



SAN BERNARDINO COUNTY EMERGENCY MEDICAL CARE COMMITTEE



City of Rancho Cucamonga
Council Chambers
10500 Civic Center Drive
Rancho Cucamonga, CA 91730

**January 20, 2011
9:00 a.m.**

A G E N D A

I. CALL TO ORDER

II. APPROVAL OF MINUTES

October 21, 2010

III. ICEMA UPDATE

EMS MISS Status Report

INFO/ACTION

IV. ICEMA MEDICAL DIRECTOR

- A. STEMI System Update
- B. Stroke System Update
- C. AEMT (Sheriff's Search & Rescue)

INFO/ACTION

V. STANDING EMS SYSTEM MANAGEMENT REPORTS

- A. Quarterly Trauma Hospital Reports
- B. Base Hospital Quarterly Reports
- C. Hospital Bed Delay Reports
- D. Hospital Surveillance
- E. STEMI Reports

www.icema.net

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VI. OLD BUSINESS

Utilization of PBC Trust Fund

ACTION/APPROVE

VII. NEW BUSINESS

- A. Election of Chair and Vice Chair
- B. 2010 Annual Report - First Reading
- C. Annual PBC Program Report 2008
- D. Annual PBC Program Report 2009
- E. Current Status - PBC Contracts
- F. Suggested EMCC Ordinance Changes
- G. QI Plan

www.icema.net

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H. Protocols

1. Reference # 1050 MICN Certification Requirements
2. Reference # 1080 Flight Nurse Authorization
3. Reference # 3020 Continuing Education Provider Requirements
4. Reference # 3030 EMT Continuing Education Requirements
5. Reference # 5040 Radio Communication Policy
6. Reference # 6020 EMT AED Service Provider Policy
7. Reference # 6090 Fireline Paramedic
8. Reference # 10160 Axial Spinal Stabilization
9. Reference # 11040 Bradycardias - Adult

VIII. COMMITTEE/TASK FORCE REPORTS

Documentation Ad Hoc Committee Report

IX. OTHER/PUBLIC COMMENT

X. COMMITTEE MEMBER REQUESTS FOR NEXT MEETING

XI. NEXT MEETING DATE AND LOCATION

March 17, 2011

City of Rancho Cucamonga

Council Chambers

10500 Civic Center Drive

Rancho Cucamonga, CA 91730

XII. ADJOURNMENT

The San Bernardino County Emergency Medical Care Committee (EMCC) meeting facility is accessible to persons with disabilities. If assistive listening devices or other auxiliary aids or services are needed in order to participate in the public meeting, requests should be made through the Inland Counties Emergency Medical Agency at least three (3) business days prior to the EMCC meeting. The telephone number is (909) 388-5823, and office is located at 515 North Arrowhead Avenue, San Bernardino, CA.



SAN BERNARDINO COUNTY EMERGENCY MEDICAL CARE COMMITTEE



**Richard Sewell Training Center
2824 East W Street, Building 302
San Bernardino, CA 92408**

October 21, 2010

COMMITTEE	ORGANIZATION	EMS AGENCY STAFF	POSITION
<input checked="" type="checkbox"/> Jim Holbrook	Training Institution	<input checked="" type="checkbox"/> Reza Vaezazizi, MD	Medical Director
<input checked="" type="checkbox"/> Diana McCafferty	Private Ambulance Provider	<input checked="" type="checkbox"/> Virginia Hastings	Executive Director
<input type="checkbox"/> Marie Podboy	Air Ambulance Provider	<input checked="" type="checkbox"/> Denice Wicker-Stiles	Assistant Administrator
<input type="checkbox"/> James Holmes	Hospital Administrator	<input checked="" type="checkbox"/> Jerry Nevarez, RN	Nurse Educator
<input checked="" type="checkbox"/> Stephen Miller	Law Enforcement	<input checked="" type="checkbox"/> Sherri Shimshy, RN	EMS Nurse
<input checked="" type="checkbox"/> Michael Smith	Fire Chief	<input checked="" type="checkbox"/> Patricia Eickholt	EMS Nurse
<input checked="" type="checkbox"/> Troy Pennington, MD	Physician	<input checked="" type="checkbox"/> Christine Yoshida-McMath	EMS Trauma Nurse
<input checked="" type="checkbox"/> Art Andres	EMT-P	<input checked="" type="checkbox"/> Mark Roberts	EMS Technical Consultant
<input checked="" type="checkbox"/> Rick Britt	Communications	<input checked="" type="checkbox"/> Moises Evangelista	Statistical Analyst
<input checked="" type="checkbox"/> Allen Francis	EMS Nurse	<input checked="" type="checkbox"/> May Wang	Staff Analyst
<input type="checkbox"/> Pranav Kachhi, MD	ER/Trauma Physician	<input checked="" type="checkbox"/> Paul Easterling	EMS Specialist
<input type="checkbox"/> Vacant	City Manager	<input checked="" type="checkbox"/> John Mueller	EMS Specialist
<input type="checkbox"/> Vacant	Consumer Advocate	<input checked="" type="checkbox"/> Jacquie Martin	Secretary
Christina Bivona-Tellez	HASC	Pam Martinez	Ontario Fire
Debbie Bervel	SB City Fire	Michael May, RN	LLUMC
Mitch Dattilo	Sheriff's Aviation	David Mills	CRA
Jerry Douchy	CRA	Dave Molloy	AMR - Redlands
Paul Garcia	CRA	Wilma Montgomery	CRA
Cheryl Gilliatt	CVMC	Joy Peters, RN	ARMC
Nancy Hernandez	LLUMC	Art Rodriguez	Desert Ambulance
Debra Keusler	PVHMC	Chuck Spencer	MBA
Ramon Lomeli	MBA		

I. CALL TO ORDER

The meeting was called to order at 9:00 a.m.

II. APPROVAL OF MINUTES

The July 15, 2010, EMCC meeting minutes were reviewed. Stephen Miller motioned to approve minutes; Diana McCafferty seconded.

MSC:

Ayes - 8

Noes - 0

Abstaining - 0

III. ICEMA UPDATE

A. Staff Update

Virginia Hastings introduced the following new staff members:

May Wong, Staff Analyst - May replaces Joe Lick and is working with the PBC program.

Patty Eickholt, EMS Nurse - Patty is a Mobile Intensive Care Nurse with 15 years' experience at San Antonio Community Hospital. She will be concentrating on educational programs and protocols.

Paul Easterling, EMS Specialist - Paul is a certified EMT I.

On Tuesday, October 16th, the Governing Board approved a contract with Ron Holk, part-time EMS Nurse position. Ron will be working largely with the data system, reviewing the RFP and bidding process for the new system dubbed EMS MISS II. He will provide the medical oversight needed for the project.

B. ICEMA Website

Virginia Hastings reported that Denice Wicker-Stiles has been working on a new ICEMA webpage which should be ready to access in a few weeks. The new webpage should be significantly improved and useful.

C. EMS MISS Status Report

EMS MISS Report is included in agenda packet for reference. Mark Roberts reported the following:

- FirstWatch has been installed and working in a test environment.
- New printers approved at the last meeting have been installed at the following hospitals:
 1. LLUMC
 2. ARMC
 3. Redlands Community
 4. Kaiser Fontana
 5. St. Bernardine
 6. SACH
- Implementation:
 1. Inyo County - All providers have been trained, with additional follow-up training needed.
 2. Mammoth Lakes Fire Department - Hardware has been installed and training complete.

- Third Party Interface - Working with third party vendors to receive data from Desert Ambulance, Mercy Air and ConFire.

Questions/comments from EMCC Members or the public:

Diana McCafferty commented that it had been brought to her attention that toner cartridge replacement is much faster than anticipated at locations where AMR replenishes supplies. There has been a noticeable increase in toner usage and that the cartridges being replaced are not what were originally installed in the printers. She requested further research into the situation. Chris Bivona-Tellez offered to bring the situation up at the next HASC meeting.

Chief Smith asked if the Advisory Group for the Data RFP had been formed. Virginia Hastings responded that the group had not been called together and with Ron Holk on staff the group should be formed in the next few weeks for input and discussion of the "draft" RFP.

Jim Holbrook asked if there were any providers (public or private) not in the initial phase. Virginia Hastings responded that there are several public sector agencies not yet on the EMS MISS system.

Rick Britt reported that Rialto is being used as a test source for transmittal data from ConFire agencies. A meeting is scheduled for October 26th to meet with ICEMA.

IV. ICEMA MEDICAL DIRECTOR

Dr. Vaezazizi reported:

A. Medication Shortages

Most of the shortages have not translated into any major difficulties. These times of shortages are fairly common in the pharmaceutical world. Morphine has been a challenge, as ICEMA has had a policy of not using vials for morphine or controlled substances due to its difficulty being tamper proof. A memo was issued a few months ago allowing the purchase of vials and cautioned the providers and their medical directors to take precautions to assure no opportunity for diversion. ICEMA will continue to monitor the current medication shortages, with Sherri Shimshy being the contact person.

B. STEMI

The STEMI data show no significant change. One of the continuous struggles being addressed are the so-called false positives. There are many variables associated with the current false positive result. ICEMA estimates that 15 -25% are true false positives, meaning that the patient directly taken to a STEMI center were incorrectly identified by an incorrectly interpreted EKG by the machine, paramedic or both.

ICEMA is focusing on the causes of this issue. One cause identified is the lack of high quality diagnostic EKGs. The providers have been very responsive to the issue and are working hard to remedy the situation. ICEMA will continue to monitor and will take a few months to see the effects. The other issue is the concept of transmission of the EKG. There is a renewed interest for this, with some regions such as the High Desert and the West End working pilot projects that allow the transmission of EKGs.

C. Stroke Center Update

The first planning meeting was held in August. Fifty (50) people from prospective Stroke Centers were in attendance at this meeting. Also in attendance were several community hospitals, including a rural hospital (Mammoth Lakes) that were interested in being integrated as part of the referral system. These attendees will be involved in the Planning Committee, as well as a sub-committee for the development of the education portion in terms of providing a tool to educate pre-hospital providers and identification of stroke patients.

Dr. Vaezazizi anticipates the program will be ready in July of 2011, with as many as four (4) stroke centers designated, most being current STEMI centers. The process will probably involve the use a modified LA County Stroke Scale that was identified as the means by which we will use pre-hospital triage. There are still things to be decided, such as tier designation, whether a center has interventional capabilities or purely providing thrombolytic TPA treatment, which is still to be determined and be sorted through.

D. MCI Reviews

Chris Yoshida-McMath presented the recent MCI's in Lucerne Valley and Bishop. Dr. Vaezazizi stated that in light of experiences gained in these two incidents, ICEMA will draft a Mass Gathering policy for review and comment.

E. Odansetron (Zofran) Trail Study

Dr. Vaezazizi reported that the Odansetron trail study that was completed a year and half ago is ready for publication and has been accepted in a peer review journal for pre-hospital emergency care. He will make sure that everybody sees and gets a copy to those who are interested as long as no copyright laws are violated.

F. Documentation for Dead on Scene

Dr. Vaezazizi reported on a problem regarding pronouncement on scene and the legal documentation that needs to stay with a dead body (DB). He reminded providers that under State law they are required to leave documentation when a dead body (DB) is left on scene. There is a form that needs to be filled out, but is not preferred; the Coroner actually prefers a written 01A stay with the patient. Dr. Vaezazizi acknowledged this creates a problem with the Toughbooks where there are no printing capabilities in the field but asked that the minimum information sheet be provided to the Coroner.

Questions/comments from EMCC Members or public:

Art Andres stated that he has interfaced with the Coroner on multiple occasions and that they are very specific about what information they want. He asked if this is something that could be added into the ARC. Sherri Shimshy responded that the form was created by the Coroner and is included in the next ARC training.

V. STANDING EMS SYSTEM MANAGEMENT REPORTS

The following reports are available for review at <http://www.sbcounty.gov/icema/reports.htm>:

- Trauma Reports (Quarterly)
- Base Hospital Statistics (Quarterly)
- Bed Delay Reports
- Prehospital Data Reports
- Reddinet Assessment Reports

Questions/comments from EMCC Member or the public:

Art Andres asked if the STEMI Data could be added to the reports. Dr. Vaezazizi will follow-up with the STEMI Committee and have some standard reports included.

VI. OLD BUSINESS

A. Utilization of PBC Trust Fund

PBC Trust Fund Utilization report is included in the EMCC packet. Incidental expenses have exceeded the original allocation; there is a request for an additional \$5,000 to cover future expenses.

Art Andres motioned to approve; Stephen Miller seconded.

MSC: Approve additional \$5,000 allocation from PBC funds.

Ayes - 8

Noes - 0

Abstaining - 0

B. Ethics Training for EMCC Members

Jim Holbrook reminded EMCC members that ethics training is required every two (2) years. Those who need to complete the training should do so by the next meeting.

VII. NEW BUSINESS

A. Application for Special Event Permit - County Rescue Ambulance

County Rescue Ambulance submitted an application to provide special events coverage countywide.

Stephen Miller motioned to approve; Art Andres seconded.

MSC:

Ayes - 8

Noes - 0

Abstaining - 0

VIII. COMMITTEE/TASK FORCE REPORTS

A. Documentation AD HOC Committee Report

Michael Smith reported that the committee met on August 10, 2010. Meeting Minutes from the meeting were distributed at the meeting. The variety of disciplines, as well as the geographical diversity, is a testament to the fact that the community took this work seriously. He thanked the attendees for their participation and Sherri Shimshy for preparing the minutes. The committee was asked to identify the strengths, weaknesses and opportunities to improve documentation in the system.

Action items were identified at the meeting; with short term goals identified as follows:

1. Determine minimum requirements for documentation that is to be passed from one provider to another.
2. Standardization of abbreviations for documentation terms.

Jim Holbrook asked that Micheal Smith continue to chair and Diana McCafferty co-chair the committee on behalf of the EMCC. He reiterated that the mission for the committee, between now and the January 20th meeting, is to continue to identify issues and concerns and then, after January processes, start dealing with the outcomes based on those processes. Michael Smith added that, in addition to identifying issues and concerns begin to define the mission and vision.

IX. OTHER/PUBLIC COMMENT

X. COMMITTEE MEMBER REQUESTS FOR NEXT MEETING

1. Election of Chairman and Vice Chair
2. Annual Report - First Reading
3. Agenized Documentation Ad Hoc Committee

XI. NEXT MEETING DATE AND LOCATION

**January 20, 2011
City of Rancho Cucamonga
Counsel Chambers
10500 Civic Center Drive
Rancho Cucamonga, CA 91730**

XII. ADJOURNMENT

EMCC Meeting was adjourned at 10:21 a.m.

VH/jlm

Staff Report - EMCC

EMS Management Information & Surveillance System (MISS)

ICEMA SERVER

ICEMA has received the follow:

1. 2009 - 176,215 ePCR's
2. 2010 - 196,193 ePCR's
3. July - December 2010 - 107,855 ePCR's
4. December 2010 - 19,164 ePCR's

RFP - REPLACEMENT OF CURRENT EPCR SOFTWARE

ICEMA staff have met with stakeholders in the public and private sectors for input and comments on what they would like to see in the next ePCR software. ICEMA continues to work on development of an RFP to replace its current ePCR software. ICEMA's timeline for release of the RFP is April, 2011.

FIRSTWATCH EARLY EVENT DETECTION SYSTEM

FIRSTWATCH software has been installed in a production environment at ICEMA. Staff has begun to work with FirstWatch and Public Health in development of triggers and notifications.

EARLY EVENT DETECTION & SYNDROMIC SURVEILLANCE

From potential pandemic disease outbreaks to bioterrorism, FirstWatch provides real-time situational awareness for Public Health Directors, Epidemiologists and other team members via interactive FirstWatch Dashboards. The secure, detailed data displays automatically created by monitoring Public Safety Call Center Data (9-1-1 calls to EMS, Fire & Police), which FirstWatch analyzes for potentially threatening health trends, patterns or geographic clusters of occurrences, as they develop.

INYO/MONO

All providers in Inyo County have been trained on the ePCR system and are doing dual entry of PCR's. Mammoth Lakes Fire Department received training in October 2010, and roll out to the field users will begin on February 17, 2011.

THIRD PARTY INTERFACE TO MISS

Currently, ICEMA is working with third party vendors to receive data from ePCR systems other than HealthWare Solutions. Below is the current status for providers who are sending or attempting to send data to ICEMA.

1. Desert Ambulance (Zoll tabletPCR) - data is being received daily.
2. Mercy Air (emsCharts) - data is being received daily.
3. ConFire (SUNPRO/ZOLL RMS) - providers continue to use paper 01As in the field. After the call, the data is entered into Sunpro RMS (Zoll data). ICEMA continues to work with ConFire to improve the import process.

Once approved, the following providers will be sending data to ICEMA as part of Confire:

1. Colton Fire Department
2. Loma Linda Fire Department
3. Redlands Fire Department
4. Rialto Fire Department
5. San Bernardino County Fire Department

We are receiving data from Confire and are in the validating process. The following departments are pending the outcome of Confire testing:

1. Chino Fire Department
2. Crest Forest Fire Protection District
3. Montclair Fire Department
4. Ontario Fire Department
5. Rancho Cucamonga Fire Department
6. Apple Valley Fire Protection District

Mark Roberts
01/20/11

Staff Report - EMCC

UTILIZATION OF PBC TRUST FUND (LIQUIDATED DAMAGES)

Current Balance (December 31, 2010): \$796,796.42

At the May 2010 EMCC meeting, the committee recommended the use of \$25,000 to cover the cost of printer paper and toner. This request was included in ICEMA's budget and approved by the ICEMA Governing Board.

APPROVED PAPER/TONER BUDGET	Vendor	Amount	\$25,000
Expenses FY 2010:			
Paper	Office Depot (7-10 to 12-10)/Staples (1-11)	\$5,133	\$5,133
Toner	Daisy Wheel	\$13,704	\$13,704
			\$18,837
Remaining Balance			\$6,163

ICEMA has spent \$18,837 during the first six (6) months of this fiscal year. Therefore, ICEMA requests EMCC recommendation to increase this expenditure to \$40,000.

Additionally, during the October 2010 meeting, the EMCC approved the use of liquidated damages for incidental expenses (such as printer repair) related to the MISS project or performance based contracts not to exceed \$5,000. No incidental expenses were incurred during this period.

Trust Fund Expenditure History

September 2009	Printer Paper and Toner	\$28,000
January 2010	150 Ruggedized Flash Drives	\$5,000
May 2010	Printer Paper and Toner	\$25,000
July 2010	Additional Printers	\$5,177

Recommendation: Increase toner/printer funding from \$25,000 to \$40,000 for Fiscal Year 2010.



San Bernardino County Emergency Medical Care Committee

515 North Arrowhead Avenue
San Bernardino CA 92415
(909) 388-5823



March 17, 2011

San Bernardino County
Board of Supervisors
385 North Arrowhead Avenue
San Bernardino, CA 92415

Dear Members of the Board:

RE: EMERGENCY MEDICAL CARE COMMITTEE - 2010 ANNUAL REPORT

Enclosed for your review is the 2010 Annual Report for the San Bernardino County Emergency Medical Care Committee (EMCC).

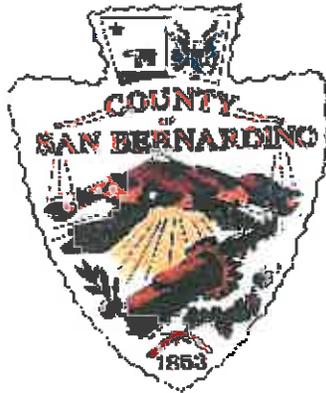
Please contact me electronically at jholbrook@craftonhills.edu or by telephone at (909) 389-3251 if I can assist you.

Thank you,

Jim Holbrook
Chair, San Bernardino County EMCC

Enclosure

cc: Virginia Hastings, Executive Director, ICEMA
Reza Vaezazizi M.D., Medical Director, ICEMA
EMCC Official file



SAN BERNARDINO COUNTY EMERGENCY MEDICAL CARE COMMITTEE

2010 ANNUAL REPORT



The purpose of this writing is to document the San Bernardino County Emergency Medical Care Committee (EMCC) processes for 2010. The EMCC provides a platform for the diverse groups and individuals which form the Emergency Medical Services System in San Bernardino County, and also in the official capacity as an advisory group to the Board of Directors for Inland Counties Emergency Medical Agency (ICEMA).

The 2010 EMCC membership consisted of eleven professionals representing the overall system.

