NORTH COAST EMERGENCY MEDICAL SERVICES
3340 Glenwood Street, Eureka, CA 95501 (707) 445-2081 (800) 282-0088 FAX (707) 445-0443

MEMORANDUM:

DATE: April 09, 2015

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
Interested Others

FROM: Rhiannon Potts, Administrative Assistant

RE: E-Informational Mailing

1. For Your Information:
   a. Change Notice # 107
   Draft- Policy # 2309 Destination Determination (Please email comments by May 03, 2015 to Rhiannon@northcoastems.com) - please note that this policy has been revised by request and to incorporate input received at Humboldt-Del Norte Medical Advisory Committee meetings.
   Add- Policy # 3101 Public Safety First Aid and CPR Training Program Course Content
   Review -Policy #2208 Inter-facility Transfer Procedure – this policy went out recently but we thought we'd send it out again for input (Please email comments by May 03, 2015 to larry@northcoastems.com)
   b. MCI Test 3-12-15
   c. MIC Test 4-4-15
   d. 3rd QTR Progress Report 14-15

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CHANGE NOTICE CHANGE #107

DATE: 4/7/15

TO: ALL PREHOSPITAL CARE POLICY MANUAL HOLDERS

INSTRUCTIONS	POLICY #	POLICY DESCRIPTION	# OF PAGES
DRAFT	2309	Destination Determination	2
ADD	3101	Public Safety First Aid and CPR Training Program Course	5

Subject: Patient Care
Destination Determination

I. Philosophy:

It is understood that the care of emergency patients has the highest priority. Therefore, in the event a patient's care can be enhanced, a patient may bypass a facility or be redireced to a different facility with the intention to improve their outcome. This may be due to trauma triage, a medical condition, a multiple-casualty incident, a private physician's location, a patient's preference, or in the event of a catastrophic internal hospital disaster. An overwhelmed Emergency Department or lack of inpatient beds will not be a sufficient reason to bypass a medical facility or be redirected to a more distant facility.

Authority and Reference (incorporated herein by reference)

A. Division 2.5 of the Health and Safety Code
B. California Code of Regulations, Title 22
C. North Coast Emergency Medical Services Policies and Procedures
D. American College of Emergency Physicians established guidelines

II. Purpose:

To provide guidelines for temporary redirection or bypass of emergency departments and define guidelines for determining patient destination.

II. Policy:

A. Unstable medical patients will be transported to the closest appropriate emergency department facility. The prehospital emergency medical care personnel under the direction of the base hospital or alternate base hospital physician will determine this. In the event of an MCI, exceptions may be made in an effort to appropriately distribute patients and optimize care.
B. Injured patients who meet the conditions established in the Prehospital Trauma Triage Criteria, will be transported according to the guidelines established in policy #7000, Trauma Transport Destination Guidelines Policy.
C. Medically stable patients will most often be transported to the closest facility due to the geographic location of hospitals in the North Coast EMS region. However, a base hospital MD may determine that a patient will be better served at another facility and authorize bypass or redirection for the following reasons:
   1. _Availability of specialty care. (i.e. neurosurgical services, orthopedics, dialysis)
   2. _A patient's private physician is waiting at another facility.
   3. _A patient's preference.
D. If both the base hospital and transporting paramedic agree that a patient is medically stable and may be transported to a more distant facility, the patient may be transported in accordance with Section IIIC above. If, however, either the treating paramedic or the base hospital physician directing online medical control have reason to believe that the benefits of immediate transfer to another facility are outweighed by the risks incurred by delaying emergency department intervention, then the patient shall be transported to the closest facility according to III A above.
E. Patients may bypass or be redirected to a facility in an effort to provide wide patient distribution during an MCI or disaster.

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Subject: Patient Care
Destination Determination

F. The declaration of activating a complete Emergency Department bypass will be limited to catastrophic internal disaster.

IV. Considerations:

A. Temporarily overwhelmed Emergency Departments, and lack of inpatient or ICU beds at a receiving facility are not sufficient reasons to implement Emergency Department bypass.

B. Patients who are in extremis will be accepted by the closest facility regardless of their bypass status.

C. Ambulances should not be unduly removed from their service areas.

D. Base and Receiving Hospital Responsibilities:

1. The Base Hospital ED that redirects or bypasses a patient should notify the receiving hospital, preferably base hospital physician to base hospital physician. The receiving facility shall accept the patient and if needed, provide feedback to or initiate a Quality Improvement review process with the PCNC of the sending facility PCNC/ PCMD.
2. If a catastrophic internal disaster has occurred:
   a. At all times be accountable for all facility functions, such as inpatient bed capabilities/capacity, discharges, transfers, staffing, equipment, physical plant operations, vital services, etc. through activation of internal disaster policy.
   b. Notify the Office of Emergency Services
3. A record of bypassed or redirected patients should be maintained by the hospital after each episode. This must include a record of appropriate approval, reason for bypass, and date/time. The bypass log should undergo periodic physician review.

E. Issues of non-compliance with this policy should be reported to North Coast EMS where they will be handled on an individual basis.

F. Hospital "diversion" is not permitted within the North Coast EMS region.

V. Documentation:

A. Any patient requesting transport to a facility other than that recommended by the paramedic, MICN and/or base hospital physician should be asked to sign an Against Medical Advice (AMA) release. Efforts to persuade the patient to follow the paramedic, MICNs and/or base hospital physician's recommendation should be documented in the PCR narrative by the responding prehospital personnel.

