AGENDA
EMERGENCY MEDICAL CARE ADVISORY BOARD (EMCAB)
REGULAR MEETING

THURSDAY – NOVEMBER 8th, 2018

4:00 P.M.

Location: Kern County Public Health Services Department

San Joaquin Room – 1st Floor

1800 Mount Vernon Avenue - Bakersfield, California 93306

(661) 321-3000

I. Call to Order

II. Flag Salute

III. Roll Call

IV. Consent Agenda (CA): Consideration of the consent agenda.

All items listed with a "CA" are considered by Division staff to be routine and non-controversial. Consent items may be considered first and approved in one motion if no member of the Board or audience wishes to comment or discuss an item. If comment or discussion is desired, the item will be removed from consent and heard in its listed sequence with an opportunity for any member of the public to address the Board concerning the item before action is taken.

V. (CA) **Approval of Minutes:** EMCAB Meeting August 9th, 2018**–** approve

VI. Subcommittee Reports: None

VII. Public Comments:

This portion of the meeting is reserved for persons desiring to address the Board on any matter not on this Agenda and over which the Board has jurisdiction. Members of the public will also have the opportunity to comment as agenda items are discussed.

VIII. Public Requests:

IX. Unfinished Business:

a. Opioid Overdose Data-receive and file
b. State Regulations on Naloxone Release-receive and file

X. New Business:

a. ALS First Responder Policy-approve
b. Against Medical Advice Policy-approve
c. Proposed 2019 EMCAB dates-approve

XI. Director's Report: Hear presentation

XII. Miscellaneous Documents for Information:

(CA) EMS Fund Report – receive and file

XIII. Board Member Announcements or Reports:

On their own initiative, Board members may make a brief announcement or a brief report on their own activities. They may ask a question for clarification, make a referral to staff, or take action to have staff place a matter of business on a future agenda. (Government Code Section 54954.2 [a.])

XIV. Announcements:

A. Next regularly scheduled meeting: Thursday, February 14th, 2019, 4:00 p.m., at the Kern County Public Health Services Department, Bakersfield, California.

B. The deadline for submitting public requests on the next EMCAB meeting agenda is Thursday, January 31st, 2019, 5:00 p.m., to the Kern County EMS Division Senior Emergency Medical Services Coordinator.

XV. Adjournment

Disabled individuals who need special assistance to attend or participate in a meeting of the Kern County Emergency Medical Care Advisory Board (EMCAB) may request assistance at the Kern County Public Health Services Department located at 1800 Mount Vernon Avenue, Bakersfield, 93306 or by calling (661) 321-3000. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting materials available in alternative formats. Requests for assistance should be made at least three (3) working days in advance whenever possible.

EMERGENCY MEDICAL CARE ADVISORY BOARD
Membership Roster

Name and Address	***Representing***
Mike Maggard, Supervisor Third District 1115 Truxtun Avenue Bakersfield, CA 93301 (661) 868-3670 Alternate Mick Gleason, Supervisor First District 1115 Truxtun Avenue Bakersfield, CA 93301 (661) 868-3651	Board of Supervisors
Donny Youngblood, Sheriff Kern County Sheriff's Department 1350 Norris Road Bakersfield, CA 93308 (661) 391-7500 Alternate Vacant	Police Chief's Association
Brian Marshall, Kern County Fire Department 5642 Victor Street Bakersfield, CA 93308 (661) 391-7011 Alternate Vacant	Chief Fire Chief's Association
James Miller 14113 Wellington Court Bakersfield, CA 93314 (817) 832-2263 Alternate Vacant	Urban Consumer

Name and Address	***Representing***
Vacant	Rural Consumer
Alternate Vacant	
Randy Miller Mayor, City of Taft 209 E. Kern Street Taft, CA 93268	City Selection Committee
Alternate Cathy Prout Mayor, City of Shafter 435 Maple Street Shafter, CA 93263 (661) 746-6409	
Scott Hurlbert City of Shafter 336 Pacific Avenue Shafter, CA 93263	Kern Mayors and City Managers Group
Alternate Greg Garrett City of Tehachapi 115 S. Robinson Street Tehachapi, CA 93561	
Vacant	Kern County Medical Society
Alternate Vacant	
Bruce Peters, Chief Executive Officer Mercy and Mercy Southwest Hospitals 2215 Truxtun Avenue P.O. Box 119 Bakersfield, CA 93302 (661) 632-5000	Kern County Hospital Administrators
Alternate Jared Leavitt, Chief Operating Officer Kern Medical Center 1700 Mount Vernon Avenue Bakersfield, CA 93306 (661) 326-2000	

Name and Address	***Representing***
John Surface Hall Ambulance Inc. 1001 21st Street Bakersfield, CA 93301 (661) 322-8741	Kern County Ambulance Association
Alternate Aaron Moses Delano Ambulance Service P.O. Box 280 Delano, CA 93216 (661) 725-3499	
Kristopher Lyon, M.D. 1800 Mount Vernon Avenue, 2rd floor Bakersfield, CA 93306 (661) 321-3000	EMS Medical Director
Support Staff	
Jeff Fariss, Senior EMS Coordinator 1800 Mount Vernon Avenue, 2nd floor Bakersfield, CA 93306 (661) 321-3000	EMS Division
Karen Barnes, Chief Deputy 1115 Truxtun Avenue, 4th Floor Bakersfield, CA 93301 (661) 868-3800	County Counsel
Amanda Ruiz 1115 Truxtun Avenue, 5th Floor Bakersfield, CA 93301 (661) 868-3164	County Administrative Office

V. Approval of Minutes

August 9, 2018

MINUTES
EMERGENCY MEDICAL CARE ADVISORY BOARD (EMCAB)
REGULAR MEETING

THURSDAY – August 9, 2018

4:00 P.M.

Location: Kern County Public Health Services Department

San Joaquin Room – 1st Floor

1800 Mount Vernon Avenue - Bakersfield, California 93306

(661) 321-3000

I. Call to Order

II. Flag Salute
Led By: Prout

III. Roll Call: Gleason, Youngblood, Marshall, Miller, Prout, Peters, Moses, Lyon

IV. Consent Agenda (CA): Consideration of the consent agenda.

All items listed with a "CA" are considered by Division staff to be routine and non-controversial. Consent items may be considered first and approved in one motion if no member of the Board or audience wishes to comment or discuss an item. If comment or discussion is desired, the item will be removed from consent and heard in its listed sequence with an opportunity for any member of the public to address the Board concerning the item before action is taken.

