3340 Glenwood Street, Eureka, CA 95501 (707) 445-2081 (800) 282-0088 FAX (707) 445-0443

MEMORANDUM:

DATE: November 15, 2010

TO: Joint Powers Governing Board Members
County Health Officers
Lake County Administrative Officer
Prehospital Care Medical Directors
Prehospital Care Nurse Coordinators
Fire Chiefs' Associations/EMS Liaisons
EMCC Chairpersons

FROM: Tracy D'Amico, Administrative Assistant

RE: E-Informational Mailing

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1. **Policy Change**
   a. **Policy #4010**

2. **For Your Information:**
   a. **Final Progress Report General Fund Contract #EMS -9051**
   b. **First Quarter Progress Report General Fund Contract #EMS -1051**
   c. **North Coast EMS Quarterly QIP Summary dated October 10, 2010**
   d. **First Quarter Report for Contract #EMS -1070**
   e. **CA State Trauma Summit III Brochure**
   f. **Rural Trauma Team Development Flyer**

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CHANGE NOTICE CHANGE #90

NOVEMBER 15, 2010

TO: ALL PREHOSPITAL CARE POLICY MANUAL HOLDERS

INSTRUCTIONS	POLICY #	POLICY DESCRIPTION	# OF PAGES
ADD	4010	Emergency Medical Technician Incident Investigation; Determination of Action, Notification and Administrative Hearing Process	9

SUBJECT: Emergency Medical Technician Incident Investigation, Determination of Action, Notification and Administrative Hearings Process

I. Authority and Reference (incorporated herein by references)
  A. Division 2.5 of Health and Safety Code
  B. California code of Regulations, Title 22
  C. North Coast EMS Policies and Procedures

II. Purpose
  A. To establish a policy and procedure governing reportable situations and the evaluation and determination regarding whether or not disciplinary cause exists.

III. Definitions

Certificate - means a valid Emergency Medical Technician (EMT) certificate issued pursuant to Division 2.5 of the California Health and Safety Code.

Certifying entity - as used in this policy, means the Medical Director of the North Coast EMS Agency.

Certification Action - means those actions that may be taken by the North Coast EMS Medical Director that include denial, suspension, revocation of a certificate, or placing a certificate holder on probation.

Certificate Holder – for the purpose of this policy, shall mean the holder of a certificate, as that term is described above.

CCR – means the California Code of Regulations, Title 22, Division 9.

Discipline - means either a disciplinary plan adopted by a relevant employer pursuant to Section 100206.2 of the CCR or certification action taken by a Medical Director pursuant to Section 100204 of the CCR, or both a disciplinary plan and certification action.

Disciplinary Cause - means an act that is substantially related to the qualifications, functions, and duties of an EMT and is evidence of a threat to the public health and safety, per Health and Safety Code Section 1798.200.

SUBJECT: Emergency Medical Technician Incident Investigation, Determination of Action, Notification and Administrative Hearings Process

Disciplinary Plan - means a written plan of action that can be taken by a relevant employer as a consequence of any action listed in Section 1798.200 (c). The Disciplinary Plan shall be submitted to the NORTH COAST EMS Medical Director and may include recommended certification action consistent with the Recommended Guidelines for Disciplinary Orders and Conditions of Probation for EMTs (MDOs).

Functioning outside of medical control - means any provision of prehospital emergency medical care which is not authorized by, or is in conflict with, any policies, procedures, or protocols established by the Merced County EMS agency, or any treatment instructions issued by the base hospital providing immediate medical direction.

Model Disciplinary Orders (MDO) - means the Recommended Guidelines for Disciplinary Orders and Conditions of Probation (EMSA document #134) which were developed to provide consistent and equitable discipline in cases dealing with disciplinary cause.

Prehospital emergency medical personnel - means those persons who have been certified/authorized/accredited as qualified to provide prehospital emergency medical care pursuant to Division 2.5, HSC.

Relevant employer(s) - means those ambulance services permitted by the Department of the California Highway Patrol or a public safety agency that the certificate holder works for or was working for at the time of the incident under review, as an EMT either as a paid employee or a volunteer.

Valid, Validate or Validated – for the purpose of this policy means to determine by preliminary investigation, within reasonable certainty, that a violation of Health and Safety Code §1798.200 may have occurred and that said violation may be reason for disciplinary cause.

IV. Policy

A. Any information received from any source, including discovery through medical audit or routine follow-up on complaints, which purports a violation of, or deviation from, state or local EMS laws, regulations, policies, procedures or protocols will be evaluated pursuant to this policy and consistent with the CCR, Title 22, Division 9, Chapter 6.

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V. Procedure

A Responsibilities of Relevant Employer

1. Under the provisions of the CCR and this policy, relevant employers:
   a) May conduct investigations to determine disciplinary cause.
   b) Shall notify the North Coast EMS Medical Director within three (3) working days after an allegation has been validated as potential for disciplinary cause.
   c) Upon determination of disciplinary cause, the relevant employer may develop and implement a disciplinary plan, in accordance with the Model Disciplinary Orders (MDOs).
      1) The relevant employer shall submit that disciplinary plan to the North Coast EMS along with the relevant findings of the investigation related to disciplinary cause, within three (3) working days of adoption of the disciplinary plan.
      2) The employer's disciplinary plan may include a recommendation that the Medical Director consider taking action against the holder's certificate to include denial of certification, suspension of certification, revocation of certification, or placing a certificate on probation.
   d) Shall notify the Medical Director within three (3) working days of the occurrence of any of following:
      1) The employee is terminated or suspended for a disciplinary cause,
      2) The employee resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause, or
      3) The employee is removed from employment-related duties for a disciplinary cause after the completion of the employer's investigation.

B Jurisdiction of the North Coast EMS Medical Director

1. The Medical Director shall cause to have conducted investigations to validate allegations for disciplinary cause when the EMT is not an employee of a relevant employer or the relevant employer does not conduct an investigation. Upon determination of disciplinary cause, the Medical Director may take certification action as necessary against a certificate holder.
2. The Medical Director may, upon determination of disciplinary cause and according to the provisions of this policy, take certification action

SUBJECT: Emergency Medical Technician Incident Investigation, Determination of Action, Notification and Administrative Hearings Process

3. against an EMT to deny, suspend, or revoke, or place a certificate holder on probation, upon the findings by the Medical Director of the occurrence of any of the actions listed in Health and Safety Code, Section 1798.200 (c) and for which any of the following conditions are true:
   a) The relevant employer, after conducting an investigation, failed to impose discipline for the conduct under investigation, or the Medical Director makes a determination that discipline imposed by the relevant employer was not in accordance with the MDOs and the conduct of the certificate holder constitutes grounds for certification action.
   b) The Medical Director determines, following an investigation conducted in accordance with this policy, that the conduct requires certification action.
3. The Medical Director, after consultation with the relevant employer or without consultation when no relevant employer exists, may temporarily suspend, prior to a hearing, a certificate holder upon a determination of the following:
   a) The EMT has engaged in acts or omissions that constitute grounds for revocation of the certificate; and
   b) Permitting the EMT to continue to engage in certified activity without restriction poses an imminent threat to the public health and safety.
4. If the Medical Director takes any certification action the Medical Director shall notify the State EMS Authority of the findings of the investigation and the certification action taken by entering said information into the state registry.

C <u>Evaluation of Information</u>

1. A relevant employer who receives an allegation of conduct listed in Section 1798.200 (c) of the Health and Safety Code against a certificate holder and once the that relevant employer has validated the allegation, shall notify the North Coast EMS Medical Director, within three (3) working days, of the certificate holder's name, certification number, and the allegation(s).
2. When North Coast EMS receives a complaint against a certificate holder, North Coast EMS shall forward the original complaint and any supporting documentation to the relevant employer for investigation, if there is a relevant employer, within three (3) working days of receipt of the information. If there is no relevant employer or the relevant employer does not wish to investigate the complaint, the Medical Director shall evaluate the information received from a credible source, including but not limited to, information obtained from an application,

medical audit, or public complaint, alleging or indicating the possibility of a threat to the public health and safety by the action of an applicant for, or holder of, a certificate issued by North Coast EMS or pursuant to Division 2.5, H&SC.

