



MONO COUNTY
EMERGENCY MEDICAL CARE COMMITTEE



Mammoth Hospital
ED Lounge/Conference Room

May 24, 2011
9:00 a.m.

A G E N D A

- I. CALL TO ORDER**
- II. APPROVAL OF MARCH 29, 2011 MINUTES** **ACTION**
- III. ICEMA UPDATE** **INFO/ACTION**
 - A. QI Plan
 - B. Intubation CQI Project
 - C. Data System RFP
- IV. EMS SYSTEM MANAGEMENT REPORTS** **INFO/ACTION**
 - A. Scantron Reports
 - B. Base Hospital Report
- V. OLD BUSINESS** **INFO/ACTION**
 - A. Town of Mammoth Lakes AED Program
 - C. Status of CHP Waiver
 - D. EMCC Annual Report
 - E. MTWC/Mutual Aid Agreement
 - F. Other
- VI. NEW BUSINESS** **INFO/ACTION**
 - A. Field Treatment Site Plan
 - B. Proposed 2011-12 Fee Schedule
 - C. Continuation of Trauma Care Protocol
 - D. Neurovascular Stroke Receiving Center Designation Criteria
 - E. ICEMA Policy Exemptions – Mono/Inyo
- VII. OTHER/PUBLIC COMMENT**
- VIII. COMMITTEE MEMBER REQUEST FOR TOPICS FOR NEXT MEETING**
- IX. NEXT MEETING DATE AND LOCATION**
- X. ADJOURNMENT**

The Mono 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



MONO COUNTY EMCC MEETING

Mammoth Hospital
A/B Conference Room
Mammoth Lakes, CA

MINUTES March 29, 2011

Committee Members	Affiliation
<input checked="" type="checkbox"/> Mark Mikulicich	Mono County Paramedic Rescue Chief
<input checked="" type="checkbox"/> Dr. Rick Johnson, MD	Mono County Health Officer
<input type="checkbox"/> Bob Rooks	Mono County Fire Chief's Association
<input checked="" type="checkbox"/> Lori Baitx, RN	Mammoth Hospital
<input checked="" type="checkbox"/> Rosemary Sachs, RN	Mammoth Hospital

Other Attendees	Affiliation
Ales Tomaier	Mammoth Lakes Fire Department
Denice Wicker-Stiles	ICEMA Assistant Administrator
Paul Easterling	ICEMA EMS Specialist
Kevin Sullivan	Marine Corps Fire Chief (MWTC)
Keith Preston	Marine Corps Fire (MWTC)
Stacey Simon	Mono County Assistant County Counsel

I. CALL TO ORDER

The meeting was called to order at 9:03 a.m.

II. APPROVAL OF NOVEMBER 2, 2010 MINUTES

Motion to approve by Dr. Johnson, second by Rosemary Sachs. All in favor with none opposed.

III. ICEMA UPDATE

A. Legislative Update

ICEMA is keeping an eye on AB 881, which involves 5150 patients and was stimulated by a legal case filed by Desert Ambulance against ICEMA. AB 163 involves background checks for CalFire, and AB 1245 is a bill that addresses EMRs (Emergency Medical Responders). EMSAC is supportive of all three bills.

B. QI Plan

Went to EMSA, and was approved. Next step: Central QI Committee meeting and the development of a template/method for providers to access data.

IV. EMS SYSTEM MANAGEMENT REPORTS

A. Scantron Data

Continued effort to be applied to improve upon accuracy of data collected as well as completeness and correct form. Mark will work with the Captains to include individual member's scantron proficiency statistics into personnel performance evaluations*

B. Base Hospital Report

Minimal discussion regarding report. Mammoth Hospital continues to be busy.

Dr. Johnson wanted to add that Symons Ambulance did a good job of providing ambulance coverage during the recent Big Pine wildfire.

V. OLD BUSINESS

A. EMTs and First Responders Update

ICEMA reported that the NREMT testing site at Cerro Coso College in Ridgecrest is up and running and efforts are continuing to facilitate another testing site at Cerro Coso in Bishop. ICEMA is willing to provide the software upgrade for the facility, and it is hopeful that Pearson Vue will approve this testing location in the near future. This would be a very good development for Inyo and Mono County EMT students! ICEMA also noted that Baldy View ROP in San Bernardino has been very successful in EMT education with a 97% pass rate. Mark noted that the current NREMT class criteria contains a lot of information that does not apply to, or effect the current scope of accepted BLS practice. This is due to implementation of the new National Education Standards.

B. Town of Mammoth Lakes AED Program

ICEMA has sent letters to the Town regarding the regulations required for such a program and the noted deficiencies. Dialog has begun with the State, and ICEMA will get back to Dr. Johnson, the EMCC and the Town with additional information as it becomes available.

C. DMV Licensing Exemption for Rural Volunteer Ambulance Providers

The requested exemption letter (for volunteer ambulance driver's meeting the criteria) has been approved by the EMCC, the Health Officer and the Board of Supervisors and was taken in person by Mark to the local DMV management. The object was to introduce the concept (for familiarity) to personnel at that location prior to the actual presentation of the request letter by future applicants. The local DMV manager suggested that the Request Letter be sent directly to

DMV Director, George Valverde with a cover letter of explanation; however she added that an exemption could not be granted at the Director level (even though the DMV's own California Vehicle Code says otherwise). Mark will follow up with this correspondence to Director Valverde.

D. EMCC Annual Report for 2010

Denice offered to initiate draft and send to Mark with hopes of presenting to the Mono County Board of Supervisors in June.

E. MCI Policy

The policy has been approved by the Mono and Inyo County EMCCs and has final ICEMA approval. Many thanks to Dr. Johnson for authoring the document and to others that provided input. Mono County, Mammoth Fire and Mammoth Hospital will utilize direction from the Plan during their upcoming MCI drill in June.

F. California Public Health and Medical Emergency Operations Plan

A 232 page document is out for public comment. This deployment plan is intended to replace the current CDMOM. Dr. Johnson utilized elements of the plan during the Big Pine fire. The plan goes before the State EMS Commission in June for final approval.

G. Other

None at this time.

VI. NEW BUSINESS

A. MWTC/Mono County EMS Mutual Aid Agreement

Mono County EMS and MWTC Fire have been working on a mutual aid (MA) agreement and MWTC Fire Chief Kevin Sullivan and crews presented some questions for ICEMA regarding recognized certifications and legal requirements for providing mutual aid off of the Base. Kevin also stated that Base Command is interested in ALS (on the Base) for transport of Base personnel that require more than simple treatment at the clinic. The Federal Base requirements involve National Military Medical Certification levels and/or NREMT, NREMT-P to operate on the Base, but do not require local or State certification/licensure. Kevin posed several questions and potential scenarios, and Denice is looking into the regulations that define those scenarios and what Federal pre-exemptions might exist. An example: does MWTC Fire need to be ICEMA and State certified/licensed to provide mutual aid off the Base as a first response, or only if patients are *being transported* under mutual aid request from Mono County?

Chief's Note: At this time (10:05) Stacey Simon (Mono County Assistant County Counsel) came in to participate in the rest of the meeting. Stacey has been working on the mutual aid agreement with Kevin and Mark.

Denice noted that 29 Palms does provide mutual aid off the Base (including some transports) and all responding members are State and ICEMA accredited/licensed. This does not automatically crossover as policy for MWTC Fire, as 29 Palms Fire and MWTC Fire are now under completely separate command. More research is pending from ICEMA and Kevin should have further direction for operational objectives in the near future.

VII. OTHER/PUBLIC COMMENT

The EMCC was reminded that there is a ePCR training for Mammoth Fire on April 7th. Mono County crews are welcome!

VIII. COMMITTEE MEMBER REQUEST FOR TOPICS FOR NEXT MEETING

None at this time.

IX. NEXT MEETING DATE AND LOCATION

Tuesday, May 24, 2011, 9:00 a.m. at Mammoth Hospital ED break room.

X. ADJOURNMENT

The meeting was adjourned at 10:20 a.m.

Staff Report - EMCC

MONO COUNTY

Town of Mammoth Lakes AED Program

Mark Moscovitz, Mammoth Lakes PD has been assigned to review the AEDs and policy. The community AEDs will probably be removed and only remain in the police cars and town offices. They need a medical director and will be contacting Dr. Johnson.

Mutual Aid MOU with Mountain Warfare Training Center

ICEMA is working with Stacey Simon, Mono Counsel on final language for the MOU. BAI is ready when I get those issues resolved.

EMCC Annual Report

There is a draft version prepared by Denice which Mark is reviewing.

Denice Wicker-Stiles
5/19/11

FIELD TREATMENT SITE PLAN

**DRAFT
MAY 2011**



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Concept of Operations

Duration	1 to 48 Hours
Types of Events	Multi/mass Casualty Event/Incident, such as <ul style="list-style-type: none"> • Earthquake • Bomb blast • Transportation accident • Any event where the local capacity for transporting patients is overwhelmed (per state plan)
Function	<ul style="list-style-type: none"> • Patient congregation / registration • Triage • Medical care • Patient holding / evacuation
Scope of Medical Care	<ul style="list-style-type: none"> • EMS medical care (ALS and/or BLS) <ul style="list-style-type: none"> ○ Wound care ○ Control of bleeding ○ Treatment of shock ○ Fluid replacement (ALS only - when available) ○ Splinting of fractures ○ Pain relief (ALS only - when available) ○ Initial care of burns • Mental health support
Staffing	Staffing provided by EMS personnel, with surge from neighboring jurisdictions, regional support (through ICEMA), Public Health staff (admin), and medical volunteers (DHV)
Location	<ul style="list-style-type: none"> • Near incident site¹ • Near hospital • Pre-designated sites geographically and/or strategically located
Objective	Provide a clear and concise approach for Field Treatment Sites (FTS) that can be dynamically implemented when the field triage and transport needs of a mass casualty incident in Mono County will surpass one hour.
Assumptions	During an incident lasting more than one hour, it is estimated that there could be between 20-100 casualties needing medical care and/or transportation to a hospital. This will exceed the standard Mass Casualty Incident (MCI) management approach and require a more formal FTS to initially triage and eventually transport the injured casualties to different hospitals and trauma centers. As the FTS is anticipated to be open for no longer than 48 hours, no state or federal support is expected to be available. There may be regional support available from neighboring counties, assuming the event has not affected them to the same degree.

¹ During a localized MCI event (e.g. bus crash, bleacher collapse), the IC, MGS, and MHOAC will determine the optimal location for the FTS. Ideally, it will be located close enough to the event to not require vehicle transportation, but far enough to be independent from the event and its initial triage area. However, in most instances, this will not be possible, and a pre-designated disaster facility will be selected.

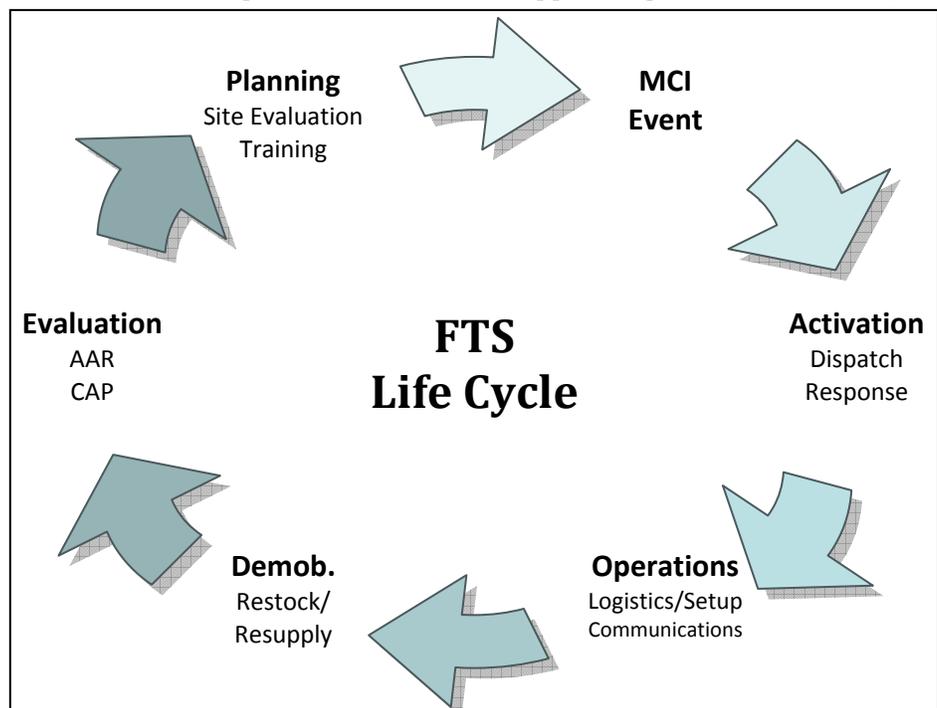
Executive Summary

The objective of the Field Treatment Site (FTS) plan is to triage and temporarily treat patients until they can be transported to an acute care hospital.

The Mono County EMCC, the MHOAC, and ICEMA have identified that the existing EMS system can transport up to 20 patients within the first hour of a major event, such as a bomb blast. Therefore, an FTS location is a suitable option when there are expected to be more than 20 patients or there will be delays greater than one hour in removing/extricating patients from the incident. This is very incident dependent, e.g., weather, remote location, etc. An FTS location is meant to be operational for up to 48 hours, at which time planners should consider establishing one or more Alternate Care Sites (ACS) to accommodate the patients for a longer period of time.

The location of an FTS is dependent on the type of event, on-going threat, weather, and available resources. The scene Incident Commander (IC), the Medical Group Supervisor (MGS), and the FTS Commander (all on-scene) will ultimately select the FTS location. Ideally, this site will be outside the incident area and any hazard zone, but close to enough to carry patients to the FTS triage area (i.e. no ambulance required). However, in most instances, this will not be possible, and a pre-designated disaster facility will be selected. The FTS will be supported by the Medical/Health Branch of the Operational Area Emergency Operations Center (OA EOC) through the Medical and Health Operational Area Coordinator (MHOAC) functions.