V. (CA) **Approval of Minutes:** EMCAB Meeting May 10, 2018 **–** approve
Peters-Prout: All ayes

VI. Subcommittee Reports: None

VII. Public Comments:

This portion of the meeting is reserved for persons desiring to address the Board on any matter not on this Agenda and over which the Board has jurisdiction. Members of the public will also have the opportunity to comment as agenda items are discussed.
NO ONE HEARD

VIII. Public Requests:

A. Accreditation Policy – Paula Isbell – Kern Medical

Paula Isbell-Caughron heard concerning the Accreditation Policy to add the requirement for Live Scan DOJ/FBI background checks for Mobile Intensive Care Nurses (MICNs).

IX. Unfinished Business: Continued to November 8, 2018

A. State Regulations on Naloxone Release - receive and file

B. Opioid Overdose Data – receive and file

X. New Business:

A. Impact of ALS to BLS Handoff Protocol – receive and file
Youngblood-Marshall: All ayes

B. Ambulance Performance Standards – approve
Youngblood-Lyon: All ayes

C. ALJ/EMSA Commission Decision – receive and file
Marshall-Lyon: All ayes

XI. Director's Report: Hear presentation – receive and file
Youngblood-Marshall: All ayes

XII. Miscellaneous Documents for Information:

A. (CA) EMS Fund Report – receive and file
Peters-Prout: All ayes

XIII. Board Member Announcements or Reports:

On their own initiative, Board members may make a brief announcement or a brief report on their own activities. They may ask a question for clarification, make a referral to staff, or take action to have staff place a matter of business on a future agenda. (Government Code Section 54954.2 [a.])

Peters heard concerning the Mercy Southwest incident. He wanted to thank all of the agencies for their help during this incident.

XIV. Announcements:

A. Next regularly scheduled meeting: Thursday, November 8, 2018, 4:00 p.m., at the Kern County Public Health Services Department, Bakersfield, California.

B. The deadline for submitting public requests on the next EMCAB meeting agenda is Thursday, October 25, 2018, 5:00 p.m., to the Kern County EMS Division Senior Emergency Medical Services Coordinator.

XV. Adjournment
Lyon

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IX. Unfinished Business

A. Opioid Overdose Data

KERN COUNTY
Public Health Services
DEPARTMENT

MATTHEW CONSTANTINE
DIRECTOR

1800 MT. VERNON AVENUE BAKERSFIELD, CALIFORNIA, 93306-3302 661-321-3000 WWW.KERNPUBLICHEALTH.COM

EMS Division Staff Report for EMCAB-November 8th, 2018

Opioid Overdose Data: Kern County

Drug overdoses due to opioids have been on the rise since the 1990's. Nationally, the Midwest has seen the most significant increase in opioid use and overdoses over this time frame. Fortunately, California has avoided the worst of the opioid epidemic, ranking in the bottom 10 of all states for drug use issues. Additionally, Kern County's opioid-related hospitalization rates remain low. In 2017, an estimated 100 Kern County residents visited the ED for acute opioid overdose.

However, opioid overdoses are still of concern for Kern County EMS and Public Health, particularly when it comes to the use of naloxone by our providers and members of the community.

In 2018, the Kern County Public Health Services Department participated in a state-wide naloxone distribution project. By participating in this project, Kern County Public Health acquired 984 doses of naloxone that were to be distributed to entities within Kern County that regularly interact with high-risk communities, including entities that have naloxone distribution systems already in place. The task of distributing naloxone to the appropriate entities or communities was given to public health nursing staff. The nursing staff in charge of this project asked EMS to aid in their decision-making process by providing information about opioid overdoses in Kern County.

To provide the appropriate information, we analyzed opioid overdose data from two sources available to us:

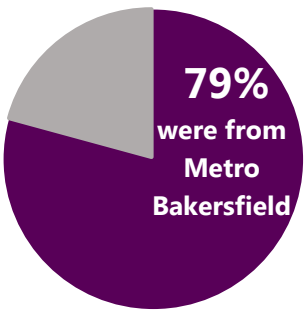
1) Electronic patient care records (ePCR) from Sept 2017-Sept 2018. All patients with a primary impression of narcotic overdose or poisoning were pulled for these dates and used for the analysis. Additionally, all ePCRs from Sept 2017 – Sept 2018 with recorded naloxone use were analyzed.
2) Hospital Discharge Data for 2016 provided by the Office of Statewide Health Planning and Development (OSHPD). All patients with an external cause of injury related to opioid abuse were used for the analysis.

The following are summaries of this data.

Kern County Opioid Overdose Crisis: Who is Affected?

From September 2017 – September 2018, EMS responded to **650 calls** for suspected opioid overdose. Here is some information about the communities hardest hit by this issue.

Of all calls received by EMS,



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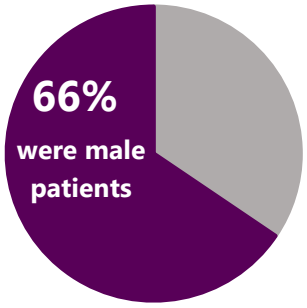
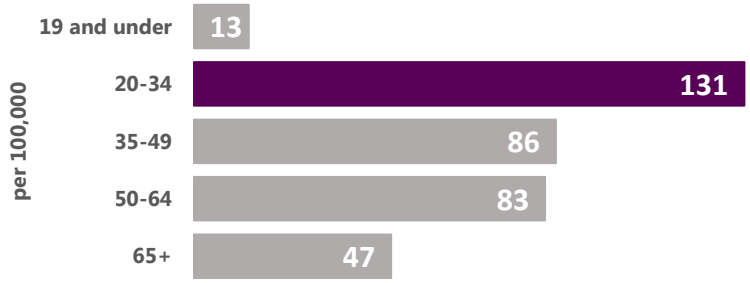
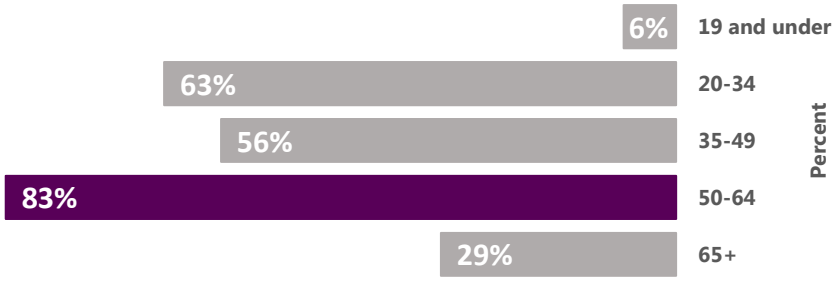


