AGENDA
EMERGENCY MEDICAL CARE ADVISORY BOARD (EMCAB)
REGULAR MEETING

THURSDAY – February 9, 2017

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 November 10, 2016 - 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: None

IX. Unfinished Business: None

X. New Business:

A. (CA) Ambulance Destination Decision Policies and Procedures – approve

B. (CA) Patient Care Record Policies and Procedures – approve

C. (CA) Burn Center Designation Policy – approve

XI. Director's Report: Hear presentation

XII. Miscellaneous Documents for Information:

A. (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, May 11, 2017, 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, April 27, 2017, 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
Doug Greener, Chief Bakersfield City Fire Department 2101 H Street Bakersfield, CA 93301 (661) 326-3651 Alternate Brian Marshall, Chief Kern County Fire Department 5642 Victor Street Bakersfield, CA 93308 (661) 391-7011	Fire Chief's Association
James Miller 14113 Wellington Court Bakersfield, CA 93314 (817) 832-2263 Alternate Vacant	Urban Consumer

Name and Address	***Representing***
Mary C. Barlow 106 Spruce Street Kernville, CA 93238 Alternate Vacant	Rural Consumer
Randy Miller Mayor, City of Taft 209 E. Kern Street Taft, CA 93268 Alternate Cathy Prout Mayor, City of Shafter 435 Maple Street Shafter, CA 93263 (661) 746-6409	City Selection Committee
Alfonso Noyola City of Arvin 200 Campus Drive Arvin, CA 93203 (661) 854-3134 Alternate Paul Paris City of Wasco 746 8th Street Wasco, CA 93280 (661) 758-7214	Kern Mayors and City Managers Group
Vacant Alternate Vacant	Kern County Medical Society
Bruce Peters, Chief Executive Officer Mercy and Mercy Southwest Hospitals 2215 Truxtun Avenue P.O. Box 119 Bakersfield, CA 93302 (661) 632-5000 Alternate Jared Leavitt, Chief Operating Officer Kern Medical Center 1700 Mount Vernon Avenue Bakersfield, CA 93306 (661) 326-2000	Kern County Hospital Administrators

Name and Address	***Representing***
John Surface Hall Ambulance Inc. 1001 21st Street Bakersfield, CA 93301 (661) 322-8741 Alternate Aaron Moses Delano Ambulance Service P.O. Box 280 Delano, CA 93216 (661) 725-3499	Kern County Ambulance Association
Kristopher Lyon, M.D. 1800 Mount Vernon Avenue, 2rd floor Bakersfield, CA 93306 (661) 321-3000	EMS Medical Director
Support Staff	
Jana Richardson, Senior EMS Coordiantor 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
Kaler Ayala 1115 Truxtun Avenue, 5th Floor Bakersfield, CA 93301 (661) 868-3164	County Administrative Office

V. Approval of Minutes

EMCAB Meeting November 10, 2016

SUMMARY OF PROCEEDINGS
EMERGENCY MEDICAL CARE ADVISORY BOARD (EMCAB)
REGULAR MEETING

THURSDAY – November 10, 2016

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
BOARD RECONVENED

II. Flag Salute
LED BY: Mary Barlow

III. Roll Call
ROLL CALL: All present

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 11, 2016 – approve
Peters-Greener: 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: None

IX. Unfinished Business: None

X. New Business:

A. (CA) Pediatric Advisory Committee – approve
Peters-Greener: All ayes

B. (CA) EMS Quality Improvement Plan – approve
Peters-Greener: All ayes

C. (CA) Withholding Resuscitative Measures – approve
Peters-Greener: All ayes

D. (CA) Determination of Death Protocol – approve
Peters-Greener: All ayes

E. (CA) 2017 EMCAB Meeting Schedule – approve
Peters-Greener: All ayes

XI. Director's Report: Hear presentation: RECEIVE AND FILE
Barlow-Lyon: All ayes

XII. Miscellaneous Documents for Information:

A. (CA) EMS Fund Report – receive and file
Peters-Greener: 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.])
NO BOARD MEMBER ANNOUNCEMENTS OR REPORTS

XIV. Announcements:

A. Next regularly scheduled meeting: Thursday, February 9, 2017, 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 26, 2017, 5:00 p.m., to the Kern County EMS Division Senior Emergency Medical Services Coordinator.

XV. Adjournment
Surface

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.

X. New Business

A. Ambulance Destination Decision Policies and Procedures

EMS Division Staff Report for EMCAB- February 9, 2017

Ambulance Destination Decision Policies and Procedures (4001.00)

Background

Health and Safety Code (HSC) 1797.120, effective January 1, 2016, mandated the State EMS Authority (EMSA) develop a statewide methodology to calculate and report ambulance patient off load time. Ambulance patient offload time, is the time interval from the arrival of an ambulance at an emergency department to the patient being placed in a bed and the emergency department assumes responsibility for the care of the patient.

Health and Safety Code 1797.225, effective January 1, 2016, allows for the Division to adopt policies and procedures for calculating and reporting ambulance patient offload time. This statute also requires that the Division use the adopted statewide methodology and develop quality indicators.

On December 14, 2016, the Commission on EMS approved the methodology developed by EMSA and an accompanying guideline document which assists the local EMS agencies in development of policies.

The Dilemma

It is not uncommon for an ambulance to be delayed at an emergency department for greater than thirty minutes to hours. When an ambulance is delayed at an emergency department, the ambulance is not available to respond to other emergency calls. This causes the ambulance providers to have to deploy additional ambulances to meet contractual obligations. This issue occurs all over the State of California and impacts EMS systems. The State has posted a toolkit to their website to help hospital facilities and local EMS agencies address these delays.

The EMS Division Plan of Action

The Division has revised the *Ambulance Destination Decision Policies and Procedures* to include measurement of ambulance patient offload time. The policy already had an appendix that addressed offload delays at the emergency department. The proposed changes are consistent with EMSA methodology and guidelines. The policy was discussed at two EMS System Collaborative meetings, and published for a thirty day public comment period.

Therefore IT IS RECOMMENDED, the Board approve the *Ambulance Destination Decision Policies and Procedures*, and set an implementation date of February 10, 2017.

Ambulance Destination Decision Policies and Procedures (4001.00)

I. INTENT

A. The intent of these policies and procedures is to provide appropriate emergency medical care for the public by ensuring ambulance personnel make appropriate destination decisions. Patients should be delivered to the most accessible emergency medical facility appropriately equipped, staffed, and prepared to administer care to the needs of the patient.

II. GENERAL PROVISIONS

A. This policy shall be used by and is applicable to ambulance services and hospital emergency departments for determining prehospital ambulance destinations within the County.

B. E.D. Closure Status shall only be applicable to: 1) areas served by two or more hospital emergency departments, and 2) where reasonable and timely alternatives exist for patient care, as authorized by the EMS Department. Centralized Ambulance Routing Status or Hospital Disaster Closure Status may be implemented for any area of the County as determined by EMS Department.

C. This policy shall not be applicable to transfers to a general acute care hospital under the provisions of Sections 1317, et al. of the California Health and Safety Code unless Hospital Disaster Closure Status is placed into effect.

D. The Division shall be responsible for maintaining policy compliance within the EMS system. The Division may at any time inspect availability of emergency medical services within the system. In conjunction with ambulance providers and hospital emergency departments, the Division may revise or modify this policy when necessary to protect public health and safety. Hospital E.D. Status categories shall not apply to mass casualty incidents or multi-casualty incidents when the Kern County Med-Alert system is activated.

E. Only the EMS Department may authorize E.D. Closure Status, authorize or cancel E.D. Rotation Status, authorize or cancel Centralized E.D. Routing Status, or authorize or cancel Hospital Disaster Closure Status within the EMS system.

F. An emergency department shall not order or direct ambulances to another emergency department or facility. Ambulance destinations shall be

determined under the full authority of the ambulance attendant or as specified by Division staff.

G. At the time of ambulance communications with a hospital emergency department, the hospital may advise the incoming ambulance of unavailable services normally provided.

H. The emergency department shall be the responsible contact source for Division staff when determining emergency department status. The Division may contact the hospital or conduct an on-site inspection at any time to validate, clarify or update emergency department status.

I. Rotor-Wing Air Ambulance destination decisions shall be in accordance with these policies for hospital emergency departments that have a State approved helipad. Hospitals without a State approved helipad shall not be an air ambulance destination.

J. Specific patient problems (Case Specific Hospitals) described in Section IV.D.1. (Orthopedic, Cardiac, Neonatal, Obstetrical, Sexual Assault, Trauma, Psychiatric, Prisoner, Stroke, STEMI, and Pediatric) shall be transported to one of the designated hospital emergency departments, on E.D. Open Status. Absolute patient refusals shall be left at the discretion of the attending ambulance personnel. Division on-call staff may be contacted for directions in these cases.

III. HOSPITAL EMERGENCY DEPARTMENT STATUS CATEGORIES

A. The status of each hospital shall be categorized as listed below. These status categories are explained further in Sections V, VI, VII, and VIII.

1. E.D. Open Status: the hospital emergency department is open and able to provide care for ambulance patients.

2. E.D. Rotation Status: ambulance patients are delivered to hospitals on a rotational basis. This condition will not be instituted except for declared disasters.

3. Centralized E.D. Routing Status: Division makes ambulance destination decisions; this is reserved for Med-Alert operations.

4. Hospital Disaster Closure Status: a hospital is closed to ambulance traffic due to an internal or external facility hazard. Internal and External disasters are defined as:

a. Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual

occurrence which threatens the welfare, safety or health of patients, personnel or visitors being reported to the local health officer and to the California Department of Public Health, in accordance with California Code of Regulations, Title 22, Division 5, Chapter 1, Article 7, Section 70737. In other words, the event must be significant enough to warrant report to CDPH Licensing and Certification and the local Health Officer.

B. Hospitals have the ability to issue Temporary Hospital Service Advisories to ambulance providers regarding a hospital's capability for serving patients, (example – E.D. C-T Scanner down), through the Hospital E.D. Status Web Site. Temporary hospital service advisories are provided as information only. Advisories should not directly influence destination decisions, but the advisories should be considered in the decision process. Emergency departments shall update the Hospital E.D. Status Web Site when the advisory is no longer needed.

IV. AMBULANCE DESTINATION DECISION PROCEDURES

A. Entire Kern County Area:

1. Ambulance companies providing service within metropolitan Bakersfield shall continually monitor current hospital status information and shall be responsible to provide that status to ambulance personnel staffing basic life support (BLS) ambulances and advanced life support (ALS) ambulances.

2. Ambulance companies providing service outside of the metropolitan Bakersfield that are transporting patients into metropolitan Bakersfield shall determine the status of hospital emergency departments prior to transport or as soon as possible thereafter. Contact ECC or check the Kern County Hospital E.D. Status Web Site to determine hospital status.

3. BLS and ALS ambulance personnel shall initiate hospital emergency department communications as soon as possible.

B. Decision Process - Transport to a Metropolitan Bakersfield Hospital Emergency Department:

1. The ambulance attendant is authorized to make the final decision regarding the destination in accordance with these policies. The destination decision shall be based upon a) current Hospital Emergency Department Status, b) any Case Specific Hospital category applicable to the patient problem, c) patient or patient

physician choice, and d) the current Hospital Emergency Department Overload Score as follows:

a. Current Hospital Emergency Department Status: if an emergency department is on E.D. Disaster Closure Status, the patient shall not be transported to that destination.

b. Case Specific Hospital: patient shall be transported to a Case Specific Hospital if the ambulance attendant determines the patient will be best served by capabilities of that facility, as specified in Section IV.D.

c. Patient or Patient's Physician Preference: patient choice shall be factored into the destination decision. But, patient choice shall not prevail over E.D. Disaster Closure Status or Case Specific Hospital criteria.

d. E.D. Overload Score: the E.D. Overload Score shall be used in making destination decisions as follows:

i. An E.D. Overload Score of 10 indicates that the hospital emergency department is operating at its optimum maximum capacity (factoring in licensed beds, staffing levels, and patient acuity). Scores above 10 indicate overload; scores significantly above 10 indicate varying levels of extreme overload.

ii. A significant difference in an E.D. Overload Score is five points or more. If transport is requested to an open E.D. that has a higher score by five points or more compared to another open E.D. (appropriate for the patient problem), the patient or physician shall be advised. If the requesting party continues to request the E.D. after being informed, the patient shall be transported to the requested E.D.

iii. If no particular request is applicable, the patient should be transported to the hospital appropriate for the patient problem that has the lowest E.D. Overload Score.

2. The paramedic attendant on a Paramedic Ambulance shall have the final decision over destination in accordance with these policies and procedures, except when directed otherwise by Division staff.

3. ALS Ambulance patients that meet ALS extremis criteria shall be transported to the most appropriate hospital emergency department based on the patient problem, which is not on E.D. Disaster Closure Status.

4. ALS Extremis Criteria shall include any one of the following:

   a. Unmanageable airway or respiratory arrest;
   b. Uncontrolled hemorrhage with signs of hypovolemic shock; or
   c. Cardiopulmonary arrest.

5. BLS Ambulance patients that meet BLS extremis criteria shall be transported to the most appropriate hospital emergency department based on the patient problem, within Bakersfield, that is not on E.D. Disaster Closure Status.

6. BLS Extremis Criteria shall include any one of the following:

   a. Unconscious, unresponsive;
   b. Respiratory arrest;
   c. Unmanageable airway;
   d. Uncontrolled hemorrhage; or
   e. Cardiopulmonary arrest.

7. Obstetrical Cases - ALS transports that meet ALS Extremis Criteria; or BLS transports that meet BLS Extremis Criteria or have 2nd or 3rd trimester altered mental status, trauma with abdominal pain, respiratory distress, vaginal hemorrhage, history of pregnancy problems, or no pre-natal care shall be transported to Kern Medical, CHW-Bakersfield Memorial Hospital, CHW-Mercy Southwest Hospital, or San Joaquin Community Hospital.

8. ALS transports that meet ALS Extremis Criteria, and BLS transports that meet BLS Extremis Criteria, that meet Case Specific Hospital criteria for Orthopedic, Cardiac, Neonatal, Sexual Assault, Trauma, Psychiatric, Prisoners, or Stroke shall be transported to a Case Specific Hospital as listed in Section IV. D. 1.

9. ALS and BLS pediatric extremis cases shall be transported to the closest Hospital Emergency Department not on E.D. Disaster Closure Status.

10. For BLS Ambulance transports into the Bakersfield area, the EMT-1 attendant may decide to bypass any hospital emergency department within the Bakersfield area to transport to a Bakersfield hospital that can provide more appropriate patient care based on the patient

problem, in accordance with destination criteria specified in Section IV.D., if applicable.

11. All patients meeting Kern County Trauma Care System Adult Trauma Triage Criteria (ATTC) or Pediatric Trauma Triage Criteria (PTTC) for Trauma Care System activation shall be transported in accordance with Kern County Prehospital Trauma Care System Policies and Procedures. If the designated Trauma Center emergency department is on E.D. Disaster Closure Status, trauma patients shall be transported to the most appropriate emergency department based on factors of travel time and capability of a hospital to meet patient needs.

12. All patients meeting Kern County Stroke Center Policies Activation Protocol criteria shall be transported in accordance with Stroke Center Policies. If designated Stroke Center emergency departments are on E.D. Disaster Closure Status, stroke patients shall be transported to the most appropriate emergency department based on the factors of travel time and capability of a hospital to meet patient needs.

C. Decision Process - Transports Outside the Metropolitan Bakersfield Area:

1. An ALS ambulance outside the Bakersfield area, transporting a patient meeting ALS Extremis Criteria shall be transported to the closest hospital emergency department in travel time from the incident location.

2. Outside of the Bakersfield area, a BLS Ambulance is required to provide transport to the closest hospital emergency department in travel time from the incident location.