There are six components to the FTS Plan and its life cycle. During the planning cycle, the existing facilities designated for potential disaster response in Mono County will be evaluated for their potential use as FTS. EMS and public health officials will train using this plan and incorporate changes as appropriate. When an MCI event occurs, the scene IC will communicate with the Medical Group Supervisor regarding the potential need to activate the FTS plan. Once the need is confirmed, the scene IC and the MGS will activate the FTS plan. This will include appointing a FTS Commander, and notifying dispatch of the selected FTS location. Dispatch will in turn notify the MHOAC. Once activated, the operations cycle begins. The FTS Commander will identify individuals to fill the immediate and secondary roles as staffing permits, request resources as needed, and ensure the rapid triage and transport of patients. The MHOAC role is to provide support and coordination to the FTS Commander. Communications is a



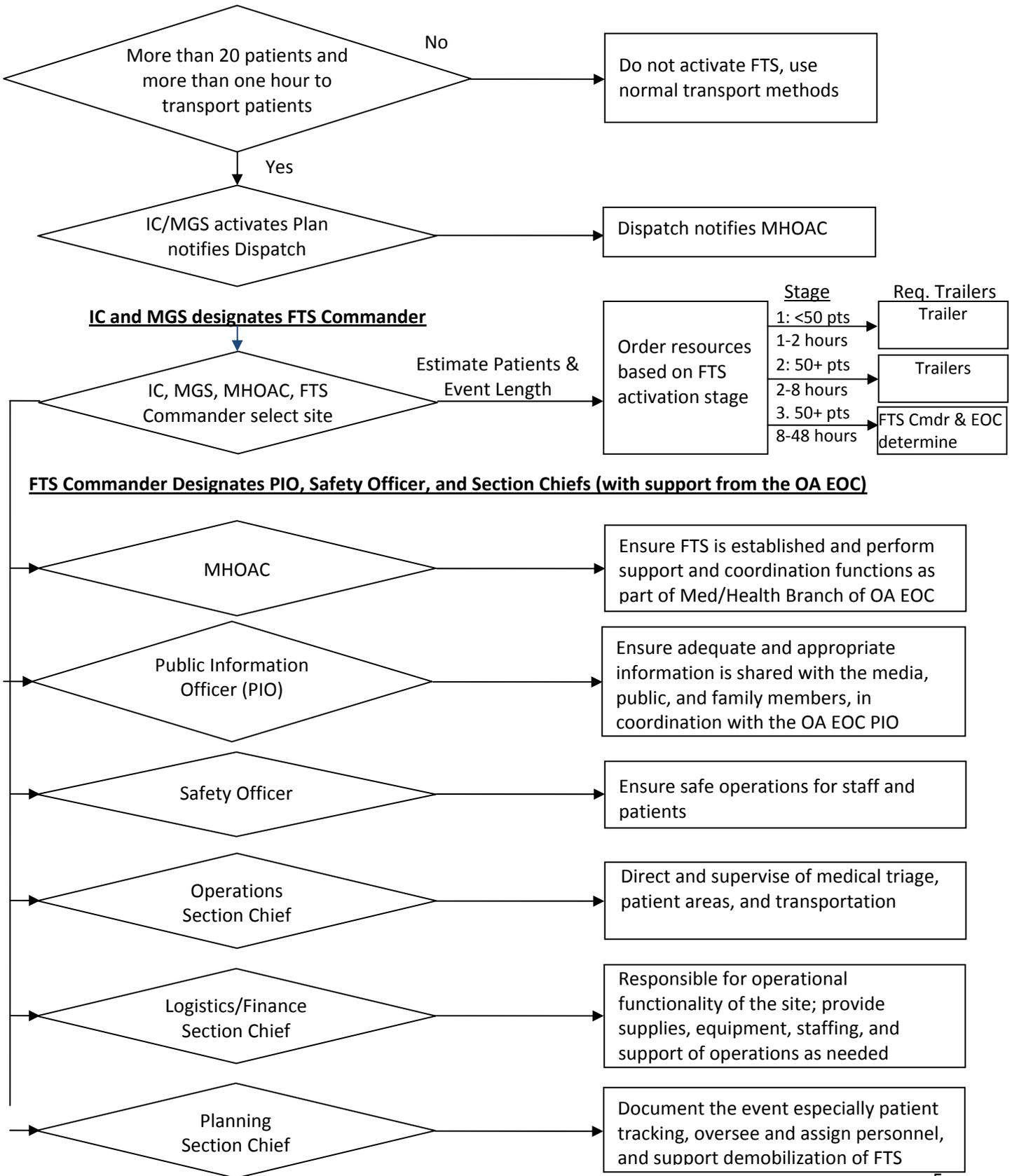
crucial element during this cycle. Once the EMS system regains the ability to transport all patients to hospitals, the demobilization cycle will commence. During this time, all paperwork should be completed, equipment stored, supplies restocked, staff released from their positions, and the location cleaned. When the owner of the FTS location accepts back control of the property, the evaluation cycle begins. An After Action Report (AAR) and subsequent Improvement Plan (IP) are the priorities during this phase of the FTS life cycle. The plan recommendations are incorporated into future training during the planning cycle to prepare Mono County for the next deployment of the FTS plan.

For clarification, the following crosswalk provides a comparison of the various functions within the healthcare continuum.

Location Name	Definitional Considerations	Possible Reasons for Site Activation (one or more)
<p>Field Treatment Site</p>	<p>Definition: A temporary site for triage, emergency medical treatment, and management and care of casualties in a field setting usually when permanent medical facilities are limited, overwhelmed, or unavailable. Stabilized patients requiring acute inpatient care are transported to receiving facilities when available.</p> <p>FTSs are generally intended to operate for up to 48 hours or until injured patients stop arriving.</p> <p>Activation and Lead: Activated by EMS (EF-8) for onsite field incidents, may also be activated by Operational Area EOC Medical Health Branch (EF-8).</p>	<ul style="list-style-type: none"> • A casualty incident expected to exceed local emergency or hospital capacity. • Delay in arrival of sufficient levels of medical aid • A protracted, large-scale response with multiple casualties • A planned event where the provision of medical treatment is anticipated, not necessarily when resources are overwhelmed.
<p>Medical Shelter</p>	<p>Definition: A temporary shelter which provides sufficient medical care to ensure that sheltered individuals maintain their usual level of health when displaced during an incident. These sites are typically located outside the impact zone and serve individuals from the impacted community with needs that require skilled medical care, but do not require hospitalization, or have an acute emergency medical condition.</p> <p>Activation and Lead: Typically activated by public health (EF-8) with support from social services and select non-governmental organizations (EF-6)</p>	<ul style="list-style-type: none"> • Displacement of a large population with medical needs • The immediate needs of the incident exceed the ability to accommodate the impacted population in “like facilities” • A need to reduce the strain on the overall healthcare system when resource requirements exceed resource capability • A higher level of in medical skill, resources or infrastructure is required by individuals within a General Population Shelter(i.e. those requiring continuous monitoring) • The immediate needs of the incident do not allow for the appropriate level of activation of the emergency plans or

<p>Government Authorized Alternate Care Site</p>	<p>Definition: A location that is not currently providing healthcare services and will be converted to enable the provision of healthcare service to support, at a minimum, inpatient and/or outpatient care required after a declared catastrophic emergency. These sites are not part of the expansion of an existing healthcare facility, but rather are designated under the authority of the local government. A Government Authorized Alternate Care Site may be a Mobile Field Hospital.</p> <p>Activation and Lead: Typically activated by public health and/or State EMS Authority (EF-8) utilizing a public-private partnership and CALMAT teams.</p>	<p>agreements and contingencies are</p> <ul style="list-style-type: none"> • The overall healthcare system has exhausted all available resources through surge, additional capacity still required • Incident creates need for an increased localized acute medical care capacity
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Activation Algorithm



Roles and Responsibilities, utilizing the town and/or OA EOP/EOC, and ICS/SEMS

Legend: ○ = Support, Coordination, and Involvement ● = Primary Responsibility

FTS Functions	On-Scene Command	OA Public Safety Dispatch	Hospitals, Clinics	OA EOC Environmental Health Branch	OA EOC Mental Health Branch	OA EOC Medical/Health Branch (MHOAC)	Town/OA EOC Construction and Engineering Branch	town/OA EOC Law Enforcement Branch or Local Law Enforcement	OA EOC Care and Shelter Branch	town/OA EOC Logistics Section	Other
Command and Control (Scene)	●										
Coordination if more than one EMS FTS						●					
Notification		●	○	○	○	○			○	○	
Provision of Personnel		○	○	○	○	○				● ²	○ ³
Medical Supply			○			●				○	○ ⁴
Medical Equipment			●			●				●	○ ⁴
Non-Medical Supply				○						●	○ ⁴
Communications Equipment		○								●	○ ⁴
Facility Support (utilities)							●			○	
Food									●	○	
Water										●	
Sanitation				○						●	
Child/Companion Animal Care									●		
Security and Perimeter Control							○	●		○	
Level of Care Decisions						●					
Mental Health Counseling			○		●				○		
Infection Control Instructions			○	○		●					
Helicopters			○							●	○ ⁵
Alternative Ground Transportation										●	
Public Information	●				○						● ⁶

² All departments agreeing to provide staffing during the pre-planning phase are listed as support. The lead for filling requests from the field for additional staff will be through the Staffing Unit of the EOC.

³ DHV, MRC, CAL-MAT, DMAT, and Federal Health Care workers

⁴ Vendors

⁵ Logistics Air Operations contacts Regional Emergency Operations Center (REOC) for assistance from the National Guard and other military sources.

⁶ Coordination on Public Information should be through the field to the JIC, if established.

FTS Planning Checklist

Objective: Identify the necessary resources and staff to activate and operate an FTS. Evaluate potential sites ahead of time and established agreements as needed

<input type="checkbox"/>	Evaluate existing facilities for potential use as pre-designated FTS locations during a major event, such as an earthquake (use appendix 1: site list and Mono County Facility Profile)
<input type="checkbox"/>	Establish a Memorandum of Understanding with these sites as necessary
<input type="checkbox"/>	Create a site plan for these locations, including air/ground transportation access (use appendix 1: site/facility map/floor plan)
<input type="checkbox"/>	Identify equipment necessary to support each FTS
<input type="checkbox"/>	Maintain equipment through regular testing and inspections to support up to two FTS locations
<input type="checkbox"/>	Establish transportation plan/agreement for moving the FTS equipment between locations
<input type="checkbox"/>	Require all personnel that may be placed in a leadership position to attend the appropriate training, e.g. ICS 100/200/300

FTS Activation Checklist

Objective: Establish one or more FTS locations when existing resources will not be able to transport all incident casualties within the first hour of the event.

Scene Incident Commander (IC) and/or Medical Group Supervisor (MGS)	
<input type="checkbox"/>	Activate the FTS Plan
<input type="checkbox"/>	Notify Mono County Dispatch that the FTS Plan is being activated that there are more patients than can be transported within one hour (e.g. > 20 patients)
<input type="checkbox"/>	Establish communication with the MHOAC
<input type="checkbox"/>	Identify the following:
<input type="checkbox"/>	How many expected casualties and any unique needs (e.g. decon, burns, peds)
<input type="checkbox"/>	Where patients are currently being triaged
Mono County Dispatch	
<input type="checkbox"/>	Contact the MHOAC, as well as OA Law and Fire Coordinators if not already notified.
Mono County MHOAC	
<input type="checkbox"/>	Along with the IC, MGS, and FTS Commander, select FTS site(s)
<input type="checkbox"/>	Conduct situational assessment, and provide Situational Reporting according to the California Public Health and Medical Emergency Operations Manual (EOM) policy and procedures
<input type="checkbox"/>	Coordinate the acquisition of needed health and medical resources.
<input type="checkbox"/>	Activate Medical/Health Branch of the OA EOC; virtual, partial, or full as needed
Mono County Health Department DOC (as part of the Medical/Health Branch of the OA EOC)	
<input type="checkbox"/>	Deploy resources to the FTS locations, including:
<input type="checkbox"/>	trailers, one for each 50 casualties per site
<input type="checkbox"/>	provide personnel to the FTS as requested by the FTS Commander and the MHOAC
FTS Commander	
<input type="checkbox"/>	Contact on scene MGS or designee
<input type="checkbox"/>	Establish FTS location(s) along with the IC, MGS, and MHOAC
<input type="checkbox"/>	Ensure necessary functions are staffed, utilizing the EOC for support and coordination
<input type="checkbox"/>	Determine need for resources, and coordinate requesting, acquisition, and tracking with

EOC
<input type="checkbox"/> Establish and maintain on-site communications with the field level and the OA EOC
<input type="checkbox"/> Assign a Safety Officer
<input type="checkbox"/> Assign a Public Information Officer
<input type="checkbox"/> Assign an Operations Section Chief to accept, triage, treat, and transport casualties
<input type="checkbox"/> Assign a Logistics Section Chief to track resources requested and received
<input type="checkbox"/> Assign a Planning Section Chief to coordinate patient tracking and situation reports
<input type="checkbox"/> Assign a Finance Section Chief to track staff time on-site and ensure patient records tracking and security as per HIPAA
<input type="checkbox"/> If not a pre-designated FTS location, identify a site layout diagram to accommodate triage, patient types, air/ground transportation, equipment, administration, etc.
<input type="checkbox"/> Assign additional positions as needed (use appendix 2: sample organizational charts and job descriptions)

FTS Operations Checklist

Objective: Provide for the safe and rapid triage and transport of injured casualties to a definitive level of care

FTS Commander
<input type="checkbox"/> Receive briefings from MGS or designee at the incident
<input type="checkbox"/> Re-estimate the number of expected casualties and any special needs (e.g. decon, peds, burns)
<input type="checkbox"/> Establish a command post/administration area following the site layout diagram
<input type="checkbox"/> Provide briefings to the DOC every hour
<input type="checkbox"/> Establish and maintain communications with MGS and DOC
Operations Section Chief
<input type="checkbox"/> Using the site layout diagram (appendix 1), identify:
<input type="checkbox"/> Casualty reception/triage area
<input type="checkbox"/> Minor injury casualty area – green tarps and tape
<input type="checkbox"/> Delayed injury casualty area – yellow tarps and tape
<input type="checkbox"/> Immediate injury casualty area – red tarps and tape
<input type="checkbox"/> Deceased casualty area – black tarps and tape
<input type="checkbox"/> Air/Ground ambulance transportation ingress and egress
<input type="checkbox"/> Assign a Triage Group Supervisor to rescreen incoming casualties and reprioritize as their conditions may have changed since the initial triage; implement or continue using START tags
<input type="checkbox"/> Assign a Treatment Group Supervisor(s), as needed, to accomplish incident objectives
<input type="checkbox"/> Assign Treatment Team Leaders for minor, delayed, and immediate teams, as needed
<input type="checkbox"/> Assign Transportation Group Supervisor to manage ambulance flow and patient destinations
<input type="checkbox"/> Assign a Morgue Group Supervisor, as needed, to oversee and secure deceased casualties
<input type="checkbox"/> Task medical personnel assigned to FTS Operations
Logistics Section Chief
<input type="checkbox"/> Identify what medical resources are on scene
<input type="checkbox"/> Identify what medical resources have been requested
<input type="checkbox"/> Identify what additional medical resources are necessary and make official request (use

appendix 3: resource inventory and map)
<input type="checkbox"/> Establish secure area for medical supply cache
<input type="checkbox"/> Identify site needs for up to 48 hour deployment, ONLY if stage 2 or 3 activation
<input type="checkbox"/> Food
<input type="checkbox"/> Water
<input type="checkbox"/> Bathrooms
<input type="checkbox"/> Tents/shelters
<input type="checkbox"/> Generators/fuel
<input type="checkbox"/> Lighting
<input type="checkbox"/> HVAC
<input type="checkbox"/> Consider requesting the EOC for logistical support, specifically food and water for staff and casualties
Planning Section Chief
<input type="checkbox"/> Establish sign-in and out procedures for all personnel assigned to FTS
<input type="checkbox"/> Assign personnel to support FTS operations, logistics, finance, and planning as needed
<input type="checkbox"/> Assign a Document Unit Leader
<input type="checkbox"/> Document patient destinations
<input type="checkbox"/> Prepare Incident Action Plan (IAP)
<input type="checkbox"/> Provide situation reports to FTS Commander
<input type="checkbox"/> Complete and communicate Site Report Form (use appendix 4) to FTS Commander and/or EOC
<input type="checkbox"/> Track needs when the FTS is demobilized
Finance Section Chief
<input type="checkbox"/> Track staff time on-site and ensure patient records tracking and security as per HIPAA

FTS Demobilization Checklist

Objective: Turn FTS location back over to responsible party in the same and better condition and ensure all FTS, staff, and patient documentation is provided to the EOC

Logistics Section Chief
<input type="checkbox"/> Clean non-disposable FTS supplies and repack for storage
<input type="checkbox"/> Arrange for transportation of FTS resources back to their storage locations
<input type="checkbox"/> Used disposable medical supplies should be disposed of properly
<input type="checkbox"/> Arrange for removal of trash and biohazard waste
<input type="checkbox"/> Ensure facility is clean and left in the same or better condition
<input type="checkbox"/> Ensure staff have adequate and appropriate mental health debriefing and counseling
Planning Section Chief
<input type="checkbox"/> Ensure all paperwork is completed, especially patient care and destination
<input type="checkbox"/> All FTS, staff, and patient information should be given to the MHOAC
<input type="checkbox"/> Have all FTS staff check-out and report any injuries or other issues needing follow-up
<input type="checkbox"/> Turn facility back over to owner or responsible party after walk-through
<input type="checkbox"/> Prepare After Action Report (AAR)
Finance Section Chief
<input type="checkbox"/> Ensure staff time is reported to the appropriate agency for reimbursement
<input type="checkbox"/> Identify billing and/or cost recovery opportunities for care provided