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Subject: Training
Public Safety First Aid and CPR Training Program – Course Content

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I. Authority and Reference (incorporated herein by references)
- A. Division 2.5 of Health and Safety Code
- B. U.S. Department of Transportation, National Highway Traffic Safety Administration "Instructor Lesson Plans" of the Emergency Medical Services Education Standards
- C. North Coast EMS Policies and Procedures
- D. California Code of Regulations Title 22. Social Security Division 9. Prehospital Emergency Medical Services Chapter 1.5. First Aid and CPR Standards and Training for Public Safety Personnel

II. Purpose

To establish a minimum standard for time and content requirements of North Coast EMS approved Public Safety First Aid and Refresher Courses.
- A. Public Safety First Aid means the recognition of and immediate care for injury or sudden illness, including medical emergencies, by public safety personnel prior to the availability of medical care by licensed or certified health care professionals.
- B. Except those whose duties are primarily clerical or administrative, the following regularly employed public safety personnel (lifeguard, firefighter, and peace officer) shall be trained to administer first aid, CPR, and use an AED according to the standards set for.

III. Minimum Required Course Content for a Public Safety First Aid and CPR Course Content – twenty five (25) Hours:
- A. Role of Public Safety First Aid provider:
  1. Personal Safety
  2. Scene Size Up
  3. Body Substance Isolation, including removing contaminated gloves
  4. Legal Considerations
  5. Emergency Medical Services (EMS) access
  6. Integration with EMS personnel to include active shooter incident
  7. Minimum equipment and First Aid Kits
- B. General First Aid Principles
  1. Patient survey and evaluation.
     - a. Primary assessment
     - b. Secondary assessment
     - c. Obtaining a patient history
  2. Shock.
     - a. Signs and symptoms
     - b. Basic treatment of shock
     - c. Importance of maintaining normal body temperature
  3. Bleeding
     - a. Internal bleeding
     - b. Control of bleeding

c. Training in the use of hemostatic dressings shall result in competency in the application of hemostatic dressings including the review of basic methods of bleeding control to include but not limited to direct pressure, pressure tourniquets, and hemostatic dressings and wound packing.
d. Dressings and chest seals

4. Trauma and care of injuries:
   a. Soft tissue injuries and wounds
   b. Amputations and impaled objects
   c. Chest and abdominal injuries
      i. basic treatment for chest wall injuries
      ii. application of chest seals
   d. Head, neck and back injuries
   e. Spinal immobilization and Spinal Motion Restriction
   f. Musculoskeletal trauma and splinting
   g. Facial injuries
      i. objects in the eye
      ii. chemicals in the eye
      iii. nose bleeds
      iv. dental emergencies
5. Medical emergencies:
   a. Pain, severe pressure or discomfort in the chest
   b. Breathing difficulties, including asthma and COPD
   c. Allergic reactions and anaphylaxis
   d. Altered mental status
   e. Stroke.
   f. Diabetic emergencies
      i. administration of Oral Glucose
   g. Seizures
   h. Poisoning, including drugs and alcohol.
      i. assisted naloxone administration and accessing EMS
      ii. ingested poison
      iii. inhaled poisoning
      iv. exposure to chemical, biological, radiological, or nuclear (CBNR) substances
      -recognition of exposure
      -scene safety
      v. Poison Control System
   i. Severe abdominal pain
   j. Obstetrical emergencies
6. Care of environmental emergencies:
   a. Heat emergencies.
   b. Cold exposure emergencies.
   c. Drowning

7. Bites and Stings
   a. Insect bites and stings
   b. Animal and Human Bites
   c. Assisted administration of epinephrine auto-injector
8. Burns
   a. Thermal Burns
   b. Chemical Burns
   c. Electrical Burns
9. Identifying signs and Symptoms of psychological emergencies.

C. Heart Attack and Sudden Cardiac Arrest
   1. Respiratory and Circulatory Systems
   2. Heart Attack
   3. Sudden Cardiac Arrest and early defibrillation
   4. Chain of Survival

D. CPR and AED for adults, children and infants following current AHA ECC Guidelines at the Healthcare provider level
   1. Basic Airway management
      a. A manual airway opening methods including head-tilt chin-lift and jaw thrust
      b. Suctioning techniques
   2. Rescue Breathing
      a. Mouth to mouth
      b. Mouth to mask
      c. Bag Valve mask (BVM)
   3. Chest Compressions and CPR/AED
      a. Basic AED operation
      b. Using the AED
      c. Troubleshooting and other considerations
   4. Single rescuer CPR/AED on adult, child, and infant
   5. Two Rescuer CPR/AED on adult, child, and infant
   6. Recovery position

E. Management of foreign body airway obstruction on adults, children, and infants
   1. Conscious patients
   2. Unconscious patients
   3. One and two rescuer CPR for:
      a. Adults
      b. Children
      c. Infants

F. Patient Movement
   1. Emergency movement of patients
   2. Lifts and carries
      a. Soft litters
      b. Manual extractions

G. Tactical and rescue first aid principles applied to violent circumstances

1. Principles of tactical casualty care
   a. Determining treatment priorities

H. EMS System Orientation:
1. 911 access
2. Interaction with EMS personnel
3. Local EMS system structure.
4. Incident command system structure.