- (1) Accredited Paramedic - Art Andres
- (2) Emergency Dispatch or Communication Center - Rick Britt
- (3) EMS Nurse - Allen Francis
- (4) EMS Training Institution - Jim Holbrook
- (5) Hospital Administrator - Jim Holmes
- (6) ER Physician - Pranav Kachhi, MD
- (7) Private Ambulance Provider - Diana McCafferty
- (8) Law Enforcement - Steve Miller
- (9) Physician - Troy Pennington, MD
- (10) Air Ambulance Provider - Marie Podboy (Resigned November 2010)
- (11) Fire Chief - Mike Smith

The EMCC positions representing City Manager and Consumer Advocate continued to be unfilled during the 2010 sessions. These vacancies originated during the 2009 sessions, and the liaison agency has been working to fill these positions. EMS nurse Allen Francis and emergency room physician Pranav Kachhi replaced Kelly Bernatene and Chad Clark.

All but one EMCC members were in compliance with the requirements for Ethic training as defined by Article 2.4 of Chapter 2 of Title 5 of the Government code (AB 1234).

During the July meeting, the EMCC approved the amended Bylaws to forward to the Board of Supervisors for approval. The EMCC requested the liaison agency to begin the process of ordinance change to add an additional paramedic to the EMCC. This proposed membership change will result in two accredited field paramedics, one representing public and one representing private agencies, on the EMCC.

The medical control protocols and system processes continue to assure overall medical control of system. Sixteen (16) protocols, both regular updates and new protocols, were discussed during the 2010 EMCC sessions. The protocol changes were stimulated by changes in scientific or local system needs. The system continues through local provider and hospital based agency processes to forward the educational, training, and personnel needs of the basic and advanced life support personnel system wide.

The EMCC received standing emergency medical services system management reports at each of the scheduled meetings. These standing reports included quarterly reports for Trauma systems and base hospital statistics and the monthly reports of electronic patient care reports, hospital bed delays, medication / procedures / and type of patient summary reports, and hospital surveillance reports. These standing reports assist the overall system as it continues to explore and advance in communication and systems knowledge between all groups.

There were discussions on transportation issues during the 2010 sessions. These committee deliberations were for new permit requests for both air ambulance provider and special permits. The full implementation of Upland Air Ambulance and ICEMA Ambulance Rate Setting Policy were the essential transportation discussions. Continued funding from the performance-based contract fines was added to other funding sources to augment the system needs of the region.

The following fire departments remain outside of the ICEMA Management Information and Surveillance System (MISS):

- 1) Apple Valley Fire Department
- 2) CAL FIRE - City of Highland Fire Department
- 3) CAL FIRE - City of Yucaipa Fire Department
- 4) Chino Fire Department
- 5) Combat Center Fire Department - Twentynine Palms
- 6) Crest Forest Fire Department
- 7) Marine Corp Logistics Base - Barstow
- 8) Montclair Fire Department
- 9) Ontario Fire Department
- 10) Rancho Cucamonga Fire Department

Due to changes in the administrative and structural process of the American Heart Association and other large network training agencies, an accurate number of individuals trained in cardiopulmonary resuscitation and first aid are not and will not be available.

It has been the goal of the EMCC to allow broad-based system participation and discussions. It is our sense that these activities have advanced the local system. The EMCC applauds our system and the participants as an amazing collection of the best and brightest in California.

Staff Report - EMCC

STATUS OF PERFORMANCE BASED CONTRACTING

CITATIONS:

Statutory:

- H&SC 1797.201 (Attachment A)
- H&SC 1797.224 “ ”
- H&SC 1797.226 “ ”

Emergency Medical Services Authority (EMSA):

- Guideline 141 “Review Criteria and Policy for Transportation and Exclusive Operating Area (EOA) Components of EMS Plan” February, 1987
Under Revision

BACKGROUND:

- San Bernardino County developed Exclusive Operating Areas (EOA) under the provisions of 1797.224, “No competitive process is required if the local EMS agency develops or implements a local plan that continues the use of existing providers operating within a local EMS area in the manner and scope in which the services have been provided without interruption since **January 1, 1981.**”
- There are 24 EOA’s in San Bernardino County and three additional operating areas that have No Designated Provider (NAP). There were no responders to an RFP for EMS transportation in these three remote locations.
- On April 29, 2003, the Board of Supervisors acting as the Governing Board for ICEMA approved requirements for Performance Based Contracts (PBC). On April 20, 2004, the Board approved contracts for those EOA’s listed on Attachment B. Subsequently, the Board approved PBC contracts/MOU’s with Baker and Needles Ambulance, Morongo Valley Ambulance, Crest Forest Fire Department, Running Springs Fire Department and Bear Valley Community Healthcare District dba Bear Valley Paramedics.
- The majority of the EOA contracts expire on April 30, 2012.
- Although there have been some expectations that the ICEMA/Governing Board will redraw existing EOA’s and enter into a competitive process to select transporters, there is no legal requirement to do so if the EOA’s are maintained in the same manner and scope in which the services have been provided without interruption since January 1, 1981.

- EMSA, to date, will not approve two of the existing EOA's:

- EOA 25 - Lucerne Valley Area - SB Co Fire

EMSA opines that there has been a change in the "manner and scope" of operations created by large annexations to the area.

- EOA 20 - Bear Valley Community Healthcare District dba Bear Valley Paramedics

An RFP was issued for this area in 1985 thereby making it ineligible for continued operation without a competitive process.

ICEMA continues to work with EMSA on the status of EOAs 20 and 25.

NOTE: Our legal analysis, supported by County Counsel, is that EMSA approval only confers anti-trust protection; it does not preclude a county's decision to maintain an EOA. However, if EMSA elected not to approve a county's **ENTIRE** Transportation Plan due to one or specific EOA's, the County could assume significant anti-trust risks.

CURRENT DISCUSSION:

ICEMA has entered into discussions with first responders and EOA contractors to determine whether to recommend to the Governing Board that existing EOA contracts be amended and extended through an agreed upon date, presumably three to five years. There are several valid reasons for these discussions:

- The existing contractors have met performance standards and other requirements outlined in the contracts. NOTE: San Bernardino County Fire has not entered into a contractual relationship with ICEMA.
- Sufficient experience with the PBC program has been gained to modify certain contract provisions that will facilitate interactions among contractors and first responders. Examples include but are not limited to the following:
 - Contracts currently require the contractor to resupply first responder units at no cost to the first responders with disposable medical supplies utilized in direct patient care where the patient is transported by contractor. The current one-for-one field exchange of supplies has created some logistical problems.
 - Certain exemptions are allowed for response time standards. These eligible exemptions can be significantly shortened.
- Following 25 years of contentiousness, precedent setting legal actions, and various legislative efforts by special interest groups, the California Emergency Medical Services Commission which has regulatory authority has adopted a plan to pursue statutory/regulatory compromise on the statutory citations noted earlier. This process will take one to two years to complete.

- EMSA Guidelines 141 noted earlier is under revision and in somewhat disarray. It is highly unlikely this document will be finalized before the statutory/regulatory activities discussed above are finalized.

The San Bernardino County Chiefs Association and the San Bernardino County Ambulance Association have each selected a negotiating team to work with ICEMA to address some issues that, based upon experience, have been identified as provisions that should be modified.

ICEMA will continue to keep the EMCC informed of progress in the PBC contract negotiations.

Virginia Hastings
01/20/11

1797.201. Upon the request of a city or fire district that contracted for or provided, as of June 1, 1980, prehospital emergency medical services, a county shall enter into a written agreement with the city or fire district regarding the provision of prehospital emergency medical services for that city or fire district. Until such time that an agreement is reached, prehospital emergency medical services shall be continued at not less than the existing level, and the administration of prehospital EMS by cities and fire districts presently providing such services shall be retained by those cities and fire districts, except the level of prehospital EMS may be reduced where the city council, or the governing body of a fire district, pursuant to a public hearing, determines that the reduction is necessary.

Notwithstanding any provision of this section the provisions of Chapter 5 (commencing with Section 1798) shall apply.

Statutes in Effect as of
January 1, 2010

This section shall not be construed as prohibiting the helicopter program of the Department of the California Highway Patrol from a role in providing emergency medical services when the best medically qualified person at the scene of an accident determines it is in the best interests of any injured party.

[Added by SB 358 (CH 1237) 1983.]

1797.224. A local EMS agency may create one or more exclusive operating areas in the development of a local plan, if a competitive process is utilized to select the provider or providers of the services pursuant to the plan. No competitive process is required if the local EMS agency develops or implements a local plan that continues the use of existing providers operating within a local EMS area in the manner and scope in which the services have been provided without interruption since January 1, 1981. A local EMS agency which elects to create one or more exclusive operating areas in the development of a local plan shall develop and submit for approval to the authority, as part of the local EMS plan, its competitive process for selecting providers and determining the scope of their operations. This plan shall include provisions for a competitive process held at periodic intervals. Nothing in this section supersedes Section 1797.201.

[Added by AB 3153 (CH 1349) 1984.]

1797.226. Without altering or otherwise affecting the meaning of any portion of this division as to any other county, as to San Bernardino County only, it shall be competent for any local EMS agency which establishes exclusive operating areas pursuant to Section 1797.224 to determine the following:

(a) That a minor alteration in the level of life support personnel or equipment, which does not significantly reduce the level of care available, shall not constitute a change in the manner and scope of providing service.

(b) That a successor to a previously existing emergency services provider shall qualify as an existing provider if the successor has continued uninterrupted the emergency transportation previously supplied by the prior provider. [Added by AB 3434 (CH 965) 1986.]

**REPORT/RECOMMENDATION TO THE BOARD OF SUPERVISORS
OF SAN BERNARDINO COUNTY, CALIFORNIA
AND RECORD OF ACTION**

B

April 20, 2004

FROM: JAMES FELTEN, Public Health Director
Department of Public Health - Inland Counties Emergency Medical Agency

SUBJECT: PERFORMANCE-BASED CONTRACTS

RECOMMENDATION: Acting as the Governing Board for the Inland Counties Emergency Medical Agency (ICEMA), approve performance-based contracts with private urban and rural advanced life support (ALS) ambulance providers effective May 1, 2004, as listed below:

Exclusive Operation Areas	Provider	General Description*	Contract Number
EOA 1 (Urban)	American Medical Response	Rancho Cucamonga and Upland	04-299
EOA 2 (Urban)	American Medical Response	Montclair and Chino	04-300
EOA 3 (Urban)	American Medical Response	Ontario and Chino Hills	04-301
EOA 4 (Urban)	American Medical Response	Fontana and Lytle Creek	04-302
EOA 5 (Urban)	American Medical Response	Rialto - 9-1-1 calls in unincorporated areas; interfacility calls in entire EOA	04-303
EOA 6 (Urban)	American Medical Response	San Bernardino	04-304
EOA 7 (Urban)	American Medical Response	Grand Terrace	04-305
EOA 8 (Rural)	American Medical Response	Yucaipa, Mentone, Forest Falls	04-306
EOA 9 (Urban)	American Medical Response	Loma Linda	04-307
EOA 11 (Rural)	American Medical Response	Crest Forest Area	04-308
EOA 12 (Rural)	American Medical Response	Victorville Area	04-309
EOA 13 (Rural)	Desert Ambulance	Barstow Area	04-310

*A description and maps are included as attachments in each contract

Page 1 of 2

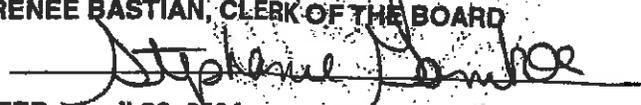
cc: Public Health/ICEMA-Felten w/ Agreements
Contractor w/agreements c/o Public Health
Auditor-Valdez w/agreements
IDS w/agreements
Risk Management
County Counsel-Larkin
County Counsel-Green
HSS/Admin.-Hughes
HSS/Admin.-Anselmi
File w/agreements

Record of Action of the Board of Supervisors
See Recommendation Above

**APPROVED BOARD OF SUPERVISORS
COUNTY OF SAN BERNARDINO**

MOTION SECOND AYE AYE MOVE AYE
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J. RENEE BASTIAN, CLERK OF THE BOARD

BY 

DATED: April 20, 2004

PERFORMANCE-BASED CONTRACTS

April 20, 2004

Page 2 of 2

BACKGROUND INFORMATION: On April 29, 2003 the Board approved the following requirements for performance-based contracts with private ambulance companies in urban areas:

1. All private ambulance providers will be required to enter into a performance-based contract with an 8-year fixed term and open for competitive bidding at the end of the term.
2. Wilderness/Rural and Underserved Areas will be given special consideration regarding term of contract, penalty provisions (if applicable), breach language, bond requirements and other areas discovered in negotiations that would seriously effect the providers ability to continue to provide Advanced Life Support ambulance services.
3. Financial penalties will be part of the performance based contract modeled after the Riverside County fee structure, which will include language regarding breach and the distribution of compliance reports to the public, city councils, and governing boards.

On August 19, 2003 the Board approved model performance-based contracts for privately-owned ambulance services in San Bernardino County and authorized ICEMA to proceed with contract negotiations. Negotiations have resulted in the attached contracts with AMR and Desert Ambulance Service in urban and rural areas.

During the last few months, extensive efforts have ensued to review area boundaries and make changes in order to provide consistency with computer aided dispatch systems, ensure the best possible response time, and ensure accurate and complete reporting and compliance measurements. Both public and private providers affected by the change in boundaries have participated in discussions regarding the proposed changes. The EOA Plan was amended by the Health Officer following a hearing held by the EMCC on March 25, 2004.

Negotiations are in progress with the wilderness area providers: EOA 22 (Needles), EOA 23 (Baker) and EOA 26 (Liberty Ambulance). Meetings will continue with the providers in these areas to negotiate contracts. Following completion of these contracts, staff will continue to work on the development of a model Memorandum of Understanding between ICEMA and public ambulance providers and public and private basic life support (BLS) ambulance providers.

REVIEW AND APPROVAL BY OTHERS: This item has been reviewed and approved by County Counsel (Charles Larkin, Deputy County Counsel, (909) 387-4177 and Alan Green, Deputy County Counsel, (909) 387-5287) on April 1, 2004. This item has also been reviewed and approved by County Administrative Office (Carol Hughes, Administrative Analyst, (909) 388-0211) on April 1, 2004.

FINANCIAL IMPACT: Approval of this item imposes no additional cost to the County. A management/monitoring fee of approximately \$400,000 will be collected annually to cover ICEMA's costs related to monitoring and enforcing the provisions of these Agreements. A separate board item will be submitted to request necessary positions to administer and monitor the performance based contracts and MOUs.

COST REDUCTION REVIEW: The County Administrative Office has reviewed this agenda item and recommends approval as it will impose no local cost to the County.

SUPERVISORIAL DISTRICT(S): All

PRESENTER: James Felten, Public Health Director, (909) 387-9146

Staff Report - EMCC

EMERGENCY MEDICAL CARE COMMITTEE ORDINANCE CHAPTER 11, SECTIONS 31.1101 - 31.1106

At the October meeting, the EMCC requested that ICEMA staff pursue a revision of the EMCC County Ordinance to incorporate additional members. Additionally, the last revision of the Ordinance was in 1992 and ICEMA has undergone administrative reporting changes which will also be incorporated into the revision.

Through discussions with County Counsel, ICEMA has been advised that since the EMCC committee is no longer a mandated committee through Health and Safety Code 1797.270 - 1797.276, the scope of work is determined by the Board of Supervisors.

Recommendation: ICEMA recommends that the EMCC remove the annual reporting of first aid and CPR training which is outlined in the Ordinance and Bylaws and provide input for a revised Scope of Work.

Denise Wicker-Stiles
01/20/11

Section

- [31.1101](#) Title.
- [31.1102](#) Definitions.
- [31.1103](#) Purpose and Scope.
- [31.1104](#) Membership, Appointment of Members.
- [31.1105](#) EMCC Meetings.
- [31.1106](#) Review of Local Operations.

§ 31.1101 Title.

This Chapter shall be known and cited as the San Bernardino County Emergency Medical Care Committee Chapter.

(Ord. 3495, passed - -1992)

§ 31.1102 Definitions.

For the purpose of this Chapter, the following terms, phrases, words, and their derivations, shall have the meaning set forth herein. Words used in the present tense include the future tense, plural words include the singular, and singular words include the plural. All references to gender shall include both masculine and feminine. Words not specifically defined shall be given their common meaning. The word “shall” is mandatory and not directory.

BOARD OF SUPERVISORS (BOARD). The Board of Supervisors for the County of San Bernardino.

COUNTY. The County of San Bernardino.

DIRECTOR. “Director” shall refer to the Executive Director of Inland Counties Emergency Medical Agency.

Deleted: The Director of the Public Health Department for the County of San Bernardino.

EMCC. The Emergency Medical Care Committee for the County of San Bernardino.

EMS. Emergency Medical Services.

EMS AUTHORITY. The EMS Authority of the State of California.

ICEMA. “ICEMA” shall refer to the Inland Counties Emergency Medical Agency, the local EMS Agency for San Bernardino County pursuant to Health and Safety Code section 1797.200.

Level I Trauma Hospital. "Level I Trauma Hospital" shall refer to a hospital designated by the Governing Board of ICEMA as having complied with the requirements of California Code of Regulations (CCR), Division 9, Chapter 7, for a Level I Trauma Hospital.

Level II Trauma Hospital. "Level II Trauma Hospital" shall refer to a hospital designated by the governing board of ICEMA as having complied with the requirements of CCR, Division 9, Chapter 7, for a Level II Trauma Hospital.

(Ord. 3495, passed - -1992)

§ 31.1103 Purpose and Scope.

It is the purpose of this Chapter to establish the County's EMCC. It is the responsibility of the EMCC to act in an advisory capacity to the Board of Supervisors, and ICEMA on all matters relating to emergency medical services and to perform such other duties as the Board of Supervisors may specify.

Deleted: as required under Health and Safety Code § 1797.270

Deleted: the local EMS Agency on all matters relating to emergency medical services,

(Ord. 3495, passed - -1992)

§ 31.1104 Membership, Appointment of Members.

(a) *Appointment.* The members of the EMCC shall be appointed by the Board of Supervisors. The members of the EMCC serve at the pleasure of the Board of Supervisors. The EMCC shall consist of the following:

- (1) An emergency department physician or trauma surgeon from a designated Level I Trauma Hospital. A Level I Trauma Hospital shall not appoint the same specialty (i.e., emergency physician or trauma physician) as a Level II Trauma Hospital.
- (2) An emergency department physician or trauma surgeon from a designated Level II Trauma Hospital. A Level II Trauma Hospital shall not appoint the same specialty (i.e., emergency physician or trauma physician) as a Level I Trauma Hospital.
- (3) A licensed registered nurse with a minimum of three (3) years' experience in an emergency department, critical care, or trauma services in a hospital located in San Bernardino County.
- (4) A fire chief with a minimum of three (3) years' experience at a Chief Officer level.
- (5) A private ambulance provider with a minimum of three (3) years' experience in the ambulance industry.
- (6) A representative of an approved EMT-P training program with a minimum of

three (3) years' teaching experience in EMS.

- (7) A hospital administrator currently employed by a hospital located within San Bernardino County with a minimum of three (3) years' related experience.
- (8) A physician with a minimum of three (3) years' practicing experience in an emergency department.
- (9) A city manager, deputy city manager, or assistant city manager with a minimum of three (3) years' experience.
- (10) A representative of a permitted/authorized air ambulance provider based in San Bernardino County with a minimum of three (3) years' experience in the air ambulance industry.
- (11) A law enforcement representative with a minimum of three (3) years' experience in law enforcement.
- (12) A representative currently assigned to emergency medical dispatching in a secondary Public Safety Answering Point (PSAP) with a minimum of (3) three years' related experience.
- (13) A consumer advocate residing in San Bernardino County.
- (14) A licensed, locally accredited field emergency medical technician -- paramedic with a minimum of three (3) years' experience in the private sector.
- (15) A licensed, locally accredited field emergency medical technician -- paramedic with a minimum of three (3) years' experience in the public sector.

(b) *Voting.* Each member of the EMCC shall have one vote. A majority vote with a quorum in attendance shall be required to take action on a matter before the EMCC. The establishment of a quorum will be determined as specified in the EMCC By-Laws.

(c) *Election of a Chairperson and Vice-Chairperson.* A Chairperson and Vice-Chairperson shall be elected annually from the voting members of the EMCC at the first meeting of each calendar year by a simple majority of the EMCC members present. The Vice-Chairperson shall assume the responsibilities of the Chairperson in his or her absence.

