



# INYO COUNTY EMERGENCY MEDICAL CARE COMMITTEE



Hosted by: Sierra LifeFlight

Held at Bishop Fire Training Facility  
960 Poleta Rd, Bishop CA 93514

**March 28, 2011**  
**QI Committee --5:00 p.m.**  
**EMCC -- 6:00 p.m.**

## A G E N D A

- I. CALL TO ORDER**
- II. APPROVAL OF JANUARY 24, 2011 MINUTES** **ACTION**
- III. ICEMA UPDATE** **INFO/ACTION**
  - A. Legislative Update
  - B. QI Plan
- IV. EMS SYSTEM MANAGEMENT REPORTS** **INFO/ACTION**
  - A. Base Hospital Report
  - B. Scantron/ePCR Report
- V. OLD BUSINESS** **INFO/ACTION**
  - A. EMS Strategy Subcommittee Report
  - B. EMT Education/NREMT Testing Sites
  - C. EMS Debriefing Program
  - D. MCI Plan
  - E. Other
- VI. NEW BUSINESS** **INFO/ACTION**
  - A. EMCC Annual Report – First Reading
  - B. Tactical Interoperable Communications Plan (TCIP)
  - C. EMS Volunteer of the Year
- VII. OTHER/PUBLIC COMMENT**
- VIII. COMMITTEE MEMBER REQUEST FOR TOPICS FOR NEXT MEETING**
- IX. NEXT MEETING DATE AND LOCATION**
- X. ADJOURNMENT**

*The Inyo 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.*



**INYO COUNTY EMCC MEETING  
OWENS VALLEY UNIFIED SCHOOL DISTRICT, CAFETERIA BUILDING**

**Hosted by:**

**Lone Pine Fire Department**

**MINUTES**

**January 24, 2011**

**Voting Members Present:**

Dr. Michael Dillon	ER Physician	<a href="mailto:MichaelDillon@qnet.com">MichaelDillon@qnet.com</a>
Dr. Rick Johnson	Inyo County Public Health	<a href="mailto:drrickjohn@gmail.com">drrickjohn@gmail.com</a>
Joe Cappello	Independence Fire Department	<a href="mailto:jcappello@cebridge.net">jcappello@cebridge.net</a>
Judd Symons, Vice Chair	Symons Emergency Specialties, Inc.	<a href="mailto:juddsymons@aol.com">juddsymons@aol.com</a>
Le Roy Kritz	Lone Pine Fire Department, Chief	<a href="mailto:LChief2401@lonepinetv.com">LChief2401@lonepinetv.com</a>
Lee Barron	Southern Inyo Hospital	<a href="mailto:leebee40@aol.com">leebee40@aol.com</a>
Lloyd Wilson	Big Pine Fire Department	<a href="mailto:dlwilson41@msn.com">dlwilson41@msn.com</a>
Mike Patterson	Sierra Life Flight, Program Director	<a href="mailto:mike@sierraaviation.com">mike@sierraaviation.com</a>
Phil Ashworth	Independence Fire Department	<a href="mailto:philinyo@usamedia.tv">philinyo@usamedia.tv</a>
Steven Davis	Olancha Cartago Fire Dept., Chief	<a href="mailto:olanchafire@aol.com">olanchafire@aol.com</a>

**Voting Members Absent:**

Andrew Stevens	Northern Inyo Hospital	<a href="mailto:Andrew.stevens@nih.org">Andrew.stevens@nih.org</a>
Martha Reynolds	Northern Inyo Hospital	<a href="mailto:marthareynolds@nih.org">marthareynolds@nih.org</a>
Paul Postle, Chairperson	So. Inyo Fire Prot. District, Chief	<a href="mailto:paul2701@wildblue.net">paul2701@wildblue.net</a>

**Other Attendees:**

Charles Abbott	Olancha Cartago Fire Dept.	<a href="mailto:charlesabott@gotsky.com">charlesabott@gotsky.com</a>
Colleen Wilson	Southern Inyo Hospital	<a href="mailto:cwilson@sihd.org">cwilson@sihd.org</a>
Denice Stiles	ICEMA	<a href="mailto:dwickler-stiles@cao.sbcounty.gov">dwickler-stiles@cao.sbcounty.gov</a>
George Stone	ICEMA	<a href="mailto:george.stone@cao.sbcounty.gov">george.stone@cao.sbcounty.gov</a>
Gina Ellis	ICHHS, Recording Secretary	<a href="mailto:gellis@inyocounty.us">gellis@inyocounty.us</a>
Jean Turner	Health & Human Services, Director	<a href="mailto:jturner@inyocounty.us">jturner@inyocounty.us</a>
John Marzano	Big Pine Fire Department	<a href="mailto:BigPineFire@chilitech.net">BigPineFire@chilitech.net</a>
John Mueller	ICEMA	<a href="mailto:jmueller@cao.sbcounty.gov">jmueller@cao.sbcounty.gov</a>
Lisa Erwin	Northern Inyo Hospital	<a href="mailto:Lisa.Erwin@NIH.org">Lisa.Erwin@NIH.org</a>
Marty Fortney	Inyo County Supervisor	<a href="mailto:mfortney@inyocounty.us">mfortney@inyocounty.us</a>
Melissa Best-Baker	Inyo County Public Health	<a href="mailto:mbestbaker@inyocounty.us">mbestbaker@inyocounty.us</a>
Paul Easterling	ICEMA	<a href="mailto:peasterly@cao.sbcounty.gov">peasterly@cao.sbcounty.gov</a>
Ray G. Seguine	Bishop Fire Department	<a href="mailto:Seguine@ca-bishop.us">Seguine@ca-bishop.us</a>
Tamara Cohn	Inyo County Public Health	<a href="mailto:tcohn@inyocounty.us">tcohn@inyocounty.us</a>
Virginia Hastings	ICEMA	<a href="mailto:vhastings@cao.sbcounty.gov">vhastings@cao.sbcounty.gov</a>

**I. CALL TO ORDER**

Vice Chairperson, Judd Symons called the meeting to order at 6:04 p.m.

## **II. APPROVAL OF NOVEMBER 1, 2010 MINUTES**

Motion Lloyd Wilson, seconded by Steve Davis to approve the minutes of the November 1, 2010 EMCC meeting. Motion carried unanimously.

## **III. ICEMA UPDATE**

Virginia Hastings introduced George Stone who will be assuming some of Diane Fisher's duties. She informed the group that there was a new website which is still available at [www.ICEMA.net](http://www.ICEMA.net). Anyone who has suggestions or comments on the website should send their comments to ICEMA. She reported that ICEMA continues to work with EMSA on various issues including EOA guidelines.

## **IV. EMS SYSTEM MANAGEMENT REPORTS**

### **A. Base Hospital Report**

Nothing to report; ICEMA did not received anything for this quarter from local hospitals.

### **B. Scantron/ePCR Report**

Scantron reports for the 2010 calendar year were distributed at Q.I. meeting earlier in the evening.

## **V. OLD BUSINESS**

### **A. EMS Strategy Subcommittee Report**

Nothing to report

### **B. EMT Education**

- 1. Maddy Funds; any interest in redistributing the 17%.**
- 2. Other funding sources for EMT education.**

Jean Turner led the group through a discussion on funding sources for EMT education, and discussed the distribution method for Maddy Funds. Some of the funds that were not used last year went towards partial payment of the 2010 summer EMT program. Some members of the group felt that using Maddy Funds for EMT education should be a last resort, since Maddy Funds are one of the only ways that local departments get needed equipment. A suggestion was made that if there are unspent funds after departments have requested their funding annually, then the funding should be applied towards

EMT education. Suggestions for education funding included; sponsorship from local businesses and continuing to look into grants.

There was further discussion on the challenges with the EMT courses. A comment was made that EMT education needs are not being met through local colleges; there was lengthy group discussion on the subject. Virginia Hastings commented that ICEMA could look at their regional grant and possibly assist with EMT education classes in the amount of \$10,000. She added that there would have to be a commitment from students to take the test and that ICEMA would not be a long-term, or a permanent solution, but could perhaps assist as an interim solution and that in terms of timing, the funding could be identified rather quickly. A suggestion was made that a subcommittee be created for EMT education. There was discussion on how the funding would be split between North and South County for classes. The logistics and lessons learned from past classes can help with future classes. Additionally, a follow-up class could help students pass the test. It was suggested that a class be offered in April 2011 being partially paid for by Maddy funds, and the rest paid by with ICEMA funding or grant funding. Ray Seguire of the Bishop Fire Department said that his training facility in Bishop could be made available for a class site in North County. This subject will be a standing item on the agenda. The EMCC members present agreed that \$5,000 would be carved out from future MADDY funds to be applied to EMS education.

**C. EMS Debriefing Program**

None.

**D. Other**

None.

**VI. NEW BUSINESS**

**A. EMCC Membership for 2011-2012**

A list of the 2011-2012 EMCC Membership terms were in the packet.

**B. MCI Plan**

Dr. Rick Johnson spoke about the Mass Casualty Incident (MCI) Plan, saying that he and others had been working on it for over a year and it includes considerations for all agencies. He requested that committee members review the nine (9) page plan in its draft form. The committee asked that the MCI Plan be agendized for the next meeting, where it will be voted on, and then sent to ICEMA for their

consideration. Tamara Cohn spoke about Public Health's task list, and expressed concern with regards to deadlines that are approaching in June. She added that there is a second level that needs to be looked at, and the same members should be a part of that discussion as well.

**C. California Public Health and Medical Emergency Operations Plan**

(Available at [www.bepreparedcalifornia.ca.gov](http://www.bepreparedcalifornia.ca.gov) - public comment period ends Feb 4th)

Dr. Johnson reported on travels to Sacramento, and his efforts on the California Public Health and Medical Emergency Operations Plan. The plan received a blessing from prior administration at CalEMA, but was uncertain about the new administration. The plan is out for public comment through February 4, 2011. He gave an overview of the sections in the document, and said that this is potentially a very valuable document.

**D. EMS Provider of the Year**

Steve Davis spoke about nominations for the 2011 EMS Provider of the Year. He hopes that the committee will receive multiple nominations this year. Nominations forms were handed out to those in attendance, and will also be sent out electronically. Nominations forms must be submitted to Jean Turner by March 15<sup>th</sup>, 2011. ICEMA would like to include this award in their newsletter, and requested that the information and a picture be sent to their office following the presentation.

**E. EMS Radio System**

Radio systems will be changed over to narrowbanding in 2012; the change over needs to be coordinated. There was discussion on radio frequencies, and the repeaters at Mazourka and Rogers. The site rental and costs need to be looked at. Jean Turner will check on whether or not Rogers is being paid for at this time.

**F. QI PLAN**

The draft ICEMA Quality Improvement Plan, dated September 30, 2010, was included in the packet. The plan underwent the 45-day comment period, and received very few comments. Motion by Steve Davis, second by Dr. Johnson to approve the ICEMA Quality Improvement Plan. Motion carried unanimously.

**G. 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

Virginia Hastings stated that the list of protocols on the agenda were coming before the Inyo County EMCC for endorsement. Motion Steve Davis, second Mike Patterson to approve protocols #1-#9 on the agenda. Motion carried unanimously.

**VII. OTHER/PUBLIC COMMENT**

None.

**VIII. COMMITTEE MEMBER REQUEST FOR TOPICS FOR NEXT MEETING**

Ongoing EMT Education  
MCI Plan (vote needed)

**IX. NEXT MEETING DATE AND LOCATION**

Monday, March 28, 2011. Sierra Lifelight will host at the Bishop Fire Training Facility at 960 Poleta Road, Bishop, CA. Q.I. 5:00 p.m., EMCC 6:00 p.m.

**X. ADJOURNMENT**

Motion to adjourn by Andrew Stevens and second by Lloyd Wilson. Motion carried unanimously. The meeting adjourned at 7:28 p.m.

## EMSAAC Legislative Report 3/16/2011

### **AB 40 (Yamada) Elder abuse: reporting.**

#### **Last Amend:**

**Status:** 01/24/2011-Referred to Coms. on AGING & L.T.C. and PUB. S.

**Location:** 01/24/2011-A AGING & L.T.C.

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Calendar:** 03/29/11 2 p.m. - State Capitol, Room 127 ASM AGING AND LONG-TERM CARE

**Summary:** The Elder Abuse and Dependent Adult Civil Protection Act establishes various procedures for the reporting, investigation, and prosecution of elder and dependent adult abuse. The act requires certain persons, called mandated reporters, to report known or suspected instances of elder or dependent adult abuse. The act requires a mandated reporter to report the abuse to the local ombudsperson or the local law enforcement agency if the abuse occurs in a long-term care facility. Failure to report physical abuse and financial abuse of an elder or dependent adult under the act is a misdemeanor. This bill would, instead, require the mandated reporter to report the abuse to both the local ombudsperson and the local law enforcement agency. This bill would also make various technical, nonsubstantive changes. This bill contains other related provisions and other existing laws.