D. Prehospital Transport to the Bakersfield area – Case Specific Hospitals:

1. One of the destination decision factors listed in Section IV.B.1. is Case Specific Hospital. Some hospitals are staffed and equipped to address specific ailments more comprehensively than others. It is advantageous to match a patient's problem with a hospital's specialty capabilities, when possible.

a. Orthopedic: Patients with orthopedic injuries or problems shall be transported to one of the following hospital emergency departments:

i. Mercy Hospital,
ii. Kern Medical,

iii. Bakersfield Memorial Hospital,
iv. San Joaquin Community Hospital, or
v. Mercy Southwest Hospital.

b. Cardiac: Patients presenting with symptoms of unstable angina pectoris or acute myocardial infarction shall be transported to one of the following hospital emergency departments:

i. Bakersfield Memorial Hospital,
ii. San Joaquin Community Hospital, or
iii. Bakersfield Heart Hospital.

c. Neonatal: Neonatal patients (less than 1 month of age or under 5 kilograms body weight) shall be transported to one of the following hospital emergency departments:

i. Bakersfield Memorial Hospital,
ii. Kern Medical,
iii. Mercy Southwest Hospital, or
iv. San Joaquin Community Hospital.

d. Obstetrical: Obstetrical patients shall be transported to one of the following hospital emergency departments:

i. Kern Medical,
ii. Bakersfield Memorial Hospital,
iii. Mercy Southwest Hospital, or
iv. San Joaquin Community Hospital.

e. Sexual Assault: Sexual assault patients shall be transported to the following hospital emergency department:

i. San Joaquin Community Hospital

f. Psychiatric Hold: Patients that have a psychiatric hold placed into effect by law enforcement that do not have an apparent emergency medical condition shall be transported to the following emergency department:

i. Kern Medical

g. Trauma: Patients that meet Kern County EMS Division Adult Trauma Triage Criteria or Pediatric Trauma Triage Criteria for Trauma Care System activation shall be transported in

accordance with Kern County EMS Division – Prehospital Trauma Care System Policies and Procedures.

h. Local, State or federal prisoners: patients that are local, State or federal prisoners shall be transported to the contracted hospital emergency department.

i. Stroke: Patients that meet Kern County Stroke Center Policies Activation Protocol criteria shall be transported to one of the following hospital emergency departments, further defined in Stroke Center Policies:

i. San Joaquin Community Hospital,
ii. Bakersfield Memorial Hospital,
iii. Mercy Hospital,
iv. Mercy Southwest Hospital, or
v. Kern Medical.

j. STEMI: Patients that meet STEMI Alert criteria, as specified in the *Kern County STEMI System of Care Policy* shall be transported to one of the following hospital emergency departments:

i. San Joaquin Community Hospital,
ii. Bakersfield Memorial Hospital, or
iii. Bakersfield Heart Hospital.

It may be appropriate to transport a STEMI patient into one of the designated STEMI centers from outlying areas and bypass the closest hospital if the patient meets the STEMI Referral Center Bypass criteria, as specified in the *Kern County STEMI System of Care Policy*.

k. Pediatric: Patients that are fourteen (14) years and younger with an emergent medical complaint shall be transported to a Level I or Level II Pediatric Receiving Center (Ped RC) if ground transport time is thirty (30) minutes or less. Ground transport times that are greater than thirty (30) minutes may be transported to the closest, most appropriate receiving hospital. The use of air ambulance transport shall be in accordance with *EMS Aircraft-Dispatch-Response-Utilization Policies*. Emergent medical complaints are defined as:

- Cardiac dysrhythmia
- Evidence of poor perfusion
- Severe respiratory distress

- Cyanosis
- Persistent altered mental status
- Status Epilepticus
- Any apparent life threatening event in less than one (1) year of age

Appropriate transport destinations for pediatric patients suffering emergent conditions are:

i. Bakersfield Memorial Hospital, (Level II), or
ii. Kern Medical (Level II).

Non-emergent Medical Pediatric Criteria: Patients that are fourteen (14) years and younger with a medical complaint who do not meet trauma, medical extremis or emergent medical criteria shall have the option of transport to the above listed hospitals as well as:

i. San Joaquin Community Hospital, (Level III)

2. If the specified hospital emergency department is on Hospital Disaster Closure Status, the ambulance shall provide transport to another appropriate emergency department based on the process specified in Section IV. B.

3. In a prehospital setting, in the Greater Bakersfield area, where a physician requests ambulance transport of an emergency patient to a specialty care center or tertiary care facility outside Kern County (e.g. amputation reimplantation), the patient should be transported to the nearest appropriate hospital emergency department in accordance with this policy. An exception may be granted to allow direct out-of-county prehospital transports to a specialty care center or tertiary care facility, in consultation with on-call EMS staff, on a case-by-case basis. Factors that will be considered in this decision are: the physician's arrangements for patient receipt at the destination facility, patient condition as assessed by the attending physician, and patient safety during travel as assessed by the attending Paramedic or EMT-1.

4. Upon activation of Centralized E.D. Routing Status, EMS Division will specify ambulance destinations, in accordance with Section VII.

V. E.D. OPEN STATUS

A. E.D. Open Status: the hospital emergency department is open and able to provide care for ambulance patients. Hospital emergency department staff or EMS Department staff activates E.D. Open Status. Open status is denoted on the Kern County Hospital E.D. Status Web Site. Open status becomes effective when shown on the web site. If the web site is not functioning or temporarily inaccessible, the status change is effective when ambulance providers receive notification from the EMS Division.

B. Ambulance services shall provide current hospital emergency department status updates to ambulance personnel upon confirmation that patient transport is to be provided.

VI. E.D. ROTATION STATUS

A. E.D. Rotation Status will only be implemented secondary to a declared disaster when medical resources are limited. The Division may activate E.D. Rotation Status for defined times and may deactivate when appropriate. Provisions for extremis patients and Case Specific Hospitals will be applied during E.D. Rotation Status.

B. The following standard E.D. Rotation Status sequence will be used:

1. San Joaquin Community Hospital
2. Mercy Hospital
3. Bakersfield Memorial Hospital
4. Kern Medical
5. Bakersfield Heart Hospital
6. Mercy Southwest Hospital

C. Division staff may deactivate E.D. Rotation Status when no longer indicated.

VII. *MULTI-CASUALTY AND MED-ALERT STATUS OPERATIONS*

A. The proper management of a large number of medical casualties following a natural or human induced event is imperative if morbidity and mortality are to be minimized. The recognition of the type and number of injured, and a rapid dissemination of known information are necessary elements to begin an effective response to a medical disaster.

B. Responsibility lies with responders to accurately report incident information and casualty data. Coordinators of EMS resources must have reliable situation awareness data. It is important for decision-makers to know the EMS system's capabilities at any given time during a medical incident response and recovery phase. Together, incident information and resource

knowledge can be combined to implement an appropriate medical response. ReddiNet, an Internet-based software application, shall be used to communicate casualty information for multi-casualty and Med-Alert incidents.

C. The number of patients and type of incident will govern the EMS system's medical response.

1. A MED-ALERT is an event with any of the following circumstances:

a. An incident with 5 or more patients/victims; or

b. Any incident involving exposure to hazardous materials, regardless of the number of victims; or

c. A serious and unusual overload of the EMS system, as determined by the Division, which is not necessarily related to a specific incident, and the use of centralized routing to manage ambulance destinations is necessary.

D. The procedure and sequence of events for using ReddiNet to communicate information about a MED-ALERT shall be as follows:

1. The first arriving unit, whether it be fire or ambulance shall declare a MED-ALERT upon determining that the criteria established in Section C, 1.a. or 1.b. above, have been met and notify their respective dispatch centers.

2. Once an ambulance dispatch center has been notified that a MED-ALERT has been declared, the dispatch center will initiate an MCI event in ReddiNet. Using the MCI tab in ReddiNet, ambulance dispatch center will:

a. Send general notification to all hospitals in the area,

b. Conduct a hospital poll to determine bed availability in the EMS system, and

c. Provide hospitals with any other pertinent information regarding the event.

3. Upon notification from an ambulance dispatch center that a MED-ALERT has been initiated, hospital staff will accomplish the following:

a. Begin to prepare for possible incoming patients.

b. Hospitals will receive a polling inquiry from the ambulance company through ReddiNet.

c. Hospitals must respond immediately to the poll inquiry, and provide the number of patients that can be reasonably accepted, by acuity level. This information assists the ambulance crews in making destination decisions.

4. Please note that hospitals may receive fewer or more patients than those listed in the response to the poll. Actual transport numbers to any hospital will be dependent upon the size of the incident and other factors. A hospital emergency department shall not refuse to accept an ambulance patient routed through the MED-ALERT process. During a Med-Alert, E.D. Closure Status shall not be applicable.

5. Ambulance dispatch center will forward bed availability information received from each hospital to the on-scene paramedic supervisor or lead paramedic, (or transportation coordinator if one has been assigned).

6. On-scene paramedic supervisor or lead paramedic, (or transportation coordinator if one has been assigned) will receive hospital availability information from their dispatch center. The on-scene paramedic supervisor or lead paramedic, (or transportation coordinator if one has been assigned) shall make the destination decision for each ambulance.

   a. Destination decisions shall be made in accordance with Section IV of this policy.

   b. It may be necessary to distribute traumatic injuries to a hospital other than the trauma center because the incident exceeds the trauma center capacity.

   c. Effort needs to be made to evenly disperse patients among closest appropriate hospitals as to avoid overloading one particular facility.

   d. To the extent possible, avoid transporting minor children to a hospital separate from the destination of both parents; parental consent may be needed by the hospital for care of the minor children later.

   e. The incident commander (IC) shall be informed of destinations decisions and ambulance assignments.

7. Ambulances shall transport patients in accordance with their destination instructions/assignment.

8. Each ambulance crew will notify their dispatch center when they begin transport and leave the scene. Notification will include:

   a. Unit identification;

   b. Number of patients, by acuity level; and

   c. Hospital destination/assignment.

9. Dispatch center will, upon receiving patient and hospital destination information from each ambulance crew, enter the information into ReddiNet. Dispatch will enter the "Send Patients" link and complete the "Destination", "Ambulance" and "Patients in this rig" sections.

10. As ambulances arrive at the assigned destination, hospital staff will update ReddiNet and reflect that the specific ambulance unit has arrived using the "Arrived" column within the "Ambulances" tab.

11. Once patients are registered in the emergency department, hospital staff will enter patient information into the "Patients" tab section of ReddiNet. Hospitals must enter the patient information as soon as possible into the ReddiNet system. In no case should this step be delayed greater than two hours from receiving the patient.

12. On-scene paramedic supervisor or lead paramedic, (or transportation coordinator if one has been assigned) will notify the ambulance dispatch center when all patients have been transported from the scene. He/she shall declare the on-scene phase of the MED-ALERT "Ended".

13. Upon notification from the on-scene paramedic supervisor or lead paramedic that all patients have been transported from the scene, the dispatch center will "END" the MED-ALERT in ReddiNet. Please note that "END" is different than "CLOSE". An incident should not be closed in ReddiNet until 2 to 3 days later.

14. After 48 to 72 hours following the MCI the initiating ambulance company dispatch center will "CLOSE" the MED-ALERT in ReddiNet.

E. All hospital emergency departments and ambulance dispatch centers will be continually logged into the ReddiNet system, and the computer shall be

configured to alert staff of incoming messages or activation of a MED-ALERT.

F. In the case of centralized routing by the EMS Division, all ambulance services shall comply with EMS Division destination orders.

1. When Centralized E.D. Routing Status is activated, each ambulance shall contact EMS Division when prepared for patient transport and provide the following:

a. Unit identification and location;

b. Patient age, sex, and paramedic impression;

c. Any patient request for a specific hospital, and if applicable the paramedic's recommendation.

2. EMS Division will route the ambulance to a specific emergency department based on the information provided and current system status. The process will be maintained until deactivated by EMS Division. The destination decision process used by EMS Division will follow the parameters of Section IV of this policy.

VIII. ***HOSPITAL DISASTER CLOSURE STATUS***

A. Hospital Disaster Closure Status may be authorized for a facility hazard constituting and internal or external disaster that threatens the health or safety of patients. Internal and external disasters are defined as:

1. Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel or visitors being reported to the local health officer and to the California Department of Public Health, in accordance with California Code of Regulations, Title 22, Division 5, Chapter 1, Article 7, Section 70737. In other words, the event must be significant enough to warrant report to CDPH Licensing and Certification and the local Health Officer.

B. Hospital Disaster Closure Status applies to the entire hospital facility, and no ambulance patient transports are to be received to any area of the hospital. Hospital Disaster Closure Status must be authorized by EMS Division. E.D. Disaster Closure Status is only authorized and valid if approved by EMS Division. The Division may deactivate Hospital Disaster Closure Status when appropriate.

IX. ***TRAINING AND MAINTENANCE***

A. All existing and new ambulance service EMT-1 personnel, paramedics, ambulance service dispatchers, and hospital emergency department nurses and physicians shall receive training consisting of policies review and practical exercises regarding ambulance destination decisions and hospital emergency department status.

B. The Division may specify on-going training requirements in hospital E.D. status for ambulance service or hospital emergency department personnel as needed.

X. ***DOCUMENTATION, DATA & MEDICAL CONTROL***

A. The Division shall maintain records of hospital emergency department status.

B. Hospital shall maintain records of emergency department status and define conditions that cause any status change. Records shall be available for Division review, upon request.

C. A valid copy of internal emergency department status policies, procedures, and protocols shall be submitted to the Division by each participating hospital.

D. The Division should be immediately contacted regarding any incident or issue regarding ambulance patient transportation that indicates any threat or risk to public health and safety. A written complaint and related records must be submitted to the Division for investigation of any incident or issue related to this policy.

E. The Division may contact the California EMS Authority and/or California Department Health Services to provide information regarding Hospital Emergency Department status in Kern County as appropriate.

F. The Division is available on a continuous basis through the EMS On-call Duty Officer.

G. EMS On-Call Duty Officer should only be contacted through the use of the E.D. Status Web Site using the “Contact EMS On-Call Staff” button. ECC is only to be contacted when access to the E.D. Status Web Site has been interrupted or during an emergency. ECC is not the regular contact for day-to-day issues.

H. The EMS On-call Duty Officer should be contacted after regular business hours only when immediate action is necessary. Routine inquiries,

questions about policies, complaints, and other matters not requiring immediate action shall only be brought to our attention during the EMS Division's regular business hours.

I. Hospital emergency departments shall enter E.D. status data timely and accurately into the Kern County Hospital E.D. Status Web Site.

G:_Active Policies\Pending-In Devleopment\Amb Hosp ED Policy 32 4-01-2013.doc

Revision Log:

07/01/1991 – Implemented
12/01/1994 – Revised
05/28/1999 – Revision Draft
06/25/1999 – Revision Draft #3 – Restructured
07/21/1999 – Revision Draft #4
08/05/1999 – Revision Draft #5
09/15/1999 – Final Revision #6 & Implemented
11/01/1999 – Revised (SJH Pediatric deleted & Neuro added – Case Specific Hospitals)
12/16/1999 – Revised (Orthopedic added as category for Case Specific Hospitals – BHH excluded)
07/20/2000 – Revised (Pediatric Extremis to Closest E.D., Spinal Cord Injury added under Case Specific for Neurosurgical, Previous E.D. Closure Addendum added, E.D. Rotation Revised)
11/01/2000 – Revised (SJH removed from Case Specific for Obstetrical until they have an NICU at request from SJH Administration)
04/25/2001 – Revised ED Saturation Criteria to ED Overload Scale & ED Web Site Functional Changes
05/04/2001 – Revised ED Saturation Criteria
08/31/2001 – Revised ED Closure & pre-arranged Transfers, revised Case Specific due to CHW-Mercy Changes
11/01/2002 – Eliminated ED Saturation post-trial study, eliminated Neurosurgical Case Specific, refined ED Overload Scale to be provided to the field, ED Rotation Refined.
01/20/2003 – BHH ED Reopened
01/25/2003 – Revised ED Closure, removing BHH wording, adding Cardiac Only Status
10/11/2004 – Clarified procedure for prehospital out-of-county transport
01/19/2005 – Mercy SW ED Opening/clarify policy verbiage, and reformat
05/01/2005 – Removed pediatric case specific from policy due to no pediatric call coverage at BMH
02/13/2006 – Added SJH to Orthopedic Case Specific
04/17/2007 – Added Ambulance Patient Off-Load Protocol and Time Standard (Appendix 4)
07/26/2007 – Refined Red, Yellow and Green Categories to match ESI Triage Algorithm
11/01/2008 – Added “Stroke Case Specific” to policies and “Stroke Only” status consistent with Stroke Center Policies to be effective November 1, 2008
11/01/2008 – Added SJH to Stroke Case Specific in Policies after application approval on September 24, 2008, effective 11/01/2008.
11/01/2008 – Added BMH to Stroke Case Specific in Policies after application approval on October 7, 2008, effective 11/01/2008.
03/01/2010 – Added SJH to OB Case Specific and Neonatal Case Specific based upon NICU and SJH request.
04/01/2010 – Added MSW to Orthopedic Case Specific based upon request from MSW.
08/15/2011 – Added Mercy and MSW to Stroke Case Specific based upon request from Mercy Hospitals.
12/12/2011 – Added Decision Summary protocol as Appendix 5 (as of 3/6/12 it is appendix 6)
03/01/2012 – Added MCI/MED-ALERT procedures into section VII and changed centralized routing procedures; to become effective this date.
03/06/2012 –Appendix 4 revised to change time limit from 20 to 15 minutes; Appendix 5 added to establish criteria for offloading patients to the ED waiting room
02/08/2013 – Draft changes: Changed definition of ED Closure Status to only apply to internal or external disasters reportable to CDPH L&C; changed “EMS Department” to “Division”
02/14/2013 – EMCAB approved proposed changes; endorsed elimination of Closure Status