(d) *Term of Appointment.* Appointment shall be for four years. Terms shall expire on January 31 of the appropriate years and subsequent new terms shall begin February 1 of that year. The terms shall be staggered so that no more than two-thirds of the terms of the total number of members of the EMCC shall expire in any one-year period. Committee members shall serve at the pleasure of the Board of Supervisors and may be removed from the committee at any time only by the Board of Supervisors.

Deleted: (1) An emergency room or trauma physician;¶
(2) An EMS nurse;¶
(3) A fire chief;¶
(4) A private ambulance provider;¶
(5) A representative of an EMS training institution;¶
(6) A hospital administrator;¶
(7) A law enforcement representative;¶
(8) A representative from an emergency dispatch or communications center;¶
(9) A consumer advocate;¶
(10) A physician;¶
(11) A city manager;¶
(12) An air-ambulance provider;¶
(13) A locally accredited field Emergency Medical Technician-Paramedic.

Deleted: Seven members present shall constitute a quorum.

Deleted: The Local EMS Agency

(e) *Staff Support.* ICEMA shall provide staff support to the EMCC.

(Ord. 3495, passed - -1992)

§ 31.1105 EMCC Meetings.

The EMCC shall meet, at regular intervals necessary to fulfill its Board approved scope of operation at a time and location to be determined by the ICEMA.

(Ord. 3495, passed - -1992)

Deleted: The EMCC shall meet on the third Thursday of every month, holidays excepted, at a time and location to be determined by the EMCC.¶

§ 31.1106 Review of Local Operations.

(a) Annually review the ambulance services operating within the County; and

(b) Annually review emergency medical care offered within the County; and

(c) Review and comment on proposed EMS legislation, EMS plans, protocols and policies to be adopted by ICEMA, and shall report its findings to the ICEMA Executive Director and the Board as appropriate.

(d) The EMCC shall perform additional duties and responsibilities as directed by the Board of Supervisors, County Code, and any other duties specified in County Ordinance 31.1101 through 31.1106 and/or state laws, as well as other EMS matters.

(e) Annually report its observations and recommendations to the Board and ICEMA relative to its review of the ambulance services, emergency medical care and all other EMS matters relating to EMS in the County.

(Ord. 3495, passed - -1992)

Deleted: relating to EMS

Deleted: (a) *Annual Review.* The Emergency Medical Care Committee shall, at least annually, review the operations of each of the following:¶
(1) *Ambulance Services.* All ambulance services operating within the County;¶
(2) *MS Care.* Emergency medical care offered within the County, including programs for training large numbers of people in cardiopulmonary resuscitation and lifesaving first aid techniques; and¶
(3) *First Aid Practices.* All first aid practices within the County. ¶
(b) *Report on EMCC Observations and Recommendations.* The EMCC shall, at least annually, report, pursuant to Health and Safety Code § 1797.276, to the Board of Supervisors, the EMS Authority, and the Local EMS Agency, its observations and recommendations relative to its review of the ambulance services, emergency medical care, first aid practices, and programs for training people in cardiopulmonary resuscitation and lifesaving first aid techniques, and public participation in such programs in the County.¶
(c) *Review of the EMS Plans, Procedures and Protocols.* In addition to the responsibilities outlined above, the EMCC shall review and comment on proposed EMS legislation, EMS plans and review and comment on protocols and policies to be adopted by the Local EMS Agency, and shall report its findings to the Director and/or Board of Supervisors as appropriate.¶



BYLAWS OF
SAN BERNARDINO COUNTY
EMERGENCY MEDICAL CARE COMMITTEE

May 28, 1998

AMENDED: JANUARY, 2011

Deleted: SEPTEMBER 17, 1998

Deleted: JULY 15

ARTICLE I
AUTHORIZATION

SECTION 1: Jurisdiction

The Committee serves the geographic and political entity known as San Bernardino County.

SECTION 2: Purpose

The County's Emergency Medical Care Committee is established pursuant to the California Health and Safety Code, Chapter 2.5, Chapter 4, Article 3, Section 1797.270 through 1797.276 and San Bernardino County Ordinance No. 31.1101-31.1106. It is the responsibility of the EMCC to act in an advisory capacity to the Board of Supervisors and Inland Counties Emergency Medical Agency (ICEMA), the Local EMS Agency for San Bernardino County on all matters relating to emergency medical services, and to perform such other duties as the Board of Supervisors may specify.

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SECTION 3: Authority

California Health and Safety Code, Chapter 2.5, Chapter 4, Article 3, Section 1797.270 through 1797.276 and San Bernardino County Ordinance No. 31.1101 - 31.1106.

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Deleted: Chapter 9, Sections 1765 and 1752,

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ARTICLE II
MEMBERSHIP

SECTION 1: Appointment and Representation

a. The EMCC shall be composed of fifteen (15) members appointed by the County Board of Supervisors. The members of the EMCC shall serve at the pleasure of the Board of Supervisors. The EMCC shall consist of the following:

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(1) An emergency department physician or trauma surgeon from a designated Level I Trauma Hospital. A Level I Trauma Hospital shall not appoint the same specialty (i.e.,

- emergency physician or trauma physician) as a Level II Trauma Hospital.
- (2) An emergency department physician or trauma surgeon from a designated Level II Trauma Hospital. A Level II Trauma Hospital shall not appoint the same specialty (i.e., emergency physician or trauma physician) as a Level I Trauma Hospital.
 - (3) A licensed registered nurse with a minimum of three (3) years' experience in an emergency department, critical care, or trauma services in a hospital located in San Bernardino County.
 - (4) A fire chief with a minimum of three (3) years' experience at a Chief Officer level.
 - (5) A private ambulance provider with a minimum of three (3) years' experience in the ambulance industry.
 - (6) A representative of an approved EMT-P training program with a minimum of three (3) years' teaching experience in EMS.
 - (7) A hospital administrator currently employed by a hospital located within San Bernardino County with a minimum of three (3) years' related experience.
 - (8) A physician with a minimum of three (3) years' practicing experience in an emergency department.
 - (9) A city manager, deputy city manager, or assistant city manager with a minimum of three (3) years' experience.
 - (10) A representative of a permitted/authorized air ambulance provider based in San Bernardino County with a minimum of three (3) years' experience in the air ambulance industry.
 - (11) A law enforcement representative with a minimum of three (3) years' experience in law enforcement.
 - (12) A representative currently assigned to emergency medical dispatching in a secondary Public Safety Answering Point (PSAP) with a minimum of (3) three years' related experience.
 - (13) A consumer advocate residing in San Bernardino County.

(14) A licensed, locally accredited field emergency medical technician – paramedic with a minimum of three (3) years’ experience in the private sector.

(15) A licensed, locally accredited field emergency medical technician – paramedic with a minimum of three (3) years’ experience in the public sector.

b. Voting. Each member of the EMCC shall have one vote. A majority vote with a quorum in attendance shall be required to take action on a matter before the EMCC. The establishment of a quorum will be determined as specified in the EMCC By-Laws.

- Deleted: An emergency room or trauma physician ¶
- # An EMS nurse¶
- # A fire chief¶
- # A private ambulance provider¶
- # A representative of an EMS training institution ¶
- # A hospital administrator¶
- # A law enforcement representative ¶
- # A representative from an emergency dispatch or communications center ¶
- # A consumer advocate¶
- #>A physician¶
- #>A city manager ¶
- # An air-ambulance provider¶
- # A locally accredited field Emergency Medical Technician-Paramedic ¶

SECTION 2: ICEMA

- a. The **Inland Counties Emergency Medical Agency (ICEMA)** shall be the Liaison Agency for this **Committee**.
- b. ICEMA shall be responsible for reviewing and making recommendations as to the continuation and/or role of the Committee pursuant to County policy.
- c. ICEMA shall provide guidance to the Committee as to its responsibilities and adherence to County policy.
- d. ICEMA Executive Director shall act as “Liaison Officer” for the **Committee**.
- e. ICEMA immediately shall report to the Clerk of the **Board** of Supervisors any unscheduled vacancy.
- f. ICEMA shall determine the conflict of interest statutes, ordinances and policies applicable to the EMCC committee members (by consultation with County Counsel as necessary) and shall so advise committee members.
- g. ICEMA shall provide staff support in the preparation and distribution of agenda materials and minutes for the Committee.

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- Deleted: San Bernardino County EMS Agency
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- Deleted: and the Board of Supervisors shall fill all committee position vacancies.
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- Deleted: The staff liaison agency
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SECTION 3: Term of Office

Members’ terms of office shall be four (4) years expiring on January 31 of the appropriate years and subsequent new terms shall begin February 1 of that year. The terms shall be staggered so that no more than two thirds (2/3) of the terms of the total number of members of the EMCC shall expire in any one (1) year period. A member whose term of office has expired shall continue to serve in that capacity until a new appointment is made. Committee members shall serve at the pleasure of the Board of Supervisors and may be removed from the Committee at any time only by the Board of Supervisors.

SECTION 4: Committee Vacancies

The members of the EMCC are appointed by the Board of Supervisors. A resigning committee member shall submit his/her original written resignation to the Clerk of the Board of Supervisors (COB). ICEMA shall notify immediately the COB of any unscheduled vacancies. ICEMA will

provide the Board of Supervisors with written notification of vacancies and the Board of Supervisors will take the necessary action to declare the position vacant and fill the position.

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The absence of a committee member from two (2) consecutive meetings of the Committee shall be cause for the Chairman of the EMCC to contact the committee member to discuss participation in the meetings. Whenever a committee member fails to attend two (2) consecutive meetings or three (3) total meetings in a calendar year, without good cause entered into the minutes, the EMCC Chairman shall correspond with the Chairman of the Board of Supervisors and recommend that the committee member be removed from the Committee. Committee members serve at the pleasure of the Board of Supervisors and may be removed only by the Board of Supervisors. Without good cause shall be defined as failure to notify ICEMA of inability to attend or failure to attend after notification of planned attendance.

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SECTION 5: Quorum

The meeting will be called and a minimum of eight (8) members is required. A quorum is requisite for the transaction of any business of this Committee.

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SECTION 6: Voting

Each member as defined in Article II, Section 1 of these Bylaws shall have one (1) vote and shall not have the right to accumulate votes. A majority vote with a quorum in attendance shall be required to take action on a matter before the EMCC.

SECTION 7: Election of Chairperson and Vice-Chairperson

A Chairperson and Vice-Chairperson shall be elected annually from the voting members of the EMCC at the first meeting of each calendar year by a simple majority of the EMCC members present. The Vice-Chairperson shall assume the responsibilities of the Chairperson in his/her absence.

**ARTICLE III
MEETINGS**

SECTION 1: Regular Meetings

The EMCC shall meet, at regular intervals necessary to fulfill its Board of Supervisors approved scope of operation at a time and location to be determined by the ICEMA.

SECTION 2: Special Meetings

Special meetings may be called at the discretion of the Chairperson or at the request of a majority of the members. Committee members must be given at least ten (10) working days notice in writing of all special meetings.

Deleted: The EMCC shall meet on the third Thursday of every other month, holidays excepted, at a time and location to be determined by the EMCC
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SECTION 3: Meeting Announcements

All meetings of the Committee shall be open to the public and notices of the meeting posted in a location fully accessible to the public seventy-two (72) hours before the meeting pursuant to the Brown Act.

SECTION 4: Meeting Agendas

Meeting agendas for all scheduled committee meetings shall be transmitted in advance in writing to all committee members and other interested persons who have submitted a request in writing. Agenda items proposed for consideration at a scheduled meeting of the Committee shall be submitted to the ICEMA no later than thirty (30) working days prior to the meeting. Agendas will be prepared by ICEMA staff in cooperation with the Chairperson. Where appropriate and feasible, written backup information material should be submitted concurrently with the proposed agenda items for advance distribution to committee members. There shall be a notation on the agenda for public comments. Agendas should be mailed one (1) week prior to the next scheduled meeting.

Deleted: administrative
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SECTION 5: Meeting Commencement

All EMCC meetings will begin at precisely the time stated on the agenda. If there is no quorum at the designated starting time of the meeting, those in attendance may receive and discuss information, but no official business requiring an action by the Committee may be conducted.

Deleted: the meeting will not be conducted
Deleted: . A meeting may be held to discuss views, but no decisions can be made. ¶

SECTION 6: Rules of Order

All meetings will be governed by Robert's Rules of Order unless otherwise agreed to by the majority of the members present.

SECTION 7: Review of Bylaws

Bylaws shall be reviewed every three (3) years.

**ARTICLE IV
AD HOC COMMITTEES**

SECTION 1: Establishment and Appointment

Ad Hoc Committees may be established and appointed by the Chairperson of the EMCC. The Chairperson, with the concurrence of the Committee, shall appoint the members and the chair of the Ad Hoc Committee(s) Regular, ex officio and non-members may be appointed to the Ad Hoc Committee(s). Only appointed members of the Committee can vote on a decision to be presented to the Committee at Large.

SECTION 2: Assignments

The Chairperson will define in precise terms the assignment to be completed providing a definitive timeframe for reporting to the Committee. The Ad Hoc Committee will be dissolved once the assignment is completed and a report is submitted for consideration to the Committee.

ARTICLE V

COMMITTEE RESPONSIBILITIES

SECTION 1: The Committee shall perform duties as outlined in County Ordinance No. 31.1101-31.1106 as follows:

Deleted: stated in the Health and Safety Code, Section 1797.276 and

- (a) Annually review the ambulance services operating within the County; and
(b) Annually review emergency medical care offered within the County; and
(c) Review and comment on proposed EMS legislation, EMS plans, protocols and policies to be adopted by ICEMA, and shall report its findings to the ICEMA Executive Director and the Board as appropriate.
(d) The EMCC shall perform additional duties and responsibilities as directed by the Board of Supervisors, County Code, and any other duties specified in County Ordinance 31.1101 through 31.1106 and/or state laws, as well as other EMS matters.
(e) Annually report its observations and recommendations to the Board and ICEMA relative to its review of the ambulance services, emergency medical care and all other EMS matters relating to EMS in the County.

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Deleted: a. Annually review the ambulance services operating within the County; and
Deleted: b. Annually review emergency medical care offered within the County, including programs from training large numbers of people in cardiopulmonary resuscitation and lifesaving first aid techniques; and
Deleted: c. Annually review first aid practices within the County; and
Deleted: d. Annually report its observations and recommendations to the Board of Supervisors, the State EMS Authority,

SECTION 2: Additional duties and responsibilities

The EMCC shall perform additional duties and responsibilities as directed by the Board of Supervisors, County Code, and any other duties specified in County Ordinance 31.1101 through 31.1106 and/or state laws, as well as other EMS matters relating to EMS.

Deleted: the Health Officer

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ARTICLE VI
STANDARDS OF ETHICS AND CONDUCT

SECTION 1: County Policies

Committee members shall comply with the current policies approved by the Board of Supervisors.

Deleted: Local EMS agency relative to its review of the ambulance services, emergency medical care, first aid practices, and programs for training people in cardiopulmonary, resuscitation and lifesaving first aid techniques, and public participation in such programs in the County.

Deleted: e. Review and comment on proposed EMS legislation, EMS plans, protocols and policies to be adopted by, the local EMS agency, and shall report its findings to the

SECTION 2: Responsibilities of Public Office

Individuals appointed to the Committee are agents of the public and serve for the benefit of the public. They shall uphold and act in accordance with the Constitution of the United States, the Constitution of the State of California, the Charter of the County of San Bernardino, and ordinances, rules regulations, and policies of the County.

Deleted: County Health Officer and/or

Deleted: the Board of Supervisors as appropriate.

Deleted: San Bernardino County Board

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ARTICLE VII
AMENDMENT TO BYLAWS

SECTION 1: Adoption of Bylaws

The proposed Bylaws shall be circulated to the Committee in writing at least thirty (30) days in advance of the meeting at which a vote may be called.

Deleted: Ambulance Ordinance, the EMS Transportation Plan for San Bernardino County, and any subsequent

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SECTION 2: Required Vote for Adoption

The Bylaws of the Committee shall be adopted if approved by a majority of the voting committee members and approved by the Board of Supervisors.

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SECTION 3: Proposed Amendments

Proposed Bylaw amendments shall be circulated to the Committee in writing at least thirty (30) days in advance of the meeting at which a vote may be called.

SECTION 4: Required Vote for Adoption of Amendments

The Bylaws of the Committee may be amended if approved by a majority of the voting Committee members and approved by the Board of Supervisors.

Deleted: Board



ICEMA

Quality Improvement Plan

**DRAFT
9/30/2010**

TABLE OF CONTENTS

	Page
INTRODUCTION	3
SECTION I - ORGANIZATION & STRUCTURE DESCRIPTION	4
I. ORGANIZATION	4
A. Organizational Chart	4
B. Mission Statements	4
C. Goals of the Quality Improvement Process	5
II. STRUCTURE	6
A. ICEMA CQI Team	6
B. ICEMA's Duties	6
C. Description of Committees	7
1. Medical Advisory Committee	7
2. Central Continuous Quality Improvement Committee	7
3. Regional Continuous Quality Improvement Committees	8
4. STEMI Continuous Quality Improvement Committee	9
5. Trauma System Advisory Committee	9
6. Trauma and Air Audit Committee	10
D. Term of Committee Memberships	10
E. Attendance	10
F. Chairperson	11
G. Voting	11
H. Alternate Members	11
I. Minutes	11
J. Responsibilities	12
K. Confidentiality	12
III. PARAMEDIC BASE STATION REQUIREMENTS	13
A. QUALITY IMPROVEMENT INFORMATION AND DATA REQUIREMENTS	14
1. Structure	14
2. Responsibilities	14
3. Annual Reports	15
B. REVIEW OF PATIENT CARE DATA	15
1. Mobile Intensive Care Nurse Report	15
2. Base Station Wave Reviews	16
3. Concurrent/Retrospective Clinical Review Report	16
4. Base Station Statistics	16
5. Case Review Reports	16
6. Radio Communications Failure Reports	17
7. Quarterly Reports	17

	Page
IV. EMERGENCY MEDICAL SERVICE PROVIDER	18
A. QUALITY IMPROVEMENT INFORMATION AND DATA REQUIREMENTS	18
1. Structure	18
2. Responsibilities	19
3. Annual Reports	20
B. ALS STAFFING REQUIREMENTS AND RESPONSIBILITIES	20
1. ALS Provider Agency Medical Director Guidelines	20
2. ALS Provider Agency Medical Director Responsibilities	20
3. ALS Provider Agency Quality Improvement Coordinator Requirements	21
4. ALS Provider Agency Quality Improvement Coordinator Responsibilities	21
C. REVIEW OF PATIENT CARE DATA	21
1. ALS Run Report Forms	21
2. Concurrent and Retrospective Clinical Review Topics	22
3. ALS Provider Agency Log	22
V. CASE REVIEW FORMS/CASE REVIEW CONFERENCE	23
A. Initiating a Case Review	23
B. Conducting a Case Review	23
C. Conducting a Case Review Conference	24
1. Responsible Receiving Party	24
2. Review of Information	24
3. Plan of Action	25
4. Disciplinary Action Needed	25
SECTION II - DATA COLLECTION AND REPORTING	26
SECTION III - EVALUATION OF INDICATORS	28
SECTION IV - ACTION TO IMPROVE	28
I. FOCUS-PDSA	28
II. MEETINGS	29
SECTION V - TRAINING AND EDUCATION	30
SECTION VI - ANNUAL UPDATE	30

INTRODUCTION

In 1991, the California Emergency Medical Services Authority (EMSA) promulgated legislation which mandated that local Emergency Medical Services (EMS) agencies establish a system-wide quality assurance program. This legislation requires Advanced Life Support (ALS) service providers and base stations to develop and implement a quality assurance program approved by Inland County Emergency Medical Agency (ICEMA).

On January 1, 2006, EMSA implemented regulations related to quality improvement for EMS throughout the State. ICEMA's Continuous Quality Improvement Program (CQIP) satisfies the requirements of Title 22, Chapter 12, Section 4 of the California Code of Regulations.

Continuous Quality Improvement (CQI) is an ongoing process in which all levels of health care are encouraged to team together, without fear of management repercussion, to develop and enhance the EMS system. Based on EMS community collaboration and a shared commitment to excellence, CQI reveals potential areas for improvement of the EMS system, training opportunities, highlights outstanding clinical performance, audits compliance of treatment protocols and allows the review of specific illnesses or injuries and their associated treatments. This program contributes to the continued success of our emergency medical services system through a systematic process of review, analysis and improvement.