**Position:** SIA

**Notes:** Amendment to include EMS personnel as mandated reporters.

### **AB 74 (Ma) Public events: Raves: prohibitions.**

#### **Last Amend:**

**Status:** 01/27/2011-Referred to Com. on PUB. S.

**Location:** 01/27/2011-A PUB. S.

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Summary:** Existing law generally prohibits certain assemblages or events that disturb the peace. This bill would provide, subject to exceptions, that any person who conducts a public event at night that includes prerecorded music and lasts more than 3 1/2 hours is guilty of a misdemeanor punishable by a fine of \$10,000 or twice the actual or estimated gross receipts for the event, whichever is greater. This bill contains other related provisions and other existing laws.

**Position:** Watch

### **AB 163 (Jeffries) Department of Forestry and Fire Protection: employment: criminal background checks.**

#### **Last Amend:**

**Status:** 02/10/2011-Referred to Com. on NAT. RES.

**Location:** 02/10/2011-A NAT. RES.

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Calendar:** 03/21/11 2:30 p.m. - State Capitol, Room 447 ASM NATURAL RESOURCES

**Summary:** Existing law requires the Department of Forestry and Fire Protection to be responsible for the fire protection, fire prevention, maintenance, and enhancement of the state's forest, range, and brushland resources, contract fire protection, associated emergency services, and assistance in civil disasters and other nonfire emergencies. This bill would require the department to conduct a state and federal level criminal offender record information search through the Department of Justice prior to hiring an applicant,

as defined, for a position with the department or the State Board of Forestry and Fire Protection, with exceptions. The bill would require the Department of Justice to provide the information electronically, and require the department to request the Department of Justice to provide subsequent arrest notification services. This bill contains other related provisions.

**Position:** Watch

**AB 210 (Solorio) Emergency medical services.**

**Last Amend:**

**Status:** 02/18/2011-Referred to Com. on HEALTH.

**Location:** 02/18/2011-A HEALTH

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Summary:** Existing law establishes the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, which governs local emergency medical service systems. The act authorizes the establishment of an emergency medical care committee in each county and requires the committee to annually review ambulance services operating within the county, emergency medical care offered within the county, and first aid practices in the county. The act also requires the committee to report its observations and recommendations relative to this review to the Emergency Medical Services Authority, and the local EMS agency. This bill would require the establishment of an emergency medical care committee in each county. By increasing the duties of local officials, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

**Position:** Watch

**AB 215 (Beall) Emergency services: Emergency Medical Air Transportation Act.**

**Last Amend:**

**Status:** 02/01/2011-From printer. May be heard in committee March 3.

**Location:** 01/31/2011-A PRINT

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Summary:** The Emergency Medical Air Transportation Act imposes specified penalties for certain Vehicle Code and local ordinance violations. The act requires that the moneys generated from those penalties be deposited by counties into a county emergency medical air transportation act fund, and thereafter requires the counties to transfer those moneys, less administrative costs, to the Emergency Medical Air Transportation Act Fund established in the State Treasury, as provided. The act requires moneys in the Emergency Medical Air Transportation Act Fund to be made available, upon appropriation by the Legislature, to the State Department of Health Care Services for administrative costs, and to offset the state portion of the Medi-Cal reimbursement rate for emergency medical air transportation services and to augment emergency medical air transportation reimbursement payments made through the Medi-Cal program, as specified. This bill would make technical, nonsubstantive changes to these provisions.

**Position:** Watch

**AB 412 (Williams) Emergency medical services.**

**Last Amend:** 03/14/2011

**Status:** 03/15/2011-Re-referred to Com. on HEALTH.

**Location:** 03/15/2011-A HEALTH

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Calendar:** 03/29/11 1:30 p.m. - State Capitol, Room 4202 ASM HEALTH

**Summary:** Existing law authorizes each county to establish an emergency medical services fund, known as a Maddy Emergency Medical Services (EMS) Fund, funded by specified revenue penalties, and makes money in the fund available for the reimbursement of physicians and surgeons and hospitals for losses incurred in the provision of emergency medical services when payment is not otherwise made for

those services. Existing law requires any county that has established a Maddy EMS Fund to deposit into that fund \$2 for every \$7 of additional penalties imposed by the courts for criminal offenses. This bill would reenact those provisions that were repealed on January 1, 2011. The bill would make specified findings and declarations that the special legislation contained in the act is necessarily applicable only to Santa Barbara County. By extending the duties of local officials relating to the collection of those penalty assessments, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

**Position:** Watch

**AB 449 (Mitchell) Telecommunications: mobile telephony service: emergency contact information.**

**Last Amend:**

**Status:** 03/03/2011-Referred to Com. on U. & C.

**Location:** 03/03/2011-A U. & C.

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Summary:** Under existing law, the Public Utilities Commission has regulatory authority over public utilities, including telephone corporations, as defined. This bill would require a mobile telephony services provider, upon activation of service, to cause an emergency contact information, as defined, number to be programmed into the subscriber's mobile telephone, unless the subscriber expressly declines, in writing, to have this service performed.

**Position:** S-1

**AB 655 (Hayashi) Healing arts: peer review.**

**Last Amend:**

**Status:** 03/07/2011-Referred to Com. on B., P. & C.P.

**Location:** 03/07/2011-A B.,P. & C.P.

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Summary:** Existing law provides for the professional review of specified healing arts licentiates through a peer review process conducted by peer review bodies, as defined. This bill would require a peer review body to respond to the request of another peer review body and produce a summary of specified information concerning a licentiate under review, as specified. The bill would provide that the information produced pursuant to this provision is not subject to discovery, as specified, and may be used only for peer review purposes. The bill would require the requesting peer review body, upon request, to sign a specified sharing agreement with the responding peer review body, and to indemnify the responding peer review body for certain claims relating to the improper release or disclosure of information.

**Position:** Watch

**AB 672 (Pan) Emergency medical services.**

**Last Amend:**

**Status:** 02/18/2011-From printer. May be heard in committee March 20.

**Location:** 02/17/2011-A PRINT

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Summary:** Existing law establishes the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, which governs local emergency medical service systems. This bill would make technical, nonsubstantive changes to the act.

**Position:** WC

**AB 706 (Torres) California Public Safety Telecommunicators Week.**

**Last Amend:**

**Status:** 03/07/2011-Referred to Com. on RLS.

**Location:** 03/07/2011-A RLS.

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Summary:** The Warren-911-Emergency Assistance Act requires every local public agency to establish and operate, or to be a part of, an emergency telephone system using the digits "911," and creates the State 911 Advisory Board to assist in facilitating the purpose of the act to establish the number 911 as the primary emergency telephone number statewide. This bill would designate the second full week of April of each year, commencing in 2012, as California Public Safety Telecommunicators Week for the purpose of heightening citizen awareness of the great importance of 911 service and its role in keeping the public safe. The bill would require the Governor and the Legislature to annually issue proclamations and resolutions, as specified, that draw public attention to the week in order to encourage the private sector and state and local agencies to initiate activities recognizing public safety telecommunicators.

**Position:** S-3

**AB 731 (Jeffries) Firefighting.**

**Last Amend:**

**Status:** 03/07/2011-Referred to Coms. on G.O. and NAT. RES.

**Location:** 03/07/2011-A G.O.

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Summary:** This bill would annually appropriate \$1,030,000 of revenue currently received by the state from specified tax and fee revenue sources for firefighting and emergency response purposes, including, but not limited to, the purchase of firefighting and rescue vehicles and equipment. The bill would also require the secretary to consult with additional specified individuals involved in firefighting before adopting certain regulations.

**Position:** Watch

**AB 770 (Torres) Emergency telephone systems.**

**Last Amend:**

**Status:** 03/07/2011-Referred to Com. on U. & C.

**Location:** 03/07/2011-A U. & C.

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Calendar:** 03/21/11 3 p.m. - State Capitol, Room 437 ASM UTILITIES AND COMMERCE

**Summary:** Existing law, the Warren-911-Emergency Assistance Act, requires the office of the State Chief Information Officer to review and update technical and operational standards for public agency systems in each even-numbered year, after consultation with specified entities and individuals. The bill would require the review and update of technical and operational standards for public agency systems to include standards for recruitment and training of public safety dispatchers. This bill contains other related provisions and other existing laws.

**Position:** SIA

**AB 861 (Hill) California Stroke Registry.**

**Last Amend:**

**Status:** 03/10/2011-Referred to Com. on HEALTH.

**Location:** 03/10/2011-A HEALTH

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Calendar:** 03/29/11 1:30 p.m. - State Capitol, Room 4202 ASM HEALTH

**Summary:** Existing law authorizes the State Department of Public Health to perform studies, demonstrate innovative methods, and disseminate information relating to the protection, preservation, and advancement of public health. This bill would establish the California Stroke Registry, to be administered by the State Department of Public Health, as specified, to serve as a centralized repository for stroke data to promote quality improvement for acute stroke treatment. The bill would require that the program be implemented only to the extent funds from federal or private sources are made available for this purpose.

**Position:** Watch

**AB 881 (Cook) Mental health: involuntary commitment: transportation.**

**Last Amend:**

**Status:** 02/18/2011-From printer. May be heard in committee March 20.

**Location:** 02/17/2011-A PRINT

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Summary:** Under existing law, when a person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, he or she may, upon probable cause, be taken into custody and placed in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation. Existing law exempts from criminal or civil liability specified people and entities who detain a person for 72-hour treatment and evaluation pursuant to this provision. This bill would authorize a provider of ambulance services, as defined, and the employees of those providers to further detain a person in custody for the purpose of transporting him or her to a county-designated facility, whether or not accompanied by a person otherwise authorized. The bill would also exempt from criminal and civil liability individuals transporting a person for 72-hour treatment and evaluation pursuant to this provision.

**Position:** S-1

**AB 1074 (Fuentes) Personal liability immunity: telecommunication service providers.**

**Last Amend:**

**Status:** 02/20/2011-From printer. May be heard in committee March 22.

**Location:** 02/18/2011-A PRINT

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Summary:** Existing law provides that a telecommunications service provider is generally liable for any claim, damage, or loss caused by their conduct. This bill would provide that a provider of telecommunication service, or other service, that is involved in providing 9-1-1 service, as defined, is not liable for any claim, damage, or loss caused by an act or omission of the company, and other individuals, in the design, development, maintenance, or provision of 9-1-1 service, unless the act or omission that proximately caused the claim, damage, or loss constituted gross negligence, recklessness, or intentional misconduct.

**Position:** Watch

**AB 1116 (Fong) Emergency services: populations with limited English proficiency.**

**Last Amend:**

**Status:** 02/20/2011-From printer. May be heard in committee March 22.

**Location:** 02/18/2011-A PRINT

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Summary:** Existing law, the California Emergency Services Act, requires the California Emergency Management Agency to coordinate the emergency services of all state agencies in connection with

emergencies, and to establish a standardized emergency management system for use by all emergency response agencies. This bill would require the Secretary of California Emergency Management to consider the multiple languages and needs of populations who have limited proficiency in the English language during emergency preparedness planning, response, and recovery. The bill would also require the secretary to work in collaboration with ethnic media and ethnic community-based organizations in developing communication strategies about alert and warning information, and to use a registry of qualified bilingual persons in public contact positions, as defined, to assist in emergency preparedness, response, and recovery, as the secretary deems necessary.

**Position:** Watch

**AB 1245 (Williams) Emergency medical services.**

**Last Amend:**

**Status:** 02/20/2011-From printer. May be heard in committee March 22.

**Location:** 02/18/2011-A PRINT

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Summary:** Existing law establishes the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, which governs local emergency medical service systems. The act establishes the Emergency Medical Services Authority (EMSA), which is responsible for the coordination and integration of all state agencies concerning emergency medical services. This bill would require the EMSA, if it proposes to adopt or adopts a regulation for the state approval of an emergency medical responder course that is a condition for being an employee or volunteer in a public safety capacity to render first aid in an emergency setting without an EMT-I, EMT-II, or EMT-P certificate, to also require the submission of fingerprint images and related information to the EMSA for a specified criminal background search. This bill contains other existing laws.

