Solano Emergency Medical Services Cooperative

Board of Directors Meeting

Meeting Date: 10/12/2017

I. REPORTS

a. SEMSC Medical Director's Report (verbal update, no action)

Copies of policies enacted since the last Board Meeting are attached for reference, as requested by the SEMSC Board.

Solano EMS policies and protocols are available on the internet at http://www.co.solano.ca.us/depts/ems/

GERALD HUBER
Director

EMERGENCY SERVICES BUREAU
355 Tuolumne Street,
Suite 2400, MS 20-240
Vallejo, CA 94590

DEPARTMENT OF HEALTH & SOCIAL SERVICES
Medical Services Division

SOLANO COUNTY

BRYN MUMMA, MD, MAS
EMS Agency Medical Director

TED SELBY
EMS Agency Administrator

(707) 784-8155
www.solanocounty.com

POLICY MEMORANDUM 3200

Effective Date: March 31, 2010
Revised Date: July 1, 2017
Review Date: July 1, 2019

REVIEWED/APPROVED BY:

BRYN MUMMA, MD, MAS, EMS AGENCY MEDICAL DIRECTOR

TED SELBY, EMS AGENCY ADMINISTRATOR

SUBJECT: EMERGENCY MEDICAL TECHNICIAN (EMT) CERTIFICATION & RECERTIFICATION

AUTHORITY: California Code of Regulations (CCR), Title 22, Division 9, Chapter 2, Article 4, Section 100079, Article 5, Sections 100080 and 100081, and Article 6 Section 100083

I. PURPOSE/POLICY

To outline the requirements of initial California EMT certification and California EMT recertification. Also outlines the procedure to reinstate an expired California EMT certification.

II. INITIAL EMT CERTIFICATION

A. To be eligible for initial California EMT certification, an individual must fulfill one of the following requirements:

1. Pass the cognitive examination and psychomotor National Registry (NR) EMT exam within two (2) years from the date of application for EMT certification and have a valid EMT course completion record or other documented proof of successful completion of any initial EMT course approved pursuant to CCR Section 100066 issued within two years of the date of application, OR

2. Pass the cognitive examination and psychomotor NR-EMT exam within two years from the date of application for EMT certification and have documentation of successful completion of an approved out-of-state initial EMT training course, within the last two years, that meets the requirements of CCR Section 100066, OR
3. Pass the cognitive examination and psychomotor NR-EMT exam within two years from the date of application for EMT certification and have a current and valid out-of-state EMT certificate, OR
4. Possess a current and valid National Registry EMT, Advanced EMT, or Paramedic certification, OR
5. Possess a current and valid out-of-state Advanced EMT or Paramedic certificate, OR
6. Possess a current and valid California Advanced EMT certificate or a current and valid California Paramedic license.

B. In addition to meeting one of the criteria in Section II(A), to be eligible for Initial EMT certification, an individual shall:
   1. Be 18 years of age or older;
   2. Complete the criminal history background check requirement (LiveScan) as specified in CCR Title 22, Division 9, Chapter 10. The certifying entity shall receive the State and Federal criminal background check results before issuing an initial certification;
   3. Submit a copy of a current and valid Basic Life Support (BLS) CPR card;
   4. Complete the Solano County EMS Agency online application;
   5. Disclose any prior and/or current certification, licensure, or accreditation actions:
      a. Against an EMT or Advanced EMT certificate, or any denial of certification by a LEMSA, including any active investigations;
      b. Against a Paramedic license, or any denial of licensure by the California State EMS Authority, including any active investigations;
      c. Against any EMS-related certification or license of another state or other issuing entity, including denials and any active investigations; or
      d. Against any health-related license.
   6. Disclose any pending or current criminal investigations.
   7. Disclose any pending criminal charges.
   8. Disclose any prior convictions.
   9. Disclose each and every certifying entity or LEMSA to which the applicant has applied for certification in the previous 12 months.

10. Pay the established fees set forth in Solano County EMS Policy 3000.

III. EMT RECERTIFICATION

A. In order to recertify as an EMT, the EMT shall:

1. Possess a current EMT Certification in California
2. Meet one of the following continuing education (CE) requirements:
   a. Successfully complete a 24 hour refresher course from an approved EMT training program within the 24 months prior to applying for renewal, OR
   b. Obtain at least 24 hours of CEs within the 24 months prior to applying for renewal, from an approved CE provider in accordance with the provisions contained in CCR Title 22, Division 9, Chapter 11.
      i. CEs may be used to renew multiple licensure/certification types as long as they are earned within the licensure/certification cycle being renewed and were not used in a previous cycle.
3. Complete an application form and all other processes outlined in Section II(B)(1 – 10) of this policy.
4. Complete the criminal history background check (Live Scan) requirements as specified in CCR Title 22, Divison 9, Chapter 10 when changing certifying entities. The certifying entity shall receive the State and Federal criminal background check results before issuing a certification.
   a. The recertifying EMT is not required to perform a second Live Scan if one was done as a part of their previous initial EMT certification process.
5. Submit a completed skills competency verification form, EMSA-SCV (01/17). Skills competency shall be verified by direct observation of an actual or simulated patient contact. Skills competency shall be verified by an individual who is currently certified or licensed as an EMT, AEMT, Paramedic, Registered Nurse, Physician's Assistant, or Physician and who shall be designated by an EMS approved training program (EMT training program, AEMT training program, Paramedic training program or CE provider), or an EMS service provider. EMS service providers include, but are not limited to, public safety agencies, private ambulance providers and other EMS providers. Verification of skills competency shall be valid for a maximum of two years for the purpose of applying for recertification.
6. If an EMT is also obtaining initial accreditation or recertifying accreditation for the items listed in Solano County EMS Policy 6300, EMT Scope of Practice, Section III, documentation of training of the items listed in that section must also be submitted.

7. Starting 24 months after the effective date of this policy, any EMT renewing for the first time, following implementation, shall submit documentation of successful completion by an approved EMT training program or approved CE provider in the following training:
   a. The use and administration of naloxone (Narcan) or other opioid antagonist that meets the standards and requirements of CCR Title 22, Division 9, Article 3, Section 100075(c).
   b. The use and administration of epinephrine by auto-injector that meets the standards and requirements of CCR Title 22, Divison 9, Article 3, Section 100075(d).
   c. The use of a glucometer that meets the standards and requirements of CCR Title 22, Divison 9, Article 3, Section 100075(e).
8. If an individual possesses a current California issued Paramedic license or California Advanced EMT certificate then the individual need not provide proof of Sections III(7)(a – c) of this policy.

B. If the EMT renewal requirements are met within six months prior to the current certification expiration date, the Solano County EMS Agency shall make the effective date of renewal the date immediately following the expiration date of the current certificate. The certification will expire the last day of the month two years from the day prior to the effective date.

C. If the EMT renewal requirements are met greater than six months prior to the expiration date, the Solano County EMS Agency shall make the effective date of renewal the day the certificate is issued. The certification expiration date will be the last day of the month two years from the effective date.

D. A California certified EMT who is a member of the Armed Forces of the United States and whose certification expires while deployed on active duty, or whose certification expires less than six (6) months from the date they return from active duty deployment, with the Armed Forces of the United States shall have six (6) months from the date they return from active duty deployment to complete the requirements of Section III(2 – 5) of this policy and Section III(7) after July 1, 2019. In order to qualify for this exception, the individual shall:
   1. Submit proof of their membership in the Armed Forces of the United States; and
   2. Submit documentation of their deployment starting and ending dates.
   3. Continuing education credit may be given for documented training that meets the requirements of CCR Title 22, Division 9, Chapter 11 while the individual was deployed on active duty.
   4. The continuing education documentation shall include verification from the individual's Commanding Officer attesting to the training attended.

IV. REINSTATEMENT OF AN EXPIRED EMT CERTIFICATE

The following requirements apply to individuals who wish to be eligible for reinstatement after their California EMT certificate has expired:

A. For a lapse of less than six months, the individual shall meet the requirements outlined in Section III of this policy.

B. For a lapse of greater than six months but not less than 12 months, the individual shall meet the requirements outlined in Section III of this policy plus an additional 12 hours of CEs.

C. For a lapse of greater than 12 months, the individual shall meet the requirements outlined in Section III of this policy plus an additional 24 hours of CEs.

   1. The individual also must retake and pass the cognitive and psychomotor NR-EMT exams unless the individual possesses a current and valid NR-EMT, NR-AEMT, or NR-EMTP certificate or a current and valid California Advanced EMT certificate or California Paramedic License.

V. GENERAL INFORMATION

A. The EMT shall be responsible for notifying Solano County EMS of her/his proper and current mailing address and shall notify the certifying entity in writing within 30 calendar days of any and all changes of the mailing address giving both the old and the new address and EMT certification number.

B. An EMT shall only be certified by one certifying entity during a certification period.

C. If recertifying within the same month of expiration or applying for reinstatement, the EMT will be charged a late fee in accordance with Solano County EMS Policy 3000.

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GERALD HUBER
Director

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355 Tuolumne Street,
Suite 2400, MS 20-240
Vallejo, CA 94590

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SOLANO COUNTY

BRYN MUMMA, MD, MAS
EMS Agency Medical Director

TED SELBY
EMS Agency Administrator

(707) 784-8155
www.solanocounty.com

POLICY MEMORANDUM 3303

Effective Date: July 1, 2017
Review Date: July 1, 2019

REVIEWED/APPROVED BY:

BRYN MUMMA, MD, MAS, EMS AGENCY MEDICAL DIRECTOR

TED SELBY, EMS AGENCY ADMINISTRATOR

SUBJECT: EMERGENCY MEDICAL TECHNICIAN (EMT) LOCAL OPTIONAL SCOPE OF PRACTICE PROVIDER AUTHORIZATION

AUTHORITY:

California Code of Regulations (CCR), Title 22, Division 9, Chapter 2, Article 4, Section 100079, Article 5, Sections 100080 and 100081, and Article 6, Section 100083

PURPOSE:

To establish requirements and standards for medical control so an Emergency Medical Services (EMS) provider within Solano County may utilize the EMT Local Optional Scope of Practice.

I. EMT Local Optional Scope of Practice

A. The following BLS Local Optional Scope of Practice skills are authorized for use within Solano County for an EMT that is employed with a Solano County EMS provider:

1. Utilization of a perilaryngeal airway.

a. The preferred perilaryngeal airway for Solano County is the King Airway.

B. In order for an EMT to be eligible to be accredited to use a perilaryngeal airway, the training requirements stated in Solano County EMS Policy 6300, EMT Scope of Practice, must be met and documentation submitted to Solano County EMS upon initial training and EMT recertification.

II. EMT Local Optional Scope of Practice Service Provider Requirements

A. If an EMS Provider within Solano County wishes to utilize the Local Optional EMT Scope of Practice skill(s), the EMS provider must submit the following documentation prior to utilization of the skills(s):

1. A letter of intent to provide EMT Local Optional Scope of Practice skills signed by a chief officer, expressing willingness to abide by all Solano County EMS Agency policies, protocols, and program requirements.
2. Identification of the Local Optional skill(s) begin requested for utilization.
3. A description of the geographical area in which the Local Optional skill(s) will be utilized.
4. Designation of an EMT Local Optional Scope of Practice Medical Director and a Program Coordinator/Lead Instructor.
    a. The Program Coordinator/Lead Instructor shall be a physician, Registered Nurse (RN), physician assistant, or Paramedic licensed in California.
5. A description of the plans for initial accreditation and reaccreditation training for the Local Optional skill(s) to be utilized including, but not limited to, written exams, skills demonstration, equipment, and recurring skills competency.
    a. The training requirements for the utilization of a perilaryngeal airway are included in Policy 6300, EMT Scope of Practice, Section III.
    b. Refer to Policy 6608, Advanced Airway Mangement, Section II for the procedure for utilization of the King Airway.

III. Responsibilities of the EMT Local Optional Scope of Practice Program Coordinator

A. The responsibilities of the EMT Local Optional Scope of Program Coordinator are as follows:

1. Provide the Solano County EMS Agency with a description of the data collection methodology, which shall also include the effectiveness of the use of the Local Optional skill(s).
2. Submit to the Solano EMS Agency the Patient Care Report (PCR) when a Local Optional skill is used within 72 hours after the incident.
3. Perform a monthly review of any Local Optional skill(s) that was used in the prior month.
4. Provide an annual update by the end of January to Solano County EMS that includes:
    a. A list of all EMTs that are currently accredited to use Local Optional skills;
    b. Any changes to program personnel;

c. Any changes to training curriculum.

5. Report any unusual events or detrimental outcomes when utilizing a Local Optional skill by submitting a Field Advisory Report (FAR) in compliance with Solano County EMS Policy 6100.

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GERALD HUBER
Director

EMERGENCY SERVICES BUREAU
355 Tuolumne Street,
Suite 2400, MS 20-240
Vallejo, CA 94590

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SOLANO COUNTY

BRYN MUMMA, MD, MAS
EMS Agency Medical Director

TED SELBY
EMS Agency Administrator

(707) 784-8155
www.solanocounty.com

POLICY MEMORANDUM 3400

Implementation Date: September 28, 2008
Revised Date: July 1, 2017
Review Date: July 1, 2019

REVIEWED/APPROVED BY:

BRYN MUMMA, MD, MAS, EMS AGENCY MEDICAL DIRECTOR

TED SELBY, EMS AGENCY ADMINISTRATOR

SUBJECT: PARAMEDIC ACCREDITATION/REACCREDITATION PROCESS

AUTHORITY: California Code of Regulations Title 22, Division 9, Chapter 4, Article 1, Section 100142 and Article 2, Section 100146 and Article 5, Section 100165, 100166 California Health & Safety Code Division 2.5, §1797.7, 1797.84, 1797.178, 1797.185, 1797.194, 1797.214, & 1797.220

PURPOSE/POLICY:

Accreditation is a process by which the Solano County Emergency Medical Services (EMS) Agency and its Medical Director can be assured that all Paramedics functioning in the EMS system are oriented to local policies, procedures, and EMS system features as well as possess those skills necessary to perform any optional scope of practice skills and procedures currently being used in Solano County.

Nothing in this policy prohibits an employer from imposing stricter requirements for the employment or orientation of Paramedic personnel.

I. INITIAL ACCREDITATION

A. To be eligible for accreditation in Solano County, an individual must:

1. Provide evidence of possession of a valid California Statewide Paramedic license which is current. State Licensure means that the individual has met specified training and education standards and has been deemed competent to practice throughout the State of California in the Paramedic scope of practice, as defined in Title 22 of the California Code of Regulations (CCR).
2. Provide proof of employment with an authorized Solano County Advanced Life Support (ALS) Provider.

a. A Paramedic may become accredited as a Paramedic in Solano County if they are a volunteer firefighter for an authorized Solano County ALS Provider. The ALS fire department employing the Volunteer Firefighter/Paramedic must provide employment verification.

3. Provide evidence of a valid, current certification card in the following:
   a. Basic Life Support (BLS) Cardiopulmonary Resuscitation (CPR) for Healthcare Provider or equivalent; **and**
   b. Advanced Cardiac Life Support (ACLS) card issued in accordance with the guidelines of the Journal of the American Medical Association (JAMA); **and**
   c. Pediatric Advanced Life Support (PALS) **OR** Pediatric Education for Prehospital Professionals (PEPP); **and**
   d. Prehospital Trauma Life Support (PHTLS) **OR** Basic Trauma Life Support (BTLS) **OR** International Trauma Life Support (ITLS).
4. Apply to Solano County EMS Agency. Application includes the following:
   a. Completion of an on-line application form; and
   b. Check or money order payable to "Solano County EMS" for the amount specified in Solano County EMS Policy Memo #3000.
5. Attend an EMS Agency orientation not to exceed eight (8) classroom hours, and submit orientation forms as specified in Solano County Policy #3600.
6. An application that has not had any activity in 120 days from creation will be considered abandoned. If the application is abandoned, the Paramedic must restart the accreditation process.

B. EMS Agency Orientation

1. Paramedics will be oriented to the local EMS system including EMS Agency organization, function, staff, policies, procedures, treatment protocols, base and receiving hospital protocols, specialty care center protocols, EMS Quarterly Meeting requirements, and other unique system features.
2. The orientation should not repeat items within the Paramedic scope of practice which are already covered in the State's written and skills examinations.
3. The orientation may not exceed eight (8) hours, excluding any necessary testing in the optional scope of practice.
4. The orientation shall be completed within 120 days of receipt of a completed application.

C. Pre-Accreditation Field Evaluation

1. The purpose of the field evaluation is to validate that the applicant is knowledgeable to begin functioning under local policies and protocols.
2. The performance of skills and procedures by the accreditation applicant will be done in the presence of a field preceptor designated by the Solano County EMS Agency. Although the applicant may be licensed as a Paramedic in California, the preceptor has the ultimate responsibility for patient care rendered by the Paramedic during the evaluation period.

3. It is the responsibility of the field preceptor to determine if the applicant is ready to begin functioning within Solano County; practicing optional scope in accordance with local policies and procedures.
4. The pre-accreditation field evaluation is limited to a minimum of five (5) but no more than ten (10) ALS calls. An ALS call is defined as at least one (1) invasive skill performed or one (1) medication administered.
    a. This requirement may be waived by providing documentation of a minimum of five (5) but no more than ten (10) ALS calls during a Paramedic education program field internship with a Solano County ALS Provider within the previous six (6) months.
5. The EMS Medical Director, or EMS Agency designee, shall evaluate the calls submitted to the EMS Agency to ensure that EMS Agency policy and protocol were followed and to evaluate the quality of patient care given. If it is demonstrated in this evaluation that the Paramedic applicant did not perform treatment as outlined in policy/protocol, the Paramedic applicant may be required to report back to his preceptor for further instruction or calls. The call documentation will also be submitted back to the Paramedic's precepting provider for further Quality Improvement review.
6. The EMS Medical Director shall evaluate any Paramedic applicant who fails to successfully complete the field evaluation and may recommend further evaluation or training. If, in the course of the field evaluation, the applicant's proficiency in the scope of practice comes into question, then the qualification of the individual to hold a license becomes an issue and the Solano County EMS Agency shall evaluate the situation for appropriate action including, but not limited to, forwarding to the State EMS Authority for further review.

D. Accreditation Procedure

1. Upon completion of an application, verification of employment with a Solano County ALS provider, submission of required documentation, and issuance of an "A-Number" identifier, the licensed Paramedic may practice the Solano County EMS scope of Paramedic practice as a second Paramedic on a unit. A designated preceptor need not be present at this time.
2. After issuance of the "A-Number" identifier, the Paramedic applicant may only utilize the optional scope of practice in the presence of a Solano County Designated Paramedic Preceptor during the pre-accreditation field evaluation.
3. The applicant may work as a single Paramedic once the pre-accreditation field evaluation, base hospital orientation, and provider employer orientations have been completed and reviewed by the EMS Agency and a Solano County Paramedic Number has been issued.
4. The applicant shall complete the EMS Agency orientation within 120 days of initiating the accreditation process.
    a. If a Paramedic is issued a Solano County Paramedic Number prior to attending the EMS Agency orientation and fails to attend the next scheduled orientation, the Paramedic will be issued a mandatory notice to attend the next orientation. If the Paramedic fails to attend a second scheduled orientation, the Paramedic's accreditation will be suspended until the orientation until the orientation is attended.

b. If the EMS Agency cancels an EMS Agency orientation Paramedics will not be penalized.