Appendix 1: Designated Disaster Facilities and Facility Profile Checklist

Mono County

Designated Disaster Facilities

Facility Profile Checklist

**Facility Profile for Use as Field Treatment Site (FTS), Alternate Care Site (ACS), Point of
Dispensing (POD), and/or Shelter**

Inspected By: _____ **Date:** _____

General

Type of Facility (circle): aircraft hanger, church, community/recreation center, long-term care facility, hospital, clinic, fairgrounds, local government building, military facility, private building, hotel/motel, meeting hall, school, sports facility/stadium, trailer/tent, other (describe):

Site Name: _____ Phone: _____

Physical Address (#, street, town, zip):

Major cross street/highway: _____

GIS Coordinates: _____

Proximity (miles) to nearest hospital: _____ police station: _____ fire station: _____

Local EMS Provider: _____

Located on flood plain (circle): Y N UNK

Year Built: _____ If before 1933, earthquake retrofitted (circle): Y N

Owner: _____ MOU in place (circle): Y N Not needed

Is there the potential for mixed usage during a disaster (the owner plus the responding agency)(circle)? Y N

Has the facility been identified for use at the time of a disaster by other agencies (circle)? Y N

Who? _____

Point of Contact (POC) w/key (Name - Title):

Work #: _____ Cell #: _____ Home #: _____

POC for facility maintenance(Name/Title):

Work #: _____ Cell #: _____ Home #: _____

POC for site security(Name/Title):

Work #: _____ Cell #: _____ Home #: _____

Overall suitability of this site to support the indicated emergency response (FTS, ACS, POD, RSS,

shelter long term – evacuation, shelter short term – warming, cooling), based on the following

assessment of the exterior and the interior of the site/facility:

FTS (circle): Low Average High

ACS (circle): Low Average High

POD (circle): Low Average High

Shelter long term (circle): Low Average High

Shelter short term (circle): Low Average High

Potential limitations with this site (narrative):

Assessment of the Exterior of the Site

- | | | |
|--|---|---|
| 1. Is vehicle or pedestrian access to the facility perimeter controllable by a fence, wall, or other physical barrier (preferably at least 4 feet high)? | Y | N |
| 2. If Yes, is a gate solid and able to be securely locked? | Y | N |
| 3. Is there a potential helicopter landing zone nearby? | Y | N |
| 4. Are there external hazards potentially useful to intruders (hiding places, items that could be used as weapons, missiles, or tools)? | Y | N |
| 5. Is there a parking lot? | Y | N |
| a. # of spaces _____ | | |
| b. # of marked ADA spaces meeting ADA requirements: _____ | | |
| 6. Is there ADA access to the building (ramp, etc.)? | Y | N |
| 7. Is there adequate access and entry for emergency vehicles with a gurney? | Y | N |
| 8. Is there a separate loading dock/area? | Y | N |
| 9. Are there forklifts or pallet jacks available (if Yes, circle which and indicate #): _____ | Y | N |
| 10. Is there access to the loading dock/area for a semi-trailer truck (18 wheeler)? | Y | N |
| 11. Is the responsibility for potential snow removal assigned? | Y | N |
| 12. Does flooding ever interfere with access to the parking and facility? | Y | N |
| 13. Is there the ability to lock down the building (all entrances/exits/windows)? | Y | N |
| 14. External lighting: | | |
| a. Is the entire perimeter lighted? | Y | N |
| b. Is the parking area adequately lighted? | Y | N |
| c. Is the exterior of the building, especially entry points, adequately lighted? | Y | N |
| d. Are control switches for external lighting automatic (versus manual)? | Y | N |
| e. Are control switches inaccessible to unauthorized persons? | Y | N |
| f. Do any exterior lights have an auxiliary power source? | Y | N |
| g. | | |

15. Describe access to the parking lot and main entrance from major roads?

16. Can all street/road/highway access to the site be blocked off if necessary? Y N

17. Could a secure route be ensured for access by supply or emergency vehicles? Y N

18. Are there any facilities nearby which might pose a security threat (jail, halfway house, storage of hazardous materials, bars)? Y N

Describe:

19. Are there any problems with vehicular traffic congestion in the area? Y N

Describe:

20. Briefly describe the type of neighborhood (i.e., residential, commercial, industrial):

Based upon this assessment of the **exterior** of the site, the suitability of this site to support the

indicated emergency response is:

FTS (circle): Low Average High

ACS (circle): Low Average High

POD (circle): Low Average High

Shelter long term (circle): Low Average High

Shelter short term (circle): Low Average High

Comments (narrative):

Assessment of the Interior of the Site

1. Are all exterior doors solid core wood, metal clad, or metal? Y N
2. Are all exterior doors equipped with cylinder locks, deadbolts, or solid locks? Y N
3. Are all exterior doors equipped with intrusion alarms? Y N
 - a. Where does the alarm system terminate (circle): commercial law enforcement
4. Is the main power source dependable? Y N
 - a. Utility company (circle): SCE DWP
5. Is there an auxiliary power source/generator? Y N
 - a. # watts: _____
 - b. # gallons of fuel on hand: _____
 - c. # hours of operation without additional fuel: _____
6. Is there (circle): heat, A/C, hot water, propane tank on the premises?
7. Is interior lighting adequate in all anticipated workplaces for safe movement/tasks? Y N
8. Are light switches key controlled? Y N
9. When was the facility last inspected by the fire marshal? _____
10. Did the fire marshal approve the building? Y N
 - a. If no, why not? _____
11. Does the building have functioning fire alarms? Y N
12. Does the building have functioning smoke detectors? Y N
13. Does the building have a sprinkler system? Y N
14. Does the building have fire extinguishers? Y N
 - a. If Yes, last inspected: _____
15. Does the building have emergency fire hoses/standpipes? Y N
16. Does the building have a functioning and inspected AED? Y N
17. Does the building have any first aid supplies? Y N

18. Is there a written evacuation plan (fire, flood, earthquake, etc.) for the facility? Y N

19. Are exits clearly marked? Y N

20. Describe communications resources:

a. PA system, intercom, overhead paging (describe):

b. Internet – none, dial-up, broadband, Wi-Fi (circle all that are available)

c. Computers available for emergency response personnel use (#): _____

d. Phone (# lines, phones, TDD capable):

e. FAX (# machines): _____

f. During tests, did 2-way radios transmit and receive clearly from inside the building?

Y N

21. What is the total square footage of the building? _____ sq ft

22. What is the total sq ft of the largest room (basketball court = 5,000 sq. ft.)? _____ sq ft

23. How many rooms are there in the building? _____ rooms

24. According to the fire marshal, what is the maximum occupancy for the building? _____ people

25. According to the fire marshal, what is the max occupancy for the largest room? _____ people

26. What is the bed capacity of the largest room (50 sq ft per non-ambulatory patient)? _____ beds

27. How many stories are there in the building? _____ stories

28. Are the doorways ADA accessible from the entrance to the largest room? Y N

29. How many functioning electrical outlets are there in the largest room (#)? _____

30. How many restrooms are there (#)? Men: _____ Women: _____ Unisex: _____ ADA:: _____

31. How many showers are there (#)? Men: _____ Women: _____ Unisex: _____

32. What is the availability/number of tables: _____, chairs: _____, room dividers: _____?

33. Is there built-in oxygen delivery capability in the facility? Y N

34. Is there a large amount of cash retained in any office overnight, and if so, is there an adequate safe, vault, or strongbox? Y N

35. Are there separate rooms/areas potentially available for the following:

- | | | |
|---------------------------------------|---|---|
| a. Staff rest/breakroom | Y | N |
| b. Kitchen | Y | N |
| i. Stove (#): ____ | Y | N |
| ii. Microwave (#): ____ | Y | N |
| iii. Food supply and preparation area | Y | N |
| iv. Refrigerator (#): ____ | Y | N |
| v. Freezer (#): ____ | Y | N |
| vi. Sink (#): ____ | Y | N |
| vii. Dishwasher (#): ____ | Y | N |
| viii. Waste disposal (#): ____ | Y | N |

c. Some or all of the following rooms/areas:

-
- | | | |
|---|---|---|
| <u>laundry</u> – separate area or room with washers and dryers | Y | N |
| <u>incident manager</u> – separate room able to be secured, with adequate electrical outlets, ability to transmit and receive radio communication, and Internet broadband or wireless communication, with tables or desks and chairs, room for at least 2 workstations | Y | N |
| <u>triage</u> – room/area near public entrance, either separate or able to be partitioned off, to setup up at least 2 stations for staff to provide initial evaluation (history, vital signs) of potentially affected individuals (sick, injured, exposed, contaminated, etc.) | Y | N |
| <u>medical counseling</u> – private area/room for medical staff to counsel individuals or families regarding proposed medical intervention (prophy, vacc., Rx, placement) | Y | N |
-

medical equipment storage – temperature controlled, securable room near loading dock or staff entrance able to store multiple boxes up to the volume of several pallets

Y N

secure pharmaceutical storage – temperature controlled, securable room near loading dock or staff entrance able to store medications, including refrigeration

Y N

isolation - separate room with ability to be separately ventilated (no shared HVAC, open windows OK), ability for privacy and tight control of ingress/egress, ability to move cots, gurney in/out, large enough for at least 5 beds

Y N

palliative care –separate private room large enough for at least 5 cots and family members, able to move cots or gurney in/out

Y N

mortuary – separate secured area for temporary storage of bodies in body bags, near loading dock or staff entrance

Y N

decontamination – location with ability to do decontamination outside (requires ability to set up decon tent with heated water) or inside (showering), while providing privacy, management of biowaste, and protection of non-contaminated individuals (staff and public)

Y N

family – separate private area for families of affected persons to rest, eat, sleep, with shower and bathroom facilities

Y N

media staging – separate area near loading dock/staff entrance, with ability to be securely separated from the public, large enough to conduct interviews/briefings

Y N

service animals/pets – separate room for affected persons with service animals or small pets in cages, kennels, on leash, and well controlled

Y N

environmental supply storage – room/area to store cleaning equipment, bathroom supplies, soap and hand sanitizers, etc., able to be secured Y N

lab specimen preparation – secured room/area with table/desk/cabinet/refrigerator suitable for storage of lab equipment (specimen collection) and for packaging and refrigeration of specimens prior to shipment, separate from any food preparation area Y N

biohazard/waste disposal – secured room near loading dock or staff entrance able to contain large bags of contaminated waste pending final disposition Y N

law enforcement holding – secured private room/area able to temporarily hold individuals being detained by law enforcement Y N

Based on this assessment of the **interior** of the site, the suitability of this site to support the indicated emergency response is:

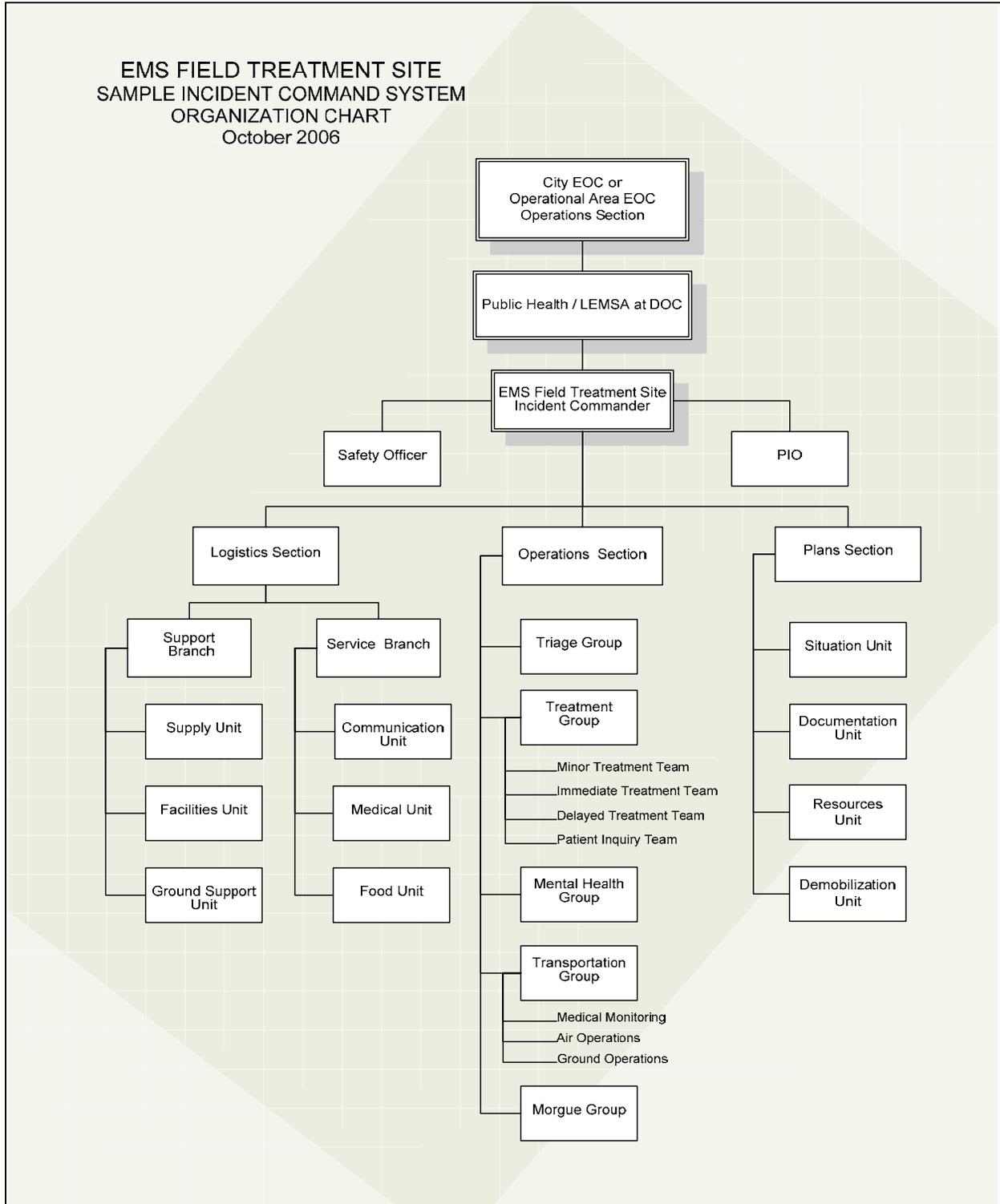
FTS (circle):	Low	Average	High
ACS (circle):	Low	Average	High
POD (circle):	Low	Average	High
Shelter long term (circle):	Low	Average	High
Shelter short term (circle):	Low	Average	High

Comments (narrative):