CQI implements the principles of quality improvement by defining standards, monitoring the standards and evaluating their effectiveness. It places increased emphasis on the processes of care and service rather than on the performance of individuals. It also emphasizes the role of leadership in continuous quality improvement rather than only on solving identified problems and maintaining improvement over time.

The by-product of the program is the alliance of municipal agencies and private providers that offer EMS within the ICEMA region. This provides all participants the opportunity to provide optimal service and to provide input and support to an EMS system in which they have ownership.

The ICEMA CQIP has been written in accordance with the Emergency Medical Services System Quality Improvement Program Model Guidelines #166 (Rev. 03/04).

PURPOSE

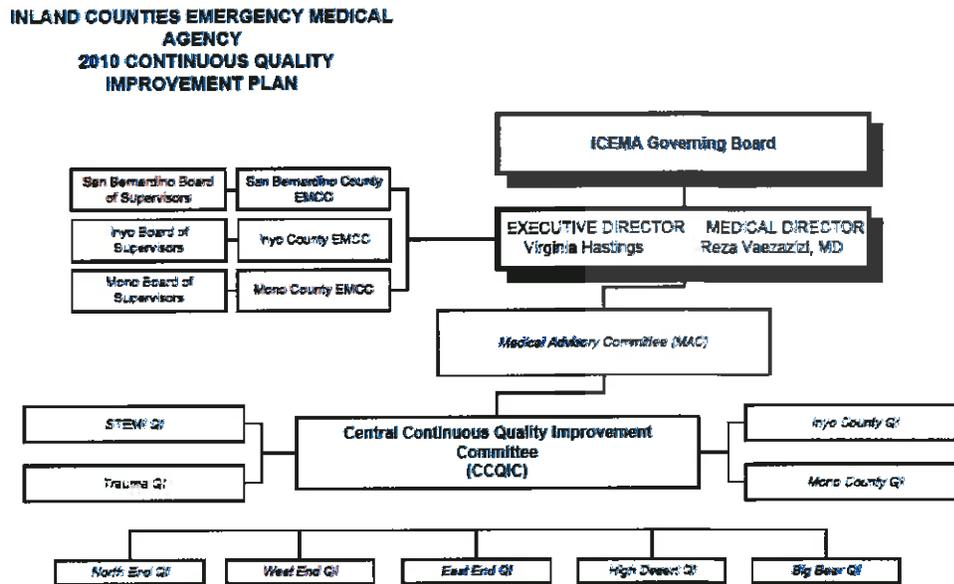
The purpose of the ICEMA CQIP is to establish a system-wide process and provide an effective tool for evaluating and improving the quality of prehospital care within the ICEMA region. This tool will focus on improvement efforts to identify root causes of problems and interventions to eliminate or reduce those problems. While striving to improve the system, the CQIP will also recognize excellence in performance and service to the stakeholders.

SECTION I - STRUCTURE & ORGANIZATIONAL DESCRIPTION

I. ORGANIZATION

ICEMA is a three county Emergency Medical Services Agency serving the counties of San Bernardino, Inyo, and Mono counties. The three counties largely provide advanced life support and basic life support services.

A. Organizational Chart



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B. Mission Statements

ICEMA

ICEMA is tasked with ensuring an effective system of quality patient care and coordinated emergency medical response by planning, implementing and evaluating an effective EMS system including prehospital providers and specialty care hospitals.

CQI

The CQI mission is to promote the highest level of quality in prehospital care within the ICEMA region by providing CQI, education, monitoring tools and anticipatory planning.

C. Goals of the Continuous Quality Improvement Program

1. Empower EMS providers to provide consistently the highest quality of emergency medical care in the ICEMA region.
2. Provide leadership and guidance in promoting quality in the local EMS system with the cooperation of EMS providers in an educational and non-punitive environment.
3. Develop leadership to create an acceptance and belief in quality improvement and educate provider management regarding the importance of the commitment to quality improvement.
4. Provide leadership in developing programs that implement the CQI process by providing examples of high quality training and educational resources.
5. Develop and provide an atmosphere of encouragement and support that promotes excellence and personal accountability to provider personnel in all levels of management and field staff.
6. Create constancy in the CQI process to maximize efficiency and effectiveness in each EMS provider organization.
7. Promote rapid and appropriate quality treatment of all patients regardless of economic or social status in the quickest and most efficient manner possible.
8. Evaluate the benefits of new programs and procedures to provide “State of the Art” health care within the ICEMA region.
9. Provide a conduit for communication between EMS providers and other agencies to positively resolve issues in addition to providing education and encouraging growth within the EMS system.

II. STRUCTURE

A. ICEMA CQI Team

1. ICEMA is responsible for the oversight and implementation of the regional CQIP, data collection and evaluation of the EMS system in the region.
2. ICEMA CQI Team will function with direction and under the auspices of the Medical Director and Executive Director. This team shall include an educational coordinator, QI Coordinator, data analyst, ICEMA Medical Director and Executive Director.

B. ICEMA's Duties

Shall include but not be limited to:

1. Serve as the central repository of data gathered from CQI activities.
2. Provide an annual review of the CQIP for compatibility to the system and update, if needed.
3. Facilitate a performance improvement action plan with the cooperation of the appropriate EMS providers when the CQIP recognizes a need for improvement. EMS system clinical issues will require ICEMA Medical Director involvement.
4. Provide information to EMS provider advisory groups to assist in the development of performance improvement plans.
5. Work in conjunction with the EMSA to:
 - Participate in the EMSA Technical Advisory Group.
 - Assist with the responsibilities of the state-wide CQIP.
 - Assist in development, approval and implementation of State required and optional EMS system indicators.
6. Provide monitoring, data collection, reporting and evaluation of EMS system indicators from EMS providers and hospitals in the ICEMA region.
7. Identify and develop specific indicators for system evaluation based on the unique needs of the ICEMA region.
8. Annually review, expand on and improve State and local EMS system indicators as needed.

9. Provide opportunities for review of QI indicators and performance improvement plans by designated EMS providers.
10. Provide technical assistance, training and in-service education to all organizations participating in the ICEMA CQIP.
11. Provide an annual summary of activity and CQIP implementation. The summary will be provided annually to the EMSA and should include but not limited to a summary of QI indicators.

C. Description of Committees

1. Medical Advisory Committee

The Medical Advisory Committee (MAC) will function under the direction of the ICEMA Medical Director. The ICEMA Medical Director shall serve as chair and may appoint an alternate chair in his absence. The members shall have education and experience in EMS systems and regional prehospital care. This committee meets quarterly. The members shall be multidisciplinary and include the following:

- Base Station Physician
 - Trauma Base Physicians (2 representatives)
 - Non Trauma Base Physicians (2 representatives)
- Non Base Station Physician
- Public Transport Medical Director
- Private Transport Medical Director
- Fire Department Medical Director
- Ambulance Association Representative
- EMS Nurses Representative
- EMS Officers Representative
- Inyo County Representative
- Mono County Representative

2. Central Continuous Quality Improvement Committee

The Central Continuous Quality Improvement Committee (CCQIC) will function under the direction of the ICEMA Medical Director and Executive Director. The members shall have education and experience in evaluation of EMS data systems and EMS QI program management. The members will participate in monitoring and evaluating the CQIP. This committee meets quarterly. The members shall be multidisciplinary and include the following:

- ICEMA Medical Director
- ICEMA Executive Director
- ICEMA Representative(s)
 - CQI Program Coordinator

- Educational Coordinator
- Data Program Coordinator
- Regional Continuous QI Committee Members (7, one from each committee)
- EMS Service Provider Medical Director (2)
(one public and one private provider representative)
- Base Station Medical Director (2)
(one Trauma Center and one non-Trauma Center)
- EMS Provider QI Program Coordinator (2)
(one public and one private provider representative)
- Paramedic Training Program Representative (2)
 - Crafton Community College
 - Victor Valley Community College
- Base Station Nurse Coordinator (2)
(one Trauma Center Paramedic Liaison Nurse (PLN) and one non-Trauma Center PLN)
- Nurse from a non-base STEMI Center
- Representatives from 9-1-1 receiving facilities emergency department representatives (2)
(Non Base Station)
- EMT and EMT-P Representative
Certified/licensed personnel accredited within ICEMA (2)
(one public and one private provider representative)

3. Regional Continuous Quality Improvement Committees

Due to the size of the ICEMA region, QI Committees are regionalized under the umbrella of the CCQIC. The Regional CQI Committees (RCQIC) function under the direction of the ICEMA Medical Director and Executive Director. The members shall have education and experience in the evaluation of EMS data system and CQIP management. The members will participate in monitoring the process as it unfolds within the system. These committees meet monthly. The members shall be multidisciplinary and include the following established committees:

- West End CQI Committee
- East End CQI Committee
- North End CQI Committee
- Big Bear CQI Committee
- Hi Desert CQI Committee (Joshua Tree/29 Palms)
- Inyo County CQI Committee
- Mono County CQI Committee

4. **STEMI CQI Committee**

The STEMI CQI Committee (STCQIC) functions under the direction of the ICEMA Medical Director and Executive Director. The members will have education and experience in the evaluation of Cardiovascular QI program management. The members will participate in ongoing monitoring and evaluation of the ICEMA STEMI program as it unfolds in the system. This committee meets quarterly. The members shall be multidisciplinary and include the following:

- ICEMA Medical Director
- ICEMA Executive Director
- ICEMA Representative(s)
 - STEMI CQIP Coordinator
 - Educational Coordinator
 - Data Program Coordinator
- STEMI Center Medical Director(s)
(One from each facility either ED Director or Cath Lab Director, or their designee)
- Base Station Medical Director (2)
(one STEMI center and one non-STEMI center)
- EMS Provider CQI Program Coordinator (2)
(one public and one private provider representative)
- Base Station Nurse Coordinator (2)
(one STEMI center PLN and one non-STEMI center PLN)
- Representatives from local receiving facilities emergency department physicians (2)
(Non STEMI center)
- Representative Advanced Life Support (ALS) Providers Certified/licensed personnel accredited within ICEMA (2)
(one public and one private provider representative)
- Cath Lab Nursing Directors or designee

5. **Trauma System Advisory Committee**

The Trauma System Advisory Committee (TSAC) monitors trauma related care and system related issues, including air utilization. TSAC also serves as the prehospital and hospital medical care and system advisory committee. This committee meets quarterly.

TSAC functions under the direction of the ICEMA Medical Director and Executive Director. TSAC members will have education and experience in the management and evaluation of the Trauma QIP. The members will participate in ongoing monitoring and evaluation of the Trauma QIP. The members shall be multidisciplinary and include the following:

- ICEMA Medical Director
- ICEMA Executive Director

- ICEMA Representative(s)
 - Trauma Coordinator
 - Educational Coordinator
 - Data Program Coordinator
- Trauma Center Medical Director(s)
(one from each trauma center)
- Pediatric Trauma Attending(s)
(one from each trauma center)
- Base Station Medical Director (2)
(one from a trauma center and one from a non-trauma center)
- Non-Trauma Center Emergency Department Physicians
(with an interest in trauma care)
- Trauma Center Coordinator (2)
 - ARMC
 - LLUMC (Adult)
 - LLUMC (Pediatric)
- Trauma Center PLNs
(one from each trauma center)
- EMS CQI Program Coordinators
- Prehospital Personnel
 - Fire Chief's Association Representative
 - Ambulance Representative
 - Air Rescue Representative
 - Coroner or Representative

6. Trauma and Air Audit Committee

ICEMA participates in a joint San Bernardino County and Riverside County Quality Improvement committee called Trauma and Air Audit Committee (TAAC). TAAC is a closed, regional QI committee addressing multi-county system and medical issues. This committee meets quarterly. The TAAC committee is comprised of representatives from both San Bernardino and Riverside Counties:

- Riverside EMS Agency Representatives
- ICEMA Representatives
- Medical Directors (ED/Trauma and non-trauma hospital)
- Nurse Managers (ED/Trauma and non-trauma hospital)
- Trauma Hospital Paramedic Liaison Nurses (PLNs)

D. Term of Committee Memberships

Term of Membership shall be two (2) years expiring December 31 and subsequent new terms shall begin January 1. The terms shall be staggered so that no more than two-thirds of the membership shall expire in any one-year period. A member whose term has expired shall continue to serve until a new appointment is confirmed. Members may be reappointed.

E. Attendance

1. Members will notify ICEMA in advance of any scheduled meeting they will be unable to attend.
2. At the discretion of ICEMA, other individuals may participate in the meetings when their expertise is essential to make appropriate determinations.
3. The absence of a committee member from two (2) consecutive meetings of the committee shall be cause for the Chairman to contact the committee member to discuss participation in the meetings. Whenever a committee member fails to attend two (2) consecutive meetings or three (3) total meetings in a calendar year, without good cause, the Chairman shall discuss with the committee and recommend the members removal from the committee.
4. Resignation from the committees must be submitted, in writing, to ICEMA, and is effective upon receipt, unless otherwise specified.

F. Chairperson

The ICEMA Medical Director shall serve as chair of the CCQIC. Other committees will allow nominations and voting for a Chairperson and a Co-Chairperson. The term of elected members will be for two (2) years.

G. Voting

Due to the advisory nature of these committees, many issues will require input rather than a vote process. Vote process issues will be identified as such by the Chairperson. When voting is required, a simple majority of the members present will constitute a quorum. The chair will break any tie vote.

H. Alternate Members

Alternate members may serve as a representative of an appointed member in the event that an appointed member is unable to attend scheduled meetings due to conflict in scheduling and/or illness. The appointed member must designate in writing the alternate member to serve in his/her absence. The written notice must be submitted to and approved by ICEMA at least five (5) working days prior to a scheduled meeting. Alternate members shall not be utilized on a regular basis.

I. Minutes

Minutes will be kept by a designee from ICEMA and distributed to the members prior to each meeting. Due to the potential need for confidentiality, certain documents may be collected by the ICEMA staff at the close of each meeting and no copies may be made or processed by members of the committee without written consent from ICEMA.

J. Responsibilities

1. If a representative is unable to attend a meeting, he or she is responsible to appoint an alternate for attendance and representation as mentioned above under “Alternate Members”.
2. Disseminate non-confidential information, as appropriate, and discuss at meetings to the represented groups.
3. Determine indicators for system evaluation based on EMS QI indicators and identify and develop other indicators as deemed necessary.
4. Re-evaluate and improve locally developed EMS system indicators annually or as needed.
5. Establish a mechanism to incorporate input from EMS provider advisory groups for the development of performance improvement CQIP templates.
6. Recommend the chartering of RCIQCs and review of their reports.
7. Seek and maintain relationships with all EMS participants including, but not limited to:
 - State EMSA
 - Other Local EMS Agencies (LEMSAs)
 - EMS Service Providers
 - Local Departments of Public Health
 - Specialty Care Centers
 - Law Enforcement
 - Public Safety Answering Points (PSAPs)
 - Dispatch Centers
 - Constituent Groups

K. Confidentiality

All proceedings, documents and discussion of the committees are confidential and are covered under Sections 1040, 1157.5, and 1157.7 of the Evidence Code of the State of California. The prohibition relating to the discovery of testimony provided to the committees shall be applicable to all proceedings and records of this group, which is established by a local government agency as a professional standards review organization. This organization is designed in a manner which makes available professional competence to monitor, evaluate, and report on the necessity, quality, and level of specialty health services, including but not limited to prehospital care services. Guests may be invited to discuss specific issues in order to assist in making final determinations. Guests may only be present for the portion (s) of the meeting about which they have been requested to review or testify.

All members shall sign a confidentiality agreement not to divulge or discuss information that would have been obtained solely through committee membership. Prior to the invited guests participating in the meeting, the Chairperson is responsible for explaining and obtaining a signed confidentiality agreement for invited guests.

III. PARAMEDIC BASE STATION REQUIREMENTS

A. QUALITY IMPROVEMENT INFORMATION AND DATA REQUIREMENTS

The Base Station CQIP should involve all EMS system participants including, but not limited to dispatch agencies, ALS and BLS service providers, receiving hospitals and specialty care hospitals.

1. Structure

The Base Station CQIP shall be reviewed by ICEMA for compatibility with the State CQIP guidelines. The organizational chart should reflect the integration of the CQIP in the organization.

Listed below are minimum requirements of Base Station CQIP:

- a. A CQI Team under the direction of the Base Station Medical Director. Lead staff should have expertise in management of the Base Station's CQIP. The following staffing positions are identified (note: organizations with limited resources may combine positions):

- Base Station Medical Director (or designee)
- EMS QI Program Coordinator
- Data Specialist

NOTE: Availability of resources can vary greatly between urban and rural facilities. It is understood that there are variances in staffing and staff responsibilities.

- b. An internal CQIP Technical Advisory Group with members, which include but are not limited to:

- Base Station Medical Director
- Prehospital Liaison or Equivalent
- Base Station Mobile Intensive Care Nurse (MICN)

2. Responsibilities

The Base Station CQI Team should be a primary source of EMS activity reporting for state-wide and regional EMS system indicators. The Base Station CQIP will perform the following functions:

- a. Cooperate with ICEMA in carrying out the responsibilities of the ICEMA CQIP and participate in the ICEMA CQI process.

- b. Cooperate with ICEMA in the implementation of State required EMS system indicators.
- c. Cooperate with ICEMA in monitoring, collecting data, and evaluating State required and ICEMA EMS system indicators.
- d. Cooperate with the EMSA and ICEMA in the re-evaluation and improvement of State and local EMS system indicators.
- e. Participate in meetings for internal review of Base Station indicators and development of performance improvement programs related to the findings.
- f. Establish a mechanism to incorporate input from ICEMA, service providers and other hospitals for the development of performance improvement programs.
- g. Assure reasonable availability of CQIP training and in-service education for Base Station personnel.
- h. Prepare plans for expanding or improving the Base Station CQIP.
- i. Provide technical assistance to all EMS provider's CQIPs in the Base Station's jurisdiction.

3. Annual Reports

Base Stations must maintain on-going records ensuring compliance to the requirements set forth in the CQIP. This monitoring system should provide a standardized guideline for the assessment, identification, evaluation, feedback and implementation of changes to meet the needs of the EMS system.

B. REVIEW OF PATIENT CARE DATA

1. Mobile Intensive Care Nurse Report

A minimum of 30 (or the total if <30) randomly selected MICN reports with waveforms, or 10%, whichever is greater, will be reviewed monthly by the PLN and/or Base Station Medical Director, or designated peer review staff, for the following:

- a. Complete documentation.
- b. Prehospital patient care treatment orders.
- c. Compliance with ICEMA protocols.

2. Base Station Wave Reviews

All waves that fall into the following categories must be reviewed for determination of cause and must be logged and included in the quarterly report submitted to ICEMA:

- a. A case review request is submitted.
- b. Any call where a physician has ordered an EMT-P to administer a medication or perform a skill that is out of his scope of practice, or in deviation with protocol.
- c. Runs involving internal disaster or trauma diversion.
- d. High profile cases.

3. Concurrent/Retrospective Clinical Review Report

The CCQIC may select a clinical topic on a quarterly basis to be audited by the Base Stations and provider agencies. Examples are cardiac arrest, head trauma and respiratory distress patients. The audit may be used to evaluate efficacy of prehospital care in relation to the topic chosen, utilizing data obtained from electronic patient care records (e-PCRs). Examples may include timely administration of ACLS medications, documentation of responses to the administration of medications and/or procedures. This report will be forwarded to ICEMA and may be used to determine recommendations to the ICEMA Medical Director regarding the appropriateness of certain drugs, equipment, procedures, etc., for improvement in the delivery of quality patient care in the EMS system.

4. Base Station Statistics

Base Stations are required to keep on-going statistics for periodic review by the EMS agency staff. Requirements for documentation in this log are included in the Base Station Statistics Policy and Base Station Data Collection Tool. Monthly reports shall be submitted as required by ICEMA.

5. Case Review Reports

A confidential file of case review reports will be maintained by the PLN and/or Base Station Medical Director. Documentation should include the case review report and any other pertinent data. The case review report is confidential information and will not be reviewed by anyone other than ICEMA's designated staff, the involved parties and/or their immediate supervisors without prior written notification. See QI Form 008, 009 and 010.

The laws protecting the discoverability of information received through the quality assurance process state very clearly that information must be maintained in a confidential manner. Breaches that result in loss of the confidentiality of these records allow the information to be accessible to

discoverability and seriously jeopardize the quality assurance/quality improvement process. All case review records must be kept in a confidential file and maintained to protect all parties involved.