5. An applicant who fails to complete the accreditation process may not practice as a Paramedic in Solano County.
6. The local EMS Agency accredits individuals to practice in Solano County. Accreditation to practice shall be continuous as long as State of California Paramedic license is maintained and local requirements are met.
7. Accreditation is indicated by the issuance of a Solano County Accreditation Card bearing the date of issuance, date of expiration, and the signature of the EMS Agency Medical Director.
8. The EMS Agency shall notify individuals applying for accreditation of the decision to accredit within ten (10) working days of completion of the above requirements.
9. Every attempt will be made to mail the Solano County Accreditation Card to the applicant within ten (10) working days of completion of the above requirements.

E. Paramedics Employed by Solano County EMS Agency

1. Paramedics that are employed by the Solano County EMS Agency are eligible for initial Solano County Paramedic Accreditation so long as requirements of Section I(A)(1), (3), and (4)(a) of this policy are met. All other accreditation requirements may be waived at the discretion of the EMS Agency Medical Director.

II. MAINTAINING ACCREDITATION

A. Requirements to maintain accreditation:

1. Maintenance of a valid State of California Paramedic license;
2. Maintenance of a valid, current certification card in the following:
   a. BLS CPR for Healthcare Provider or equivalent; **and**
   b. ACLS card issued in accordance with the guidelines of the Journal of the American Medical Association; **and**
   c. PALS **or** PEPP; **and**
   d. PHTLS **or** BTLS OR ITLS
3. Employment with an authorized ALS Provider or volunteer fire department within Solano County;
4. Compliance with the following requirements:
   a. Maintenance of Continuing Education Requirements as specified in Policy #3700;
   b. Completion of a four (4) hour Advanced/Difficult Airway Management Course and manipulative skills as specified in Policy #6608;
      i. If the Advanced/Difficult Airway Management Course is a portion of another Continuing Education (CE) Course, only the hours for Advanced/Difficult Airway Management will be used for reaccreditation and not the total hours of the course.
      ii. One hour of AHA ACLS may be used to satisfy this requirement.

iii. One hour of AHA PALS may be used to satisfy this requirement.

c. Completion of eight (8) hours, **four (4) hours annually**, of STEMI/12 Lead EKG training as specified in Policy #6609;

i. If the time from an initial accreditation to the date of renewal is less renewal is less than one (1) year, four (4) hours of STEMI/12 Lead EKG training will satisfy this requirement.

ii. If the STEMI/12 Lead EKG course is including in another Continuing Education (CE) Course, only the hours required for STEMI/12 Lead will be credited toward reaccreditation (not the total hours for the course).

d. Paramedics may, at the discretion of the EMS Agency Medical Director, be required to:

i. Complete training courses on revised policies and procedures, treatment protocols, and/or optional scopes of practice.

ii. Obtain education aimed at specific clinical conditions or problems identified in the quality improvement program, which may include specialized training or certification in pre-established courses.

iii. Demonstrate competency of infrequently used skills.

e. All required reaccreditation documentation shall be turned into Solano County EMS 30 days prior to the current accreditation expiration date to allow adequate time for processing.

i. Failure to turn in reaccreditation documentation 30 days prior to the current accreditation expiration will result in a late fee as set forth in Solano County EMS Policy 3000. Reaccreditation will not be processed until the late fee is received.

B. Paramedics Employed by Solano County EMS Agency

1. Paramedics that are employed by the Solano County EMS Agency are eligible for Solano County Paramedic Reaccreditation provided the requirements of Section II(A)(1), (2), and (4) of this policy are met. All other reaccreditation requirements may be waived at the discretion of the EMS Agency Medical Director.

III. ADVERSE ACTIONS ON ACCREDITATION

A. Accreditation may be denied or suspended by the Solano County EMS Agency for cause.

B. If a Paramedic does not meet ALL local reaccreditation requirements by close of business (5:00pm) on the date of accreditation expiration, the Paramedic's accreditation will be considered expired and therefore Paramedic accreditation will be suspended.

1. If the Paramedic accreditation is set to expire on a weekend or holiday, all reaccreditation documentation shall be submitted by close of business (5:00 pm) on the Friday prior to the weekend or the day prior to the holiday or the reaccreditation will be considered expired.

2. If the EMS Agency has not received the Paramedic's completed reaccreditation documentation by 2:00pm on the day of, Friday prior to the weekend, or day prior to the holiday of expiration, a letter of eminent suspension will be sent to the Paramedic.

C. Suspension of accreditation means that the Paramedic cannot work as a Paramedic in Solano County. If a Paramedic's accreditation is suspended, a letter explaining the circumstances will be sent to the Paramedic. Copies of this letter may also be sent to all EMS Agency staff, the Paramedic's immediate supervisor/employer, and the California State EMS Authority.

D. If a California State Licensed Paramedic allows their Solano County Paramedic accreditation to lapse, Paramedic accreditation may be reinstated if ALL requirements for reaccreditation are met **AND** the appropriate late and reinstatement fees as stated in Policy 3000 are paid within 60 days of expiration.

E. If a California State Licensed Paramedic allows their Paramedic accreditation to lapse for longer than 60 days, the California State Licensed Paramedic will be required to perform the initial requirements for Solano County Paramedic Accreditation.

F. Accreditation will not be denied based on a Paramedic's accreditation history with another EMS Agency or their provider affiliation.

G. Any circumstances and actions against a Paramedic's accreditation may be forwarded to the California State EMS Authority for further investigation and Paramedic Licensure action.

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GERALD HUBER
Director

EMERGENCY SERVICES BUREAU
355 Tuolumne Street,
Suite 2400, MS 20-240
Vallejo, CA 94590

DEPARTMENT OF HEALTH & SOCIAL SERVICES
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SOLANO COUNTY

BRYN MUMMA, MD, MAS
EMS Agency Medical Director

TED SELBY
EMS Agency Administrator

(707) 784-8155
www.solanocounty.com

POLICY MEMORANDUM 4100

Implementation Date: February 3, 2014
Revised Date: August 1, 2017
Review Date: August 1, 2019

REVIEWED/APPROVED BY:

BRYN MUMMA, MD, MAS, EMS AGENCY MEDICAL DIRECTOR

TED SELBY, EMS AGENCY ADMINISTRATOR

SUBJECT: APPROVAL FOR EMERGENCY MEDICAL TECHNICIAN (EMT) TRAINING PROGRAMS

AUTHORITY:

California Health & Safety Code, Division 2.5, Chapter 3 Article 1, Section 1797.109, Chapter 3, Article 5, Section 1797.170, 1797.173; Chapter 4, Article 1, Section 1797.208, 1797.210, 1797.213, and 1797.220.
California Code of Regulations (CCR), Title 22, Division 9, Article 3, Sections 10065 - 10078.

PURPOSE:

To establish the requirements and process to approve an EMT Training Program(s) operating within Solano County.

I. ELIGIBILITY TO BECOME AN EMT TRAINING PROGRAM:

1. Eligibility for EMT Training program approval shall be limited to:
   A. Accredited universities and colleges, including community colleges, school districts, and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau of Private, Postsecondary, and Vocational Education;
   B. Medical training units of a branch of the Armed Forces, including the Coast Guard of the United States;

C. Licensed general acute care hospitals which meet the following criteria:

i. Hold a special permit to operate a Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Title 22, CCR, Division 5; and

ii. Provide continuing education to other health care professionals; and

D. Agencies of government including public safety agencies and Solano County Emergency Medical Services (EMS) Agency.

2. A program shall not begin instruction until eligibility has been determined.

II. REQUIRED DOCUMENTATION FOR EMT PROGRAM APPROVAL AND ONGOING ACCREDITATION:

A qualified agency electing to implement an EMT training program in Solano County must comply with all requirements listed in the CCR and submit the following information to the Solano EMS Agency:

A. Completed application with appropriate fees;

B. A statement verifying adherence to the U.S. Department of Transportation (DOT) National EMS Education Standards (DOT HS 811 077A, January 2009);

C. A statement verifying the program's CPR training is equivalent to the current American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the Healthcare Provider level, as this is a prerequisite for admission to an EMT basic course;

D. Samples of written and skills examinations used for periodic testing;

E. A final skills competency examination;

F. A final written examination;

G. The name and qualifications of the program director, program clinical coordinator, and principal instructor(s);

H. Documented provision for clinical experience:

1. EMT training program shall have written agreement(s) with one or more general acute care hospital(s), and/or operational ambulance provider(s), or rescue vehicle provider(s) for the clinical portion of the EMT training course;

2. The written agreement(s) shall specify the roles and responsibilities of the training program and the clinical provider(s) for supplying the supervised clinical experience for the EMT student(s);

3. Supervision for the clinical experience shall be provided by an individual who meets the qualifications of a principal instructor or teaching assistant;

4. No more than three (3) students will be assigned to one (1) qualified supervisor during the supervised clinical experience;

I. Documented provision for course completion by challenge process, including a challenge examination (if different from final examination);

J. Documented provision for a 24 hour refresher course including items from letters B through G, which is required for recertification;

1. A statement verifying adherence to the United States Department of Transportation's EMT-Basic Refresher National Standard Curriculum, DOT HS 808 624, September 1996;

K. The location at which the courses are to be offered and their proposed dates;

L. EMT training programs shall assure that no more than ten (10) students are assigned to one (1) principal instructor/teaching assistant during skills practice/laboratory sessions and provide a plan to ensure compliance with the ratios;

M. A Table of Contents listing the required information listed in this subdivision, with corresponding page numbers;

N. Maintain annual accreditation with Solano County EMS Agency by:

1. Completing the annual report to the Agency, as described in Section IX.
2. Attend the quarterly Quality Improvement Meeting.
3. Pay the annual accreditation fee.

III. REQUIRED COURSE HOURS

A. The EMT course shall consist of not less than 170 hours. The minimum hours shall not include the examinations for EMT certification. These training hours shall be divided into:

1. A minimum of 146 hours of didactic instruction and skills laboratory; and
2. A minimum of 24 hours of supervised clinical experience. The clinical experience shall include a minimum of ten (10) documented patient contacts wherein a patient assessment and other EMT skills are performed and evaluated.

a. High fidelity simulation, when available, may replace up to six (6) hours of supervised clinical experience and may replace up to three (3) documented patient contacts.

IV. REQUIRED COURSE CONTENT

A. The content of an EMT course shall meet the objectives contained in the U.S. Department of Transportation (DOT) National EMS Education Standards (DOT HS 811 077A, January 2009), incorporated herein by reference, to result in the EMT being competent in the EMT basic scope of practice specified in the California Code of Regulations (CCR) Title 22, Division 9, Chapter 2, Section 100063.

B. Training in the use of hemostatic dressings shall result in the EMT being competent in the use of the dressing. Included in the training shall be the following topics and skills:

1. Review of basic methods of bleeding control to include but not be limited to direct pressure, pressure bandages, tourniquets, and approved hemostatic dressings;

2. Review treatment of open chest wall injuries;
3. Types of hemostatic dressings;
4. Importance of maintaining normal body temperature.

C. Training in the administration of naloxone as stated in Solano County EMS Policy 4700, EMT & Law Enforcement Initial Training Guidelines: Naloxone.

D. Training in the administration of an epinephrine auto injector as stated in Solano County EMS Policy 4701, EMT & Law Enforcement Initial Training Guidelines: Epinephrine Auto Injector.

E. Training in the use of finger stick blood glucose testing as stated in Solano County EMS Police 4702, EMT Initial Training Guidelines: Finger Stick Blood Glucose Testing.

F. In addition to the above, the content of the training course shall include a minimum of four (4) hours of Tactical Casualty Care (TCC) principles applied to violent circumstances with the topics and skills as stated in CCR Title 22, Division 9, Chapter 2, Article 3, Section 100075(f).

V. TEACHING STAFF

All certified, authorized, or licensed personnel involved in the instruction of EMT students shall be in good standing with their certifying, authorizing, or licensing agency. Good standing implies that no negative action to the certificate, authorization, or license, has been taken by the granting authority. The roles may be filled by the same individual as long as they are qualified to do so.

A. Each EMT training program shall have a qualified and approved Program Director.

1. The qualifications of a Program Director include but are not limited to:
    a. Document completion of a minimum of 40 hours teaching methodology course, examples include but are not limited to:
        i. State Fire Marshal Instructor Course 1A and 1B
        ii. National Fire Academy's Instructional Methodology Course
        iii. Training program that meets the United States Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors
2. The duties of the Program Director, in coordination with the program clinical coordinator, shall include, but not be limited to:
    a. Administering the training program;
    b. Approving course content;
    c. Approving all written examinations and the final skills examination;
    d. Coordinating all clinical and field activities related to the course;
    e. Approving the principal instructor(s) and teaching assistants;
    f. Signing all course completion records;

g. Assuring that all aspects of the EMT training program are in compliance with this Policy and other related laws.

B. Each EMT training program shall have a qualified and approved Program Clinical Coordinator.

1. The qualifications of a Program Clinical Coordinator include but are limited to:

a. Currently licensed in California as a physician, registered nurse, physician assistant, or paramedic;

b. Have at least two (2) years of academic or clinical experience in the practice of emergency medicine or pre-hospital care in the last five (5) years.

2. The duties of the Program Clinical Coordinator shall include but are not limited to, the quality of the program's medical content.

C. Each EMT training program shall have a qualified and approved Principal Instructor

1. The qualifications of a Principal Instructor include, but are not limited to:

a. Currently licensed in California as a physician, registered nurse, physician assistant, paramedic, Advanced EMT, or EMT;

b. Have at least two (2) years of academic or clinical experience in the practice of emergency medicine or pre-hospital care in the last five (5) years;

c. Be approved by the Program Director in conjunction with the Clinical Coordinator as qualified to instruct the topics assigned; and

d. Documented completion of a minimum of a 40 - hour teaching methodology course, as describe in Section A. 1. A., above.

2. The duties of the Primary Instructor shall include, but are not limited to, the instruction of EMT students.

D. Each EMT training program shall have a qualified and approved Teaching Assistant(s)

1. The qualifications of a Teaching Assistant(s) include, but are not limited to:

a. Currently certified or licensed in the State of California, at a minimum, as an EMT;

b. Have at least one (1) year of experience;

c. Be approved by the Program Director in conjunction with the Clinical Coordinator and Principal Instructor as qualified to instruct the topics assigned.

2. The duties of a Teaching Assistant(s) shall include, but are not limited to, assisting the Principal Instructor with the instruction of EMT students.

V. EMT TRAINING PROGRAM REVIEW AND REPORTING AND RECORDS

1. All programs material specified in this policy shall be subject to periodic review by the Solano County EMS Agency.
2. All program materials specified in this policy shall be subject to periodic on-site review by Solano County EMS Agency representatives.
3. Approved EMT Training Programs shall notify the Solano County EMS Agency in writing, in advance when possible, and in all cases within 30 days of any change in Program Director, Program Clinical Coordinator, Principal Instructor, change of address, phone number or program contact.
4. Student records shall be kept for a period of not less than four (4) years.
5. An approved EMT program shall report, in writing to the EMS Agency, within 15 days the names of students who have successfully completed the training program. An approved EMT program shall issue a tamper resistant course completion record to a student who successfully completes the training.
6. The course completion record shall contain the following information:
   a. The name of the individual;
   b. The date of course completion;
   c. Type of course completed (i.e. EMT, EMT Refresher, EMT Challenge) and the number of hours in training;
   d. The EMT approving authority, Solano County EMS Agency;
   e. The signature of the program director;
   f. The name and location of the training program;
   g. The following statement in bold print: "**This is not an EMT certificate.**"
7. The course completion record is valid for two (2) years and is valid statewide.

VI. WITHDRAWAL OF EMT TRAINING PROGRAM APPROVAL

Noncompliance with any criterion required for program approval, use of any unqualified teaching personnel, or noncompliance with any other applicable provision of this policy may result in denial, probation, suspension, or revocation of program approval by the Solano County EMS Agency. Notification of noncompliance and action to place on probation, suspend, or revoke shall be done as follows:

1. Solano County EMS shall notify the approved EMT training program course director in writing of the provisions of this policy with which the EMT training program is not in compliance.
2. Within 15 working days of receipt of the notification of noncompliance, the approved EMT training program shall submit in writing to Solano County EMS Agency one of the following:
   a) Evidence of compliance with the provisions of this policy; or

b) A plan for meeting compliance with the provisions of this policy within 60 calendar days from the date of receipt of the notification of noncompliance.

3. Within 15 working days of receipt of the response from the approved EMT training program, or within 30 calendar days from the mailing date of the noncompliance notification, if no response is received from the approved EMT training program Solano County EMS shall notify the EMS Authority and the approved EMT training program in writing of the decision to accept the evidence of compliance, accept the plan for meeting compliance, place on probation, suspend, or revoke the EMT training program's approval.
4. If Solano County EMS Agency decides to suspend, revoke, or place an EMT training program on probation the notification specified in this section of the policy shall include the beginning and ending dates of the probation or suspension and the terms and conditions for lifting of the probation or suspension, or the effective date of the revocation, which may not be less than 60 calendar days from the date of Solano County EMS Agency's letter of decision to the California EMS Authority and the EMT training program.

VII. EMT PROGRAM NOTIFICATION

1. Solano County EMS shall notify the applicant within seven (7) days that:
   a) The application packet has been received;
   b) The application packet contains, or does not contain, the required information from Section III and any items missing from the packet.
2. Solano County EMS shall provide written approval or disapproval to the requesting applicant within a three month period of time after receipt of all the application material.
3. Solano County EMS shall establish an effective date of program approval upon satisfactory documentation of compliance with all program requirements.
4. Program approval shall be for four (4) years and may be renewed every four (4) years, contingent upon achieving and maintaining Solano County EMS Accreditation.
5. Approved EMT training programs shall also receive approval as a continuing education (CE) provider effective the same date as the EMT training program approval. The CE program expiration date shall be the same expiration date as the EMT training program. The CE provider shall comply with all the requirements contained in CCR, Title 22, Division 9, Chapter 11.
6. Solano County EMS shall notify the California EMS Authority concurrently with the training program of approval, renewal of approval, or disapproval of the training program, and include the effective date. This notification is in addition to the name and address of training program, name of the program director, phone number of the contact person, frequency and cost for both basic and refresher.

