

**STATE OF CALIFORNIA  
COMMISSION ON EMERGENCY MEDICAL SERVICES**

**June 15, 2016**

**10:00 A.M. – 1:00 P.M.**

**(Meeting may end early at the completion of all agenda items)**

**Crowne Plaza Sacramento**

**5321 Date Avenue**

**Sacramento, CA 95841**

**Reservations 877-504-0054**

- 1. Call to Order and Pledge of Allegiance**
- 2. Review and Approval of March 16, 2016 Minutes**
- 3. Director's Report**
  - A. EMSA Budget Status
  - B. EMSA Program Updates [Personnel] [Systems] [DMS]
- 4. Legislative Report**
- 5. Consent Calendar**
  - A. Administrative and Personnel Report
  - B. Legal
  - C. EMS Plan Status Update
  - D. Enforcement Report
  - E. Community Paramedic Pilot Project
  - F. EMT Regulation Revisions
  - G. Paramedic Regulation Revisions

**Regular Calendar**

- 6. EMS Authority's Strategic Plan**
- 7. Commission on EMS Bylaws Revision Approval**
- 8. Election to fill Vacancy on Administrative Committee**
- 9. EMS Personnel**
  - A. Tactical Casualty Care Guidelines Approval [Interim] [Proposed]
- 10. EMS Systems**
  - A. Ambulance Patient Offload Time Methodology Guidelines Approval [APOT 1] [APOT 2]
  - B. Wireless 911 Routing Status – William Anderson, Acting Chief of 911 Public Safety Communications, Cal OES
  - C. EMS Plan Appeal Process Update
  - D. CEMSIS Reporting

E. American College of Surgeons State Trauma System Consultation

**11. Disaster Medical Services Division**

A. Disaster Healthcare Volunteer Program

B. Disaster Medical Response Training and Exercises

**12. National EMS Memorial Bike Ride**

**13. Items for Next Agenda**

**14. Public Comment**

**15. Adjournment**

**A full agenda packet will not be provided at the meeting; however, you can print a full packet, including the agenda from the Department's website at [www.emsa.ca.gov](http://www.emsa.ca.gov).** This event will be held in an accessible facility. Individuals with disabilities requiring auxiliary aids or services to ensure accessibility such as language interpreting, assisted listening device, materials in alternate formats or other accommodations, should contact Sandra (Sandi) Baker at (916) 431-3701 ext. 447, no less than 7 days prior to the meeting.

**STATE OF CALIFORNIA  
COMMISSION ON EMS  
WEDNESDAY, MARCH 16, 2016  
EMBASSY SUITES BY HILTON ANAHEIM SOUTH  
11767 HARBOR BOULEVARD, SALON A  
GARDEN GROVE, CA 92840  
(714) 539-3300**

**MINUTES**

**COMMISSIONERS PRESENT:**

Steve Barrow, Dan Burch, Jaison Chand, Steve Drewniany, James Dunford, MD, Aaron Hamilton, Richard O. Johnson, MD, Daniel Margulies, MD, David Rose, Eric Rudnick, MD, Lew Stone, Susan Webb

**COMMISSIONERS ABSENT:**

Linda Broyles, Mark Hartwig, Ruth Haskins, MD, James Hinsdale, MD, Kristi L. Koenig, MD, Alexis F. Leiser, MD, Jane Smith, Kathleen Stevenson, Joy P. Stovell, Dave Teter

**EMS AUTHORITY STAFF PRESENT:**

Howard Backer, MD, Daniel R. Smiley, Sean Trask, Jennifer Lim, Lou Meyer, Michael Frenn

**AUDIENCE PRESENT:**

Severo (Tré) Rodriguez, Executive Director, National Registry  
Mike DuRee, President-Elect, California Fire Chiefs Association

**1. CALL TO ORDER AND PLEDGE OF ALLEGIANCE**

Chairman Lew Stone called the meeting to order at 10:06 a.m. Twelve Commissioners were present. He asked Commissioner Rudnick to lead the Pledge of Allegiance and it was recited.

**2. INTRODUCTION OF NEW COMMISSIONERS**

Chair Stone stated Commissioners Rose, Drewniany, Johnson, and Hamilton have been reappointed to the Commission. He welcomed new Commissioners Steve Barrow, James Dunford, MD, James Hinsdale, MD, and Susan Webb. Chair Stone asked the new Commissioners to introduce themselves and stated Commissioner Hinsdale was unable to attend today's meeting.

**3. REVIEW AND APPROVAL OF DECEMBER 2, 2015, MINUTES**

**Action: Commissioner Rudnick moved approval of the December 2, 2015, Commission on Emergency Medical Services Meeting Minutes as presented.**

**Commissioner Chand seconded. Motion carried unanimously with three abstentions.**

#### **4. DIRECTOR'S REPORT**

Howard Backer, MD, the EMSA Medical Director, presented his report:

##### **A. EMSA Budget Status**

The EMSA 2016 budget was slightly increased due to several grants. Additional grant funding to support the data transformation is in progress.

##### **B. EMSA Program Updates**

###### Personnel

- Lisa Galindo, the EMS Plans Coordinator, has returned to work after a leave.
- Nancy Marker was hired as the Data Analyst.
- Ryan Stanfield was hired as the Health Information Exchange Project Assistant.

###### Legislation

- An air ambulance data bill, which addresses cross-jurisdiction data management
- Two 911 communication bills
- Two Mobile Field Hospital Program bills
- Two CPR education bills that extend the involvement of the public

###### Appeals Regulations Status

The regulations were approved by the Office of Administrative Law (OAL) and go into effect in April of 2016.

###### Comprehensive Data Strategy

Staff has been working with the newly-formed data advisory group to develop a cooperative strategy for improving EMS data and its application that has received widespread acceptance. Assembly Bill (AB) 1129 mandated the use of electronic Patient Care Records (ePCR) and the most recent version of the National EMS Information System, NEMSIS 3.4, by all EMS providers. AB 1129 will help with data quality and consistency but much more is required. The data advisory group is working to optimize the effectiveness and efficiency of the data.

###### Health Information Exchange

EMSA awarded the first local grant and will move into a more technical and developmental phase.

###### Stroke Registry

Staff is working with the Department of Public Health to develop a Stroke Registry across the state. Recently, a group at Stanford has joined in the work with some of the local agencies to apply the stroke data for quality improvement.

## PULSE

Staff is working with the California Health Care Foundation (CHCF) on the Patient Unified Lookup System for Emergencies (PULSE), which is progressing rapidly. Requests for proposal (RFPs) have gone out for the technical component and soon will go out to local sites to pilot the project.

## AB 1223

The AB 1223 Advisory Group has met several times and agreed on some of the components specified in the bill. The next step is to discuss how data should be displayed and reported to EMSA.

## Trauma System Review

The Trauma System Review by the American College of Surgeons will be held in San Diego next week.

## Disaster Activities

- Mobile Field Hospital – If no funding is received this year, this program will be demobilized.
- System Interface Issues – Staff met with the Director of the California Governor’s Office of Emergency Services (Cal OES) on operational issues, which will be resolved at the executive level with Cal OES.
- Field Exercises – The U.S. Department and Health and Human Services (HHS) and the Assistant Secretary for Preparedness and Response (ASPR), has reached out to partner on exercises such as the patient movement plan and patient tracking system. Further details will be supplied in the division and program reports later today.

## Vision for the EMS System

- Develop data that will provide a valid and accurate picture of the EMS System, integrate with EHRs to more easily share and obtain outcomes data, and support quality improvement activities
- Resolve current issues with EMS plans to improve both the information in and the process for submitting those plans
- Complete the regulations governing the system of EMS exclusivity, which are effectively 33 years overdue
- Continue the gradual transformation of the EMS system to expand the role of paramedics and to integrate further within the health care system

## **5. CONSENT CALENDAR**

**A. Legislative Report**

**B. Administrative and Personnel Report**

- C. Legal
- D. Enforcement
- E. EMS Plan Status Report

**Action: Commissioner Rudnick moved approval of the consent calendar. Commissioner Rose seconded. Motion carried unanimously. The item was noted and filed.**

## **REGULAR CALENDAR**

### **6. EMS PERSONNEL**

Sean Trask, the Chief of the EMS Personnel Division, presented his report:

#### **A. Trial Studies**

Mr. Trask summarized the history, enrollment date and numbers, and implementation of the four active trial studies currently underway: three that are studying tranexamic acid (TXA) and an Air-Q (supra-glottic) airway device study. The 18-month report on these trials will be presented at the September and December meetings. Staff received a request for a fourth TXA trial study from the county of Napa, and a request to study the use of ketamine for excited delirium in the pre-hospital setting from the Orange County EMS agency. These applications were reviewed yesterday by the Scope of Practice Committee and are anticipated to be approved soon.

Dr. Backer stated subsequent similar trials must use the same methodology and protocols used by the first county to set up a multi-center trial approach that will pool the results to show a higher level of significance in the outcomes.

Commissioner Margulies cautioned against patients receiving a second dose of TXA as an IV push when they arrive at the hospital. Dr. Backer stated the Scope of Practice Committee discussed this issue yesterday and suggested that TXA information be included in the outcome measures of the EMS report to the trauma center.

Commissioner Margulies suggested that patients receive the dose in the ambulance so it does not delay transport. Commissioner Rudnick stated this point was brought up in the Emergency Medical Directors Association of California (EMDAC) meeting yesterday and someone suggested the use of armbands to indicate that patients have received the drug to help alleviate that issue.

Commissioner Barrow agreed with visual alerts such as the old T on the forehead that indicates there is a tourniquet somewhere on the person.

#### **B. EMT Regulations**

The Fiscal Impact Statement is in review at Agency. Next, the regulations will be reviewed by the Department of Finance (DOF) and then will go out for public comment. Mr. Trask summarized the proposed revisions:

- Add mandatory naloxone training, epinephrine auto-injector training, and tactical care principle training to all EMTs under the local optional scope section
- Remove the Skills-Based Competency Verification Form

- Increase the minimum hours of EMT basic training from 160 to 174 hours and add glucometer training, mandatory training, and tactical casualty care principles

Commissioner Burch stated EMTs should remain at the basic-skill level. There was a unanimous agreement among the local EMS agencies at the Emergency Medical Services Administrators' Association of California (EMSAAC) meeting to not include the drawing of epinephrine in the optional scope section of the regulations. There was concern about scope creep with the additional advanced skills and training hours and the additional requirements make it more difficult to complete the program. There was also concern that most hospital-based medication errors occur at that point.

Dr. Backer stated the majority of the votes in the EMDAC meeting were in favor of the proposed regulation changes, including the additional requirements for EMTs. Although there is acknowledged risk of dosing errors, Dr. Backer stated the rural medical directors needed the option of carrying epinephrine on their rigs because of the expensive nature and relatively short shelf life of auto-injectors.

Commissioner Rudnick stated he, as medical director of a local EMS agency (LEMSA) that represents a rural ideology, has mixed emotions on this issue. He stated geographic distances in rural counties result in negative outcomes. He gave the example of patients being two hours from care. However, he also agreed with Commissioner Burch's concerns about the dosing errors that happen at that point and the difficulty of ensuring adequate training. He stated his LEMSA has an annual training instead of a two-year cycle to try to ensure minimum competency.

### **C. Paramedic Regulations**

Chapter 4 of the Paramedic Regulations was reorganized for better flow. The OAL approved the proposed non-substantive changes; the regulations have been posted on the EMSA website. This completes Phase 1 of a two-part process.

Phase 2 proposes revisions to training program reviews, paramedic approval and training program accreditation requirements, and paramedic applications for licensure and renewal, and will include tactical casualty care training requirements mandated in AB 1598. The Phase 2 revisions are out for stakeholder review prior to public comment phase.

### **D. Community Paramedicine**

Lou Meyer, the Project Manager for the Community Paramedicine Project, stated the pilot projects are running smoothly. He presented his report:

- Re-admission to hospitals has been reduced by 50 percent with paramedics making post-discharge home visits.
- Positive results have been seen from the Behavioral Health Alternate Destination Program with approximately \$800,000 in savings to date.
- The CHCF awarded a mini-grant to do a short video on the Behavioral Health Program in Stanislaus County.

- Positive results have been seen from the Hospice Support Program, where a great number of patients who would normally be transported to an emergency room have been treated in their homes.
- The Frequent User 911 Program continues to refer patients to services. The challenge is costing out the savings in keeping patients out of the ER system. UCSF, the independent evaluator, will use an economist to work through the numbers.
- The Alternate Destination Programs has low enrollment numbers due to a combination of strict criteria, reluctance by some paramedics to refer to urgent care centers, and unreliable service availability.
- All pilot sites submitted their data for last quarter on time for the independent evaluator's review and analysis. The report will be available by the end of the month.
- The Office of Statewide Health Planning and Development (OSHPD) has conducted seven site visits to date and found them to be in full compliance with OSHPD regulations. Three additional site visits will take place this month.

Commissioner Barrow asked if there have been any reports of reimbursement issues for the responders who transport to alternative location destinations. Mr. Meyer stated the majority of the providers are doing this for in-kind services and not seeking reimbursement but, as this program expands across the state, the data to support the funding for these programs will be critical.

Commissioner Barrow asked if the data is being captured for patients who have used the alternative destination location to see if they are frequent flyers. Mr. Meyer stated the Alternative Destination, Mental Health, and Frequent Flyer Programs may touch on that.

#### **E. National Registry of EMTs**

Mr. Trask introduced Severo (Tré) Rodriguez, the Executive Director at the National Registry, who was invited to report on the National Registry skills testing.

Mr. Rodriguez provided an overview, by way of a PowerPoint presentation, of the history, demographics, goals, objectives, saturation level by state, certification logistics, website, YouTube channel, cognitive and psychomotor exams, portfolio process, scenario-testing stations, scenario development workshop process, and process for recertification with the National Registry. Mr. Rodriguez stated the process for recertification has been updated. By April 1, more than 75 percent of the nation will have switched to the National Continued Competency Program model.

Mr. Trask presented his report on the National Registry EMT/Paramedic test pass rates. He showed how California pass rates compared to the national averages and how each school in each LEMSA compared to each other over the past six years. He noted there is a disparity among the EMT training programs but stated there is no explanation for it.

Dr. Backer agreed with the disparity and stated the EMT training certification is at the local level. There are 33 training programs with no set standards. He asked

Mr. Rodriguez to comment on the issue of setting standards for training agencies, how that is done, and how often the results are applied nationally.

Mr. Rodriguez stated it is not uncommon for a state through stakeholder engagement to set a minimum passing threshold of 70 percent or a standard that results must meet or exceed the national first-time pass average. It is a way of measuring performance across geography, population density settings, and resources. He suggested contacting the state office for more details.

Daniel Smiley, the EMSA Chief Deputy Director, stated one of the goals in annually reporting the test pass rates is to recognize that LEMSAs are ultimately responsible for their program approval. This transparent process allows LEMSAs to compare their program to other local programs. Student capabilities and enrollment requirements vary among the schools. The goal of the National Registry testing process for both cognitive and psychomotor activities is to ensure that there is a base level of competency of those students that wish to be certified.

## **7. EMS SYSTEMS**

Jennifer Lim, the Assistant Division Chief of the Disaster Medical Services Division, presented her report highlighting legislation that affects the EMS system. Staff is tracking 21 bills. She encouraged Commissioners and members of the audience to submit opposition or support letters to these bills, as they will help with staff analysis. She stated she was particularly interested in feedback on AB 1300 and the Williams and Rodriguez emergency 911 bills.

Ms. Lim stated AB 1386 will increase community access to auto-injectors, which may also drive the cost up. Staff is working with the author's office to ensure the bill references the new Lay Rescuer Program.

Ms. Lim asked Commissioner Barrow to discuss AB 2425.

Commissioner Barrow stated he was the state co-chair of the two-year project of eight subcommittees looking at unintentional injury, the leading cause of death in hospitalization, for children ages 0 to 19, that came out with 110 recommendations. A number of pieces of legislation have been introduced from them. AB 2425 is a spot bill.

Prevention strategies are not effective due to a lack of uniformity in the environmental and lead-in issues that result in unintentional injuries. The project subcommittees suggested that that information be collected statewide and that incidents be categorized to develop protocols for parents and families to help stop these incidents from happening. Counties with forms for collecting that information will be used as models for developing a state standard.

Mr. Smiley presented his report. He summarized the topics of data, quality improvement, and information:

The EMS Core Measures Project

- Goal: To connect the 17 clinical measures with the National EMS Compass Performance Measures Project

- Next: Convert existing Core Measures elements to match the NEMESIS 3.4

#### Electronic Health Records (EHRs)

- Every EMS provider is mandated per AB 1129 to have an EHR
- Funding is being sought through the National Highway Traffic Safety Administration to help with the transition to EHRs
- EHRs must be interoperable - the Health Information Exchange Project is helping to drive some of that
  - A grant has been awarded to San Diego Health Connect for the implementation of the Search, Alert, File, and Reconcile (SAFR) model - a model for EMS bidirectional information
  - A grant will soon be awarded to the Patient Unified Look-Up System for Emergencies (PULSE), which connects multiple health information organizations
  - A 90-10 funding grant will be available to EMS for implementation of interoperability from EMS to hospitals

The Physicians Order for Life-Sustaining Treatment (POLST) technology platform and site grant requests will be going out from the CHCF next week

The Ambulance Patient Offload Time Criteria Methodology Group is developing a standard methodology, as required by AB 1223, to measure the time from hospital arrival until transfer of care.

The Health Information Exchange Summit will be held at the Garden Grove Hyatt Regency on April 19th and 20th.

Commissioner Margulies stated the use of tourniquets hearing was canceled. The National Association of EMTs (NAEMT) is working with the American College of Surgeons (ACS) to revise the course. He asked if EMSA should be involved in this process.

Mr. Smiley stated he could report on current EMSA training activities in tactical casualty care at the next meeting. The use of tourniquets by bystanders has not yet been addressed.

Commissioner Margulies suggested broadening the revised training to bleeding control rather than just tourniquets and considering local implementation of the training.

Commissioner Chand stated the Commission appointed a task force two years ago to look into the patient offload delay issue. Over the last two years, the problem has worsened. He stated the importance of ensuring that the resolution of this issue remains a high priority. He gave examples from across the state to demonstrate the gravity of the situation and the impact this issue has on EMS.

#### **A. EMS Plan Appeal Regulations**

Mr. Smiley stated the EMS Plan Appeal Regulations were approved by the Office of Administrative Law and will become effective on April 1st. The regulations have been posted on the EMSA website.

Commissioner Burch asked staff to keep the Commission advised of the scheduling process for the pending ALJ hearings.

**B. Wireless 911 Routing Status**

Mr. Smiley stated a representative from the Cal OES will be invited to discuss wireless 911 routing at the June meeting in Sacramento.

**C. State Trauma Plan**

Mr. Smiley stated the State Trauma Plan is currently under review at the California Health and Human Services Agency (CHHS).

**D. Chapter 13 Workgroup**

Mr. Smiley stated the Chapter 13 Workgroup has been temporarily suspended.

**8. DISASTER MEDICAL SERVICES DIVISION**

Michael Frenn, a Specialist in the Disaster Medical Services Division, presented his report:

**A. Patient Movement**

The EMSA contracted with Emerging Technologies in 2014 to develop a Statewide Patient Movement Plan for patient movement, evacuation, and repatriation during major catastrophic events. A work group made up of subject matter experts has been meeting over the past year to study multi-casualty events (MCEs) that have occurred nationally. A draft plan is expected later in the year.

Commissioner Drewniany asked if a representative from the National Disaster Medical System (NDMS) is partnering with the EMSA on how to move patients out of the state. Mr. Frenn answered in the affirmative. Federal integration is a large component of the plan.

Commissioner Dunford suggested including the American Red Cross in the discussion to avoid duplication since they already have a system in place. Mr. Frenn agreed and stated the American Red Cross is at the table on this project.

Commissioner Barrow stated the importance of tracking licensees to learn where they practice. He suggested contacting the licensing boards to find out if they have made any progress on this issue.

Mr. Frenn stated EMSA manages the Disaster Health Care Volunteer Registry that is implemented at the local level. Seventy thousand individuals comprised of 45 disciplines are in the system and the registry is continually growing.

**B. HICS Update**

The Hospital Incident Command System (HICS), originally created in 1991 through a grant project between EMSA and Orange County, is now being implemented internationally.

Materials are being translated into other languages and issued an International Standard Book Number (ISBN). Representatives from other countries are contacting EMSA to assist with the translations.

Recently, Mr. Smiley and former Division Chief Schoenthal traveled to Dubai to present HICS at a conference.

## **9. ELECTION OF OFFICERS**

Chairman Stone reminded Commissioners of the officer nominations from the last meeting. No further nominations were made. Chair Stone declared the nominations closed and that the following Commissioners were voted into office by acclamation:

- Chairman of EMSA for 2016 is Dan Burch
- Vice Chair of EMSA for 2016 is Steven Drewniany
- Jaison Chand and Lewis Stone are part of the Administrative Committee as representatives of EMSA

Dr. Backer presented a plaque in appreciation of former Chairman Stone's leadership of the Commission to thank him for his service over the last few years. Dr. Backer stated the hope that former Chairman Stone will continue to participate in EMS matters in the state.

## **10. ITEMS FOR NEXT AGENDA**

Commissioner Hamilton suggested a report on ambulance patient offload delays.

Commissioner Margulies suggested a report on the findings from the ACS trauma assessment.

Commissioner Dunford suggested a discussion on school CPR in the state.

## **11. PUBLIC COMMENT**

Mike DuRee, the President-Elect of the California Fire Chiefs Association (CalChiefs), stated he was frustrated with the lack of public comment on the individual items presented on the agenda, specifically on the nomination of officers. He stated CalChiefs does not agree with Mr. Burch regarding the interpretation of some sections of the California Health and Safety Code that impact the delivery of emergency medical service. Mr. DuRee requested that steps be taken to ensure that matters under Chairman Burch's responsibility as chair of EMSA be handled fairly and without bias.

Mr. Meyer spoke as a member of the public. He acknowledged the good work and skill level that Lewis Stone brought as Chairman over the past years in moving the Commission through tough discussions in a professional manner.

## **12. ADJOURNMENT**

**Action: Commissioner Drewniany moved to adjourn the meeting. Commissioner Barrow seconded. Motion carried unanimously.**

Chairman Burch adjourned the meeting at 12:29 p.m.