**Position:** None

**SB 49 (Strickland) Local government: emergency response: fees.**

**Last Amend:**

**Status:** 02/10/2011-Referred to Com. on PUB. S.

**Location:** 02/10/2011-S PUB. S.

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Summary:** Existing law authorizes public agencies, as defined, to hold liable any person who is under the influence of an alcoholic beverage, any drug, or the combination of an alcoholic beverage and any drug, whose negligent operation of a motor vehicle, a boat or vessel, or a civil aircraft caused by that influence proximately causes any incident resulting in an appropriate emergency response, and any person whose intentionally wrongful conduct proximately causes an incident resulting in an appropriate emergency response, for the expense of that emergency response. This bill would prohibit a city, including a charter city, county, district, municipal corporation, or public authority from charging a fee to any person, regardless of residency, for the expense of an emergency response, as specified, except where a fee is otherwise authorized. This bill contains other related provisions.

**Position:** Watch

**SB 63 (Price) Pupil and personnel health: automatic external defibrillators.**

**Last Amend:** 02/22/2011

**Status:** 03/09/2011-Set for hearing March 23.

**Location:** 03/03/2011-S ED.

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Calendar:** 03/23/11 9 a.m. - John L. Burton Hearing Room (4203) SEN EDUCATION

**Summary:** Existing law authorizes a school district or school to provide a comprehensive program in first aid or cardiopulmonary resuscitation training, or both, to pupils and employees, and requires the program to be developed using specified guidelines. This bill would require a public school maintaining any of grades 9 to 12, inclusive, to acquire and maintain at least one automatic external defibrillator (AED) in a centralized location on campus and to ensure that an AED is available for use at a school-sponsored athletic event, as that term is defined, by July 1, 2012. The bill would require the school to check the AED for readiness and maintain records of those checks, as prescribed. The bill would require the school to prepare a written emergency preparedness plan for use of an AED and to require all persons expected to administer an AED in an emergency to complete a certified training course. By placing additional duties on public schools to acquire and maintain an AED as specified, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

**Position:** Watch

**SB 161 (Huff) Schools: emergency medical assistance: administration of epilepsy medication.**

**Last Amend:** 03/09/2011

**Status:** 03/09/2011-From committee with author's amendments. Read second time and amended. Re-referred to Com. on ED.

**Location:** 03/09/2011-S ED.

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Calendar:** 03/16/11 9 a.m. - John L. Burton Hearing Room (4203) SEN EDUCATION

**Summary:** Existing law provides that in the absence of a credentialed school nurse or other licensed nurse onsite at the school, a school district is authorized to provide school personnel with voluntary medical training to provide emergency medical assistance to pupils with diabetes suffering from severe hypoglycemia. This bill would authorize a school district to provide school employees with voluntary emergency medical training to provide, in the absence of a credentialed school nurse or other licensed nurse onsite at the school, emergency medical assistance to pupils with epilepsy suffering from seizures, in accordance with guidelines developed by specified entities. The bill would allow a parent or guardian of a pupil with epilepsy who has been prescribed Diastat by the pupil's health care provider to request the pupil's school to have one or more of its employees receive voluntary training, as specified, in order to administer Diastat, as defined, in the event that the pupil suffers a seizure when a nurse is not available. The bill would require a school that decides to train school employees to distribute an electronic notice, as specified, to all staff regarding the request. The bill would make various legislative findings and declarations and state the intent of the Legislature in enacting this measure. The bill would repeal these provisions on January 1, 2017.

**Position:** Watch

**SB 336 (León, De) Emergency room crowding.**

**Last Amend:**

**Status:** 02/24/2011-Referred to Com. on HEALTH.

**Location:** 02/24/2011-S HEALTH

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Calendar:** 03/23/11 1:30 p.m. - John L. Burton Hearing Room (4203) SEN HEALTH

**Summary:** Existing law establishes various programs for the prevention of disease and the promotion of health to be administered by the State Department of Public Health, including, but not limited to, the licensure and regulation of health facilities, including general acute care hospitals. Violation of these provisions is a crime. This bill would require every licensed general acute care hospital with an emergency department to determine the range of crowding scores, as defined, that constitute each category of the crowding scale, as provided, for its emergency department. The bill would require every licensed general acute care hospital with an emergency department to calculate and record a crowding score every 4 hours, except as specified, to assess the crowding condition of its emergency department. The bill would require, by January 1, 2013, every licensed general acute care hospital with an emergency

department to develop and implement a full-capacity protocol for each of the categories of the crowding scale. This bill contains other related provisions and other existing laws.

**Position:** Watch

**SB 359 (Hernandez) Medi-Cal: ground ambulance rates.**

**Last Amend:**

**Status:** 02/24/2011-Referred to Com. on HEALTH.

**Location:** 02/24/2011-S HEALTH

2YR/Dead	1st Desk	1st Policy	1st Fiscal	1st Floor	2nd Desk	2nd Policy	2nd Fiscal	2nd Floor	Conf./Conc.	Enrolled	Vetoed	Chaptered
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**Summary:** Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which health care services, including medical transportation services, are provided to qualified low-income persons. The Medi-Cal program is partially governed and funded under federal Medicaid provisions. Existing law and regulations prescribe various requirements governing payment policies and reimbursement rates for these services. This bill would require the department, by July 1, 2012, to adopt regulations establishing the Medi-Cal reimbursement rate for ground ambulance services using one of 2 specified methodologies.

**Position:** Watch



**ICEMA**

**Quality Improvement Plan**

**February 2011**

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## **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**

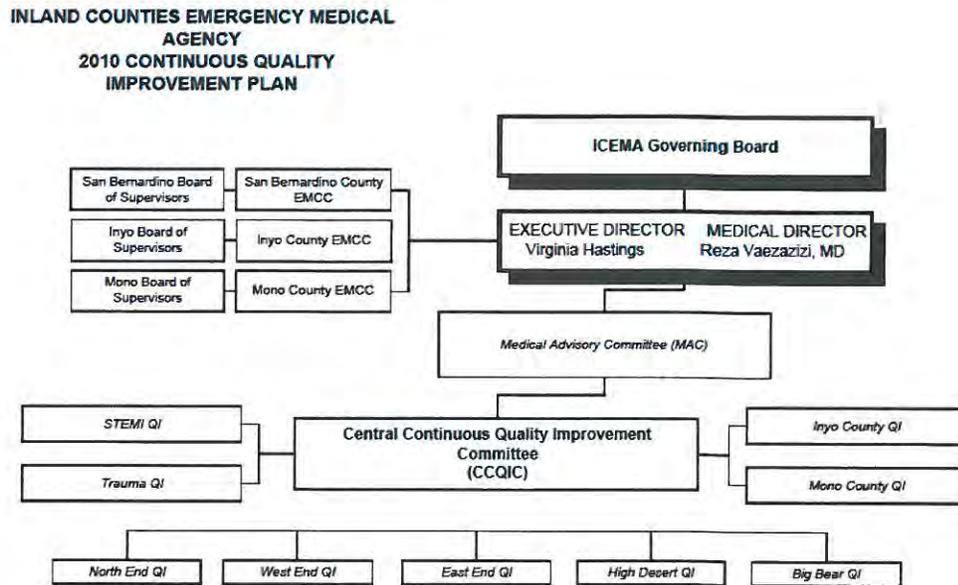
The purpose of the ICEMA CQIP is to establish a system-wide process and provide an effective tool for evaluating and improving the quality of prehospital care within the ICEMA region. This tool will focus on improvement efforts to identify root causes of problems and interventions to eliminate or reduce 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 Critical Care Specialty 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 , 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 Audio File Reviews**

All audio files 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 review 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 or Agency 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 (CEMISIS) 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	WELLNESS WORKLOAD POLICIES AND PROCEDURES ED1 Education and Training Indicator A, B (if provider has EMT-I training school)	WELLNESS WORKLOAD POLICIES AND PROCEDURES BHI Base Hospitals-Activity Indicator B - D
Equipment and Supplies	ePCR INVENTORY CONTROL	COMMUNICATIONS COVERAGE	PREVENTIVE MAINTENANCE PLANS PHARMACEUTICALS	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/VTach 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/VTach 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/VTach 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/VTach 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 PP1 Public Education and Prevention	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 PP1 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 PP1 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 PP1 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/colleagues.
- 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](http://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.

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

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.



# Inland Counties Emergency Medical Agency

*Serving San Bernardino, Inyo, and Mono Counties*

*Virginia Hastings, Executive Director*  
*Reza Vaezazizi, M.D., Medical Director*

February 18, 2011

Dan Smiley, Interim Director  
Emergency Medical Services Authority  
1930 Ninth Street, Suite 100  
Sacramento, CA 95814

Dear Mr. Smiley:

## **RE: NREMT TESTING SITES**

Attached you will find copies of various correspondence sent to EMSA over the past few years from ICEMA, the Mono County Emergency Medical Care Committee (EMCC) and the Inyo County Board of Supervisors. All of these letters have expressed the need for additional National Registry Emergency Medical Technician (NREMT) testing sites within the ICEMA region, specifically Inyo and Mono Counties. These counties have now reached a critical point of declining EMT certifications in the area.

As you are aware, the ICEMA region consists of over 26,000 square miles. Much of Inyo and Mono Counties are either wilderness or rural and served by volunteer fire departments. These fire departments serve a very large tourist population and cover one of the major routes along the Eastern Sierras.

Below is a history of certifications in both counties:

EMT-I	INYO	MONO	TOTAL
Apr-Jun 06	122	112	<b>234</b>
Jul-Sep 06	131	119	250
Oct-Dec 06	123	109	232
Jan-Mar 07	127	102	229
Apr-Jun 07	111	102	213
Jul-Sep 07	107	97	204
Oct-Dec 07	100	91	191
Jan-Mar 08	95	86	181
Apr-Jun 08	95	92	187
Jul-Sep 08	102	96	198
Oct-Dec 08	101	97	198

Jan-Mar 09	98	97	195
Apr-Jun 09	92	95	187
Jul-Sep 09	92	100	192
Oct-Dec 09	91	101	192
Jan-Mar 10	72	80	152
Apr-Jun 10	69	86	155
Jul-Sep 10	70	88	158
Oct-Dec 10	66	83	149

As demonstrated above, the area has experienced a thirty-six percent (36%) decrease in EMT personnel since the initiation of NREMT testing in 2006. This is a significant decline and a serious concern to ICEMA and its constituents. Providers believe this decline is directly related to the additional costs associated with certification and the testing burden. Training sites have also seen a steady decline in those interested in becoming EMTs, especially in the rural environment. ICEMA is working closely with these two counties to increase enrollment in training programs.

It is essential that an additional site be made available within Inyo and/or Mono County. These concerns were first addressed prior to implementation of NREMT testing and ICEMA was assured that additional sites would be explored after the initial year. Cerro Coso Community College in Ridgecrest has an approved Pearson Vue instructor on staff and has received approval as an EMT testing site. The delay appears to be with NREMT.

ICEMA has been in contact with multiple Pearson Vue and NREMT program managers without resolution. We ask that EMSA use its influence as our State Agency to have the Cerro Coso testing center approved and accessible to our constituents in an effort to address our serious concerns about the loss of volunteers in these counties.

Very truly yours,



Virginia Hastings  
Executive Director

VH/dws

Enclosures

c: Inyo Board of Supervisors  
Mono Board of Supervisors  
Inyo EMCC  
Mono EMCC  
Heidi Erb, NREMT  
Catherine Hernandez, Pearson Vue  
File Copy

**EMERGENCY MEDICAL SERVICES AUTHORITY**

1930 9<sup>th</sup> STREET  
SACRAMENTO, CA 95811-7043  
(916) 322-4336 FAX (916) 324-2875



April 8, 2008

Supervisor Linda Arcularius, Chairperson  
Inyo County Board of Supervisors  
P.O. Box N  
Independence, CA 93526

Paul Postle, Chairperson  
Inyo County Emergency Medical  
Care Committee

Dear Chairpersons Arcularius and Postle:

This is in response to your letter regarding the need for an additional testing site in your region for the National Registry of EMTs (NREMT) certification and licensure examinations. I understand and sympathize with the concerns you have for the time and cost for EMT applicants in your jurisdiction to travel to the Los Angeles area to take the examination. I will be discussing your request with the executives of NREMT.

As you may know, when placement of the testing sites was initially being discussed with the representatives of the NREMT and its testing vendor, Pearson VUE, a testing site in Bakersfield was being considered and discussions were being held with Bakersfield College. However, it is my understanding that Bakersfield College did not pursue becoming a test center.