VIII. QUALITY IMPROVEMENT

Solano County approved EMT Training Programs shall participate in the appropriate quarterly Quality Improvement committees meeting, pay the annual accreditation fee, and provide an annual report to Solano EMS. The report shall include, but not be limited to, the following:

1. The number of students enrolled in the EMT class for each class offered;
2. The number of students that drop out of EMT class for each class offered;
3. The number of students that successfully pass the EMT class;
4. The number of former students that successfully pass the National Registry of EMT exam on the initial attempt;
5. The number of former EMT students passing National Registry of EMT exam on subsequent attempts;
6. Any change to training personnel (e.g. Principal instructor(s), Program Clinical Coordinator, etc.;
7. Any new equipment purchased;
8. Any issue(s) that could affect the EMT training program e.g., changes in clinical contract(s), changes in enrollment fees, etc.;
9. Any other information the EMT Training Program should communicate to the EMT approving authority.

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GERALD HUBER
Director

EMERGENCY SERVICES BUREAU
355 Tuolumne Street,
Suite 2400, MS 20-240
Vallejo, CA 94590

DEPARTMENT OF HEALTH & SOCIAL SERVICES
Medical Services Division

SOLANO COUNTY

BRYN MUMMA, MD, MAS
EMS Agency Medical Director

TED SELBY
EMS Agency Administrator

(707) 784-8155
www.solanocounty.com

POLICY MEMORANDUM 4700

Implementation Date: August 1, 2017
Review Date: August 1, 2019

REVIEWED/APPROVED BY:

BYRN MUMMA, MD, MAS, EMS AGENCY MEDICAL DIRECTOR

TED SELBY, EMS AGENCY ADMINISTRATOR

SUBJECT: EMERGENCY MEDICAL TECHNICIAN (EMT) & LAW ENFORCEMENT INITIAL TRAINING GUIDELINES: NALOXONE

AUTHORITY:
CALIFORNIA CODE OF REGULATIONS, TITLE 22, DIVISION 9, CHAPTER 2, SECTION 100075, EFFECTIVE JULY 1, 2017.

PURPOSE/POLICY:
To establish initial training guidelines for administration of naloxone for EMTs and law enforcement personnel.

I. INITIAL TRAINING GUIDELINES

A. Initial training in the administration of naloxone or other opioid antagonist will result in EMT and law enforcement personnel being competent in the administration of naloxone and managing a patient of a suspected narcotic overdose and shall include the following topics and skills:

1. Common causative agents.
2. Patient assessment and relevant findings.
3. Management to include, but not limited to:
   a. Need for appropriate personal protective equipment and scene safety awareness.
4. Profile of naloxone to include, but not limited to:
   a. Indications;
   b. Contraindications;

c. Side/adverse effects;

d. Routes of Administration;

i. EMTs may administer naloxone by the intranasal (IN) or intramuscular (IM) routes.

ii. Law enforcement personnel may administer naloxone by the IN route only.

e. Dosages;

i. Calculating drug dosages.

f. Mechanisms of drug action;

g. Medical asepsis;

h. Disposal of contaminated items and sharps;

i. Medication administration.

B. At the completion of this training, the EMT or law enforcement personnel must complete a competency based written and skills examination for administration of naloxone which will include:

1. Assessment of when to administer naloxone;
2. Managing a patient before and after administering naloxone;
3. Using universal precautions and body substance isolations procedures during medication administration;
4. Demonstrating aseptic technique during medication administration;
5. Demonstrating preparation and administration of parenteral medications by the IM and IN routes for EMTs and IN route for law enforcement personnel;
6. Proper disposal of contaminated items and sharps.

C. After completion of initial training, EMTs may administer naloxone as a part of the EMT basic scope of practice. Reference Solano County EMS Policy 6300.

D. After completion of initial training, law enforcement personnel may administer naloxone only while on duty with an EMS Agency approved optional skills provider.

1. The process outlined in EMS Policy 3303, EMT Local Optional Skills Provider Authorization will serve as the approval process for law enforcement departments to become an optional skills provider.

E. All EMTs must complete this training by July 1, 2019. After that date, EMTs will not be recertified without submitting proof of training to the EMS Agency. Reference EMS Policy 3200 EMT Certification and Recertification.

GERALD HUBER
Director

EMERGENCY SERVICES BUREAU
355 Tuolumne Street,
Suite 2400, MS 20-240
Vallejo, CA 94590

DEPARTMENT OF HEALTH & SOCIAL SERVICES
Medical Services Division

SOLANO COUNTY

BRYN MUMMA, MD, MAS
EMS Agency Medical Director

TED SELBY
EMS Agency Administrator

(707) 784-8155
www.solanocounty.com

POLICY MEMORANDUM 4701

Implementation Date: August 1, 2017
Review Date: August 1, 2019

REVIEWED/APPROVED BY:

BYRN MUMMA, MD, MAS, EMS AGENCY MEDICAL DIRECTOR

TED SELBY, EMS AGENCY ADMINISTRATOR

SUBJECT: EMERGENCY MEDICAL TECHNICIAN (EMT) & LAW ENFORCEMENT PERSONNEL INITIAL TRAINING GUIDELINES: EPINEPHRINE AUTO INJECTOR

AUTHORITY:

CALIFORNIA CODE OF REGULATIONS, TITLE 22, DIVISION 9, CHAPTER 2, SECTION 100075, EFFECTIVE JULY 1, 2017.

PURPOSE/POLICY:

To establish initial training guidelines for administration of epinephrine auto injectors for EMT and law enforcement personnel.

I. INITIAL TRAINING GUIDELINES

A. Initial training in the administration of epinephrine for suspected anaphylaxis and/or severe asthma will result in EMT and law enforcement personnel being competent in the administration of an epinephrine auto injector and managing a patient of a suspected allergic reaction and/or experiencing severe asthma symptoms. The training will include the following topics and skills:

1. Common causative agents.
2. Patient assessment and relevant findings.
3. Management to include, but not limited to:
   a. Need for appropriate personal protective equipment and scene safety awareness.
4. Profile of epinephrine to include, but not limited to:

a. Indications;
b. Contraindications;
c. Side/adverse effects;
d. Routes of Administration;
e. Dosages;
    i. Calculating drug dosages.
f. Mechanisms of drug action;
g. Medical asepsis;
h. Disposal of contaminated items and sharps;
i. Medication administration.

B. At the completion of this training, the EMT or law enforcement personnel must complete a competency based written and skills examination for administration of epinephrine which will include:
    1. Assessment of when to administer epinephrine;
    2. Managing a patient before and after administering epinephrine;
    3. Using universal precautions and body substance isolations procedures during medication administration;
    4. Demonstrating aseptic technique during medication administration;
    5. Demonstrating preparation and administration of parenteral medications by auto injector;
    6. Proper disposal of contaminated items and sharps;
    7. For law enforcement personnel, accessing 9-1-1 or Advanced Life Support Services for all patients suffering anaphylaxis/severe asthma or receiving epinephrine.

C. After completion of initial training, EMTs may administer an epinephrine auto injector as a part of the EMT basic scope of practice. Reference Solano County EMS Policy 6300.

D. After completion of initial training, law enforcement personnel may administer an epinephrine auto injector only while on duty with an EMS Agency approved optional skills provider.
    1. The process outlined in EMS Policy 3303, EMT Local Optional Skills Provider Authorization will serve as the approval process for law enforcement departments to become an optional skills provider.

E. All EMTs must complete this training by July 1, 2019. After that date, EMTs will not be recertified without submitting proof of training to the EMS Agency. Reference EMS Policy 3200 EMT Certification and Recertification.

GERALD HUBER
Director

EMERGENCY SERVICES BUREAU
355 Tuolumne Street,
Suite 2400, MS 20-240
Vallejo, CA 94590

DEPARTMENT OF HEALTH & SOCIAL SERVICES
Medical Services Division

SOLANO COUNTY

BRYN MUMMA, MD, MAS
EMS Agency Medical Director

TED SELBY
EMS Agency Administrator

(707) 784-8155
www.solanocounty.com

POLICY MEMORANDUM 4702

Implementation Date: August 1, 2017
Review Date: August 1, 2019

REVIEWED/APPROVED BY:

BYRN MUMMA, MD, MAS, EMS AGENCY MEDICAL DIRECTOR

TED SELBY, EMS AGENCY ADMINISTRATOR

SUBJECT: EMERGENCY MEDICAL TECHNICIAN (EMT) INITIAL TRAINING GUIDELINES: FINGER STICK BLOOD GLUCOSE TESTING

AUTHORITY:
CALIFORNIA CODE OF REGULATIONS, TITLE 22, DIVISION 9, CHAPTER 2, SECTION 100075, EFFECTIVE JULY 1, 2017.

PURPOSE/POLICY:
To establish initial training guidelines for the use of finger stick blood glucose testing for EMT personnel.

I. INITIAL TRAINING GUIDELINES

A. Initial training in the use of finger stick blood glucose testing will result in the EMT being competent in the use of a glucometer and managing a patient with a diabetic emergency. The training will include the following topics and skills:

1. Blood glucose determination.
   - a. Assess blood glucose level;
   - b. Indications:
     - i. Decreased level of consciousness in the suspected diabetic;
     - ii. Decreased level of consciousness of unknown origin.
   - c. Procedure for use of a finger sick blood glucometer:
     - i. Medical asepsis;
     - ii: Refer to manufacturer's instructions for device being used.

d. Disposal of contaminated items or sharps;

e. Limitations;

i. Lack of calibration.

2. Interpretation of results;

3. Patient assessment;

4. Managing a patient before and after finger stick glucose testing.

B. At the completion of this training, the EMT must complete a competency based written and skills examination to perform finger stick blood glucose testing which will include:

1. Assessment of when to use and interpret the results of finger stick blood glucose testing;

2. Managing a patient before and after use of finger stick blood glucose testing;

3. Using universal precautions and body substance isolations procedures during finger stick blood glucose testing;

4. Proper use and proper calibration of a finger stick blood glucometer;

5. Demonstrating aseptic technique during finger stick blood glucose testing;

6. Proper disposal of contaminated items and sharps;

C. After completion of initial training, EMTs may use finger stick blood glucose testing as a part of the EMT basic scope of practice. Reference Solano County EMS Policy 6300.

E. All EMTs must complete this training by July 1, 2019. After that date, EMTs will not be recertified without submitting proof of training to the EMS Agency. Reference EMS Policy 3200 EMT Certification and Recertification.

Solano County Health & Social Services Department

Gerald Huber, Director

EMERGENCY SERVICES BUREAU

Bryn E. Mumma, MD, MAS
EMS Agency Medical Director

355 Tuolumne St., MS 20-240
Suite 2400, Vallejo, CA. 94590
(707) 784-8155
www.solanocounty.com

Ted Selby
EMS Agency Administrator

POLICY MEMORANDUM 5900

Implementation Date: April 7, 2011
Revised Date: May 1, 2017
Review Date: May 1, 2019

REVIEWED/APPROVED BY:

BRYN E. MUMMA, MD, MAS, EMS AGENCY MEDICAL DIRECTOR

TED SELBY, EMS AGENCY ADMINISTRATOR

SUBJECT: SOLANO COUNTY TRAUMA SYSTEM

AUTHORITY: California Health & Safety Code, Division 2.5, Section 1797.220 and 1798.163.

PURPOSE/POLICY:

This policy shall provide the basic outline of the Trauma System in Solano County including but not limited to, trauma system design, participants, Trauma Center geographic service areas, trauma data collection, analysis and management, coordination of trauma care with neighboring jurisdictions, and quality improvement and evaluation.

I. DEFINITIONS:

A. Trauma Center: Designation received by a hospital after undergoing extensive review from the Local EMS Agency and complying with the appropriate State of California regulations. These hospitals provide trauma data to Solano County EMS Agency.

B. Pediatric Trauma Center: Designation received by a hospital after undergoing extensive review from the Local EMS Agency and complying with the appropriate State of California regulations.

C. Receiving Hospital: A system hospital with a Basic Emergency Department as defined in the appropriate State of California regulations.

II. OVERVIEW OF SOLANO COUNTY TRAUMA SYSTEM:

Solano County is a medium sized county with a population of approximately 420,000 located in the Bay Area region of California. The county has five community hospitals and one military hospital providing care to the residents. The Solano County EMS in-county Designated Level II Trauma Center is Kaiser Foundation Hospital, Vacaville (KVV); the in-county Designated Level III Trauma Center is NorthBay Medical Center (NBMC). Solano County EMS has also designated John Muir Medical Center (JMMC), Walnut Creek and UC Davis Medical Center (UCDMC), Sacramento as out-of-county Level II and I Trauma Centers respectively. The closest pediatric trauma centers are located in Sacramento, UCDMC and Alameda Counties, Children's Hospital Oakland (CHO). Based on the Solano County Trauma Triage criteria the most severe pediatric trauma cases are transported via ground or air ambulance to the out-of-county pediatric trauma centers. Those patients who do not meet the Solano County Trauma Triage criteria are transported to a local hospital for assessment and treatment. Solano Trauma Triage criteria was developed with input from all of the constituents of our EMS system. This document is reviewed periodically by the EMS Agency Medical Director and other groups. The Physician's Advisory Forum (advisory group to the Medical Director) and Trauma Advisory Committee (TAC) provide information on quality improvement, policies, and procedures to the Solano County EMS Agency Medical Director.

A. TRAUMA CENTER CATCHMENT BY SOLANO COUNTY CITIES:

Generally trauma patients living in the following cities have this geographic distribution:

CITY	ADULTS	PEDIATRIC
Vallejo	• Victims of Level I and II trauma go to JMMC	• Victims of Level I and II trauma go to CHO
Benicia	• Victims of Level I and II trauma go to JMMC	• Victims of Level I and II trauma go to CHO
Fairfield	• Victims of Level I and II trauma go to KVV or JMMC	• Victims of Level I and II trauma go to CHO
Suisun City	• Victims of Level I and II trauma go to KVV or JMMC	• Victims of Level I and II trauma go to CHO
Rio Vista	• Victims of Level I and II trauma go to KVV or UCDMC	• Victims of Level I and II trauma go to UCDMC
Vacaville	• Victims of Level I and II trauma go to KVV or UCDMC	• Victims of Level I and II trauma go to UCDMC
Dixon	• Victims of Level I and II trauma go to KVV or UCDMC	• Victims of Level I and II trauma go to UCDMC

B. PHYSICIANS' ADVISORY FORUM

This is an advisory group to the EMS Agency Medical Director comprised of select individuals who provide feedback on trauma care, policies, and protocols. See Policy 1790.

C. TRAUMA ADVISORY COMMITTEE (TAC)

This committee was formerly titled Pre-hospital Trauma Advisory Committee; the group was asked to change their focus in 2013 and thus was renamed to better reflect their new role. More detailed information is provided in Section V(A)(1).

D. TRAUMA DATA COLLECTION

The Solano County EMS Agency works with our trauma center partners to collect trauma data elements pursuant to California Health & Safety Code, Sections 100257 and 100176.

III. TRAUMA CARE SYSTEMS FOR QUALITY IMPROVEMENT:

A. Solano County Designated Trauma Centers are responsible for conducting quality improvement activities in accordance with the requirements of the various guiding documents, such as but not limited to, designation contracts and American College of Surgeons' (ACS) guidelines.

B. Representatives from trauma centers with designations from Solano County are required to:

1. Participate in the Solano County EMS Agency TAC;
2. Submit trauma reports and analysis regarding patients received from Solano County to the Solano County EMS Agency as appropriate; and
3. Notify the Solano County EMS Agency of unusual occurrences or other significant matters

C. Trauma centers located in neighboring jurisdictions which are not designated by Solano County are responsible for conducting quality improvement activities in accordance with the requirements of their designation contracts.

D. Representatives from trauma centers located in neighboring jurisdictions, which are not designated by Solano County, are invited to:

1. Participate in the Solano County EMS Agency TAC;
2. Submit trauma reports and analysis regarding patients received from Solano County to the Solano County EMS Agency as appropriate; and
3. Notify the Solano County EMS Agency of unusual occurrences or other significant matters.

IV. GENERAL TRAUMA FIELD OPERATIONAL CONCEPTS:

A. Solano County Paramedics will follow the Solano County Trauma Triage Policy and Algorithm when determining a trauma patient's destination. Mode of transportation will be based on the following factors (this is not an all-inclusive list of considerations): time of day, day of week, traffic, scene location, distance to trauma center, and resource availability.

B. After the destination and mode of transportation decisions have been made, transport will be to the closest appropriate facility.

V. TRAUMA SYSTEM QUALITY IMPROVEMENT AND EVALUATION:

QI and evaluation of the Trauma Plan must be focused on two primary objectives: providing optimal care for trauma patients and reducing injuries through education and prevention. The trauma system quality improvement and evaluation will be done using a multi-disciplinary approach involving an improvement team comprised of individuals from local BLS and ALS providers, local receiving hospitals, and receiving trauma centers. Feedback will be directed to the appropriate individual, agency, or committee.

Evaluation parameters will include, at a minimum, measurements of trauma on-scene time and transport times, evaluation of helicopter transports, determination of over triage and under triage rates, common mechanism of injury, determination of preventable deaths, complications, average patient ages, lengths of stay, Intensive Care Unit days, and discharge status.

The Trauma Improvement Team provides quality improvement and oversight to various system agencies as data is evaluated. It will also produce generic educational materials to enhance trauma care. Because of the confidential nature of this Team, confidentiality statements are required of all participants.

A. TRAUMA ADVISORY COMMITTEE (TAC)

TAC evaluates the trauma system in Solano County. The committee evaluates the cumulative trauma data the EMS Agency collects and specific cases which have some benefit to the various providers in our system.

1. TAC COMPOSITION

The TAC shall be chaired by the Solano County EMS Agency Medical Director. The TAC membership shall include, but is not limited to:

- Solano County EMS Agency Staff
  - EMS Medical Director
  - EMS Administrator
  - EMS Associate Administrator
  - EMS Operations Manager
  - EMS Coordinator(s)
  - Other EMS Staff as directed

- Trauma Centers Designated by Solano County
  - Trauma Program Medical Director(s)
  - Trauma Program Nurse Coordinator(s)
- Solano County Designated Trauma Centers Located outside Solano County
  - Trauma Program Medical Director(s)
  - Trauma Program Nurse Coordinator(s)
- Solano County ALS Providers and Air Ambulance Providers
  - Operations Manager
  - CQI Coordinators
- Other Invited Guests as approved by the Committee chairperson

2. TAC CASE SELECTION:

Cases presented at the TAC meeting will be selected by the EMS Operations Manager and/or EMS Coordinator in consultation with the EMS Medical Director. In general, and based on the allotted time for the TAC meeting, the following types of cases will be selected: trauma death cases, patients transported to local hospital and subsequently transferred to a trauma center, patients with ISS scores of ≤10 and LOS of ≤ 3, patients discharged from trauma centers in less than 24 hours.

