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

MEETING AGENDA

MEETING DATE & TIME INFORMATION

- **Wednesday, April 8, 2026, 9:00 am – 12:00 pm**

MEETING LOCATION & ALTERNATE ATTENDANCE INFORMATION

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

IMPORTANT NOTIFICATONS

Public comments on proposed policy/protocol actions listed on this agenda will be taken during the review/discussion of the applicable item. Individuals unable to attend the meeting may provide written public comment on any item listed on this agenda, no later than seven (7) calendar days prior to the scheduled meeting date, by sending an email to Jared.Gunter@ssvems.com.

Policy/protocol actions listed on this agenda may be approved by a majority vote of the REMAC members present at the meeting. If necessary, proposed policy/protocol actions may be continued to subsequent REMAC meetings until consensus is reached by the committee.

All REMAC approved policy/protocol actions shall also be approved by the S-SV EMS Medical Director and Regional Executive Director prior to implementation. S-SV EMS may make non-substantive corrections to approved policy/protocol actions to address any technical defect, error, irregularity, or omission prior to final publication.

EMS system participants will be notified of approved policy/protocol actions a minimum of 30 calendar days prior to the effective implementation date. Policy/protocol action updates are routinely published on a bi-annual basis as follows:

October & January meeting approved policy actions: April 1st implementation date.

March & July meeting approved policy actions: October 1st implementation date.

Some policy/protocol actions may require immediate action to maintain compliance with statutes/ regulations, or to preserve medical control/integrity of the EMS system. Policy/protocol actions of this type may be implemented by S-SV EMS as urgency measures and scheduled for discussion at the next regularly scheduled REMAC meeting, if necessary.

Sierra – Sacramento EMS Agency – REMAC Meeting Agenda

MEETING AGENDA		
ITEM	**TITLE**	**LEADER**
A	**Call to Order/Introductions**	**Chairperson**
B	**Approval of Previous Meeting Minutes**	**Chairperson**
C	**Approval of Meeting Agenda**	**Chairperson**
D	**Public Comment**	**Attendees**
E	**S-SV EMS Consent Policy/Protocol Action Items** These policies/protocols items are due for routine review, with no substantive changes recommended by S-SV EMS staff or the S-SV EMS Medical Director. All Consent Policy/Protocol Actions will be approved by a single vote. Anyone may ask to address specific Consent Policy/Protocol Action items prior to the committee acting, and the item(s) may be removed for additional discussion.	**Chairperson**
	306: Base/Modified Base Hosp. Recording & Maint. Of EMS Pt Care Comm.	
	835: Medical Control At The Scene Of An Emergency	
	836: Hazardous Materials Incidents	
	851: EMS Care Of Minor Patients	
	E-7: Hazardous Material Exposure	
F	**S-SV EMS Discussion Policy/Protocol Action Items**	**S-SV EMS Staff**
	405: Emergency Medical Dispatch Programs	Poland
	853: Tasered Patient Care & Transport	Quirk
	E-8: Nerve Agent Treatment	Pohley
	M-6: General Medical Treatment	Moss
	T-5: Burns	Gunter
G	**Ambulance Provider Rate Approval Process**	**Poland**
H	**EMS Aircraft Provider Reports**	**Attendees**
I	**EMS Ground Provider Reports**	**Attendees**
J	**Hospital Provider Reports**	**Attendees**
K	**Quality Improvement (QI) & Case Review**	**Pohley**

Sierra – Sacramento EMS Agency – REMAC Meeting Agenda

ITEM	TITLE	LEADER
L	**S-SV EMS Agency Reports**	**S-SV EMS Staff**
	EMS Data System	McManus
	Regional Specialty Committees	Moss
	REMAC Committee Voting Member Appointments	Gunter
	REMAC Committee Chairperson & Vice Chairperson Elections	Gunter
	Operations	Comstock
	Regional Executive Director	Poland
	Medical Director	Falck, MD
M	**Next Meeting/Adjournment: July 8, 2026**	**Chairperson**

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

MEETING MINUTES

Meeting Date
Wednesday, January 14, 2026

A. Call to Order/Introductions

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

B. Approval of Previous Minutes: October 28, 2025

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

C. Approval of Agenda

- The committee approved the agenda with no changes.

D. Public Comment

- No comments.

E. S-SV EMS Consent Policy/Protocol Action Items

Policy	Name	Motion	Second	Committee Vote
211	**S-SV EMS Prehospital Advisory Committee** • There were no proposed changes.	Clayton Thomas	Dr. Morris	Passed Unanimously
416	**Alternate Transport Vehicles** • There were no proposed changes.	Clayton Thomas	Dr. Morris	Passed Unanimously
812	**Base/Modified Base/Receiving Hospital Contact** • There were no proposed changes.	Clayton Thomas	Dr. Morris	Passed Unanimously
838	**Crisis Standard of Care Procedures (including addendums A, B, C, D)** • There were no proposed changes.	Clayton Thomas	Dr. Morris	Passed Unanimously

F. S-SV EMS Discussion Policy/Protocol Action Items

Policy	Name	Motion	Second	Committee Vote
307	**Ambulance Patient Offload Time (APOT) (including addendum A)** • Many regulatory changes regarding APOT. • AB40 (Oct 2023) required each LEMSA to establish a standardized APOT for their region. S-SV did this and had several hospitals that were non-compliant with the standards. At that point, S-SV increased from 20 minutes to 30 minutes to work with the hospitals and get them compliant. • In November, every single hospital in the S-SV region was compliant with the APOT standard. In December, all hospitals were compliant, and all but one of those were at or below 25 minutes. • This policy has been updated to match the AB40 regulations. • On pages 3-5, S-SV recommends there be a gradual decrease in the APOT standard. On April 1st, the standard will be 25 minutes. 6 months after that, it will reduce to 23 minutes, and then on April 1st, 2027, it will reduce to 20 minutes. • The APOT audit tool will only allow hospitals to audit calls that are exceeding the LEMSA established APOT standard. • The data should be as accurate as possible. If there is an obvious discrepancy, S-SV should be made aware. • A 20-minute standard is where S-SV wants to be. The hospital administrations need to be accountable. • Hospital committee members had strong feelings about this. There was ample discussion. • S-SV does not want to set unobtainable goals for the hospitals. • It was suggested to form another APOT committee so everyone can work together. • It was suggested on page 3, to remove lines 10 and 11 for now, and edit line 9 to read 'effective July 1, 2026, 25 minutes'. This allows time to gather more data, form a new APOT committee, and have more discussion.	Clayton Thomas	Rose Colangelo	Passed Unanimously

462	**Temporary Recognition of EMS Personnel** • This was first used last year. Initially there were a few obstacles. • On page 2, line 11, added 'by a Provider Organization'. • On page 4, line 11, added 'and tracking', line 12 removed 'these' and added 'names and credentials, including employer,'. • On page 5, added letter g, and Item 3.	Clayton Thomas	Debbie Madding	Passed Unanimously
605	**EMS Documentation** • There is some minor language clean-up on pages 1 and 2. • On page 1, line 5, the Chapters were updated. On line 20, removed 'prior to a transport provider'. • On page 2, lines 32-33, removed 'at the receiving facility' and added 'with the receiving nurse or physician at the'.	Clayton Thomas	Debbie Madding	Passed Unanimously
848	**Reduction/Cancellation of ALS Response** • On page 1, line 5 the Title 22 chapters were updated. Line 24 added 'ALS'. Line 25 removed 'by ALS personnel'. • On page 2, item b, removed 'Cardiac symptoms' and added 'Suspected Acute Coronary Syndrome (ACS)'.	Clayton Thomas	Rich Lemmon	Passed Unanimously
C-1	**Non-Traumatic Pulseless Arrest** • On page 2, in the bottom yellow boxes, added 'for refractory VF/VT' after Amiodarone in the top box, and added 'for continued refractory VF/VT' in the bottom box.	Clayton Thomas	Dr. Morris	Passed Unanimously
C-1P	**Pediatric Pulseless Arrest** • On page 1, under 'Infant CPR' the 2 finger compressions was removed and added 'Use the heel of 1 hand or'. • On page 2, under Epinephrine, removed 'Max: 4 total doses.' Under Amiodarone added 'max single dose 150/mg'.	Alex Burk	Clayton Thomas	Passed Unanimously
C-4	**Tachycardia With Pulses** • In the bottom left box, under Amiodarone, removed '150 mg intermittent IV/IO push over 10 mins OR'. Added '(preferred) OR 150 mg IV/IO push'. • In the Synchronized Cardioversion box, added, "Use the energy level recommended by your defibrillator manufacturer. For atrial fibrillation and atrial flutter ≥200 J is preferred'. Removed 'Initial synchronized cardioversion doses:' and the doses.	Clayton Thomas	Rich Lemmon	Passed Unanimously

