

Sierra – Sacramento Valley Emergency Medical Services Agency



Regional Executive Director
John Poland, Paramedic

Medical Director
Troy M. Falck, MD, FACEP, FAAEM

JPA Board Chairperson
Jim Holmes, Placer County Supervisor

Address & Contact Information
535 Menlo Drive, Suite A
Rocklin, CA 95765
(916) 625-1702
info@ssvems.com
www.ssvems.com

Serving Butte, Colusa, Glenn, Nevada, Placer, Shasta, Siskiyou, Sutter, Tehama, & Yuba Counties

ADMINISTRATIVE BULLETIN

Date: January 20, 2026

To: EMS System Participants

From: Troy M. Falck MD, FACEP, FAAEM, Medical Director
John Poland, Regional Executive Director

Subject: S-SV EMS Prehospital Policy/Protocol Update #78

Enclosed are S-SV EMS Policy/Protocol Update #78 documents, effective April 1, 2026. Please be aware of the following information related to this update:

- EMS system participants are responsible for distribution of new/revised S-SV EMS policies/protocols to their personnel. In addition to the update summary information contained on the following pages, all applicable policy and protocol documents included in this update packet are marked up to identify specific revisions.
- Final versions of all new/revised policy/protocol documents will be published on the S-SV EMS website (www.ssvems.com) and the S-SV EMS mobile applications prior to April 1, 2026.

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POLICY UPDATES SUMMARY		
Policy #	Policy Title	Summary of Changes & Notes
201 & 201-A	S-SV EMS Agency Organizational Chart & Staff Responsibilities	<ul style="list-style-type: none">Updated S-SV EMS Certification Specialist staff information. (Note: effective 11/1/2025)
211	S-SV EMS Prehospital Advisory Committee	<ul style="list-style-type: none">Routine review, no substantive changes.
307	Ambulance Patient Offload Time (APOT)	<ul style="list-style-type: none">Policy updated for consistency with recent APOT regulations updates.S-SV EMS APOT 90th percentile standard reduced to 25 minutes, effective 7/1/2026.
411	LALS/ALS Provider Agency Responsibilities	<ul style="list-style-type: none">Routine review, no substantive changes.
414	911 Ground Ambulance Dispatch Requirements	<ul style="list-style-type: none">Routine review, no substantive changes.
416	Alternate Transport Vehicles	<ul style="list-style-type: none">Routine review, no substantive changes.
450	HEMS Aircraft Authorization, Classification & Operations	<ul style="list-style-type: none">Routine review, no substantive changes.
462	Temporary Recognition of EMS Personnel	<ul style="list-style-type: none">Minor policy updates to address issues identified from the previous wildfire season.

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POLICY UPDATES SUMMARY (continued)		
Policy #	Protocol Title	Summary of Changes & Notes
504	Emergency Department Downgrade/Cessation	<ul style="list-style-type: none">• Removal of LEMSA approval or denial recommendation language.
605	EMS Documentation	<ul style="list-style-type: none">• Minor revisions to clarify when ALS/LALS personnel must complete an ePCR.• Clarification related to leaving an interim patient care report with the receiving hospital RN or physician.
621	HEMS Aircraft Quality Management	<ul style="list-style-type: none">• Routine review, no substantive changes.
710	Management Of Controlled Substances	<ul style="list-style-type: none">• Revised language regarding wastage of unused controlled substances.
812	Base/Modified Base/Receiving Hospital Contact	<ul style="list-style-type: none">• Routine review, no substantive changes.
838	Crisis Standard of Care Procedures	<ul style="list-style-type: none">• Routine review, no substantive changes.
848	Reduction/Cancellation of ALS Response	<ul style="list-style-type: none">• Clarification regarding when a responding ALS resource should be reduced/cancelled.
862	HEMS Aircraft Requesting & Utilization	<ul style="list-style-type: none">• Additional Medical Control language.• Additional response time language/data.• Updated HEMS aircraft utilization criteria.• Update HEMS aircraft response/cancellation language.• Additional HEMS aircraft abort reporting language.

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PPROTOCOL UPDATES SUMMARY		
Protocol #	Protocol Title	Summary of Changes & Notes
C-1 & C-1 (LALS)	Non-Traumatic Pulseless Arrest	<ul style="list-style-type: none"> C-1 – Clarification on amiodarone administration. C-1 (LALS) – Clarification on lidocaine administration.
C-4 & C-4 (LALS)	Tachycardia With Pulses	<ul style="list-style-type: none"> C-4 – Clarification on amiodarone administration & updated synchronized cardioversion directions. C-4 (LALS) – Updated synchronized cardioversion directions.
T-6 & T-6 (LALS)	Traumatic Pulseless Arrest	<ul style="list-style-type: none"> Clarification language related to the use of epinephrine and timing of patient transport.
C-1P & C-1P (LALS)	Pediatric Pulseless Arrest	<ul style="list-style-type: none"> Updated infant CPR directions based on recent AHA standard changes. Removal of maximum epinephrine doses. Clarification on amiodarone administration (C-1P only)
M-2P & M-2P (LALS)	Newborn Care/ Neonatal Resuscitation	<ul style="list-style-type: none"> Minor clarification language related to advanced airway and epinephrine administration.
R-3P & R-3P (LALS)	Pediatric Respiratory Distress	<ul style="list-style-type: none"> R-3P – Addition of magnesium sulfate (base order). R-3P (LALS) – No substantive changes.
G-1 & G-1 (LALS)	Multiple Patient Incidents	<ul style="list-style-type: none"> Routine review, no substantive changes. Updated MCI Plan requirement for Control Facilities (CFs) to conduct an EMResource poll for EMS Surge Incidents in addition to declared MCIs.
G-2 & G-2 (LALS)	Determination of Death	<ul style="list-style-type: none"> Clarification language related to termination of resuscitation once patient transport has begun and prior to arrival at the rendezvous location/destination hospital.

