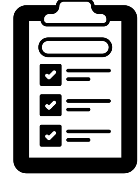
Sierra – Sacramento Valley EMS Agency
Regional Emergency Medical Advisory Committee
(REMAC)



MEETING AGENDA

MEETING DATE & TIME INFORMATION

- **Tuesday, April 22, 2025, 9:00 am – 12:00 pm**

MEETING LOCATION & ALTERNATE ATTENDANCE INFORMATION

- **Primary Meeting Location:** 535 Menlo Drive, Suite A, Rocklin, CA 95675
- **Alternate Meeting Location:** 1255 East Street, 2nd Floor, Redding, CA 96001
- **Zoom:** https://us02web.zoom.us/j/81440904296?pwd=6rnbmOmFum6GPfG35dGcvrfhgKMnvg.1
- **Telephone:** (669) 900-9128, **Meeting ID:** 814 4090 4296 **Passcode:** 1702

IMPORTANT NOTIFICATONS

- Public comments on proposed policy/protocol actions listed on this agenda will be taken during the review/discussion of the applicable item. Individuals unable to attend the meeting may provide written public comment on any item listed on this agenda, no later than seven (7) calendar days prior to the scheduled meeting date, by using the following comment form link: https://www.ssvems.com/s-sv-ems-remac-public-comment/.
- Policy/protocol actions listed on this agenda may be approved by a majority vote of the REMAC members present at the meeting. If necessary, proposed policy/protocol actions may be continued to subsequent REMAC meetings until consensus is reached by the committee.
- All REMAC approved policy/protocol actions shall also be approved by the S-SV EMS Medical Director and Regional Executive Director prior to implementation. S-SV EMS may make non-substantive corrections to approved policy/protocol actions to address any technical defect, error, irregularity, or omission prior to final publication.
- EMS system participants will be notified of approved policy/protocol actions a minimum of 30 calendar days prior to the effective implementation date. Policy/protocol action updates are routinely published on a bi-annual basis as follows:
    - October & January meeting approved policy actions: April 1st implementation date.
    - March & July meeting approved policy actions: October 1st implementation date.
- Some policy/protocol actions may require immediate action to maintain compliance with statutes/ regulations, or to preserve medical control/integrity of the EMS system. Policy/protocol actions of this type may be implemented by S-SV EMS as urgency measures and scheduled for discussion at the next regularly scheduled REMAC meeting, if necessary.

MEETING AGENDA		
ITEM	**TITLE**	**LEADER**
A	Call to Order/Introductions	Chairperson
B	Approval of Previous Meeting Minutes	Chairperson
C	Approval of Meeting Agenda	Chairperson
D	Public Comment	Attendees
E	REMAC & Policy/Protocol Process Survey Results	Jared Gunter
F	S-SV EMS Policy/Protocol Actions	S-SV EMS Staff
	412: Ground Ambulance Provider Rate Approval Process	John Poland
	461: Automatic Aid/Mutual Aid/Disaster Assistance (Including FEMP, AST & MTF Resource Requests)	John Poland
	462: Temporary Recognition of EMS Personnel (Note: urgency policy, previously released to preserve medical control of the EMS system)	John Poland
	710: Management of Controlled Substances (Note: will include discussion on ketamine availability & required stocking quantities)	Trenton Quirk
	806: Unified Paramedic Optional Scope of Practice for Qualified Transport Programs	Michelle Moss
	915: MICN Authorization/Reauthorization	Michelle Moss
	C-1: Non-Traumatic Pulseless Arrest	Brittany Pohley
	C-5: Ventricular Assist Device (VAD)	Brittany Pohley
	E-1: Hyperthermia	Brittany Pohley
	R-3: Acute Respiratory Distress	Michelle Moss
	PR-3P: Pediatric Pleural Decompression	Michelle Moss
G	Law Enforcement Response to Behavioral Crisis Incidents	Patrick Comstock
H	EMS Aircraft Provider Reports	Attendees
I	EMS Ground Provider Reports	Attendees

ITEM	TITLE	LEADER
J	Hospital Provider Reports	Attendees
K	Quality Improvement (QI) Case Review	Brittany Pohley
M	S-SV EMS Agency Reports	S-SV EMS Staff
	- EMS Data System	Jeff McManus
	- EMS Quality Management/QI Matters – including new S-SV EMS Performance Measures Process	Michelle Moss & Jared Gunter
	- Regional Specialty Committees	Michelle Moss
	- Operations	Patrick Comstock
	- Regional Executive Director	John Poland
	- Medical Director	Troy M. Falck, MD
N	Next Meeting/Adjournment: July 22, 2025	Chairperson

	Sierra – Sacramento Valley EMS Agency Regional Emergency Medical Advisory Committee (REMAC)	

MEETING MINUTES

Meeting Date
Tuesday, January 28, 2025

A. Call to Order/Introductions

- Dr. Royer called the meeting to order at 9:01 am, and all attendees introduced themselves.

B. Approval of Previous Minutes: October 22, 2024

- The minutes were unanimously approved by the committee with no changes.

C. Approval of Agenda

- Dr. Falck motioned to add policy 510 to the agenda, to be discussed. The committee approved the agenda with the change.

D. Public Comment

- Kaiser Roseville is collaborating with AMR for a STEMI talk on 5/21, and a Stroke talk on 8/24.

E. S-SV EMS Agency Processes

- A 3-page letter was distributed that talks about the Prehospital Advisory Committee (PAC), and the changes that have been made to policies/protocols over the past 2 years.
  - The S-SV EMS Agency acknowledges that the frequency and quantity of the protocol/policy updates over the last year and a half have been more than anticipated and are not expected to continue at that rate.
  - Jared Gunter, the new S-SV EMS Specialist, will be looking at the REMAC processes to help streamline them.
  - After this meeting, a survey will be put together for the providers asking about the REMAC process, and the frequency/timing of the EMS updates.
  - Going forward, the changes will not be so overwhelming.
  - The Agency will continue to look for ways to get easy feedback from providers.
  - Going forward, when a change is suggested that will have a financial/training related impact for providers, a rationale will accompany those policies/protocols.
  - Many of the other LEMSAs have an April/October annual update schedule. The agency is reconsidering the current June/December update schedule. The agency would like feedback on this.
    - From the fire season perspective, it would be helpful to have the April update.

F. S-SV EMS Policy Actions

Policy Actions for Final Review & Approval:

Policy	Name	Motion	Second	Committee Vote
220	**S-SV EMS Policy/Protocol Actions** • On page 2, added #'s 3 and 6. Under Item C, line 35, added 'April or October.'	Clayton Thomas	Rich Lemmon	Passed Unanimously
506	**STEMI Receiving Center Designation Criteria, Requirements & Responsibilities** • On page 5, line 18, added 'by email to info@ssvems.com'.	Steve Halterman	Teri Arrwood	Passed Unanimously
510	**Rapid Re-Triage & Interfacility Transport Of STEMI, Stroke & Trauma Patients** • On page 1, under Purpose, added ' or critically ill patients whose condition requires time-sensitive intervention or care beyond the capabilities available at the sending facility.' Under Definitions, added Item D. • On page 2, added item D.	Dr. Iwai	Dr. Morris	Passed Unanimously
809	**EMS Naloxone Leave-Behind Program** • This is a new policy and is optional. • On page 2, line 20, it was suggested to add 'Opiates' after 'never use'.	Dr. Royer	Clayton Thomas	Passed Unanimously
1007	**EMS Student Field Training** • This change was to allow any provider level to take students at the provdier's level of certification/license or lower level.	Clayton Thomas	Dr. Morris	Passed Unanimously
C-1	**Non-Traumatic Pulseless Arrest** • On page 2, the bottom right box, removed 'Consider termination of resuscitation after 20 minutes of ALS intervention'. In the bottom left box, added '(see page 1) at the end of the last bullet point. • This will be taken to the PAC meeting and brought back to this committee.			This policy will be brought back
C-3	**Bradycardia With Pulses** • It was recommended to remove the double star sentence from the Transcutaneous Pacing Sedation/Pain Control box. • It was suggested to add the range back in.	Dr. Iwai	Clayton Thomas	Passed Unanimously

M-8	**Pain Management** • Under Ketamine, all but pregnancy was removed. • Michelle suggested the following change: under the Fentanyl/Midazolam box, remove 'Reduce fentanyl does to 25 mcg for pts ≥65', and add 'Consider reducing' to the next line before 'fentanyl doses to 25 mcg for pts ≥65 yo'.	Chris Britton	Dr. Morris	Passed Unanimously
OB-G2	**Obstetric Emergencies** • Under Eclampsia there are a set of protocols. Under the 'No' box, added 'If seizure has terminated prior to midazolam administration move directly to magnesium'.	Clayton Thomas	Dr. Iwai	Passed Unanimously
T-1	**General Trauma Management** • Any CoTCCC approved pelvic binder can be utilized. • On page 2, under the first 'Yes' box, removed 'GCS ≤13'. • It was suggested to spell out the 'CoTCCC' abbreviation.	Rich Lemmon	Debbie Madding	Passed Unanimously
T-3	**Suspected Moderate/Severe Traumatic Brain Injury (TBI)** • An error that was previously discovered was changed. It had pediatric dosing instead of adult dosing. The range was also removed. • Removed 'Oral glucose' from the 'Yes' box.	Clayton Thomas	Dr. Iwai	Passed Unanimously
T-4	**Hemorrhage** • Any CoTCCC approved limb tourniquet can be utilized.	Clayton Thomas	Dr. Iwai	Passed Unanimously
M-2P	**(formerly C1-N): Newborn Care/Neonatal Resuscitation** • The first page is Newborn Care, and the second page is the Neonatal Resuscitation.	Clayton Thomas	Dr. Iwai	Passed Unanimously

M-6P	**Pediatric General Medical Treatment** • On page 1, in the bottom box, removed 'PO acetaminophen for febrile symptoms (N-2P & M-6P)'. • On page 4, in the bottom box, added 'consider:'.	Rich Lemmon	Dr. Morris	Passed Unanimously
PR-2	**Airway & Ventilation Management** • This was a policy that was transitioned to a protocol. • On page 2, under 'Endotracheal (ET) Intubation Procedure', the 5th bullet point, it was suggested to remove 'for pts with an anticipated difficult airway'. • Under the 'Post Procedure' box, it was suggested to change the Midazolam dose to 10mg, with a repeat dose.	Clayton Thomas	Dr. Morris	Passed Unanimously
PR-3	**Pleural Decompression** • Discussed at the Trauma QI meeting. • Under 'Indications', added 'a history of chest trauma, unilateral' to the first sentence. In the first listed indication changed 'Combined hypotension (SBP <90) and' to 'Severe respiratory distress with an'. In the second listed indication changed 'Penetrating injury to the thorax' to 'SBP ≤ 90mm Hg or loss of radial pulse due to shock'. In the 3rd listed indication removed 'if chest or multi system trauma is suspected'. • In the 'Procedure' box, added the last bullet point – 'For Pediatrics, only the mid-clavicular site utilizing a 14g x 3.25 catheter w/Capnospot® is approved'. • In the 'Procedure' box, the second bullet point, it was recommended to remove 'Capnospot®'. • There was a lot of discussion. It was suggested to leave it as is and revisit it in a year.	Dr. Falck	Clayton Thomas	Passed Unanimously

<table>
<tr>
<td>1110-F</td>
<td>Infrequently Used Skills Checklist – Needle Cricothyrotomy
• The changes reflect the new devices used for pleural decompression and to remove the language for jet insufflation.
• On page 1, under ‘Equipment’, removed ‘or 14ga’, and ‘and jet insufflation device or ENK Oxygen Flow Modulator,’.
• On page 2, under ‘Description’,
▪ Step 5, first bullet point, changed to ‘12ga, 3” airway catheter’. The third bullet point changed to ‘Ensure a 3.0mm endotracheal tube connector is available to attach to the catheter to the BVM following placement’.
▪ Under step 9, first bullet point added ‘caudally’.
▪ Under step 12, first bullet point added ‘a 12ga catheter’, ‘inspiratory to expiratory ratio (seconds):’. Added the last 2 bullet points.
▪ Under step 13, first bullet point, removed ‘(jet insufflation device and QuickTrach Cricothyrotomy Kit only):’.</td>
<td>Rich Lemmon</td>
<td>Dr. Morris</td>
<td>Passed Unanimously</td>
</tr>
<tr>
<td>1110-G</td>
<td>Infrequently Used Skills Verification Checklist Needle Thoracostomy
• The changes reflect the new devices used for pleural decompression and to remove the language for jet insufflation.
• On page 1:
▪ Removed step 7
▪ Added all of step 8
• On page 2:
▪ Removed steps 9-11
▪ Step 12: removed ‘Attaches stopcock or one way valve and secures catheter/tubing’ and added ‘Adequately secures catheter’.</td>
<td>Rich Lemmon</td>
<td>Dr. Morris</td>
<td>Passed Unanimously</td>
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G. EMS Aircraft Provider Updates

- There were no EMS Aircraft provider updates.