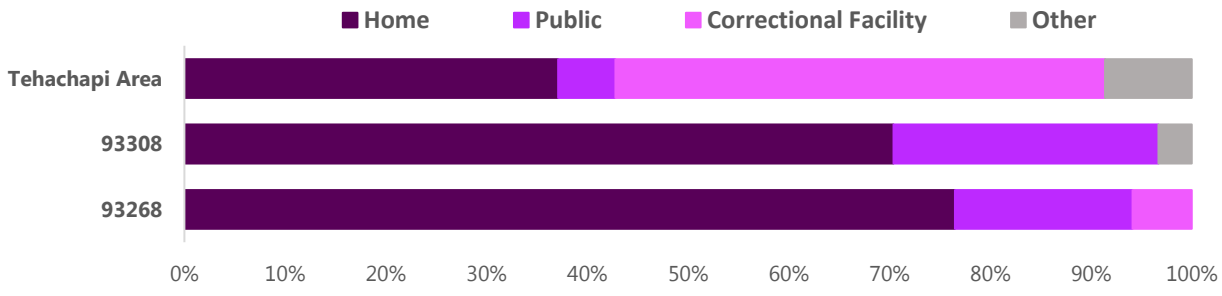
Young adults aged 20-34 had the highest rate of EMS calls for suspected opioid overdose.



In contrast, adults aged 50-64 accounted for a larger percentage of opioid-related hospital discharges.



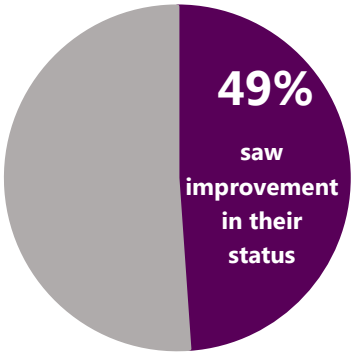
The majority of incidents for high volume areas occurred in private residences, with the exception of Tehachapi. Most calls in this area originated from a correctional facility.



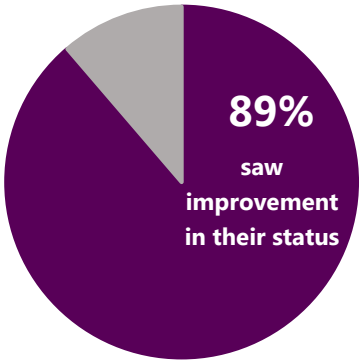
Kern County Opioid Overdose Crisis: Naloxone Use

From September 2017 – September 2018, naloxone was used **1706 times** by EMS personnel. Here is some information about its use and effectiveness.

Of all 1706 patients with documented naloxone use,

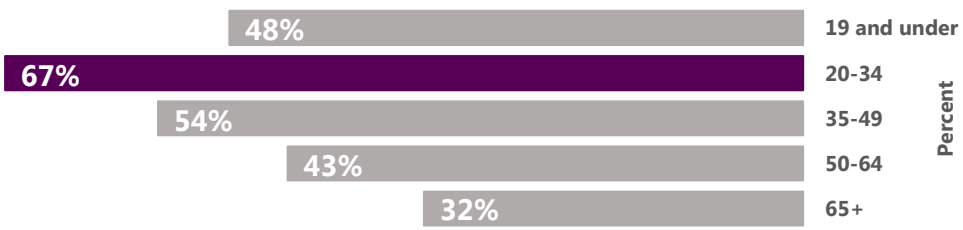


319 patients given naloxone were identified by EMS as experiencing a suspected opioid overdose. Of those patients,



Aside from the youngest age group, naloxone administration did not differ between adult age groups.

However, naloxone was more effective for a larger percentage of young adults aged 20-34.



By participating in the project, EMS not only helped the public health department to distribute naloxone to those who might benefit, but we also designed a surveillance tool for opioid overdoses and naloxone use in Kern County. This tool may allow us to detect changes in opioid abuse in our county, thus allowing us to stay ahead of a potential crisis. Furthermore, by identifying populations that are at higher risk for opioid overdoses and tracking the use of naloxone by our EMS providers, we may be able to provide public health and our communities with the information they need to prevent opioid-related overdoses and deaths. Such interventions may include: education of families, users, and their health care providers on how and when to use naloxone. This includes increasing awareness of the California Assembly Bill AB 1535, which allows the purchase of naloxone without a prior prescription.

Therefore IT IS RECOMMENDED, the Board Receive and File this report

IX. Unfinished Business

B. State Regulations on Naloxone Release

KERN COUNTY
Public Health Services
DEPARTMENT

MATTHEW CONSTANTINE
DIRECTOR

1800 MT. VERNON AVENUE BAKERSFIELD, CALIFORNIA, 93306-3302 661-321-3000 WWW.KERNPUBLICHEALTH.COM

EMS Division Staff Report for EMCAB-November 8th, 2018

State Legislation Regarding the Release of Naloxone

AB 635

Provides protection to licensed health care professionals statewide from civil and criminal liability when, if acting with reasonable care, they prescribe, dispense, or oversee the distribution via a standing order of naloxone via an overdose prevention program or standard medical practice.

Permits individuals to possess and administer naloxone in an emergency and protect these individuals from civil or criminal prosecution for practicing medicine without a license.

Clarifies that licensed prescribers are encouraged to prescribe naloxone to individual patients on chronic opioid pain medications in order to address the prescription drug overdose epidemic.

SB 1438

Adds peace officers to those allowed to administer an opioid antagonist to a person at risk of an opioid-related overdose, when issued by standing order or prescribed by a licensed health care provider who is authorized by law to prescribe an opioid antagonist, without being subject to professional review, liable in a civil action, or subject to criminal prosecution for the act.

AB 1535

This bill would authorize a pharmacist to furnish naloxone hydrochloride in accordance with standardized procedures or protocols developed and approved by both the board and the Medical Board of California, in consultation with specified entities. The bill would require the board and the Medical Board of California, in developing those procedures and protocols, to include procedures requiring the pharmacist to provide a consultation to ensure the education of the person to whom the drug is furnished, as specified, and notification of the patient's primary care provider of drugs or devices furnished to the patient, as specified. The bill would prohibit a pharmacist furnishing naloxone hydrochloride pursuant to its provisions from permitting the person to whom the drug is furnished to waive the consultation described above. The bill would require a pharmacist to complete a training program on the use of opioid antagonists prior to performing this procedure. The bill would require each board to enforce these provisions with respect to its respective licensees.