Sierra – Sacramento Valley EMS Agency Program Policy

S-SV EMS Agency Organizational Chart



Effective: 11/01/2025

Next Review: As Needed

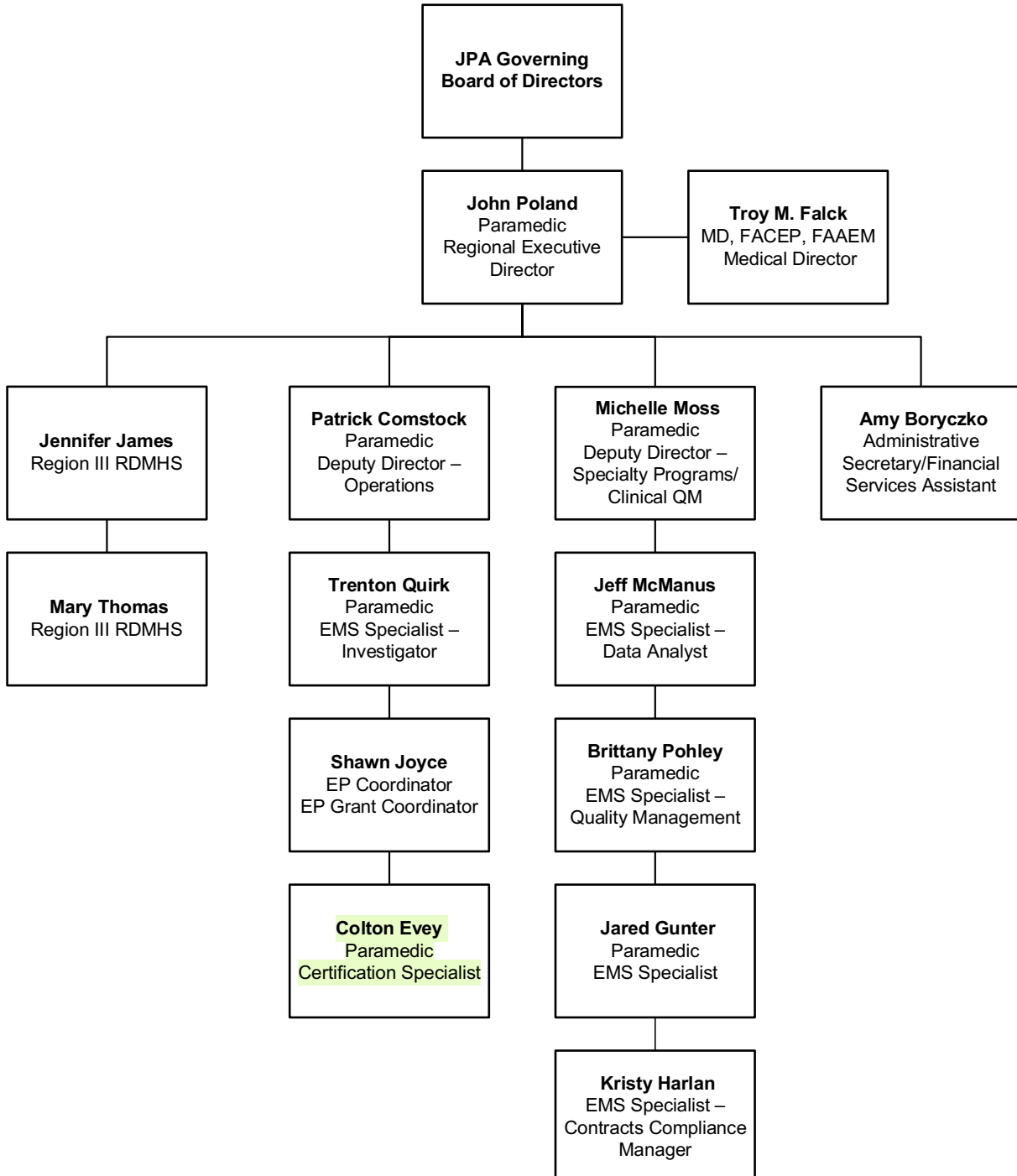
201

Approval: Troy M. Falck, MD – Medical Director

SIGNATURE ON FILE

Approval: John Poland – Executive Director

SIGNATURE ON FILE





S-SV EMS Agency Staff Primary Responsibilities

201-A


Name, Title, & Contact Info	Primary Responsibilities
John Poland, Paramedic Regional Executive Director John.Poland@ssvems.com (916) 625-1719	<ul style="list-style-type: none">• S-SV EMS member county BOS, CAO & PHO contact• S-SV EMS legal counsel contact• Hospital administration contact• S-SV EMS & personnel oversight• S-SV EMS contracts• S-SV EMS fiscal management• S-SV EMS EMS Plan• S-SV EMS EMS system policies/protocols• Region III RDMHC/S program oversight
Troy M. Falck, MD Medical Director Troy.Falck@ssvems.com (916) 625-1715	<ul style="list-style-type: none">• Medical control, direction & oversight of the S-SV EMS system and all EMS personnel within the S-SV EMS region• Assist in the development/approval of all S-SV EMS policies and treatment protocols
Patrick Comstock, Paramedic Deputy Director – Operations Patrick.Comstock@ssvems.com (916) 625-1714	<ul style="list-style-type: none">• EMS training programs approval/oversight• S-SV EMS personnel credentialing & investigation/enforcement program oversight/management• S-SV EMS RFPs, provider agreements, & permitting oversight/management• EMCC/EMAG/HPP/HP liaison• S-SV EMS data system oversight• S-SV EMS personnel oversight
Michelle Moss, Paramedic Deputy Director – Specialty Programs/Clinical Quality Management Michelle.Moss@ssvems.com (916) 625-1711	<ul style="list-style-type: none">• Regional STEMI/stroke/trauma systems oversight/management• Regional HEMS program oversight/management• Regional specialty systems contracting oversight• Clinical quality management (QA/QI) oversight/management• EMS for children/pediatric specialty center liaison• S-SV EMS data system/patient registries oversight• S-SV EMS personnel oversight
Amy Boryczko Administrative Secretary/ Financial Services Assistant Amy.Boryczko@ssvems.com (916) 625-1712	<ul style="list-style-type: none">• Secretary to the S-SV EMS Regional Executive Director• Secretarial support for S-SV EMS staff• Clerk of the Board to the S-SV EMS JPA Governing Board• Technical/clerical support for HPP & other grant activities• Assist with S-SV EMS fiscal management• Placer County Auditor-Controller's Office liaison
Jennifer Johnson Region III RDMHS Jennifer.Johnson@ssvems.com (530) 722-6615	<ul style="list-style-type: none">• Region III Regional Disaster Medical Health Specialist (RDMHS) program operational responsibilities• EMCC/EMAG/HPP/EP liaison
Mary Thomas Region III RDMHS Mary.Thomas@ssvems.com (530) 722-6615	<ul style="list-style-type: none">• Region III Regional Disaster Medical Health Specialist (RDMHS) program operational responsibilities• EMCC/EMAG/HPP/EP liaison



S-SV EMS Agency Staff Primary Responsibilities

201-A

Name, Title, & Contact Info	Primary Responsibilities
Trenton Quirk, Paramedic EMS Specialist – Investigator Trenton.Quirk@ssvems.com (916) 625-1716	<ul style="list-style-type: none">• Processing/managing California DOJ and/or FBI CORI background and subsequent arrest/disposition records• Overseeing/assisting with S-SV EMS investigation and personnel enforcement related matters• Assist with S-SV EMS operational duties as necessary
Shawn Joyce EP/EP Grant Coordinator Shawn.Joyce@ssvems.com (916) 625-1718	<ul style="list-style-type: none">• Emergency preparedness (EP) & EP grant coordination
Colton Evey, Paramedic Certification Specialist info@ssvems.com (916) 625-1702	<ul style="list-style-type: none">• EMS personnel certification, accreditation, & authorizations• Assist with S-SV EMS operational duties as necessary
Jeff McManus, Paramedic EMS Specialist – Data Analyst Jeff.McManus@ssvems.com (916) 625-1721	<ul style="list-style-type: none">• Supports S-SV EMS & EMS system participants with the EMS data system and patient data registries• Analysis/reporting of statistical EMS & specialty program data• HIE data oversight• Assist with S-SV EMS QA/QI activities as necessary
Brittany Pohley, Paramedic EMS Specialist – QM Brittany.Pohley@ssvems.com (916) 625-1724	<ul style="list-style-type: none">• EMS system participant QA/QI primary liaison• Development, coordination, and oversight of EMS QA/QI activities/initiatives• QI indicator reporting to the S-SV EMS and EMS system participants• Development, oversight, planning, and coordination of S-SV EMS initiated training/education programs
Jared Gunter, Paramedic EMS Specialist Jared.Gunter@ssvems.com (916) 625-1717	<ul style="list-style-type: none">• Oversight/coordination of the S-SV EMS Regional Emergency Medical Advisory Committee (REMAC) process• S-SV EMS clinical data auditing, analysis, and reporting• Assist with prehospital provider contract compliance• Assist with EMS training programs approval/oversight• Assist with S-SV EMS QA/QI activities as necessary
Kristy Harlan EMS Specialist – Contracts Compliance Manager Kristy.Harlan@ssvems.com (916) 625-1722	<ul style="list-style-type: none">• EMS system participant liaison• Prehospital provider contract compliance• Internal/external compliance reporting• Assist with S-SV EMS QA/QI activities as necessary

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

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 assumes 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:~~

~~○ APOT 1.1: 31 – 40 minutes~~

~~○ APOT 1.2: 31 – 40 minutes~~

~~○ APOT 2: 31 – 60 minutes~~

~~d. Significantly Exceeds APOT Standard:~~

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

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

~~○ 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.~~

Ambulance Patient Offload Time (APOT)**307**

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.24	Type of Destination	Hospital Emergency Department
eDisposition.04	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. Effective 7/1/2026, the S-SV EMS APOT 1.2 (90th percentile) standard is 25 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 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
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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.	<input type="checkbox"/>
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.	<input type="checkbox"/>
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.	<input type="checkbox"/>
The APOT reduction protocol includes systems to improve coordination between the ED and other hospital departments, including consults for ED patients.	<input type="checkbox"/>
The APOT reduction protocol includes direct operational changes designed to facilitate the rapid reduction of APOT to meet the S-SV EMS standard.	<input type="checkbox"/>
The hospital shall submit its APOT reduction protocol to EMSA and report any revisions annually on or before June 30 th . All updates should include required data elements and action plans.	<input type="checkbox"/>



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			
LALS/ALS Provider Agency Responsibilities			
	Effective: 04/01/2026	Next Review: 10/2028	411
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish LALS/ALS prehospital service provider agency responsibilities.


AUTHORITY:

- A. HSC, Division 2.5.
- B. CCR, Title 22, Division 9, Chapters 3.2 and 4.3.3.

POLICY:

- A. An S-SV EMS approved LALS/ALS prehospital service provider agency shall:
 1. Provide LALS/ALS prehospital emergency medical services on a continuous twenty-four (24) hours per day basis unless otherwise approved by S-SV EMS, in which case there shall be adequate justification for the exemption.
 2. Maintain and utilize telecommunications as specified in S-SV EMS policies.
 3. Maintain medical equipment and supplies as specified in S-SV EMS policies.
 4. Ensure that security mechanisms and procedures are established for storage and administration of controlled substances as required by S-SV EMS policies.
 5. Have a written agreement with S-SV EMS to participate in the EMS system, and comply with all applicable EMS laws, regulations, and policies, including participation in the S-SV EMS Emergency Medical Services Quality Improvement Program (EMSQIP).
 6. Participate in S-SV EMS regional committee meetings and other EMS activities that affect the region.
 7. Participate in the S-SV EMS data collection program.
 8. Be responsible for training and assessing the knowledge/skills of their prehospital personnel in S-SV EMS policies/protocols.
 9. Maintain approval as an EMS continuing education (CE) provider and provide training deemed necessary by S-SV EMS.
 10. Provide supervised field internship experience for prehospital students in accordance with CCR Title 22 and S-SV EMS policies.

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11. Provide remedial education/training for prehospital personnel as needed.
 12. Actively participate in local/regional disaster planning efforts, and reasonably participate in local/regional MCI and disaster drills.
 13. Follow the procedures specified in regional plans and S-SV EMS policies during an MCI or disaster response.
- B. If, through the EMSQIP the relevant employer or S-SV EMS Medical Director determines that an AEMT or paramedic requires additional training, observation, or testing, the relevant employer and the S-SV EMS Medical Director may create a remediation program based on the identified need. If there is disagreement between the relevant employer and the S-SV EMS Medical Director regarding remediation matters, the decision of the S-SV EMS Medical Director shall prevail.
 - C. No organization or responding unit shall advertise itself as providing LALS/ALS services unless they are approved by S-SV EMS and staffed with appropriately credentialed AEMT and/or paramedic personnel.
 - D. S-SV EMS may deny, suspend, or revoke LALS/ALS prehospital service provider agency approval for failure to comply with applicable EMS policies, procedures, laws or regulations.

Sierra – Sacramento Valley EMS Agency Program Policy			
911 Ground Ambulance Dispatch Requirements			
	Effective: 04/01/2026	Next Review: 10/2028	414
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish minimum 911 ground ambulance dispatch requirements.

AUTHORITY:


- A. HSC, Division 2.5, Chapter 4, Article 1, § 1797.223.
- B. CCR, Title 22, Division 9, Chapter **43**.
- C. GC, Title 5, Division 2, Part 1, Chapter 1, Article 6, § 53110.

