS for the duration of the incident. S-SV EMS notifications required under this section of the policy shall be made in a timely manner, as incident conditions/personnel allow.

B. The following EMS personnel do not require S-SV EMS approval prior to utilizing their scope of practice identified in applicable California statutes/regulations and LEMSA policies/protocols (note: for medical control *and tracking* purposes, S-SV EMS notification of ~~these~~ personnel *names and credentials, including employer,* shall be made in a timely manner, as incident conditions/personnel allow).

1. Individuals with a current/valid California EMT certificate, regardless of EMS employer.

2. Individuals with a current/valid California AEMT certificate who are employed by an LALS/ALS provider approved by the LEMSA with whom they are certified.

3. Individuals with a current/valid California paramedic license and California LEMSA accreditation, who are employed by an ALS provider approved by the LEMSA with whom they are accredited.

C. EMT/paramedic personnel not credentialed in California must obtain temporary recognition from S-SV EMS before they may provide EMS care within the S-SV EMS region.

1. S-SV EMS staff, under the direction of the S-SV EMS Medical Director, will evaluate all submitted documentation as it relates to a request for temporary recognition of EMT/paramedic personnel not credentialed in California.

   a. It is recommended that the private EMS provider organization information/ documents required by this policy (attachment 462-A, excluding the incident specific EMS personnel credentialling documents) be submitted to S-SV EMS prior to accepting any assignment, if the organization anticipates providing EMS services within the S-SV EMS region. These documents will be valid for the remainder of the calendar year in which they are submitted/approved.

   b. Failure to submit the documentation required by this policy will result in the denial of temporary recognition of applicable EMT/paramedic personnel not credentialed in California.

   c. Additional information/documentation may be requested by S-SV EMS prior to authorizing temporary recognition of applicable EMT/paramedic personnel not credentialed in California.

d. Any concerns by S-SV EMS staff related to their review of the documentation required by this policy will be forwarded to the S-SV EMS Medical Director for additional review/consideration.

e. The decision of the S-SV EMS Medical Director to approve or deny temporary recognition of EMT/paramedic personnel not credentialed in California is final.

f. The S-SV EMS Medical Director may revoke temporary recognition of EMT/ paramedic personnel not credentialed in California at any time, upon providing written notification and an explanation for any such revocation.

g. S-SV EMS will review all submitted documents within 5 business days of receiving all required documents. Submitted documents will only be reviewed Monday through Friday during regular business hours.

2. The S-SV EMS Medical Director may waive certain requirements for temporary recognition of EMT/paramedic personnel not credentialed in California on an urgent/emergent basis when there is a current/imminent threat to the public health and safety. However, no such waiver shall apply to personnel who are employed by an EMS provider organization who is unwilling/unable to comply with the requirements contained in this policy

3. If an incident starts in an adjoining LEMSA and subsequently moves to the S-SV EMS region, the Private EMS Provider Organization's personnel may complete their deployment even if the Private EMS Provider Organization is not compliant with Policy 462. Once the original deployment is completed and if the Private EMS Provider Organization is not compliant with Policy 462 then the Private EMS Provider Organization cannot complete a crew 'swap'.

S-SV EMS AGENCY CONTACT INFORMATION:

S-SV EMS contact information for notifications or documentation submissions related to this policy are as follows:

A. Telephone Contact:

1. Primary 24/7 Duty Officer: (916) 625-1710
2. Backup #1: (712) 229-2164
3. Backup #2: (530) 906-0079

B. Email Contact:

1. Primary 24/7 Duty Officer: DutyOfficer@ssvems.com
2. Backup #1: info@ssvems.com

Sierra – Sacramento Valley EMS Agency Program Policy			
EMS Documentation			
	Effective: DRAFT	Next Review: DRAFT	**605**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To specify EMS patient care report (PCR) documentation and data requirements.

AUTHORITY:

A. HSC, Division 2.5, § 1797.202, 1797.204, 1797.220, 1797.227, and 1798.

B. CCR, Title 22, Div. 9, ~~Chapters 3 and 4~~ *Ch. 3.1, Ch. 3.2, Ch. 3.3*.

POLICY:

A. BLS non-transport providers shall complete a PCR for any EMS incident that results in a patient refusal of EMS care without ALS/LALS involvement.

B. BLS non-transport providers shall complete a S-SV EMS BLS Skills Utilization PCR (605-A), or electronic PCR (ePCR) compliant with current California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) date standards (if available), to document the utilization of any of the following prior to ALS/LALS arrival:

1. Defibrillation (AED shock delivered).
2. BLS optional skills included in S-SV EMS Policy No. 477.

C. ALS/LALS non-transport providers and all transport providers shall utilize an ePCR software system, compliant with current CEMSIS/NEMSIS standards, for EMS documentation as follows:

1. ALS/LALS non-transport personnel shall complete an ePCR for any EMS incident that results in their arrival at scene ~~prior to a transport provider~~, unless patient contact was limited to BLS assessment and/or oxygen administration only, and patient care was assumed by a transport provider.
2. Transport personnel shall complete an ePCR for any EMS incident that results in their arrival on scene. If the non-transport and transport personnel are from the same agency, a single ePCR by the appropriate unit is adequate.
3. For multiple patient incidents, an ePCR shall be completed for each individual patient (including patients who are determined to be deceased on scene).

4. For multiple casualty incidents (MCIs), the Medical Group Supervisor (or designee) shall complete a separate ePCR documenting pertinent incident information (MCI type, incident details, patient count/triage categories, etc.).

D. A PCR is a legal medical record. EMS personnel shall provide clear, legible, concise, complete, and accurate patient care documentation. Any form of misrepresentation is a serious infraction, which may result in disciplinary action.

E. EMS providers who fail to comply with EMS documentation laws, regulations, and/or policies may be suspended from providing service until they comply.

PROCEDURE:

A. All applicable/required PCR data fields shall be accurately completed.

1. EMS procedures and/or medication administrations, including specific dose, route, and response to treatment as applicable, shall be adequately documented in the Treatment/Procedures section. ALS/LALS personnel shall also document all pertinent procedures/medications utilized by bystanders or BLS personnel (including prior to their arrival on scene) in the Treatment/Procedures section.

2. The total volume of IV/IO fluid infused shall be adequately documented in the Treatment/Procedures and/or Narrative section.

3. All pertinent vital signs, including applicable cardiac rhythm interpretations, shall be adequately documented in the Vital Signs section. Vital signs shall be obtained/documented as close as possible to initial patient contact, a minimum of every 15 minutes during patient care (or more frequently if clinically indicated), and as close as possible to transfer of patient care at the receiving hospital.

4. The Narrative section shall be completed utilizing one of the following formats:

   a. SOAP (Subjective, Objective, Assessment, and Plan).

   b. CHART (Complaint, History, Assessment, Rx/pt. medications, and Treatment).

   c. Chronological order.

5. Response, patient care, and/or transport delays shall be adequately documented in the appropriate section(s) of the PCR.

6. A written or electronic legal signature of the individual completing the PCR is required.

B. The following information, when available, shall be documented on an interim PCR (605-B or equivalent), and left ~~at the receiving facility~~ *with the receiving nurse or physician* at *the* time of patient delivery:

1. Basic incident and patient demographic information.

2. Chief complaint, time of symptom onset, pertinent medical history, medications, and medication allergies.

3. Pertinent vital signs.
4. EMS treatment rendered (time, type, dose, route, response, etc.).
5. Relevant patient care related documents (DNR/POLST forms, 12 Lead EKGs, cardiac monitor rhythm strips, etc.).
6. Name, title, and ID of EMS personnel completing the documentation.

C. PCRs shall be completed within twenty-four (24) hours after completion of the patient encounter (NEMSIS V3.5 data element eTimes.13 – 'Unit Back in Service Date/Time'), and shall be distributed as follows:

1. If a BLS optional skill was utilized, a copy of the completed PCR shall be provided/ available to S-SV EMS within seven (7) calendar days of the incident.
2. PCRs shall be provided/available to the applicable receiving, base, and/or modified base hospital upon completion, but no later than twenty-four (24) hours after completion of the patient encounter.

D. Any EMS provider required to complete/submit ePCR data pursuant to this policy, and who chooses not to utilize the S-SV EMS ImageTrend ePCR software system, shall submit EMS data to S-SV EMS in the following manner:

1. EMS data shall be continually compliant with current CEMSIS/NEMSIS standards and the current S-SV EMS data schematron.
2. EMS data for all incidents required by this policy shall be submitted to the EMS data system utilized by S-SV EMS within twenty-four (24) hours after completion of the patient encounter. Any ePCR record that fails to import shall be identified, corrected, and successfully submitted to the EMS data system utilized by S-SV EMS within seventy-two (72) hours after completion of the patient encounter.

E. PCRs for adult and emancipated minor patients shall be preserved for at least seven (7) years. PCRs for unemancipated minor patients shall be preserved for at least one (1) year after such minor has reached the age of 18 years old and, in any case, not less than seven (7) years.

Sierra – Sacramento Valley EMS Agency Program Policy			
Reduction/Cancellation Of ALS Response			
	Effective: DRAFT	Next Review: DRAFT	**848**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish criteria for the reduction or cancellation of responding ALS resources.

AUTHORITY:

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

B. CCR, Title 22, Div. 9, ~~Chapter 4, § 100147, 100169 and 100170~~ *Ch. 3.1, Ch. 3.2, Ch. 3.3.*

DEFINITIONS:

A. **Code 2 –** Proceeding expeditiously but obeying all traffic laws without exception.

B. **Code 3 –** Proceeding with red lights and siren according to the vehicle code.

C. **Competent Individual –** An individual responsible for their own healthcare, or legally responsible for healthcare decisions involving the patient (parent, legal guardian, conservator, agent/attorney-in-fact, etc.), who has the capacity to understand the circumstances for which EMS care is indicated and the risks associated with refusing all or part of such care. They are alert and their judgement is not impaired by alcohol, drugs/medications, illness, injury, or grave disability.

POLICY:

A. The IC/designee on the scene of a medical incident may reduce a responding ALS resource from Code 3 to Code 2 upon determination that the patient's illness or injury is not immediately life-threatening and the difference in Code 3 and Code 2 response time would not likely have an impact on patient safety (note: when an ALS ambulance is reduced to Code 2, it is possible that the resource will be redirected to a higher priority call, resulting in a delayed subsequent ambulance response).

B. The IC/designee may cancel a responding ALS resource upon determination that the incident does not involve an illness or injury which would require *ALS* assessment, treatment and/or transport ~~by ALS personnel~~, or when a competent individual is refusing ALS assessment, treatment and/or transport.

1. BLS personnel should not cancel responding ALS resources for 'high risk' patients, including but not limited to:
    a. Cardiac arrest with active CPR.
    b. ~~Cardiac symptoms~~ *Suspected Acute Coronary Syndrome (ACS).*
    c. Difficulty breathing.
    d. Altered mental status.
    e. Drug ingestion.
    f. Attempted suicide, verbalized suicidal/homicidal ideations.
    g. Seizures.
    h. Near drowning.
    i. Active or significant hemorrhage.
    j. Pediatric patient's ≤3 years old.
    k. Patients who meet Field Trauma Triage Criteria as defined in S-SV EMS General Trauma Management Protocol (Reference No. T-1).
2. Once they have arrived on scene, ALS personnel shall attempt to make patient contact unless they are cancelled by BLS personnel prior to patient contact, and there is no indication that the patient meets any of the 'high risk' criteria listed in this policy.

Sierra – Sacramento Valley EMS Agency Treatment Protocol

Non-Traumatic Pulseless Arrest

C-1

Approval: Troy M. Falck, MD – Medical Director | Effective: DRAFT

Approval: John Poland – Executive Director | Next Review: DRAFT

MANUAL CHEST COMPRESSIONS

- Rate: 100-120/min
- Depth: 2 inches - allow full chest recoil
- Minimize interruptions (≤10 secs)
- Rotate compressors every 2 mins
- Perform CPR during AED/defibrillator charging
- Resume CPR immediately after shock

MECHANICAL CHEST COMPRESSION DEVICES

Indications

- Adult pt (≥15 yo)

Contraindications

- Pt does not fit the device
- 3rd trimester pregnancy

ⓘ Apply following completion of at least one manual CPR cycle, or at the end of a subsequent cycle

ⓘ Use in accordance with manufacturer guidelines

DEFIBRILLATION & GENERAL PT MANAGEMENT

- Analyze rhythm & check pulse after every 2 min CPR cycle
- Biphasic manual defibrillation detail:
  - Follow manufacturer recommendations
  - If unknown, start at 200 J (subsequent doses should be equivalent or higher)
- Movement of pt may interrupt CPR or prevent adequate depth and rate of compressions
- Consider resuscitation on scene up to 20 mins
- Go to ROSC protocol (C-2) if ROSC is obtained

ADVANCED AIRWAY MANAGEMENT

- Consider/establish advanced airway at appropriate time during resuscitation
- Do not interrupt chest compressions to establish an advanced airway
- Waveform capnography (if available) shall be used on all pts with an advanced airway in place
  - An abrupt increase in $PETCO_2$ is indicative of ROSC
  - Persistently low $PETCO_2$ levels (<10 mmHG) suggest ROSC is unlikely

TREAT REVERSIBLE CAUSES

- **H**ypovolemia
- **H**ypoxia
- **H**ydrogen Ion (acidosis)
- **H**ypo-/hyperkalemia
- **H**ypothermia
- **T**amponade, cardiac
- **T**ension pneumothorax
- **T**hrombosis, pulmonary
- **T**hrombosis, cardiac
- **T**oxins

ⓘ Consider early transport of pts who have reversible causes that cannot be adequately treated in the prehospital setting

ⓘ Contact the base/modified base hospital for consultation & orders as appropriate

ⓘ Refer to Hypothermia & Avalanche/Snow Immersion Suffocation Resuscitation Protocol (E-2) or Traumatic Pulseless Arrest Protocol (T-6) as appropriate

BLS TERMINATION OF RESUSCITATION (TOR)

Base/Mod. Base Hosp. Physician Order Required

- BLS providers may use the following TOR criteria when ALS is not available (**all 3 must apply**):

1. Arrest not witnessed by EMS
2. No AED shocks delivered
3. No ROSC after 3 rounds of CPR/AED analysis

ALS TERMINATION OF RESUSCITATION (TOR)

- ALS providers may use the following TOR criteria:

1. Arrest not witnessed by EMS
2. No AED shocks or defibrillations delivered
3. No ROSC after full ALS care

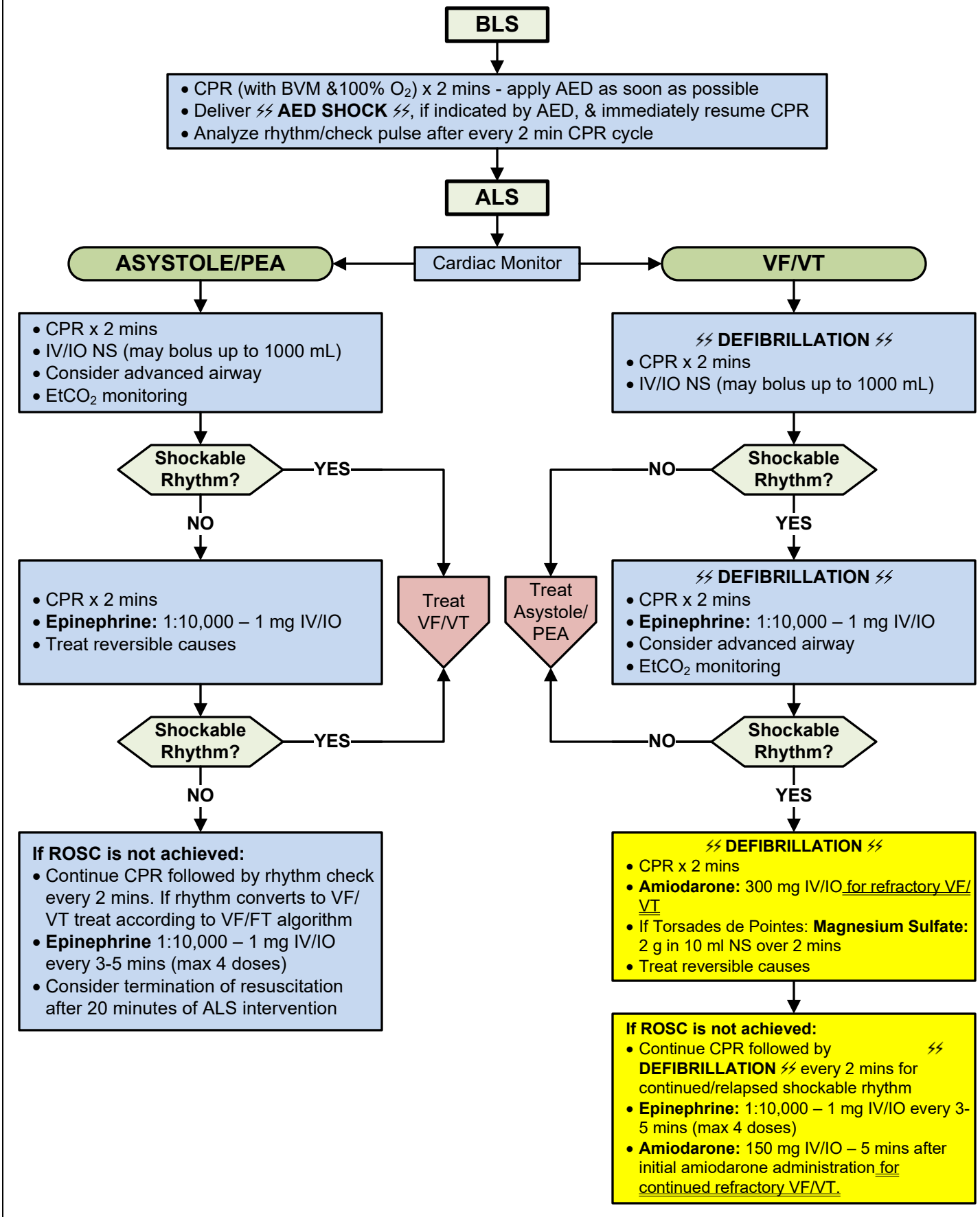
Base/Mod. Base Hosp. Physician Order only required for pt's not meeting all 3 ALS criteria

SPECIAL TOR CIRCUMSTANCES

- In the event of communication failure, BLS/ALS providers may terminate resuscitation on pts requiring base/modified base hospital physician order when rescuers are exhausted or physically unable to continue resuscitation

SEE PAGE 2 FOR TREATMENT ALGORITHM

Non-Traumatic Pulseless Arrest



Sierra – Sacramento Valley EMS Agency Treatment Protocol	C-1P
Pediatric Pulseless Arrest	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

INFANT CPR

- Perform chest compressions with minimal interruptions (≤10 secs)
  - ~~1 rescuer: 2 finger compressions~~
  - ~~2 rescuer:~~ ***Use the heel-of-1-hand or*** 2 thumb-encircling hands ~~chest~~ technique
- Rate: 100-120/min
- Depth: 1/3 diameter of the chest (approx. 1 ½")
- Compression/ventilation ratio:
  - 1 rescuer: 30:2
  - 2 rescuer: 15:2
- Perform CPR during AED/defibrillator charging & resume CPR immediately after shock

CHILD CPR

- Perform chest compressions with minimal interruptions (≤10 secs)
  - 1 or 2 hand compressions
- Rate: 100-120/min
- Depth: 1/3 diameter of the chest (approx. 2")
- Compression/ventilation ratio:
  - 1 rescuer: 30:2
  - 2 rescuer: 15:2
- Perform CPR during AED/defibrillator charging & resume CPR immediately after shock

DEFIBRILLATION & OVERALL MANAGEMENT

- Analyze rhythm & check pulse after every 2 min CPR cycle
- AED detail:
  - Use child pads, if available, for infants & children <8 years old
  - If child pads not available, use adult pads, make sure pads do not touch each other or overlap
  - Adult pads deliver a higher shock dose, but a higher shock dose is preferred to no shock
- Manual defibrillation detail:
  - Initial dose: 2 J/kg, subsequent doses: 4 J/kg
- Movement of pt may interrupt CPR or prevent adequate depth and rate of compressions
- Consider resuscitation on scene up to 20 mins

ADVANCED AIRWAY MANAGEMENT

- Consider/establish advanced airway (ALS only) at appropriate time during resuscitation
- Do not interrupt chest compressions to establish an advanced airway
- Waveform capnography shall be used on all pts with an advanced airway in place
  - An abrupt increase in $PETCO_2$ is indicative of ROSC
  - Persistently low $PETCO_2$ levels (<10 mmHG) suggest ROSC is unlikely

TREAT REVERSIBLE CAUSES

- **H**ypovolemia
- **H**ypoxia
- **H**ydrogen Ion (acidosis)
- **H**ypo-/hyperkalemia
- **H**ypothermia
- **T**amponade, cardiac
- **T**ension pneumothorax
- **T**hrombosis, pulmonary
- **T**hrombosis, cardiac
- **T**oxins

ⓘ Refer to Hypothermia & Avalanche/Snow Immersion Suffocation Resuscitation Protocol (E-2) or Traumatic Pulseless Arrest Protocol (T-6) as appropriate

ⓘ Contact the base/modified base hospital for consultation & orders as appropriate

ⓘ Consider early transport of pts who have reversible causes that cannot be adequately treated in the prehospital setting

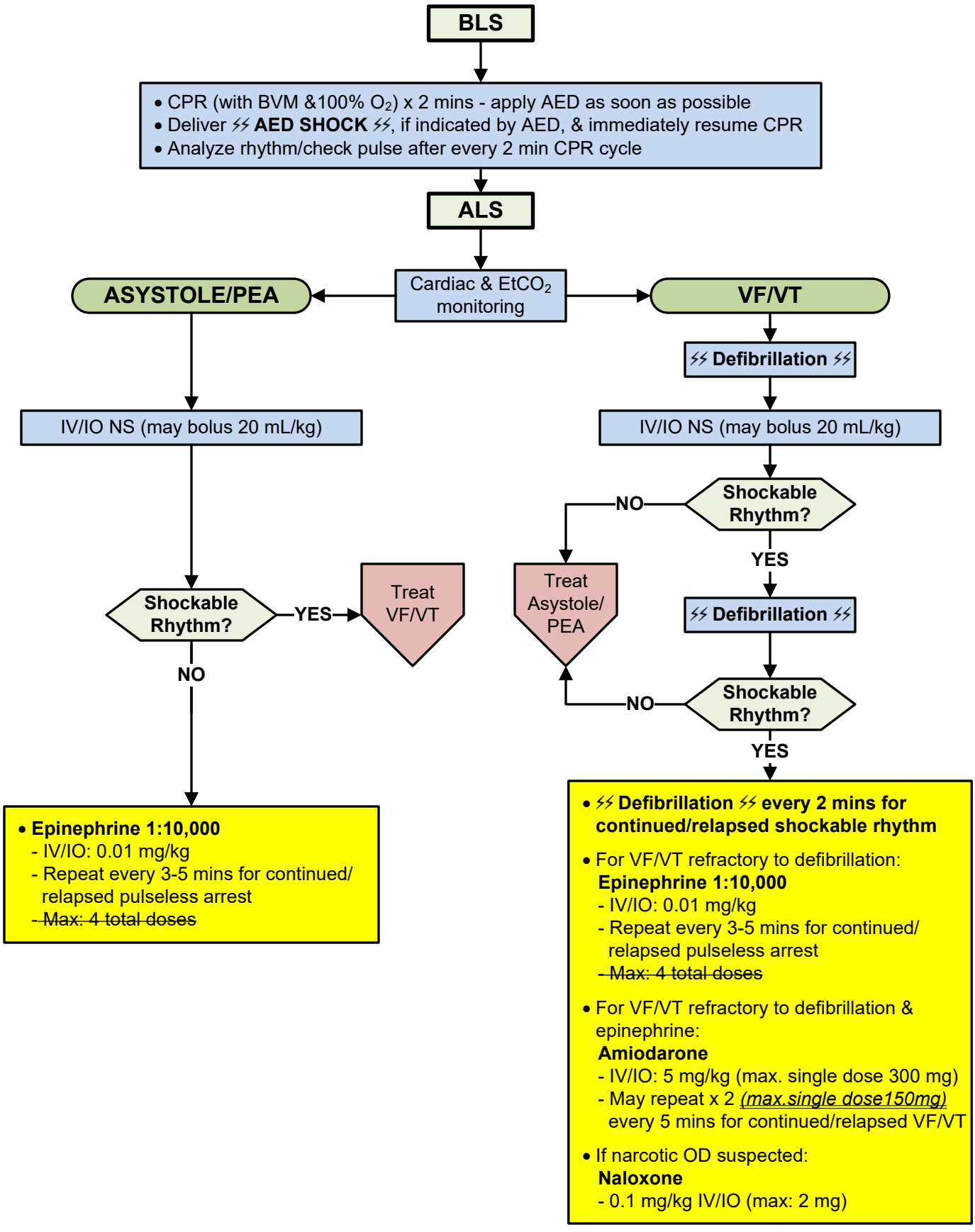
TERMINATION OF RESUSCITATION

Base/Modified Base Hospital Physician Order Only

- If non-shockable rhythm persists, despite appropriate, aggressive ALS interventions for 30 mins (or if $EtCO_2$ is <10 mm Hg after 20 mins in a pt with an advanced airway), consider discontinuation of CPR

SEE PAGE 2 FOR TREATMENT ALGORITHM

Pediatric Pulseless Arrest



Sierra – Sacramento Valley EMS Agency Treatment Protocol	C-4
Tachycardia With Pulses	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

- **Unstable pts with persistent tachycardia require immediate cardioversion.**
- **It is unlikely that symptoms of instability are caused primarily by the tachycardia if the HR is <150/min.**

BLS

- Manage airway & assist ventilations as necessary
- Assess V/S, including SpO_2 - reassess V/S every 3 - 5 min if possible
- O_2 at appropriate rate if hypoxemic (SpO_2 <94%), short of breath, or signs of heart failure/shock

ALS

- Cardiac monitor, 12-lead ECG at appropriate time (do not delay therapy)
- IV/IO NS at appropriate time (may bolus up to 1000 mL for hypotension)

Persistent tachycardia causing any of the following?
- Hypotension
- Acutely altered mental status
- Signs of shock
- Ischemic chest discomfort
- Acute heart failure

YES

Synchronized Cardioversion
- ***Use the energy level recommended by your defibrillator manufacturer. For atrial fibrillation and atrial flutter ≥200 J is preferred***
- ~~Initial synchronized cardioversion doses:~~
  - ~~Narrow regular: 50 - 100 J~~
  - ~~Narrow irregular: 120 - 200 J~~
  - ~~Wide regular: 100 J~~
- Consider pre-cardioversion sedation/pain control
- If no response to initial shock, increase dose in a stepwise fashion for subsequent attempts
- If rhythm is wide-irregular or monitor will not synchronize, & pt is critical, treat as VF with unsynchronized defibrillation doses (protocol C-1)

NO

Wide QRS (≥0.12 seconds)?

NO → Valsalva Maneuver

YES

- **Amiodarone:** ~~150 mg intermittent IV/IO push over 10 mins~~ **OR** ~~150 mg in 100 mL D5W or NS IV/IO infusion~~ (preferred) **OR** 150 mg IV/IO push over 10 mins
- If Torsades de Pointes: **Magnesium Sulfate:** 2 g in 100 ml D5W or NS IV/IO infusion over 15 mins
- Contact base/modified base hospital for consultation if necessary

If no response to Valsalva Maneuver, consider:

Adenosine:
- First dose: 6 mg rapid IV/IO push
- Second dose (if rhythm does not convert within 1-2 mins): 12 mg rapid IV/IO push
- Flush IV/IO line with 20 mL NS after each dose

Pre-Cardioversion Sedation/Pain Control
- Consider one of the following for pts in need of sedation/pain control:
  - **Midazolam:** 2.5 - 5 mg IV/IO; **OR**
  - **Fentanyl:** 25 - 50 mcg IV/IO
- Continuous $EtCO_2$ monitoring required for pts receiving midazolam or fentanyl

Clinical judgement shall be utilized to determine the appropriate dose of midazolam or fentanyl for pts requiring pre-cardioversion sedation/pain control

Sierra – Sacramento Valley EMS Agency Treatment Protocol **Determination Of Death**	**G-2**
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

General Procedures/Considerations:

- ~~CPR~~ ***Resuscitation*** need not be initiated and may be ~~discontinued~~ *terminated* for pts who meet Obvious Death or Probable Death criteria as contained in this protocol, at the time of initial assessment.
- A valid Do Not Resuscitate (DNR) should be honored for any pt with absent respirations, pulses and neurological response, regardless of the cause of death (e.g. terminal illness, trauma).
- Hypothermia, drug and/or alcohol overdose can mask neurological reflexes. If any doubt exists about contributing environmental factors (e.g. cold water submersion) and no valid DNR exists, initiate resuscitation and treat according to applicable S-SV EMS protocol.
- In the event of a declared MCI, death may be determined in accordance with START/JUMP START criteria.
- For all pts treated under this protocol, the following must be assessed/confirmed (as possible):

  - Absent respirations: look, listen (auscultate), and feel for respirations for a minimum of 30 secs.
  - Absent pulses: palpate both the carotid and apical pulses for a minimum of 30 secs.
  - Absent neurological response: check pupil response with a light and check for response to painful stimuli.