G-2	**Determination of Death** • Page 1 has language clean-up to make the protocol language more precise. • On page 2, under the BLS box, added 'valid and applicable' and removed 'DNR' from the box. Under the ALS box, added 'valid and applicable DNR/POLST/Advanced Directive'.	Dr. Morris	Rich Lemmon	Passed Unanimously
M-2P	**Newborn Care/Neonatal Resuscitation** • On page 2, under HR <100/min? box, added 'ALS Personnel' in that box. And under HR <60 box, removed '(0.1 0.3 ml/kg),' under Epinephrine.	Rich Lemmon	Alex Burk	Passed Unanimously
R-3P	**Pediatric Respiratory Distress** • On page 2 in the Epinephrine box, added Magnesium Sulfate with the dosing. • In the Epinephrine box, it was suggested to separate the Epinephrine from the rest of the box.	Clayton Thomas	Dr. Morris	Passed Unanimously
T-6	**Traumatic Pulseless Arrest** • In the top box, added 'The primary goals of care are to treat immediate life-threats and initiate rapid transport without delay'. • Under the ALS box, the language has been updated.	Rich Lemmon	Robert Kehoe	Passed Unanimously
G-1	**Multiple Patient Incidents & Regional Multiple Casualty Incident (MCI) Plan** • The updated MCI plan was approved last December. • It is recommended that on a Surge Level 1, the hospitals should be polled so they have a heads-up. • It is recommended to Add to the feedback form any type of extrication, so that details are known as well as time impact due to extrication.	Dr. Morris	Clayton Thomas	Passed Unanimously

G. EMS Aircraft Provider Reports

- REACH – The fog has been rough. They're starting training discussions.

H. EMS Ground Provider Reports

- BiCounty:
  - Staffing continues to improve. They're starting to double up some of their medic shifts to allow some of the newer medics to have guidance in the field.
  - They continue to sponsor students.
- South Placer FD:
  - Chiefs Duerr and Magnuson retired.
  - Darin Snedeker in the new Chief.
  - They are recruiting for: Deputy, Engineer, and Fire Fighter.

I. Hospital Provider Reports

- Sutter Roseville:
  - Imagetrend – they've been developing the hospital side which will allow the PCRs immediately into the charts.
  - They're working on error reports. They will update everyone on the process.

J. Quality Improvement (QI) Case Review

- The case was presented by Brittany Pohley.
- There was a lot of good discussion.

K. S-SV EMS Agency Reports

- **EMS Data System**
  - Jeff sent out a memo around 11/5 regarding trauma triage criteria. Please implement validation rules to ensure these are being captured. Contact Jeff if you need info.
  - Versions 3.5 and 3.5.1 are both being used now. This will end on 11/1/2026. Transition as soon as possible.
  - Finalizing the EMS data systems report. This will get sent out very soon for review.
- **Regional Specialty Committees**
  - The Chapter 6 Regs are done and approved. Policies 506, 507 and 509 are being updated and will be brought to the April 2026 meeting.
  - There will be Stroke Committee meetings this year, this will be led by Jeff.
  - Jared will be leading the STEMI Committee meetings, and Michelle will continue to lead the Trauma QI meetings.
- **S-SV EMS Drug Reference Guide**
  - This was talked about at the previous meeting. An example was shown to everyone.
- **S-SV EMS Regional Training Module**
  - The training numbers for 2025 = 1088.
  - S-SV does not track training completion. Each provider agency should be tracking this.
  - The 2026 Regional Training will focus on pediatrics and should be out by June/July.
- **Operations**
  - Colton Evey, the Certification Specialist, will be reaching out to schedule ambulance inspections.
  - Trenton Quirk will be sending out provider applications for renewal in the next month. Please get those in by 6/30.
- **Regional Executive Director's Report**
  - Chapter 6 regulations were passed and should be in place in the next couple of months. S-SV is updating their policies and protocols now.
  - The State EMS Authority is still working on Chapter 1, and the public comment period is anticipated in the next month or so.
  - The APOT regulations will be updated to be permanent.
  - If providers have received communication from a vendor regarding SB660. A lot of this communication is either inaccurate or premature. S-SV will continue to provide updates. Please reach out to Mr. Poland with any questions.

L. Medical Director's Report

- Nothing to report.

M. **Next Meeting Date & Adjournment**

- The next meeting will be on April 8, 2026, at 9:00 am.
- The meeting was adjourned at 11:58 am.

Sierra – Sacramento Valley EMS Agency Program Policy			
Base/Modified Base Hospital Recording & Maintenance Of EMS Patient Care Communications			
	Effective: DRAFT	Next Review: DRAFT	**306**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish base/modified base hospital requirements for recording and maintaining EMS patient care communication.

AUTHORITY:

A. HSC, Div. 2.5, § 1797,220, 1798.104, 1798.2.

B. CCR, Title 22, Div. 9.

C. GC, Section 34090.6.

POLICY:

A. Base/modified base hospitals shall record all telephone and radio EMS patient care communications with prehospital personnel. Audio files shall be maintained for a minimum of 100 days, or longer if required for evidence or pending litigation.

B. Base/modified base hospital personnel shall document all telephone and radio EMS patient care related communications with prehospital personnel on an appropriate hospital developed report/log. EMS patient care records and hospital communication reports/logs shall be maintained for a minimum of seven (7) years, or, if for a minor, one (1) year past the age of majority, whichever is greater.

C. All communication records shall be maintained in such a manner to allow for medical control and continuing education of prehospital personnel. Quality Improvement records shall be maintained for a minimum of (2) two years.

D. In the event of pending litigation or evidence requests, all audio files and written records shall be maintained until completion/resolution of all issues arising therefrom.

Sierra – Sacramento Valley EMS Agency Program Policy			
Medical Control At The Scene Of An Emergency			
	Effective: DRAFT	Next Review: DRAFT	**835**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To define patient care and incident management responsibilities at the scene of a medical emergency.

AUTHORITY:

A. HSC, Div. 2.5, § 1797.220, 1798.6.

B. CCR, Title 22, Div. 9.

POLICY:

A. Authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional, which may include any paramedic, or other prehospital emergency personnel, at the scene of the emergency, who is most medically qualified specific to the provision of rendering emergency medical care. If no licensed or certified health care professional is available, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency.

B. Notwithstanding the above, authority for the overall management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority. The scene of an emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition, and priority shall be placed upon the interests of those persons exposed to the more serious and immediate risks to life and health. Public safety officials shall consult EMS personnel or other authoritative health care professionals at the scene in the determination of relevant risks. Some limited examples are as follows:

1. California Highway Patrol – All freeways; all roadways in unincorporated areas to include right-of-way.
2. Sheriff's Office – Off-highway unincorporated areas (parks, private property, etc.).
3. Local Fire/Police – Specific areas of authority within their jurisdiction, except freeways.
4. Airport Fire/Police – Airports.