POLICY:

- A. A public agency shall not delegate, assign, or enter into a contract for 911 call processing services for the dispatch of emergency response resources except if the delegation or assignment is to, or the contract or agreement is with, another public agency.
- B. If applicable, a public safety agency that provides 911 call processing services for emergency medical response shall make a connection available from the public safety agency dispatch center to an emergency medical services (EMS) provider's dispatch center for the timely transmission of emergency response information.
 - 1. For purposes of this policy, "connection" means either a direct computer aided dispatch (CAD) to CAD link, where permissible under law, between the public safety agency and an EMS provider or an indirect connection, including, but not limited to, a ring-down line, intercom, radio, or other electronic means for timely notification of caller data and the location of the emergency response.
 - 2. A public safety agency shall be entitled to recover from an EMS provider the actual costs incurred in establishing and maintaining this connection.
 - 3. An EMS provider that elects not to use this connection shall be dispatched by the appropriate public safety agency and charged a rate negotiated by the parties.
- C. Any dispatch center (including non-emergency providers) receiving a request for emergency medical assistance from any member of the public, either through the 911 system or a non-emergency number, shall promptly notify the applicable dispatch center for the first responder and/or 911 ambulance provider of the call.

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- D. All 911 ambulance providers shall operate their own dispatch center, contract with an existing dispatch center, or join with other providers to operate a dispatch center. If a 911 ambulance provider utilizes dispatch services provided by another organization, it must have a written contract for those services.
- E. All 911 ambulance providers shall maintain dispatch services necessary to receive and respond to requests for emergency ambulance services. The 911 ambulance provider's dispatch center shall:
1. Receive calls for emergency medical assistance from applicable public safety answering points (PSAPs) and non-emergency telephone lines.
 2. Identify and dispatch the closest available 911 ambulance to the scene of the emergency in accordance with current EOA and non-EOA agreements/permits.
 3. Only dispatch the number of ambulances appropriate for the type of incident or as requested by the Incident Commander (IC).
 4. Notify responding personnel and agencies of pertinent incident information.
 5. Monitor and track responding resources.
 6. Coordinate with law enforcement, first responders and other EMS providers.
 7. Provide required dispatch data to S-SV EMS.
- F. To maintain the integrity of EOA's within the S-SV EMS region, the exclusive 911 ambulance provider for the service area where the call is located shall be dispatched to all emergency medical incidents within that service area, unless a closer authorized provider is requested through automatic/mutual aid.
- G. If the dispatch center utilizes an S-SV EMS approved MPDS, the dispatcher shall follow the protocols associated with that system.
- H. Ambulances shall not at any time proceed at a level of response other than as directed by the applicable PSAP or ambulance provider dispatch center.
- I. 911 ambulance providers shall have a written policy and shall make all reasonable efforts to immediately notify the jurisdictional PSAP, if applicable, of the location from where the ambulance is responding from.
- J. The dispatch center shall be staffed with sufficient properly trained personnel to accomplish all applicable dispatch functions.
- K. A computer-aided dispatch (CAD) system shall be utilized to record dispatch information for all 911 ambulance requests. CAD system information shall include a minimum of caller, incident date, incident location, assigned unit ID, reason for cancellation (if applicable), and all appropriate incident times (hours, minutes, and seconds).
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- L. The dispatch center shall have capabilities for 24-hour real time recordings of all emergency telephone lines and radio frequencies. All radio and telephone communications shall be recorded on tape or other digital recording medium and maintained for a minimum of 90 days.
- M. 911 ambulance providers shall have a plan to provide ambulance dispatch services during any period of primary dispatch failure. The plan shall ensure that an equivalent dispatch center or dispatch system is able to serve as a backup within five (5) minutes of failure of the primary dispatch center.

Sierra – Sacramento Valley EMS Agency Program Policy			
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			
HEMS Aircraft Authorization, Classification & Operations			
	Effective: 04/01/2026	Next Review: 10/2028	450
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

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

AUTHORITY:

- A. HSC, Division 2.5, § 1797.200 – 1797.276, 1798 – 1798.8 & 1798.170.
- B. CCR, Title 22, Chapter ~~8-7~~.
- C. Federal Aviation Regulations, ~~§ 91.3, 91.11 and 91.12.~~

DEFINITIONS:

- A. **Helicopter Emergency Medical Services (HEMS) Aircraft** – Rotor wing aircraft utilized for the purpose of prehospital emergency response and patient transport. HEMS aircraft include air ambulances and all ALS/BLS rescue aircraft.
- B. **Air Ambulance** – Any aircraft specially constructed, modified or equipped and used for the primary purpose of responding to emergency incidents and transporting critically ill and/or injured (life or limb) patients, whose medical flight crew has, at a minimum, two (2) attendants certified or licensed in advanced life support.
- C. **Rescue Aircraft** – Aircraft whose usual function is not patient transport but may be used for patient transport when the use of an air or ground ambulance is inappropriate or not readily available. Rescue aircraft are classified as one of the following:
 - 1. **Advanced Life Support (ALS) Rescue Aircraft** – A rescue aircraft whose medical flight crew has, at a minimum, one (1) attendant licensed as a paramedic.
 - 2. **Basic Life Support (BLS) Rescue Aircraft** – A rescue aircraft whose medical flight crew has, at a minimum, one (1) attendant certified as an EMT.
 - 3. **Auxiliary Rescue Aircraft** – A rescue aircraft that does not have a medical flight crew, or whose flight crew does not meet ALS/BLS rescue aircraft requirements.

POLICY:


- A. S-SV EMS is responsible for classifying/authorizing HEMS aircraft based within the S-SV EMS region, except that the California EMS Authority (EMSA) is responsible for classifying aircraft of the California Highway Patrol, CAL FIRE, and California National Guard. S-SV EMS classification/authorization will be provided by written agreements with HEMS aircraft providers.
- B. No person or organization shall provide or hold themselves out as providing HEMS aircraft services unless that organization has aircraft which have been classified/authorized by a local EMS agency (LEMSA) or, in the case of the California Highway Patrol, CAL FIRE, and California National Guard, by EMSA.
- C. Except for mutual aid requests, HEMS aircraft must be classified/authorized by S-SV EMS and possess a current/valid S-SV EMS air ambulance service provider permit to operate within the S-SV EMS region. A request from a designated dispatch center shall be deemed as authorization of aircraft operated by the California Highway Patrol, CAL FIRE, California National Guard, or the Federal Government.
- D. HEMS aircraft providers, owners, operators, or any hospital where a HEMS aircraft is based, housed, or stationed permanently or temporarily shall adhere to all federal, state, and local statutes, ordinances, policies, and procedures related to HEMS aircraft operations, including qualifications of flight crews and aircraft maintenance.
- E. All ALS HEMS aircraft shall employ a provider medical director who is a physician licensed in the State of California who by training and experience, is qualified in emergency medicine. The medical director shall be responsible for the supervision of the quality assurance/improvement program of air medical transport patient care.
- F. Medical Control:
 - 1. The medical direction/management of the EMS system shall be under the medical control of the S-SV EMS medical director.
 - 2. Flight paramedics shall operate under S-SV EMS policies/protocols. Paramedics employed by S-SV EMS authorized air ambulance providers who have been approved for Unified Paramedic Optional Scope of Practice may perform skills and administer medications in accordance with applicable S-SV EMS and/or HEMS aircraft provider approved policies/protocols.
 - 3. Flight RNs may perform skills and administer medications beyond the S-SV EMS paramedic scope of practice, in accordance with RN specific policies/protocols developed/approved by the provider's medical director and agreed to by the S-SV EMS medical director. HEMS aircraft provider patient care policies/protocols shall be submitted to S-SV EMS initially and upon subsequent revision.
- G. Personnel:
 - 1. Air ambulances shall be staffed with a minimum of two (2) ALS medical flight crew members. Staffing can be achieved with any combination of:

- a. S-SV EMS accredited paramedic.
 - b. Registered nurse (RN) who has successfully completed an S-SV EMS paramedic accreditation course or similar S-SV EMS approved training.
2. Rescue aircraft shall be staffed with a minimum of one (1) S-SV EMS accredited paramedic or EMT medical flight crew member, based on their classification level.
3. The medical flight crew of HEMS aircraft shall have training in aeromedical transportation equivalent to DOT Air Medical Crew National Standard Curriculum.
4. Medical flight crews shall participate in such continuing education requirements as required by their license/certification.
5. In situations where the flight crew is less medically qualified than the ground personnel from whom they receive patients; they may only assume patient care responsibility in accordance with applicable S-SV EMS policies/protocols.

H. Communications:

1. HEMS aircraft providers shall be honest, open, ethical, and responsible for accurately informing the air ambulance coordination center and/or requesting PSAP of any changes in availability or response status. This shall include any circumstance and/or activity that will delay their ability to respond (maintenance, training flights, interfacility transports, need for refueling, etc.).
2. HEMS aircraft shall provide an updated ETA to the air ambulance coordination center, requesting PSAP and/or designated LZ contact when enroute.
3. All communications between HEMS aircraft and the designated LZ contact should be done using CALCORD operational frequency of 156.075.
4. HEMS aircraft shall have the capability of communicating directly, while in flight, with the following entities:
 - a. Required FAA facilities.
 - b. Air ambulance coordination center and/or requesting PSAP.
 - c. Ground units.
 - d. Base, modified base and receiving hospitals.
 - e. S-SV EMS air to air EMS aircraft on frequency 123.025.
5. Air ambulance providers shall notify the applicable air ambulance coordination center when entering/flying through their geographical area. The air ambulance coordination center will inform air ambulance personnel of any other known aircraft activities in the area (fire suppression, other responding aircraft, etc.).

6. Air ambulance coordination centers will not routinely perform flight-following operations with HEMS aircraft. This will remain the responsibility of the requesting PSAP and/or the HEMS aircraft provider's dispatch center.
 7. ~~Air ambulance providers shall maintain and update their availability on EMResource a minimum of once per pilot shift. EMResource will not be used as a primary method of determining HEMS aircraft availability by the air ambulance coordination centers.~~ Each permitted HEMS resource is responsible for maintaining current availability status in EMResource.
- I. Air Ambulance Coordination Center Data Recording and Reporting:
1. Air ambulance coordination centers shall adequately record all air ambulance resource request activities.
 2. Air ambulance coordination centers shall provide air ambulance coordination data to S-SV EMS upon request.
- J. Space & Equipment:
1. HEMS aircraft shall be configured so that:
 - a. There is sufficient space to accommodate one (1) patient on a stretcher and one (1) patient attendant. Air ambulances shall have space to accommodate one (1) patient and two (2) patient attendants, at a minimum.
 - b. There is sufficient space for medical personnel to have adequate patient access to carry out necessary procedures on the ground and in the air.
 - c. There is sufficient space for medical equipment and supplies required by applicable regulations and S-SV EMS policies.
 2. HEMS aircraft shall have adequate safety belts and tie-downs for all personnel, patients, stretchers, and equipment to prevent inadvertent movement.
 3. HEMS aircraft shall have onboard equipment and supplies commensurate with the scope of practice of the medical flight crew, as approved by S-SV EMS.
 4. HEMS aircraft shall be equipped with a radio headset for each crew member, ride along and patient. Each crew member headset should allow for communications with ground stations, base/modified base and receiving hospitals.