- If the base/modified base hospital physician directs EMS personnel to ~~stop~~ ***terminate*** resuscitation efforts once transport has begun, the ambulance shall ~~reduce transport code~~ ***discontinue lights and siren*** and continue transport to the original destination hospital. ***In such situations, EMS pesonnel shall transport the patient to the emergency department (ED) where turnover will be given to ED staff for legal determination/pronouncement of death.***
- If ~~determination of death is made~~ ***termination of resuscitation occurs*** at rendezvous location with HEMS aircraft, the body shall not be moved from the ambulance ~~and an immediate request for law enforcement shall be made~~. ***Follow Instructions for EMS Personnel Upon Determination of Death (below).***
- If there is any objection/disagreement by family members or EMS personnel to terminating or withholding resuscitation for pts who have a valid DNR or meet probable death criteria, BLS measures (including defibrillation) shall continue or begin immediately and EMS personnel shall contact the base/modified base hospital for further direction.

Instructions for EMS Personnel Upon Determination of Death:

- If not already on scene, request law enforcement
- Minimize contact with the body and scene to protect potential crime scene evidence
- Appropriate EMS personnel shall remain on scene until released by law enforcement
- Provide law enforcement with the following minimum information:

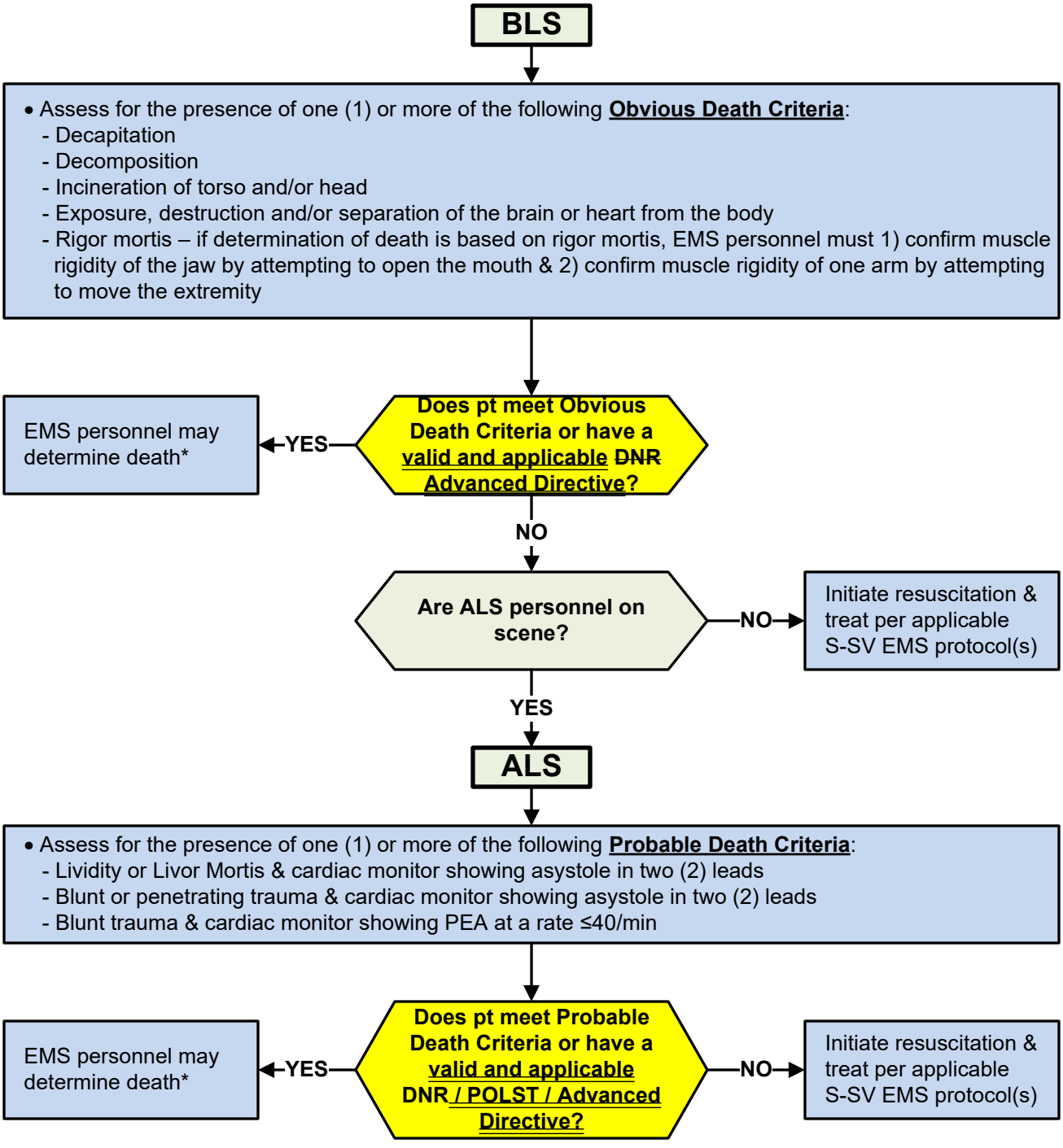
  - Unit ID
  - Name and certification/license # of EMS provider determining death
  - Patient demographics and known, pertinent medical history
  - Determination of death date and time

- At a minimum, the PCR must include the following:

  - Time of determination of death/***termination of resuscitation***
  - Six-second cardiac monitor strip of two (2) leads for pts meeting probable death criteria

See page 2 for Determination of Death Assessment Criteria

Determination of Death Assessment Criteria
(all pts must have absent respirations, pulses & neurological response)



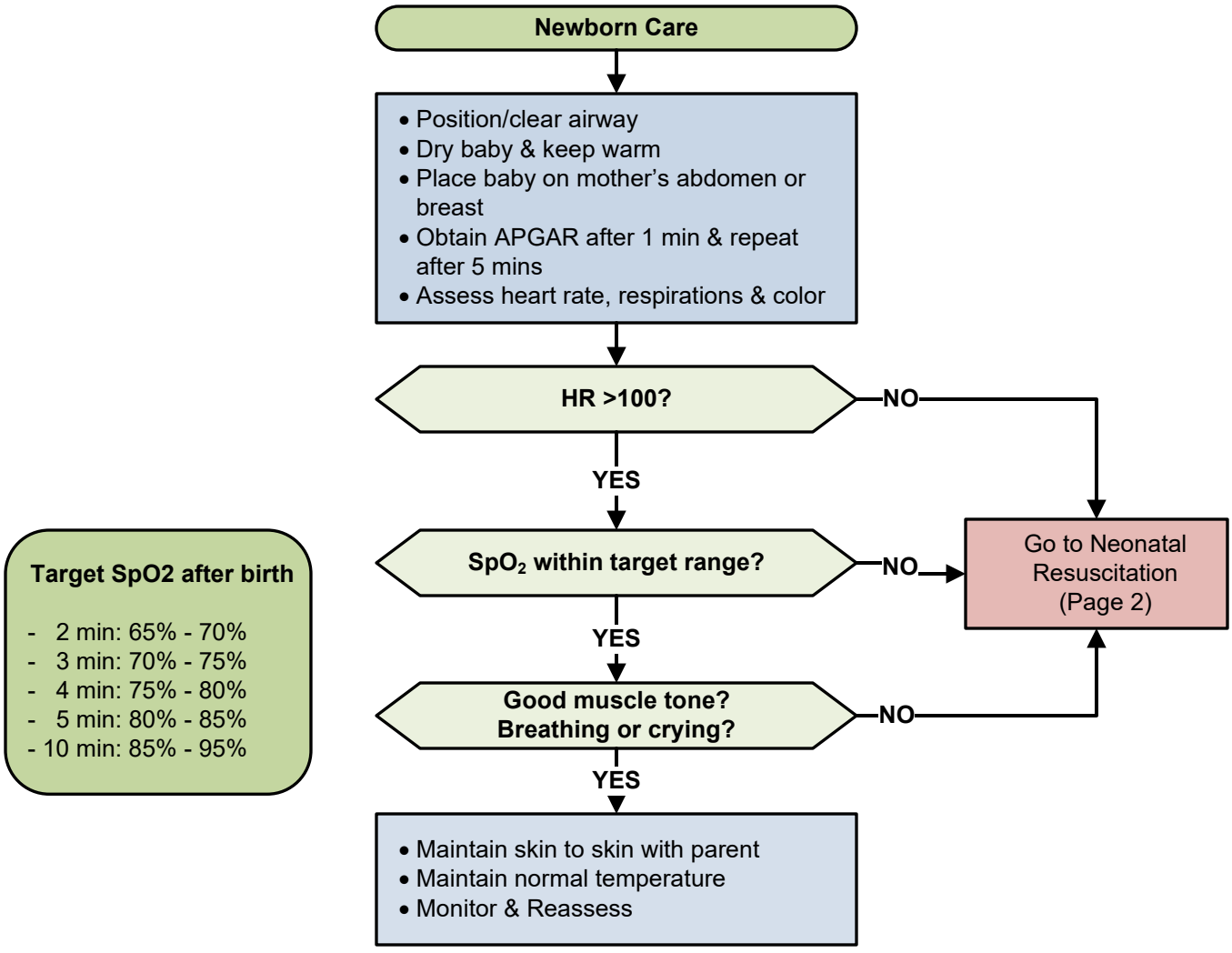
***Once EMS personnel have determined death, they shall follow the 'Instructions for EMS Personnel Upon Determination of Death' contained on page 1 of this protocol**

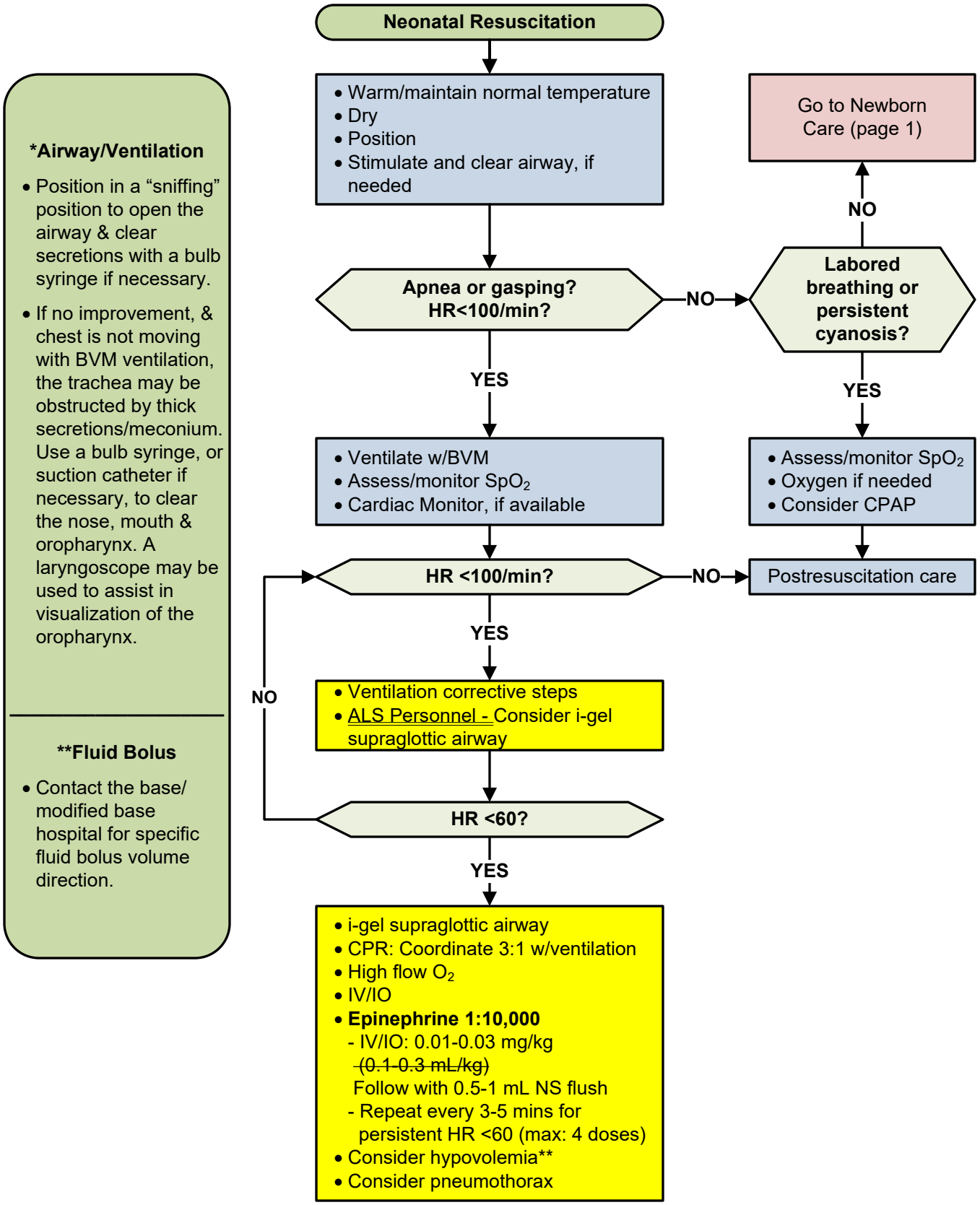
Sierra – Sacramento Valley EMS Agency Treatment Protocol	M-2P
Newborn Care/Neonatal Resuscitation	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

- A newborn/neonate is a child ≤28 days of age.
- Initial & ongoing assessments are critical to identifying and correcting life threats.
- If resuscitation is not required, EMS personnel should prioritize the following:
  - Whenever possible keep mother & baby together.
  - Maintain skin-to-skin contact between mother & baby.
  - Keep the baby warm – dry & cover the head, hands & feet.