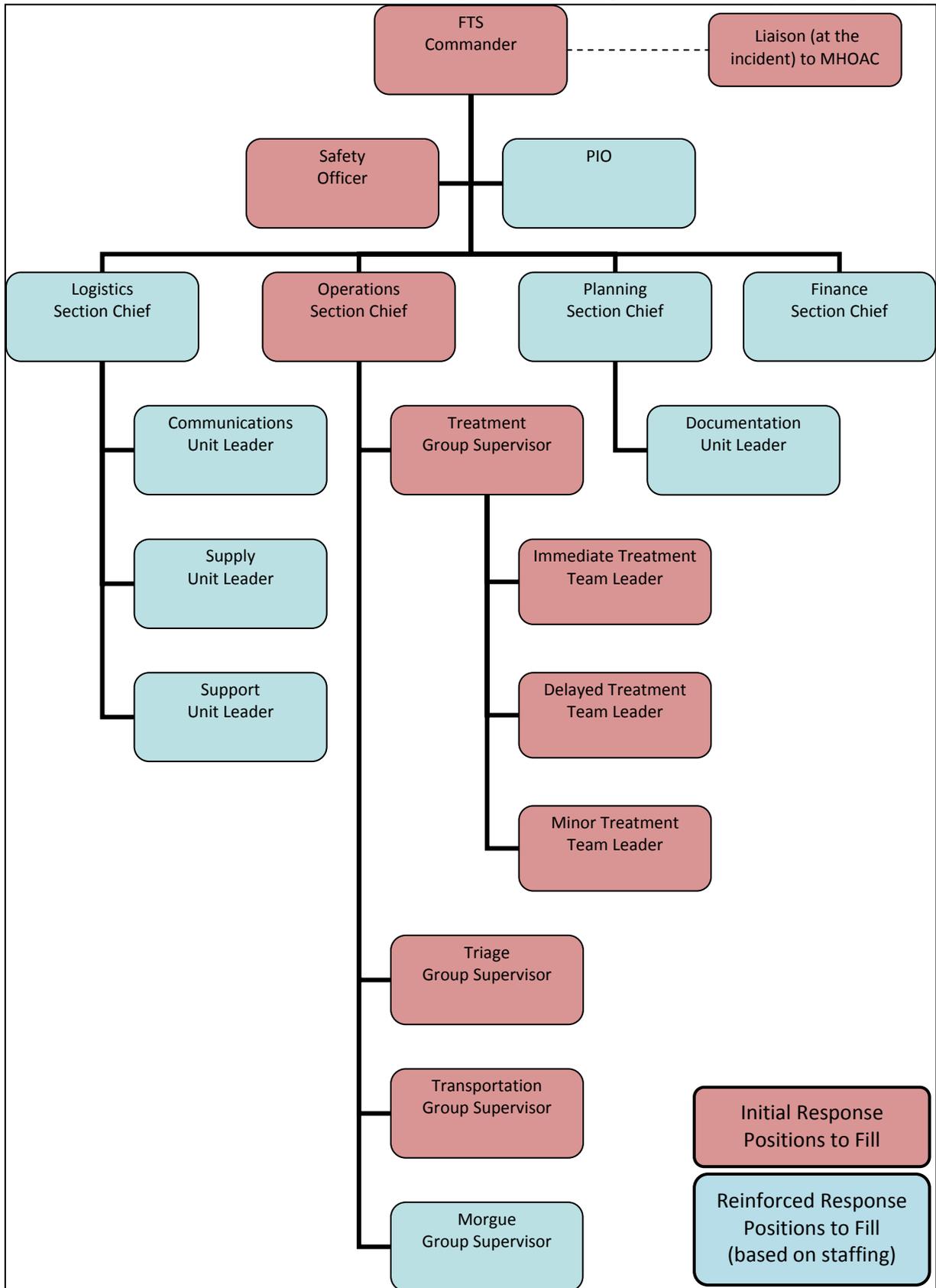
Site/Facility Map, Floor Plan, Photographs

Appendix 2: Sample Organizational Charts & Job Descriptions

California EMSA Model - considered ideal model, if resources are available



Mono Model - considered min. necessary to open FTS (multiple roles filled by same person)



JOB ACTION SHEET	MHOAC
FUNCTION:	Ensure FTS is established and maintain on-going communications with IC, MGS, FTS Commander, and DOC/EOC
AGENCY TO FILL JOB:	Public Health, EMS
REPORT TO:	EOC Operations Section Chief or Unified Command
REPORTS TO YOU:	FTS Commander, MGS through liaison or designee
PRIMARY DUTIES:	Activation
	<input type="checkbox"/> Establish contact with MGS and FTS Commander(s)
	<input type="checkbox"/> Work with IC, MGS, and FTS Commander (s) to identify how many FTS are needed and where
	<input type="checkbox"/> Conduct situational assessment, and provide Situational Reporting according to EOM policy and procedures.
	<input type="checkbox"/> Coordinate the acquisition of needed health and medical resources.
	<input type="checkbox"/> Activate Department Operations Center (DOC); virtual, partial, or full as needed (may be the Medical/Health Branch of the EOC if open)
	Operations
	<input type="checkbox"/> Establish and maintain on-going communications between Scene IC, MGS, FTS Commander, DOC/EOC, ICEMA, and Region 6.

JOB ACTION SHEET		FTS COMMANDER
FUNCTION:		Ensure efficient operation of the FTS
AGENCY TO FILL JOB: (1st & 2nd Choice)		EMS Specialist, Public Health
REPORT TO:		MHOAC, EOC
REPORTS TO YOU:		Safety Officer
		Public Information Officer (PIO)
		Operations Section Chief
		Logistics Section Chief
		Planning Section Chief
		Finance Section Chief
PRIMARY DUTIES:		Activation
ICS Forms	201, 202, 203, 207	<input type="checkbox"/> Establish Incident Action Plan including briefings, objectives, organization assignment list and chart
		<input type="checkbox"/> Confirm incoming resources with DOC/EOC; order additional resources (e.g. trailers) as needed
		<input type="checkbox"/> If not a pre-designated FTS location, identify a site layout diagram to accommodate triage, patient types, air/ground transportation, equipment, administration, etc.
		<input type="checkbox"/> Assign liaison to Scene IC, MGS, and MHOAC, as needed
		<input type="checkbox"/> Assign a Safety Officer
		<input type="checkbox"/> Assign a Public Information Officer
		<input type="checkbox"/> Assign an Operations Section Chief to accept, triage, treat, and transport casualties
		<input type="checkbox"/> Assign a Logistics Section Chief to track resources requested and received
		<input type="checkbox"/> Assign a Planning Section Chief to coordinate patient tracking and situation reports
		<input type="checkbox"/> Assign a Finance Section Chief to track staff time on-site and ensure patient records tracking and security as per HIPAA
Appendix	2	<input type="checkbox"/> Assign additional positions as needed (use appendix 2: sample organizational charts and job descriptions)
		Operations
		<input type="checkbox"/> Re-estimate the number of expected casualties and any special needs (e.g. decon, peds, burns)
		<input type="checkbox"/> Establish a command post/administration area following the site layout diagram
		<input type="checkbox"/> Coordinate with command staff and liaison(s)
ICS Form	214	<input type="checkbox"/> Provide briefings to MHOAC/DOC/EOC as needed

JOB ACTION SHEET		Safety Officer
FUNCTION:		Ensure safe operations for staff and patients
AGENCY TO FILL JOB:		Fire or Law Enforcement, senior personnel
REPORT TO:		FTS Commander
REPORTS TO YOU:		Assistant Safety Officer(s), if any
PRIMARY DUTIES:		Activation
ICS Forms	208, 215A	<input type="checkbox"/> Establish sufficient security to ensure the safety of staff and patients
		<input type="checkbox"/> Identify where supplies and other items needing security are to be stored
		<input type="checkbox"/> Coordinate with local law enforcement when additional security is required

JOB ACTION SHEET	Public Information Officer (PIO)
FUNCTION:	Ensure adequate and appropriate information is shared with the media, public, and family members
AGENCY TO FILL JOB:	Public Health, EMS, SO
REPORT TO:	FTS Commander
REPORTS TO YOU:	Assistant PIO(s), if any
PRIMARY DUTIES:	Activation
	<input type="checkbox"/> Prepares information for the public regarding the FTS location and care available.
	<input type="checkbox"/> Coordinates all messages with the FTS Commander and/or the JIC, if established
	<input type="checkbox"/> Escorts media representatives, while protecting patient privacy
	<input type="checkbox"/> May assist with patient inquiries by family members, while protecting patient privacy

JOB ACTION SHEET		Operations Section Chief
FUNCTION:		Direct and supervise of medical triage, patient areas, and transportation
AGENCY TO FILL JOB:		EMS Specialist, Public Health
REPORT TO:		FTS Commander
REPORTS TO YOU:		Triage Unit Leader
		Treatment Unit Leader
		Transportation Unit Leader
		Medical Group Supervisor, if appointed
PRIMARY DUTIES:		Operations
Appendix	1	<input type="checkbox"/> Using the site layout diagram, identify and supervise:
		<input type="checkbox"/> Casualty reception/triage area
		<input type="checkbox"/> Minor injury casualty area – green tarps and tape
		<input type="checkbox"/> Delayed injury casualty area – yellow tarps and tape
		<input type="checkbox"/> Immediate injury casualty area – red tarps and tape
		<input type="checkbox"/> Deceased casualty area – black tarps and tape
		<input type="checkbox"/> Air/Ground ambulance transportation ingress and egress
ICS Form	215B	<input type="checkbox"/> Establish a Medical Group Supervisor(s), as needed, to accomplish incident objectives
		<input type="checkbox"/> Establish a Triage Unit Leader to rescreen incoming patients and reprioritize as their conditions may have changed since the initial triage; implement or continue using START tags; assigns infectious individuals to isolation, if an isolation area is available; document patient movement within FTS or assign clerk to manage patient registration and tracking, if available
		<input type="checkbox"/> Establish Treatment Unit Leader, possibly identify separate coordinators for minor, delayed, immediate, and morgue teams, as needed
		<input type="checkbox"/> Establish Team Leaders for each treatment area- Minor, Immediate, and Delayed
		<input type="checkbox"/> Establish Morgue Unit Leader to secure area and coordinate activities with coroner as needed
		<input type="checkbox"/> Establish Ground/Air Transportation Unit Leader (assign subordinate Air Operations Leader, if possible) to manage ambulance flow and assign/document casualty destinations; assign clerk to record patient destinations, if available
		<input type="checkbox"/> Task medical personnel assigned to FTS Operations
ICS Form	214	<input type="checkbox"/> Maintain Activity Log
SECONDARY DUTIES:		<input type="checkbox"/> Establish child care and mental health/quiet areas with appropriate specialists for those uninjured
		<input type="checkbox"/> Establish crisis counseling for patients and stress counseling for staff, possibly request religious staff and children specialists, as needed

JOB ACTION SHEET		Logistics Section Chief
FUNCTION:		Responsible for operational functionality of the site; provide supplies, equipment, staffing, and support of operations as needed
AGENCY TO FILL JOB: (1st & 2nd Choice)		EMS Specialist, Public Health
REPORT TO:		FTS Commander
REPORTS TO YOU:		Communications Unit Leader
		Supply Unit Leader
		Support Unit Leader
PRIMARY DUTIES:		Operations
		<input type="checkbox"/> Identify what medical resources are on scene
		<input type="checkbox"/> Identify what medical resources have been requested
Appendix	3	<input type="checkbox"/> Identify what additional medical resources are necessary and make official request (use appendix 3: resource inventory)
		<input type="checkbox"/> Establish secure area for medical supply cache
		<input type="checkbox"/> Manage inventory of medical and non-medical supplies
		<input type="checkbox"/> Distribute supplies as requested by Operations
ICS Form	205	<input type="checkbox"/> Ensure all sections can communicate with each other and FTS Commander and Logistics Section Chief can communicate with DOC; provide radio training as needed; consider requesting assistance through DOC for RACES and/or County Dispatch; maintain inventory of equipment used
		<input type="checkbox"/> Determine traffic and patient flow patterns with Operations (assuming not already established in pre-designated FTS location)
		<input type="checkbox"/> In pre-designated FTS location, ensure set-up according to pre-determined layout
		<input type="checkbox"/> Identify site needs for up to 48-hour deployment, ONLY if stage 2 or 3 activation
		<input type="checkbox"/> Food
		<input type="checkbox"/> Water
		<input type="checkbox"/> Bathrooms and sinks
		<input type="checkbox"/> Tents/shelters
		<input type="checkbox"/> Generators/fuel
		<input type="checkbox"/> Lighting
		<input type="checkbox"/> HVAC
		<input type="checkbox"/> Consider requesting the EOC for logistical support, specifically food and water for staff and casualties, as needed
SECONDARY DUTIES:		Demobilization
		<input type="checkbox"/> Clean non-disposable FTS supplies and repack for storage
		<input type="checkbox"/> Arrange for transportation of FTS resources back to their storage locations
		<input type="checkbox"/> Used disposable medical supplies should be disposed of properly
		<input type="checkbox"/> Arrange for removal of trash and biohazard waste
		<input type="checkbox"/> Ensure facility is clean and left in the same or better condition

JOB ACTION SHEET		Planning Section Chief
FUNCTION:		Document the event especially patient tracking, oversee and assign personnel, and support demobilization of FTS
AGENCY TO FILL JOB: (1st & 2nd Choice)		EMS Specialist, Public Health
REPORT TO:		FTS Commander
REPORTS TO YOU:		Documentation Unit Leader
PRIMARY DUTIES:		Operations
ICS Form	211	<input type="checkbox"/> Establish sign-in and out procedures for all personnel assigned to FTS
		<input type="checkbox"/> Assign personnel to support FTS operations, logistics, finance, and planning as needed; provide orientation for new arrivals
		<input type="checkbox"/> Appoint a Document Unit Leader
		<input type="checkbox"/> Document patient arrivals in collaboration with Triage Unit Leader or Clerk
		<input type="checkbox"/> Document patient destinations in collaboration with Transport Officer or Clerk
ICS Forms	201, 202, 203, 207	<input type="checkbox"/> Assist FTS Commander prepare an Incident Action Plan (IAP)
		<input type="checkbox"/> Provide situation reports to FTS Commander and to MHOAC
Appendix	4	<input type="checkbox"/> Complete and communicate Site Report Form to FTS Commander and/or DOC
		<input type="checkbox"/> Track needs for when the FTS is demobilized
SECONDARY DUTIES:		Demobilization
		<input type="checkbox"/> Ensure all paperwork is completed, especially patient care and destination
		<input type="checkbox"/> All FTS, staff, and patient information should be given to the EMS agency
		<input type="checkbox"/> Have all FTS staff check-out and report any injuries or other issues needing follow-up
		<input type="checkbox"/> Return all borrowed or rented equipment and unused supplies; reconcile mutual aid resources
		<input type="checkbox"/> Turn facility back over to owner or responsible party after walk-through
ICS Forms	221, 225	<input type="checkbox"/> Prepare Incident Personnel Performance Ratings
		<input type="checkbox"/> Prepare After Action Report (AAR) with MHOAC

JOB ACTION SHEET		Finance Section Chief
FUNCTION:	Track staff time on-site and ensure patient records tracking and security as per HIPAA	
AGENCY TO FILL JOB: (1st & 2nd Choice)	HHS Finance Department	
REPORT TO:	FTS Commander	
REPORTS TO YOU:		
PRIMARY DUTIES:	Operations	
	<input type="checkbox"/> Track staff time on-site and ensure patient records tracking and security as per HIPAA	
SECONDARY DUTIES:	Demobilization	
	<input type="checkbox"/> Ensure staff time is reported to the appropriate agency for reimbursement	
	<input type="checkbox"/> Identify billing and/or cost recovery opportunities for care provided	
	<input type="checkbox"/> Approve work necessary to return FTS facility back to pre-incident condition or better	
	<input type="checkbox"/> Turnover FTS financial paperwork to county financial services	

Additional positions to be appointed as needed, recommended in the Cal EMSA FTS draft plan