Sierra – Sacramento Valley EMS Agency Program Policy			
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 LEMSAs 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 LEMSAs 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 LEMSAs 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 LEMSAs.

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 credentialing 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 credentialing 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 credentialing 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			
Emergency Department Downgrade/Cessation			
	Effective: 04/01/2026	Next Review: 10/2028	504
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

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

AUTHORITY:

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

POLICY:

- A. Any hospital proposing a reduction or elimination of emergency medical services in their facility shall notify the State Department of Health Services, the County Department of Public Health, S-SV EMS, and all health service plans under contract with the hospital, no later than 90 days prior to any such change.
- B. The hospital implementing a change shall provide for public notification of the proposed changes no less than 90 days prior to implementing any changes. The notification shall be of such magnitude as to inform a significant number of residents within the hospital's service area and be in terms likely to be understood by a layperson.
- C. Upon notification, S-SV EMS shall proceed with an impact evaluation in collaboration with the California Healthcare Association and the local Public Health Department. The report shall include, but is not limited to, the following:
 1. Geography: service area population density, travel time and distance to the next nearest facility, number and type of other available emergency services and availability of prehospital resources.
 2. Base hospital designation: number of calls; impact on patients, prehospital personnel, and other base hospitals.
 3. Level of care: assessment of level of emergency services provided, i.e., basic, standby, and next nearest availability.
 4. Trauma care: number of trauma patients; impact on other hospitals, trauma centers and trauma patients.
 5. Specialty services provided: neurosurgery, obstetrics, burn center, pediatric critical care, stroke, STEMI, etc. and the next nearest availability.


6. Patient volume: number of emergency department patients annually, both 911 transports and walk-ins.
7. Notification of the public: process to be used: public hearing, advertising, etc.; ensure that all appropriate health care providers are consulted with.
8. Availability of prehospital care: availability and level of prehospital care and EMS aircraft resources.
9. Public and emergency provider comments: obtained through local EMS committees and public hearing.

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

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

1. Ensure planning or zoning authorities have been notified.
2. Conduct, in conjunction with the local Department of Public Health, at least one public hearing on the proposed changes.
3. Distribute a draft of the impact evaluation report to the local County Department of Public Health, the S-SV EMS Regional Medical Control Advisory Committee, the affected county's Emergency Medical Control Committee (or similar county EMS committee), the S-SV EMS JPA Governing Board, and any other emergency care provider affected by the changes.

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

Sierra – Sacramento Valley EMS Agency Program Policy			
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) data 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.

EMS Documentation	605
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- 1 3. Pertinent vital signs.
- 2 4. EMS treatment rendered (time, type, dose, route, response, etc.).
- 3 5. Relevant patient care related documents (DNR/POLST forms, 12 Lead EKGs,
- 4 cardiac monitor rhythm strips, etc.).
- 5 6. Name, title, and ID of EMS personnel completing the documentation.
- 6 C. PCR's shall be completed within twenty-four (24) hours after completion of the patient
- 7 encounter (NEMSIS V3.5 data element eTimes.13 – 'Unit Back in Service Date/Time'),
- 8 and shall be distributed as follows:
- 9 1. If a BLS optional skill was utilized, a copy of the completed PCR shall be provided/
- 10 available to S-SV EMS within seven (7) calendar days of the incident.
- 11 2. PCR's shall be provided/available to the applicable receiving, base, and/or modified
- 12 base hospital upon completion, but no later than twenty-four (24) hours after
- 13 completion of the patient encounter.
- 14 D. Any EMS provider required to complete/submit ePCR data pursuant to this policy, and
- 15 who chooses not to utilize the S-SV EMS ImageTrend ePCR software system, shall
- 16 submit EMS data to S-SV EMS in the following manner:
- 17 1. EMS data shall be continually compliant with current CEMSIS/NEMSIS standards
- 18 and the current S-SV EMS data schematron.
- 19 2. EMS data for all incidents required by this policy shall be submitted to the EMS
- 20 data system utilized by S-SV EMS within twenty-four (24) hours after completion
- 21 of the patient encounter. Any ePCR record that fails to import shall be identified,
- 22 corrected, and successfully submitted to the EMS data system utilized by S-SV
- 23 EMS within seventy-two (72) hours after completion of the patient encounter.
- 24 E. PCR's for adult and emancipated minor patients shall be preserved for at least seven
- 25 (7) years. PCR's for unemancipated minor patients shall be preserved for at least one
- 26 (1) year after such minor has reached the age of 18 years old and, in any case, not
- 27 less than seven (7) years.

Sierra – Sacramento Valley EMS Agency Program Policy			
HEMS Aircraft Quality Management			
	Effective: 04/01/2026	Next Review: 10/2028	621
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish HEMS aircraft quality management requirements.

AUTHORITY:

- A. HSC, Division 2.5, § 1797.204, 1797.220 and 1798.
- B. CCR, Title 22, Chapters 4, 8 7 & 12 10.

POLICY:

- A. Records
 - 1. HEMS aircraft providers shall submit patient care data as required by S-SV EMS policies.
 - 2. HEMS aircraft providers shall submit dispatch/flight records to S-SV EMS for quality management and/or investigative purposes upon request.
- B. Emergency Medical Services Quality Improvement Program (EMSQIP):
 - 1. HEMS aircraft providers shall develop, implement, and maintain an EMSQIP, which is approved by S-SV EMS.
 - 2. The EMSQIP shall be designed to objectively, systematically and continuously monitor, assess and improve the quality and appropriateness of patient care and safety. The EMSQIP indicators should be tracked and trended to determine compliance with established thresholds as well as reviewed for potential issues.
 - 3. When the EMSQIP identifies a need for improvement, the HEMS aircraft provider shall develop, in cooperation with other EMS system participants when applicable, a performance improvement action plan. If the area identified as needing improvement includes system clinical issues, collaboration is required with the provider's medical director and the S-SV EMS medical director.
 - 4. The EMSQIP shall be reviewed annually for appropriateness to the operation of the HEMS aircraft provider. A summary of this review, including how the provider's EMSQIP addressed the program indicators, shall be provided to S-SV EMS.
 - 5. HEMS aircraft providers are responsible for conducting initial and recurring planned/structured safety training to public safety agencies and hospital personnel who interface with their medical services. This training at a minimum shall include:


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

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

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

C. HEMS Aircraft Utilization Review:

1. HEMS aircraft scene calls will be routinely reviewed by S-SV EMS staff to evaluate appropriate utilization, deviation from applicable policies/protocols, dispatch trends and to assess EMS system management.
2. S-SV EMS may select a committee to systematically review HEMS aircraft scene incidents for appropriate utilization and adherence to applicable policies/protocols.

Sierra – Sacramento Valley EMS Agency Program Policy			
Management Of Controlled Substances			
	Effective: 04/01/2026	Next Review: 10/2028	710
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

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

AUTHORITY:

- A. Code of Federal Regulations, Title 21.
- B. HSC, Division 2.5 & Division 10.
- C. CCR, Title 22, Division 9, Chapter 3.

POLICY:

A. S-SV EMS Approved Controlled Substances:

1. Fentanyl.
2. Ketamine.
3. Midazolam.

B. Obtaining Controlled Substances:

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

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

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


1. Prehospital service provider agencies shall ensure that security mechanisms and procedures are established for controlled substances, including, but not limited to:
 - a. Controlled substance ordering & order tracking.
 - b. Controlled substance receipt & accountability.
 - c. Controlled substance master supply storage, security & documentation.

-
- d. Controlled substance labeling & tracking.
 - e. Controlled substance vehicle storage & security.
 - f. Controlled substance usage procedures & documentation.
 - g. Controlled substance reverse distribution.
 - h. Controlled substance disposal.
 - i. Controlled substance re-stocking procedures.
2. Prehospital service provider agencies shall ensure that mechanisms for investigation and mitigation of suspected controlled substance tampering or diversion are established, including, but not limited to:
- a. Controlled substance testing.
 - b. Controlled substance discrepancy reporting.
 - c. Controlled substance tampering, theft & diversion prevention/detection.
 - d. Controlled substance usage audits.
- D. Controlled Substance Security:
- 1. AEMT II and paramedic personnel are responsible for maintaining the correct inventory of controlled substances at all times.
 - 2. All controlled substances shall be stored/secured in one of the following manners:
 - a. Preferred: Secured in a commercially developed drug locker specifically designed for controlled substance storage. The drug locker shall be securely mounted to the vehicle to prevent theft and shall have an electronic access keypad with an individual PIN code assigned to each individual authorized to access/utilize controlled substances. The drug locker shall be able to produce an electronic audit trail showing the date, time and PIN code of each instance the locker was opened. The double lock requirement does not apply to providers storing their controlled substance utilizing this method.
 - b. Alternative: Secured in the vehicle under double lock, in an appropriate manner to prevent theft. The outside driver/passenger/patient access door(s) of the vehicle shall not be considered one of the two locks.
 - 3. Prehospital service provider agencies shall abide by all State and Federal laws/regulations related to the storage/security of controlled substances.
 - 4. Each unit shall maintain a standardized written record of the controlled substance inventory. Controlled substance inventory and administration records shall be maintained in accordance with all applicable State and Federal laws/regulations.
-

5. Controlled substances shall be inventoried any time there is a change in personnel. The key to access the controlled substances, if applicable, shall be in the custody of the individual who performed the inventory.
6. Any discrepancies in the controlled substance count shall be reported as soon as possible to an appropriate supervisor and the issuing agent. A discrepancy report must be appropriately documented.