APGAR SCORE

	Sign/Score	0	1	2
A	Appearance	Blue/Pale	Peripheral cyanosis	Pink
P	Pulse Rate	None	<100	>100
G	Grimace	None	Grimace	Cries
A	Activity	Limp	Some motion	Active
R	Respiration	Absent	Slow/irregular	Good/strong cry




Neonatal Resuscitation
• Warm/maintain normal temperature
• Dry
• Position
• Stimulate and clear airway, if needed
Apnea or gasping? HR<100/min?
NO
Labored breathing or persistent cyanosis?
NO
Go to Newborn Care (page 1)
YES
YES
• Ventilate w/BVM
• Assess/monitor SpO2
• Cardiac Monitor, if available
• Assess/monitor SpO2
• Oxygen if needed
• Consider CPAP
HR <100/min?
NO
Postresuscitation care
YES
NO
• Ventilation corrective steps
• ALS Personnel - Consider i-gel supraglottic airway
HR <60?
YES
• i-gel supraglottic airway
• CPR: Coordinate 3:1 w/ventilation
• High flow O2
• IV/IO
• Epinephrine 1:10,000
- IV/IO: 0.01-0.03 mg/kg
(0.1-0.3 mL/kg)
Follow with 0.5-1 mL NS flush
- Repeat every 3-5 mins for persistent HR <60 (max: 4 doses)
• Consider hypovolemia**
• Consider pneumothorax
*Airway/Ventilation
• Position in a "sniffing" position to open the airway & clear secretions with a bulb syringe if necessary.
• If no improvement, & chest is not moving with BVM ventilation, the trachea may be obstructed by thick secretions/meconium. Use a bulb syringe, or suction catheter if necessary, to clear the nose, mouth & oropharynx. A laryngoscope may be used to assist in visualization of the oropharynx.
**Fluid Bolus
• Contact the base/ modified base hospital for specific fluid bolus volume direction.

Sierra – Sacramento Valley EMS Agency Treatment Protocol	R-3P
Pediatric Respiratory Distress	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

- Consider respiratory failure for pts with a history of increased work of breathing & presenting with ALOC & a slow or normal respiratory rate without retractions.
- The hallmark of upper airway obstruction (croup, epiglottitis, foreign body aiway obstruction) is inspiratory stridor.
- Do not attempt to visualize the throat or insert anything into the mouth if epiglottitis suspected.

Continuous Positive Airway Pressure (CPAP) Utilization Information

- **Indications:**
  - CHF with pulmonary edema
  - Moderate to severe respiratory distress
  - Near drowning
- **Contraindications:**
  - <8 years of age
  - Agonal respirations
  - SBP <90
  - Respiratory or cardiac arrest
  - Inability to maintain airway
  - Major trauma/head injury/chest trauma
  - Suspected croup/epiglottitis
  - Suspected pneumothorax
  - Severe decreased LOC
- **Complications:**
  - Hypotension
  - Pneumothorax
  - Corneal drying

Epinephrine Administration

- Epinephrine is indicated for pts with suspected asthma who are in severe distress.
- Administer Auto-Injector/IM epinephrine into the lateral thigh, midway between waist & knee.

BLS

- Assess & support ABCs
- High flow O_2
- Assess V/S, including SpO_2
- Assess history & physical, determine degree of illness
- Minimize stimulation – keep pt calm & consider allowing parent to hold the child &/or O2 delivery device if their presence calms the child
- Consider CPAP, when appropriate/indicated, for moderate to severe distress (pts ≥8 yo only)

Suspected asthma & in severe distress

YES

Epinephrine 1:1,000 IM (authorized/trained EMTs only)

- Pts 7.5 – 30 kg
  - 0.15 mg pediatric auto-injector **OR** 0.15 mg (0.15 mL) via approved syringe
- Pts >30 kg
  - 0.3 mg adult auto-injector **OR** 0.3 mg (0.3 mL) via approved syringe

SEE PAGE 2 FOR ALS TREATMENT OF WHEEZING OR SUSPECTED CROUP/EPIGLOTTITIS

Pediatric Respiratory Distress

Wheezing

ALS

Mild Distress
- Mild wheezing
- Mild shortness of breath
- Cough

- Cardiac & $EtCO_2$ monitoring

Albuterol 5 mg & Ipratropium 500 mcg
- Nebulizer
- May repeat **(albuterol 2.5-5 mg only)** for continued respiratory distress

Moderate – Severe Distress
- Cyanosis
- Accessory muscle use
- Inability to speak >3 words
- Severe wheezing/shortness of breath
- Decreased or absent air movement

- Cardiac & $EtCO_2$ monitoring
- IV/IO NS (may bolus 20 mL/kg)

Albuterol 5 mg & Ipratropium 500 mcg
- Nebulizer, CPAP, or BVM
- May repeat **(albuterol 2.5-5 mg only)** for continued respiratory distress

Epinephrine 1:1,000 (for severe distress only)
- 0.01 mg/kg IM (max: 0.3 mg)

Hx of asthma with severe distress only
Base/Modified Base Hospital Order Only

Magnesium Sulfate
- *50 mg/kg IV/IO mixed in 100mL D5W or NS and infuse over 10 mins (max dose 2 g)*

Suspected Croup/Epiglottitis

ALS

- Cardiac & $EtCO_2$ monitoring
- Consider nebulized saline
- **MINIMIZE PT STIMULATION**
- If full upper airway occlusion suspected – ensure proper airway positioning & BVM seal, attempt to ventilate & reassess – **DO NOT ATTEMPT I-GEL**

Unable to ventilate/maintain airway utilizing less invasive procedures?

YES → Perform needle cricothyrotomy (pts ≥3 yo) as airway of last resort

NO

Base/Modified Base Hospital Order Only

Racemic epinephrine
- One (1) - 0.5 ml vial of 2.25% inhalation solution (mix with NS to = 5 ml of volume)

OR

Nebulized epinephrine
- 1:1000 - 0.5 mL/kg (max: 5 mL) nebulizer or BVM (if <5 mL, mix with NS to = 5 mL of volume)

Sierra – Sacramento Valley EMS Agency Treatment Protocol	T-6
Traumatic Pulseless Arrest	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

- ***The primary goals of care are to treat immediate life-threats and initiate rapid transport without delay***
- Assess etiology – if there is suspicion that a medical event caused the traumatic arrest, treat per the applicable Non-Traumatic Pulseless Arrest Protocol (C-1 or C-1P).
- Epinephrine ~~is likely not beneficial and~~ may be harmful in traumatic pulseless arrest and should not be used.
- Utilize mechanical chest compression devices in accordance with manufacturer indications/contraindications. If a mechanical chest compression device is used, transport shall not be significantly delayed for application of the device.
- Biphasic manual defibrillation detail: follow manufacturer's recommendations, if unknown, start at 200 J (subsequent doses should be equivalent or higher).
- CPR need not be initiated, and may be discontinued, for patients who meet S-SV EMS Obvious Death or Probable Death Criteria (Refer to Protocol G-2).

BLS

- High-Quality CPR (with BVM &100% O_2) – apply AED as soon as possible
- Deliver ⚡ **AED SHOCK** ⚡, if indicated by AED, & immediately resume high-quality CPR
- Hemorrhage control as appropriate
- Consider Spinal Motion Restriction (SMR) with a backboard for the following:
  - CPR
  - Blunt mechanism indicating a high risk for spinal injury

ALS

- ~~ALS treatment/monitoring should be performed during transport~~
- ~~Bilateral needle thoracostomy if chest or multi-system trauma is suspected~~
- Attach Cardiac monitor rapidly, but do not delay:
- Hemorrhage control
- Needle thoracostomy (if chest or multi-system trauma is suspected)
- Airway/Oxygenation/Ventilation
- Rapid Transport
- Continue CPR followed by ⚡ **DEFIBRILLATION** ⚡ every 2 mins for continued/relapsed shockable rhythm (VF/VT)
- IV/IO NS:
  - **Adult pts:** Administer 1 L fluid bolus
  - **Pediatric pts:** Administer 20 mL/kg fluid bolus

Return of Spontaneous Circulation (ROSC)

- Manage airway as needed, optimize ventilation & oxygenation
  - O_2 at appropriate rate to maintain SpO_2 ≥94% (do not hyperventilate)
- Assess V/S, including SpO_2 – reassess V/S every 3-5 mins if possible
- Continuous $ETCO_2$ monitoring – goal 35-45 mmHg
- Titrate fluid boluses:
  - **Adult pts:** Titrate to SBP of ≥90 for pts <65 years of age, or ≥100 for pts ≥65 years of age
  - **Pediatric pts:** Titrate to age appropriate SBP (max: 60 mL/kg)
- Monitor for reoccurrence of pulseless arrest

Sierra – Sacramento Valley EMS Agency Treatment Protocol	G-1
Multiple Patient Incidents	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

DEFINITIONS

Control Facility (CF): An acute care hospital or EMS dispatch center responsible for situation status reporting and patient dispersal during a MCI or URVI.

EMS Surge Incident: An incident that does not overwhelm prehospital resources but has the potential to overwhelm hospital resources with multiple patients.

Unified Response to Violent Incident (URVI): An evolving event, primarily managed by law enforcement (LE), involving the use of force or violence on a group of people (e.g. mass shooting, bombing, riots, etc.). These incidents present a significantly higher threat of injury or loss of life to first responders, victims, and the public.

Multiple Casualty Incident (MCI): An incident that requires more prehospital and/or hospital resources to adequately manage patients than those available during a routine response. A MCI is categorized by the following levels:

LEVEL 1 MCI: Approximately 5-14 patients, expected duration ≤1 hour

LEVEL 2 MCI: Approximately 15-49 patients, expected duration ≥1 hour

LEVEL 3 MCI: 50+ patients, expected duration ≥1 hour

EMS SURGE ALERT

When:

- Three (3) or more ground or air transport resources are requested to respond to an incident; or
- Three (3) or more patients are identified after arrival at the scene of an incident; or
- Multiple patients are released at scene who may arrive at a hospital by private vehicle.
- A URVI.

Who:

- Dispatch center or first dispatched ground transport resource.

Why:

- To provide early notification to the CF for situation status reporting and hospital polling.

MCI ALERT

When:

- An incident that requires more EMS system resources to manage patients than those available during a routine response; or
- The number of patients from a single incident overwhelms the CF or closest appropriate receiving hospital.

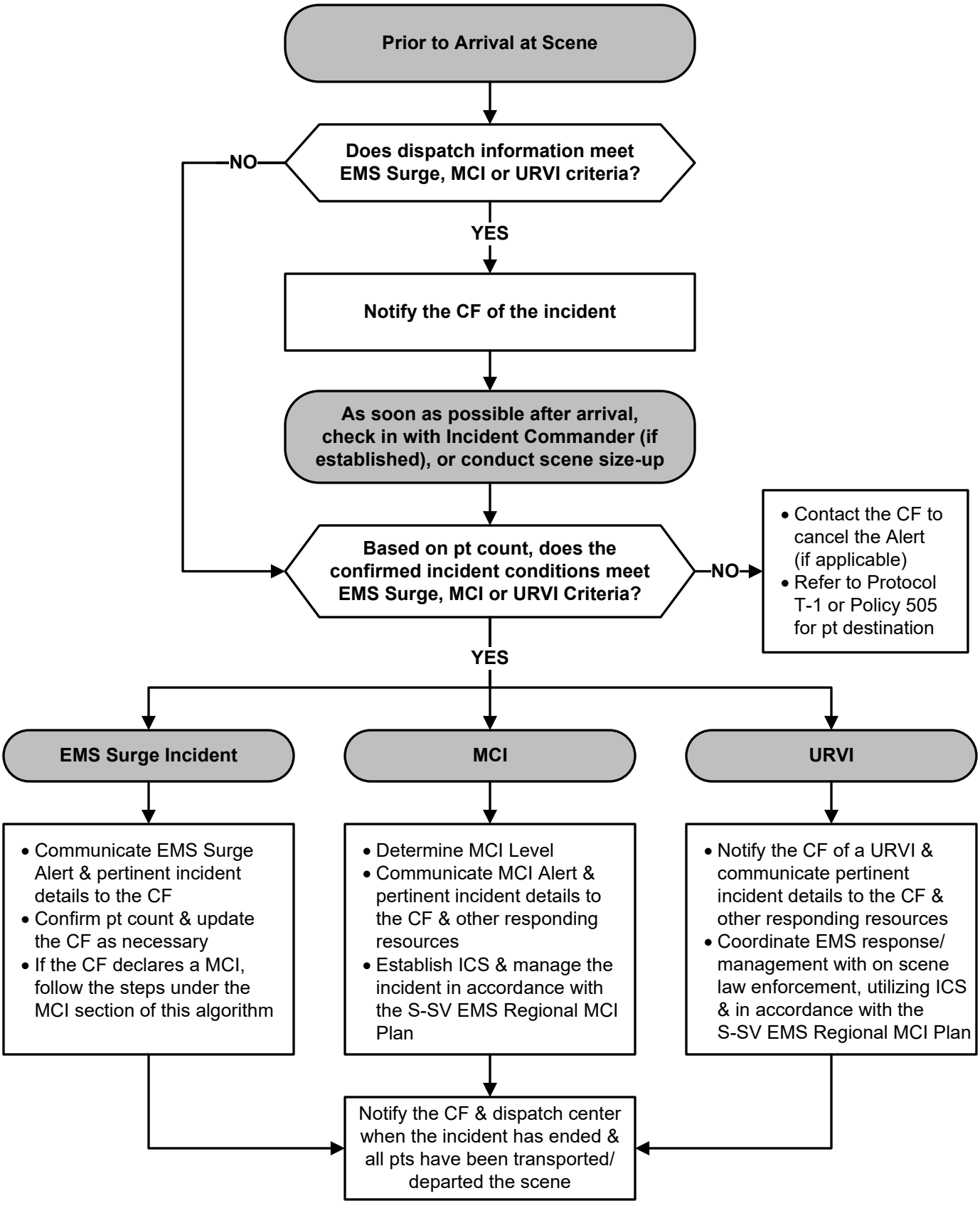
Who:

- Dispatch center, prehospital resources, or CF.

Why:

- To provide early notification for situation status reporting, hospital polling and initiation of the Regional MCI Plan.

Multiple Patient Incidents



REGIONAL MULTIPLE CASUALTY INCIDENT (MCI) PLAN

Sierra-Sacramento Valley EMS Agency

Effective: December 1, 2024

CONTENTS

ADMINISTRATIVE

PURPOSE

- The S-SV EMS Regional MCI Plan is intended to establish minimum standards/ guidelines for managing these types of incidents and does not prevent local agencies from developing additional policies, protocols or procedures that do not conflict with the S-SV EMS Regional MCI plan.
- The ICS organizational structure is designed to be developed/expanded/contracted in a modular fashion, based on the size/scope of the incident and changing incident conditions. This plan contains standardized positions, procedures, checklists, and forms to more efficiently and effectively utilize regional resources during an MCI.

AUTHORITY

- California Health and Safety Code, Section 1797.151, 1797.204, 1797.206, 1797.214, 1797.218, 1787.220, 1798, 1798.2 & 1798.6.