5. U.S. Military – National Defense Area; a military reservation or an area with "military reservation status" that is temporarily under military control, e.g., military aircraft crash site.

PROCEDURE:

A. Medical management at the scene of a medical emergency includes:

1. Medical evaluation and care.
2. Medical aspects of extrication and patient movement.
3. Patient destination decisions, in consultation with base/modified base hospital when necessary.
4. Method and mode of transport.

B. The first on duty ALS licensed/accredited or certified responder on the scene shall assume responsibility for the patient's care unless they are cancelled by BLS personnel prior to patient contact, and there is no indication that ALS assessment/ treatment is necessary.

Sierra – Sacramento Valley EMS Agency Program Policy			
Hazardous Materials Incidents			
	Effective: DRAFT	Next Review: DRAFT	**836**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish guidelines for the response of EMS prehospital personnel to hazardous materials incidents.

AUTHORITY:

A. HSC, Div. 2.5, § 1797.150, 1797.151, 1797.204, 1797.214, 1798.6.

B. CCR, Title 22.

C. OSHA Regulations, CFR 1910.120.

D. Applicable County Hazardous Materials Response Plans.

DEFINITIONS:

A. **County Hazardous Materials Response Plan –** County specific plan defining hazardous materials incident types and establishing response protocols/ responsibilities of agencies within the county.

B. **Hazardous Materials (Haz Mat) –** Any material which is explosive, flammable, poisonous, corrosive, reactive, or radioactive, or any combination, and requires special care in handling because of the hazards it poses to public health, safety, and/or the environment.

C. **Hazardous Materials (Haz Mat) Response Team –** An emergency team that has received specialized training and equipment for the purpose of protecting the public and the environment in the event of an accidental or intentional release of hazardous materials into the environment.

D. **Decontamination –** The process of removing or neutralizing contaminates that have accumulated on a victim to the extent necessary to prevent/alleviate the occurrence of heath and/or environmental effects.

E. **First Responder Awareness Level –** First responders at the awareness level are individuals who are likely to witness or discover a hazardous substance release and who have been trained to initiate an emergency response sequence by notifying the proper authorities of the release.

F. **Exclusion Zone (Hot Zone) –** The contaminated area, Immediately Dangerous to Life and Health (IDLH).

G. **Contamination Reduction Zone (Warm Zone) –** The area where decontamination takes place.

H. **Support Zone (Cold Zone) –** The uncontaminated area where individuals should not be exposed to hazardous conditions.

TRAINING AND COMPETENCY:

The minimum training for EMS prehospital personnel is Haz Mat First Responder Awareness level. Annual refresher training is required to be provided by the employer to be of sufficient content and duration to maintain competencies or to demonstrate those competencies. Additional training may be required to function at an emergency incident.

POLICY:

A. Responsibility for Haz Mat containment, identification, decontamination, and victim evacuation rests with the Incident Commander (IC)/Unified Command (UC).

B. Responding ambulances should stage off-site until the IC/UC provides for safety, a clear assignment and approach to scene.

C. EMS personnel must avoid contamination and not transport patients until they have been completely decontaminated. (Exception: For radiation contaminated patients that meet immediate triage criteria, treatment and transport should not be delayed for decontamination processes).

D. EMS personnel shall not enter or provide treatment in the Contamination Reduction Zone (Warm Zone) or Exclusion Zone (Hot Zone) unless specifically trained, equipped and authorized to do so.

E. EMS personnel shall not use Haz Mat specific personal protective equipment (PPE), including self-contained breathing apparatus (SCBA), unless specifically trained, fit tested and authorized to do so.

F. EMS personnel shall contact the base/modified base or receiving hospital as soon as possible, so they may prepare to receive victims. The base/modified base hospital may also assist field personnel in determining a decontamination and treatment plan.

DISPATCH:

Ambulances dispatched to a possible hazardous materials incident shall be advised by dispatch of the following additional information when known/available:

A. On scene wind direction and recommended approach route (coordinated with IC/UC).

B. Location of incident command post and staging area location.

C. Communication frequencies.

D. Type of hazardous material(s) involved.

E. Estimated number of patients.

SCENE MANAGEMENT:

A. Once cleared to respond into the scene (Support Zone/Cold Zone) from staging, ambulance personnel shall follow directions provided by IC/UC or designee.

B. Recognition of a Haz Mat on-scene or during transport:

If ambulance personnel become aware of hazardous materials while on scene or during transport, they shall:

1. Consider themselves contaminated and part of the incident (Hot Zone).
2. Evacuate to a safe location (if safe/appropriate to do so) to minimize exposure, and consider self-decontamination.
3. Isolate the scene and deny entry (keep others away). Move uninvolved victims to a safe zone.
4. Confirm Haz Mat using DOT Emergency Response Guidebook and notify appropriate jurisdictional authorities to respond to the scene for site control and decontamination.

PATIENT CARE:

A. EMS personnel shall not render medical care beyond the Support Zone (Cold Zone) unless specifically trained, equipped, and authorized to do so.

B. Medical treatment and transportation is secondary to the prevention of spreading the contaminate, and the management of the Haz Mat incident. The IC/UC or designee is responsible for determining the treatment priority for the patient(s). EMS transport personnel may be requested to receive non-ambulatory patients from the Contamination Reduction Zone (Warm Zone) after decontamination has been completed.

C. For radiation contaminated patients that meet immediate triage criteria, treatment and transport should not be delayed for decontamination processes.

D. Deceased victims shall be left undisturbed at the scene, or moved at the direction of the coroner, IC/UC, or designee.

E. The use of HEMS aircraft for the transport of potentially contaminated Haz Mat patient(s) is generally not appropriate. Patient transport by HEMS aircraft shall only occur by direction of the IC/UC or designee. HEMS aircraft may be utilized, at the discretion of the IC/UC or designee, to transport immediate radiation contaminated patients under the same criteria as ground based transportation assets.

F. If necessary, request CHEMPACK resources utilizing county specific activation procedures (refer to S-SV EMS Nerve Agent Treatment Protocol E-8).

G. Treat patients as directed by applicable S-SV EMS protocols, and/or direction from the base/modified base hospital.

Sierra – Sacramento Valley EMS Agency Program Policy			
EMS Care Of Minor Patients			
	Effective: DRAFT	Next Review: DRAFT	**851**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish criteria and procedures for EMS assessment, treatment and/or transport (collectively referred to in this policy as "EMS care") of minor patients.

AUTHORITY:

A. HSC, Div. 2.5.

B. CCR, Title 22, Div. 9.

C. FAM, § 6922, 6924, 6925, 6926, 6927, 6928, & 6929.

D. WIC, § 305 & 625.

DEFINITIONS:

A. **Emancipated –** An individual under the age of 18 years old who is married, on active duty in the military, or emancipated by court declaration.

B. **Emergency –** A situation requiring immediate services for alleviation of severe pain or immediate diagnosis of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death.

C. **Legal Guardian –** An individual granted legal authority to care for another individual.

D. **Minor –** An individual under the age of 18 years.

E. **Parent –** The lawful mother or father of a non-emancipated minor.

POLICY:

A. Parent/legal guardian consent for EMS care is not required for minor patients meeting any of the following criteria:

1. Has an emergency medical condition and a parent/legal guardian is not available.
2. Is an emancipated minor.
3. Is fifteen (15) years of age or older, living separate and apart from their parents and managing their own financial affairs.
4. Is twelve (12) years of age or older and in need of medical care for an infectious, contagious communicable disease, or for a sexually transmitted disease.