H. Ground EMS Provider Updates

- Dignity Healthcare:
  - They intend to put video-laryngoscope on the trucks.
  - They're working on airway improvement.
  - Asked for consideration in the protocols to have magnesium sulfate for respiratory asthma.

- Roseville FD:
  - Asked for the approved changes, from this meeting, to be sent out with the changes highlighted so they're easier to find.

I. S-SV EMS Agency Reports

- **EMS Data System**
  - There is a small update coming (3.5.1) but without a current implementation date.
  - The State is working on a procedures and medication list for data.

- **EMS Quality Management/QI Initiatives Report**
  - The 5-year QI plans are due.
  - The annual forms have been sent out and are due 3/31. Please make sure to update the QI contacts on this form – this is very important.
  - Jared Gunter is the newest edition to the staff. His role right now will be to take over the REMAC process to streamline it. He will also be looking at the NASEMSO prehospital guidelines and making sure S-SV is in line.

- **Regional Specialty Committees**
  - The last Trauma QI meeting was in December.
  - The next STEMI meeting will be in May.

- **Operations**
  - Enloe/Butte County EMS will have a leadership training course. Information will be on the S-SV website. Please make sure to look at the S-SV training/education page for listed courses/opportunities.
  - Sierra College has been approved for their Paramedic Course. They had over 100 applicants for their first class. They will have 18-20 students in this first class.
  - There has been an increase in incorrectly documented APOT times.
  - S-SV is in the final internal review of the EMS plan for the State.

- **Regional Executive Director's Report**
  - The EMS Authority has finalized the renumbering of all 14 chapters of Title 22 of the EMS regulations. They didn't change any of the wording, but did merge chapters together. This became effective on January 1st.
    - The EMS Authority is now working on individual chapters. Chapter one will be developing equitable and personal centered care. It will include LEMSA

requirements, EMS plans, RFPs, and exclusive operating areas. Public comments are required to be submitted by 2/7.
    - Chapter 3 is the new EMS personnel (which includes EMTs, AEMTs, and Paramedics) which is currently being reviewed and revised.
    - They merged Trauma, STEMI, Stroke, and EMS for children into Chapter 6. This is supposed to be the first chapter to go through the rule making process for updating.
  - AB40 is new legislation that was passed at the end of 2023, regarding ambulance patient offload time (APOT).
    - There were several stakeholder meetings at the end of 2024.
    - It's unknown when these will be released for public comment.
  - AB716 has to do with ground ambulance billing and was passed in 2023 as well.
    - There were several stakeholder meetings at the end of 2024.
    - There have been no additional status updates.
  - The EMSA EMS Quality and Planning Chief, Tom McGuiness, is leaving in the next couple weeks to become the new Sacramento County EMS Administrator – replacing Dave Magnino, which may delay States implementation of above initiatives.
  - There have been some struggles recently with Google and the S-SV EMS app for Apple and Android phones. S-SV is working through this.

J. Medical Director's Report

- Going forward, there needs to be more discussion in this meeting regarding quality issues/initiatives.
- APOT – please keep working on keeping APOT times as low as possible.
- 2024 Regional Training Module – 967 have taken this, please make sure to have your crews complete this mandatory training soon.

K. Next Meeting Date & Adjournment

- Jack Wood announced that he is stepping down as the Medical Director for AMR, and Riley McDonald will be the new Medical Director. This will be Jack Wood's last meeting.
- The meeting was adjourned at 11:48 am.

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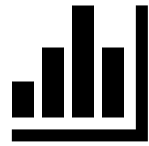
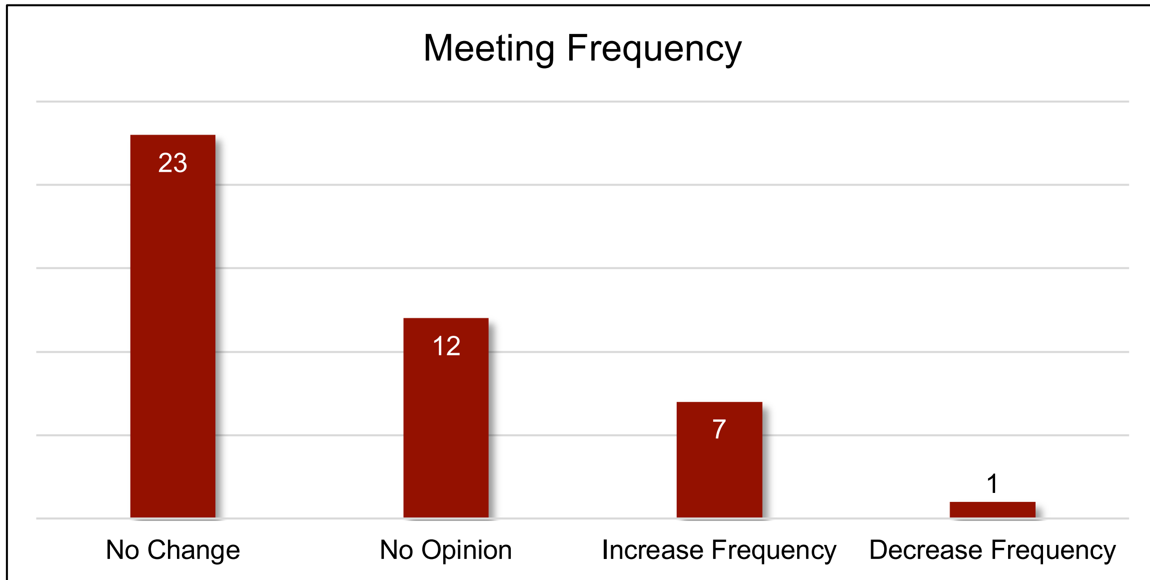
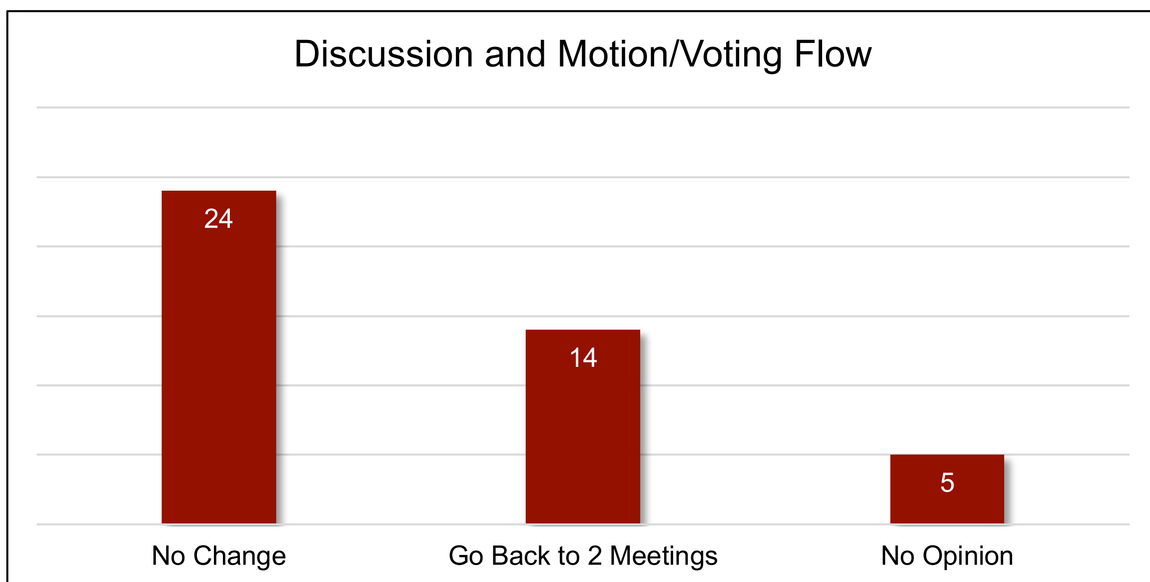


REMAC Survey Results

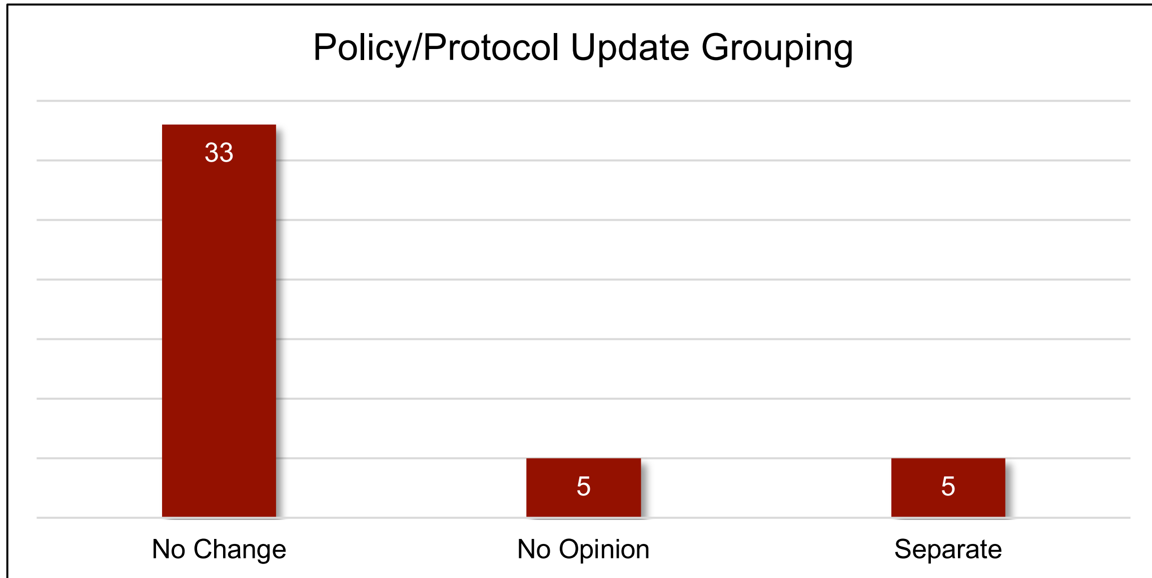
1. REMAC meetings are currently held quarterly. How would you change this cadence?



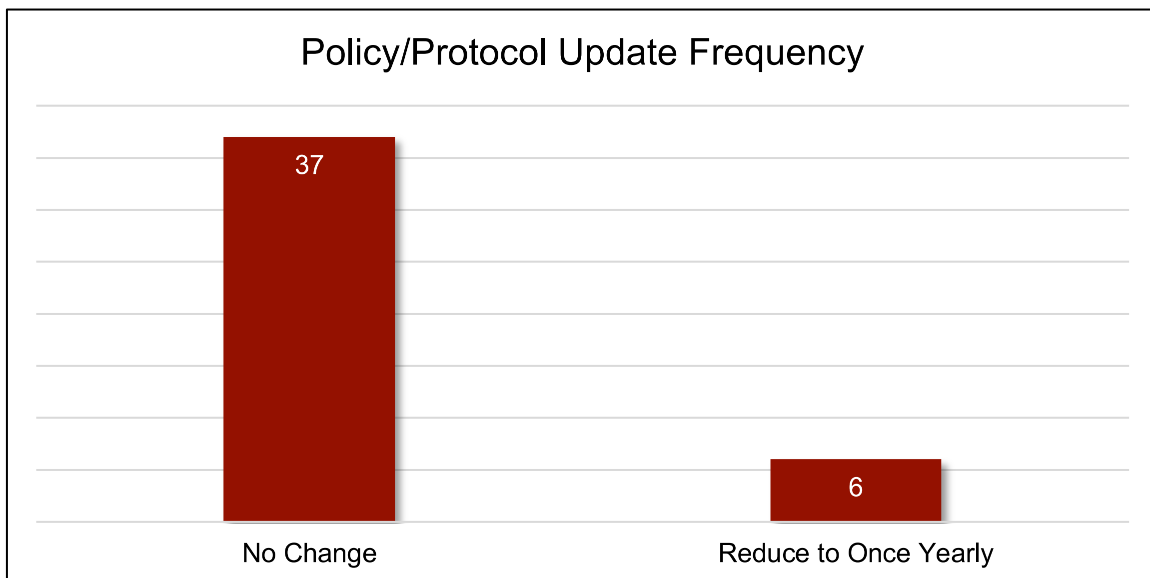
2. The policy and protocol discussions and motions occur in the same meeting. Would you change this back to a 'two-meeting' method where discussion happens in one meeting, and a motion/vote happens at the following meeting?