TRAINING/EDUCATION

- Initial Training:
  - Who: Prehospital EMS personnel and MICNs.
  - Course: S-SV EMS Regional MCI Training course.
  - When: Course completion valid for (2) years.
- Refresher Training:
  - Who: Prehospital EMS personnel and MICNs.
  - Course: S-SV EMS Regional MCI Refresher Training course.
  - When: Course completion valid for (2) years.
- EMS system participants are responsible for ensuring that their personnel complete the initial and ongoing MCI training/education.

CONCEPTS OF OPERATIONS

ACTIVATION

- Activation of the MCI plan may be made by a first responder agency, ambulance provider, or hospital. If sufficient information is provided, activation may be made prior to on-scene arrival.
- As the number of patients increases, the focus shifts from individual incident management to system sustainability and performance. Activation levels are based on factors such as size, type, location, and other regional incidents that may impact both the EMS and hospital system.

POSITIONS & RESPONSIBILITIES

- Overall on-scene operations shall be under the direction/control of the Incident Commander (IC).
- The IC shall establish incident objectives that prioritize the four (4) T's: Triage, Treatment, Transport, and Tracking.
- Incident positions critical to success are:
  - Incident Commander (IC).
  - Triage Unit Leader.
  - Transportation Unit Leader.
  - Medical Communications Coordinator.
- If there are minimal resources available, the Medical Communications Coordinator may also initially fill the position of Transportation Unit Leader. The expectation is when additional resources arrive on scene, the Transportation Unit Leader ICS position should be handed off to the appropriate designee, as determined by the IC.
- The Medical Communications Coordinator ICS position should remain assigned to the person that made initial contact with the Control Facility (CF). Minimal hand off will allow for consistent communications throughout the incident.
- Due to the unique aspects of multi patient incidents, the first AEMT or paramedic on scene will not be able to effectively perform the same patient health care management responsibilities as they would during a single incident. The first arriving/initial AEMT or paramedic is expected to receive an ICS position from the IC. The position assigned will depend on the size and needs of the incident, as determined by the IC.
- Regardless of assigned ICS positions, '*authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional, which may include any paramedic or other prehospital emergency personnel, at the scene of the emergency who is most medically qualified specific to the provision of rendering emergency medical care. If no licensed or certified health care professional is available, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency.'* (HSC Div. 2.5 § 1798.6).

- The expectation is that if/when an EMS Paramedic Field Supervisor arrives on scene, they will check in with the IC and receive an ICS position when appropriate.
- Each EMS system participant has specific responsibilities during an MCI response. Depending on the nature, size, and complexity of the event, certain activities may be modified from normal daily operating procedures.
- For MCIs involving multiple pediatric victims or multiple family members, consider a position to assist with family reunification at a designated area.

RESOURCES

- Resources should typically function within their pre-assigned responsibilities, i.e.- fire service personnel should focus efforts on incident command, patient triage, and disentanglement/extrication, while ground ambulance providers should focus on patient treatment and rapid transportation.
- Aside from safety hazard mitigation, the priority of the first resource on scene is completing a scene size up and obtaining an approximate patient count.
- Upon arrival at the incident, resources must check in with the IC or their assigned ICS supervisor.
- Typically, the first arriving ambulance will not be utilized for transport as those personnel will hold ICS positions/responsibilities.
- The positions of Transport Unit Leader and Medical Communications Coordinator should remain in close physical proximity to the IC to maintain effective communication and effective/efficient scene management.
- If a HEMS provider is assigned to an MCI, they will typically transport their assigned patient(s) to the furthest hospital. They may also be assigned patients and receiving hospital destinations based on clinical needs.

COMMUNICATIONS

- EMResource shall be used for notification/situational awareness purposes, and to quickly obtain bed availability from appropriate receiving hospitals.
- Patient destination is determined in coordination between the on-scene Medical Communications Coordinator and the CF. Level 3 incidents may include assistance from the S-SV EMS Duty officer if necessary.

Unified Response to Violent Incident (URVI)

DEFINITIONS:

- **Unified Response to Violent Incident (URVI):** An evolving event, primarily managed by law enforcement (LE), involving the use of force or violence on a group of people (e.g. mass shooting, bombing, riots, etc.). These incidents present a significantly higher threat of injury or loss of life to first responders, victims, and the public.
- **Cleared:** An area checked by LE and no apparent threats have been found.
- **Secured:** An area methodically/deliberately searched by LE and no threats have been found.
- **Hot Zone:** The area where a direct/immediate threat exists based on the complexity and circumstances of the incident, as determined by LE. An area within range of direct gunfire, suspected explosive devices or an unsecured/unsearched area where a suspect could be hiding.
- **Warm Zone:** The area where a potential threat exists, however the threat is not direct/immediate. This area is considered clear, however not secure. FD/EMS personnel operating within the Warm Zone should have adequate personal protective equipment, including body armor, and appropriate Force Protection.
- **Cold Zone:** An area where no significant danger/threat can be reasonably anticipated. The Cold Zone is the appropriate location for the Incident Command Post (ICP), Treatment Areas, Staging and logistical functions of the incident.
- **Life Saving Intervention (LSI):** A modified prioritization process for a tactical environment that focuses on major hemorrhage control, opening the airway, chest decompression due to pneumothorax, and providing chemical exposure antidotes.
- **Casualty Collection Point (CCP):** A location within the Hot Zone or Warm Zone, secured by Force Protection, where casualties can be temporarily moved for LSI while awaiting evacuation to the Cold Zone. A CCP established in the Hot Zone is staffed with LE SWAT teams or rescue teams with Tactical Medics/Tactical Emergency Medical Support (TEMS) Specialists.

PRINCIPLES

- Incident Command System (ICS), S-SV EMS Regional Multiple Casualty Incident (MCI) Plan, and Firescope ICS 701 Unified Response to Violence concepts shall be utilized for all URVIs.
- During an initial URVI response, LE personnel are focused on locating, containing, and eliminating the threat. Tactical Medics/TEMS Specialists are generally limited in number, not immediately available, and committed to their tactical team's assignment.
- Considerations, planning, and interagency training should occur around the concept of properly trained/equipped FD/EMS personnel who are escorted by LE into areas of higher but mitigated risk to execute rapid triage, LSI, and evacuation of casualties.

CONCEPTS

- Unified Command, including a single co-located ICP, should be established with FD and LE as Unified Incident Commanders (ICs) to effectively manage the incident.
- Immediate EMS considerations are for MCI operations. Appropriate resource ordering (through the IC) and staging considerations are essential for a successful operation.
- The IC will determine which FD/EMS personnel will locate/triage casualties, administer appropriate LSI, and/or provide/facilitate extrication to a safe location.
- Utilize staging areas to limit the number of responders. Stage responders for rapid evacuation and always have an escape route open to leave the scene quickly if needed.
- Utilize a deliberate/cautious approach to the scene. FD/EMS personnel should be escorted by LE when possible.
- Be alert for the presence of additional devices/hazards at the main scene and secondary scenes. If exposed to gunfire, explosions or threats, withdraw to a safe area or shelter in place.
- Only LE or specially trained/equipped FD/EMS personnel shall enter the Hot Zone to provide evacuation care. The goal of evacuation care is to provide LSI and prevent additional injuries. Minimal EMS interventions are warranted in this phase of care.
- Limited numbers of FD/EMS personnel, as directed by the IC, should enter the Warm Zone to provide casualty extrication or to establish a CCP. The goal of CCP care is to stabilize casualties to permit safe evacuation to dedicated medical treatment and transport assets. o Assess casualties and initiate appropriate LSI, as permitted by FD/EMS personnel/equipment resources.
- Utilize a ‘scoop and run’ response within the Warm Zone. Treatment, including splinting/spinal motion restriction/ALS procedures, can wait until the casualty is in a cleared or secured location.
- Upon approval of the IC, non-tactical FD/EMS personnel may enter the area once it has been cleared by LE to provide evacuation care. These personnel should utilize appropriate protective equipment, including body armor, and be escorted by LE personnel.

COMMUNICATIONS

- When establishing communication with the CF, assure that a single individual is assigned to the Medical Communications Coordinator position.
- The patient count may be dynamic and change throughout the incident. The CF should provide bed availability (including pertinent updates) to the Medical Communications Coordinator throughout the incident.
- The CF and Medical Communications Coordinator will work together to appropriately assign patient destinations as patients are identified.
- Due to the nature of URVIs, the incident may spread across a large physical location. It is imperative that an on-scene communication plan is established early.

DOCUMENTATION

PATIENT CARE REPORTS (PCRs)

- EMS PCRs shall be completed for all victims (patients and individuals determined to be deceased on-scene), according to applicable S-SV EMS policies, unless this requirement is waived by S-SV EMS on an incident specific basis.
- Patient triage tag numbers should be documented on the applicable PCR(s).

ICS FORMS

- EMS personnel shall complete additional ICS paperwork if requested by the IC, based on the nature/size of the incident.
- Patient Tracking Worksheet (Appendix H).
  - This worksheet shall be utilized to track all patients during an MCI.
  - Copies of completed patient tracking worksheets shall be submitted to S-SV EMS as soon as possible (either during or immediately following the conclusion of the event as appropriate based on specific incident circumstances).
- Patient Transportation Resource Staging Log (Appendix F).
  - This log shall be utilized by the Ground Ambulance Coordinator and/or HEMS Coordinator (as applicable) to track patient transportation resource availability and activities anytime a ground ambulance and/or HEMS staging area is established.
- ICS 214 Activity Log (Appendix I).
  - This log is used to record details of notable activities at any ICS level including:
    - Single resources.
    - Ambulance strike team/task force resources.
  - These logs provide basic incident activity documentation and are used as reference for after action reports.
  - These logs can be initiated/maintained by personnel in various ICS positions, as necessary/appropriate.
  - Personnel should document how relevant incident activities are occurring/ progressing, or any notable events/communications.

MCI FEEDBACK/REPORTING FORM

- An MCI Details/Feedback Form (Appendix J) shall be submitted to S-SV EMS within seven (7) calendar days of the incident by the following EMS providers:
  - Prehospital ground and air transport providers.
  - Control Facility (CF) and receiving facilities.
  - Incident Commander
  - Prehospital non-transport/first responder providers (recommended/optional).
- S-SV EMS will evaluate the incident details/documentation and determine if additional formal after-action review/follow-up is necessary.

APPENDIX A – MCI LEVELS

MULTIPLE-PATIENT INCIDENT LEVELS			
EMS SURGE INCIDENT	**LEVEL 1 MCI 5 - 15 PATIENTS**	**LEVEL 2 MCI 15 - 49 PATIENTS**	**LEVEL 3 MCI 50+ PATIENTS**
• An incident that does not overwhelm prehospital resources but has the potential to overwhelm hospital resources with multiple patients. • Three (3) or more ground or air transport resources are requested to respond to a single incident. • Multiple patients are released at scene who may arrive at a hospital(s) by private vehicle. • Three (3) or more patients are identified after arrival at the scene of an incident. • A Unified Response to Violent Incident (URVI).	• Single event, generally handled with local resources. • Can be declared enroute to the incident, with adequate dispatched information, or on scene.	• Simultaneous minor to moderate incidents or single moderate to large scale incident. • Requires modifications to the routine EMS system to support the incident. • Will likely require mutual aid/assistance. • Notification of the S-SV EMS Duty Officer required. • May require MHOAC Program notification.	• Catastrophic events producing excessive numbers of patients that overwhelm local and routine mutual aid resources. • Requires modifications to the routine EMS system to support the incident, including significant use of mutual aid resources. • Notification of the S-SV Duty Officer and MHOAC Program required.
EXAMPLES			
• Dispatched to a multiple vehicle collision at a high rate of speed. • Report of active shooter. • Hazmat incident with unknown patient count. • Structure fire with possible victims.	• Vehicle accident involving high occupancy vehicles. • Multiple acute overdoses. • Multiple confirmed shooting victims. • Multiple patients requiring transport to specialty receiving centers.	• Public transit or school bus accident. • Commercial structure fire with possible victims. • Vehicle into a large public gathering. • Hazmat incident at a public gathering.	• Catastrophic explosion with widespread damage. • Commercial aircraft crash. • Catastrophic earthquake.

APPENDIX B – PROVIDER RESPONSIBILITIES

CONTROL FACILITY (CF)

PRIMARY AREA(S) OF RESPONSIBILITY

- Coordinate patient distribution with on-scene Medical Communications Coordinator and receiving hospitals.

LEVEL 1 MCI	LEVEL 2 MCI	LEVEL 3 MCI
✓ Confirm location, type of incident and initial patient count. ✓ Complete EMResource event notice and receiving hospital polling. ✓ Coordinate appropriate patient distribution with on scene Medical Communications Coordinator.	✓ All Level 1 MCI responsibilities. ✓ Consider activating the hospital's surge plan.	✓ All Level 2 MCI responsibilities. ✓ Coordinate with the S-SV EMS Agency Duty Officer for regional/statewide bed availability as necessary.

RECEIVING HOSPITALS

PRIMARY AREA(S) OF RESPONSIBILITY

- Provide timely MCI patient receiving capability information to the Control Facility (CF) and receive/treat EMS transported patients.

LEVEL 1 MCI	LEVEL 2 MCI	LEVEL 3 MCI
✓ Respond to the CF generated EMResource event hospital bed availability poll within 5 minutes. ✓ Make internal notifications and institute appropriate emergency department procedures per hospital protocol. ✓ Monitor EMResource for CF generated incident updates and patient destination assignments.	✓ All Level 1 MCI responsibilities. ✓ Assess ability to handle additional patients. ✓ Consider activating the hospital's surge plan.	✓ All Level 2 MCI responsibilities.

S-SV EMS AGENCY DUTY OFFICER

PRIMARY AREA(S) OF RESPONSIBILITY

- Take any appropriate actions to ensure objectives are met. This may include suspension of hospital diversion, policy modification or suspension, modified dispatch procedures, etc.
- Assume the role of MHOAC or notify the MHOAC Program (as applicable) and possibly assume the Medical Health Branch Director ICS position.
- Coordinate medical mutual aid requests with the applicable Regional Disaster Medical Health Coordinator/Specialist (RDMHC/S) Program.

LEVEL 1 MCI	LEVEL 2 MCI	LEVEL 3 MCI
✓ Monitor the incident. ✓ Offer EMS system support as needed/requested.	✓ All Level 1 MCI responsibilities. ✓ Consider activation of the MHOAC Program. ✓ Make necessary notifications. ✓ Consider notifying the applicable OES coordinator for possible EOC activation.	✓ All Level 2 MCI responsibilities. ✓ Activate the MHOAC Program. ✓ Notify the applicable OES coordinator in order to establish an EOC. ✓ Perform ICS role as needed/requested by IC.