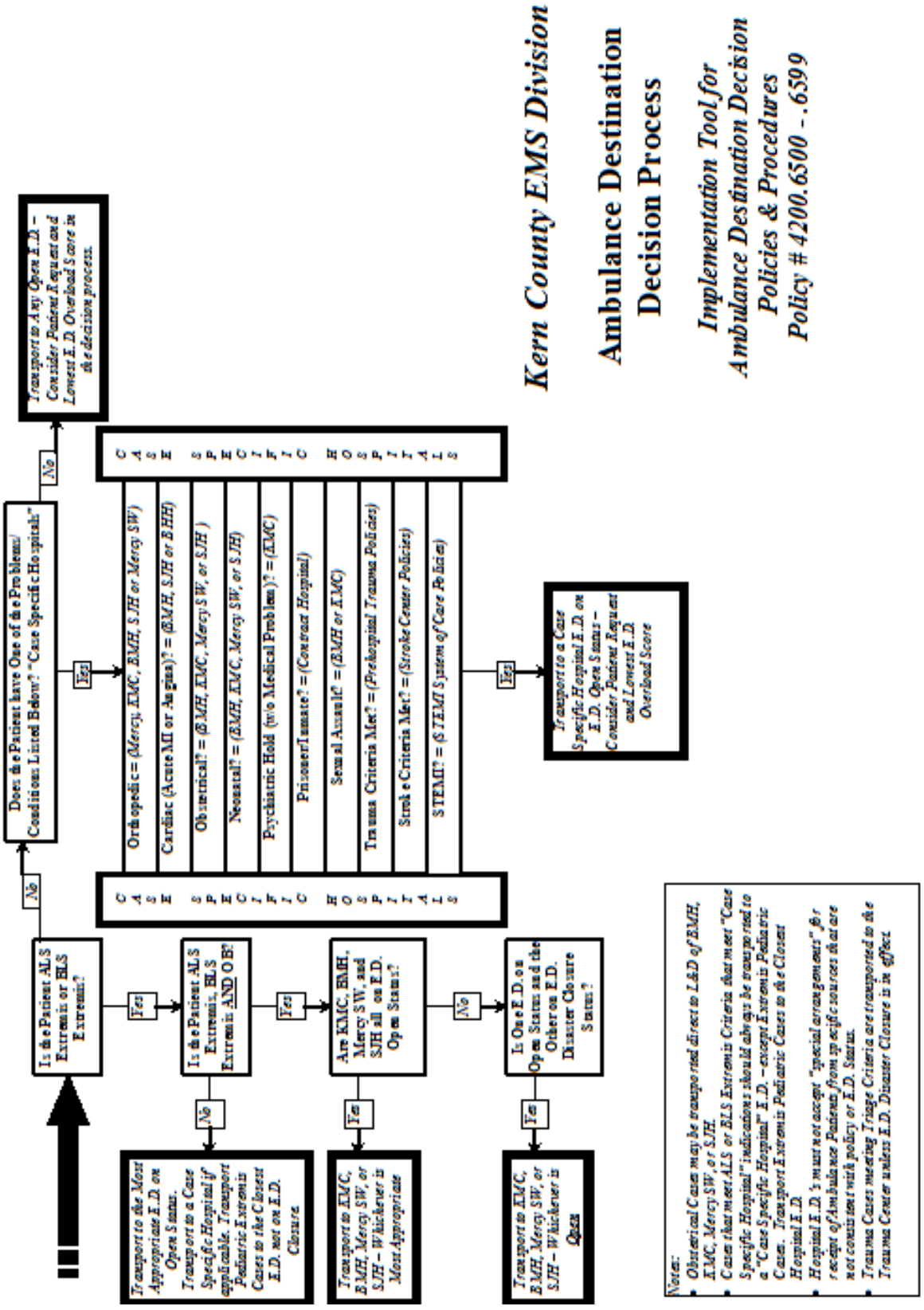
03/05/2013 – BOS approved proposed changes; approved elimination of Closure Status
04/01/2013 – Effective date of BOS-approved changes
06/03/2013 – Added Bakersfield Heart Hospital to Stroke Case Specific based upon request from BHH

06/18/2013 – Addition of STEMI designation as case-specific condition, and added Bakersfield Heart, San Joaquin Community and Bakersfield Memorial hospitals as STEMI Receiving Centers, per BOS approval of contracts

05/14/2014- Added San Joaquin Community Hospital as sexual assault destination. Removed Memorial Hospital and Kern Medical Center as sexual assault destinations.

04/26/2016- Added Kern Medical as Primary Stroke Center. Revised Kern Medical Center to Kern Medical. Added specialty designation of Pediatric Receiving Centers to be consistent with Paramedic Protocols and Pediatric Receiving Center Designation Policies and Procedures. Add Kern Medical, San Joaquin Community, and Bakersfield Memorial hospitals as Pediatric Receiving Centers, per BOS approval of contracts.

10/6/2016- Removed Bakersfield Heart Hospital as a Stroke Case Specific hospital due to lapse in certification as a Primary Stroke Center.


Kern County EMS Division
Ambulance Destination Decision Process
Implementation Tool for Ambulance Destination Decision Policies & Procedures Policy # 4200.6500 - .6599
Amb Hosp ED Model 31 01-30-20
Is the Patient ALS Extremis or BLS Extremis?
Is the Patient ALS Extremis, BLS Extremis AND OB?
Are KMC, BMH, Mercy SW, and SJH all on E.D. Open Status?
Is One E.D. on Open Status and the Other on E.D. Disaster Closure Status?
Yes
No
Does the Patient have One of the Problems/ Conditions Listed Below? "Case Specific Hospitals"
Yes
No
CASE SPECIFIC HOSPITALS
Orthopedic = (Mercy, KMC, BMH, SJH or Mercy SW)
Cardiac (Acute MI or Angina)? = (BMH, SJH or BHH)
Obstetrical? = (BMH, KMC, Mercy SW, or SJH)
Neonatal? = (BMH, KMC, Mercy SW, or SJH)
Psychiatric Hold (w/o Medical Problem)? = (KMC)
Prisoner/Inmate? = (Contract Hospital)
Sexual Assault? = (BMH or KMC)
Trauma Criteria Met? = (Prehospital Trauma Policies)
Stroke Criteria Met? = (Stroke Center Policies)
STEMI? = (STEMI System of Care Policies)
CASE SPECIFIC HOSPITALS
Yes
Transport to a Case Specific Hospital E.D. on E.D. Open Status – Consider Patient Request and Lowest E.D. Overload Score
Transport to Any Open E.D. – Consider Patient Request and Lowest E.D. Overload Score in the decision process.
Transport to the Most Appropriate E.D. on Open Status. Transport to a Case Specific Hospital if applicable. Transport Pediatric Extremis Cases to the Closest E.D. not on E.D. Closure.
Transport to KMC, BMH, Mercy SW, or SJH – Whichever is Most Appropriate
Transport to KMC, BMH, Mercy SW, or SJH – Whichever is Open
Notes:
Obstetrical Cases may be transported direct to L&D of BMH, KMC, Mercy SW, or SJH.
Cases that meet ALS or BLS Extremis Criteria that meet "Case Specific Hospital" indications should always be transported to a "Case Specific Hospital" E.D. – except Extremis Pediatric Cases. Transport Extremis Pediatric Cases to the Closest Hospital E.D.
Hospital E.D.'s must not accept "special arrangements" for receipt of Ambulance Patients from specific sources that are not consistent with policy or E.D. Status.
Trauma Cases meeting Triage Criteria are transported to the Trauma Center unless E.D. Disaster Closure is in effect.

Current Bed Capacity based on staffing: The number of beds (including chairs, cots, gurneys, hallway beds, etc.) the hospital can manage based on the number of licensed nurses available during the current shift. For example, based on a nurse to patient ratio of 1:4; if three nurses are available during the shift the current bed capacity is 12. Typically, the charge nurse and the triage nurse are not counted in calculating current bed capacity of the emergency department.

	Nurse Ratio	Percent Change	Relative Value (Multiplier)
Med-Surg Holds	0.33	24.2%	1.32
ICU/CCU holds (1:1)	1	75.0%	4
ICU/CCU holds (1:2)	0.5	50.0%	2
ESI Triage Level 1	2	87.5%	8
ESI Triage Level 2	1	75.0%	4
ESI Triage Level 3	0.25	0.0%	1
ESI Triage Level 4	0.25	0.0%	1
ESI Triage Level 5	0.25	0.0%	1

Equalization Scale - Overload Score based on Patient Volume and Staffed Bed Capacity

	Bed Capacity, based on staffing											
	1	2	3	4	5	6	7	8	9	10	11	12
Patient Volume	Multiplier 10	Multiplier 5	Multiplier 3.2	Multiplier 2.5	Multiplier 2	Multiplier 1.7	Multiplier 1.4	Multiplier 1.2	Multiplier 1.1	Multiplier 1	Multiplier 0.9	Multiplier 0.8
0	0	0	0	0	0	0	0	0	0	0	0	0
1	10	5	3	3	2	2	1	1	1	1	1	1
2	20	10	6	5	4	3	3	2	2	2	2	2
3	30	15	10	8	6	5	4	4	3	3	3	2
4	40	20	13	10	8	7	6	5	4	4	4	3
5	50	25	16	13	10	9	7	6	6	5	5	4
6	60	30	19	15	12	10	8	7	7	6	5	5
7	70	35	22	18	14	12	10	8	8	7	6	6
8	80	40	26	20	16	14	11	10	9	8	7	6
9	90	45	29	23	18	15	13	11	10	9	8	7
10	100	50	32	25	20	17	14	12	11	10	9	8
11	110	55	35	28	22	19	15	13	12	11	10	9
12	120	60	38	30	24	20	17	14	13	12	11	10
13	130	65	42	33	26	22	18	16	14	13	12	10
14	140	70	45	35	28	24	20	17	15	14	13	11
15	150	75	48	38	30	26	21	18	17	15	14	12
16	160	80	51	40	32	27	22	19	18	16	14	13
17	170	85	54	43	34	29	24	20	19	17	15	14
18	180	90	58	45	36	31	25	22	20	18	16	14
19	190	95	61	48	38	32	27	23	21	19	17	15
20	200	100	64	50	40	34	28	24	22	20	18	16
21	210	105	67	53	42	36	29	25	23	21	19	17
22	220	110	70	55	44	37	31	26	24	22	20	18
23	230	115	74	58	46	39	32	28	25	23	21	18
24	240	120	77	60	48	41	34	29	26	24	22	19
25	250	125	80	63	50	43	35	30	28	25	23	20

Appendix 3- E.D. Website Procedures

I. Overview

A. The objective of the Kern County Hospital E.D. Status Web Site is to provide for more efficient Hospital E.D. Status related communications, improve reaction time in management of E.D. Closure requests, and to provide users with a systemic E.D. Overload status view.

B. The Division may change, modify, revise or delete these procedures at any time.

C. The Division may change, modify, revise or remove the Kern County Hospital E.D. Status Web Site at any time.

II. Primary Use

A. The Kern County Hospital E.D. Status Web Site will be used as the primary means of Hospital E.D. Status communications for each Hospital E.D. Status change (Open, E.D. Closure, or E.D. Advisory) made on the Kern County Hospital E.D. Status Web Site.

B. Requests for E.D. Closure, Med-Alert or other issues requiring contact of On-Call EMS will be conducted through the E.D. Status Web Site. ECC will only be contacted if there is a disruption of service in the site or in response to an internal or external disaster. ECC can be reached at (661) 868-4055.

III. Kern County Hospital E.D. Status Web Site Functional Procedures

A. Each Hospital Emergency Department must have staff positions continuously assigned to enter changes and regular updates on the Kern County Hospital E.D. Status Web Site. Only Emergency Department staff should be allowed to enter E.D. Status changes or updates.

B. Passwords for Web Site access are permission controlled. A Hospital Emergency Department is only permitted to see and make changes to their Emergency Department's status information including: Hospital E.D. Status changes (Open, E.D. Advisories), detailed E.D. Overload scale data, evaluate change history or generate reports.

C. E.D. Staff shall enter regular updates based on the time intervals or an "Emergency Update Alert" issued by On-Call EMS Staff. E.D. Staff are held responsible for accuracy of the data and timeliness of the information. On-Call EMS Staff may conduct on-site verification of the data at any time.

D. E.D. Status Update Requests are timed for update entry. During normal periods, the update time will be set for 120 minutes. On-Call EMS Staff

may adjust update timing to shorter time frames during peak overload periods. On-Call EMS Staff may issue an Emergency Update Alert. An Emergency Update Alert is a prompt for rapid entry of update data to manage an E.D. Closure request or to manage a large scale Med-Alert incident. It is critical that Emergency Update Alerts are answered quickly. Update requests include entry of the following information:

1. Current Bed Capacity based on staffing: The number of beds (including chairs, cots, gurneys, hallway beds, etc.) the hospital can manage based on the number of licensed nurses available during the current shift. For example, based on a nurse to patient ratio of 1:4; if three nurses are available during the shift the current bed capacity is 12. Typically, the charge nurse and the triage nurse are not counted in calculating current bed capacity of the emergency department.

2. Med-Surg, Peds Tele Admit Holds:: Enter the total number of Medical/Surgical, Telemetry or Pediatric cases with admission orders, awaiting in-hospital admission within the Emergency Department. Do not include cases in this category that do not have specific admission orders by the E.D. or are potential admissions. Do not include cases within the E.D. Waiting Room that have private physician admission orders;

3. ICU/CCU/DOU Holds (1:1 ratio): Enter the total number of ICU, CCU or DOU cases with admission orders in which patient acuity is serious enough to warrant a nurse-to-patient ratio of 1:1 and is awaiting in-hospital admission within the Emergency Department. Do not include cases in this category that do not have specific admission orders by the E.D. or are potential admissions. Do not include cases within the E.D. Waiting Room that have private physician admission orders;

4. ICU/CCU/DOU Holds (1:2 ratio): Enter the total number of ICU, CCU, or DOU cases with admission orders in which patient acuity is serious enough to warrant a nurse-to-patient ratio of 1:2 and is awaiting in-hospital admission within the Emergency Department. Do not include cases in this category that do not have specific admission orders by the E.D. or are potential admissions. Do not include cases within the E.D. Waiting Room that have private physician admission orders;

5. Volume of Triaged Patients Pending Orders: Enter the total number of ESI Triage Level 1, 2, 3, 4, and 5 patients that have been triaged, but have not had orders issued. Do not include patients that have had orders issued by the E.D.

E. It is highly important that this data is accurate based on the time entered. Once the data is entered, input username and password, update the data and return to the main summary page.

F. Each change in E.D. status or E.D. overload score will result in an automated pager notification from the E.D. Status Web Site to field personnel to use in the transport destination decision process. Accuracy and timeliness of data updates by emergency department personnel are highly important.

G. E.D. Disaster Closure Requests: Requests for E.D. Disaster Closure will be conducted through the E.D. Status Web Site. ECC will only be contacted if there is a disruption of service in the site or in response to an internal or external disaster. ECC can be reached at (661) 868-4055. On-Call EMS Staff will verify that CDPH L&C has been notified. Upon verification, On-Call EMS Staff will grant E.D. Disaster Closure. E.D. Disaster Closure becomes effective when entered by EMS Staff and is shown on the E.D. Status Web Site.

H. Med-Alert Activation: EMS On-Call Staff may be contacted through ECC or through website notification.

IV. Troubleshooting

A. E.D. Status paging from ECC to EMS On-Call Staff will be maintained in place as a back-up to the Kern County Hospital E.D. Status Web Site for E.D. Open, E.D. Closure, or advisories if needed. If a Hospital E.D. loses access to the Web Site and cannot access after repeated attempts, contact ECC immediately for contact of On-Call EMS Staff. On-Call EMS Staff will go through a series of questions to validate the level of the problem.

B. If an E.D. cannot access the site and the problem cannot be corrected immediately, EMS Staff may direct the E.D. to call basic E.D. status changes (Open Status, E.D. Advisories) through ECC until the problem is corrected. On-Call EMS Staff will call regularly to update E.D. Status data. On-Call EMS Staff will make Kern County Hospital E.D. Status Web Site entries of the changes if accessible.

C. If a Hospital E.D. staff username or password is lost or forgotten, contact the EMS Division during normal business hours.

V. Data

A. Data and information on individual Hospital E.D. staffing, admission holds, ambulance volume received and total registered patients contained in the Kern County Hospital E.D. Status Web Site shall be maintained strictly confidential by the Division and all users of the Kern County Hospital E.D. Status Web Site.

B. Data and information on individual Hospital E.D. staffing, admission holds, ambulance volume received and total registered patients shall be considered the individual Hospital E.D.'s data and shall not be released to any person, organization or entity without the express written permission of the Division and the specific Hospital E.D.

C. The Department may change or modify permissions of any authorized user or delete access authorization of any user at any time.

D. Other data, information or reports contained, entered, or extracted from the Kern County Hospital E.D. Status Web Site that have been previously used by the Division as public information, records or reports shall be considered public information, records or reports by the Department.

Non-Disclosure Policies

Kern County Hospital Emergency Department Status Web Site

User Name:	**Provider Name:**
User ID:	
Password:	

The Kern County Emergency Medical Services Division ("Division") has developed an Internet based Hospital Emergency Department Status Web Site ("System") to which the User, as a staff person at the above named Hospital or Ambulance Company ("Provider"), is being given password secured access. The information maintained in the System is of a highly confidential nature, and therefore preserving the confidentiality of a User password is of the utmost importance in maintaining the confidentiality of the System. The following policies are applicable to User access, use and continued permission to use the System:

1. These policies are effective upon issuance and will continue at the discretion of the Division. These policies may be modified, revised or amended by the Division at any time. The Division shall control all username and password access to the System. The Division may, at any time, delete or block a username or password for access to the System.