## EMS PERSONNEL DIVISION PROGRESS REPORT

June 15, 2016

ACTIVITY	PRIMARY CONTACT	STATUS/COMMENT
1. First Aid Practices for School Bus Drivers	Lucy Chaidez	There are 11 school bus driver training programs currently approved. Renewal reviews are ongoing. Technical assistance to school staff and school bus drivers is ongoing.
2. Child Care Provider First Aid/CPR Training Programs	Lucy Chaidez	There are currently 21 approved programs. Renewal reviews are ongoing. Technical assistance is being provided to child care training program instructors and directors, licensing staff, and child care providers. EMSA First Aid and CPR sticker sales are ongoing.
3. Preventive Health Training Programs	Lucy Chaidez	There are 22 preventive health training programs approved. EMSA continues to provide extensive technical assistance to child care providers and licensing staff regarding AB 290, the new children's nutrition training. EMSA is continuing its work to revise the Chapter 1.1 Training Standards for Child Care Providers. EMSA continues to be a part of the Child Care Disaster Preparedness Workgroup which developed a child care disaster annex to the state disaster plan; that plan will be distributed July 2016. EMSA is serving on the state-wide Child Care Regulatory Workgroup to improve child care licensing regulations and children's health and safety; topics we are tackling include overall training needs, infant safe sleep, medication administration, and inclusion of children with special needs. EMSA is also participating, along with CDPH, in a CDC grant to reduce obesity in preschoolers; the project focuses on improving the EMSA Child Care Nutrition Website. Renewal reviews are ongoing. Technical assistance to instructors and child care providers is ongoing. EMSA Preventive Health sticker sales are ongoing.
4. Child Care Training Provider Quality Improvement/Enforcement	Lucy Chaidez	Technical assistance and education regarding compliance issues is continually given to approved training programs, child care providers, DSS community care licensing, and child care resource and referral staff. Currently, there is one open complaint case involving EMSA-approved training programs.
5. Automated External Defibrillator (AED) Requirements for EMT's, Public Safety and Layperson	Betsy Slavensky Extension 461	On September 3, 2015 Senate Bill (SB) 658 (Hill, 2015) <i>Automated external defibrillators</i> was signed by the Governor and amended Section 1714.21 of the Civil Code and Section 1797.196 of the Health and Safety Code. This bill reduces liability conditions on persons or entities that acquire an AED. In addition, the statute removes numerous requirements that are identified in Chapter 1.8, making these regulations inconsistent and in conflict with the statute. EMSA is in the process of reviewing ways to address the new implications of SB 658, while fielding many phone calls regarding the changes.
6. BLS Training and Certification Issues	Betsy Slavensky	Providing ongoing daily support and technical assistance to EMTs and Certifying Entities. EMSA is editing and opening the EMT regulations for public comment, implementing SB 1438, which requires the addition of naloxone to training and scope of practice for all EMTs. In addition to changes for SB 1438, regulation revisions under consideration include: <ul style="list-style-type: none"> <li>• Scope of practice changes to allow EMTs to use epinephrine auto-injectors and glucometers.</li> <li>• Addition of tactical casualty care found in Assembly Bill (AB) 1598 (Rodriguez, 2014) <i>Emergency response services: active shooter incidents</i>.</li> </ul>

## EMS PERSONNEL DIVISION PROGRESS REPORT

June 15, 2016

		<ul style="list-style-type: none"> <li>• Simplification of the initial and renewal certification requirements.</li> <li>• Changes to reinstatement requirements and consistent expiration dates.</li> <li>• The skills verification process along with the inclusion of high fidelity simulation patient contacts.</li> </ul> <p>EMSA currently anticipates opening the rule-making in June 2016 and seeking approval of the regulations from the Commission on EMS at the September 2016 meeting.</p>
7. State Public Safety Program Monitoring	Betsy Slavensky	Provide ongoing review, approval & monitoring of State Public Safety EMSA approved Public Safety First Aid/CPR, EMR, and EMT programs for statutory and regulatory compliance. Revisions to the Chapter 1.5 regulations were approved and took effect April 1, 2015. The regulations require 21 hours of initial training for peace officers, firefighters and lifeguards, and eight hours of retraining every two years. Working with POST to develop the curriculum and testing competency standards as they apply to peace officers. All training programs must include a curriculum that complies with the new public safety course content no later than April 1, 2017.
8. My License Office/ EMT Central Registry Audit	Betsy Slavensky	EMSA is continuing to monitor the EMT Central Registry to verify that the 80+ certifying entities are in compliance with the California Code of Regulations regarding data entry including background checks and disciplinary notification for all EMT personnel. Correspondence is maintained via Newsletter, email, phone, and EMS Coordinator meetings with certifying entities to disseminate updates, changes and corrections. Website improvements continue for ease of certification staff use and EMT resources. Ongoing development of discipline and certification procedures is in progress to support central registry processes and reduce time spent on technical support.
9. Epinephrine Auto-injector Training and Certification	Corrine Fishman Extension 927	On January 1, 2016 the EMS Authority began accepting applications for training programs to provide training and certification for the administration of epinephrine auto-injectors to the general public and off-duty EMS personnel. EMSA has approved two epinephrine auto-injector training programs and has certified 8 individuals.

**EMS SYSTEMS PROGRESS REPORT**  
**June 15, 2016**

<p>1. Trauma:</p>	<p>Bonnie Sinz          Extension          460</p>	<p><u>State Trauma Advisory Committee (STAC):</u>          The STAC met on May 2, 2016. The main agenda item was the American College of Surgeons' (ACS) State Trauma System Consultation visit in March 2016. Other agenda items included an update on the trauma regulation revision process, the ACS <i>Needs Based Assessment of Trauma Systems</i> Tool, the re-triage guidance draft and study, and the June Trauma Summit.</p> <p><u>Regional Trauma Coordinating Committees (RTCC)</u>          Each Regional Trauma Coordinating Committee representative provides regional activity updates at the STAC meeting and provides documents approved by the RTCC and available for statewide use. Details of current activities can be found on the EMSA website at <a href="http://www.emsa.ca.gov">www.emsa.ca.gov</a>. The State Trauma Coordinator participated in RTCC conference calls and attends meetings as schedule permits.</p> <p><u>Performance Improvement and Patient Safety (PIPS) Subcommittee</u>          The DRAFT State PIPS Plan is under review by the EMS Authority management staff. Revisions will be made as needed.</p> <p><u>Regional Trauma Network for Re-Triage Subcommittee</u>          The <i>Regional Trauma Network for Re-Triage</i> guidance document draft was presented at the May STAC meeting with minor revisions recommended. The draft will be revised and forwarded to the EMS Division management for approval to send out for public comment. The document provides re-triage guidelines, non-trauma center early management protocols, data collection and analysis regarding re-triage and IFT patterns throughout the state, and the identification and development of functional regional trauma networks linked by regional cooperative agreements that will reduce delays and improve communication and collaboration.</p> <p><u>Trauma Centers</u>          Ridgecrest Regional Hospital in Kern County was designated as a level IV Trauma Center May 2016. There are now 78 designated Trauma Centers in</p>
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**EMS SYSTEMS PROGRESS REPORT**  
**June 15, 2016**

		<p>California.</p> <p><u>American College of Surgeons Visit</u>  The American College of Surgeons (ACS) conducted a State Trauma System Consultation survey for California March 22-25, 2016. The ACS team met with California trauma partners at the Holiday Inn Bayside in San Diego. More detail on the visit is provided in the June 2016 Issue Memo.</p>
2. STEMI/Stroke Systems of Care	Farid Nasr Extension 424	<p>EMSA staff created a small work group to evaluate and solve the issue on the Data section of the STEMI Regulations, and continue to work with the STEMI Regulations Taskforce members to revise the draft STEMI regulations to bring them in compliance with Rulemaking requirements under the Administrative Procedure Act.</p> <p>EMSA in collaboration with the California Department of Public Health is working on a project to create and implement a Stroke Registry based on the Paul Coverdell National Acute Stroke Program for the Stroke Centers in California to capture the data variables related to Stroke patients and use them for the program quality improvement based on the National recommendation in Stroke patient management.</p>
3. EMS Systems, Standards, and Guidelines	Lisa Galindo Extension 423	<p>The EMS System, Standards, and Guidelines (dated June 1993) are available on the EMS Authority's website. An EMS Plan Workgroup continues to meet, discuss, and draft proposed changes to the Guidelines and EMS Plan submission process.</p>
4. EMS Transportation	Laura Little Extension 412	<p><u>EMS Systems Regulations Work Group / Chapter 13 Task Force</u>: Suspended pending outcome of Federal Lawsuit.</p> <p><u>Request for Proposals</u>:  Request for Proposals (RFPs) for Exclusive Operating Areas continue to go through a dual review process, to ensure that they meet statutory requirements as well as address EMSA Guideline #141 "Competitive Process for Creating Exclusive Operating Areas". The EMS Authority continues to provide technical</p>

**EMS SYSTEMS PROGRESS REPORT**  
**June 15, 2016**

		<p>assistance to LEMSAs by email, phone, and mail in order to help them create a RFP that meets all required criteria.</p> <p><u>Bi-Annual Statewide Public Safety Air Rescue Inspections:</u>          Bi-Annual inspections of all CHP helicopters will begin Fall of 2016.</p> <p>Based on the inability to conduct required CAL FIRE helicopter inspections, they are not an authorized air medical provider.</p>
5. Poison Center Program	Lisa Galindo Extension 423	<p>The California Poison Control System (CPCS) is one of the largest single providers of poison control services in the U.S. The CPCS receives approximately 330,000 calls a year from both the public and health professionals through a toll-free hotline that is accessible 24-hours a day, 7 days a week.</p> <p>Quarterly reports continue to be submitted to the EMS Authority for review to ensure contractual compliance.</p> <p>In May 2016, a program presentation was provided to the California Department of Public Health for continued support of Federal Block Grant funding.</p>
6. EMS Plans	Lisa Galindo Extension 423	<p>The EMS Authority continues to review EMS Plans and annual Plan Updates submitted by the LEMSAs. A quarterly report to the Commission reflecting the progress and timelines of the EMS plan submissions has been provided.</p> <p>The EMS Plan Workgroup meets regularly and continues to review <i>EMSA Guidelines #101</i>, for revision.</p> <p>In May 2016, a program presentation was provided to the California Department of Public Health for continued support of Federal Block Grant funding.</p>
7. EMS for Children Program	Heidi Wilkening Extension 556	<p><u>Regulations:</u>          EMS Authority staff is in the final step in revisions to the EMS for Children Regulations to ensure clarity of the language. EMS Authority staff is anticipating the proposed regulations will be finalized and the OAL process will be expected</p>

**EMS SYSTEMS PROGRESS REPORT**  
**June 15, 2016**

		<p>to begin following an EMS for Children meeting in June 2016.</p> <p><u>CFED:</u>  The partnership with CFED has been a great opportunity for EMS for Children outreach within the EMS system in California. The EMS for Children program coordinator will attend the pediatric sessions available at CFED 2016.</p> <p><u>Educational Forum:</u>  The EMS for Children Educational Forum in northern California will be held on October 24, 2016 in Sacramento at the Doubletree by Hilton Hotel. Staff has been working on obtaining speakers with pediatric presentations for the forum.</p> <p><u>HRSA Grant:</u>  The next four-year HRSA grant cycle will start on March 1, 2017. Discussions have begun regarding the upcoming 2017-2021 HRSA grant application.</p>
<p>8. CEMSIS-EMS Data</p>	<p>Adrienne Kim  Extension 742</p>	<p>CEMSIS now has 20 LEMSAs participating as some level in the submission of EMS data. We are in the process of providing technical assistance and guidance to local EMS agencies, providers and software vendors on the transition to NEMSIS Version 3.4 consistent with AB 1129 which implemented HSC 1797.227 on January 1, 2016. We will stop accepting NEMSIS Version 2.2.1 at the state level effective January 1, 2017. We are in the final stages of preparation to send out the first state level aggregate data report from the information we have in CEMSIS. This report factors many of the common data elements and is our first run at putting out state level data reports from CEMSIS EMS.</p>
<p>9. CEMSIS – Trauma Data</p>	<p>Bonnie Sinz  Extension 460</p>	<p>There are 27 Local EMS agencies (LEMSA) with designated Trauma Centers. Trauma Centers are physically located in 37 of the 58 counties. Currently 26 LEMSAs are transmitting into CEMSIS-Trauma representing 73 of the 75 designated Trauma Centers. The State Trauma Coordinator is providing technical assistance to Imperial County (2-level IV Trauma Centers) to obtain their trauma data. For years 2013 through 2015 there are over 139,000 records in the CEMSIS-Trauma data system. The EMS Authority is currently developing a report for each LEMSA showing data completion compliance to be shared with</p>

**EMS SYSTEMS PROGRESS REPORT**  
**June 15, 2016**

		their Trauma Centers.
10. Grant Activity Coordination	Kay Spencer Extension 441	<p><u>Office of Traffic Safety (OTS) Grants:</u>          EMSA currently is involved with two (2) OTS grants. The CEMSIS project continues to improve the data traffic profile within the EMS and Trauma data that is collected in CEMSIS. The Traffic-related EMS Data Mapping project continues to develop a Geographic Information System (GIS) spatial boundaries map that will display traffic crash related data.</p> <p>In January 2016, EMSA applied for three (3) OTS grants for the upcoming 2017 Federal Fiscal Year. These grant applications concentrate on further implementation of NEMSIS Version 3 with CEMSIS, increased storage capability for data that will be stored and formatted using NEMSIS Version 2.2.1 and Version 3, and will assist local EMS providers in post-crash survivability data collection efforts. The anticipated tentative award letters for these potential grants will be released in June 2016.</p> <p><u>Health Resource Services Administration (HRSA) Grant:</u>          EMSA staff continues the work associated with the Health Resource Services Administration (HRSA) grant in further integration of the Emergency Medical Service for Children (EMSC) into the State EMS system. EMSA staff is compiling information and data for the Annual HRSA Performance Report. This report measures the integration of the EMS for Children program into the State EMS system.</p> <p><u>Preventative Health and Health Services Federal Block Grant (PHHSFBG):</u>          EMSA staff remained continually involved in the Preventative Health and Health Services Federal Block Grant and have identified and outlined goals, objectives and annual activities associated with the EMS Systems Division for the upcoming 2016/17 SFY.</p> <p>EMSA staff participated in the Centers for Disease Control and Prevention (CDC) compliance review with CDPH that focused on Federal Fiscal Years 2013</p>

**EMS SYSTEMS PROGRESS REPORT**  
**June 15, 2016**

		and 2014. EMSA management and PHHSBG Program Coordinators presented the nine (9) identified programs that align their goals and objectives with the National Healthy People 2020 Objectives to CDC representatives. The compliance review was successful and CDC will recommend a full compliance rating.
11. Communications	Heidi Wilkening Extension 556	EMSA personnel are working with the Office of Emergency Services (OES) to address public concerns on issues related to Wireless 9-1-1.
12. Core Measures	Adam Davis Extension 409	The Core Measure Reports for 2015 data have been collected by EMSA. 28 of the 33 LEMSAs provided information to EMSA. The Quality Improvement Coordinator is compiling the submitted information and will be developing the annual core measures report. EMSA continues to host Core Measures Task Force meetings. Currently Core Measures Task Force is determining the best approaches to the 2016 and 2017 data year and the transition to NEMSIS 3.4.
13. EMS Plan Appeal Regulations	Teri Harness Extension 462	The appeal regulations became effective April 1, 2016. The Commission now has a process in place to address appeals of EMS Plans by the EMS Authority. As of April 1, 2016, two local EMS agencies have appeals pending with the Commission and we are working with those local EMS agencies to get their appeals scheduled for hearing.
14. HIE Summit	Adam Davis Extension 409	The 2016 HIE in EMS Summit at the Hyatt Regency Orange County in Garden Grove, CA and was attended by over 190 EMS representatives. The event took place on April 19 <sup>th</sup> and 20 <sup>th</sup> and hosted EMSA's federal, state, and regional partners in HIE. EMSA is now hosting the presentations files on the EMSA website at <a href="http://www.emsa.ca.gov/hie">www.emsa.ca.gov/hie</a> .
15. Office Support	Lori O'Brien Extension 401	Attended and participated as note taker in three APOT meetings. Continue to work on the production of several statewide EMS reports (Reports had to be completely recreated due to new data runs). Provided logistics support and production for the ACS Meeting, the HIE Summit, and am currently working on the upcoming Trauma Summit. Created a new procedure for Non-State employees Travel Expense Claims (TECs) for reimbursement (procedure is currently under review by management and has not yet been implemented).

**EMS SYSTEMS PROGRESS REPORT**  
**June 15, 2016**

		Created a new procedure for submission and routing of correspondence that reduces paper used, and eliminates unnecessary email attachments. Continue to streamline office processes including redesigning forms, correspondence tracking, report formatting, TECs ordering office supplies, and other general support duties.
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**Emergency Medical Services Authority  
Disaster Medical Services Division  
Major Program Activities  
June 2016**

<b>Activity &amp; Description</b>	<b>Primary Contact EMSA (916) 322-4336</b>	<b>Updates</b>
<b>1. Ambulance Strike Team (AST)</b>	Michael Frenn, ext. 435	<p>AST/MTF Leader Trainings continue on an ongoing basis, when requested. In April, courses were conducted in Central and Southern California. A Northern California course is anticipated in late spring. The curriculum continues to improve and a standardized method for tracking units working a strike team is being developed. Information regarding the AST Program can be found at: <a href="http://www.emsa.ca.gov/Ambulance_Strike_Team">http://www.emsa.ca.gov/Ambulance Strike Team</a>.</p> <p>The Disaster Medical Support Units (DMSU), which support and have affiliated ASTs are strategically placed with local EMS Agencies and ambulance providers throughout the State. All available DMSUs have been distributed providing a total of 41 DMSUs with affiliated ASTs in the State.</p>
<b>2. California Medical Assistance Teams (CAL-MAT) Program</b>	Michael Frenn, ext. 435	EMSA continues its reorganization of the CAL-MAT program with a strategic focus on balancing resources with anticipated response needs. Efforts that were focused on identifying the appropriate Civil Service route for hiring CAL-MAT personnel have been successful and progress continues towards recruitment. EMSA maintains a response readiness level for this program in accordance with previously published standards.
<b>3. CAL-MAT Cache</b>	Craig Johnson, ext. 4171	EMSA has completed bi-annual inventory maintenance on all three CAL-MAT caches. Medical supplies and pharmaceuticals are 100% accounted for and ready for immediate deployment. Annual servicing of the biomedical equipment has been completed.
<b>4. California Public Health and Medical Emergency Operations Manual (EOM)</b>	Jody Durden, ext. 702	The Regional Disaster Medical and Health Specialists (RDMHS) conduct EOM training on an ongoing basis. The EOM Workgroup is currently in the process of revising the EOM based on lessons learned since the initial 2011 release. Additional Function Specific topics will be added.
<b>5. California Crisis Care Operations Guidelines</b>	Bill Campbell, ext. 728	This project is on hold at this time as EMSA and California Department of Public Health (CDPH) assess priorities due to current fiscal challenges.
<b>6. Disaster Interest Group (DIG)</b>	Patrick Lynch, ext. 467	The DIG has been suspended due to the re-prioritization of DMS staff projects.

**Emergency Medical Services Authority  
 Disaster Medical Services Division  
 Major Program Activities  
 June 2016**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p><b>7. Disaster Healthcare Volunteers (DHV) of California (California's ESAR-VHP program): Registering, Credentialing &amp; Mobilizing Health Care Personnel</b></p>	<p>Patrick Lynch, ext. 467</p>	<p>The DHV Program has over 21,000 volunteers registered. Over 19,009 of these registered volunteers are in healthcare occupations.</p> <p>All 58 counties have trained System Administrators. EMSA provides routine training and system drill opportunities for all DHV System Administrators.</p> <p>Over 8,900 of the 21,000 DHV registered responders are Medical Reserve Corps (MRC) members. EMSA trains and supports DHV System Administrators in each of the 41 participating MRC units.</p> <p>EMSA has distributed copies of the "DHV Volunteer Handbook." This handbook informs volunteers about the state's DHV Program, and provides information about deploying in response to a disaster.</p> <p>DHV System Administrator training, DHV user group webinars, and quarterly DHV drills are ongoing.</p> <p>EMSA publishes the "DHV Journal" newsletter for all volunteers on a tri-annual basis. The most recent issue was released in mid-May of 2016.</p> <p>The "DHV Journal" is available on the DHV webpage of the EMSA webpage: <a href="http://www.emsa.ca.gov/disaster_healthcare_volunteers_journal_page">http://www.emsa.ca.gov/disaster_healthcare_volunteers_journal_page</a>.</p> <p>The DHV website is: <a href="https://www.healthcarevolunteers.ca.gov">https://www.healthcarevolunteers.ca.gov</a>.</p> <p>The DHV Deployment Operations Manual (DOM) is available on the EMSA webpage: <a href="http://www.emsa.ca.gov/Media/Default/PDF/DHV_DOMRevisionFebruary21-2012.pdf">http://www.emsa.ca.gov/Media/Default/PDF/DHV_DOMRevisionFebruary21-2012.pdf</a>.</p>

**Emergency Medical Services Authority  
Disaster Medical Services Division  
Major Program Activities  
June 2016**

<b>Activity &amp; Description</b>	<b>Primary Contact EMSA (916) 322-4336</b>	<b>Updates</b>
<p><b>8. Exercises and Training</b></p> <p><b>Weapons of Mass Destruction (WMD)</b></p> <p><b>Medical Health Operations Center Support Activities (MHOCSA)</b></p> <p><b>Statewide Exercises: California Capstone 2015 - 2016</b></p>	<p>Bill Campbell, ext. 728</p> <p>Bill Campbell, ext. 728</p> <p>Bill Campbell, ext. 728</p>	<p>The California Emergency Medical Response to Weapons of Mass Destruction Incidents (with Med-Plus) course is offered on a request basis, requiring a minimum enrollment of 12 students.</p> <p>The initial Medical Health Operations Center Support Activities (MHOCSA) course was offered in Southern California on February 23 &amp; 24, 2016. The curriculum is being updated based on feedback received at that class. Additional classes will be scheduled soon.</p> <p>California Capstone 2015 was based on the Southern California Catastrophic Earthquake Plan Scenario and response. EMSA participated in the multi-day Emergency Operations Center (EOC) exercise in May 2015. The lessons learned in the exercise will be tested in upcoming exercises.</p>
<p><b>2015 Statewide Medical and Health Exercise (2015 SWMHE)</b></p>	<p>Theresa Gonzales, ext. 1766</p>	<p>On November 19th, 2015 the EMS Authority participated in the Statewide Medical and Health Exercise (SWMHE) in partnership with the California Department of Public Health (CDPH). The exercise was designed as a multiphase exercise program for statewide participants to exercise response to an influenza pandemic. The SWMHE included objectives for Ambulance Services, Community Clinics, EMS Agencies, Fire Services, Hospitals, Law Enforcement, Long Term Care Facilities, Medical Examiners/Coroners, Offices of Emergency Management, and Public Health. The jurisdiction-specific objectives were designed to further enhance participants' exercise play. This year's exercise is scheduled for November 17, 2016. The 2016 exercise scenario is a mass casualty incident.</p>
<p><b>9. Hospital Available Beds for Emergencies and Disasters (HAvBED)</b></p>	<p>Nirmala Badhan, ext. 1826</p>	<p>EMSA continues working with the California Department of Public Health (CDPH) and other partners to integrate hospital data collection that meets federal HavBED requirements.</p>