5. Is twelve (12) years of age or older and in need of medical care for drug or alcohol abuse.
6. Is in need of medical care for rape or sexual assault.
7. Is pregnant and requires medical care related to the pregnancy.

B. EMS personnel shall make every effort to inform a parent/legal guardian of a non-emancipated minor of the situation requiring EMS care, and where their child has been transported.

1. EMS personnel are not permitted to inform a parent/legal guardian without the minor's consent under the following circumstances:
    a. Is pregnant and requires medical care related to the pregnancy.
    b. Is twelve (12) years of age or older and in need of medical care for an infectious, contagious communicable disease, or for a sexually transmitted disease.
2. EMS personnel are not permitted to inform a parent or legal guardian of a minor who needs medical care for rape or sexual assault when they reasonably believe that the parent/guardian committed the rape or assault.

C. If EMS personnel believe a parent or legal guardian is making a decision which appears to be endangering the health and welfare of a minor patient, law enforcement involvement shall be utilized.

Sierra – Sacramento Valley EMS Agency Treatment Protocol	E-7
Hazardous Material Exposure	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

Refer to S-SV EMS Hazardous Material Incidents Policy (836)

Important caveats for medical responders:

- EMS personnel shall not enter or provide treatment in the Contamination Reduction Zone (Warm Zone) or Exclusion Zone (Hot Zone) unless trained, equipped and authorized to do so.
- EMS personnel shall not use Haz Mat specific personal protective equipment (PPE), including self-contained breathing apparatus (SCBA), unless trained, fit tested and authorized to do so.
- Do not transport pts until they have been completely decontaminated. If transport personnel become contaminated, they shall immediately undergo decontamination.
- Do not delay treatment/transport of immediate pts contaminated with radioactive material.
- Early base/modified base hospital contact, and CHEMPACK activation when appropriate (S-SV EMS Nerve Agent Treatment Protocol E-8), will maximize assistance from necessary resources.
- Refer to Hazardous Materials Medical Management Reference as appropriate.

Information that must be obtained by EMS personnel on every hazardous materials incident:

- Number of pts.
- Material involved or DOT 4-digit placard #.
- Route(s) of exposure for each pt.
- Signs & symptoms for each pt.
- Decontamination procedure completed for each pt.
- Procedure utilized to determine effectiveness of decontamination procedure.
- Risk of secondary exposure to rescuers.
- PPE required to transport pt.

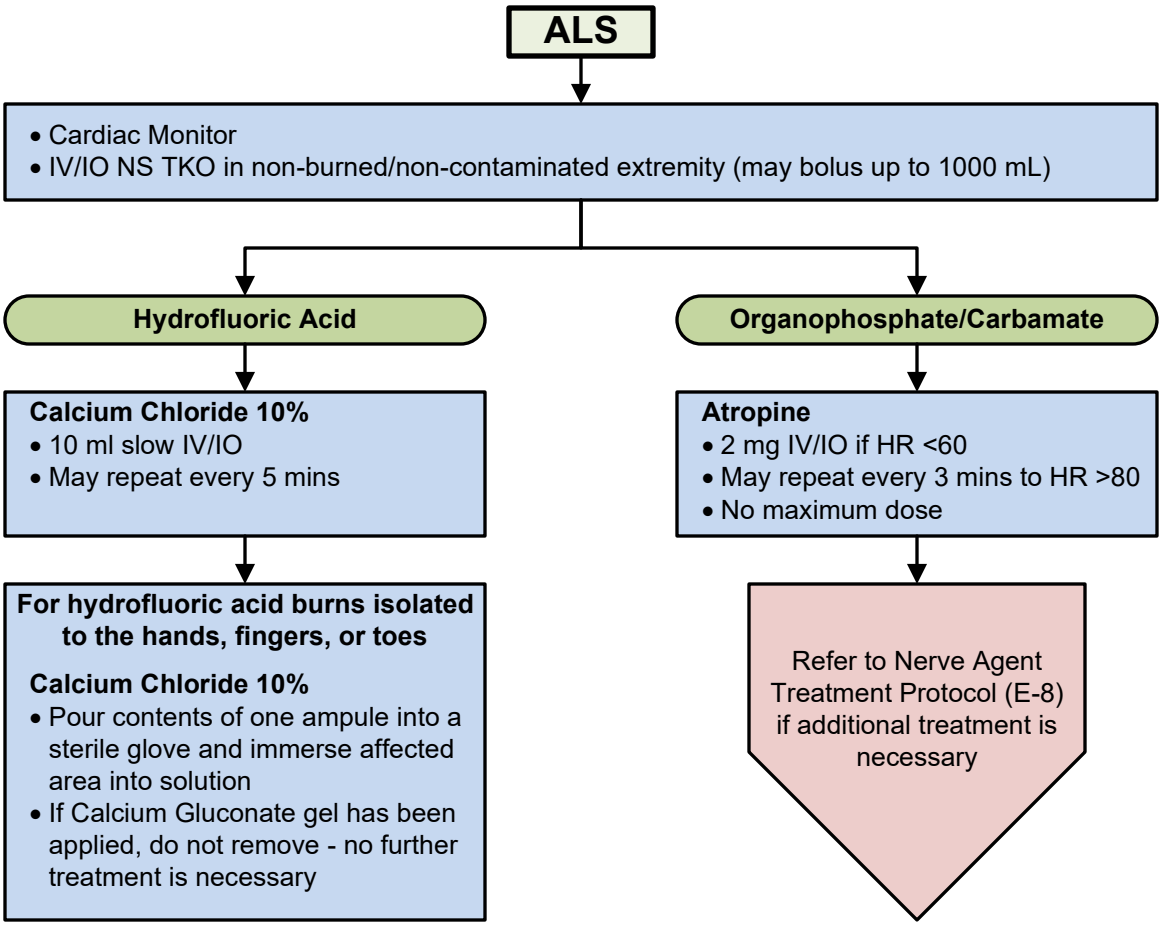
BLS

- Establish and secure airway as necessary
- O_2 at appropriate rate
- Contact base/modified base hospital for assistance in determining a decontamination/treatment plan
- After pt is fully decontaminated, cover with blankets and/or sheets as appropriate
- If eye exposure occurs, irrigate each exposed eye with NS – ensure contact lenses are removed

See pages 2 & 3 for additional treatment

Treatment Notes

- Skin exposure to hydrofluoric acid with a concentration >20% can cause fatal hypocalcemia and should be treated. Provide continuous EKG monitoring to look for QT-interval prolongation which is an early sign of hypocalcemia.
- Precautions must be taken to prevent direct contact with secretions of a pt who has ingested organophosphates or carbamate pesticides.



Radiation Emergencies

- Pt care takes priority over radiological concerns - addressing contamination issues should not delay treatment of life-threatening injuries.
- Viable pts are a high priority - rapidly extricate, treat and transport pts who are most critical and likely to survive.
- It is highly unlikely that the levels of radioactivity associated with a contaminated pt would pose a significant health risk to care providers.
- Body substance isolation clothing (gloves, gowns, N-95 masks, protective eyewear, shoe protectors, and head cap) are recommended, including 2-3 pair of disposable gloves.
- Due to fetal sensitivity to radiation, assign pregnant staff to other duties.

Ambulance Preparation (to the degree possible)

- Avoid using internal and external compartments - work out of mobile kits as much as possible.
- Close all internal compartments prior to loading pt.
- Cover radio communication microphones with a rubber glove.
- Cover floor of ambulance with disposable papers or pads.