PUBLIC SAFETY AGENCIES

PRIMARY AREA(S) OF RESPONSIBILITY

- Overall on-scene incident management.

LEVEL 1 MCI	LEVEL 2 MCI	LEVEL 3 MCI
✓ Establish incident command. ✓ Fill appropriate ICS positions, guided by the 'Level 1 MCI Initial Response Organization Chart' (Appendix C). ✓ Fill additional positions as needed. ✓ Communicate with dispatch and all incoming units. ✓ Ensure early notification to the applicable Control Facility (CF), in coordination with ambulance provider agency personnel (as applicable). ✓ Consider additional resource needs if MCI escalates/expands.	✓ All Level 1 MCI responsibilities. ✓ Scale ICS positions according to the size of the incident. ✓ Fill appropriate additional ICS positions, guided by the 'Level 2/3 MCI Initial Response Organization Chart' (Appendix C). ✓ Evaluate current medical supply needs and consider requesting MCI Disaster Cache(s) or other additional resources.	✓ All Level 2 MCI responsibilities. ✓ Fill appropriate additional ICS positions, guided by the 'Level 2/3 MCI Initial Response Organization Chart' (Appendix C).

GROUND AMBULANCE PROVIDER AGENCIES

PRIMARY AREA(S) OF RESPONSIBILITY

- Assume/manage appropriate ICS positions, as assigned by the IC.
- Patient treatment and transportation to assigned hospital(s).

LEVEL 1 MCI	LEVEL 2 MCI	LEVEL 3 MCI
✓ Ensure early notification to the applicable Control Facility (CF), in coordination with the IC. ✓ Ensure response from an on-duty Paramedic Field Supervisor (if available). ✓ Evaluate the need for additional EMS/ transportation resources, in coordination with the IC.	✓ All Level 1 MCI responsibilities. ✓ Ensure response from an on-duty Paramedic Field Supervisor (if available). ✓ A Paramedic Field Supervisor may fill an appropriate ICS position, as assigned by the IC. ✓ Remain assigned to the incident until released by the IC/designee. ✓ Consider initiating internal disaster plans for extended operations. ✓ Consider recalling off-duty personnel to support extended medical operations.	✓ All Level 2 MCI responsibilities. ✓ Initiate internal disaster plans for extended operations. ✓ Recall personnel for extended operations.

HEMS PROVIDER AGENCIES

PRIMARY AREA(S) OF RESPONSIBILITY

- Patient treatment and transportation to assigned hospital(s).
- Provide clinical care on scene as appropriate/necessary.

LEVEL 1 MCI	LEVEL 2 MCI	LEVEL 3 MCI
✓ Monitor incident enroute. ✓ Provide aircraft availability if requested. ✓ Initiate/maintain contact with the IC/designee. ✓ Confirm patient/destination assignment with the IC or Transportation Unit Leader (as applicable) once on-scene.	✓ All Level 1 MCI responsibilities. ✓ Consider cancelling non-emergency HEMS activity. ✓ Remain in contact with other possible aircraft responding to the incident. ✓ Remain assigned to the incident until released by the IC/designee. ✓ Consider initiating internal disaster plans for extended operations. ✓ Consider recalling off-duty personnel to support extended medical operations.	✓ All Level 2 responsibilities. ✓ Initiate internal disaster plans for extended operations. ✓ Recall personnel for extended operations.

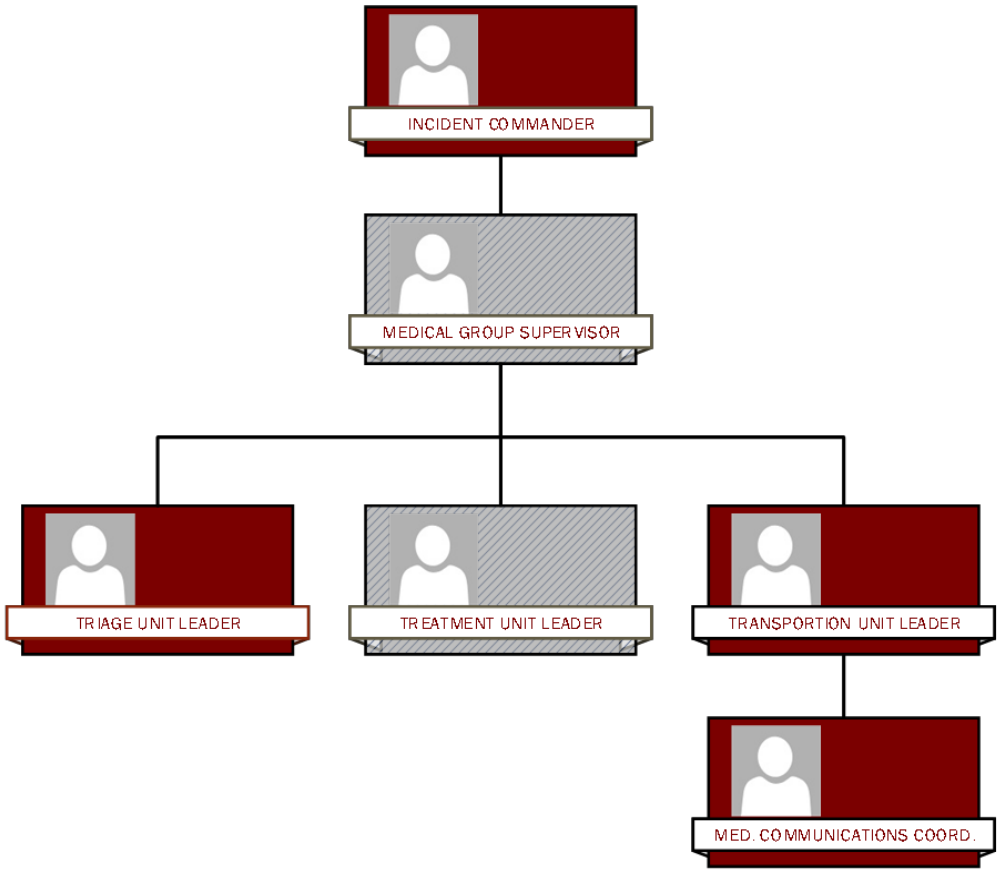
APPENDIX C – MCI ORGANIZATIONAL CHARTS

The following organizational charts are intended to provide the Incident Commander (IC) with a basic, expandable system to manage multiple-casualty incidents of varying complexity. The degree of organizational structure should be driven by the Incident needs, as determined by the IC. These charts may also be referenced by any responder so they may be able to anticipate their position and expectation prior to arrival on scene.

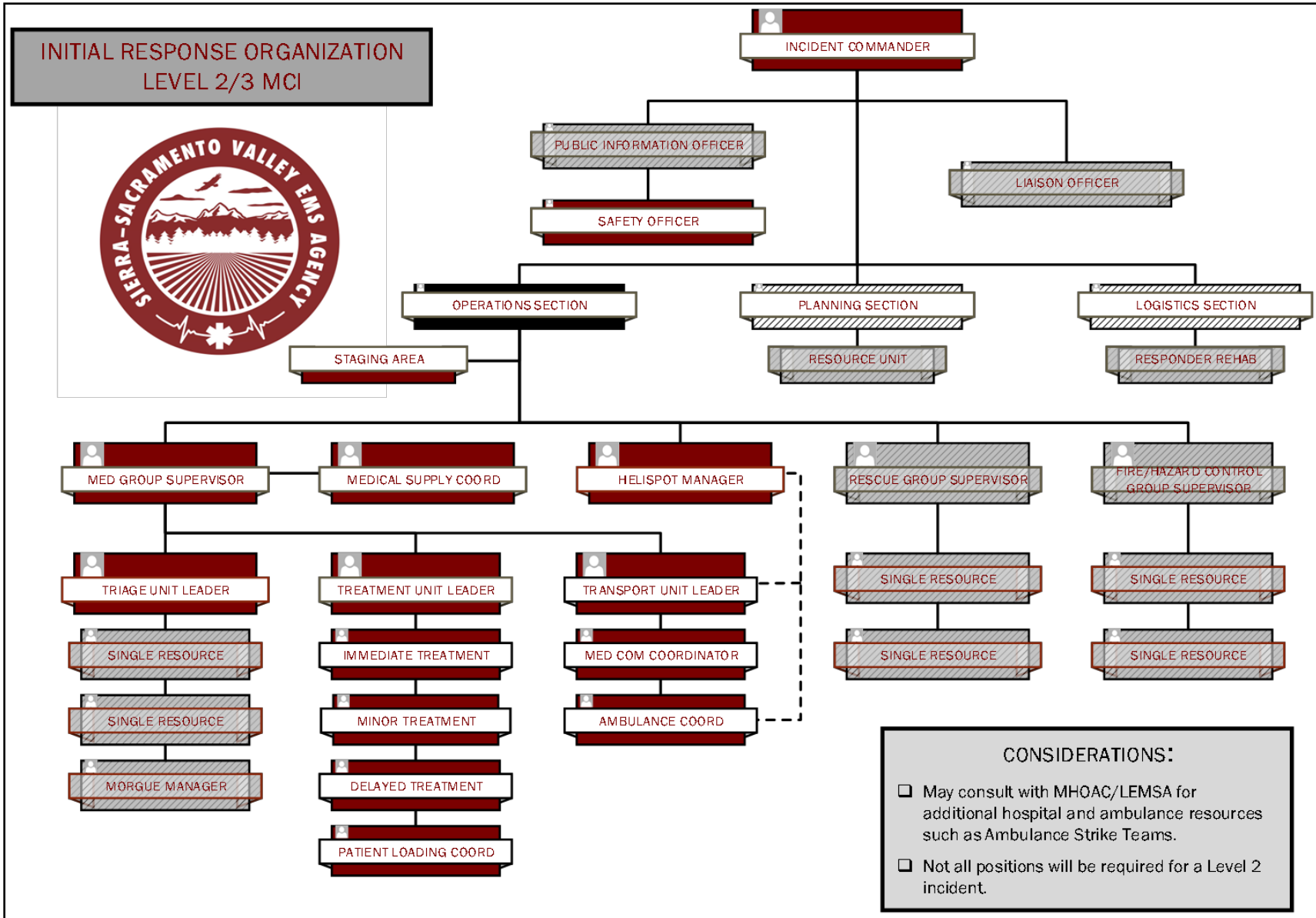
INITIAL RESPONSE ORGANIZATION
LEVEL 1 MCI

CONSIDERATIONS:

- ❑ Declare MCI
- ❑ Assume command
- ❑ Scene survey, size-up, initial resource order
- ❑ Assess scene hazards including need for decontamination
- ❑ At a minimum, assign Triage Unit Leader and Transportation Unit Leader (Transportation Unit Leader will assume the Medical Communication Coordinator position until additional resources are available)
- ❑ Begin START/JUMPSTART triage
- ❑ Establish appropriate treatment areas
- ❑ Complete patient tracking forms