**Emergency Medical Services Authority  
Disaster Medical Services Division  
Major Program Activities  
June 2016**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p><b>10. Hospital Incident Command System (HICS)</b></p>	<p><a href="mailto:hics@emsa.ca.gov">hics@emsa.ca.gov</a></p>	<p>The Fifth Edition of HICS was released in May of 2014 and is available on the EMSA website for download: <a href="http://www.emsa.ca.gov/disaster_medical_services_division_hospital_incident_command_system">http://www.emsa.ca.gov/disaster_medical_services_division_hospital_incident_command_system</a>.</p> <p>The 2014 revision project did not include the development of education and training materials. Refer to the list of HICS Trainers to view vendors which have identified themselves as providers HICS training based on The HICS Guidebook, Fifth Edition: <a href="http://www.emsa.ca.gov/media/default/HICS/HICS_Training_7.pdf">http://www.emsa.ca.gov/media/default/HICS/HICS_Training_7.pdf</a>. The California Emergency Medical Services Authority does not endorse or recommend any provider. If you are a trainer that would like to be added to this list, please send a request to: <a href="mailto:hics@emsa.ca.gov">hics@emsa.ca.gov</a> along with your contact information.</p> <p>EMSA would like to receive copies of After Action Reports (AAR) and presentations on the use of HICS. This information will aid future revisions. These informative documents should be addressed to the HICS Coordinator via email: <a href="mailto:hics@emsa.ca.gov">hics@emsa.ca.gov</a>.</p>
<p><b>11. Medical Sheltering</b></p>	<p>Bill Campbell, ext. 728</p>	<p>The California Department of Public Health (CDPH) released the guidance entitled “California Guidance and Toolkit for Sheltering Persons with Medical Needs” in October 2014. This document will be used as a foundational document when EMSA has the staff resources to revise the “Emergency Medical Services Field Treatment Site (EMS FTS) Guidelines.”</p>
<p><b>12. Mission Support Team (MST) System Development</b></p>	<p>Michael Frenn, ext. 435</p>	<p>Based on lessons learned from the last two full scale exercises conducted by EMSA (Golden Guardian 2012 at Sacramento State University and Golden Guardian 2013 at Moffett Field), the MST program is being reviewed in an effort to structure it to adequately support EMSA’s Mobile Medical Assets. Inter-Governmental Employee Exchange Agreements are now being sent to local governments to permit compensating them for their employee’s participation when deployed by EMSA on an MST. Use of CAL-MAT personnel is also being evaluated for suitability with this response capability.</p>

**Emergency Medical Services Authority  
Disaster Medical Services Division  
Major Program Activities  
June 2016**

<b>Activity &amp; Description</b>	<b>Primary Contact EMSA (916) 322-4336</b>	<b>Updates</b>
<b>13. Response Resources</b>	Craig Johnson, ext. 4171	<p>The Bi-annual inventory maintenance of the Mission Support Team (MST) caches has been completed. The MST caches are constantly being refined on After Action Reports following exercises and real word deployments. In addition, the Response Resources Unit (RRU) is currently working to add I.T. equipment to improve MST networking and Internet functionality in the field.</p> <p>The RRU has begun conducting audits on the 42 Disaster Medical Support Unit (DMSU) vehicles located around the State. During the audits, EMSA will verify that all the DMSU vehicles are being properly maintained and utilized according to written agreements. 32 audits have been completed so far with no major problems noted. Annual servicing of the biomedical equipment for the California Medical Assistance Teams (CAL-MAT) caches is completed. The RRU is currently working to establish a multi-year contract to service the biomedical equipment.</p> <p>General annual maintenance for generators, forklifts, and fleet vehicles has been completed with no major problems noted.</p>
<b>14. Regional Disaster Medical/Health Specialists (RDMHS) Program and Medical Mutual Aid System</b>	Nirmala Badhan, ext. 1826	<p>The RDMHS program continues to work with EMSA and California Department of Public Health (CDPH) staff in supporting major disaster planning activities in addition to supporting information management processes. The RDMHSs have been instrumental in the response to recent events such as the Butte and Valley Wildfires in California and the Waterman Incident in San Bernardino County.</p>
<b>15. Mobile Field Hospital (MFH) Program</b>	Craig Johnson, ext. 4171	<p>Three 200-bed MFHs are being stored in Sacramento, California. Due to a loss in program funding the MFHs are no longer considered rapidly deployable. However, the MFH shelters remain a viable asset and can be deployed to support a response. In addition, EMSA will continue to work with the Regional disaster Medical Health Coordinators (RDMHC) program to pre-identify sites for a MFH deployment. The identified sites remain viable options for CAL-MAT, ACS, and other Federal resources. Although the MFH program is without funding, EMSA continues to try to identify alternatives to sustain this valuable program without stressing the State budget.</p>

**Emergency Medical Services Authority  
Disaster Medical Services Division  
Major Program Activities  
June 2016**

<b>Activity &amp; Description</b>	<b>Primary Contact EMSA (916) 322-4336</b>	<b>Updates</b>
<b>16. Medical Reserve Corps (MRC)</b>	Sheila Martin, ext. 465	41 MRC units have trained Disaster Healthcare Volunteers (DHV) System Administrators. These MRCs are regular users of the DHV system and active participants in quarterly DHV drills and quarterly DHV user group webinars. Over 8,900 of the DHV Program's 21,000 volunteers are Medical Reserve Corps volunteers.
<b>17. Statewide Emergency Plan (SEP) Update</b>	Jody Durden, ext. 702	The Governor's Office of Emergency Services (Cal OES) is in the process of updating the Statewide Emergency Plan (SEP) and is moving toward implementing Emergency Functions (EFs). EMSA is a lead participant in the development of the Public Health and Medical Emergency Function of the SEP and is supporting the development of six other EFs.
<b>18. Emergency Medical Services Field Treatment Site (EMS FTS) Guidelines</b>	Bill Campbell, ext. 728	The revision of this document is on hold as EMSA has insufficient staff resources to complete a review at this time.
<b>19. Southern California Catastrophic Earthquake Response Plan</b>	Bill Campbell, ext. 728	EMSA continues to participate in the validation of the Southern California Catastrophic Earthquake Plan. EMSA participated in the SoCal Rocks exercise that was held in March 2015. The SoCal Rocks exercise was designed to examine the processes required to establish, communicate and coordinate public health and medical resource needs. The scope of this design included the coordinated efforts of local, state, federal, and private sector partners in response to a catastrophic earthquake in Southern California.
<b>20. Patient Movement Plan</b>	Jody Durden, ext. 702	The Statewide Patient Movement Workgroup will be meeting next in late spring/early summer. The contractor selected to assist with the development of the plan will be presenting the draft plan to the Workgroup at that meeting.
<b>21. Bay Area Catastrophic Earthquake Plan</b>	Bill Campbell, ext. 728	EMSA participated as part of the Medical Planning Group for this plan revision and anticipates that the draft plan for public comment will be released soon.

**Emergency Medical Services Authority  
 Disaster Medical Services Division  
 Major Program Activities  
 June 2016**

<b>Activity &amp; Description</b>	<b>Primary Contact EMSA (916) 322-4336</b>	<b>Updates</b>
<b>22. Northern California Catastrophic Flood Response Plan</b>	Nirmala Badhan, ext. 1826	EMSA is working with the Governor’s Office of Emergency Services (Cal OES) for the development of the concept of operations for a catastrophic event based upon historically occurring atmospheric rivers that result in catastrophic flooding. Input was provided for “Courses of Action” based on identified response capabilities. An operational framework for the development of local flood plan annexes, training, and exercises is also a primary objective for this plan.

**COMMISSION ON EMERGENCY MEDICAL SERVICES**

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**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
Director

**PREPARED BY:** Jennifer Lim, Deputy Director

**SUBJECT:** Legislative Report

**RECOMMENDED ACTION:**

Receive information regarding EMS-related legislation.

**FISCAL IMPACT:**

None.

**DISCUSSION:**

Due to the dynamic nature of the legislative process, the Legislative Report to the Commission on EMS will be posted on the EMSA website at [http://www.emsa.ca.gov/current\\_legislation](http://www.emsa.ca.gov/current_legislation). Copies of the printed Legislative Report will also be available at the Commission Meeting on June 15, 2016.

**EMERGENCY MEDICAL SERVICES AUTHORITY**

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**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
Director

**PREPARED BY:** Rick Trussell, Chief  
Fiscal, Administration, and Information Technology Division

**SUBJECT:** Fiscal and Administration

**RECOMMENDED ACTION:**

Information Only

**FISCAL IMPACT:**

None.

**DISCUSSION:****EMS Authority Budget****2015/16**

The Department is currently in the process of transitioning from CalSTARS to the Financial Information System for California (**FI\$Cal**) which is a business transformation project for state government in the areas of budgeting, accounting, procurement, and cash management. This transition has not been without its issues, one of which is that the Department is unable to print out accounting data from FI\$Cal at this time. It is anticipated that accounting reports will be available by June 30, 2016 and an updated report will be distributed prior to the next Commission meeting.

**2016/17**

The Governor's May Revise Budget for 2016/17 released in May 2016 did not contain any substantive changes and budgetary authority remains at \$36.1 million and a staffing level of 66.9 permanent positions. Of this amount, \$15.2 million is delegated for State operations and \$20.9 million is delegated to local assistance.

**EMS Authority Current Staffing Levels**

The EMS Authority is currently authorized for 71.2 positions and also has 19 temporary (blanket positions and retired annuitants) positions for an overall staffing level of 90.2. Of the 90.2 positions, 6 positions are vacant at this time and we are in the process of recruiting to fill the positions.

	<b>Admin/Exec Division</b>	<b>DMS Division</b>	<b>EMSP Division</b>	<b>EMS Division</b>	<b>Total</b>
Authorized	18.0	18.0	26.2	9.0	71.2
Temporary Staff	8.0	3.0	0.0	8.0	19.0
<b>Staffing Level</b>	<b>26.0</b>	<b>21.0</b>	<b>26.2</b>	<b>17.0</b>	<b>90.2</b>
Authorized (Vacant)	-2.0	-2.0	-1.0	0.0	-5.0
Temporary (Vacant)	-1.0	0.0	-1.0	0.0	-2.0
<b>Current Staffing Level</b>	<b>23.0</b>	<b>19.0</b>	<b>24.2</b>	<b>17.0</b>	<b>83.2</b>

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**DATE:** June 15, 2016  
**TO:** Commission on EMS  
**FROM:** Howard Backer, MD, MPH, FACEP, Director  
**PREPARED BY:** Steven A. McGee, Administrative Adviser  
**SUBJECT:** Update on Legal Office Activity

**RECOMMENDED ACTION:**

Receive the Legal Office Report.

**FISCAL IMPACT:**

None.

**DISCIPLINARY CASES:**

From February 12, 2016, to May 20, 2016, the Authority issued twenty-four new Accusations against existing paramedic licenses, issued six Statements of Issues denying an unrestricted license, issued two notices of Administrative Fine, and one Temporary Suspension Order. Of the newly issued actions, three of the Respondents have requested that an administrative hearing be set. There are currently twenty hearings scheduled. There are currently fifty open active disciplinary cases in the legal office.

**LITIGATION:**

**California Fire Chiefs Association, Inc., vs. Howard Backer and Daniel Smiley.** The suit pertains to federal anti-trust protections claimed by Calchiefs on behalf of its members pursuant to Health and Safety Code section 1797.201. The Authority's response was filed on January 11, 2016. Calchiefs' filed a response on February 11, 2016, and the Authority's reply was filed on February 18, 2016. The Eastern District Court is currently reviewing the matter.

**Kenneth M. Silverman vs. EMSA.** This is a petition for writ of mandate, seeking review of an Administrative Law Judge's proposed decision that was adopted without modification by EMSA. Petitioner was denied an unrestricted license and was offered a probationary license by EMSA. Petitioner appealed the denial and a hearing was held. The ALJ granted a license with probationary terms. Petitioner seeks to have that decision overturned.

**EMERGENCY MEDICAL SERVICES AUTHORITY**

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**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
Director

**PREPARED BY:** Lisa Galindo  
EMS Plans Coordinator

**SUBJECT:** Update on EMS Plan Activity

**RECOMMENDED ACTION:**

Receive updated information on the activity related to EMS Plan submissions, as well as progress related to the EMS Plan Workgroup.

**FISCAL IMPACT:**

None

**DISCUSSION:**

The EMS Authority is providing the Commission with a report on the statewide EMS plan activity.

Topics covered in this report include:

- LEMSA EMS Plan Determinations (2/1/16 – 4/30/16)
- Status of LEMSA EMS Plan Submissions (As of 5/18/16)
- Average Review Time of Active EMS Plan Submissions

The EMS Plan Workgroup consists of EMSA and LEMSA Administrators who are scheduled to meet twice a month to focus on improving the processes related to EMS plans. To date, the workgroup has discussed meeting goals and objectives, and proposed online database configurations. The workgroup is finalizing the draft changes to the Minimum Standards/Recommended Guidelines section of *EMSA Guidelines #101*; the goal is to complete this section by May 26, 2016. The review of the Table section of *EMSA Guidelines #103 (Rev. June 1994)* is anticipated to begin on June 9, 2016.

The EMS Authority will continue to keep the Commission apprised of the activity involving EMS Plans and the progress of the EMS Plan Workgroup.

Attachment

### EMS PLAN ACTIVITY

LEMSA EMS Plan Determinations (2/1/16 – 4/30/16)	# of Plans
Plans Submitted	3
Plans Approved	2
Plans Not Approved	0

Status of LEMSA EMS Plan Submissions (As of 5/18/16)	# of LEMSAs	%
<b>On Schedule</b> <i>(Approved Plan on File &lt; 12 months)</i>	<b>14</b>	<b>42%</b>
<b>Active Submissions*</b> <i>Under Initial EMSA Review</i> <i>Under EMSA Subject Matter Expert Review</i> <i>Awaiting Info/Clarification from LEMSA</i> <i>On Hold, Pending Appeal of Previous Plan</i> <i>On Hold, Pending Transportation Discussion with Management</i> <i>Review/Routing through Management for Signature</i>	<b>13</b> 1 3 6 1 2 0	<b>39%</b>
<b>Not Approved</b> <i>(Appeal Requested)</i>	<b>0</b>	<b>0%</b>
<b>Submission Past Due*</b> <i>(No Plan Submitted &gt; 12 months from Previous Approval)</i>	<b>7</b>	<b>21%</b>

\* San Diego County is counted twice due to the receipt of two plans.

Average Review Time of Active EMS Plan Submissions	# of Days
Under Initial EMSA Review	14
Under EMSA Subject Matter Expert Review	16
Awaiting Info/Clarification from LEMSA	157
Review/Routing through Management for Signature	8

**EMERGENCY MEDICAL SERVICES AUTHORITY**

10901 GOLD CENTER DR., SUITE 400  
RANCHO CORDOVA, CA 95670  
(916) 322-4336 FAX (916) 324-2875



**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
Director

**PREPARED BY:** M.D. Smith  
Supervising Special Investigator  
Enforcement Unit

**SUBJECT:** Update on Enforcement Activities

**RECOMMENDED ACTION:**

Receive information on Enforcement Unit activities.

**FISCAL IMPACT:**

None

**DISCUSSION:****Unit Staffing:**

As of May 1, 2016, the Enforcement Unit has 5 full-time Special Investigators and 1 Retired Annuitant working as Special Investigator.

**Investigative Workload:**

The following is a summary of currently available data extracted from the paramedic database.

Cases opened since January 1, 2016, including:

Cases opened:	107
Cases completed and/or closed:	101
EMT-Paramedics on Probation:	228

In 2015:

Cases opened:	337
Cases completed and/or closed:	366
EMT-Paramedics on Probation:	236

Status of Current Cases:

The Enforcement Unit currently has 105 cases in “open” status.

As of May 1, 2016, there are 39 cases that have been in “open” status for 180 days or longer; 4 Fire Fighters’ Bill of Rights (FFBOR) cases and 4 are California Society of Addiction Medicine (CSAM....cases where Respondents are directed to a physician who specializes in addiction medicine for an examination/review) cases.

Those 39 cases are divided among 5 Special Investigators are in various stages of the investigative process, (i.e. awaiting documents, preparing for and/or setting up interviews, report writing and corrections to be made, awaiting action by local law enforcement jurisdictions, the courts, etc.).

[Delays in the interview process are common due to unforeseen difficulties in obtaining certified copies of documents, court records, availability of witnesses and/or the subject(s) of an investigation (due to medical action/disability issues, on-going investigations for FFBOR staff or on-going criminal investigations, court actions), plus the routine requirement for two or more follow-up interviews.]

**EMERGENCY MEDICAL SERVICES AUTHORITY**

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**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
 Director

**PREPARED BY:** Priscilla Rivera, Manager  
 Personnel Standards Unit

**SUBJECT:** Community Paramedicine

**RECOMMENDED ACTION:**

Receive information regarding Community Paramedicine Pilot Project.

**DISCUSSION:**

Strong progress continues with all of the Community Paramedicine Project's now in the implementation phase. The discussion that follows will provide an update on the progress and challenges faced by the pilot project sites.

<b>Project #</b>	<b>Concept</b>	<b>Lead Agency</b>	<b>Implementation Date</b>	<b>IRB Expires</b>
CP 001	Alternate Destination	UCLA	9-08-15	7-13-18
CP 002	Post Discharge	UCLA	9-01-15	7-28-18
CP 003	Alternate Destination	Orange County	9-14-15	5-21-16
CP 004	Post Discharge	Butte EMS (Enloe)	7-01-15	1-27-17
CP 005	TB Observation	Ventura (AMR)	6-01-15	6-16-16
CP 006	Hospice Support	Ventura (AMR)	8-01-15	6-16-16
CP 007	Post Discharge Frequent 911 User	Alameda City Fire	6-01-15 7-01-15	5-26-16
CP 008	Post Discharge	San Bernardino Fire	8-13-15	1-12-17
CP 009	Alternate Destination	Carlsbad Fire	10-09-15	4-25-17
CP 010	Frequent 911 User	City of San Diego (Rural)	10-12-15	8-27-16
CP 012	Alternate Destination (Behavioral Health)	Stanislaus County (AMR)	9-25-15	9-17-16
CP 013	Post Discharge	Solano (Medic Amb)	9-15-15	8-25-16

## Data Submission

All Pilot Project site partners have submitted initial Phase III Implementation Data to the Philip R. Lee Institute for Health Policy Studies UCSF evaluation team. UCSF in turn has submitted their initial analysis of the early data to OSHPD for their review and comment, and will be presenting a 4<sup>th</sup> Quarter 2015 & 1<sup>st</sup> Quarter 2016 Data Presentation to the OSHPD Advisory Committee on May 31, 2016

Months for which data reported	Due date for sites to submit data to UCSF	Sites included	UCSF report due to OSHPD	Completed
Oct, Nov, & Dec 2015	February 18, 2016	All sites	March 30, 2016	Pending OSHPD Review & Comments
Jan, Feb, March 2016	May 15, 2016	All sites	June 30, 2016	
April, May, June 2016	August 15, 2016	All sites	September 30, 2016	
July, Aug, Sept 2016	November 15, 2016	All sites	December 30, 2016	

## Institutional Review Board (IRB)

Prior to implementation, each project site must receive approval from an Institutional Review Board (IRB) as a measure of ensuring patient safety and ethical treatment of human subjects during research. Most of the IRB Approval is for a one year period; therefore two of the Project Sites, CP 003 Orange County & CP 007 Alameda require IRB Renewals in May 2016

## OSHPD & EMSA Site Visits

In accordance with HWPP Regulations, members of the HWPP program management and EMSA have continued to conduct Site Visits and found the following projects to be in compliance with the objectives submitted within EMSA's application to OSHPD.

Project #	Concept	Lead Agency	Phase	Site Visit Date
CP 001	Alternate Destination	UCLA	Training	06-18-15
CP 005 CP 006	Directly Observed TB	Ventura	Implementation	08-15-15
CP 007	Frequent 911 User Post Discharge	Alameda City	Implementation	09-24-15
CP 012	Alt Destination Behavioral Health	Stanislaus	Implementation	11-19-15
CP 013	Post Discharge	Solano	Implementation	12-17-15
CP 002	Post Discharge	UCLA	Implementation	01-12-16
CP 003	Alternate Destination	Orange County	Implementation	02-09-16
CP 004	Post Discharge	Butte EMS	Implementation	3-17-16
CP 001	Alternate Destination	UCLA	Implementation	3-29-16
CP 010	Frequent 911 User	San Diego	Implementation	3-30-16
CP 008	Post Discharge	San Bernardino	Implementation	4-12-16
CP 009	Alternate Destination	Carlsbad Fire	Implementation	5-19-16

### **Independent Evaluator Site Visits Scheduled To Date**

<b>Project #</b>	<b>Concept</b>	<b>Lead Agency</b>	<b>Phase</b>	<b>Site Visit Date</b>
CP 007	Post Discharge/Freq 911	Alameda City	Implementation	3-31-16
CP 005	TB Direct Observation	Ventura	Implementation	4-12-16
CP 006	Hospice Support	Ventura	Implementation	4-12-16
CP 003	Alternate Destination	Orange County	Implementation	4-20-16
CP 009	Alternate Destination	Carlsbad Fire	Implementation	4-29-16
CP 012	Alt Destination Behavioral Health	Mountain Valley EMS	Implementation	5-03-16
CP 001/002	Alt Destination/Post Discharge	UCLA	Implementation	5-10-16
CP 004	Post Discharge	Butte/Enloe	Implementation	6-06-16
CP 010	Frequent 911 Users	City of San Diego	Implementation	7-26-16
CP 008	Post Discharge	San Bernardino	Implementation	7-27-16

### **Challenges**

The 3 Alternate Destination to Urgent Care Centers Pilot Projects (UCLA, Orange County & Carlsbad) continues to show low enrollment, particularly due to the very tight Inclusion/Exclusion Criteria coupled with the Urgent Care Centers Hours of Operations and capabilities.

The EMS Authority will continue to keep the Commission informed on the progress of the Community Paramedicine pilot program.