2. The User password is a highly confidential piece of information and is paramount to maintaining the confidentiality of the System. User shall not give, transfer, distribute, relinquish or in any other way knowingly furnish their User password to another person and shall make every effort to preclude their User password from becoming known to another person.

3. Username and password shall be kept facility specific and the User agrees not to attempt to use the username and password at or for a Provider other than the one identified above.

4. User(s) shall only use a username and password when on duty for the Provider identified above.

5. User, if applicable, shall only enter accurate and current information into the System. The Division may validate such data or conduct an on-site check at any time to ensure accuracy.

6. Some of the information put into or contained within the System is of a confidential nature. User shall only disclose information put into or contained within the System to those Provider staff with a need-to-know and will not disclose any such information to a third party and shall protect the confidentiality of the System to the same extent as other confidential information maintained by Provider.

7. System hospital data, including staffing, admission holds, and potential admissions shall be maintained as confidential information by the Division. The Division will not publicly release such information unless approved by the specific provider. Hospital data and the accuracy of hospital data shall be the responsibility of the particular hospital.

8. Any suspected or actual violation in confidentiality, misuse of the System, misuse of System data or noncompliance with these policies will be grounds for deletion of username and password for access to the System. The Division may continue such action in accordance with provisions contained in California Health and Safety Code

Ambulance off-load delays at hospital emergency departments continues to be a critical and recurring problem. When a patient remains on the ambulance gurney within the emergency department, the ambulance is not available for additional responses, including emergency responses. This situation could negatively impact patient care, and it impacts response time performance, and the EMS system overall. The purpose of this protocol is to define the ambulance off-load process at hospital emergency departments and define maximum time limits pursuant to Health and Safety Code §1797.120 and 1797.225.

Definitions:

Ambulance arrival at the ED: the time the ambulance stops at the location outside the hospital ED where the patient is unloaded from the ambulance

Ambulance Patient Offload Time (APOT)- The time interval between the arrival of an ambulance patient at an ED and the time the patient is transferred to the ED gurney, bed, chair, or other acceptable location and the ED assumes responsibility for the care of the patient. This is defined by the following actions that must occur simultaneously:

1. The patient is removed from the ambulance gurney
2. Verbal report is given to appropriate ED Medical Personnel
3. The ED Medical Personnel sign the patient care report
4. Ambulance personnel time stamp the field “destination patient transfer of care”

Ambulance Patient Offload Time (APOT) Standard – the time interval standard established by the Division within which an ambulance patient that has arrived in an ED should be transferred to an emergency department gurney, bed, chair, or other acceptable location and the ED assumes the responsibility for the care of the patient. The Division has adopted the State recommended 20 minutes as the time standard.

Non-Standard Patient Offload Time- the APOT for a patient exceeds a period of twenty (20) minutes. This definition is synonymous with the definition of APOD.

APOT 1- an ambulance patient offload time process measure. This metric is a State defined continuous variable measured in minutes and seconds, aggregated and reported at the 90th percentile that will be displayed against the benchmark twenty (20) minutes or less. Aggregated values may be reported by County and facility. This metric may be reported by the Division publicly and to the State, as required.

APOT 2- an ambulance patient offload time process measure. This metric is a State defined metric that demonstrates the incidence of ambulance patient offload times that exceed the twenty (20) minute reporting benchmark reported in reference to sixty (60), one-hundred-twenty (120), and one-hundred-eighty (180) minute time intervals, expressed as a percentage of total emergency patient transports. Aggregated values may be reported by County and facility. This metric may be reported by the Division publicly and to the State, as required. There are four measurements for APOT 2:

1. Percentage of ED patient transfer occurring between twenty (20) and sixty (60) minutes
2. Percentage of ED patient transfer occurring between sixty-one (61) and one-hundred-twenty (120) minutes.
3. Percentage of ED patient transfer occurring between one-hundred-twenty-one (121) and one-hundred-eighty (180) minutes.
4. Percentage of ED patient transfer occurring over one-hundred-eighty-one (181) minutes.

Ambulance Patient Offload Delay (APOD)- The occurrence of a patient remaining on the ambulance gurney and/or the ED has not assumed responsibility for patient care beyond the twenty (20) minute standard.

Clock Start- The timestamp that captures when APOT begins. This is captured as the time the ambulance arrives at the destination/receiving hospital (NEMSIS 3.4 (eTimes.11)).

Clock Stop- The timestamp that captures when APOT ends. This is captured as the time of destination patient transfer of care (NEMSUS 3.4 (eTimes.12)).

Emergency Department (ED) Medical Personnel- An ED physician, mid-level practitioner, or Registered Nurse (RN).

Transfer of Patient Care- the transition of patient care responsibility from EMS personnel to the receiving hospital ED medical personnel.

Verbal Patient Report- The face to face verbal exchange of key patient information between EMS personnel and ED medical personnel provided that is presumed to indicate transfer of patient care.

Written Patient Report- The written electronic patient care report (ePCR) that is completed by EMS personnel. Requirements for ePCR are located in *Patient Care Report Policy*. Data for collection of APOT will be generated from ePCR data.

Time Standard:

A patient arriving by ambulance to a hospital emergency department shall be offloaded from the ambulance gurney and hospital staff shall assume patient care responsibility immediately upon entry into the ED. In no case shall this process exceed ~~fifteen~~ twenty (20) minutes from ED entry. Initial triage of patient by hospital personnel shall occur within one (1) to five (5) minutes from entry into ED. In such cases where ~~15~~ twenty (20) minutes has elapsed from ED entry and ambulance crew has not been released, ambulance supervisor should make contact, at their discretion, with the designated hospital manager to advise of the delay and request immediate action to release the crew.

Protocol:

1. Emergency Department Entry: Immediately upon ambulance crew entry to the emergency department, ~~ED staff will receive a verbal report from ambulance staff on the patient problem.~~ambulance crew shall notify ED medical personnel of their arrival.

2. Initial Triage Determination: ED ~~staff~~ medical personnel shall immediately (one to five minutes) determine if the patient can safely be referred to the ED waiting room. If not, ED staff will immediately determine if an open ED gurney is available and direct ambulance staff to the open gurney. ~~Ambulance staff shall provide hospital with written patient care record upon transfer of care~~The responsibility for patient care shall be transferred from EMS personnel to ED medical personnel as defined by the APOT process above.

3. Internal Actions to Accommodate Patient: 1) Triage of other ED patients to determine if space can be cleared for the ambulance patient; 2) Mobilize additional ED gurneys from other areas of the hospital; 3) Mobilize Temps Beds into the ED to off-load the ambulance patient; and 4) any other actions consistent with hospital's internal procedures to accommodate patient placement.

4. Administrative Contact: If the ambulance crew has not been released from the emergency department within ~~15~~ twenty (20) minutes of entry, the ambulance supervisor should contact the designated hospital manager and advise of the problem. Contact should be made initially with the manager of the emergency department, if during regular working hours. If after hours, contact should be made with the House Supervisor and/or the on-call hospital administrator.

Quality Assurance:

The Division will convene quality assurance committees on a quarterly basis for follow-up on non-standard patient offload times. The Division may further define quality assurance review in the *EMS Quality Improvement Program*. The Division may address sentinel events, which may include, but not limited to:

1. Occurrence of "never event": transfer of care greater than four (4) hours
2. Occurrence of individual APOD associated with APOT 2 metrics
3. Occurrence of APOD with the patient decompensating or worsening in condition
4. Occurrence of APOD associated with patient complaints
5. Occurrence of APOD associated with delayed ambulance response(s)
6. Facility or system performance below the established standard of twenty (20) minutes or less at the 90th percentile.

Appendix 5 Criteria for Offloading Patients to ED Waiting Room

When a patient is transported to a hospital by ambulance, the ambulance crew is responsible for that patient until arriving onto the hospital grounds, in accordance with 42. CFR 482.55, the Conditions of Participation for Hospitals for Emergency Services and the Emergency Medical Treatment and Labor Act (EMTALA). However, it is recognized that in practice it may take some time to physically transfer a patient from an ambulance to the care of hospital personnel. This policy establishes a target/goal that such delay in transfer of care shall not exceed ~~15~~ twenty (20) minutes. In situations where transfer of care exceeds ~~15~~ twenty (20) minutes, the following guidance for offloading a patient to the hospital emergency department waiting room is provided.

A. Ambulance personnel shall use the emergency department ambulance entrance for prehospital patients.

B. Ambulance personnel shall maintain care and treatment of the patient for a period of ~~15~~ twenty (20) minutes upon arriving to the emergency department ambulance entrance, unless earlier relieved by ~~hospital staff~~ ED medical personnel. Once ~~15~~ twenty (20) minutes has elapsed and no bed assignment or other placement directives have been given, the patient who meets the following criteria can be taken directly to the emergency department waiting room, after consulting with the ~~hospital personnel~~ED medical personnel responsible for triaging:

    1. At least 18 years old or minors accompanied by a responsible adult;
    2. Normal, age-appropriate blood pressure (± 10 points of mm/hg);
    3. Alert and oriented to person, place, time, and event;
    4. A Glasgow Coma Scale score of 15;
    5. Skin that is pink, warm, and dry;
    6. Can sit unassisted and has reasonable mobility (example: patient is not in spinal precautions);
    7. Does not require continuous monitoring (example: cardiac monitoring or breathing treatment);
    8. Is not on a psychiatric hold or in custody; and
    9. Patient does not have IV access started by EMS personnel.

C. Ambulance personnel must give a verbal report to the authorized ~~hospital personnel~~ED medical personnel, and ~~hospital personnel~~ ED medical personnel must ~~take possession~~ take over responsibility for the care of the patient. ~~The ambulance personnel must obtain a signature for transfer of patient care.~~ The transfer of responsibility for the care of the patient is defined in ambulance patient offload time

DRAFT

in Appendix 4 of this policy. If there is a difference of opinion as to the appropriate waiting area, or location of the patient, the emergency department manager or designee (charge nurse) will make the final decision.

D. At no time, will a critical patient- Severity Red and complex severity Yellow (such as chest pain or shortness of breath requiring frequent reevaluation and ongoing therapy), be left without paramedic or ~~hospital nurse~~ED medical personnel supervision.

X. New Business

B. Patient Care Record Policies and Procedures

EMS Division Staff Report for EMCAB- February 9, 2017

Patient Care Record Policies and Procedures

Background

On January 5, 2016 the California Emergency Medical Services Authority (EMSA) implemented statutes & regulations related to patient care data collection for emergency medical services throughout the state. AB 1129, became effective January 1, 2016, and requires, among other provisions, that each emergency medical care provider use an electronic health record; and the electronic record must be compliant with the current version of the National Emergency Medical Services Information System (NEMSIS) and the California Emergency Medical Services Information System (CEMSIS.) The deadline for implementation of AB 1129 was January 1, 2017.

The Dilemma

As January 1, 2017, Kern County EMS' Electronic Patient Care Report (ePCR) Policy became out dated. The ePCR policy provides direction for the collection, completion, and submission of data as well as identifies the specified elements mandated by the County of Kern, State of California, and Federal Government.

The EMS Division Plan of Action

The Kern County ePCR policy was revised to better align with the new mandate. The revised policy was opened for public comment on November 4, 2016, and closed on December 4th, 2016, with no comments being submitted. The proposed revisions were also discussed at two EMS system collaborative meetings.

Therefore, IT IS RECOMMENDED, the Board approves the revised ePCR Policy and set an effective date of February 10th, 2017.

County of Kern

Emergency Medical Services

PATIENT CARE RECORD POLICIES AND PROCEDURES

~~August 8, 2013~~DRAFT

~~Ross Elliott~~
~~Director~~

~~Robert Barnes, M.D.~~
~~Medical Director~~

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~~*REVISION & ACTION LISTING:*~~

~~02/13/95 Complete Draft for Limited Trial Project~~
~~02/27/95 Draft revised for Full Scope Trial Project (to remain as authorized use draft until trial completed)~~
~~03/17/95 Revision - Consistent with Project Progression for Reference~~
~~07/15/95 Revision - Consistent with feedback to date, for full implementation.~~
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~~10/18/95 Revision - Consistent with revised forms for full implementation.~~
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~~05/29/2012 Minor changes/edits per final staff review~~
~~06/01/2012 Effective date for revisions made in May 2012~~
~~10/10/2012 Defined "Preliminary Record"~~
~~08/02/2013 Updated Ambulance Report Form in Appendix Three~~

I. ~~Section 1 -~~ GENERAL PROVISIONS

A. This policy defines all requirements regarding electronic data collection (Electronic Patient Care Report) and their uses, completion, referral, retention and reporting within Kern County.

B. The patient care report (PCR) and mandatory electronic data elements (e-PCR), are established and maintained under the authority of the Emergency Medical Services Division (Division) in accordance with California Health and Safety Code, Division 2.5, Sections 1797.204 and 1797.227 and California Code of Regulations Title 22, section 100171(f).

C. The mandatory data elements, ~~,~~ and electronic records are official medical records and upon submission are the property of the Division. The ~~-~~mandatory electronic data elements shall be retained and maintained by the care provider's employer as the legal custodian of the medical record. Electronic Patient Care Records are confidential medical records and are limited to the possession of the Division, authorized EMS providers involved with response to the patient location or direct patient care, and authorized medical facilities that receive the patient if transported.

~~D.~~ The Division recognizes the current version of the National Highway Traffic Safety Administration (NHTSA) Uniform Pre-Hospital Emergency Medical Services Dataset, National Emergency Medical Services Information System (NEMSIS) for the collection and aggregation of all electronic data in the local EMS system. All references herein to "Mandatory Elements", "Data Elements", "Elements" or "Data" are taken directly from the NEMSIS Dataset and can be located and referenced in the NEMSIS Data Dictionary located at:

~~E.~~D. ~~-~~http://www.nemsis.org/media/nemsis_v3/release-3.4.0/DataDictionary/PDFHTML/DEMEMS/index.html

~~F.~~E. The electronic patient care report may be provided to other sources only in accordance with applicable state and/or federal laws; or may be provided to the patient or patient responsible party by valid written authorization.

~~G.~~F. The electronic patient care report shall be accurately completed in accordance with these policies and procedures. Willful falsification of a patient care record or failure to comply with these policies and procedures shall result in formal investigative action per 1798.200 of the California Health and Safety Code and Ordinance Code 8.12.190.

~~H.~~G. The mandatory data elements (e-PCR) listed in Appendix A ~~-,~~ below shall be generated by the service provider and transmitted to the Division in accordance with ~~ePCR Operational Procedures~~this policy.

~~I.~~H. The data obtained through an electronic patient care report will be used for, but not limited to, the following purposes:

1. Documentation of patient problem history, assessment findings, care, response to care and patient outcome for the purposes of effective continued patient care by responsible medical professionals; and medical-legal documentation.
2. Development of aggregate data reports of various topics determined by the Division to drive the continuous quality improvement (CQI) system action plan;
3. Evaluation of compliance with Ordinance Code 8.12;
4. Indicator for individual case evaluation; and
5. Divisional issue or case investigation.

~~J.~~I. The Division, in consultation with EMS providers, may revise these policies and procedures and mandatory data elements (e-PCR) as necessary.

~~K.~~J. Each agency is responsible for developing and maintaining a data collection back up plan.

~~L.~~K. Any agency that experiences a failure of its electronic data collection system shall immediately notify the Division of said failure. Said agency is responsible for maintaining the collection of all mandatory data elements should a failure occur. Said agency shall have 48 hours to correct the above mentioned electronic data collection failure and begin submitting all mandatory electronic data elements. All data elements collected during the above mentioned failure shall be maintained and entered into the electronic collection system immediately following the system's availability. In addition, any agency planning system maintenance or upgrades that could cause a delay in data transmission, will notify the division at least 24 hours in advance of said maintenance or upgrade.

II. ~~Section 2 -~~ DEFINITIONS

A. **"Division":** Kern County EMS Division of Public Health.
B. **"Ordinance":** Kern County Ordinance Code.
C. **National EMS Information System (NEMSIS**): The national data standard for emergency medical services as defined by the National Highway Traffic and Safety Administration (NHTSA) and the NEMSIS Technical Assistance Center (TAC).
D. **California EMS Information System (CEMSIS):** The California data standard for emergency medical services as defined by the California Emergency Medical Services Authority (EMSA). The data standard includes the NEMSIS standards and state defined data elements.
E. **Kern County Emergency Medical Data System (KCEMDS):** The Kern County EMS data standard for emergency medical services as managed and defined by Kern County Emergency Medical Services (KCEMS). The data standard includes the NEMSIS, CEMSIS, and Kern County specific data elements.
F. **Patient Care Reporting System (PCRS):** An electronic software platform that allows for real time collection of patient care information at the time of service.
G. **"Mandatory Element":** a data field identified by the EMS Division that must be completed and transmitted by EMS provider.
H. **"e-PCR":** the mandatory electronic data elements that as a whole make up the electronic patient care record that is completed by the EMS provider which shall serve as the permanent patient care report documenting patient condition, treatment, and all associated circumstances pertaining to a response.