3. Policy updates and protocol updates are published at the same time. Do you have an opinion on whether they should be separated so that policies should be updated separately from protocols?



4. Updates are released twice yearly, April and October. Would you change this frequency?



Open-ended Comments: (16 respondents)

Protocol Update Concerns

- Frequency and Volume: Some respondents feel updates occur too frequently with too many changes at once. A couple suggest reducing to annual updates rather than biannual.
- Implementation Challenges: Allowing a policy to be utilized prior to its effective date creates confusion for field personnel who may be trained on one version but learn another.
- Quality Issues: Two respondents noted an increase in clerical errors, inconsistencies, and contradictions in recent updates, suggesting insufficient review time and undermining the credibility of the protocols.
- Training Impact: Field providers struggle to digest and implement frequent changes before the next update arrives six months later.

Suggested Improvements for Protocol Updates

- Simplify protocols where possible as they are too complex for high-pressure situations.
- Set fixed implementation dates (one suggestion for January 1st to align with fire season rehire academies).
- Include explanations for each change to help field providers understand the rationale.
- Create a period between release and implementation to allow for proper training.

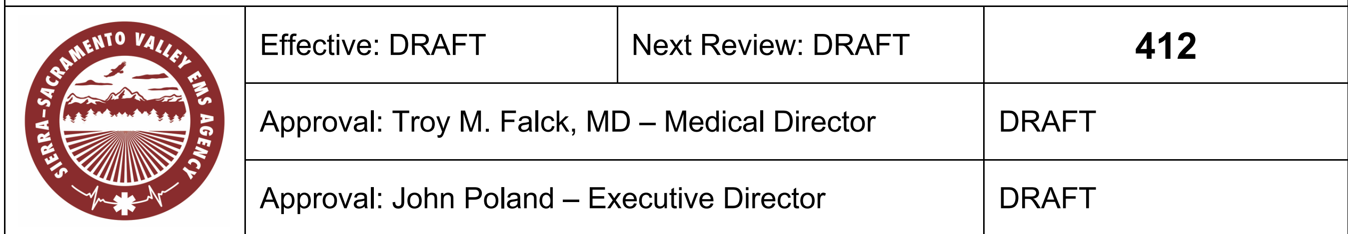
Meeting Structure Feedback

- Mixed Opinions: Some appreciate the combined meeting approach for efficiency, while others feel it makes meetings too long and that individual discipline updates (air, ground, etc.) may not be relevant to everyone and should be separated out.
- Frequency Preferences: Varied views on meeting frequency—some prefer quarterly, others suggest every other month for "leaner" meetings.
- Discussion Time: Concerns that important items requiring extensive discussion get rushed or carried to subsequent meetings, negating the "single meeting" efficiency.

Communication Methods

- Email updates to the field are generally viewed positively.
- Website updates are considered timely and helpful.
- The highlighting of changes in the previous updates is appreciated.
- One respondent requested more context and explanations behind changes.

Sierra – Sacramento Valley EMS Agency Program Policy			
Ground Ambulance Provider Rate Approval Process			



	Effective: DRAFT	Next Review: DRAFT	**412**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish a ground ambulance provider rate approval process to comply with applicable statutes/regulations and ensure adequate availability of ground ambulance resources within the S-SV EMS region to protect the public health and safety.

AUTHORITY:

A. HSC § 1371.56, § 1707.124, 1797.232.

B. CIC § 10126.66.

C. CCR, Title 22, Div. 9.

POLICY:

A. A health care service plan shall require an enrollee who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that an enrollee would pay for the same covered services received from a contracting ground ambulance provider (“in-network cost-sharing amount”). An enrollee shall not owe the noncontracting ground ambulance provider more than the in-network cost sharing amount for covered services. A noncontracting ground ambulance provider shall only advance to collections the in-network cost-sharing amount that an enrollee individual failed to pay.

B. Unless otherwise agreed to by the noncontracting ground ambulance provider and the health care service plan, the plan shall directly reimburse a noncontracting ground ambulance provider for ground ambulance services the difference between the in-network cost-sharing amount and the amount described, as follows:

   1. If there is a rate established or approved by a local government, at the rate established or approved by the governing body of the local government having jurisdiction for that area or subarea, including an exclusive operating area pursuant to Section 1797.85 of the Health and Safety Code (HSC).

2. If the local government having jurisdiction where the service was provided does not have an established or approved rate for that service, the reasonable and customary value for the services rendered, based upon statistically credible information that is updated at least annually and takes into consideration all the following:

   - The ambulance provider's training, qualifications, and length of time in practice.
   - The nature of the services provided.
   - The fees usually charged by the ground ambulance provider.
   - Prevailing ground ambulance provider rates charged in the general geographic area in which the services were rendered.
   - Other aspects of the economics of the ambulance provider's practice that are relevant.
   - Any unusual circumstances in the case.

3. A local government has jurisdiction over the ground ambulance transport if either of the following applies:

   - The ground ambulance transport is initiated within the boundaries of the local government's regulatory jurisdiction.
   - In the case of ground ambulance transports provided on a mutual or automatic aid basis into another jurisdiction, the local government where the noncontracting ground ambulance provider is based.

4. A payment made by the health care service plan to the noncontracting ground ambulance provider, plus the applicable cost sharing owed by the enrollee, shall constitute payment in full for services rendered.

5. Notwithstanding any other law, the amounts paid by a health care service plan for ground ambulance services shall not constitute the prevailing or customary charges, the usual fees to the public, or other charges for other payers for an individual ground ambulance provider.

C. Ground ambulance service providers remain subject to the balance billing protections for Medi-Cal beneficiaries under Section 14019.4 of the Welfare and Institutions Code.

D. A ground ambulance provider shall not require an uninsured patient or self-pay patient to pay an amount more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater. A ground ambulance provider shall only advance to collections the Medicare or Medi-Cal payment amount, that an uninsured or self-pay patient failed to pay.

PROCEDURE:

A. The S-SV EMS JPA Governing Board has adopted resolution #06-1325-01 that as of July 1, 2025:

  1. Approved S-SV EMS authorized ground ambulance provider rates.

  2. Authorized the S-SV EMS Regional Executive Director to:

     - Approve S-SV EMS authorized ground ambulance provider annual rate increases, based on changes to the San Francisco-Oakland-Hayward, CA Consumer Price Index for All Urban Consumers (CPI-U). The maximum allowable annual rate increases will be three (3) percent, or the actual increase for the applicable year (whichever is greater).
     - Approve rates for new services provided by existing S-SV EMS authorized ground ambulance providers.
     - Approve rates for new S-SV EMS authorized ground ambulance providers.

B. In the event changed circumstances significantly impact the costs of providing ground ambulance services within the S-SV EMS region, or there are substantial reductions in revenue caused by factors beyond the provider's control, the provider may request a special rate increase to mitigate the financial impact of such circumstances.

  1. A special rate increase request shall be submitted to S-SV EMS at least thirty (30) days prior to the regularly scheduled JPA Governing Board meeting at which the item will be heard/considered.

  2. The S-SV EMS JPA Governing Board shall have sole authority to approve or disapprove a ground ambulance provider special rate increase request.

C. The processes described in this policy do not apply to the following circumstances:

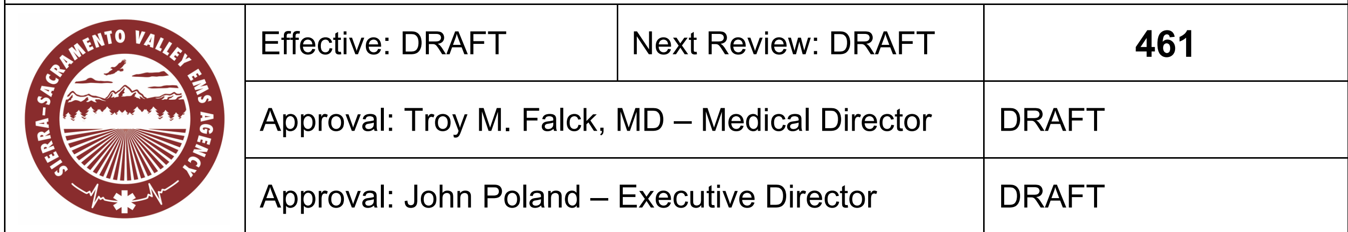
  1. Ground ambulance providers who have an exclusive operating area (EOA) agreement with S-SV EMS that contains specific rate setting provisions.

  2. Public (local government) ground ambulance providers who's governing body is responsible for publicly establishing/approving ground ambulance rates. Public ground ambulance providers shall notify S-SV EMS of any changes to their ground ambulance rates within 30 days of such change, so that S-SV EMS can comply with the reporting requirements established by applicable statutes/regulations.

D. S-SV EMS will post all currently approved ground ambulance provider rates on its internet website and provide such information to the California EMS Authority (EMSA) as required by applicable statutes/regulations.

Sierra – Sacramento Valley EMS Agency Program Policy

Automatic Aid/Mutual Aid/Disaster Assistance (Including EMPF, AST & MTF Resource Requests)



	Effective: DRAFT	Next Review: DRAFT	**461**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

A. To define the conditions/circumstances under which prehospital personnel may utilize the scope of practice for which they are trained and certified/licensed/accredited for during automatic aid/mutual aid/disaster assistance responses.

B. To describe the purpose, requesting process and utilization of Paramedic Fireline (EMPF), Ambulance Strike Team (AST) and Medical Task Force (MTF) resources.

AUTHORITY:

A. HSC, § 1797.170(b), 1797.204 & 1797.220.

B. CCR, Title 22, Div. 9.

C. California Disaster and Civil Defense Master Mutual Aid Agreement (11/1950).

D. EMSA ‘Ambulance Strike Team (AST)/Medical Task Force System Manual’ (4/2010).

E. California Fire and Rescue Emergency Mutual Aid System, Mutual Aid Plan (02/2012).

F. Emergency Management Assistance Compact (EMAC).

G. Supplemental Interstate Compact For Emergency Mutual Assistance, July 2007.

H. FIRESCOPE California Incident Command System Position Manual Fireline Emergency Medical Technician/Fireline Paramedic (EMTF/EMPF) ICS 702 (12/2016)

DEFINITIONS:

A. **Ambulance Strike Team (AST)** – Consists of five ALS or BLS ambulances (two personnel each) and one leader in a separate command vehicle or Disaster Medical Support Unit (DMSU).

B. **Automatic Aid** – Agreements between two or more jurisdictions where the nearest available resource is dispatched to an emergency irrespective of jurisdictional boundaries, or where two or more agencies are automatically dispatched simultaneously to predetermined types of emergencies. This type of agreement is typically utilized on a routine basis.

C. **Disaster Assistance** – Requests for assistance in the event that a disaster overwhelms local resources. These requests may be under existing mutual aid agreements or the result of unforeseen needs arising from a large-scale disaster.

D. **Medical Task Force (MTF)** – Any combination of resources assembled to support a specific medical mission or operational need. All resource elements within a Task Force must have common communications and a designated leader.

E. **Mutual Aid** – Agreements between two or more jurisdictions to provide assistance across jurisdictional boundaries, when requested, as a result of the circumstances of an emergency exceeding local resources.

F. **Paramedic Fireline (EMPF)** – A paramedic who meets FIRESCOPE requirements, and is authorized by their department to provide ALS care on the fireline.

PRINCIPLES:

A. When requested by an authorized automatic aid/mutual aid/disaster assistance response requester, EMS personnel may utilize the scope of practice for which they are trained and certified/licensed/accredited according to CCR, Title 22 and their Local EMS Agency (LEMSA) policies and procedures.

B. EMPF personnel provide emergency medical care on an active fireline, division or other physically challenging assignment. These resources may also provide care in the medical unit and/or at other locations as directed by the Incident Commander or designee.