I. Oxygen Administration
1. Use of supplemental oxygen by non-rebreather mask or nasal cannula based on EMS protocols.
2. Assessment and management of patients with respiratory distress.
3. Profile of Oxygen to include:
   a. Class
   b. Mechanism of action
   c. Indications
   d. Contraindications
   e. Dosage and route of administration
   f. Side/adverse effects
4. Oxygen delivery systems
   a. Set up of oxygen delivery including tank opening, use of regulator and liter flow selection
   b. Percent of relative oxygen delivered by type of mask
   c. Oxygen delivery for a breathing patient, including non-rebreather mask and nasal cannula.
   d. Bag Valve Mask and oxygen delivery for a non breathing patient.
5. Safety precautions

J. Oropharyngeal/Nasopharyngeal Airways
1. Anatomy and physiology of the respiratory system
2. Assessment of the respiratory system
3. Review of basic airway management techniques
4. The role of the OPA and NPA airway adjuncts in the sequence of airway control.
5. Indications and contraindications of OPA's and NPA's.
6. The role of the pre-oxygenation in preparation for OPA and NPA.
7. OPA and NPA insertion and assessment of placement.
8. Methods of prevention of basic skills deterioration.
9. Alternatives to the OPA and NPA.

IV. Public Safety First Aid and CPR Retraining requirements

A. The retraining requirements of this policy shall be satisfied every two years by successful completion of:
1. An approved retraining course which includes a review of the topics and demonstration of skills prescribed in this policy and which consists of no less than eight (8) hours of first aid and CPR including AED; or

Subject: Training
Public Safety First Aid and CPR Training Program – Course Content

2. By maintaining current and valid licensure or certification as an EMR, EMT, Advanced EMT, Paramedic, Registered Nurse, Physician's Assistant, Physician or by maintaining current and valid EMR, EMT, AEMT, or Paramedic registration from the National Registry of EMTs; or
3. Successful completion of a competency based on written and skills pretest of the topics and skills prescribed in this policy with the following restrictions:
   a. The appropriate retraining be provided on those topics indicated necessary by the pretest, in addition to any new developments in first aid and CPR;
   b. A final test be provided covering those topics included in the retraining for those persons failing to pass the pretest; and
   c. The hours for the retraining may be reduced to those hours needed to cover the topics indicated necessary by the pretest

Approved: _____ Date: 9/2/15

Approved as to Form: _____ Date: 9/2/15

Subject: Administration - Provider
Inter-Facility Transfer Procedure

Associated Policies:

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

II. Policy

Patient transfers between acute care hospitals will be completed based upon the medical needs of the patient and through the cooperation of both the sending and receiving hospitals in accordance with approved procedures.

III. Procedures

A. Application of Policy and Procedure:

This policy shall be utilized for all patient transfers between acute care hospitals. These procedures are suggested for patient transfers from skilled care facilities to acute care hospitals, but are not necessary for transfers to a chronic care skilled care facility.

This procedure is not a substitute for required transfer policies and agreements. Each hospital shall have its own internal written transfer policy, clearly establishing administrative and professional responsibilities. Transfer agreements must also be negotiated and signed with hospitals that have specialized services not available at the transferring facility.

B. Responsibilities:

Hospitals licensed to provide emergency services must fulfill their obligation under California Health and Safety Code to provide emergency treatment to all patients regardless of their ability to pay. Transfers made for reasons other than immediate medical necessity must be evaluated to assure that the patient can be safely transferred without medical hazard to the patient's health and without decreasing the patient's chances for or delaying a full recovery. In these cases, the involved physicians and hospitals should generally take a conservative view, deciding in favor of patient safety.

If a hospital does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency exists and shall direct the persons seeking emergency medical care to a nearby facility which can render the needed services, and shall assist in obtaining the emergency services, including ambulance transportation services, in every way reasonable under the circumstances.

Notwithstanding the fact that the receiving facility or physicians at the receiving facility have consented to the patient transfer, the transferring physician and facility have responsibility for the patient that he or she transfers until that patient arrives at the receiving hospital. The transferring physician determines what professional medical assistance should be provided for the patient during the

transfer (if necessary, with the consultation of the appropriate EMS Base Hospital Physician).
The transferring physician has a responsibility to candidly and completely inform the receiving physician of the patient's condition so that the receiving physician can make suitable arrangements to receive the patient.
It is the responsibility of the receiving facility, when accepting the patient, to provide personnel and equipment reasonably required in the exercise of good medical practice for the care of the transferred patient, in order to assure continuity of care.

C. Standard for Transfers:
   1. Physicians considering patient transfer should exercise conservative judgment, always deciding in favor of patient safety.
   2. If the patient presents to an emergency department, the patient must be evaluated to determine if the patient has emergency medical condition or is in active labor. If an emergency medical condition or active labor exists, the emergency department must provide emergency care and emergency services where appropriate facilities and qualified personnel are available. Emergency care shall be limited to diagnostics and procedures which directly contribute to patient survival.
   3. Immediate transfer of Major Trauma Patients
      a. Immediate transfer is at the discretion of the examining physician. It may be based on patient condition, availability of surgeon and operating room but not the patient's ability to pay.
      b. Those patients immediately transferred may be audited for both medical care and compliance with this procedure.
      c. As in all transfers, prior acceptance of the transfer by the receiving facility is required prior to transfer. Cases that are refused may be audited.
   4. The transferring physician must determine whether the patient is medically fit to transfer and when indicated, will take steps to stabilize the patient's condition.
   5. No transfer shall be made without the consent of the receiving physician and hospital. The receiving hospital may designate physicians who may provide consent for both the physician and the hospital. It is the responsibility of the receiving physician to inform the transferring physician of the need for additional administrative consent.
   6. The patient or the patient's legal representative must be advised, if possible, of the impending transfer. Adequate information shall be provided regarding the proposed transportation plans. This process should be documented according to State and Federal requirements.