Position	Job Description	Cal EMSA Guidelines (+ 1 Backup)	Agency/Department Able to Provide Staff
Logistics Section			
Facilities Unit Leader/Team	<p>Responsible for operational functionality of the facility. Coordinates with the Support Branch/Supply Unit for utilities, tents, cots, lighting, generators, and fuels. In pre-designated sites; ensures set-up according to pre-determined layout.</p> <p>Ensures setup of sanitation facilities. Obtains water for medical operations sanitation and hand wash stations. Arranges for water storage and waste water holding containers when sewer is unavailable. Arranges for removal of waste from the site, including bio-medical waste.</p> <p>Coordinates with the Services Branch/Food Unit to determine shared resource/equipment needs to supply food and water.</p>	2-4 per shift	
Supply Unit Leader/Team	<p>Coordinates medical and non-medical equipment and supply requests, and mutual aid through in coordination with the Resources Unit and Logistics Section at the DOC. Responsible for establishing a staging area, and provides location information to deployed resource teams, and vendors. Coordinates with the Resources Unit regarding requests for staffing and volunteers.</p> <p>Manages inventory of medical and non-medical supplies. Distributes supplies as requested by Operations.</p>	1 -2 per shift	
Ground Support Unit Leader/Team	<p>In pre-designated sites, uses pre-determined traffic and patient flow layout, to coordinate traffic flow at the site. At impromptu site, determines traffic and patient flow patterns with Operations. Requests volunteers, traffic control supplies as necessary.</p>	1 -2 per shift	
Logistics Section/ Service Branch			

Position	Job Description	Cal EMSA Guidelines (+ 1 Backup)	Agency/Department Able to Provide Staff
Communications Group Supervisor/Team	Review site communication plan and revise as necessary. Ensure all units can communicate with response partners. Maintain inventory of equipment issued. Provide radio training to new users. Request additional assistance through DOC for RACES and/or Dispatch.	1-2 per shift	
Medical Unit Leader/Team	Provides first aid and light medical treatment for <u>personnel assigned to the incident.</u>	2-3 per shift	
Food Unit Leader/Team	Coordinates with DOC to request staff and patient feeding, canteen, kitchen, or catering. Establishes water delivery (if required) for drinking purposes.	2-3 per shift	
Operations Section			
Triage Group Supervisor/Team	The Triage Group Supervisor and Triage Team assign and moves casualties to the appropriate Treatment Unit. Assigns infectious individuals to isolation, if an isolation area is available. Maintains the Triage Area A Registration Clerk initiates patient records. Litter bearers move patients to appropriate treatment areas. Paramedic level training is required for triage, preferably supervisor.	1-7+ per shift (EMTs)	
Treatment Group Supervisor/Team	<p>Treatment Group Supervisor and Minor Treatment Team Leader, Immediate Treatment Team Leader and Delayed Treatment Team Leader and Teams.</p> <p>Medical personnel who provide treatment of casualties received in the Minor, Immediate and Delayed treatment areas utilizing their current certified scope of practice. Assign stabilized patients to appropriate holding areas. Paramedics and EMTs staff this group.</p> <p>Within the confines of HIPAA, the Patient Inquiry Team Leader provides information to family members on the location of status of casualties received within the EMS FTS. Coordinates with Transportation Recorder, Triage Registration Clerk, EMS FTS PIO, and the American Red Cross.</p>	10+ per shift (Paramedics, EMTs)	

Position	Job Description	Cal EMSA Guidelines (+ 1 Backup)	Agency/Department Able to Provide Staff
Mental Health Group Supervisor/Team	Provides crisis counseling to casualties and stress counseling for staff. In some circumstances, may request, through the Operations Section Chief, drug and alcohol, religious practitioner staff, and preferred specialties for children with mental health conditions practitioners.	1 per shift	
Transportation Group Supervisor/Team	The Transportation Group Supervisor coordinates transportation of casualties to local hospitals, ACSs, or to out of area hospitals. Transportation Recorder initiates and maintains patient tracking records, using a triage tag that complies with EMS Authority 214, <i>Disaster Medical Systems Guidelines</i> (or an electronic system). The Air Operations Controller (Team Leader) manages traffic flow within the helicopter landing area, assures patient and personnel safety, heliport area maintenance, and appropriate placement of heliport markings. The Ground Operations Controller (Team Leader) manages traffic flow of arriving and departing ambulances and other means of ground transportation. Medical Monitoring Team Leader (paramedic, preferably supervisor) and Teams maintain patient stability while in holding areas.	Transportation Control Officer: 1 per shift, Transportation Recorder: 1 per shift, Air Operations Controller: 1 per shift, Ground Operations Controller: 1 per shift, Monitoring Team members 4 per shift (paramedics, EMTs).	
Morgue Group Supervisor/Team	Establishes temporary morgue area Coordinates with Medical Examiner/Coroner for certifications and assistance with establishing identity if necessary. Maintains belongings of deceased individuals. Maintains chain of custody and evidence tracking records, if the incident is crime related or suspected. Instructs other Sections in evidence management.	1+ per shift.	
Plans Section	If required. Supervises Situation, Documentation, Resources, and Demobilization Units.	1 per shift.	

Position	Job Description	Cal EMSA Guidelines (+ 1 Backup)	Agency/Department Able to Provide Staff
Situation Unit Leader	Coordinates with Triage, Treatment, Mental Health, Transportation, and Morgue Groups to develop status reports of the EMS FTS. Provides responses to requests for information from the DOC. Documents briefing sessions and Incident Action Planning sessions. Communicates Site Report Form to DOC.	2-4 per shift.	
Documentation Unit Leader	Prepares the EMS FTS Incident Action Plan, maintains all EMS FTS related documentation, and provides duplication services. Prepares after-action report (s).	2+ per shift.	
Resources Unit Leader	Identifies personnel needs for EMS FTS, ensuring all shifts coverage. Assigns medical and non-medical volunteers, providing orientation for new arrivals. Coordinate all EMS FTS medical and non-medical staff requests through the DOC. Ensure all EMS FTS workers are signed in, and keeping track of time.	2-4 per shift	
Demobilization Unit Leader	Assists in ensuring orderly, safe close out of EMS FTS activities. Assists to arrange transportation of EMS FTS personnel (if needed); ensures that rented equipment is returned and mutual aid resources reconciled; coordinates with the facility/site owner or operator to leave the premises in good order.	1-2	

Appendix 3: Resource Inventory and Map

California EMSA Recommended Supplies for FTS		Quantity per Mono County Trailer (# of trailers)		
Item	Qty/50 Patients	per trailer	# trailers	Notes
Medications				
Dextrose, pre-filled syringe, 50%, 50 cc	1 case, 10/case			
Eye wash, sterile saline, bag, 1000 cc	1 each			
Furosemide ampoules, 10 mg/cc	1 box, 10/box			
Morphine sulfate, injectable, pre-filled syringe	1 box, 10/box			
Naloxone HCl, injectable, ampoules, 1 ml	1 box, 10/box			
Nitroglycerin tablets, 0.4 mg	1 bottle, 25/bottle			
Pedialyte/osmolyte solution, 8oz	1 case, 24/case			
Sterile water for irrigation, plastic bottles, 500 cc	48 each			
Bandages and Dressings				
Adhesive strip, 1" x 3"	1 box, 100/box			
Bandage, elastic, (Ace wrap) 2"	1 box, 12/box			
Bandage, elastic, (Ace wrap) 4"	1 box, 12/box			
Bandage, gauze, Non-Sterile, stretchable, 4" x 10 yards (Kerlix)	1 case, 96/case			
Bandage, triangular	24 each			
Burn pack, major, Ref: Dynamed #G17585	1 case, 6/case			
Burn pack, minor, Ref: Dynamed #49026	1 case, 18/case			
Compresses, gauze, bulk, sterile, 4" x 4", 2/pack	1 case, 1200 - 1500/case			
Eye shield	6 each			
Eye, pad, oval, sterile	1 box, 50/box			
Gauze, petrolatum, sterile, 5" x 9"	1 box, 50/box			
Pad, gauze, sterile, 5" x 9"	1 case, 420/case			
Tape, adhesive, waterproof, 1" x 10 yards	5 boxes, 12/box			
Tape, adhesive, waterproof, 2" x 10 yards	6 boxes, 12/box			

California EMSA Recommended Supplies for FTS		Quantity per Mono County Trailer (# of trailers)		
Item	Qty/50 Patients	per trailer	# trailers	Notes
Trauma dressing, 12 x 30 and approx. 3/4" thick, cotton and rayon fiber w/cellulose wadding, for use where heavy drainage is present	1 case, 50/case			
Non-Disposable Medical Supplies				
Backboard, straps	10 each			
Backboards, 18" x 72"	5 each			
Basin, wash, sturdy plastic, 7 quart	6 each			
Batteries, appropriate for the Mini-Mag-Lite flashlight	8 - 12 each			
Blankets, lightweight	48 each			
Bulbs, appropriate for Mini-Mag-Lite flashlight	4 each			
Gloves, work type, leather/canvas, sizes, med and large	25 pair			
Glucose test kit, w/50 pins, 50 test strips and battery, (one touch)	1 each			
Laryngoscope, multi blade set, adult, w/batteries	1 each			
Laryngoscope, multi blade set, infant/child, w/batteries	1 each			
Litters, folding, rigid poles	10 each			
Magnifying glass	1 each			
Mini-Mag-Lite flashlights	2 each			
Multi-cuff BP kit, must include thigh and infant cuffs	1 each			
Ophthalmoscope set, portable, battery powered, w/batteries	1 each			
Safety goggles	10 pair			
Sphygmomanometer, adult	6 each			
Sphygmomanometer, pediatric	3 each			
Splinter forceps	2 each			
Stethoscope	6 each			
Trauma/Paramedic scissors	12 each			

California EMSA Recommended Supplies for FTS		Quantity per Mono County Trailer (# of trailers)		
Item	Qty/50 Patients	per trailer	# trailers	Notes
IV Sets, Needles and Syringes				
Blood administration set	1 box, 48/box			
Catheter and needle, IV, 18 gauge	1 box, 50/box			
Catheter and needle, IV, 22 gauge	1 box, 50/box			
Intravenous administration set, adult	1 box, 48/box			
Intravenous administration set, pediatric	1 box, 48/box			
IV extension tubing	1 box, 48/box			
IV piggyback tubing	12 each			
Lactated ringers solution, plastic bag, 1000 cc	8 cases, 12/case			
Needle and syringe, disposable, 3 cc, 20 gauge x 1"	1 box, 100/box			
Needle and syringe, insulin 1 cc/u-100, 28 gauge x 1/2"	1 box, 100/box			
Needle, hypodermic, disposable, 20 gauge x 1-1/2"	1 box, 100/box			
Needle, hypodermic, disposable, 22 gauge x 1"	1 box, 100/box			
Sharps collector, (needle disposal)	6 each			
Sterile saline, IV solution (bags), 500 cc	50 each			
Syringe, luer lock, sterile, disposable, 5 cc	1 box, 100/box			
Immobilization Supplies				
Collar, extrication, hard foam, non-absorbing, adult (stores flat)	30 each			
Collar, extrication, hard foam, non-absorbing, pediatric (stores flat)	10 each			
Headbraces, cardboard	5 each			
Splint, cardboard, 12"	2 pkgs., 12/pkg.			
Splint, cardboard, 18"	2 pkgs., 12/pkg.			
Splint, cardboard, 24"	1 pkg., 12/pkg.			
Splint, cardboard, 36"	1 pkg., 12/pkg.			
Splint, traction, femur, adult	1 each			

California EMSA Recommended Supplies for FTS		Quantity per Mono County Trailer (# of trailers)		
Item	Qty/50 Patients	per trailer	# trailers	Notes
Splint, traction, femur, pediatric	1 each			
Miscellaneous Medical Supplies				
Airways, esophageal obturator	2 each			
Airways, nasopharyngeal size # 24	4 each			
Airways, nasopharyngeal size # 28	4 each			
Airways, nasopharyngeal size # 32	4 each			
Airways, oropharyngeal size # 1	6 each			
Airways, oropharyngeal size #3	6 each			
Airways, oropharyngeal size # 5	6 each			
Alcohol preps	2 boxes, 100/box			
Ambu Bag, w/adult and pediatric masks	3 each size			
Bags, plastic, 30 gallon, 8 mil	100 each			
Bedpan, fracture, plastic, disposable	6 each			
Bedpan, plastic, disposable	25 each			
Betadine scrub	1 gallon			
Blankets, disposable, plastic backing	3 cases, 40/case			
Bulb syringe, 2 oz	6 each			
Crutches, adjustable, adult	2 each			
Crutches, adjustable, child	2 each			
Diapers	1 case, 100/case			
Disposable nursing sets, including nipples, caps, rings and bottles	1 case, 36/case			
Disposable wipes	2 boxes, 40/box			
Duct tape	12 rolls			
Emesis basins, plastic	1 carton, 10/carton			
Endotracheal tubes, French 2 sizes	2 each (2 of each size)			

California EMSA Recommended Supplies for FTS		Quantity per Mono County Trailer (# of trailers)		
Item	Qty/50 Patients	per trailer	# trailers	Notes
Esophageal obturator airway or Combitube	2 each			
Face masks, disposable, combination use Ref: Dynamed #G17114 and #G17116	25 each			
Face masks, disposable, combination use Ref: Dynamed #G17114 and #G17116	25 each			
Facial tissues, 140 to 200 count per box	1 case, 36 - 48 boxes/case			
Feeding tube, size # 8 French	6 each			
Gloves, patient, exam, ambidextrous, nitrile, Non-Sterile, 4 mil, small	1 box, 100/box			
Gloves, patient, exam, ambidextrous, nitrile, Non-Sterile, 4 mil, medium	4 boxes, 100/box			
Gloves, patient, exam, ambidextrous, nitrile, Non-Sterile, 4 mil, large	1 box, 100/box			
Gloves, patient, exam, ambidextrous, nitrile, Non-Sterile, 4 mil, extra large				
Hot cups	200 ea			
Morgue pack (Disaster pouch), Ref: Dynamed #G27111	6 each			
Napkins, sanitary	48 each			
Obstetrical kits	2 each			
Suction apparatus, multi-patient use (V-vac)	2 each			
Suction catheters, French (2 sizes)	2 each (2 each Size)			
Surgical masks, with eye shield, flat	100 each			
Syringe, irrigation, 60 cc	1 box, 30/box			
Toilet paper, rolls	24 rolls			
Tongue depressors, wood	1 box 500/box			
Tourniquets, 1" width	1 pkg., 10/pkg.			
Towel set (1 ea, towel/washcloth)	48 sets			

California EMSA Recommended Supplies for FTS		Quantity per Mono County Trailer (# of trailers)		
Item	Qty/50 Patients	per trailer	# trailers	Notes
Towels, paper, rolls	1 case, 12/case			
Urinals with lids, male, disposable	1 case, 50/case			
Urinals, female, disposable	5 cases, 10/case			
Water purification tabs	1 bottle			

Need to insert a map containing:

- Major highways
- Main towns
- Location of trailers
- Location of ALS units
- Location of BLS units
- Location of hospitals

Anything else you think is important

Appendix 4:
FTS and ICS Forms

Additional useful forms may include:

ICS Forms, available at

[http://www.fema.gov/pdf/emergency/nims/ics forms 2010.pdf](http://www.fema.gov/pdf/emergency/nims/ics%20forms%202010.pdf)

or refer to

Mono County Emergency Operations Plan

And

**California Public Health and Medical
Emergency Operations Manual (EOM)**

Available at:

www.bepreparedcalifornia.ca.gov

including:

Health and Medical Situation Report (SITREP) as Appendix C

and

Resource Request: Health and Medical – out of OA as Appendix D

FTS SITUATION REPORT FORM

INSTRUCTIONS: The FTS Planning Section is to complete this form at the end of each shift and fax one copy to the EOC as directed. .