Radiation Exposure Haz Mat Pt

- If O_2 is warranted, use a non re-breather mask (if tolerated) to provide protection from inadvertent respiratory contamination hazards - an N95 mask is appropriate to protect pt from inadvertent respiratory contamination hazards when O_2 is not indicated
- Frequent glove changes will reduce the spread of contamination and should be considered prior to handling the pt or pt care adjuncts
- All medical procedures should be utilized to save an immediate pt - if it is medically necessary to intubate a pt that is contaminated, then do so - change gloves prior to intubation, and maintain ET tube sterility if possible

Limited or no field decontamination

- Initiate ALS care as necessary
- Keep pt wrapped (cocoon style) to minimize potential for contamination spread - only expose areas to assess and treat
- If necessary, cut and remove the pts clothing away from the body, being careful to avoid contamination to the unexposed skin - contain all removed clothing by placing in a sealable bag
- Continue to reassess/monitor vitals while transporting pt to the appropriate receiving facility
- Contact with pt may result in transfer of contamination - change gloves as necessary

Field decontamination performed

- Pts with non life-threatening injuries should have field decontamination prior to removal from the Exclusion (Hot) Zone
- Pts condition permits a more thorough radiological survey prior to continued care
- Conduct head to toe assessment as appropriate
- Initiate ALS care as necessary
- If pts clothing has not been removed during decontamination, keep pt wrapped (cocoon style) to minimize potential for contamination spread - only expose areas to assess and treat
- Contact with pt may result in transfer of contamination - change gloves as necessary

Sierra – Sacramento Valley EMS Agency Program Policy			
Emergency Medical Dispatch *(EMD)* ~~Programs~~			
	Effective: DRAFT	Next Review: DRAFT	**405**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish criteria for EMD approval/utilization in the S-SV EMS region. ~~It is the goal of S-SV EMS that all callers requesting emergency medical assistance from any area within the S-SV EMS region have access to EMD services~~.

AUTHORITY:

A. HSC, Div. 2.5, § 1797.

B. CCR, Title 22, Div. 9.

POLICY:

A. *No later than January 1, 2027, all public safety agencies that process 911 emergency medical response requests, shall provide a minimum of the following EMD prearrival medical instructions:*

1. *Airway and choking instructions for infants, children, and adults.*
2. *Automatic external defibrillator (AED) and CPR instructions for children and adults.*
3. *Childbirth instructions.*
4. *Hemorrhage/bleeding control instructions.*
5. *Epinephrine auto-injector administration instructions for suspected anaphylaxis.*
6. *Naloxone administration instructions for suspected narcotics overdoses.*

B. *A public safety agency may also satisfy the above minimum EMD requirements by one of the following methods:*

1. *Utilizing a nationally recognized EMD program that includes all prearrival medical instructions listed above, or;*
2. *Contracting with another agency that provides all prearrival medical instructions listed above.*

C. *A public safety agency that processes 911 emergency medical response requests may additionally utilize a nationally recognized EMD program that consists of Medical Priority Dispatch System (MPDS) processes used to determine the appropriate number, type, and response priority of assigned EMS resources.*

D. *A private ground ambulance provider may also utilize a nationally recognized EMD program for providing applicable prearrival medical instructions and MPDS services.*

E. ~~EMD may be provided utilizing pre-arrival instructions only or may incorporate, using standardized caller interrogation questions, a Medical Priority Dispatch System (MPDS) process to determine the appropriate number, type, and response priority of assigned EMS transport resources.~~

F. All EMD providers, programs *and services* in the S-SV EMS region shall be approved by *the* S-SV EMS *Medical Director.* Approved EMD providers, programs *and services* ~~program materials~~ are subject to periodic review by S-SV EMS.

G. The S-SV EMS Medical Director is authorized to exercise medical control of all ~~EMS dispatch~~ *EMD* programs*/services* ~~operating~~ within the S-SV EMS region~~, including EMD programs, EMD providers, training policies, procedures, and protocols~~.

H. ~~EMS dispatch centers electing to provide EMD services may determine the extent to which they wish to utilize EMD. If an EMD provider utilizes an S-SV EMS approved MPDS, the dispatcher shall follow the response protocols associated with that system.~~

CONTINOUS QUALITY IMPROVEMENT (CQI):

A. *A public safety agency that provides only the minimum EMD prearrival medical instructions listed in this policy ('POLICY' Section, Item A.1. - A.6.) shall work collaboratively with S-SV EMS in providing EMD data for CQI purposes.*

B. ~~S-SV EMS approved EMD providers~~ *Any public or private EMS dispatch center that utilizes a nationally recognized EMD program* must ~~have~~ *maintain* ~~an approved continuous quality improvement (~~ *standardized* CQI~~)~~ program, which includes the following:

1. An EMD CQI coordinator who meets the following minimum qualifications:

   a. A currently licensed/certified physician, RN, PA, paramedic, AEMT or EMT, who has at least two (2) years of practical experience within the last five (5) years in prehospital EMS with a basic knowledge of EMD, and who has received specialized training in the CQI/case review process, or;

   b. An emergency medical dispatcher with at least two (2) years of practical experience within the last five (5) years, and who has received specialized training in the CQI/case review process.

2. The EMD CQI coordinator will work collaboratively with S-SV EMS in providing data used for EMS system analysis.

3. EMS dispatch center and personnel performance will be evaluated through reviewing of dispatch records, audio recordings and applicable provider field records. All written CQI records shall be maintained for a minimum of two (2) years. EMD programs shall maintain telecommunication records for a minimum of 100 days, or longer if required for evidence or pending litigation.

PROCEDURE:

A. ~~EMS dispatch centers requesting~~ EMD program*/service* ~~approval~~ *requests* shall *be* submitt*ed* ~~a request~~ to S-SV EMS, ~~which~~ *and* shall include the following:

1. The type(s) of EMD services to be provided.

2. A plan for how EMD *services* will be provided ~~and the name of the proposed EMD program to be utilized~~.

3. The name and qualifications of the EMD program administrator.

4. A description of the EMD provider CQI program *(if applicable)*.

5. The name and qualifications of the CQI coordinator *(if applicable)*.

B. ~~EMS dispatch center r~~*R*equests to provide EMD services will be processed within 30 calendar days of submission of all required program materials.

C. If a request to provide EMD services is denied, S-SV EMS will provide written notice of the reason for denial, and specific recommendations to fulfill compliance requirements (if any) within 30 calendar days of receiving all required program materials.

1. If a public safety agency's request to provide EMD services is not timely approved or is denied, an appeal shall be conducted in conformance with the administrative adjudication proceedings set forth in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the California Government Code. A final decision rendered pursuant to this appeal may be further appealed to a court of competent jurisdiction.

2. If a private *ground ambulance* provider's request to provide EMD services is not timely approved or is denied, an appeal may be made to the S-SV EMS JPA Governing Board of Directors. The decision rendered by the S-SV EMS JPA Governing Board of Directors shall be final.

D. If an ~~EMS dispatch center's~~ approval to provide EMD services is suspended or revoked, S-SV EMS will provide written notice of the reason for the suspension or revocation. This written notice will include the effective date of such suspension or revocation and any requirements necessary to become compliant (if applicable).

Sierra – Sacramento Valley EMS Agency Program Policy			
Tasered Patient Care & Transport			
	Effective: DRAFT	Next Review: DRAFT	**853**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish guidelines for EMS personnel on the treatment and transportation of patients on whom a Taser has been used.

AUTHORITY:

A. HSC, § 1797.204, 1797.220, & 1798.

B. CCR, Title 22, Div. 9.

GENERAL CONSIDERATIONS:

A. A Taser is designed to transmit electrical impulses that temporarily disrupt the body's nervous system. The Electro-Muscular Disruption (EMD) technology causes an uncontrollable contraction of the muscle tissue, allowing the Taser to physically debilitate a target regardless of pain tolerance or mental focus.

B. The scene must be safe and secured by law enforcement before EMS personnel will evaluate or treat the patient.

C. Assess the patient for any potential cause of the abnormal or combative behavior such as head trauma, hypoxia, alcohol or drug related problems, hypoglycemia or other metabolic disorders, stress or psychiatric disorders.