E. Controlled Substances Administered to Patients:

1. Controlled substances shall be administered in accordance with applicable S-SV EMS policies/protocols.
2. The following information must be documented on a controlled substance administration record:
 - a. Date & time administered.
 - b. Unit number.
 - c. Patient name.
 - d. Drug administered.
 - e. Amount administered.
 - f. AEMT II or paramedic signature & number.
3. If only a portion of the controlled substance was administered to the patient, the remainder shall be wasted in accordance with the prehospital service provider agency's policy/procedure. At a minimum, this policy/procedure shall require that unused controlled substance wastage be done in the presence of another EMS or receiving hospital provider (EMT or above), and that both individuals document this action on the applicable controlled substance administration form. ~~in the presence of a registered nurse or physician at the receiving hospital, or the provider's immediate supervisor. Both parties shall document this action on the controlled substance administration form.~~
4. Controlled substance inventories/logs are subject to inspection by the California Board of Pharmacy, Bureau of Narcotic Enforcement Administration of the Justice Department, Federal Drug Enforcement Administration, S-SV EMS, the issuing agent, and/or officers of the prehospital service provider agency.

Sierra – Sacramento Valley EMS Agency 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.

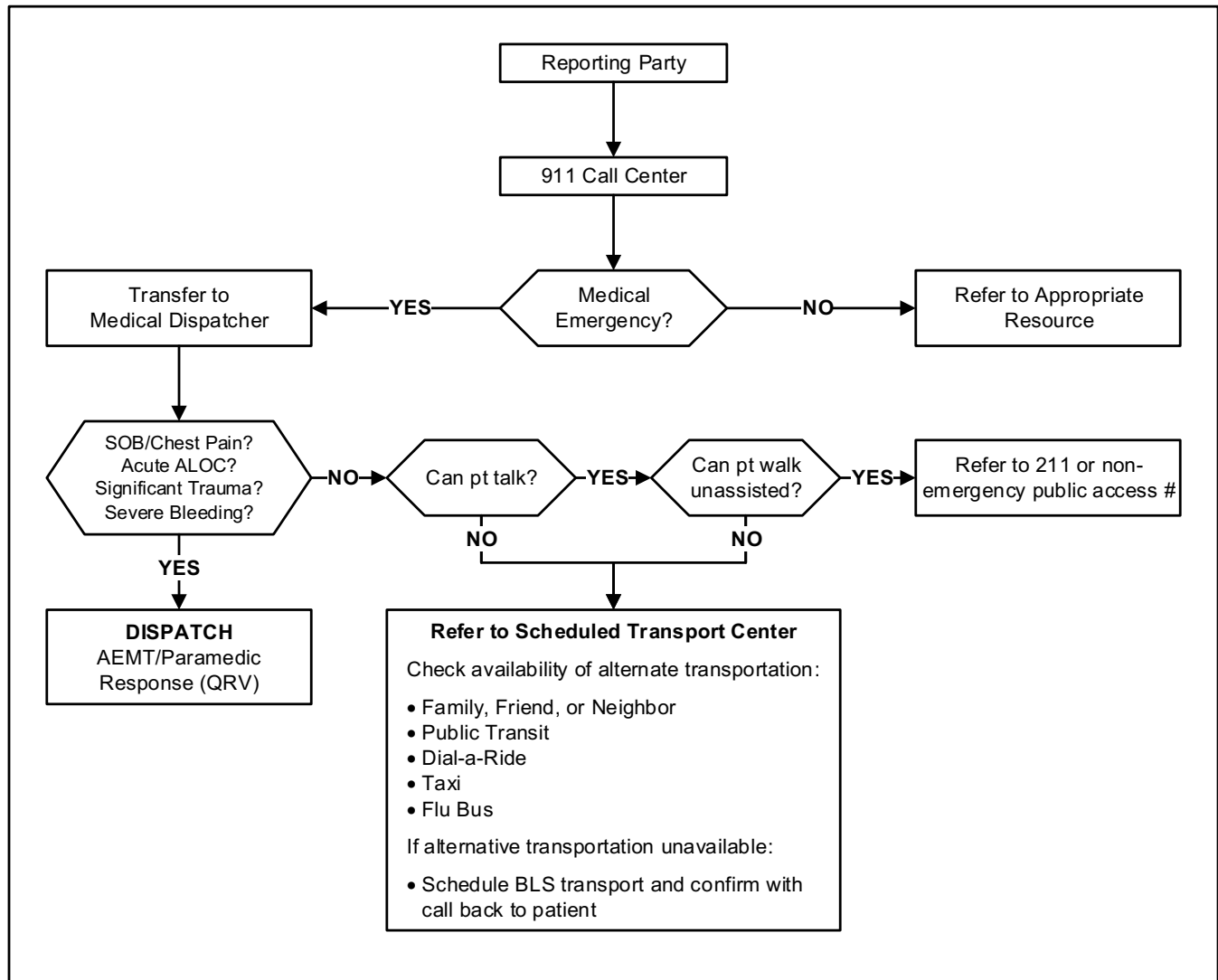
- d. Developing additional disaster caches to augment EMS supplies (i.e., flu cache of electrolyte replacement fluids, ibuprofen, Pepcid, etc.).
 - e. Developing, equipping and deploying a specialty response team to respond to specific types of patients.
2. The OA EOC should work collaboratively with 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.





Crisis Standard Of Care EMS System Orders

838-B

NOTICE

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

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. <u>Patients not in immediate need will not be transported.</u>
	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: <input type="checkbox"/> Off-duty times <input type="checkbox"/> Meal breaks <input type="checkbox"/> 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: <table border="0"><thead><tr><th><u>RESOURCE</u></th><th><u>LOCATION</u></th></tr></thead><tbody><tr><td>#1 _____</td><td>_____</td></tr><tr><td>#2 _____</td><td>_____</td></tr></tbody></table>	<u>RESOURCE</u>	<u>LOCATION</u>	#1 _____	_____	#2 _____
<u>RESOURCE</u>	<u>LOCATION</u>							
#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 REPRESENTATIVE

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



Crisis Standard Of Care Prehospital Treatment Orders

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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



Crisis Standard Of Care Prehospital Treatment Orders

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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



Crisis Standard Of Care Prehospital Treatment Orders

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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.



Medical & Health Disaster Responsibilities By Primary Entity

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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.




Medical & Health Disaster Responsibilities By Primary Entity

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RESPONSE (cont.)	Butte	Colusa	Glenn	Nevada	Placer	Shasta	Siskiyou	Sutter	Tehama	Yuba	COMMENT
<ul style="list-style-type: none"> 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			
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 Program Policy			
HEMS Aircraft Requesting & Utilization			
	Effective: 04/01/2026	Next Review: 10/2028	862
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

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

AUTHORITY:

- A. HSC, Division 2.5, § 1797.200 – 1797.276, 1798 – 1798.8 & 1798.170.
- B. CCR, Title 22, Division 9, Chapters 4 3 & 8-7.

DEFINITIONS:

- A. **Air Ambulance Coordination Center** – One of the following CAL FIRE Emergency Command Centers (ECCs) designated by S-SV EMS for the purpose of coordinating air ambulance requests within the S-SV EMS region:
 - 1. CAL FIRE Grass Valley Emergency Command Center: Colusa, Nevada, Placer, Sutter, and Yuba counties.
 - 2. CAL FIRE Oroville Emergency Command Center: Butte, Glenn, Shasta, and Tehama counties.
 - 3. CAL FIRE Yreka Interagency Command Center: Siskiyou County
- B. **Public Safety Answering Point (PSAP)** – A public safety dispatch center where a 911 call is first received (primary PSAP) or where a 911 call is transferred/relayed for the purpose of dispatching resources (secondary PSAP).
- C. **Helicopter Emergency Medical Services Aircraft (HEMS Aircraft)** – Rotor wing aircraft utilized for the purpose of prehospital emergency response and patient transport. HEMS aircraft include air ambulances and all ALS/BLS rescue aircraft.
- D. **Air Ambulance** – Any aircraft specially constructed, modified or equipped and used for the primary purpose of responding to emergency incidents and transporting critically ill and/or injured (life or limb) patients, whose medical flight crew has, at a minimum, two (2) attendants certified or licensed in advanced life support.
- E. **Rescue Aircraft** – Aircraft whose usual function is not patient transport but may be used for patient transport when the use of an air or ground ambulance is inappropriate or not readily available. Rescue aircraft are classified as one of the following:

1. **Advanced Life Support (ALS) Rescue Aircraft** – A rescue aircraft whose medical flight crew has, at a minimum, one (1) attendant licensed as a paramedic.
2. **Basic Life Support (BLS) Rescue Aircraft** – A rescue aircraft whose medical flight crew has, at a minimum, one (1) attendant certified as an EMT.
3. **Auxiliary Rescue Aircraft** – A rescue aircraft that does not have a medical flight crew, or whose flight crew does not meet ALS/BLS rescue aircraft requirements.

POLICY:

A. Medical Control

1. Treatment rendered in all prehospital care situations, including HEMS transport, shall be in accordance with current S-SV EMS protocols.
2. Flight nurse protocols must be approved in writing by the S-SV EMS Medical Director.

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

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

1. The flight crew should limit on-scene treatment as much as possible to ensure that the advantages of rapid air transport are not diminished.
2. Prehospital providers must consider delays associated with the utilization of HEMS aircraft (e.g. flight planning, time to lift-off, safe-landing operations) when making transport decisions. Providers must ensure that the shortest and most appropriate transportation method is utilized. See table below for average HEMS response times by county.