C. AST/MTF resources provide an EMS operational response to disaster situations with a focus on transportation. These resources may also work in concert with California Medical Assistance Team (CAL-MAT) or other disaster medical personnel, and be used for medical and health system support in various settings including first aid sites, shelters, command posts, and Mobile Field Hospitals.

POLICY:

A. Automatic Aid/Mutual Aid/Disaster Assistance Responses Within California

1. BLS (EMR/EMT) Personnel:

- BLS personnel may utilize their basic scope of practice in a volunteer or paid capacity. There is no requirement that BLS personnel be affiliated with a prehospital provider to utilize their basic scope of practice.
- While functioning under the authority/oversight of a LEMSA approved prehospital provider during an automatic aid/mutual aid/disaster assistance response, BLS personnel may utilize the optional/expanded scope of practice for which they are trained, certified and accredited for by their LEMSA.

2. LALS/ALS (AEMT/Paramedic) Personnel:

- LALS/ALS personnel may provide LALS/ALS care anywhere in California provided all of the following conditions are met:
  - They possess a valid California AEMT Certificate or Paramedic License.
  - They are accredited by a California LEMSA.
  - They are affiliated with a California LEMSA approved LALS/ALS provider, and are functioning under the authority/oversight of the LALS/ALS provider with whom they are affiliated.
  - They utilize the scope of practice for which they are trained and accredited for by their LEMSA.

B. Automatic Aid/Mutual Aid/Disaster Assistance Responses Outside California

Prehospital personnel are normally approved to utilize the scope of practice for which they are trained and certified/licensed/accredited according to their respective classification, but must check in with the Medical Unit Leader or other appropriate incident representative for any special restrictions or credentialing requirements.

PROCEDURE:

A. General Automatic Aid/Mutual Aid/Disaster Assistance Response Requirements

1. Prehospital personnel shall follow all S-SV EMS policies/protocols during an automatic aid/mutual aid/disaster assistance response, and shall not administer any medication or perform any procedures listed as ‘Base/Modified Base Hospital Physician Order Only’ without appropriate medical control approval.

2. Controlled substances shall be obtained, secured and inventoried as indicated in S-SV EMS Management of Controlled Substances Policy (710).

3. Documentation of patient care shall be completed as indicated in S-SV EMS Prehospital Documentation Policy (605).

B. EMPF Programs

1. EMPF programs shall be approved by S-SV EMS.

2. Designation of an individual as an EMPF by an S-SV EMS approved provider verifies that the paramedic has completed standard FIRESCOPE education.

3. The EMPF position is like any other single resource position requested for incident management, and is ordered at the discretion of an Incident Commander through normal ordering channels.

4. EMPF personnel shall carry the items listed in S-SV EMS ALS Specialty Program Provider Inventory Requirements Policy (702) when responding to wildland fires to provide ALS care in this capacity.

5. The EMPF shall present their credentials to the Medical Unit Leader upon arrival at the incident. The Medical Unit Leader is responsible for verifying credentials of all EMPF personnel assigned to the incident, and shall notify S-SV EMS of any EMPF personnel not affiliated with an S-SV EMS approved prehospital provider assigned to an incident in the S-SV EMS region.

C. AST/MTF Resources:

1. AST/MTF resources shall be requested/approved by one of the following entities:

   - Medical Health Operational Area Coordinator (MHOAC).
   - Regional Disaster Medical Health Coordinator/Specialist (RDMHC/S).
   - California State EMS Authority (EMSA).

2. Upon receipt of an official verbal or written AST/MTF resource request, S-SV EMS representatives will identify/coordinate the assignment/deployment of resources. AST/MTF resource assignments will be done in a fair and consistent manner, based on system/incident needs and provider resource availability. ASTs/MTFs may be comprised of resources from multiple different provider agencies at the discretion of S-SV EMS. Any verbal AST/MTF request shall be followed up with an official written resource request from the AST/MTF requesting/approving entity as soon as incident conditions allow.

3. Any S-SV EMS approved ground ambulance transport provider agency may participate in an AST/MTF deployment. By participating in an AST/MTF deployment, provider agencies/personnel agree to the following:

- Resources/personnel should be able to deploy within 1 – 2 hours of a request, and are expected to be self-sufficient for up to 72 hours.
- Personnel will likely be working in austere environments and performing tasks outside their normal day-to-day duties.
- Provider agencies shall not commit resources/personnel that will negatively impact their normal EMS coverage responsibilities.
- Provider agencies agree to accept the current hourly Ambulance Strike Team Reimbursement rates adopted by the California State Association of Counties (CSAC) as recommended by the Emergency Medical Services Administrators Association of California (EMSAAC). Reimbursement shall be "portal to portal" (time of dispatch to return to home base), and no billing for transport or other costs are allowed.

4. Every AST/MTF shall have a leader selected/approved by S-SV EMS. Preference will be given to those individuals who have completed the Ambulance Strike Team Leader training. Provider agencies may choose to assign additional personnel to accompany the leader for training purposes, but the cost of these additional personnel will not be reimbursed by the requesting entity, unless previously agreed to.

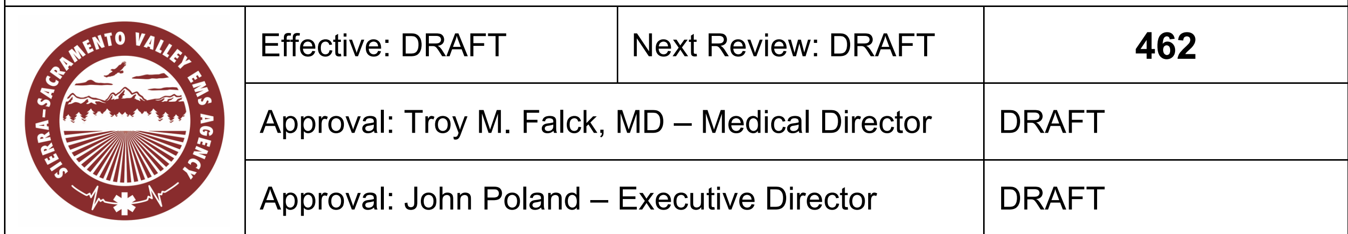
5. The following shall apply to AST/MTF deployments within the S-SV EMS region:

   - S-SV EMS will assign appropriate representatives (within the affected area whenever possible) to support/oversee the affected EMS system(s) and all deployed AST/MTF resources as long as necessary/appropriate.
   - S-SV EMS representatives will assess, identify and order (in coordination with the AST/MTF requesting/approving entity) additional AST/MTF support resources/personnel (EMS overhead, fleet maintenance, CISM, etc.).
   - As soon as incident conditions allow, the AST/MTF requesting/approving entity shall be responsible for providing ongoing support to the AST/MTF resources (food, lodging, medical supplies, fuel, etc.).

6. For deployments outside the S-SV EMS region, AST/MTF resources will respond to the requested reporting location and follow the direction of requesting entity or other appropriate incident management personnel.

Sierra – Sacramento Valley EMS Agency Program Policy

Temporary Recognition Of EMS Personnel



	Effective: DRAFT	Next Review: DRAFT	**462**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish a process for temporary recognition of EMS personnel on mutual aid/disaster incidents within the S-SV EMS region, to allow the S-SV EMS Medical Director to maintain adequate medical control of the EMS system and protect the public health and safety.

AUTHORITY:

A. HSC § 1797.202, § 1797.204, § 1797.206, § 1797.218, § 1797.220, 1797.227, § 1798.

B. CCR, Title 22, Div. 9, Ch. 3.1, § 100066.01 (c), § 100066.02 (d), 100066.04 (i).

C. CCR, Title 22, Div. 9, Ch. 3.2, § 100076.02 (c), § 100079.01 (a).

D. CCR, Title 22, Div. 9, Ch. 3.2, § 100091.01 (c), 100091.02 (b), 100094.02 (l).

POLICY:

A. California Credentialed EMS Personnel

1. California Certified EMT Personnel:

- During a mutual aid/disaster response into the S-SV EMS region, a California certified EMT may utilize the scope of practice for which they are trained/ authorized according to the policies and procedures of the local EMS agency (LEMSA) where they are certified and/or employed as part of an organized EMS system.

2. California Certified Advanced EMT (AEMT) Personnel:

- During a mutual aid/disaster response into the S-SV EMS region, a California certified AEMT may utilize the scope of practice for which they are trained/ authorized according to the policies and procedures of the LEMSA within the jurisdiction where the AEMT is employed as part of an organized EMS system.

3. California Licensed/LEMSA Accredited Paramedic Personnel:

    - A California licensed paramedic shall be affiliated with a LEMSA approved paramedic service provider to provide EMS care in the S-SV EMS region.
    - During a mutual aid/disaster response into the S-SV EMS region, a California licensed/accredited paramedic employed by a LEMSA approved paramedic service provider may utilize the scope of practice for which they are trained/ accredited according to the policies and procedures of the accrediting LEMSA.

B. EMS Personnel not Credentialed in California

1. EMT/paramedic personnel not credentialed in California must obtain temporary recognition from S-SV EMS before they may provide EMS care within the S-SV EMS region. AEMT personnel not credentialed in California may only be granted temporary recognition to function as an EMT within the S-SV EMS region.

2. EMT/paramedic personnel not credentialed in California who have received temporary recognition from S-SV EMS may utilize the scope of practice for which they have been trained/authorized by a recognized EMS credentialling entity.

3. For the S-SV EMS Medical Director to maintain adequate medical control of the EMS system, and to protect the public health and safety, the following information/ documentation shall be submitted to and approved by S-SV EMS prior to authorizing temporary recognition of EMT/paramedic personnel not credentialed in California.

    - **Public EMS Provider Organization Requirements:**
        - The public EMS provider organization, incident Medical Unit Leader (MEDL), or authorized designee shall submit the following EMS personnel documents to S-SV EMS at the time of incident assignment, which will be valid for the applicable incident assignment only:
            - Copies of current/valid EMS credentials for each EMT/paramedic.
            - Confirmation that the EMT/paramedic is employed by and in good standing with the public EMS provider organization.
        - By requesting temporary recognition to provide EMS care within the S-SV EMS region, the public EMS provider organization agrees to submit all incident related patient care reports (PCRs) to S-SV EMS within 7 calendar days of incident demobilization, or within 24-hours of a request from an authorized S-SV EMS representative in response to an EMS complaint/ investigation related to an incident.
    - **Private EMS Provider Organization Requirements:**
        - A private EMS provider organization not authorized/permitted by a California LEMSA shall submit the following documents to S-SV EMS prior to operating within the S-SV EMS region (attachment 462-A):

- Name, telephone number, and email address of the EMS provider organization's management contact and medical director.
- Copies of applicable EMS business license(s)/permit(s).
- A letter from the entity/state where the organization is authorized to provide EMS services, stating they are an authorized EMS provider in good standing.
- Identification of which patient care protocols will be utilized by the organization's EMS personnel (State EMS protocols, EMS provider organization protocols, etc.).
- The organization's EMS documentation & data collection policy/process and an explanation of how the organization will submit incident PCRs to S-SV EMS.
- Attestation that the organization agrees to submit all incident related PCRs to S-SV EMS within 7 calendar days of incident demobilization, or within 24-hours of a request from an authorized S-SV EMS representative in response to an EMS complaint/investigation related to an incident.
- Copy of the organization's policy/process ensuring secure storage/ handling of controlled substances (if applicable).
- Copy of the organization's quality improvement plan/process.
- Attestation that any patient transport vehicle used in the provision of EMS services within the S-SV EMS region is mechanically sound and that the organization's personnel agree not to transport any patient from the incident directly to an acute care hospital without the direction/ approval of the IC, MEDL, or authorized designee.

- A private EMS provider organization shall submit the following EMS personnel documents to S-SV EMS at the time of incident assignment, which will be valid for the applicable incident assignment only:
  - Copies of current/valid EMS credentials for each EMT/paramedic.
  - A brief resume for each EMT/paramedic verifying a minimum of 1 year EMS experience.
  - Confirmation that the EMT/paramedic is not under investigation by the employer or any applicable EMS personnel credentialling entity. If applicable, a summary of any open investigations shall also be included.