Date:	Time:	Site:	Person Reporting:
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Shift (Time Period Covered By This Report):

Phone #	Fax #
----------------	--------------

# Patients Triage:	Current	Day Total	# Patients Minor Injury (GREEN) - Treated and Released:	Current	Day Total
# Patients in Delayed (YELLOW):	Current	Day Total	# Patients in Immediate (RED)	Current	Day Total
# Patients Transported to Hospital or Other	Current	Day Total	# Patients Deceased	Current	Day Total

Approximate # Waiting to be Triage:

Overall Status of Site Operations: No Problems to Report

- Problems With: (Describe)**
- Communications
 - Staffing
 - Security
 - Supplies
 - Public Information
 - Translation
 - Other

Resource Orders Pending:	Staffing Requirements Next Shift:
--------------------------	-----------------------------------

EOC Received By:	Date:	Time:
------------------	-------	-------

FTS COMMUNICATIONS PLAN		
Position	Telephone # or Radio Available	To Communicate With
Communications Unit Leader		ALL
Transportation Group Supervisor		ALL
Air Operations Controller		Helicopters
Ground Operations Controller		Ambulances
Transportation Control Officer		Hospitals and/or ACSs, MHOAC
Resources Unit Leader		DOC, EOC, Hospitals, vendors, other jurisdictions, MHOAC
Site Incident Commander		PH DOC, EOC, MHOAC
Safety Officer		Law Enforcement
Public Information Officer		DOC PIO, OA EOC PIO (JIC), media
Medical Unit Leader		Hospitals, PH DOC, EOC, MHOAC
Situation Unit Leader		DOC, EOC, MHOAC
Morgue Group Supervisor		Coroner/Medical Examiner Office

FTS ON-SITE TRAINING					
Orientation/ Training Subject	Command Staff	Support Branch	Service Branch	Operations Section	Plans Section
EMS FTS ICS organization, chain of command, first line supervisor		All	All	All	All
Authorities for patient status change, clear for transport, or to other treatment or waiting area				All	
Safety: infection control and PPE	All		Medical Unit	All	
Safety: emergency procedures for the site	All	All	All	All	All
Contamination/Decontamination awareness				Triage and Minor Groups	
Policies for media interaction		All	All	All	All
Triage policies and procedures (basic/introductory information)	PIO	All	All	All	All
Triage refresher and in depth training				Triage Group	
Level of care and treatment to be offered	All	All	All	All	All
Other services available (Mental health, CISD, etc.)	All	All	All	All	All
Patient flow throughout EMS FTS	All	All	All	All	All
Incident Action Planning	All	All	All	All	All
Resource ordering procedures and authorities		All	All	All	All
Resource shortfalls and effects on treatment, transportation, etc.		All	All	All	All
Locations of supplies, equipment, restrooms, break areas	All	All	All	All	All
Bio-waste disposal procedures and location				All	
Operation of communication equipment	All	All	All	All	All
Food and break area; availability and timing	All	All	All	All	All
Patient rights, confidentiality	All	All	All	All	All
Evidence protection (if the incident was, or is suspected to be criminal)	All	All	All	All	All
Vulnerability of special populations with increased susceptibility				All	
Social, cultural or spiritual awareness				All	
Helicopter safety; authority to enter landing/takeoff zone; and entry limitations	All	All	All	All	All
Review of procedures and policies for deceased individuals				Morgue Group	
Reporting requirements for EMS FTS activities					Documentation Group
Debriefing, after action reporting	All	All	All	All	All

FTS PERSONNEL TIME SHEET

FROM DATE/TIME:			TO DATE/TIME:		SITE:		UNIT LEADER:	
#	Name (Please Print) Employee (E) Volunteer (V)	E/V	Employee Number	Assignment	Date/Time In	Date/Time Out	Signature	Total Hours
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
CERTIFYING OFFICER:					DATE/TIME SUBMITTED:			

PATIENT READY?	PATIENT STATUS:	INJ TYPE ?HEAD	MODE TRANS AIR GRND	DESTINATION HOSPITAL	AMBULANCE CO. AND ID	PATIENT NAME/ TRIAGE TAG #	DEPART TIME	ETA	HOSPITAL ADVISED
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N

PATIENT READY?	PATIENT STATUS:	INJ TYPE ?HEAD	MODE TRANS AIR GRND	DESTINATION HOSPITAL	AMBULANCE CO. AND ID	PATIENT NAME/ TRIAGE TAG #	DEPART TIME	ETA	HOSPITAL ADVISED
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N
Y/N	R/Y/G								Y/N

Appendix 5: Acronyms

AAR	After-Action Report
ACS	Alternate Care Site
AC	Air Conditioning
ADA	American Disabilities Act
AED	Automated External Defibrillator
ALS	Advanced Life Support
BLS	Basic Life Support
Cal-MAT	California Medical Assistance Team (state resource)
CISD	Critical Incident Stress Debriefing
DHV	Disaster Healthcare Volunteer
DMAT	Disaster Medical Assistance Team (federal resource)
DOC	Department Operations Center
DWP	Department of Water and Power (Los Angeles)
EMCC	Emergency Medical Care Committee
EMS	Emergency Medical Services
EMSA	Emergency Medical Services Authority
EMT	Emergency Medical Technician
EOC	Emergency Operations Center
EOM	California Public Health and Medical Emergency Operations Manual
EOP	Emergency Operations Plan
FTS	Field Treatment Site
HIPAA	Health Insurance Portability and Accountability Act
HVAC	Heating, Ventilation, and Air Conditioning
IAP	Incident Action Plan
IC	Incident Commander
IP	Improvement Plan
ICEMA	Inland Counties Emergency Medical Agency
ICS	Incident Command System
JIC	Joint Information Center

LEMSA	Local Emergency Medical Services Agency
MCI	Multi-Casualty Incident
MGS	Medical Group Supervisor
MHOAC	Medical Health Operational Area Coordinator
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
OA	Operational Area
PA	Public Address
PIO	Public Information Officer
POC	Point of Contact
POD	Point of Dispensing
PPE	Personal Protective Equipment
RACES	Radio Amateur Civil Emergency Service
REOC	Regional Emergency Operations Center
SCE	Southern California Edison
SEMS	Standardized Emergency Management System
SITREP	Situation Report
SO	Sheriff's Office
START	Simple Triage and Rapid Treatment
TDD	Telecommunications Device for the Deaf
Wi-Fi	Trademark name for a wireless Internet access point



2011-2012 PROPOSED FEE SCHEDULE

PURPOSE

To establish the ICEMA fee schedule for 2011/2012.

FEE SCHEDULE

ADMINISTRATION

1. Transportation (annual)
 - A. EMS Pre-hospital Provider Permit/Authorization\$1,570.00
 - B. EMS Pre-hospital Provider Permit/Authorization -
Late Penalty\$315.00
 - C. EMS Aircraft Provider\$15,000.00
 - D. EMS Drug and Equipment Inspection \$315.00/unit
2. EMS Certification Fees (bi-annual)
 - A. Mobile Intensive Care Nurse (MICN)
 1. Certification\$90.00
 2. Recertification\$90.00
 3. Challenge\$225.00
 - B. Flight Nurse (FN)
 1. Authorization\$45.00
 2. Reauthorization\$45.00
 - C. Emergency Medical Technician - Paramedic (EMT-P)
 1. Accreditation\$90.00
 2. Re-verification\$50.00

3.	Failure to Complete EMT-P Continuing Education - Penalty Fee (per course)	\$100.00
D.	Emergency Medical Technician (EMT)	
1.	Certification	\$45.00
2.	Recertification	\$45.00
E.	Emergency Medical Services Dispatchers (EMSD)	
1.	Certification	\$45.00
2.	Recertification	\$45.00
3.	Challenge	\$60.00
F.	Emergency Medical Responders (EMR)	
1.	Certification	\$45.00
2.	Recertification	\$45.00
3.	Challenge	\$75.00
G.	Accreditation/Certification Re-test	\$55.00
H.	Certification/Accreditation Card Replacement	\$20.00
I.	Certification/Accreditation Card Name Change	\$20.00
3.	Training Program Approval Fees (every four years)	
A.	MICN	\$300.00
B.	EMR	\$575.00
C.	EMT	\$575.00
D.	EMT-P	\$1,000.00
E.	Annual Review Curriculum Instruction	\$400.00
F.	Continuing Education Provider	\$500.00

4. Hospitals
 - A. Base Hospital Application Fee.....\$5,000.00
 - B. Base Hospital Re-designation Fee (bi-annual)\$2,500.00
 - C. Trauma Hospital Application Fee\$5,000.00
 - D. Trauma Hospital Re-designation Fee (annual)\$25,000.00
 - E. ST Elevation Myocardial Infarction (STEMI) Receiving
Center Designation Application Fee\$5,000.00
 - F. ST Elevation Myocardial Infarction (STEMI) Receiving
Center Designation Fee (annual)\$20,560.00
 - G. Neurovascular Stroke Receiving Center Designation
Application Fee.....\$2,500.00
 - H. Neurovascular Stroke Receiving Center Designation
Fee (annual)\$20,560.00

5. EMS Temporary Special Events
 - A. Minor Event Application\$75.00
 - B. Major Event Application\$315.00

6. Protocol Manual
 - A. With Binder\$26.00
 - B. Inserts Only\$15.00
 - C. CD\$5.00

7. Equipment Rental
 - A. Standard Equipment \$10.00/item
 - B. Deluxe Equipment \$25.00/item

8. Statistical Research \$50.00/hour

This rate schedule shall take effect July 1, 2011.



Inland Counties Emergency Medical Agency

Serving San Bernardino, Inyo, and Mono Counties

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

DATE: May 4, 2011

TO: EMS Providers – ALS, BLS, EMS Aircraft
Hospital CEOs, ED Directors, Nurse Managers and PLNs
EMS Training Institutions and Continuing Education Providers
Inyo, Mono and San Bernardino County EMCC Members
Other Interested Parties

FROM: Virginia Hastings, ICEMA Executive Director
Reza Vaezazizi, MD, ICEMA Medical Director

SUBJECT: CONTINUATION OF TRAUMA CARE - 14 DAY PUBLIC COMMENT

Attached is the public comment draft of the **CONTINUATION OF TRAUMA CARE** protocol. The protocol has been reviewed extensively by the Trauma System Advisory Committee (TSAC), the Protocol and Education Committee (PEC) and the Medical Advisory Committee (MAC). Due to the extensive committee reviews and the desire to implement this protocol prior to the summer months, we have shortened the comment period to 14 days.

ICEMA encourages all system participants to submit comments in writing to ICEMA during the 14-day comment period. **Written comments will be accepted until May 18, 2011 at noon.** Comments may be sent hardcopy, faxed to (909) 388-5825 or via email to Chris Yoshida-McMath, RN at c.yoshida-mcmath@cao.sbcounty.gov. Comments will be compiled and presented at the Emergency Medical Care Committee (EMCC) meeting on May 19, 2011 at 9 a.m. The protocol will be placed on the Inyo and Mono County EMCC's the following week.

RV/VH/mae



CONTINUATION OF TRAUMA CARE

THIS POLICY IS FOR TRANSFER OF TRAUMA PATIENTS FROM A REFERRAL HOSPITAL (RH) TO A TRAUMA CENTER (TC) ONLY AND SHALL NOT BE USED FOR ANY OTHER FORM OF INTERFACILITY TRANSFER OF PATIENTS.

PURPOSE:

To support a system of trauma care that is consistent with ACS standards and ensures the minimal time from patient injury to receiving the most appropriate definitive trauma care.

DEFINITIONS:

Trauma Center (TC) - a licensed general acute care hospital designated by ICEMA's Governing Board as a trauma hospital in accordance with State laws, regulations and ICEMA policies.

Referral Hospital (RH): any licensed general acute care hospital that is not an ICEMA designated TC.

INCLUSION CRITERIA:

Any patient meeting ICEMA Trauma Triage Criteria, (Reference ICEMA Policy 15030) arriving at a non-trauma hospital by EMS or non-EMS transport.

INITIAL TREATMENT GOALS (at RH)

1. Initiate resuscitative measures within the capabilities of the facility.
2. Ensure patient stabilization is adequate for subsequent transfer.
3. Transfer timeline goal is <30 minutes door-to-transfer out.
4. DO NOT DELAY TRANSFER by initiating any diagnostic procedures that do not have direct impact on IMMEDIATE resuscitative measures.
5. RH ED physician will make direct physician-to-physician contact with the ED physician at the TC.

6. The TC will accept all referred trauma patients unless they are on Internal Disaster as defined in ICEMA Policy# 8060.
7. The TC ED physician is the accepting physician at the TC and will activate the internal Trauma Team according to internal TC protocols.
8. RH ED physician will determine the appropriate mode of transportation for the patient. If ground transportation is >30 minutes consider the use of an air ambulance. Requests for air ambulance shall be made to 9-1-1 and normal dispatching procedures will be followed; however, the air ambulance continuation of trauma run patient will be transported to the TC identified by the RH.
9. Simultaneously call 9-1-1 and utilize the following script to dispatch:

“This is a Trauma Continuation of Trauma Run Interfacility Transfer from _____ hospital to _____ Trauma Center”

Dispatchers will only dispatch transporting paramedic units without any fire apparatus.
10. RH must send all medical records, test results, radiologic evaluations to the TC. DO NOT DELAY TRANSFER- these documents may be FAXED to the TC.

SPECIAL CONSIDERATIONS:

1. If the patient has arrived at the RH via EMS, the RH ED physician may request that transporting team remain with patient and immediately transport them once the minimal stabilization is done at the RH.
2. The RH may consider sending one of its nurses with the transporting paramedic unit if deemed necessary due to the patient’s condition or scope of practice.
3. Nurse staffed critical care (ground or air) transport units maybe used; but may create a delay due to availability. Requests of nurse staffed critical care transport units must be made directly to the transporter agency by land line.



STROKE “NSRC” RECEIVING CENTERS

PURPOSE

To provide guidelines to rapidly transport stroke patients who access the 9-1-1 system to a designated Neurovascular Stroke Receiving Center (NSRC) when indicated. Patients transported to NSRC will benefit from rapid assessment, intervention and treatment at a dedicated stroke specialty center. Patients will meet the defined criteria for triage as an acute ischemic or hemorrhagic cerebral vascular event. At this present time, this policy is limited to the San Bernardino County area.

DEFINITIONS

1. **Neurovascular Stroke Receiving Centers (NSRC):** ICEMA designated Level I or Level II receiving hospital for patients triaged as having a cerebral vascular event requiring hospitalization for treatment, evaluation and/or management of this event.
2. **NSRC Level I (NSRC-I):** A twenty-four (24) hours per day, seven (7) days per week acute care hospital that has successfully completed and maintains The Joint Commission (TJC) or Healthcare Facilities Accreditation Program (HFAP) accreditation as a Primary Stroke Center, has interventional neuroradiologic and neurosurgical capabilities and enters into a memorandum of understanding with ICEMA relative to being a Stroke Center.
3. **NSRC Level II (NSRC-II):** A twenty-four (24) hours per day, seven (7) days per week acute care hospital that has successfully completed and maintains The Joint Commission (TJC) or Healthcare Facilities Accreditation Program (HFAP) accreditation as a Primary Stroke Center and enters into a memorandum of understanding with ICEMA relative to being a Stroke Center.
4. **Neurovascular Stroke Referral Hospital(s) (NSRH):** General acute care hospitals that refer possible stroke patients to NSRC.
5. **Neurovascular Stroke Base Station(s):** Facilities that have TJC or HFAP Primary Stroke Center accreditation that also function as a Paramedic Base Station.
6. **TJC:** The Joint Commission
7. **HFAP:** Healthcare Facilities Accreditation Program
8. **Interventional Neuroradiologic capabilities:** Facilities with qualified interventional radiologists and/or neurosurgeons able to administer inter-arterial tissue plasminogen activator and/or perform mechanical clot retrieval.

9. **CQI:** Continuous Quality Improvement.
10. **EMS:** Emergency Medical Services.
11. **CE:** Continuous Education.
12. **mLAPSS:** Modified Los Angeles County Prehospital Stroke Screening Scale.

POLICY

The following requirements must be met for a hospital to be an ICEMA designated NSRC-I or NSRC-II:

1. An ICEMA approved paramedic receiving hospital which is a full service acute care facility.
2. Accreditation as a Primary Stroke Center by TJC or HFAP and proof of re-accreditation every two (2) years.
3. A facility alert system for incoming stroke patients available twenty-four (24) hours per day, seven (7) days per week (i.e. in-house paging system).
4. Provide CE opportunities for NSRC, NSRH and EMS personnel in areas of pathophysiology, assessment, triage and management for stroke patients and report annually to ICEMA.
5. Lead public stroke education efforts at the appropriate educational level and report annually to ICEMA.