Average HEMS Response Times by County

County/Area	General Area	Average PSAP Request to Arrival at Scene Time
Butte – Central	Chico, Magalia, Oroville, Gridley	25 mins
Butte – Eastern	Forbestown	28 mins
Butte – Northeastern	Butte Meadows	27 mins
Colusa – Central	Colusa, Williams	23 mins
Colusa – Eastern	Lodoga, Stonyford, Fouts Springs	31 mins

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Average HEMS Response Times by County (continued)		
County/Area	General Area	Average PSAP Request to Arrival at Scene Time
Glenn	All areas	24 mins
Nevada	All areas	28 mins
Placer	All areas	25 mins
Shasta – Central	Redding, Igo, French Gulch, Montgomery, Creek, Lakehead, Shingletown, Round Mountain, Igo	32 mins
Shasta - Northeastern	Burney, Fall River Mills, Hat Creek, Old Station, Big Bend	37 mins
Shasta - Southern	Platina	43 mins
Siskiyou	All areas	49 mins
Sutter	All areas	22 mins
Tehama	All areas	30 mins
Yuba – Eastern	Brownsville, Camptonville, Dobbins, Oregon House, Oak Valley	38 mins
Yuba – Western	Marysville, Olivehurst, Browns Valley, Loma Rica	22 mins

D. HEMS aircraft utilization criteria:

1. Trauma patients who meet RED Field Trauma Triage Criteria, and transport time to an appropriate level trauma center is ≥30 minutes by ground.
2. Prolonged extrication of an entrapped patient.
3. Multi-casualty incidents with a need for additional resources or distribution of patients to facilities ≥30 minutes by ground from the incident location.
4. Time-sensitive conditions where a decrease in transport time may reduce the risk of long-term disability or death.
5. Significantly reduced transport time for patients with specialty resource needs (significant burns, pediatric trauma, etc.).
6. Patients who are likely to require advanced procedures, medications, blood the scope of practice not available on ground providers ambulances.

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

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

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

1. Trauma patients meeting only mechanism of injury criteria

2. Patients with CPR in progress.

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

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

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

G. HEMS Aircraft Requesting and Coordination:

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

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

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

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

a. If communication with the IC is not possible or practical, HEMS aircraft shall be requested through the applicable PSAP.

b. If a private ambulance arrives on scene before the arrival of public safety personnel, HEMS aircraft shall be requested through the applicable PSAP. If unable to contact the PSAP directly from the field, the private ambulance dispatch center may be used to relay the request to the PSAP.

5. HEMS aircraft requests received from providers still enroute may be overridden by the IC/designee on scene. Excluding safety reasons, the IC/designee shall consult with the most medically qualified provider on scene to determine the necessity for HEMS aircraft.
6. The PSAP shall utilize the following procedures, based on the type and availability of HEMS aircraft resource requested:
 - a. Air ambulance resource request:
 - i. Contact the designated air ambulance coordination center for air ambulance resource requesting.
 - b. Rescue aircraft resource request:
 - i. The PSAP is responsible for contacting the applicable air rescue provider directly for resource requests.
7. PSAPs are required to provide the following information to the air ambulance coordination center or air rescue provider for all HEMS aircraft resource requests:
 - a. Incident or LZ location: the general geographic location will suffice.
 - b. Nature of call: type of incident and severity of injuries, if known.
 - c. The designated LZ contact – as follows:
 - i. Identified by incident name (i.e., 'Jones Road LZ'), if HEMS aircraft is being requested to respond directly to the incident scene; or
 - ii. Identified by LZ name (i.e., 'Rood Center LZ'), if HEMS aircraft is being requested to respond to a pre-established local/regional LZ location.
 - d. Any known aircraft hazards in the area, including hazardous materials, other aircraft, or inclement weather conditions at the scene.
8. The air ambulance coordination center will complete the following for all air ambulance resource requests:
 - a. Verify the incident/LZ location and identify the closest air ambulance.
 - b. Contact the closest air ambulance provider to obtain their availability to respond to the incident.
 - i. If the air ambulance resource is available and accepts the request, they will be assigned to the incident by the air ambulance coordination center.
 - ii. If the air ambulance resource is unavailable/declines the request, the air ambulance coordination center will contact the next closest air ambulance provider to obtain their availability to respond to the incident. This process will continue until an air ambulance is assigned, or it is determined that no timely air ambulance resources are available to respond to the incident.

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- iii. Air ambulance coordination centers shall consider the location of an available airborne air ambulance in determining the closest resource to the incident when this information is known to the coordination center.
 - iv. Air ambulance providers who have multiple aircraft shall accept/decline the request based on the availability of the specific aircraft resource requested.
 - v. The air ambulance provider will be allowed up to five (5) minutes to check weather. If the air ambulance provider does not accept/decline the assignment within five (5) minutes, the air ambulance coordination center will re-contact the air ambulance provider to confirm their status prior to contacting the next closest air ambulance provider.
 - vi. If an air ambulance provider declines due to inclement weather at the incident/LZ location, it is unlikely that an alternate air ambulance provider will subsequently accept the request. The IC/designee shall be notified of this information as soon as possible. Personnel on scene may consider appropriate alternatives (utilizing an alternate LZ/rendezvous location; requesting the availability of rescue aircraft which are allowed to operate under different weather minimums; initiating ground ambulance transport; etc.).
 - c. Relay the assigned air ambulance resource identifier and initial ETA to the requesting PSAP.
- 9. The requesting PSAP shall notify all responding agencies when a HEMS aircraft has been requested/assigned and shall keep responding agencies updated as to the HEMS aircraft status (delays, aborts, etc.).
 - 10. HEMS aircraft personnel are responsible for communicating to the requesting PSAP any response delays or aborts in a timely manner.
 - 11. Once assigned to an incident, HEMS aircraft shall not commit/respond to another assignment unless cancelled by the initial incident requestor.
 - 12. HEMS aircraft shall remain enroute to an incident until one of the following events has occurred:
 - a. No patients are found at scene or the responders are unable to locate the incident.
 - b. The highest-level medical provider on scene has completed an appropriate physical assessment of the patient(s). Following assessment, the highest-level medical provider may, through the IC/ designee, cancel the aircraft if it is determined that ground transport would be more appropriate.
 - 13. If multiple aircraft are responding to or in the area of the incident, the air ambulance coordination center and/or the requesting PSAP shall notify all agencies of multiple aircraft responders.
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14. All parties are responsible for informing HEMS aircraft providers of inclement weather related to the response, including previous HEMS aircraft providers who declined the flight due to weather conditions (at base, enroute, or at scene).
15. CALCORD operational frequency (156.075) should be utilized for air-to-ground communication. The IC/designee will communicate to all responding agencies if an alternate frequency will be utilized for the event.

H. Ground Provider Responsibilities:

1. If the event is a declared MCI, the IC/designee is responsible for notifying all responding HEMS aircraft of such.
2. If required by S-SV EMS policies/protocols, the most medically qualified provider on scene shall contact the appropriate facility for patient destination consultation prior to EMS aircraft arrival (when possible).
3. ~~If ground personnel are at scene,~~ The IC/designee shall assign appropriate personnel to establish/prepare a landing zone (LZ) and assure scene safety during landing. The LZ should meet the following criteria:
 - a. 100' x 100' open area, clear of hazards, obstacles, sloped terrain, loose surface materials, animals, overhead wires, foreign object debris (FOD).
 - b. If the LZ is on a dirt surface, assure that the area is watered down to reduce the risk of brown out upon aircraft landing.
 - c. Locate the LZ upwind from any incident with known hazardous materials.
4. The IC/designee shall have the authority for allowing a HEMS aircraft to land at scene. Notwithstanding, the pilot has final authority to determine if a landing is appropriate, including instances when no ground personnel are at scene.
5. Ground personnel shall not approach the aircraft under a running/hot rotor unless accompanied by HEMS personnel.
6. If requested, ground EMS personnel may accompany a patient in a rescue aircraft if the appropriate medical equipment is available and they have received an adequate safety briefing prior to transport.
7. S-SV EMS Transfer of Patient Care policy shall be followed, and a verbal patient care report shall be provided to HEMS aircraft personnel.

I. HEMS Aircraft Provider Responsibilities:

1. Each permitted HEMS resource is responsible for maintaining current availability status in EMResource.
2. HEMS aircraft providers are expected to be enroute within 15 minutes of incident acceptance. Response delays shall be documented in the PCR.

3. HEMS aircraft providers are expected to transport within 15 minutes from at the time patient contact is made. Scene delays shall be documented in the PCR.
4. The pilot in command shall have the final authority in decisions to continue or abort the response. The pilot may also dictate the need to identify an alternate LZ/ rendezvous location.
5. S-SV EMS Patient Destination policies/protocols shall be followed for all patients requiring HEMS aircraft transport. Patients shall be transported to the closest/most appropriate hospital with an approved helipad or HEMS aircraft landing site. The pilot in command has the authority to deviate from S-SV EMS patient destination policies.
6. HEMS aircraft providers are required to submit an abort report to S-SV EMS anytime a flight request has been accepted and the provider is unable to arrive at the incident or complete the requested transport due to any reason other than being cancelled by the requestor or if it is determined that HEMS transport is not needed. These reports must be submitted through the following link within 48 hours of the event. <https://www.ssvems.com/hems-aircraft-aborted-flight-reporting-form/>

**Non-Traumatic Pulseless Arrest**

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)
- ① Apply following completion of at least one manual CPR cycle, or at the end of a subsequent cycle
- ① Use in accordance with manufacturer guidelines

Contraindications

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

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 PETCO₂ is indicative of ROSC
 - Persistently low PETCO₂ levels (< 10 mmHG) suggest ROSC is unlikely

TREAT REVERSIBLE CAUSES

- Hypovolemia
 - Hypoxia
 - Hydrogen Ion (acidosis)
 - Hypo-/hyperkalemia
 - Hypothermia
 - Tamponade, cardiac
 - Tension pneumothorax
 - Thrombosis, pulmonary
 - Thrombosis, cardiac
 - Toxins
- ① Consider early transport of pts who have reversible causes that cannot be adequately treated in the prehospital setting
- ① Contact the base/modified base hospital for consultation & orders as appropriate
- ① 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