- **Incident Command/Management Requirements:**
  - Confirmation from the incident Medical Unit Leader (MEDL), or authorized designee, that there is a need to utilize EMT/paramedic personnel not credentialed in California to meet the medical needs of the incident.
  - Submission of the California Emergency Medical Services Authority's 'REQUEST FOR TEMPORARY RECOGNITION OF OUT-OF-STATE EMS PERSONNEL RESPONDING ON MUTUAL AID IN CALIFORNIA' (EMSA-920) or equivalent form listing all applicable EMT/paramedic personnel and their relevant credentialing information (minimum of EMS provider level, certifying/ licensing entity & certification/license number).

PROCEDURE:

A. The incident MEDL, or authorized designee, shall notify S-SV EMS of any incident within the S-SV EMS region where an incident action plan (IAP) and incident medical plan involving the utilization of EMS personnel to provide incident related medical care has been established. The MEDL, or authorized designee, shall provide appropriate incident related medical system updates to S-SV EMS for the duration of the incident. S-SV EMS notifications required under this section of the policy shall be made in a timely manner, as incident conditions/personnel allow.

B. The following EMS personnel do not require S-SV EMS approval prior to utilizing their scope of practice identified in applicable California statutes/regulations and LEMSA policies/protocols (note: for medical control purposes, S-SV EMS notification of these personnel shall be made in a timely manner, as incident conditions/personnel allow):

   1. Individuals with a current/valid California EMT certificate, regardless of EMS employer.

   2. Individuals with a current/valid California AEMT certificate who are employed by an LALS/ALS provider approved by the LEMSA with whom they are certified.

   3. Individuals with a current/valid California paramedic license and California LEMSA accreditation, who are employed by an ALS provider approved by the LEMSA with whom they are accredited.

C. EMT/paramedic personnel not credentialed in California must obtain temporary recognition from S-SV EMS before they may provide EMS care within the S-SV EMS region.

   1. S-SV EMS staff, under the direction of the S-SV EMS Medical Director, will evaluate all submitted documentation as it relates to a request for temporary recognition of EMT/paramedic personnel not credentialed in California.

      - It is recommended that the private EMS provider organization information/ documents required by this policy (attachment 462-A, excluding the incident specific EMS personnel credentialling documents) be submitted to S-SV EMS prior to accepting any assignment, if the organization anticipates providing EMS services within the S-SV EMS region. These documents will be valid for the remainder of the calendar year in which they are submitted/approved.
      - Failure to submit the documentation required by this policy will result in the denial of temporary recognition of applicable EMT/paramedic personnel not credentialed in California.

- Additional information/documentation may be requested by S-SV EMS prior to authorizing temporary recognition of applicable EMT/paramedic personnel not credentialed in California.
- Any concerns by S-SV EMS staff related to their review of the documentation required by this policy will be forwarded to the S-SV EMS Medical Director for additional review/consideration.
- The decision of the S-SV EMS Medical Director to approve or deny temporary recognition of EMT/paramedic personnel not credentialed in California is final.
- The S-SV EMS Medical Director may revoke temporary recognition of EMT/ paramedic personnel not credentialed in California at any time, upon providing written notification and an explanation for any such revocation.

2. The S-SV EMS Medical Director may waive certain requirements for temporary recognition of EMT/paramedic personnel not credentialed in California on an urgent/emergent basis when there is a current/imminent threat to the public health and safety. However, no such waiver shall apply to personnel who are employed by an EMS provider organization who is unwilling/unable to comply with the requirements contained in this policy.

S-SV EMS AGENCY CONTACT INFORMATION:

S-SV EMS contact information for notifications or documentation submissions related to this policy are as follows:

A. Telephone Contact:

1. Primary 24/7 Duty Officer: (916) 625-1710
2. Backup #1: (712) 229-2164
3. Backup #2: (530) 906-0079

B. Email Contact:

1. Primary 24/7 Duty Officer: Duty.Officer@ssvems.com
2. Backup #1: info@ssvems.com

Temporary Recognition Of EMS Personnel – Provider Organization Required Information/Documentation Form

462-A

PRIVATE EMS PROVIDER ORGANIZATION INFORMTION			
Provider Organization Name:			
Provider Organization Business Location:			
Position	**Name**	**Telephone Number**	**Email Address**
Management Contact			
Medical Director			

PRIVATE EMS PROVIDER ORGANIZATION INFORMATION/DOCUMENTATION CHECKLIST		
Required Information/Documentation	**Enclosed (Provider)**	**Approved (SSVEMS)**
Copies of applicable EMS business license(s)/permit(s)	☐	☐
A letter from the entity/state where the organization is authorized to provide EMS services, stating they are an authorized EMS provider in good standing	☐	☐
Identification of which patient care protocols will be utilized by the organization's EMS personnel (State EMS protocols, EMS provider organization protocols, etc.)	☐	☐
The organization's EMS documentation & data collection policy/process and an explanation of how the organization will submit incident PCRs to S-SV EMS	☐	☐
Copy of the organization's policy/process ensuring secure storage/handling of controlled substances (if applicable)	☐	☐
Copy of the organization's EMS quality improvement plan/process	☐	☐

ATTESTATION

I attest that all information contained on this form and attached documents is true and correct to the best of my knowledge. I further attest that our organization agrees to submit all incident related PCRs to S-SV EMS within 7 calendar days of incident demobilization, or within 24-hours of a request from an authorized S-SV EMS representative in response to an EMS complaint/investigation related to an incident. I further attest that any patient transport vehicle used in the provision of EMS services within the S-SV EMS region is mechanically sound and that our EMS personnel agree not to transport any patient from the incident directly to an acute care hospital without the direction/approval of the applicable IC, MedL, or authorized designee.

______________________	______________________	______________
Name	Signature	Date

REQUEST FOR TEMPORARY RECOGNITION OF OUT-OF-STATE EMS PERSONNEL RESPONDING ON MUTUAL AID IN CALIFORNIA

(Print or type all information, Use additional forms as necessary)

Out-of-state EMS personnel must obtain authorization from the Local EMS Agency (LEMSA) where they will be working before they may practice in California. Under California Law, out-of-state EMS personnel who have received authorization may utilize the scope of practice for which they have been licensed/certified.

Authorization for temporary recognition is requested for the following medical personnel assigned to:

INCIDENT:________________________ in the **COUNTY(s)** of:________________________________

under the jurisdiction of the following **LEMSA(s)**:____

beginning on ________________ and ending on ________________

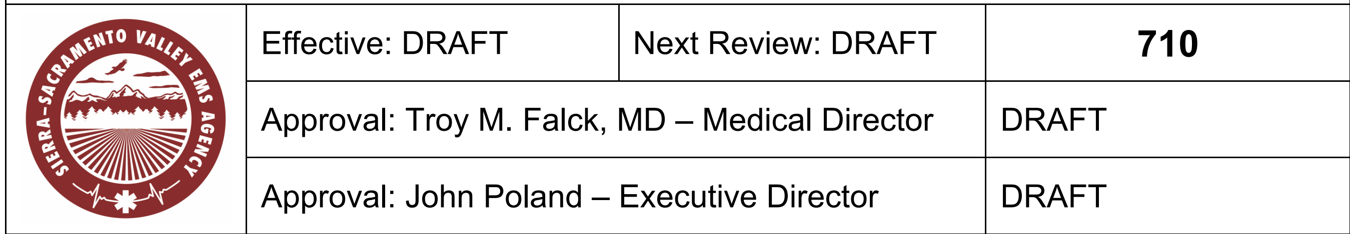
	Full Name	EMT Level (circle)	Certification/ License #	Issuing Agency
1		Basic / Paramedic		
2		Basic / Paramedic		
3		Basic / Paramedic		
4		Basic / Paramedic		
5		Basic / Paramedic		
6		Basic / Paramedic		
7		Basic / Paramedic		
8		Basic / Paramedic		
9		Basic / Paramedic		

I attest that I have physically examined the certification/licenses of the above individuals.

			Telephone	
Medical Unit Leader - Print		Agency	Fax	
Signature			Date	

			Telephone	
Medical Director - Print		LEMSA	Fax	
Signature			Date	

EMERGENCY MEDICAL SERVICES AUTHORITY • CALIFORNIA • EMSA

Sierra – Sacramento Valley EMS Agency Program Policy			
Management Of Controlled Substances			
	Effective: DRAFT	Next Review: DRAFT	**710**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To ensure accountability in the management of controlled substances utilized by ALS/ LALS prehospital service provider agencies/personnel.

AUTHORITY:

A. Code of Federal Regulations, Title 21.

B. HSC, Div. 2.5 & Div. 10.

C. CCR, Title 22, Div. 9.

POLICY:

A. S-SV EMS Approved Controlled Substances:

1. Fentanyl.

2. Ketamine.

3. Midazolam.

4. ~~Morphine sulfate~~.

B. Obtaining Controlled Substances:

Prehospital service provider agencies shall obtain controlled substances through one of the following methods:

1. The medical director of the prehospital service provider agency.

2. The base/modified base hospital shall ensure that a mechanism exists for prehospital service provider agencies to contract for the provision of controlled substances.

C. Prehospital Service Provider Agency Controlled Substances Policies/Procedures:

1. Prehospital service provider agencies shall ensure that security mechanisms and procedures are established for controlled substances, including, but not limited to:

   - Controlled substance ordering & order tracking.
   - Controlled substance receipt & accountability.
   - Controlled substance master supply storage, security & documentation.
   - Controlled substance labeling & tracking.
   - Controlled substance vehicle storage & security.
   - Controlled substance usage procedures & documentation.
   - Controlled substance reverse distribution.
   - Controlled substance disposal.
   - Controlled substance re-stocking procedures.

2. Prehospital service provider agencies shall ensure that mechanisms for investigation and mitigation of suspected controlled substance tampering or diversion are established, including, but not limited to:

   - Controlled substance testing.
   - Controlled substance discrepancy reporting.
   - Controlled substance tampering, theft & diversion prevention/detection.
   - Controlled substance usage audits.

D. Controlled Substance Security:

1. AEMT II and paramedic personnel are responsible for maintaining the correct inventory of controlled substances at all times.

2. All controlled substances shall be stored/secured in one of the following manners:

   - Preferred: Secured in a commercially developed drug locker specifically designed for controlled substance storage. The drug locker shall be securely mounted to the vehicle to prevent theft and shall have an electronic access keypad with an individual PIN code assigned to each individual authorized to access/utilize controlled substances. The drug locker shall be able to produce an electronic audit trail showing the date, time and PIN code of each instance the locker was opened. The double lock requirement does not apply to providers storing their controlled substance utilizing this method.
   - Alternative: Secured in the vehicle under double lock, in an appropriate manner to prevent theft. The outside driver/passenger/patient access door(s) of the vehicle shall not be considered one of the two locks.

3. Prehospital service provider agencies shall abide by all State and Federal laws/ regulations related to the storage/security of controlled substances.

4. Each unit shall maintain a standardized written record of the controlled substance inventory. Controlled substance inventory and administration records shall be maintained in accordance with all applicable State and Federal laws/regulations.

5. Controlled substances shall be inventoried any time there is a change in personnel. The key to access the controlled substances, if applicable, shall be in the custody of the individual who performed the inventory.

6. Any discrepancies in the controlled substance count shall be reported as soon as possible to an appropriate supervisor and the issuing agent. A discrepancy report must be appropriately documented.

E. Controlled Substances Administered to Patients:

1. Controlled substances shall be administered in accordance with applicable S-SV EMS policies/protocols.

2. The following information must be documented on a controlled substance administration record:

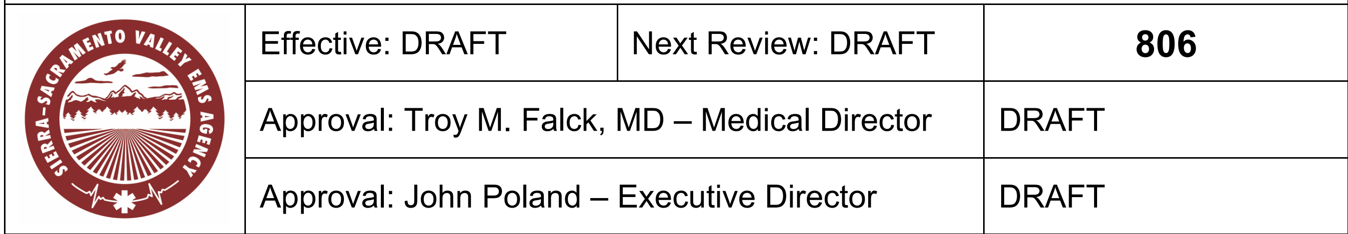
   - Date & time administered.
   - Unit number.
   - Patient name.
   - Drug administered.
   - Amount administered.
   - AEMT II or paramedic signature & number.