7. Once the decision to transfer the patient has been reached, every effort should be made to effect the transfer as rapidly and safely as possible. The transferring physician must take into account the needs of the patient during transport and the ability of the transport personnel to care for the patient.
   Transport personnel are not authorized to, and shall not, provide services beyond their scope of practice.
   North Coast EMS Policy and Procedure details the scope of practice for EMT-I's, EMT-II's, and EMT-Paramedics. If the patient's needs are within the scope of practice of an EMT-IA, no interaction with a base hospital is necessary. EMT-II and EMT-P personnel may only function under the direction of a Base Hospital Physician or MICN. If the patient requires EMT-II or EMT-P level care, the transferring physician must contact the base hospital so that the patient's care can be coordinated during transport.
   If the patient's care needs exceed the scope of practice of the available EMS personnel, the transferring physician will arrange for the patient to be accompanied by a physician or registered nurse along with any other personnel, equipment, and supplies necessary for patient care. In these cases, while assisting the MD or RN with patient care, EMS personnel must function as EMT-IA's, unless authorized by the base hospital to function as an EMT-II or EMT-P, as appropriate.
8. Additional Requirements for Transfer for Non-Medical Reasons
   When patients are transferred for non-medical reasons, the transferring hospital must follow all of the above requirements. In particular, the transferring physician must ensure that emergency care and emergency services have been provided, and shall determine the transfer would not create a medical hazard to the patient and would not decrease the patient's chances for or delay the patient's full recovery.

D. Transfer Procedures:
   The following are the basic transfer procedures for all patient transfers:
   1. Transferring Facility
      a. The transferring hospital will first provide all immediately necessary diagnostic tests, procedures, and treatment (including, if necessary, consultation) deemed appropriate by the transferring physician.
      b. After determining the need for transfer, the transferring physician will notify the patient or his/her representative, explaining the reason for transfer. This process should be documented according to State and Federal requirements.

c. The transferring physician will contact and consult the receiving physician. The receiving physician will be advised of all information regarding the patient's condition, test results, procedures, and current treatment. (In case of STAT transfers, consider faxing information, so that patient transfer is not unnecessarily delayed.) The patient may be transferred only with the approval of the receiving facility and physician. The receiving hospital may designate physicians who may provide consent for both the physician and the hospital. It is the responsibility of the receiving physician to inform the transferring physician of the need for additional administrative consent.
If EMT-II or EMT-P personnel are requested for the transfer, the transferring physician must be consulted by base hospital personnel to facilitate care by EMS personnel.

d. To request an ambulance:
   1) Call the appropriate ambulance service directly.
   2) Identify sending and receiving facilities.
   3) Identify sending and receiving physicians.
   4) Provide patient's name, location, and condition.
   5) Detail the level of care and type of equipment needed (EMT-I, EMT-II or EMT-P) or advise if a RN or MD will accompany the patient.
   6) If the transferring facility is not the base, the base hospital should be informed that an ALS or LALS transfer is under way.

e. The transferring physician and nurse will complete documentation of the medical record. All pertinent test results, x-rays, and other patient data, including the patient transfer form will be sent with the patient at the time of transfer. If data is not available at the time of transfer, such data will be telephoned or faxed to the receiving hospital and sent as soon thereafter as possible.

2. Receiving Facility
The receiving hospital shall instruct its personnel (including physicians who are authorized to accept patient transfers) on the appropriate procedures for completing transfers.

E. Audit of Transfer Procedures:
Violations of transfer procedures can result from either clinical or procedural errors on the part of individual hospitals and physicians, and/or other parties involved in the transfer process.
Examples of candidates for audit might include:

1. Inadequate stabilization of the patient.

2. Patient sent without adequate level of personnel or equipment.
3. Patient subject to excessive delay in transfer.
4. Patient sent without medical records and results of diagnostic tests.
5. Serious deterioration of the patient's condition enroute.
6. Inappropriate refusal or delay of the transfer by the receiving facility.

Audits may be conducted by North Coast EMS upon notification of any of the above, or complaints may be forwarded to the State Department of Health Services.

F. Procedure for Complaint Review:
The receiving hospital, and all physicians, other licensed emergency room health personnel, and certified prehospital emergency personnel who know of apparent violations of transfer procedures shall, and the corresponding personnel at the transferring hospital and the transferring hospital may, report the apparent violations to the State Department of Health Services on a form prescribed by the Department of Health Services within one week following its occurrence.

IV. Consideration for Emergency Trauma Transfer

A. Based on the patient's condition, geographic locale, expertise of prehospital providers, and the resources of the base, a decision must be made to accept the patient, to stabilize and transfer, or to bypass the patient to a more appropriate facility for definitive care.

B. Deactivation and mechanism of transfer arrangements should be simultaneous with patient stabilization. Once the need for transfer is recognized, this should be expedited. Obtain diagnostics and intervene only on aspects of patient care needed for safe transfer. (If obvious severe head injury is present and no neurosurgeon is available, initiate transfer proceedings without awaiting elaborate diagnostics.)

C. Consider and prepare for transfer early for children with severe multi-system injury.

Subject: Administration - Provider
Inter-Facility Transfer Procedure

D. Permission for emergency transfer should be predetermined by written transfer agreements.
E. Fax of transfer documents is encouraged.

Approved: _____

Approved as to Form: _____

MCI CHANNEL TEST

03/12/2015

- The Tuesday before the Second Wednesday of each month (Thursday after second Wednesday for PM test)
- Contact City Ambulance 10 minutes prior to drill
- At 1000 switch MED-NET ENHANCED on the Moducom to tone "EMERGENCY" (2100 for PM test)
- Stack and send page over Med Net
- Announce "Fortuna with the monthly MCI channel test, standby by for check-back". Wait 15 to 30 seconds and do check:

ROLL CALL: IMPORTANT! Pause 3-5 seconds each time after pressing transmit before speaking into microphone.

Phelps Hospital	NR	GRA1	X
Redwood Memorial	X	FRA 1	X
St. Josephs Hospital	X	FRA 2	X
Mad River Hospital	X	CTA1	X
Eureka Medcom	X	CTA2	X
		CTA3	X
		Arcata 1	NR
		Arcata 2	X

- After the test, announce "The test is complete and the MCI channel will be deactivated in 1 minute".
- Reset Med-Net channel to Enhanced repeater tone
- This should stack "emergency off", send this over Med Net enhanced
- **E-MAIL TO HUUECC ->MCI TEST**
- **NR=No Response U/S=Unstaffed U/A- Unavailable**

MCI CHANNEL TEST

04/04/2015

- The Tuesday before the Second Wednesday of each month (Thursday after second Wednesday for PM test)
- Contact City Ambulance 10 minutes prior to drill
- At 1000 switch MED-NET ENHANCED on the Moducom to tone "EMERGENCY" (2100 for PM test)
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		CTA3	X
		Arcata 1	nr
		Arcata 2	x

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North Coast EMS
3340 Glenwood Street
Eureka, CA 95503

Agreement # C14-014

3nd Quarter Report
January 1, 2015 to April 1, 2015

Below each bulleted item, include a detailed description of the work performed and a summary of the activities that have taken place during the specific quarter related to the individual task.

Component 1 - System Organization and Management

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

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

- Staff development, training, and management

  North Coast EMS personnel attended or participated in the following state EMS activities including: state EMS for Children meetings, EMSAAC Legislative Committee calls, EMSA/LEMSA calls, State HPP Disaster related calls and meetings, EMSAAC QIP Coordinator calls and meetings, EMSA/Regional contract calls, EMSAAC, EMDAAC & EMS Commission meetings – Los Angeles, numerous Ebola related calls, EMSA STEMI Work Group call; and, in the following local EMS activities: two Joint Powers Governing Board meetings; Humboldt/Del Norte Medical Advisory Committee (MAC) meetings, Lake County Emergency Medical Care Committee (EMCC), Lake County Inter-facility Transfer (IFT) meetings, EMSC TACTICAL meetings and calls, federal SPROC calls, Health Information Exchange meetings, Humboldt County Child Death Review Team meetings, Humboldt County Child Passenger Safety Committee meeting, Humboldt County Fire Chiefs Association meetings, Emergency Preparedness and numerous HPP Disaster related meetings and calls, Exclusive Operating Area planning meetings, 5150 Handbook meeting, STEMI Receiving Center planning meeting, Hmong Community Partnership conference and other meetings.

- Allocating and maintaining office space, office equipment, and office supplies

  North Coast EMS continued plans to expand the video conferencing capabilities throughout the region, purchasing the Lake County Department of Health and Human Services – Public Health equipment.

- Executing and maintaining contracts with member counties, service providers, consultants, and contractual staff

The State General Fund second quarter progress was submitted to EMSA in the new format. EMSA convened two meetings with regional administrators and reviewed next year's scope of work and contract process. Substantial progress was made and specific requests are under consideration.

Following a public input process and JPA Governing Board approval, North Coast EMS submitted the annual EMS Plan and Trauma Plan updates to the EMSA. The QIP Plan is being drafted and will be submitted as soon as possible. We executed or continued administrative contracts with: UCD for the federal EMS for Children TACTICAL REGIONALIZATION program (Year Three), the EMSC rollover contract with UCD, the third year Regional HPP Disaster contract with CDPH, and the HIE Discovery contract with EMSA; Dr. Stiver as Regional Medical Director, Pam Mather as EMSC and Trauma Coordinator, EPCIS/ePCR IT programmer Jay Myhre, Ezequiel Sandoval - Office IT, Moss, Levy and Hartzhiems- fiscal audit, Stayce Curry - Regional Mental Health Contractor, Kayce Hurd – Paramedic and EMT policy revisions, Dennis Louy, Tina Wood (and Continuing Education for Hoopa), Kimberly Miinch - County HPP Disaster Liaisons, Selinda Shontz – STEMI, Matt Dennis – Public Safety and EMR policy development; Keith Taylor, EMSC Cultural Liaison; Humboldt County Counsel; ICEMA – Image Trend management; Rick Narad – EMS Plan consultation; TempBev, Inc., HIE Discovery project; Ellen . Coats web site design. North Coast EMS continued to receive Pediatric Maddy Funds from all three counties. We continued contracts with seven designated base hospitals, 14 Paramedic Service Providers, numerous First Responder agencies, two Emergency Medical Dispatch Centers, six EDAPs and two Trauma Centers. We also continued contracts with five hospitals (i.e., Sutter-Coast, Mad River, Jerold Phelps, Sutter-Lakeside and St Helena Clearlake) specific to IRB approved pediatric outcome information as part of the EMSC Regionalization grant and have almost completed data collection. The process to approve Air Methods and REACH as an ALS Provider/Aero Medical Provider within Lake County continues to be on hold until the Sutter Health System completes its aero medical inter-facility transfer bid process. We met with St Joseph Hospital representatives re: STEMI Receiving Center Check List review and followed up with two letters to specify needs and next steps.

- In person attendance to a minimum of 3 EMSAAC meetings annually

North Coast EMS staff attended the EMSAAC meeting in Los Angeles. While we plan to attend at least three meetings annually, the EMSA is instead considering by request required attendance at 3 quarterly EMSA/LEMSA meetings.

Component 2 - Staffing and Training

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

Task: The staffing and training responsibilities of the regional EMS agency, at a minimum, include:

- Ongoing assessment of local training program needs

North Coast EMS has numerous mechanisms for determining training program needs, including: surveys sent to paramedics and providers specific to pediatric training needs; committee meetings where EMS system and training needs are discussed; staff attendance at state and federal meetings where best practices are reviewed; communications with regional EMS instructors; etc.

- Authorizing and approving training programs and curriculum for all certification levels

As stated in the EMS Plan and annually submitted updates (See B.2.02 & Inventory Sections in EMS Plan), North Coast EMS has numerous approved training programs that have been verified to meet or exceed state minimum standards, including curriculum requirements. These programs include: First Responder, EMT-I, Paramedic, MICN, continuing education, etc. We also are developing new policies to implement the revised Public Safety regulations and later, replace the First Responder program with national Emergency Medical Responder program. Aspirin was added to the EMT-I scope of practice and Oral Glucose is under consideration. We renewed North Coast Paramedic Training program approval this quarter.

- Providing training programs and classes (as needed)

No training programs or classes were conducted this quarter.

- Providing ongoing certification/authorization/accreditation or personnel approval of local scope of practice for all certification levels

As reported in the Inventory Section of the EMS Plan and in the fourth quarter reports, North Coast EMS issues numerous EMT-I certifications, paramedic accreditations and MICN authorizations annually. We have policies specific to BLS and ALS scope of practice and numerous continuously updated protocols and policies specific to the EMT-I and EMT-P scope of practice. This requirement is redundant with the EMS Plan and appears to be a new addition to the contract without discussion with regional directors and it should be dropped in future contracts and quarterly reports.

- Developing and maintaining treatment protocols for all certification levels

As stated above, we have numerous policies specific to the BLS and ALS scope of practice and continuously update protocols and policies specific to the EMT-I and EMT-P scope of practice.

- Maintaining communication link with Quality Improvement program to assess performance of field personnel

North Coast EMS has QI policies, is revising the QIP Plan for submission to EMSA for approval and has an extensive QIP program. We previously approved base hospital and ALS Providers QIP Plans and require all approved ALS providers and designated base hospitals to submit quarterly QIP reports summarizing progress in each of the QIP regulation required categories. We also select a focused review topic each quarter. We received HIE special project grant approval with EMSA (thank you!) to help develop a similar QI administrative tool for the Image Trend program. We also submitted the required Core Measures Report this quarter; the new program it is unable to capture the correct data in some of the fields.

- Conducting investigations and taking action against certification when indicated

No investigations were conducted or requested this quarter, but we received and reviewed a summary after action report conducted in Del Norte County.

- Providing personnel recognition programs for exemplary service

For many years North Coast EMS participated in EMS Week events and annually gave Kris Kelly Star of Life Awards for outstanding service. We may participate in EMS Week activities this year if staff time allows.

- Authorizing, maintaining, and evaluating EMS continuing education programs

See #2 above. North Coast EMS has 33 approved CEU providers. Each approved CEU program is required to reapply every four years as required in state regulation.

Other: The Agency currently has 1 approved Paramedic, 1 approved MICN, six approved EMT-I, 12 approved First Responder training programs, and 33 approved Continuing Education Providers. We continued to monitor these important programs as staff resources allow and make additional modifications to policies and protocols as needed. We continue to assess Community Paramedic Program developments within California and plan to implement revised Public Safety regulations this coming quarter.

Component 3 - 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:

- On-going assessment of communications status and needs

The Med Net System was narrow-banded last year throughout the region. Overall Med Net coverage has decreased as a result and local issues continue to be assessed and addressed as needed.

- Assuring appropriate maintenance of communications systems integrity

We plan to continue to work with each county, hospital and provider to help ensure future Med Net Communication Systems integrity.

- Approving ambulance dispatch centers

All three counties have centralized dispatch for ambulances (with the exception of Hoopa {K'ima:w} Ambulance in Humboldt County). We continued to assess and work with the local community to improve results of WIDE-AREA Med Net radio tests in Humboldt County.

- Providing acceptable procedures and communications for the purpose of dispatch and on-line medical control

Communications procedures and medical control policies have been in place for decades and are updated as needed.

- Approving emergency medical dispatch (EMD) training and/or operational programs

Nothing new this quarter

Component 4 - Response and 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 of the regional EMS agency, at a minimum, include:

- Designating EMS responders including first responders, Limited Advanced Life Support (LALS)/Advanced Life Support (ALS) providers, ambulance providers, EMS helicopter providers, and rescue providers

North Coast EMS designates First Responder training programs (see 2.1 above) Each county Board of Supervisors permits or contracts with ambulance providers and North Coast EMS is drafting a Humboldt County Transportation Plan that will include Exclusive Operating Areas if approved by EMSA. All ambulance providers, four non-transporting providers and one fixed wing aircraft provider are North Coast EMS designated ALS Providers. North Coast EMS has policies and MOUs specific to in- and out-of-area EMS helicopters.

- Enforcing local ordinances

North Coast EMS works closely with each county to assist with assessment and evaluation of designated transport ALS Providers as part of the QI program.

- Establishing policies and procedures to the system for the transportation of patients to trauma centers and/or specialty care hospitals as needed

North Coast EMS has established and periodically updates policies and procedures for the transportation of patients to trauma and other specialty centers as needed. See our website (Northcoastems.com) for our Patient Destination and Trauma Patient Destination Policies. We also continued to assist with the assessment and resolution of inter-facility transfer related issues in each county.

- Implementing and maintaining contracts with providers

North Coast EMS has contracts with all approved ALS Providers and AED Providers.

- Providing direction and coordination for EMS resources during time of hospital overcrowding or closures

North Coast EMS has policies and procedures specific hospital closure. We also have a long standing Patient Destination Policy that allows an incapacitated hospital, due to structural damage but not overcrowding, to selectively bypass or redirect to another hospital. Diversion was discontinued years ago.

- Creating exclusive operating areas

North Coast EMS has no EOAs at this time but is in the process of developing a Humboldt County Transportation Plan to create two EOAs within Humboldt County.

- Inspecting ambulance or LALS/ALS providers

We continue to await execution of the Base Hospital contract amendment to add Air Methods/Mercy Air and REACH as assigned ALS Providers in Lake County so we can begin the associated paramedic accreditation process. North Coast EMS delegates ambulance inspections to Base Hospital Prehospital Care Nurse Coordinator (PCNC)s for new ALS providers or for cause.

- Developing performance standards as needed

We added Aspirin to the EMT-I scope of practice. We are considering adding Oral Glucose and Epinephine. Authorized ALS Providers and designated Base Hospitals continue to submit quarterly QIP reports with a pre-selected relevant quarterly focus determined by NCEMS. We are developing ambulance performance standards associated with the Humboldt County Transportation Plan.

Component 5 - Facilities and Critical Care

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:

- Designating base hospital(s) for on-line medical control and direction

We continue to await execution of the Base Hospital contract amendment to add Air Methods and REACH as assigned ALS Providers at Sutter-Lakeside Hospital. All seven base hospitals are designated by contract, six as "modified base hospitals" who are no longer required utilize MICNs. We need additional staff time to adequately monitor base hospitals.

- Identifying ambulance receiving centers including hospitals and alternative receiving facilities

All seven hospitals are designated receiving centers; another is a mental health receiving facility. We have no alternate receiving centers.

- Identifying and designating, as needed, trauma centers and other specialty care facilities

Please see the annual Trauma Plan update submitted last quarter. Two Level IV trauma centers are currently designated, one in Del Norte and the other in Lake County. One or more trauma centers need to be designated in Humboldt County and there is recent interest by at least one hospital in requesting designation in the near future. North Coast EMS is in the process of designating a STEMI receiving Center in Eureka and plans to complete this process before proceeding with designation of trauma centers. All seven hospitals are EDAP designated, including the recent addition this quarter of Jerald Phelps Community Hospital in Garberville. The latter has a pediatric telemedicine connection to UC-Davis secured as part of the federally funded EMCS regionalization grant.

- Periodically assessing trauma system and plan as needed

We continue to submit Trauma registry data to EMSA but we are trying to resolve ongoing issues with data transfer.

- Coordinating trauma patients to appropriate trauma center(s) or approved receiving hospitals

North Coast EMS has an approved Trauma Triage Policy that integrates with Coastal Valley's EMS policy and is very similar to the national standard. These direct patients meeting Trauma Triage Criteria to our two designated Level IV trauma centers or by air, in Lake County, to the closest higher level TC located out of county. Humboldt County has no designated trauma centers at this time - trauma patients are transported to the closest ED.

- Periodically assessing hospitals (e.g., pediatric critical care centers, emergency departments approved for pediatrics, other specialty care centers)

North Coast EMS continued to receive and distribute Pediatric Maddy "Richie's" funding for EDAPs, completed the second year of the EMSC TACTICAL Regionalization program with UCD and continued the third year subcontract. We continued the process to verify EDAP compliance at St. Helena Clearlake Hospital and designated Jerald Phelps Community Hospital in Garberville. The EMSC Regionalization Project Manager continues data collection at five or the seven hospitals. All EDAPs are periodically assessed. North Coast EMS EDAP standards currently meet draft EMSC regulation standards for Pediatric Receiving Centers.

We reviewed and responded to the completed Pre-Hospital STEMI Receiving Center Survey Checklist from St Joseph Hospital. We will continue the designation process upon receipt of all required documents. Sutter-Lakeside Hospital reported are now a certified stroke center; we assessed the need for modifying the catchment area in Lake County and determined that no change needs to be made as both facilities provide the same level of service for stroke patients.

North Coast EMS completed development of an online draft of the 5150 Handbook. The latter incorporates input from the California Hospital Council and is out for public review.

- Completing hospital closure impact reports

None were requested or completed in this quarter. Sutter-Coast Hospital continues to evaluate Critical Access Hospital designation.

Component 6 - Data Collection and System 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:

- Reviewing reportable incidents

North Coast EMS reviews all discovered or received reportable incidents. During the three quarter we took no formal action but reviewed an After Action Report.

- Reviewing prehospital care reports including Automated External Defibrillators (AED) reports

The North Coast EMS Image Trend PCR program housed at ICEMA continues to provide EMS data to the State and the HIE QI Discovery contract was executed by the EMSA. Because this project that ends in September started this quarter, we are hopeful that we will be able to roll over funds to complete the project next year. E-PCRs are available for review by assigned base hospital, ALS provider and North Coast EMS personnel for routine or special review. We discontinued review of AED reports as this requirement has been discontinued by the EMSA. We receive and review REACH aero medical transports occurring in Lake County, CEMSIS-Trauma data from Sutter-Lakeside and Sutter-Coast Hospitals, internship records for periodic review, and disclosure protected case review is conducted as needed. Trauma Registry reports continue to have intermittent transmission problems and we are working to resolve those. We also continued to transmit CEMSIS – EMS data to the EMSA, including the state required Cores Measures Report.

- Processing and investigating quality assurance/improvement incident reports

During this quarter we participated in the review of two unusual incidents, including the convening of a Debriefing/After Action Report specific to an MCI. 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 ALS Providers, who also submit quarterly QIP updates. We temporarily discontinued Associate Director QIP Report summaries due to the increasing workload related to the HPP Disaster project, the HIE grant, the Ebola issue, this report and other priorities. Associate Director Bruhnke continued to be directly involved with the EMSAAC QI Group and remained instrumental in development a Provider and LEMSA QIP template. We also plan to submit the revised QIP Plan to the EMSA in March after public review and JPA Board approval.

- Monitoring and reporting on EMS System Core Measures by March 31, 2015

North Coast EMS cannot submit Core Measure Data through the Image Trend program we utilize administered by ICEMA. We therefore contract with Jay Myhre for this purpose and submitted 2014 Core Measures as required. However, there are issues with the reliability of the data – very different than in the past when we utilized as different e-PCR program. North Coast EMS does not have the staff time to validate this information and we are hopeful that this will be done at the state level. Also, the Core Measures data extraction process should be built into the Image Trend program at ICEMA, as they are the EMSA designated repository for all state EMS data.

- Providing data to CEMSIS monthly

See above. Image Trend data goes directly to ICEMA upon completion of each e-PCR by each EMT and paramedic.

- Making progress towards implementing a system that will provide data to CEMSIS in the NEMSIS Version 3 data format no later than January 1, 2016

We understand that Image Trend was the first program to successfully transmit NEMSIS 3.0 data to the federal level and we plan to work with ICEMA to implement the 3.0 version as soon as it is available. They recently notified us that this will be delayed beyond the January 2016 target date.

Component 7 - Public Information and Education

Objective - To provide programs to establish an awareness of the EMS system, how to access and use the system and provide programs to train members of the public in first-aid and CPR.

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

- Information and/or access to CPR and first-aid courses taught within the EMS system

Draft policies and procedures to approve Public Safety training programs pursuant to the revised state regulations are soon to be distributed for public input. North Coast EMS approved Public Safety training programs will include CPR and first aid training.

- Involvement in public service announcements involving prevention or EMS related issues

North Coast EMS staff members participated in local injury and illness prevention and children's safety programs.

- Availability of information to assist the population in catastrophic events

North Coast EMS participates in the HPP program and is involved with disaster planning. Each county has PSAs and other means of providing information to the pubic in catastrophic events.

- Participating in public speaking events and representing the regional EMS agency during news events and incidents

North Coast EMS contributed to a newspaper article explaining the status of aero medical services in Humboldt County.

Component 8 - Disaster Medical Response

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

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

- Participating in disaster planning and drills as needed

As part of our HPP disaster planning role, funded by CDPH, the North Coast EMS Disaster Coordinator and our HPP County Disaster Liaisons continue to attend and

participate in state, regional and local disaster planning meetings and drills.

- Identifying disaster preparedness needs

  As part of our HPP disaster planning activities we have been evaluating existing North Coast EMS and regional disaster preparedness needs. This includes review of numerous documents, attending meetings and working collaboratively with each JPA member county. This includes recent focus on infectious disease preparations and preparedness for pediatric patients during special events.

- Coordinating the operational area disaster medical/health coordinator

  North Coast EMS staff and HHP contractors coordinated with the RDMHC in each county, attended meetings, participated in local, state and regional Medical Disaster meetings and events. This included verification of the local process used to prepare for the return of a health care worker returning from an Ebola impacted country to Humboldt County.

- Coordinating the regional disaster medical/health coordinator system

  See above.

- Developing policies and procedures for EMS personnel in response to a multi-casualty or disaster incident

  North Coast EMS has MCI and disaster related policies and updates these as needed.

- Facilitating mutual aid agreements

  North Coast EMS has facilitated development of mutual aid agreements for decades and all ambulance providers have mutual aid arrangements with surrounding providers.

- Collaborating with all EMS personnel on training of incident command and Standardized Emergency Management System (SEMS)

  North Coast EMS has supported and worked with County OES and other EMS organizations to help ensure ICS and SEMS training. Local training programs are conducted periodically and each approved EMT-I and paramedic training program includes these topics.