3. The relevant employer or Medical Director shall conduct an investigation of the allegations in accordance with the provisions of this policy, if warranted.

D Investigations Involving Firefighters

1. The rights and protections described in Chapter 9.6 of the Government Code shall only apply to a firefighter during events and circumstances involving the performance of his or her official duties.
2. All investigations involving certificate holders who are employed by a public safety agency as a firefighter shall be conducted in accordance with Chapter 9.6 of the Government Code, Section 3250 et. seq.

E Due Process

1. The certification action process shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

F Determination of Action

1. Upon determining the disciplinary or certification action to be taken, the relevant employer or Medical Director shall complete and place in the personnel file or any other file used for any personnel purposes by the relevant employer or North Coast EMS, a statement certifying the decision made and the date the decision was made. The decision must contain findings of fact and a determination of issues, together with the disciplinary plan and the date the disciplinary plan shall take effect.
2. In the case of a temporary suspension order pursuant to Section 100209 (c) of the CCR, it shall take effect upon the date the notice required by Section 100213 of the CCR is mailed to the certificate holder.
3. For all other certification actions, the effective date shall be thirty days from the date the notice is mailed to the applicant for, or holder of, a certificate unless another time is specified or an appeal is made.

SUBJECT: Emergency Medical Technician Incident Investigation, Determination of Action, Notification and Administrative Hearings Process

G Temporary Suspension Order

1. The North Coast EMS Medical Director may temporarily suspend a certificate prior to hearing if there is a valid complaint that the certificate holder has engaged in acts or omissions that constitute grounds for denial or revocation according to Section 100216(c) of the CCR and, if in the opinion of the Medical Director, permitting the certificate holder to continue to engage in certified activity would pose an imminent threat to the public health and safety.
2. Prior to, or concurrent with, initiation of a temporary suspension order of a certificate pending hearing, the Medical Director shall consult with the relevant employer of the certificate holder.
3. The notice of temporary suspension pending hearing shall be served by registered mail or by personal service to the certificate holder immediately, but no longer than three (3) working days from making the decision to issue the temporary suspension. The notice shall include the allegations that allowing the certificate holder to continue to engage in certified activities would pose an imminent threat to the public health and safety.
4. Within three (3) working days of the initiation of the temporary suspension by North Coast EMS, North Coast EMS and the relevant employer shall jointly investigate the allegation in order for the North Coast EMS Medical Director to make a determination of the continuation of the temporary suspension.
   a) All investigatory information, not otherwise protected by the law, held by North Coast EMS and the relevant employer shall be shared between the parties via facsimile transmission or overnight mail relative to the decision to temporarily suspend.
   b) North Coast EMS shall serve within fifteen (15) calendar days an accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code (Administrative Procedures Act).
   c) If the certificate holder files a Notice of Defense, the administrative hearing shall be held within thirty (30) calendar days of North Coast EMS's receipt of the Notice of Defense.
   d) The temporary suspension order shall be deemed vacated if the North Coast EMS fails to serve an accusation within fifteen (15) calendar days or fails to make a final determination on the merits within fifteen (15) calendar days after the Administrative Law Judge (ALJ) renders a proposed decision.

SUBJECT: Emergency Medical Technician Incident Investigation, Determination of Action, Notification and Administrative Hearings Process

H Final Determination of Certification Action by the Medical Director

1. Upon determination of certification action following an investigation, and appeal of certification action pursuant to Section 100211.1 of the CCR, if the respondent so chooses, the Medical Director may take the following final actions on an EMT certificate:
   a) Place the certificate holder on probation
   b) Suspension
   c) Denial
   d) Revocation

I Placement of a Certificate Holder on Probation

1. The North Coast EMS Medical Director may place a certificate holder on probation any time an infraction or performance deficiency occurs which indicates a need to monitor the certificate holder's conduct in the EMS system, in order to protect the public health and safety. The term of the probation and any conditions shall be in accordance with the MDOs. North Coast EMS may revoke the EMT certificate if the certificate holder fails to successfully complete the terms of probation.

J Suspension of a Certificate

1. The Medical Director may suspend an individual's EMT certificate for a specified period of time for disciplinary cause in order to protect the public health and safety.
2. The term of the suspension and any conditions for reinstatement shall be in accordance with the MDOs.
3. Upon the expiration of the term of suspension, the individual's certificate shall be reinstated only when all conditions for reinstatement have been met. The Medical Director shall continue the suspension until all conditions for reinstatement have been met.
4. If the suspension period will run past the expiration date of the certificate, the EMT shall meet the recertification requirements for certificate renewal prior to the expiration date of the certificate.

K Denial or Revocation of a Certificate

1. The Medical Director may deny or revoke any EMT certificate for disciplinary cause that has been investigated and verified by application of this policy.
2. The North Coast EMS Medical Director shall deny or revoke an EMT certificate if any of the following apply to the applicant:

a) Has committed any sexually related offense specified under Section 290 of the Penal Code.
b) Has been convicted of murder, attempted murder, or murder for hire.
c) Has been convicted of two (2) or more felonies.
d) Is on parole or probation for any felony.
e) Has been convicted and released from incarceration for said offense during the preceding fifteen (15) years for the crime of manslaughter or involuntary manslaughter.
f) Has been convicted and released from incarceration for said offense during the preceding ten (10) years for any offense punishable as a felony.
g) Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to the use, sale, possession, or transportation of narcotics or addictive or dangerous drugs.
h) Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offence relating to force, threat, violence, or intimidation.
i) Has been convicted within the preceding five (5) years of any theft related misdemeanor.

3. The Medical Director may deny or revoke an EMT certificate if any of the following apply to the applicant:
   a) Has committed any act involving fraud or intentional dishonesty for personal gain within the preceding seven (7) years.
   b) Is required to register pursuant to Section 11590 of the Health and Safety Code.
4. Subsection 3. (a) and (b) shall not apply to convictions that have been pardoned by the Governor, and shall only apply to convictions where the applicant/certificate holder was prosecuted as an adult. Equivalent convictions from other states shall apply to the type of offenses listed in (a) and (b). As used in this Section, "felony" or "offense punishable as a felony" refers to an offense for which the law prescribes imprisonment in the state prison as either an alternative or the sole penalty, regardless of the sentence the particular defendant received.
5. This Section shall not apply to those EMT's who obtain their California certificate prior to July 1, 2010; unless:
   a) The certificate holder is convicted of any misdemeanor or felony after July 1, 2010.
   b) The certificate holder committed any sexually related offense specified under Section 290 of the Penal Code.

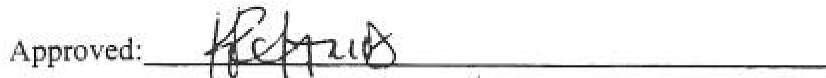
SUBJECT: Emergency Medical Technician Incident Investigation, Determination of Action, Notification and Administrative Hearings Process

c) The certificate holder failed to disclose to the certifying entity any prior convictions when completing his/her application for initial EMT certification or certification renewal.

6. Nothing in this Section shall negate an individual's right to appeal a denial of an EMT certificate pursuant to this policy.
7. Certification action by the North Coast EMS Medical Director shall be valid statewide and honored by all certifying entities for a period of at least twelve (12) months from the effective date of the certification action. An EMT whose application was denied or an EMT whose certification was revoked by the North Coast EMS Medical Director shall not be eligible for EMT application by any other certifying entity for a period of at least twelve (12) months from the effective date of the certification action. An EMT whose certification is placed on probation must complete their probationary requirements with the EMS Agency that imposed the probation.