**EMERGENCY MEDICAL SERVICES AUTHORITY**

10901 GOLD CENTER DR., SUITE 400  
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**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
Director

**PREPARED BY:** Corrine Fishman, Program Analyst

**SUBJECT:** EMT Regulation Revisions

**RECOMMENDED ACTION:**

Receive information regarding proposed revisions to the EMT Regulations.

**SUMMARY**

SB 1438 requires all EMTs to be trained in the administration of naloxone hydrochloride, which is currently an EMT optional skill. This bill also requires the Emergency Medical Services Agency (EMSA) to develop training and standards for all prehospital emergency care personnel in the administration of naloxone hydrochloride and other opioid antagonists by July 1, 2016. The use and administration of epinephrine by auto-injector was added to the EMT basic scope of practice, with local EMS agency approval, in response to the adoption of legislation (Huff, Chapter 725, Statutes of 2013) requiring EMSA to develop lay rescuer epinephrine regulations. Further, EMSA has revised the public safety regulations to allow public safety personnel to administer epinephrine as an optional skill. Mandatory tactical casualty care training is being proposed in this revision to include the statutory elements found in AB 1598 (Rodriguez, Chapter 668, Statutes of 2014) that provide for additional requirements regarding coordination between emergency medical services personnel during terrorism incidents or active shooter events

With this rulemaking, the EMS Authority is proposing to:

1. Amend existing EMT regulations by removing naloxone hydrochloride administration as an EMT *optional skill*, include it in the basic skills and making the administration of naloxone hydrochloride a mandatory training item. The administration of naloxone will still require local EMS agency (LEMSA) approval.

2. Add training in the administration of epinephrine by auto-injector and the use of a glucometer. The use of a glucometer and an epinephrine auto-injector will require the LEMSA approval.
3. The use of an epinephrine auto-injector will be removed from the EMT Optional Skills section and replaced with drawing up epinephrine for administration for anaphylaxis.
4. Add tactical casualty care principles to required course content.
5. Remove the skills-based competency verification form and replace it with 6 hours of skills-based continuing education.
6. Increase the required course hours from 160 to 174 to include Naloxone, epinephrine, glucometer training and tactical casualty care principles.
7. Move the monitoring of preexisting vascular access devices and intravenous lines delivering fluids with additional medications from a basic skill to an optional skill to clarify this is a local optional request.
8. Provide clarity and consistency with the NREMT registration requirements.
9. Provide clarification of the initial certification pathways.

### **IMPLEMENTATION STEPS AND TIMELINE**

June 2016	Rulemaking file opened with Office of Administrative law; regulations must be approved within one year.
June 2016	Proposed regulations released for 45-day public comment.
July 2016	Proposed regulations released for 15-day public comment periods as needed.
September 2016	Proposed regulations submitted to Commission on EMS for approval.
October 2016	Office of Administrative Law reviews and approves regulations.
January 1, 2017	Regulations become effective.

**EMERGENCY MEDICAL SERVICES AUTHORITY**

10901 GOLD CENTER DR., SUITE 400  
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**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
 Director

**PREPARED BY:** Corrine Fishman, Program Analyst

**SUBJECT:** Paramedic Regulation Revisions

**RECOMMENDED ACTION:**

Receive information regarding paramedic regulation revisions.

**SUMMARY**

The EMS Authority is proposing to make changes to Paramedic Regulations to clarify and specify methods for training program reviews, approvals and accreditation requirements, and to update applications and licensure processes. Based on the passage of AB 1598 (Rodriguez, Chapter 668, Statutes of 2014) the new regulations will also include the addition of tactical casualty care principles to the course content for consistency. The tactical requirements have already been added to the public safety regulations and are being added to the EMT regulations.

The proposed regulations were sent out for pre-public comment on April 4, 2016 to a group of stakeholders and subject matter experts for review and input.

**IMPLEMENTATION STEPS AND TIMELINE**

April 2016	Paramedic regulations with proposed changes sent out to workgroup
May 2016	EMSA will review all comments and make necessary changes to the proposed regulations
June 2016	Open rulemaking file with Office of Administrative law; regulations must be approved within one year.

June 2016	Proposed regulations released for 45-day public comment.
July 2016	Proposed regulations released for 15-day public comment periods as needed.
September 2016	Proposed regulations submitted to Commission on EMS for approval
October 2016	Office of Administrative Law reviews and approves regulations
January 1, 2017	Regulations become effective

**COMMISSION ON EMERGENCY MEDICAL SERVICES**

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**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
Director

**PREPARED BY:** Jennifer Lim, Deputy Director

**SUBJECT:** EMSA's Strategic Plan 2016

**RECOMMENDED ACTION:**

Information only

**FISCAL IMPACT:**

None.

**DISCUSSION:**

Author and Trainer John Bryson, in *Strategic Planning for Public and Non-Profit Organizations*, defines the process of strategic planning as: "A disciplined effort to produce fundamental decisions and actions that shape and guide what an organization is, what it does, and why it does it." Given the organizational and community changes that have influenced the California Emergency Medical Services Authority (EMSA) in recent months and years, the Authority used this point in time as an opportunity to reassess the future direction of the organization.

A select design team from EMSA convened on an "as-needed" basis from June 2015 through January 2016 to prepare a one-day strategic planning workshop, that was executed on December 15, 2015, and to construct all elements of this plan. The effort was facilitated by Sacramento State University's Center for Collaborative Policy, to ensure neutral third party involvement and guidance for the process.

This plan brings together the following key elements that will now focus the current and future activities of the Authority:

### **EMSA VISION STATEMENT**

*(Defining an image of EMSA's mission accomplished and reflecting an ideal future state.)*

EMSA is a leader in innovative, effective, and collaborative emergency medical services. We inspire EMS systems to advance the quality, safety, and satisfaction of healthcare in their communities.

### **EMSA MISSION STATEMENT**

*(EMSA's unique reason for existence and its overarching goal and purpose.)*

The mission of EMSA is to prevent injuries, reduce suffering, and save lives by developing standards for and administering an effective statewide coordinated system of quality emergency medical care and disaster medical response that integrates public health, public safety, and healthcare.

### **GUIDING PRINCIPLES AND CORE VALUES**

*(Fundamental perspectives held that reflect the collective culture and priorities that steer the organization and define the key driving priorities and belief systems applied daily. Values that reflect the Authority's shared processes, rules of engagement, and procedural priorities.)*

#### **The following principles drive all EMSA's efforts and daily work:**

- We strive for excellence in all we do to ensure the public's health and well-being.
- We work in partnership with our constituents to promote a collaborative business relationship, solicit feedback, and seek continuous improvement.
- We treat our customers with respect and in a courteous and professional manner.

#### **We value a creative and enjoyable work environment where a climate of trust, respect, and concern for all exists:**

- We support teamwork and collaboration.
- We promote clear, meaningful, transparent, and concise communication and information sharing with others.
- We encourage initiative and self-motivation.
- We strive to develop the full potential of every employee with opportunities for learning, achievement, growth, and accountability.

## **GOALS AND STRATEGIES**

*(Desired results, reflecting the most important strategic issues and directions pursued; outlining specific and measurable targets to accomplish each goal.)*

### **Goal 1: Develop professional and high performing employees by fostering and enriching a supportive work environment to ensure the delivery of EMSA's mission.**

1.1 - Create a Workforce Development and Succession Plan.

- 1.1.2 Attract and acquire quality talent.
- 1.1.3 Retain qualified and high performing staff by investing in employees.
- 1.1.4 Build a culture of high performance.

### **Goal 2: Support the development of EMS systems in California that are sustainable, visionary, and integrated with the evolving healthcare system.**

2.1 - Perform statewide periodic assessments of EMS systems for quality improvement.

2.2 - Integrate EMS into mainstream healthcare systems.

2.3 - Explore new roles for EMS providers within healthcare systems.

2.4 - Create and update EMS regulations.

2.5 - Build and enhance disaster preparedness and response programs.

2.6 - Facilitate standardization of EMS systems including, policies, protocols, and discipline while maintaining local flexibility.

2.7 - Strengthen EMSA's role in injury and illness prevention and education initiatives.

### **Goal 3: Improve communication methods to promote timely and transparent information sharing.**

3.1 - Continuously strive to improve EMSA's professional communications.

3.2 - Increase transparency through use of the open data portal and other data initiatives.

3.3 - Improve EMSA's internal communications.

**Goal 4: Leverage new and existing technologies to promote improved data and information systems.**

- 4.1 - Maximize EMSA's technology solutions.
- 4.2 - Promote interoperability between multiple information sources and EMSA.
- 4.3 - Provide leadership concerning data and quality standards.
- 4.4 - Adopt technology solutions to enhance statewide disaster response.

**Goal 5: Engage stakeholders to identify trends and collaboratively advance the statewide EMS system.**

- 5.1 - Enhance communication with stakeholders.
- 5.2 - Provide technical assistance and support to local EMS agencies and providers.
- 5.3 - Support stakeholders to align with the statewide EMS system.

**Goal 6: Obtain stable, secure, and diversified funding to support EMSA's mission.**

- 6.1 - Advocate and educate policy makers to promote the role and importance of EMS.
- 6.2 - Seek out and apply for funding sources to support new, and enhance existing projects and programs.
- 6.3 - Ensure expenditures are aligned with EMSA's mission.

This plan will be referenced often and utilized as a directional key tool for the Authority as it moves forward. Although this is a five year plan, it is expected to be reviewed and updated during this cycle to reflect changing conditions and factors influencing EMSA and the state.

**EMERGENCY MEDICAL SERVICES AUTHORITY**

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**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
Director

**PREPARED BY:** Sean Trask, Chief  
EMS Personnel Division

**SUBJECT:** Commission on EMS Bylaws

**RECOMMENDED ACTION:**

Approve the Proposed Changes to the Commission on EMS Bylaws.

**FISCAL IMPACT:**

In the event the Commission calls a special or emergency meeting, there will be costs associated with travel reimbursement for commissioners.

**DISCUSSION:**

The EMS Authority has prepared proposed amendments to the Commission on EMS Bylaws (Bylaws). The proposed changes are designated with strikeouts for deleted text and underlines for new text. The proposed amendments are in response to the direction of the Commission on EMS at the December 3, 2014 Commission meeting to prepare emergency and non-emergency regulations to delegate the Commission's authority to hear appeals of the EMS Authority's decision on a local EMS plan to the Office of Administrative Hearings.

The current version of the Bylaws, dated September 2010, lacks the details of the appeal process and is in need of updates for consistency with the Bagley-Keene Open Meeting Act.

In order for the Commission to delegate its authority to hear local EMS plan appeals, Bylaws need to be amended and adopted by the Commission.

In addition to the delegation of the appeal authority, other sections of the bylaws contain proposed amendments for consistency with the Bagley-Keene Open Meeting Act, those amendments are:

1. Pages 1 & 2
  - a. Change the effective date.
  - b. Item II Appeal Functions – amended old language and inserted new appeal process consistent with the proposed appeal regulations.
2. Page 4, Item I Officers – Delete the closed ballot language. This is inconsistent with the Open Meeting Law. Clarified that the Chair shall not serve in that position for more than two consecutive one-year terms.
3. Page 5, Item II Officer Vacancies – Struck references to written ballots. This is inconsistent with the Open Meeting Law.
4. Page 5, Item IV Duties of the Secretary - Clarified that the Secretary shall take recorded minutes.
5. Page 6, Administrative Committee Membership, Item I – Struck references to closed ballots. This is inconsistent with the Open Meeting Law.
6. Page 6, Regular Meetings, Item I:
  - a. Clarified that exceptions to the open meeting law are pursuant to the Government Code.
  - b. Struck “Items for discussion may be added at each meeting”. Items for discussion need to be contained in the agenda that is noticed at least 10-days in advance of the meeting.
7. Page 7, Notification of Meetings:
  - a. Replace one week with ten day notice for consistency with the Open Meeting Law.
8. Page 7, Special Meetings – Special meetings may be called pursuant to Section 11125.4 of the Government Code.
9. Page 7, Emergency Meetings, the word “general” was struck because it is unnecessary in reference to the agenda being sent to the commissioners and interested parties.
10. Page 9, Emergency Meetings, Items b and c are struck because these definitions of an emergency fall under the Special Meeting requirements.
11. Page 10, Committees, Item I, the word “the” was added for clarification.
12. Page 1, Code of Parliamentary Procedure, the Sturgis Standard Code of Parliamentary Procedure was struck and replaced Robert’s Rules of Order.

## Commission on EMS Bylaws

*The Emergency Medical Services Authority has illustrated changes to the original text in the following manner:*

- Additions to the original text = underline
- Deletions to the original text = ~~strikeout~~

~~September 2010~~

June 2016

The Commission on Emergency Medical Services (EMS) for the State of California was created in the Health and Welfare Agency effective January 1, 1981. The statutory base for the Commission is found in Chapter 1260, Section 1799 of the Health and Safety Code and its role as an appeal body for local EMS agency systems plans is found in Section 1797.105. The following constitutes the Rules of Procedure of the Commission:

### PURPOSE AND REGULAR DUTIES

#### I. Regular Duties

Section 1799.50 through 1799.56 specifies:

The Commission shall review and approve regulations, standards, and guidelines to be developed by the authority to implement its emergency medical services responsibilities.

The Commission shall advise the Authority on the development of an emergency medical data collection system.

The Commission shall advise the Director concerning the assessment of emergency facilities and services.

The Commission shall advise the Director with regard to communications, medical equipment, training personnel, facilities and other components of an emergency medical services system.

Based upon evaluations of the EMS systems in the state and their coordination, the Commission shall make recommendations for further development and future directions of emergency medical services in the State.

The Commission shall review and comment upon the emergency medical services portion of the State Health Facilities and Service Plan developed pursuant to Section 437.7.

## II. Appeal Functions

Section 1797.105 specifies that the EMS Authority shall receive plans for the implementation of EMS from local EMS agencies. ~~These~~ Local EMS agencies may implement a local plan developed pursuant to Section 1797.250, unless the authority determines such plan does not effectively meet the needs of residents and is not consistent with coordinating activities in the geographical area served, or the plan is not concordant and consistent with applicable guidelines and/or regulations established by the authority.

Section 1797.105 (c) and (d) specify that a local EMS agency may appeal a determination of the Authority to the Commission. The Authority will start the appeal process and notify the Commission at the next scheduled meeting, if an appeal is submitted to the Authority before the Commission meeting. ~~In response to that appeal, the Commission may sustain the determination of the Authority or overrule and permit local implementation of a plan, and the decision of the Commission is final.~~

The Commission adopts Chapter 13 of the California Code of Regulations, Title 22, Division 9 for the appeal of the denial of a local EMS agency plan.

## MEMBERSHIP

### I. Membership Qualification and Appointment

Section 1799.2 specifies the Commission shall consist of 18 members appointed as follows:

- a. One full-time physician and surgeon, whose primary practice is emergency medicine, appointed by the Senate Rules Committee from a list of three names submitted by the California Chapter of the American College of Emergency Physicians.
- b. One physician and surgeon, who is a trauma surgeon, appointed by the Speaker of the Assembly from a list of three names submitted by the California Chapter of the American College of Surgeons.
- c. One physician and surgeon appointed by the Senate Rules Committee from a list of three names submitted by the California Medical Association.
- d. One county health officer appointed by the Governor from a lists of three names submitted by the California Conference of Local Health Officers.
- e. One registered nurse, who is currently or has been previously authorized as a mobile intensive care nurse and who is

knowledgeable in state emergency medical services programs and issues, appointed by the Governor from a list of three names submitted by the Emergency Nurses Association.

- f. One full-time paramedic or EMT-II, who is not employed as a full-time peace officer, appointed by the Senate Rules Committee from a list of three names submitted by the California Rescue and Paramedic Association.
- g. One prehospital emergency medical service provider from the private sector, appointed by the Speaker of the Assembly from a list of three names submitted by the California Ambulance Association.
- h. One management member of an entity providing fire protection and prevention services appointed by the Governor from a list of three names submitted by the California Fire Chiefs Association.
- i. One physician and surgeon who is board eligible or board certified in the specialty of emergency medicine by the American Board of Emergency Medicine and who is knowledgeable in state emergency medical services programs and issues, appointed by the Speaker of the Assembly.
- j. One hospital administrator of a base station hospital who is appointed by the Governor from a list of three names submitted by the California Association of Hospitals and Health Systems.
- k. One full-time peace officer who is either an EMT-II or paramedic, who is appointed by the Governor from a list of three names submitted by the California Peace Officers Association.
- l. Two public members who have experience in local EMS policy issues, at least one of whom resides in a rural area as defined by the Authority, and who are appointed by the Governor.
- m. One administrator from a local EMS agency appointed by the Governor from a list of four names submitted by the Emergency Medical Services Administrators Association of California.
- n. One medical director of a local EMS agency who is an active member of the EMS Medical Directors Association of California, and who is appointed by the Governor.
- o. One person appointed by the Governor, who is an active member of the California State Firefighters Association
- p. One person who is employed by the Department of Forestry and Fire Protection (CAL-FIRE) appointed by the Governor from a list of three names submitted by the California Professional Firefighters.

- q. One person who is employed by a city, county, or special district that provides fire protection appointed by the Governor from a list of three names submitted by the California Professional Firefighters.

## II. **Membership Terms**

Section 1799.4 of the Health and Safety Code describes the membership terms. Except as otherwise provided in Section 1799.4, the terms of the members of the commission shall be three calendar years, commencing January 1 of the year of appointment. No member shall serve more than two consecutive full terms.

## III. **Membership Compensation**

Section 1799.6 specifies the members of the Commission shall receive no compensation for their services, but shall be reimbursed for their actual necessary travel and other expenses incurred in the discharge of their duties. All necessary expenses must be approved by the EMS Authority in accordance with State rules of reimbursement.

## IV. **Membership Vacancies**

A position on the Commission of Emergency Medical Services shall be considered vacant and the appointing authority is to be informed if the Commissioner dies, resigns, or moves his/her permanent place of residence out of the State of California. Should a Commissioner conduct himself/herself in a manner grossly inappropriate to the position or absent himself/herself from two consecutive regular noticed meetings of the full Commission without prior notification of a justifiable reason or without permission of the Chairperson, then the Commission shall describe the facts and circumstances in its minutes or by special resolution and shall submit said minutes or special resolution to the Commissioner's appointment authority for appropriate action.

# OFFICERS

## I. **Officers**

The officers of the Commission on EMS shall consist of a Chairperson, Vice-chairperson and Secretary. The Chairperson and Vice-chairperson shall be elected by the Commission annually from its members ~~by closed ballot~~ at the first regular meeting of the calendar year. No member shall serve as Chairperson for more than two consecutive one-year terms. The Director of the EMS Authority shall hold the office of Secretary and may participate in Commission and committee meetings but has no vote. The officers shall serve for the calendar year of election.

## II. **Officer Vacancies**

In the event of an officer or Administrative Committee member vacancy prior to the end of the calendar year, the Chairperson shall open nominations and hold an election to fill the vacancy at the next scheduled meeting following the vacancy. Election to a vacant office seat shall ~~be by written ballot requiring~~ require a majority vote of ~~ballots cast~~ by the membership.

## III. **Duties of Chairperson and Vice-Chairperson**

The Chairperson shall preside at the Commission meetings; the Vice-chairperson shall function in the Chairperson's absence.

The Chairperson and Vice-chairperson shall be entitled to vote, make and second motions, and may serve on committees.

The Chairperson shall create committees as recommended by the Commission. The charge of the committee and its duration shall be designated at the time of its creation. The Chairperson may create ad hoc committees as deemed appropriate to study and recommend action on specific topics.

The Chairperson shall make all committee appointments and shall appoint the chairperson for each committee.

The Chairperson, upon the advice of the Administrative Committee, prepares the agenda for upcoming Commission meetings. The Director or any members of the Commission may add items to that agenda.

The Chairperson will assign business to the committees with the advice of the Administrative Committee.

The Chairperson or his/her designee may represent the Commission at legislative hearings, in public meetings, in press interviews and other public situations within the limits of established Commission policy or subject to confirmation at the subsequent regular Commission meeting.

The Chairperson shall annually appoint a committee to address System Platform Principles adopted by the EMS Commission. This committee shall submit their recommendations to the Commission.

## IV. **Duties of the Secretary**

The Secretary shall cause to be ~~taken~~ recorded minutes which accurately reflect business conducted at Commission meetings. Approved minutes are public record. The Secretary will be responsible for providing notification of meetings to Commission members and others as specified below and for making materials available for inspection as specified.

In the absence of the Chairperson and Vice-chairperson, the Secretary shall convene the meeting of the Commission whose first act of business will be the election of a temporary chairperson from among its members.

## ADMINISTRATIVE COMMITTEE

### I. Administrative Committee Membership

The Administrative Committee shall consist of the Chairperson, Vice-chairperson, Secretary, immediate Past Chairperson of the Commission on EMS and two other members of the Commission elected annually ~~by the closed ballot~~ at the first regular meeting of the calendar year. The members of the Administrative Committee shall serve for the calendar year following election.

### II. Duties of the Administrative Committee

The Administrative Committee is advisory to the Chairperson and the Commission on administrative matters. Their deliberations will include, but not be restricted to, prioritizing agenda items, organizing reports, advising the chair on committee appointments and business assignments and assisting in development of interim positions of the Commission on urgent matters where Commission policy is unclear and an emergency meeting of the Commission seems unwarranted. The Administrative Committee may recommend the format in which agenda items are to be presented to the Commission.

## MEETINGS

### I. Regular Meetings

Section 1799.8 specifies that the Commission shall meet at least quarterly on the call of the Director, Chairperson, or three or more members of the Commission.

The Commission meeting dates will be set at the last meeting of the year for the next calendar year. All meetings of the Commission will be open with the exception of private or executive sessions permitted pursuant to the ~~under~~ Government Code. Notice of all regular meetings of the Commission and an agenda of such meetings enumerating the items to be considered at the meeting shall be mailed to each commissioner at least ~~seven~~ ten days before the day on which the regular meeting of the Commission is scheduled. The agenda shall include the items of business to be transacted. ~~Items for discussion may be added at each meeting.~~ No action item shall be added to the agenda unless a statement is included setting forth the emergency condition as provided below.

## II. **Notification of Meetings**

Notice of Commission meetings, including the agenda, date and place of the meeting and the name, address, and telephone number to receive inquiries prior to this meeting shall be given at least ~~one week~~ ten days in advance of such meeting to any person who requests such notice in writing. A person may request and be provided notice for all meetings of the Commission or may limit his request to notice for a specific meeting or meetings. Any mailing list maintained pursuant to this rule will be subject to annual correction as provided in Government Code Section 14911.

## III. **Special Meetings**

A special meeting of the Commission may be called at any time by the Chairperson or a majority of the members of the Commission pursuant to Section 11125.4 of the California Government Code.