D. Assess the patient for any potential injury resulting from Taser deployment.

POLICY:

A. Taser probes may be removed by EMS personnel if they interfere with the treatment or safe transportation of the patient. Only EMT, AEMT and paramedic personnel are approved to remove Taser probes in the prehospital setting.

B. If removed by EMS, Taser probes shall be offered to law enforcement prior to disposal.

C. Mode of transportation and destination will be determined by law enforcement, in consultation with EMS personnel and/or the base/modified base hospital if necessary.

PROCEDURE:

A. When safe to do so, patients should be immediately evaluated, with particular attention to signs and symptoms of ~~excited delirium~~ *behavioral emergencies*.

B. Treat any injuries/medical conditions according to appropriate protocol(s).

C. The patient will normally be in law enforcement custody, and will require transportation to an emergency department for medical clearance.

D. If EMS personnel determine that the patient is a danger to self or others, law enforcement may be requested to accompany the patient *in the ambulance or follow the ambulance* during transport.

E. The patient should be appropriately restrained if indicated.

F. If one or both of the Taser probes requires removal:

1. Verify the wires to the probes have been severed.
2. Use routine biohazard precautions. Place one hand on the patient in the area where the probe is embedded and stabilize the skin surrounding the puncture site between two fingers. Keep your hand away from the probe. With your other hand, in one fluid motion pull the probe straight out from the puncture site.
3. Inspect probes to ensure that all parts were removed, and all barbs are intact.
4. Follow law enforcement direction regarding the preservation or disposal of probes.
5. Apply direct pressure for bleeding and apply a sterile dressing to the wound site.
6. Bo not remove probes located in the eyes, face, neck, genitals, or any other potentially vulnerable area.

DOCUMENTATION:

The following information shall be documented on the patient care report:

A. Patient's presenting behavior or signs/symptoms which resulted in Taser use.

B. Adequate patient assessment including, but not limited to, neurological assessment, oxygen saturation, blood glucose level, and other pertinent vital signs.

C. Anatomic location of the Taser probes (note: if Taser probes were removed by EMS, document time of removal and if probes were intact following removal).

Sierra – Sacramento Valley EMS Agency Treatment Protocol	E-8
Nerve Agent Treatment	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

Refer to S-SV EMS Hazardous Material Incidents Policy (836)

Important caveats for medical responders:

- EMS personnel shall not enter or provide treatment in the Contamination Reduction Zone (Warm Zone) or Exclusion Zone (Hot Zone) unless trained, equipped and authorized to do so.
- EMS personnel shall not use Haz Mat specific personal protective equipment (PPE), including self-contained breathing apparatus (SCBA), unless trained, fit tested and authorized to do so.
- Do not transport pts until they have been completely decontaminated. If transport personnel become contaminated, they shall immediately undergo decontamination.

Treatment notes:

- A base/modified base hospital physician order must be obtained prior to utilizing this protocol for pt treatment. Once an order is obtained, the entire protocol becomes a standing order that applies to all authorized/trained EMS personnel operating at the incident.
- Atropine (2mg) and pralidoxime chloride (600mg) auto-injectors included in MARK I/DuoDote nerve agent antidote kits shall only be used by authorized/trained EMS personnel.
- Paramedics may administer atropine and/or pralidoxime chloride IM/IV in situations where auto-injector nerve agent antidote kits are not available.
- EMS personnel may self-administer nerve agent antidote kits when authorized/trained to do so.
- Adult auto-injectors are not to be used in children under 40 Kg.
- Nerve agent antidote medications are only given if the pt is showing signs & symptoms of nerve agent poisoning, they are not to be given prophylactically. A decrease in bronchospasm and respiratory secretions are the best indicators of a positive response to atropine and pralidoxime.

Signs/Symptoms of Nerve Agent Exposure (mild to severe)

1. Runny nose
2. Chest tightness
3. Difficulty breathing
4. Bronchospasm
5. Pinpoint pupils/blurred vision
6. Drooling
7. Excessive sweating
8. Nausea/vomiting
9. Abdominal cramps
10. Involuntary urination/defecation
11. Jerking/twitching/staggering
12. Headache
13. Drowsiness
14. Coma
15. Convulsions
16. Apnea

Nerve Agent Exposure Mnemonic (SLUDGEM)

Salivation
Lacrimation
Urination
Defecation
GI distress
Emesis
Miosis/muscle fasciculation

CHEMPACK

Description:

- The Centers for Disease Control and Prevention (CDC) established the CHEMPACK project resulting in the forward placement of sustainable caches of nerve agent antidotes.
- CHEMPACK caches have been placed at select sites throughout the S-SV EMS region and surrounding areas according to program requirements and effective transportation alternatives.
- EMS CHEMPACK caches contain enough antidote to treat approximately 454 patients. These caches contain primarily auto-injectors for rapid administration, but also contain some multi-dose vials for variable dosing (including pediatric patients) and prolonged treatment.
- Authorization to deploy CHEMPACK assets will be limited to an event that:

  1. Threatens the medical security of the community; and
  2. Places multiple lives at risk; and
  3. Is otherwise beyond local emergency response capabilities; and
  4. Will likely make the material medically necessary to save human life.

CHEMPACK requesting/deployment:

- A requestor is considered to be one of the following entities at the scene of a suspected nerve agent or organophosphate release with known, suspected, or potential contaminated, exposed, or affected patients:

  1. EMS prehospital personnel; or
  2. Incident Commander (IC); or
  3. Medical Group Supervisor (MGS).

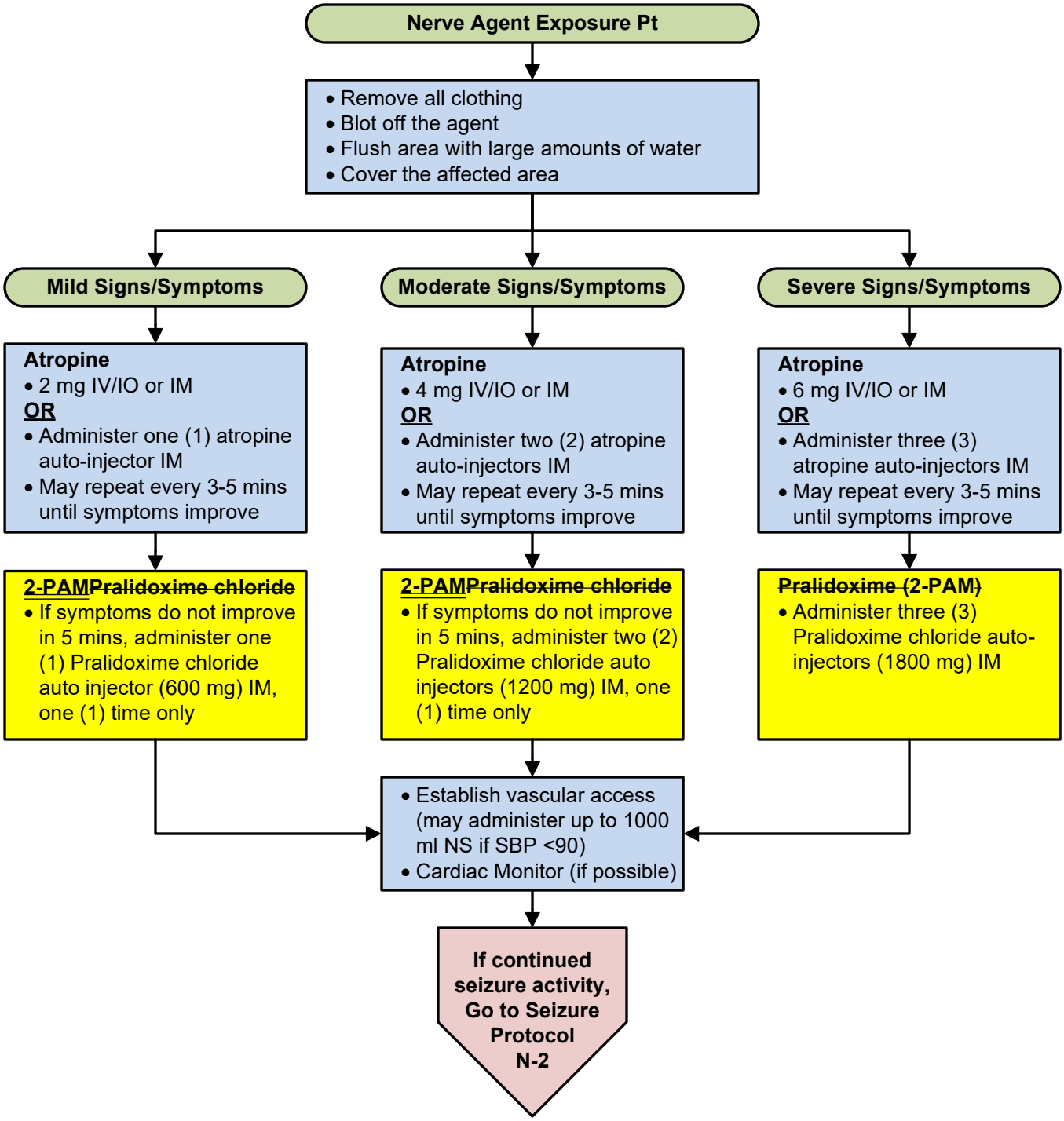
- Potential requestors should be familiar with and follow their Operational Area (OA)/county specific CHEMPACK plans and procedures
- The S-SV EMS Duty Officer and applicable MHOAC Program(s) shall be notified as soon as possible in the event of a CHEMPACK request/deployment.