L <u>Notification of Final Decision of Certification Action</u>

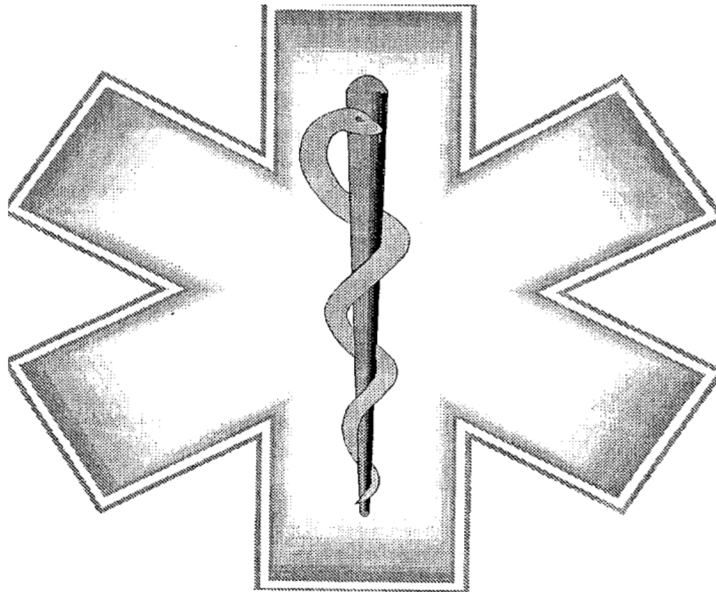
1. For the final decision of certification action, the North Coast EMS Medical Director shall notify the applicant/certificate holder and his/her relevant employer(s) of the certification action within ten (10) working days after making the final determination.
2. The notification of final decision shall be served by registered mail or personal service and shall include the following information:
   a) The specific allegations or evidence which resulted in the certification action;
   b) The certification action(s) to be taken, and the effective date(s) of the certification action(s), including the duration of the action(s);
   c) Which certificate(s) the certification action applies to in cases of holders of multiple certificates;
   d) A statement that the certificate holder must report the certification action within ten (10) working days to any other LEMSA and relevant employer in whose jurisdiction s/he uses the certificate.



Dated 11/3/10

NORTH COAST EMERGENCY MEDICAL SERVICES 3340 Glenwood Street, Eureka, California 95501

Serving Del Norte, Humboldt, Lake and southern Trinity Counties



Final Progress Report

July 1, 2009 to June 30, 2010

General Fund Contract # EMS-90S1

September 1, 2010

North Coast Emergency Medical Services
General Fund #9051 Final Progress Report

Fiscal Year 2009-2010

The following report on progress at North Coast EMS during the fourth quarter of Fiscal Year 2009-10 meets the requirements of the California EMS Authority General Fund Contract #EMS-9051 and the document entitled: "EMSA Policy for Funding Regional EMS Agencies with State General Fund (July 2005; EMSA #104)."

1.0 System Organization and Management

Objective: To develop and maintain an effective management system to meet the emergency medical needs and expectations of the population served.

Task: The organization and management responsibilities of the regional EMS agency, at a minimum, include:

1. Staff development, training and management: North Coast EMS personnel attended or participated in state EMS functions, including: visit to the north coast by Dr. Tharratt of the EMSA; EMSAAC Legislative Committee meetings, EMS for Children meeting, EMSAAC QIP Coordinators meetings, State Trauma Advisory Committee meeting, North Regional Trauma Coordinating Committee meetings, EMS System Planning Guidelines meetings; RCRC planning meetings; AHA Western States Affiliate Mission Lifeline Task Force meeting; EMSA/LEMSA meetings; EMT 2010 Rollout meetings; State Trauma-MAC meeting; EMS Regional Planning and Restructuring meetings and, in local EMS functions: Humboldt/Del Norte Medical Advisory Committee (MAC) meetings; Lake County Emergency Medical Care Committee (EMCC) meetings; EPCIS & CEMSIS meetings; Humboldt County Child Death Review Team meetings; Humboldt County Injury Prevention Committee meetings; Humboldt County Child Passenger Safety Committee meetings; Youth Safe Driving Committee meetings; Humboldt County Fire Chiefs Association meetings; Humboldt Cardiac Coordinating Committee meetings; Joint Powers Governing Board meeting; Cardiac and Trauma Planning meetings; PCNC Orientation meetings; Trinity County meetings etc.

2. Allocating and maintaining office space, office equipment, supplies: North Coast EMS acquired supplies as needed. Lake County Fire set up a connection for a Polycom Phone, which has been successfully tested at both fire stations! We extend our appreciation to Lakeport and Lake County Fire for helping to improve communications with our office.

executed State GF contract; submitted and received Bertha Russ Lytel Foundation great for next year; etc. We also initiated a process to update all hospital contracts this coming year.

4. **Trinity County:** North Coast EMS staff met with representatives and the Board of Supervisors of Trinity. The latter elected to join our region effective July 1,2010, but this was delayed and then rescinded later to allow more time to address scope of practice and policy differences. We remain hopeful that Trinity County will join North Coast EMS beginning next fiscal year.

5. **State Policy Contributions:** North Coast EMS staff commented on the draft Aero Medical Guidelines and the draft EMS System Standards and Guidelines. We also submitted and requested submission ofletters in opposition to AB 2456 Torrico.

6. **Regional Restructuring:** North Coast EMS participated in a seven region effort to assess and respond to the EMSA's proposal to restructure EMS regions and substantially change state funding policy.

2.0 Staffing and Training

Objective: To ensure LEMSA authorized personnel functioning within the EMS system are properly trained, licensed/certified/authorized and/or accredited to provide medical care to the public.

Workload Indicators for the Staffing Training responsibilities:

1. **Total number and type of training programs conducted by regional agency:** The North Coast Paramedic Training Program at College of the Redwoods (CR) completed the didactic and clinical phases and started the internship. Several students completed the class. CR is planning a second class begin next fiscal year. The North Coast Paramedic Training Program is nationally accredited until March 2012, and the next Self-Study Packet is due October 1, 2010, with a site -visit projected between December 2010 and February 2011. The next Operating Council meeting is scheduled for September

2. **EMT 2010:** North Coast EMS revised policies associated with certification, fees and discipline. We also purchased a new printer for issuing new state certification cards, initiated printing in July and began to transmit state required data. Because of the limitations with the new EMT Central Registry, we have to double enter all data on our own registry to be able to generate the related data for this report.

3. **Field Training Officers Program:** North Coast EMS staff completed an extensive review of an FTO Instructor Packet from Lake County, and are waiting for the revision to be submitted sc we can proceed with formal approval.

4. **Pediatric Training Program:** North Coast EMS sponsored a day long pediatric focused workshop including two nationally renowned lectures, Drs. Marianne Gausche-Hill and Ray Johnson. Sixty-five EMTs, paramedics and nurses attended.

3.0 Communications

Objective: To develop and maintain an effective communications system that meets the needs of the EMS system.

Task: The communications responsibilities of the regional EMS agency, at a minimum, include:

1. On-going assessment of the communications status and needs: Nothing new to report.

2. Approval of ambulance dispatch centers (as delegated): This function is not delegated, but all three counties have centralized dispatch for ambulances (with the exception of Hoopa Ambulance in Humboldt County). The Agency continues to support efforts to optimize use of dispatch for EMS responders in all three counties, recently including tally of all EMS helicopter utilized in Humboldt County. North Coast EMS provided substantial input, with EMSAAC, on the EMSA draft Aero Medical Guidelines and we are very pleased with the reVISIOn.

3. Approval of emergency medical dispatch (EMD) training and/or operational programs: North Coast EMS continues to utilize Priority Dispatch Corp, USA Emergency Medic al Dispatch (EMD) training and certification. This quarter we completed the revision of all EMD policies that are now more congruent with State EMD Guidelines. In mid-July, 2010, we formally designated Eureka Police Dispatch and CALFIRE Dispatch in Fortuna as EMD providers and revoked all past authorizations. Thank you to CALFIRE, EPD and our EMD team for working with us to upgrade this critical program.

4.0 Transportation

Objective: To develop and maintain an effective EMS response and ambulance transportation system that meets the needs of the population served.

Task: The response and transportation responsibilities ofthe regional EMS agency, at a minimum, include:

1. Inspection of ambulance or LALA/ALS providers (as delegated): North Coast EMS previously discontinued ALS inspections other than for cause due to staff reductions. We are continue to awaiting receipt of the contract to authorize Briceland Fire as a non-transporting ALS Provider. We also met recently with Humboldt Fire District # 1, which is planning to become an non-transport ALS Provider within a year or so.