## IV. **Emergency Meetings**

Emergency meetings of the Commission may be called at any time by the Chairperson, the Director of the EMS Authority, or by a majority of the Commission, when such a meeting is necessary to discuss an emergency condition as defined below. In the event such an emergency meeting is called, notice stating the ~~general~~ agenda item(s) will be sent to those members entitled to vote and to those non-members who have requested such notice by such means as the Secretary deems appropriate.

## V. **Emergency Condition**

An emergency condition shall be defined as:

- a. Any condition requiring any action by the Commission because of a disaster involving mobilization of State disaster medical resources or other activities requiring the Commission's input to statewide mobilization.
- ~~b. Any condition requiring any action by the Commission because of the action or requirement of Congress or of the Legislature of the State of California, or because of any act, rule or regulation promulgated by any public body which has an effect upon the state EMS system or any activity under the jurisdiction of the Commission.~~
- ~~c. Any condition requiring any action by the Commission caused by any court action brought in State or Federal Court which has an effect upon the EMS system or any activity under the jurisdiction of the Commission.~~

- b. Any other condition, which in the opinion of the Director, Chairperson, or a majority of the Commission could seriously affect the health and safety of the people of California if not acted upon by the Commission.

**VI. Public Inspection of Material**

Documents which are public records and which are distributed prior to commencement of a public meeting shall be made available at the Office of the Director for public inspection upon request prior to commencement of such meeting. If said material is distributed during a public meeting, it shall be made available for public inspection immediately or as soon as is practicable. The Authority, at the discretion of the Director, may charge a fee for a copy of any public records.

**VII. Quorum**

A majority of the appointed membership of the Commission or subcommittees shall constitute a quorum.

**VIII. Voting**

Each member entitled to vote shall be entitled to cast one vote for each matter submitted to a vote of the members.

If a quorum is present, all questions shall be decided by a majority of those members present. Voting may not take place without a quorum present.

No member shall be permitted to vote by proxy.

**IX. Conflict of Interest**

Commissioners must disqualify themselves from making or participating in the making of any decision when the Commissioner has a financial interest (as defined in Section 87103) which it is reasonably feasible may be affected materially by the decision. No Commissioner, however, shall be required to disqualify himself with respect to any matter which could not legally be acted upon without his/her participation. If such is the case (i.e., tie-breaking vote), the Commissioner should declare in the minutes a potential conflict of interest and then discharge his duty as a Commissioner in casting a vote.

**X. Guests**

Guests at Commission meetings may be allowed to participate in the discussion at the discretion of the Chairperson of the Commission. Guests addressing the Commission should identify themselves by name and organization prior to speaking on an issue.

## COMMITTEES

### I. Committees of the Commission

Committees of the Commission will meet as the business of the committee and budget dictate. Committee meetings may be called by the Chairperson of the Commission or of the committee. All committees are advisory to the full Commission and any action of the committees shall be referred to the commission for affirmation.

Minutes of committee meetings are the responsibility of the chairperson of that committee or his/her designee. Committee minutes become public record when adopted by the full Commission.

### II. Consent Calendar

Any member of the Commission may pull any item from the consent calendar. All consent items must be accompanied by a description of the issue including the committee's recommendation. Except in emergency conditions, this description must be available for public inspection prior to the meeting of the Commission. Guests may address the Commission with regard to any item on the consent calendar.

All recommendations receiving a unanimous vote by a committee shall be referred to the Commission on a consent calendar.

## CODE OF PARLIAMENTARY PROCEDURE

~~Sturgis Standard Code of Parliamentary Procedure~~ Robert's Rules of Order shall prevail in all instances not covered by the above rules.

**EMERGENCY MEDICAL SERVICES AUTHORITY**

10901 GOLD CENTER DR., SUITE 400  
RANCHO CORDOVA, CA 95670  
(916) 322-4336 FAX (916) 324-2875



**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
Director

**PREPARED BY:** Sean Trask, Chief  
EMS Personnel Division

**SUBJECT:** Election to Fill Vacancy on Administrative Committee

**RECOMMENDED ACTION:**

1. Nominate a Commissioner for the vacancy on the Administrative Committee.
2. Hold the election.

**FISCAL IMPACT:**

There is no fiscal impact.

**DISCUSSION:**

The following individuals were elected as Commission Officers at the March 16, 2016 Commission meeting:

Chair:	Dan Burch
Vice Chair:	Steve Drewniany
Administrative Committee:	Jaison Chand Lewis Stone

The Commission on EMS Bylaws requires that the immediate past chair of the Commission fill one of the Administrative Committee positions and that two additional Commissioners be elected to the Administrative Committee. Only two members of the Commission were nominated for the Administrative Committee at the December 2, 2015 Commission meeting one member was the immediate past chair. This leaves one open position on the Administrative Committee that needs to be filled.

**EMERGENCY MEDICAL SERVICES AUTHORITY**

10901 GOLD CENTER DR., SUITE 400  
RANCHO CORDOVA, CA 95670  
(916) 322-4336 FAX (916) 324-2875



**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
Director

**PREPARED BY:** Corrine Fishman, Program Analyst

**SUBJECT:** Tactical Casualty Care Training Standards Guidelines

**RECOMMENDED ACTION:**

Receive information regarding the interim guideline, *Training Standards for Basic Tactical Casualty Care and Coordination with EMS during Terrorism Incidents*.

Receive Information on the proposed draft of the next version of the *Training Standards for Basic Tactical Casualty Care and Coordination with EMS during Terrorism Incidents*.

**SUMMARY**

In response to the passage of AB 1598 (Rodriguez, Statutes of 2014) the EMS Authority along with the California Tactical EMS (CTEMS) advisory committee drafted the *Training Standards for Basic Tactical Casualty Care and Coordination with EMS During Terrorism Incidents* (Tactical Guidelines) as an interim guideline. This document is meant to guide both training programs and first responder agencies, including law enforcement, fire, and emergency medical services (EMS), on the development of curriculum related to a coordinated response to active shooter and other terrorism related multi-casualty events. These interim guidelines are attached for your review.

Because not all local EMS agencies have developed training program approval policies and assessment criterion pertinent to terrorism awareness training, the EMS Authority is temporarily serving as the approving agency for these training programs. After the next version of the Tactical Guidelines is approved by the Commission, the local EMS agencies may develop policies to review and approve these training programs. The EMS Authority is also proposing that after the next version of the Tactical Guidelines becomes effective, local training program approval will be retroactive to the date of EMS Authority's approval and will be valid for three years from the EMS Authority approval date. The EMS Authority or local EMS agency training program approval shall be valid statewide.

**Next Version of the Tactical Guidelines**

CTEMS and the EMS Authority are proposing to add a 40 hour course to the interim Tactical Guidelines for a Tactical Life Saver/Technician Course. This draft is currently open for a 30-day public comment period which started on May 25, 2016 and will close June 23, 2016. This draft guideline may be viewed at the EMS Authority's web page, [www.emsa.ca.gov](http://www.emsa.ca.gov) under the Public Comment link. We anticipate the final draft will be presented to the Commission for approval at the September 21, 2016 meeting. The next version of the Tactical Guidelines are also attached for your review.



# Training Standards for Basic Tactical Casualty Care and Coordination with EMS during Terrorism Incidents

Emergency Medical Services Authority  
California Health and Human Services Agency

**Interim Guidelines**

EMSA #170

June 2016





**HOWARD BACKER, MD, MPH, FACEP  
DIRECTOR**

**DANIEL R. SMILEY  
CHIEF DEPUTY DIRECTOR**

**SEAN TRASK  
DIVISION CHIEF**

Interim Guidelines  
EMSA #170  
June 2016

# Training Standards for Basic Tactical Casualty Care and Coordination with EMS during Terrorism Incidents: Guidelines for Law Enforcement, Fire Service, and Emergency Medical Services Personnel

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# 1

## INTRODUCTION

### Statutory and Regulatory Basis

This document provides the framework for training standards necessary for the preparation of law enforcement, fire service, and emergency medical services personnel to respond to terrorism incidents. It seeks to harmonize and incorporate the many new and existing requirements now found in California's various statutes and regulations.

First, it recognizes the regulatory requirements found in California Code of Regulations, Title 22, Division 9, Chapter 1.5 that guide the training of public safety personnel in first aid and cardiopulmonary resuscitation. Specifically, this document highlights the specific training criteria concerning tactical casualty care. Second, it adds the statutory elements found in AB 1598 (Rodriguez, Chapter 668, Statutes of 2014) that provide for additional requirements regarding coordination with emergency medical services personnel during terrorism incidents or active shooter events.

These many requirements taken as a whole will guide both training programs and first responder agencies, including law enforcement, fire, and emergency medical services (EMS), on development of curriculum and protocols related to the coordinated response to active shooter and other terrorism related multi-casualty events.

This document is focused upon developing the training program approval process with respect to prehospital emergency medical services training as this training relates to terrorism related responses; and describing the care provided at the basic life support level as those skills are authorized under existing California Regulations for public safety personnel who have received training at the public safety first aid and CPR level, or those individuals trained at the Emergency Medical Technician (EMT) level (California Code of Regulations, Title 22, Division 9, Chapter 2.) Individuals who are certified or licensed at an advanced level including Advanced EMTs (AEMT) or paramedics should consult with their local EMS agency for guidance on scope of practice and local protocols for use during tactical operations.

### Legislative Intent

In enacting AB 1598, the legislature made several important additions or changes to statutory language found in California Health and Safety Code 1797.116, 1797.134, California Government Code 8588.10, California Penal Code 13514.1 and 13519.12 to better prepare public safety personnel to provide tactical casualty care and coordinate with emergency medical services during terrorism incidents. Moreover, the changes

which AB 1598 sought to make need to be harmonized with existing law and regulations.

For the purposes of AB 1598, and this document, a “terrorism incident” includes, but is not limited to, an active shooter incident. An “active shooter incident” is an incident where an individual is actively engaged in killing or attempting to kill people.

The California legislature noted in their intent language that “since the Columbine High School shootings that occurred in 1999, more than 250 people have been killed in the United States during what has been classified as active shooter and mass casualty incidents.” They observed that “these incidents involve one or more suspects who participate in an ongoing, random, or systematic shooting spree, demonstrating the intent to harm others with the objective of mass murder.” Moreover, the legislature said, “It also became evident that these events may take place in any community or venue and that they impact fire and police departments, regardless of their size or capacity. Local jurisdictions vary widely in available emergency response resources, staffing, and equipment allocations.”

In enacting AB 1598, the legislature was prescribing that protocols and training for response to active shooter incidents must be established locally to work within the resource capabilities and limitations of each jurisdiction. The legislature intended AB1598 to do the following:

- Require the development of collaborative protocols and relationships between local and state first response entities, including law enforcement agencies, fire departments, and emergency medical services providers and agencies, in order that those entities shall act effectively and in concert to address active shooter incidents across California.
- Require first response entities to seek collaborative training opportunities, including, but not limited to, table top or simulation exercises, to assess plan implementations, and to include other entities that may be involved in active shooter incidents in those trainings, such as schools, city or county personnel, and private businesses.
- Require basic and ongoing training for law enforcement agency personnel, fire department personnel, emergency medical services personnel, and the personnel for other first responders include, as appropriate, training and education on active shooter incidents and tactical casualty care.

It was the intent of the Legislature that each first response entity, in collaboration with other law enforcement agencies, fire departments, and emergency medical services providers and agencies, develop protocols for responding to active shooter incidents.

Those protocols must be reviewed annually to ensure that they are current, and address any policy, geographic, or demographic changes that warrant a response strategy review. The Legislature intended that the protocols address all of the following:

- The roles, responsibilities, and policies of each entity in responding to an active shooter incident.

- Pre-assessment and contingency planning that includes identification of potential targets within the jurisdiction.
- Implementation of an Incident Command System (ICS), including emergency protocols for a unified command structure for entities responding to an active shooter incident.
- Interagency communication issues and needs, including, but not limited to, radio interoperability and establishment of common language, terms, and definitions to be used on the scene of an active shooter incident.
- Identification of resources for responding to an active shooter incident, including, but not limited to, primary and secondary needs and hospitals.
- Tactical deployment of available resources for responding to an active shooter incident.
- Emergency treatment and extraction of persons injured in an active shooter incident.

## EMSA Statutory Requirements regarding this Document

As part of Division 2.5 of the California Health and Safety Code, the California Emergency Medical Services Authority (EMSA or authority), is charged with setting training standards for all levels of emergency medical care personnel including public safety, Emergency Medical Technicians (EMT), Advanced EMT (AEMT), and paramedics.

Specifically, existing law requires EMSA to establish “additional training standards” that include the criteria for curriculum content involving the responsibilities of first responders to terrorism incidents. The Health and Safety Code notes this below:

*1797.116. (Terrorism Response Training Standards)*

*(a) The authority shall establish additional training standards that include the criteria for the curriculum content recommended by the Curriculum Development Advisory Committee established pursuant to Section 8588.10 of the Government Code, involving the responsibilities of first responders to terrorism incidents and to address the training needs of those identified as first responders. Training standards shall include, but not be limited to, criteria for coordinating between different responding entities.*

*(b) Every EMT I, EMT II, and EMT-P, as defined in Sections 1797.80, 1797.82, and 1797.84, may receive the appropriate training described in this section. Pertinent training previously completed by any jurisdiction’s EMT I, EMT II, or EMT-P personnel and meeting the training requirements of this section may be submitted to the training program approving*

*authority to assess its content and determine whether it meets the training standards prescribed by the authority. (Amended by Stats. 2014, Ch. 668, Sec. 3. Effective January 1, 2015.)*

In addition, as part of Title 2, Division 1 of the California Government Code, EMSA works in coordination with the Office of Emergency Services (OES) to jointly develop a course of instruction for use in training all emergency response personnel, using the concepts and procedures associated with California's Standardized Emergency Management System (SEMS). In turn, SEMS uses the Incident Command System (ICS) as originally developed by FIRESCOPE as a framework for responding and managing emergencies and disasters involving multiple jurisdictions or multiple agency responses. All state agencies must use SEMS to coordinate multiple jurisdiction or multiple agency emergency and disaster operations.

For this reason, Tactical First Aid training that does not incorporate ICS principles and terminology into the approved course curriculum does not qualify for "AB 1598" course recognition within the meaning of this document.

## **Role of the California Tactical EMS Advisory Committee**

The California Tactical EMS Advisory Committee was initially formed in 2013 to share information and best practices statewide among Tactical emergency medical services (TEMS) leaders. The committee is designed to collaborate and harmonize the efforts of State and local agencies, groups, individuals, and training programs representing law enforcement, emergency medical services, and fire service centered about tactical emergency medical services. Through the cooperative efforts of law enforcement, fire service, and EMS, the committee can identify a shared direction for the improvement of TEMS activities in California.

The formation of this Committee was inspired by Ken Whitman, POST Special Consultant, who championed the multi-disciplinary nature of tactical EMS. As a tribute, this Committee is nicknamed the Whitman Committee.

This Committee was formalized upon the passage of AB1598 (Rodriguez, Statutes of 2014) that added Health and Safety Code 1797.116 and 1797.134 effective January 1, 2015 as indicated below:

*1797.134. (EMS & Peace Officer Training Coordination)  
The Interdepartmental Committee on Emergency Medical Services or another committee designated by the director shall consult with the Commission on Peace Officer Standards and Training regarding emergency medical services integration and coordination with peace officer training. (Added by Stats. 2014, Ch. 668, Sec. 4. Effective January 1, 2015.)*

In conformance with the statute, Dr. Howard Backer, Director of the California EMS Authority, has formally designated the California Tactical EMS Advisory Committee as the body responsible, under Health and Safety Code 1797.134, for carrying out the activities described in Health and Safety Code 1797.116.

As noted above, AB 1598 now requires the California Tactical Advisory Committee to consult with POST regarding emergency medical services integration and coordination with peace officer training.

## **Role of the Local Emergency Medical Services Agency**

The EMS Act under existing law creates the local emergency medical services agency or LEMSA. Under existing law the LEMSA is the training program approval authority for non-state agencies

## **Role of the Office of Emergency Services**

Existing law establishes the Office of Emergency Services (OES) within the Office of the Governor of the State of California. Existing law requires the Director of OES to establish a Curriculum Development Advisement Committee (CDAC) to advise the Office on the development of course curricula, as specified by the Director of OES. Existing law also requires OES to establish regulations requiring a standardized emergency management system (SEMS) for use by all emergency response agencies. Existing law further requires that the standardized emergency management system shall include as a framework for responding to and managing emergencies and disasters involving multiple jurisdictions and agencies the incident command system (ICS) and multi-agency coordination system (MACS) as developed by FIRESCOPE, the use of mutual aid, the operational area concept and the roles and responsibilities of the individually involved agencies. Finally, existing law requires that all state and local agencies are required to use SEMS to coordinate multiple jurisdiction or multiple agency emergency or disaster operations.

## **Role of the Curriculum Development and Advisory Committee**

Existing law makes the Curriculum Development Advisory Committee (CDAC) primarily responsible for recommending criteria for terrorism awareness curriculum content to meet the training needs of state and local emergency response personnel and volunteers. Existing law further requires the Commission on Peace Officer Standards and Training (POST), the California Emergency Medical Services Authority (EMSA), and the California Joint Apprentice Committee (CALJAC) to include within any course of instruction the “criteria for curriculum content” recommended by the CDAC. Finally,

existing law requires that basic terrorism awareness training shall include understanding the structure and function of an incident command system and coordination with other emergency service first responders.

As noted above, AB 1598 further defines a “terrorism incident” as now including, “but not limited to, an active shooter incident.” An “active shooter incident is defined as “an incident where an individual is actively engaged in killing or attempting to kill people.” Additionally, AB 1598 now requires the “CDAC” to consult with POST in the development of terrorism awareness course curricula and response training.

## **Role of the Commission on Peace Officer Standards and Training**

Existing law establishes in the Department of Justice the Commission on Peace Officer Standards and Training (POST) and requires POST to both adopt rules prescribing the minimum standards regarding police officer recruitment and discharge various duties relating to the education and training of existing officers. Existing law also provides that POST shall develop and disseminate guidelines and standardized training recommendations for law enforcement officers assigned to SWAT operations on or before July 1, 2005.

Under AB 1598 POST must develop training standards and a course of instruction that includes the criteria for the curriculum content now recommended by the “Curriculum Development Advisory Committee” (CDAC), involving the responsibilities of first responders to terrorism incidents. AB 1598 further provides that the training standards and course of instruction may, if appropriate, include coordination with emergency medical services providers that respond to an incident, tactical casualty care and other standards of emergency care as established by the Emergency Medical Services Authority. Next, AB 1598 now provides that POST guidelines developed for SWAT operations may address “tactical casualty care.”

## **California Tactical EMS Advisory Subcommittee**

A subcommittee of the California Tactical EMS Advisory Committee, chaired by Val Bilotti RN, reviewed the requirements for Public Safety First Aid and CPR training and AB1598, and provided the framework for this document.

Brendalyn Val Bilotti BS RN  
POST Master Instructor  
Alameda County Sheriff’s Office

Kimberly Petersen, Captain  
Patrol Division Commander

Dan Toomey  
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Gerry Malais  
Battalion Chief  
Los Angeles Fire Dept. Homeland Security

Jim Morrissey  
Terrorism Preparedness Director  
ALCO EMS  
Senior SF FBI Tactical Medic

Fire Captain/ Paramedic  
Tactical Response Program Coordinator  
Rancho Cucamonga Fire Protection  
District

Carlos Mejia  
San Bernardino Sheriff's Department

Christopher D. Waite, Officer  
Berkeley Police Department

# 2

## APPLICATION OF TRAINING STANDARDS

First responder resources vary greatly at the local levels across the state. For this reason, preparing for terrorist incidents or active shooter events must be coordinated at the local level based on each area’s unique resources and needs. Local first responder agencies should work together on developing protocols, policies and combined training to prepare for active shooter or terrorist events.

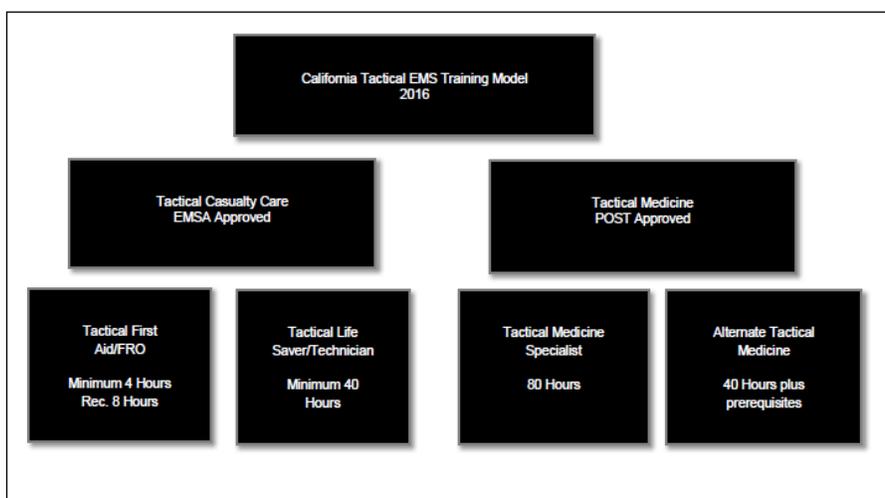
### Target Audience

This document is meant to provide guidance to training programs for public safety personnel, to include peace officers, fire service personnel, and public lifeguards, to ensure that those individuals are prepared and maintain a skill set that incorporates the basic elements of tactical casualty care and coordination with emergency medical services.

EMTs, Advanced EMTs (AEMT), and Paramedics are trained to provide a higher level of medical care. However, the concepts of tactical casualty care are not presently part of the required curriculum found in the California regulations. Consequently, it is highly recommended that all EMTs, Advanced EMTs, and paramedics are trained to the standards described in this curriculum.

Separately, Tactical Medicine training, approved by POST and EMSA, is geared towards EMT and paramedics in law enforcement or SWAT operations and is further described in the Tactical Medicine Guidelines published by POST and EMSA.

### Tactical EMS Training Model



### Tactical Casualty Care Personnel

Course	Training Hours	Training	Prerequisite
Tactical First Aid/FRO	4 hours minimum 8 Hours recommended	Care Under Fire Principles Basic Hemorrhage Control Basic Airway Management Evacuation and Patient Movement Active Shooter Integration with Law Enforcement	Per training program
Tactical Life Saver/Technician	40 Hours minimum	Care Under Fire Principles Tactical Field Care Principles Medical Threat Assessment and Planning Active Shooter Scenarios	Per training program
Tactical Medicine Specialist	80 Hours	As indicated in POST and EMSA approved Tactical Medicine Guidelines	Per POST guidelines
Alternate Tactical Medicine	40 Hours	As indicated in POST and EMSA approved Tactical Medicine Guidelines	SWAT 80 Hour

## Policies by Local Agencies

Public safety, first responder, and EMS agencies in a local area should establish policies on protocols and coordinated response to active shooter and/or terrorism related events based on a needs assessment for local training. Policies developed should encourage joint training and exercises between law enforcement, fire service, and EMS personnel using ICS principles and terminology.