See page 3 for specific treatment

Nerve Agent Treatment

Treatment Notes

- Only treat pts located in the Exclusion Zone (Hot Zone) with IM auto-injectors



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

- The purpose of this protocol is to provide standing order assessment/treatment modalities for pt complaints not addressed by other S-SV EMS treatment protocols – including nausea/vomiting and suspected sepsis.

BLS

- Assess V/S, including SpO_2 & temperature (if able)
- O_2 at appropriate rate if pt hypoxemic (SpO_2 <94%), short of breath, or has signs of heart failure/shock
- Assess history & physical
- Check blood glucose – if indicated & able

Blood glucose ≤60 mg/dl, or hx & clinical presentation fits hypoglycemia

NO

YES

Oral glucose (BLS) – ONLY if pt is conscious & able to swallow
- Pre-packaged glucose solution/gel or 2-3 tbsp of sugar in water/juice

OR

Dextrose 10% (ALS)
- 10 – 25 g (100 – 250 mL) IV/IO

OR

Glucagon (ALS)
- 1 mg (1 unit) IM/IN

ALS

Consider the following additional assessment/treatment modalities, as appropriate based on pt's condition & clinical presentation

- Cardiac monitor/12-lead EKG
- $EtCO_2$ monitoring
- IV/IO NS (may bolus up to 1000 mL if indicated)

- Refer to other sections of this protocol as appropriate
  - Suspected Sepsis – Page 2
  - Suspected AAA (Abdominal Aortic Aneurysm) – Page 3
  - Nausea/Vomiting – Page ~~3~~ *4*

Suspected Sepsis

- Early recognition of sepsis is critical to expedite hospital care and antibiotic administration.
- Aggressive IV fluid therapy is the most important prehospital treatment for sepsis.
- Septic pts are especially susceptible to traumatic lung injury and ARDS. If BVM ventilation is necessary, avoid excessive tidal volumes.
- Attempt to identify the source of infection (skin, respiratory, etc.), previous treatment and related history.
- Consider the possibility of sepsis when a combination of two or more of the following Systemic Inflammatory Response Syndrome (SIRS) criteria are present:
  - Temperature <96.8°F or >100.4°
  - RR >20bpm
  - HR >90bpm
  - ETCO2 ≤25 mmHg

High-Risk Indicators for Sepsis:

- Hx of pneumonia, UTI, MRSA
- Cancer pts
- Nursing home residents
- Pts with indwelling catheters
- Immune-compromised pts

Shock Index (SI):

- SI is used to assess the severity of hypovolemic shock
- SI = HR/SBP
  - Normal SI range is 0.5 to 0.7
  - HR>SBP (SI>1) may indicate sepsis

ALS

- Assess Temperature
- $EtCO_2$ monitoring
- IV/IO NS 500 mL boluses to a maximum of 2 L if SIRS criteria remain present
  - Reassess vital signs between boluses
  - Discontinue boluses and provide supportive care if signs of pulmonary edema develop

If SBP <90 after 2 L NS:
Push-Dose Epinephrine
- Eject 1 mL NS from a 10 mL flush syringe
- Draw up 1 mL epinephrine 1:10,000 & gently mix
- Administer 1 mL IV/IO push every 1-5 mins for continued SBP <90

If pt is febrile:
Acetaminophen
- 1 g IV/IO infusion over 15 mins (single dose)

- Monitor & reassess
- Provide early notification to the receiving hospital for suspected sepsis pts

Suspected Dissecting or Ruptured Abdominal Aortic Aneurysm (AAA)

New Page

Patients at high risk for AAA include:
- Men age > 65
- History of smoking
- History of hypertension
- Family/patient history of AAA

Hallmark symptoms of AAA often include one or more of the following:
- Sudden onset of abdominal, flank, back or groin pain
- Pain described as “ripping” or “tearing”
- Pain is typically severe, constant and progressive
- Sudden onset of weakness or syncope/near-syncope
- Nausea and/or vomiting
- Sense of impending doom/Restlessness

One or more of the following vital signs/assessment findings may be present:
- Hypotension (late or rapidly developing)
- Narrowing pulse pressure
- Tachycardia (caution: patients with history of hypertension may be on beta blockers)
- Weak or thready peripheral pulses
- Asymmetric femoral pulses
- Pulsatile abdominal mass (often absent or difficult to assess)

ALS

- Cardiac monitor/12-lead EKG
- $EtCO_2$ monitoring
- When possible, establish two large-bore IVs or IO
- Do not aggressively treat hypotension – allow for permissive hypotension
  - Target SBP 80-90 mmHg if patient has palpable pulses and is conscious
  - 250 mL NS boluses only if signs of critical hypoperfusion (mental status changes, delayed capillary refill, bilateral absent femoral pulses)
- Prioritize pain management

Refer to M-8 Pain Management

- Monitor & reassess
- Provide early notification to the receiving hospital for suspected AAA patients

Nausea/Vomiting

- Nausea/vomiting can be symptoms of a multitude of different causes. If possible, the specific underlying cause should be determined and treated. The use of an antiemetic may relieve symptoms while leaving the cause untreated, and possibly, more difficult to detect. EMS personnel should weigh the benefits of antiemetic use against the possible risk of making an accurate diagnosis more difficult, and the possible side effects of the antiemetic agent.
- Treatment of nausea/vomiting is indicated for pts where it may contribute to a worsening of their medical condition, or where the pt's airway may be endangered.
- EMS personnel may consider administering Zofran (Ondansetron) prophylactically, prior to or immediately after opioid administration, for a pt with a history of nausea/vomiting secondary to opioid administration. Zofran (Ondansetron) may also be administered prior to transport to a pt with a history of motion sickness.