3. TAC CONFIDENTIALITY:

a. All proceedings, documents, and discussions of the TAC, and its subcommittees are confidential and protected under Sections 1040 and 1157.7 of the Evidence Code of the State of California. The prohibition relating to discovery or testimony provided in Section 1157 shall be applicable to proceedings and records of any committee established by a local governmental agency to monitor, evaluate, and report on the necessity, quality, and level of specialty healthcare services, including but not limited to, trauma care service provided by a general acute care hospital which has been designated or recognized by that governmental agency as qualified to render specialty healthcare services.

b. All members and guests sign a confidentiality agreement memorializing that they will not divulge or discuss publicly information obtained through Committee membership. Prior to a guest participating in the meeting, the Committee Chair is responsible for explaining and obtaining a signed confidentiality agreement from the guest.

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GERALD HUBER
Director

EMERGENCY SERVICES BUREAU
355 Tuolumne Street,
Suite 2400, MS 20-240
Vallejo, CA 94590

DEPARTMENT OF HEALTH & SOCIAL SERVICES
Medical Services Division

SOLANO COUNTY

BRYN MUMMA, MD, MAS
EMS Agency Medical Director

TED SELBY
EMS Agency Administrator

(707) 784-8155
www.solanocounty.com

POLICY MEMORANDUM 6155

Implementation Date: November 30, 2012
Revised Date: August 1, 2017
Review Date: August 1, 2019

REVIEWED/APPROVED BY:

BRYN MUMMA, MD, MAS, EMS AGENCY MEDICAL DIRECTOR

TED SELBY, EMS AGENCY ADMINISTRATOR

SUBJECT: RESUSCITATION PARAMETERS

AUTHORITY: CALIFORNIA HEALTH & SAFETY CODE § DIVISION 2.5; § 1797.220

PURPOSE/POLICY:

Defines obvious death and when Emergency Medical Technicians (EMTs) and Paramedics can declare deceased patients. Defines probable death and when Paramedics can declare deceased patients and terminate resuscitation. Defines when EMTs and Paramedics should not initiate resuscitation due to a "Do Not Resuscitate" (DNR) Order or an End of Life Option Act Attestation.

I. DETERMINATION OF OBVIOUS DEATH (EMTs and PARAMEDICS)

A. EMTs and Paramedics may determine death if any one of the following criteria is met:

1. Decapitation (separation of the head at the neck)
2. Total incineration of the body;
3. Decomposition of the body;
4. Rigor mortis in two or more joints or signs of lividity.
5. Total separation of the heart or brain from the body or destruction of these organs accompanied by no detectable pulse or respirations.

6. During a Multi Casualty Incident, a patient that has no pulse and is apneic may be declared dead using triage guidelines and/or when sufficient resources are not available to provide resuscitation.

B. If any of the above criteria are met, the EMT or Paramedic will:

1. Cancel the Advanced Life Support (ALS) response, if applicable;
2. Report the death to the appropriate public safety agency with the jurisdiction for the decedent's location and the county coroner. Follow the instructions regarding the decedent from the county coroner.
   a. Provide appropriate comfort and care to bystanders and family.
   b. The decedent will be attended by a responsible party such as family, funeral home personnel, or law enforcement. Do not leave the decedent unattended.

II. DETERMINATION OF PROBABLE DEATH (PARAMEDICS)

A. Paramedics may determine death using the obvious death criteria in Section I of this policy.

B. Paramedics may determine probable death in medical adult or pediatric patients if the patient meets the following criteria:

1. Patient has been observed to be not breathing with no CPR in progress and the patient exhibits all of the following:
   a. Asystole in two leads on a cardiac monitor;
   b. Fixed and dilated pupils.

C. Paramedics may determine probable death in adult and pediatric trauma patients (blunt or penetrating) if the patient meets ALL of the following:

1. Pulseless and apneic upon arrival of paramedic;
2. Asystole or PEA with a heart rate of less than 40 in two leads on a cardiac monitor (any other rhythm is transported according to trauma treatment and transport policies).

D. After determining probable death, the Paramedic will use the steps outlined in Section I(B) for reporting the death.

III. DO NOT RESUSCITATE (DNR) AND SIMILAR ORDERS

A. Solano County EMS personnel may encounter several types of directives in the prehospital setting. Any one of the following are approved DNR orders by the Solano County EMS Agency:

1. A fully executed original or photocopy of the California Emergency Medical Services/California Medical Association Prehospital DNR form;

2. A fully executed original or photocopy of the Physicians' Order for Life-Sustaining Treatment (POLST) form;
3. A written or electronic DNR order by a physician;
4. A medical alert necklace or bracelet stating DNR.

B. Other forms of documentation stating patient wishes such as, but not limited to, an Advance Health Care Directive (AHCD), Durable Power of Attorney for Healthcare (DPAHC), Living Will, or Declaration under the California Natural Death Act, will result in a Base Hospital Physician consult for direction.

IV. DNR PROCEDURES

A. Once the EMS system has been activated, Solano County's policy is to require the presentation of a valid DNR/DNI (Do Not Intubate) authorization to the field personnel before any resuscitation can be withheld.

B. **DNR** means that no chest compressions, defibrillation, endotracheal intubation assisted ventilation or cardiac drugs will be utilized.

C. The patient should receive full palliative treatment for pain, dyspnea, major hemorrhage or other medical condition.

D. Relief of choking caused by a foreign body is usually appropriate, although if breathing has stopped and the patient is unconscious, ventilation should not be assisted. Oral suctioning is permissible for patient comfort.

E. **DNI** means that no means of invasive ventilation or advanced airway will be used.

1. The use of oxygen administration without invasive ventilation is authorized, including the use of CPAP.
2. Use of methods of relieving airway obstruction such as nasal airways or maneuvers to open the airway such as abdominal thrusts are still to be used if indicated.

F. If upon presentation of the DNR/DNI authorization there exists a discrepancy as to the wishes of the patient, **full resuscitation will commence**. If the patient is unconscious and the family directs that resuscitation be done then EMS personnel will do so, and bring the DNR/DNI authorization form to the receiving facility.

1. If the validity of the DNR request is questioned (e.g., form signed by the patient but not by the physician; a family member strongly objecting to the withholding of resuscitative measures), EMS personnel may temporarily disregard the DNR request and institute resuscitative measures until paramedics consult with a Base Hospital physician.

2. If the DNR order is issued verbally over the phone to EMS personnel by the patient's physician, institute resuscitative measures until Paramedics consult with a Base Hospital physician. Obtain a call back number from the patient's physician in case the Base Hospital physician wishes to contact the patient's physician

G. All cases of application of a DNR/DNI in the field will be reviewed by the ALS Provider Agencies as part of their routine quality assurance activities and any problems reported to the EMS office.

V. AB15 END OF LIFE OPTION ACT

AB15 End of Life Option Act is a California State law that authorizes an adult who meets certain qualifications and who has been determined by his/her attending physician to be suffering from a terminal disease to make a request for an "aid-in-dying drug" prescribed for the purpose of ending his/her life in a humane manner. The following guidelines are provided for EMS personnel when responding to a patient who has self-administered an aid-in-dying drug.

A. Within 48 hours prior to self-administering the aid-in-dying drug, the patient is required to complete a "Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner." However, there is no mandate for the patient to maintain the final attestation in close proximity. If a copy of the final attestation is available, EMS personnel should confirm the patient is the person named in the final attestation. This will normally require either the presence of a witness who can reliably identify the patient or the presence of a form of identification.

B. There are no standardized "Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner" forms. If available, EMS personnel should make a good faith effort to review and verify that the document is identified as a "Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner" and includes the patient's name, signature and date.

C. Provide comfort measures (airway positioning, suctioning) when applicable.

D. Withhold resuscitative measures if patient is in cardiopulmonary arrest. If a POLST or EMSA DNR form is present, follow the directive as appropriate for the clinical situation.

E. The patient may at any time withdraw or rescind his or her request for an aid-in-dying drug regardless of their mental state. In this instance, EMS personnel shall provide medical care according to standard treatment protocols. EMS personnel are encouraged to consult with a Base Hospital Physician in these situations.

F. Family members may be at the scene of a patient who has self-administered an aid-in-dying drug. If there is objection to the End of Life Option Act, inform the family that comfort measures will be provided and consider Base Hospital Physician consultation for further direction.

VI. TERMINATION OF RESUSCITATION

A. Termination of resuscitation should be considered for those patients without Return of Spontaneous Circulation (ROSC) if one of the following applies:

1. 20 minutes of ALS resuscitation if the patient's cardiac rhythm is asystole, Pulseless Electrical Activity (PEA), or any other agonal rhythm per the American Heart Association (AHA) ACLS algorithm;
2. The arrest was not witnessed, had no bystander CPR, and an Automatic External Defibrillator (AED) was not used OR used but "no shock advised" after three rounds of CPR.

B. Contact with a physician at the intended receiving hospital should be made after resuscitative measures have been underway for 20 minutes without ROSC. The Base Hospital Physician may elect to terminate a field resuscitation by voice contact with the paramedics at the scene or a field resuscitation prior to and/or after initiating ALS measures in any case where it is determined that further ACLS measures are futile. The final decision to terminate resuscitative efforts should be a consensus between the paramedic and the base hospital physician.

C. Adult patients who fail to respond to 20 minutes of full field resuscitative efforts (CPR, defibrillation, airway management, and medication administration in accordance with ACLS Guidelines) are very unlikely to recover or receive no benefit from being transported to a receiving facility.

VII. RESUSCITATION AND TRANSPORT

A. Transportation of adult patient should be initiated in the following circumstances:

1. ROSC.
2. Refractory ventricular tachycardia.
3. Scene factors preclude declaration of death (public places), or in the opinion of the team leaders, the immediate grief response may endanger field personnel and declaration of death may be better handled at the receiving hospital.

B. Pediatric cardiac arrests that do not fit the criteria stated in Sections I and II should be transported to the hospital as soon as reasonably possible.

VIII. DOCUMENTATION FOR TERMINATION OR RESUSCITATION

A. In each instance where the Base Hospital physician has determined further ALS measures are futile and has elected to terminate resuscitation, the paramedic shall:

1. Note in the narrative section of the Patient Care Report (PCR) the name of the physician who orders termination of resuscitative effort AND time of the medical order to terminate resuscitation.
2. Complete a PCR and forward the "Base Hospital Copy" with appropriate ECG strips to the appropriate Base Hospital.

IX. CAUTION

Hypothermia - *A patient who has drowned, has a history consistent with hypothermia, or there is any likelihood that resuscitation is in the patient's best medical interest should have resuscitative efforts started and be transported to the closest appropriate facility as soon as possible.*

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GERALD HUBER
Director

EMERGENCY SERVICES BUREAU
355 Tuolumne Street,
Suite 2400, MS 20-240
Vallejo, CA 94590

DEPARTMENT OF HEALTH & SOCIAL SERVICES
Medical Services Division

SOLANO COUNTY

BRYN MUMMA, MD, MAS
EMS Agency Medical Director

TED SELBY
EMS Agency Administrator

(707) 784-8155
www.solanocounty.com

POLICY MEMORANDUM 6300

Implementation Date: June 19, 2014
Revised Date: July 1, 2017
Review Date: July 1 ,2019

REVIEWED/APPROVED BY:

BYRN MUMMA, MD, MAS, EMS AGENCY MEDICAL DIRECTOR

TED SELBY, EMS AGENCY ADMINISTRATOR

SUBJECT: EMERGENCY MEDICAL TECHNICIAN (EMT) SCOPE OF PRACTICE

AUTHORITY:
CALIFORNIA CODE OF REGULATIONS, TITLE 22, DIVISION 9, CHAPTER 2, SECTION 100063 and 100064, EFFECTIVE JANUARY 1, 2017.

PURPOSE/POLICY:
To establish EMT Scope of Practice for certified EMT or supervised EMT student operating in Solano County.

I. During training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfer, a certified EMT or supervised EMT student is authorized to do any of the following:

   A. Evaluate the ill and injured.

   B. Render Basic Life Support (BLS), rescue, and provide emergency medical care to patients.

   C. Obtain diagnostic signs to include, but not be limited to, temperature, blood pressure, pulse and respiration rates, pulse oximetry, level of consciousness, and pupil status.

   D. Perform Cardiopulmonary Resuscitation (CPR), including the use of mechanical adjuncts to basic CPR.

   E. Administer oxygen.

F. Use the following adjunctive airway and breathing aids:
   1. Oropharyngeal airway;
   2. Nasopharyngeal airway;
   3. Suction devices;
   4. Basic oxygen delivery devices for supplemental oxygen therapy including, but not limited to, humidifiers, partial re-breathers, and venturi masks;
   5. Manual and mechanical ventilating devices designed for pre-hospital use including Continuous Positive Airway Pressure (CPAP).

G. Use various types of stretchers and Spinal Motion Restriction (SMR) or immobilization devices.

H. Provide initial pre-hospital emergency care to patients, including, but not limited to:
   1. Bleeding control through the application of tourniquets;
   2. Use of hemostatic dressings from a list approved by the Solano County EMS Agency;
   3. SMR or immobilization;
   4. Seated SMR or immobilization;
   5. Extremity splinting;
   6. Traction splinting;
   7. Administer oral glucose or sugar solutions;
   8. Extricate entrapped persons;
   9. Perform field triage;
   10. Transport patients;
   11. Apply mechanical patient restraint;
   12. Set up for Advanced Life Support (ALS) procedures, under the direction of an Advanced EMT or Paramedic;
   13. Perform automated external defibrillation;
   14. Assist patients with the administration of physician-prescribed devices including, but not limited to, patient-operated medication pumps, sublingual nitroglycerin, and self-administered emergency medications, including epinephrine devices.

II. The Solano County EMS Medical Director may also establish policies and procedures to allow a certified EMT or a supervised EMT student who is part of the organized EMS system and in the prehospital setting and/or during interfacility transport to:

A. Monitor intravenous lines delivering glucose solutions or isotonic balanced salt solutions including Ringer's lactate for volume replacement. Monitor, maintain, and adjust if necessary in order to maintain, a preset rate of flow and turn off the flow of intravenous fluid;

B. Transfer a patient, who is deemed appropriate for transfer by the transferring physician, and who has nasogastric (NG) tubes, gastrostomy tubes, heparin locks, Foley catheters, tracheostomy tubes and/or indwelling vascular access lines, excluding arterial lines;

C. Administer naloxone (Narcan) or other opioid antagonist by intranasal and/or intramuscular routes for suspected narcotic overdose;

D. Administer epinephrine by auto-injector for suspected anaphylaxis and/or severe asthma;

E. Perform finger stick blood glucose testing;

F. Administer over-the-counter medications, such as Aspirin, when approved by the Medical Director.

III. EMT LOCAL OPTIONAL SKILLS

The Solano County EMS Agency may establish policies and procedures for local accreditation of an EMT student or certified EMT to perform the following optional skills. Accreditation for EMTs to practice optional skills shall be limited to those whose EMT certificate is active and are employed within the jurisdiction of Solano County EMS by an employer who is part of the EMS system.

The preferred perilaryngeal airway for use in Solano County is the King Airway. Refer to Policy 6608, Advanced Airway Management for the procedure for use of this device.

A. Use of perilaryngeal airway adjuncts.

1. Training in the use of perilaryngeal airway adjuncts shall consist of not less than five hours to result in the EMT being competent in the use of the device and airway control. Included in the above training house shall be the following topics and skills:

   a. Anatomy and physiology of the respiratory system.

   b. Assessment of the respiratory system.

   c. Review of basic airway management techniques, with includes manual and mechanical.

   d. The role of the perilaryngeal airway adjuncts in the sequence of airway control.

   e. Indications and contraindications of the perilaryngeal airway adjuncts.

   f. The role of pre-oxygenation in preparation for the perilaryngeal airway adjuncts.

   g. Perilaryngeal airway adjuncts insertion and assessment of placement.

h. Methods for prevention of basic skills deterioration.

i. Alternatives to the perilaryngeal airway adjuncts.

2. At the completion of initial training a student shall complete a competency based written and skills examination for airway management which shall include the use of basic airway equipment and techniques and use of perilaryngeal airway adjuncts.
3. A skills competency demonstration shall be required for the reaccrediting EMT every two (2) years for the EMT to continue using perilaryngeal airways.

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GERALD HUBER
Director

EMERGENCY SERVICES BUREAU
355 Tuolumne Street,
Suite 2400, MS 20-240
Vallejo, CA 94590

DEPARTMENT OF HEALTH & SOCIAL SERVICES
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SOLANO COUNTY

BRYN MUMMA, MD, MAS
EMS Agency Medical Director

TED SELBY
EMS Agency Administrator

(707) 784-8155
www.solanocounty.com

POLICY MEMORANDUM 6608

Implementation Date: August 18, 2014
Revised Date: July 1, 2017
Review Date: July 1, 2019

REVIEWED/APPROVED BY:

BRYN MUMMA, MD, MAS, EMS AGENCY MEDICAL DIRECTOR

TED SELBY, EMS AGENCY ADMINISTRATOR

SUBJECT: ADVANCED AIRWAY MANAGEMENT

AUTHORITY:

California Health & Safety Code §1797.220

PURPOSE/POLICY:

Airway management is a critical and potentially lifesaving skill for paramedics to master and maintain proficiency. This Policy is written to address both training and authorization requirements, as well as, audit outcome expectations for advanced airway management by Solano County Accredited Paramedics. This policy encompasses the use of all advanced airway techniques authorized in Solano County: oral endotracheal intubation, King Airway™, and the Endotracheal Tube Introducer (Gum-Elastic Bougie).

DEFINITIONS:

Endotracheal Intubation Attempt – An attempt at endotracheal intubation is defined as the insertion of a laryngoscope (i.e. past the teeth/gums) with the intention of intubation.

I. INITIAL ADVANCED AIRWAY AUTHORIZATION

A. Adult endotracheal (ET) intubation is within the basic Emergency Medical Technician-Paramedic (EMT-P) scope of practice for the State of California, therefore, an EMT-P licensed by the State of California will be considered authorized to perform adult endotracheal intubation in Solano County for the purpose of initial accreditation.

B. Pediatric endotracheal intubation is in the optional EMT-P scope of practice for the State of California. Documentation of training in this skill is required for accreditation in Solano County. Documentation of this skill may be by:

1. Completion of an advanced pediatric life support course such as PALS or APLS; or
2. Documentation of a course designed to specifically train and test the skill of pediatric endotracheal intubation (e.g., Special Procedures Testing in other counties); or
3. Other considerations as approved by the Solano County Emergency Medical Services (EMS) Agency Medical Director.

C. Use of use of lower airway multi-lumen adjuncts and supralaryngeal airway is a part of the basic EMT-P scope of practice for the State of California, therefore, an EMT-P licensed by the State of California will be considered authorized to use lower multi-lumen adjuncts and supralaryngeal airways in Solano County for the purpose of initial accreditation.

D. Solano County Accredited Paramedics, with proper training, are authorized to use the endotracheal tube introducer (gum-elastic Bougie), for all ET intubations.