6. Radio Communication Failure Reports

The Base Station Medical Director or PLN will be required to report any radio equipment failures to ICEMA within 72 working hours. See QI Form 001.

7. Quarterly Reports

Quarterly reports must include all relevant information and be forwarded to ICEMA at the first of every quarter (the first of January, April, July and October). Requirements for these reports are illustrated in the Quarterly Report Form. See QI Form 007.

IV. EMERGENCY MEDICAL SERVICE PROVIDER

A. QUALITY IMPROVEMENT INFORMATION AND DATA REQUIREMENTS

The EMS Provider's CQIP should involve EMS system participants including but not limited to dispatch agencies, ICEMA, training programs, hospitals, specialty care centers and other EMS service providers. A regional approach, with collaboration between EMS service providers serving neighboring communities, is highly recommended.

CQIP's should include indicators, covering the areas listed in the California Code of Regulations, Title 22, Chapter 12 of the Emergency Medical Services System Quality Improvement Program, which address, but are not limited to, the following:

- Personnel
- Equipment and Supplies
- Documentation and Communication
- Clinical Care and Patient Outcome
- Skills Maintenance/Competency
- Transportation/Facilities
- Public Education and Prevention
- Risk Management

Indicators should be tracked and trended to determine compliance with their established thresholds as well as reviewed for potential issues. Indicators should be reviewed for appropriateness on a quarterly basis with an annual summary of the indicators performance. Air Medical Providers may reference **CAMTS** to identify potential indicators they may wish to implement in their system.

ALS Provider agencies must maintain on-going records ensuring compliance to the requirements set forth in the CQIP. This monitoring system should provide a standardized guideline for the assessment, identification, evaluation, feedback and implementation of changes to meet the needs of the EMS system.

1. Structure

The EMS Provider's CQIP shall be reviewed and approved by ICEMA for compatibility with the guidelines.

The organizational chart shall reflect the integration of the CQIP in the organization. The EMS Provider's CQIP should include the following:

- a. An EMS CQI Team under the direction of the EMS Provider's Medical Director or EMS Administrator. Lead staff should have

expertise in management of the EMS provider's CQIP. The following staffing positions are identified:

- EMS Provider's Medical Director or designee having substantial experience in the practice of emergency medicine. A practicing ED physician or a physician practicing in emergency medical care is highly recommended.
- QI Program Coordinator
- Data Specialist

NOTE: Availability of resources can vary greatly between urban and rural agencies. It is understood that there are variances in staffing and staff responsibilities (organizations with limited resources may combine positions).

- b. An internal CQI Technical Advisory Group with members including, but not limited to:
- EMS Provider's Medical Director or designee having substantial experience in the practice of emergency medicine. A practicing ED physician or a physician practicing in emergency medical care is highly recommended.
 - Chief/EMS Administrator or designee.
 - QI Program Coordinator.
 - Service Personnel (Physicians, RNs, Paramedics, EMTs).
 - Other system participants.

2. Responsibilities

The EMS Provider's CQIC should be the primary source of CQIP activity reporting for state-wide and local EMS system information. The EMS Provider's CQIC will perform the following functions:

- a. Cooperate with ICEMA in carrying out the responsibilities of ICEMA's CQIP and participate in ICEMA's CCQIC.
- b. Cooperate with ICEMA in the implementation of State required EMS system indicators.
- c. Cooperate with ICEMA in monitoring, collecting data, and evaluating the State and regional/local EMS system indicators, both required and optional.
- d. Cooperate in the re-evaluation and improvement of State and local EMS system indicators.

- e. Conduct meetings for internal review of EMS provider information and development of performance improvement programs related to the findings.
- f. Establish a mechanism to receive input from ICEMA, other service providers and other EMS system participants for the development of performance improvement programs.
- g. Assure routinely scheduled CQIP training and in-service education for EMS provider personnel.
- h. Prepare plans for expanding or improving the EMS Provider's CQIP.
- i. Participate in meetings and presentations of state and local EMS system information for peer review to local designated advisory groups and other authorized constituents.

3. Annual Reports

The EMS Provider's CQI Team will annually publish summary reports of CQIP activity for distribution to ICEMA and other groups as determined.

B. ALS STAFFING REQUIREMENTS AND RESPONSIBILITIES

1. ALS Provider Agency Medical Director Guidelines

Shall be a physician licensed in the State of California with experience in emergency medical care. Must be knowledgeable of the policies, protocols, and procedures set forth by ICEMA.

2. ALS Provider Agency Medical Director Responsibilities

- a. Demonstrate management's commitment and dedication to the goals outlined in the CQIP by serving as a team leader for the organization, providing educational opportunities, training, support and encouraging communication of skills to facilitate the team building network.
- b. Shall be responsible for coordinating and implementing an approved provider agency CQIP that focuses on the opportunity for improvement as well as identification and prevention of potential concerns within the organization, implements resolutions to these problems and evaluates the outcome, as well as provides the positive recognition when an opportunity is provided.
- c. Shall provide a written operational protocol manual for approval by ICEMA (applies only to Air Transport Teams utilizing flight nurses in the EMS region).

3. ALS Provider Agency Quality Improvement Coordinator Requirements

Each ALS provider agency shall have a CQI Coordinator. This person shall be either: 1) a physician, registered nurse or physician assistant that is licensed in California and has experience in emergency medicine and emergency medical services or 2) a paramedic who is or has been licensed in California within the last two (2) years and who has at least two (2) years experience in prehospital care.

4. ALS Provider Agency Quality Improvement Coordinator Responsibilities

- a. Shall act as a liaison between the prehospital personnel and the Base Station Medical Director, PLN, ED physician, other provider agencies and ICEMA.
- b. Shall initiate, implement and evaluate the agency's quality improvement program.
- c. Shall be responsible for monitoring documentation of program operations within the agency, as required for evaluation by ICEMA.
- d. Shall monitor EMS personnel compliance to policies, procedures and protocols and ability to function within the scope of practice.
- e. Shall demonstrate management's commitment and dedication to the goals outlined in the CQIP by serving as a team leader when providing training and educational opportunities, encouragement, support and communication skills to promote an EMS system that delivers the best available patient care.
- f. Shall participate in their regional CQI committees and Base Station CQI process.

C. REVIEW OF PATIENT CARE DATA

1. ALS Run Report Forms

A minimum of thirty (or the total if <30) randomly selected ALS runs, or 10 %, whichever is greater, must be reviewed each month by the CQI Coordinator or by the designated peer review staff for at least the following:

- a. Complete documentation.
- b. Ordering of prehospital patient care treatment.
- c. Compliance with protocols.

- d. Response times and prolonged on-scene times
- e. E.T. attempts and placement.
- f. MCI as defined by Protocol Ref. #5050, Multi-Incident Operational Procedures (review with Paramedic PLM).
- g. Proper documentation of Against Medical Advice (AMA) forms (review with PLN).

2. Concurrent and Retrospective Clinical Review Topics

The ICEMA Regional CQIC may select a clinical topic on a quarterly basis to be audited by the Base Station and ALS Provider agencies; examples; cardiac arrest patients, patients with head trauma, respiratory distress patients. The audit may be used to evaluate efficacy of prehospital care in relation to the topic chosen (utilizing data obtained from e-PCRs). Examples of this may include: timely administration of ACLS drugs, documentation of responses to the administration of medications and/or procedures. These reports will be forwarded by the Base Station to the committee and may be used to determine recommendations to the ICEMA Medical Director.

3. ALS Provider Agency Log

ALS Provider agencies will be required to keep an on-going log for periodic review by ICEMA. Requirements for documentation in this log are spelled out in the Quality Improvement Log Form. See QI Form 005.

A confidential file of case review reports will be maintained by the Provider Agency CQI Coordinator and/or ALS Provider Agency Medical Director in accordance with specifications under CASE REVIEW FORMS, Section IV. Documentation should include the case review report and any pertinent data. This is confidential information and will not be reviewed by anyone other than ICEMA's designated staff, the involved parties and/or their immediate supervisors.

V. CASE REVIEW FORMS/CASE REVIEW CONFERENCE

A. INITIATING A CASE REVIEW

To request that a call be reviewed, a Case Review Form must be initiated, and forwarded to the QI Coordinator, ALS Provider Agency Medical Director, PLN or Base Station Medical Director. The report should be forwarded to the person responsible for reviewing the incident within the agency or facility. For example, if an EMT-P initiates a report, EMT-P should forward it to the agency QI Coordinator for review. If an MICN initiates a report, MICN should forward the report to the PLN. See QI Form 008.

A Case Review Form may be initiated by any physician, MICN, EMT-P, or EMT, who feels that any of the following have occurred:

- Treatment/action resulting in positive patient outcome.
- Patient care related to an adverse patient outcome.
- Deviation from ICEMA treatment protocols.
- Conflicts with existing State law and/or ICEMA policy.
- Situations that pose a threat to the safety of patients or providers of prehospital care.
- Situations that serve as an educational tool for EMS providers.

When the request involves the QI Coordinator, PLN or Medical Director normally responsible for the initiation of the case review form, the request should be forwarded to ICEMA.

If there is any doubt as to who is the responsible reviewing party, ICEMA will provide direction.

B. CONDUCTING A CASE REVIEW

Upon receipt of a Case Review Form, the person responsible for the investigation shall:

- Review the EMS patient care record, MICN record, Base Station wave, and the patient outcome records (if applicable).
- Collect statements from the involved personnel if needed to determine action necessary.
- Establish the need for further action.
- Involve the appropriate agency representatives (i.e., ALS Provider Agency QI Coordinator should contact the PLN and Base Station Medical Director if determination of further action is necessary).
- Conduct a Case Review Conference, if necessary. See QI Form 010.

C. CONDUCTING A CASE REVIEW CONFERENCE

1. Responsible Reviewing Party

The responsible reviewing party shall notify the appropriate personnel and determine a time and date that the Base Station Medical Director, PLN and all involved personnel can attend the Case Review Conference (CRC). A CRC must be done within thirty (30) days of the decision to conduct a CRC unless it meets the exception criteria.

Exception Criteria:

- a. Involved personnel could not be contacted (written explanation required in summary).
- b. Documents needed for review could not be gathered in this time frame (explanation must be included in summary).

2. Review of Information

The Case Review Conference will require a review of all information necessitating the conference and any additional information that may be pertinent to the review. The Medical Director is responsible for determining the need for further action. The Medical Director may make the determination that the incident requires one of the following:

- a. Positive Recognition:

A CRC may be held to evaluate outstanding performance to be utilized for positive education feedback. An evaluation and recommendations report shall be forwarded to the ICEMA Medical Director.

- b. No Further Action Necessary:

Complete a Case Review Conference Report stating the conclusion of the investigation and forward a copy of the report to the ICEMA Medical Director. Maintain the original document in the Case Review Report File.

- c. Need For Education:

The Base Station Medical Director shall determine if the need for education is related to an individual or is of an educational value to the EMS system, or both.

d. EMS System Education:

The review has led to the opportunity to provide educational value to benefit the system (i.e., a piece of equipment has proven to be defective when used in certain environments). A Case Review Conference Report shall be completed and a copy forwarded to the ICEMA Medical Director. Maintain the original report in the Case Review Report File. Suggestions for system-wide improvements will be submitted to ICEMA CCQIC and the EMCC, and addressed through education.

3. Plan of Action

The determination has been made that an individual or individuals would benefit from the initiation of the education process.

- a. Identify the Area of Improvement - i.e., skills deficiency, lack of working knowledge of ICEMA protocols, etc.
- b. Recommend a Plan of Action - For example, the Base Station or ALS provider agency may be requested to provide skills training, further monitoring, protocol updates, etc. In this circumstance, the ICEMA Medical Director will request follow-up in writing from the ALS provider agency and will determine the period in which this is to be provided. Complete the Case Review Conference Report (QI Form 008) providing the appropriate information and forward a copy to the ICEMA Medical Director upon completion of the conference. Maintain the original Case Review Conference Report in the Case Review Report File.
- c. Initiate the Plan of Action - Provide the education, monitoring, etc., as determined by ICEMA Medical Director.
- d. Evaluation of the Outcome - The ICEMA Medical Director will evaluate the outcome of the process, the need to re-evaluate at a future date if necessary or to provide further education. This information should be included in follow-up form on a Case Review Conference Report and a copy submitted to the ICEMA Medical Director. Maintain the original report in the Case Review Report File.

4. Disciplinary Action Needed

The need for disciplinary action should only be initiated if ICEMA's Medical Director determines the situation reflects grounds for disciplinary action under Chapters 4 and 6 of the California Code of Regulations (CCR), Title 22. All pertinent information should then be forwarded immediately to the ICEMA Medical Director for consideration of further action.

SECTION II - DATA COLLECTION AND REPORTING

Data collection and reporting are two of the most important elements in CQI. The data collected must be valid, reliable, and standardized with all other system participants. ICEMA encourages the sharing of data through summary reports among all EMS system participants.

This chart provides suggested indicators for each Indicator category per organizational structure. Use of these indicators is not mandatory.

Assumptions: 1. California EMS Information System (CEMSIS) will provide state-wide data.

INDICATOR	EMS AUTHORITY	ICEMA	PROVIDER	HOSPITAL
Personnel	WELLNESS WORKLOAD POLICIES AND PROCEDURES LICENSURE ED1 Education and Training Indicator A - H	WELLNESS WORKLOAD POLICIES AND PROCEDURES CERTIFICATION /ACCREDITATION ED1 Education and Training Indicator A - D, G, H COMMUNICATIONS COVERAGE	WELLNESS WORKLOAD POLICIES AND PROCEDURES ED1 Education and Training Indicator A, B (if provider has EMT-I training school) PREVENTIVE MAINTENANCE PLANS PHARMACEUTICALS	WELLNESS WORKLOAD POLICIES AND PROCEDURES BH1 Base Hospitals-Activity Indicator B - D
Equipment and Supplies	ePCR INVENTORY CONTROL			INVENTORY CONTROL
Documentation		DATA VALIDATION ePCR POLICIES AND PROCEDURES QUALITY REVIEW PROCESSES	DATA VALIDATION NARCOTIC RECORDS ePCR POLICIES AND PROCEDURES QUALITY REVIEW PROCESSES	TIMELINESS ACCURACY OUTCOME REPORTING QUALITY REVIEW PROCESSES
Clinical Care and Patient Outcome	SCOPE OF PRACTICE COMMITTEE STRUCTURE RESEARCH CA1 Pulseless V-Fib/V-Tach Unwitnessed Indicator A - B CA2 Pulseless V-Fib V-Tach Witnessed Indicator A - B	TREATMENT PROTOCOLS COMMITTEE STRUCTURE MEDICAL OVERSIGHT RESEARCH QI and CASE REVIEW CA1 Pulseless V-Fib/V-Tach Unwitnessed Indicator A - N CA2 Pulseless V-Fib/V-Tach - Witnessed Indicator A - N CA3 Chest Pain-Suspected Cardiac Origin Indicator A - J MA1 ALS Staffing Levels Indicator A - D RE1 Shortness of Breath/Bronchospasm Indicator A - G RE2 Shortness of Breath/Fluid Overload Indicator A - K	TREATMENT PROTOCOLS COMMITTEE STRUCTURE MEDICAL OVERSIGHT RESEARCH QI and CASE REVIEW CA1 Pulseless V-Fib/V-Tach Unwitnessed Indicator A - N CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A - N CA3 Chest Pain-Suspected Cardiac Origin Indicator A - J RE1 Shortness of Breath, Bronchospasm Indicator A - G RE2 Shortness of Breath/Fluid Overload Indicator A - K	TREATMENT PROTOCOLS RESEARCH QI and CASE REVIEW CA1 Pulseless V-Fib/V-Tach Unwitnessed Indicator A, B, N CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B, N CA3 Chest Pain-Suspected Cardiac Origin Indicator J RE1 Shortness of Breath Bronchospasm Indicator G RE2 Shortness of Breath Fluid Overload Indicator K

INDICATOR	EMS AUTHORITY	ICEMA	PROVIDER	HOSPITAL
Skills Maintenance Competency	SCOPE OF PRACTICE	SCOPE OF PRACTICE SKILLS UTILIZATION BENCHMARKING SK1 Skills-Advanced Provider Indicator A - J	SCOPE OF PRACTICE SKILLS UTILIZATION INFREQUENT SKILLS REVIEW SUCCESS RATES (BENCHMARKING) SK1 Skills-Advanced Provider Indicator A - J	SCOPE OF PRACTICE SKILLS UTILIZATION INFREQUENT SKILLS REVIEW SUCCESS RATES
Public Education and Prevention	COMMUNITY INVOLVEMENT PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1 Pulseless V-Fib/V-Tach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PPI Public Education and Prevention Indicator A, B	COMMUNITY INVOLVEMENT REWARD AND RECOGNITION PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1 Pulseless V-Fib/V-Tach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PPI Public Education and Prevention Indicator A, B	COMMUNITY INVOLVEMENT REWARD AND RECOGNITION PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1A Pulseless V-Fib/V-Tach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PPI Public Education and Prevention Indicator A, B	PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1 Pulseless V-Fib/V-Tach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PPI Public Education and Prevention Indicator A, B
Risk Management	ISSUE RESOLUTION PROCESS SYSTEM MONITORING	ISSUE RESOLUTION PROCESS SYSTEM MONITORING CA1 Pulseless V-Fib/V-Tach Unwitnessed Indicator A, B MA1 ALS Staffing Levels Indicator A - D	ISSUE RESOLUTION PROCESS OSHA COMPLIANCE POST-INCIDENT PEER REVIEW PERSONNEL SAFETY SYSTEM MONITORING MA1 ALS Staffing Levels Indicator A - D RS1 Response Indicator A - C SK1 Skills - Advanced Provider Indicator A - J	OSHA COMPLIANCE POST-INCIDENT PEER REVIEW PERSONAL SAFETY SYSTEM MONITORING

SECTION III - EVALUATION OF INDICATORS

The ICEMA QI Coordinator will analyze the quality indicators on a monthly basis and then create relevant reports for presentation to the MAC and/or EMCC.

SECTION IV - ACTION TO IMPROVE

I. FOCUS-PDSA

Once a need for improvement in performance has been identified by ICEMA, MAC or the EMCC, ICEMA will be utilizing the FOCUS-PDSA model for performance improvement. FOCUS-PDSA involves the following steps:

Find a process to improve - the CCQIC will identify improvement needs.

Organize a team that knows the process - the CQI Team will form Task Force(s) as needed and review process documents.

Clarify current knowledge of the process - review indicator trends relevant to the process, collect other information

Understand - causes of process variation utilizing tools, such as fishbone diagrams, Pareto analyses, etc.

Select - process improvement to reduce or eliminate cause(s).

Plan - State objective of the test, make predictions, develop plan to carry out the test (who, what where, when).

Do - Carry out the test, document problems and unexpected observations, begin analysis of the data.

Study - Complete the analysis of the data, compare the test data to predictions, and summarize what was learned.

Act - What changes are to be institutionalized?
What will be the objective of the next cycle?
What, if any, re-education or training is needed to effect the changes?

Once a Performance Improvement Plan has been implemented, the results of the improvement plan will be measured. Changes to the system will be standardized and/or integrated. A plan for monitoring future activities will be established.

II. MEETINGS

During its quarterly or other meetings, ICEMA or MAC may identify indicators that signal a need for improvement and make recommendations for chartering a Quality Task Force, if needed. ICEMA or the CCQIC may select members and charter a Task Force with a specific objective for improvement. Each Task Force will use the FOCUS-PDSA model to conduct improvement planning and prepare recommendations or a report for review by ICEMA. ICEMA will prepare a report including the findings and recommendations of the Task Force and make recommendations to the Task Force and prepare the report for distribution to the MAC. ICEMA will also disband the Quality Task Force at the appropriate time.

Presentation of quality indicator analyses will most frequently be in a run chart, a Pareto chart, or a histogram format. This will enable ICEMA and/or MAC to easily identify trends and to rapidly interpret the data.

ICEMA, CCQIC and MAC will meet at least quarterly to evaluate and discuss the data provided by the ICEMA QI Coordinator according to the following agenda:

- Review of prior meeting action items.
- Presentation of indicators and results/trends.