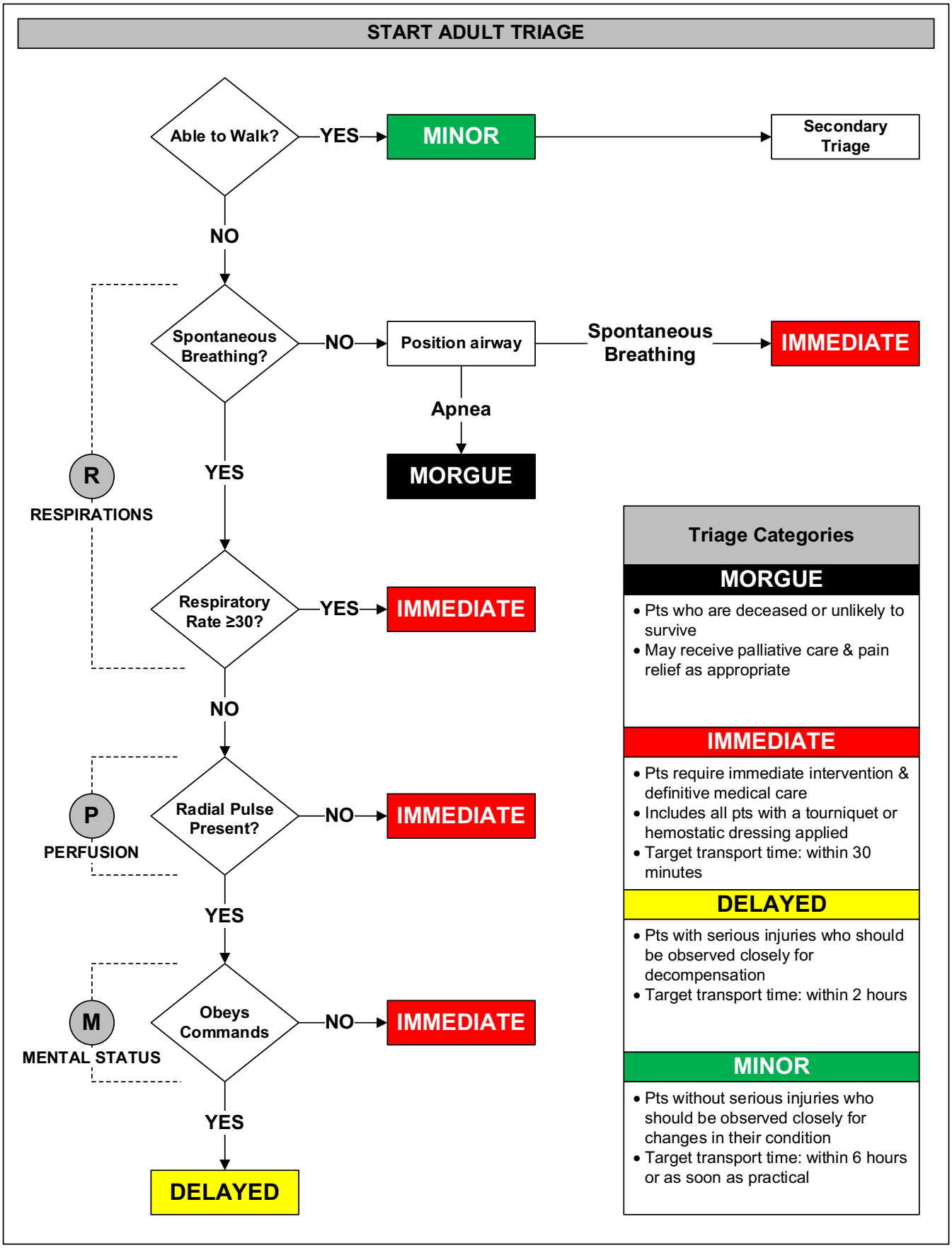


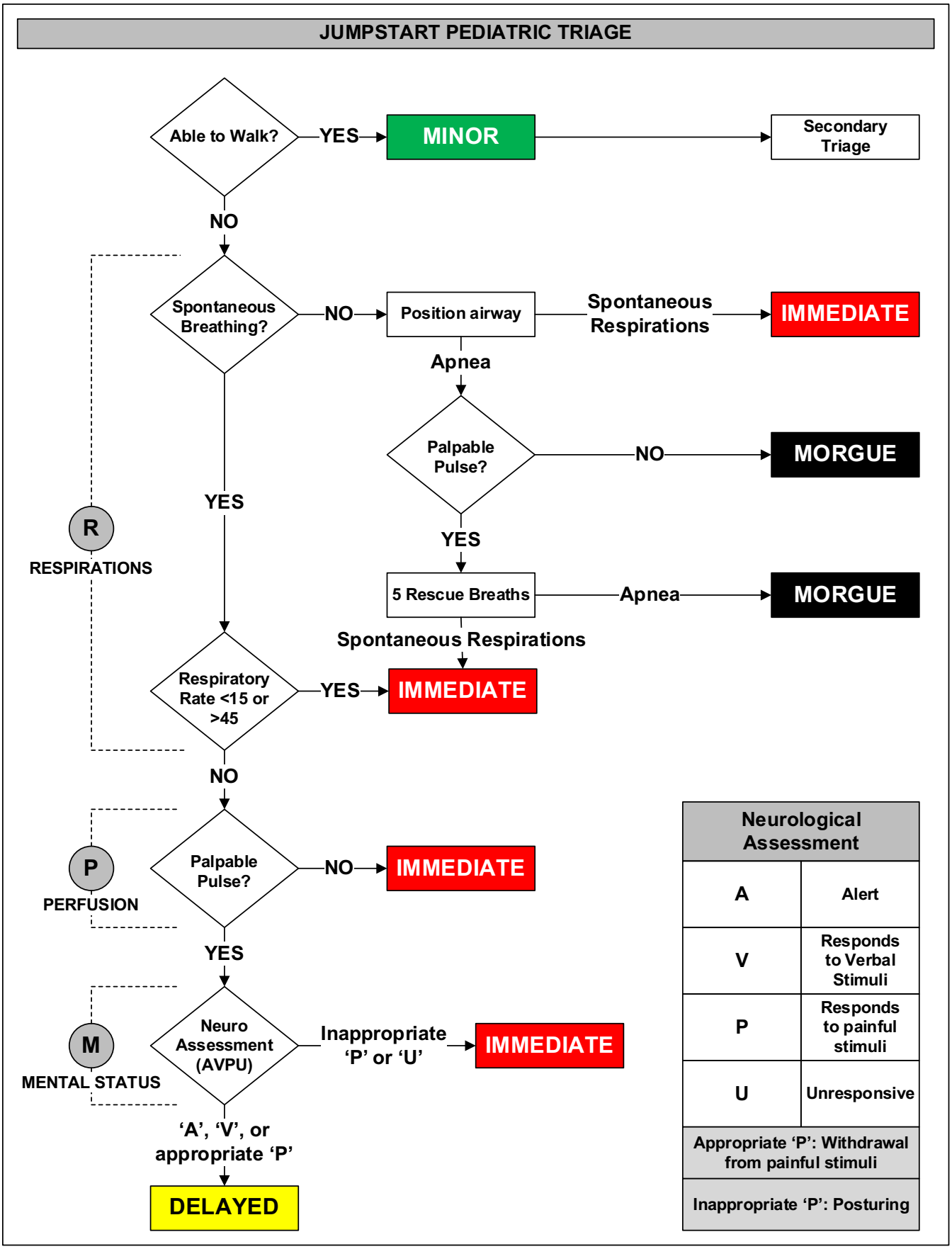
Initial Response Organization: The Incident Commander manages initial response resources as well as all Command and General Staff responsibilities. All arriving resources shall check in with the Incident Commander for assignment. Positions in red shall be assigned prior to assigning other positions. As additional ALS/LALS resources become available, the Transportation Unit Leader and/or Triage Unit Leader positions may be re-assigned. The Medical Communications Coordinator position should not be transferred after communication with the hospital has been established. The Incident Commander, Transportation Unit Leader and Medical Communication Coordinator should remain in close physical proximity throughout the event.



Multi-Group Response: All positions within the Medical Group are now filled. Rescue Group may be established to free entrapped victims. Fire/Hazard Control Group may be established to control any fire or hazardous conditions.

APPENDIX D – START & JUMPSTART TRIAGE ALGORITHMS


START ADULT TRIAGE
Able to Walk?
YES
MINOR
Secondary Triage
NO
Spontaneous Breathing?
NO
Position airway
Spontaneous Breathing
IMMEDIATE
Apnea
MORGUE
R
RESPIRATIONS
YES
Respiratory Rate ≥30?
YES
IMMEDIATE
NO
P
PERFUSION
Radial Pulse Present?
NO
IMMEDIATE
YES
M
MENTAL STATUS
Obeys Commands
NO
IMMEDIATE
YES
DELAYED
Triage Categories
MORGUE
• Pts who are deceased or unlikely to survive
• May receive palliative care & pain relief as appropriate
IMMEDIATE
• Pts require immediate intervention & definitive medical care
• Includes all pts with a tourniquet or hemostatic dressing applied
• Target transport time: within 30 minutes
DELAYED
• Pts with serious injuries who should be observed closely for decompensation
• Target transport time: within 2 hours
MINOR
• Pts without serious injuries who should be observed closely for changes in their condition
• Target transport time: within 6 hours or as soon as practical


JUMPSTART PEDIATRIC TRIAGE
Able to Walk?
YES
MINOR
Secondary Triage
NO
Spontaneous Breathing?
NO
Position airway
Spontaneous Respirations
IMMEDIATE
Apnea
Palpable Pulse?
NO
MORGUE
YES
YES
R
RESPIRATIONS
5 Rescue Breaths
Apnea
MORGUE
Spontaneous Respirations
Respiratory Rate <15 or >45
YES
IMMEDIATE
NO
P
PERFUSION
Palpable Pulse?
NO
IMMEDIATE
YES
M
MENTAL STATUS
Neuro Assessment (AVPU)
Inappropriate 'P' or 'U'
IMMEDIATE
'A', 'V', or appropriate 'P'
DELAYED
Neurological Assessment
A
Alert
V
Responds to Verbal Stimuli
P
Responds to painful stimuli
U
Unresponsive
Appropriate 'P': Withdrawal from painful stimuli
Inappropriate 'P': Posturing

APPENDIX E – MCI ICS POSITION JOB SHEETS

TRIAGE UNIT LEADER

Description:

The Triage Unit Leader supervises Triage Personnel. The Triage Unit Leader assumes responsibility for providing triage management and movement of patients from the triage area. When triage has been completed and all patients have been moved to treatment areas, the Triage Unit Leader may be reassigned.

Responsibilities:

- ✓ Determines initial patient count.
  - Notifies IC of initial patient count as soon as determined.
  - If Medical Communications Coordinator and/or Transportation Unit Leader have been established, also notifies these positions of initial patient count.
- ✓ Informs IC or appropriate ICS supervisor of needs.
- ✓ Implements triage process.
  - Utilize START (adult)/Jump START (pediatrics) criteria.
- ✓ Assures triage tags are utilized for all patients.
- ✓ Receives/maintains all triage tag stubs until they are passed to the Treatment Unit Leader.
- ✓ Coordinates movement of patients from the triage area to the treatment area if different location.
- ✓ Gives periodic status updates to the IC or appropriate ICS supervisor.
- ✓ At the completion of START/Jump START triage, patients may be re-triaged as time and resources permit.

Who is Appropriate for This Position?

- ✓ **Fire Department EMT, AEMT, or Paramedic (Preferred).**
- ✓ Ground ambulance EMT, AEMT, or Paramedic.

Equipment Needed

- ✓ ICS vest.
- ✓ Radio/cell phone for CF communications.
- ✓ Patient Tracking Worksheet.

TRANSPORTATION UNIT LEADER

Description:

The Transportation Unit Leader supervises the Medical Communications Coordinator, Ground Ambulance Coordinator, and Air Ambulance Coordinator (if applicable). They are responsible for coordination of patient transportation and maintenance of records relating to patient's identification, condition, and destination. The responsibilities of this position may initially be assigned to/managed by the Medical Communications Coordinator. Upon arrival of additional resources, the Transportation Unit Leader position shall be handed off to an appropriate designee (in coordination with the IC). Depending on the size/complexity of the incident, this position may need to be upgraded to Group Supervisor level as determined by the IC.

Responsibilities:

- ✓ Designates ambulance staging area(s).
- ✓ Establishes communication with Medical Communications Coordinator, Ground/Air Ambulance Coordinators.
- ✓ Directs transportation of patients as determined by the Medical Communications Coordinator.
- ✓ Assures the documentation of patient information and destinations.
- ✓ Coordinates the establishment of the Helispot(s).
- ✓ Requests additional medical transportation resources as needed from IC or appropriate ICS supervisor.

Who is Appropriate for This Position?

- ✓ **Paramedic Field Supervisor (Preferred).**
- ✓ Non-transport provider AEMT or paramedic.
- ✓ Ground ambulance provider AEMT or paramedic.
- ✓ Non-transport or ground ambulance provider EMT (if no AEMT/paramedic available).

Equipment Needed

- ✓ ICS vest.
- ✓ Patient Tracking Worksheet.

TREATMENT UNIT LEADER

Description:

The Treatment Unit Leader supervises treatment area managers and the Patient Loading Coordinator. The Treatment Unit Leader assumes responsibility for re-triage, treatment, preparation for transport, and movement of patients to the loading locations.

Responsibilities:

- ✓ Directs/supervises the Immediate, Delayed, and Minor Treatment Areas and the Patient Loading Coordinator.
- ✓ Establishes communication with the Transportation Unit Leader (when applicable) and Patient Loading Coordinator.
- ✓ Ensures proper patient decontamination and notifications (when applicable).
- ✓ Ensures continued re-triage and movement of patients within the treatment areas when necessary.
- ✓ Coordinates movement of patients from the Triage Area to the Treatment Area(s).
- ✓ Assigns treatment personnel, in coordination with the IC or appropriate ICS supervisor.
- ✓ Requests sufficient medical caches/supplies.
- ✓ Coordinates movement of patients to the patient loading area(s).
- ✓ Gives periodic status updates to the appropriate ICS supervisor.
- ✓ Requests special medical resources through the IC.

Who is Appropriate for This Position?

- ✓ **Ground ambulance paramedic (preferred for Level 1 MCIs).**
- ✓ **Paramedic Field Supervisor (preferred for Level 2/3 MCIs).**
- ✓ Non-transport provider paramedic.
- ✓ AEMT or EMT (if no paramedic available or ETA is extended).

Equipment Needed

- ✓ ICS vest.
- ✓ Treatment Area Worksheets.

MEDICAL COMMUNICATIONS COORDINATOR

Description:

The Medical Communications Coordinator establishes communication with the appropriate Control Facility (CF) to determine patient destination assignments. They should remain near the IC or appropriate ICS supervisor. The Medical Communications Coordinator should not be assigned additional ICS positions or be involved in triage or treatment of patients. The position of Medical Communications Coordinator is crucial to the success of the tracking of patients from the scene to hospitals. This position should be established as early as possible.

Responsibilities:

- ✓ Establishes communication with the appropriate CF.
- ✓ Provides pertinent basic patient information to the CF as follows:
  - Patient Age.
  - Patient Gender.
  - Triage Category.
  - Triage Tag #.
- ✓ Receives basic patient information and triage information from the Triage Unit Leader and re-triage information from the Treatment Unit Leader (if applicable).
- ✓ Receives patient destinations from the CF.
- ✓ Works with the Transportation Unit Leader to coordinate patient transportation needs.

Who is Appropriate for This Position?

- ✓ **Ground ambulance paramedic (preferred).**
- ✓ Paramedic Field Supervisor.
- ✓ Non-transport provider paramedic.
- ✓ Ground ambulance AEMT or EMT (if no paramedic available).

Equipment Needed

- ✓ ICS vest.
- ✓ Radio/cell phone for CF communications.
- ✓ Patient Tracking Worksheet.

GROUND AMBULANCE COORDINATOR

Description:

The Ground Ambulance Coordinator manages the ground ambulance staging area(s) and dispatches ground ambulances as requested.

Responsibilities:

- ✓ Establishes appropriate staging area for ground ambulance resources and communicates the location of the staging area(s) to the IC or appropriate ICS supervisor.
- ✓ Establishes route of travel from staging area to the patient loading area
- ✓ Establishes communications/mode of contact with ambulance personnel in the ground ambulance staging area(s).
- ✓ Establishes/maintains communication with the Medical Communications Coordinator.
- ✓ Provides ambulance resources upon request from the Medical Communications Coordinator or appropriate ICS position.
- ✓ Ensures the necessary equipment/personnel to manage patient needs is provided in each ambulance.
- ✓ Requests additional ground ambulance resources through the IC or appropriate ICS position, based on incident needs.
- ✓ Considers the use of alternative transportation resources, when necessary, in conjunction with Medical Communications Coordinator and the Control Facility (CF).
- ✓ Provides an inventory of medical supplies available in the ground ambulance staging area.

Who is Appropriate for This Position?

- ✓ **BLS fire department/district personnel (preferred).**
- ✓ Ground ambulance EMT.
- ✓ Other fire department/district personnel.

Equipment Needed

- ✓ Patient Transportation Resource Staging Log.

HEMS COORDINATOR

Description:

The HEMS Coordinator communicates with the Transportation Unit Leader and Ground Ambulance Coordinator. They coordinate patient air transportation needs with the Helispot Manager.

Responsibilities:

- ✓ Establishes communication with the Transportation Unit Leader to determine hospital destinations.
- ✓ Coordinates patient loading from ground ambulances with the Helispot Manager.
- ✓ Confirms type of HEMS resources/patient capabilities with the Helispot Manager and provides this information to the Medical Communications Coordinator and the Transportation Unit Leader.

Who is Appropriate for This Position?

- ✓ **BLS fire department/district personnel (preferred).**
- ✓ Other fire department/district personnel.

Equipment Needed

- ✓ Patient Transportation Resource Staging Log.

PATIENT LOADING COORDINATOR

Description:

The Patient Loading Coordinator is responsible for coordinating with the Transportation Unit Leader (or Group Supervisor if established), the transportation of patients out of the Treatment Areas.