2. Development of performance standards as needed. Numerous policies and procedures were executed or drafted for public review in two periodic mailings. Authorized ALS Providers continue to submit quarterly QIP reports, each with a pre-selected relevant quarterly focus. These are summarized by staff and used to enhance system coordination and patient care. Thanks to the Humboldt Area Foundation grant to the AHA, four 12-lead EKGs were acquired for local transport providers and the Hoopa Ambulance cardiac monitor maintenance policy was funded.

5.0 Assessment of Hospitals and Critical Care Centers

Objective: To establish and/or identify appropriate facilities to provide for the standards and care required by a dynamic EMS patient care delivery system.

Task: The facilities and critical care responsibilities of the regional EMS agency, at a minimum~ **include:**

1. **Complete hospital closure impact reports:** None were requested or completed in this quarter

2. **Emergency Departments Approved for Pediatrics (EDAPs):North** Coast EMS continued to receive Maddy "Richie's" funding for EDAPs through the fourth quarter of this fiscal year and will reimburse eligible hospitals after invoices are received. We are pleased to announce that Redwood Memorial Hospital was formally designated which means all targeted facilities in the region have been designated as EDAPs!

3. **Base Hospital Monitoring:** North Coast EMS continued to monitor base hospitals and designated MRCH as a Modified Base Hospital. We welcome Judy Gallagher to the PCNC position at Redwood and helped orient new PCNCs at Mad River, St. Joseph and Redwood.

4. **Trauma Center Designation:** Numerous efforts were made this quarter to encourage designation trauma centers in Humboldt County, including conducting several meetings, extending the timeline for letters of commitment and bringing Johnathan Jones, State Trauma Coordinator and Cheryl Wraa, UCD, to promote designation. St. Joseph, Redwood Mad River indicated an interest in pursuing designation in the future, but this has be tabled to focus on the EMSA's interest restructuring EMS regional funding policy. Trauma Coordinators at SutterLakeside and Sutter-Coast Hospitals continue to enter Trauma 1 registry data but we are still unable to transmit data to the EMSA. Please see the separate CEMSIS - Trauma and EMS Final Report for additional information. The Agency Director continued to serve as Co-Chair the North Regional Trauma Coordinating Committee and as a member of the State Trauma Advisory Committee.

4. **Cardiac Subsystem Development:** North Coast EMS continued to work with the American Heart Association, Humboldt Area Foundation and Humboldt Cardiac Coordinating Committee to utilize grant funding to the AHA to acquire l2-lead EKGs, train paramedics and designate St. Joseph Hospital as a STEMI Receiving Center. Associated polices were approved this quarter but implementation of Cardiac Subsystem Plan in Humboldt County will be delayed to focus on the EMSA's proposal to revise regional funding policy. The Executive Director continued to participate as an EMSAAC appointed member
of AHA Western Affiliates Work Group. We are very pleased with the final State STEMI Planning document.

6.0 Data Collection and Evaluation

Objective: To provide for appropriate system evaluation through the use of quality data collection and other methods to improve system performance and evaluation.

Task: The data collection and system evaluation responsibilities of the regional EMS agency, at a minimum, include:

1. **Review of reportable incidents:** North Coast EMS reviews all received reportable incidents. During the quarter three reviews were conducted.

2. **Review of prehospital care reports including Automated External Defibrillators (AED) reports:** The Agency maintains the regional prehospital care computerized reporting system and annually submits the AED report to the EMSA. All PCRs are electronically submitted and we prepare data reports upon request. Aero medical transports in Lake County, trauma patient information at Sutter-Lakeside and Sutter-Coast Hospitals, internship records and Prehospital Care Records are routinely reviewed, and case review is conducted as needed. The new *Trauma 1* registry program is being utilized at Sutter-Lakeside and Sutter-Coast although we are still unable to transmit trauma data to the EMSA. Please see the separate CEMSIS quarterly report for more information.

3. **Quality Improvement Program:** North Coast EMS oversees an extensive Quality Improvement Program and utilizes an EMSA approved Regional QIP Plan. QIP Plans have been approved by North Coast EMS for all base hospitals and providers, who are also required to submit quarterly QIP reports. Late reports result in a notification process and potential probation, although reports are generally submitted on time. The EMS Coordinator summarizes the QIP quarterly reports each quarter to highlight excellence and selects, with input from QIP Liaisons, a different QIP focus each quarter.

4. **Trauma Advisory Committee:** We conduct periodic Lake County Trauma Advisory Committee meetings; one occurred this quarter. In Del Norte County, the Trauma Coordinator regularly attends Oregon and Nor Cal EMS Inc TAC-type meetings.

5. **Processing and investigation of quality assurance/improvement incident reports:** The Agency has numerous policies regarding processing and investigation of incident reports. Three cases were reviewed this quarter.

6. **CEMSIS Data Transmission:** North Coast EMS has worked very closely with the EMSA and our EMS constituents to upgrade the EPCIS PCR program over the last three years and we are very pleased that as of August 31, 2010, we were the first LEMSA in California to successfully transmit PCR data to the State!

7.0 Public Information and Education (PI&E)

Objective: To collaborate with community partners so that the population within the jurisdiction of the regional EMS agency has access to information and public information courses as it relates to emergency medical services.

Task: The public information and education responsibilities of the regional EMS agency, at a minimum, include:

1. Involvement in the public service announcements involving prevention or EMS related issues: North Coast EMS staff participates in local injury and illness prevention, children's safety programs as staff time and funding permits. We also help the EMSA coordinate annual state EMSC conference and this quarter collaborated with the AHA to promote public education on cardiac disease.

2. Participation in public speaking events, and represent EMS agency during news events and incidents: Nothing to report this quarter.

8.0 Disaster Medical Response

Objective: To collaborate with Office of Emergency Services, Public Health and EMS responders in the preparedness and response of the regions EMS system in the event of a disaster or catastrophic event within the region or in neighboring jurisdiction.

Task: The disaster medical response system responsibilities of the EMS region, at a minimum, include:

1. Coordination with the regional disaster medical/health coordinator system: North Coast EMS coordinates with the RDMHC as needed, including attending disaster planning meetings and observing exercises and drills as staff time permits.

2. Collaborate with all EMS personnel on training of incident command and Standardized Emergency Management System (SEMS): All North Coast EMS approved EMT-r and paramedic training programs include incident command, MCr and disaster training. The Agency collaborates with county disaster resources to help ensure SEMS training and maintains a Regional Mcr Plan. This quarter we submitted HPP approval letters to each county.

The fourth quarterly report includes all of the above tasks plus the following Workload Indicators (please note that due to the transition to CEMSIS compliance we assume we have not received all data, so the numbers are lower than expected):

Component 1

Workload Indicator(s):

1) Total static population served (Determined by DOF estimates) **226,299**
2) Total annual tourism population (Determined by identified source(s) **3 million**
3) Number of counties 3.3
4) Geographic size of region (in square miles) **6,840**

Component 2:

Workload Indicators (please note we are unable to pull the following information for EMTs from the Central Registry and are therefore required to double enter all data on our own registry):

1) Total number of personnel certified/authorized/accredited by regional agency **713**

2) Total number of personnel completing training courses approved by regional agency during the reporting year **250 estimated**
3) Total number and type of training programs approved by regional agency **33**
4) Total number and type of training programs conducted by regional agency 1
5) Total number of continuing education providers authorized by regional agency **36**

Component 3:

Workload Indicators:

1) Total number of primary and secondary Public Safety Answering Point (PSAPs) **11**
2) Total number of EMS responses **20,860**
3) Total number of ambulances dispatched **20,860**
4) Total number of EMD training programs approved by regional agency 1
5) Total number and type of EMD programs authorized by regional agency 3

Component 4:

Workload Indicators:

1) Total ambulance response vehicles estimate **65.**
2) Total first responder agencies **51**
3) Total patients transported **19,571**
4) Total patients not transported (e.g., treated and released, total dry runs) **1,494**
5) Total number of LALS/ALS providers authorized by regional agency **15**
6) Total number of transport providers in region **11**

Component 5:

Workload Indicators:

1) Total base hospital contacts **14,398**
2) Total patients received **19,571**
3) Total number of hospitals designated by regional agency (e.g., base, receiving, trauma, specialty centers, etc). **7 Base, 7 Receiving, 2 Trauma, 6 EDAP**