For each indicator that the CCQIC reviews, the following process will be followed:

- Identify the objectives of the evaluation.
 - Present indicators and related EMS information.
 - Compare performance with goals or benchmarks.
 - Discuss performance with peers/colleague.s
 - Determine whether improvement or further evaluation is required.
 - Establish plan based upon decision.
 - Assign responsibility for post-decision action plan.
-
- Examine correlations between/among trends.
 - Acknowledgement of positive trends; discussion of unsatisfactory trends.
 - Receive reports from Quality Task Forces, if any.
 - Discuss changes needed to indicators.
 - Recommend the chartering of Quality Task Forces, if any.
 - Provide input to ICEMA to regarding improvement priorities.
 - Summarize action items identified at this meeting.

- Recommend training/educational needs.
- Evaluation of the meeting.

SECTION V - TRAINING AND EDUCATION

Once the decision to take action or to solve a problem has occurred, training and education are critical components that need to be addressed. Education needs will be identified in reports given at quarterly MAC and CCQIC meetings. The EMS Agency will make recommendations for educational offerings county-wide based on these reports and reports from CQI Task Forces.

Once a Performance Improvement Plan recommended by a Task Force, the ICEMA QI Team, or MAC has been implemented, ICEMA will standardize the changes within the appropriate policies and procedures. The EMS Specialist responsible for educational oversight maintains the Policy and Procedure Manual, which is updated twice per year. Changes recommended by a Quality Task Force or other system participants are implemented via policy changes or new policies being written as indicated. The new policy or change in policy is presented at the various EMCCs for discussion. Changes may be made based on those discussions. The policy is then posted on the ICEMA website at www.ICEMA.net for a 45-day public comment period. Final changes to the policy are made based on public comments received. The new or improved policy is then implemented. If additional training is required of system participants, time is allotted for that training prior to the implementation of the policy. Policies also may be changed to comply with State or Federal mandates. These changes are written into the policies and are discussed at various committee meetings and the EMCCs and posted on the ICEMA website, but do not go out for a public comment period.

The EMS Specialist who is responsible for educational oversight also ensures that providers submit documentation that all training requirements have been met by all EMS system participants, usually twice per year and on an as-needed basis. This is accomplished via training memos, training program development, or by train-the-trainer programs. Providers are ultimately responsible for ensuring that staff is adequately trained. The rosters and records of training are available to ICEMA upon request.

SECTION VI - ANNUAL UPDATE

The Annual Update is a written account of the progress of an organization's activities as stated in the EMS CQIP. An EMS Specialist is responsible for annually updating the EMS Plan, in alignment with current EMS strategic goals. The CQI Coordinator will do an initial review of the CQIP, identifying what did and did not work. The CQI Coordinator will work in conjunction with the EMS Specialist responsible for updating the EMS Plan to ensure that both the CQIP and the EMS Plan are focusing on the same objectives. Once both the CQIP and the EMS Plan have been reviewed in this fashion, the CQI Coordinator will present his/her findings to the CCQIC and to the CQI Team.

The following chart will be the template for the presentation of the update.

Indicators Monitored	Key Findings/Priority Issues Identified	Improvement Action Plan/Plans for Further Action	Were Goals Met? Is Follow-up Needed?

As part of the Annual Update, the ICEMA CQI Team and the CCQIC will offer recommendations for changes needed in the CQIP for the coming year, including priority improvement goals/objectives, indicators monitored, improvement plans, how well goals/objectives were met, and whether follow-up is needed.

A current CQIP will be submitted to the State EMS Authority every five (5) years.

March 1, 2011 Protocol Manual Changes

Policy #	Title	Changes/Comments
1000 ACCREDITATION AND CERTIFICATION		
1050	MICN	Clarification of the language for certification and the education requirements
1080	Flight Nurse Authorization Requirements	Clarification of the language for certification and the education requirements and removal of testing requirements
2000 DATA COLLECTION		
	NONE	
3000 EDUCATION		
3020	Continuing Education Requirements	The order of the definitions have been changed. Formatting changes.
3030	EMT Continuing Education Requirements	Change in format of protocol and clarification of requirements. Change of education requirements to mandatory sixteen (16) hours of medical based CE's and eight (8) hours of other.
4000 QUALITY IMPROVEMENT		
4010	Continuous Quality Improvement Plan	New document
5000 MISCELLANEOUS SYSTEM POLICIES		
5040	Radion Communication Plan	Complete rewrite to simplify and clarify radio communications between base stations and EMS providers.
6000 SPECIALTY PROGRAM/ PROVIDER POLICIES		
6020	EMT AED Service Provider	Delete policy out dated and redundant
6090	Fireline Paramedic	Change from emergency protocol to permanent protocol
7000 STANDARD DRUG & EQUIPMENT LISTS		
7010		
7020		
8000 TRANSPORT/TRANSFERS AND DESTINATION POLICIES		

March 1, 2011 Protocol Manual Changes

Policy #	Title	Changes/Comments
8010	Interfacility Transfer Guidelines	Changed to Monitor thoracostomy tubes to water or dry sealed drainage
9000 GENERAL PATIENT CARE POLICIES		
NONE		
10000 SKILLS		
10160	Axial Spinal Stabilization	Change of format and clarification of the protocol
11000 ADULT EMERGENCIES		
11040	Bradycardia	Correction of typographical error.
12000 END OF LIFE CARE		
NONE		
13000 ENVIRONMENTAL EMERGENCIES		
NONE		
14000 PEDIATRIC EMERGENCIES		
NONE		
15000 TRAUMA		
NONE		
POLICY DELETIONS		
Below are some of the protocols/policies designated for review in the next few months. If there are specific protocols/policies recommended for review, please contact ICEMA		

March 1, 2011 Protocol Manual Changes

Policy #	Title	Changes/Comments
NONE		

45 Day Comment Period for Protocols
 October 26, 2010 thru December 10, 2010

Protocol Reference #'s 1050 and 1080

PROTOCOL #	AGENCY	COMMENT	RESPONSE
Both	Redlands Fire	Good	
1050	Rancho Cucamonga FD	On Page 3, #5 – I presume this is regarding certs. Issued for short periods of time to match RN license, but it is confusing when you read it. Could use an intro line to clarify.	No change
1050	RFCFD	On page 6, #e. "an additional 6 hours of field care audit. I assume this is because they are not answering the radio. Most of these RNs review many tapes for audits, QA, QI. Is it possible to read "6 hours of reviewing tapes of calls" or something of that sort instead of official field care audits? Many tapes are reviewed for many reasons but may be by themselves. It would be nice to get credit for those and not have to attend an additional 6 hours of official FCA	As long as the review is properly documented on a roster or review form it may count towards the audits. There has to be a tracking mechanism.
1080	RCFD	No comments	
1050	SACH	1) Grammatical consistency: Pg 1 of 6, 5. a and b: should state "candidate who failsmust pay..." as in other similar sections. The same for Pg. 5 of 6, 6.a 2) Grammar on pg. 3 of 6, 2.h should state "Continuous certification applicants not meeting the above requirement must pay..." 3) Pg. 2 of 6, 5.b: request reduction of remedial training from eight (8) to four (4) hours given by the PLN/Medical Director. Rationale: extremely tight time and budget constraints.	We will make grammar consistent We will make grammar consistent No change

45 Day Comment Period for Protocols
 October 26, 2010 thru December 10, 2010

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		All else looks good to me. VS	
1080	SACH	Looks good to me; defer to flight nurses and their providers. VS	
1050	Barstow Fire	No changes needed	
1080	Barstow Fire	No Changes needed	
1050	San Manuel FD	Agree with policy as it is	
1080	San Manuel FD	<ol style="list-style-type: none"> 1. I believe PALS should be added to the requirements. It demonstrated the standard of care. 2. Many organizations require advanced certifications for their flight crews. I believe ICEMA should require the CFRN for all our flight nurses. Providing Critical care in the flight environment is demanding. There are many proven standards that we should uphold in our region. The CFRN requirement is a good way to ensure our patients receive the standard of care. 	This will be referred back to Protocol Review and Medical Advisory committees for proper consideration and recommendation.
1050	Ontario Fire	On Page 3 under Number 5 – Is this section referring to individuals whose certification has lapsed? If so, can this be clarified? It is confusing.	This refers to initial certification.
1080	Ontario Fire	No Comment	

45 Day Comment Period for Protocols
 October 26, 2010 thru December 10, 2010

Protocol Reference # 3020 and 3030

PROTOCOL #	AGENCY	COMMENT	RESPONSE
3020	Redlands Fire	Good	
3030	Redlands Fire	Under "Continuing Education" 1L. If there is only one instructor, does there need to be a separate CE roster for one person?	Yes and it must be clearly marked Instructor
3030	Redlands Fire	Under "Continuing Education" 1M it states "Credit will be given, one time only, for each specific course, during a certification/licensure cycle," but in 1L it states "Credit will be given, one time only, for each specific course, during a certification/licensure cycle." Therefore, you can only get half the credit if you are an instructor. It would seem the person whom takes the time to master a subject should receive at least the same credit.	No change Consistent with state regulations
3020	Rancho Cucamonga FD	No comments	
3030	RCFD	Page 3 #L – For Instructor Credit – the separate roster – would that be the standard ICEMA Roster with the same class info with the addition of "Instructor(s)". Wouldn't it be easier to just give the person(s) listed at the top as instructor's credit vs. creating duplicate rosters and adding the word "instructor"? They are required to be listed at the top of the roster currently. The separate list/roster seems like additional paper and possible confusion.	No change
3020	SACH	Minimal change so noted; no comments. VS	

45 Day Comment Period for Protocols
 October 26, 2010 thru December 10, 2010

PROTOCOL #	AGENCY	COMMENT	RESPONSE
3030	SACH	I approve all changes; well written and reflects ICEMA's advocacy for continuing education.	
3020	Barstow Fire	Instructor Maybe you could add and instructor 1A or 1B or equivalent teaching class	No change
3030	Barstow Fire	Good no changes needed	
3020	San Manuel FD	1. We should waive the requirement of a copy of the license for our physician lectures. We invite Physicians to teach because they are on the cutting edge of medical care. They will not usually have a copy of their license readily available. They may even be conducting the class remotely and in real time. We want to provide as many Physician taught CE hours as possible. The copy of the license seems a bit excessive.	No change This is part of a physician CV and credentials are an important part of validating a speaker
3030	San Manuel FD	<ol style="list-style-type: none"> 1. I agree with the ratio of 16 medical hours to 8 non-medical hours. After all it is a "medical Technician" certification. 2. Under Policy we should eliminate #3. Then take the phrase "and complete a verification of skills. (EMSA form SCV) Add that phrase to the ends of both #1` and #2. Thus the POLICY heading will have only two numbers. The "or" is most confusing. E.G. Obtain at least twenty-four continuing education hours (CEH) from an approved continuing education provider and complete a verification of skills. 3. Page 2, Letter B. Does this mean that every hour of every shift someone is monitored by any preceptor (possible his partner on their regular shift), will now count as CE hours? 4. Page 2, Letter J. Precepting students in the hospital is valuable and worthy of CE's for the 	No change

45 Day Comment Period for Protocols
 October 26, 2010 thru December 10, 2010

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		preceptor. The same value should be given to the field preceptors. ICEMA should add field preceptors to this.	No change, precepting can not account for all of the education hours necessary for recertification no change.
3020	Ontario Fire	Under the definitions, just confirming that the only changes to the definitions are the order?	Yes
3030	Ontario Fire	Page 3 Under letter L – Would the instructor use the same class number as the students just on a separate roster? Would it be possible for the instructor to just turn in the roster that shows them as the instructor with the hours and the CE provider number on it – to receive CE credit? Otherwise, you will have a roster with just one name on it and who is the instructor of the instructor?	No change
3030	ICEMA	On Protocol #3030, letter “P”, page 3, states EMT-II when it should read A-EMT.	Change accepted

45 Day Comment Period for Protocols
 October 26, 2010 thru December 10, 2010

Protocol Reference # 5040

PROTOCOL #	AGENCY	COMMENT	RESPONSE
Radio Communication 5040	AMR	Under Base Station Contact for ALS: 3. "ALS interventions" Would like to see this clearly defined as to whether the ALS unit must contact when a glucose check and monitor reading are used as an assessment tool, but the patient does not need any ALS treatment.	No change This is handled via proper education.
5040	Ontario Fire	We agree with the revision of the radio communication policy as presented in the draft. It is our opinion that these revisions will benefit the MICNs, the paramedics, and ultimately our patients by allowing each member of the "EMS chain" to focus their attention where it should be, on patient care. We anticipate that after an initial transition period the MICNs, who are arguably overwhelmed by the volume of radio reports they are currently handling, will appreciate the changes and the additional time it affords them. Additionally, the changes will allow paramedics to focus their efforts where they should be, on patient care, rather than transmitting unnecessary information simply because it's become the custom.	
5040	Rancho Cucamonga FD	Under the Purpose on the second line "The purpose of communication between EMS (add personnel) and hospitals is to relay essential information..... Adding personnel will make it consistent with the first line in the paragraph	Change accepted

45 Day Comment Period for Protocols
October 26, 2010 thru December 10, 2010

PROTOCOL #	AGENCY	COMMENT	RESPONSE
	RCFD	Page 2 – under ALS Units – Make ETA a letter D by itself to remain consistent	No change
	RCFD	Page 2 – Under Base Station communication report suggest adding a #7. To include Diversion or destination change per protocol	No change
	RCFD	Pg. 4 of 9 - #2 should read Trauma base contact.... Ground EMS personnel and/or aircrew (to emphasize that the aircrew should be communicating with the ground crew who is giving updates to the trauma base).	No change handle through education
5040	SACH	1) Grammatical only: pg. 4 of 9: Helicopter Transports: no need to capitalize "C" in Trauma Base contacts. Same for "prior to contact protocols" under "For Interfacility Protocol." 2) Page 3 of 9: under Base Stations will provide:... include "acknowledgement of prior-to-contact treatment and patient response."	Accept change
		Otherwise: well written and clear changes to a problematic protocol. VS	
5040	Barstow Fire	Good no changes needed	
5040	San Manuel FD	1. Page 1 under Purpose, consider breaking it up into paragraphs. 2. Page 1 below Purpose, We are defining three distinct reports with this protocol. We should delineate them before we describe them in	No change

45 Day Comment Period for Protocols
 October 26, 2010 thru December 10, 2010

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		<p>detail. E.G. BLS REPORT given only by an EMT level BLS transporting unit. Receiving Hospital report: given by an ALS provider directly to any hospital they are in route to. When a base hospital report is not required. Base Station Report Be Given by an ALS provider to the base station</p> <p>3. Page 2 Line 5, After the work medications add the phrase "not ordered by the sending physician"</p>	
5040	Ontario Fire	<p>Under the Purpose on the second line "The purpose of communication between EMS (add personnel) and hospitals is to relay essential information..... Adding personnel will make it consistent with the first line in the paragraph"</p>	Change accepted
		<p>Page 2 – under ALS Units – Break ETA out into letter D. by itself to remain consistent with the rest of the document</p>	No change
		<p>Page 2 – Under Base Station communication report Add a #7. To include Diversion or destination change per protocol</p>	No change

45 Day Comment Period for Protocols
 October 26, 2010 thru December 10, 2010

Protocol Reference #'s 6020 and 6090

PROTOCOL #	AGENCY	COMMENT	RESPONSE
6020	Redlands Fire	Okay with deletion	
6090	Redlands Fire	Okay	
6020	Rancho Cucamonga FD	No Comments	
6090	RCFD	Fireline Paramedic- Needs some clarifying language that the fireline medic is A medic that is an individual specifically assigned to an incident as the fireline Medic. This does not pertain to the medics sent on a Type I or Type III strike Teams.	No change. This is a specialty program and the description of the medic duties is in the application.
6020 and 6090	SACH	Agree with deletions and changes. VS	
6090	Barstow Fire	Good no changes needed	
6020	San Manuel FD	I agree with its removal	
6090	San Manuel FD	I agree with ICEMA's adaptation of the fire scope guidelines.	
6020	Ontario Fire	No Comments	
6090	Ontario Fire	No Comments	

45 Day Comment Period for Protocols
 October 26, 2010 thru December 10, 2010

Protocol Reference #'s 10160 and 11040

PROTOCOL #	AGENCY	COMMENT	RESPONSE
10160	Redlands Fire	Field Assessment items 7 and 8 are interpreted to say axial spinal stabilization is clinically indicated on every ALOC, anyone who has had one drink of alcohol, and if they cannot communicate in the same language as the responders. This should include some sort of trauma.	No change. This is clarified in the opening statement of the protocol.
10160	Rancho Cucamonga FD	Page 1 – Take number 7 Altered mental status and add it under number 4 to read: “Unconscious or altered mental status patients where the mechanism of injury is unknown”.	No change
	RCFD	Axial spinal Stabilization- bottom of page 1 of 2. Why do we want to remove a Person from AS Stabilization? Do we know how often a patient is taken out of SI? Still not that comfortable with it. Pg. 2 of 2 #6, Should include language of any pregnant women with a notably gravid abdomen be placed in left lateral. (You can have some 2 nd trimester ladies with pretty big bellies that could have the same effect).	No change No change
11040	RCFD	No Comments	
10160	SACH	1) Suggest the following wording: “Any patient in which not limited to the following: Those who...” Then follow with each criteria that	

45 Day Comment Period for Protocols
 October 26, 2010 thru December 10, 2010

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		grammatically agrees, i.e., 1) Meet the mechanism of injury criteria... 2) Have soft tissue damages associated with... 3) Are unconscious or altered and the mechanism is unknown... 4) Have cervical pain or pain to the ... And so on. I think it flows better with this change.	No change
		2) Suggest this wording of the last paragraph of that section : "ALS personnel may remove axial spinal stabilization placed by first responders or BLS personnel only if the patient does not meet..."	No change
		Agree with content. VS	
11040	SACH	Agree to change. VS	
10160	Barstow Fire	Good	
11040	Barstow Fire	No change needed	
10160	San Manuel FD	1. I agree with the BPM change 2. Page 2, under ALS Interventions – the last part of the sentence seems disconnected. To make it clear use: Consider Dopamine 400 mg in 250cc NS at 5-20 mcg/kg/min, titrated to sustain a systolic B/P greater than 90mmHg, (than either of the following) a. for signs of inadequate perfusion/shock. b. To relieve signs of inadequate tissue perfusion /shock.	Good comment, refer to Protocol Education Committee (PEC) for review and change.
10160	Ontario Fire	Page 1 – Take number 7 Altered mental status and add it under number 4 to read: "Unconscious or altered mental status patients where the mechanism	No change

45 Day Comment Period for Protocols
 October 26, 2010 thru December 10, 2010

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		of injury is unknown"	
		Under the last paragraph ALS personnel may remove patients placed in axial spinal stabilization by First Responders and/or BLS personnel if the patient does not meet any of the above.....	No change
11040	Ontario Fire	No Comments	

45 Day Comment Period for Protocols
October 26, 2010 thru December 10, 2010

QI PLAN

PROTOCOL #	AGENCY	COMMENT	RESPONSE
QI Plan	Redlands Fire	On page four the link between the Regional QI groups and the Central QI is missing.	
QI Plan	Redlands Fire	On page five, item number eight, the term "State of Art" is ambiguous.	
QI Plan	Redlands Fire	On page 21, item C-1 is requesting that we review 30 or 10% of the monthly runs. Randomly choosing 30 or more runs is not an effective way to manage a QI program. It would be a better practice if providers can QI a specific call type and report their findings. The way the plan is written now, ICEMA wants to see the providers QI at least 30 runs, which include all MCJs, AMAs, ET tube insertions, and other factors. This is fine except for the fact that many departments will fall into the 10% category, which could easily amount to 50 to 70 runs per month. The problem is not the amount of calls to QI but what objective parameters are established to form an improvement program. Having a provider define the objective parameters and notify ICEMA before a review occurs will create a more robust QI program.	No change. Random audits of runs are an effective way of identifying indicators that will require closer scrutiny. QI plan has been extensively reviewed and discussed at appropriate committees with appropriate constituency input in its development.
QI Plan	Redlands Fire	On page 21, item C-3 discusses QI form 005 but there is no form to view. Is this the form that is used to submit the monthly QI reports? Is there a format for the monthly report? If the provider report is submitted annually, what will the regional and Central QI groups discuss when they have their monthly and quarterly meetings?	Forms will be available once plan approved. Education will be provided
QI Plan	Rancho Cucamonga FD	A BIG thank you for completing this document. It is an excellent document and great starting point for all of the agencies that are rewriting their CQI Plan. Pg. 5 # 1 might read better by switching provide constantly to constantly provide (A small item for easier reading)	No change
	RCFD	<u>Pg 8</u> Should there be a spot for the ICEMA QI	