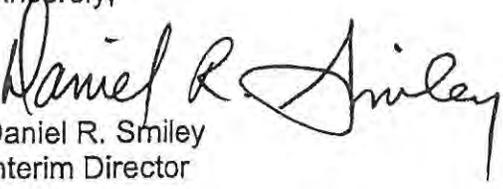
As you may know, there are two types of testing centers – the Pearson Professional Centers, and Pearson VUE Authorized Test Centers. The Pearson Professional Centers are owned and operated by Pearson VUE and provide testing for other professions in addition to EMTs. Pearson VUE Authorized Test Center are entities that meet specific criteria established by Pearson VUE (see enclosed information). There are significant costs associated with operating a designated test site, therefore, the test site must have sufficient examination applicants in order for the test site to be able to continue to operate. We have found that while some agencies have offered to become an approved test site, they were unable to meet the criteria and/or realize sufficient numbers of examinees in order to make the test center fiscally viable.

APR 30 2008

Supervisor Linda Arcularius  
Chairperson Paul Postle  
April 8, 2008  
Page 2

It would be helpful if you could identify an entity in your region that would be interested in becoming a Pearson VUE Authorized Test Center and reviewing the criteria to see if they could meet it. In the meantime your request will be discussed with the staff of the NREMT, and we will advise you of their response.

Sincerely,



Daniel R. Smiley  
Interim Director

Enclosure

cc: Diane Fisher, ICEMA  
Governor Arnold Schwarzenegger  
Senator Roy Ashburn  
Assemblyman Bill Maze  
RCRC  
CSAC

DRS:njs

# INLAND COUNTIES EMERGENCY MEDICAL AGENCY



515 N Arrowhead Avenue  
San Bernardino CA 92415-0060  
(909) 388-5823 Fax (909) 388-5825

April 24, 2008

Dan Smiley, Interim Director  
Emergency Medical Services Authority  
1930 Ninth Street, Suite 100  
Sacramento, CA 95814

## RE: NREMT TESTING SITES

Dear Mr. Smiley:

Attached you will find copies of various correspondence sent to Dr. Aristeiguieta between November 2006 and March, 2008 from ICEMA, the Mono County Emergency Medical Care Committee (EMCC) and the Inyo County Board of Supervisors. All of these letters request additional National Registry Emergency Medical Technician (NREMT) testing sites within the ICEMA region. To date, we have not received a response to these letters.

As you are aware, the ICEMA region consists of over 26, 000 square miles. Much of Inyo and Mono Counties are either wilderness or rural and served by volunteer fire departments. These fire departments serve a very large tourist population and cover one of the major routes along the Eastern Sierras.

Below is a history of certifications in both counties:

EMT-I	INYO	MONO	TOTAL
<b>Apr-Jun 06</b>	122	112	<b>234</b>
<b>Jul-Sep 06</b>	131	119	250
<b>Oct-Dec 06</b>	123	109	232
<b>Jan-Mar 07</b>	127	102	229
<b>Apr-Jun 07</b>	111	102	213
<b>Jul-Sep 07</b>	107	97	204
<b>Oct-Dec 07</b>	100	91	191
<b>Jan-Mar 08</b>	95	86	<b>181</b>

This is a significant decline and a serious concern to ICEMA and its constituents. Providers believe this decline is directly related to the additional cost and testing burden. Training sites have also seen a steady decline in those interested in becoming EMT-Is.

Emergency Medical Services Authority  
NREMT Testing Sites  
April 24, 2008  
Page 2

It is essential that additional sites be made available, within the ICEMA region. These concerns were first addressed prior to implementation of NREMT testing and ICEMA was assured that additional sites would be explored after the initial year.

I look forward to your response.

Very truly yours,

A handwritten signature in cursive script, appearing to read "Virginia Hastings".

Virginia Hastings  
Executive Director

cc: Diane Fisher  
Inyo EMCC  
Mono EMCC  
Inyo Board of Supervisors  
Mono Board of Supervisors



## BOARD OF SUPERVISORS COUNTY OF INYO

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*Assistant Clerk of the Board*

January 8, 2008

Mr. Cesar A. Aristeiguieta, M.D.  
Emergency Medical Services Authority  
1930 Ninth Street, Suite 100  
Sacramento, CA 95814

Re: NREMT Sites

Dear Dr. Aristeiguieta:

The Inyo County Board of Supervisors strongly supports our Inyo County Emergency Medical Care Committee (EMCC), which values the standardization of Emergency Medical Technicians through the National Registry as a means to ensure all EMTs are trained to the same level. However, the Board and the EMCC are concerned the certification process has placed an unusual strain on local EMS agencies and their volunteer EMTs along the Eastern Sierras.

Additionally, we are concerned about the availability of National Registry testing sites for EMTs in our region. EMS providers along the Eastern Sierra's are made up of volunteer staff that are required to obtain certification at their own expense. Besides losing time and money from work to complete the EMT certification process, volunteer EMTs in Inyo County will be required to travel between 235 and 264 miles in order to become certified. The closest National Registry Testing Center is in the Los Angeles area and is estimated to cost a minimum of \$227.95 per round trip. The EMCC predicts that many volunteer EMT's in Inyo County may allow their certification to expire because the cost associated with the distance of testing for National Registry is too much to deal with. A decrease in EMS staff in Inyo County will severely impact the availability of pre hospital care and significantly impact the health care system within Inyo County.

The EMCC recognizes that National Registered EMTs translates into better pre hospital care providers. However, the cost associated with becoming an EMT in California is placing a financial burden on local EMS agencies and their volunteers. To help reduce the financial burden to local EMS agencies and their volunteers, the EMCC is respectfully asking the EMSA to consider placing a National Registry Testing Center along the Eastern Sierra corridor. The Board and the EMCC believe there are a couple of locations that are secure and readily available for local National Registry testing. Please let us know what the County of Inyo and our EMCC can do to help you facilitate our request.

Sincerely,

  
Supervisor Linda Arcularius, Chairperson  
Inyo County Board of Supervisors

Sincerely,

  
Paul Postle, Chairperson  
Inyo County Emergency Medical Care Committee

cc: Diane Fisher, ICEMA  
Governor Arnold Schwarzenegger  
Senator Roy Ashburn  
Assemblyman Bill Maze  
RCRC  
CSAC

# COUNTY OF MONO

## DIVISION OF EMERGENCY MEDICAL SERVICES

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P.O. Box 476 Bridgeport, Ca. 93517 \* (760) 934-3049 \* Fax (760) 934-5198

March 1<sup>st</sup>, 2008

Dr. Cesar A. Aristeiguieta  
Director, Emergency Medical Services Authority  
State of California  
1930 9<sup>th</sup> Street  
Sacramento, Ca. 95814

Re: NREMT testing sites

Dear Dr. Aristeiguieta,

I am writing this letter as Chairman of the Mono County Emergency Medical Care Committee. The E.M.C.C. and the County of Mono are concerned with the current process of testing requirements for new and re-certifying EMTs within our State. I am aware that Inyo County, our neighbor to the south, has also recently expressed their concerns along the same lines. Both Mono and Inyo Counties utilize a predominance of volunteer Fire Departments that deploy EMTs as first responders for emergency medical requests, thru the 911 system. We support the State's efforts to improve and standardize training and oversight for EMT operations. However, the logistical difficulties and expenses related to accessing testing sights are proving to be too much of a burden for volunteer EMTs. In many cases the local Fire Districts have very limited budgets and paying for these increased EMT testing costs is difficult. Even if costs can be covered, the amount of time needed to travel to the observed testing sights is prohibitive for the average volunteer that works fulltime. The end result is a decrease in EMT availability and a negative impact on public safety in our rural area.

Like Inyo County, we would suggest a testing center somewhere along the Eastern Sierra corridor that could be better accessed by both Mono and Inyo County EMTs. This concept has merit; as it could potentially help maintain the EMT-based first response currently serving the citizens and visitors within the thousands of square miles that make up both Counties. I believe that both Inyo and Mono Counties could work cooperatively through their prospective Emergency Medical Care Committees to help the State identify a new testing sight with greater accessibility for our combined EMTs; should the State consider this a viable option.

Thank you for your consideration of this issue and please feel free to contact me if there is anything that I can do to help facilitate this request. I am also interested in exploring any other options or suggestions provided by your office.

Sincerely,

Mark Mikulicich,  
Chief, Fire and Paramedic Rescue  
County of Mono, California  
(760) 684-1565 (cell) or (760) 934-3049  
P.O. Box 2415, Mammoth Lakes, Ca. 93546  
[mmikulicich@mono.ca.gov](mailto:mmikulicich@mono.ca.gov)

cc: Diane Fisher, ICEMA



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**Officials work to save EMTs**

Friday, 11 January 2008

By Mike Gervais  
Register Staff

1-10-2008

In an attempt to ensure that Inyo County doesn't lose its cadre of volunteer EMTs and firefighters, local officials are working on a way to make it easier for first responders to become and stay certified.

Three local fire officials along with a representative from Inyo County Health and Human Services are lobbying the California Emergency Medical Services Authority for a new first-responder testing site in the Eastern Sierra.

Those four individuals got support from the Inyo County Board of Supervisors on Tuesday, when they explained that all they really want is a standardized EMT testing facility somewhere in or near Inyo County to help cut the costs incurred by local volunteers who currently have to go to the Los Angeles area to complete their EMT mandates.

Southern Inyo Fire Protection District Chief Paul Postle (also chairman of the Inyo County Emergency Medical Care Committee), Lone Pine Fire Chief Leroy Kritz, Big Pine Assistant Fire Chief Lloyd Wilson and Inyo County Health and Human Services Director Jean Dickinson were in attendance at Tuesday's Board of Supervisors meeting in support of drafting a letter to Emergency Medical Services Authority Director Cesar A. Aristeiguieta, M.D. requesting more regional training sites for EMTs.

The Board of Supervisors showed unanimous support and agreed to sign the letter Postle drafted to the Emergency Medical Services Authority and attempt to reach local legislators and garner more support for the cause.

"The Inyo County Emergency Medical Care Committee (EMCC) values the standardization of Emergency Medical Technicians through the National Registry as a means to ensure all EMTs are trained to the same level," states the letter to the Emergency Medical Services Authority. "However, the EMCC is concerned the certification process has placed an unusual strain on local EMS agencies and their volunteer EMTs along the Sierra."

Postle explained that the Inyo County EMCC fears that these added burdens on the county's mostly volunteer EMT staff may result in a decline in trained emergency medical responders.

"The EMCC is concerned about the availability of National Registry testing sites for EMTs," Postle told the board of Supervisors on Tuesday. "All the National Registry testing sites are on the Coast."

Local EMS providers throughout most of Inyo and Mono counties work on a volunteer basis and have traditionally obtained the required training and certification to work as an EMT at their own expense. Lately those expenses, including the cost of physicals, testing, classes and gas expenses to travel between 235 and 264 miles to testing sites, have been on the rise. According to Postle, the closest National Registry testing center is in the Los Angeles area "and is estimated to cost a minimum of \$227.95 per round trip" just to get to the testing site. There is also a charge to take the test, he said. In his letter to the Emergency Medical Services Authority, Postle also points out that because most local EMTs are volunteers, they are taking time off from their regular jobs and losing pay to take the test and

receive certification.

"The EMCC predicts that many volunteer EMTs in Inyo County may allow their certification to expire because the cost associated with the distance of testing for National Registry is too much to deal with," states the letter.

"The EMCC recognizes that the National Registered EMTs translates into better pre-hospital care," Postle told supervisors, reading from the letter to the Emergency Medical Services Authority. "However, the cost associated with becoming an EMT in California is placing a financial burden on local EMS agencies and their volunteers."

Postle is hoping that, with the aid of Inyo County and local emergency service agencies, the Emergency Medical Services Authority will consider placing a National Registry Testing Center along the Eastern Sierra corridor.

According to Postle, the EMCC can even help the Emergency Medical Services Authority identify "secure and available locations within the area that could serve as a National Registry testing site.

Inyo County First District Supervisor Linda Arcularius suggested that the board get involved by contacting local legislators to obtain more support.

The Board of Supervisors also suggested getting in touch with first responders in Mono and Alpine counties and requesting they generate a similar letter, as both those counties rely on volunteer EMTs, much like Inyo County, and are facing the same financial hardships.

Second District Supervisor Susan Cash recommended that the Inyo County Board of Supervisors agendaize a discussion regarding a new National Registry testing center on the Eastern Sierra Council of Governments agenda to ensure that the City of Bishop, Mammoth Lakes and Mono County all have the opportunity to participate.

Last Updated ( Friday, 22 February 2008 )

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It...



It...

...good idea for kids to have a safe path to school and not worry about the increased traffic on West Line Street during the peak hours in the morning.