Those local policies should be reviewed annually to ensure their continued application.

## Curriculum Content Review of Training Programs

Training programs shall develop curriculum and training that meet the following standards. Adherence to the minimum topics is essential to ensure that both the existing regulatory standards and AB 1598 standards are met.

Pursuant to Health and Safety Code 1797.116, training program approving authorities are required to assess the content of training programs and determine whether it meet the training standards prescribed by the California EMS Authority. Therefore, entities that offer training programs that intend to meet the provisions of these requirements, and are offered for EMT, AEMTs, and Paramedics, must submit their curriculum for evaluation to the local EMS agency or the California EMS Authority.

The California EMS Authority serves as the training program approval authority for programs offered by California Commission on Peace Officer Standards and Training (POST), California Highway Patrol, or the State Fire Training. EMSA will maintain a list of approved tactical casualty care training programs on the EMSA website. The

California EMS Authority can also approve programs that will have a statewide application.

Programs seeking approval for tactical casualty care shall be evaluated and categorized as follows:

**PROGRAM CATEGORIES:**

1. Tactical First Aid / FRO: Minimum 4 hour training program
2. Tactical Life Saver/Technician: Minimum 40 hour training program.

## **Initial and Ongoing Training**

Programs are expected to be competency based. No specific hourly requirement has been set to meet the training standards outlined in this document. However, the instructor must ensure that the students have demonstrated a level of competency in the topics described in the Curriculum Content section through written and skills testing. This is highly dependent upon the students' prior experience in medical care and tactical operations.

For training at the Tactical First Aid/FRO level, a minimum of 4 hours of training is recommended to meet the training topics for the most well prepared students with a strong background in tactical team operations. This Tactical First Aid level of training can be with or without the required AB1598 component.

For training at the Tactical LifeSaver/Technician level, a more complete training program with a minimum of 40 hours of training is recommended to standardize the knowledge and skills level for both tactical medicine and tactical casualty care components, and to provide adequate time for realistic scenario practice and competency testing.

Training programs who wish to offer these approved programs shall seek approval in advance from either their local EMS agency or the California EMS Authority. Since many training programs will also be continuing education providers, the criteria found in the California Code of Regulations, Title 22, Division 9, Chapter 11, EMS Continuing Education may be utilized to guide the approving authority and the entity seeking approval. The application form for training program approval is found in Chapter 6 of this document. Training program approval shall be for 3 years. Training programs shall keep records of student trained, and original documents related to written and skills competency testing for 4 years. These records are subject to review by the approving authority.

Training programs shall issue certificates that reflect the title of the approved course and the number of hours of training to students that successfully complete the course.

Prior and current training should be evaluated by local first response entities in order to avoid duplicative training. Local first response entities should seek collaborative training opportunities, set training goals and objectives as identified by a collaborative training needs assessment. Review of training goals and objectives should be included in the annual policy review.

Pursuant to the regulations for public safety first aid and CPR training, the 8 hour refresher training every 2 years should include the elements of tactical casualty care and coordination with emergency medical services.

## **Previously Completed Training**

AB 1598 provides and allows for agencies or entities that have previously completed Tactical First Aid training to submit to the training program approval authority for approval any pertinent training to assess its content and determine whether or not the prior training meets the training standards as prescribed by EMSA.

In making this determination, EMSA or the local EMS agency should utilize the guidelines, publications, and recommended existing training programs for guidance in this area when assessing the previously-completed course content. EMSA recognizes and acknowledges that multiple entities have assisted in developing the foundations and principles upon which this publication uses for providing training program approval guidance.

As not all local EMS agencies have developed training program approval authorities and assessment criterion pertinent to terrorism awareness training, previously completed programs may elect to submit their training curriculum to EMSA for initial approval. State and local Training Program approval will be retroactive from the date of EMSA approval and shall be valid for three years from the EMSA approval date. EMSA or local EMS agency training program approval shall be statewide in effect.

# 3

## Curriculum Content: Tactical First Aid/FRO Minimum 4 hour course

### Domain 1: History and Background

#### Competency 1.1: Demonstrate knowledge of tactical casualty care

- 1.1.1 Demonstrate knowledge of tactical casualty care
- History of active shooter and domestic terrorism incidents
  - Define roles and responsibilities of first responders including
    - Law Enforcement
    - Fire
    - EMS
  - Review of local active shooter policies
  - California Law and Regulations
    - California Code of Regulations, Title 22, Division 9, Chapter 1.5
    - Health and Safety Code 1797.116 (Amended by AB1598, Rodriguez, Chapter 668, Statutes of 2014)
    - Government Code 8607 (ICS)
    - California Code of Regulations, Title 29, Division 2, Chapter 1
  - Scope of Practice and Authorized Skills and Procedures by level of training, certification, and licensure zone<sup>1</sup>
  - Brief history of Tactical Combat Casualty Care (TCCC)
  - The Hartford Consensus (2013)
    - THREAT
    - Utilize the acronym to identify crucial action in an integrated active shooter response

### Domain 2: Terminology and definitions

#### Competency 2.1: Demonstrate knowledge of terminology

- 2.1.1 Demonstrate knowledge of terminology
- Hot zone/warm zone/cold zone
  - Casualty collection point
  - Rescue task force
  - Cover/concealment

---

<sup>1</sup> NOTE: Always stay within scope of practice for level of certification/licensure and follow the protocols approved by the local EMS agency

## **Domain 3: Coordination Command and Control**

### **Competency 3.1: Demonstrate knowledge of incident command and how agencies are integrated into tactical operations.**

- 3.1.1 Demonstrate knowledge of team command, control and communication
- Incident Command System/National Incident Management System
  - Mutual Aid considerations
  - Unified Command
  - Communications, including radio interoperability
  - Command post
    - Staging areas
    - Ingress/egress
  - Managing priorities—some priorities must be managed simultaneously

## **Domain 4: Tactical and Rescue Operations**

### **Competency 4.1: demonstrate knowledge of tactical and rescue operations.**

- 4.1.1 Tactical Operations
- The priority is to neutralize the threat
  - Contact Team
  - Search and rescue operations
- 4.1.2 Rescue Operations
- The priority is to evacuate civilians and injured parties
  - Integrated police/fire/EMS movement and coordination
  - Formation of Rescue Task Force (RTF)
  - Force protection
  - Casualty collection points
  - Patient movement
  - Other local methods for tactical operation and EMS integration ( i.e. rescue corridor, shrink Hot Zone)

## **Domain 5: Basic Tactical Casualty Care and Evacuation**

### **Competency 5.1: Demonstrate appropriate casualty care at your level of training**

- 5.1.1 Demonstrate knowledge of the components of the IFAK
- The priority is to care for the wounded
  - Individual First Aid Kit equipment
  - Understand the Priorities of Tactical Casualty Care as applied by zone
- 5.1.2 Demonstrate competency through practical testing of the following medical treatment skills:
- Bleeding control
    - Apply Tourniquet

- Self-Application
- Application on others
- Apply Direct Pressure
- Apply Israeli Bandage
- Apply Hemostatic Dressing with Wound Packing, utilizing California EMSA-approved products
- Apply Pressure Dressing
- Airway management
  - Perform Chin Lift/Jaw Thrust Maneuver
  - Place casualty in the Recovery Position
  - Place casualty in the Sitting Up/Lean Forward Airway Position
  - Insert Nasopharyngeal Airway, if approved by the Local EMS agency
- Breathing, to include chest/torso wounds
  - Apply Vented and Non-Vented Chest Seals
- Recognition and Treatment of Shock
- Prevention of Hypothermia
- Eye Injury Management
  - Cover Eye with Rigid Shield
- Perform Secondary, Head-to-Toe Assessment
- Fracture Management
- Management of Burns
- Documentation of Care

#### 5.1.3 Demonstrate competency in Evacuation and patient movement

- Drags and Lifts
  - Demonstrate Modified Fireman's – Hawes Carry (1 person)
  - Demonstrate Shoulder-Belt drag – Seal Team 3 Carry (2 Person)
  - Demonstrate Rapid Shoulder-to-Shoulder drag (2 person)
- Carries
  - Demonstrate Fore-Aft Carry (2 Person)
  - Demonstrate Side-by-Side Carry (2 person)
  - Demonstrate Side-by-Side Carry (3 person)
- Patient Movement
  - Use Soft-Litter
  - Use SKED or similar device
  - Use local movement devices

#### 5.1.4 Demonstrate knowledge of local multi-casualty/mass casualty incident protocols

- Triage procedures (ie START or SALT)
- Treatment
- Coordinate transport to higher level of care

## **6 Medical Planning and Threat Assessment**

**Competency 6.1: Demonstrate knowledge in medical planning and threat assessment.**

6.1.1 Understand and demonstrate knowledge of situational awareness

- Scene Size-up
- Pre-assessment of Situation
- Pre-assessment of Risks and Threats
- Medical Resources Available

## **7 Practical Skills/Scenario Training**

**Competency 7.1: Demonstrate knowledge and skills through written and practical exam.**

7.1.1 Demonstrate through skills and written exam

- Medical skills
  - Bleeding control
  - Airway management
  - Respiratory Care, including open chest wounds
- Patient extrication and evacuation
- Self and Buddy Care scenarios in hot and warm zones
- Coordinated law enforcement/fire/EMS response with formation of Rescue Task Force, following ICS and unified command principles

# 4

## TRAINING PROGRAM REQUEST FOR APPROVAL FORM

**California Tactical Casualty Care Training Program**  
**Request for Approval**

Applicant: \_\_\_\_\_

Date of Application: \_\_\_\_\_

Program Director: \_\_\_\_\_

Contact Information: \_\_\_\_\_

All prospective tactical training programs shall submit a written request for training program approval to the California EMS Authority. All requests shall include the following:

- Course being requested for Approval
  - Tactical First Aid/FRO – minimum 4 hour course
  - Tactical Life Saver/Technician – minimum 40 hour course
  
- Class Schedule with Hourly distribution
  
- Course outline and curriculum
  
- List of psychomotor skills and tactical medical scenarios
  
- Written and skills competency examinations
  
- Written course safety policy
  
- Instructor resume

Submit completed application to:  
EMS Authority  
Tactical Coordinator  
10901 Gold Center Drive #400  
Rancho Cordova, CA 95670

Form#TCCApp  
Effective May 2016

# 5

## RESOURCE GUIDE 1: CALIFORNIA TACTICAL CASUALTY CARE GUIDELINES

**BASIC TACTICAL CASUALTY CARE (TCC)  
CALIFORNIA QUICK REFERENCE GUIDE**



HOT ZONE / DIRECT THREAT CARE (DTC) / CARE UNDER FIRE (CUF)
1. Mitigate any threat and move to a safer position.
2. Direct the casualty to stay engaged in operation, if appropriate.
3. Direct the casualty to move to a safer position and apply self-aid, if appropriate.
4. <b>Casualty Extraction.</b> Move casualty from unsafe area, to include using manual drags or carries, or use a soft litter or SKEDCO as needed.
5. <b>STOP LIFE-THREATENING EXTERNAL HEMORRHAGE,</b> using appropriate PPE, if tactically feasible: - Apply effective tourniquet for hemorrhage that is anatomically amenable to tourniquet application.
6. Consider quickly placing casualty in position to protect airway. <b>Recovery Position,</b> if unable to move patient immediately and tactically feasible.

WARM ZONE / INDIRECT THREAT CARE (ITC) / TACTICAL FIELD CARE (TFC)
1. Law Enforcement casualties should have weapons made safe once the threat is neutralized or if mental status is altered.
2. <b>AIRWAY MANAGEMENT:</b> a. Unconscious patient without airway obstruction: - Chin lift or jaw thrust maneuver. - <b>Nasopharyngeal airway,</b> if approved by LEMSA as an optional skill - Place patient in Recovery position. b. Patient with airway obstruction or impending airway obstruction: - Chin lift or jaw thrust maneuver. - <b>Nasopharyngeal Airway,</b> if approved by LEMSA as an optional skill - Allow patient to assume position that best protects the airway, including sitting up. - Place unconscious patient in Recovery Position.
3. <b>BREATHING:</b> a. All open and/or sucking chest wounds should be treated by applying an Vented Chest Seal or non-vented occlusive seal to cover the defect and securing it in place. Monitor for development of a tension pneumothorax.
4. <b>BLEEDING:</b> a. Assess for unrecognized hemorrhage and control all sources of bleeding. If not already done, use a tourniquet, and appropriate pressure dressing. b. For compressible hemorrhage not amenable to tourniquet use, apply a California EMS-approved hemostatic dressing with a pressure bandage. c. Reassess all tourniquets that were applied during previous phases of care. Consider exposing the injury and determining if a tourniquet is needed. If a tourniquet is not needed, use other techniques to control bleeding and remove TQ. d. Apply Emergency Bandage or direct pressure to the wound, if appropriate. e. For hemorrhage that cannot be controlled with a tourniquet, apply California EMSA-Approved Hemostatic Dressing.

5. <b>ASSESS FOR HEMORRHAGIC SHOCK</b> a. Elevate Lower Extremities if patient in shock.
6. <b>PREVENTION OF HYPOTHERMIA:</b> a. Minimize patient's exposure to the elements. Keep protective gear on if feasible. b. Replace wet clothing with dry if possible. Place onto an insulated surface ASAP. c. Cover the casualty with self-heating Blanket or rescue blanket to torso. Place hypothermia prevention cap on the patient's head. Use dry blankets, poncho liners, sleeping bags, or anything that will retain heat and keep the patient dry.
7. <b>PENETRATING EYE TRAUMA:</b> If a penetrating eye injury is noted or suspected: a) perform a rapid field test of visual acuity, b) cover the eye with a rigid eye shield (NOT a pressure patch).
8. <b>REASSESS CASUALTY AND TREAT OTHER CONDITIONS AS NECESSARY:</b> a. Complete Secondary Survey checking for additional injuries or conditions. Inspect and dress known wounds that were previously deferred. b. Consider Splinting known/suspected fracture or Spinal Immobilization, if indicated. c. Use <b>Nerve Agent Auto-Injector</b> (ie Duo-Dote) for Nerve Agent intoxication, if approved by LEMSA as an optional skill. d. Use <b>EquipSet</b> for Anaphylactic Reaction, if approved by LEMSA as an optional skill.
9. <b>BURNS:</b> a. Aggressively monitor airway and respiratory status for casualties with smoke inhalation or facial burns, including oxygen or cyanide antidote treatment when significant symptoms are present. b. Estimate TBSA and cover burn area with dry, sterile dressings.
10. <b>MONITORING:</b> Apply monitoring devices or diagnostic equipment if available. Obtain vital signs.
11. <b>PREPARE CASUALTY FOR MOVEMENT:</b> - Move packaged patient to site where evacuation is anticipated. - Monitor airway, breathing, bleeding, and reevaluate the patient for shock.
12. <b>COMMUNICATE WITH THE PATIENT IF POSSIBLE:</b> - Encourage, reassure, and explain care.
13. <b>CARDIOPULMONARY RESUSCITATION (C-PR) AND AED:</b> Resuscitation in the tactical environment for victims of blast or penetrating trauma who have no pulse or respirations should only be treated when resources and conditions allow.
14. <b>DOCUMENTATION:</b> Document clinical assessments, treatments rendered, and changes in the patient's status. Forward this information with the patient to the next level of care.

California EMS Authority (2015 Revision)

BLUE—Authorized Basic Skills For Public Safety First Aid Providers and EMTs  
RED—Local Optional Skill which may be added by the Local EMS Agency Medical Director

# 6

## **RESOURCE GUIDE 2: MEDICAL PLANNING AND THREAT ASSESSMENT QUICK REFERENCE GUIDE**



**TACTICAL MEDICAL PLANNING AND THREAT ASSESSMENT QUICK REFERENCE GUIDE**

MEDICAL INTELLIGENCE (MISSION AND PATIENTS)
1. Mission Type?
2. Number of Potential Patients?
3. Ages of Potential Patients?
4. Pre-Existing Conditions?
5. Special Populations? (Pediatric, Elderly, Language)
6. Other

MEDICAL THREAT ASSESSMENT (TEAM)
1. Weather, including Temperature, (Cold, Hot) and Precipitation (Rain, Snow)? - Wind? Wind Direction? - Health Considerations?
2. Hazardous Materials? Explosive Threats? - Chemical? - Nuclear/Radiological? - Improvised Explosive Devices?
3. Biological Threats?
4. Animal Threats?
5. Plant Threats?
6. Regional Specific Threats?
7. Personal Protective Equipment Needed (Ballistic Vest, Helmet, Mask)? - As locally determined

MEDICAL PLANNING AND RESOURCES
1. Communication - Tactical Frequency _____ - Base Hospital _____
2. Location of Key Areas - Staging Area _____ - Casualty Collection Point(s) _____ - Triage Area/Treatment Area _____
3. Hospital - Closest Hospital _____ - Trauma Center/Burn Center _____
4. EMS Transport - Ground Ambulance _____ Standby Location? - Air Ambulance _____ Landing Zone, Lat/Long?
5. Support Services - Poison Control System 1-800-222-1222 - Veterinary Services? Animal Control? - Mental Health/Chaplain? - Social Services/CPS? - Public Works?

TEAM HEALTH CONSIDERATIONS
1. Completed Team Medical Records? - Access to Records?
2. Exposure Protection
3. Hydration
4. Food/Nutrition
5. Extended Operations, Inc. Sleep/Fatigue
6. Need for Rehabilitation Station/First Aid Station - Medical Equipment - OTC Meds
7. Other

California EMS Authority (2015 Revision)

# 7

## **RESOURCE GUIDE 3: ACTIVE SHOOTER QUICK REFERENCE GUIDE**

EMS INTEGRATION WITH LAW ENFORCEMENT  
DURING ACTIVE SHOOTER  
EVENTS QUICK REFERENCE GUIDE



PREPARATORY PHASE	
1. ARRIVE AND REPORT to Staging Area in Secure Area	
2. REPORT TO UNIFIED COMMAND - Notify UC that an EMS Team/Rescue Group is ready, staged, and awaiting direction.	
3. PPE (Ballistic Vest, Ballistic Helmet)	
4. Ensure Clear IDENTIFICATION of Rescue personnel	
5. Prepare MEDICAL EQUIPMENT (Tourniquets, Trauma Kit, Soft Stretcher/Skedoo)	
6. Perform Brief MEDICAL INTEL AND THREAT ASSESSMENT - Identify Hot, Warm, and Cold Zone Areas	
7. Establish COMMUNICATION with respective on-scene medical, fire, and law enforcement - Determine and Broadcast Response Routes for Additional Responding Resources - Obtain Duress Code	
RESCUE TASK FORCE FORMATION AND PRIORITY SETTING PHASE	
1. Form Rescue Task Force, minimum - 2 LE Officers - 2 EMS Personnel - Designate a team leader	
2. Follow Direction of law enforcement officer assigned as RTF leader - Know Hot, Warm, and Cold Zone Areas - Follow Protected Access Routes	
3. Brief objective and direction of movement - Identify initial Emergency Egress Routes - Identify secure Extractions Lane - Identify initial Safe Refuge Area - Identify Rally Point - "Mayday" operations emergency evacuation	
4. Identify Casualty Collection Points, both Dynamic and Static	
5. Reinforce Mission Priorities (THREAT) - T - Threat suppression - H - Hemorrhage control - RE - Rapid Extrication to safety - A - Assessment by medical providers - T - Transport to definitive care	

INDIRECT THREAT/WARM ZONE/YELLOW ZONE OPERATIONS PHASE	
1. Maintain Cover and Concealment as directed by Rescue Task Force Leader (LE) - Triage as required	
2. Utilize Principles of Tactical Casualty Care (TCC) - Identify secure Extractions Lane - Identify Safe Refuge Area	
3. Finalize Direction of movement based upon prevailing conditions - Identify Emergency Egress Routes - Identify secure Extractions Lane - Identify Safe Refuge Area	
4. Maintain Situational Awareness for Secondary devices at main and secondary scenes	
5. Identify Dynamic Casualty Collection Points, as necessary	
6. Move casualties to identified Casualty Collection Points or Cold Zone Treatment Area - Preference is movement from Warm Zone to Cold Zone Treatment Area - Transfer care to additional medical providers for treatment and transport	
7. Prepare to re-enter Warm Zone	

POST INCIDENT PHASE	
1. Ensure Rescue Task Force accountability	
2. Collect any incident management records and unit logs	
3. Determine and announce an incident debriefing strategy	
4. Assess mental and physical health of the responders - Determine and announce a stress debrief plan	
5. Manage a formal unit-release process	

California EMS Authority (2015)

# 8

## RESOURCE GUIDE 4: INDIVIDUAL FIRST AID KIT RECOMMENDATIONS

Each individual on a team should minimally carry the following individual first aid equipment, or have it readily accessible.