ALS

Zofran (Ondansetron)
- 4 - 8 mg oral disintegrating tablet, **OR** 4 - 8 mg IM, **OR** 4 - 8 mg slow IV/IO (over 30 seconds)
- May repeat as needed (max total dose: 16 mg)

Zofran (Ondansetron) is contraindicated during the first 8 weeks of pregnancy

Sierra – Sacramento Valley EMS Agency Treatment Protocol	T-5
Burns	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

20CRW stands for 20 minutes of Cool Running Water — the recommended initial treatment for burns involving < 30% total body surface area (TBSA). It helps stop the burning process, reduce pain, limit tissue damage, and improve healing outcomes. Avoid cold water in small children to prevent hypothermia. Avoid ice.

BLS

Initial Actions

- Stop the burn (remove clothing/jewelry)
- Assess for inhalation injury (singed nasal hairs, hoarseness, carbonaceous sputum
  - If signs/symptoms:
    - High-flow O2
    - Airway management as appropriate
- Assess V/S, including SpO_2

Secondary Actions

- For thermal burns <30% TBSA, and in the absence of life threatening injuries, cool with 20CRW
- Estimate % TBSA burned and severity
- Cover burns (dry sterile dressings, burn sheets or loose clear plastic wrap)
- Maintain normothermia

ALS

- Cardiac & $EtCO_2$monitoring
- Consider early advanced airway if evidence of inhalation injury or compromised respiratory effort
  - If wheezes are present, administer **Albuterol:** 5 mg in 6 mL NS via HHN, mask or BVM
- Refer to M-8/M-8P for pain management
- IV/IO – NS/LR
  - For patients with >10% 2^o or 3^o burns, initial fluid resuscitation:
    - ≦ 5 years: 125 ml/hr
    - 6 – 13 years: 250ml/hr
    - ≥ 14 years: 500ml/hr
  - If patient is hypotensive, refer to M-6/M-6P for fluid resuscitation guidelines

Does pt meet trauma triage criteria?

YES → Destination Per General Trauma Management Protocol (T-1)

NO

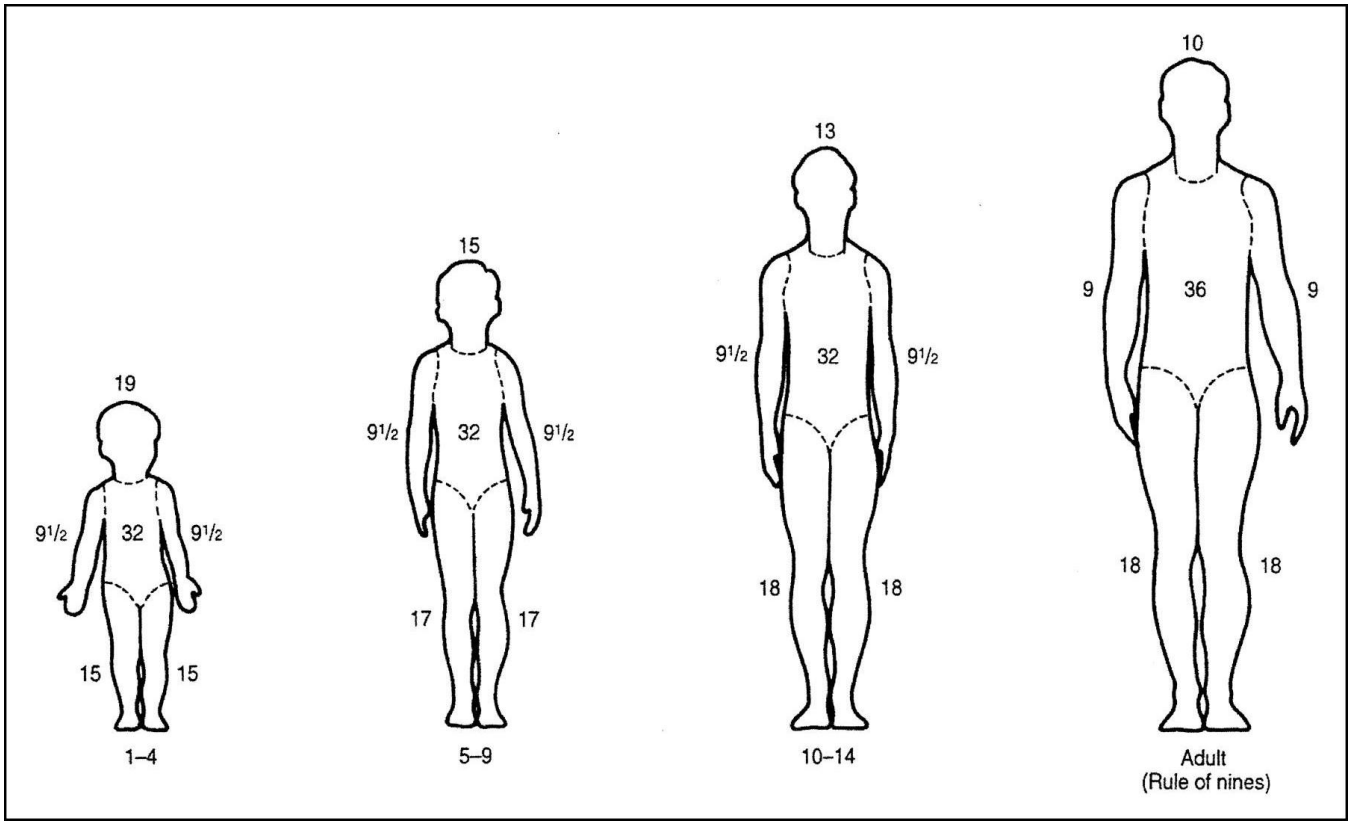
Does pt meet criteria for transport to Burn Center?

- Transport time ≦ 45 minutes, hemodynamically stable, manageable airway, **AND** one or more of the following:
  - >10% TBSA partial-thickness burns
  - Burns involving face, hands, feet, genitalia, perineum, joints
  - Full-thickness burns in any age group
  - Electrical, lightning or chemical burns
  - Inhalation injuries

YES → Consult closest base/modified base hospital for destination

NO → Transport to closest, most appropriate hospital

Burn Chart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Sierra – Sacramento Valley Emergency Medical Services Agency (S-SV EMS)

Regional Executive Director
John Poland, Paramedic

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

JPA Board Chairperson
Sue Hoek, Nevada County Supervisor

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

S-SV EMS MEMORANDUM

Date: January 30, 2026

To: S-SV EMS System Participants

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

Re: S-SV EMS Ground Ambulance Provider Rate Approval Process Policy (412) Suspension

S-SV EMS has determined that our Ground Ambulance Provider Rate Approval Process Policy (412) has failed to function as intended resulting in unmanageable/unsustainable expectations. We have also determined that this policy is inconsistent with most other California Local EMS Agency (LEMSA) policies/processes related to these matters. Pursuant to S-SV EMS Policy/Protocol Actions Policy (220), POLICY Section:

> D. *Some policy/protocol actions may require immediate action to maintain compliance with statutes/regulations, or to preserve medical control/integrity of the EMS system. Policy/protocol actions of this type may be implemented by S-SV EMS as urgency measures and scheduled for discussion at the next regularly scheduled REMAC meeting, if necessary.*

The purpose of this memorandum is to notify applicable EMS system participants that the S-SV EMS Ground Ambulance Provider Rate Approval Process Policy (412), is being suspended, effective immediately. We are currently re-evaluating this matter and intend to modify or rescind this policy based on further direction from our JPA Board during their February 13, 2026 meeting.

Applicable ground ambulance rates approved during the August 2025 S-SV EMS JPA Board meeting remain in effect at this time. Additionally, pursuant to relevant statute, this matter is not applicable to ground ambulance providers who have an agreement with S-SV EMS that contains specific rate setting provisions or public ground ambulance providers who's governing body is responsible for publicly establishing/approving ground ambulance rates.