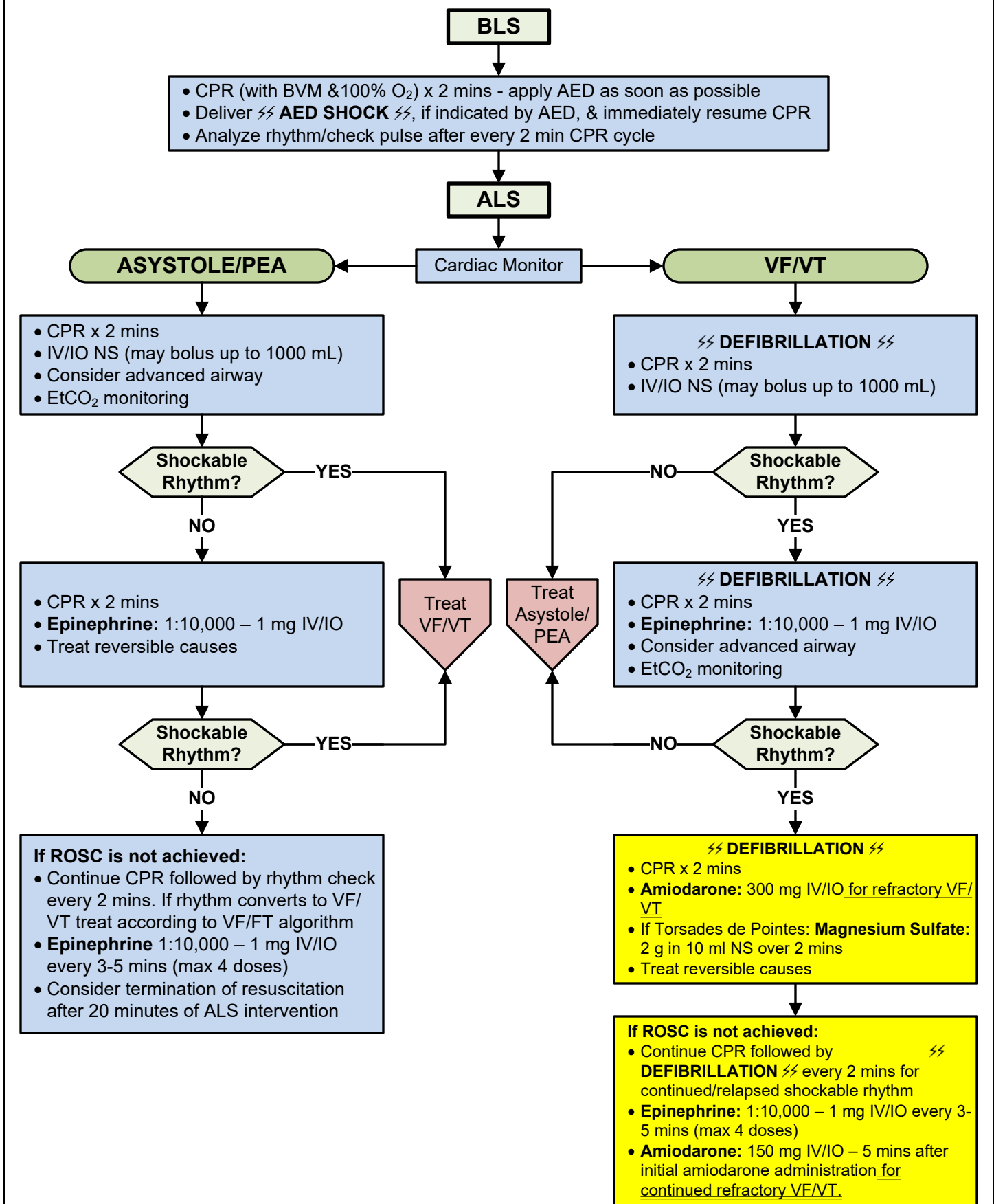
SPECIAL TOR CIRCUMSTANCES

- 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





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 SpO₂ - reassess V/S every 3 - 5 min if possible
- O₂ at appropriate rate if hypoxemic (SpO₂ <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

NO

Wide QRS (≥0.12 seconds)?

NO

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

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 EtCO₂ 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

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)

Valsalva Maneuver

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

**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% O₂) – 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
 - O₂ at appropriate rate to maintain SpO₂ ≥94% (do not hyperventilate)
- Assess V/S, including SpO₂ – reassess V/S every 3-5 mins if possible
- Continuous ETCO₂ 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

**Pediatric Pulseless Arrest**

Approval: Troy M. Falck, MD – Medical Director

Effective: DRAFT

Approval: John Poland – Executive Director

Next Review: DRAFT

INFANT CPR**CHILD 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 1/2")
- Compression/ventilation ratio:
 - 1 rescuer: 30:2
 - 2 rescuer: 15:2
- Perform CPR during AED/defibrillator charging & resume CPR immediately after shock

- 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**ADVANCED AIRWAY 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

- 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 PETCO₂ is indicative of ROSC
 - Persistently low PETCO₂ levels (<10 mmHG) suggest ROSC is unlikely

TREAT REVERSIBLE CAUSES**TERMINATION OF RESUSCITATION**

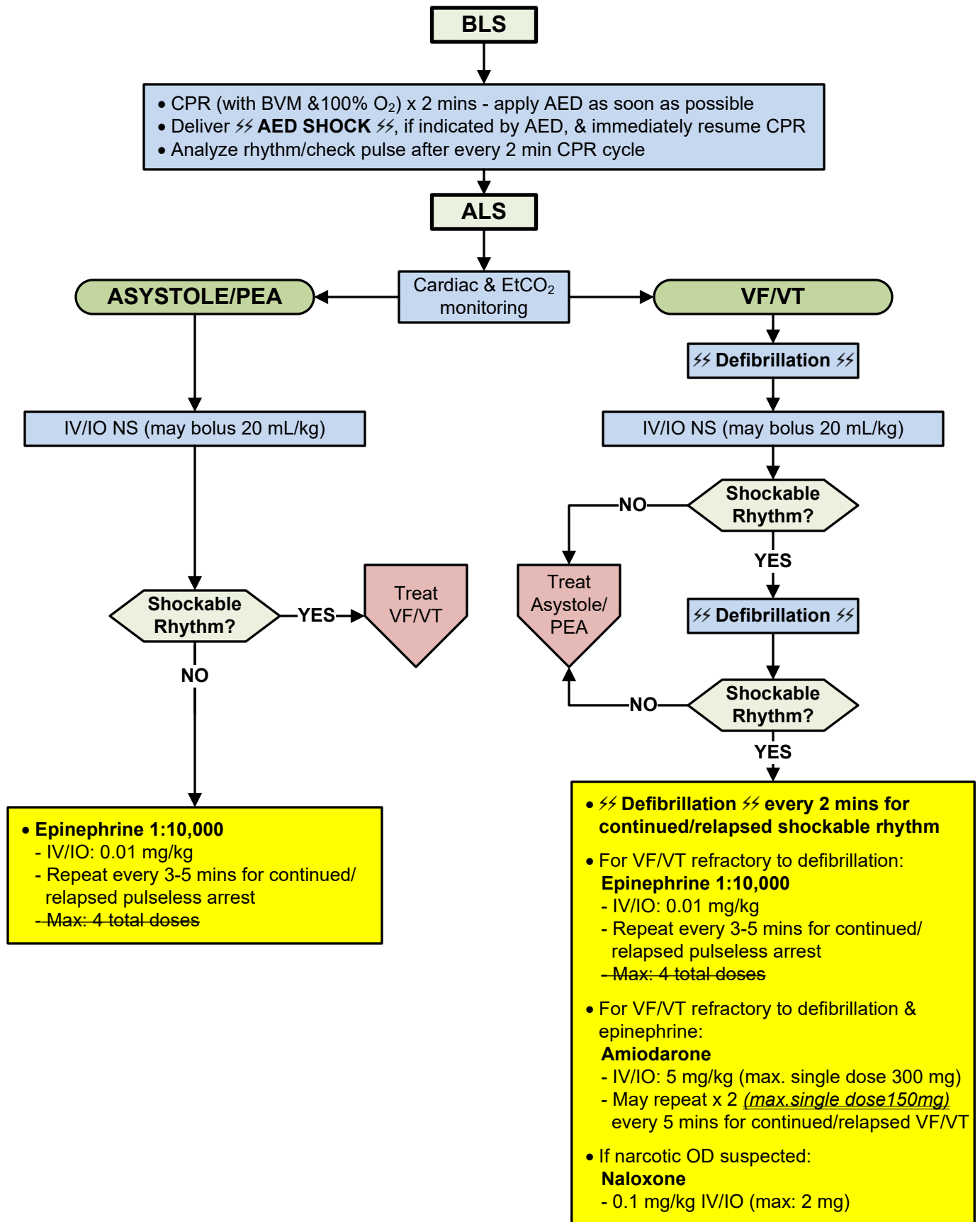
- Hypovolemia
 - Hypoxia
 - Hydrogen Ion (acidosis)
 - Hypo-/hyperkalemia
 - Hypothermia
 - Tamponade, cardiac
 - Tension pneumothorax
 - Thrombosis, pulmonary
 - Thrombosis, cardiac
 - Toxins
- ① Refer to Hypothermia & Avalanche/Snow Immersion Suffocation Resuscitation Protocol (E-2) or Traumatic Pulseless Arrest Protocol (T-6) as appropriate
- ① Contact the base/modified base hospital for consultation & orders as appropriate
- ① Consider early transport of pts who have reversible causes that cannot be adequately treated in the prehospital setting

- Base/Modified Base Hospital Physician Order Only**
- If non-shockable rhythm persists, despite appropriate, aggressive ALS interventions for 30 mins (or if EtCO₂ 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





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

Newborn Care

- Position/clear airway
- Dry baby & keep warm
- Place baby on mother's abdomen or breast
- Obtain APGAR after 1 min & repeat after 5 mins
- Assess heart rate, respirations & color

HR >100?