E. Re-Accrediting Paramedics will demonstrate skills competency by attending a Continuing Education Course in advanced airway management for a minimum length of four (4) hours. AHA ACLS and/or PALS courses may be used to satisfy one (1) hour of this requirement for each certification. Refer to Policy 3400, Paramedic Accreditation/Reaccreditation Process, Section II(A)(4)(b).

II. KING AIRWAY™

The King Airway™ is available in three sizes and cuff inflation varies by model:

- Size 3 – Patient between 4 and 5 feet tall (50 ml air)
- Size 4 – Patient between 5 and 6 feet tall (70 ml air)
- Size 5 – Patient over 6 feet tall (80 ml air)

A. INDICATIONS FOR USE:

1. Cardiac and/or respiratory arrest **and**
2. Prior failed (maximum of two (2)) attempts at endotracheal intubation.
3. Situations where the airway cannot be visualized for intubation:
   a. Trauma/blood/vomit/other secretions.
   b. Entrapment of the patient with limited access to the patient.

B. CONTRAINDICATIONS FOR USE:

1. Intact gag reflex.
2. Ingestion of caustic substances.

3. Known disruption of esophageal anatomy.
4. Presence of a tracheostomy or stoma.

C. EQUIPMENT:

1. King Airway™ LTS-D kit (adult sizes 3, 4 and 5);
2. Water soluble lubricant;
3. Syringe 50 – 100 ml varies by size;
4. Stethoscope;
5. Portable suction;
6. Bag Valve Mask (BVM) device;
7. PPE (Personal Protective Equipment).

D. INSERTION PROCEDURE:

1. Assure an adequate BLS airway;
2. Oxygenate with 100% oxygen;
3. Select appropriately sized King Airway™;
4. Check the King Airway™ cuffs to ensure patency. Deflate tube cuffs. Leave syringe attached. Lubricate the tip of the tube;
5. Position the head. The ideal position is the "sniffing position". A neutral position should be used if traumatic injury to the cervical spine is suspected;
6. Without exerting excessive force, advance tube until the base of connector is aligned with teeth or gums;
7. Inflate cuffs based on size and recommended volume;
8. Attach bag-valve to King Airway™. While gently bagging the patient to assess ventilation, withdraw the airway until ventilation is easy and free flowing;
9. If breath sounds are present, continue to ventilate. If air leak is noted, up to 10 ml of air can be added to the cuff;
10. Secure the tube with tape. Note depth marking on tube;
11. Continue to monitor the patient for proper tube placement throughout pre-hospital treatment and transport (e.g. lung sounds, waveform capnography). Waveform capnography should be used on all patients with such an extraglottic airway. Do not use an esophageal detector device with extraglottic airways;
12. Document King Airway™ placement times and results of tube placement checks performed throughout the resuscitation and transport.

E. TROUBLESHOOTING AND ADDITIONAL INFORMATION

1. If placement is unsuccessful, remove tube, ventilate via BVM and repeat sequence of steps.
2. If unsuccessful on second attempt, Basic Life Support (BLS) airway management should be resumed.
3. Most unsuccessful placements relate to failure to keep tube in midline during placement.
4. Cuffs can be lacerated by broken teeth or dentures. Remove dentures before placing tube.
5. Do not force tube, as airway trauma may occur.

III. ENDOTRACHEAL TUBE INTRODUCER OR GUM-ELASTIC BOUGIE

The endotracheal tube introducer (gum-elastic bougie), is a flexible intubating stylet with a bent distal tip. The introducer can be bent or straightened as needed.

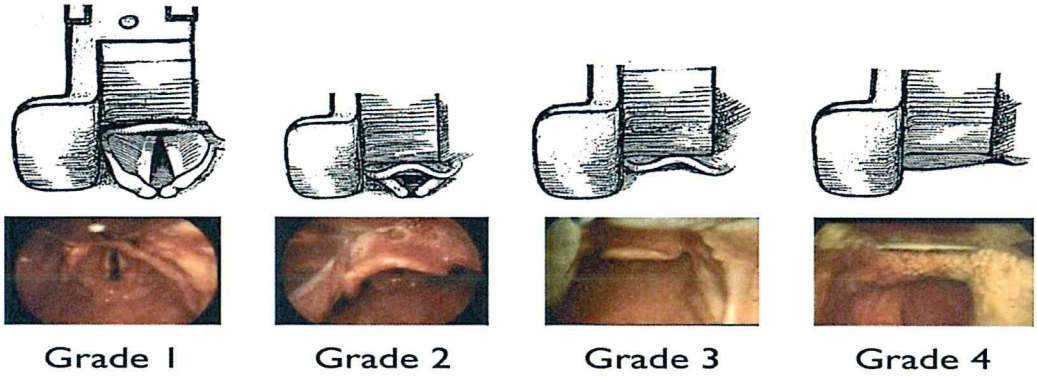
Newly Accredited Solano County Paramedics shall be trained on the usage of the introducer upon initial hiring. Current Solano County Accredited Paramedics shall be trained on the use of the introducer prior to the effective date of this policy. The Advanced Life Support (ALS) Provider will submit proof of training to the EMS Agency within thirty (30) days of class completion.

A. INDICATIONS FOR USE

The introducer was developed to assist with endotracheal intubation on patients with difficult airway anatomy where the vocal cords cannot be visualized.

However, Solano County Accredited Paramedics are encouraged to use the introducer on all intubation attempts.

Airways can be graded on scale of one to four using the Cormack-Lehane Scale. Grade one = full view of cords, grade two = partial view of cords, grade three = epiglottis only, grade four = no airway structures identifiable.



B. CONTRAINDICATIONS

Patient age < 8 years old or ET tube size < 6.5mm.

C. EQUIPMENT

1. Endotracheal Tube Introducer (Gum-Elastic Bougie), adult or pediatric size;
2. Water soluble lubricant;
3. Laryngoscope and blade appropriately sized for patient;
4. ET tube, appropriately sized for the patient;
5. 10 mL syringe for ET tube cuff inflation;
6. Device to secure the ET tube;
7. Bag-Valve-Mask Device.

D. INSERTION PROCEDURE

1. Oxygenation of the patient should be ongoing during the set up for intubation;
2. Select and assemble ET tube as standard procedure. Do not use a metal standard endotracheal tube stylette.
3. Lubricate the distal end of the ET tube using water soluble lubricant;
4. Select and assemble laryngoscope and blade per standard procedure;
5. Insert the laryngoscope into the patient's mouth and identify the airway noting the Airway Grade using the Cormack-Lehane Scale as described above;
6. Insert the introducer into the airway with the tip oriented anteriorly. A "clicking" may be felt as the bent tip passes over the rings of the trachea. Upon further passage of the introducer, a "hold up" or increased resistance may be noted. This implies that the tip is in the lower airway. Take care not to forcefully advance the introducer as it can cause trauma to the lower airways. A lack of "hold up" suggests that the introducer is in the esophagus.
7. Thread the ET tube over the introducer while maintaining the laryngoscope in place to displace the tongue;
8. Insert the ET to standard depth based on the size of the patient;
9. Remove the introducer;
10. Ventilate the patient using the BVM;
11. Confirm ET placement by using a waveform capnography device and confirm equal breath sounds by auscultation. Alternatively, in a patient without a pulse, the esophageal intubation detection (EID) device may also be used to confirm placement;
12. Secure ET Tube;

13. Continue to monitor the patient for proper tube placement throughout pre-hospital treatment and transport (e.g. lung sounds, waveform capnography, or esophageal intubation detection device). Waveform capnography should be used on all patients with an advanced airway;
14. Document the on the PCR the Airway Scale Grade (1 to 4), depth of ET tube placement, and ET tube securing device.

E. TROUBLESHOOTING AND ADDITIONAL INFORMATION

1. If you are unable to advance the ET tube into the trachea, withdraw the ET tube several centimeters and rotate the ET tube 90 degrees COUNTER clockwise to turn the bevel of the ET tube posteriorly and re-advance the tube.

IV. EDUCATION AND CONTINUOUS QUALITY IMPROVEMENT

Advanced Airway Management is viewed as a critical life saving skill. However, field intubations are becoming less frequent. Therefore, ongoing education is essential to maintain proficiency.

In order to maintain paramedic competency with Advanced Airway Maneuvers; the ALS Provider will provide annual training. The training will be a minimum of four (4) hours in duration annually. The training must provide both didactic instruction and include a skills portion showing proficiency in all relevant airway tools. At a minimum the following topics will need to be addressed:

- Anatomical features of the airway;
- The use of the Cormack-Lehane Scale to identify the classifications of patients with difficult airways;
- Patient preparation for and the use of BLS and ALS airway adjuncts to include, but not limited to, oropharyngeal (OPA) and nasopharyngeal (NPA) airways, adult and pediatric endotracheal intubation, use of the King Airway™, and the intubation of difficult airways using the endotracheal tube inducer (bougie).

The Advanced Life Support (ALS) Provider will submit proof of training to the EMS Agency within thirty (30) days of class completion.

The ALS provider will also perform an airway management skill proficiency evaluation on all paramedics to be held on a quarterly basis. The skill proficiency evaluation will include all airway adjuncts to include but not limited to: OPA insertion, NPA insertion, an intubation on an adult and pediatric mannequin, use of the ET tube introducer, and use of the King Airway™. The ALS Provider will submit proof of training to the EMS Agency within thirty (30) days of class completion.

A. The ALS Provider Medical Director shall construct airway training curriculum using the information above for their Agency. Prior to any training the educational material will be submitted to the EMS Agency for review.

B. Any adverse outcomes will be reported via Field Advisory Report (FAR) to the Medical Director of the Program, the Program CQI Coordinator, and the EMS Agency within 24 hours. These calls will be investigated and the outcome of the investigation will be reported to the Process Improvement Committee. The information to be reported is: Date of occurrence, the nature of the adverse outcome, what can be done to prevent the problem again.

C. ALS Providers may be requested to report the number of uses of Advanced Airway Maneuvers for the quarter during the quarterly Process Improvement Committee Meeting. The report will include (at a minimum) the total number of intubations attempted and completed, clinical indications for intubation, type of airway management and proportion of first pass success (i.e. % of patients intubated successfully on first attempt). Additionally, compliance of documentation in relation to Policy 8100, Respiratory-2, Verification of Out-of-Hospital ET Tube Placement will be tracked and reported.

D. ALS Providers will track individual paramedic statistics for use of the Advanced Airway Maneuvers. This information will be available for the EMS Agency and the Process Improvement Committee to review when requested.

E. ALS Providers will maintain records to document training in the use of Advanced Airway Maneuvers. These records will be sent to the EMS Agency upon request within 30 days.

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Solano County Health & Social Services Department

Gerald Huber, Director

EMERGENCY SERVICES BUREAU

Bryn Mumma, MD, MAS
EMS Agency Medical Director

355 Tuolumne St., MS 20-240
Suite 2400, Vallejo, CA. 94590
(707) 784-8155
www.solanocounty.com

Ted Selby
EMS Agency Administrator

POLICY MEMORANDUM 6700

Effective Date: March 31, 2010
Revised Date: April 24, 2017
Review Date: April 24, 2019

REVIEWED/APPROVED BY:

BRYN MUMMA, MD, MAS, EMS AGENCY MEDICAL DIRECTOR

TED SELBY, EMS AGENCY ADMINISTRATOR

SUBJECT: DESTINATION PROTOCOLS FOR AMBULANCES

AUTHORITY: CALIFORNIA HEALTH & SAFETY CODE, DIVISION 2.5, 1797.222

I. PURPOSE/POLICY:

To ensure that patients are transported to the appropriate facility and to establish the on-line medical control responsibilities of the designated base hospitals. This policy does not apply to trauma or ST Elevation Myocardial Infarction (STEMI) patients.

II. DEFINITIONS

A. **Emergency Patient**: A person who experiences an injury and who is subsequently transported by ambulance on an unscheduled basis.

B. **Critical Patient:** An emergency patient who is at immediate risk to life or limb as evidenced by one or more of the following circumstances:

1. Cardiogenic, hypovolemic, septic or anaphylactic shock.
2. Severe respiratory distress and/or need for assisted ventilation.
3. Coma or severe alteration of mental status.

4. Airway problems when measures available to the prehospital personnel are insufficient to establish and/or maintain a patent airway.
5. Trauma patients as defined by Policy 6105, Solano County Prehospital Trauma Triage Plan.
6. Active labor when delivery is imminent and complications are expected.
7. Any patient who has a 12-lead EKG which is interpreted to show "acute MI" or "STEMI" per Policy 6609, ST Segment Elevation Myocardial Infarction.
8. Any patient with the new onset of stroke symptoms that are less than three hours old.
9. Any other patient that the Paramedic deems critical.

C. **Non-Critical Patient:** An emergency patient who does not meet the criteria for "critical patient".

D. **Patient Choice:** The chosen destination facility as stated by the patient or surrogate decision maker. If a patient is unable to communicate a choice the prehospital personnel shall use whatever other sources of information that might be available to indicate a pre-existing relationship. In the absence of a stated choice or indications of a usual provider, the patient is considered an undesignated patient.

E. **Undesignated Patient**: A patient, or surrogate decision maker, who does not or cannot choose a destination facility.

F. **Base Hospital:** A receiving hospital in Solano County which has contracted with the Solano County EMS Agency to provide on-line medical direction to ALS ambulances. The base hospitals in Solano County are:

1. North Bay Medical Center (NBMC)
2. Kaiser Permanente Medical Center, Vallejo (KVH)
3. Sutter Solano Medical Center (SSMC)
4. VacaValley Hospital (VVH)
5. Kaiser Foundation Medical Center, Vacaville (KVV)

G. **Ambulance Zone A:** The cities of Vallejo and Benicia plus both directions of Interstate 80 (I-80) west of the American Canyon Road overcrossing, including the overcrossing. Zone A also includes the westbound lanes of I-80 between Red Top Road and the American Canyon Road overcrossing and both directions of Interstate 680 from Lake Herman Road up to but not including the Parish Road overcrossing.

III. GENERAL

A. No ambulance shall transport an emergency patient to any facility other than one licensed pursuant to Title 22, California Code of Regulations as having Basic or Comprehensive Emergency Medical Service.

B. Patients are entitled to choose the hospital where their care is to be given. With all Solano County hospitals participating in giving on-line medical control, in most cases the base hospital guiding their prehospital care will be their chosen facility. With the exception of situations when the patient requests David Grant Medical Center (DGMC), the base hospital will also be the receiving hospital.

C. All patient advisories and requests for physician orders or destination decisions shall be made to the base hospital using the established pre-recorded phone lines. In event of communication failure or inability to contact a physician at the receiving facility, prehospital personnel may contact another base hospital to obtain orders.

D. In "Ambulance Zone A", SSMC and KVH are considered equidistant and will alternate in receiving undesignated patients by date. KVH will receive undesignated patients on the odd days of the month. SSMC will receive undesignated patients on even days of the month. The day of the call is determined by the time the call is dispatched. In the event of multiple undesignated patients during a single call, the patients will be divided equally among receiving facilities.

E. Solano County EMS policy does not allow for ambulance diversion except in cases when a facility is incapacitated or temporarily unable to provide a vital service such as, but not limited to, CT scanning. These will be rare events and such redirection should be documented by the Base Hospital using a Field Advisory Report. Hospitals may not divert patients due to problems with staffing or hospital or Emergency Department (ED) bed availability.

F. Destination for all Multi Casualty Incident (MCI) patients will be determined by the designated MCI base as outlined in Policy 6180 MCI Response.

IV. DESTINATION PROTOCOLS

A. Critical patients will be transported to the closest facility regardless of patient preference. Prehospital personnel will contact that hospital for any requested orders and for a patient advisory. If DGMC is the receiving facility, prehospital personnel will contact NBMC or VVH for physician orders.

B. Non-critical patients may be transported to the receiving facility of the patient's choice. In the event that a non-critical patient being transported to DGMC requires physician orders, Paramedics will contact NBMC or VVH.

C. In the event that a patient does not meet the definition of a critical patient but the evaluating Paramedic is concerned that the patient may be unstable for transport to a more distant facility, the paramedic is advised to discuss the case with the base physician at the facility of the patient's choice. The base hospital physician may then, if appropriate, override the patient's choice destination and direct the ambulance to the nearest receiving facility. In these cases, the base hospital will be responsible for communicating with the receiving facility.

D. Patients requesting transport to receiving facilities outside of Solano County which are not the closest receiving facility may be accommodated only if **all** the following circumstances are met:

1. The patient is non-critical;
2. The patient's chosen facility is open to receive ambulances and is licensed as having Basic or Comprehensive Emergency Services and;
3. The ambulance provider agency has the capability to provide the requested transport without adversely impacting any of their responsibilities regarding 911 system response.

##########

BLS TRAUMA EMERGENCIES
t-3 HEAD and SPINAL TRAUMA

PRIORITIES:

- ABCs
- Identify airway compromise/obstruction, respiratory insufficiency/arrest, active bleeding, shock, altered mental status and initiate appropriate management
- Assure an advanced life support response

HEAD TRAUMA

1. Manage airway using the appropriate adjunct. If spinal injury is suspected use the jaw-thrust technique.
2. Support ventilation.
3. Perform Spinal Motion Restriction (SMR) as defined in Solano County EMS Policy 6611.
4. CONSIDERATIONS
   - -- Control face and head bleeding with direct pressure. Utilize extreme caution with potential skull fractures.
   - -- Check the oropharynx for teeth and dentures.
   - -- Frequent airway suctioning is needed to prevent aspiration of blood, etc.
   - -- Avoid applying direct pressure to an injured eye. Do not attempt to replace the partially torn globe – stabilize it
   - -- in place with a saline soaked gauze.
   - -- DO NOT assume alcohol intoxication as primary cause. All persons with altered level of consciousness associated with trauma require treatment and transport to a medical facility where the patient can receive a complete medical examination.

SPINAL TRAUMA

For treatment of spinal trauma, please refer to Solano County EMS Policy 6611, Spinal Motion restriction, for SMR procedures.

Special Procedures
S-1 Pleural Decompression

Approved Sites for Pleural Decompression

Anterior: 2nd intercostal space in mid-clavicular line (preferred)

Lateral: 4th or 5th intercostal space in mid-axillary line

Procedure

Pleural decompression may only be used on an unstable patient **AND** has decreased or absent lung sounds on one side of the chest.

This procedure may be performed during transport.

1. Locate one of the approved sites for decompression.
2. Prepare the site using proper sterile technique.
3. Attach a 10mL syringe to a minimum size 14 gauge angiocath that is 3 inches long.
4. Insert the angiocath at a 90 degree angle over the superior edge of the rib. Advance until a rush of air is heard. Air should be freely aspirated, if not, the needle is not in the pleural space.
5. Remove the needle and syringe.
6. Attach one-way valve or stopcock.
7. Secure the angiocath to the chest wall.
8. Check for lung sounds bi-laterally.
9. Continuously monitor and reassess the patient as needed.
10. Document the procedure and notify the receiving hospital as early as possible.