STAFFING REQUIREMENTS

The hospital will have the following positions filled prior to becoming a NSRC-I or NSRC-II:

1. Medical Directors

The hospital shall designate two (2) physicians with hospital privileges as co-directors of its NSRC program. One (1) physician shall be Board-certified or Board-eligible by the American Board of Medical Specialties or American Osteopathic Association, neurology or neurosurgery board. The co-director shall be a Board-certified or Board-eligible emergency medicine physician.

2. Nursing Coordinator

The hospital shall designate a NSRC Nursing Coordinator who has experience in critical care or emergency nursing, and who has advanced education in stroke physiology or at least has two (2) years’ dedicated stroke patient management experience. Certification in critical care or emergency nursing is preferred.

3. On-Call Physicians Specialists / Consultants

A daily roster of the following on-call physician consultants and staff must be promptly available within thirty (30) minutes of notification of “Stroke Alert” twenty-four (24) hours per day, seven (7) days per week.

- a. Radiologist experienced in neuroradiologic interpretations.
- b. On-call Neurologist available twenty-four (24) hours per day; seven (7) days per week.
- c. Additional requirements for:

<p>NSRC-I</p> <ul style="list-style-type: none"> 1) Interventional Neuroradiologist or Interventional vascular neurosurgeon and an angiogram suite available twenty-four (24) hours per day; seven (7) days per week. 2) Neurosurgeon available twenty-four (24) hours per day; seven (7) days per week.

<p>NSRC-II:</p> <ul style="list-style-type: none"> 1) For NSCR-II designation only, ICEMA may waive the on-call neurologist requirement, for tele-neurology, upon submission of the following written documentation: <ul style="list-style-type: none"> • Demonstration of geographic and/or population based need. • Demonstration of active planning to obtain a twenty-four (24) hours per day; seven (7) days per week call-panel of neurologists. • Assurance of an in-person neurologist’s evaluation of stroke patients within twelve (12) hours of hospital admission. • Assurance of 100% QI of all tele-neurology patients. <p><i>Request for waiver must be re-submitted and re-evaluated by ICEMA every 12 months.</i></p>

NSRC-II Continued

2) If neurosurgical services are not available in-house, the facility must have a rapid transfer agreement in place with a facility that provides this service. The agreement must be on file with the local EMS agency. NSRC-I’s must promptly accept rapid transfer requests from NSRC-II’s. Additionally, the facility must have a rapid transport agreement in place with an ICEMA permitted transport agency for that EOA.

INTERNAL HOSPITAL POLICIES

The hospital shall develop internal policies for the following situations:

1. Stroke Team alert response policy upon EMS notification of a “Stroke Alert”.
2. Rapid assessment of stroke patient by Emergency and Neurology teams
3. Prioritization of ancillary services including laboratory and pharmacy with notification of “Stroke Alert”.
4. Arrangement for priority bed availability in Acute Stroke Unit or Intensive Care Unit (ICU) for “Stroke Alert” patients.

Acknowledges that stroke patients may **only** be diverted during the times of Internal Disaster in accordance to protocol #8060 *Requests for Hospital Diversion*, (applies to physical plant breakdown threatening significant patient services or immediate patient safety issues i.e. bomb threat, earthquake damage, hazardous material or safety and security of the facility.) A written notification describing the event must be submitted to ICEMA within twenty-four (24) hours.

5. Additional requirements for:

NSRC-I

- a. Emergent thrombolytic and mechanical therapy protocol to be used by Neurology, Emergency, Pharmacy, Interventional and Critical Care teams.
- b. Maintaining readiness of diagnostic computed tomography (CT), magnetic resonance imaging (MRI) and therapeutic resources such as an interventional suite upon notification of Stroke Team.
- c. Prompt acceptance of stroke patients from any NSRH as well as referral from NSRC-II to NSRC-I when interventional skills are required.

NSRC-II

- a. Emergent thrombolytic and tele-neurology (if waiver is approved) protocol to be used by Neurology, Emergency, Pharmacy and Critical Care teams.
- b. Maintaining readiness of diagnostic computed tomography (CT), upon notification of Stroke Team.

DATA COLLECTION

Data will be reported to the ICEMA Medical Director on a monthly basis using an ICEMA approved registry.

CONTINUOUS QUALITY IMPROVEMENT PROGRAM

NSRC shall develop an on-going CQI program which monitors all aspects of treatment and management of stroke patients and identifies areas needing improvement. At a minimum, the program will monitor the following parameters:

1. Morbidity and mortality related to procedural complications.
2. Tracking door to intervention times and adherence to minimum performance standards.

ICEMA will utilize current Get with the Guidelines (GWTG) performance indicators. Any specific or additional performance indicators will be determined in collaboration with the Stroke CQI Committee.

3. Active participation in ICEMA Stroke CQI Committee activities.

PERFORMANCE STANDARDS

Compliance with the American Stroke Association Performance Measures as a Primary Stroke Center.

DESIGNATION

1. The NSRC applicant shall be designated by ICEMA after satisfactory review of written documentation, a potential site survey and completion of an agreement between the hospital and ICEMA.
2. Documentation of current accreditation as a Primary Stroke Center by TJC or HFAP shall be accepted in lieu of a formal site visit by ICEMA.
3. Initial designation as a NSRC shall be for a period of two (2) years. Thereafter, redesignation shall occur every two (2) years contingent upon satisfactory review.

4. Failure to comply with the agreement, criteria and performance standards outlined in this policy may result in probation, suspension or rescission of the NSRC designation.

PATIENT DESTINATION

1. The NSRC should be considered as the destination of choice if all of the following criteria are met:
 - a. Stroke patients eligible for transport to NSRC (identified stroke patients) will be identified using the mLAPSS triage criteria.
 - b. Identified acute stroke patients with "last seen normal" time plus transport time equaling greater than (8) eight hours or if "last seen normal" time is unknown, transport to the closest paramedic receiving hospital.
 - c. Identified stroke patients with "last seen normal" time plus transport time between (3) three to (8) eight hours will be transported to NSRC-I.
 - d. Identified stroke patients with "last seen normal" time plus transport time less than (3) hours will be transported to any closest NSRC-I or NSRC-II.
 - e. NSRC Base Station contact is **mandatory** for all patients identified as a possible stroke patient.
 - f. The NSRC base station is the only authority that can direct a patient to a NSRC. The destination may be changed at NSRC base station discretion.
 - g. The NSRC base station, if different from the NSRC will notify the NSRC of the patient's pending arrival as soon as possible, to allow timely notification of Stroke Team.
 - h. Air transport may be considered if ground transport is greater than thirty (30) minutes.
2. The following factors should be considered in determining choice of destination for acute stroke patients. NSRC base station contact and consultation is mandatory in these situations:
 - a. Patients with unmanageable airway, unstable cardiopulmonary condition or in cardiopulmonary arrest should be transported to the closest paramedic receiving hospital.
 - b. Patients with obvious contraindication to thrombolytic therapy should be strongly considered for transport to closest NSRC-I.

- c. Patients with hemodynamic instability and exhibiting signs of inadequate tissue perfusion should be transported to the closest paramedic receiving hospital.

DRAFT



STROKE TREATMENT - ADULT

FIELD ASSESSMENT/TREATMENT INDICATORS

Patient exhibiting signs/symptoms of a possible stroke. These signs may include: speech disturbances, altered level of consciousness, parasthesias, new onset seizures, dizziness unilateral weakness and visual disturbances.

BLS INTERVENTIONS

1. Oxygen therapy as clinically indicated.
2. Position patient as tolerated. Consider left lateral position, if indicated.
3. Place patient in axial spinal stabilization, if trauma is suspected.
4. If patient history includes insulin or oral hypoglycemic medications, administer Glucose sublingual.

ALS INTERVENTIONS

1. Obtain vascular access and place on monitor.
2. Obtain blood glucose. If hypoglycemic, refer to Altered Level of Consciousness/Seizures-Adult Protocol Reference #11080.
3. For tonic/clonic type seizure activity, refer to Altered Level of Consciousness /Seizures-Adult Protocol Reference #11080.

Modified Los Angeles County Prehospital Stroke Screen (mLAPSS): A screening tool used by prehospital care providers to assist in identifying patients who may be having a stroke.

mLAPSS CRITERIA

1. Ask when “last seen normal” or without stroke symptoms. Refer to Stroke Decision Tree.
2. No history of seizures or epilepsy.

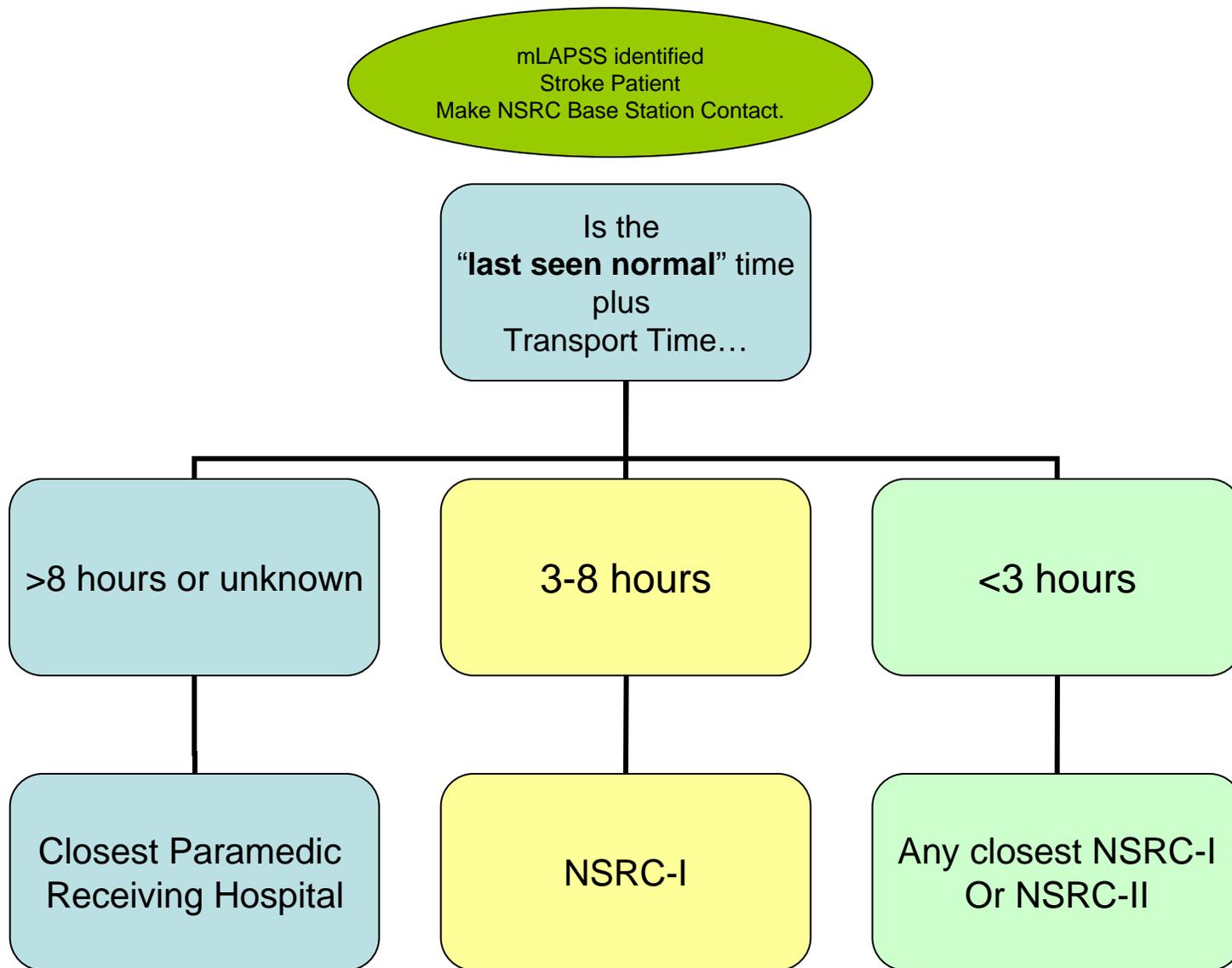
3. Age greater than or equal to 40. If less than 40, with suspected stroke, continue mLAPSS assessment, make NSRC base station contact for destination.
4. At baseline, patient is not wheelchair bound or bedridden.
5. Blood glucose between 60-400 mg/dl.
6. Motor Exam: Examine for obvious asymmetry-unilateral weakness (exam is positive, if one (1) or more of the following are present).
 - a. Facial smile/Grimace asymmetry.
 - b. Grip asymmetry.
 - c. Arm Strength asymmetry.

If Stroke Scale is positive, initiate “Stroke Alert”, contact NSRC base station and transport immediately.

If time is available, and the patient or family can provide the information, assess the patient using the criteria listed below and report to ED personnel:

THROMBOLYTIC ASSESSMENT

Onset greater than 4 hours?	Yes	No
History of recent bleeding?	Yes	No
Use of anticoagulant?	Yes	No
Major surgery or serious trauma in the previous fourteen (14) days?	Yes	No
Sustained systolic blood pressure above 185mm Hg.?	Yes	No
Recent stroke or intracranial hemorrhage?	Yes	No



Stroke Decision Tree

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Protocol Reference #'s XXXX & XXXX

PROTOCOL #	AGENCY	COMMENT	RESPONSE
Stroke "NSRC" Receiving Center Policy	Redlands Community Hospital (RCH)	STAFFING REQUIRMENTS: <ul style="list-style-type: none"> • "Medical Director- The protocol establishes the standard that the NSRC must have a board certified emergency room physician and board-certified neurologist as the medical director. All physicians at RCH who participate in the hospital's stroke program are board certified; the neurologist providing initial response are not only board certified but have a specialty focus in stroke, which is a higher level than that at our neighboring facilities." 	Policy revised. <ul style="list-style-type: none"> • NSRC-II Tele-neurology waiver.
	RCH	STAFFING REQUIRMENTS: <ul style="list-style-type: none"> • "Nursing Coordinator-The protocol asserts that this position be certified in critical care nursing, Not only do the critical care nurses care for the acute stroke, so do the emergency care nurses, in fact, emergency care nurses see and care for more stroke patients than any critical care nurse. Experience and certification in either should be acceptable to ICEMA." 	Policy revised. <ul style="list-style-type: none"> • CCRN/CEN preferred. • Critical care, emergency nursing experience and has advanced education in stroke physiology or at least 2 years of dedicate stroke patient management.
	RCH	STAFFING REQUIREMENTS: <ul style="list-style-type: none"> • "On-call Physicians Specialists/Consultants- According to the ICEMA stroke protocol, the NSRC must have a neurologist on call 24 hours/day, seven days per week. At RCH, <u>we do not have board-certified neurologists</u> available 24 hours/day, seven days per week. As stated about the neurologists are not only board certified but have <u>a specialty focus in</u> 	Policy revised. <ul style="list-style-type: none"> • NSRC-II Tele-neurology waiver.