45 Day Comment Period for Protocols
 October 26, 2010 thru December 10, 2010

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		representative (nurse or EMT-P) From ICEMA?	
	RCFD	Pg 15- B 1. Clarify # of runs to review. 30% should include random audits and requested reviews. PLNs do a large number of requested reviews and adding 30% random on top of the already large work load may be too much. We agree with the 30%, but it should include many of the audits already being done as part of the role of PLN.	No change See previous comment in this topic
	RCFD	Pg. 21 C. 1 Lots of PCRs are reviewed, but not always randomly. The number of audits should include the reviews already being conducted along with a % of random audits such as 5-7 % (same as above). Specific reviews are equally as important as random reviews and should be recognized in the total amount.	No change
	RCFD	Page 22 under Review of Patient Care Data ALS Run Report Forms – Add H. Advanced Scope Skills	No change This is a specific indicator. Specific indicator will be decided by the Central QI Committee.
	RCFD	Page 24 under Conducting a Case Review Conference 2. Review of Information b. No Further Action Necessary – Remove the word investigation and replace with review (discussed in QI committee meeting to remove all language using Investigations) c. Need for Education – can you add Agency Medical Director so that both the Base Hospital Medical Director and the Agency Medical Director	Change accepted

45 Day Comment Period for Protocols
October 26, 2010 thru December 10, 2010

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		are able to determine the need for education	
	RCFD	Thank you for the opportunity to make comments. Great work done by all involved.	
QI Plan	SACH	1) Page 14: III.A.- What is meant by "specialty care hospitals"? And why are they included in the Base Station CQIP? 2) Definition of CQIP Technical Advisory Group? 3) Page 15: B. 1. REVIEW OF PATIENT CARE DATA: The requirement of 10% <u>randomly selected</u> MICN reports with waveforms is a waste of valuable CQI time. Our facility finds that CQI focused on newer protocols (such as STEMI or Stroke) or protocols with infrequent use (ROSC or Trauma), and runs referred by the MICN staff, and/or other EMS providers is more productive. Auditing a clinical topic selected by the CCQIC or RCQIC would also be more valuable than random audits.	Good comment. We will change to "Critical Care Specialty Hospitals" STEMI, Trauma, Stroke No change. The specialty programs and specialty destination policies have their own QI groups as subdivisions of the overall QI program. The CQI program looks at everything in the system. Random audits identify issues with the system that may not be obvious when focusing on specific protocols
QI Plan	Barstow Fire	Complicated but very good no change.	
QI Plan	San Manuel FD	1. Page 4 under ORGANIZATION CHART we should add two boxes. One for the PEDS death QI and one in anticipation of the Stroke QI. Both will need to be defined in this document. 2. Page 4 under CQI mission. At the end of the mission add "There by advancing the discussion of evidenced based care and make it our mission." 3. Page 5 add a #10 "The CQI process will generate changes in our EMS system and will	The Child Death Review Committee is a County wide committee consisting of social workers, district attorneys, and others. It is not an ICEMA committee. Stroke QI can be added to the committees as needed. Committee designation and org chart may be updated without affecting the CQI plan.

45 Day Comment Period for Protocols
 October 26, 2010 thru December 10, 2010

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		<p>result in the modification of the CQI process itself.”</p> <p>4. Page 7 Committees. There is no mention of whether a meeting is closed or open. Except for the Trauma and Air Audit Committee which is designated as a closed meeting. Please add this distinction to all the other committee meetings.</p> <p>5. Page 8 under Central Continuous Quality Improvement committee. I would like to see two additions;</p> <ul style="list-style-type: none"> a. Native American EMS representative b. Air ambulance representative. There is a possibility we may need an air ambulance CQI committee that will report to the central CQI. If adopted the air ambulance committee should be defined in this document and added to page 7’s flow chart. <p>6. Page 16 Wave reviews please use another name for this. I believe it is a recorded audio file.</p> <p>7. Page 14 with regard to base station requirements; the base stations cannot be expected to accomplish the amount of work outlined in the policy. It requires; MICN reports, wave reviews, concurrent and retrospective clinical reviews, statistical data gathering in case review reports annual CQIP reports, quarterly reports. IN most cases this is assigned to only one person. We have precious few base hospitals presently. I hope we do not lose another one due to excessive workloads and expenses. The amount of work this policy will require of them is not reasonable. The cost in</p>	<p>No change We indicate meetings that are closed on the website.</p> <p>No change</p> <p>Change accepted “ Audio file”</p> <p>No change. Actual reviews and studies will be determined by the Central QI Committee and will take into account work loads and feasibility of the reviews. Most of the data we will be looking at is gathered by the base stations already.</p>

45 Day Comment Period for Protocols
 October 26, 2010 thru December 10, 2010

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		<p>overtime and personnel is far more than can be absorbed with the present economic situation. Our base hospitals have more than enough responsibility regulating STMEI, Trauma, Stroke as well as EMS and walk in traffic, The base hospitals should review as they presently do. Reports should be given to the EMS directors of each agency as needed. Trends should be reported to ICEMA as it is presently done. While this policy is ideal it is far too aggressive for the current economic climate. The question could be asked that, at what point does the regulating agency become responsible for the cost of the policies it requires of others.</p>	
<p>QI Plan</p>	<p>Ontario Fire</p>	<p>Page 22 under Review of Patient Care Data A. ALS Run Report Forms – Add H. Advanced Scope Skills</p>	<p>No change This is a specific indicator. Specific indicator will be decided by the Central QI Committee.</p>
		<p>Page 24 under Conducting a Case Review Conference 2. Review of Information b. No Further Action Necessary – Remove the word investigation and replace with review (discussed in QI committee meeting to remove all language using Investigations) c. Need for Education – can you add Agency Medical Director so that both the Base Hospital Medical Director and the Agency Medical Director are able to determine the need for education</p>	<p>Change accepted Change accepted</p>

45 Day Comment Period for Protocols
 October 26, 2010 thru December 10, 2010

PROTOCOL #	AGENCY	COMMENT	RESPONSE
	Ontario Fire	Thank you for the opportunity to make comments. Excellent work on all documents done by ICEMA and committees.	



MICN CERTIFICATION REQUIREMENTS

PURPOSE

To define the requirements for Mobile Intensive Care Nurse (MICN) certification within the ICEMA Region.

PROCEDURE

Initial MICN Certification

1. Possess a current California RN License
2. Successfully complete the ICEMA approved MICN course with a passing score of at least eighty percent (80%), and within six (6) months of course completion, submit the appropriate ICEMA application with:
 - a. Fee as set by ICEMA. The fee is not refundable or transferable.
 - b. Written verification of employment at a designated Base Station within the ICEMA Region.
 - c. A signed copy (front and back) of the individual's current American Heart Association BLS Healthcare Provider or American Red Cross Professional Rescuer CPR card.
 - d. A signed copy (front and back) of the individual's current Advanced Cardiac Life Support Card.
 - e. Copy of current government issued photo identification (i.e. Driver's License)
3. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
4. Upon completion of 1-3 above, the applicant will be scheduled to take the ICEMA written examination.
5. Upon passing the ICEMA written examination with a minimum score of eighty percent (80%), a provisional MICN card will be issued.

- a. A candidate who fails to pass the ICEMA written examination on the first attempt will have to pay the ICEMA approved fee and re-take the examination with a score of at least 85%.
 - b. A candidate who fails to pass the ICEMA written examination on the second attempt will have to pay the ICEMA approved fee, and provide documentation of eight (8) hours of remedial training given by their PLN/Medical Director relating to ICEMA protocols, policies/procedures and pass the ICEMA written examination with a minimum score of 85%.
 - c. If the candidate fails to pass the ICEMA written examination on the third attempt, the applicant must repeat the course and reapply.
6. A provisional MICN may function under the direct supervision of the Base Station MD, PLN or ICEMA approved designee for a maximum of six (6) months. The supervising individual must sign all MICN call forms. This timeframe may be extended upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.
 7. The PLN will choose three (3) tapes for review (one trauma, one medical and one other) and submit them to their partnered Base Station PLN for review.
 8. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.
 9. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

Continuous MICN Certification

1. Possess a current California RN License and current ICEMA MICN certification.
2. Submit the appropriate completed ICEMA application with:
 - a. Written verification of employment at a designated Base Station within the ICEMA Region.

(This requirement may be waived for RN's that work in EMS for non base stations in administrative or supervisory positions that require MICN certification. Written request for waiver from the RN's supervisor or Fire Chief must be submitted to ICEMA. Evidence of field care audits and other

CE classes taught will replace the radio time. Requests will be reviewed on an individual basis by ICEMA)

- b. A signed copy (front and back) of the individual's current American Heart Association BLS Healthcare Provider or American Red Cross Professional Rescuer CPR card.
- c. A signed copy (front and back) of the individual's current Advanced Cardiac Life Support Card.
- d. Documentation of eight (8) hours of field time.
- e. Documentation of one (1) ICEMA approved Skills Day.
- f. Documentation of six (6) hours of field care audits obtained within the ICEMA region.
- g. Documentation of two (2) consecutive ICEMA Annual Review Class (ARC), one during each year of certification.
- h. Continuous certification applicants not meeting the above requirements must pay the ICEMA approved fee and successfully pass the ICEMA written examination with a minimum score of 80%.

ICEMA written examination does not replace or fulfill the requirement for a Skills Day or Field Care Audits. These must be completed prior to recertification.

3. Current photo (within last 6 months) on file at ICEMA. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
4. If the certification has lapsed for more than one (1) year, the applicant must comply with the above Initial Certification Procedure.
5. Individuals certified less than six (6) months must submit a new application and a current state license. No education is required and a fee is not applicable.

Individuals certified more than six (6) months but less than one (1) year must submit a new application, items a-c above and complete one (1) ARC, three (3) hours of field care audits and either a skills day or eight (8) hours of field time.

Individuals certified more than one (1) year must complete all requirements.

Inactive MICN Certification

1. Maintain a current California RN License.
2. Submit the appropriate completed ICEMA application with all of the following documentation every two (2) years of inactivation.
 - a. Copy of front and back of a current, signed ACLS Card.
 - b. Copy of front and back of current California RN License.
 - c. Documentation of one (1) ICEMA approved Skills Day taken during the year of inactivation.
 - d. Documentation of six (6) hours of field care audits obtained within the ICEMA region.
 - e. Documentation of one (1) ICEMA Annual Review class for each year of inactivation.

Return to Active MICN Status

1. Submit the appropriate ICEMA application with documentation of all inactive MICN Certification requirements and written verification of employment at a designated Base Station within the ICEMA Region.

(This requirement may be waived for RN's that work in EMS for non base stations in administrative or supervisory positions that require MICN certification. Written request for waiver from the RN's supervisor or Fire Chief must be submitted to ICEMA. Evidence of field care audits and other CE classes taught will replace the radio time. Requests will be reviewed on an individual basis by ICEMA.)
2. A provisional MICN may function under the direct supervision of the Base Station MD, PLN or ICEMA approved designee for a maximum of six (6) months. The supervising individual must sign all MICN call forms.
3. After obtaining a provisional MICN, the individual must complete eight (8) hours of field time.
4. The PLN will choose three (3) tapes for review (one trauma, one medical and one other) and submit them to their partnered Base Station PLN for review.
5. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.

6. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

Certification by Challenge Examination

1. Possess a current California RN License.
2. Meet one (1) of the following eligibility requirements:
 - a. MICN in another county within previous twelve (12) months
 - b. MICN in ICEMA Region, but has let certification expire within the previous forty-eight (48) months, and has not fulfilled requirements for inactive MICN status
3. Submit the appropriate ICEMA application with:
 - a. Fee as set by ICEMA.
 - b. Written verification of employment at a designated Base Station within the ICEMA Region.
 - c. Copy of front and back of a current, signed ACLS Card.
 - d. Copy of front and back of current California RN License.
4. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
5. Upon completion of 1-4 above, the applicant will be scheduled to take the ICEMA written examination.
6. Upon passing the ICEMA written examination with a minimum score of 80%, a provisional MICN card will be issued.
 - a. A candidate who fails to pass the ICEMA written examination on the first attempt will have to pay the ICEMA approved fee and re-take the written examination with a minimum score of 85%.
 - b. A candidate who fails to pass the ICEMA written examination on the second attempt will be deemed ineligible for challenge certification. Applicant will

need to take an ICEMA approved MICN course and comply with initial certification requirements.

7. The individual may then function as a provisional MICN under the direct supervision of the Base Station MD, PLN or ICEMA approved designee. The supervising individual must sign all MICN call forms.
8. The PLN will choose three (3) tapes for review (one trauma, one medical and one other).
9. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.
10. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

MICN Recertification for RN's Working in a Non-Base Station (MICN – A)

Applies to MICN's working in administrative/supervisory positions which have been approved by ICEMA:

- a. Must complete 2c through 2e under Initial Certification above.
- b. Fee as set by ICEMA
- c. Must submit proof of employment with an approved non base station employer.
- d. Must teach or attend an additional skills day.
- e. Must teach or attend an additional six (6) hours of field care audits.

If employment with approved entity is terminated the MICN must change status to inactive unless employed by a Base Station or another approved non Base Station employer.

This certification may be converted to regular MICN status upon written verification of employment at a designated Base Station within the ICEMA Region.



FLIGHT NURSE AUTHORIZATION

PURPOSE

To define the requirements for EMS Aircraft Flight Nurse Authorization within the ICEMA Region.

PROCEDURE

Initial Authorization

1. Fee as set by ICEMA. The fee is not refundable or transferable.
2. Written verification of employment with an authorized EMS Aircraft provider within the ICEMA Region.

If employment with authorized EMS Aircraft provider is terminated, Flight Nurse Authorization will be rescinded unless proof of other qualifying EMS Aircraft employment is received by ICEMA within thirty (30) days.

3. Copy of current government issued photo identification (i.e. Drivers License).
4. Copy of front and back of a current, signed ACLS Card.
5. Copy of front and back of current California RN License.
6. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
7. Proof of attendance of four (4) hour Flight Nurse Orientation course.
8. Upon passing the local authorization written examination with a minimum score of eighty percent (80%), a Flight Nurse Authorization card will be issued with the same expiration date as the candidate's RN license.
9. Flight Nurse Authorizations issued within six (6) months of nursing license expiration are exempt from reauthorization fee.

REAUTHORIZATION

Submit the Flight Nurse Reauthorization application form with the following:

1. Fee as set by ICEMA. The fee is not refundable or transferable.
2. Written verification of employment with an authorized EMS Aircraft provider within the ICEMA Region.

If employment with authorized EMS Aircraft provider is terminated, Flight Nurse Authorization will be rescinded unless proof of other qualifying EMS Aircraft employment is received within thirty (30) days.

3. Copy of front and back of a current, signed ACLS Card.
4. Copy of front and back of current California RN License.
5. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.



CONTINUING EDUCATION PROVIDER REQUIREMENTS

PURPOSE

To define the requirements for approval of Continuing Education (CE) Providers within the ICEMA Region.

AUTHORITY

California Code of Regulations, Title 22, Division 9, Chapter 11 EMS Continuing Education

DEFINITIONS

Emergency Medical Services (EMS) Continuing Education (CE) Provider: An individual or organization approved by the requirements of Title 22, Division 9, Chapter 11, to conduct continuing education courses, classes activities or experiences and to issue earned continuing education hours to EMS personnel for the purpose of maintaining certification/licensure or re-establishing lapsed certification or licensure.

Continuing Education: A course, class, activity or experience designed to be educational in nature, with learning objectives and performance evaluations for the purpose of providing EMS personnel with reinforcement of basic EMS training as well as knowledge to enhance individual and system proficiency in the practice of prehospital emergency medical care.

Clinical Director: A person currently licensed as a physician, registered nurse, physician assistant or paramedic. The clinical director shall have had two (2) years of academic, administrative or clinical experience in Emergency Medicine or EMS care within the last five (5) years. The clinical director shall be responsible for monitoring all clinical and field activities approved for CE credit, approving instructors and monitoring the overall quality of the EMS content of the program.

Program Director: A person qualified by education and experience in methods, materials and evaluation of instruction, which shall be documented by at least forty (40) hours in teaching methodology. The program director will administer the CE program, ensure adherence to all state regulations, local policies, approve course content and assign course hours to any sponsored CE program per State regulations and ICEMA policy.

Instructor: A person approved by the program director and clinical director as qualified to teach the topics assigned or have evidence of specialized training which may include, but is

not limited to, a certificate of training or an advanced degree in a given subject area, or have at least one (1) year of experience within the last two (2) years in the specialized area in which they are teaching or be knowledgeable, skillful and current in the subject matter of the course, class or activity.

PROCEDURE

1. To become an approved CE provider, an organization or individual shall submit an application packet at least sixty (60) days prior to the date of the first educational activity. The application packet shall include:
 - a. Name and address of the applicant;
 - b. Name of the program director, program clinical director, and contact person, if other than the program director or clinical director;
 - c. Type of organization requesting approval;
 - d. Program director and clinical director resumes including copies of all licenses/certifications; and,
 - e. ICEMA approved fee.
2. The applicant will be notified in writing within fourteen (14) working days that their request was received and informed if any information is missing.
3. Notice of approval or disapproval of the application will be made in writing to the applicant within sixty (60) calendar days of receipt of the completed application.
4. If the application is approved, an EMS CE provider number will be issued and valid for four (4) years.
5. If an application is disapproved and the organization or individual elects to submit a new application, the application packet must include all items listed in "1" above.

MAINTAINING RECORDS

1. All records will be maintained by the CE provider for four (4) years, and shall include:
 - a. Complete outlines for each course given including a brief overview, instructional objectives, comprehensive topical outline, method of evaluation and a record of participant performance.

- b. Record of time, place, date and CE hours granted for each course.
 - c. A resume and copies of licenses/certifications for all instructors.
2. An ICEMA approved CE roster:
 - a. Signed by course participants to include name and license/certification/accreditation number of each participant. Signing for another individual is strictly prohibited and subject to actions against certification or licensure.
 - b. A line should be drawn through any empty lines after the last attendee has signed the roster.
 - c. Copies of class rosters shall be sent to ICEMA within fifteen (15) days of class completion. These rosters shall be considered final and revisions will not be accepted.
 - d. A record of all CE certificates issued.
3. CE providers will notify ICEMA within thirty (30) calendar days of any changes in name, address, and telephone number of the program director, clinical director or contact person.
4. All records shall be made available to ICEMA upon request.
5. The Clinical Director shall submit a complete list of courses with the number of individuals attending each course on a monthly basis to ICEMA on the ICEMA approved form. The form shall be submitted to ICEMA by the 10th of every month for the previous month. If no classes were taught, submit form with "No Classes This Month"
6. It is the responsibility of the CE provider to submit an application for renewal with the ICEMA approved fee at least sixty (60) calendar days prior to the expiration date in order to maintain continuous approval.
7. All CE provider requirements required by State legislation must be met and maintained.

POLICY

1. When two (2) or more CE providers cosponsor a course, only one (1) approved provider number may be used for that course, class or activity. The CE provider

- assumes the responsibility for all applicable provisions of Chapter 11 EMS Continuing Education.
2. The State EMS Authority shall be the agency responsible for approving CE providers for statewide public safety agencies and CE providers whose headquarters are located out-of-state if not approved by the Continuing Education Board for Emergency Medical Services (CECBEMS) or approved by the EMS offices of other states or courses in physical, social or behavioral sciences offered by accredited colleges and universities.
 3. An approved CE provider may sponsor an organization or individual located within California that wishes to provide a single activity or course. The CE provider shall be responsible for ensuring the course meets all requirements and shall serve as the CE provider of record. The CE provider shall review the request to ensure that the course/activity complies with the minimum requirements.



EMT CONTINUING EDUCATION REQUIREMENTS

PURPOSE

To define requirements for continuing education for certified Emergency Medical Technicians (EMT's) in the Counties of San Bernardino, Inyo and Mono.

AUTHORITY

California Code of Regulations, Title 22, Division 9, Chapter 11 EMS Continuing Education

POLICY

To maintain certification, an EMT shall:

1. Obtain at least twenty-four hours' (24) continuing education hours (CEH) from an approved continuing education provider *or*
2. Complete a twenty-four (24) hour refresher course meeting National Standard Curriculum from an approved EMT training program.
3. Complete a verification of skills. (EMSA Form SCV)

DEFINITIONS

1. Continuing education (CE) is a course, class, activity or experience designed to be educational in nature, with learning objectives and performance evaluations for the purpose of providing EMS personnel with reinforcement of basic EMS training as well as the knowledge to enhance individual and system proficiency in the practice of prehospital emergency medical care.
2. A continuing education hour (CEH) consists of a minimum of fifty (50) minutes of approved classroom or skills laboratory activity. CE courses or activities shall not be approved for less than one (1) hour of credit. For courses greater than one CEH, credit may be granted in no less than half hour increments.

