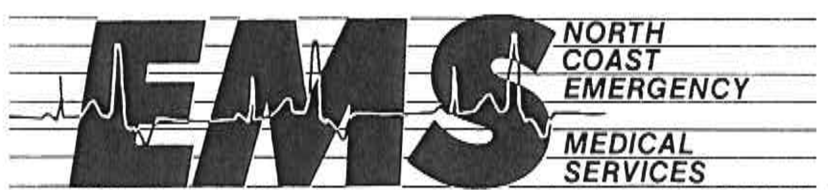

3340 Glenwood Street, Eureka, CA 95501 (707) 445-2081 (800) 282-0088 FAX (707) 445-0443

MEMORANDUM:

DATE: January 29, 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

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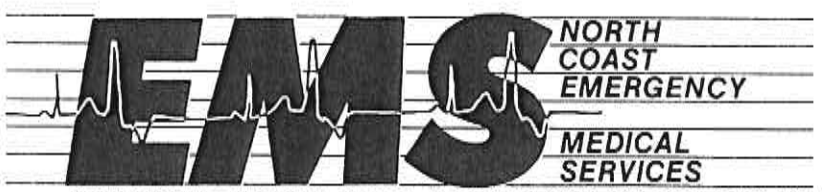
1. **For Your Information:**
   a. **Change Notice # 106**
   Review- Policy #2208 Inter-facility Transfer Procedure (At the recent Humboldt-Del Norte Medical Advisory Committee Meeting we committed to sending out this policy to initiate an update process. (Please email comments by February 27, 2015 to Louis Bruhnke Louis@northcoastems.com).
   Draft- Policy #3101 Public Safety First Aid and CPR Training Program – Course Content (Please email comments by February 27, 2015 to Wendy Chapman Wendy@northcoastems.com).
   Replace- Policy #6007 Hypertension
   Replace- Policy #6528 Respiratory Arrest
   Replace- Policy #6530 Asthma/Bronchospasm
   Replace- Policy #6536 Vaginal Hemorrhage with Shock
   Replace- Policy #6537 Vaginal Hemorrhage without Shock
   Replace- Policy #6538 Imminent Delivery
   Replace- Policy #6539 Severe Pre-Eclampsia/Eclampsia

   b. **Aspirin Addition to EMT-I Basic Scope of Practice**
   c. **MCI Channel Test 11/13/14**
   d. **MCI Channel Test 12/11/14**
   e. **General Fund 1st Quarter Report**
   f. **General Fund 2nd Quarter Report**



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

CHANGE NOTICE CHANGE #106

DATE: 1/29/15

TO: ALL PREHOSPITAL CARE POLICY MANUAL HOLDERS

INSTRUCTIONS	POLICY #	POLICY DESCRIPTION	# OF PAGES
REVIEW	2208	Inter-facility Transfer Procedure	6
DRAFT	3101	Public Safety First Aid and CPR Training Program-Course Content	5
REPLACE	6007	Hypertensive Emergency	1
REPLACE	6528	Respiratory Arrest	1
REPLACE	6530	Asthma/Bronchospasm	2
REPLACE	6536	Vaginal Hemorrhage with Shock	2
REPLACE	6537	Vaginal Hemorrhage without Shock	2
REPLACE	6538	Imminent Delivery	2
REPLACE	6539	Severe Pre-Eclampsia/ Eclampsia	1

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.

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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: ____________________

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

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

Subject: Treatment Guidelines – BLS
Hypertensive Emergency

Associated Policies:

I. Priorities
   A. ABC's.
   B. Oxygen per Oxygen Administration Policy # 6030..
   C. Position of comfort.
   D. Gather patient history.
   E. Communicate with transporting ambulance or base hospital.

II. Hypertensive Emergency
   A. Hypertensive emergency (aka: hypertensive crisis) exists when the blood pressure reaches levels that are damaging organs. Blood pressures usual exceed 180 systolic and/or diastolic over 120. However, hypertensive emergencies can occur to patients whose blood pressure had not been previously high. Blood pressures in this range if left uncontrolled can cause Stroke, Loss of consciousness, memory loss, Heart attack, Aortic dissection, Angina, vision loss and Pulmonary edema. In the pregnant patient, it can cause eclampia.
   B. Identify Patients with elevated blood pressures with any signs or symptoms of:
      Chest pain,
      Respiratory Distress
      Alter Level of Consciousness
      Numbness or weakness
      Difficulty speaking

   1..Position patients with their head elevated regardless of their mental status.
   2..Administer oxygen per policy.
   3. Use Pulse Oximetry when available.
   4. Re-assess vital signs frequently.
   5. Be prepared for vomiting and have suction ready.
   6..Communicate with transporting ambulance or base hospital.

Approved: [signature] Date: 1/22/15

Approved as to Form: [signature] Date: 1/22/15

Subject: Treatment Guidelines – ALS Personnel
Respiratory Arrest

Associated Policies:

I. Priorities
A. ABC's.
B. Maintain airway, provide oxygen and ventilatory support.
C. Determine possible cause that best fit patient signs and symptoms, initiate treatment.
D. Transport (after initial therapy) Code 3 for patients that remain in severe distress. Code 2 for other patients.

II. Respiratory Arrest
Absence of spontaneous ventilations without cardiac arrest. Consider narcotic overdose.

A. Ensure a patent airway. Suction secretions.
B. Provide oxygen administration via Bag Valve Mask. Ventilate at appropriate rate for age.
C. Use appropriate airway adjuncts.
D. Use Pulse oximetry.
E. If available, Naloxone IN 2mg if narcotic overdose is suspected.
F. IV access TKO. If unable to place IV consider IO access.
G. Naloxone 0.8mg-2.0 mg IVP/IM initially, if narcotic overdose suspected. Pediatric dose 0.01mg/kg IVPIf no improvement after Naloxone, consider intubation for long transport time for the apneic patient.
H. Transport and provide further treatment, as indicated by patient response.
I. Contact Base Hospital.

Approved: [signature] Date: 1/22/15
Approved as to Form: [signature] Date: 1/22/15

Subject: Treatment Guidelines – ALS
Asthma/Bronchospasm

Associated Policies: 5307, 5329, 5411, 5413, 5440

I. Priorities
  A. ABC's.
  B. Determine degree of physiologic distress: respiratory rate > 20, use of accessory muscles, cyanosis, inadequate ventilation, depressed level of consciousness.
  C. Maintain airway, provide oxygen and ventilatory support.
  D. Determine which causes best fit patient signs and symptoms, initiate treatment.
  E. Transport (after initial therapy) Code 3 for patients in severe respiratory distress. Code 2 for other patients.

II. Asthma/Bronchospasm
Acute onset of respiratory difficulty usually with a history of prior attacks, wheezes, and coughing.
Pediatric note: Drug doses listed are for adults. Refer to a pediatric length based tape for appropriate drug concentrations and dosages, defibrillator energy settings, and equipment sizes.

  A. Ensure a patent airway.
  B. Determine Pulse Oximetry.
  C. Deliver oxygen per the Oxygen Administration Policy.
  D. Cardiac monitor.
  E. IV access with fluid bolus, 250cc500cc. Do not delay medication administration while obtaining IV access.
  F. Consider:
    1. Albuterol Sulfate 1 via nebulizer using 2.5mg in 3cc unit dose vial mixed with Atrovent 0.5mg in 2cc for the initial dose.
    2. Repeat Albuterol Sulfate 2.5mg as needed.
    3. Repeat Atrovent only for Adult patients when transport times are prolonged.
    4. Epinephrine 0.01mg/kg of 1:1000 IM (intramuscular) (maximum 0.5mg), for severe distress. May repeat in twenty (20) minutes. Use caution in patients over 40 years of age and in patients with coronary artery disease.
    5. CPAP may be initiated at any time during treatment unless contraindicated. Continue inline Albuterol during CPAP therapy.

Approved: [signature] Date: 1/22/15

Approved as to Form: [signature] Date: 1/22/15

Subject: Treatment Guidelines – ALS
Asthma/Bronchospasm

Associated Policies: 5307, 5329, 5411, 5413, 5440

Associated Policies:

6. May consider Magnesium Sulfate 10% 2 Grams over 20 minutes for severe asthma episodes.
7. Contact Base Hospital.

Approved: [signature] Date: 1/22/15

Approved as to Form: [signature] Date: 1/22/15

Subject: Treatment Guidelines – ALS
Vaginal Hemorrhage with Shock

Associated Policies:

I. Priorities
   A. ABC's.
   B. Identify signs of shock.
   C. Administer Oxygen per policy.
   D. If pregnant, determine stage (trimester) of pregnancy.
   E. If patient is not pregnant identify possible causes of bleeding. History of trauma, postpartum vaginal bleed etc.
   F. Determine the degree of physiologic distress, estimate amount of blood loss.

II. Vaginal Hemorrhage with Shock – Pregnancy
   A. Determine if history of placenta previa or other complications. Identify severity of the bleeding. Determine if patient is in labor.
      1. Ensure a patent airway and provide high concentrated oxygen.
      2. Transport early to appropriate facility..
      3. IV access – Two (2) large bore cannulas Administer fluid titrated to blood pressure. Recheck vitals after every 250cc or five (5) minutes.
      4. Transport patient left lateral with legs elevated.
      5. Reevaluate bleeding and visually check perineum for signs of active labor or impending birth.
      6. Contact hospital early.

Vaginal Hemorrhage with Shock – without Pregnancy
   A. Obtain complete history. Identify severity of bleeding.
      1. Ensure a patent airway and provide high concentrated oxygen.
      2. Transport early to appropriate facility.
      3. IV access. Fluid bolus to maintain adequate blood pressure. Reassess vital signs frequently. Consider second line if time allows.
      4. Transport in shock position if tolerated.
      5. Reevaluate bleeding frequently.
      6. Contact hospital early.

Approved: [signature] Date: 1/22/15

Approved as to Form: [signature] Date: 1/22/15

Subject: Treatment Guidelines – ALS
Vaginal Hemorrhage without Shock

Associated Policies:

I. Priorities
   A. ABC's.
   B. Identify signs of shock.
   C. Determine stage (trimester)of pregnancy (if pregnant).
   D. Determine the degree of physiologic distress, estimate amount of blood loss.

II. Vaginal Hemorrhage without Shock
Identify possible causes. Abnormal (non-menstrual) vaginal bleeding, during pregnancy, post-partum or post-operative. Rule out possible trauma.
   1. Ensure a patent airway.
   2. Administer Oxygen per policy.
   3. Contact base hospital.
   4. Obtain IV access. Administer fluid to maintain adequate blood pressure. If signs of shock occur, treat per NCEMS Policy # 6536.
   5.
   6. Transport early to appropriate facility.

Approved: [signature] Date: 1/22/15

Approved as to Form: [signature] Date: 1/22/15

Subject: Treatment Guidelines – ALS
Imminent Delivery

Associated Policies:

I. Priorities
  A. ABC's.
  B. Identify the signs of shock.
  C. Determine stage (trimester) of pregnancy.
  D. Determine the degree of physiologic distress, estimate amount of blood loss.

II. Imminent Delivery
  A. Normal Presentation:
  Regular contractions, bloody show, low back pain, feels like bearing down, crowning.
    1. Ensure a patent airway.
    2. Administer Oxygen per policy.
    3. Re-assure mother, instruct during delivery.
    4. Consider base hospital contact and IV access, if time allows prior to delivery.
    5. As head is delivered, gently suction baby's mouth and nose, keeping the head dependent. If cord is wrapped around neck and can't be slipped over the infant's head, double clamp and cut between clamps.
    6. Allow delivery, dry baby and keep warm, placing baby on mother's abdomen or breast.
    7. Allow cord to stop pulsating, then clamp and cut 6-8 inches from baby.
    8. Assess baby by Apgar score at one (1) and five (5) minutes (see Neonatal Resuscitation).
    9. Allow delivery of the placenta - save it and bring it to the hospital with mother and child.
    10. Rub the fundus after delivery of placenta unless there is excessive bleeding after the delivery of the infant. Ensure the fundus is firm and continues to contract if bleeding is severe.
    11. Perform #4 above, if not already accomplished.
    12. If delivery is premature (< 36 weeks gestation), prepare for neonatal resuscitation and early transport.
  B. Abnormal Presentation:
    1. Breech:
    Presenting part of the fetus is the buttocks or foot instead of the head.
      a. Ensure a patent airway (mother).
      b. Administer Oxygen per policy.

   c. Begin transport with early base hospital contact.
   d. Allow delivery to proceed passively until the baby's waist appears.
   e. Wrap the torso of the baby and rotate baby to face down position (do not pull).
   f. If the head does not readily deliver in 4-6 minutes, insert a gloved hand into the vagina to create an air passage for the infant.
   g. If transport is lengthy, place the mother on her hands and knees position with the head down and support the baby's torso below her hips. Head may present more readily with this position.
   h. Contact hospital early.
   i. IV access TKO, if time allows.

2. Prolapsed Cord:
   Cord presents first and is compressed during delivery compromising infant circulation.
   a. Ensure a patent airway (mother).
   b. Place mother on her hands and knees with the head down to bring the baby's head off the cord.
   c. Insert gloved hand into vagina and gently push the presenting part off of cord. Do not attempt to re-position the cord. Do not manipulate the cord or handle it.
   d. Administer Oxygen per protocol. Transport rapidly to appropriate facility.
   e. Contact base hospital early. .
   f. IV access if time allows.

Approved: [signature] Date: 1/22/15

Approved as to Form: [signature] Date: 1/22/15

Subject: Treatment Guidelines-ALS
Sever Pre-Eclampsia/ Eclampsia

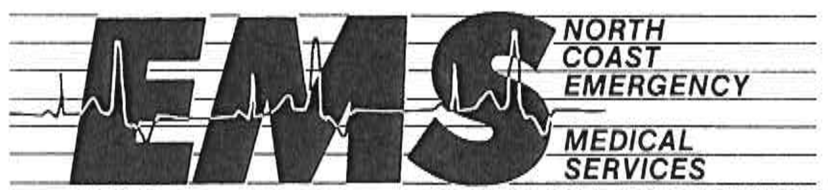
Associated Policies:

I. Priorities
   A. ABC's
   B. Identify signs of shock.
   C. If pregnant, determine stage (trimester) of pregnancy.
   D. Determine the degree of physiologic distress, estimate amount of blood loss.

II. Severe Pre-Eclampsia/ Eclampsia
   Third trimester pregnancy with hypertension (BP systolic > 160, diastolic> 110), mental status changes, visual disturbances, peripheral edema (pre-eclampsia), seizures and/or coma (eclampsia).
   A. Ensure a patent airway
   B. Administer Oxygen per protocol
   C. Auscultate for fetal heart tones if equipment is available.
   D. Position mother on her left side.
   E. Transport quickly and maintain a quiet environment.
   F. IV access TKO while en route.
   G. Determine blood glucose. Treat hypoglycemia per Policy #6515.
      H. Contact bas hospital for orders for Mag Sulfate 10% (Policy #5428) in the presence of ALOC or seizures in the third trimester pregnancy.
   I. Be prepared to treat seizures per Policy # 6516 if Mag Sulfate 10% is delayed.
   J. Transport to appropriate facility.

Approved: [signature] Date: 1/22/15

Approved as to Form: [signature] Date: 1/22/15



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

MEMORANDUM

DATE: January 22, 2015

TO: All NCEMS Providers

FROM: Wendy Chapman, Programs Manager

RE: Aspirin Addition to EMT-I Basic Scope of Practice

Effective February 1, 2015 North Coast EMS will be adding Aspirin to the basic scope of practice for all certified EMT's. Aspirin was added as an option in the State EMT regulations in 2013. After careful review and discussion with regional BLS providers North Coast EMS has decided to add this to the local North Coast EMS scope of practice for EMT's.

Prior to any agency implementing the use of aspirin they will need to ensure that their currently certified EMT-I have been trained to competency and oriented to the North Coast EMS related policies and procedures. This training shall be at a minimum of one (1) hour. The instructor for this training should be at least the paramedic level or higher. Providers must retain documentation of this training/competency for at least four (4) years. Providers need only furnish North Coast EMS copies of this training upon request.

To review the North Coast EMS aspirin policy you can find it at http://www.northcoastems.com/wp-content/uploads/60391.pdf.

Subject: Scope of Practice/Procedure - BLS
Aspirin

Associated Policies: 6006, 6511

I. Indications
  A. Chest pain or other signs and symptoms suggestive of acute myocardial infarction (AMI).

II. Therapeutic Effects
  A. Appears to impede clotting by blocking prostaglandin synthesis, which prevents formation of the platelet - aggregating substance thromboxane.

III. Contraindications
  A. Absolute:
    1. Known hypersensitivity to aspirin.
  B. Relative:
    1. None. Benefits of anti-platelet effect strongly outweigh risks of single dose use.

IV. Adverse Effects
  A. Hypersensitivity, manifested by anaphylaxis or asthma.
  B. Nausea.
  C. Vomiting.
  D. Gastrointestinal distress.
  E. Occult bleeding/minor bleeding.

V. Administration and Dosage
  A. 324 mg nonenteric-coated (4 (four) chewable 81 mg tablets or 1(one) 325 mg adult tablet), chewed and swallowed.

VI. Special Information
  A. Does not increase risk of hemorrhagic stroke.
  B. Produces a 23% decrease in AMI mortality, even when used without thrombolytic drugs.
  C. Appears to be safe for use during pregnancy.

Approved: [signature] Date: 10-1-14

Approved as to Form: [signature] Date: 10-1-14

MCI CHANNEL TEST

11/13/2014

- 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	X	GRA1	X
Redwood Memorial	NR	FRA 1	X
St. Josephs Hospital	X	FRA 2	OC
Mad River Hospital	X	CTA1	OC
Eureka Medcom	x	CTA2	NR
		CTA3	OC
		Arcata 1	X
		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 O/C – On Call**

MCI CHANNEL TEST

12/12/2014

- 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:

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Phelps Hospital	X	GRA1	X
Redwood Memorial	NR	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	X
		Arcata 2	

- 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**
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North Coast EMS
3340 Glenwood Street
Eureka, Ca, 95501

Agreement #C14-014

1st Quarter Report
July 1 - September 30, 2014

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: federal, state and regional EMS for Children meetings and calls, EMSAAC Legislative Committee calls, EMSA/LEMSA call, State HPP Disaster related calls and meetings, EMSAAC QIP Coordinator calls and meetings, EMSA/Regional Contract call, LEMSA Attorney Network call, STEMI EMSA/LEMSA EMS Plan Section call, EMSAAC & EMS Commission meetings San Diego; and, in the following local EMS activities: Joint Powers Governing Board meeting; Humboldt/Del Norte Medical Advisory Committee (MAC) meetings, Lake County Emergency Medical Care Committee (EMCC) and Trauma Advisory Committee meetings, Lake Inter-facility Transfer (IFT) meetings, EMSC TACTICAL meetings and calls, federal SPROC pre-conference meeting and conference Washington D.C. and calls, Sutter-Coast Hospital Trauma Center Survey with State of Oregon, Health Information Exchange planning discussion, Humboldt County Child Death Review Team meetings, Humboldt County Child Passenger Safety Committee meeting, Humboldt County Fire Chiefs Association meetings, Medical Advisory Committee – North meeting, Del Norte County EMS Helicopter Use meeting, CALFIRE, City Ambulance of Eureka and Arcata Ambulance Dispatch meeting, Humboldt County Med Net Communications meeting, Petrolia Fire meeting, Humboldt Bay Fire meeting, Hoopa Ambulance meeting, Emergency Preparedness and numerous HPP Disaster related meetings and calls, EMS for Children TACTICAL Core Group planning meetings, Cultural Liaison interviews, Hoopa Ambulance meeting, STEMI/Stroke Planning meeting, EMS Plan, QIP and Trauma Plan planning meetings and other meetings as needed.

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

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

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

The State General Fund fourth quarter progress was submitted to EMSA with EMS data as required. The EMSA, however, requested the Quarter Four report in mid-August (it is due at the end of August), and because the Executive Director was out of the country with limited internet connections, an earlier draft of the report was inadvertently submitted. We therefore submitted the corrected FY 2014-15 quarter four report last week.

This year's first quarter report was late due to numerous high priority state and local matters, including: regional Ebola preparations, a JPA Governing Board meeting, Health Information Exchange proposal development, etc. Despite having an excellent many decades long record of on time quarterly reports and a written request that we would be delayed, this year for the first time, our advanced reimbursement check was withheld until the report is completed. We've consequently had to divert attention from the other high priority patient care and EMS system matters, including many of those desired by the EMSA, to immediately complete a report and avoid cash flow issues. Also, the contract requiring the first quarter report was not executed by the EMSA until the after quarter ended. Finally, the addition of new objectives and sub-objectives within the contract has substantially increased the time involved with completion of the quarterly report work, and many of the changes are unnecessarily duplicative with annual EMS and Trauma Plan updates.

Despite prior written and verbal requests by the combined regional administrators that the EMSA not to make late fiscal year changes to the State General Fund contract to allow sufficient time for evaluation, discussion and implementation of new objectives in the coming fiscal year, the EMSA withdrew the North Coast EMS executed contract for FY2014-15 and, in mid-August, sent a new contract with numerous new, redundant and largely un-discussed objectives that increase workload and divert attention away from high priority and patient care related local programs. Although we had concerns about the new additions, we were forced to execute the revised contract in late-August to avoid cash flow problems. Also, past procedures adopted by the EMSA in collaboration with the regional administrators to ensure that state contracts were prepared early to avoid cash flow issues, have been unilaterally discontinued by the EMSA. The combination of mid-quarter contract changes, contract processing delays at the EMSA and withholding of the advance could, in lean years, force us to close the office due to the lack of revenue.

North Coast EMS, as part of its statutory (H & S Code 1797.254) and contractual obligation initiated the process to update the annual EMS Plan during the first quarter, which was due in early December, 2014. The EMSA, however, without discussion, reinstituted the long abandoned and far more time expensive Five-Year Plan requirement and created substantial confusion of LEMSAs across the State, including North Coast EMS. We requested and appreciate receiving an extension to submit the EMS Plan, Trauma Plan and Quality Improvement Plan revisions until the month of February 2015. However, at this time it is unlikely that we will be able to prepare the draft Five–Year Plan and solicit public input on the three different plans prior to Joint Powers Governing Board acceptance before mid-March. Our JPA Governing Board consequently set the next meeting for March 19, 2015 and we will not be able to submit the plans prior to that time. At this writing, we have not yet received a response from the EMSA specific to which report version we need to prepare. We also plan to present an EOA/Transporation Plan Addendum for EMSA approval in the near future and inadvance of EMS PLan, Trauma and QIP Plan submission in February or March.

We executed or continued administrative contracts with: UCD for the federal EMS for Children TACTICAL REGIONALIZATION program (Year Three) and the third year Regional HPP Disaster contract with CDPH; 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 as 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. North Coast EMS continued to receive and dispense 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 executed or 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 initiated the data collection process in Lake County. The process to approve Air Methods and REACH as an ALS Provider/Aero Medical Provider within Lake County is on hold. At this time every ALS Provider is using the new e-PCR program within region and contract work by Selinda Shontz continues to be on hold until we receive the Pre-Site Check List from St. Joseph Hospital.

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

North Coast EMS staff attended the EMSAAC conference and meeting in San Diego. While we plan to attend at least three meetings annually, the EMSA verbally agreed with the six regional directors that they would not require strict adherence to this requirement if

inability to attend was justified due to illness or need to attend to other higher priority local matters.

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

  As stated in the EMS Plan and annually submitted updates when changes occurred (See B.2.01 in EMS Plan), this standard has been met for decades. North Coast EMS has numerous mechanisms for determining training program needs, including: recent surveys sent to paramedics and providers specific to pediatric training needs; numerous committee meetings where EMS system and training needs are discussed; staff attendance at State and federal meetings where best practices are reviewed; numerous communications with regional EMS instructors; etc. This requirement is redundant with the EMS Plan and was dropped from this report in collaboration between the regional directors and EMSA many years ago. It was readded by EMSA in our contracts after the beginning of the fiscal year without consultation with the regional directors. This task should be dropped in the quarterly report.

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

  As stated in the EMS Plan and annually submitted updates when changes occurred (See B.2.02 in EMS Plan), this standard has been met and reported upon for decades. North Coast EMS has, as reported in the Inventory Section of the EMS Plan, numerous approved training programsthat have been verified to meet or exceed state minimum standards, including the curriculum. These programs include: First Responder (local program only), EMT-I, Paramedic, MICN, continuing education, etc. We also plan to develop new policies to implement the new Public Safety regulations and later, replace the First Responder program with national Emergency Medical Responder program. We would have added EMT-I use of Aspirin and Oral Glucose to the EMT-I scope of practice other priorotes forced us to delay those plans. This requirement is redundant with the EMS Plan and was dropped from this report in collaboration between the regional directors and EMSA many years ago. It was readded by EMSA in our contracts after the beginning of the fiscal year without consultation with the regional directors. This task should be dropped in the quarterly report.

- 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 stated in the EMS Plan and annual updates, this standard has been met and reported

upon for decades. North Coast EMS issues, as reported in the Inventory Section of the EMS Plan and in the fourth quarter report, numerous EMT-I certifications, paramedics 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 the quarterly report.

- Developing and maintaining treatment protocols for all certification levels

See # 4 above. We have numerous 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 the quarterly report. It is also redundant with the EMS Plan narrative sections A.14, 1.15, etc.

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

This new and redundant requirement is addressed in detail in the EMS Plan and updated as needed annually in Section E. North Coast EMS also has QI policies, was the first LEMSA to submit a QIP Plan to the EMSA for approval and has an extensive QIP program. We have approved base hospital and ALS Providers QIP Plans and as explained annually in the EMS Plan update and each quarterly report, we require all approved ALS Providers and designated base hospitals to submit a QIP report summarizing progress in each of the QIP regulation required categories. We also select a focused review topic each quarter. Until we shifted from the EPCIS to Image Trend electronic program with EMSA and ICEMA support, North Coast EMS and our prehospital and hospital liaisons could query EMS data as a powerful QI tool. We plan to submit a HIE special project proposal today to develop a similer QI tool for the Image Trend program, which unfortunately not able to assess performance of field personnel or provide QI information similar to our prior e-PCR program at this time.

- Conducting investigations and taking action against certification when indicated

This requirement was dropped by EMSA year's ago and the revised wording was moved to 6.05. of this report. It should be revised as before. We conducted no formal investigations during this quarter.

- Providing personnel recognition programs for exemplary service

This new and redundant requirement is addressed in detail in the EMS Plan and updated as needed annually in Section F. Most importantly, this kind of nice but time expensive requirement was dropped by EMSA years ago in collaboration with regional directors and most LEMSAs do not have sufficient staff size to provide personnel recognition programs. For many years North Coast EMS participated in EMS Week events and annually gave Kris Kelly Star of Life Awards for outstanding service. With approval of our Governing Board, we discontinued these programs due to our small staff size. This addition to the contractual requirement should be dropped.

- Authorizing, maintaining, and evaluating EMS continuing education programs

  See #2 above. North Coast EMS has 33 approved CEU providers as reported in the last quarterly report and EMS Plan update. Each approved CEU program is required to reapply every four years as required in state regulation. This new addition needs to be dropped.

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. A meeting with Humboldt County representatives to discuss ownership, maintenance and replacement responsibility took place during this quarter. Also, with support of the Humboldt County Communications Officer and Public Health Department, North Coast EMS plans to request JPA Board approval next quarter to utilize the Med Net Trust Fund to replace Enhanced Med Net antennas on the Pratt Mountain Repeaters and tune each of the narrow-banded repeaters tuned to help improve coveage. We also support the effort initiated by Arcata Mad River Ambulance and endorsed by the Fire Chiefs Association to enhance microwave issues in Fortuna. The latter should improve ambulance dispatch quality in the Arcata area.

- Assuring appropriate maintenance of communications systems integrity

  This is a new addition to the contract objectives that is unclear and should be removed. As reported in EMS Plans and quarterly reports for decades, North Coast EMS originally purchased the Med Net System in the mid-1970's and in the mid-1980's transferred ownership, maintenance and replacement responsibility to each county, hospital and provider. In the 1990's we also established a Med Net Trust Fund to assist with county maintenance of the Mt Top Repeaters, and all have since been replaced and narrow-banded. We plan to continue to work with each county, hospital and provider to help ensure future Med Net Communications integrity.

- Approving ambulance dispatch centers

  All three counties have centralized dispatch for ambulances (with the occasional 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

  This is a new and redundant requirement that needs to be dropped. Communications procedures and medical control policies have been in place and repeatedly reported on for decades. North Coast EMS developed related policies many years ago and updates these as needed to continue to provide acceptable EMS related dispatch and on-line medical

control procedures.

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

North Coast EMS convened a meeting between one of our two EMD designated dispatch centers and local ambulance managers to address issues, each of which is being addressed including those presented in 3.1. above.

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

This is a new and EMS Plan redundant requirement that needs to be dropped. North Coast EMS designates First Responder training programs (see 2.1 above) but our 53 responding agencies, mostly volunteer fire, are not designated by us. These responding entities were established in many cases long before North Coast EMS existed pursuant to the State's Master Mutual Aid Agreement and this exceeds or contractual and statutory authority. As reported repeated to your office previously, the LALS program was discontinued years ago. Each county Board of Supervisors adopted, as is their statutory right, county ambulance ordinances that either permit or contract with ambulance providers. North Coast EMS has policies and an MOU specific to in region and out-of-area EMS helicopters. Designation of rescue providers exceeds our authority and staff time, although we have MOUs with any rescue helicopter that transports a medical patient.

- Enforcing local ordinances

This is a new and EMS Plan redundant and needs to be dropped. See 4.1. above. As reported in past EMS Plans and quarterly report, local ambulance enforcement authority rests with the county pursuant to the BOS adopted ambulance ordinance. North Coast EMS works closely with each county to assist with assessment and evaluation of all of our designated transport ALS Providers as part of an extensive QI program as reported in each EMS Plan, quarterly report for decades, 2.6 above and Component 6.

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

This is redundant with the EMS and Trauma Plans and has been reported in quarterly reports for decades. It needs to be dropped. North Coast EMS has established and periodically updates policies and procedures for the transportation of patients to trauma and other specialty centers as needed.

- Implementing and maintaining contracts with providers

North Coast EMS has contracts with all ALS Providers and reported in all EMS Plans,

including the listing of each within the Inventory section. We also contract with AED Providers. Our one ETAD Provider discontinued use of this device last year.

- 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 not overcrowding, to selectively bypass to another hospital. Diversion was discontinued years ago. This newly added objective should be dropped.

- Creating exclusive operating areas

North Coast EMS has no EOAs but is evaluating the need to create one or more EOAs within Humboldt County. We initiated the process by soliciting information from two local ambulance providers to determine whether either are eligible for grandfathering. We planon presenting an EOA/Transportation Addendum for EMSA approval as soon as possible. This objective needs to be dropped as it is redundant with the EMS Plan.

- 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 discontinued ambulance inspections long ago as reported in EMS Plan and quarterly report updates due to our small staff size, other than for cause or for a new provider. This responsibility is usually delegated to our Base Hospital Prehospital Care Nurse Coordinator (PCNC). This objective is redundant with the EMS Plan and needs to be dropped.

- Developing performance standards as needed

We continue to plan to add Aspirin, and recently added Oral Glucose to the plan, to expand the EMT-I scope of practice. We are also assessing the possible addition of EPI for anaphylaxis to option scope of practice. We are discontinuing our plans to implement an AEMT program at this time. Authorized ALS Providers and designated Base Hospitals continue to submit quarterly QIP reports with a pre-selected relevant quarterly focus determined by NCEMS, although summary reports by Associate Director Bruhnke were not completed due to focus on the HPP Disaster program and other priorities. Although our attention has been diverted by the HIE grant proposal and this report, we initiated a process to review and, in collaboration with our Health Officers, to respond to the Ebola crisis to ensure that EMS responders are properly protected.

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 are awaiting execution of the Base Hospital contract amendment to add Air Methods and REACH as assigned ALS Providers at Sutter-Lakeside Hospital. New PCNC and PCMDs continue to be assigned. We designated and contracted with seven base hospitals for over 30 years.

- Identifying ambulance receiving centers including hospitals and alternative receiving facilities

All seven hospitals are designated by contract as base hospitals and all have been identified as ambulance and paramedic receiving centers.

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

We continue to submit Trauma registry data to EMSA but we are trying to resolve ongoing issues. As reported in the annual Trauma Plan update, we have two designated Level IV Trauma Centers. During this quarter we participated in the Oregon State conducted follow-up survey of Sutter-Coast Hospital. The latter is facing challenges with a shift to Critical Access and staff turnover, including resignation of the Trauma Coordinator. They did, however, address the prior site survey concerns and a follow-up letter will be sent next quarter.

- Periodically assessing trauma system and plan as needed

As reported in the annual Trauma Plan update, we have two designated Level IV Trauma Centers. During this quarter we participated in the Oregon State conducted follow-up survey of Sutter-Coast Hospital. The latter is facing challenges with a shift to Critical Access and staff turnover, including resignation of the Trauma Coordinator. They did, however, address the prior site survey concerns and a follow-up letter will be sent next quarter. We also conducted a Lake County TAC meeting this quarter.

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

This is redundant with the Trauma Plan and EMS Plan and should be dropped. We have long approved Trauma Triage Policy that integrates with Coastal Valley's EMS policy and is very similar to the national standard.

- 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 executed the third year subcontract. We continued the process to verify EDAP compliance at St. Helena Clearlake and Jerold Phelps Community Hospitals. New Pediatric Liaison Nurses were orientated by Pam Mather RN, we continued the EMSC TACTICAL project, selected a new Cultural Liaison Keith Taylor, sent the UCD/NCEMS team to Washington DC as part of the HRSA grant, we submitted a JPA Board approved rollover budget to UCD, initiated patient outcome data collection in Lake County as part of the UCD IRB process, etc. At this time five of the seven hospitals have executed Data Collection MOUs with UC Davis and NCEMS as part of the EMSC TACTICAL program; St Joseph Hospital Health System elected to not execute the MOU.

- Completing hospital closure impact reports

  None were requested or completed in this quarter. The assessment at Sutter-Coast Hospital has been completed and the most likely option will be to seek 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 received reportable incidents. During the first quarter, we took no formal action but were requested to participate in the review of a few cases.

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

  The Agency completed the regionwide process to implement Image Trend and the Image Trend PCR program at ICEMA continues to provide EMS data to the State. We executed a contract with ICEMA and, until the end of this fiscal year, have decided to cover new Tier 1 costs for the region. The Image Trend program appears to be working well but our ability to generate reports for quality improvement purposes has diminished. We plan to submit an HIE proposal to the EMSA to help fund development of an administrative program, We also submit the AED report to the EMSA when requested and have recently contracted with Matt Davis to help compile this information for us; no requests have been made for years and we understand that 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 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. Late reports can result in a notification process and potential probation, although reports are generally submitted on time. 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 local priorities. Associate Director Bruhnke continued to be directly involved with the EMSAAC QI Group and remained instrumental in development a Provider QIP template.

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

North Coast EMS submits Core Measure Data through the Image Trend program by contract with ICEMA. All Image Tend data is sent directly to ICEMA by each EMT or paramedic completing the PCR from the North Coast EMS region. ICEMA is the state repository for our data and we contract with Jay Myhre to utilize this data to prepare Core Measure reports.

- Providing data to CEMSIS monthly

See #4 above. Image Trend data goes directly to ICEMA upon completion of each e-PCR at the local level.

- 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.

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

This objective was dropped decades ago in collaboration with EMSA and the other regions and we do not have access to this information. This needs to be dropped. We are planning to establish policies and procedures to approve Public Safety training programs pursuant to the revised state Public Safety regulations to be adopted next quarter. Public Safety training programs 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 as shown in Section 1.0.1.

- Availability of information to assist the population in catastrophic events

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

Nothing new this quarter.

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 have been attending and participating in numerous 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 counties. This includes recent focus on EMS Ebola preparations.

- Coordinating the operational area disaster medical/health coordinator

  North Coast EMS staff and HHP contractors coordinated with the RDMHC, attended meetings, participated in several local, state and regional Medical Disaster meetings and events.

- Coordinating the regional disaster medical/health coordinator system

  See # 3 above.

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

  This is redundant with the EMS Plan and needs to be dropped. North Coast EMS has MCI and disaster related policies and updates these as needed.

- Facilitating mutual aid agreements

  This is redundant with the EMS Plan and needs to be dropped. North Coast EMS has facilitated development of mutual aid agreements for many decades.

- 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.

North Coast EMS
3340 Glenwood Street
Eureka, CA 95503

Agreement # C14-014

2nd Quarter Report
October 1, 2014 to December 31, 2014

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: federal, state and regional EMS for Children meetings and calls, EMSAAC Legislative Committee calls, EMSA/LEMSA call, State HPP Disaster related calls and meetings, EMSAAC QIP Coordinator calls and meetings, EMSA/Regional Contract calls, LEMSA Attorney Network call, EMSAAC, EMDAAC & EMS Commission meetings - San Francisco, numerous Ebola related calls and training sessions, the EMSC Conference - Sacramento, Health Information Exchange Summit – Los Angeles; and, in the following local EMS activities: Joint Powers Governing Board meeting; Humboldt/Del Norte Medical Advisory Committee (MAC) meetings, Lake County Emergency Medical Care Committee (EMCC), Lake Inter-facility Transfer (IFT) meetings, EMSC TACTICAL meetings and calls, federal SPROC calls, Health Information Exchange planning meetings, Humboldt County Child Death Review Team meetings, Humboldt County Child Passenger Safety Committee meeting, Humboldt County Fire Chiefs Association meetings, Humboldt County Disaster Council meeting, Emergency Preparedness and numerous HPP Disaster related meetings and calls, EMS for Children TACTICAL Core Group planning meetings, Cultural Liaison meetings, EMS Plan, QIP and Trauma Plan planning meetings, Exclusive Operating Area planning meetings – Humboldt County, Mercy/Air Methods meeting – Lake County, 5150 Handbook meeting, Dan Larkin's Retirement event, 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, including at the Lake County Department of Health and Human Services – Public Health.

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

The State General Fund first quarter progress was submitted to EMSA in the required new format.

For the first time EMSA denied the October fiscal invoice due to a new interpretation of the #104 document, that is, invoices will not be reimbursed until the quarterly report is submitted. This new policy could result in cash flow problems and we have since met with EMSA representatives to discuss alternatives.

As of this writing, the EMSA has not clarified which EMS Plan update version will be required, the more streamlined annual update agreed to by EMSA representatives several years ago or the previously discontinued and more time consuming 5-Year Plan update. Consequently, North Coast EMS now plans to submit the EMS Plan, QIP Plan and Trauma Plan updates after JPA Governing Board approval in March 2015.
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 Special Project 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 as 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. 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 initiated the data collection process in Lake County. 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. The Pre-Site Visit STEMI Receiving Center Check List was received from St. Joseph Hospital and is under review by Selinda Shontz.

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

North Coast EMS staff attended the EMSAAC meeting in San Francisco. While we plan to attend at least three meetings annually, the EMSA verbally agreed with the six regional directors that they would not require strict adherence to this requirement if inability to attend was justified due to illness or need to attend to other higher priority local matters.

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

As stated in the EMS Plan and annually submitted updates when changes occurred (See B.2.01 in EMS Plan), North Coast EMS has numerous mechanisms for determining training program needs, including: recent 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; numerous communications with regional EMS instructors; etc. This requirement is redundant with the EMS Plan and was dropped from this report in collaboration between the regional directors and EMSA many years ago. It was re-added by EMSA in our contracts after the beginning of the fiscal year without consultation with the regional directors. This task should be dropped in future contracts and quarterly reports.

- 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 the curriculum requirements. These programs include: First Responder, EMT-I, Paramedic, MICN, continuing education, etc. We also plan to develop new policies to implement the new Public Safety regulations and later, replace the First Responder program with national Emergency Medical Responder program. The addition to the EMT-I scope of practice of Aspirin and Oral Glucose has been delayed by other priorities, such as the Ebola issue. This requirement is redundant with the EMS Plan and was dropped from this report in collaboration between the regional directors and EMSA many years ago. It was re-added by EMSA in our contracts after the beginning of the fiscal year without consultation. This task should be dropped from future contracts and quarterly report.

- 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, paramedics 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. 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. It is also redundant with the EMS Plan narrative sections A.14, 1.15, etc.

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

This new and redundant requirement is addressed in detail in the EMS Plan and updated as needed annually in Section E. North Coast EMS also has QI policies, was the first LEMSA to submit a QIP Plan to the EMSA for approval and has an extensive QIP program. We have approved base hospital and ALS Providers QIP Plans and as explained annually in the EMS Plan update and each quarterly report, we require all approved ALS Providers and designated base hospitals to submit a QIP report summarizing progress in each of the QIP regulation required categories. We also select a focused review topic each quarter. Until we shifted from the EPCIS to Image Trend electronic program with EMSA and ICEMA support, North Coast EMS and trained prehospital and hospital liaisons could query EMS data as a powerful QI tool. We submitted a HIE special project proposal to EMSA that has been approved to develop a similar QI administrative tool for the Image Trend program, is not currently able to assess performance of field personnel.

- Conducting investigations and taking action against certification when indicated

This requirement was modified by EMSA several year's ago and moved to 6.05. of this report. We conducted one formal MCI related Debriefing in Humboldt County and received and reviewed one After Action report from Del Norte

- Providing personnel recognition programs for exemplary service

This new and redundant requirement is addressed in the EMS Plan and updated as needed annually in Section F and in past quarterly reports. Importantly, this time expensive requirement was dropped by EMSA years ago in collaboration with regional directors as many LEMSAs do not have sufficient staff size to provide personnel recognition programs. For many years North Coast EMS participated in EMS Week events and annually gave Kris Kelly Star of Life Awards for outstanding service. With approval of our Governing Board, we discontinued these programs due to our small and increasingly overloaded staff. This addition of this contractual requirement should be dropped.

- Authorizing, maintaining, and evaluating EMS continuing education programs

See #2 above. North Coast EMS has 33 approved CEU providers as reported in the last quarterly report and EMS Plan update. Each approved CEU program is required to reapply every four years as required in state regulation. This new addition should be dropped.

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 plan to add Aspirin and Oral Glucose, and possibly Epinephrine to the EMT-I scope of practice but this has been delayed by other priorities. We plan to focus on these additions rather than implement the Advanced EMT program as previously planned. We continue to assess Community Paramedic Program developments within California and submitted several rounds of comments on the public draft of the Public Safety regulations.

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. North Coast EMS received JPA Board approval to utilize the Med Net Trust Fund to replace Enhanced Med Net antennas on the Pratt Mountain Repeaters and tune each of the narrow-banded repeaters in Humboldt County to help improve coverage.

- Assuring appropriate maintenance of communications systems integrity

  This is a new addition to the contract objectives that is unclear and should be removed. As reported in EMS Plans and quarterly reports for decades, North Coast EMS originally purchased the Med Net System in the mid-1970's and in the mid-1980's transferred ownership, maintenance and replacement responsibility to each county, hospital and provider. In the 1990's we also established a Med Net Trust Fund to assist with county maintenance of the Mt Top Repeaters, and all have since been replaced and narrow-banded. We plan to continue to work with each county, hospital and provider to help ensure future Med Net Communications 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

  This is a new and redundant requirement that needs to be dropped. Communications procedures and medical control policies have been in place and repeatedly reported on for four decades. North Coast EMS developed related policies many years ago and updates these as needed to continue to provide

acceptable EMS related dispatch and on-line medical control procedures.

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

North Coast EMS convened a meeting between the two EMD designated dispatch centers, local ambulance managers, St Joseph Hospital and the Humboldt County Health Officer to assess the need for implementing the new EMD Ebola and Infectious Disease protocol. We elected not to implement this tool because the existing system to identify and monitor possible Ebola patients is working. Del Norte County dispatch implemented a screening program to help identify potential Ebola patients.

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

This is a new and EMS Plan redundant requirement that needs to be dropped. North Coast EMS designates First Responder training programs (see 2.1 above) but our 53 responding agencies, mostly volunteer fire services, are not designated by us. These responding entities were established in many cases long before North Coast EMS existed pursuant to the State's Master Mutual Aid Agreement or Master Plan and this exceeds our contractual and statutory authority. Each county Board of Supervisors adopted county ambulance ordinances that either permit or contract with ambulance providers. All ambulance providers are North Coast EMS designated ALS Providers; we also have four designated non-transporting ALS Providers. North Coast EMS has policies and an MOU specific to in-area and out-of-area EMS helicopters. Designation of rescue providers exceeds our authority and staff time, although we have MOUs with rescue helicopter services originating within the region that transports a medical patient.

- Enforcing local ordinances

This is a new and EMS Plan redundant requirement is unclear and needs to be dropped. As reported in past EMS Plans and quarterly reports, local ambulance enforcement authority rests with the county pursuant to the BOS adopted ambulance ordinance. North Coast EMS works closely with each county to assist with assessment and evaluation of all of our designated transport ALS Providers as part of an extensive QI program as reported in each EMS Plan and quarterly report for decades, above and Component 6.

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

This is redundant with the EMS and Trauma Plans and has been reported in quarterly reports for decades. It needs to be dropped. 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

This is redundant with a prior contract section above and should be dropped. North Coast EMS has contracts with all approved ALS Providers as reported in all EMS Plan updates, including the listings within the Inventory Section. We also contract with AED Providers. Our one ETAD Provider discontinued use of this device last year.

- 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 not overcrowding, to selectively bypass to another hospital. Diversion was discontinued years ago. This newly added objective should be dropped.

- Creating exclusive operating areas

North Coast EMS has no EOAs but has been evaluating the need to create one or more EOAs within Humboldt County for many months. We determined that City Ambulance of Eureka, Inc., is eligible for grandfathering in the Eureka Zone and Arcata-Mad River Ambulance is eligible for grandfathering within the Arcata Zone and are in the process of preparing the Humboldt County Transportation Plan that will include EOAs. The Transportation Plan is designed to ensure long term high quality ambulance services throughout the county, including high and low volume areas. This objective needs to be dropped as it is redundant with the EMS Plan.

- 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 discontinued ambulance inspections long ago as reported in EMS Plan and quarterly report updates due to our small staff size, other than for cause or for a new provider. This responsibility is usually delegated to our Base Hospital Prehospital Care Nurse Coordinator (PCNC). This objective is redundant with the EMS Plan and needs to be dropped.

- Developing performance standards as needed

We continue to plan to add Aspirin and Oral Glucose to expand the EMT-I scope of practice although this has been delayed by other priorities. We are also assessing the possible addition of EPI for anaphylaxis to option scope of practice but discontinued plans to implement an AEMT program. Authorized ALS Providers and designated Base Hospitals continue to submit quarterly QIP reports with a pre-selected relevant quarterly focus determined by NCEMS, although summary reports were not completed due to other priorities. We are currently assessing 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. We designated and continuously contracted with seven base hospitals for over 30 years.

- Identifying ambulance receiving centers including hospitals and alternative receiving facilities

  Seven hospitals are designated ambulance receiving centers and one is a mental health receiving facility. We have no alternate receiving centers.

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

  We continue to submit Trauma registry data to EMSA although we continue to address ongoing issues with data transfer.

- 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

  This is redundant with the Trauma Plan and EMS Plan and should be dropped. We have long 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, so trauma patient go 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 Pediatric Maddy "Richie's" funding for Emergency Depts Approved for Pediatrics (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 and Jerold Phelps Community Hospitals. The latter was ready to be designated when the PCMD and EDAP Medical Director was killed in a plane crash near the hospital. The EMSC TACTICAL project initiated hospital data collection, began development of a Cultural Sensitivity training curriculum for EMS personnel, participated in a pediatric training session with CAL Ore/REACH, prepared a budget and federal request to utilize rollover funds, etc. We canceled planned Pediatric Regional Council meetings due to inclement weather and other priorities.

We received the completed Pre-Hospital STEMI Receiving Center Survey Checklist from St Joseph Hospital and initiated a review process. SJH also requested more information regarding costs. We also provided information specific to our process and timeline to designate them as a STEMI Receiving Center. Sutter-Lakeside Hospital reported that they are now a certified stroke center and we plan to assess this as time allows. Stayce Curry completed the first draft of the 5150 Handbook that is currently under internal review.

- Completing hospital closure impact reports

None were requested or completed in this quarter. The assessment at Sutter-Coast Hospital has been completed and they are seeking 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 received reportable incidents. During the first quarter, we took no formal action but participated in the review of a few cases including an MCI.

- 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 proposal was submitted and approved by the EMSA. Thank you! The former does not easily allow e-PCR review or preparation of queries, but the latter is designed to help fund development of an Image Trend administrative management program and to work with our two HIE programs. We understand that the AED 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 submits Core Measure Data through the Image Trend program by contract with ICEMA. All Image Tend data is sent directly to ICEMA by each EMT or paramedic completing the PCR from the North Coast EMS region. ICEMA is the state repository for our data and we contract with Jay Myhre to utilize this data to prepare Core Measure reports.

- 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.

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

  This objective was dropped decades ago in collaboration with EMSA and the other regions and we do not have access to this information. This needs to be dropped. We are planning to establish policies and procedures to approve Public Safety training programs pursuant to the revised state Public Safety regulations over the next quarter or two. 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

  Nothing new this quarter.

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 numerous state, regional and local disaster planning meetings and drills. This included: numerous Ebola sessions and calls and the Humboldt County Disaster Council meeting.

- 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 EMS Ebola preparations.

- 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 several local, state and regional Medical Disaster meetings and events.

- 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

This is redundant with the EMS Plan and needs to be dropped. North Coast EMS has MCI and disaster related policies and updates these as needed.

- Facilitating mutual aid agreements

This is redundant with the EMS Plan and needs to be dropped. North Coast EMS has facilitated development of mutual aid agreements for many decades.

- 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.