Component 6:

Workload Indicators:

1) Total patient care reports generated **20,860**
2) Total trauma patients **2,341**
3) Total cardiac patients **1,642**
4) Total medical patients **18,519**
5) Total pediatric patients **405**
6) Total number of situational/unusual occurrence reports processed by the LEMSA. **+10**

Component 7:

Workload Indicators:

1) Total number of public information and education courses conducted and/or approved by regional agency 0
2) Total number of public information and education events involving regional agency 1

Component 8:

Workload Indicators:

1) Total number of Disaster/Multiply Casualty Incident (MCI) Responses (response with 5 or more victims) **NA**

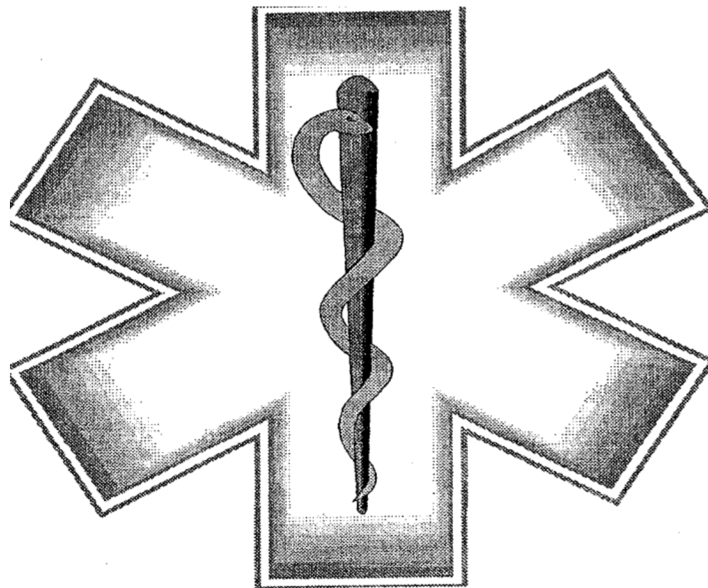
Total number of disaster drills involving staff 1

Total disaster-related meetings attended by staff **Several**

NORTH COAST EMERGENCY MEDICAL SERVICES 3340

Glenwood Street, Eureka, California 95501

Serving Del Norte, Humboldt, Lake and southern Trinity Counties



First Quarter Progress Report July 1, 2010 to September 30, 2011 General Fund Contract # EMS-10S1

October 25, 2010

Overview:

In Fiscal Year 2010-11, North Coast Emergency Medical Services (EMS) continued to serve as the local EMS agency for the functions delegated by Del Norte, Humboldt, Lake and southern Trinity Counties. The Agency managed the regional EMS system in accordance with state law, regulation and guideline, under direction of the Joint Powers Governing Board and in coordination with a large network of organizations and individuals. North Coast EMS staff and contractors facilitated the planning, coordination and evaluation of the EMS system through a program of community consensus, patient and EMS participant advocacy and continuous quality improvement (CQI).

Our primary focus during the first quarter was to address substantial changes proposed by the EMSA to modify the state General Fund document # 1 04 that could have further destabilized EMS regions across the northern third of California. Tpjs focus contributed to delays in several EMS activities, including trauma and STEM! center designation. Since then all seven regions and numerous other organizations worked closely with the EMSA to collaborate on future less radical changes to the 104 document. We did not receive the executed State GF contract until October 21,2010 due to the ongoing state fiscal crisis and are therefore submitting a condensed version of this report.

Other highlights included: North Coast EMS was the first agency in the State to successfully transmit CEMSIS -EMS data to the EMSA; we began to transmit Trauma Registry data to the EMSA and successfully implemented EMT 2010; the Northern Paramedic Program Operating Council and associated Consortium was phased out and College of the Redwoods is now the sole administrative entity (the North Coast EMS role shifted back to progranl approval rather than Consortium membership and administration); we fully implemented the new state guidelines compliant Emergency Medical Dispatch program at the Eureka Police Department and CALFIRE in Fortuna; we participated in the process that resulted in the veto of AB 2456 - Torrico; we preliminarily assessed the impact of the Butte County Appellate Court decision on the North Coast EMS region; and, we began a review of the options to continue to ensure that national EMT testing is available on the north coast. Also, we remain hopeful that Trinity County elects to join us next fiscal year and, if Napa County in fact leaves Coastal Valley EMS, we plan to invite Mendocino County to rejoin the region.

Finally, many thanks to City Ambulance of Eureka for assisting North Coast EMS with replacement of Morphine Sulfate in Lake County as a result of a reduction in available supplies and the Northern California Safety Consortium for continuing to provide EMT testing in Humboldt County despite a large revenue loss.

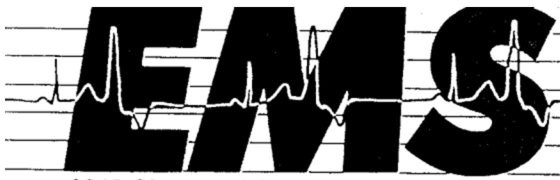
The Joint Powers Governing Board directed the activities of North Coast EMS during the first quarter ofFY 2010-2011. The Board consisted ofthe following members:: Supervisor Rob Brown, Lake County, Chairperson; Supervisor Martha McClure, Vice-Chairperson, Del Norte County; and \Supervisor Mark Lovelace, Humboldt County. Alternates to the JPA Board were: Supervisors Mike Sullivan, Del Norte County; Ann Lindsay, M.D., Humboldt County; and Supervisor Denise Rushing, Lake County. The Agency was managed by the following general fund employees (totaling 4.8 FTE):

- Larry Karsteadt, Executive Director (1.0 FTE)
- Wendy Chapman, Training Coordinator (1.0 FTE)

- Maris Hawkins, Program Assistant II (0.8 FTE)
- Louis Bruhnke, EMT-P, EMS Coordinator (1.0 FTE)
- Linn Tyhurst and beginning this quarter, Tracy D' Amico, Administrative Assistant (1.0 FTE)

Several part-time independent consultants totaling less than 0.5 FTE were involved with general fund operations, including:

- Ken Stiver, M.D., Regional Medical Director
- Pam Mather, R.N., Nurse Contractor
- Cindy Henderson, EMT-P, AED and ETAD Review
- Jay Myhre, EPCIS Programmer
- Ezequiel Sandoval, Office Computer Maintenance
- Moss, Levy and Hartzhiem, Agency Audit



2.

NORTH
COAST
EMERGENCY

MEDICAL
SERVICE

3340 Glenwood Street, Eureka, CA 95501 (707) 445-2081 (800) 282-0088 FAX (707) 445-0443

North Coast EMS Quarterly **QIP** Summary
Regional reporting to October 10, 2010

North Coast EMS would like to extend a special thanks to Jaison Chand of City Ambulance and Willie Sapeta of Lake County Fire Department for their willingness to assist fellow ALS provider agencies with the challenges encountered recently with medication shortages.

BEST PRACTICES

Southern Trinity Area Rescue - ETAD and ET training are offered bi-monthly to maintain proficiency.

Southern Trinity Area Rescue - Is implementing a safe vehicle driving and EMT safety program offered through their insurance company.

Northshore Fire Protection District - just completed our annual preventative maintenance program on all of our 12-lead Zoll monitors. For a period of approx. 2 weeks each station had a loaner monitor while their monitor was being service. All of our Zolls are now back in service.

Northshore Fire Protection District - A lesser used skills class has been scheduled for November 4, 2010 at Station 80 and is mandatory for all ALS personnel.

Lake County Fire Protection District - Beginning the week of October 11 th thru the 17th, 2010 shift supervisors will make as part of there morning shift briefing the importance of proper documenting of patient interactions with an emphasis on the potential legal outcomes from inadequate patient care documentation resulting in financial and criminal charges against Fire/EMS personnel. Along with this training each shift will be responsible for conducting a peer review of at least 10 PCR's per month to identify shortfalls in our documentation and to assist in the development of a corrective action plan to implement for success.

Mad River Community Hospital - The hospital has purchased temporal artery thermometers for all departments.