Carlos Hernandez - Bishop, CA

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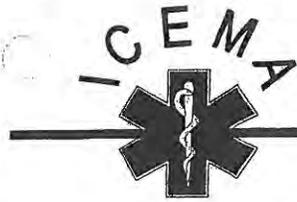
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# INLAND COUNTIES EMERGENCY MEDICAL AGENCY



515 N Arrowhead Avenue  
San Bernardino CA 92415-0060  
(909) 388-5823 Fax (909) 388-5825

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November 1, 2006

Cesar A Aristeiguieta, M.D.  
Emergency Medical Services Authority  
1930 Ninth Street, Suite 100  
Sacramento, CA 95814

## RE: NREMT TESTING SITES

Dear Dr. Aristeiguieta:

This Agency is extremely supportive of EMSA's move to standardize EMT-I testing and consider this a positive direction for testing continuity within the California EMS system; however, we have major concerns over the lack of testing sites within the ICEMA region. Additionally, according to information we have received, there are only 14 seats available at any given time for testing and we anticipate delays in NREMT testing at peak periods.

As you are aware, the region consists of over 26, 000 square miles and at the present time, only one test site has been approved. This site is a four to six hour drive for Inyo and Mono County EMT-I testing candidates. Much of Inyo and Mono Counties are either wilderness or rural and served by volunteer fire departments. This additional difficulty, combined with adding hours of travel to a test site, will create volunteer recruitment challenges.

It is essential that additional sites be made available, within the ICEMA region, as soon as possible.

Very truly yours,

  
Virginia Hastings  
Executive Director



# Inland Counties Emergency Medical Agency

*Serving San Bernardino, Inyo, and Mono Counties*

*Virginia Hastings, Executive Director  
Reza Vaezazizi, M.D., Medical Director*

February 22, 2011

Dan Smiley, Interim Director  
Emergency Medical Services Authority  
1930 Ninth Street, Suite 100  
Sacramento, CA 95814

Dear Mr. Smiley:

**RE: EMR TO EMT BRIDGE PROGRAM**

As you are aware, the ICEMA region consists of over 26,000 square miles. Much of Inyo and Mono Counties are either wilderness or rural and served by volunteer fire departments. These fire departments serve a very large tourist population and cover one of the major routes along the Eastern Sierras.

Due to the loss of certified EMTs in the area, these counties and ICEMA are extremely interested in establishing bridge programs for Emergency Medical Responder (EMR) to Emergency Medical Technician (EMT). As stated in previous letters over the years to the EMS Authority the area has experienced a thirty-six percent (36%) decrease in EMT personnel since the initiation of NREMT testing in 2006. This is a significant decline and a serious concern to ICEMA and its constituents. Providers believe this decline is directly related to the additional costs associated with certification.

We ask that EMSA initiate discussions regarding solutions for the rural areas across the State. During this difficult economical climate, and with the implementation of new educational standards EMSA is poised to take the lead in ensuring that rural counties continue to provide citizens the best level of care possible.

Very truly yours,

  
Virginia Hastings  
Executive Director

VH/dws

c: Inyo Board of Supervisors  
Mono Board of Supervisors  
Inyo EMCC  
Mono EMCC  
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# Inland Counties Emergency Medical Agency

*Serving San Bernardino, Inyo, and Mono Counties*

*Virginia Hastings, Executive Director*  
*Reza Vaezazizi, M.D., Medical Director*

**DATE:** February 25, 2011

**TO:** Inyo County Board of Supervisors  
Mono County Board of Supervisors

**FROM:** Virginia Hastings  
ICEMA Executive Director

**SUBJECT:** INYO COUNTY NREMT TEST SITE

This morning a conference call was conducted with representatives from the National Registry of EMT's (NREMT), the State EMS Authority (EMSA) and ICEMA to discuss the status of the NREMT testing site in Inyo County. Discussions were successful and it is expected the site at Cerro Coso Community College - Ridgecrest will be approved by NREMT within the next couple of weeks.

Additionally, discussions were held regarding a second testing facility at the Cerro Coso - Bishop campus. NREMT has agreed to request a waiver from Pearson Vue regarding the minimum operating hours which should enable testing at this additional location. ICEMA will continue to work with representatives of Cerro Coso College, Pearson Vue and NREMT to ensure the location meets requirements. It is our understanding that there will be a \$495 fee for software which ICEMA will cover from its budget.

A great deal of time and effort was spent on making the Inyo County test site a reality and I would like to thank everyone who participated in the process as we attempt to serve the citizens of Inyo and Mono counties.

VH/jlm

c: Dan Smiley, EMSA  
Inyo County EMCC  
Mono County EMCC  
Jean Turner, Inyo County, Health & Human Services  
Deanna Ing Campbell, Cerro Coso Community College  
Michael Metcalf, Cerro Coso Community College  
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# Inland Counties Emergency Medical Agency

*Serving San Bernardino, Inyo, and Mono Counties*

*Virginia Hastings, Executive Director  
Reza Vaezazizi, M.D., Medical Director*

**DATE:** March 11, 2011

**TO:** Inyo County Board of Supervisors  
Mono County Board of Supervisors

**FROM:** Virginia Hastings  
ICEMA Executive Director

**SUBJECT:** INYO COUNTY NREMT TEST SITE

Yesterday, ICEMA received notification from the National Registry of EMTs (NREMT) that the Cerro Coso Community College - Ridgecrest site is approved and now available for EMT testing.

ICEMA will continue to work with representatives of the Cerro Coso College - Bishop Campus, Pearson Vue and NREMT for an additional testing location.

I would like to thank everyone who participated in the process of making the Inyo County test site a reality as we attempt to serve the citizens of Inyo and Mono counties.

VH/jlm

c: Dan Smiley, EMSA  
Inyo County EMCC  
Mono County EMCC  
Deanna Ing Campbell, Cerro Coso Community College  
Michael Metcalf, Cerro Coso Community College  
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## MEDICAL RESPONSE TO A MULTI-CASUALTY INCIDENT IN INYO AND MONO COUNTIES

**DRAFT 01/11/11**

### PURPOSE

1. To outline and coordinate the responses by EMS system participants to Multi-Casualty Incidents (MCI) in Mono and Inyo Counties.
2. To standardize definitions, as outlined in the Firescope Field Operations Guide (FOG) and the responsibilities of each participating entity.

### PRINCIPLES

1. Field responses to an MCI will follow the procedures/guidelines consistent with the Incident Command System (ICS) as outlined in Firescope.
2. Hospitals shall receive as much advanced notice as possible to prepare for arriving patients.

### SCOPE

An MCI is any incident where personnel (law, fire, or medical) on scene have requested additional resources to care for all victims. This may include one or more of the following criteria:

- An incident requiring three or more ambulances and/or involving five or more patients.
- The utilization of triage (e.g. START) tags,
- Patient distribution beyond one hospital.

### PROCEDURE

#### General Operational Procedures:

1. First arriving resource with the appropriate communications capability shall declare an MCI, establish command, and name the incident. This resource shall remain in command until relieved by the public safety agency having jurisdictional authority.

2. Sheriff's Office (SO) Dispatch shall alert/notify all other 911 dispatch centers (CHP and adjacent jurisdictions) OES Mutual Aid Coordinators (fire, law, Medical/Health Operational Area Coordinator (MHOAC)) of the declaration of an MCI.
3. The first medical personnel (e.g. ambulance crew) on scene shall:
  - a. Become the Medical Group Supervisor, and
  - b. Initiate triage. Adults shall be triaged according to START as outlined in Firescope. Pediatric patients shall be triaged according to JumpSTART developed by California Emergency Medical Services for Children. Triage and patient tracking and coordination with receiving hospitals shall be accomplished utilizing standard triage tags.
  - c. Assume responsibility for requesting additional resources (e.g. ambulances, personnel, equipment) in coordination with the base station, SO and/or CHP Dispatch, and the OES Operational Area Coordinators (fire, law, and/or MHOAC), as requested and available and relevant (dependent on geographical location and availability and communications capability), and
  - d. Assume responsibility for patient tracking and matching patient types/needs with appropriate and available transportation resources and staff and receiving hospitals, in coordination with the base station, SO and/or CHP Dispatch, and the OES Operational Area Coordinators (fire, law, and/or MHOAC), and
  - e. Contact base station and/or receiving hospitals and/or EMS aircraft providers for patient destination and coordination once the MCI has been declared.
4. All operation functions and procedures on scene will be in accordance with Firescope and National Incident Management System (NIMS).
5. The Medical Group Supervisor shall establish communications with the base station and/or receiving hospitals through available methods for situation update (i.e. Medical Sit Rep) and to obtain hospital bed availability/coordination, with the assistance and support of SO and/or CHP Dispatch, EMS aircraft providers, and the OES Operational Area Coordinators (fire, law, and/or MHOAC), as requested and relevant (dependent on geographical location and availability and communications capability).
6. The Medical Group Supervisor will identify and request the necessary resources through the IC or designee. The IC or Medical Group Supervisor will contact the base station and/or receiving hospitals and/or OES Mutual Aid Coordinators (fire,

- law, MHOAC), with the assistance and support of SO and/or CHP Dispatch, as available and appropriate, to fulfill medical resource requests.
7. During incidents with multiple destination hospitals, the Medical Group Supervisor may assign a Medical Communications Coordinator (Med Comm). The Med Comm will provide the following information when initially communicating with Dispatch (SO or CHP), the base station and/or receiving hospitals, or OES Mutual Aid Coordinators (fire, law, MHOAC):
    - Name of incident, type, location, initial patient estimate and agency in charge.
    - Patients should be transported to the appropriate hospitals as provided to the Med Comm by the Medical Group Supervisor.
  8. The Medical Group Supervisor, shall notify the base station and the receiving hospital(s) (or Med Comm shall notify Dispatch, if available and assigned, to relay to the hospitals) (or EMS aircraft providers shall communicate with receiving hospitals) of the following information for all patients departing the scene:
    - a. Transport method (e.g. air, ground, bus).
    - b. Transport agency and unit.
    - c. Number of patients (adult and pediatric).
    - d. Identification (triage tag number) and classification of patients (i.e. Immediate, Delayed, Minor).
    - e. Destination (only when Med Comm is coordinating multiple hospital destinations based on base station, EMS aircraft providers, and/or Medical Group Supervisor evaluation of hospital availability).
  9. Transporting units shall make attempts by available means to contact the receiving hospital en route to provide patient(s) report using the incident name to identify the patient and provide the following information:
    - a. Incident name.
    - b. Transporting name and unit number.
    - c. Age/sex.
    - d. Illness or mechanism of injury.

- e. Triage classification (immediate (red), delayed (yellow), green (minor), and any significant deterioration in condition/status during transport).
- f. Chief complaint and related illness/injury that may need specialty services, (e.g. respiratory, neuro, vascular, decontamination, burns).
- g. Glasgow Coma Scale (GCS), if relevant.
- h. Estimated Time of Arrival (ETA).
- i. Tracking of patients and destinations is the primary joint responsibility of the base station and field medical personnel, with assistance as requested and available from the Dispatch.

If the destination is changed en route, the transporting unit shall notify the initial receiving hospital, if possible, and shall make attempts to contact the new receiving hospital en route. If the base station is coordinating patient destinations in conjunction with the Med Comm, the transporting unit will notify the base station, who will notify the original destination that the patient has been diverted by the base station physician or that the patient condition has deteriorated.

#### **Special Operational Procedures - Use of Non-Emergency Vehicles:**

The Medical Group Supervisor, in coordination with the IC, may utilize non-emergency vehicles to transport patients triaged as Minor (green). The Medical Group Supervisor (or Med Comm, if assigned) will coordinate the destinations with the base station and/or receiving hospitals, if there are multiple receiving facilities. In such cases, the following conditions shall apply:

1. Non-emergency vehicles may be requested through the IC, through Dispatch or by special arrangement made on scene by the Medical Group Supervisor.
2. If resources allow, at least one ALS team (minimum of one paramedic and one EMT) with appropriate equipment will accompany each non-emergency transport vehicle. Generally, the ratio of patients to ALS team should not exceed 15:1.
3. When resources do not permit an ALS team to accompany a non-emergency transport vehicle, a BLS team consisting of at least two EMT's and/or First Responders will accompany the vehicle. Generally, the ratio of patients to BLS team should not exceed 9:1.
4. In the event of deterioration of a patient en route, the non-emergency unit shall immediately call for an ALS emergency ambulance, if available, and transfer care for transport to the closest emergency department.

### **Responsibilities of Dispatch:**

1. SO Dispatch shall alert/notify all other 911 dispatch centers (CHP and adjacent jurisdictions), and County OES Mutual Aid Coordinators (fire, law, Medical/Health Operational Area Coordinator (MHOAC)) of the declaration of an MCI.
2. SO Dispatch shall assist, collaborate, and help to coordinate the filling of resource requests from the base station, IC, the Medical Group Supervisor, and/or the OES Mutual Aid Coordinators (fire, law, MHOAC), as available. This may include mutual aid resources from outside the operational area, including ground and/or air transportation resources and personnel.

### **Responsibilities of the Base Station:**

1. Upon field notification of an MCI, the base station shall immediately notify area hospitals. If there is the potential for multiple patient destinations, the base station will poll area hospitals for bed availability.
2. The base station shall assist, collaborate, and help to coordinate the filling of all resource requests from the IC, the Medical Group Supervisor, and/or the OES Mutual Aid Coordinators (fire, law, MHOAC), as requested. This may include mutual aid medical resources from outside the operational area.
3. The base station shall coordinate with Dispatch, the IC, the Medical Group Supervisor or designee, and the OES Mutual Aid Coordinators, the deployment of all air resources for the MCI, as requested.
4. The base station shall notify ICEMA and the MHOAC when three or more ambulances are requested for an incident.
5. If the base station is coordinating patient destinations, it will confirm patient departure from scene with Med Comm, if assigned, by providing the departure time and estimated time of arrival (ETA) to the receiving hospital.
6. The base station will advise receiving hospitals of the number/categories of patients en route via approved method (e.g. radio, telephone).
7. If the base station needs additional resources, it shall contact the MHOAC.

### **Responsibilities of the Receiving Hospital:**

1. All hospitals shall respond immediately to any request from the Medical Group Supervisor or designee for bed availability.
2. A receiving facility may not change the destination of a patient.

3. If the receiving facility needs additional resources, it shall contact the MHOAC.
4. Each hospital that received patients from the MCI shall participate in after action reports and improvement plans as necessary.

**Responsibilities of the OES Mutual Aid Coordinators (fire, law, MHOAC):**

1. The Medical Health Operational Area Coordinator (MHOAC) Program is comprised of the personnel, facilities, and supporting entities that fulfill the functions of the MHOAC role as directed by the MHOAC. The MHOAC is a functional designation within the Operational Area, filled by the Health Officer and the local emergency medical services agency administrator (or designee/s), that shall assist the other Operational Area Coordinators (fire, law) in the coordination of situational information and medical and health mutual aid during emergencies.
2. The MHOAC Program is the principal point-of-contact within the Operational Area for information related to the public health and medical impact of an emergency. Within two hours of incident recognition, it is expected that the MHOAC Program will prepare and submit the electronic Health and Medical Situation Report to the activated local emergency management agency (Duty Officer, IC/UC, EOC), to the RDMHC/S Program (REOC), to CDPH, and to EMSA (Duty Officers or JEOC if activated).
3. The Mutual Aid Coordinators (fire, law, MHOAC) are responsible for coordinating the process of requesting, obtaining, staging, tracking, using, and demobilizing mutual aid resources. If Unified Command has been established for an incident, health and medical entities request resources through the Operations and Logistics Section of field-level Unified Command, which coordinates the resource fulfillment within the Operational Area, or from neighboring Operational Areas where there are cooperative assistance agreements or day-to-day relationships in existence.
4. If the resource cannot be obtained locally, the MHOAC Program will request health and medical resources from outside of the Operational Area by working with the RDMHC/S Program in preparing and submitting a Health and Medical Resource Request Form to the activated local emergency management agency (Duty Officer, IC/UC, EOC) and to the RDMHC/S Program (REOC). Examples include, but are not limited to, additional transportation resources (ambulance strike teams, EMS aircraft), accepting specialty facility beds/physicians (multi-trauma, burns, pediatrics), and ventilators.

**Medical Control:**

1. EMS personnel shall operate within ICEMA “prior to contact” protocols for both medical and trauma patients.

2. When base station consultation occurs, medical control refers to a specific patient and not to the incident as a whole (operational aspects).
3. When multiple hospital destinations exist, medical control has the option of referring the resource establishing radio contact to the base station for bed availability.

**Field Documentation:**

1. The Medical Group Supervisor (or Med Comm, if established) maintains responsibility to ensure the following:
  - a) Utilization of the approved ICEMA/MCI patient care report. This form will include:
    1. Name and location of the incident
    2. Triage tag number for each patient and the hospital destination
    3. Brief description of the incident
  - b) Completion of an individual patient care report for each deceased individual at the incident.
  - c) Completion of an individual patient care report for all patients with a chief complaint and who “refuse treatment.” As feasible, ask patients to sign a release of liability (e.g. Against Medical Advice (AMA) liability form).
2. Each transporting unit is responsible for generating a patient care report for each patient transported excluding patients transported by non-emergency vehicles. Those transported in non-emergency vehicles will be identified by triage tags. This should include patient tracking tag/number and will indicate the incident name and location.

## ADDENDUM

### Firescope Operations Procedures of a Multi-Casualty Incident

#### Operational System Description

The Multi-Casualty Organizational Module within the Firescope Field Operations Guide (ICS 420-1) is designed to provide for the necessary supervision and control of essential functions required during an MCI. The primary functions will be directed by the Medical Group Supervisor who reports in most cases to the IC, or the Multi-Casualty Branch Director, if activated. Resources having direct involvement with patients are supervised or coordinated by one of the functional leaders or coordinators.

The Medical Branch structure in the ICS system is designed to provide the IC with a basic, expandable modular system for managing the incident. The system is designed to be set up consistent in all incidents involving mass casualties and has the ability to expand the incident organization as needed.

**Initial Response Organization:** Initial response resources are managed by the IC, who will handle all Command and General Staff responsibilities. The resources will respond based on the **operational procedures** (as outlined in this protocol).

**Reinforced Response Organization:** In addition to the initial response, the Medical Group Supervisor may establish a Triage Unit Leader, Treatment Unit Leader, Patient Transportation Unit Leader, Medical Communications Coordinator (Med Comm), and Ambulance Coordinator. Also patient treatment areas are established, if needed.

**Multi-Group Response:** All positions within the Medical Group are now filled. The Air Operations Branch may be designated to provide coordination between the Ambulance Coordinator and the Air Operations Branch. The Extrication Group is established to free entrapped victims.

**Multi-Branch Incident Organization:** The complete incident organization shows the Multi-Casualty Branch and other Branches. The Multi-Casualty Branch now has multiple Medical Groups (geographically separate) but only one Patient Transportation Group. This is because all patient transportation must be coordinated through one point to avoid overloading hospitals. If necessary for span of control, the IC may appoint a Medical Branch Director to oversee the Medical Group and other relevant groups.

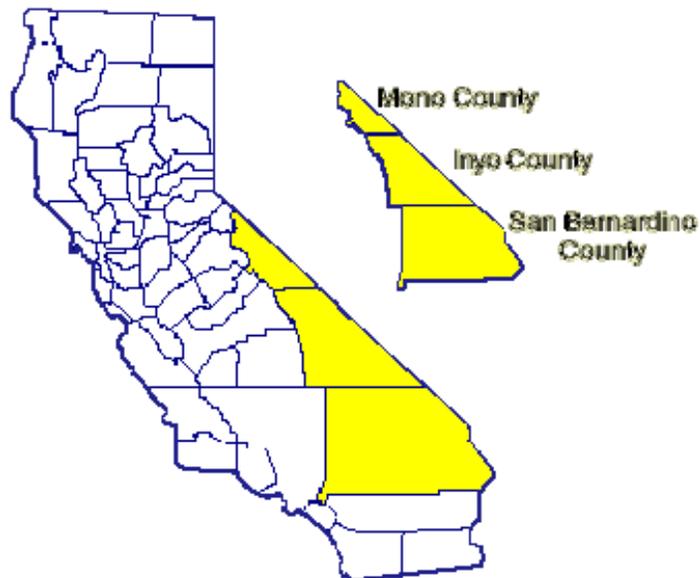
#### Operational Principles

1. First arriving resource with the appropriate communications capability shall declare an MCI, establish command, and name the incident. This resource will remain in command until relieved by the public safety agency having jurisdictional authority.

2. The IC will assign the first available resource to triage. Victims shall be triaged according to START/JumpSTART criteria, and ICS shall be implemented according to Firescope and NIMS.
3. The IC will assign the resource with the appropriate communications capability to establish communications with the base station for resource requests, as needed.
4. Treatment areas are set up based upon needs and available resources according to classification of patients (Immediate, Delayed and Minor.) The Treatment Unit Leader will notify Patient Transportation Unit Leader when a patient is ready for transportation and of any special needs (e.g. burns, pediatrics, decontamination). If these positions are not assigned, the Medical Group Supervisor will retain this responsibility.
5. Patients are transported to the appropriate facility based upon patient condition, bed availability, and transport resources. The Medical Group Supervisor is responsible for patient transportation and destination and may assign/delegate this responsibility to a Patient Transportation Unit Leader and a Medical Communications Coordinator who would work together to transport the patients using the appropriate methods to the most appropriate destinations.
6. The Patient Transportation Unit Leader and Med Comm, if assigned, will determine all patient destinations in coordination with the base station.
7. The IC will designate a staging area(s). Transportation personnel should stay with their vehicles to facilitate rapid transport, unless reassigned by the IC or designee.
8. The Patient Transportation Unit Leader will then call for an ambulance or other designated transportation vehicle to respond to the loading area.
9. The Patient Transportation Unit Leader, in coordination with the IC, may put in a request through Dispatch for buses to transport minor or uninjured patients.
10. The Patient Transportation Unit Leader will copy the information from the triage tag onto a Patient Transportation Log, and confirm destination with the ambulance crew, bus, or other driver.
11. The Patient Transportation Unit Leader will notify the Med Comm, if assigned, of patient departure.
12. The transporting unit should contact the receiving facility en route with a patient report, using the incident name to identify the patient.



**INYO COUNTY  
EMERGENCY MEDICAL  
CARE COMMITTEE  
2010  
ANNUAL REPORT**



## **INTRODUCTION**

The California Health and Safety Code, Division 2.5 (Emergency Medical Services) requires emergency medical care committees (EMCC) to, at least annually, report to the State of California Emergency Medical Services Authority (EMSA) through the county Board of Supervisors, on their observations and recommendations regarding ambulance services, emergency medical care, programs for training people in CPR, first aid and public participation in such programs.

The EMCC and the EMS (Emergency Medical Services) system must continually adapt to changes in prehospital care standards, review and adopt new clinical and research information, use universal healthcare practices and meet local community needs.

## **MEMBERSHIP**

The Inyo County EMCC consists of thirteen (13) voting members, each appointed by the Inyo County Board of Supervisors for staggered terms of two (2) years as follows:

- a) Voting members shall have a professional interest in or personal commitment to prehospital emergency medical care in their community. These members shall include, but not be limited to, representatives from each of the local agencies providing prehospital emergency medical care in the county of Inyo. The voting membership shall also include three members at large.
- b) Ex Officio, non-voting members, each appointed by the Inyo County Board of Supervisors, consist of the following individuals who receive all agendas and notification of the EMCC.
  - 1) Bishop Police Department Chief or designee
  - 2) Inyo County Sheriff or designee
  - 3) California Highway Patrol Area Commander or designee
  - 4) Death Valley National Monument/EMS Coordinator or designee
  - 5) American Red Cross representative
  - 6) Furnace Creek Fire Department Chief or designee
  - 7) Emergency Room Physicians representative

## **PURPOSE**

The Committee functions in an advisory manner to the Inyo County Board of Supervisors and the Local EMS Agency known as ICEMA.

- 1) Participate in the planning process for the establishment of goals, objectives, policies and procedures for the local emergency services agency.
- 2) Assist in the establishment and offer advice on policy and procedures governing prehospital care in Inyo County.
- 3) Encourage and educate the public to understand the nature of prehospital Emergency medical care and encourage support throughout the county for the development and implementation of effective EMS plans.

- 4) At least annually, review the operations of each of the following:
- a) Ambulance services operating within the county.
  - b) Emergency medical care offered within the county, including programs for training large numbers of people in cardiopulmonary resuscitation and lifesaving first aid techniques.
  - c) First aid practices in the county.
  - d) Report to the authority and the local EMS agency its observations and recommendations relative to its review of the ambulance services, emergency medical care, and 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. The emergency medical care committee submits its observations and recommendations to the county board or boards of supervisors which it serves and shall act in an advisory capacity to the county board of boards of supervisors which it serves, and to the local EMS agency, on all matters relating to emergency medical services as directed by the board or boards of supervisors.

## 2010 MEETINGS

Meetings were held on January 25<sup>th</sup>, March 22<sup>nd</sup>, May 24<sup>th</sup>, July 19<sup>th</sup>, and November 1<sup>st</sup>. Paul Postle served as the Chair.

## 2010 EMCC MEMBERSHIP

NAME	AFFILIATION	APPOINTMENT DATE
Lloyd Wilson	Big Pine Fire Department	09/11/2007
Mykala Howard	Big Pine Fire Department	09/11/2007
Phil Ashworth	Independence Fire Department	
Joe Cappello	Independence Fire Department	
Jean Turner	Inyo Health & Human Services Director	09/11/2007
Chief Leroy Kritz	Lone Pine Fire Department	09/11/2007
Dr. Michael Dillon	Northern Inyo Hospital	02/05/2008
Martha Reynolds	Northern Inyo Hospital	02/05/2008
Andrew Stevens	Northern Inyo Hospital	09/11/2007
Steven Davis	Olancha-Cartago Fire Department	09/11/2007
Michael Patterson	Sierra Lifeflight	09/11/2007
Lee Barron	Southern Inyo Hospital	09/11/2007
Chief Paul Postle	Southern Inyo Fire Department	09/11/2007
Judd Symons	Symons Emergency Specialties	09/11/2007

## GEOGRAPHICS AND DEMOGRAPHICS

- ◆ The population of the **U.S.** on July 1, 2009 was **307,006,550**
- ◆ The population of **California** on July 1, 2009 was **36,961,664**
- ◆ The population of **Inyo County** on July 1, 2009 was **17,293**

Inyo County Population	Housing units	Area in square miles			Density per square mile of land area	
		Total area	Water area	Land area	Population	Housing units
17,293	9,131	10,227	24	10,203	1.8	0.9

Census Designated Places	
City	Population
Bishop City	3,575
Big Pine	1,350
Cartago	109
Darwin	54
Dixon Lane-Meadow Creek	2,702
Furnace Creek	31
Homewood Canyon-Valley Wells	75
Independence	574
Keeler	66
Lone Pine	1,655
Mesa	214
Olancho	134
Pearsonville	27
Round Valley	278
Shoshone	52
Tecopa	99
West Bishop	2,807
Wilkerson	562

## POPULATION BY AGE (2009 CENSUS)

Age	Number	%
Under 5 years	1025	5.9
5 to 9 years	988	5.7
10 to 14 years	1,166	6.7
15 to 19 years	1,087	6.2
20 to 24 years	976	5.6
25 to 34 years	1,534	8.8
35 to 44 years	2,074	11.9
45 to 54 years	3,077	17.6
55 to 59 years	1,475	8.5
60 to 64 years	1,137	6.5
65 to 74 years	1,517	8.7
75 to 84 years	1,071	6.1
85 years and over	311	1.8

Median age (years)	44.5
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Source: US Census, Profile of General Demographic Characteristics: 2005-09 Community Survey

## MEDICAL RESOURCES

Medical care in Inyo County is provided through special districts, federal, state, and private providers. All agencies use ground transportation of patients to Northern Inyo and Southern Inyo Hospitals, and EMS aircraft are used to provide transportation to trauma centers and other hospitals that are located out of the county.

### Inyo County Prehospital Providers

		LEVEL
Big Pine Fire Volunteer Fire Department	(760) 938-2293	BLS
Cal Fire – Independence	(760) 878-2258	BLS
Cal Fire - Round Valley	(760) 387-2565	BLS
Death Valley National Park	(760) 786-3240	BLS
Independence Fire Department	(760) 937-2004	BLS
Lone Pine Fire Department	(760) 876-4626	ALS
Olancho-Cartago Fire Department	(760) 764-2370	ALS
Sierra Lifeflight	(760) 872-2201	ALS/AIR
Southern Inyo Fire Protection District	(760) 852-4130	BLS
Symons Emergency Services	(760) 873-8904	ALS

The following illustration represents the exclusive operating areas within Inyo County.

# Inyo County Ambulance Exclusive Operating Areas

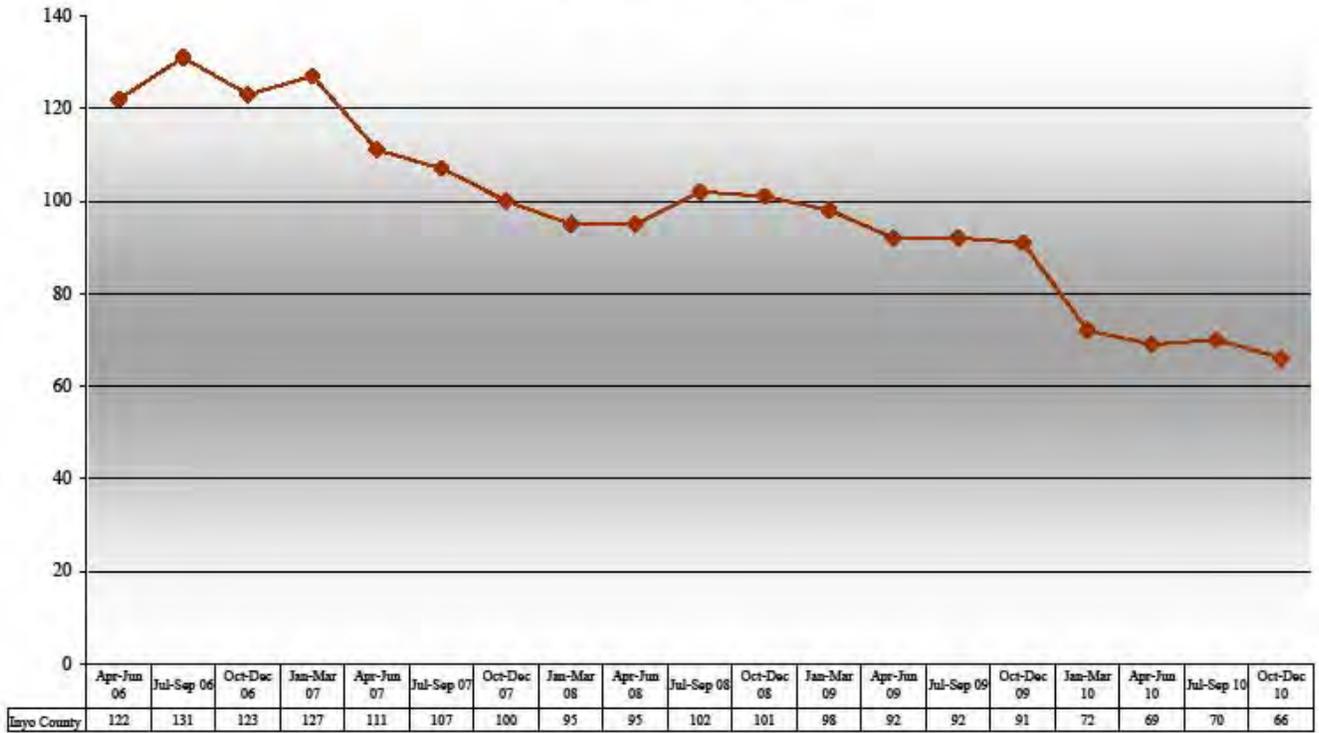


## **MANPOWER AND TRAINING**

EMS training in Inyo County is limited and recent legislation in California has made certification as an EMT and EMT-P even more difficult. EMS providers in Inyo County have reported a decrease in the number of certified EMTs. One of the most significant issues points to the mandate to become certified through the National Registry. California has created several testing sites that are intended to be centralized locations for inspiring EMTs requiring an initial test and EMTs that require retesting. The Inyo County EMCC successfully communicated with the Administration of the National Registry and was able to negotiate an approved National Registry Testing site within Inyo County.

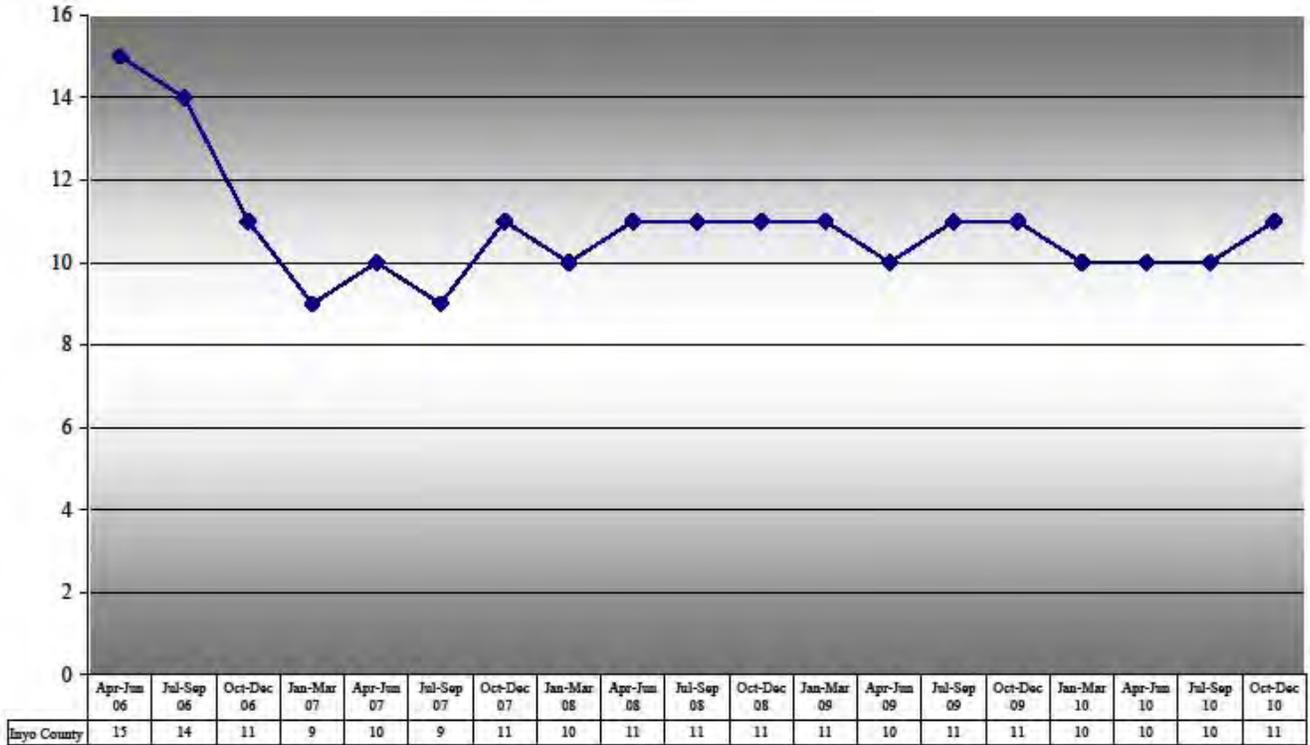
The following charts show the number of EMTs that are certified in Inyo County for April 2006 through December 2010. In addition, information is provided on the number of EMTPs and MICNs for the same period.

**EMT Certification  
Inyo County  
April 2006 - December 2010**



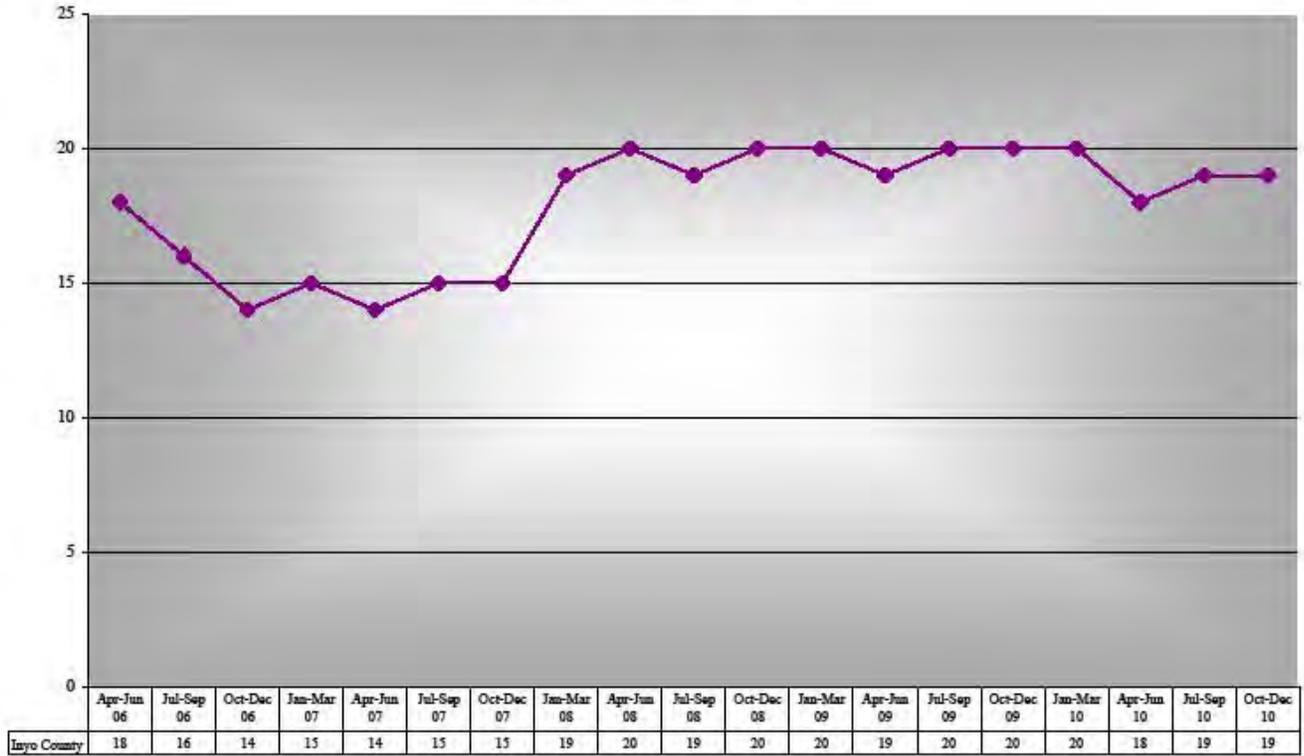
Prepared by ICEMA 1/18/2011

**EMT-P Accreditation  
Inyo County  
April 2006 - December 2010**



Prepared by ICEMA 1/18/2011

**MICN Certification  
Inyo County  
April 2006 - December 2010**



Prepared by ICEMA 1/18/2011

## **COMMUNICATIONS**

Inyo County has very challenging communications problems due to the mountainous terrain and vast geographical distance. Radio communications are available throughout the county. However, there are a vast number of areas where radio communication is unavailable due to terrain. On the other hand, many of the EMS providers in Inyo County are now equipped with satellite phones that have access to almost any location within the county. Furthermore, cellular phone service is available, but limited in range due to the number and location of cellular service repeaters. Furthermore, cellular phone service is limited to the Owens Valley, Highway 395 corridor.

## **MEDICAL CONTROL**

Medical control assures that physicians (or Mobile Intensive Care Nurse (MICN) in consultation with the Emergency Room physician) provide direction to prehospital Advanced Life Support (ALS) personnel authorized to provide prehospital emergency medical care at the scene of an emergency and during transport or transfer to a hospital. Medical control is achieved by direct voice communication between the ALS unit and the base hospital.

The medical control protocols and system processes continue to assure overall medical control of the EMS system. Sixteen (16) 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 input by local providers and hospital based agencies, to promote 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 include quarterly base hospital statistics, bi-annual electronic and Scantron patient care reports, medications, procedures, and type of patient summary reports. These standing reports assist the overall system as it continues to explore and advance in communication and systems knowledge between all groups.

## **TRANSPORTATION**

The ambulance administration program ensures compliance with transportation system regulations. Ambulances are inspected by ICEMA for equipment and supplies. Additionally, all ALS and BLS ambulances in Inyo County are inspected annually.

## **DATA COLLECTION AND EVALUATION**

EMS providers are responsible for collecting information in the field and to transfer certain data to either SCANTRON data sheets or to EMS data collection software. As of December 31, 2010, ICEMA has supplied and trained all EMS providers in Inyo County with hardware and software for EMS data collection. During the transition from paper SCANTRONS to electronic data collection, EMS providers will be doing dual entry of calls. It's ICEMA's goal to have all EMS providers submitting EMS data electronically by July 2011.

BLS RUN SUMMARY		RUN LOCATION	
Month	Runs	City	Runs
January 2010	90	Bishop	183
February 2010	52	Big Pine	105
March 2010	54	Lone Pine	69
April 2010	47	Independence	38
May 2010	59	Tecopa	25
June 2010	52	Olancha	24
July 2010	60	Mammoth Lakes	23
August 2010	58	Coso	13
September 2010	29	Shoshone	13
October 2010	23	Inyo Co. Other	9
November 2010	39	Cargago	4
December 2010	60	Death Valley	3
<b>Total</b>	<b>623</b>	Wilkerson	3
		Swall Meadows	2
		40 Acres	1
<b># of Patients per Run</b>	<b>Runs</b>	Rovana	1
1	519	Data Missing	107
2	30	<b>Total</b>	<b>623</b>
3	11		
4	13		
5	0		
6	5		
8	11	<b>PATIENT SUMMARY</b>	
9	1	<b>Category</b>	<b>Patients</b>
Data Missing	33	Other Medical	176
<b>Total</b>	<b>623</b>	Trauma	168
		Transfer	112
		Data Missing	60
		Cardiac	49
<b>Outcome</b>	<b>Runs</b>	Respiratory	33
Xport-Ground	456	Behavior/OD	10
Xport-Refused	60	Obstetric	8
Pt/Parent Refused Care/Xport	27	Poisoning	5
Xport-Air	20	5150	1
Cancelled	10	Spinal Injury	1
No Treat Required	10	<b>Total</b>	<b>623</b>
No Treatment Req/No Xport	8		
Dry Run	6		
Treated/Refused Xport	5	<b>Mechanism</b>	<b>Patients</b>
Obviously Dead	2	Auto/Truck-MVA	78
Treated & Not Xport	1	Other	27
Xport Pt Refused Care	1	Motor vehicle traffic accident	12
Data Missing	17	Motorcycle	11
<b>Total</b>	<b>623</b>	Falls: 1 to 15 feet	7
		Blunt Injury	5
		Unknown	5
		Assault	3
		Other Penetrating	2

<b>BLS Response Time Minutes</b>	<b>Runs</b>	<b>Cum %</b>	<b>Fall&gt;20'</b>	
1-3	27	6.4%	Motorcycle Crash	1
4-6	96	29.1%	Near-Drowning	1
7-9	66	44.8%	Strike by Blunt/Thrown Object	1
10-12	56	58.1%	Data Missing	14
13-15	58	71.8%	<b>Total</b>	<b>168</b>
16-19	37	80.6%		
20-29	49	92.2%		
30-39	9	94.3%	<b>Gender</b>	<b>Pts</b>
40-49	12	97.2%	Male	289
50-59	11	99.8%	Female	278
60-79	1	100.0%	Unknown	6
80-99	0		Data Missing	50
>99	0		<b>Total</b>	<b>623</b>
Data Missing	52			
Data Error	22			
Cancelled Call	9			
Unreadable	6			
<b>Total</b>	<b>511</b>			
			<b>Age Group</b>	<b>Patients</b>
<b>Receiving Hospital</b>	<b>Patients</b>		<9	23
Northern Inyo Hosp	242		9-15	12
Southern Inyo Hosp	107		16-25	72
Other Facility (Out of County)	98		26-35	44
Out of Region	17		36-45	45
Renown Regional Medical Center	15		46-55	73
Other Destination	11		56-64	75
Patient Residence	7		65-74	70
Mammoth Hospital	5		>74	166
St. Mary Med Cntr	5		Data Missing	43
Carson Tahoe, NV	3		<b>Total</b>	<b>623</b>
Ridgecrest Regional Hospital	3			
Carson Valley Med Cntr, NV	2			
LLUMC	2			
ARMC	1			
Bakersfield Memorial Hospital	1			
Bishop Airport	1			
Bishop Care Center	1			
Loma Linda Community Hospital	1			
No Base Contact Made	1			
Riverside Community Hospital	1			
Southern Hills Hospital	1			
St. Bernardine Med Cntr	1			
Data Missing	68			
<b>Total</b>	<b>594</b>			

ALS RUN SUMMARY		RUN LOCATION	
Month	Runs	City	Runs
January 2010	102	Bishop	988
February 2010	81	Big Pine	31
March 2010	91	Mammoth Lakes	12
April 2010	93	Lone Pine	9
May 2010	113	Chalfant Valley	8
June 2010	98	Olancha	8
July 2010	97	40 Acres	6
August 2010	146	Benton	6
September 2010	119	Aspendell	2
October 2010	103	Coso	2
November 2010	65	Round Valley	2
December 2010	61	Rovana	2
<b>Total</b>	<b>1,169</b>	Cartago	1
		Chipmunk Canyon	1
		Independence	1
<b># of Patients</b>	<b>Runs</b>	Little Lake	1
1	1150	Pleasant Valley	1
2	19	Swall Meadows	1
3	0	Toms Place	1
4	0	Wilkerson	1
5	0	Data Missing	85
6	0	<b>Total</b>	<b>1,169</b>
Data Missing	0		
<b>Total</b>	<b>1,169</b>		
<b>Outcome</b>	<b>Runs</b>	<b>Category</b>	<b>Pts</b>
Xport-Ground	1,017	Other Medical	461
Pt/Parent Refused Care/Xport	103	Trauma	247
Cancelled	20	Cardiac	138
Obviously Dead	14	Respiratory	83
Data Missing	3	Transfer	64
Dry Run	3	Poisoning	19
No Treatment Req/No Xport	3	5150	10
Treated & Not Xport	2	Obstetric	7
Xport-Air	2	Environment	3
Xport Pt Refused Care	1	Behavior/OD	2
Xport-Refused	1	Domestic Violence	0
<b>Total</b>	<b>1,169</b>	Data Missing	135
		<b>Total</b>	<b>1,169</b>

ALS Response Time Minutes	Runs	Cum %	Trauma Mechanism of Injury	Patients
1-3	191	18.6%	Falls: 1 to 15 feet	121
4-6	448	62.2%	Motor vehicle traffic accident	34
10-12	74	69.4%	Strike by Blunt/Thrown Object	12
13-15	48	74.0%	Falls: 15 feet and greater	8
16-19	14	75.4%	Motorcycle Crash	6
20-29	23	77.6%	Unintentional	6
30-39	16	79.2%	Bicycle accident	5
40-49	3	79.5%	Pedestrian traffic accident	4
50-59	2	79.7%	Stabbing / Cutting accident	4
60-79	6	80.3%	ATV/Recreational Vehicle	3
7-9	202	99.9%	Motor vehicle non-traffic accident	3
80-99	1	100.0%	Non-Motorized accident	2
>99	0		Not Applicable	2
Cancelled Call	0		Stabbing /assault	2
Data Error	7		Auto/Truck-MVA	1
Data Unreadable	2		Falls: Height unknown	1
Data Missing	68		Falls: Peds less than 3x height	1
<b>Total</b>	<b>1,105</b>		Firearm assault	1
			Not Known	1
			Unknown	1
			Water transport accident	1
<b>Hospital</b>	<b>Patients</b>		Data Missing	28
Northern Inyo Hosp	748		<b>Total</b>	<b>247</b>
Other Facility (Out of County)	119			
Renown Regional Medical Center	33		<b>Gender</b>	<b>Patients</b>
Southern Inyo	22		Female	587
No Base Contact Made	19		Male	502
Mammoth Hospital	4		Unknown	0
Loma Linda Community Hospital	3		Data Missing	80
St. Mary Med Cntr	3		<b>Total</b>	<b>1,169</b>
LLUMC	2			
Bishop Airport	1			
Carson Tahoe, NV	1		<b>Age Group</b>	<b>Patients</b>
Country Villa Bella Vista	1		<9	22
Eisenhower Memorial Hospital	1		9-15	12
Kaiser Sunset - LA	1		16-25	79
Other Destination	1		26-35	54
Data Missing	68		36-45	80
<b>Total</b>	<b>1,027</b>		46-55	153
			56-64	149
			65-74	138
			>74	416
			Data Missing	66
			<b>Total</b>	<b>1,169</b>

## **PUBLIC INFORMATION AND EDUCATION**

Information regarding CPR and First Aid training is not available at this time because of the available information from participating agencies. CPR training sites provide training statistics to their respective training or administrative centers. This information should be available in the 2009 EMCC report.

## **DISASTER PLANNING**

The County of Inyo is actively participating in disaster training. Disaster preparedness includes all EMS providers within the county and both hospitals. The disaster planning and exercises conducted in Inyo test the county's EMS resources for current capabilities. Lessons learned from each exercise are used to develop better plans for the county.

## **RECOMMENDATIONS OF THE 2010 EMCC**

## **FUTURE OBJECTIVES**

## **SUMMARY**

The EMCC encourages system wide participation and discussions. Through this interaction Inyo County is able to advance its local EMS system and provide quality patient care to its citizens and the thousands of individuals who travel its highways.