3. If only a portion of the controlled substance was administered to the patient, the remainder shall be wasted in the presence of a registered nurse or physician at the receiving hospital, or the provider's immediate supervisor. Both parties shall document this action on the controlled substance administration form.

4. Controlled substance inventories/logs are subject to inspection by the California Board of Pharmacy, Bureau of Narcotic Enforcement Administration of the Justice Department, Federal Drug Enforcement Administration, S-SV EMS, the issuing agent, and/or officers of the prehospital service provider agency.

Sierra – Sacramento Valley EMS Agency Program Policy

Unified Paramedic Optional Scope Of Practice For Qualified Transport Programs



	Effective: DRAFT	Next Review: DRAFT	**806**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To specify the unified paramedic optional scope of practice for qualified transport programs, and establish provider requirements and personnel qualifications for utilization.

AUTHORITY:

A. HSC, Div. 2.5, § 1797.67, 1797.88, 1798.102, 1798.150, 1798.170 & 1798.172.

B. CCR, Title 22, Div. 9.

DEFINITIONS:

A. **Air Ambulance Provider –** A prehospital service provider agency that utilizes specially constructed, modified or equipped aircraft for the primary purpose of responding to emergency incidents and transporting critically ill and/or injured patients. An air ambulance provider utilizes a medical flight crew consisting of a minimum of two attendants certified or licensed in advanced life support.

B. **CAMTS –** Commission on Accreditation of Medical Transport Systems.

C. **CAMTS Emergency Critical Care (ECC) Accreditation –** A level of accreditation issued by CAMTS verifying that the medical transport provider has met all Emergency Critical Care (ECC) level accreditation standards. CAMTS recognizes FP-C for ECC accreditation, but also requires the FP-C to be paired with a qualified transport nurse partner.

D. **FP-C –** A ‘Certified Flight Paramedic’ educated and trained in critical care transport and flight medicine, who holds a current certification as an FP-C by the International Board of Specialty Certification (IBSC).

E. **FP-C in training –** A paramedic who has completed the qualified transport program’s initial training but has not completed their FP-C testing/certificate. The FP-C in training must pass the FP-C exam by the end of their second year with the qualified transport program.

F. **Qualified Flight Paramedic –** A California licensed, S-SV EMS accredited and FP-C certified/FP-C in training paramedic who meets the requirements for utilization of the unified paramedic optional scope of practice. These individuals have at least three (3) years of critical care experience and have completed the qualified transport program's initial academy training with additional education in flight and altitude physiology. They work for a qualified transport program and are paired with a qualified transport nurse.

G. **Qualified Transport Program –** An S-SV EMS permitted air ambulance provider that has met the requirements to participate in the unified paramedic optional scope of practice program by obtaining/maintaining CAMTS ECC accreditation, and meeting the training, education, competencies, QI and medical direction requirements.

H. **Qualified Transport Nurse –** A registered nurse with at least three (3) years of critical care experience, who has completed the qualified transport program's initial academy training and is working on obtaining the CEN, CCRN, CFRN or CTRN certification required by the CAMTS ECC accreditation. A qualified transport nurse is employed by and practicing with the qualified transport program.

I. **Qualified Transport Program Medical Director –** A physician board certified/eligible in emergency medicine, who meets the CAMTS ECC accreditation medical director requirements.

J. **Qualified Transport Program Physician –** A physician affiliated with the qualified transport program, who is not the qualified transport program medical director, who is board certified/eligible in emergency medicine or in the specialty appropriate for the scope of services being provided (neonate, pediatrics, critical care, etc.).

POLICY:

A. The unified paramedic optional scope of practice procedures include:

   1. Pediatric intubation.

   2. Rapid sequence intubation/induction (RSI) medication administration, including sedatives, paralytics, analgesics, and induction agents.

   3. Ventilator initiation, maintenance and management.

B. Prehospital service provider agencies shall meet the following requirements to be approved by S-SV EMS as a qualified transport program:

   1. Have a current S-SV EMS air ambulance provider permit.

   2. Obtain/maintain CAMTS ECC accreditation.

3. Have a qualified transport program medical director.

4. Utilize all unified paramedic optional scope of practice procedures.

5. Provide all required optional scope of practice training, education and competency testing, which has been reviewed/approved by S-SV EMS.

6. Allow only qualified flight paramedics to utilize the unified paramedic optional scope of practice.

7. Have a unified paramedic optional scope of practice QI program, which has been reviewed/approved by S-SV EMS.

8. Collect/submit unified paramedic optional scope of practice data to S-SV EMS. Data submission elements/frequency shall be established, and modified as necessary, by S-SV EMS pursuant to EMS Medical Directors Association of California (EMDAC) and California Emergency Medical Services Authority (EMSA) requirements.

C. Paramedic personnel shall meet the following requirements to be approved by S-SV EMS to utilize the unified paramedic optional scope of practice:

1. Have a current California paramedic license.

2. Have a current S-SV EMS paramedic accreditation.

3. Completed a minimum of 200 hours of training conducted by the qualified transport program, and meet the FP-C certified/FP-C in training requirements.

4. Follow the qualified transport program provider's policies/protocols for utilization of unified paramedic optional scope of practice procedures.

5. Remain competent/proficient in the unified paramedic optional scope of practice by passing required competency testing as follows:

   - Pediatric Intubation: Quarterly (every 3 months)
   - RSI: Quarterly (every 3 months)
   - Ventilator Use: Annually

6. Be employed by a qualified transport program provider and functioning under the oversight of this provider during any transports where the unified paramedic optional scope of practice is utilized.

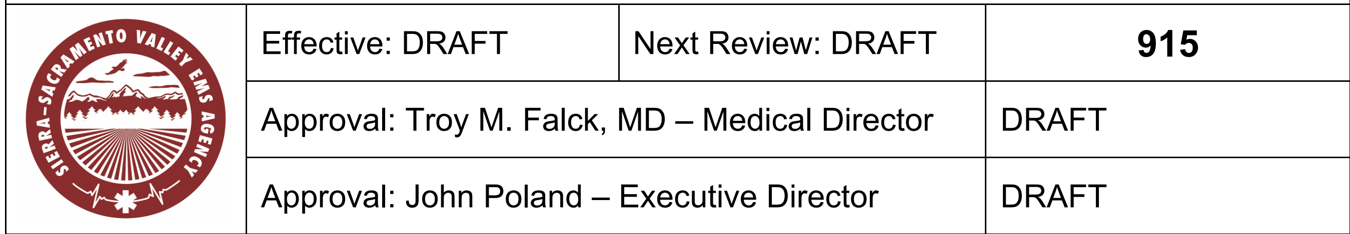
7. Be partnered with a qualified transport nurse, qualified transport program medical director or qualified transport program physician during any transports where the unified optional scope of practice is utilized.

D. Unified paramedic optional scope of practice medical control:

1. Medical control for the utilization of the unified paramedic optional scope of practice shall remain the primary responsibility of S-SV EMS, according to established S-SV EMS policies/protocols, and is delivered in conjunction with the qualified transport program provider's policies/protocols specific to the utilization of the unified paramedic optional scope of practice procedures.

2. During an interfacility transport, online medical control may be obtained from the sending physician, receiving physician, Qualified Transport Program Medical Director, or Qualified Transport Program Physician as necessary.

Sierra – Sacramento Valley EMS Agency Program Policy		
MICN Authorization/Reauthorization		



Effective: DRAFT	Next Review: DRAFT	**915**
Approval: Troy M. Falck, MD – Medical Director		DRAFT
Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish a mechanism for obtaining authorization or reauthorization as a Mobile Intensive Care Nurse (MICN) within the S-SV EMS region. MICN means a registered nurse (RN) authorized by the S-SV EMS Medical Director to provide instructions to prehospital EMS personnel according to approved S-SV EMS policies/protocols.

AUTHORITY:

A. HSC, Div. 2.5, § 1797.56, 1797.204, 1797.206, 1797.218, 1797.220, 1798, 1798.2, 1798.100, 1798.102 & 1798.105.

B. CCR, Title 22, Div. 9.

C. BPC, § 2725.

POLICY:

A. An individual shall comply with the initial authorization requirements and obtain S-SV EMS MICN authorization prior to functioning as a MICN in the S-SV EMS region.

B. A MICN shall comply with the reauthorization requirements, prior to the expiration date of their current authorization, to maintain S-SV EMS MICN authorization. Failure to comply with the reauthorization requirements means that the MICN has failed to maintain authorization and shall not function as a MICN in the S-SV EMS region until all reauthorization requirements are met.

C. A MICN shall only provide medical direction to prehospital personnel when they are on-duty in a S-SV EMS base hospital emergency department.

PROCEDURE:

MICN Initial Authorization Requirements:

A. To be eligible for initial MICN authorization, an individual shall comply with the following requirements:

1. Be currently licensed as an RN in California.

2. Be currently employed in a S-SV EMS base hospital emergency department and be recommended for MICN authorization by the base hospital.

3. Have a minimum of six months (1040 hours) of clinical experience within the last 24 months in an acute care hospital emergency department.

4. Meet one of the following training program criteria:

   - Successful completion of a S-SV EMS approved MICN training program (including the four-hour ground ambulance ride-along and base hospital orientation components) within the previous 12 months.
   - Successful completion of a S-SV EMS approved MICN training program within the previous 12 – 24 months, successful completion of a MICN training program from another California LEMSA within the previous 24 months, or possess a current/valid MICN authorization from another California LEMSA, and complete the following additional requirements within the previous 90 days:
     - A minimum four-hour ride-along with a S-SV EMS approved ALS 911 ground ambulance provider, which includes two ALS contacts, or two ALS patient scenarios conducted by the paramedic.
     - A base hospital orientation with the S-SV EMS designated base hospital.

5. Attend the S-SV EMS Paramedic Accreditation course within the last 90 days (note: this training may also be conducted by S-SV EMS representatives during the initial MICN training program).

6. Submit a completed MICN initial authorization application.

7. Provide documentation/evidence of the items listed above, in addition to copies of the following current/valid items:

   - U.S. state-issued driver's license or photo identification card.
   - Healthcare Provider CPR recognition.
   - ACLS recognition.
   - PALS or APLS recognition.

8. Pay the S-SV EMS MICN initial authorization fee.

B. S-SV EMS will issue a MICN authorization certificate within ten business days to eligible individuals who apply for initial MICN authorization and comply with the initial authorization requirements listed in this policy. The effective date of the MICN authorization certificate will be the day the certificate is issued, and the expiration date will be the last day of the month two years from the effective date of the initial authorization.

MICN Reauthorization:

A. A MICN shall comply with the following requirements, prior to the expiration date of their current authorization, to be eligible for S-SV EMS MICN reauthorization:

1. Submit a completed MICN reauthorization application.

2. Maintain and provide copies of the following current/valid items:

    - California RN license.
    - U.S. state-issued driver's license or photo identification card.
    - Healthcare Provider CPR recognition.
    - ACLS recognition.
    - PALS or APLS recognition.

3. Complete 12 hours of EMS continuing education during the current authorization cycle as follows:

    - ~~A minimum of~~ *Field care audits (4 hours) - Review of base hospital audio tapes and/or written patient care records.* ~~of prehospital care focused education of recorded or written patient care records~~.
    - *Field experience (4 hours)* - ~~A minimum four-hour~~ Ride-along with a S-SV EMS approved ALS 911 ground ambulance provider, which *must* include two ALS contacts, or two ALS patient scenarios conducted by the paramedic.
    - ~~The remaining four hours may be from either of the categories above, or the MICN may complete an additional four-hour ride-along with a S-SV EMS approved ALS non-transport provider, which includes two ALS contacts, or two ALS patient scenarios conducted by the paramedic~~.
    - *EMS CE topics (4 hours) – CEs may be obtained from one of the following sources:*
        - *Attendance at an S-SV EMS Paramedic Accreditation course (limit – one per year)*
        - *Attendance at an S-SV EMS REMAC meeting (limit – two per year)*
        - *Completion of the S-SV EMS Regional Training Module*
        - *Attendance at formal field care case reviews*
        - *EMS related continuing education offered by an S-SV EMS approved CE provider*

4. Maintain employment in a S-SV EMS base hospital emergency department and provide documentation of base hospital reauthorization recommendation.