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AB 2256

Adds Section 4119.9 to the Business and Professions Code;

4119.9 Notwithstanding any other law, a pharmacy, wholesaler, or manufacturer may furnish naloxone hydrochloride or other opioid antagonists to a law enforcement agency if both of the following are met:

(a) The naloxone hydrochloride or other opioid antagonist is furnished exclusively for use by employees of the law enforcement agency who have completed training, provided by the law enforcement agency, in administering naloxone hydrochloride or other opioid antagonists.

(b) Records regarding the acquisition and disposition of naloxone hydrochloride or other opioid antagonists furnished pursuant to this section shall be maintained by the law enforcement agency for a period of three years from the date the records were created. The law enforcement agency shall be responsible for monitoring the supply of naloxone hydrochloride or other opioid antagonists and ensuring the destruction of expired naloxone hydrochloride or other opioid antagonists.

Therefore IT IS RECOMMENDED, the Board receive and file this report.

X. New Business

A. ALS First Responder Policy

KERN COUNTY
Public Health Services
DEPARTMENT

MATTHEW CONSTANTINE
DIRECTOR

1800 MT. VERNON AVENUE BAKERSFIELD, CALIFORNIA, 93306-3302 661-321-3000 WWW.KERNPUBLICHEALTH.COM

EMS Division Staff Report for EMCAB-November 8th, 2018

Advanced Life Support First Responder Policy

Background

First responders are vital for a healthy EMS system and Kern County's system is no different. First responders in Kern County are made up of non-transporting agencies that respond to an emergency scene to initiate care to the sick and injured pending the arrival of the transporting agency. Historically Kern County has had Basic Life Support (EMT) first response followed by an Advanced Life Support (Paramedic) transport response throughout our system. However, there are three areas of Kern County that provide paramedic first response. California City, Pine Mountain Club and the City of Bakersfield have all been providing paramedic first response for several years.

The Dilemma

In the past the process of approving these Advanced Life Support first responders included the creation of a new policy for each request. As a result we have three Advanced Life Support First Responder policies which have created multiple conflicting response criteria.

The EMS Division Plan of Action

In response to these conflicts EMS has created a single Advanced Life Support First Responder policy to replace the current policies. This new policy addresses the needs of the entire county and creates a single reference point for stake holders wishing to become an advanced life support first responder. It removes any confusion created by the three old policies and creates a streamlined and clear blueprint for those entities working towards becoming an Advanced Life Support First Responder.

I believe that the creation of a single Advanced Life Support First Responder Policy represents a significant improvement to our EMS system by providing our first response agencies a clear path to become an ALS First Responder.

Therefore IT IS RECOMMENDED, the Board approve the Advanced Life Support First Responder Policy.

Paramedic First Responder Policies and Procedures- (Number)

PURPOSE:

The primary purpose of the Paramedic-FR Program is to provide expedient ALS response and care prior to transport unit scene arrival at emergency medical calls and/or to provide support for a transport unit already at scene which may require additional emergency medical personnel, equipment, supply; or resources for medical operations, communication and patient care. Additionally, the Paramedic-FR Program is intended to provide closest ALS response when the Paramedic-FR unit is closest or can provide the shortest response to an EMS call and immediate ALS access and care to patients in areas inaccessible to an ambulance.

AUTHORITY:

This policy is administered under the authority of Health and Safety Code Sections 1797.107, 1797.172, 1797.173, 1798, and California Code of Regulations, Title 22, Division 9, Chapter 4, Sections 100145.

I. GENERAL PROVISIONS

A. The Paramedic First Responder Program is an optional prehospital advanced life support program administered by the Kern County EMS Division (Division) through Division authorized Kern County Paramedic First Responder (Paramedic-FR) Providers. The program functions in accordance with state and county Paramedic rules, regulations, policies, procedures, protocols and operates under medical control and authority of the Division Medical Director.

B. A Kern County EMS Division authorized Paramedic First Responder Provider is limited to prehospital first responder BLS and ALS patient care and shall not provide patient transport services within the County of Kern. EMT-1 or Paramedic level transportation services shall only be provided by a Kern County Ambulance Service Permittee in accordance with Kern County Ordinance Code 8.12. and Ordinance Code 8.12. Regulations and Policies.

C. The Paramedic-FR Program entails utilization of specially equipped and trained Paramedic(s) in the first responder, non-transport patient care capacity with valid state Paramedic licensure and local Paramedic accreditation. The Paramedic-FR operates from an emergency response vehicle that is not to be used for patient transport.

D. The Paramedic-FR vehicle shall have and maintain valid emergency vehicle authorization from the California Highway Patrol and valid Paramedic-FR MICU authorization from the Division. The Paramedic-FR MICU shall only be operated in a Paramedic-FR capacity when staffed by a minimum of one (1) Paramedic that meets Paramedic-FR qualification and training requirements as specified in these policies.

E. Use of Paramedic-FR shall not be construed, interpreted or allowed to replace or modify in any way transportation resources maintained by a Kern County Paramedic Provider or a Kern County Ambulance Service Permittee. The Paramedic-FR program shall be operated as an adjunct to the Kern County EMS System and not to replace or supplant any existing level of services.

II. PARAMEDIC FIRST RESPONDER SCOPE OF PRACTICE

A. The Paramedic-FR is authorized to provide prehospital Advanced Life Support within the scope of practice allowed by the State of California and the Division according to these policies and procedures.

B. The Paramedic-FR is authorized to provide prehospital advanced life support skills and procedures according to Paramedic treatment protocols authorized by the Division Medical Director. This authorization shall be commensurate with the Paramedic-FR MICU advanced life support supplies and equipment inventory specified in these policies and specially refined for Paramedic-FR function.

C. The Paramedic-FR shall comply with all Kern County Paramedic rules, regulations, policies, procedures and protocols at all times.

D. The Paramedic-FR shall coordinate appropriate planning, notification, response, communications and utilization of local EMS resources.

III. PARAMEDIC FIRST RESPONDER PROVIDER

A. Valid Kern County EMS Division authorization as a Paramedic-FR Provider shall be required for a provider to operate the Paramedic-FR Program.

B. Paramedic-FR Provider authorization shall immediately be terminated if the provider is unable to provide personnel meeting the requirements of these policies or the program is terminated.

C. A provider wishing to be authorized as a Paramedic-FR Provider shall provide a written application to the Division. The written application shall include a thorough description of unit(s), Paramedic-FR personnel qualifications and

training, staffing, and availability with commitment to comply with Paramedic-FR policies and procedures.

D. To be eligible for Paramedic-FR Provider authorization all of the following minimum requirements shall be met:

1. Be an existing EMT-1 First Responder Provider within Kern County authorized by the Division;
2. Have a Medical Director responsible for all controlled substances and Quality Improvement.