III. Data Submission Process:

EMS Providers shall submit data using any third party PCRS that meets data submission requirements as defined in the Patient Care Reporting section of this policy. All data element requirements as set forth by the current versions of NEMSIS, CEMSIS, and KCEMDS must be met. To submit data, the EMS provider shall do all of the following:

A. The provider must be an approved Kern County EMS provider.
B. Private based EMS provider who is currently licensed by KCEMS as an Ambulance Provider.

C. Public or private based first responders (i.e. Fire Department, Oil Fields, Law Enforcement, etc.) in which response and patient care activities occur within the jurisdictional boundaries of Kern County.
D. The PCRS used by the EMS Provider shall be certified compliant with the current version of NEMSIS.
E. Submit a written request for access to the KCEMS NEMSIS Web Service. The request must include the following:
F. Provider Name and Agency ID
G. PCRS Vendor Information (including 24 hour technical support contact)
H. The request will be reviewed by KCEMS within 14 business days. If approved, access to the KCEMS NEMSIS Service will be granted to the PCRS vendor.
I. Once access to the KCEMS NEMSIS Service has been granted, KCEMS will work with the provider and the PCRS vendor to conduct data submission testing.
J. Provider Responsibilities:
    (1) Establish and continuously maintain a connection with the KCEMS NEMSIS Web Service.
        (a) The provider should be prepared to submit incident data for every completed Patient Care Report in real time immediately upon completion by the provider.
        (b) The provider shall immediately report any technical difficulties with establishing or maintaining a connection to the KCEMDS System Administrator.
    (2) Upon initially establishing a connection, submit dAgency data followed by at least five (5) test incident records that constitute a complete Patient Care Report for the following types of patients:
        (a) Cardiac Arrest
        (b) Chest pain/Acute Coronary Syndrome
        (c) Stroke
        (d) Trauma
        (e) Respiratory Distress
        (f) Adult
        (g) Pediatric
    (3) Inform KCEMS when test incident records have been submitted.
    (4) Address and correct technical and/or data validation issues that are identified
K. KCEMS Responsibilities:
    (1) Provide web service access information, including: web service URL, username and password.
    (2) Review test incidents submitted by the provider/vendor.
    (3) Provide guidance and support to address technical and/or data validation issues.

IV. PATIENT CARE REPORTING:

A. As of the effective date of this policy, the KCEMDS is compliant with and able to accept NEMSIS 3.4 data.

B. EMS providers who are already submitting data in the NEMSIS v2.2.1 or v3 format may continue to do so through December 31, 2016.

C. As of 0001hrs, January 1, 2017, EMS providers shall only submit data in the current NEMSIS v3.4 format, as per A.B.1129.

D. Provider agencies shall ensure that their PCRS complies with all national (NEMSIS), state (CEMSIS), and local (KCEMS) data elements and field values.

E. Provider agencies shall be responsible to ensure that their PCRS is able to establish and maintain a connection with the KCEMDS. Such responsibilities include but are not limited to:

(1) All costs associated with establishing and maintaining a connection with the KCEMDS up to the provider side of the interface.

(2) Initial and continued compliance with established data standards.

F. On occasion, changes to existing data elements may be needed as changes to the local EMS system occur. Such changes may include but are not limited to the addition of new procedures, medications, or changes to provider or facility names.

G. When changes described above are necessary, the PCRS used by the provider agency will need to be updated as soon as possible upon written notification from KCEMS.

H. A provider PCRS must transmit PCRs in the established format to the KCEMDS immediately upon completion by EMS personnel.

V. DOCUMENTATION STANDARDS:

A. PCRs shall be completed and submitted electronically to KCEMS.

B. Except in rare cases of system downtime or inoperability of electronic devices, the PCR shall be made available to the receiving center physicians and staff before leaving the receiving center.

C. It shall be the responsibility of EMS personnel to document accurately on their PCR.

~~**A.**~~ KCEMS may request specific documentation elements related to CQI, Field Study, Syndromic Surveillance or Emergency Management data collection. ~~**Section 3 – PCR OPERATIONAL PROCEDURES**~~

~~B.~~D. EMS providers shall accurately complete and submit all mandatory electronic data for each response to a call for service as described herein. This includes all emergency responses, non-emergency responses, responses that are canceled before scene arrival, ~~and~~ any pre-arranged stand-by~~ambulance standbys~~, and ~~ambulance~~ patient transfers originating in Kern County. In addition, any contact between an EMT, Paramedic, or CCT Nurse and a potential patient requires completion of a~~an ePCR or~~ PCR.

All mandatory ~~electronic~~ data elements ~~(e-PCR),~~ shall be completed by the EMT, Paramedic, or CCT Nurse responsible for patient care. (See Appendix A for Mandatory Data Elements)

Prior to submitting the mandatory data elements (e-PCR) to the Division, the EMT, Paramedic, or CCT Nurse responsible for patient care shall review in detail each mandatory data element to ensure its accuracy.

C. All electronic data elements (e-PCR), once submitted to the server, become a locked legal document and the contents cannot be modified. Kern County EMS uses a Secure Socket Layer system for transferring mandatory data elements which adheres to HIPPA and HITECH standards.

VI. PCR OPERATIONAL PROCEDURES

A. The mandatory data elements are contained in Appendix One.

B. The EMS report becomes part of the patient's medical record and as such is a legal and confidential document. In addition to serving an immediate medical communication purpose, the report also provides a historical record of this specific incident. In the event of future legal action, the report may also serve as a reminder to the author of the events and details surrounding this patient's medical event. Any detail or information which may benefit the patient's immediate medical care, or which may protect the patient from potential harm related to this incident, or that may prove useful in the event of a future legal action shall be included in the narrative portion of the ePCR.

Each patient contact (as described in section III, A.) made in the field will result in a completed ePCR that contains a narrative data element that includes, at minimum:

SUBJECTIVE – THE PATIENT'S STORY

1. Patient Description
2. Chief complaint
3. History of the Present Event: What happened? When did it happen? Where did it happen? Who was involved? How did it happen? How long did it occur? What was done to improve or change things?
4. Allergies, Current Medications, Past Medical History (Pertinent), and Last oral intake.

OBJECTIVE INFORMATION – THE Rescuer's STORY

1. The Rescuer's Initial Impression: Description of the scene. What was your first impression of the scene and patient?
2. Vital Signs
3. Physical Exam findings
4. General Observations: Other noteworthy information such as environmental conditions, patient location upon arrival, patient behavior, etc.

ASSESSMENT – THE Rescuer's IMPRESSION

1. Conclusions made based on chief complaint and physical exam findings
2. Often, this is the "narrowed-down" version of the differential diagnosis

PLAN – THE Rescuer's PLAN OF THERAPY(Treatment)

1. What was done for the patient. This should include treatment provided prior to your arrival as well as what you did for the patient.
2. Describe what you did with the patient – Disposition. This could be "patient loaded and prepared for transport", "patient handed off to flight crew", or "patient signed refusal of transport and is left home with family."

EN ROUTE – Re-Assessment(Patient Trending)

1. Information regarding therapies provided during transport as well as changes in the patient's condition during transport.
2. It may also include pertinent events surrounding the transfer of the patient at the hospital.

C. Use of abbreviations is permitted in the e-PCR narratives and comments elements. Acceptable abbreviations can be found in Appendix 2.

D.A. Times entered in Interventions, Vital Signs, and Assessments are considered estimates based on the approximate time the particular skill or procedure was completed.

E. **At minimum an e-PCR "PRELIMINARY RECORD" shall be printed, or a handwritten Kern County Ambulance Report Form shall be completed and filed with the physician, MICN, or RN immediately upon delivery of the patient to the base/receiving hospital emergency department.** Ambulance crews may use either a printout from electronic data collection hardware or the handwritten version of the Kern County Ambulance Report Form. **In no case shall a unit depart an emergency department without delivering a preliminary e-PCR, a completed e-PCR, or a completed Kern County Ambulance Report Form to emergency department staff.** The Division may consider an exception to this requirement on a case-by-case basis, if so requested by the ambulance provider for an unusual circumstance. However, normal procedures are to leave a PCR at the hospital, with the patient every time.

1. Hospitals shall be responsible for maintaining printer hardware (including paper, toner, etc.) compatible with electronic data collection devices being used, to facilitate the printing of the electronic record. Should printer hardware be temporarily unavailable, hospital shall allow the completed handwritten Kern County Ambulance Report Form to be submitted as the patient record and photocopied by ambulance crews.
2. Habitual non-maintenance of hospital printer equipment is problematic, failure by hospitals to maintain printer equipment or failure to provide ambulance crews with the ability to leave a printed record for greater than one week is deemed permission by the hospital to not leave a written report. Base and receiving hospitals will make every reasonable effort to maintain the ability to print the electronic preliminary patient care report, at all times.
3. It is understood that technological failures occur, and the hospital printer or the ambulance crew's electronic device may malfunction from time to time. The Kern County Ambulance Report Form will be used to leave a written patient report when technology fails. Hospitals shall be responsible for maintaining a supply of the Kern County Ambulance Report Form for use by ambulance crews. Failure by hospitals to provide ambulance crews with the ability to leave a handwritten record will be deemed permission by the hospital to not leave a written record. Ambulance Report Form can be found in Appendix 3.
4. The ambulance provider shall assure that the final electronic patient care record is delivered to the hospital within 15 hours of call time.

F.B. Patients who are transported to medical facilities or hospitals outside of Kern County or to medical facilities within Kern County other than hospital emergency departments, a print out of the electronic patient care report can be submitted via fax to the facility, if

requested by that facility. If written documentation is requested at time the patient is delivered, the attending EMT, Paramedic, or CCT Nurse shall provide a completed Kern County Ambulance Report Form. (See Appendix B)

~~G. Submission of each mandatory electronic data element (e-PCR) to the Division shall be completed as soon as possible, after transferring patient to care of hospital staff. In no case shall e-PCR submission to the Division be in excess of (15) hours from call time.~~

~~H.~~C. The Division may also request immediate submission of the e-PCR for a specific call or calls. EMS providers shall immediately submit requested e-PCR to the Division.

REVISION & ACTION LISTING:

02/13/95	Complete Draft for Limited Trial Project
02/27/95	Draft revised for Full Scope Trial Project (to remain as authorized use draft until trial completed)
03/17/95	Revision - Consistent with Project Progression for Reference
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10/10/2012	Defined "Preliminary Record"
08/02/2013	Updated Ambulance Report Form in Appendix Three
Xx/xx/xxxx	Updated for NEMSIS 3.4 compliance.

~~I. Implementation of the e-PCR policy for those agencies (such as Fire/Law) that have yet to submit electronic patient care reports shall be accomplished in two (2) phases:~~

~~1. Agencies (Fire/Law) will immediately begin working with the EMS Division to send data already being collecting electronically, to match as many of the NEMSIS data elements and locally required data elements as possible. Target date for implementation of Phase 1 (submitting incomplete electronic data to EMS) is December 1, 2012.~~

~~2. Agencies (Fire/Law) will begin submitting complete NEMSIS compliant data locally required data by July 1, 2014.~~

APPENDIX A – MANDATORY DATA ELEMENTS

dAgency.01	EMS Agency Unique State ID	N	S
dAgency.02	EMS Agency Number	N	S
dAgency.03	EMS Agency Name		S
dAgency.04	EMS Agency State	N	S
dAgency.05	EMS Agency Service Area States	N	S
dAgency.06	EMS Agency Service Area County(ies)	N	S
dAgency.07	EMS Agency Census Tracts	N	S
dAgency.08	EMS Agency Service Area ZIP Codes	N	S

dAgency.09	Primary Type of Service	N	S
dAgency.10	Other Types of Service		S
dAgency.11	Level of Service	N	S
dAgency.12	Organization Status	N	S
dAgency.13	Organizational Type	N	S
dAgency.14	EMS Agency Organizational Tax Status	N	S
dAgency.15	Statistical Calendar Year	N	S
dAgency.16	Total Primary Service Area Size	N	S
dAgency.17	Total Service Area Population	N	S
dAgency.18	911 EMS Call Center Volume per Year	N	S
dAgency.19	EMS Dispatch Volume per Year	N	S
dAgency.20	EMS Patient Transport Volume per Year	N	S
dAgency.21	EMS Patient Contact Volume per Year	N	S
dAgency.22	EMS Billable Calls per Year		S
dAgency.25	National Provider Identifier	N	S
dAgency.26	Fire Department ID Number	N	S

dContact.01	Agency Contact Type		S
dContact.02	Agency Contact Last Name		S
dContact.03	Agency Contact First Name		S
dContact.05	Agency Contact Address		S
dContact.06	Agency Contact City		S
dContact.07	Agency Contact State		S
dContact.08	Agency Contact ZIP Code		S
dContact.10	Agency Contact Phone Number		S
dContact.11	Agency Contact Email Address		S
dContact.12	EMS Agency Contact Web Address		S
dContact.13	Agency Medical Director Degree		S
dContact.14	Agency Medical Director Board Certification Type		S

dConfiguration.01	State Associated with the Certification/Licensure Levels	N	S
dConfiguration.02	State Certification/Licensure Levels	N	S
dConfiguration.03	Procedures Permitted by the State	N	S
dConfiguration.04	Medications Permitted by the State	N	S
dConfiguration.05	Protocols Permitted by the State	N	S
dConfiguration.06	EMS Certification Levels Permitted to Perform Each Procedure	N	S
dConfiguration.07	EMS Agency Procedures	N	S
dConfiguration.08	EMS Certification Levels Permitted to Administer Each Medication	N	S

dConfiguration.09	EMS Agency Medications	N	S
dConfiguration.10	EMS Agency Protocols	N	S
dConfiguration.11	EMS Agency Specialty Service Capability	N	S
dConfiguration.13	Emergency Medical Dispatch (EMD) Provided to EMS Agency Service Area	N	S
dConfiguration.14	EMD Vendor	N	S
dConfiguration.15	Patient Monitoring Capability(ies)	N	S
dConfiguration.16	Crew Call Sign	N	S

dVehicle.01	Unit/Vehicle Number	S
dVehicle.04	Vehicle Type	S
dVehicle.10	Vehicle Model Year	S

dPersonnel.01	EMS Personnel's Last Name	S
dPersonnel.02	EMS Personnel's First Name	S
dPersonnel.03	EMS Personnel's Middle Name/Initial	S
dPersonnel.11	EMS Personnel's Date of Birth	S
dPersonnel.12	EMS Personnel's Gender	S
dPersonnel.13	EMS Personnel's Race	S
dPersonnel.22	EMS Personnel's State of Licensure	S
dPersonnel.23	EMS Personnel's State's Licensure ID Number	S
dPersonnel.24	EMS Personnel's State EMS Certification Licensure Level	S
dPersonnel.31	EMS Personnel's Employment Status	S
dPersonnel.32	EMS Personnel's Employment Status Date	S
dPersonnel.34	EMS Personnel's Primary EMS Job Role	S
dPersonnel.35	EMS Personnel's Other Job Responsibilities	S

eCustomConfiguration.01	Custom Data Element Title	KC
eCustomConfiguration.02	Custom Definition	KC
eCustomConfiguration.03	Custom Data Type	KC
eCustomConfiguration.04	Custom Data Element Recurrence	KC
eCustomConfiguration.05	Custom Data Element Usage	KC
eCustomConfiguration.06	Custom Data Element Potential Values	KC
eCustomConfiguration.07	Custom Data Element Potential NOT Values (NV)	KC
eCustomConfiguration.08	Custom Data Element Potential Pertinent Negative Values (PN)	KC
eCustomConfiguration.09	Custom Data Element Grouping ID	KC

eRecord.01	Patient Care Report Number	N	S	
eRecord.02	Software Creator	N	S	
eRecord.03	Software Name	N	S	
eRecord.04	Software Version	N	S	
eResponse.01	EMS Agency Number	N	S	
eResponse.02	EMS Agency Name		S	
eResponse.03	Incident Number	N	S	
eResponse.04	EMS Response Number	N	S	
eResponse.05	Type of Service Requested	N	S	
eResponse.07	Primary Role of the Unit	N	S	
eResponse.08	Type of Dispatch Delay	N	S	
eResponse.09	Type of Response Delay	N	S	
eResponse.10	Type of Scene Delay	N	S	
eResponse.11	Type of Transport Delay	N	S	
eResponse.12	Type of Turn-Around Delay	N	S	
eResponse.13	EMS Vehicle (Unit) Number	N	S	
eResponse.14	EMS Unit Call Sign	N	S	
eResponse.15	Level of Care of This Unit	N	S	
eResponse.19	Beginning Odometer Reading of Responding Vehicle		S	
eResponse.20	On-Scene Odometer Reading of Responding Vehicle		S	
eResponse.21	Patient Destination Odometer Reading of Responding Vehicle		S	
eResponse.22	Ending Odometer Reading of Responding Vehicle		S	
eResponse.23	Response Mode to Scene	N	S	
eResponse.24	Additional Response Mode Descriptors	N	S	
eDispatch.01	Complaint Reported by Dispatch	N	S	
eDispatch.02	EMD Performed	N	S	
eDispatch.03	EMD Card Number			KC
eDispatch.04	Dispatch Center Name or ID			KC
eCrew.01	Crew Member ID		S	
eCrew.02	Crew Member Level		S	
eCrew.03	Crew Member Response Role		S	