5. Pay the S-SV EMS MICN reauthorization fee.

B. S-SV EMS will issue a MICN authorization certificate within ten business days, to eligible individuals who apply for MICN reauthorization and comply with the MICN reauthorization requirements listed in this policy. If the reauthorization requirements are met within six months prior to the current authorization expiration date, the effective date of reauthorization certificate will be the date immediately following the expiration date of the current authorization certificate and will expire two years from the day prior to the effective date. If the reauthorization requirements are met greater than six months prior to the current authorization certificate expiration date, the effective date of reauthorization certificate will be the date the individual applied for reauthorization, and the authorization certificate expiration date will be the last day of the month two years from the effective date.

MICN Reauthorization After Lapse:

A. In addition to the reauthorization requirements specified in this policy, an individual with a lapsed MICN authorization shall also meet the following requirements to be eligible for reauthorization:

1. If the authorization has lapsed for less than 12 months, the MICN shall attend the S-SV EMS Paramedic Accreditation course within the previous 90 days.

2. If the authorization has been lapsed between 12 – 24 months, the MICN shall:

   - Attend the S-SV EMS Paramedic Accreditation course within the previous 90 days.
   - Complete a base hospital MICN re-orientation with the S-SV EMS base hospital within the previous 90 days.
   - Complete an additional four-hour ride-along with a S-SV EMS approved ALS 911 ground ambulance provider, which includes two additional ALS contacts, or two additional ALS patient scenarios conducted by the paramedic (total of eight hours of ambulance ride-along). At least four hours of ambulance ride along shall be completed within the previous 90 days.

3. If the authorization has lapsed for greater than 24 months, all initial authorization requirements must be met.

B. S-SV EMS will issue a MICN authorization certificate within ten business days, to eligible individuals who apply for MICN reauthorization and successfully complete the requirements listed in this policy. The effective date of the MICN reauthorization certificate will be the day the certificate is issued, and the certificate expiration date will be the last day of the month two years from the effective date of the reauthorization certificate.

APPLICATION PROCESSING:

1 A completed MICN authorization/reauthorization application and all required supporting
2 documentation must be submitted to S-SV EMS prior to processing.

Non-Traumatic Pulseless Arrest

C-1

Approval: Troy M. Falck, MD – Medical Director	Effective: 12/01/2024
Approval: John Poland – Executive Director	Next Review: 10/2027

MANUAL CHEST COMPRESSIONS

- Rate: 100-120/min
- Depth: 2 inches – allow full chest recoil
- Minimize interruptions (≤10 secs)
- Rotate compressors every 2 mins
- Perform CPR during AED/defibrillator charging
- Resume CPR immediately after shock

MECHANICAL CHEST COMPRESSION DEVICES

Indications	**Contraindications**
• Adult pt (≥15 yo)	• Pt does not fit in the device • 3rd trimester pregnancy

ⓘ Use in accordance with manufacturer indications/ contraindications

ⓘ Apply following completion of at least one manual CPR cycle, or at the end of a subsequent cycle

DEFIBRILLATION & GENERAL PT MANAGEMENT

- Analyze rhythm/check pulse after every 2 min CPR cycle
- Biphasic manual defibrillation detail:
  - Follow manufacturer recommendations
  - If unknown, start at 200 J (subsequent doses should be equivalent or higher)
- Movement of pt may interrupt CPR or prevent adequate depth and rate of compressions
- Consider resuscitation on scene up to 20 mins
- Go to ROSC protocol (C-2) if ROSC is obtained

ADVANCED AIRWAY MANAGEMENT

- Consider/establish advanced airway at appropriate time during resuscitation
- Do not interrupt chest compressions to establish an advanced airway
- Waveform capnography (if available) shall be used on all pts with an advanced airway in place
  - An abrupt increase in $PETCO_2$ is indicative of ROSC
  - Persistently low $PETCO_2$ levels (<10 mmHG) suggest ROSC is unlikely

TREAT REVERSIBLE CAUSES

- **H**ypovolemia
- **H**ypoxia
- **H**ydrogen Ion (acidosis)
- **H**ypo-/hyperkalemia
- **H**ypothermia
- **T**amponade, cardiac
- **T**ension pneumothorax
- **T**hrombosis, pulmonary
- **T**hrombosis, cardiac
- **T**oxins

ⓘ Refer to Hypothermia & Avalanche/Snow Immersion Suffocation Resuscitation Protocol (E-2) or Traumatic Pulseless Arrest Protocol (T-6) as appropriate

ⓘ Contact the base/modified base hospital for consultation & orders as appropriate

ⓘ Consider early transport of pts who have reversible causes that cannot be adequately treated in the prehospital setting

TERMINATION OF RESUSCITATION

Base/Modified Base Hospital Physician Order**

- ~~If resuscitation attempts do not obtain ROSC~~ ***If ROSC is not achieved***, consider termination of resuscitation efforts
- BLS termination of resuscitation criteria (all):
  - (1) Arrest not witnessed by EMS
  - (2) No AED shocks delivered
  - (3) No ROSC after 3 rounds of CPR/AED analysis
- ALS Termination of Resuscitation Criteria ~~(all)~~:
  - (1) Arrest not witnessed by EMS
  - ~~(2) No effective bystander CPR was provided, or effective CPR cannot be maintained~~
  - (2 ~~3~~) No AED shocks or defibrillations delivered
  - (3 ~~4~~) No ROSC after full ALS care

***If all ALS criteria are met, or in the event of communication failure, EMS personnel may terminate resuscitation without base/modified base hospital physician order*

SEE PAGE 2 FOR TREATMENT ALGORITHM

Non-Traumatic Pulseless Arrest

BLS

- CPR (with BVM &100% O_2) x 2 mins - apply AED as soon as possible
- Deliver ⚡⚡ **AED SHOCK** ⚡⚡, if indicated by AED, & immediately resume CPR
- Analyze rhythm/check pulse after every 2 min CPR cycle

ALS

Cardiac Monitor

ASYSTOLE/PEA

- CPR x 2 mins
- IV/IO NS (may bolus up to 1000 mL)
- Consider advanced airway
- $EtCO_2$ monitoring

Shockable Rhythm? YES → Treat VF/VT; **NO** →

- CPR x 2 mins
- **Epinephrine:** 1:10,000 – 1 mg IV/IO
- Treat reversible causes

Shockable Rhythm? YES → Treat VF/VT; **NO** →

~~If no signs of ROSC~~ If ROSC is not achieved:

- Continue CPR followed by rhythm check every 2 mins. If rhythm converts to VF/VT treat according to VF/FT algorithm
- **Epinephrine** 1:10,000 – 1 mg IV/IO every 3-5 mins (max 4 doses)
- Consider termination of resuscitation after 20 minutes of ALS intervention *(see page 1)*

VF/VT

⚡⚡ DEFIBRILLATION ⚡⚡

- CPR x 2 mins
- IV/IO NS (may bolus up to 1000 mL)

Shockable Rhythm? NO → Treat Asystole/PEA; **YES** →

⚡⚡ DEFIBRILLATION ⚡⚡

- CPR x 2 mins
- **Epinephrine:** 1:10,000 – 1 mg IV/IO
- Consider advanced airway
- $EtCO_2$ monitoring

Shockable Rhythm? NO → Treat Asystole/PEA; **YES** →

⚡⚡ DEFIBRILLATION ⚡⚡

- CPR x 2 mins
- **Amiodarone:** 300 mg IV/IO
- If Torsades de Pointes: **Magnesium Sulfate:** 2 g in 10 ml NS over 2 mins
- Treat reversible causes

~~If no signs of ROSC~~ If ROSC is not achieved:

- Continue CPR followed by ⚡⚡ **DEFIBRILLATION** ⚡⚡ every 2 mins for continued/relapsed shockable rhythm
- **Epinephrine:** 1:10,000 – 1 mg IV/IO every 3-5 mins (max 4 doses)
- **Amiodarone:** 150 mg IV/IO – 5 mins after initial amiodarone administration
- ~~Consider termination of resuscitation after 20 minutes of ALS intervention~~

Sierra – Sacramento Valley EMS Agency Treatment Protocol

C-5

Ventricular Assist Device (VAD)

Approval: Troy M. Falck, MD – Medical Director	Effective: 06/01/2022
Approval: John Poland – Executive Director	Next Review: 05/2025

- **VAD pts may also have an Implanted Cardioverter-Defibrillator (ICD) or a Pacemaker/ICD.**
- **VAD pts may not have a palpable pulse as these are continuous flow devices. Utilize a cardiac monitor to accurately establish the pt's heart rate/rhythm. Arrhythmias with signs of inadequate perfusion should be treated according to applicable S-SV EMS protocols. If defibrillation or cardioversion is indicated, follow the applicable treatment protocol (the pump is insulated so that electrical therapy should not be an issue).**
- **VAD pts may not have a blood pressure obtainable by standard EMS measurement methods. An accurate blood pressure is typically obtained via doppler, however, auscultation or NIBP readings may be possible.**
- **SpO_2 may not be measurable or accurate. $EtCO_2$ monitoring should be utilized.**
- **VAD pts/companions are taught to call 911 and page the on-call VAD coordinator in an emergency. The VAD coordinator will typically be on the telephone to provide additional assistance to EMS personnel. Contact information for the VAD coordinator is usually attached to or located inside the pt's VAD equipment bag.**
- **VAD pts should be transported to the nearest appropriate VAD center. If the pt's condition does not warrant transportation to the VAD center, the base/modified base hospital shall be consulted for pt destination. The VAD equipment bag, power source, battery & charger shall be brought with any transported VAD pt.**

- Manage airway/assist ventilations, O_2 at appropriate rate if short of breath, or signs of heart failure/shock
- Assess perfusion (mental status, skin color & temperature, capillary refill)

↓

Adequate perfusion?
- YES → Refer to other treatment protocols as necessary
- NO ↓

Assess VAD function
- Look/listen for alarms
- Listen for VAD hum (left chest/LUQ of abdomen)

↓

VAD functioning?
- NO → Attempt to correct malfunction with VAD coordinator &/or trained companion assistance → **VAD functioning?**
  - YES → Monitor & reassess (see below)
  - NO → Signs of life or $EtCO_2$ >20 mmHg?
- YES ↓

Signs of life or $EtCO_2$ >20 mmHg?
- NO → **Perform chest compressions** → Refer to Pulseless Arrest treatment protocol
- YES ↓

- Monitor & reassess
- Refer to other treatment protocols as necessary
- Contact base/modified base hospital for treatment consultation as needed

Hyperthermia

Approval: Troy M. Falck, MD – Medical Director	Effective: 06/1/2022
Approval: John Poland – Executive Director	Next Review: 03/2025

BLS

- Move pt to a cool environment, remove excess clothing & begin cooling measures as soon as possible
- Assess V/S, including temperature if thermometer available
- O_2 at appropriate rate if hypoxemic (SpO2 <94%)

HEAT CRAMPS

- Neuro: Normal, may have muscle cramps (usually in the legs)
- Skin: Sweaty, may be warm to the touch
- Temp: Usually normal

Treatment:

- Give cool/cold fluids slowly by mouth
- Rest cramping muscles

→ Monitor & reassess

HEAT EXHAUSTION

- Neuro: Feels weak with otherwise normal function
- Skin: Sweaty, usually hot to the touch
- Temp: Usually normal to slightly elevated
- Typically feels sick with flu like symptoms

ALS

- Cardiac monitor
- Give cool/cold fluids slowly by mouth as tolerated
- IV/IO NS: 1000 mL bolus

→ Monitor & reassess

HEAT STROKE

- Neuro: Altered mental status, may have persistent seizures
- Skin: Usually flushed, hot; may or may not be moist
- Temp: Usually ≥104

ALS

- Aggressive cooling - cold packs on neck, axilla & inguinal areas; fanning & misting if possible, undress pt, cover with sheet & wet thoroughly
- Cardiac monitor
- IV/IO NS: 1000 mL bolus, reassess & repeat if necessary for SBP <90, or signs of poor perfusion

→ Monitor & reassess

Monitor & reassess

Sierra – Sacramento Valley EMS Agency Treatment Protocol	R-3
Acute Respiratory Distress	