*Note: During a level 1 MCI, this position may be held by the Treatment Unit Leader

Responsibilities:

- ✓ Establishes communication with treatment area managers and the Transportation Unit Leader.
- ✓ Verifies prioritization of patients for transport.
- ✓ Advises the Medical Communications Coordinator when patients are ready for transport.
- ✓ Coordinates transportation of patients with the Medical Communications Coordinator.
- ✓ Coordinates ambulance loading with treatment managers and ambulance personnel.

Who is Appropriate for This Position?

- ✓ **BLS fire department/district personnel (preferred).**
- ✓ Other fire department/district personnel.

Equipment Needed

- ✓ N/A

MEDICAL GROUP SUPERVISOR

Description:

The Medical Group Supervisor reports to the IC on smaller incidents and the Medical Branch Director on larger incidents. The Medical Group Supervisor supervises the Triage Unit Leader, Treatment Unit Leader, Transportation Unit Leader, and Medical Supply Coordinator if applicable.

Responsibilities:

- ✓ Supervises Triage, Treatment, and Transportation Unit Leaders.
- ✓ Ensures that proper medical care is rendered at the treatment areas.
- ✓ Determines resources and supplies needed for the medical aspect of the incident.
- ✓ Establishes direct communication with the Transportation Unit Leader.

Who is Appropriate for This Position?

- ✓ **Paramedic Field Supervisor (preferred).**
- ✓ ALS/LALS non-transport provider fire captain.
- ✓ Non-transport provider AEMT or paramedic.
- ✓ Ground ambulance AEMT or paramedic.

Equipment Needed

- ✓ ICS vest.
- ✓ Appropriate ICE forms.

MEDICAL BRANCH DIRECTOR

Description:

The Medical Branch Director is responsible for implementing the Incident Action Plan (IAP) within the medical branch. They supervise the medical group(s) and Transportation Unit/Group.

Responsibilities:

- ✓ Reviews/modifies group assignments as needed.
- ✓ Provides input to the Operations Section Chief for the IAP.
- ✓ Supervises Medical Branch activities and confers with the Safety Officer.
- ✓ Reports to the Operations Section Chief on branch activities.

Who is Appropriate for This Position?

- ✓ **S-SV EMS Agency Duty Officer (preferred).**
- ✓ Fire department/district Battalion Chief.

Equipment Needed

- ✓ ICS vest.
- ✓ Appropriate ICE forms.

APPENDIX F – PATIENT TRANSPORTATION RESOURCE STAGING LOG

PATIENT TRANSPORTATION RESOURCE STAGING LOG

Incident Name			Ground Ambulance/HEMS Coordinator		
Provider Agency	**Unit ID**	**Unit Type**	**Staging Time In**	**Staging Time Out**	**Unit Disposition**

APPENDIX G – TREATMENT AREA LOGS

IMMEDIATE TREATMENT AREA LOG

INCIDENT NAME:	
INCIDENT DATE:	
TREATMENT MANAGER NAME:	

TRIAGE TAG #	AGE	GENDER	INJURIES	TRANSPORT TIME

DELAYED TREATMENT AREA LOG

INCIDENT NAME:	
INCIDENT DATE:	
TREATMENT MANAGER NAME:	

TRIAGE TAG #	AGE	GENDER	INJURIES	TRANSPORT TIME

MINOR TREATMENT AREA LOG

INCIDENT NAME:	
INCIDENT DATE:	
TREATMENT MANAGER NAME:	

TRIAGE TAG #	AGE	GENDER	INJURIES	TRANSPORT TIME

MORGUE AREA LOG

INCIDENT NAME:	
INCIDENT DATE:	
TREATMENT MANAGER NAME:	

TRIAGE TAG #	AGE	GENDER	INJURIES	TRANSPORT TIME

APPENDIX H – PATIENT TRACKING WORKSHEETS

S-SV EMS Region MCI Patient Tracking Worksheet (Horizontal) - Updated 10-2024

Incident Name/Location	Incident Date	Form Completed By	Contact Telephone #

Triage Status	Triage Tag # (Last 4) Pt Name (First & Last)	Age Sex	Primary Injury Type	County of Origin Code	Transport Destination	Trans. Unit ID	Trans. Time	ETA	CF Advised
I D M		M F U							
I D M		M F U							
I D M		M F U							
I D M		M F U							
I D M		M F U							

County of Origin Codes

Butte **(XBU)** Colusa **(XCO)** Glenn **(XGL)** Lassen **(XLS)** Modoc **(XMO)** Nevada **(XNE)** Placer **(XPL)** Plumas **(XPU)**
Shasta **(XSH)** Sierra **(XSI)** Siskiyou **(XSK)** Sutter **(XSU)** Tehama **(XTE)** Trinity **(XTR)** Yuba **(XYU)**

Submit completed worksheets via email to Dutyofficer@ssvems.com

S-SV EMS Region MCI Patient Tracking Worksheet (Vertical) - Updated 10-2024

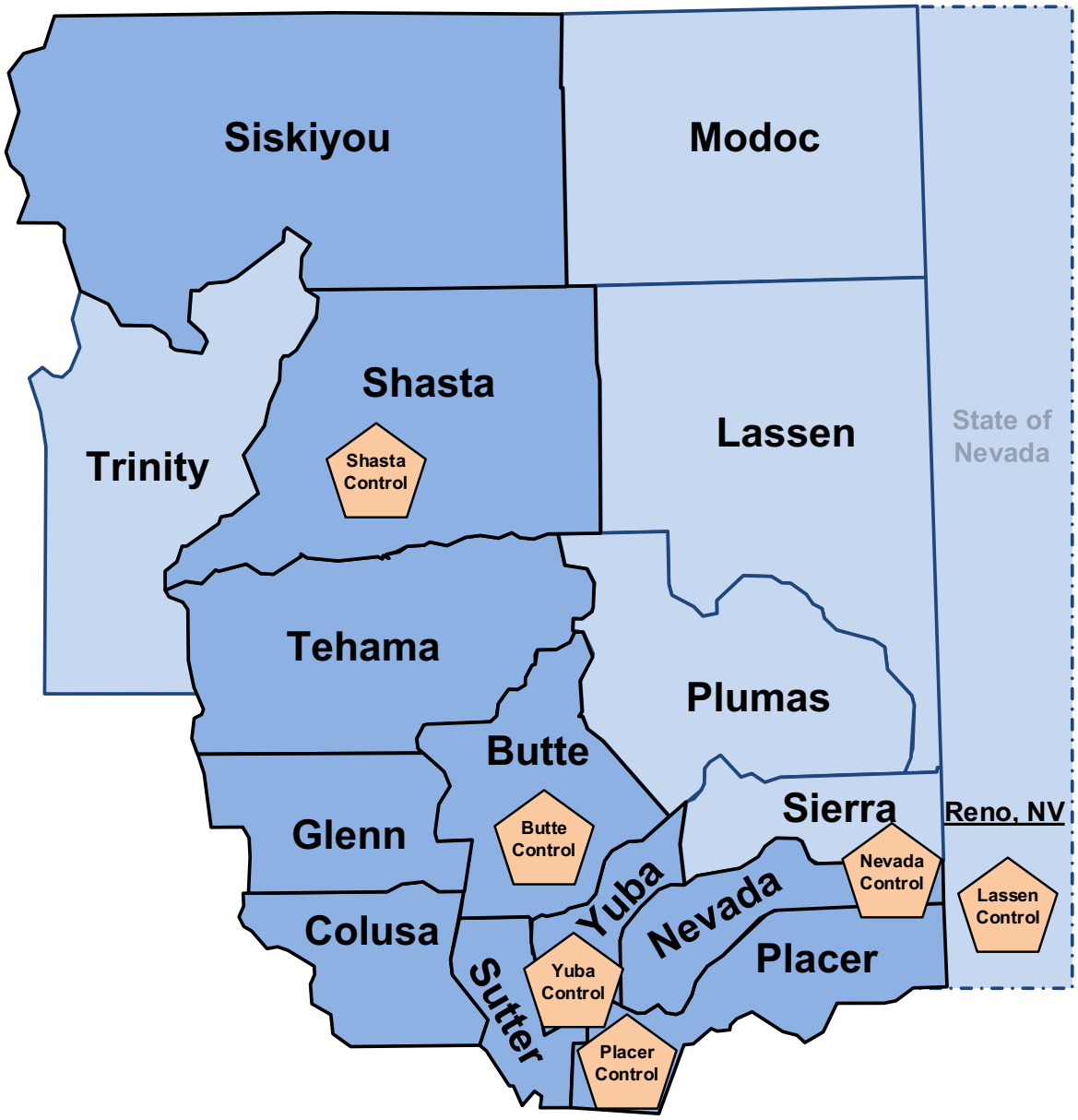
Incident Name:	Incident Date:

Triage Status (I/D/M)	Triage Tag # (Last 4)	Pt Age/ Gender	Pt Name	Injury Type	Transport Destination	Trans. Unit	Trans. Time

Submit Completed Patient Tracking Worksheets by email to Dutyofficer@ssvems.com

APPENDIX I – CONTROL FACILITY (CF) MAP

Control Facility (CF) Map



Local EMS Agencies (LEMSAs)

- Nor-Cal EMS Counties (Lassen, Modoc, Plumas, Sierra, Trinity)
- S-SV EMS Counties (Butte, Colusa, Glenn, Nevada, Placer, Shasta, Siskiyou, Sutter, Tehama, Yuba)

Control Facilities (CFs)

- "Butte Control" – Enloe Medical Center (EMC) – Chico, CA
- "Lassen Control" – Regional Emergency Medical Services Authority (REMSA) – Reno, NV
- "Nevada Control" – Tahoe Forest Hospital (TFH) – Truckee, CA
- "Placer Control" – Sutter Roseville Medical Center (SRMC) – Roseville, CA
- "Shasta Control" – Mercy Medical Center Redding (MMCR) – Redding, CA
- "Yuba Control" – Adventist Health +Rideout (AHR) – Marysville, CA

APPENDIX J – ICS 214 ACTIVITY LOG

ACTIVITY LOG (ICS 214)

1. Incident Name:	2. Operational Period: Date From: Date To: Time From: Time To:

3. Name:	4. ICS Position:	5. Home Agency (and Unit):

6. Resources Assigned:

Name	ICS Position	Home Agency (and Unit)

7. Activity Log:

Date/Time	Notable Activities

8. Prepared by: Name: _____ Position/Title: _____ Signature: _____

ICS 214, Page 1 Date/Time: _____

ACTIVITY LOG (ICS 214)

1. Incident Name:	**2. Operational Period:** Date From: Date To: Time From: Time To:

7. Activity Log (continuation)**:**

Date/Time	Notable Activities

8. Prepared by: Name: ____________ Position/Title: ____________ Signature: ____________

ICS 214, Page 2 Date/Time: ____________

ICS 214
Activity Log

Purpose. The Activity Log (ICS 214) records details of notable activities at any ICS level, including single resources, equipment, Task Forces, etc. These logs provide basic incident activity documentation, and a reference for any after-action report.

Preparation. An ICS 214 can be initiated and maintained by personnel in various ICS positions as it is needed or appropriate. Personnel should document how relevant incident activities are occurring and progressing, or any notable events or communications.

Distribution. Completed ICS 214s are submitted to supervisors, who forward them to the Documentation Unit. All completed original forms must be given to the Documentation Unit, which maintains a file of all ICS 214s. It is recommended that individuals retain a copy for their own records.

Notes:

- The ICS 214 can be printed as a two-sided form.
- Use additional copies as continuation sheets as needed, and indicate pagination as used.

Block Number	Block Title	Instructions
1	**Incident Name**	Enter the name assigned to the incident.
2	**Operational Period** • Date and Time From • Date and Time To	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	**Name**	Enter the title of the organizational unit or resource designator (e.g., Facilities Unit, Safety Officer, Strike Team).
4	**ICS Position**	Enter the name and ICS position of the individual in charge of the Unit.
5	**Home Agency** (and Unit)	Enter the home agency of the individual completing the ICS 214. Enter a unit designator if utilized by the jurisdiction or discipline.
6	**Resources Assigned**	Enter the following information for resources assigned:
	• Name	Use this section to enter the resource's name. For all individuals, use at least the first initial and last name. Cell phone number for the individual can be added as an option.
	• ICS Position	Use this section to enter the resource's ICS position (e.g., Finance Section Chief).
	• Home Agency (and Unit)	Use this section to enter the resource's home agency and/or unit (e.g., Des Moines Public Works Department, Water Management Unit).
7	**Activity Log** • Date/Time • Notable Activities	• Enter the time (24-hour clock) and briefly describe individual notable activities. Note the date as well if the operational period covers more than one day. • Activities described may include notable occurrences or events such as task assignments, task completions, injuries, difficulties encountered, etc. • This block can also be used to track personal work habits by adding columns such as "Action Required," "Delegated To," "Status," etc.
8	**Prepared by** • Name • Position/Title • Signature • Date/Time	Enter the name, ICS position/title, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).

APPENDIX K – MCI FEEDBACK/REPORTING FORM

MCI FEEDBACK/REPORTING FORM

REPORTING ENTITY	
Reporting Agency:	Reporting Person:
Telephone:	Email Address:

INCIDENT INFORMATION (COMPLETE AS APPLICABLE TO YOUR AGENCY'S ROLE)	
Incident Date:	Incident Name:
Incident Location:	
Dispatch Time:	First Unit On Scene Time:
First Transport Unit On Scene Time:	Supervisor On Scene Time:
Incident End Time:	

NUMBER & TYPE OF PREHOSPITAL EMS RESOURCES			
First Responder Agencies Utilized:			
Ground Amb. Providers Utilized:			
# of Ground Amb. Requested:		# of Ground Amb. Utilized	
HEMS Providers Utilized:			
# of HEMS Aircraft Requested:		# of HEMS Aircraft Utilized:	
Other Transport Resources:			
Incident Commander:		Transportation Unit Leader:	
Triage Unit Leader:		Med. Communications Coord.:	
Treatment Unit Leader:		Were MCI ID Vests Used? ☐ Yes ☐ No	
Were Triage Tags Used? ☐ Yes ☐ No		Were Pt. Tracking Sheets Used? ☐ Yes ☐ No	

NUMBER & TYPE OF PATIENTS			
IMMEDIATE:	DELAYED:	MINOR:	DECEASED:
# Of Adult Pts:		# Of Pediatric Pts:	
# Of Pts Transported by EMS:		# Of Pts Refusing Transport:	

HOSPITAL INFORMATION (CF = CONTROL FACILITY)	
CF Name:	Initial CF Contact Time:
Initial CF Notification Received From:	
Number Of CF Staff Assigned:	CF Pt Dispersal Officer:
Receiving Facilities Utilized:	

MCI COMMENTS/ISSUES/SUGGESTIONS/OBSERVATIONS (REQUIRED)