eTimes.01	PSAP Call Date/Time	N	S	
eTimes.02	Dispatch Notified Date/Time			KC
eTimes.03	Unit Notified by Dispatch Date/Time	N	S	
eTimes.05	Unit En Route Date/Time	N	S	
eTimes.06	Unit Arrived on Scene Date/Time	N	S	
eTimes.07	Arrived at Patient Date/Time	N	S	
eTimes.08	Transfer of EMS Patient Care Date/Time		S	
eTimes.09	Unit Left Scene Date/Time	N	S	
eTimes.11	Patient Arrived at Destination Date/Time	N	S	
eTimes.12	Destination Patient Transfer of Care Date/Time	N	S	
eTimes.13	Unit Back in Service Date/Time	N	S	
eTimes.14	Unit Canceled Date/Time		S	
eTimes.16	EMS Call Completed Date/Time			KC
ePatient.02	Last Name		S	
ePatient.03	First Name		S	
ePatient.04	Middle Initial/Name			KC
ePatient.05	Patient's Home Address		S	
ePatient.06	Patient's Home City		S	
ePatient.07	Patient's Home County	N	S	
ePatient.08	Patient's Home State	N	S	
ePatient.09	Patient's Home ZIP Code	N	S	
ePatient.10	Patient's Country of Residence		S	
ePatient.13	Gender	N	S	
ePatient.14	Race	N	S	
ePatient.15	Age	N	S	
ePatient.16	Age Units	N	S	
ePatient.17	Date of Birth		S	
ePatient.18	Patient's Phone Number			KC
ePayment.01	Primary Method of Payment	N	S	
ePayment.50	CMS Service Level	N	S	
eScene.01	First EMS Unit on Scene	N	S	
eScene.02	Other EMS or Public Safety Agencies at Scene			KC
eScene.03	Other EMS or Public Safety Agency ID Number			KC

eScene.04	Type of Other Service at Scene			KC
eScene.06	Number of Patients at Scene	N	S	
eScene.07	Mass Casualty Incident	N	S	
eScene.08	Triage Classification for MCI Patient	N	S	
eScene.09	Incident Location Type	N	S	
eScene.10	Incident Facility Code		S	
eScene.11	Scene GPS Location		S	
eScene.12	Scene US National Grid Coordinates		S	
eScene.13	Incident Facility or Location Name		S	
eScene.14	Mile Post or Major Roadway		S	
eScene.15	Incident Street Address		S	
eScene.16	Incident Apartment, Suite, or Room		S	
eScene.17	Incident City		S	
eScene.18	Incident State	N	S	
eScene.19	Incident ZIP Code	N	S	
eScene.20	Scene Cross Street or Directions		S	
eScene.21	Incident County	N	S	
eSituation.01	Date/Time of Symptom Onset	N	S	
eSituation.02	Possible Injury	N	S	
eSituation.03	Complaint Type		S	
eSituation.04	Complaint		S	
eSituation.05	Duration of Complaint		S	
eSituation.06	Time Units of Duration of Complaint		S	
eSituation.07	Chief Complaint Anatomic Location	N	S	
eSituation.08	Chief Complaint Organ System	N	S	
eSituation.09	Primary Symptom	N	S	
eSituation.10	Other Associated Symptoms	N	S	
eSituation.11	Provider's Primary Impression	N	S	
eSituation.12	Provider's Secondary Impressions	N	S	
eSituation.13	Initial Patient Acuity	N	S	
eSituation.14	Work-Related Illness/Injury		S	
eSituation.17	Patient Activity		S	
eSituation.18	Date/Time Last Known Well			KC
eInjury.01	Cause of Injury	N	S	
eInjury.02	Mechanism of Injury		S	
eInjury.03	Trauma Center Criteria	N	S	
eInjury.04	Vehicular, Pedestrian, or Other Injury Risk Factor	N	S	
eInjury.05	Main Area of the Vehicle Impacted by the		S	

	Collision			
eInjury.06	Location of Patient in Vehicle		S	
eInjury.07	Use of Occupant Safety Equipment		S	
eInjury.08	Airbag Deployment		S	
eInjury.09	Height of Fall (feet)		S	
eArrest.01	Cardiac Arrest	N	S	
eArrest.02	Cardiac Arrest Etiology	N	S	
eArrest.03	Resuscitation Attempted By EMS	N	S	
eArrest.04	Arrest Witnessed By	N	S	
eArrest.05	CPR Care Provided Prior to EMS Arrival	N	S	
eArrest.06	Who Provided CPR Prior to EMS Arrival		S	
eArrest.07	AED Use Prior to EMS Arrival	N	S	
eArrest.08	Who Used AED Prior to EMS Arrival		S	
eArrest.09	Type of CPR Provided	N	S	
eArrest.11	First Monitored Arrest Rhythm of the Patient	N	S	
eArrest.12	Any Return of Spontaneous Circulation	N	S	
eArrest.14	Date/Time of Cardiac Arrest	N	S	
eArrest.15	Date/Time Resuscitation Discontinued		S	
eArrest.16	Reason CPR/Resuscitation Discontinued	N	S	
eArrest.17	Cardiac Rhythm on Arrival at Destination	N	S	
eArrest.18	End of EMS Cardiac Arrest Event	N	S	
eArrest.19	Date/Time of Initial CPR			KC
eHistory.01	Barriers to Patient Care	N	S	
eHistory.05	Advance Directives		S	
eHistory.06	Medication Allergies		S	
eHistory.07	Environmental/Food Allergies			KC
eHistory.08	Medical/Surgical History		S	
eHistory.09	Medical History Obtained From			KC
eHistory.17	Alcohol/Drug Use Indicators	N	S	
eHistory.18	Pregnancy			KC
eHistory.19	Last Oral Intake			KC
eNarrative.01	Patient Care Report Narrative		S	
eVitals.01	Date/Time Vital Signs Taken	N	S	
eVitals.02	Obtained Prior to this Unit's EMS Care	N	S	

eVitals.03	Cardiac Rhythm / Electrocardiography (ECG)	N	S	
eVitals.04	ECG Type	N	S	
eVitals.05	Method of ECG Interpretation	N	S	
eVitals.06	SBP (Systolic Blood Pressure)	N	S	
eVitals.07	DBP (Diastolic Blood Pressure)		S	
eVitals.08	Method of Blood Pressure Measurement	N	S	
eVitals.09	Mean Arterial Pressure			KC
eVitals.10	Heart Rate	N	S	
eVitals.11	Method of Heart Rate Measurement			KC
eVitals.12	Pulse Oximetry	N	S	
eVitals.13	Pulse Rhythm			KC
eVitals.14	Respiratory Rate	N	S	
eVitals.15	Respiratory Effort			KC
eVitals.16	End Tidal Carbon Dioxide (ETCO2)	N	S	
eVitals.17	Carbon Monoxide (CO)		S	
eVitals.18	Blood Glucose Level	N	S	
eVitals.19	Glasgow Coma Score-Eye	N	S	
eVitals.20	Glasgow Coma Score-Verbal	N	S	
eVitals.21	Glasgow Coma Score-Motor	N	S	
eVitals.22	Glasgow Coma Score-Qualifier	N	S	
eVitals.23	Total Glasgow Coma Score		S	
eVitals.24	Temperature		S	
eVitals.25	Temperature Method			KC
eVitals.26	Level of Responsiveness (AVPU)	N	S	
eVitals.27	Pain Scale Score	N	S	
eVitals.28	Pain Scale Type		S	
eVitals.29	Stroke Scale Score	N	S	
eVitals.30	Stroke Scale Type	N	S	
eVitals.31	Reperfusion Checklist	N	S	
eVitals.32	APGAR			KC

eExam.01	Estimated Body Weight in Kilograms		S	
eExam.02	Length Based Tape Measure		S	
eExam.03	Date/Time of Assessment			KC
eExam.04	Skin Assessment			KC
eExam.05	Head Assessment			KC
eExam.06	Face Assessment			KC
eExam.07	Neck Assessment			KC
eExam.08	Chest/Lungs Assessment			KC
eExam.10	Abdominal Assessment Finding Location			KC
eExam.11	Abdomen Assessment			KC

eExam.12	Pelvis/Genitourinary Assessment			KC
eExam.13	Back and Spine Assessment Finding Location			KC
eExam.14	Back and Spine Assessment			KC
eExam.15	Extremity Assessment Finding Location			KC
eExam.16	Extremities Assessment			KC
eExam.17	Eye Assessment Finding Location			KC
eExam.18	Eye Assessment			KC
eExam.19	Mental Status Assessment			KC
eExam.20	Neurological Assessment			KC
eExam.21	Stroke/CVA Symptoms Resolved		S	
eProtocols..01	Protocols Used	N	S	
eProtocols..02	Protocol Age Category	N	S	
eMedications.01	Date/Time Medication Administered	N	S	
eMedications.02	Medication Administered Prior to this Unit's EMS Care	N	S	
eMedications.03	Medication Given	N	S	
eMedications.04	Medication Administered Route	N	S	
eMedications.05	Medication Dosage	N	S	
eMedications.06	Medication Dosage Units	N	S	
eMedications.07	Response to Medication	N	S	
eMedications.08	Medication Complication	N	S	
eMedications.09	Medication Crew (Healthcare Professionals) ID		S	
eMedications.10	Role/Type of Person Administering Medication	N	S	
eMedications.11	Medication Authorization			KC
eProcedures.01	Date/Time Procedure Performed	N	S	
eProcedures.02	Procedure Performed Prior to this Unit's EMS Care	N	S	
eProcedures.03	Procedure	N	S	
eProcedures.04	Size of Procedure Equipment			KC
eProcedures.05	Number of Procedure Attempts	N	S	
eProcedures.06	Procedure Successful	N	S	
eProcedures.07	Procedure Complication	N	S	
eProcedures.08	Response to Procedure	N	S	
eProcedures.09	Procedure Crew Members ID		S	
eProcedures.10	Role/Type of Person Performing the	N	S	

	Procedure			
eProcedures.11	Procedure Authorization			KC
eProcedures.13	Vascular Access Location		S	
eAirway.01	Indications for Invasive Airway		S	
eAirway.02	Date/Time Airway Device Placement Confirmation		S	
eAirway.03	Airway Device Being Confirmed		S	
eAirway.04	Airway Device Placement Confirmed Method		S	
eAirway.05	Tube Depth			KC
eAirway.06	Type of Individual Confirming Airway Device Placement		S	
eAirway.07	Crew Member ID		S	
eAirway.08	Airway Complications Encountered		S	
eAirway.09	Suspected Reasons for Failed Airway Management		S	
eDivice.02	Date/Time of Event (per Medical Device)			KC
eDivice.03	Medical Device Event Type			KC
eDivice.06	Medical Device Mode (Manual, AED, Pacing, CO2, O2, etc)			KC
eDivice.07	Medical Device ECG Lead			KC
eDivice.08	Medical Device ECG Interpretation			KC
eDivice.09	Type of Shock			KC
eDivice.10	Shock or Pacing Energy			KC
eDivice.11	Total Number of Shocks Delivered			KC
eDivice.12	Pacing Rate			KC
eDisposition.01	Destination/Transferred To, Name		S	
eDisposition.02	Destination/Transferred To, Code		S	
eDisposition.03	Destination Street Address		S	
eDisposition.04	Destination City		S	
eDisposition.05	Destination State	N	S	
eDisposition.06	Destination County	N	S	
eDisposition.07	Destination ZIP Code	N	S	
eDisposition.11	Number of Patients Transported in this EMS Unit		S	
eDisposition.12	Incident/Patient Disposition	N	S	
eDisposition.13	How Patient Was Moved to Ambulance			KC
eDisposition.14	Position of Patient During Transport			KC

eDisposition.15	How Patient Was Transported From Ambulance			KC
eDisposition.16	EMS Transport Method	N	S	
eDisposition.17	Transport Mode from Scene	N	S	
eDisposition.18	Additional Transport Mode Descriptors	N	S	
eDisposition.19	Final Patient Acuity	N	S	
eDisposition.20	Reason for Choosing Destination	N	S	
eDisposition.21	Type of Destination	N	S	
eDisposition.22	Hospital In-Patient Destination	N	S	
eDisposition.23	Hospital Capability	N	S	
eDisposition.24	Destination Team Pre-Arrival Alert or Activation	N	S	
eDisposition.25	Date/Time of Destination Prearrival Alert or Activation	N	S	
eDisposition.26	Disposition Instructions Provided			KC
eOutcome.01	Emergency Department Disposition	N	S	
eOutcome.02	Hospital Disposition	N	S	
eOther.02	Potential System of Care/Specialty/Registry Patient			KC
eOther.03	Personal Protective Equipment Used			KC
eOther.04	EMS Professional (Crew Member) ID			KC
eOther.05	Suspected EMS Work Related Exposure, Injury, or Death	N	S	
eOther.06	The Type of Work-Related Injury, Death or Suspected Exposure		S	
eOther.07	Natural, Suspected, Intentional, or Unintentional Disaster			KC
eOther.08	Crew Member Completing this Report		S	
eOther.12	Type of Person Signing			KC
eOther.13	Signature Reason			KC
eOther.14	Type Of Patient Representative			KC
eOther.15	Signature Status			KC
eOther.19	Date/Time of Signature			KC

APPENDIX **ONE** MANDATORY DATA ELEMENTS

Element Code	**Data Element**
D01_01	EMS Agency Number
D01_03	EMS Agency State
D01_04	EMS Agency County
D01_07	Level of Service
D01_08	Organizational Type
D01_09	Organization Status
D01_21	National Provider Identifier
D02_07	Agency Contact Zip Code
E01_01	Patient Care Report Number
E01_02	Software Creator
E01_03	Software Name
E01_04	Software Version
E02_01	EMS Agency Number
E02_02	Incident Number
E02_03	EMS Unit (Vehicle) Response Number
E02_04	Type of Service Requested
E02_05	Primary Role of the Unit
E02_06	Type of Dispatch Delay
E02_07	Type of Response Delay
E02_08	Type of Scene Delay
E02_09	Type of Transport Delay
E02_10	Type of Turn-Around Delay
E02_11	EMS Unit/Vehicle Number
E02_12	EMS Unit Call Sign (Radio Number)
E02_17	On-Scene Odometer Reading of Responding Vehicle
E02_18	Patient Destination Odometer Reading of Responding Vehicle
E02_20	Response Mode to Scene
E03_01	Complaint Reported by Dispatch
E03_02	EMD Performed

E04_01	Crew Member ID
E04_02	Crew Member Role
E04_03	Crew Member Level
E05_01	Incident or Onset Date/Time
E05_02	PSAP Call Date/Time
E05_03	Dispatch Notified Date/Time
E05_04	Unit Notified by Dispatch Date/Time
E05_05	Unit En Route Date/Time
E05_06	Unit Arrived on Scene Date/Time
E05_07	Arrived at Patient Date/Time
E05_09	Unit Left Scene Date/Time
E05_10	Patient Arrived at Destination Date/Time
E05_11	Unit Back in Service Date/Time
E06_01	Last Name
E06_02	First Name
E06_04	Patient's Home Address
E06_08	Patient's Home Zip Code
E06_10	Social Security Number
E06_11	Gender
E06_12	Race
E06_13	Ethnicity
E06_14	Age
E06_15	Age Units
E06_16	Date of Birth
E06_17	Primary or Home Telephone Number
E06_19	Driver's License Number
E07_01	Primary Method of Payment
E07_09	Insurance Group ID/Name
E07_10	Insurance Policy ID Number
E07_11	Last Name of the Insured
E07_12	First Name of the Insured
E07_14	Relationship to the Insured
E07_15	Work Related
E07_34	CMS Service Level
E07_35	Condition Code Number
E08_06	Mass Casualty Incident
E08_07	Incident Location Type
E08_08	Incident Facility Code

~~E08_11~~	~~Incident Address~~
~~E08_12~~	~~Incident City~~
~~E08_13~~	~~Incident County~~
~~E08_14~~	~~Incident State~~
~~E08_15~~	~~Incident ZIP Code~~
~~E09_01~~	~~Prior Aid~~
~~E09_02~~	~~Prior Aid Performed by~~
~~E09_03~~	~~Outcome of the Prior Aid~~
~~E09_04~~	~~Possible Injury~~
~~E09_05~~	~~Chief Complaint~~
~~E09_09~~	~~Duration of Secondary Complaint~~
~~E09_11~~	~~Chief Complaint Anatomic Location~~
~~E09_12~~	~~Chief Complaint Organ System~~
~~E09_13~~	~~Primary Symptom~~
~~E09_14~~	~~Other Associated Symptoms~~
~~E09_15~~	~~Providers Primary Impression~~
~~E09_16~~	~~Provider's Secondary Impression~~
~~E10_01~~	~~Cause of Injury~~
~~E10_02~~	~~Intent of the Injury~~
~~E10_03~~	~~Mechanism of Injury~~
~~E10_05~~	~~Area of the Vehicle impacted by the collision~~
~~E10_08~~	~~Use of Occupant Safety Equipment~~
~~E10_09~~	~~Airbag Deployment~~
~~E11_01~~	~~Cardiac Arrest~~
~~E11_02~~	~~Cardiac Arrest Etiology~~
~~E11_03~~	~~Resuscitation Attempted~~
~~E11_04~~	~~Arrest Witnessed by~~
~~E11_05~~	~~First Monitored Rhythm of the Patient~~
~~E11_06~~	~~Any Return of Spontaneous Circulation~~
~~E11_07~~	~~Neurological Outcome at Hospital Discharge~~
~~E11_08~~	~~Estimated Time of Arrest Prior to EMS Arrival~~
~~E11_09~~	~~Date/Time Resuscitation Discontinued~~
~~E11_10~~	~~Reason CPR Discontinued~~
~~E11_11~~	~~Cardiac Rhythm on Arrival at Destination~~
~~E12_01~~	~~Barriers to Patient Care~~
~~E12_08~~	~~Medication Allergies~~
~~E12_09~~	~~Environmental/Food Allergies~~
~~E12_10~~	~~Medical/Surgical History~~
~~E12_11~~	~~Medical History Obtained From~~