DISRUPTED COMMUNICATIONS
In the event of a “disrupted communications” situation, Solano County Paramedics may utilize all portions of this treatment protocol without Base Hospital Contact as needed to stabilize an immediate patient.

Trauma Emergencies
T-1 – T-4 Specific Treatments

T-1 Traumatic Shock

- Stabilize Airway
- Spinal Motion Restriction per Policy 6611 as necessary
- Control external hemorrhage using direct pressure, tourniquets, or hemostatic dressings
- Evaluate for non-obvious causes of shock. Treat tension pneumothorax per Protocol S-1, Needle Thoracostomy.

T-2 Traumatic Cardiac Arrest

- Consider field pronouncement per Policy 6155, Resuscitation Guidelines
- CPR with emphasis on good quality chest compressions
- Treat cardiac dysrhymias per specific Cardiac Protocols
- Control external hemorrhage using direct pressure, tourniquets, or hemostatic dressings
- Perform a Needle Thoracostomy if tension pneumothorax is suspected

T-3 Head and Spinal Trauma

- Stabilize airway
- Spinal Motion Restriction per Policy 6611
- Hyperventilate patients with signs of cerebral herniation
- Assess for and remove all foreign body airway obstructions (FBAO). If the FBAO cannot be removed, perform a Needle Cricothyrotomy per Protocol S-4.
- Control external hemorrhage using direct pressure or hemostatic dressings. Do not use a tourniquet on head or neck hemorrhaging.

T-4 Chest Trauma

Impaled Object
- Stabilize the object. Do not remove the object unless it interferes with CPR.

Flail Chest
- Stabilize the chest wall
- Support ventilations and stabilize the airway
- Assess for signs of tension pneumothorax

Open Chest Wound
- Cover the wound with an occlusive dressing
- Assess for signs of tension pneumothorax

Tension Pneumothorax
- Treat per Protocol S-1

Cardiac Tamponade/Contusion
- Assess for life threatening cardiac dysrhymias
- Treat cardiac dysrthymias per specific Cardiac Protocols

DISRUPTED COMMUNICATIONS

In the event of a "disrupted communications" situation where a base hospital physician CANNOT be contacted for orders, Solano County Paramedics MAY NOT utilize the portions of this protocol requiring base physician orders AND must transport to the closest receiving facility.

Policy and Protocol Discontinuation

Policy 3210 Certification Process for Prehospital Personnel (obsolete)
Policy 3300 EMT-Defibrillation Authorization (obsolete)
Policy 3302 Esophageal Tracheal Airway Device Authorization (obsolete and replaced)
Policy 3410 Endotracheal Intubation Authorization (obsolete and replaced)
Policy 6604 Pre-existing Vascular Access Device (PVAD) (obsolete)
Policy 6601 Combi-tube (obsolete and replaced)
Protocol S-5 Adenosine
Protocol S-6 Endotracheal Suctioning for Meconium Aspiration
Protocol S-7 Intraosseous Cannulation
Protocol S-8 External Cardiac Pacing
Protocol S-9 Continuous Positive Airway Pressure (CPAP)
Protocol S-10 Percutaneous Ventricular Assist Device (PVAD)

***Policies/protocols are either obsolete and/or replaced/superseded by another policy/protocol*

County of Solano
Office of the Auditor-Controller

AN AUDIT OF THE
SOLANO EMERGENCY MEDICAL SERVICES COOPERATIVE
OF SOLANO COUNTY

Independent Auditor's Report and Financial Statements
For the fiscal year ended June 30, 2016

Auditor-Controller: Simona Padilla-Scholtens, CPA
Assistant Auditor-Controller: Phyllis S. Taynton, CPA
Audit Manager: Kirk Starkey
Auditor: Melinda S. Ingram, CPA

Solano Emergency Medical Services Cooperative
For the fiscal year ended June 30, 2016

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Solano Emergency Medical Services Cooperative
Board of Directors

(As of audit report date)

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Solano County Administrator

Richard Watson, Vice Chair
Health Care Consumer Representative

Caesar Djavaherian, MD
Physicians' Forum Representative

Daniel Keen
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Anthony Velasquez
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Michael W. Stacey, MD, MPH

Medical Director:
Bryn Mumma, MD

EMS Administrator:
Ted Selby

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OFFICE OF THE AUDITOR-CONTROLLER

SIMONA PADILLA-SCHOLTENS, CPA
Auditor-Controller

PHYLLIS TAYNTON, CPA
Assistant Auditor-Controller

SOLANO COUNTY

675 Texas Street, Suite 2800
Fairfield, CA 94533-6338
(707) 784-6280
Fax (707) 784-3553

www.solanocounty.com

Independent Auditor's Report

Board of Directors
Solano Emergency Medical Services Cooperative
Vallejo, CA 94590

Report on the Financial Statements

We have audited the accompanying financial statements of the governmental activities and the major fund of the Solano Emergency Medical Services Cooperative (SEMSC) as of and for the fiscal year ended June 30, 2016, and the related notes to the financial statements, which collectively comprise the SEMSC's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.
We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the governmental activities and the major fund of SEMSC as of June 30, 2016, and the respective changes in financial position thereof for the fiscal year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Accounting principles generally accepted in the United States of America require the Management's Discussion and Analysis and the Budgetary Comparison Information on pages 6 through 9 and page 23, respectively, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

In connection with the audit contained herein, there are certain disclosures that are necessary pursuant to *Generally Accepted Auditing Standards,* more specifically, the general standard related to independence. As required by various statutes within the California Government Code, County Auditor-Controllers are mandated to perform certain accounting, auditing, and financial reporting functions. These activities could impair an audit organization's independence. Specifically, "auditors should not audit their own work or provide non-audit services in situations where the amounts or services involved are significant/material to the subject matter of the audit."

Although the Auditor-Controller is statutorily obligated to maintain the accounts of departments, districts, or funds that reside within the county treasury, we believe the following safeguards and division of responsibility exists:

- The Internal Audit Division has the responsibility to perform audits and as such has no other responsibility for the accounts and records being audited including the approval or posting of financial transactions that would therefore preclude the reader of this report from relying on the information contained therein.
- In addition, the Auditor-Controller is an independent elected official and does not engage in management decisions on behalf of the audited entity.

Other Reporting Required by Generally Accepted Auditing Standards

As discussed in Note I, the financial statements present only the SEMSC and do not purport to, and do not present fairly the financial position of the County of Solano, as of June 30, 2016, the changes in its financial position for the fiscal year then ended in accordance with accounting principles generally accepted in the United States of America.

Simona Padilla-Scholtens, CPA
Auditor-Controller

Fairfield, California

June 9, 2017

Solano Emergency Medical Services Cooperative
Management's Discussion and Analysis

As management of the Solano Emergency Medical Services Cooperative (SEMSC), we offer readers of the SEMSC's financial statements this narrative overview and analysis of the financial activities of the SEMSC for the fiscal year ended June 30, 2016. We encourage readers to consider the information presented here in conjunction with additional information in our financial statements.

Financial Highlights

- The SEMSC's net position totaled $491,865 at June 30, 2016. The entire amount represents the unrestricted net position, which may be used to meet SEMSC's ongoing obligation to citizens and creditors.
- SEMSC's total net position increased by $167,608 as a result of the current year's operations.
- SEMSC's governmental funds reported an ending fund balance of $491,865 at June 30, 2016. The entire amount is available for spending at SEMSC's discretion (unassigned fund balance).

Overview of the Financial Statements

This discussion and analysis is intended to serve as an introduction to the SEMSC's basic financial statements. The SEMSC's basic financial statements are comprised of three components: 1) government-wide financial statements, 2) fund financial statements, and 3) notes to the financial statements.

Government-wide Financial Statements. The government-wide financial statements are designed to provide readers with a broad overview of the SEMSC's finances, in a manner similar to a private-sector business.

The statement of net position presents information on the SEMSC's assets and liabilities, with the difference between the two reported as net position. Over time, increases or decreases in net position may serve as a useful indicator of whether the financial position of the SEMSC is improving or deteriorating.

The statement of activities presents information showing how the SEMSC's net position changed during the most recent fiscal year. All changes in net position are reported as soon as the underlying event giving rise to the change occurs, regardless of timing of related cash flows. Thus, revenues and expenses are reported in this statement for some items that will only result in cash flows in future fiscal periods.

The government-wide financial statements can be found on pages 11-12 of this report.

Fund financial statements. A fund is a grouping of related accounts used to maintain control over resources that have been segregated for specific activities or objectives. The SEMSC, like other state and local governments, uses fund accounting to ensure and demonstrate compliance with finance-related legal requirements.

Governmental funds. Governmental funds are used to account for essentially the same functions reported as governmental activities in the government-wide financial statements. However, unlike the government-wide financial statements, governmental fund financial statements focus on near-

term inflows and outflows of spendable resources, as well as on balances of spendable resources available at the end of the fiscal year. Such information may be useful in evaluating the SEMSC's near-term financing requirements.

Since the focus of governmental funds is narrower than the government-wide financial statements, it is useful to compare the information presented for governmental funds with similar information presented for governmental activities in the government-wide financial statements. By doing so, readers may better understand the long-term impact of the SEMSC's near-term financing decisions. Both the governmental fund balance sheet and the governmental fund statement of revenues, expenditures, and changes in fund balances provide a reconciliation to facilitate this comparison between governmental funds and governmental activities.

The basic governmental fund financial statements can be found on pages 13-16 of this report.

Notes to the financial statements. The notes provide additional information that is essential to a full understanding of the data provided in the government-wide and fund financial statements. The notes to the financial statements can be found on pages 17-20 of this report.

Other information. In addition to the basic financial statements and accompanying notes, this report also presents certain required supplementary information concerning SEMSC's budgetary comparison schedule for the General Fund. Required supplementary information can be found on pages 22-23 of this report.

Government-wide Financial Analysis

As noted earlier, net position may serve over time as a useful indicator of the SEMSC's financial position. In the case of the SEMSC, assets exceeded liabilities by $491,865 at June 30, 2016. The SEMSC's net position is entirely categorized as unrestricted net position which is typically used to meet an organization's ongoing obligations to citizens and creditors.

Comparative Analysis of the Statement of Net Position:

	6/30/2016	6/30/2015
Assets		
Cash & equivalents	$ 582,861	$ 468,132
Accounts receivable	540	115
Due from other agencies	472,445	416,334
Total assets	$ 1,055,846	$ 884,581
Liabilities		
Accounts payable	$ 14,857	$ 10,800
Due to others	11,810	-
Due to other agencies	518,564	524,211
Unearned revenue	18,750	25,313
Total liabilities	$ 563,981	$ 560,324
Net Position		
Unrestricted	$ 491,865	$ 324,257
Total net position	$ 491,865	$ 324,257

The key elements in the significant changes in assets and liabilities are as follows:

Assets: Assets increased by $171,265 or 19% from 2015 to 2016, which is mainly due to the change in the cash balance at year end which was driven by increased business license revenue. Changes in assets are as follows:

	6/30/2016	6/30/2015	Change
Cash & equivalents	$ 582,861	$ 468,132	$ 114,729
Receivables:			
Public private partnership fees	367,667	367,667	-
Franchise fees	41,667	41,667	-
EMS vehicle	-	7,000	(7,000)
EMS services reimbursement	63,111	-	63,111
Other	540	115	425
Total assets	$ 1,055,846	$ 884,581	$ 171,265

Liabilities: Liabilities increased by a minimal amount totaling $3,657. There were no specific fluctuations identified to account for the change.

Government activities increased the SEMSC's net position by $167,608 during fiscal year 2015/16, which represents an increase of approximately 52% from fiscal year 2014/15's total net position.

Comparative Analysis of the Change in Net Position:

	6/30/2016	6/30/2015
Program expenses		
Public private partnership fees	$ 1,464,320	$ 1,465,195
Professional & specialized services	793,778	782,519
Total program expenses	2,258,098	2,247,714
Program revenue		
Public private partnership fees	1,464,320	1,470,670
Franchise fees	500,000	500,000
Business licenses	340,350	404,000
Forfeitures & penalties	48,260	46,509
EMS vehicle permits	52,613	32,187
EMS personnel	15,490	11,575
Total program revenue	2,421,033	2,464,941
Net program revenues	162,935	217,227
General revenue		
Interest income	4,673	4,105
Total general revenue	4,673	4,105
Changes in net position	167,608	221,332
Net position		
Beginning of the year	324,257	102,925
End of the year	$ 491,865	$ 324,257

The key elements in the significant changes in net position are as follows:

Program expenses: Program expenses increased by $10,384 primarily due a combination of the following:

- Contracted services increased in the amount of $40,758 due to several contracts for specialized services entered into with *Page, Wolfberg & Wirth, LLC.*
- Other Professional Services decreased in the amount of $26,951 due to lower pass through costs incurred by the Department of Health & Social Service Emergency Medical Service Division (EMS) to administer the JPA. This was primarily due to a change in personnel providing management oversight of EMS.

Program revenues: Program revenues decreased from prior year by $43,908 primarily due to a combination of the following:

- Business license revenue consists of designation fees collected for S-T Elevation Myocardial Infarction (STEMI) Centers, Emergency Department Approved for Pediatrics (EDAP) Centers, Trauma Centers, and Base Hospitals. Such revenue decreased by $69,750 primarily because the annual fee for John Muir Medical Center's STEMI designation ($4,000) was not renewed as well as John Muir Medical Center's Level II Trauma Center Designation renewal fee for both 2014 and 2015 ($75,000 annually) were paid in FY 2014/15.
- EMS vehicle permit revenue consists of air ambulance, ground ambulance, critical care transport provider permits and other inspection fees. Such revenue increased by $20,426 due to changes in providers applying for the permits to operate within Solano County.

General revenues: General revenues consist solely of interest income earned during the fiscal year for SEMSC's cash maintained in the County Treasury.

Financial Analysis of the SEMSC's Governmental Funds

SEMSC uses fund accounting to ensure and demonstrate compliance with finance-related legal requirements.

Governmental funds. The General Fund is a governmental fund type used to account for general government functions of the SEMSC. The focus of the SEMSC's governmental fund is to provide information on near-term inflows, outflows, and balances of spendable resources. Such information is useful in assessing the SEMSC's financing requirements. In particular, unassigned fund balance may serve as a useful measure of a government's net resources available for spending at the end of the fiscal year. At June 30, 2016 and 2015, the SEMSC's governmental fund reported an ending fund balance of $491,865 and $324,257, respectively.

Governmental revenues totaled $2,425,706 and $2,469,046 in fiscal year ending June 30, 2016 and 2015, respectively. This represents a 1.76% decrease from fiscal year 2014/15 to fiscal year 2015/16. Changes were minimal as operations remained stable.

Expenditures totaled $2,258,098 and $2,247,714 in fiscal year ending June 30, 2016 and 2015, respectively. This represents an increase of less than 1% from fiscal year 2014/15 to fiscal year 2015/16.

Budgetary Highlights

The General Fund budget (Adopted and Final versions) is reflected in the Schedule of Revenues, Expenditures, and Changes in Fund Balance – Budget and Actual, as presented on page 22 in the Required Supplementary Information (RSI) section of this report.

There were changes between the adopted budget and the final budget resulting in a decrease in appropriations for professional & specialized services expenditures. Revenues recognized were less than budget by $130,323 and expenditures incurred were less than budget by $283,931. The variance in revenue was mainly due to lower than expected revenues from business licenses and vehicle permits while lower than anticipated pass through costs incurred by the EMS Division resulted in expenditures being less than budgeted.

Economic Factors and Next Year's Operating Activities

SEMSC's management anticipates no significant changes to current operations. They will continue to play the key role in coordination and collaboration of emergency services for Solano County. SEMSC plans to maintain its fiscal policy of managing costs associated with SEMSC operations and at the same time is dedicated to continue upholding the highest standards for the delivery of effective pre-hospital care to the citizens of Solano County.

Requests for Information

This financial report is designed to provide a general overview of the SEMSC's finances for all those with an interest with the organization's finances. Questions concerning any of the information provided in this report or requests for additional financial information should be addressed to the Solano Emergency Medical Services Cooperative's Board of Directors, 355 Tuolumne Street, Vallejo, CA 94590.

Solano Emergency Medical Services Cooperative
Statement of Net Position
June 30, 2016

Assets		
Cash & equivalents	$	582,861
Accounts receivable		540
Due from other agencies		472,445
Total assets		1,055,846
Liabilities		
Accounts payable		14,857
Due to others		11,810
Due to other agencies		518,564
Unearned revenue		18,750
Total liabilities		563,981
Net Position		
Unrestricted		491,865
Total net position	$	491,865

The notes to the financial statements are an integral part of this statement.

Solano Emergency Medical Services Cooperative
Statement of Activities
For the fiscal year ended June 30, 2016

Program expenses:		
Public private partnership fees	$	1,464,320
Professional & specialized services		793,778
Total program expenses		2,258,098
Program revenues:		
Public private partnership fees		1,464,320
Franchise fees		500,000
Business licenses		340,350
Forfeitures & penalties		48,260
EMS vehicle permits		52,613
EMS personnel		15,490
Total program revenues		2,421,033
Net program revenues		162,935
General revenues:		
Interest income		4,673
Total general revenues		4,673
Change in net position		167,608
Net position - beginning		324,257
Net position - ending	$	491,865

The notes to the financial statements are an integral part of this statement.

Solano Emergency Medical Services Cooperative
Balance Sheet
Governmental Fund
June 30, 2016

Assets		
Cash & equivalents	$	582,861
Accounts receivable		540
Due from other agencies		472,445
Total assets	$	1,055,846
Liabilities		
Accounts payable		14,857
Due to others		11,810
Due to other agencies		518,564
Total liabilities		545,231
Deferred Inflows of Resources		
Unavailable revenue		18,750
Total deferred inflows of resources		18,750
Fund Balance		
Unassigned		491,865
Total fund balance		491,865
Total liabilities, deferred inflows of resources and fund balance	$	1,055,846

The notes to the financial statements are an integral part of this statement.

Solano Emergency Medical Services Cooperative
Reconciliation of the Balance Sheet
of the Governmental Fund to the Statement of Net Position
For the fiscal year ended June 30, 2016

Governmental Fund Balance	$	491,865
There are no differences between the amounts reported for governmental activities in the statement of net position from amounts reported for governmental funds in the balance sheet.		-
Net position of governmental activities	$	491,865

The notes to the financial statements are an integral part of this statement.

Solano Emergency Medical Services Cooperative
Statement of Revenues, Expenditures, and Changes in Fund Balance
Governmental Fund
For the fiscal year ended June 30, 2016

Revenues:		
Public private partnership fees	$	1,464,320
Franchise fees		500,000
Business licenses		340,350
Forfeitures & penalties		48,260
EMS vehicle permits		52,613
EMS personnel		15,490
Interest income		4,673
Total revenues		2,425,706
Expenditures:		
Public private partnership fees		1,464,320
Professional & specialized services		793,778
Total expenditures		2,258,098
Excess of revenues over expenditures		167,608
Fund balance - beginning		324,257
Fund balance - ending	$	491,865

The notes to the financial statements are an integral part of this statement.