Quantity	Type of Equipment
1	Medical Pouch
6	Gloves (Trauma, latex-free, 3 pair)
1	Tourniquet, CoTCCC-Recommended
1	Emergency Bandage
1	Hemostatic Dressing, California EMSA approved
1	Nasopharyngeal Airway (28f size with water-based lubricant), if approved by the local EMS agency Medical Director
1	Chest Seal
1	Pen, Permanent Marker
1	Rescue Blanket (disposable-consider thermal reflective material)
1	Shears, Trauma
1	Gauze, Roller Bandage or Elastic Bandage

# 9

## REFERENCES

### Further Suggested Reading on Best Practices

- Refer to the Tactical Emergency Casualty Care guidelines for information on trauma care: [http://c-tecc.org/images/content/TECC\\_Guidelines\\_-\\_JUNE\\_2014\\_update.pdf](http://c-tecc.org/images/content/TECC_Guidelines_-_JUNE_2014_update.pdf)
- Refer to Hartford Consensus II for national consensus strategies on improving survivability for mass casualty shooting events: [http://www.naemt.org/Files/LEFRTCC/Hartford\\_Consensus\\_2.pdf](http://www.naemt.org/Files/LEFRTCC/Hartford_Consensus_2.pdf)
- Refer to study from the American College of Surgeons for more information on management of prehospital trauma care: <http://informahealthcare.com/doi/pdf/10.3109/10903127.2014.896962>
- Refer to FEMA.gov for guidance on the incident command system: <https://www.fema.gov/incident-command-system-resources>
- Refer to the following documents for guidance on integrated response:
  - <http://www.cffjac.org/go/jac/media-center/video-gallery/tcm-active-shooter-scenario/>
  - [https://www.usfa.fema.gov/downloads/pdf/publications/active\\_shooter\\_guide.pdf](https://www.usfa.fema.gov/downloads/pdf/publications/active_shooter_guide.pdf)
- Assembly Bill No. 1598 [http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320140AB1598](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB1598)
- FBI Study of Active Shooter Incidents - <http://www.fbi.gov/news/stories/2014/september/fbi-releases-study-on-active-shooter-incidents/pdfs/a-study-of-active-shooter-incidents-in-the-u.s.-between-2000-and-2013>
- FBI Resources for Active Shooter/MCI Incidents - <http://www.fbi.gov/about-us/cirg/active-shooter-and-mass-casualty-incidents>

- Firescope-Emergency Response to Law Enforcement Incidents ICS 701 <http://www.firescope.org/docs-operational-guidelines/ics%20701.pdf>
- Texas State University Study of Active Shooter Events 2000 - 2010 - <http://alerrt.org/files/research/ActiveShooterEvents.pdf>
- POST/EMSA Tactical Medicine Guidelines: <http://lib.post.ca.gov/Publications/TacticalMedicine.pdf>
- C-TECC- IAFF position paper <http://www.jsomonline.org/TEMS/1401CTECC%20Update.pdf>

Training Standards for  
Basic Tactical Casualty Care  
and  
Coordination with EMS during Terrorism Incidents

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# Training Standards for Basic Tactical Casualty Care and Coordination with EMS during Terrorism Incidents

Emergency Medical Services Authority  
California Health and Human Services Agency

**Proposed Guidelines**

EMSA #170  
May 2016





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Proposed Guidelines  
EMSA #170  
May 2016

# Training Standards for Basic Tactical Casualty Care and Coordination with EMS during Terrorism Incidents: Guidelines for Law Enforcement, Fire Service, and Emergency Medical Services Personnel

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# 1

## INTRODUCTION

### Statutory and Regulatory Basis

This document provides the framework for training standards necessary for the preparation of law enforcement, fire service, and emergency medical services personnel to respond to terrorism incidents. It seeks to harmonize and incorporate the many new and existing requirements now found in California's various statutes and regulations.

First, it recognizes the regulatory requirements found in California Code of Regulations, Title 22, Division 9, Chapter 1.5 that guide the training of public safety personnel in first aid and cardiopulmonary resuscitation. Specifically, this document highlights the specific training criteria concerning tactical casualty care. Second, it adds the statutory elements found in AB 1598 (Rodriguez, Chapter 668, Statutes of 2014) that provide for additional requirements regarding coordination with emergency medical services personnel during terrorism incidents or active shooter events.

These many requirements taken as a whole will guide both training programs and first responder agencies, including law enforcement, fire, and emergency medical services (EMS), on development of curriculum and protocols related to the coordinated response to active shooter and other terrorism related multi-casualty events.

This document is focused upon developing the training program approval process with respect to prehospital emergency medical services training as this training relates to terrorism related responses; and describing the care provided at the basic life support level as those skills are authorized under existing California Regulations for public safety personnel who have received training at the public safety first aid and CPR level, or those individuals trained at the Emergency Medical Technician (EMT) level (California Code of Regulations, Title 22, Division 9, Chapter 2.) Individuals who are certified or licensed at an advanced level including Advanced EMTs (AEMT) or paramedics should consult with their local EMS agency for guidance on scope of practice and local protocols for use during tactical operations.

### Legislative Intent

In enacting AB 1598, the legislature made several important additions or changes to statutory language found in California Health and Safety Code 1797.116, 1797.134, California Government Code 8588.10, California Penal Code 13514.1 and 13519.12 to better prepare public safety personnel to provide tactical casualty care and coordinate

with emergency medical services during terrorism incidents. Moreover, the changes which AB 1598 sought to make need to be harmonized with existing law and regulations.

For the purposes of AB 1598, and this document, a “terrorism incident” includes, but is not limited to, an active shooter incident. An “active shooter incident” is an incident where an individual is actively engaged in killing or attempting to kill people.

The California legislature noted in their intent language that “since the Columbine High School shootings that occurred in 1999, more than 250 people have been killed in the United States during what has been classified as active shooter and mass casualty incidents.” They observed that “these incidents involve one or more suspects who participate in an ongoing, random, or systematic shooting spree, demonstrating the intent to harm others with the objective of mass murder.” Moreover, the legislature said, “It also became evident that these events may take place in any community or venue and that they impact fire and police departments, regardless of their size or capacity. Local jurisdictions vary widely in available emergency response resources, staffing, and equipment allocations.”

In enacting AB 1598, the legislature was prescribing that protocols and training for response to active shooter incidents must be established locally to work within the resource capabilities and limitations of each jurisdiction. The legislature intended AB1598 to do the following:

- Require the development of collaborative protocols and relationships between local and state first response entities, including law enforcement agencies, fire departments, and emergency medical services providers and agencies, in order that those entities shall act effectively and in concert to address active shooter incidents across California.
- Require first response entities to seek collaborative training opportunities, including, but not limited to, table top or simulation exercises, to assess plan implementations, and to include other entities that may be involved in active shooter incidents in those trainings, such as schools, city or county personnel, and private businesses.
- Require basic and ongoing training for law enforcement agency personnel, fire department personnel, emergency medical services personnel, and the personnel for other first responders include, as appropriate, training and education on active shooter incidents and tactical casualty care.

It was the intent of the Legislature that each first response entity, in collaboration with other law enforcement agencies, fire departments, and emergency medical services providers and agencies, develop protocols for responding to active shooter incidents.

Those protocols must be reviewed annually to ensure that they are current, and address any policy, geographic, or demographic changes that warrant a response strategy review. The Legislature intended that the protocols address all of the following:

- The roles, responsibilities, and policies of each entity in responding to an active shooter incident.
- Pre-assessment and contingency planning that includes identification of potential targets within the jurisdiction.
- Implementation of an Incident Command System (ICS), including emergency protocols for a unified command structure for entities responding to an active shooter incident.
- Interagency communication issues and needs, including, but not limited to, radio interoperability and establishment of common language, terms, and definitions to be used on the scene of an active shooter incident.
- Identification of resources for responding to an active shooter incident, including, but not limited to, primary and secondary needs and hospitals.
- Tactical deployment of available resources for responding to an active shooter incident.
- Emergency treatment and extraction of persons injured in an active shooter incident.

## EMSA Statutory Requirements regarding this Document

As part of Division 2.5 of the California Health and Safety Code, the California Emergency Medical Services Authority (EMSA or authority), is charged with setting training standards for all levels of emergency medical care personnel including public safety, Emergency Medical Technicians (EMT), Advanced EMT (AEMT), and paramedics.

Specifically, existing law requires EMSA to establish “additional training standards” that include the criteria for curriculum content involving the responsibilities of first responders to terrorism incidents. The Health and Safety Code notes this below:

*1797.116. (Terrorism Response Training Standards)*

*(a) The authority shall establish additional training standards that include the criteria for the curriculum content recommended by the Curriculum Development Advisory Committee established pursuant to Section 8588.10 of the Government Code, involving the responsibilities of first responders to terrorism incidents and to address the training needs of those identified as first responders. Training standards shall include, but not be limited to, criteria for coordinating between different responding entities.*

*(b) Every EMT I, EMT II, and EMT-P, as defined in Sections 1797.80, 1797.82, and 1797.84, may receive the appropriate training described in this section. Pertinent training previously completed by any jurisdiction’s EMT I, EMT II, or EMT-P personnel and meeting the training requirements*

*of this section may be submitted to the training program approving authority to assess its content and determine whether it meets the training standards prescribed by the authority. (Amended by Stats. 2014, Ch. 668, Sec. 3. Effective January 1, 2015.)*

In addition, as part of Title 2, Division 1 of the California Government Code, EMSA works in coordination with the Office of Emergency Services (OES) to jointly develop a course of instruction for use in training all emergency response personnel, using the concepts and procedures associated with California's Standardized Emergency Management System (SEMS). In turn, SEMS uses the Incident Command System (ICS) as originally developed by FIRESCOPE as a framework for responding and managing emergencies and disasters involving multiple jurisdictions or multiple agency responses. All state agencies must use SEMS to coordinate multiple jurisdiction or multiple agency emergency and disaster operations.

For this reason, Tactical First Aid training that does not incorporate ICS principles and terminology into the approved course curriculum does not qualify for "AB 1598" course recognition within the meaning of this document.

## **Role of the California Tactical EMS Advisory Committee**

The California Tactical EMS Advisory Committee was initially formed in 2013 to share information and best practices statewide among Tactical emergency medical services (TEMS) leaders. The committee is designed to collaborate and harmonize the efforts of State and local agencies, groups, individuals, and training programs representing law enforcement, emergency medical services, and fire service centered about tactical emergency medical services. Through the cooperative efforts of law enforcement, fire service, and EMS, the committee can identify a shared direction for the improvement of TEMS activities in California.

The formation of this Committee was inspired by Ken Whitman, POST Special Consultant, who championed the multi-disciplinary nature of tactical EMS. As a tribute, this Committee is nicknamed the Whitman Committee.

This Committee was formalized upon the passage of AB1598 (Rodriguez, Statutes of 2014) that added Health and Safety Code 1797.116 and 1797.134 effective January 1, 2015 as indicated below:

*1797.134. (EMS & Peace Officer Training Coordination)  
The Interdepartmental Committee on Emergency Medical Services or another committee designated by the director shall consult with the Commission on Peace Officer Standards and Training regarding emergency medical services integration and coordination with peace*

*officer training. (Added by Stats. 2014, Ch. 668, Sec. 4. Effective January 1, 2015.)*

In conformance with the statute, Dr. Howard Backer, Director of the California EMS Authority, has formally designated the California Tactical EMS Advisory Committee as the body responsible, under Health and Safety Code 1797.134, for carrying out the activities described in Health and Safety Code 1797.116.

As noted above, AB 1598 now requires the California Tactical Advisory Committee to consult with POST regarding emergency medical services integration and coordination with peace officer training.

## **Role of the Local Emergency Medical Services Agency**

The EMS Act under existing law creates the local emergency medical services agency or LEMSA. Under existing law the LEMSA is the training program approval authority for non-state agencies

## **Role of the Office of Emergency Services**

Existing law establishes the Office of Emergency Services (OES) within the Office of the Governor of the State of California. Existing law requires the Director of OES to establish a Curriculum Development Advisement Committee (CDAC) to advise the Office on the development of course curricula, as specified by the Director of OES. Existing law also requires OES to establish regulations requiring a standardized emergency management system (SEMS) for use by all emergency response agencies. Existing law further requires that the standardized emergency management system shall include as a framework for responding to and managing emergencies and disasters involving multiple jurisdictions and agencies the incident command system (ICS) and multi-agency coordination system (MACS) as developed by FIRESCOPE, the use of mutual aid, the operational area concept and the roles and responsibilities of the individually involved agencies. Finally, existing law requires that all state and local agencies are required to use SEMS to coordinate multiple jurisdiction or multiple agency emergency or disaster operations.

## **Role of the Curriculum Development and Advisory Committee**

Existing law makes the Curriculum Development Advisory Committee (CDAC) primarily responsible for recommending criteria for terrorism awareness curriculum content to meet the training needs of state and local emergency response personnel and volunteers. Existing law further requires the Commission on Peace Officer Standards

and Training (POST), the California Emergency Medical Services Authority (EMSA), and the California Joint Apprenticeship Committee (CALJAC) to include within any course of instruction the “criteria for curriculum content” recommended by the CDAC. Finally, existing law requires that basic terrorism awareness training shall include understanding the structure and function of an incident command system and coordination with other emergency service first responders.

As noted above, AB 1598 further defines a “terrorism incident” as now including, “but not limited to, an active shooter incident.” An “active shooter incident is defined as “an incident where an individual is actively engaged in killing or attempting to kill people.” Additionally, AB 1598 now requires the “CDAC” to consult with POST in the development of terrorism awareness course curricula and response training.

## **Role of the Commission on Peace Officer Standards and Training**

Existing law establishes in the Department of Justice the Commission on Peace Officer Standards and Training (POST) and requires POST to both adopt rules prescribing the minimum standards regarding police officer recruitment and discharge various duties relating to the education and training of existing officers. Existing law also provides that POST shall develop and disseminate guidelines and standardized training recommendations for law enforcement officers assigned to SWAT operations on or before July 1, 2005.

Under AB 1598 POST must develop training standards and a course of instruction that includes the criteria for the curriculum content now recommended by the “Curriculum Development Advisory Committee” (CDAC), involving the responsibilities of first responders to terrorism incidents. AB 1598 further provides that the training standards and course of instruction may, if appropriate, include coordination with emergency medical services providers that respond to an incident, tactical casualty care and other standards of emergency care as established by the Emergency Medical Services Authority. Next, AB 1598 now provides that POST guidelines developed for SWAT operations may address “tactical casualty care.”

## **California Tactical EMS Advisory Subcommittee**

A subcommittee of the California Tactical EMS Advisory Committee, chaired by Val Bilotti RN, reviewed the requirements for Public Safety First Aid and CPR training and AB1598, and provided the framework for this document.

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# 2

## APPLICATION OF TRAINING STANDARDS

First responder resources vary greatly at the local levels across the state. For this reason, preparing for terrorist incidents or active shooter events must be coordinated at the local level based on each area's unique resources and needs. Local first responder agencies should work together on developing protocols, policies and combined training to prepare for active shooter or terrorist events.

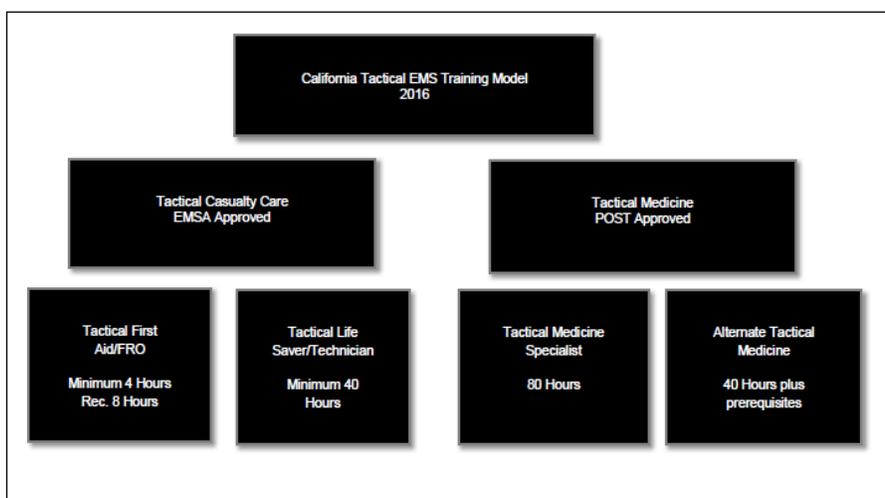
### Target Audience

This document is meant to provide guidance to training programs for public safety personnel, to include peace officers, fire service personnel, and public lifeguards, to ensure that those individuals are prepared and maintain a skill set that incorporates the basic elements of tactical casualty care and coordination with emergency medical services.

EMTs, Advanced EMTs (AEMT), and Paramedics are trained to provide a higher level of medical care. However, the concepts of tactical casualty care are not presently part of the required curriculum found in the California regulations. Consequently, it is highly recommended that all EMTs, Advanced EMTs, and paramedics are trained to the standards described in this curriculum.

Separately, Tactical Medicine training, approved by POST and EMSA, is geared towards EMT and paramedics in law enforcement or SWAT operations and is further described in the Tactical Medicine Guidelines published by POST and EMSA.

### Tactical EMS Training Model



### Tactical Casualty Care Personnel

Course	Training Hours	Training	Prerequisite
Tactical First Aid/FRO	4 hours minimum 8 Hours recommended	Care Under Fire Principles Basic Hemorrhage Control Basic Airway Management Evacuation and Patient Movement Active Shooter Integration with Law Enforcement	Per training program
Tactical Life Saver/Technician	40 Hours minimum	Care Under Fire Principles Tactical Field Care Principles Medical Threat Assessment and Planning Active Shooter Scenarios	Per training program
Tactical Medicine Specialist	80 Hours	As indicated in POST and EMSA approved Tactical Medicine Guidelines	Per POST guidelines
Alternate Tactical Medicine	40 Hours	As indicated in POST and EMSA approved Tactical Medicine Guidelines	SWAT 80 Hour

## Policies by Local Agencies

Public safety, first responder, and EMS agencies in a local area should establish policies on protocols and coordinated response to active shooter and/or terrorism related events based on a needs assessment for local training. Policies developed should encourage joint training and exercises between law enforcement, fire service, and EMS personnel using ICS principles and terminology.

Those local policies should be reviewed annually to ensure their continued application.

## Curriculum Content Review of Training Programs

Training programs shall develop curriculum and training that meet the following standards. Adherence to the minimum topics is essential to ensure that both the existing regulatory standards and AB 1598 standards are met.

Pursuant to Health and Safety Code 1797.116, training program approving authorities are required to assess the content of training programs and determine whether it meet the training standards prescribed by the California EMS Authority. Therefore, entities that offer training programs that intend to meet the provisions of these requirements, and are offered for EMT, AEMTs, and Paramedics, must submit their curriculum for evaluation to the local EMS agency or the California EMS Authority.

The California EMS Authority serves as the training program approval authority for programs offered by California Commission on Peace Officer Standards and Training (POST), California Highway Patrol, or the State Fire Training. EMSA will maintain a list of approved tactical casualty care training programs on the EMSA website. The

California EMS Authority can also approve programs that will have a statewide application.

Programs seeking approval for tactical casualty care shall be evaluated and categorized as follows:

**PROGRAM CATEGORIES:**

1. Tactical First Aid / FRO: Minimum 4 hour training program
2. Tactical Life Saver/Technician: Minimum 40 hour training program.

## **Initial and Ongoing Training**

Programs are expected to be competency based. No specific hourly requirement has been set to meet the training standards outlined in this document. However, the instructor must ensure that the students have demonstrated a level of competency in the topics described in the Curriculum Content section through written and skills testing. This is highly dependent upon the students' prior experience in medical care and tactical operations.

For training at the Tactical First Aid/FRO level, a minimum of 4 hours of training is recommended to meet the training topics for the most well prepared students with a strong background in tactical team operations. This Tactical First Aid level of training can be with or without the required AB1598 component.

For training at the Tactical LifeSaver/Technician level, a more complete training program with a minimum of 40 hours of training is recommended to standardize the knowledge and skills level for both tactical medicine and tactical casualty care components, and to provide adequate time for realistic scenario practice and competency testing.

Training programs who wish to offer these approved programs shall seek approval in advance from either their local EMS agency or the California EMS Authority. Since many training programs will also be continuing education providers, the criteria found in the California Code of Regulations, Title 22, Division 9, Chapter 11, EMS Continuing Education may be utilized to guide the approving authority and the entity seeking approval. The application form for training program approval is found in Chapter 7 of this document. Training program approval shall be for 3 years. Training programs shall keep records of student trained, and original documents related to written and skills competency testing for 4 years. These records are subject to review by the approving authority.

Training programs shall issue certificates that reflect the title of the approved course and the number of hours of training to students that successfully complete the course.

Prior and current training should be evaluated by local first response entities in order to avoid duplicative training. Local first response entities should seek collaborative training opportunities, set training goals and objectives as identified by a collaborative training needs assessment. Review of training goals and objectives should be included in the annual policy review.

Pursuant to the regulations for public safety first aid and CPR training, the 8 hour refresher training every 2 years should include the elements of tactical casualty care and coordination with emergency medical services.

## **Previously Completed Training**

AB 1598 provides and allows for agencies or entities that have previously completed Tactical First Aid training to submit to the training program approval authority for approval any pertinent training to assess its content and determine whether or not the prior training meets the training standards as prescribed by EMSA.

In making this determination, EMSA or the local EMS agency should utilize the guidelines, publications, and recommended existing training programs for guidance in this area when assessing the previously-completed course content. EMSA recognizes and acknowledges that multiple entities have assisted in developing the foundations and principles upon which this publication uses for providing training program approval guidance.

As not all local EMS agencies have developed training program approval authorities and assessment criterion pertinent to terrorism awareness training, previously completed programs may elect to submit their training curriculum to EMSA for initial approval. State and local Training Program approval will be retroactive from the date of EMSA approval and shall be valid for three years from the EMSA approval date. EMSA or local EMS agency training program approval shall be statewide in effect.