Mad River Community Hospital - The hospital has purchased portable pulse oximeters for all departments.

Mad River Community Hospital- All staff attended the hospital's annual skills fair in September.

Mad River Community Hospital- All staff attended the hospital's annual safety fair in September.

Redwood Memorial Hospital - We are now Live with our Robotic Telemedicine program for consulting physicians. Dr.Gude from Palm Drive Hospital in Sebastopol is the sponsoring physician. We now have consultative support for Neurology, and a number of other Intensivist specialties. This will allow our Physician's to consult and collaborate with specialty physicians from outside the area to enable patients to stay and be treated here as opposed to be transferred. This will greatly benefit ED patients who may be suffering from stroke or may be in need of other consultative physicians to collaborate regarding critical care and ultimate decisions regarding transfers to a higher level of care if necessary.

Redwood Memorial Hospital - The Radiology department has installed a new Digital Mammography machine that will enhance patient care and improve outcomes for our female population.

Redwood Memorial Hospital - The Medical Surgical department has installed a state of the art whirl-pool bath with side entrance which makes for a much safer experience for both patient and nurse.

Redwood Memorial Hospital - RMH had a very successful Health Fair in early October; the Eel River Valley Health Fair.

St. Joseph Hospital- Has begun EDM electronic charting in the emergency department. There are now computers in every room.

St. Joseph Hospital- The entire emergency department staff attended Skills day.

Sutter Coast Hospital - Eight nurses attended the two-day Emergency Nursing Pediatric Course in August.

City Ambulance of Eureka - Atomizes have been added to City Ambulance scope of practice for use with intranasal administration of Narc an and Versed.

City Ambulance of Eureka - Two Lifepak 15s were purchased with AHA grant monies and placed into service in the Fortuna units.

City Ambulance of Eureka - Zofran has been added to City Ambulance scope of practice.

City Ambulance of Eureka - City Ambulance participated in 15 elementary school show and tells.

City Ambulance of Eureka - 25 Paramedics participated in the AHA online STEMI training this spring.

City Ambulance of Eureka - CAE Participated in the following exercises, drill and training in coordination with other agencies.
"You've Got Nerve" Hazardous Materials exercise
Airline crash exercise at the Eureka! Arcata Airport
Radiologic Emergencies at PG & E.

City Ambulance of Eureka - All flight paramedics are participating in monthly chart audits for flights

City Ambulance of Eureka - All flight paramedics are participating in monthly chart audits for flights

FOCUSED REVIEW

This quarters focus is on code three transports to the hospital.
We have to go back to January of2009 to find a code three transport to the hospital This patient was involved in a single vehicle MY A on an isolated private mountain road. It was snowing and a medical helicopter was not an option. Code three transport, once out of the snow, was appropriate due to the injuries sustained and suspected.

We will run code three to a landing zone when appropriate, if the medical helo has an ETA significantly earlier than that of the ground ambulance.

The safe speed of the road, rather than traffic congestion, is the limiting factor of response and transport times. We do not run code three often, especially in the winter.

A. CQI Finding Procedures:

1. A review of PCRs that were documented with a "transport code" of code 3 or code 2 to 3 transport to the ED . We had a total of 51 reports for 3rd quarter 2010.

3. To calculate the findings in #5 I took a small sampling of 12 code 2 transports and 12 code 3 transports with 3 from each station and calculated the average transport times for each transport code. I could not find a way to run this report using the management program so I did this manually. I also did not include incidents from the outlaying areas; the averages were for within the "city center" areas.

B. QIP/CQI Findings:

1. Of the 51 reports of either code 3 transport or upgraded to code 3 transport 5 of the reports were mistakenly labeled in the documentation as a code 3 transport but were actually code 2. This was determined by inconsistencies between narrative and dropdown option and general patient condition not warranting code 3 transport.
2. A break down of what type of patients that make up our code 3 transports are as follows:
   16 - ALOC or Neuro Deficit
   13 - Trauma related
   8 - Cardiac related
   5 - Respiratory related
   4 - Overdose or ingestion related
3. Of the 46 actual code 3 returns, fourteen of them were code 3 transports to a landing zone for air transport to a higher level of care.
4. It appears that approximately 10% of our transports are code 3 transports to either a landing zone or to a receiving facility.
5. The overall code 2 transport is approx. 12 minutes. The overall code 3 transport is approx. 10.8 minutes.

C. QIP/CQI Mitigation:

1. There does not seem to be an excess of illegitimate code 3 transports. Several of the reports seemed to indicate that code 3 transports was bit overkill for the situation but this is a personal choice of the paramedic in charge and usually has to do with experience level and prior experience in different regions.
2. 1.2 minutes is on average all that is saved transporting code 3 vs code 2. Depending upon time of day and traffic flow it is no more time saving to transport code 3 from most of our areas because our transport path consists mainly of highways and not busy residential and commercial streets.
3. All EMS personnel were encouraged to continue to provide patient care with the professionalism and quality they do.

Code 3 transports.
Over the past 3 months limited code 3 transports were completed. Since January of2010, Lakeport Fire has had 10 documented code 3 transports. Of those transports, 2 were code blues, 3 were respiratory calls, 1 was a trauma call, 2 were

other medical problems and 2 were trauma codes. Of those 10 calls, 1 was flown to a trauma center.

A. Although Lakeport Fire is not a very busy dept. I feel that the previous numbers do not reflect the accurate transport info.

B More details will be reviewed on the PCR's to try and get more accurate dcumentation in the future.

A. QIP/CQI Finding Procedures:

1. 16 PCR's were reviewed with an emphasis on Code Three Transport related calls. A total of 16 Code Three Transport calls were reviewed by peer review. Focus was appropriate treatment, spelling/grammar, and to determine if Code Three Transport was warranted.

2. Review of routinely used Seldom Used Skills via previous QIP's.

B. QIP/CQI Findings:

1. Of the 16 Code Three Transport PCR's reviewed there were a few that were borderline whether they had actually met the criteria for Code Three Transport.

2. A need to provide periodic review on NCEMS polices and procedures regarding Code Three Transports as defined in the various medical and/or trauma related policies and procedures.

Kelseyville fire was asked to research Code 3 returns. In the evaluation we looked at 12 random calls out of the 195 911 calls during July, August and September. It was found that of the 12 random code 3 returns, 3 of the calls were of cardiac in nature, 3 calls were stroke(CV A) related. 2 of the calls were trauma, both being assaults, 2 ALOC calls and 1 call of shock due to sepsis and 1 shortness of breath call. Also of those 12 calls, 8 of them were transported to Sutter Lakeside, 2 were transported to St. Helena-Clearlake, and 2 calls were handed of to REACH to be flown to either a level 2 **or higher trauma center or a STEMI center. It also appears that in** all 12 **calls the decision to transport the patient code 3 was based on the good judgement of the paramedic treating the patient. Lastly, it should be noted that in none of the 12 calls evaluated did it mention any abnormal incidents such as traffic hazards or vehicle accident while transporting the patients code 3.**

FOCUS AREA - Code 3 transports
There was a total of27 patients transported code 3. Eight (8) of these were interfacility transfers primarily between Mad River Hospital and St. Joseph HospitaL Five of these

patients were on ventilators, 3 with sepsis, one 2 year old, and 1 with surgical complications. The other three were transferred for acute coronary syndrome for cardiac catheterization. A comparison of transfer times for code 2 vs. code 3 for the quarter indicated an average reduction in transport time of 4 minutes for code 3 transfers between hospitals.

Nineteen (19) patients were transferred from the field to the hospital code 3. All but one of these was to Mad River Hospital. The following table shows the patient type and number.

Cardiac Arrest	1
Near Arrest cardiac dysrhythmias	2
CVA	3
Sepsis	1
Respiratory Distress	3
Overdose	2
Trauma	3
U nconscious/unresponsi ve	3
Thoracic aneurysm	1
Total	19

A review of all related PCRs by the General Manager found that 16 of the 19 patients were transported appropriately code 3. One of the trauma patients did not appear to require code 3 transport. One patient with agonal respirations had a DNR order and was found not to warrant code 3 transport. One of the possible overdose patients appeared to present more as a psychiatric patient. All calls found to be questionable regarding code 3 transport were discussed with the report author.