NO

YES

SpO₂ within target range?

NO

YES

Good muscle tone?
Breathing or crying?

NO

YES

- Maintain skin to skin with parent
- Maintain normal temperature
- Monitor & Reassess

Target SpO₂ after birth

- 2 min: 65% - 70%
- 3 min: 70% - 75%
- 4 min: 75% - 80%
- 5 min: 80% - 85%
- 10 min: 85% - 95%

Go to Neonatal
Resuscitation
(Page 2)



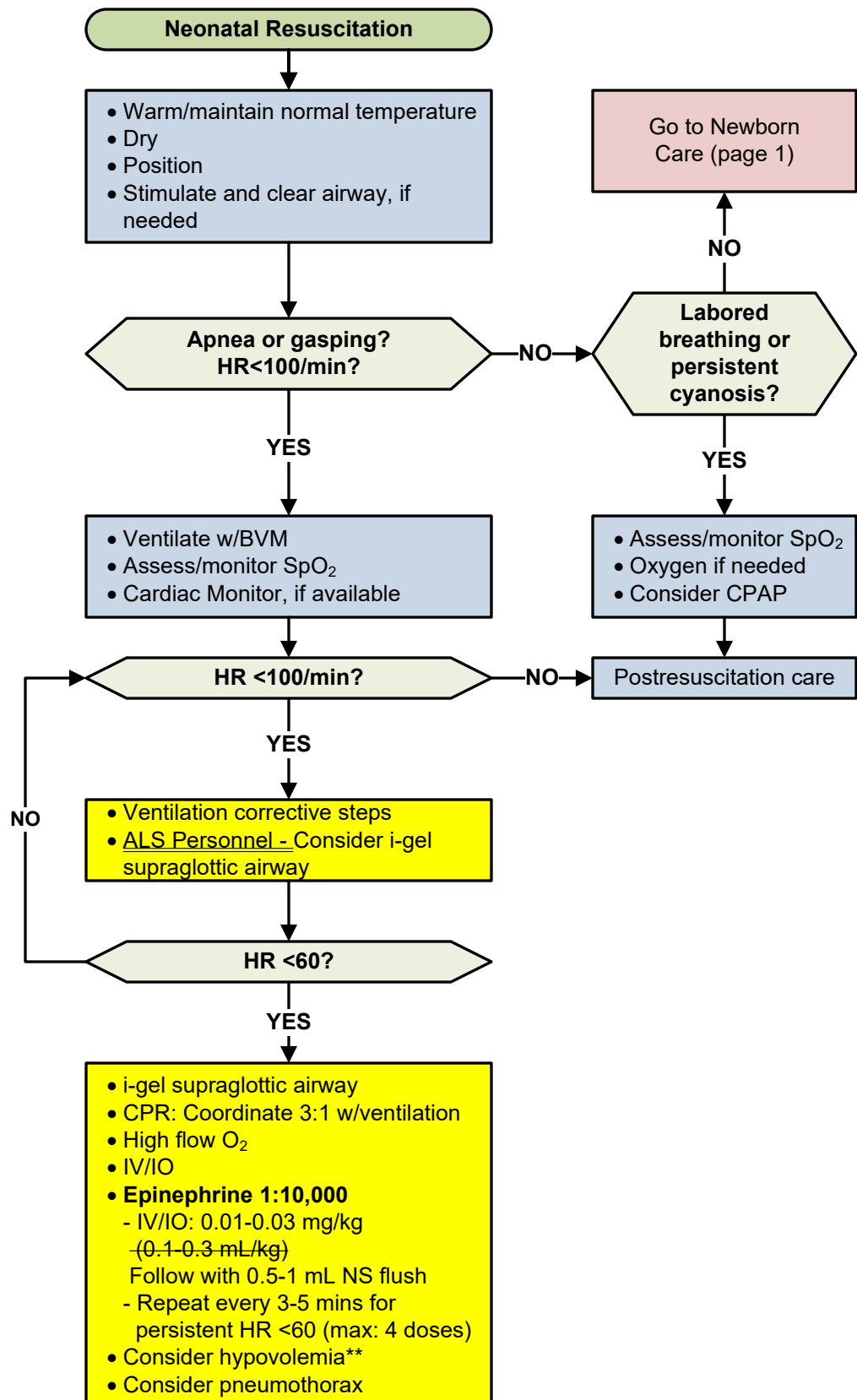
Newborn Care/Neonatal Resuscitation

***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.



**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 airway 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
- Respiratory or cardiac arrest
- Suspected croup/epiglottitis
- Agonal respirations
- Inability to maintain airway
- Suspected pneumothorax
- SBP <90
- Major trauma/head injury/chest trauma
- 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 O₂
- Assess V/S, including SpO₂
- 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 & EtCO₂ 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 & EtCO₂ 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 & EtCO₂ 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)

**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:

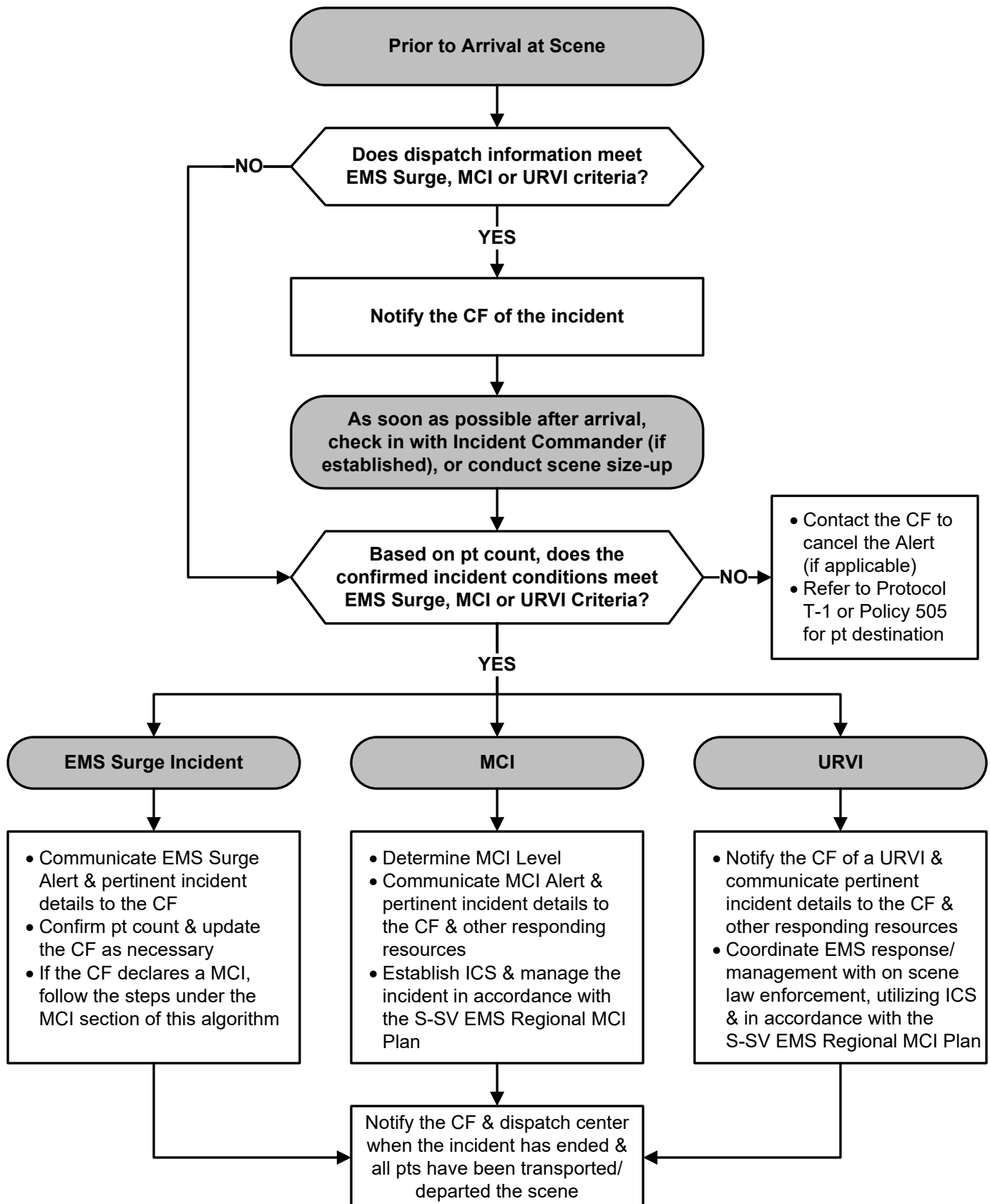
- Dispatch center, prehospital resources, or CF.

Why:

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



Multiple Patient Incidents



**Determination Of Death**

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

- Assess for the presence of one (1) or more of the following **Obvious Death Criteria**:

- Decapitation
- Decomposition
- Incineration of torso and/or head
- Exposure, destruction and/or separation of the brain or heart from the body
- Rigor mortis – if determination of death is based on rigor mortis, EMS personnel must 1) confirm muscle rigidity of the jaw by attempting to open the mouth & 2) confirm muscle rigidity of one arm by attempting to move the extremity

EMS personnel may determine death*

Does pt meet Obvious Death Criteria or have a valid and applicable DNR Advanced Directive?

←YES

NO

Are ALS personnel on scene?

→NO

Initiate resuscitation & treat per applicable S-SV EMS protocol(s)

YES

ALS

- Assess for the presence of one (1) or more of the following **Probable Death Criteria**:

- Lividity or Livor Mortis & cardiac monitor showing asystole in two (2) leads
- Blunt or penetrating trauma & cardiac monitor showing asystole in two (2) leads
- Blunt trauma & cardiac monitor showing PEA at a rate ≤ 40 /min

EMS personnel may determine death*

Does pt meet Probable Death Criteria or have a valid and applicable DNR / POLST / Advanced Directive?

←YES

→NO

Initiate resuscitation & treat per applicable S-SV EMS protocol(s)

*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