Solano Emergency Medical Services Cooperative
Reconciliation of the Statement of Revenues, Expenditures, and
Changes in Fund Balance of Governmental Fund to the Statement of Activities
For the fiscal year ended June 30, 2016

Net change in fund balance	$	167,608
There are no differences between the amounts reported for governmental activities in the statement of activities and amounts reported for governmental fund in the statement of revenues, expenditures and changes in fund balance.		-
Change in net position of governmental activities	$	167,608

The notes to the financial statements are an integral part of this statement.

I. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

A. Reporting Entity

Solano County is a political subdivision of the State of California. An elected, five-member Board of Supervisors governs the County. The Solano County Board of Supervisors determined that a "cooperative partnership" between cities, fire districts and private ambulance providers may be the best way to provide a high quality, cost effective system of pre-hospital emergency medical services for residents of Solano County.

The Solano Emergency Medical Services Cooperative (SEMSC) was established under the authority of Government Code §6500 through a Joint Powers Agreement between the County of Solano, the cities of Benicia, Dixon, Fairfield, Rio Vista, Suisun and Vallejo, and the Cordelia, Montezuma, Suisun, East Vallejo, Dixon and Vacaville Fire Protection Districts. SEMSC's Board of Directors consists of seven members from the multi-disciplined professionals that constitute the parties to the Joint Powers Authority. Each board member serves a term of four years.

Solano County Ordinance No. 1527 designated SEMSC as the local Emergency Medical Services Agency. SEMSC has the primary responsibility for the administration and implementation of an emergency medical services system in Solano County and serves as the regulatory agency for the delivery of emergency medical services within Solano County.

B. Government-wide and Fund Financial Statements

SEMSC's financial accounts are maintained in accordance with generally accepted accounting principles (GAAP) and the uniform accounting system for special purpose governments prescribed by the State Controller in compliance with the Government Code of the State of California.

The government-wide financial statements (i.e., the statement of net position and the statement of activities) report information on all of the activities of the primary government. The statement of activities demonstrates the degree to which the direct expenses of a given function or segment is offset by program revenues. Direct expenses are those that are clearly identifiable with a specific function. Program revenues include: 1) charges to customers or applicants who purchase, use, or directly benefit from goods, services, or privileges provided by a given function and 2) grants and contributions that are restricted to meeting the operational or capital requirements of a particular function. Interest income, intergovernmental (funding from the state) and other items not properly included among program revenues are reported as general revenues.

C. Measurement Focus, Basis of Accounting and Basis of Presentation

The government-wide financial statements are reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of related cash flows.

Governmental fund financial statements are reported using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized as soon as they are both measurable and available. Revenues are considered to be available when they are collectible within the current period or soon enough thereafter to pay liabilities of the current period.

For this purpose, the government considers revenues to be available if they are collected within 90 days of the end of the current fiscal period. Expenditures are generally recorded when a liability is incurred, as under accrual accounting.

Interest earnings associated with the current fiscal period are considered to be susceptible to accrual and so have been recognized as revenue of the current fiscal period. All other revenue items are considered to be measurable and available only when the government receives cash.

The *General Fund* is the SEMSC's primary operating fund. It accounts for all financial resources of the general government, except those that are required to be accounted for in another fund.

D. Assets, Liabilities and Net Position or Equity

1. Cash and Cash Equivalents

SEMSC's cash resides in the Solano County Treasury. The cash maintained in the County Treasury is pooled with the County of Solano and various other external participants. In accordance with SEMSC Bylaws, Article IX.A, SEMSC is a mandatory depositor. SEMSC's ability to withdraw large sums of cash from the County Treasury may be subject to certain restrictions set forth by the County Treasurer.

The County's pooled cash and investments are invested pursuant to investment policy guidelines established by the County Treasurer as well as California State Government Code, and approved by the County Board of Supervisors. The objectives of the policy (in order of priority) are: legality, preservation of capital, liquidity, and yield. The policy addresses the soundness of financial institutions in which the County will deposit funds, types of investment instruments as permitted by the California Government Code, and the percentage of the portfolio which may be invested in certain instruments with longer terms of maturity. A detailed breakdown of cash and investments and a categorization of risk factors per GASB Statement No. 40, *Deposits and Investment Risk Disclosures,* are presented in the County of Solano Comprehensive Annual Financial Report.

2. Accounts Receivable

Accounts receivable represents the amount due from licensing operations and/or service contracts.

3. Due from Other Agencies

Due from other agencies represents amounts owed by entities outside the JPA, mainly due from Medic Ambulance for the Public Private Partnership fees and from Solano County to adjust for over-reimbursement for EMS costs, according to their respective agreements.

4. Accounts Payable

Accounts payable represents the balance owed for goods received and/or services rendered.

5. Due to Others

Due to others represents non-compliance penalties assessed to the participating cities who fail to meet the response performance requirements per the terms of the Public Private Partnership Agreement. Proceeds from assessed fines are to be maintained in a separate account for use by participating departments supporting disaster training and preparedness efforts.

6. Due to Other Agencies

Due to other agencies represents amounts owed to participating cities for the Public Private Partnership payments and Solano County Health & Social Services, County Counsel, and Auditor-Controller Departments for services provided.

7. Unearned Revenue

Unearned revenue represents financial resources received before eligibility requirements are met. These resources are advances paid by service providers for various application, license and inspection fees.

8. Deferred Inflows of Resources

This separate financial statement element represents an acquisition of fund balance that applies to future period(s) and so will not be recognized as an inflow of resources (revenue) until that time. This amount represents advances paid by service providers for various application, license and inspection fees.

9. Net Position/Fund Balance

The government-wide financial statements utilize a net position presentation. The net position is categorized as unrestricted.

- *Unrestricted* – This category represents SEMSC net position, which is not restricted for any project or other purpose.

The various categories of fund balance represent relative strength or hierarchy of spending constraints. These categories are established either by inherent, external, or internal limitations.

As of June 30, 2016, fund balance was categorized as follows:

- *Unassigned Fund Balance* – This classification represents fund balance not assigned to other funds and not restricted, committed or assigned to specific purposes within the General Fund, and is available for financing future budgets. The General Fund is the only fund that reports a positive unassigned fund balance amount.

10. Fund Balance Policy

SEMSC Spending Priority Policy
SEMSC's spending priority policy applies to fund balance and revenue sources. In circumstances when an expenditure is made for a purpose for amounts available in multiple fund balance classifications, the use of fund balance will be applied in the following order:

1) Restricted
2) Committed
3) Assigned
4) Unassigned

11. Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions. These estimates and assumptions affect the reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses/expenditures during the reporting period. Actual results could differ from those estimates.

II. OTHER INFORMATION

Risk Management

The Solano County Board of Supervisors adopted Resolution No. 2008-194 approving inclusion of the Solano Emergency Medical Services Cooperative as an additional insured under Solano County's General Liability Insurance Program. Coverage includes all risks under a multi-peril policy, including accident and property, and general liability insurance.

Solano County also participates in the California State Association of Counties–Excess Insurance Authority (CSAC-EIA), a joint powers authority created to provide self-insurance programs for California counties.

Required Supplemental Information

Solano Emergency Medical Services Cooperative
Schedule of Revenues, Expenditures and Changes in Fund Balance - Budget and Actual
General Fund
For the fiscal year ended June 30, 2016

	Budget Amounts			Variance with Final Budget
	Adopted	Final	Actual Amounts	Positive (Negative)
Revenues				
Public Private Partnership fees	$ 1,470,700	$ 1,470,700	$ 1,464,320	$ (6,380)
Franchise fees	500,000	500,000	500,000	-
Business licenses	443,000	443,000	340,350	(102,650)
Forfeitures & penalties	50,160	50,160	48,260	(1,900)
EMS vehicle permits	76,000	76,000	52,613	(23,387)
EMS personnel	15,000	15,000	15,490	490
Interest income	1,169	1,169	4,673	3,504
Total revenues	2,556,029	2,556,029	2,425,706	(130,323)
Expenditures				
Public Private Partnership fees	1,470,700	1,470,700	1,464,320	6,380
Professional & specialized services	1,085,329	1,071,329	793,778	277,551
Total expenditures	2,556,029	2,542,029	2,258,098	283,931
Excess of revenues over expenditures	-	14,000	167,608	153,608
Fund balance - beginning	324,257	324,257	324,257	-
Fund balance - ending	$ 324,257	$ 338,257	$ 491,865	$ 153,608

The notes to the required supplementary information are an integral part of this statement.

Budgetary Information

On or before April 1st of each year, in conformance with the Article VIII (B) of the SEMSC Bylaws, the Commission shall adopt by resolution a budget for the ensuing fiscal year. The budget shall set forth anticipated administrative, operational, and capital expenditures and sources of funds for SEMSC.

Solano Emergency Medical Services Cooperative

Board of Directors Meeting

Meeting Date: 10/12/2017

I. REPORTS

b. EMS Administrator's Report (verbal update, no action)

a. General Update
b. System Performance
c. System Updates
d. Announcements

Solano Emergency Medical Services Cooperative

Board of Directors Meeting

Meeting Date: 10/12/2017

I. REPORTS

c. Medic Ambulance Operator Report (verbal update, no action)

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Solano Emergency Medical Services Cooperative

Board of Directors Meeting

Meeting Date: 10/12/2017

II. REGULAR CALENDAR

a. Review and Consider Approval of Revision to Resolution 12-001 – Critical Care Transport (CCT)/Specialty Care Transport (SCT) for clarification purposes

BACKGROUND:
Local facilities have recently raised questions as to how to differentiate Critical Care Transports (CCT) from Advance Life Support – Registered Nurse (ALS-RN) transports. Changes are recommended to Resolution 12-001 to bring the resolution in line with current practice and accepted use of ALS-RN versus CCT transfer. As Resolution 12-001 is currently written, it has been interpreted that patients receiving an intravenous (IV) blood infusion or blood products should be sent via CCT. These revisions clarify what should be considered for purposes of CCT transport.

The revisions to Resolution 12-001 (Attachment II-A) will allow these patients to go ALS-RN, in line with current practice. Furthermore, this will minimize, if not remove, confusion around some of the distinctions between ALS-RN and CCT transports, as the revised resolution will reflect current accepted practice.

REVIEWED: This item has been reviewed by Physicians' Forum, Trauma, ST-Elevation Myocardial Infarction, Quality Assurance/Quality Improvement groups.

LEGAL REVIEW SUFFICIENCY: This item has been reviewed as to form by County Counsel.

BOARD ACTION:

Motion:

By: _____ 2nd: _____

AYES: NAYS:

ABSENT ABSTAIN

Attachment II-A

RESOLUTION NO. 12-001

RESOLUTION OF THE SOLANO COUNTY EMERGENCY MEDICAL SERVICES COOPERATIVE REQUIRING OPERATORS OF EMERGENCY AMBULANCES TO OBTAIN A PERMIT TO CONDUCT CRITICAL CARE TRANSPORTS ORIGINATING IN SOLANO COUNTY

Draft as of 10/10/2017 2:45 PM

WHEREAS, the Solano County Emergency Medical Services Cooperative ("SEMSC') serves as the local EMS agency for Solano County; and

WHEREAS, as the local EMS agency for Solano County, SEMSC has the authority to regulate the operation of emergency ambulances, defined as any ambulances capable of providing emergency medical services ("EMS"), including basic life support ("BLS"), limited advanced life support ("LALS"), and advanced life support ("ALS"); and

WHEREAS, the California Health & Safety Code permits SEMSC to establish policies and procedures to ensure medical control of the EMS system in Solano County and make any such policies and procedures binding upon operators of emergency ambulances; and

WHEREAS, a small number of ambulance transports originating in Solano County involve the Interfacility Transportation of Critically Injured or Ill Patients with critical care needs that during transport require, or in the judgment of the transferring physician, may reasonably require the use of special equipment and the provision of Critical Care Interventions by a crew that includes personnel who possess skills in a medical specialty area such as nursing care, emergency medicine, respiratory care, or cardiovascular care; and

WHEREAS, the only ambulances that engage in the Interfacility Transportation of Critically Injured or Ill Patients are emergency ambulances; and

WHEREAS, SEMSC has, through a competitive process, awarded an exclusive agreement for all ALS ambulance services throughout an Exclusive Operating Area, including all 911 requests (but excluding those requests originating from within the City of Vacaville and Travis Air Force Base) and all ALS interfacility transport requests in -Solano County and which prohibits any other person or entity from providing ALS ambulance service in the County, excluding critical are transports ("CCTs"); and

WHEREAS, as a condition precedent for the CCT of Critically Injured or Ill Patients, SEMSC, as the local EMS agency for Solano County, has the authority in exercising medical control of the EMS system in the County to require training and qualifications for the ambulance crew involved in a CCT for the use of drugs, devices and skills in such transports; and

WHEREAS, to facilitate its medical control of the EMS system in Solano County, SEMSC seeks to require all operators of emergency ambulances that intend to engage in the CCT of Critically Injured or Ill Patients originating in the County to secure a permit as a CCT provider from SEMSC; and

WHEREAS, SEMSC seeks to require all operators of emergency ambulances that intend to engage in the CCT of Critically Injured or Ill Patients that originate in Solano County to satisfy SEMSC's medical control requirements as a condition to receive and maintain a permit to engage in CCTs originating in the County; and

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WHEREAS, SEMSC has entered into agreements with ambulance providers, as set forth in Resolution 11-001, and seeks to protect the rights of those providers to operate in accordance with the provisions of Resolution 11-001 and consistent with this Resolution; and

WHEREAS, as SEMSC has entered into an agreement with an ambulance provider to serve as the exclusive provider of ALS interfacility transports in Solano County, and such agreement excludes CCTs, SEMSC seeks to define and regulate CCTs that originate in the County to ensure that the transports conducted pursuant to this Resolution do not interfere with the rights and responsibilities of that ambulance provider under that agreement or the benefits the County receives under that agreement.

NOW, THEREFORE, IT IS RESOLVED that:

1. **Definitions.** For purposes of this Resolution the following words and terms have the following meanings unless the context clearly indicates otherwise:

CCT-RN. A critical care transport registered nurse.

County. The County of Solano.

Critical Care Interventions. Interventions including but not limited to the use of medications and devices listed in Paragraph 2.B (as may later be amended in accordance with the provisions of Paragraph 2.C) attributable to high complexity decision making to assess, manipulate, and support vital system functions to treat single, or multiple, vital organ system failure; and/or to prevent further life- threatening deterioration of the patient's condition. Examples of vital organ system failure include but are not limited to:

(i) Central nervous system failure.
(ii) Circulatory failure.
(iii) Shock.
(iv) Renal, hepatic, metabolic, or respiratory failure.

Critical Care Transportation (CCT). CCT is the Interfacility Transportation by ground ambulance vehicle, including the provision of medically necessary supplies and services, of a Critically Injured or Ill Patient who during transport requires, or in the judgment of the sending physician may reasonably require, Critical Care Interventions in a medical specialty area such as nursing care, emergency medicine, respiratory care, or cardiovascular care exceeding the scope of practice of an EMT-P. A CCT includes a "specialty care transport" as defined in 42 CFR § 414.605, whether or not it involves a Medicare beneficiary. A CCT does not include an interfacility transport begun by an air ambulance service but that must be completed by ground ambulance due to mechanical issues, weather, or other factors which prohibit the completion of the transport by air.

Critically Injured or Ill Patient. A patient who has an injury or illness that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition, such that the failure to initiate Critical Care Interventions on an urgent basis would likely result in sudden, clinically significant or life-threatening deterioration of the patient's condition.

Interfacility Transportation. For purposes of a CCT, a transport between the following facilities only:

(i) Cancer hospitals.
(ii) Children's hospitals.
(iii) Critical access hospitals.
(iv) Inpatient acute care hospitals.
(v) Rehabilitation hospitals.
(vi) Sole community hospitals.
(vii) Psychiatric hospitals.
(viii) Skilled nursing facilities.

EMT-P. An emergency medical technician-paramedic.

Permitted Critical Care Transportation (CCT) Provider. A ground ambulance provider with a current permit issued by SEMSC to conduct CCTs.

RN. A registered nurse.

SEMSC. The Solano County Emergency Medical Services Cooperative.

Scope of Practice of an EMT-Paramedic. The basic scope of practice of an EMT-P in Solano County as defined in Title 22, California Code of Regulations, § 100145(c)(1) or a superseding regulation.

2. **Performance of Critical Care Transports.**

A. A CCT is appropriate when a Critically Injured or Ill Patient's condition requires, or, in the judgment of the sending physician may reasonably require, Critical Care Interventions during Interfacility Transportation that must be furnished by one or more health professionals in an appropriate specialty area, such as emergency or critical care nursing, emergency medicine, respiratory care or cardiovascular care.

B. The Interfacility Transportation of a Critically Injured or Ill Patient is a CCT if the patient's condition during transport requires or may reasonably require the use of any of the following procedures, devices or medications during the transport:

1) Intra-aortic balloon pump.

2) Swan-Ganz/Central Venous access or maintenance of infusions via central venous access.

3) Arterial line monitoring.

4) Transvenous pacing.

5) Extra corporeal membrane oxygenation.

6) High risk Labor and Delivery that may lead to Neonatal Critical Care.

7) Intracranial pressure monitoring devices.

~~8) Medications via infusion pump.~~

~~9)~~8) Parenteral administration of the following categories of agents, which may include:

~~a. Vasoactive agents (including anti-hypertensives and vasopressors)~~
- ~~Anti-hypertensives: e.g., labetalol, nitroprusside, nitroglycerin etc.~~
- ~~Vasopressors: e.g., dopamine, epinephrine, norepinephrine etc.~~

~~b.~~a. Neuromuscular blocking agents
- e.g., succinylcholine, rocuronium, vecuronium etc.

~~c. Anti-fibrinolytic or anti-platelet agents~~
- ~~e.g. Tissue plasminogen activators (tPA, TNK), streptokinase, epitifibatide, etc.~~

~~d. Blood products~~
- ~~e.g. packed red blood, platelets, fresh frozen plasma etc.~~

~~e.~~b. Analgesics and sedative agents that are beyond paramedic scope of practice
- e.g. propofol, meperidine, ~~fentanyl~~

~~f. Anti-epileptic agents~~
- ~~e.g. phenytoin, valproate, phenobarbital etc.~~

~~g. Hypoglycemic agents~~
- ~~e.g. insulin etc.~~

~~h. Diuretic agents that are beyond paramedic scope of practice~~
- ~~e.g. bumetanide, mannitol etc.~~

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~~i. Total Parenteral Nutrition (TPN)~~

C. The SEMSC Board of Directors delegates to the Medical Director and the EMS Agency Administrator the power to adopt regulations specifying procedures, devices and medications in addition to those listed in B.