This quarter the quality improvement topic was to review calls for the proper use of code 3 transfers to the hospital. We had 40 calls this quarter where the patient was transferred code 3 to MRCH.

3 were for seizures, 13 were for altered level of consciousness, 13 were for trauma, and 5 for respiratory depression, 1 shock patient, and 1 patient with chest pain, 1 for active labor with hemorrhage, and 3 were for codes.
Of those, only 3 patients were discharged home from the Emergency Room. 8 patients were transferred to other acute facilities, 7 were flown to trauma centers from the field (these were all trauma that occurred on 299 or in Hoopa), 1 went to SJH (they were the closer facility), and 5 were declared deceased in the ER. 16 patients were admitted: 4 to

med/surg, 1 to telemetry, 8 to the intensive care unit, 1 to OB, and 2 to were sent to Sempervirens after medical clearance.

I believe that the paramedics are using good discretion when using Code 3 to transport patients. Based on patient complaints, mechanism of injury, level of consciousness, and/or vital signs, all of these transports were appropriate. The medics seem to utilize the code 2, level 3 more than coming in with lights and sirens.

Clinical and Patient Outcomes: This is a sampling of Code Three transport patients:

- Diabetic Patient with ALOC, Acute Renal Failure, Hyerkalemia; stabilized in the ED and transported to higher level of Care to Enloe Medical Center; ultimately returned home after discharge.
- Opioid overdose; possibly accidental, history of COPD; history of suicidal ideation; patient found apneic with a pulse by family, administered narcan 0.8 in the field, patient became more responsive and was able to support her own airway. Admitted with respiratory failure; and ultimately discharged home.
- Patient bypassed from JPCH as a result of motorcycle accident; splenic laceration with hemoperitoneum; acute left rib fractures and distal fibula fracture. Subsequently underwent a splenectomy and repair of his distal fractured fibula at RMH. Patient ultimately transferred to Kaiser as he is a Kaiser patient.
- Cardiac arrest; CPR in the field with 100% 02; unresponsive, pulseless, apneic, monitor showing asystole. Transported and code called shortly after arrival to RMH ED.
- Unresponsive patient, pale cool to touch, diaphoretic, monitor reveal A-Fib at 130-140, at least one period of V-Tach. BG 10 mg/dcl, patient given 1 amp ofD50 in the field. Patient admitted to hospital with diagnosis of hyperglycemia and right sided pneumonia. Patient was able to maintain his blood glucose with diet, was treated for his pneumonia and sent home after two days on Coumadin for his chronic A-Fib.

QIP FOCUS: Code 3

Objectives:
To examine Code 3 ambulance runs with respect to: };>
Chief complaint
};> Number of miles traveled from scene to the hospital

Sample size and distribution:

A total of26 PCRs were reviewed.
Chief complaints (number of patients per category): ~

10 - Trauma
~ 8 - Cardiac
~ 5 -ALOC
~ 1 - Poison/Drugs ~
1 - Respiratory
~ 1 - Other (GI bleed)

Miles traveled (number of patients per category): ~

15 - Less than 3
~ 7 - 3-10
~ 4 - More than 10

Policies used to correlate treatment with NCEMS protocol: ~

Trauma: 6541
~ Cardiac: 6502,6504,6506,6507,6508,6509,6510,6511,6534 ~
ALOC: 6514, 6515, 6516, 6517
~ Poison/Drugs: 6524
~ Respiratory: 6527, 6528, 6529, 6530, 6531, 6532 ~
Other: 6521

Findings:

~ Trauma: 38% of all code 3 transfers were trauma activations, and half of these traumas were due to MVCs.
~ Cardiac: 40% of the code 3 returns related to a cardiac chief complaint were due to cardiopulmonary arrest. The other 60% were unstable chest pain.
~ ALOC: 60% of Code 3 ALOC transports had a GCS of3.

Discussion:
All of the Code 3 runs met the parameters ofNCEMS policy to transfer Code 3. The treatment guideline for the "respiratory" patient could have been a cardiac treatment guideline, as the patient's SOB was most likely related to chest tightness and profound hypotension after administration of Nitro prior to EMS arrival. The patient had a respiratory rate of22 or less, 100% 02 sat, and GCS 15. This was reviewed with the paramedic.

Some thought might be given to consider the necessity of Code 3 transport on patients with a less than a 3 mile transport to the hospital. Fifty-eight percent of all code 3 transfers for the quarter were less than 3 miles from the hospital, with over half of these averaging 1.5 miles.

Next Steps:
Based on my findings through chart review, all code 3 transports for the quarter appropriately followed NCEMS policy. Future discussions may be warranted with respect to the acceptability of Code 3 transports with short ETAs.

34 patient care rep0D:s were selected for audit in which Code 3 transport waS utilized. 32 charts were selected for review. 2 charts were inter facility transfers. Of the 32 charts reviewed:

7 charts were determined to be cardiac arrests in the field, 4 were witnessed arrests by fire or EMS.
9 charts were determined to trauma patients. 1 of the trauma patients was a 'second patient' on a MCA and 1 patient was air lifted from the scene and was not transported by ground ambulance.
3 charts were determined to be unstable cardiac patients with unstable rhythms and hemodynamically unstable.
6 charts were determined to be severe respiratory failure or respiratory arrest patients with unstable respiratory status.
2 charts were status seizures unresponsive to medication. 1
chart was reviewed with unstable poly drug overdose.
5 charts were determined to be ALOC patients. Of these 5 charts, 3 were diabetics, (2 with low BGs and 1 hyperglycemic) and 1 chart of a CV A patient.

Of the 32 charts reviewed, 3 charts did not clearly indicate Code 3 transport. 2 charts found to have stable vital signs and improving patients. 1 chart was documented DNR.
5 charts document critical patients but interventions were not made until after transport was started. Of those 5, 1 improved dramatically with care, 2 were treated but with limited interventions and 2 received no treatment other than supportive care.

Recommendations:
It is apparent that some patients require Code 3 transport when necessary medical interventions are not available in the field.
Every attempt should be made to treat those patients who can be treated and stabilized prior to Code 3 transport.
Transporting Code 3 due to proximity to the ED without interventions should be avoided.
Patients with valid DNRs should be respected.

North Coast Emergency Medical Services Agency

Contract Number: EMS-1070

3340 Glenwood Street, Eureka, California 95501 First

Quarter Report: - July 1,2010 to September 30, 2010

Performance Requirement:

Program Reports: North Coast EMS Agency shall submit quarterly reports to EMSA that summarizes all accomplishments during the report term. All reports shall be submitted in a format and manner as prescribed by EMSA, to include: name of agency, full address, contract number, start and end date of report penod. An original and one copy of each Quarterly Progress Report shall be sent to the EMS Authority. Quarterly reports are due on the 15th calendar day of the month following the end of each quarter. Failure to submit Quarterly Progress Reports on time may delay payment of claims for reimbursement.

Vendor Qualifications: It is the responsibility of the North Coast EMS Agency to ensure that their vendor's software is either a Gold or Silver NEMSIS/CEMSIS compliant product.

Services to Be Performed: The executed CEMSIS contract was received on October 22,2010.

North Coast EMS Agency shall perform the following services:

Goal: To establish consistent and standardized data policy development, prevention activities related to traffic safety, system evaluation and quality improvement measures.

We are very pleased to report that North Coast EMS was the first agency in California to successfully transmit CEMSIS EMS data to the EMS Authority. Over 9,000 records have been submitted and we are grateful to contractor Jay Myhre, Associate Director Louis Bruhnke and all of our ALS Providers, particularly Hoopa Ambulance and Lake County Fire, for their continuous efforts to make this possible.

Objective:

1 . Acquire any necessary hardware and software to accomplish the objectives of the grant.

All ALS Providers in the region except Del Norte Ambulance are currently utilizing with the new CEMSIS compliant EPCIS 2010 program with the necessary hardware. The software will be installed at Del Norte Ambulance as soon as possible.