~~E12_19~~	~~Alcohol/Drug Use Indicators~~
~~E13_01~~	~~Run Report Narrative~~
~~E14_01~~	~~Date/Time Vital Signs Taken~~
~~E14_02~~	~~Obtained Prior to this Units EMS Care~~
~~E14_03~~	~~Cardiac Rhythm~~
~~E14_04~~	~~SBP (Systolic Blood Pressure)~~
~~E14_05~~	~~DBP (Diastolic Blood Pressure)~~
~~E14_06~~	~~Method of Blood Pressure Measurement~~
~~E14_07~~	~~Pulse Rate~~
~~E14_08~~	~~Electronic Monitor Rate~~
~~E14_09~~	~~Pulse Oximetry~~
~~E14_10~~	~~Pulse Rhythm~~
~~E14_11~~	~~Respiratory Rate~~
~~E14_12~~	~~Respiratory Effort~~
~~E14_13~~	~~Carbon Dioxide~~
~~E14_14~~	~~Blood Glucose Level~~
~~E14_15~~	~~Glasgow Coma Score-Eye~~
~~E14_16~~	~~Glasgow Coma Score-Verbal~~
~~E14_17~~	~~Glasgow Coma Score-Motor~~
~~E14_18~~	~~Glasgow Coma Score-Qualifier~~
~~E14_19~~	~~Total Glasgow Coma Score~~
~~E14_20~~	~~Temperature~~
~~E14_21~~	~~Temperature Method~~
~~E14_22~~	~~Level of Responsiveness~~
~~E14_23~~	~~Pain Scale~~
~~E14_24~~	~~Stroke Scale~~
~~E15_01~~	~~NHTSA Injury Matrix External/Skin~~
~~E15_02~~	~~NHTSA Injury Matrix Head~~
~~E15_03~~	~~NHTSA Injury Matrix Face~~
~~E15_04~~	~~NHTSA Injury Matrix Neck~~
~~E15_05~~	~~NHTSA Injury Matrix Thorax~~
~~E15_06~~	~~NHTSA Injury Matrix Abdomen~~
~~E15_07~~	~~NHTSA Injury Matrix Spine~~
~~E15_08~~	~~NHTSA Injury Matrix Upper Extremities~~
~~E15_09~~	~~NHTSA Injury Matrix Pelvis~~
~~E15_10~~	~~NHTSA Injury Matrix Lower Extremities~~
~~E15_11~~	~~NHTSA Injury Matrix Unspecified~~
~~E16_01~~	~~Estimated Body Weight~~
~~E16_03~~	~~Date/Time of Assessment~~

~~E16_04~~	~~Skin Assessment~~
~~E16_05~~	~~Head/Face Assessment~~
~~E16_06~~	~~Neck Assessment~~
~~E16_07~~	~~Chest/Lungs Assessment~~
~~E16_09~~	~~Abdomen Left Upper Assessment~~
~~E16_10~~	~~Abdomen Left Lower Assessment~~
~~E16_11~~	~~Abdomen Right Upper Assessment~~
~~E16_12~~	~~Abdomen Right Lower Assessment~~
~~E16_14~~	~~Back Cervical Assessment~~
~~E16_15~~	~~Back Thoracic Assessment~~
~~E16_16~~	~~Back Lumbar/Sacral Assessment~~
~~E16_17~~	~~Extremities Right Upper Assessment~~
~~E16_18~~	~~Extremities Right Lower Assessment~~
~~E16_19~~	~~Extremities Left Upper Assessment~~
~~E16_20~~	~~Extremities Left Lower Assessment~~
~~E16_21~~	~~Eyes Left Assessment~~
~~E16_22~~	~~Eyes Right Assessment~~
~~E16_23~~	~~Mental Status Assessment~~
~~E16_24~~	~~Neurological Assessment~~
~~E18_01~~	~~Date/Time Medication Administered~~
~~E18_02~~	~~Medication Administered Prior to this Units EMS Care~~
~~E18_03~~	~~Medication Given~~
~~E18_04~~	~~Medication Administered Route~~
~~E18_05~~	~~Medication Dosage~~
~~E18_06~~	~~Medication Dosage Units~~
~~E18_07~~	~~Response to Medication~~
~~E18_08~~	~~Medication Complication~~
~~E18_09~~	~~Medication Crew Member ID~~
~~E18_10~~	~~Medication Authorization~~
~~E18_11~~	~~Medication Authorizing Physician~~
~~E19_01~~	~~Date/Time Procedure Performed Successfully~~
~~E19_02~~	~~Procedure Performed Prior to this Units EMS Care~~
~~E19_03~~	~~Procedure~~
~~E19_04~~	~~Size of Procedure Equipment~~
~~E19_05~~	~~Number of Procedure Attempts~~
~~E19_06~~	~~Procedure Successful~~
~~E19_07~~	~~Procedure Complication~~
~~E19_08~~	~~Response to Procedure~~
~~E19_09~~	~~Procedure Crew Members ID~~
~~E19_10~~	~~Procedure Authorization~~
~~E19_12~~	~~Successful IV Site~~

~~E19_13~~	~~Tube Confirmation~~
~~E19_14~~	~~Destination Confirmation of Tube Placement~~
~~E20_01~~	~~Destination/Transferred To, Name~~
~~E20_02~~	~~Destination/Transferred To, Code~~
~~E20_03~~	~~Destination Street Address~~
~~E20_07~~	~~Destination Zip Code~~
~~E20_10~~	~~Incident/Patient Disposition~~
~~E20_14~~	~~Transport Mode from Scene~~
~~E20_15~~	~~Condition of Patient at Destination~~
~~E20_16~~	~~Reason for Choosing Destination~~
~~E20_17~~	~~Type of Destination~~
~~E22_01~~	~~Emergency Department Disposition~~
~~E23_03~~	~~Personal Protective Equipment Used~~
~~E23_05~~	~~Suspected Contact with Blood/Body Fluids of EMS Injury or Death~~
~~E23_06~~	~~Type of Suspected Blood/Body Fluid Exposure, Injury, or Death~~
~~E23_10~~	~~Who Generated this Report?~~

~~**Plus Data**~~	~~**Name / Value**~~
~~EMD~~	~~CardNumber~~
	~~Level~~
	~~Determinant~~
	~~Suffix~~
~~Mapping~~	~~Key~~
	~~Section~~
	~~Quarter Section~~
~~Trauma~~	~~Trauma 1~~
	~~Trauma 2~~
	~~Trauma 3~~
	~~Trauma 4~~
	~~Trauma 5~~

APPENDIX TWO – ACCEPTABLE ABBREVIATION LIST

-	Negative, without, decrease
&	And
?	Possible, questionable
+	Positive, with, increase
<	Less than
=	Equal
>	Greater than
5150	Danger to self, others, gravely disabled with mental illness
A/OX1,2,3,4	Alert, and (1) Oriented to Person, (2) Place, (3) Time, and (4) Event.
Abd	Abdomen
Abr	Abrasion
ACE	Angiotension converting enzyme
AED	Automated External Defibrillator
A-fib	Atrial Fibrillation
A-flutter	Atril Flutter
AICD	Automatic Internal Cardiac Defibrillator
AIDS	Acquired immunodeficiency syndrome
ALOC	Altered level of consciousness
ALS	Advanced life support
AM	Morning
AMI	Acute myocardial infarction
AOS	Arrived On Scene
AMS	Altered mental status
A-P	Anteroposterior (front to back)
APAP	Acetaminophen
APGAR	Appearance, Pulse, Grimace, Activity, Respiration
ASA	Acetylsalicylic acid
ASHD	Arteriosclerotic heart disease
AV	Atrioventricular
BG	Blood glucose
BID	Twice a day
BLS	Basic life support
BM	Bowel movement
BP	Blood pressure
BVM	Bag-valve-mask
C/C	Chief complaint
C/o	Complains of
C1, C2	First, Second, etc., cervical vertebra
CA	Cancer or Carcinoma
Ca++	Calcium
CABG	Coronary artery bypass graft
CAD	Coronary artery disease

~~CALF — CalFire*~~
~~Cap — Capsule~~
~~CBC — Complete blood count~~
~~cc — Cubic centimeter~~
~~CCU — Coronary care unit~~
~~Chemo — Chemotherapy~~
~~CHF — Congestive heart failure~~
~~CHP — California Highway Patrol*~~
~~cm — Centimeter~~
~~CNS — Central nervous system~~
~~CO — Carbon monoxide~~
~~CO2 — Carbon dioxide~~
~~COPD — Chronic obstructive pulmonary disease~~
~~CP — Chest Pain~~
~~CPAP — Continuous Positive Airway Pressure~~
~~CPR — Cardiopulmonary resuscitation~~
~~CSF — Cerebral spinal fluid~~
~~CSMT — Circulation, sensation, movement, temperature~~
~~C-spine — Cervical precautions applied~~
~~CT or CAT — Computed tomography (Scan)~~
~~CVA — Cerebrovascular accident~~
~~D/C — Discontinue~~
~~DNR — Do not resuscitate~~
~~DOB — Date of birth~~
~~DOE — Dyspnea on exertion~~
~~DT — Delirium tremens~~
~~DVT — Deep vein thrombosis~~
~~Dx — Diagnosis~~
~~ECG or EKG — Electrocardiogram~~
~~ED — Emergency Department~~
~~EMS — Emergency Medical Services~~
~~EMT — Emergency Medical Technician~~
~~EMT-P — Emergency Medical Technician - Paramedic~~
~~ENT — Ears, nose, throat~~
~~ET or ETT — Endotracheal tube~~
~~ETCO2 — End-Tidal Carbon Dioxide (level)~~
~~ETOH — Ethyl alcohol~~
~~FHR — Fetal heart rate~~
~~FHx — Family history~~
~~FR — First responder or French sizing~~
~~FTB — Full-Thickness Burn~~
~~Fx — Fracture~~
~~gm — Gram~~
~~g — Gauge~~
~~GB — Gallbladder~~
~~GCS — Glasgow coma score~~
~~GERD — Gastroesophageal reflux disease~~
~~GI — Gastrointestinal~~

~~GPA~~	~~Gravida, Para, Abortus (i.e., G2, P1, A1)~~
~~GSW~~	~~Gunshot wound~~
~~gtt(s)~~	~~Drop(s)~~
~~GYN~~	~~Gynecology~~
~~H2O~~	~~Water~~
~~HA~~	~~Headache~~
~~HBV~~	~~Hepatitis B virus~~
~~HCV~~	~~Hepatitis C virus~~
~~HIV~~	~~Human immunodeficiency virus~~
~~HPI~~	~~History of present illness~~
~~HSV-1, HSV-2~~	~~Herpes simplex virus type 1 or 2.~~
~~HTN~~	~~Hypertension~~
~~Hx~~	~~History~~
~~IC~~	~~Incident Commander~~
~~ICP~~	~~Incident Command Post~~
~~ICU~~	~~Intensive care unit~~
~~IDDM~~	~~Insulin-dependent diabetes mellitus~~
~~IM~~	~~Intramuscular~~
~~IO~~	~~Intraosseous~~
~~IV~~	~~Intravenous~~
~~IVDU~~	~~Intravenous drug use~~
~~JVD~~	~~Juggler vein distention~~
~~K+~~	~~Potassium~~
~~KED~~	~~Kendrick Extrication Device~~
~~Kg~~	~~Kilogram (1000 grams)~~
~~L1, L2~~	~~First, second, etc., lumbar vertebra~~
~~Lat~~	~~Lateral~~
~~LBBB~~	~~Left bundle branch block~~
~~LLE~~	~~Left lower extremity~~
~~LLQ~~	~~Left lower quadrant~~
~~LNMP~~	~~Last normal menstrual period~~
~~LOC~~	~~Loss of consciousness~~
~~LP~~	~~Lumbar puncture~~
~~LR~~	~~Lactated ringers~~
~~Lt~~	~~Left~~
~~LUE~~	~~Left upper extremity~~
~~LUQ~~	~~Left upper quadrant~~
~~LV~~	~~Left ventricle~~
~~LVH~~	~~Left ventricular hypertrophy~~
~~LVN~~	~~Licensed vocational nurse~~
~~MAE~~	~~Moves all extremities~~
~~MCC~~	~~Motor cycle collision~~
~~mcg~~	~~Micrograms~~
~~MD~~	~~Medical Doctor~~
~~Meds or Med~~	~~Medications~~
~~meth~~	~~Methamphetamine~~
~~mg~~	~~Milligram (1/1000 gram)~~
~~MI~~	~~Myocardial infarction~~

ml	Milliliter (1/1000 liter)
mm	Millimeter (1/1000 meter)
MOI	Mechanism of injury
MRI	Magnetic resonance imaging
MRSA	Methicillin-resistant Staphylococcus aureus
MS	Morphine sulfate
MVC	Motor vehicle collision
N/V/D	Nausea, vomiting, diarrhea
Na+	Sodium
NC	Nasal cannula
NIDDM	Non-insulin dependent diabetes
NKA	No known allergies
NKDA	No known drug allergies
NP or FNP	Nurse practitioner / family nurse practitioner
NPA	Nasal pharyngeal airway
NPO	Nothing by mouth
NRB	Non-rebreather
NRS	Numeric Rating Scale (1-10) (1= Low, 10=High)
NS	Normal saline
NSAID	Non-steroidal anti-inflammatory drug
NSR	Normal sinus rhythm
NTG	Nitroglycerin
O2	Oxygen
OA	Osteoarthritis
OD	Overdose
OOS	Out of Service
OPA	Oral pharyngeal airway
OPQRST	Mnemonic for: Onset, Provoke, Quality, Radiates, Severity, and Time.
P	Pulse
PA	Physician assistant
PAC	Premature atrial contraction
PE	Physical examination or pulmonary embolism
PEA	Pulseless electrical activity
PERRL	Pupils equal, round, and reactive to light
PID	Pelvic inflammatory disease
PM	Afternoon
PMD	Primary medical doctor
PMH	Past medical history
PN	Pain
PNS	Peripheral nervous system
POP	Pain on palpation
PRN	As needed
Pt	Patient
PTA	Prior to arrival
PTB	Partial-Thickness Burn
PVC	Premature ventricular contraction
Q	Every
QH	Each hour

~~QID — Four times a day~~
~~Resp. — Respirations~~
~~RR — Respiratory Rate~~
~~R/O — Rule out~~
~~RA — Rheumatoid arthritis or Right Atrium~~
~~RBBB — Right bundle branch block~~
~~RBC — Red blood cell~~
~~RLE — Right lower extremity~~
~~RLQ — Right lower quadrant~~
~~RMCT — Refusal of medical care and/or transport~~
~~RN — Registered nurse~~
~~ROM — Range of motion~~
~~ROS — Review of symptoms~~
~~RSV — Respiratory syncytial virus~~
~~Rt — Right~~
~~RUE — Right upper extremity~~
~~RUQ — Right upper quadrant~~
~~RV — Right ventricle~~
~~Rx — Prescription~~
~~S/S — Signs and symptoms~~
~~SA — Sinoatrial node~~
~~SAMPLE — Mnemonic for: Signs and symptoms, Allergies, Medications, Past history, Last oral intake, Events leading up to.~~
~~Sc or Sq — Subcutaneous~~
~~SL — Sublingual~~
~~SNF — Skilled nursing facility~~
~~SOAP — Mnemonic for: Subjective, Objective, Assessment, and Plan.~~
~~SOB — Shortness of breath~~
~~SpO2 — Oxygen Saturation of peripheral Hgb~~
~~START — Simple Triage and Rapid Treatment~~
~~Stat — Immediately~~
~~STB — Superficial Thickness Burn~~
~~STD — Sexually transmitted disease~~
~~STEMI — S-T elevation myocardial infarction~~
~~Strep — Streptococci (bacteria)~~
~~Sx — Symptoms~~
~~T or Temp. — Temperature~~
~~T1, T2 — First, second, etc., thoracic vertebra~~
~~TA — Traffic Accident~~
~~Tab — Tablet~~
~~TB — Tuberculosis~~
~~TC — Traffic Collision~~
~~TIA — Transient ischemic attack~~
~~TID — Three times a day~~
~~TKO — To keep open~~
~~Trans — Transport~~
~~Tx — Treatment~~
~~Unk — Unknown~~

~~URI — Upper respiratory infection~~
~~UTL — Unable to locate~~
~~V/S — Vital signs~~
~~VF — Ventricular fibrillation~~
~~VT or V-Tach — Ventricular tachycardia~~
~~WBC — White blood cell~~
~~WMD — Weapon of mass destruction~~
~~WNL — Within normal limits~~
~~X Times — (used as multiplication sign)~~
~~Y/O — Year(s) old~~

APPENDIX B~~THREE~~ - KERN COUNTY AMBULANCE REPORT FORM

See form on next page.