CONTINUING EDUCATION

1. Continuing education hours may be earned in the following manner:
 - a. Any of the topics contained in the respective National Standard Curricula for training EMS personnel.
 - b. Each hour of structural clinical or field experience when monitored by a preceptor assigned by an EMS training program, EMS service provider, hospital or alternate base station approved according to this division.
 - c. Each hour of media based/serial production CE (e.g. films, videos, audiotape programs, magazine articles offered for CE credit, home study, computer simulations or interactive computer modules) A maximum of twelve (12) CE hours may be obtained in a twenty-four (24) hour period.
 - d. Classroom, didactic and/or skills laboratory with direct instructor interaction
 - e. Organized field care audits of patient care records
 - f. Advanced topics in subject matter outside the scope of practice of the certified or licensed EMS personnel but directly relevant to emergency medical care
 - g. Courses offered by accredited universities and colleges, including junior and community colleges. Acceptable courses include physical, social or behavioral sciences (i.e. anatomy, physiology, sociology, psychology) Credit shall be given on the following basis:
 - 1) One academic quarter unit shall equal ten (10) CE hours
 - 2) One academic semester unit shall equal fifteen (15) CE hours
 - h. Structured clinical experience, with instructional objectives, to review or expand the clinical expertise of the individual;
 - i. Sixteen (16) hours of required CEHs must come from courses involving medical management of patients. Non-medical EMS system courses (e.g. ICS, HazMat FRO, Vehicle Extrication, Rope Rescue, etc) will be limited to eight (8) hours maximum per certification cycle.
 - j. Precepting EMS students or EMS personnel as a hospital clinical preceptor, as assigned by the EMS training program, EMS service provider, hospital or base hospital. In order to receive CEHs for precepting, all the requirements

for a course including objectives and student evaluations of the preceptors. CEHs for precepting are limited to a maximum of fifty percent (50%) of required continuing education hours per licensure/certification cycle for all EMS personnel.

- k. At least fifty percent (50%) of the required CE hours must be in an instructor-based format, where an instructor is readily available to the student to answer questions, provide feedback, (e.g., on-line CE course where an instructor is available to the student). The CE provider approving authority shall determine whether a CE course, class or activity is instructor based.
- l. An instructor for a CE course, class or activity will earn credit equal to the same number of CEHs applied to the course, class or activity. This shall be documented on a separate roster, clearly labeled "Instructor" and include the course name. Credit will be given, one time only, for each specific course, during a certification/licensure cycle.
- m. Credit may be given for taking the same CE course, class or activity no more than two (2) times during a single certification cycle.
- n. At the time of the educational event, the student must sign and provide certification/licensure number on the Continuing Education Course Roster. Failure to do so will result in loss of CE credit.
- o. An individual shall provide proof of approved continuing education hours obtained to ICEMA upon request and at the time of application.
- p. An individual who is currently licensed in California as a Paramedic or certified as an EMT-II or who has been certified within six (6) months of the date of application may be given credit for continuing education hours earned as a Paramedic or EMT-II to satisfy the continuing education requirement for EMT recertification.
- q. Continuing education may be obtained at any time throughout the current certification period.



RADIO COMMUNICATION POLICY

PURPOSE

To define the requirements for communication reports between EMS personnel and hospitals. The purpose of communication between EMS and hospitals is to relay essential information to allow the hospital to prepare for the patient, and as necessary, to allow a Base Station to provide Medical Control and consultation to the ALS provider. The communication report should be brief, concise, and include only the information that impacts the care of the patient in the field, and when the patient initially arrives in the hospital. It should not include unnecessary information, or impede the EMS providers focus on patient care. The communications report is not intended to be the complete patient report nor is it equivalent to the “face-to-face” report to the Emergency Department staff at the hospital. Communication reports should be given to the hospital by EMS while on scene, or as soon as possible after departing the scene. Transport of unstable patients, or patients meeting Trauma Triage Criteria shall not be delayed for a communications report. ALS providers may only accept orders from Base Stations within the ICEMA region. Patient names shall not be given over the radio except at the request of the base station physician, and with the prior approval of the patient. Base Station Physicians may give any medically appropriate order within the prehospital provider’s scope of practice.

BLS UNITS

BLS communication reports contain minimal information since BLS units:

- a) Cannot be diverted; and
- b) Cannot carry out medical control orders

BLS communications reports contain:

- a) The EMS unit identifier, and that it is a BLS report;
- b) The patient’s age, sex, chief complaint/injury, and ETA;
- c) Vital signs, Glasgow Coma Scale, and other pertinent signs/symptoms and information.

ALS UNITS

Receiving Hospital communication reports are designed for:

Informing the **receiving** hospital (Base station or otherwise) of incoming patients not requiring medical control orders or consultation.

Receiving Hospital communications reports contain:

- a) The EMS unit identifier, that it is a **receiving hospital** report, and the provider's name/certification level;
- b) The patient's age, sex, chief complaint/injury and ETA;
- c) Information that impacts patient care.

Base Station communication reports are for:

1. Requesting consultation or medical control orders from a Base Station;
2. Informing or consulting with a Specialty Base Station (Trauma, STEMI, Stroke Center, etc...)
3. Patients receiving ALS interventions:
 - a. Who do not improve; or
 - b. Who are not being transported by ambulance; or
 - c. Prior to terminating resuscitative efforts.
4. All patients under nine years old that are not transported by ambulance. Base Station contact shall be made while the EMS provider is on scene (if safe).
5. Interfacility transfers needing medications and/or a destination change per protocol #8010.
6. Multiple Casualty Incidents (MCI) per protocol #5050.

Base Station communications reports are to contain:

- a) The EMS unit identifier, that it is a **Base Station** report, and the provider's name/certification level;

- b) The severity of the patient, and if the patient is a “specialty” patient (Trauma, STEMI, Stroke, etc.);
- c) Patient age, sex, general appearance, weight in kilos, and level of responsiveness (or Glasgow Coma Scale when appropriate);
- d) Chief complaint/injuries, and mechanism of injury/patient situation;
- e) Vital signs, cardiac monitor reading, and remarkable physical exam findings;
- f) Pertinent medical history;
- g) Prior to contact treatment initiated and patient response;
- h) Information that impacts patient care;
- i) ETA.

Base Stations will provide:

- a) Contact time, and the name of the MICN (and Base Station Physician when present);
- b) Consultation and medical control orders appropriate to the patient condition.

PATIENT DESTINATION

Patient/guardian/family/law enforcement requests for a given hospital with Emergency Department capability should be honored. Exceptions may include:

- a) Patient condition and/or protocol require transport to a closer or more appropriate (Specialty) hospital.
- b) All patients on a 5150 hold must go to the closest facility for medical clearance prior to transfer to a psychiatric facility.
- c) Requested hospital is on internal disaster.
- d) Requested hospital is significantly beyond the primary transport area of the transporting department or division.

In cases where the patient/guardian is demanding transport to a facility against the judgment of the paramedic, Base Station contact will be made, and patient destination becomes the responsibility of the Base Station Physician. If the patient/guardian continues

to demand transport to a facility against the judgment of the Base Station Physician, they must be informed of the risks of their decision, up to and including death. The patient/guardian may sign a Release of Liability to go to their hospital choice. The Patient Care Report will document the circumstances of the refusal.

HELICOPTER TRANSPORTS

In San Bernardino County, the San Bernardino County Communications Center (Comm Center) will assign the destination hospital for trauma patients when a request for a helicopter is received.

1. When possible, Comm Center will notify both the ground EMS units and the responding helicopter of the assigned destination hospital.
2. Trauma Base Contact should be made as soon as practical by the ground EMS personnel or the aircrew.
3. Whenever possible, **Trauma Base Contact will be made with the Trauma Hospital that will actually be receiving the patient.**
4. Upon arrival of the helicopter, the ground EMS personnel will give a patient report to the aircrew, and include:
 - a) The assigned destination hospital (if known);
 - b) If Trauma Base Contact has been made (and with which Trauma Base); and
 - c) If the assigned destination hospital was changed (and the reason for the change).
5. The helicopter aircrew will contact the *actual* receiving Trauma Hospital to:
 - a) Request a landing pad assignment;
 - b) Provide a patient report, or update on patient condition; and
 - c) Inform them if Trauma Base Contact was originally made with a different Trauma Base.

If the original Trauma Base Contact was made with a different Trauma Base, the actual receiving Trauma Hospital will notify the original Trauma Base of the change in destination.

INTERFACILITY TRANSPORT GUIDELINES (ALS) PROTOCOL 8010

Interfacility transport patients with a deteriorating condition significant enough to require medication administration and/or a destination change require Base Station contact.

- a. Paramedics may initiate Prior to Contact protocols, and shall make Base Station contact. The Base Station will be notified of the status change of the patient, the medications administered prior to contact and any need for further orders or destination changes.
- b. The Base Station shall notify both the sending facility and the original receiving facility of a destination change.
- c. The Base Station will include an evaluation of any destination change in their ICEMA CQI report.



EMT AED SERVICE PROVIDER POLICY

DELETE POLICY

PURPOSE

To establish a standard mechanism for approval and designation of EMT AED Service Providers in the ICEMA region.

AUTHORITY

Health and Safety Code, Division 2.5, Sections 1797.196, California Code of Regulations Title 22 Division 9., Chapter 2 Emergency Medical Technician I.

POLICY

ICEMA shall approve all EMT AED service providers prior to beginning service. Approval may be revoked or suspended for failure to comply with requirements of this policy or Title 22.

EMTAED SERVICE PROVIDER APPROVAL

Provider agencies that are seeking approval to implement AED services shall submit the following to ICEMA for review and approval prior to beginning service:

1. Description of the area served by the provider agency.
2. The model name of the AED(s) to be utilized.
3. Identify the individual responsible for managing the AED program.
4. Identify the primary instructor with qualifications and the training program to be used.
5. Policies and procedures to ensure orientation of AED authorized personnel.
6. Procedures for maintenance of the AED.
7. Policies and procedures to collect, maintain and evaluate patient care records. Attached AED Event Summary Worksheet may be utilized.

RECORD KEEPING AND REPORTING REQUIREMENTS

1. The following data will be collected and reported to ICEMA by March 1 for the previous calendar year.
 - a. The number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care.
 - b. The total number of patients on whom defibrillatory shocks were administered, witnessed (seen or heard) and not witnessed.
 - c. The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation.
2. Provider must maintain a listing of all AED personnel and provide upon request to ICEMA.

DELETE POLICY



FIRELINE PARAMEDIC

PURPOSE

To provide guidance and medical oversight for an ICEMA paramedic deployed to function as a fireline paramedic.

This protocol is for use by authorized fireline paramedics during fire suppression activities and treatment of fire suppression personnel only.

AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.220 California Code of Regulations, Title 22, Division 9, Sections 100165 and 100167 California Fire Service and Rescue Emergency Mutual Aid System, Mutual Aid Plan, (3-2002). California Code of Regulations Title 22, Division 9, Section 100165 (l) states: *“During a mutual aid response into another jurisdiction, a paramedic may utilize the scope of practice for which s/he is trained and accredited according to the policies and procedures established by his/her accrediting local EMS agency.”*

DEFINITIONS

Fireline Emergency Medical Technician-P (FEMP): A paramedic who meets all prerequisites established by FIREScope and is authorized by the paramedic’s department to provide ALS treatment on the fireline to ill or injured fire suppression personnel.

REQUIREMENTS

1. Must be a currently licensed paramedic in California.
2. Must be currently accredited paramedic in the ICEMA region.
3. Must be currently employed by an ICEMA approved ALS provider.
4. The FEMP will follow FIREScope FEMP ICS 223-11 Position Manual and all other ICS protocols.
5. The FEMP will check in and obtain briefing from the Logistics Section Chief or the Medical Unit Leader, if established. Briefing will include current incident situation, anticipated medical needs, and local emergency medical system orientation.
6. The FEMP will provide emergency medical treatment to personnel operating on the fireline.

7. The FEMP will follow ICEMA prior to contact protocols if unable to contact the assigned base station.
8. The FEMP may not perform skills outside of the ICEMA scope of practice.

PROCEDURE

1. The provider agency will notify ICEMA of the deployment of the FEMP to an incident.
2. The FEMP will carry inventory in the ALS pack as per the attached inventory list. Inventory will be supplied and maintained by the employing provider agency. Additional items for restock should also be maintained and secured in a vehicle or in the Medical Unit trailer.
3. Incident Medical Units may not have the capability of resupplying controlled substances (narcotics). Providers should stock sufficient quantities of medical supplies and medications, especially controlled substance medications, to assure adequate supplies and medications.
4. Narcotics must be under double lock and maintained on the FEMP person or secured in his/her vehicle at all times as per the ICEMA Drug and Equipment List.
5. FEMP may carry an inventory of controlled substances (i.e. Morphine and Midazolam) if authorized by the employing agency's Medical Director. The authorizing Medical Director is responsible to assure full compliance with all federal and state laws relating to purchase, storage and transportation of controlled substances. Only controlled substances approved for use in the ICEMA region may be carried and their use must be in accordance with current ICEMA patient care protocols.
6. Radio communication failure protocols will not be used. Prior to base contact protocols will be followed. If further treatment is needed, radio contact with the base station should be established as soon as possible.
7. Documentation of patient care must follow ICEMA protocol utilizing the ePCR, if available, or a paper O1A form. All patient care reports will be reviewed by the provider agency and ICEMA for QI purposes.
8. A FEMP will be paired with a fireline EMT (FEMT) or another FEMP who will assist with BLS treatment and supplies.

FIRELINE EMT-P (ALS) PACK INVENTORY

Minimum Requirements. The weight of the pack will dictate if the paramedic chooses to carry additional ALS supplies.

ALS AIRWAY EQUIPMENT

1. Endotracheal intubation equipment:
 - a. 6.0, 7.0 and/or 7.5 ET
 - b. Mac 4, Miller 4, and handle (pediatric suggested for weight)
 - c. Stylet and/or gum elastic intubation stylet
2. King Airway -- one each - Size 3, 4 and 5
3. ET tube holder
4. End tidal CO2 Detector
5. Needle cricothyrotomy kit
6. Needle thoracostomy kit

IV/MEDICATION ADMINISTRATION SUPPLIES

1. IV administration set macro drip (2)
2. Venaguard (2)
3. Alcohol preps (6)
4. Betadine swabs (4)
5. Tourniquet (2)
6. Razor (1)
7. Tape (1)
8. IV catheters 2 each - 14, 16, 18 and 20 gauge
9. 10cc syringe (2)
10. 1 cc TB syringe (2)
11. 18 gauge needle (4)
12. 25 gauge needle (2)
13. Lancets

MISCELLANEOUS

1. Sharps container (1)
2. Narcotic storage per protocol
3. FEMP pack inventory sheet (1)
4. Patient care record or ePCR (Toughbook)
5. AMA forms (3)

EQUIPMENT

1. Compact AED or compact monitor defibrillator combination
2. Appropriate cardiac pads
3. Pulse oximetry (optional)
4. Glucometer and test strips (4)

MEDICATIONS

1. Albuterol Solution 2.5 mg (4) Handheld Nebulizer or Multidose Inhaler
2. Atropine Sulfate 1 mg (2)
3. Ipratropium Bromide Solution 0.5mg (4) Handheld Nebulizer or Multidose Inhaler
4. Lidocaine 100 mg IV pre-load (2)
5. Aspirin 80 mg chewable bottle (1)
6. Dextrose 50% 25gm pre-load (1)
7. Diphenhydramine 50 mg (4)
8. Epinephrine 1: 10,000 1mg (2)
9. Epinephrine 1: 1000 1mg (4)
10. Glucagon 1mg (1)
11. Midazolam 20 mg
12. Morphine Sulfate 10 mg/ml (amount determined by the medical director)
13. Nitroglycerin spray 0.4 metered dose (1)
14. Saline 0.9% IV 1000 ml may be divided in two 500ml bags or four 250 ml bags.

The BLS pack and supplies will be carried by the FEMT or accompanying FEMP. Personal items and supplies cannot be carried in either the ALS pack or the BLS pack.



AXIAL SPINAL STABILIZATION

FIELD ASSESSMENT/TREATMENT INDICATORS

Any patient in which axial spinal stabilization is clinically indicated, including but not limited to the following:

1. Patient meets Mechanism of injury as described in Protocol reference #15030, Trauma Triage Criteria and Destination Policy
2. Soft tissue damage associated with trauma and/or blunt trauma above the clavicles
3. Unconscious patients where the mechanism of injury is unknown.
4. All intubated neonatal and pediatric patients.
5. Cervical pain or pain to the upper 1/3 of the thoracic vertebrae. Spinal tenderness or pain, with or without movement of the head or neck, distal numbness, tingling, weakness or paralysis.
6. Altered mental status.
7. Appear to be under the influence of alcohol or other drugs (even if the patient is alert and oriented).
8. Additional sites of significant distracting pain or is experiencing emotional distress.
9. Less than four (4) years of age with appropriate injuries requiring axial spinal stabilization.
10. Unable to adequately communicate with the EMS personnel due to a language barrier or other type of communication difficulty.
11. Any other condition that may reduce the patient's perception of pain.

ALS personnel may remove patients placed in axial spinal stabilization by First Responders and BLS personnel if the patient does not meet **any** of the above indicators after a complete assessment and documentation on the patient care record:

INTERVENTIONS

1. Apply manual axial stabilization.
2. Assess and document distal function before and after application.
3. For pediatric patients: If the level of the patient's head is greater than that of the torso, use an approved pediatric spine board with a head drop or arrange padding on the board to keep the entire lower spine and pelvis in line with the cervical spine and parallel to the board.
4. For patients being placed on a board, consider providing comfort by placing padding on the backboard.
5. Any elderly or other adult patient who may have a spine that is normally flexed forward should be stabilized in patient's normal anatomical position.
6. When a pregnant patient in the third trimester is placed in axial spinal stabilization, place in the left lateral position to decrease pressure on the Inferior Vena Cava.
7. Certain patients may not tolerate normal stabilization positioning due to the location of additional injuries. These patients may require stabilization in their position of comfort. Additional materials may be utilized to properly stabilize these patients while providing for the best possible axial spinal alignment.



BRADYCARDIAS - ADULT

ASYMPTOMATIC BRADYCARDIA

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Heart rate less than 60 bpm.
2. Signs of adequate tissue perfusion.

BLS INTERVENTIONS

1. Recognition of heart rate less than 60 bpm..
2. Reduce anxiety, allow patient to assume position of comfort.
3. Administer oxygen as clinically indicated.

ALS INTERVENTIONS

1. Establish vascular access if indicated. If lung sounds clear, consider bolus of 300cc NS, may repeat.
2. Place on cardiac monitor and obtain rhythm strip for documentation with copy to receiving hospital

SYMPTOMATIC BRADYCARDIA

FIELD ASSESSMENT/TREATMENT INDICATORS

Signs of inadequate tissue perfusion/shock.

BLS INTERVENTIONS

1. Recognition of heart rate less than 60 bpm.
2. Reduce anxiety, allow patient to assume position of comfort.
3. Administer oxygen as clinically indicated.

ALS INTERVENTIONS

1. Consider advanced airway, as indicated.
2. Administer IV bolus of 300cc. Maintain IV rate at 300cc/hr if lungs remain clear to auscultation.
3. Place on Cardiac monitor and obtain rhythm strip for documentation. Provide copy to receiving hospital.
4. Administer Atropine 0.5mg IVP. May repeat every five (5) minutes up to a maximum of 3mg or 0.04mg/kg.
5. **Consider TCP**, per Protocol Reference #10110, instead of Atropine for documented MI, 3rd degree AV Block with wide complex and 2nd degree Type II AV Block.
6. Attempt transcutaneous cardiac pacing of a bradycardic rhythm with continued symptoms of inadequate tissue perfusion.
7. Consider Dopamine 400mg in 250 cc of NS to infuse at 5-20 mcg/ kg/min, titrated to sustain a systolic B/P greater than 90mmHg, and signs of inadequate tissue perfusion/shock.
8. Contact Base Station.