2. Coordinate with EMSA for receipt, storage, retrieval and transmission of all data in the format required by the project

As stated above, North Coast EMS successfully coordinated with the EMSA the first transmission of CEMSIS- EMS data in the State to the EMSA this quarter.

3. Successfully complete the data transmission in the CEMSIS- specified transmission format by the required date

As stated above, North Coast EMS successfully coordinated with the EMSA the first transmission of CEMSIS- EMS data in the State to the EMSA this quarter.

4. Provide oversight and management of the project objectives, time lines and budget

Continuous

5. Evaluate the transmission capability and adjust transmission protocol, as required.

Activity 1: Transmit Pre-hospital data to the EMS in approved CEMSIS format by July 30,2010 for at least two providers.

Target date was delayed slightly but North Coast EMS was instrumental in working closely with the EMSA to ensure that thev could receive EMS data from North Coast EMS.

Activity 2: Expand transmission of data for up to nine or more additional users by June 30, 2011

including Trinity County.

Completed - although the planned addition of Trinity County did not occur as expected due a scope of practice difference that required more time for EMSA approval. We are hopeful that Trinity County will join us in full next year with enough time to evaluate and organize a scope of practice transition period.

Activity 3: Utilize EPCIS 2010 data to help evaluate the EMS system, traffic safety and quality improvement measures by June 30, 2011.

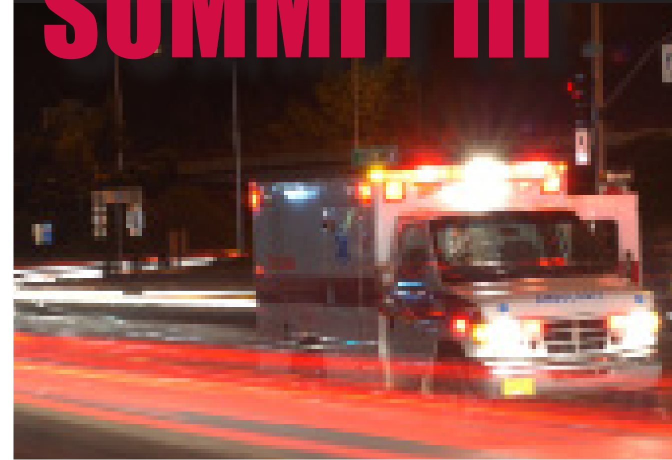
Continuous as staff time allows.

Activity 4: Enhance EPCIS 2010 with provider input from both North Coast and Marin counties and develop the Manual.

After all ALS Providers are activated project focus will shift to software program enhancement.

EMS Authority
1930 9th Street
Sacramento, CA 95811

CALIFORNIA TRAUMA SYSTEM SUMMIT III



Date: Thursday, December 2, 2010

Site: Marines' Memorial Club & Hotel San Francisco, CA

Cost: Free

EVENT LOCATION

Accommodations

Marines' Memorial Club & Hotel

609 Sutter Street
San Francisco, CA 94102
(415) 673-6672

Room block: "Trauma Summit"

SUMMIT SCHEDULE

8:30 am **Registration & Continental Breakfast**
Provided by: Regional Medical Center of San Jose

9:00 am **Welcome**
Johnathan Jones, RN, BSN

9:05 am **State of the State Address**
Dan Smiley, MBA, EMT-P

9:15 am **State Trauma System Update**
Robert Mackersie, MD, FACS

9:25 am **Regional Trauma Coordinating Committees: Update**
Johnathan Jones, RN, BSN

9:45 am **RTCC & Local EMS Agency: Going in the Same Direction**
Nancy Lapolla, MPH

10:00 am **Break**
Provided by: Regional Medical Center of San Jose

10:15 am **CDC Field Triage Presentation: Does One Size Fit All?**
TBA

10:45 am **Significance of Over & Under Triage**
Joe Barger, MD, FACS

11:05 am **Re-Triage & Interfacility Transfer: How it works**
Lynette Scherer, MD, FACS

11:25 am **Relevance of Quality Improvement Taxonomy**
H. Gill Cryer, MD, PhD

11:45 am **Lunch**
Provided by: Stanford Hospital & Clinics

1:00 pm **State Trauma Plan Process**
Robert Mackersie, MD, FACS

1:10 pm **Writing Group Leaders Summary**
Robert Mackersie, MD, FACS

1:40 pm **Key Concepts From Draft State Trauma Plan**
Robert Mackersie, MD, FACS

2:10 pm **Break**
Provided by: Trauma Managers Association of California

2:30 pm **State Trauma Plan: Panel Discussion**
TBA

3:10 pm **Next Steps for California State Trauma System**
Robert Mackersie, MD, FACS

3:30 pm **Adjournment**

Thank you to our sponsors!

The Santa Clara Valley Medical Center (SCVMC) is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education (CME) for physicians. The SCVMC takes responsibility for the content, quality and scientific integrity of this CME activity.

The SCVMC designates this educational activity for a maximum of 4 hours AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.

4 C.E. hours by the CA BRN, BRN Provider #13574
EMT & EMT-P, Provider #94-0001

California Trauma System Summit III
Marines' Memorial Club & Hotel
San Francisco, CA
December 2, 2010 9:00 am - 3:30 pm

Cost: FREE

Please detach and mail/fax or email information to:

Emergency Medical Services Authority
1930 9th Street
Sacramento, CA 95811
Attention: Johnathan Jones
Phone: (916) 322-4336 Ext. 415
Fax: (916) 324-2875
Johnathan.Jones@emsa.ca.gov

Name ______________________

Agency ______________________

Address ______________________

City ______________________

State ______________________

Zip ______________________

Phone ______________________

Email ______________________

REGISTRATION

American College of Surgeons'

Rural Trauma Team Development Instructor Course©

Date: Wednesday, December 1, 2010, 2:00-6:00 p.m.
(Day before California Trauma System Summit III)

Course Description: The Rural Trauma Team Development Instructor Course (RTTDC) will provide the information and training necessary to organize and present RTTDC to rural facilities. To review RTTDC course material and course content with candidates who meet the requirements to be a Course Director, Course Instructor, or Course Coordinator.

Instructor Course Director: W. Christopher Bandy, MD, FACS has directed or taught over 20 RTTDC courses throughout the state of Kansas Dr. Bandy is a West Point graduate and served as US Army Trauma Surgeon. He recently relocated from Stormont-Vail Healthcare in Topeka, KS as the Trauma Medical Director to Enloe Medical Center in Chico, CA.

Cost: $25 (Make checks payable to: TMAC)

Target Audience:

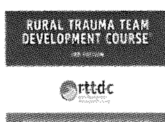
Course Directors: Surgeons certified to teach ATLS

Course Instructors: Surgeons, emergency physicians, family practice physicians, nurse practitioners, physician assistants, and registered nurses who are experienced trauma care providers/educators in a developed trauma system from a Level I or II Trauma Center.

Course Coordinators: Current members of Trauma Manager's Association of California (TMAC)

Location: Marine's Memorial Club & Hotel, 609 Sutter, San Francisco, CA (Room Block: Trauma Summit)

Sponsored by: American College of Surgeons (ACS), Trauma Managers Association of California (TMAC), & EMS Authority (State of California)



Registration information on back

American College of Surgeons'

Rural Trauma Team Development Instructor Course©

Registration: Mail, fax, or email
Wendy Hums, BSN, RN
Trauma Program Manager, Stanford Trauma Services
300 Pasteur Dr., HG021, MC5239
Stanford, CA 94305
(650) 724-9313 (fax)
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Questions: email or call Wendy Hums at
(O) 650-723-0563 or (C) 650-353-8497

NAME ______________________

HOSPITAL ______________________

ADDRESS ______________________

City ______________ State ________ Zip ________

Phone (______) ______________ Ext ________

FAX (______) ______________

EMAIL: ______________________

Check all that apply:

Trauma Center ❑ Level I ❑ Level II ❑ Other ________

Title: ❑ TMD ❑ TPM ❑ ATLS Instructor ❑ Other ________

MD Service: ❑ Trauma ❑ EM ❑ NS ❑ Ortho ❑ Other ________

Certification: ❑ MD ❑ RN ❑EMS ❑ Other Provider ________

Registration Deadline: Friday, November 19, 2010