KERN COUNTY
AMBULANCE REPORT FORM

INCIDENT #:	**STEMI** ☐	**At Pt. Time:**	**12 LEAD TIME:**	**At Hosp time:**		
Date:	**Amb Provider:**	**Unit #:**	**INCIDENT LOCATION:**	**STROKE** ☐	**LAST NORM TIME:**	**Face Arm Drift Speech**
Call Time:	**Patient Age:**	**Patient Sex:**	**Weight (Kg):**	**DESTINATION FACILITY:**	**TRAUMA ACTIVATION** ☐	**ACTIVATION LEVEL** 1 2 3 4
Patient Name-Last	**First**	**MI**				

CHIEF COMPLAINT:

SKIN VITAL SIGNS:

COLOR:
Normal
Pale
Ashen
Peripheral Cyanosis
Central Cyanosis
Jaundice
Flushed

TEMPERATURE:
Normal
Cool
Cold
Warm
Hot

MOISTURE:
Normal
Dry
Moist
Diaphoretic

CAPILLARY REFILL:
Normal
Delayed >2 Seconds
None

GLASGOW COMA SCALE:

BEST EYE RESPONSE:
4 Opens Spontaneously
3 Open to Command
2 Open to Pain
1 Never

BEST VERBAL RESPONSE:
5 Oriented
4 Confused
3 Inappropriate Words
2 Garbled
1 No Response

BEST MOTOR RESPONSE:
6 Obeys Command
5 Localizes to Pain
4 Withdraw to Pain
3 Abnormal Flexion
2 Extension to Pain
1 No Response to Pain

_____ **Total GCS**

REVISED TRAUMA SCORE:

B/P SYSTOLIC:
4 90 or Greater
3 76 to 89
2 50 to 75
1 1 to 49
0 No Pulse

RESPIRATION/MIN:
4 10 to 29
3 30 or Greater
2 6 to 9
1 1 to 5
0 None

GCS TOTAL:
4 13 to 15
3 9 to 12
2 6 to 8
1 4 to 5
0 3

_____ **Total RTS**

PUPILS:

P.E.R.L. Unreactive/Fixed Pin-Point Unequal Dilated

MEDICAL HX:

MEDICATIONS:

ALLERGY(S):

ECG RHYTHM: TIME:	**ECG INTERPRETATION:**

EMERGENCY CARE:
BLS: Oral Airway Ventilation Oxygen _____ Liters/min NRB/Nasal Cannula Suction C-Spine CPR King Airway
ALS: Blood Glucose _____ E.T. Intubation Size_____ Defibrillation/Cardiovert/Pacing-Capture @: _____
Other: _____

VITAL SIGNS:

TIME	B/P	RESP RATE	PULSE RATE	O2 SAT%

IV ADMIN:

LOCATION	CATH SIZE	SOLUTION	RATE

MEDICATION ADMINISTRATION:

TIME	MEDICATION	DOSE	ROUTE/RATE

MICU NARCOTIC USE RE-SUPPLY:

NARCOTIC	AMT USED	AMT WASTED	PARAMEDIC SIGNATURE	R.N. SIGNATURE

NARRATIVE:

BASE HOSPITAL:	**TRANSPORT TYPE:** CODE 2 GROUND CODE 3 AIR	**RECEIVING R.N./MICN/M.D. NAME:**	**RECEIVING R.N./MICN/M.D. SIGNATURE:**	**SIGN TIME:**

ATTENDANT NAME:	**LIC/CERT#:**	**ARR ED TIME:**	**OFF LOAD TIME:**	**ATTENDANT SIGNATURE:**	**SIGN TIME:**

X. New Business

C. Burn Center Designation Policy

EMS Division Staff Report for EMCAB- February 9, 2017

Burn Center Designation (####.##)

Background

Health and Safety Code 1797.220 and 1797.222 allows for the Division to implement policies and procedures in order to maintain medical control of the EMS System, which includes patient destination policies relating to burn. Several years ago a local hospital established a burn unit within the facility; however, the interest in becoming a burn receiving center for ambulance traffic was not expressed. Recently, a second hospital in Kern County has expanded services to include a burn unit which brought about an interest in seeking designation by the Division as a Burn Center for ambulance destination.

The Dilemma

Kern County did not have a policy to designate a Burn Center, nor were there any established standards for designation. By designating a hospital as a Burn Center, changes would affect the destination decision of pre-hospital personnel and patients suffering from burn injuries. These patients would be directed to hospitals which provide for specialized burn care for the most severely burned patients.

The EMS Division Plan of Action

The Division sought to bridge the gap in burn care by establishing standards for designation, data collection, education and quality assurance participation. The Division created the *Burn Designation Policy* for hospitals to have the opportunity to apply for designation. The policy was discussed at five EMS System Collaborative meetings, and published for three separate public comment periods. The policy has been reviewed and approved by the Division Medical Director.

Therefore IT IS RECOMMENDED, the Board approve the *Burn Designation Policy*, authorize Division staff to make necessary adjustments to related policies for consistency with the *Burn Designation Policy,* and set an implementation date of February 10, 2017.

Burn Center Designation (Number)

I. PURPOSE:

This policy defines the requirements for designation as a Burn Center in Kern County. Burn Center designation establishes that burn patients are transported to the most appropriate facility, which is staffed, equipped, and prepared to administer emergency and/or definitive care appropriate to the needs of burn patients.

II. AUTHORITY:

California Health and Safety Code, Division 2.5, Section(s) 1797.103, 1797.204, 1797.220, 1797.250, 1797.252, 1798.150, 1798.170

III. DEFINITIONS:

A. Burn Center means an intensive care unit in which there are specially trained physicians, physician assistants (PA), nurse practitioners (NP), nursing and supportive personnel and the necessary monitoring and therapeutic equipment needed to provide specialized medical and nursing care to burned patients.
B. Kern County EMS Division (Division) means the Kern County Public Health Services Department, Emergency Medical Services Division. The Division is the Local Emergency Medical Services Agency or LEMSA for Kern County.
C. Interfacility transfer means the transfer of an admitted or non-admitted burn patient from one licensed healthcare facility to another.
D. Pediatric patient means children fourteen (14) years of age or younger.
E. Pediatric Receiving Center (PedRC) means a hospital that has been formally designed by the Division that meets requirements as set forth in the *Pediatric Receiving Center Designation Policies and Procedures*.
F. Trauma Center means a hospital that has been formally designated by the Division that meets requirements as set forth in the *Trauma Policies and Procedures*.

IV. BURN CENTER GENERAL REQUIREMENTS:

A. Burn centers must meet all requirements of California Code of Regulations (CCR), Title 22, Division 5, commencing with Section 70421.
B. In order for a hospital to be designated as a Burn Center for pre-hospital emergency medical services, the hospital must first be licensed by California Department of Public Health, Licensing and Certification Division, as a Burn Center. Licensing as a Burn Center shall be sufficient evidence the Burn Center meets all State requirements for personnel, space, and equipment.

C. Designated Burn Centers shall receive Burn Center Verification from the American Burn Association (ABA) within three years of designation. To maintain designation beyond three years, Burn Centers shall maintain verification.
D. Burn Center designation shall be in accordance with regulations and these policies. Re-designation shall be on three (3) year cycles and include written agreements between the Burn Center and the County of Kern.
E. Designated Burn Centers shall be an approved pre-hospital continuing education provider and provide training and education relating to burn care for EMS personnel and MICNs. Continuing education programs shall be conducted in compliance with Division *Pre-Hospital Continuing Education Provider Policies and Procedures*.
F. Burn Centers shall be designated Base Hospitals. These facilities shall provide on-line medical direction in burn care to pre-hospital personnel regardless of patient destination either in County or transports out of County.
G. All Burn Centers shall participate in community education activities relating to burn prevention efforts.
H. Air transport for burn patients within Kern County shall be in accordance with *EMS Aircraft Dispatch-Response-Utilization Policies*.
I. The Division will charge for regulatory costs incurred as a result of burn center application review, designation, and re-designation. The specific fees are based on Division costs. Fee amounts shall be specified in the County Fee Ordinance Chapter 8.13, if applicable.
J. The Burn Center shall have a representative present at Division sponsored meetings, such as the EMS System Collaborative meetings. Representation at the Trauma Evaluation Committee (TEC) and the Pediatric Advisory Committee (PAC) is recommended, but at a minimum shall be on an as needed basis.
K. At least one physician and one registered nurse in the Emergency Department shall be on duty with current certification in Advanced Burn Life Support (ABLS) or equivalent specialized training in burn care (Board Certification in Emergency Medicine is acceptable).
L. At least one physician shall be on-call at all times with advanced training in burn care, to include:
    1. One year fellowship training in burn treatment and/or two or more years' experience in caring for burns within previous five years.
    2. Board certified or board eligible physician for plastic or general surgery.

V. DATA REQUIREMENTS:

The Burn Center shall submit, at a minimum, the following data to the Division on a quarterly basis. This data will facilitate system management, allow for evaluation of system performance, and community intervention projects, as necessary. Data will be collected on an approved Division reporting tool. De-identified, aggregated data will be reported as numerical measurements for Countywide evaluation. Reports

may be shared with TEC, PAC, EMS System Collaborative, Emergency Medical Care Advisory Board, Kern County Board of Supervisors, or posted for public viewing, if applicable. If mandated by regulation, data may be reported to the Emergency Medical Services Authority of the State of California. The following data elements shall be included:

A. Baseline data, including ambulance transports, to describe the system, including, but not limited to:
    1. Arrival time/date to ED
    2. Date of birth
    3. Gender
    4. Ethnicity
    5. Mode of arrival
    6. Residence zip code
B. Cause of burn, and basic outcomes for CQI to include, but not limited to, the following:
    1. Discharge or transfer diagnosis
    2. Burn location
    3. Burn severity
    4. Cause of burn
    5. Disposition
    6. Discharge or transfer time and date from ED
    7. Admitting facility name, if applicable

VI. PROGRAM MANAGEMENT:

All Burn Centers shall identify personnel who will be responsible for primary interaction with the Division regarding burn specialty care.

A. A Physician Coordinator for burn specialty care
B. A Nursing Coordinator for burn specialty care

VII. INTERCOUNTY COORDINATION:

A. Burn Centers shall plan and implement ongoing outreach to Kern County hospitals for collaboration for education in emergency care of burn patients and consultation via telephone, telemedicine, or onsite regarding emergency care and stabilization, transfer and transport.
B. Accept patients from Kern County who require specialized care not available at non-burn center hospitals within the County through pre-arranged transfer agreements for patients needing specialized burn care.
C. Serve as a county referral center for the specialized care of burn patients or in special circumstances provide safe and timely transfer of patients to other resources for specialized care (trauma, pediatrics, etc..)

VIII. PREHOSPITAL DESTINATION DECISION:

A. Patients with Step 1 or Step 2 trauma triage criteria for injuries in addition to burns shall be transported to a Level I or II trauma center in accordance with *Trauma Policies and Procedures*.
B. Patients meeting Step 3 or Step 4 trauma triage criteria for injuries in addition to burns should consider consult with a Level I or II trauma center for assistance with destination decision in accordance with *Trauma Policies and Procedures*.
C. Patients who meet extremis criteria shall be transported in accordance with *Ambulance Destination Decision Policies and Procedures.*
D. With the exceptions stated above, patients should be transported directly to the closest most appropriate Burn Center bypassing other hospitals if:
    1. Partial thickness (2°) or full thickness (3°) burns that are more than ten percent (10%) total body surface area
    2. Partial thickness (2°) or full thickness (3°) circumferential burns of any part
    3. Partial thickness (2°) or full thickness (3°) burns to face, hands, feet, major joints, perineum, or genitals
    4. Electrical burns with voltage greater than 120 volts
    5. Chemical burns greater than five percent (5%) total body surface area. For transport times to a Burn Center greater than sixty (60) minutes, pre-hospital personnel may consult with a Burn Center for consideration of closest destination.
E. Pre-hospital personnel may consider base contact with a Burn Center to assist in destination decision.

IX. APPLICATION PROCESS FOR BURN CENTER DESIGNATION:

The following milestones outlines the application process for a hospital to become designated as a Burn Center.

A. Submit letter of application to the Division. The letter shall:
    1. Specify the intent to obtain Burn Center designation
    2. Identify names and contact information, including email addresses for the Physician Coordinator and Nursing Coordinator for burn specialty care
    3. Identify the anticipated target date for Burn Center designation
B. Submit copy of California Department of Public Health license as a general acute care hospital showing Burn Center status.
C. Current designation as a paramedic base station in Kern County.
D. Approved pre-hospital continuing education provider.
E. Provide evidence of emergency department and on-call coverage as outlined in section IV.
F. Provide evidence of community education participation relating to burn prevention.

G. Document agreeing to submit data elements as requested by the Division in accordance with section V. above.
H. All application materials will be reviewed for completeness. Additional information may be requested, if needed. Upon determination the application is complete, the Division and the applicant will work towards execution of an agreement.
I. Burn Center designation agreement will be presented to the Kern County Board of Supervisors for approval and formal designation.
J. Upon formal designation the Division will update *Ambulance Destination Decision Policies and Procedures* and *Paramedic Protocols* to reflect the designation and destination changes.

X. RE-DESIGNATION:

The process for re-designation will require submission of the information above. Re-designation of Burn Centers shall be every three (3) years. Re-designation materials must be submitted to the Division ninety (90) days in advance of the expiration date of the designation.

XI. LOSS OF DESIGNATION:

A. Any designated Burn Center which is unable to meet the following requirements shall be subject to termination or loss of Burn Center designation:
    1. Inability to maintain designation requirements as stated in this policy
    2. Failure to comply with any policy, procedure, or regulation mandate by local, state or federal government
B. If the Division finds a Burn Center to be deficient in meeting the above criteria, the Division will issue the Burn Center a written notice, return receipt requested, setting forth with reasonable specificity the nature of the apparent deficiency.
C. Within ten (10) calendar days of receipt of such notice, the Burn Center must deliver to the Division, in writing, a plan to cure the deficiency, or a statement of reasons why the Burn Center disagrees with the Division notice.
D. The Burn Center shall cure the deficiency within thirty (30) calendar days of receipt of notice of violation.
E. If the Burn Center fails to cure the deficient within the allowed period or disputes the validity of the alleged deficiency, the issue will be brought to the Emergency Medical Care Advisory Board (EMCAB) for adjudication. EMCAB may make a recommendation to the Division for resolving the issue.

DRAFT

XII. Miscellaneous Documents for Information

A. EMS Fund Report

EMS DIVISION
KERN COUNTY PUBLIC HEALTH SERVICES DEPARTMENT
MADDY EMS FUND

FISCAL YEAR 2017-17 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 2016	114,276.92	98,595.32	21,287.22	14,789.30		102,812.15			44,198.93		17,484.37	12,570.90
AUGUST 2016	113,434.27	98,749.04	21,218.33	14,812.36		102,651.34			44,038.16		17,355.44	12,590.50
SEPTEMBER 2016	117,282.12	105,288.08	22,257.02	15,793.21		109,018.52			46,129.99		17,944.16	13,424.23
Total for Quarter 1	344,993.31	302,632.44	64,762.57	45,394.87	325,697.10	314,482.01	-	0%	134,367.08	218,347.58	52,783.97	38,585.63
OCTOBER 2016	115,540.42	99,860.13	21,540.05	14,979.02		104,565.67			44,720.37		17,677.68	12,732.17
NOVEMBER 2016	109,773.28	98,570.63	20,834.39	14,785.59		100,866.60			43,180.98		16,795.31	12,567.76
DECEMBER 2016	99,534.26	89,981.32	18,951.56	13,497.20		93,272.09			39,266.71		15,228.74	11,472.62
Total for Quarter 2	324,847.96	288,412.08	61,326.00	43,261.81	313,884.13	298,704.36	-	0%	127,168.06	207,202.42	49,701.73	36,772.55
JANUARY 2017	-	-	-	-		-			-		-	-
FEBRUARY 2017	-	-	-	-		-			-		-	-
MARCH 2017	-	-	-	-		-			-		-	-
Total for Quarter 3	-	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	-
APRIL 2017	-	-	-	-		-			-		-	-
MAY 2017	-	-	-	-		-			-		-	-
JUNE 2017	-	-	-	-		-			-		-	-
Total for Quarter 4	-	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	-
YEAR-END SUP.		-	-								-	
YEAR TO DATE	669,841.27	591,044.52	126,088.57	88,656.68	639,581.23	613,186.37	-	0%	261,535.14	#DIV/0!	102,485.70	75,358.18