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PROTOCOL #	AGENCY	COMMENT	RESPONSE
		<p><u>stroke</u> which is a higher level than that at our neighboring facilities.”</p> <p><i>Several other documents and letters were submitted to ICEMA regarding the support of tele-neurology. Please contact ICEMA to view these letters.</i></p>	
Stroke “NSRC” Receiving Center Policy	St. Mary’s Medical Center (SMMC)	<p>PURPOSE</p> <ul style="list-style-type: none"> “Last line should probably read Trauma related cranial cerebral events will be managed in the ICEMA “Trauma system” rather than the current ‘stroke system’ 	<p>Policy revised.</p> <ul style="list-style-type: none"> Statement removed.
	SMMC	<p>STAFFING REQUIREMENTS</p> <ul style="list-style-type: none"> “ Does neurologist need to be board certified? What about board eligible? Currently we have a BC neurologist but thinking of the future that might be too restrictive. 	<p>Policy revised.</p> <ul style="list-style-type: none"> Added ‘board-eligible’.
	SMMC	<p>STAFFING REQUIREMENTS</p> <ul style="list-style-type: none"> On-call specialists: “No where does it exclude “teleneurology” service it just says ‘on call’ neurologist 24 hours a day. If I had not come to the meeting the other day, I would not have interpreted that to exclude on call teleneurology as they are often referred to 	<p>Policy revised.</p> <ul style="list-style-type: none"> NSRC-II tele-neurology waiver.
	SMMC	<p>INTERNAL HOSPITAL POLICIES</p> <ul style="list-style-type: none"> Mechanical therapy protocol referenced in item # 1 should be level one centers only. 	<p>Policy revised.</p> <ul style="list-style-type: none"> NSRC-I added.
	SMMC	<p>STAFFING REQUIREMENTS</p> <ul style="list-style-type: none"> Rapid transfer agreement please explain what rapid is. HFAP expects ICH transfer to take place in 2 hours as well as TJC may have similar requirements. We need accountability from the level one centers that they will accept these patients. What about 	<p>Policy revised.</p> <ul style="list-style-type: none"> Will be monitored in CQI process.

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PROTOCOL #	AGENCY	COMMENT	RESPONSE
		inpatient strokes? Will that be problematic or will level ones be expected to receive them also rapidly? There needs to be express transport through the usual bed control	
	SMMC	<ul style="list-style-type: none"> What does item “e” mean “interventional team” is that the stroke team? Level II’s are not interventional maybe it should be referenced as stroke team if so 	Policy revised. <ul style="list-style-type: none"> Clarified. Interventional Neuroradiologist or Interventional vascular surgeon and angiogram suite.
	SMMC	DATA COLLECTION <ul style="list-style-type: none"> Is the ICEMA approved registry the same as the ICEMA stroke database? If not we are using AHA get with the guidelines stroke 	No change. <ul style="list-style-type: none"> Yes, the ICEMA approved registry is the same as the ICEMA stroke database. Clarified below.
	SMMC	CQI <ul style="list-style-type: none"> I am not sure what the national quality forum (NQF) measures are for stroke do you have them to share? 	Policy revised. <ul style="list-style-type: none"> Clarified. GWTG & Indicators selected by Stroke CQI committee.
	SMMC	I love the stroke decision tree	
Stroke “NSRC” Receiving Center Policy	Barstow FD	“the protocol is good as written. we just have to train the guys to use the thrombolytic assessment, and the stroke decision tree. and we need only to emphasize that those who do not meet criteria go the closest hospital.”	

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PROTOCOL #	AGENCY	COMMENT	RESPONSE
Stroke "NSRC" Receiving Center Policy	Mammoth Hospital	<p>PATIENT DESTINATION</p> <ol style="list-style-type: none"> 1. The NSRC should be considered as the destination of choice if all of the following criteria are met: <ol style="list-style-type: none"> a. Stroke patients eligible for transport to NSRC (identified stroke patients) will be identified using the mLAPSS triage criteria. b. Identified stroke patients with "last seen normal" time plus transport time equaling greater than (8) eight hours or if "last seen normal" time is unknown, transport to the closest Paramedic Receiving Hospital. c. Identified stroke patients with "last seen normal" time plus transport time between (3) three to (8) eight hours will be transported to NSRC-I. d. Identified stroke patients with "last seen normal" time less than (3) hours will be transported to any closest NSRC-I or NSRC-II. e. NSRC Base Station contact is mandatory for all patients identified as a possible stroke patient. f. The NSRC Base Station is the only authority that can direct a patient to a 	<p>Policy revised.</p> <ul style="list-style-type: none"> • Limited policy to San Bernardino County area.

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PROTOCOL #	AGENCY	COMMENT	RESPONSE
	Mammoth Hospital	<p>NSRC. The destination may be changed at Base Station discretion.</p> <p>g. The NSRC Base Station, if different from the NSRC will notify the NSRC of the patient's pending arrival as soon as possible, to allow timely notification of neurovascular team.</p> <p>h. Air transport may be considered if ground transport is greater than 30 minutes.</p> <p>By my reading of the guidelines, if one of our paramedic units picks up a patient in our town (which is four square miles in size), then that unit will need to contact an outside-the-county NSRC base station and transport the patient to an outside-the-county facility and will mandatorily bypass the only hospital in the county, one which is no further than 2 or 3 miles away. Aside from that, there are other problems: 1) The NSRC base station will not be able to provide adequate transportation direction as it is very difficult for helicopters to reach us—most of our transports are by fixed-wing. 2) Flights are often impossible due to adverse weather. 3) The paramedic unit that is being tied up by the NSRC base station is the only one in our town and must be free to take on new patients. 4) Our closest stroke referral center is in Reno, not in ICEMA territory.</p> <p>Patients close to our hospital should generally be transported to our facility, so that we can make an appropriate transfer as needed in a manner that</p>	

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PROTOCOL #	AGENCY	COMMENT	RESPONSE
		<p>would be far faster than anything the NSRC base station could do. Patients in Mono County who are not close to our facility may be transferred by air when possible to Reno, where there is a very good stroke center.</p>	
Stroke "NSRC" Receiving Center Policy	Mammoth Hospital	<p>Stroke patients are treated the same as our STEMIs in Mono County. Medic units north of Mammoth Hospital contact Careflight for these patients depending on our weather. From Mammoth Lakes toward the south county the patients will come to our facility to be evaluated and transferred. The STEMI receiving center protocol does not really address Mono and Inyo Counties either. It has been "assumed" that we do the best we can because of our very remote locations. The STEMIs our flown to Renown or St. Mary's in Reno Nevada, sometimes Carson Tahoe Regional Medical Center in Carson, Nevada. However we cannot predict the weather. We have kept STEMIs in our ED until there was a break in the weather sometimes 24 hours or more. There are times you cannot even ground a patient north or south of here because of severe weather conditions. Hope this helps to understand our situation</p>	<p>Policy revised.</p> <ul style="list-style-type: none"> • Limited to San Bernardino County area.
Stroke "NSRC" Receiving Center Policy	CDCR/CPHCS	<p>We believe that policy is well written. We look forward to it's implementation and the development Neurovascular Stroke Receiving Centers in the ICEMA Region.</p>	
Stroke Treatment Protocol	AMR	<p>Small minor question.....should we add make "NSRC BASE CONTACT" to top of tree? This is found - <i>Under Patient Destination</i></p>	<p>Policy revised.</p> <ul style="list-style-type: none"> • NSRC base contact added

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PROTOCOL #	AGENCY	COMMENT	RESPONSE
Stroke "NSRC" Receiving Center Policy	LLUMC	<p>Under stroke NSRC receiving center, page 6:</p> <p><i>"Patients with obvious contraindication to thrombolytic therapy should be strongly considered for transport to closet paramedic receiving hospital".</i></p> <p>Recommendation: Even if patients have contraindications to thrombolytic therapy, they may be candidates for intra-arterial thrombolysis or clot retrieval. There are absolute and relative contraindications to IV thrombolytic therapy and not all are created equal. For instance, systolic blood pressure of >185 mm Hg is considered a contraindication at the same level as a patient presenting with a seizure; however, BP may be reduced in the ED vs the field so that patients can receive IV TPA. We believe patients should be transferred to a level one NSRC receiving center despite a field assessment of 'contraindications', instead of closet paramedic receiving hospital. If they are transferred to the closest hospital, they may be denied other treatment modalities for acute stroke.</p>	<p>Policy revised.</p> <ul style="list-style-type: none"> • NSRC-I
	LLUMC	<p><i>Obvious contraindication" is a vague term.</i></p> <p>Recommendations: What's obvious to one EMS may not be obvious to another and what's obvious to one neurologist may not be obvious to another. We suggest changing the term or clearly defining subsets of contraindications instead of "Obvious contraindication".</p>	<p>No change.</p> <ul style="list-style-type: none"> • Will be clarified via education.

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PROTOCOL #	AGENCY	COMMENT	RESPONSE
	LLUMC	<p>Under stroke NSRC receiving center, page 3: <i>“Neurovascular team alert response policy upon EMS notification of a ‘Stroke alert’”.</i></p> <p>Question: We find that the rate of actual acute stroke patients to acute stroke activation is around 1:20. Our neurovascular team responds within minutes of acute stroke activation but if we have to respond when the EMS activation occurs, there will be significant downtime waiting for the patient to arrive and for the initial ED assessment. This affects the efficiency neurovascular team since they are often rounding on patients throughout the day. If we can show acceptable response and assessment times if the neurovascular responds not when EMS activates the stroke protocol but when our own ED activates the stroke protocol during their initial assessment, is that acceptable?</p> <p>We used to activate the stroke team each time EMS called in for a possible stroke but found that the rate of activations for non-stroke patients was inappropriately high. Our current policy is to have the ED attending assess the patient and activate the internal neurovascular team, which responds rapidly. The key is door to TPA infusion time and our times are < 60 min on average.</p>	<p>No change.</p> <ul style="list-style-type: none"> • ICEMA would like to see the internal hospital stroke alert policy.

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PROTOCOL #	AGENCY	COMMENT	RESPONSE
	LLUMC	<p>Under the stroke decision tree, in the top blue box, page 10:</p> <p><i>“Is the Stroke Symptom Time (last seen normal) Plus Transport Time...”</i></p> <p>Recommendation: We suggest using one term i.e., “Last seen normal time” throughout the Stroke Center protocol. People may think of “stroke symptoms time” as the time patients are found rather than when their stroke symptoms began.</p>	<p>Policy revised.</p> <ul style="list-style-type: none"> • “Stroke Symptom Time” removed. • Will be reinforced by education.
Stroke Treatment Protocol	LLUMC	<p>Under Stroke Treatment-adult page 8:</p> <p><i>“mLAPSS criteria: age > 40”</i></p> <p>Question: Since the medical literature includes patients over the age of 18 and does not specify a maximum age, what is the reason to contact the base station if a patient is < 40 years old? We agree that the mLAPSS process should continue during that time but please describe why the additional call is necessary.</p>	<p>No change.</p> <ul style="list-style-type: none"> • Statement is written to reinforce that EMS providers are to make NSRC base station contact, even if the patient is <40 yrs. Old.
Stroke Treatment Protocol	San Manuel FD	<p>1. BLS INTERVENTIONS #2 Re write sentence. It is unclear. Trauma is covered by #3, SUGGEST THE FOLLOWING SENTENCE; Position of comfort, consider left lateral position.</p> <p>2. mLAPSS CRITERIA #3 There is a cut off age of 40. Both options are either less than or equal or Greater than or equal. Only one option can include the age 40. Remove the “or equal sign” from one of the options.</p>	<p>Policy revised.</p> <ul style="list-style-type: none"> • Language clarified. <p>Policy revised.</p> <ul style="list-style-type: none"> • “If <40...” • Symbols removed, and spelled out.

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PROTOCOL #	AGENCY	COMMENT	RESPONSE
	San Manuel F.D.	<p>Several of the criteria are unclear as to which is a positive (included) or negative (excluded) finding. Define the criteria to identify the result of the exam as (+) or (-). EG, #2 states” No history of seizures or epilepsy. Is “no history included or excluding criteria?</p> <p>#4 baseline wheelchair or bed ridden. Positive or negative? #5 Blood Glucose 60-400mg/Dl Is an included range? Outside this range is an excluding factor?</p> <p>Maybe include a (+) or (-) to help clarify the assessment results.</p> <p>3. THROMBOLITIC ASSESSMENT</p> <p>State that this assessment is to be delivered to the ED with the pt. For agencies not on EMS solutions, include an attachment, with the official ICEMA thrombolytic assessment.</p>	<p>No change.</p> <ul style="list-style-type: none"> • Follows closely with the mLAPSS format. • Will be clarified with education. <p>Policy revised.</p> <ul style="list-style-type: none"> • Added...”and report to ED personnel.”
Stroke “NSRC” Receiving Center Policy	Specialists On-Call	Letter summarizing support of Tele-neurology.	<p>Policy revised.</p> <ul style="list-style-type: none"> • NSRC-II Tele-neurology waiver added.
Stroke “NSRC” Receiving Center Policy	Crest Forest FPD	“Crest Forest Fire Protection Districts has no comments. Thank you!”	
Stroke “NSRC” Receiving Center Policy	LLUMC	<p>“INTRODUCTION”</p> <p style="text-align: center;"><i>Track changes in policy summarized. Original copy may be requested.</i></p>	<p>No change.</p> <ul style="list-style-type: none"> • Does not fit ICEMA policy and protocol format.
	LLUMC	JC: Joint Commission	<p>No change.</p> <ul style="list-style-type: none"> • The Joint Commission (TJC)

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PROTOCOL #	AGENCY	COMMENT	RESPONSE
	LLUMC	CME:	No change. <ul style="list-style-type: none"> Continuous education (CE)
	LLUMC	ACT F.A.S.T	No change, <ul style="list-style-type: none"> The pre-hospital assessment tool will be the mLAPSS.
	LLUMC	Medical Directors: <ul style="list-style-type: none"> Delete Certified by ABMS or AOA Add board-eligible ED MD: active privileges 	Policy revised. <ul style="list-style-type: none"> Added board eligible. No other changes made.
	LLUMC	Nursing Coordinator: <ul style="list-style-type: none"> CCRN Add: who will educate and gather data on stroke. 	Policy revised. <ul style="list-style-type: none"> Changed CCRN requirement to "preferred".
	LLUMC	On-Call Physicians Specialists/ Consultants <ul style="list-style-type: none"> On-call neurologist available in-house neurology residents... 	Policy clarified. <ul style="list-style-type: none"> NSRC-II Tele-neurology added.
	LLUMC	Delete Neuro-radiologist avail 24/7...	Policy revised. <ul style="list-style-type: none"> Clarified language.
	LLUMC	Interventional team: description added.	Policy revised. Added: <ul style="list-style-type: none"> Interventional neuroradiologist Interventional vascular radiologist
	LLUMC	Internal Hospital Policies: <ul style="list-style-type: none"> Deleted Critical care team 	Policy revised and language clarified. <ul style="list-style-type: none"> No content change.

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Protocol Reference # 3020 and 5040

PROTOCOL #	AGENCY	COMMENT	RESPONSE
	LLUMC	Internal Hospital Policies: Prompt acceptance of stroke patients from NSRH and NSRC-II to NSRC I.	Policy language clarified. <ul style="list-style-type: none"> No content change.
	LLUMC	Internal Hospital Policies: Rapid assessment-reworded statement.	Policy language clarified. <ul style="list-style-type: none"> No content change.
	LLUMC	Internal Hospital Policies: Maintaining readiness of CT-reworded statement.	Policy language clarified. <ul style="list-style-type: none"> No content change.
	LLUMC	Internal Hospital Policies: Arrangement of bed availability-changed Interventional Team to Stroke Team.	Policy language clarified. <ul style="list-style-type: none"> No content change.
	LLUMC	Continuous Quality Improvement Program: Core Measures-added Joint Commission	Policy revised. <ul style="list-style-type: none"> Added GWTG and Stroke CQI collaboration for performance indicators.
	LLUMC	Patient Destination: Several changes made.	Policy language clarified. <ul style="list-style-type: none"> No content change.
Stroke Policy	ICEMA	Layout change. Deleted statement: "An Emergency Medical Physician will be in the hospital at all times."	Policy language clarified. <ul style="list-style-type: none"> To clearly define NSRC-I and NSRC-II requirements. No content change. Deleted statement. <ul style="list-style-type: none"> Addressed elsewhere.