3. Have and maintain a Paramedic-FR training program which complies with the provisions of these policies and procedures;

4. Have and maintain at least one (1) Paramedic-FR MICU authorized by the Division;

5. Have and maintain a quality improvement mechanism for the Paramedic-FR program to ensure proper utilization and quality of care; and

6. Have and maintain records, reports and Paramedic-FR activity data according to these policies.

E. An authorized Paramedic-FR Provider shall ensure the Paramedic-FR program is continually operated according to these policies and procedures. The Division may terminate Paramedic-FR Provider authorization for non-compliance to these policies and procedures.

IV. PARAMEDIC FIRST RESPONDER QUALIFICATIONS, ACCREDITATION AND TRAINING

A. The Paramedic-FR shall have and maintain active Kern County Paramedic accreditation.

B. A Paramedic-FR shall receive a minimum of four (4) hours training in Paramedic-FR policies and procedures, Paramedic-FR scope of practice, and the EMS system before being authorized to operate in a Paramedic-FR capacity. The training shall only be provided by Division authorized instructors. Paramedic-FR training shall at minimum include a thorough briefing in Paramedic-FR policies and procedures, orientation in communications systems, Scene Control Policy, EMS resource utilization, ambulance service operating areas and prehospital care capability, dispatch and stand-by procedures, EMS aircraft utilization, multi-casualty incident and Med-Alert operations.

C. The Paramedic-FR Provider shall maintain records of Paramedic personnel that have completed Paramedic-FR training and are authorized to operate in a Paramedic-FR capacity and shall maintain an active listing on file at the Division.

D. The Division may withdraw Paramedic-FR authorization at any time for non-compliance with policies and procedures. The Division may also establish re-authorization training requirements or mandatory Paramedic-FR education sessions.

E. Paramedic-FR programs shall maintain sufficient Paramedic Preceptors to train new paramedics and ensure skills maintenance of existing Paramedics

F. Paramedic FR Preceptor candidates shall participate in the Division Preceptor program to obtain and maintain Preceptor accreditation.

V. PARAMEDIC FIRST RESPONDER ACTIVATION AND RESPONSE

A. The Paramedic-FR Provider shall ensure appropriate staffing, deployment, and utilization of all Paramedic-FR units.

B. The Paramedic-FR unit may be used in either a first responder capacity (prior to ALS transport arrival) or in a backup or support capacity when requested by on-scene medical, fire or law enforcement personnel.

C. Non-emergent activity, movement and positioning of Paramedic-FR unit(s) shall be at the discretion of the Paramedic-FR Provider within their jurisdiction.

D. The Paramedic-FR unit shall be responded to medical emergencies by the Paramedic FR-Provider dispatch center in accordance with the *Emergency Medical Services Dispatch Policies and Procedures.*

VI. PARAMEDIC FIRST RESPONDER SCENE OPERATIONS

A. First Responder Capacity:

1. First responder capacity means the Paramedic-FR unit is the first medical unit or first ALS level unit arriving at scene.

2. In a first responder capacity, the Paramedic-FR is expected to assume patient health care authority. Upon arrival of an ALS ambulance, the Paramedic FR shall provide a verbal report and patient care authority shall

automatically transition with transfer of care to the transport paramedic, as required by the Division *Scene Control Policy*.

3. The Paramedic-FR is expected to establish medical control, complete scene and patient assessment and initiate BLS/ALS patient treatment intervention according to Kern County Paramedic Policies and Procedures and Kern County Paramedic Treatment Protocols as the patient condition necessitates. The Paramedic-FR is expected to initially bring necessary medical equipment and supplies to the patient for appropriate overall patient care management (avoid making patient contact, then leaving for equipment).

4. The normal focus of the Paramedic-FR program is to provide immediate care until an ALS ambulance arrives, transfer of patient care responsibility occurs, and the Paramedic-FR rapidly becomes available for additional responses or use. In certain cases warranting specialized personal protective equipment precautions and training (hazardous materials, heavy rescue or tactical operations) the Paramedic-FR transition of care responsibility to the ALS ambulance Paramedic may be delayed until the ALS ambulance Paramedic is able to safely access the patient.

5. The Paramedic-FR shall provide a verbal report to the ALS ambulance Paramedic upon arrival which includes the following patient information at minimum:

    a. Chief complaint(s) and/or problem(s);

    b. Signs and symptoms;

    c. Vital signs;

    d. Patient history; and

    e. BLS, ALS treatment provided and patient response to treatment.

6. If a BLS ambulance arrives at scene and ALS patient care procedures are indicated, initiated or carried out, the Paramedic-FR must bring necessary equipment and supplies from the Paramedic-FR unit to manage the patient and attend the patient during transport to an ALS ambulance or the hospital. ALS to BLS Handoff shall only occur as specified in the paramedic protocol.

7. During a multi-casualty or mass casualty incident, the Paramedic-FR may use a BLS ambulance for patient transport when ALS procedures have been initiated, if an ALS ambulance is not reasonably available, or the patient(s) require rapid transport and the situation clearly indicates that the

Paramedic-FR remain at scene to administer ALS level care to additional patients.

B. Paramedic-FR Backup or Support Capacity:

1. Paramedic-FR backup or support capacity means that an ALS ambulance Paramedic is already on scene and the Paramedic-FR arrives on scene as an additional ALS level resource. In this situation the Paramedic-FR is to assist and at the discretion of the ALS ambulance Paramedic or incident commander.

VII. EMS RESOURCE UTILIZATION

A. The Paramedic-FR shall be responsible for prudent notification, response and efficient utilization of all EMS resources in conjunction with the Scene Control Policy. During Med-Alert operations, the Paramedic-FR shall coordinate incident communications and resource utilization through the Kern County EMS Division.

VIII. DOCUMENTATION AND QUALITY ASSURANCE

A. The Paramedic-FR shall complete a Kern County Patient Care (PCR) Data and Narrative Record in accordance with Kern County PCR Policies and Procedures for every public agency or 911response (with or without patient contact) and for each individual patient contact. Completed PCR's shall be referred to the Division in accordance with Kern County PCR Policies and Procedures.

B. For each case of patient transport, a copy of the ePCR shall be sent by facsimile or electronic means to the receiving hospital within one (1) hour of the start of patient transport. Emergency activity may reasonably preclude meeting the one (1) hour time requirement, but in no case shall the ePCR submission to the receiving hospital exceed twelve (12) hours.

C. The Paramedic-FR provider shall provide Paramedic-FR incident reports, documentation, data or Paramedic-FR program evaluations to the Division upon request.

D. The Division shall be notified in advance of any anticipated changes in Paramedic-FR unit(s), Paramedic-FR utilization, Paramedic-FR personnel or function of the Paramedic-FR program and shall monitor the program for operational and medical quality assurance.

E. The Paramedic-FR provider shall allow Division personnel to ride-a-long for the purpose of direct observation of FR operations.

IX. REQUIRED PARAMEDIC FIRST RESPONDER MICU EQUIPMENT AND SUPPLIES

A. The Paramedic-FR and Paramedic-FR Provider shall be responsible to maintain a complete inventory of required Paramedic-FR MICU equipment and supplies (Paramedic-FR MICU Inventory) as specified in the *Provider Mandatory Inventory List*.

B. A Paramedic-FR unit shall be inspected and designated by the Division as an Paramedic-FR MICU prior to use in an Paramedic-FR capacity. In order to be designated as a Paramedic-FR MICU, the unit shall meet all Paramedic-FR MICU inventory requirements and pass Division inspection.

C. The Paramedic-FR MICU Inventory should be configured in the Paramedic-FR unit for efficient removal and transport to the patient or incident site.

D. The Paramedic-FR and Paramedic-FR Provider shall be responsible for the care and maintenance of all Paramedic-FR MICU inventory. Paramedic-FR unit(s) MICU inventory shall also be subject to inspection by the Division. The Paramedic-FR Provider may obtain temporary authorization from the Division to operate another emergency vehicle in a Paramedic-FR MICU capacity.

E. The following information shall be provided by the Paramedic-FR provider for Paramedic-FR MICU inspection by the Division:

1. Vehicle make, model, year;

2. Vehicle license number (if not available because of new vehicle - vehicle identification number will suffice);

3. Vehicle identification number;

4. Valid vehicle registration;

5. Valid vehicle insurance documentation, name of carrier and policy number;

6. Unit call sign.

PARAMEDIC-FR MOBILE INTENSIVE CARE UNIT
INSPECTION RECORD

INSPECTION DATE: / /

APPROVED PARAMEDIC-FR PROVIDER: YES [ ] NO [ ]

PARAMEDIC-FR PROVIDER SERVICE:

NAME OF OWNER(S):

SERVICE AREA:

PRIMARY ADDRESS:

CITY: ZIP CODE:

PHONE ( ) -

UNIT DESIGNATION: _____ MODEL:_____

YEAR: _____ LICENSE NUMBER: _____

V.I.N.: _____

CURRENT VEHICLE REGISTRATION (ATTACH COPY): YES [ ] NO [ ]

CURRENT VEHICLE INSURANCE (ATTACH COPY): YES [ ] NO [ ]

NAME OF CARRIER: _____ POLICY #:_____

CURRENT CALIFORNIA HIGHWAY PATROL INSPECTION CERTIFICATE AND/OR APPROVED INSPECTION SHEET (ATTACH COPY) YES [ ] NO [ ]

CURRENT MICU MEDICAL SUPPLY AND EQUIPMENT YES [ ] NO [ ]

REQUIREMENTS SATISFIED (COPY ATTACHED) YES [ ] NO [ ]

ALL PRECEDING REQUIREMENTS SATISFIED: YES [ ] NO [ ]
SUMMARY OF DISCREPANCY(IES):

CONCLUSION:

EMS DIVISION REPRESENTATIVE NAME:

EMS DIVISION REPRESENTATIVE SIGNATURE:

DATE APPROVED: / /

Revision Log:

08/03/1999 – Initial Draft
09/15/1999 – Second Draft
10/20/1999 – Finalized
11/15/2001 – Addition of transcutaneous cardiac pacing, midazolam, and inventory adjustments
07/15/2004 - Increase minimum stock of midazolam to 12.0 mg
06/01/2010 – Added Amiodarone, MAD, ET confirmation, and ET securing device to inventory
10/01/2013 – Removed medication Furosemide from inventory and updated cover
08/15/2014 – Added Atrovent, Zofran, Fentanyl, oral glucose, multi-trauma dressing, petroleum gauze, shears, pulse oximetry. Remove pitocin, procainamide, electrode jell. Changed normal saline to isotonic balanced salt solution, pacing electrodes to multi-function pads. Removed outdated dispatch language, remove ICS position mandates. Added reference to *Emergency Medical Services Dispatch Policies and Procedures*, and *Scene Control Policy*
12/01/2015 - Removed the Mandatory Inventory List and placed in separate document
4/18/2018 – Removed California City from document. Added Division ride-a-long mandate, changed “may” to “shall” in dispatch statement.
8/1/2018 – All three ALS First Responder policies merged into one document.

X. New Business

B. Against Medical Advise Policy

KERN COUNTY
Public Health Services
DEPARTMENT

MATTHEW CONSTANTINE
DIRECTOR

1800 MT. VERNON AVENUE BAKERSFIELD, CALIFORNIA, 93306-3302 661-321-3000 WWW.KERNPUBLICHEALTH.COM

EMS Division Staff Report for EMCAB-November 8th, 2018

Against Medical Advice Policy

Background

The right to refuse care is a freedom that most patients enjoy in our county. On a daily basis Kern County EMS providers are forced to walk away from patients leaving them to care for themselves or in the care of family. The process of refusing care is called, "Against Medical Advice" and is shortened to AMA. Unfortunately, obtaining an AMA, even at the patient's request, increases the liability for the crew and provider company.

The Dilemma

With community paramedic programs popping up all over the country and the landscape of EMS and the methods for reimbursement in a constant state of change, our ambulance providers may be faced with the reality of having to leave an increased number of patients at home rather than transport to the hospital in the near future. With hospitals being used more frequently for minor issues and the ever increasing cost of an emergency room visit, Anthem Blue Cross, one of the largest insurance providers in the country, has made it known that it intends to create a pay code specifically for patients left at home and not transported to the hospital.

The EMS Division Plan of Action

In response to these and other changes to our system, EMS has spent many hours creating an Against Medical Advise Policy. The purpose of this policy is to provide guidelines for EMS personnel in the decision making process for collecting an AMA. It provides a framework for determining which patients can refuse transport vs those that require transport and if followed could provide an additional layer of protection from liability for the provider. Additionally, the AMA policy provides for "Treat and Refer" for those patients that meet the criteria and are not requesting transport.

I believe that the creation of the Against Medical Advise Policy represents a significant improvement to our EMS system by providing the providers protection for whatever changes occur in the future.