# 3

## Curriculum Content: Tactical First Aid/FRO Minimum 4 hour course

### Domain 1: History and Background

#### Competency 1.1: Demonstrate knowledge of tactical casualty care

- 1.1.1 Demonstrate knowledge of tactical casualty care
  - History of active shooter and domestic terrorism incidents
  - Define roles and responsibilities of first responders including
    - Law Enforcement
    - Fire
    - EMS
  - Review of local active shooter policies
  - California Law and Regulations
    - California Code of Regulations, Title 22, Division 9, Chapter 1.5
    - Health and Safety Code 1797.116 (Amended by AB1598, Rodriguez, Chapter 668, Statutes of 2014)
    - Government Code 8607 (ICS)
    - California Code of Regulations, Title 29, Division 2, Chapter 1
  - Scope of Practice and Authorized Skills and Procedures by level of training, certification, and licensure zone<sup>1</sup>
  - Brief history of Tactical Combat Casualty Care (TCCC)
  - The Hartford Consensus (2013)
    - THREAT
    - Utilize the acronym to identify crucial action in an integrated active shooter response

### Domain 2: Terminology and definitions

#### Competency 2.1: Demonstrate knowledge of terminology

- 2.1.1 Demonstrate knowledge of terminology
  - Hot zone/warm zone/cold zone
  - Casualty collection point
  - Rescue task force
  - Cover/concealment

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<sup>1</sup> NOTE: Always stay within scope of practice for level of certification/licensure and follow the protocols approved by the local EMS agency

## **Domain 3: Coordination Command and Control**

### **Competency 3.1: Demonstrate knowledge of incident command and how agencies are integrated into tactical operations.**

- 3.1.1 Demonstrate knowledge of team command, control and communication
- Incident Command System/National Incident Management System
  - Mutual Aid considerations
  - Unified Command
  - Communications, including radio interoperability
  - Command post
    - Staging areas
    - Ingress/egress
  - Managing priorities—some priorities must be managed simultaneously

## **Domain 4: Tactical and Rescue Operations**

### **Competency 4.1: demonstrate knowledge of tactical and rescue operations.**

- 4.1.1 Tactical Operations
- The priority is to neutralize the threat
  - Contact Team
  - Search and rescue operations
- 4.1.2 Rescue Operations
- The priority is to evacuate civilians and injured parties
  - Integrated police/fire/EMS movement and coordination
  - Formation of Rescue Task Force (RTF)
  - Force protection
  - Casualty collection points
  - Patient movement
  - Other local methods for tactical operation and EMS integration ( i.e. rescue corridor, shrink Hot Zone)

## **Domain 5: Basic Tactical Casualty Care and Evacuation**

### **Competency 5.1: Demonstrate appropriate casualty care at your level of training**

- 5.1.1 Demonstrate knowledge of the components of the IFAK
- The priority is to care for the wounded
  - Individual First Aid Kit equipment
  - Understand the Priorities of Tactical Casualty Care as applied by zone
- 5.1.2 Demonstrate competency through practical testing of the following medical treatment skills:
- Bleeding control

- Apply Tourniquet
  - Self-Application
  - Application on others
- Apply Direct Pressure
- Apply Israeli Bandage
- Apply Hemostatic Dressing with Wound Packing, utilizing California EMSA-approved products
- Apply Pressure Dressing
- Airway management
  - Perform Chin Lift/Jaw Thrust Maneuver
  - Place casualty in the Recovery Position
  - Place casualty in the Sitting Up/Lean Forward Airway Position
  - Insert Nasopharyngeal Airway, if approved by the Local EMS agency
- Breathing, to include chest/torso wounds
  - Apply Vented and Non-Vented Chest Seals
- Recognition and Treatment of Shock
- Prevention of Hypothermia
- Eye Injury Management
  - Cover Eye with Rigid Shield
- Perform Secondary, Head-to-Toe Assessment
- Fracture Management
- Management of Burns
- Documentation of Care

#### 5.1.3 Demonstrate competency in Evacuation and patient movement

- Drags and Lifts
  - Demonstrate Modified Fireman's – Hawes Carry (1 person)
  - Demonstrate Shoulder-Belt drag – Seal Team 3 Carry (2 Person)
  - Demonstrate Rapid Shoulder-to-Shoulder drag (2 person)
- Carries
  - Demonstrate Fore-Aft Carry (2 Person)
  - Demonstrate Side-by-Side Carry (2 person)
  - Demonstrate Side-by-Side Carry (3 person)
- Patient Movement
  - Use Soft-Litter
  - Use SKED or similar device
  - Use local movement devices

#### 5.1.4 Demonstrate knowledge of local multi-casualty/mass casualty incident protocols

- Triage procedures (ie START or SALT)
- Treatment
- Coordinate transport to higher level of care

## **6 Medical Planning and Threat Assessment**

### **Competency 6.1: Demonstrate knowledge in medical planning and threat assessment.**

- 6.1.1 Understand and demonstrate knowledge of situational awareness
- Scene Size-up
  - Pre-assessment of Situation
  - Pre-assessment of Risks and Threats
  - Medical Resources Available

## **7 Practical Skills/Scenario Training**

### **Competency 7.1: Demonstrate knowledge and skills through written and practical exam.**

- 7.1.1 Demonstrate through skills and written exam
- Medical skills
    - Bleeding control
    - Airway management
    - Respiratory Care, including open chest wounds
  - Patient extrication and evacuation
  - Self and Buddy Care scenarios in hot and warm zones
  - Coordinated law enforcement/fire/EMS response with formation of Rescue Task Force, following ICS and unified command principles

# 4

## **Curriculum Content: Tactical Life Saver/Technician Course Minimum 40 hour course**

### **Domain 1: Course Administration and Introduction to Tactical EMS**

#### **Competency 1.1: Administration and Safety**

##### 1.1.1 Administrative Policies

- Documentation

##### 1.1.1 Safety Requirements

- Course safety policies

#### **Competency 1.2: Roles and Responsibilities**

##### 1.2.1 History of Tactical Casualty Care

- Historical development of tactical medicine
- Brief history of Tactical Combat Casualty Care (TCCC)
- History of active shooter and domestic terrorism incidents

##### 1.2.2 Roles and Responsibilities of the tactical EMS provider in California

- Tactical medicine training program goals
- Roles and responsibilities of the tactical EMS provider
- Operational standards
- Gear and equipment

##### 1.2.3 California Requirements for EMS integration

- Scope of practice and Authorized Skills and Procedures by level of training, certification, and licensure.
- California Law and regulations
- Tactical Casualty Care versus Tactical Medicine

## **Domain 2: Tactical Casualty Care (TCC) Methodology**

### **Competency 2.1: Tactical medical skills in the Care Under Fire (CUF)/Direct Threat Care (DTC) Phase of TCC**

2.1.1 Perform appropriate casualty care at your level of training in CUF/DTC phase of TCC

- Demonstrate the ability to identify the CUF/DTC scenario
- Describe the environment during the CUF/DTC phase including the return of fire and elimination of the threat
- Demonstrate the ability to conceal and cover
- Demonstrate the ability to stop life threatening external hemorrhage
- Demonstrate the ability to position a casualty in the recovery position
- Demonstrate the ability to direct casualty to self-treat
- Describe the need to remove casualty from immediate hazards (e.g., burning vehicle)
- Discuss the possible need to defer airway management until TFC/ITC

### **Competency 2.2: Tactical medical skills in the Tactical Field Care (TFC)/Indirect Threat Care (ITC) phase of TCC**

2.2.1 Perform appropriate casualty care at your level of training in the TFC/ITC phase of TCC:

- Describe the TFC/ITC environment
- Identify when it is appropriate to search and disarm a casualty and how to remove weapons and render them safe
- Demonstrate the ability to conduct a tactical primary survey using the MARCH mnemonic, prioritize and treat casualties
- Describe key care that should be provided during the TFC/ ITC phase including: inspect and dress wounds, splint fractures and recheck pulses, reassess tourniquets, establish intravenous (IV) access, administer medications and fluids as indicated, and apply rigid eye shield for a casualty with penetrating eye injury after performing field expedient visual acuity exam.

### **Competency 2.3: Tactical medical skills in the Tactical Evacuation Care (TACEVAC)/Evacuation (EVAC) phase of TCC**

2.3.1. Perform appropriate casualty care at your level of training in the TACEVAC/EVAC phase of TCC

- Demonstrate the ability to reassess the casualty (e.g., the MARCH mnemonic and secondary assessment)
- Demonstrate the ability to re-evaluate all interventions

2.3.2. Describe the actions to arrange casualty evacuation by both ground and air

- Demonstrate the ability to transfer casualties to the landing zone or medical exchange point for transport to the next level of care according to the prearranged medical plan

2.3.3. Describe the key elements of handoff to the next level of care

- Demonstrate the ability to provide documentation of care rendered
- Demonstrate the ability to deliver an organized verbal report during transfer of care

**Competency 2.4: Use of TCC as a system in the tactical environment**

2.4.1. Describe the relevance of the TCC methodology in the law enforcement setting

- Describe the relevant aspects and limitations of military medicine to responses to acute injury and illness in the law enforcement setting.

2.4.2. Describe the components of the IFAK

- Describe the components of the IFAK and the purposes of each (e.g. nasal airway device, pressure dressing, gauze, chest seal, tourniquet, hemostatic dressing, casualty documentation card with permanent marker, 2" utility tape, gloves, catheter for chest decompression)
- Demonstrate use of the items included in your agency-provided IFAK

**Domain 3: Remote Assessment and Surrogate Care**

**Competency 3.1: Remote Assessment Methodology (RAM)**

3.1.1. Perform a remote assessment of a casualty

- Identify when a remote assessment is appropriate
- Identify appropriate resources for determining a casualty's condition remotely (e.g., binoculars, spotting scope, night vision optics)
- Determine a casualty's condition remotely
- Determine situational variables impacting rescue
- Communicate findings to command staff for integration into an extraction plan

**Domain 4: Rescue Extraction**

**Competency 4.1: High Threat Extraction Techniques**

4.1.1. Demonstrate high threat extraction techniques

- Describe appropriate extraction technique for the phase of care
- Demonstrate personal extraction techniques
- Demonstrate single- or multiple-person drag or carry technique
- Describe the extraction techniques outlined in TCCC/ TECC (e.g., one-person drag/two- person drag, Hawes carry, SEAL Team 3 carry)

- Demonstrate the ability to assess and utilize pre-rigged and improvised equipment to facilitate extraction (e.g. vest, webbing, soft litter, rigid litter)
- Describe the importance of reassessment after extraction

4.1.2. Describe alternative methods of ingress and egress

- Describe examples where alternative methods of ingress and egress may be needed
- Describe alternative methods for ingress and egress (e.g., evacuation through drywall, cinderblock, window)
- Describe basic building construction and how it relates to ingress and egress
- Demonstrate the ability to utilize common breaching equipment
- Describe how selection of extraction method is effected by egress route
- Describe which extraction methods will require modification of medical care
- Describe how selection of extraction method is affected by the casualty's specific injuries

## **Domain 5: Hemostasis**

### **Competency 5.1: Conventional hemorrhage control including: tourniquet, direct pressure, wound packing, wound dressing and pressure dressing**

5.1.1. Perform hemorrhage control at your level of training, and evaluate adequacy of hemorrhage control performed by operators

- Demonstrate basic hemorrhage control techniques (including tourniquets)
- Explain the limitations of basic hemorrhage control in the tactical environment (including when these techniques should be bypassed)
- Recognize failure of basic hemorrhage control techniques

### **Competency 5.2: Identification of life threatening hemorrhage**

5.2.1. Identify and reassess casualties that require hemorrhage control

- Recognize wound types/mechanisms associated with high-risk for life-threatening hemorrhage, both internal and external
- Demonstrate ongoing reassessment of efficacy of previously employed hemorrhage control techniques

### **Competency 5.3: Application of a tourniquet (TQ), commercial and improvised**

5.3.1. Demonstrate TQ application

- Identify and reassess casualties who require hemorrhage control
- Perform self-application of a commercial tourniquet in both a light and dark environment, on each extremity, with one hand Perform application of a commercial tourniquet on a casualty in both a light and a dark environment
- Perform application of an effective improvised tourniquet

- Assess tourniquet for adequacy of application
- Identify or discuss options to address tourniquet failure
- Assess casualty for tourniquet removal

#### **Competency 5.4: Application/administration of hemostatic agents**

##### 5.4.1. Understand indications, use and available hemostatic agents

- Describe the indications for hemostatic agents
- Perform the proper application/administration of hemostatic agents
- Reevaluate the effectiveness of hemostatic agent hemorrhage control initiated previously
- List the hemostatic dressings authorized in California.

### **Domain 6: Airway**

#### **Competency 6.1: Management of the airway including: casualty positioning (rescue position, chin-lift, jaw-thrust), basic airway clearance techniques, airway adjuncts (nasopharyngeal airway (NPA), supraglottic airway (SGA) device, surgical airway (cricothyroidotomy), and endotracheal (ET) intubation**

##### 6.1.1. Identify airway compromise during initial survey

- Demonstrate ability to assess the airway during initial survey

##### 6.1.2. Establish a patient airway

- Demonstrate appropriate airway management given patient and tactical conditions (e.g., Allow a conscious patient to assume a position of comfort; if the patient is unconscious, utilize positioning to open the airway via head tilt-chin lift or jaw thrust in the event of suspected spinal injury; repeatedly reassess the need for suctioning of the upper airway; properly place NPA if indicated; place patient into recovery position; properly place SGA if indicated; provide bag valve mask respirations; properly place and secure ET tube if indicated; perform cricothyroidotomy if indicated; verify correct placement of adjunct and secure and reassess as appropriate)

### **Domain 7: Breathing**

#### **Competency 7.1: Identify and treat thoracic injuries and respiratory distress**

##### 7.1.1. Demonstrate the ability to identify the presence of respiratory distress in the tactical setting

- Demonstrate the ability to determine respiratory rate, depth, quality and symmetry in the tactical setting
- Identify when it is tactically appropriate to use available equipment for monitoring respiratory status

**7.1.2. Identify presence of thoracic injuries in the tactical setting**

- Describe when it is appropriate to evaluate a patient for thoracic injury based on the operational situation
- Demonstrate the methods for identifying thoracic injury based on the operational situation

**7.1.3. Seal penetrating thoracic wounds in the tactical setting**

- Demonstrate the ability to select a properly sized occlusive dressing
- Demonstrate the ability to prepare the site prior to application of dressing.
- Demonstrate the ability to place an occlusive dressing over the wound
- Demonstrate the ability to replace protective equipment based on the operational situation
- Describe the importance of reassessing the patient and monitoring for potential development of a subsequent tension pneumothorax.

**7.1.4. Treatment of suspected tension pneumothorax in the tactical setting**

- Demonstrate decompression at the site of the wound (i.e., “burping the occlusive dressing”)
- Demonstrate the ability to select proper equipment to perform a needle thoracostomy.
- Demonstrate the ability to perform needle decompression
- Describe the indications for bilateral decompression
- Demonstrate the ability to reassess patient status and repeat the procedure or consider other treatments if required

## **Domain 8: Circulation**

### **Competency 8.1: Recognition and treatment of shock**

**8.1.1 Demonstrate the ability to do both a basic and an advanced assessment of the adequacy of circulation (e.g., monitoring, physical exam)**

- Describe potential causes of shock
- Perform tactically appropriate assessment of circulation status
- Identify signs and symptoms of hemodynamic compromise including changes in vital signs (where tactically appropriate)
- Apply tactically appropriate advanced monitoring techniques (e.g., blood pressure, pulse oximetry)

**8.1.2. Demonstrate proficiency in basic and advanced treatment of hypoperfusion**

- Follow tactically appropriate resuscitation guidelines
- Perform continual assessment of adequacy of intervention—monitor vital signs and mental status

### **Competency 8.2: Vascular access**

- 8.2.1. Describe the indications for and tactical considerations of obtaining IV access
  - Recognize specific clinical situations where IV access is needed including inadequate perfusion, severe pain, potential for rapid decompensation
- 8.2.2. Demonstrate familiarity with obtaining IV access commensurate with scope of practice
  - Describe the differences in obtaining IV access in the tactical environment
  - Perform or assist with obtaining IV access in the tactical environment
- 8.2.3. Describe the indications for attempting IO access
  - List specific indications where it is appropriate to place an IO including need for vascular access when unable to rapidly obtain adequate IV access
- 8.2.4. Demonstrate familiarity in obtaining IO access commensurate with scope of practice
  - Describe the differences in obtaining IO access in the tactical environment
  - Perform or assist with obtaining IO access in the tactical environment

### **Competency 8.3: Fluid resuscitation**

- 8.3.1. Describe the use of oral resuscitation for volume depletion during times of delayed definitive care.
  - Explain the indications for oral resuscitation
  - Explain the contraindications to oral resuscitation
  - Explain the appropriate volume and composition of oral resuscitation fluid
- 8.3.2. Demonstrate familiarity in providing IV/IO fluid resuscitation in the tactical setting commensurate with scope of practice
  - Describe the different resuscitative fluid options available in the tactical setting including crystalloid, colloid, and blood products
  - Describe the timing of fluid resuscitation in relation to the operational situation and the patient's condition
  - Determine an appropriate endpoint of resuscitation based on injury and patient type (e.g., controlled hemorrhage, uncontrolled hemorrhage, head injury, or pediatric patients)
  - Describe the risks of fluid resuscitation (e.g., exacerbation of hypothermia, pulmonary edema)

## **Domain 9: Medication Administration**

### **Competency 9.1: Administration of oxygen.**

- 9.1.1. Describe when it is appropriate to provide oxygen therapy in a given tactical situation.

- Describe the process for conducting a mission analysis to determine if it is safe and necessary to bring oxygen into the tactical setting.
- Describe when oxygen is medically indicated and appropriate in a tactical environment

### **Competency 9.2: Administration of analgesia**

9.1.2 Select an appropriate analgesic for a given patient and tactical setting.

- Describe how to conduct a mission analysis to determine types and amount of analgesia appropriate for a given mission. (i.e. location of mission – urban vs. rural, duration of mission, number of personnel involved, need to distribute medication to operators pre-mission, etc.)
- Describe the implications of administration of analgesia to a patient in a tactical setting. (i.e. operational status of patient under analgesia, ease of evacuation of patient, hemodynamic status, etc.)

### **Competency 9.3: Appropriate and safe use of over the counter (OTC) medications in the tactical setting**

9.3.1: Select appropriate OTC medications for a given patient population and mission profile within medical guidelines.

- Describe how to conduct a mission analysis to determine types and amounts of OTC medications appropriate for a given mission. (i.e. location of mission – urban vs. rural, duration of mission, number of personnel involved, need to distribute medications to operators pre-mission, etc.)
- Describe the implications of administration of OTC medications to a patient in a tactical setting

### **Competency 9.4: Implementation of medical formulary**

9.4.1. Utilization of a medical formulary in tactical operations.

- Describe medications likely to be needed during tactical operations and communicate those needs to the medical director
- Describe the importance of communicating the implication of drug administration to the tactical commander when it may affect mission readiness
- Describe indications, contra-indications, allergic reactions, cross-drug interactions and other considerations for approved formulary medications
- Establish and implement procedures for accountability, expiration rotation, disposal of expired medications

## **Domain 10: Casualty Immobilization**

### **Competency 10.1: Evaluation and management of suspected central nervous system (CNS) or spine injuries**

- 10.1.1: Demonstrate proficiency in the recognition of common mechanisms of CNS/spine injuries
- Identify mechanisms that are most likely to result in spinal injury
  - Identify mechanisms that are most likely to result in brain injury
- 10.1.2: Demonstrate proficiency in neurologic assessment
- Describe when and how to assess neurologic status in an operational situation
- 10.1.3: Demonstrate proficiency in providing spine protection
- Identify when it is appropriate to provide spinal immobilization in the tactical setting
  - Describe the risks and benefits of spinal immobilization during tactical operations
    - Demonstrate proficiency in applying improvised spinal immobilization

### **Competency 10.2: Fracture splinting and extremity neurovascular assessment**

- 10.2.1: Demonstrate proficiency in orthopedic injury management, including splint application and traction splinting in the tactical environment
- Identify when splinting is tactically feasible
  - Identify the most appropriate splint (e.g., standard, traction, pelvic binder) given the tactical situation
  - Describe the use of commercial and improvised splinting materials

## **Domain 11: Medical Planning**

### **Competency 11.1: Medical planning and analysis of medical intelligence.**

- 11.1.1: Define the components of a medical plan for tactical operations
- Identify likely operational hazards, including but not limited to, hostile threats, environmental threats, safety risks, infectious risks, and CBRNE/HAZMAT threats
  - Describe mitigation strategies for likely operational hazards
  - Analyze internal and external assets to determine medical capabilities
  - Describe the process of preplanning and coordinating with other agencies and organizations within operational security guidelines

- Describe how to plan appropriate medical treatment and evacuations for a tactical scenario (e.g., locations of casualty collection points and landing zones)
- Identify medical needs associated with special populations and the unique equipment or capabilities they may require
- Identify the social needs, such as adult and child protective services, potentially required by some populations and their impact on the operation
- Define the inherent risks in mission execution (to include infiltration, actions at the objective, and exfiltration) and their impact on medical planning
- Demonstrate the ability to incorporate all of these components into a medical plan and conduct a briefing

## **Domain 12: Force Health Protection**

### **Competency 12.1: Monitoring work/rest/sleep cycles**

12.1.1: Understand the importance of sleep management and work/rest cycles in the tactical setting

- Describe how to identify personal and team fatigue that may limit effectiveness
- Communicate potential degradation in capability to chain of command  
Describe the importance of work/rest/sleep cycles in sustained operations and environmental extremes
- Describe how to assess fatigue that may limit effectiveness
- Describe methods for the management of fatigue including the potential use of medications during sustained operations

### **Competency 12.2: Health monitoring and surveillance**

12.2.1: Understand the importance of an effective health monitoring and surveillance program

- Describe the need for documentation and routine capture of health data for team members
- Identify the data that are pertinent to capture as part of an effective health monitoring and surveillance program (e.g., allergies, prescription medication, chronic conditions)
- Describe the importance of updating the medical director and team commander
- Describe the need for secure but ready access to health data
- Describe the importance of appropriate documentation, reporting to medical director and commander, and follow-up of illness and injury

12.2.2: Describe the signs and symptoms of acute stress reaction and PTSD and immediate and long term interventions

- Describe the signs and symptoms of acute stress reaction and PTSD

- Describe the available resources for the prevention and mitigation of acute stress reaction and PTSD
- Describe the appropriate response for an acute stress reaction

### **Competency 12.3: Preventive medicine**

12.3.1: Identify the importance of preventive medicine for the individual and team readiness

- Identify pertinent immunizations and chemoprophylaxis (e.g., malaria prophylaxis) for a given team and setting
- Describe the importance of hydration and nutrition including the implications of an extended operation
- Describe the importance of food safety, and sanitation including the implications of an extended operation
- Describe the importance of strategies to prevent environmental injury (e.g., heat and cold injuries, insect bites, sun burn)
- Recognize the importance of monitoring the team's physical fitness and mental well-being (e.g., excessive alcohol use, suicide risk) and developing intervention strategies

### **Competency 12.4: Injury prevention (e.g., personal protective equipment (PPE))**

12.4.1: Describe importance of injury prevention for the individual and team readiness

- Identify the importance of using appropriate personal protective equipment and other safety device for specific mission conditions
- Describe mitigation techniques for reducing musculoskeletal, ophthalmologic, auditory, and other common injuries
- Describe the importance of replacing body armor after a medical evaluation or intervention
- Demonstrate the ability to provide a pre-mission medical safety briefing (based on your medical plan) to the team

## **Domain 13: Environmental Factors**

### **Competency 13.1: Management of specific threats from the environment (e.g., heat, cold, altitude, plants, animals, geography)**

13.1.2. Describe the risk factors, signs and symptoms, and treatment for heat and cold related injuries

- Describe the risk factors and mitigation strategies for heat and cold related injury in the tactical setting
- Describe heat and cold related injury and appropriate medical care in a tactical setting

13.1.2: Describe the risk factors, signs and symptoms, and treatment of altitude related illness and injury (cerebral edema, pulmonary edema, acute mountain sickness)

- Describe the risk factors and mitigation strategies for altitude related illness and injury in the tactical setting
- Describe altitude related illness and injury and appropriate medical care in a tactical setting

13.1.3: Identify common plants that may cause injury or illness and related signs and symptoms

- Describe how to identify common plants that may cause and injury or illness (e.g., poison oak, sumac, and poison ivy)
- Describe the signs and symptoms of common plant related injury or illness and the importance of immediate self-aid and/or treatment if exposed

13.1.4: Recognize the potential harm of insect bites, stings, wild/domestic animal bites and/or venomous wildlife specific to the operating environment

- