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

MEMORANDUM:

DATE: January 25, 2016

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

FROM: Rhiannon Potts, Administrative Assistant

RE: E-Informational Mailing

---

1. For Your Information:
   a. Change Notice # 109
      Draft- Policy # 2208 Inter-facility Transfer Procedure (Please email comments to Louis Bruhnke louis@northcoastems.com by February 14, 2016)
      Draft- Policy #2213 Destination for ST-Segment Elevation Myocardial Infarction Patients (Please email comments to Larry Karsteadt larry@northcoastems.com by February 14, 2016)
      Draft- Policy # 2309 Destination Determination (Please email comments to Louis Bruhnke louis@northcoastems.com by February 14, 2016)
      Add- Policy # 2509 SEMS/EOM- Establishment of Operational Area- Wide Situational Awareness Communications/ Reporting Policy
      Replace- Policy # 5332 Benzodiazepines
   b. Revised EDAP Standards
   c. 1st Quarter Report
   d. 2nd Quarter Report
   e. MCI Channel Test 9-8-15
   f. MCI Channel Test 10-29-15
   g. MCI Channel Test 11-12-15
   h. MCI Channel Test 11-17-15
   i. MCI Channel Test 1-15-16

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

CHANGE NOTICE CHANGE #109

DATE: 1/25/16

TO: ALL PREHOSPITAL CARE POLICY MANUAL HOLDERS

INSTRUCTIONS	POLICY #	POLICY DESCRIPTION	# OF PAGES
DRAFT	2208	Inter-facility Transfer Procedure	5
DRAFT	2213	Destination for ST-Segment Elevation Myocardial Infarction	2
DRAFT	2309	Destination Determination	2
ADD	2509	SEMS/EOM- Establishment of Operational Area-Wide Situational Awareness Communication/ Reporting Policy	4
REPLACE	5332	Benzodiazepines	2

Subject: Administration - Provider
Inter-Facility Transfer Procedure

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 hospital 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.

Deleted: required

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

Deleted: 1/6/2016
Deleted: 5/12/2015
Approved:
Approved as to For
Deleted:

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 Base Hospital physician).

Deleted: EMS

Deleted: P

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 by the base hospital and/or North Coast EMS for both medical care and compliance with this procedure.

   Deleted: audited

   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 by the base hospital and/or by North Coast EMS.
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. The EMT-Paramedic scope of practice includes the EMT-I, EMT-II and EMT-P scope of practice. If the patient's needs are within the scope of practice of an EMT-I, no interaction with a base hospital is necessary unless the EMT-I or EMT-Paramedic decides otherwise. EMT-Paramedic personnel may only function under the direction of a Base Hospital physician, MICN or North Coast EMS approved standing orders. If the patient requires the 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 or arrange for specialty care or critical care transport. In these cases, while assisting the MD or RN with patient care, EMS personnel must function within their approved scope of practice.
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,

Deleted: A

Deleted: , EMT-II and

Deleted:

Deleted: P

Deleted: or

Deleted: EMT-II or

Deleted: as EMT-IA's, unless authorized by the base hospital to function as an EMT-II or EMT-P, as appropriate.

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 immediate transmition of 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-P personnel are needed for the transfer, the transferring physician should so specify with the dispatching or transferring entity.

d. To request an ambulance the sending hospital or dispatch center should consider the following:

1) Early alert of the closest ambulance service to ensure availability of the appropriate level of service and minimize impact on available 9-1-1 ambulances. Provide information on the estimated time of need and other pertinent information.
2) Scope of practice needs of the transporting crew (EMT-I or EMT-P); patient emergent or non-emergeny needs; road and weather conditions; use of ground, fixed wing or aero medical helicopter; safety of all parties including the public, and other pertinent issues.
3) Identify sending and receiving facilities.
4) Provide patient's name, location, and condition.
5) If the transferring facility is not the base, the base hospital should be informed that an ALS transfer is under way.

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 base hospital or North Coast EMS audit might include:

1. Inadequate stabilization of the patient.
2. Patient sent without adequate level of personnel or equipment.
3. Patient subject to excessive delay in transfer.
4. Patient sent without medical records and results of diagnostic tests.
5. Serious deterioration of the patient's condition enroute.

Deleted: faxing
Deleted: EMT-II or
Deleted: requested
Deleted: must be consulted by base hospital personnel to facilitate care by EMS personnel.
Deleted: Call the appropriate ambulance service directly.
Deleted: As soon as IFT is considered an option by
Deleted: MD.¶
Deleted: Identify sending and receiving facilities.
Deleted: C
Deleted: all
Deleted: directly, as it needs to be part of the planning to e
Deleted: ,
Deleted:
Deleted: correct
Deleted: ,
Deleted: information
Deleted: Identify sending and receiving physicians.
Deleted: Perform "risk-to-benefit" review with ambulance service, covering the following items: Is the transfer within ambulance/crew scope
Deleted: ,
Deleted: ,
Deleted: ,
Deleted: public coverage,
Deleted: Provide patient's name, location, and condition.
Deleted: <#>Detail the level of care and type of equipment
Formatted: Bullets and Numbering
Deleted: <#>Identify sending and receiving physicians.¶
Deleted: 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.¶
I
Deleted: or LALS
Deleted: needed (EMT-I, EMT-II or EMT-P) or advise if a RN or MD will accompany the patient.¶
<#>If the transferring facility is not the base, the base hospital should be informed that an ALS or LALS transfer is under way.¶
... [1]

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.

If you have questions or complaints against Hospitals, Hospice, Health Care Facilities or Nursing Homes contact your local CDPH Licensing & Certification District Office: (North): (800) 824-0613

IV. Consideration for Emergency Transfer

A. Based on the patient's condition, geographic locale, prehospital provider scope of practice, availability of ground ambulance, fixed wing or aero medical helicopter services and the resources of the base, a decision must be made to stabilize and transfer the patient a promptly and safely as possible, or to redirect or bypass a 9-1-1 transported patient to a more appropriate facility for definitive care pursuant to Policy # 2309.

B. Transfer arrangements should be made and the appropriately staffed and equipped ambulance available to respond within the clinically recommended time frame. Once the need for transfer is recognized, patient transfer 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 or definitive care medical needs.

D. Immediate transmission of transfer documents is encouraged.

E. Emergency transfers should be considered equivalent to 9-1-1 calls.

Approved: _____ Date: _____

Approved as to Form: _____ Date: _____

Deleted: Trauma T

Deleted: expertise of

Deleted: s

Deleted: accept the patient, to stabilize and transfer

Deleted: the

Deleted: .

Deleted: Deactivation and mechanism of t

Deleted: nd the

Deleted: closest ambulance service alerted of the need for emergency (STAT) transfer as soon as possible. .

Deleted: simultaneous with patient stabilization.

Deleted: this

Formatted: Bullets and Numbering

Deleted: . ~~~~~~Section Break (Next Page)~~~~~~ Permission for emergency transfer should be predetermined by written transfer agreements.

Deleted: Fax of

Deleted: Add: signature block etc

SUBJECT: Destination for ST-Segment Elevation Myocardial Infarction Patients

---

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

II. Purpose: To define the circumstance in which patients may be directly transported to a ST-segment elevation myocardial infarction (STEMI) Receiving Center (SRC) without prior base hospital authorization.

III. Policy:
   A. Only North Coast EMS approved ALS provider agencies that utilize 12-lead EKGs with trained paramedics may initiate direct transport of STEMI patients without base hospital authorization.
   B. All paramedics must complete at least eight (8) hours of training on the use and interpretation of 12-lead ECG monitors pursuant to ALS Policy 6511a – 12 Lead EKG and have documentation of training on record.
   C. Only patients determined by both symptoms (pursuant to ALS Policy 6511a –12 Lead EKG) and a positive 12-lead EKG STEMI reading by a trained paramedic may be transported directly to a SRC without prior base hospital authorization.
   D. STEMI Patient Destination by County:
      1. In Del Norte County, paramedic identified STEMI patients shall be transported to the closest emergency department that shall consider utilization of thrombolytics as needed, transferring the patient to the closest SRC as soon as possible. A STEMI patient located closer to a designated SRC shall be transported to the SRC.
      2. In Humboldt County, paramedic identified STEMI patients shall be transported to the closest LEMSA designated SRC.
      3. In Lake County, paramedic identified STEMI patients shall be transported directly to the closest local EMS agency (LEMSA) designated SRC located outside of Lake County **ONLY** when transport to that facility will not increase the patient's total ground and/or air transport time to hospital arrival by more than **60 minutes**.
   E. STEMI patients received by a non-SRC shall be transferred to the closest SRC as soon as possible. Administration of thrombolytics shall be considered prior to transfer, particularly when transfer of a STEMI patient to a SRC may be delayed due to uncertainty as to the availability or estimated time of arrival (ETA) of air or ground transport, or marginal or poor weather.

IV. North Coast EMS approval or designation of STEMI Receiving Centers (SRC's):
   A. North Coast EMS approved SRC's are those facilities that have been designated by North Coast EMS pursuant to Policy 2215 – SRC Designation Policy or have been designated by the county or regional LEMSA within which the SRC is located.
   B. North Coast EMS designated SRC's shall enter into a North Coast EMS approved SRC contract and pay associated JPA approved fees.

SUBJECT: Destination for ST-Segment Elevation Myocardial Infarction Patients

V. Procedure:

A. Prehospital patients suffering from chest pain or suspected Acute Coronary Syndrome (ACS) (see Policy 6511a) shall receive prompt 12-lead EKG analysis by a trained paramedic. For patients suffering from chest pain or suspected ACS from a location near a SRC, or in Del Norte County, from a location near a receiving hospital, performance of the field 12-lead EKG may be withheld by joint determination of base hospital and ALS provider provided the receiving hospital is prepared to immediately perform a 12-lead ECG upon ED arrival of the patient.

B. When 12-lead interpretation confirms the presence of a STEMI, transport to the nearest SRC or hospital as indicated in III.C. above.

C. STEMI patients received by a non-SRC shall be transferred to the closest SRC as soon as possible. Administration of thrombolytics shall be considered prior to transfer, particularly when the transfer of STEMI patients from a non-SRC shall be transported to the closest
SRC. Should delays arise during transport preparations or transfer of care to the air transport provider, or should the projected total additional transport time necessary to reach a SRC exceed **60 minutes**, the patient shall immediately be transported to the nearest appropriate hospital and utilization of thrombolytics shall be considered by that facility.

D. Hospital Notification:

1. In Del Norte and Lake Counties, a paramedic who identifies a STEMI patient in the field shall notify the closest ED as soon as possible of pending STEMI patient arrival.
2. In Humboldt County, a paramedic who identifies a STEMI patient in the field shall notify the closest designated SRC located within Humboldt County as soon as possible of pending STEMI patient arrival.

VI. ECG Transmission: North Coast EMS encourages but does not require 12-lead ECG transmission. The base hospital and ALS provider agency shall jointly determine whether or not and, if so, how 12-lead EKGs are transmitted to the receiving hospital. 12-lead EKG transmission is required in Humboldt County as determined by the SRC and ALS providers.

VII. Documentation: **Paramedics who identify a patient with a chest pain suspicious of cardiac origin and/or a suspected STEMI will indicate whether a 12-lead EKG was preformed in the "Conditions" section of the ImageTrend.**

Approved: _____ Date: _____

Approved as to Form: _____ Date: _____

Subject: Patient Care
Destination Determination

I. Philosophy:

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

Authority and Reference (incorporated herein by reference)

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

II. Purpose:

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

II. Policy:

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

Deleted: (this clarifies that the ED MD decides)

Subject: Patient Care
Destination Determination

IV. Considerations:

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

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

C. When the patient is not being transported to the closest facility, and the patient's presentation suggest the need for an immediate physician evaluation upon patient arrival at the receiving facility (e.g. suspected or confirmed STEMI, stroke, major trauma, complications of labor or delivery, ALOC of unkown origin, unstable viatals or unstable airway), the transporting paramedic should provide a patient report to the receiving facility as early as possible."

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

E. Base and Receiving Hospital Responsibilities:

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

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

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

V. Documentation:

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

Approved: _____ Date: _____

Approved as to Form: _____ Date: _____

Deleted: <#>Ambulances should not be unduly removed from their service areas.¶
Formatted: Bullets and Numbering
Deleted: Bypassed or Redirected Receiving
Deleted: E
Deleted: stablish prior contact with receiving
Deleted: to ensure notification and acceptance of patient,
Deleted: . .
Deleted: Once the decision has been made for the bypass or redirection to occur, t
Deleted: must
Deleted: if agreement cannot be reached, we encourage the receiving ED t
Deleted: o accept the Patient and i
Deleted: l
Deleted: p

Subject: SEMS/EOM - Establishment of Operational Area-Wide Situational Awareness **Communications/Reporting Policy**

Associated Policies:

I. **Authority: California Health and Safety Code Section 1797.153 (c. 1-8 & 17)**

A. **Purpose:**

During a widespread emergency the establishment of situational awareness within the operational area is required in order to prioritize the use of limited health and medical human and material resources, and in order to anticipate and communicate OA needs to the Mutual Aid Regional Emergency Operations Center, and the State Emergency Operations Center.

California State Statute and the California State Public Health and Medical Emergency Operations Manual (EOM) designates the Medical Health, Operational Area Coordinator (MHOAC) as responsible for identifying Public Health and Medical needs and communicating those needs to neighboring operational areas, and to State and Federal Authorities through SEMS. The EOA establishes an expectation that the MHOAC will provide an operational area health and medical emergency situation assessment to the Regional Disaster Medical Health Coordinator within two hours of any situation that meets the following criteria:

- *The incident significantly impacts or is anticipated to impact public health or safety;*
- *The incident disrupts or is anticipated to disrupt the Public Health and Medical System;*
- *Resources are needed or anticipated to be needed beyond the capabilities of the Operational Area, including those resources available through existing agreements (day-to-day agreements, memoranda of understanding, or other emergency assistance agreements);*
- *The incident produces media attention or is politically sensitive;*
- *The incident leads to a Regional or State request for information; and/or*
- *Whenever increased information flow from the Operational Area to the State will assist in the management or mitigation of the incident's impact.*

California Public Health and Medical Emergency Operations Manual (EOM) July 2011

The EOM recognizes that, although each individual, agency and institution may be able to assess their own status during a potential disaster, authorities with operational area-wide responsibility cannot know the status of other agencies and institutions unless they have received a status report from those agencies and institutions.

B. In order to establish a common public health and medical "operational picture" within the operational area North Coast EMS **Transport Providers** shall, after discussion with the MHOAC or MHOAC designee,:

Subject: SEMS/EOM - Establishment of Operational Area-Wide Situational Awareness **Communications/Reporting Policy**

Associated Policies:

1. Establish internal policies and procedures to identify the on duty individual responsible for a written agency situational assessment and reporting to the MHOAC within two hours of any of seismic activity, flooding, wildland fire, intentional or unintentional environmental contamination, or other occurrence that:
    a. Generates (or is anticipated to generate) requests for medical or other assistance from the public, (may include mutual aid requests from within or without the county.)
    b. Causes minor to severe injury to agency personnel, or minor to severe damage to agency facilities, vehicles, or equipment.
    c. Degrades agency communications (may include interruption of cell phone communications between agency personnel and their family members.)
    d. Reduces agency staffing (may include agency personnel unable to report for normal duty in order to care for family or prevent the further loss of personnel property).
    e. Impedes the movement of agency assets (e.g. road closures).
    f. Result in circumstances that, in the judgement of the individual with responsibility for overall agency operations, merit the establishment of direct communications with the MHOAC program.
    g. Results in a reporting request from the MHOAC or MHOAC designee.

2. The agency's internal policy should identify the items to be included in the agency's report to the MHOAC*, to include:
    a. The name, job title, and contact information for the agency's reporting individual.
    b. The reason for the report.
    c. Whether, and to what degree, the agency is or anticipates experiencing an increase in ambulance responses.
    d. The type of ambulance requests being received.
    e. The current number of on duty field personnel as compared to routine staffing.
    f. The anticipated number of on duty field positions anticipated to be staffed over the next 24 hours.
    g. The likelihood that this level of staffing can be sustained beyond 48 hours.
    h. The anticipated level of staffing needed over the next 24 hours.
    i. The number of ambulances currently staffed.
    j. The number of ambulances anticipated to be staffed over the next 24 hours.
    k. Whether and the number of currently staffed ambulances are engaged or anticipated to be engaged in mutual aid and where they will be sent.
    l. The likely number of ambulances that the agency could provide for mutual aid within 6 hours of a request.
    m. Current or anticipated shortages in medical supplies.
    n. Current or anticipated degradation in agency communications.

Subject: SEMS/EOM - Establishment of Operational Area-Wide Situational Awareness **Communications/Reporting Policy**

Associated Policies:

o. Any other information considered pertinent by individual responsible for overall agency operations.

C. In order to establish a common public health and medical "operational picture" within the operational area, North Coast EMS **Emergency Departments** within the North Coast EMS shall, after discussion with the MHOAC or MHOAC designee,:

1. Establish internal policies and procedures to identify the on duty individual responsible for a written agency situational assessment and reporting to the MHOAC within two hours of any of seismic activity, flooding, wildland fire, intentional or unintentional environmental contamination, or other occurrence that:
   a. Prompts the hospital's activation of HICS.
   b. Generates (or is anticipated to generate) an increase in the number of patients requiring medical attention or other hospital services.
   c. Causes minor to severe injury to the hospital's personnel or minor to severe damage or to the hospital's facilities, vehicles, or equipment.
   d. Degrades hospital communications (may include interruption of cell phone communications between hospital personnel and their family members.)
   e. Reduces hospital staffing (may include hospital personnel unable to report for normal duty in order to care for family or prevent the further loss of personnel property).
   f. Results in circumstances that, in the judgement of the individual with responsibility for overall hospital operations, merit the establishment of direct communications with the MHOAC program.
   g. Results in a reporting request from the MHOAC or MHOAC designee.

2. The hospital's internal policy should identify the items to be included in the agency's report to the MHOAC*, to include:
   a. The name, job title, and contact information for the hospital's reporting individual.
   b. The reason for the report.
   c. Whether, and to what degree, the hospital is or anticipates experiencing an increase in patients.
   d. The type of increased medical attention or increased demand for other hospital services that the circumstances have generated.
   e. The current number of on duty hospital personnel as compared to routine staffing.
   f. The anticipated number of hospital positions anticipated to be staffed over the next 24 hours.
   g. The likelihood that this level of staffing can be sustained beyond 48 hours.
   h. The anticipated level of staffing needed over the next 24 hours.
   i. Whether and to what extent normal patient to nurse ratios have been altered.

Subject: SEMS/EOM - Establishment of Operational Area-Wide Situational Awareness **Communications/Reporting Policy**

Associated Policies:

j. The number of hospital beds currently staffed.
k. The number of hospital beds anticipated to be staffed over the next 24 hours.
l. Current or anticipated shortages in medical supplies.
m. Current or anticipated degradation in hospital communications.
n. Any other information considered pertinent by individual responsible for overall hospital operations.

D. Internal Provider and Hospital Standardized Emergency Management System (SEMS) Communications Policies should:

1. Designate the on duty position responsible for establishing provider agency or hospital communication with the MHOAC or MHOAC designee.
2. Designate an alternate or secondary on duty position responsible for establishing provider agency or hospital communication with the MHOAC or MHOAC designee in the event that the primary on duty responsible position is unable to complete this responsibility.
3. Describe the primary and secondary means of establishing contact with the MHOAC or MHOAC designee. (i.e. this Standard Operating Procedure could should include telephone, fax, text, or other specific contact information. Contact information should be validated at least annually and during drills or exercises.)
4. Include a form that can be completed and transmitted to the MHOAC or MHOAC designee.
5. Report every two hours or whenever there is a significant change in the circumstances. (The MHOAC or MHOAC designee may request that reporting be done on a different schedule.)

*This list may be modified through written agreement between the EMS transport provider agency or hospital and their MHOAC program. The agreement must be signed by both the EMS transport provider representative and their MHOAC.

Approved: _____ Date: 1/11/2016

Approved as to Form: _____ Date: 1/11/2016

Subject: Scope of Practice/Procedure - ALS
Benzodiazepines

Associated Policies:

I. Indications
- A. Sustained and/or recurrent grand mal seizures.
- B. Before cardioversion or transcutaneous pacing in conscious patients.
- C. As an adjunct for severe pain control - Midazolam ONLY
- D. Management of the combative patient - Midazolam ONLY

II. Therapeutic Effects
- A. Decreased cerebral irritability
- B. Relaxes skeletal muscles
- C. Sedation

III. Contraindications
- A. Absolute:
  1. Suspected or know allergy to Benzodiazepines.
- B. Relative:
  1. Shock
  2. Pregnancy
  3. Trauma to rectum (for rectal administration).
  4. Congenital or surgical anomaly of the rectum (for rectal administration)

IV. Adverse Effects
- A. Respiratory depression or arrest may be caused or worsened by Benzodiazepines.
- B. Drowsiness, vertigo, ataxia, transient hypotension
- C. Rectal injury may occur due to forceful entry of the syringe
- D. Inadequate absorption, following rectal administration

V. Administration of Diazepam
- A. Adult:
  1. 2.5-20 mg IV push in 2.5 mg increments titrated to effect. May give up to 40mg in status epilepticus. 5-10 mg IM.
- B. Pediatric:
  0.1-0.3 mg/kg slow IV push or 0.5 mg/kg (maximum dose 20mg) rectally.

VI. Administration of Midazolam
- A. Adult:
  1. IV: 1-2.5 mg slow IV (over 2-3 min); may be repeated if necessary in small increments (total maximum dose to 0.1 mg/kg not to exceed 10 mg)
  2. IM: 5 mg (0.07 mg/kg) IM
  3. IN: 5 mg – 10 mg maximum 1 cc volume each nostril if agency approved.

Subject: Scope of Practice/Procedure - ALS
Benzodiazepines

Associated Policies:

B. Pediatric:
   1. IV .05 mg/kg not to exceed 5 mg per dose or 10 mg total.
   2. IM 0.1 mg/kg. Further doses up to .4 mg/kg. No single dose to exceed 5 mg or 10 mg total.
   3. IN: 0.1mg/kg with maximum volume of 1cc each nostril with agency approved.

VII. Administration of Lorazepam (Ativan)
A. Adult:
   1. 2 mg IV slow (over 1-2 minutes) every 5 minutes until seizures stop to a maximum of 8mg.
B. Pediatric:
   1. Seizures: 0.1mg/kg slow IV. May repeat dose once. Additional doses requires Base Contact. Maximum single dose of 2mg.
   2. Cardioversion: 0.05mg/kg slow IV.

VII. Special Information
A. Never give without resuscitation equipment available
B. Push as close to the hub as possible as Benzodiazepines may precipitate if mixed with other drugs or IV solutions.
C. Effects of Benzodiazepines potentiated with alcohol and other sedatives.
D. Painful upon IM administration, unpredictable absorption.
E. Do not inject a single IM dose of more than 2 cc. Any dose greater than 2 cc should be administered in multiple injections.

Approved: _____ Date: _____

Approved as to Form: _____ Date: _____

NORTH COAST EMERGENCY MEDICAL SERVICES

EDAP STANDARDS FOR NON-METROPOLITAN AREAS LEVEL I

DEFINITION: An Emergency Department Approved for Pediatrics (EDAP) is a licensed basic Emergency Department(ED) that meets the requirements of a basic Emergency Department identified in Title 22, Division 5, 70413(m) (1)-(6) and 70415(c) (d) (e) and meets specific minimum standards in order to provide emergency pediatric care.

(A hospital unable to meet these licensing standards due to geographic isolation or small size may become an EDAP Level II. This facility may be a certified Base Hospital or a secondary or tertiary receiving facility providing definitive care to pediatric patients. Cases beyond the level of staffing and equipment available at the EDAP Level II hospital will be transferred, pursuant to written transfer agreements to an appropriate Base or Receiving hospital.)

For the purposes of this program, pediatric patients are defined as those between birth and 14 years of age.

The specific professional staff and equipment standards for an EDAP Level I are as follows:

STANDARDS FOR LEVEL I

SECTION A: PROFESSIONAL STAFF: PHYSICIANS

Standard 1.1 At least 50% of the ED coverage shall be provided by physicians
1) board certified in either Emergency Medicine, Pediatrics or Family Practice, or
2) qualified to sit for the certifying exam in Emergency Medicine, or
3) board prepared in Emergency Medicine, Pediatrics, or Family Practice (completion within three years.)

Standard 1.2 All emergency physicians, who are not Board certified or Board eligible, shall successfully complete and maintain Advanced Cardiac Life Support (ACLS) certification. New Physicians shall complete ACLS within 3 months of employment in the ED. All physicians who are not Board Certified or Board eligible in Emergency Medicine, Pediatrics, or Family Practice, shall successfully complete the Advanced Pediatric Life Support (APLS) or the Pediatric Advance Life Support (PALS) courses within 12 months of the recognition of the facility as an EDAP. New physicians must obtain this certification within 6 months of employment. (Completion of the Advanced Trauma Life Support (ATLS) course is also recommended.) Hospitals with contract emergency physician groups may specify by contract the necessity of the completion of the above requirements, if necessary.

Standard 1.25 All mid-level practitioners (Physician Assistants, Nurse Practitioners) regularly assigned to the ED and who care for pediatric patients should demonstrate current completion of PALS, APLS, ENPC or other equivalent

pediatric emergency care course. In addition, complete pediatric competency evaluations that are age specific and include neonates, infants, children and adolescents as required by local credentialing.

Standard 1.3 All Emergency Physicians must have documentation of completion of 4 hours of CME in pediatric topics annually.

Standard 1.4 A physician who is board certified in Pediatrics shall be on call 24 hours/day to the EDAP. Telemedicine may fulfill the 24/7 pediatric consultant requirement along with a written, approved protocol/policy defining this practice for ED providers.

Standard 1.5 A Pediatrician shall be involved in reviewing pediatric QA data. The Quality Assurance review shall include but not be limited to all the data compiled by the hospital Pediatric Liaison Nurse (see Standard 2.5.2).

SECTION B: PROFESSIONAL STAFF: NURSING

Standard 2.1 All Registered Nurses (RNs) shall have successfully completed the AHA ACLS Provider course. New nurses shall complete the ACLS provider training program within three months from date of employment. Successful completion of AHA PALS course, ENPC or other equivalent pediatric emergency care nursing course. is recommended within 12 months for all ED nurses.

Standard 2.2 At least 4 hours of BRN approved nursing CE shall be offered to ED staff nurses, in emergency pediatrics annually, by interactive instruction or self paced format.

Standard 2.3 All nurses regularly assigned to the ED shall complete a minimum of 4 contact hours of a BRN approved pediatric continuing education annually.

Standard 2.4 One RN per shift in the ED shall have completed at least 8 hours of CE in pediatric emergency or critical care within the last 2 years. This may be waived for RNs with either 2 years full time experience in an ED that sees children, or 1 year full time experience in a designated pediatric department or ward, ICU, or pediatric emergency department, all within the last 5 years.

Standard 2.5 A Pediatric Liaison Nurse (PDLN) shall be designated. This nurse may be shared between institutions and may be employed in other areas of the hospital such as ward, ICU, nursery, or Quality Assurance. The PDLN shall complete 8 hours of continuing education in pediatric topics annually and shall obtain and maintain certification in PALS, ENPC or other equivalent pediatric emergency care nursing course within 12 months of assuming the position of PDLN. Duties of the PDLN may be incorporated into existing Quality Assurance and Emergency Department review activities. Responsibilities of the PDLN include:

2.5.1 Ensuring and documenting ED nurse pediatric continuing education.

2.5.2 Maintaining a log and coordinating criteria-based review and follow-up of a sample of pediatric emergency visits. This sample shall include:

A) Emergency Department pediatric deaths.
B) Pediatric deaths within 48 hours of admit from ED or visit to ED,

C) At least 25% of all pediatric admits from the ED, including all:
    1) Admits to critical care areas (ICU, OR, Pediatric Ward)
    2) Major trauma
    3) Meningitis
    4) Admits occurring within 48 hours of ED visit, if known.
D) All transfers from ED
E) Child maltreatment cases.
F) At least 5% of pediatric ED visits not resulting in admit or transfer, selected at random.

2.5.3 A mechanism to provide for integration of findings from QI process and reviews into education and clinical competency evaluations of ED staff.

2.5.4 Coordination of the review of ALS/LALS transported pediatric cases with the Prehospital Nurse Coordinator in hospitals where the EDAP is also the Base Hospital; including tape reviews of pediatric ambulance runs.

Standard 2.6 Support Services

2.6.1 Respiratory Care Practitioners: Optimal Staffing:
A) At least one in-house 24 hours/day.
B) Educated in PALS or APLS.
C) Completion of 4 hours of pediatric related CE's every 2 years.

Radiology
A) Radiologist on call and promptly available 24 hours/day.
B) Radiology technician on call and promptly available 24 hours/day.
C) CT technician on call and promptly available 24 hours/day.

Laboratory
A) Lab technician in house 24 hours/day.
B) Clinical lab capabilities in-house or access to the following:
    1. Chemistry.
    2. Hematology.
    3. Blood Bank.
    4. Microbiology.
    5. Toxicology.

SECTION C: POLICIES AND PROCEDURES

Standard 3.1 Policies/procedures and current transfer agreements concerning the transfer of critically ill and injured patients to Pediatric Critical Care Centers shall be on file in the ED.

Standard 3.2 Policies/procedures for the identification, evaluation and referral of victims of suspected child abuse shall be on file in the ED.

Standard 3.3 Policies/procedures for pediatric care include the following:

1. Medical triage.
2. General assessment, including pain assessment and treatment.
3. Safety.
4. Physical or chemical restraint.
5. Consent (including situations in which a parent is not immediately available).
6. DNR orders.
7. Death in the ED to include SIDS and care of the grieving family.
8. Procedural sedation.
9. Radiation dosage protocol.
10. Diagnosis or conditions which mandate a pediatric consult.
11. Scheduled resuscitation medication and supply inventory check.
12. Mental health emergencies.
13. Family centered care, including family presence during care.
14. Communication with patient's primary health care provider.
15. Disaster preparedness plan that addresses the following pediatric issues:
    a. A plan to minimize parent-child separation and improved methods for reuniting separated children with their families.
    b. A plan that addresses pediatric surge capacity for both injured and non-injured children.
    c. A plan that includes access to specific medical and mental health therapies, as well as social services, for children in the event of a disaster.
    d. A plan which ensures that disaster drills include a pediatric mass casualty incident at least once every 2 years.
    e. Decontamination
16. Medication Safety.

SECTION D: EQUIPMENT, TRAYS, AND SUPPLIES

EQUIPMENT: (General)

Standard 4.0 Pediatric crash cart to store indicated supplies in an organized and accessible manner.

Standard 4.1 Cervical spine immobilization devices: sandbags for children 6 years and under. Rigid four-post or plastic/Velcro collars for children over 6 years of age in at least one pediatric size

Standard 4.2 A mechanism by which to immobilize and apply traction to suspected or diagnosed femur fractures in children.

Standard 4.3 IV Blood/fluid warmer.

Standard 4.4 An infant warming procedure/device (may be stored elsewhere in the facility and readily available to the ED).

Standard 4.5 Pediatric scale in kilograms.

Standard 4.6 An appropriate procedure/device for ensuring pediatric restraint.

Standard 4.7 Pediatric length based dosing tape (i.e. Broselow).

Standard 4.8 Pain Scale assessment tools appropriate for age.

EQUIPMENT: (Monitoring)

Standard 4.8 Blood pressure cuffs: infant, child, adult and thigh size.

Standard 4.9 Doppler sensing device for blood pressure measurement.

Standard 4.10 Monitor-defibrillator with 0-360 Watt/sec capability.

Standard 4.11 Hypothermia thermometer.

Standard 4.12 Pulse oximeter.

Standard 4.13 End tidal CO2 detector.

EQUIPMENT: (Respiratory)

Standard 4.14 Pediatric bag-valve resuscitation device.

Standard 4.15 **Preemie**, infant, child, and adult size transparent masks to use with bag-valve device.

Standard 4.16 **Laryngoscope** with infant and child blades, curved (2,3) and straight (sizes 0-3).

Standard 4.17 **Pediatric** Magill forceps.

Standard 4.18 **Pediatric** oral airways (sizes 50mm-80mm).

Standard 4.19 ET tubes (sizes 2.5-5.5 cuffed or uncuffed, 6.0-9.0 cuffed) with pedi stylets.

Standard 4.20 Feeding tubes (5, 8 Fr).

Standard 4.21 Clear oxygen masks (standard and non-rebreathing) for an infant, child.

Standard 4.22 Nasal cannulae (infant, child).

Standard 4.23 Nasogastric tubes (infant, child).

EQUIPMENT: (Vascular Access)

Standard 4.24 Arm boards (infant, child)

Standard 4.25 IV catheters (22g, 24g)

Standard 4.30 **Infusion** pumps, drip or volumetric.

Standard 4.31 **Pediatric** intraosseous needles.

Standard 4.32 Stopcocks.

Standard 4.33 Umbilical vein catheters.

TRAYS:

Standard 4.34 Pediatric tracheostomy tray with tracheostomy tubes (sizes 3-5mm).

Standard 4.35 Difficult airway supplies/kit to include: Set-up for needle cricothyrotomy (A 3.5 Portex adapter and 14 angiocath is acceptable).

Standard 4.36 Venesection tray appropriate for infants and children.

Standard 4.37 Pediatric lumbar puncture trays with 22 gauge, 1.5 inch spinal needle.

Standard 4.38 Urinary catheterization tray with catheters (8-22 Fr.).

Standard 4.39 Chest Tube Insertion Tray

SUPPLIES:

Standard 4.40 Chest tubes sizes 16-28 Fr; size 26 is unavailable.

Standard 4.41 Pediatric suction catheters (sizes 8-12 Fr.).

Standard 4.42 Central venous catheters (pediatric).

MEDICATIONS:

Resuscitation medications as per the American Heart Association PALS guidelines.

IV solutions to include: NS; D5.45NS; and D10W.

NORTH COAST EMERGENCY MEDICAL SERVICES

EDAP STANDARDS
FOR NON-METROPOLITAN AREAS
LEVEL II

DEFINITION: An Emergency Department Approved for Pediatrics (EDAP) is a licensed basic Emergency Department (ED), or a standby Emergency Department that meets the requirements of a basic Emergency Department identified in Title 22, Division 5, 70413(m) (1)-(6) and 70415 (c) (d) (e) and meets specific minimum standards in order to provide emergency pediatric care.

An EDAP Level II facility may be a certified Base Hospital or a secondary or tertiary receiving facility providing definitive care to pediatric patients. Cases beyond the level of staffing and equipment available at the EDAP Level II hospital will be transferred, pursuant to written transfer agreements, to an appropriate Base or Receiving hospital.

For the purposes of this program, pediatric patients are defined as those between birth and 14 years of age.

The specific professional staff and equipment standards for an EDAP Level II are as follows:

STANDARDS FOR EDAP LEVEL II

SECTION A. PROFESSIONAL STAFF: PHYSICIANS

Standard 1.1 At least 50% of the ED coverage shall be provided by physicians
1) board certified in either Emergency Medicine, Pediatrics or Family Practice, or
2) qualified to sit for the certifying exam in Emergency Medicine, or
3) board prepared in Emergency Medicine, Pediatrics, or Family Practice (completion within three years.)

Standard 1.2 All emergency physicians, who are not Board certified or Board eligible, shall successfully complete and maintain Advanced Cardiac Life Support (ACLS) certification. New physicians shall complete ACLS within 3 months of employment in the E.D. All physicians who are not Board Certified or eligible in Emergency Medicine, Pediatrics, or Family Practice, shall successfully complete the Advanced Pediatric Life Support (APLS) or the Pediatric Advanced Life Support (PALS), courses within 12 months of the recognition of the facility as an EDAP. New Physicians must obtain this certification within 6 months of employment. (Completion of the Advanced Trauma Life Support (ATLS) course is also recommended.) Hospitals with contract emergency physician groups may specify by contract the necessity of the completion of the above requirements, if necessary.

Standard 1.25 All mid-level practitioners (Physician Assistants, Nurse Practitioners)

regularly assigned to the ED and who care for pediatric patients should demonstrate current completion of PALS, APLS, ENPC or other equivalent pediatric emergency care course. In addition, complete pediatric competency evaluations that are age specific and include neonates, infants, children and adolescents as required by local credentialing.

Standard 1.3 All ED M.D.s must maintain at least 4 hours of C.M.E. in pediatrics annually.

Standard 1.4 If the facility is a standby Emergency Department, the Emergency Physicians must have a response time to the facility of 5 minutes or less.

Standard 1.5 The ED must maintain an on-call physician, in addition to the ED M.D. who is promptly available for crisis situations.

Standard 1.6 Backup MD Specialty Services:

1.6.1 There shall be on file in the ED a daily list of pediatricians in nearby communities available for telephone consult. This list shall coincide with the on-call status of the physicians, ensuring their availability by telephone. Telemedicine may fulfill the 24/7 pediatric consultant requirement along with a written, approved protocol/policy defining this practice for ED providers.

1.6.2 The plan should address the availability of specialists to care for pediatric patients, in at least the following specialties: surgery, orthopedics, anesthesiology and neurosurgery.

SECTION B. PROFFESSIONAL STAFF NURSING

Standard 2.1 All ED nurses must maintain ACLS certification. New nurses must obtain ACLS within 3 months of employment. Completion of the PALS course, ENPC or other equivalent pediatric emergency care nursing course.. should be strongly recommended within 12 months of employment for all ED nurses.

Standard 2.2 At least 4 hours B.R.N. Approved nursing C.E. shall be offered to ED nurses on pediatrics related topics annually, either by interactive instruction or by self paced format.

Standard 2.3 All ED nurses shall complete 4 hours of B.R.N. Approved pediatric C.E. annually.

Standard 2.4 One RN per shift in the ED shall have completed at least 8 hours of C.E. in pediatric emergency or critical care within the last 2 years. This may be waived for RNs with either 2 years full time experience in an ED that sees children, or 1 year full time experience in a designated pediatric department or ward, I.C.U., or pediatric emergency department, all within the last five years.

Standard 2.5 A Pediatric Liaison Nurse (PDLN) shall be designated. This nurse may be shared between institutions and may be employed in other areas of the hospital such as a ward, I.C.U., nursery or Quality Assurance. The PDLN shall complete 8 hours of continuing education in pediatric topics annually and shall obtain and maintain certification in PALS, ENPC or other equivalent pediatric emergency care nursing course within 12 months of assuming the position of PDLN. Duties of the PDLN may be incorporated into existing Quality Assurance and Emergency Department review activities. Responsibilities of the PDLN include:

2.5.1 Ensuring and documenting ED nurse pediatric continuing education.

2.5.2 Maintaining a log and coordination criteria-based review and follow-up of a sample of pediatric emergency visits. This sample shall include:
A) Emergency Department pediatric deaths
B) Pediatric deaths within 48 hours of admit from ED or visit to ED, if known.
C) At least 25% of all pediatric admits from the ED, including all:
1) Admits to critical care areas (I.C.U., O.R., Pediatric ward).
2) Major trauma
3) Meningitis
4) Admits occurring within 48 hours of ED visit.
5) Child Abuse cases.
D) All transfers from ED.
E) Child maltreatment cases.
F) At least 5% of all emergency pediatric visits not included in the above criteria.

2.5.3 A mechanism to provide for intregration of findings from QI process and reviews into education and clinical competency evaluations of ED staff.

2.5.4 Coordination of the review of ALS/LALS transported pediatric cases with the Prehospital Care Nurse Coordinator in hospitals where the EDAP is also the Base Hospital; including tape reviews of pediatric runs.

Standard 2.6 Support Services

2.6.1 Respiratory Care Practitioners: Optimal Staffing:
A) At least one in-house 24 hours/day.
B) Educated in PALS or APLS.
C) Completion of 4 hours of pediatric related CE's every 2 years.

Radiology
D) Radiologist on call and promptly available 24 hours/day.
E) Radiology technician on call and promptly available 24 hours/day.

F) CT technician on call and promptly available 24 hours/day.

Laboratory

C) Lab technician available or on-call 24 hours/day.

D) Clinical lab capabilities in-house or access to the following:

1. Chemistry.
2. Hematology.
3. Blood Bank.
4. Microbiology.
5. Toxicology.

SECTION C. POLICIES AND PROCEDURES

Standard 3.1 There shall be on file in the ED a daily list of pediatricians in a nearby community available for telephone consult. This list shall coincide with the on call status of the physicians, ensuring their availability by telephone.

Standard 3.2 There shall be in house policies and procedures, and a current transfer agreement, with a pediatric critical care center (or PICU) on the file in the ED for the transfer of critically ill or injured children.

Standard 3.3 There shall be a policy and procedure on file in the ED concerning the management of suspected child abuse.

Standard 3.4 Policies/procedures for pediatric care include the following:

1. Medical triage.
2. General assessment, including pain assessment and treatment.
3. Safety.
4. Physical or chemical restraint.
5. Consent (including situations in which a parent is not immediately available).
6. DNR orders.
7. Death in the ED to include SIDS and care of the grieving family.
8. Procedural sedation.
9. Radiation dosage protocol.
10. Diagnosis or conditions which mandate a pediatric consult.
11. Scheduled resuscitation medication and supply inventory check.
12. Mental health emergencies.
13. Family centered care, including family presence during care.
14. Communication with patient's primary health care provider.
15. Disaster preparedness plan that addresses the following pediatric issues:
    a. A plan to minimize parent-child separation and improved methods for reuniting separated children with their families.
    b. A plan that addresses pediatric surge capacity for both injured and non-injured children.

c. A plan that includes access to specific medical and mental health therapies, as well as social services, for children in the event of a disaster.
d. A plan which ensures that disaster drills include a pediatric mass casualty incident at least once every 2 years.
e. Decontamination

16. Medication Safety.

SECTION D: EQUIPMENT, TRAYS, AND SUPPLIES

EQUIPMENT: (General)

Standard 4.0 Pediatric crash cart to store indicated supplies in an organized and accessible manner.

Standard 4.1 Cervical spine immobilization devices: sandbags for children 6 years and under. Rigid four-post or plastic/Velcro collars for children over 6 years of age in at least one pediatric size

.

Standard 4.2 A mechanism by which to immobilize and apply traction to suspected or diagnosed femur fractures in children.

Standard 4.3 Blood warmer.

Standard 4.4 An infant warming procedure/device (may be stored elsewhere in the facility and readily available to the ED).

Standard 4.5 Pediatric scale.

Standard 4.6 An appropriate procedure/device for ensuring pediatric restraint.

Standard 4.7 Pediatric length based dosing tape (i.e. Broselow).

Standard 4.8 Pain Scale assessment tools appropriate for age.

EQUIPMENT: (Monitoring)

Standard 4.8 Blood pressure cuffs: infant, child, adult and thigh size.

Standard 4.9 Doppler sensing device for blood pressure measurement.

Standard 4.10 Monitor-defibrillator with 0-360 Watt/sec capability.

Standard 4.11 Hypothermia thermometer.

Standard 4.12 Pulse oximeter.

Standard 4.13 End tidal CO2 detector.

EQUIPMENT: (Respiratory)

Standard 4.14 **Pediatric** bag-valve resuscitation device.

Standard 4.15 **Preemie**, infant, child, and adult size transparent masks to use with bag-valve device.

Standard 4.16 **Laryngoscope** with infant and child blades, curved (2,3) and straight (sizes 0-3).

Standard 4.17 **Pediatric** Magill forceps.

Standard 4.18 **Pediatric** oral airways (sizes 50mm-80mm).

Standard 4.19 ET tubes (sizes 2.5-5.5 cuffed or uncuffed, 6.0-9.0 cuffed) with pedi stylets.

Standard 4.20 Feeding tubes (5, 8 Fr).

Standard 4.21 Clear oxygen masks (standard and non-rebreathing) for an infant, child.

Standard 4.22 Nasal cannulae (infant, child).

Standard 4.23 Nasogastric tubes (infant, child).

EQUIPMENT: (Vascular Access)

Standard 4.24 Arm boards (infant, child)

Standard 4.25 IV catheters (22g, 24g)

Standard 4.30 Infusion pumps, drip or volumetric.

Standard 4.31 Pediatric intraosseous needles.

Standard 4.32 Stopcocks.

Standard 4.33 Umbilical vein catheters.

TRAYS:

Standard 4.34 Pediatric tracheostomy tray with tracheostomy tubes (sizes 3-5mm).

Standard 4.35 Difficult airway supplies/kit to include: Set-up for needle cricothyrotomy (A 3.5 Portex adapter and 14 angiocath is acceptable).

Standard 4.36 Venesection tray appropriate for infants and children..

Standard 4.37 Pediatric lumbar puncture trays with 22 gauge, 1.5 inch spinal needle.

Standard 4.38 Urinary catheterization tray with catheters (8-22 Fr.).

SUPPLIES:

Standard 4.39 Chest tubes sizes 16-28 Fr; size 26 is unavailable.

Standard 4.40 Pediatric suction catheters (sizes 8-12 Fr.).

Standard 4.41 Central venous catheters (pediatric).

MEDICATIONS:

Resuscitation medications as per the American Heart Association PALS guidelines.

IV solutions to include: NS; D5.45NS; and D10W.

North Coast EMS
3340 Glenwood Street
Eureka, CA 95503

Agreement # C15-007

1st Quarter Report
July 1, 2015 to September 30, 2015

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

Component 1 - System Organization and Management

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

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

- Staff development, training, and management

North Coast EMS personnel attended or participated in the following state EMS activities including: state EMS for Children meetings, EMSAAC Legislative Committee calls, EMSA/LEMSA call, Redwood Mednet HIE Conference, EMSA NEMSIS Version 3 Sacramento Workshop, EMSAAC QIP Coordinator calls and meetings, EMSAAC Conference and meeting, EMSAAC meeting – 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) meeting, Lake County fire related events, EMSC TACTICAL meetings and calls, federal SPROC calls, Health Information Exchange meetings and calls, Humboldt County Child Death Review Team meetings, Humboldt County Child Passenger Safety Committee meeting, Humboldt County Fire Chiefs Association meetings, Emergency Preparedness and HPP Disaster related meetings and calls, Exclusive Operating Area meetings and calls, STEMI Receiving Center site visit, meetings and calls, Shasta Med Center tour, fiscal audit, and other meetings.

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

North Coast EMS received JPA Board approval to upgrade the office computer system, including Firewall, server installation, new staff computers, etc.

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

The State General Fund fourth quarter progress report was submitted to EMSA. The Regional EMS Plan and QIP Plan were approved by EMSA. EMSC, HPP and HIE reports were submitted to HRSA, CDPH and EMSA.

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

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

  North Coast EMS staff attended the EMSAAC meeting in San Diego.

Component 2 - Staffing and Training

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

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

- Ongoing assessment of local training program needs

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

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

  North Coast EMS has numerous approved training programs that have been verified to meet or exceed state minimum standards, including curriculum requirements. These programs include: First Responder, EMT-I, Paramedic, MICN, continuing education, etc. We also developed new policies to implement the revised Public Safety regulations and later, plan replace the First Responder program with national Emergency Medical Responder program.

- Providing training programs and classes (as needed)

  Nothing new this quarter.

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

  North Coast EMS issues numerous EMT-I certifications, paramedic accreditations and MICN authorizations annually. We have policies specific to BLS and ALS scope of practice and numerous continuously updated protocols and policies specific to the EMT-I and EMT-P scope of practice.

- Developing and maintaining treatment protocols for all certification levels

  North Coast EMS has numerous policies specific to the BLS and ALS scope of practice and continuously updates protocols and policies specific to the EMT-I and EMT-P scope of practice. We are continue to work to establish a regional Policy Review Committee which will, as possible, convene using video conferencing to ensure routine review and revision of North Coast EMS clinical policies.

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

  North Coast EMS has extensive QI policies and the updated QIP Plan was approved by the EMSA for approval. We previously approved base hospital and ALS Providers QIP Plans and require all approved ALS providers and designated base hospitals to submit quarterly QIP reports summarizing activities in each of the QIP regulation required categories. We also select a focused review topic each quarter. In the past hospital and provider QI liaisons routinely used the our regional electronic prehospital care reporting management tool, which was simple and intuitive, to conduct prepare their QI reports. Despite many advantages, our new electronic PCR reporting systems reporting tools require greater IT expertise to use, and this has posed a barrier for our agency, hospital and provider QI reporting activities. With generous HIE support from EMSA, we have initiated an effort to build an electronic reporting system that will allow our agency, our hospitals, and our providers to carry out our reporting activities as we have in the past.

- Conducting investigations and taking action against certification when indicated

  One investigation was requested this quarter and is under base hospital review.

- Providing personnel recognition programs for exemplary service

  North Coast EMS drafted a generic outstanding service recognition letter.

- Authorizing, maintaining, and evaluating EMS continuing education programs

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

Other: The Agency currently has 1 approved Paramedic, 1 approved MICN, five 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 also continue to assess Community Paramedic Program developments within California and have implemented the revised 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

  North Coast EMS endorsed a plan to replace the Pratt Med Net Mt Repeater antenna and evaluate the Rogers Mt Mountain Repeater.

- Assuring appropriate maintenance of communications systems integrity

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

- Approving ambulance dispatch centers

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

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

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

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

  Implemented EMD Motor Vehicle Crash response policy change.

Component 4 - Response and Transportation

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

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

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

North Coast EMS designates First Responder training programs (see 2.1 above) Each County Board of Supervisors permits or contracts with ambulance providers and North Coast EMS continued drafting a Humboldt County Transportation Plan (HCTP) that will include grandfathered Exclusive Operating Areas if approved by EMSA. The North Coast EMS JPA Governing Board approved a Resolution supporting this HCTP, including Inter-facility Transfer (IFT), and the Plan is being finalize now. North Coast EMS is also conducting an assessment of EOA eligibility for grandfathering of IFTs in the Eureka and Arcata zones. All ambulance providers, four non-transporting providers and one fixed wing aircraft provider are North Coast EMS designated ALS Providers. North Coast EMS has policies and MOUs specific to in- and out-of-area EMS helicopters.

- Enforcing local ordinances

North Coast EMS works closely with each county to assist with assessment and evaluation of designated transport ALS Providers as part of the QI program. We plan to work with Humboldt County to assess a potential shift in Ordinance oversight to North Coast EMS.

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

North Coast EMS has established and periodically updates policies and procedures for the transportation of patients to trauma and other specialty centers as needed. See our website (Northcoastems.com) for our Patient Destination and Trauma Patient Destination Policies. We also continued to assist with the assessment and resolution of IFT related issues in each county and are in the process of updating the STEMI Patient Destination Policy for Humboldt County.

- Implementing and maintaining contracts with providers

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

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

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

- Creating exclusive operating areas

North Coast EMS has no EOAs at this time but is in the process of developing a Humboldt County Transportation Plan (see above) to create two non-competitive EOAs within Humboldt County.

- Inspecting ambulance or LALS/ALS providers

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

- Developing performance standards as needed

  We are considering adding Oral Glucose and Epinephrine but this effort is on hold due to other priorities. Authorized ALS Providers and designated Base Hospitals continue to submit quarterly QIP reports with a pre-selected relevant quarterly focus determined by NCEMS. We are planning to develop ambulance performance standards associated with the Humboldt County Transportation Plan.

Component 5 - Facilities and Critical Care

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

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

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

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

- Identifying ambulance receiving centers including hospitals and alternative receiving facilities

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

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

  Please see the annual Trauma Plan update approved last quarter. Two Level IV trauma centers are designated, one in Del Norte and the other in Lake County. One or more trauma centers need to be designated in Humboldt County and there is recent interest in requesting designation by St Joseph Hospital in Eureka. North Coast EMS is in the process of designating SJH as a STEMI Receiving Center and plans to complete this process before proceeding with designation of trauma centers. All seven hospitals are EDAP designated and site visits are planned for this fiscal year, as is a Trauma Center site visit in Lake County. We also received the certificate of designation of Sutter-Coast Hospital from Oregon as a Level IV Trauma Center and recently participated in a tour of Shasta Regional Medical Center in Redding as they are receiving more transfers from our region.

- 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 from Sutter-Coast Hospital. See above, but we are excited about renewed interest in Trauma Center designation by SJH.

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

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

- 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 to designated EDAPs, completed the third year of the EMSC TACTICAL Regionalization program with UCD and executed the fourth year subcontract. The Pediatric data collection was completed and a preliminary analysis conducted and reported in the most recent EMSC newsletter. All EDAPs will be reassessed this year, as will the Lake County Trauma Center. North Coast EMS EDAP standards currently meet draft EMSC regulation standards for Pediatric Receiving Centers, and we recently added use of Telemedicine into the policies.

  The STEMI Receiving Center site visit with outside experts was conducted in August at SJH and the report, and contract, are being prepared. Sutter-Lakeside Hospital is now a certified stroke center and we will continue to evaluate potential catchment area changes if needed. Also, the Humboldt County Health Officer endorsed implementation of a stroke program prior to proceeding with trauma center designation.

  The 5150 Handbook is available on our web site – North Coast EMS.com.

- Completing hospital closure impact reports

  None were requested or completed in this quarter. Sutter-Coast Hospital discontinued evaluation of Critical Access Hospital designation.

Component 6 - Data Collection and System Evaluation

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

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

- Reviewing reportable incidents

North Coast EMS reviews all discovered or received reportable incidents. During the fourth quarter we took no formal action and reviewed no cases.

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

The North Coast EMS Image Trend PCR program housed at ICEMA continues to provide EMS data to the State and the HIE QI Discovery contract was completed. The NEMSIS Version 3 upgrade will be delayed until 2017. North Coast EMS anticipated that the NEMSIS 3 compliant version of ImageTrend would go live this past spring, and the delay in launching of NEMSIS Version 3 limited the special grant project work that our contractor could accomplish in building a new management module compatible with the NEMSIS Version 3 compliant ImageTrend electronic PCR reporting system. We were, however, able to lay the groundwork for this objective, and, provided we are able to secure funding to continue this work, we should be well prepared to complete the agency version of the PCR reporting module once the NEMSIS Version 3 version of Image Trend becomes available.E-PCRs are available for review by assigned base hospital, ALS provider and North Coast EMS personnel for routine or special review. We discontinued review of AED reports as this requirement has been discontinued by the EMSA. We receive and review REACH aero medical transports occurring in Lake County, CEMSIS-Trauma data from Sutter-Lakeside and Sutter-Coast Hospitals, internship records for periodic review, and disclosure protected case review is conducted as needed. Trauma Registry reports continue to have intermittent transmission problems and we are working to resolve those. We also continued to transmit CEMSIS – EMS data to the EMSA, including the state required Cores Measures Report.

- Processing and investigating quality assurance/improvement incident reports

During this quarter we conducted no QI reviews but directed a request for case review to one of our base hospitals. 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. 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 received QIP Plan approval from the EMSA.

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

North Coast EMS submitted the Core Measure data as required last year.

- 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 is proceeding with plans to implement the 3.X program but this will likely be delayed until 2017.

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

  Policies and procedures to approve Public Safety training programs pursuant to the revised state regulations have been implemented. North Coast EMS approved Public Safety training programs will include CPR and first aid training.

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

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

- Availability of information to assist the population in catastrophic events

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

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

  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 state, regional and local disaster planning meetings and drills. This year's HPP multi-county LEMSA objectives include focus on planning and training EMS personnel in the transition from a single incident MCI to a disaster response. North Coast EMS has, over the past two HPP funding cycles, engaged system participants in discussion regarding an OA (county) specific concept of operations for disaster response, including operational integration with the MHOAC disaster planning and response program. These discussions have led to the development of NCEMS hospital and provider disaster preparedness and SEMS/EOM

communications and reporting policy. These policies, as well as OA (county) specific SOPs will form the basis of this year's training objectives. Similarly, the last two years of EMS community and MHOAC program discussions and planning for a possible Ebola patient or patients will form the basis for achieving the Ebola or other highly pathogenic diseases suspected patient transportation plans, targeted by this year's HPP multi-county LEMSA objectives.

- 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. North Coast EMS executed the CDPH HPP contract and plans to carry out targeted goals. The EMSC Regionalization Project also targeted enhanced preparedness for pediatric patients during special events.

- Coordinating the operational area disaster medical/health coordinator

  North Coast EMS staff and HHP contractors coordinated with the RDMHC in each county, attended meetings, participated in local, state and regional Medical Disaster meetings and events. This included verification of the local process used to prepare for the return of a health care worker returning from an Ebola impacted country to Humboldt County. Staff also assisted Lake County and other areas of the region during recent fires by allowing outside resources to come in while encouraging use of mutual aid. The North Coast EMS Regional Disaster Planning Coordinator visited Lake EOCs established for the Rocky and Valley Fires, monitored Lake County ambulance activity, consulted with MHOAC program representatives, attended EOC meetings, attended a Sutter Lakeside Hospital HICS meeting, and reviewed medical assistance being rendered at various Lake County evacuation centers.

- Coordinating the regional disaster medical/health coordinator system

  See above.

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

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

- Facilitating mutual aid agreements

  North Coast EMS has facilitated development of mutual aid agreements for decades and all ambulance providers have mutual aid arrangements with surrounding providers. We also recently endorsed activation of outside fire and ambulance resources according to existing mutual aid policies.

- 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 # C15-007

2nd Quarter Report
October 1, 2015- December 31, 2015

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

Component 1 - System Organization and Management

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

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

- Staff development, training, and management

North Coast EMS personnel attended or participated in the following state EMS activities including: EMSAAC and Awards Luncheon in San Francisco, EMSA/LEMSA meeting in Sacramento, EMSAAC QIP Coordinator calls and meetings. EMSAAC Conference Planning call, EMSC Conference Sacramento, EMSA/Regions call (re: #104 document review), STEMI regulation conference calls and meeting in Sacramento, CDPH Capabilities Workshops and EPO meeting in Sacramento, Region II MHOAC meeting in San Leandro ; 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) meeting, Lake County Inter-facility transfer meeting, EMSC TACTICAL calls, federal SPROC call, EDAP site visits Redwood Memorial and St Joseph Hospital, Health Information Exchange meetings and calls, Regional Policy Review meeting, Humboldt Radio User Group meeting, Humboldt County Child Death Review Team meetings, Humboldt County Child Passenger Safety Committee meeting, Humboldt County Fire Chiefs Association meetings, Emergency Preparedness and HPP Disaster related meetings and calls and other meetings.

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

North Coast EMS upgraded the office computer system, including Firewall, server installation, new staff computers, etc.

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

We executed and/or continued administrative contracts with: EMSA General Fund, JPA member counties, the EMSA, UCD for the federal EMS for Children TACTICAL REGIONALIZATION program (Year Four) including EMSC rollover funds, and the HIE Discovery contract with EMSA; Dr. Stiver as Regional Medical Director, Pam Mather as EDAP and Trauma Coordinator, ePCR IT programmer Jay Myhre, Ezequiel Sandoval - Office IT, Moss, Levy and Hartzhiems - fiscal audit, Stayce Curry - Regional Mental Health contractor, Kayce Hurd – Paramedic and EMT policy revisions, Dennis Louy, Tina Wood (and continuing education for Hoopa), Kimberly Miinch - County HPP Disaster Liaisons, Selinda Shontz – STEMI, Matt Dennis – Public Safety and EMR policy development; Keith Taylor, EMSC Cultural Liaison; Humboldt County Counsel; ICEMA – Image Trend management; Rick Narad – EMS Plan consultation; TempDev, Inc. - HIE Discovery project, and Coats web site design. The Regional HPP Disaster contract with CDPH has not yet been executed due to turn over and revised process at CDPH; the mid-year progress report is being drafted at this time. 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, seven EDAPs and two Trauma Centers. We also completed EMSC related data collection at five of seven hospitals (i.e., Sutter-Coast, Mad River, Jerold Phelps, Sutter-Lakeside and St Helena Clearlake) and are currently working with UCD representatives to prepare an peer reviewed article. 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 – this item will be dropped from future reports unless something changes. We conducted EDAP site visits at St Joseph Hospital and Redwood Memorial Hospitals.

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

  North Coast EMS staff attended the EMSAAC meeting in San Francisco and the EMSA/LEMSA meeting in Sacramento.

Component 2 - Staffing and Training

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

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

- Ongoing assessment of local training program needs

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

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

North Coast EMS has numerous approved training programs that have been verified to meet or exceed state minimum standards, including curriculum requirements. These programs include: First Responder, EMT-I, Paramedic, MICN, continuing education, etc. We also implemented new policies specific to the revised Public Safety regulations and later, plan replace the First Responder program with national Emergency Medical Responder program. We received and initiated review of the North Coast EMS approved Paramedic program annual report to CoAEMSP.

- Providing training programs and classes (as needed)

Nothing new this quarter.

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

North Coast EMS issues numerous EMT-I certifications, paramedic accreditations and MICN authorizations annually. We have policies specific to BLS and ALS scope of practice and numerous continuously updated protocols and policies specific to the EMT-I and EMT-P scope of practice. We initiated a process this quarter to accept credit card payment for EMTs, paramedics and MICNs.

- Developing and maintaining treatment protocols for all certification levels

North Coast EMS has numerous policies specific to the BLS and ALS scope of practice and continuously updates protocols and policies specific to the EMT-I and EMT-P scope of practice. We are continue to work to establish a regional Policy Review Committee which will, as possible, convene using video conferencing to ensure routine review and revision of North Coast EMS clinical policies. This quarter we initiated a region-wide process to review protocols and policies with a Policy Review Committee utilizing video conferencing.

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

North Coast EMS has extensive QI policies and the updated QIP Plan was approved by the EMSA for approval. We previously approved base hospital and ALS Providers QIP Plans and require all approved ALS providers and designated base hospitals to submit quarterly QIP reports summarizing activities in each of the QIP regulation required categories. We also select a focused review topic each quarter. In the past hospital and provider QI liaisons routinely used our regional electronic prehospital care reporting management tool, which was simple and intuitive, to conduct prepare their QI reports. Despite many advantages, our new electronic PCR reporting systems reporting tools require greater IT expertise to use, and this has posed a barrier for our agency, hospital and provider QI reporting activities. With HIE grant support from EMSA, we initiated development of an electronic reporting system that will allow our agency, our hospitals, and our providers to carry out our reporting activities as we have in the past. Due to delays in the national implmentation of NEMSIS 3.4 and subsequent delays in the rollout of their NEMSIS Version 3 compliant software by ImageTrend, we were unable to complete this portion of the HIE grant. We are considering submission of a new HIE grant proposal to EMSA next quarter.

- Conducting investigations and taking action against certification when indicated

One investigation was requested this quarter specific to outside use of ambulances during the Lake County fires.

- Providing personnel recognition programs for exemplary service

North Coast EMS drafted a generic outstanding service recognition letter. The North Coast EMS Executive Director received the EMS Administrator of the Year Award.

- Authorizing, maintaining, and evaluating EMS continuing education programs

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

Other: The Agency currently has 1 approved Paramedic, 1 approved MICN, five 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 also continue to assess Community Paramedic Program developments within California and have implemented the revised 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

North Coast EMS endorsed a plan to replace the Pratt Med Net Mt Repeater antenna and evaluate the Rogers Mt Mountain Repeater. We also submitted background information specific to the Med Net System to Humboldt County Public Health and initiated a process to update the EMSA Med Net Frequency information on their website.

- Assuring appropriate maintenance of communications systems integrity

We plan to continue to work with each county, hospital and provider to help ensure future Med Net Communication Systems integrity. A plan to integrate Humboldt County Med Net Repeater maintenance and replacement into the existing North Coast EMS Trust Fund was discussed.

- Approving ambulance dispatch centers

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

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

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

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

Nothing new this quarter.

Component 4 - Response and Transportation

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

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

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

North Coast EMS designates First Responder training programs (see 2.1 above) Each County Board of Supervisors permits or contracts with ambulance providers and North Coast EMS completed and submitted to EMSA a JPA approved Humboldt County Transportation Plan (HCTP) that will include grandfathered Exclusive Operating Areas. If approved by EMSA as written, this will include 9-1-1 and Inter-facility Transfer exclusivity in the Eureka and Arcata zones. All ambulance providers, four non-transporting providers and one fixed wing aircraft provider are North Coast EMS designated ALS Providers. North Coast EMS has policies and MOUs specific to in- and out-of-area EMS helicopters.

- Enforcing local ordinances

North Coast EMS works closely with each county to assist with assessment and evaluation of designated transport ALS Providers as part of the QI program. We plan to work with Humboldt County to assess a potential shift in Ordinance oversight to North Coast EMS.

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

North Coast EMS has established and periodically updates policies and procedures for the transportation of patients to trauma and other specialty centers as needed. See our website (Northcoastems.com) for our Patient Destination and Trauma Patient Destination Policies. We also continued to assist with the assessment and resolution of IFT related issues in each county and are in the process of updating the STEMI Patient Destination Policy for Humboldt County. We also continued review of input received on the Patient Destination and Inter-facility Transfer policies.

- Implementing and maintaining contracts with providers

North Coast EMS has contracts with all approved ALS Providers.

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

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

- Creating exclusive operating areas

  North Coast EMS has no EOAs at this time but this quarter submitted a Humboldt County Transportation Plan (see above) to create two non-competitive EOAs within Humboldt County.

- Inspecting ambulance or LALS/ALS providers

  North Coast EMS delegates ambulance inspections to Base Hospital Prehospital Care Nurse Coordinator (PCNC)s for new ALS providers or for cause.

- Developing performance standards as needed

  We are considering adding Oral Glucose and Epinephrine but this effort is on hold due to other priorities. Authorized ALS Providers and designated Base Hospitals continue, with a few exceptions currently under review, to submit quarterly QIP reports with a pre-selected relevant quarterly focus determined by NCEMS. We are planning to implement ambulance performance standards associated with the Humboldt County Transportation Plan if approved by EMSA.

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

  All seven base hospitals are designated by contract, six as "modified base hospitals" who are no longer required utilize MICNs. We need additional staff time to adequately monitor base hospitals but are currently reviewing past submission of quarterly QIP reports by Base Hospitals.

- Identifying ambulance receiving centers including hospitals and alternative receiving facilities

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

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

  Please see the annual Trauma Plan update approved last year. Two Level IV trauma centers are designated, one in Del Norte and the other in Lake County. One or more trauma centers need to be designated in Humboldt County and there is

recent interest in requesting designation by St Joseph Hospital in Eureka. North Coast EMS is in the process of designating SJH as a STEMI Receiving Center and plans to complete this process before proceeding with designation of trauma centers. All seven hospitals are EDAP designated and two site visits were conducted this quarter and others are planned for this fiscal year, as is a Trauma Center site visit in Lake County.

- 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 from Sutter-Coast Hospital. See above, but we are excited about renewed interest in Trauma Center designation at SJH. The EMSA has also requested and received information on the North Coast EMS Trauma System and statewide rural practices for the upcoming state American College of Surgeons site visit in San Diego. Last year a peer-reviewed article including an assessment of North Coast EMS hospitals was published in the Journal of Emergencies, Trauma and Shock [1 7:]: *A Comparison of Rural versus Urban Trauma Care*, Lipsky et al, January – March 2014 was published. The study demonstrated that rural and urban trauma patients are inherently different. The rural system utilized in this study, with low volume and high blunt trauma rates, can effectively care for its population of trauma patients with an enhanced, committed trauma system, which allows for expeditious movement of patients toward definitive care. The study also demonstrated that after correcting for differences in patient population, the mortality associated with being treated in a rural hospital was not significantly different than an urban trauma center.

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

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

- 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 to designated EDAPs, completed the third year of the EMSC TACTICAL Regionalization program with UCD and executed the fourth year subcontract. The Pediatric data collection was completed and an article for peer review publication is drafted at this time. Prior to publication we hope to expend the data collection process to the remaining two EDAPs. During this quarter we conducted site visits and presented findings to Redwood Memorial and St Joseph Hospitals. All EDAPs will be reassessed this year, as will the Lake County Trauma Center. North Coast EMS EDAP standards currently meet draft EMSC regulation standards for Pediatric

Receiving Centers, and we recently added use of Telemedicine into the policies.

The STEMI Receiving Center site visit follow-up report was distributed to St Joseph Hospital and we are awaiting their response. We also are updating the draft STEMI Patient Destination Policy and during this quarter submitted a revised STEMI Receiving Center contract for review by SJH representatives. Sutter-Lakeside Hospital is now a certified stroke center and we will continue to evaluate potential catchment area changes if needed. Also, the Humboldt County Health Officer endorsed implementation of a stroke program prior to proceeding with trauma center designation.

The 5150 Handbook is available on our web site – North Coast EMS.com.

- Completing hospital closure impact reports

None were requested or completed in this quarter. Sutter-Coast Hospital discontinued evaluation of Critical Access Hospital designation.

Component 6 - Data Collection and System Evaluation

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

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

- Reviewing reportable incidents

North Coast EMS reviews all discovered or received reportable incidents. During the this quarter we took no formal action but are reviewing use of outside ambulances during the Lake County fires.

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

The North Coast EMS Image Trend PCR program housed at ICEMA continues to provide EMS data to the State and the HIE QI Discovery contract was completed. The NEMSIS Version 3 upgrade will be delayed until 2017. North Coast EMS anticipated that the NEMSIS 3 compliant version of ImageTrend would go live this past spring, and the delay in launching of NEMSIS Version 3 limited the special grant project work that our contractor could accomplish in building a new management module compatible with the NEMSIS Version 3 compliant ImageTrend electronic PCR reporting system. We were, however, able to lay the groundwork for this objective, and, provided we are able to secure funding to continue this work, we should be well prepared to complete the agency version of the PCR reporting module once the NEMSIS Version 3 version of Image Trend becomes available, particularly with additional grant funding. We are considering applying to a new HIE grant opportunity provided by EMSA. We discontinued review of AED reports as this requirement has been discontinued by the EMSA. We receive and review REACH aero medical transports occurring in Lake County, CEMSIS-Trauma data from Sutter-Lakeside and Sutter-Coast Hospitals, internship records for periodic review, and disclosure protected case review is conducted as needed. Trauma Registry reports continue to have intermittent transmission problems and we are

working to resolve those. We also continued to transmit CEMSIS – EMS data to the EMSA, including the state required Cores Measures Report.

- Processing and investigating quality assurance/improvement incident reports

During this quarter we initiated one QI review with the involved Base Hospital specific to outside of the area ambulance utilization during the Lake County fires. 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. 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 received QIP Plan approval from the EMSA and are reviewing quarterly QIP report submission by two of our Base Hospitals.

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

North Coast EMS submitted the Core Measure data as required last year.

- 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 is proceeding with plans to implement the 3.X program but this will likely be delayed until 2017.

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

Policies and procedures to approve Public Safety training programs pursuant to the revised state regulations have been implemented. North Coast EMS approved Public Safety training programs will include CPR and first aid training.

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

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

- Availability of information to assist the population in catastrophic events

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

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

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 state, regional and local disaster planning meetings and drills. This year's HPP multi-county LEMSA objectives include focus on planning and training EMS personnel in the transition from a single incident MCI to a disaster response. North Coast EMS has, over the past three HPP funding cycles, engaged system participants in discussion regarding an OA (county) specific concept of operations for disaster response, including operational integration with the MHOAC disaster planning and response program. These discussions have led to the development of NCEMS hospital and provider disaster preparedness and SEMS/EOM communications and reporting policy, and revision of the Humboldt County EOP to integrate an EMS representative into the County EOC These policies, as well as OA (county) specific SOPs will form the basis of this year's training objectives. Similarly, the last two years of EMS community and MHOAC program discussions and planning for a possible Ebola patient or patients will form the basis for achieving the Ebola or other highly pathogenic diseases suspected patient transportation plans, targeted by this year's HPP multi-county LEMSA objectives.

- 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. Due to staff turnover at CDPH and significant unanticipated changes in the multi-county LEMSA grant application process, the North Coast EMS CDPH HPP contract was delayed for several months. Nevertheless, through the North Coast EMS County Liaison contractors, North Coast EMS worked with our County Health Department partners to finalize and pursue the objectives and activities of our 2015-2016 HPP Work Plan. Maris Hawkins, the North Coast EMS Program Assistant, and Rhiannon Potts, the North Coast EMS Administrative Assistant played key roles in ensuring that North Coast EMS was able to meet grant application submission requirements and deadlines. . The EMSC Regionalization Project also targeted enhanced preparedness for pediatric patients during special

events.

- Coordinating the operational area disaster medical/health coordinator

North Coast EMS staff and HHP contractors coordinated with the RDMHC in each county, attended meetings, participated in local, state and regional Medical Disaster meetings and events. This included verification of the local process used to prepare for the return of a health care worker returning from an Ebola impacted country to Humboldt County. Staff also assisted Lake County and other areas of the region during recent fires by allowing outside resources to come in while encouraging use of mutual aid. The North Coast EMS Regional Disaster Planning Coordinator visited Lake EOCs established for the Rocky and Valley Fires, monitored Lake County ambulance activity, consulted with MHOAC program representatives, attended EOC meetings, attended a Sutter Lakeside Hospital HICS meeting, and reviewed medical assistance being rendered at various Lake County evacuation centers.

- Coordinating the regional disaster medical/health coordinator system

See above.

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

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

- Facilitating mutual aid agreements

North Coast EMS has facilitated development of mutual aid agreements for decades and all ambulance providers have mutual aid arrangements with surrounding providers. We also recently endorsed activation of outside fire and ambulance resources according to existing mutual aid policies.

- 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.

MCI CHANNEL TEST

09-08-2015

Phelps Hospital	No	GRA1	X
Redwood Memorial	No	FRA 1	X
St. Josephs Hospital	Brkn	FRA 2	X
Mad River Hospital	X	CTA1	X
Eureka Medcom	X	CTA2	X
		CTA3	X
		Arcata 1	X
		Arcata 2	X

- St. Joes can receive but not transmit – Wayne making the repair today.
- Redwood not scanning – locked on one channel
- Phelps can hear but not transmit – Wayne to look at
- Arcata 1 very scratchy but readable

MCI CHANNEL TEST

10/29/2015

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

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

Phelps Hospital	nr	GRA1	X
Redwood Memorial	X	FRA 1	oc
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	x

- After the test, announce "The test is complete. 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

MCI CHANNEL TEST

11/12/2015

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

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

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

MCI CHANNEL TEST

11/17/2015

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

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

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

MCI CHANNEL TEST

01/14/2016

- 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	X	FRA 1	X
St. Josephs Hospital	Nr	FRA 2	X
Mad River Hospital	nr	CTA1	X
Eureka Medcom	x	CTA2	Nr
		CTA3	X
		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**