Therefore IT IS RECOMMENDED, the Board approve the Against Medical Advice Policy.

Against Medical Advise (AMA) (Number)

PURPOSE:

To provide guidelines for EMS personnel to determine which patients who do not wish to be transported to the hospital have the decision-making capacity to refuse EMS treatment and/or transport, and to identify those who may be safely released at scene.

AUTHORITY:

California Health and Safety Code, Division 2.5, Sections 1797.220, 1798, (a). California Welfare and Institution Code, Sections 305, 625, 5150, and 5170.Title 22, California Code of Regulations, Section 100169.

DEFINITIONS

Adult: A person at least eighteen years of age.

Minor: A person less than eighteen years of age.

Minor Not Requiring Parental Consent is a person who:

- Is 12 years or older and in need of care for a reportable medical condition or substance abuse
- Is pregnant and requires care related to the pregnancy
- Is in immediate danger of suspected physical or sexual abuse
- Is an emancipated minor

Emancipated Minor: A person under the age of 18 years is an emancipated minor if any of the following conditions are met:

- Married or previously married
- The person has received a declaration of emancipation pursuant to Section 7122 of the California Family Code, which includes all of the following: at least fourteen (14) years of age, living separate and apart from their parents and managing their own financial affairs (may be verified by DMV Identification Card)
- On active military duty

Decision-Making Capacity: The ability to understand the nature and consequences of proposed health care. This includes understanding the significant risks and benefits, and having the ability to make and communicate a decision regarding the proposed health care. A person has decision-making capacity if they are able to:

Understand the need for treatment, the implications of receiving and of not receiving treatment, and alternative forms of treatment that are available, and relate the above information to their personal values, and then make and convey a decision.

The lack of decision-making capacity may be:

- Temporarily lost (e.g., due to unconsciousness, influence of mind altering substances, mental illness or cognitive impairment)
- Permanently lost (e.g., due to irreversible coma, persistent vegetative state, untreatable brain injury or dementia)
- Never existed (i.e., due to profound neurodevelopmental disorder, those who are deemed by the Court as incompetent or a person under conservatorship)

Emergency Medical Condition:
A condition or situation in which an individual has an immediate need for medical attention, whether actual or perceived. The presence of abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure, oxygen saturation) are also indications of an emergency condition.

Implied Consent:
This is a type of consent involving the presumption that an unconscious or person lacking decision-making capacity would consent to lifesaving care. This shall include minors with an emergency medical condition and a parent or legal representative is not available.

Primary Care Physician:
Is a physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of a diagnosed health condition.

Refusing Care Against Medical Advice (AMA):
A patient or a legal representative of a patient who has ~~the~~ decision-making capacity to refuse treatment and/or transport for an emergency medical condition.

"Release at Scene" (Patients not requiring transport):
A patient who, after an assessment by EMS personnel, does not have an emergency medical condition and does not appear to require immediate treatment and/or transportation. These patients meet one or more of the following conditions:

- Deny a medical complaint and decline need for treatment
- Called EMS personnel for assistance for non-medical related issues (i.e., public assists)
- Meet criteria for “Treat and Refer”

“Treat and Refer”:
A patient who, is stable, does not have an ongoing medical or behavioral emergency and is NOT requesting transport to an emergency department may be referred to his/her primary care physician.

Urgent Care:
walk in clinic that provides care for illnesses or injuries which require prompt attention but are not typically serious in nature.

5150 Hold:
A patient who is held against their will for evaluation under the authority of Welfare and Institutions Code, Section 5150, because the patient is a danger to themselves, a danger to others, and/or gravely disabled (i.e., unable to care for self). This is a written order placed by law enforcement officer, County mental health worker, or a health worker certified by the County to place an individual on a 5150 hold

PRINCIPLES

1. An adult or emancipated minor who has decision-making capacity has the right to determine the course of their medical care including the refusal of care. These patients must be advised of the risks and consequences resulting from refusal of medical care.

2. A patient less than eighteen (18) years of age, with the exception of minors not requiring parental consent, must have a parent or legal representative to refuse evaluation, treatment, and/or transport for an emergency condition.

3. A patient determined by EMS personnel or the base hospital to lack decision-making capacity may not refuse care AMA or be released at scene. Mental illness, drugs, alcohol, or physical/mental impairment may impair a patient's decision-making capacity but are not sufficient to eliminate decision-making capacity. Patients who have attempted suicide, verbalized suicidal intent, or if other factors lead EMS personnel to suspect suicidal intent, should be regarded as lacking the decision-making capacity. Diagnosed mental illness alone or a patient's report of ingesting drugs/alcohol does not justify a determination of lack of decision-making capacity. Capacity determinations are specific only to the particular decision that needs to be made.
4. A patient on a 5150 Hold may not be released at scene and cannot sign-out against medical advice.

5. A patient or a legal representative of a patient may contact EMS for minor complaints in order to have an assessment performed and determination made of the seriousness of the complaint and need for treatment. In such cases, the EMS personnel may perform an assessment and for those who meet the definition of "Treat and Refer" may be treated at the scene and referred to the patient's medical home or primary care physician. If the patient or legal representative requests that the patient be transported despite assurance that transport is not needed; EMS personnel should honor the request and transport the patient to the most appropriate receiving facility in accordance with applicable patient destination policies.

6. At no time are EMS personnel to put themselves in danger by attempting to treat and/or transport a patient who refuses care.

7. Patients who refuse treatment and/or transport, and all those released at the scene are high risk patients who require additional quality review.

8. Certain patients are at increased risk of having a bad outcome if released on scene. This includes patients at extremes of age (≤12 months or ≥70 years old), patients with

abnormal vital signs, and patients with high-risk chief complaints including chest pain, shortness of breath, abdominal pain, gastrointestinal or vaginal bleeding, and syncope. These patients are more challenging to fully evaluate in the field and, in general, shall be transported to the emergency department.

I. Adult with decision making capacity or Minor (not requiring parental consent)

A. EMS personnel shall advise the patient of the risks and consequences which may result from refusal of treatment and/or transport. The patient should be advised to seek immediate medical care.

B. If the patient has an emergency medical condition as defined below and a BLS unit is alone on scene, an ALS unit shall be requested for evaluation prior to AMA.

i. Extremes of age (≤12 months or ≥70 years old)
ii. Abnormal vital signs
iii. High-risk chief complaints including chest pain, shortness of breath, abdominal pain, gastrointestinal or vaginal bleeding, and syncope

C. EMS personnel shall have the patient or their legal representative, as appropriate, sign the release (AMA) section of the EMS ePCR. The signature shall be witnessed, preferably by a family member.