D. Except as provided in E, only a Permitted CCT Provider may conduct CCTs originating in the County. The performance of a CCT originating in the County other than by a Permitted CCT Provider or as provided in E is punishable under Resolution 11-001, Paragraph 9, or any successor thereto. The EMS Agency Administrator may in his discretion, upon written request, enter into a Memorandum of Understanding with an ambulance provider that is not a Permitted CCT Provider to perform certain types of specialty care transports, other than CCTs, if he finds that such transports are uniquely specialized and that compliance with the provisions of this Resolution would be unduly burdensome for the ambulance provider in the context of such specialty care transports. The decision of the EMS Agency Administrator on whether or not to enter into a Memorandum of Understanding is final and non-appealable.

E. A CCT may be performed by an ambulance provider that is not a Permitted CCT Provider only if the transferring facility requests the non-permitted ambulance provider to conduct the CCT, the transferring facility informs the non-permitted ambulance provider that it could not obtain the services of a Permitted CCT Provider within the time needed for the CCT, and the transferring facility informs the non-permitted ambulance provider that the transferring facility assumes responsibility for ensuring, and supplying as needed, all of the health care professionals needed to provide the Critical Care Interventions required by the patient during the transport and for providing the equipment, supplies and medications needed for the Critical Care Interventions that are not already on the ambulance.

F. A transferring facility may request an ambulance provider that is not a Permitted CCT Provider to conduct a CCT only after the facility has determined that a Permitted CCT Provider is not available to conduct the CCT within an acceptable period of time and that such transport by the non-permitted ambulance provider, prior to the availability of a Permitted CCT Provider, is urgently needed to treat the Critically Injured or Ill Patient's single, or multiple, vital organ system failure; and/or to prevent further life-threatening deterioration of the patient's condition. A transferring facility that requests a CCT pursuant to this provision shall also satisfy the following requirements:

1) The transferring facility shall determine the specific and anticipated needs of the patient during the CCT, and provide, as needed, health professionals who are qualified to provide Critical Care Interventions in the specialty area or areas for which the patient requires Critical Care Interventions during transport, provide all appropriate equipment and supplies for the CCT that are not available on the ambulance, and send to the receiving facility all medical records of the patient available at the time the CCT is conducted.

2) The transferring facility shall furnish to the non-permitted ambulance provider and the Medical Director of SEMSC, within five (5) days after requesting the ambulance provider to conduct the CCT, a copy of the physician's order ordering the CCT and a written statement explaining why the CCT was necessary, what the facility determined to be an acceptable period of time to begin the CCT, how it determined the acceptable period of time and that a Permitted CCT Provider was not available to conduct the CCT within that period of time, and what was needed to meet the requirements of 1) and how it satisfied those requirements. The transferring facility and the non-permitted ambulance provider shall maintain a copy of the written statement for a minimum of one (1) year.

G. Nothing in this Resolution shall be construed to prohibit a sending physician from ordering the Interfacility Transportation of a Critically Injured or Ill Patient by means other than CCT if the sending physician determines that transport by means other than CCT is appropriate based upon the patient's needs.

3. **Minimum Staffing Standards.**

A. When conducting a CCT, the minimum staffing requirement for an ambulance of a Permitted CCT Provider is one (1) CCT-RN, one (1) health professional trained to operate in a CCT environment, and an ambulance driver. The "health professional trained to operate in a CCT environment" may be an EMT, EMT- paramedic, nurse or other licensed or certified health care professional deemed by the Permitted CCT Provider to be appropriate for the types of CCTs performed by that Permitted CCT Provider. The Permitted CCT Provider shall be responsible to provide the minimum staff set forth in this section when conducting a CCT. However, if the transferring physician determines that it is appropriate to send a particular health professional along with the patient during a CCT, the Permitted CCT Provider may utilize this health professional to satisfy its minimum staffing requirement under this section. In addition, nothing in this section shall in any way be construed to limit the judgment of the transferring physician to send any additional health professionals and/or additional equipment, above and beyond the minimum standards set forth in this Resolution, with the patient during the CCT. Furthermore, nothing in this Resolution shall in any way alter or limit the scope of practice of a licensed health professional accompanying the patient during a CCT.

B. A CCT-RN is a registered nurse who satisfies the following qualifications:

1) Has a current California Registered Nurse license.

2) Has at least two (2) years full-time experience in a critical care setting.

3) Has current provider status in BLS, ACLS, and PALS.

4) Has successfully completed training and education and passed a competency assessment provided by the medical director of the Permitted CCT Provider covering cardiovascular, respiratory, neurological, and neonatal/pediatric care, and has been assessed by the medical director of the Permitted CCT Provider within the last twelve (12) months as maintaining competency in these areas.

C. A CCT-RN and another health professional trained to operate in a CCT environment shall remain with the patient during a CCT.

D. The Permitted CCT provider shall maintain a current roster of all of its personnel that staff or are available to staff a CCT, and documentation demonstrating that each CCT-RN satisfies the requirements of B and each of the other health professionals has been trained to operate in a CCT environment.

4. **Minimum Equipment Requirements.** A Permitted CCT Provider shall, when conducting a CCT, adhere to the Minimum Equipment List for Permitted CCT Providers, as published from time to time jointly by the Medical Director of SEMSC and the EMS Agency Administrator.

5. **Medication Requirements.** A Permitted CCT Provider shall, when conducting a CCT, adhere to the Minimum Medication List for Permitted CCT Providers, as published from time to time jointly by the Medical Director of SEMSC and the EMS Agency Administrator.

6. **General operating standards.** A Permitted CCT provider shall satisfy the following operational requirements:

A. Medical director requirements: A Permitted CCT Provider shall have a medical director who shall be a physician with at least five (5) years experience in critical care or qualifications that meet or exceed these standards as determined by SEMSC. The Medical Director shall be responsible for the following:

1) Ensuring that each CCT-RN and other health professional personnel of the Permitted CCT Provider who staff or may staff a CCT are familiar with this Resolution and regulations adopted pursuant to this Resolution, and SEMSC's and the Permitted CCT Provider's protocols.

2) Developing an educational, training and competency assessment program for the CCT-RN personnel of the Permitted CCT Provider covering and ensuring their competence to provide the cardiovascular, respiratory, neurological, and neonatal/pediatric care that may be required by a Critically Injured or Ill Patient during a CCT.

3) Overseeing the Permitted CCT Provider's standards of care, quality of care, educational, training and competency assessment programs, minimum competency requirements, and continuing education requirements.

4) Conducting an assessment of the competency of each CCT-RN of the Permitted CCT Provider within twelve (12) months following the last competency assessment of that CCT-RN, and documenting the assessment of their competency or lack of competency in the cardiovascular, respiratory, neurological, and neonatal/pediatric care that may be required by a Critically Injured or Ill Patient during a CCT.

5) Performing medical audits of CCTs conducted by the Permitted CCT Provider.

6) Preparing written quality assurance and improvement policies and protocols, and participating in and reviewing quality improvement and peer reviews of CCTs conducted by the Permitted CCT Provider.

7) Participating in the quality improvement activities of SEMSC.

B. Patient care reporting requirements: A Permitted CCT Provider shall maintain and employ an electronic patient care reporting system capable of tracking details of all CCTs, and shall complete an electronic patient care report for each CCT. The electronic patient care reporting system shall provide full access to SEMSC to retrieve patient care reports on a daily basis to facilitate its ability to generate quality assurance studies and reports. The EMS Agency Administrator may, at his discretion, waive the requirement for electronic patient care reporting and permit CCT patient care reports to be submitted by a Permitted CCT Provider in alternate formats acceptable to the EMS Agency Administrator.

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C. Management and supervision requirements: A Permitted CCT Provider shall provide sufficient management and supervisory personnel to manage all aspects of CCTs, including administration, operations, EMS training, clinical quality improvement, record keeping and supervision.

D. Response time requirements: A Permitted CCT Provider shall arrive at a facility requesting a CCT as follows:

1) Within forty-five (45) minutes of receiving a request for an unscheduled CCT for 90% of responses, within one standard deviation of significance.

2) Within forty-five (45) minutes of the arrival time requested for a scheduled CCT for 90% of responses, within one standard deviation of significance.

E. Documentation requirements: A Permitted CCT Provider shall maintain a copy of the following:

1) The materials it uses to educate, train and assess the competence of its CCT-RNs to provide the cardiovascular, respiratory, neurological, and neonatal/pediatric care that may be required by a Critically Injured or Ill Patient during a CCT.

2) Its CCT clinical treatment and transportation protocols.

3) Its quality assurance and improvement policies and procedures.

4) Documentation by which it determined that its CCT-RNs satisfied the requirements of Paragraph 3.B and that its other health professionals who staff or may staff a CCT have been trained to operate in a CCT environment.

5) The written or electronic competency assessments of its CCT-RNs by its medical director over the preceding three (3) years.

F. Amendment filing requirements: A Permitted CCT Provider shall file with SEMSC any amendment to a document it was required to file with its application for its CCT provider permit within ten (10) days after the amendment.

G. Reporting requirements: Upon the request of SEMSC, a Permitted CCT Provider shall provide SEMSC with records and data related to its compliance with the requirements of this Resolution and the regulations adopted under this Resolution, including but not limited to its patient care reports, billing records and its CCT clinical protocols, and shall prepare and provide SEMSC with reports of data extracted from such records.

7. **Applications and fees.**

A. An ambulance provider that seeks a permit to operate as a Permitted CCT Provider shall submit to SEMSC an application for a CCT provider permit, with a fee of $7,500.00. The application shall be made on a form or through an electronic process as prescribed and made available by SEMSC.

B. The application shall aver, and include such information and be accompanied by such documentation, including the materials specified in Paragraph 6.E, as required by SEMSC to establish that the applicant satisfies or, as appropriate, will satisfy, the operational requirements for a Permitted CCT Provider under Paragraph 6 and other applicable requirements of this Resolution and the regulations adopted under this Resolution.

C. SEMSC shall issue a CCT provider permit to the ambulance provider if the requirements of A and B are satisfied, the Medical Director of SEMSC approves the documents specified in B, and SEMSC, after conducting a background check and an on-site inspection, finds that the applicant can safely and effectively operate as a Permitted CCT Provider.

D. A CCT provider permit is valid for two (2) years. Thereafter, to continue to operate as a Permitted CCT Provider the ambulance provider shall apply for renewal of its permit to operate as a Permitted CCT Provider within thirty (30) days prior to the expiration of its current permit. The application shall be accompanied by a fee of $7,500.00 and shall be submitted on a form or through an electronic process as prescribed and made available by SEMSC, which shall require such information and documentation as SEMSC determines is needed to verify that the Permitted CCT Provider continues to satisfy the operational requirements for a Permitted CCT Provider under Paragraph 6 and other applicable requirements of this Resolution and the regulations adopted under this Resolution.

E. All fees collected under this Resolution shall be used to compensate SEMSC for the administration of this Resolution and the regulations adopted under this Resolution. SEMSC may by resolution revise any or all of the fees specified in this Resolution, as appropriate, for that purpose.

F. A fee collected under this paragraph shall not be reimbursed if the application or other matter for which the fee was submitted is denied.

G. A Permitted CCT Provider shall be assessed a delinquent fee of $2,500.00, in addition to the renewal fee, for a late filed application, if the Permitted CCT Provider does not submit an application to renew the permit within thirty (30) days prior to the expiration of the current permit and, if the late filing causes a new permit not to be issued before the current permit expires, shall cease operations as a Permitted CCT Provider until a new permit is issued.

H. No application for a permit or renewal of a permit shall be processed unless it is accompanied by the required fee, including a delinquent fee if applicable.

8. **Inspection and verification.** Authorized representatives of SEMSC, upon displaying appropriate credentials, may inspect a Permitted CCT Provider or audit a Permitted CCT Provider's performance and compliance with this Resolution and the regulations adopted under this Resolution. The Permitted CCT Provider shall afford SEMSC unobstructed and reasonable access, with or without advance notice, to all aspects of the Permitted CCT Provider's operations and records relevant to its compliance with the requirements of this Resolution and the regulations adopted under this Resolution. A Permitted CCT Provider shall fully cooperate with the inspection or audit and shall produce in a timely fashion any records it maintains outside of Solano County that it is required to produce under this paragraph.

9. **Quality assurance and improvement.** A Permitted CCT Provider shall satisfy the following quality assurance and improvement requirements:

A. A Permitted CCT Provider shall establish and maintain a Quality Improvement Program and shall participate fully in the quality improvement activities of SEMSC. Participation in the quality improvement activities of SEMSC requires that the Permitted CCT Provider furnish SEMSC access to all of the Permitted CCT Provider's CCT patient care reports and supporting documentation, including the orders of the physician ordering the CCT.

B. A Permitted CCT Provider shall employ a Quality Improvement Coordinator who shall be a registered nurse, qualified EMT-P, or physician. The Quality Improvement Coordinator shall track the clinical performance of the Permitted CCT Provider's personnel involved in CCTs, conduct audits and investigations, and prepare quality improvement reports as may be required by SEMSC. The Quality Improvement Coordinator position need not be a full time position, and the person designated to serve as the Quality Improvement Coordinator may perform other duties for the Permitted CCT Provider.

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RESOLUTION OF THE SOLANO COUNTY EMERGENCY MEDICAL SERVICES COOPERATIVE REQUIRING OPERATORS OF EMERGENCY AMBULANCES TO OBTAIN A PERMIT TO CONDUCT CRITICAL CARE TRANSPORTS ORIGINATING IN SOLANO COUNTY

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10. **On-line medical direction.** A Permitted CCT Provider may seek on-line medical direction in the event the medical command instructions of a physician are required to care for the patient during a CCT. On-line medical direction may be sought from the sending physician, the receiving physician, or any hospital that furnishes on-line medical direction. A hospital with which SEMSC has entered into an Advanced Life Support Base Hospital Agreement shall provide on-line medical direction for any member of a CCT crew who contacts it for medical direction for a CCT that is in or originates in the County.

11. **Reports to SEMSC.** Whenever an ambulance provider that is not a Permitted CCT Provider is asked to conduct a CCT originating in the County, and conducts a transport of the patient which it believes does not satisfy the definition of a CCT, the provider shall submit a written report of that transport to SEMSC, within five (5) days after completing the transport, with an explanation of the circumstance under which it conducted the transport.

12. **Automatic suspension.** A CCT provider permit issued pursuant to this Resolution shall be automatically suspended if the Permitted CCT Provider's authorization as the operator of emergency ambulances in the County is suspended.

13. **Discipline.**

A. SEMSC may discipline a Permitted CCT Provider or an applicant for a CCT provider permit or renewal of a CCT provider permit for violating a requirement of this Resolution or a regulation adopted under this Resolution, or for any of the following reasons:

1) Engaging in fraud or deceit in obtaining or attempting to obtain or renew a permit as a CCT provider.

2) Violating an order previously issued by SEMSC.

3) Repeated failure to accept CCT requests or a pattern of failure to respond to CCT requests within the response time standards set forth in this Resolution.

B. SEMSC may discipline an ambulance provider that is not a Permitted CCT Provider if it engages in any activities that would violate this Resolution if done by a Permitted CCT Provider, and for performing CCTs originating in Solano County outside of the provisions of Paragraph 2.E of this Resolution.

C. If disciplinary action is appropriate under this Resolution, SEMSC shall administer the Administrative Infraction and Clinical/Systems progressive discipline set forth in Resolution11-001, Paragraph 9, to the CCT provider permit. SEMSC may also, or alternatively, apply that progressive discipline to the Permitted CCT Provider's authorization as the operator of emergency ambulances in the County.

14. **Appeals by CCT providers and applicants.** A Permitted CCT Provider or an applicant for a CCT provider permit aggrieved by a decision under Paragraph 13.C, or denied approval of the educational, training and testing program for its CCT-RN personnel, may appeal that decision as set forth in Resolution 11-001, Paragraph 10.

15. **Transferring facility fines and appeals.**

A. After reviewing a report filed under Paragraph 2.F.2) and/or Paragraph 11, or otherwise receiving information that a transferring facility arranged for a CCT that did not qualify as a CCT, or requested an ambulance provider that was not a Permitted CCT Provider to conduct a CCT, and conducting further investigation as needed, the SEMSC Medical Director determines that the interfacility transport occurred in such manner without just cause, the SEMSC Medical Director may impose a fine of up to $1,500 upon the transferring facility for each violation.

B. A transferring facility may appeal the decision and fine to the Public Health Officer by filing a notice of appeal with the EMS Agency, on an appeal form provided by SEMSC, within fifteen (15) days after notice of the decision.

C. The decision of the SEMSC Medical Director will be provided to the transferring facility by electronic mail as well as US Postal Service, Certified Mail, Return Receipt Requested. Notice of the decision occurs when the transferring facility receives the decision by electronic mail or US Postal Service, whichever occurs first, or if neither is successful, when the transferring facility is otherwise served with the decision under California law.

D. Except as otherwise provided in this paragraph, the appeal procedures set forth in Resolution 11-001, Paragraph 10, shall apply.

E. Any decision not timely appealed is final.

16. **Regulations.** The SEMSC Board of Directors delegates to its Medical Director and the EMS Agency Administrator the power and authority to make rules and regulations consistent with this Resolution for the purpose of facilitating the regulation of CCTs originating within the County.

RESOLUTION NO. 12-001

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17. **Savings clause.** If any paragraph, subparagraph, sentence, clause, phrase or word of this Resolution is held to be invalid for any reason, such decision shall not affect the validity of the remainder of the Resolution. The SEMSC Board of Directors hereby declares that it would have passed the Resolution, and each paragraph, subparagraph, sentence, clause, phrase or word of this Resolution other than the one or more paragraphs, subparagraphs, sentences, clauses, phrases or words declared to be invalid.

18. **Indigent care.** For CCTs rendered to an uninsured patient, or to an insured patient who owes an uninsured balance, including a copayment, coinsurance or deductible, and who documents that they qualify under five (5) times the HHS Poverty Guidelines in effect on the date of transport, as published periodically by the United States Department of Health and Human Services, the ambulance provider shall charge the patient no more than the amounts approved by the Centers for Medicare and Medicaid Services for HCPCS codes A0434 and A0425 on the date of transport under the Medicare Ambulance Fee Schedule applicable to the ZIP Code corresponding to the point of patient pickup. Nothing in this paragraph shall be deemed to regulate the amount of the charge for CCTs to any insurer or third party payer.

19. **Resolution 11-001.** The provisions of Resolution 11-001 shall be applicable to all CCTs performed pursuant to this Resolution. Resolution 11-001 and this Resolution shall be read *in pari materia* so as to give full force and effect to the provisions of both.

20. **Effective date.** This Resolution shall become effective on **November 1, 2017**

Passed and adopted by the Board of Directors of the Solano County Emergency Medical Services Cooperative on _____, by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

_____
Birgitta Corsello
Chair, SEMSC Board of Directors

Attest:

_____
Rachelle Canones
SEMSC Clerk-of-the-Board