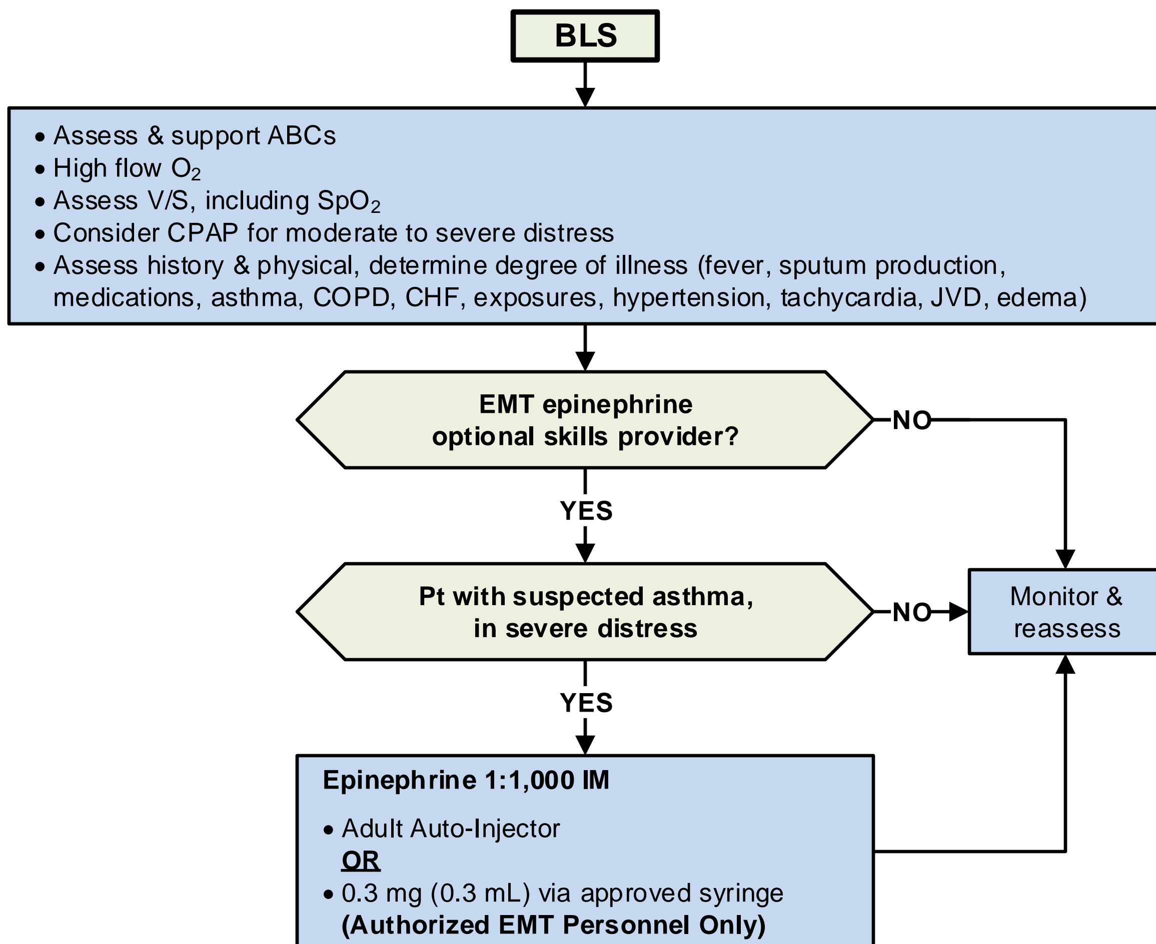
Approval: Troy M. Falck, MD – Medical Director	Effective: 06/01/2024
Approval: John Poland – Executive Director	Next Review: 01/2027

Continuous Positive Airway Pressure (CPAP) Utilization

- **Indications:**
  - CHF with pulmonary edema
  - Moderate to severe respiratory distress
  - Near drowning
- **Contraindications:**
  - <8 years of age
  - Respiratory or cardiac arrest
  - Severe decreased LOC
  - Agonal respirations
  - Inability to maintain airway
  - Suspected pneumothorax
  - SBP <90
  - Major trauma, especially head injury or significant chest trauma
- **Complications:**
  - Hypotension
  - Pneumothorax
  - Corneal drying

Epinephrine Administration

- Epinephrine is only indicated for pts with suspected asthma who are in severe distress.
- **Use epinephrine cautiously in pts >35yo, or with a history of coronary artery disease or hypertension.**
- Administer Auto-Injector/IM epinephrine into the lateral thigh, midway between waist & knee.



SEE PAGE 2 FOR ALS TREATMENT

Acute Respiratory Distress

Asthma/COPD

ALS

Mild Distress
- Mild wheezing
- Mild shortness of breath
- Cough

- Cardiac monitor
- Consider IV NS (may bolus up to 1000 mL)

Albuterol 5 mg & Ipratropium 500 mcg
- Nebulizer
- May repeat **(albuterol 2.5-5 mg only)** for continued respiratory distress

Moderate to Severe Distress
- Cyanosis
- Accessory muscle use
- Inability to speak >3 words
- Severe wheezing/shortness of breath
- Decreased or absent air movement

- Cardiac monitor
- IV/IO NS (may bolus up to 1000 mL)

Albuterol 5 mg & Ipratropium 500 mcg
- Nebulizer/CPAP/BVM
- May repeat **(albuterol 2.5-5 mg only)** for continued respiratory distress

History of asthma with severe distress only

Epinephrine 1:1,000
- **0.01 mg/kg IM (max: 0.5 mg)**

Base/Modified Base Hospital Order Only
Magnesium Sulfate
- ***2 g in 100ml NS IV infused over 20 minutes***

CHF/Pulmonary Edema

ALS

Mild Signs & Symptoms

- Cardiac monitor
- IV NS TKO

***Nitroglycerin**
- 0.4 mg SL
- May repeat every 5 mins

***Nitroglycerin Notes/Precautions**
- Do not administer if SBP <100
- Do not delay due to difficult vascular access
- Consult with base/modified base hospital prior to administration to pts taking erectile dysfunction or pulmonary HTN medication

Moderate to Severe Signs & Symptoms

- Cardiac monitor
- Assess BP x 2 to confirm accuracy
- IV/IO NS TKO

***Nitroglycerin: titrate dose based on SBP**
- SBP 100-150: 0.4 mg SL
- SBP 150-200: 0.8 mg SL
- SBP >200: 1.2 mg SL
- May repeat titrated doses every 5 mins based on repeat SBP

Pediatric Pleural Decompression

Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

INDICATIONS

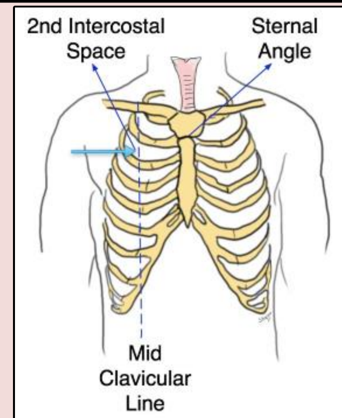
- Pleural decompression is a high-risk procedure in pediatrics requiring careful consideration due to the anatomical and physiological differences in this population which increases the risk of complications such as lung laceration, misplacement and vascular injury. Additionally, proper needle selection based on weight and age is critical to avoid inadequate decompression or unintended trauma.
- Suspected tension pneumothorax with a history of chest trauma, unilateral absent or diminished breath sounds, & at least one of the following:
  - Severe respiratory distress with an SpO_2 <94%
  - Loss of pulse due to shock OR
    - 0 – < 1 years - SBP <70
    - 1 – < 10 years – SBP <70 + age (yrs) x2
    - 10 – 14 years – SBP <90
  - Traumatic cardiac arrest

PRE-PROCEDURE

- Assess respiratory status, manage airway & assist ventilations as appropriate
- Administer high flow O_2 & monitor SpO_2
- Assess & continually monitor vital signs

PROCEDURE

- Identify & prep the site:
  - **Preferred**: Mid-clavicular line in the 2nd intercostal space just above the 3rd rib
  - **Cardiac arrest only**: Mid-axillary line in the 4th (just above the 5th rib) or 5th (just above the 6th rib) intercostal space
- Determine the appropriate needle size based on patient weight/age (see table)
- Attach 10 ml syringe to catheter hub
- Insert the needle into the chest at a 90° angle to the chest wall
- Observe for rush of air or bubbles in the syringe
- Remove needle leaving catheter in place
- Stabilize the catheter hub to the chest wall
- Auscultate bilateral breath sounds and observe for change in clinical condition and/or positive color change if using a Capnospot® (improvement in SpO_2, blood pressure, etc.)



AGE	WEIGHT	NEEDLE SIZE
0 - < 1 years	< 10 kg	22 ga x 1.00"
1 - < 5 years	10 - < 15 kg	20 ga x 1.25"
5 - < 10 years	15 - <25 kg	16 ga x 1.25"
10 - 14 years	≥ 25 kg	14 ga x 2.00"

POST-PROCEDURE

- Reassess breath sounds, and monitor for signs of development of a tension pneumothorax
- Administer O_2 at appropriate rate & monitor SpO_2
- Continuous cardiac & $EtCO_2$ monitoring
- Assess & document vital signs every 3-5 mins (if possible)

Department of Health Services
Timothy W. Lutz
Director

County of Sacramento

Divisions
Administration
Behavioral Health
Primary Health
Public Health

Date: **March 13, 2025**

To: All Sacramento County Emergency Medical Services Agency (SCEMSA) Stakeholders

From: Dr. Gregory Kann, SCEMSA Medical Director

Subject: Emergency Policy Memorandum Regarding Policy 8062.11 – Behavioral Crisis/Restraint

Effective immediately, SCEMSA is implementing a temporary modification to Policy 8062.11 – Behavioral Crisis/Restraint. This policy modification is in response to recent changes in law enforcement response to patients in behavioral health crisis. **This memorandum is intended to provide clarity to EMS providers on how to proceed in situations where they encounter a patient in behavioral crisis, with an unsafe scene, and no law enforcement partner presence.** This memorandum and policy change will remain in effect until there is consistent law enforcement presence when requested by EMS for behavioral crisis situations or otherwise altered.

Procedure:

A. Follow the established BLS/ALS[1] procedure as outlined in existing Policy 8062.11 – Behavioral Crisis/Restraint. (Enclosed.)

B. If (per Dispatch or other information source) a patient has an identified or suspected weapon, an EMS unit, in consultation with a supervisor, may not engage with the patient if determined to be unsafe. If possible, the EMS Supervisor shall conduct and document a Behavioral Activity Rating Scale (BARS) assessment consistent with all listed steps below.

C. If the scene is unsafe or patient assessment is not possible given conditions at the scene, follow BLS procedures 3. A. B. C. **AND**:

1. Request an EMS Supervisor to respond to the scene.
2. EMS Supervisor to contact appropriate law enforcement Supervisor to discuss scene safety and mitigation measures.
3. EMS Supervisor shall document in the electronic patient care record (ePCR) the law enforcement Supervisor contact and the outcome of the discussion on scene safety mitigation.

[1] Basic Life Support/Advanced Life Support

4. EMS personnel shall document procedure: **Police Requested to Attend** to indicate that law enforcement was requested to respond.
5. In consultation with on-scene staff, the EMS Supervisor SHALL document a Behavioral Activity Rating Scale (BARS) assessment as follows:

Score	Patient Description
1	Difficult or unable to arouse
2	Asleep but responds normally to verbal or physical contact
3	Drowsy, appears sedated
4	Quiet and awake (normal level of activity)
5	Signs of overt (physical or verbal) activity, calms with re-direction/instruction
6	Extremely or continuously active, not requiring restraint
7	Violent, requires restraint

6. If patient has a BARS of 6 or greater AND there is a continued non-response by law enforcement, EMS providers (per Supervisor consultation) may elect not to engage with the patient based on scene safety.
7. If measures 1-6 above have been completed AND 30 minutes have passed, the EMS Supervisor may authorize the unit to leave the scene and return to service.
8. In consultation with on-scene staff, the EMS Supervisor SHALL document *Released Following Protocol Guidelines* in the ePCR under patient disposition.

Should you have any inquiries, please contact Medical Director Gregory Kann. The above process may evolve as circumstances shift, at which time SCEMSA will issue additional written guidance.

Gregory Kann MD FACEP
Medical Director
Sacramento County EMS Agency

Enclosure(s):
SCEMSA Policy 8062.11