D. A patient's refusal to sign the AMA section should be documented on the EMS ePCR and a witness signature obtained by either a family member, another prehospital personnel, or law enforcement.

E. EMS personnel may contact the base hospital physician to discuss patient refusals, obtain guidance, and/or assistance in educating patients on the risks and benefits. This must be done prior to leaving the patient. EMS personnel shall not make base contact for documentation purposes only AFTER leaving the patient.

II. Individual lacking decision-making capacity or a Minor (requiring parental consent)

A. The patient should be transported to an appropriate receiving facility under implied consent. A 5150 hold is not required.

B. If EMS personnel determines it is necessary to transport the patient against their will and the patient resists, or the EMS personnel believe the patient will resist, assistance from law enforcement should be requested in transporting the patient. Law enforcement may consider the placement of a 5150 hold on the patient but this is not required for transport.

C. Law enforcement should be involved whenever EMS personnel believe a parent or other legal representative of the patient is acting unreasonably in refusing immediate care and/or transport.

III. Patients Released at Scene

A. EMS personnel shall ensure that the patient does not have an ongoing emergency medical condition and that they have the capacity to decline transport.

B. Patients with the following high-risk features are not appropriate for Release at the Scene and should be transported:

i. Extremes of age (≤12 months or ≥70 years old)
ii. Abnormal vital signs
iii. High-risk chief complaints including chest pain, shortness of breath, abdominal pain, gastrointestinal or vaginal bleeding, and syncope

C. EMS personnel shall advise the patient to seek follow-up treatment or immediate medical care, including re-contacting 9-1-1 if they develop symptoms at a later time. The advice given should be documented on the Patient Care Record (PCR). The following statement is recommended: “It appears that you do not require immediate care in the emergency department. You should seek care with your regular healthcare provider or a doctor’s office or clinic within 24 hours. If you have new or worsening symptoms re-contact 9-1-1”.

D. EMS personnel should not require patients released at scene, including those treated and referred, to sign the release (AMA) section of the EMS ePCR, as this implies that the patient is at significant risk by not utilizing the EMS system for treatment and/or transportation.

E. If the patient or the patient’s legal representative requests that the patient be transported after assurances that transport is not needed; EMS personnel shall honor the requests and transport to the most appropriate hospital for patient.

IV. Documentation

An EMS ePCR must be completed for each patient encounter, including those refusing emergency medical evaluation, care and/or transportation against medical advice and those released at scene. EMS personnel shall ensure that documentation includes, at a minimum, the following:

A. Patient history and assessment, including absence of findings of an emergency medical condition.

B. Description of the patient which clearly indicates their decision-making capacity

C. For Refusal of Care Against Medical Advice (AMA):
   1. What the patient is refusing (i.e., medical care, transport)
   2. Why the patient is refusing care
   3. Risk and consequences of refusing care
   4. Statement that the patient understands the risks and consequences of refusing care
   5. Signature of patient or legal representative refusing care
   6. Patient's plan for follow-up care
   7. If patient is refusing to sign a signature from a witness preferably a family member.

D. For Release at Scene:
   1. For Treat and Refer
      a. Assessment for all adult and pediatric patients
      b. Field treatments
      c. Plan for follow-up care with their primary care physician or urgent care.
      d. Instructions on when to access EMS

   2. For patients with no medical complaint and do not request for treatment, document situation and assistance required

E. For Minors, document the relationship of the person(s) to whom the patient is being released

V. Quality Improvement

All patient care records for patients who refuse medical care or transport, or who were Treated and Released without Base Contact shall have a case review by the EMS Provider Medical Director (or designee).

X. New Business

C. Proposed 2019 EMCAB Dates

EMS Division Staff Report for EMCAB – November 8th, 2018

EMCAB Meeting Dates 2019

The proposed EMCAB meeting dates for 2019 are as follows:

Thursday – February 14, 2019 from 4pm
Thursday – May 9th, 2019 from 4pm
Thursday – August 8th, 2019 from 4pm
Thursday – November 14th, 2019 from 4pm

The agenda deadline for each of the four meetings in 2019 is the Thursday, fourteen (14) days before the meeting date at 5:00 PM.

Therefore, IT IS RECOMMENDED, the Board approves the 2019 EMCAB meeting dates.

XII. Misc. Documents for Information

EMS Annual Fund Report

EMS DIVISION
KERN COUNTY PUBLIC HEALTH SERVICES DEPARTMENT
MADDY EMS FUND

FISCAL YEAR 2018-19 ACTIVITY

	MADDY Deposits + Interest	RICHIE'S Deposits + Interest	Admin 10% of Each Fund	Richie's Fund (15%) Distribution	Total Physician Claims Submitted In Quarter	Physicians 58% both funds Balance	Physician Payments in Quarter	Percent Paid to Physcians	Hospitals 25% of Both Fund Balance	Hospital Payments in Quarter	Other EMS 17% MADDY Balance	Other EMS 17% RICHIE"S Balance
JULY 2018	112,599.84	113,583.90	22,618.37	17,037.59		108,675.64			46,631.95		17,227.78	14,481.95
AUGUST 2018	109,498.56	101,991.28	21,148.99	15,298.69		102,294.69			43,760.54		16,753.28	13,003.89
SEPTEMBER 2018	113,771.67	103,913.64	21,768.53	15,587.05		105,343.49			45,082.43		17,407.07	13,248.99
Total for Quarter 1	335,870.07	319,488.82	65,535.89	47,923.33	298,025.27	316,313.82	149,029.38	50%	135,474.92	224,133.08	51,388.13	40,734.83
OCTOBER 2018	-	-	-	-		-			-		-	-
NOVEMBER 2018	-	-	-	-		-			-		-	-
DECEMBER 2018	-	-	-	-		-			-		-	-
Total for Quarter 2	-	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	-
JANUARY 2019	-	-	-	-		-			-		-	-
FEBRUARY 2019	-	-	-	-		-			-		-	-
MARCH 2019	-	-	-	-		-			-		-	-
Total for Quarter 3	-	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	-
APRIL 2019	-	-	-	-		-			-		-	-
MAY 2019	-	-	-	-		-			-		-	-
JUNE 2019	-	-	-	-		-			-		-	-
Total for Quarter 4	-	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	-
YEAR-END SUP.		-	-								-	
YEAR TO DATE	335,870.07	319,488.82	65,535.89	47,923.33	298,025.27	316,313.82	149,029.38	50%	135,474.92	#DIV/0!	51,388.13	40,734.83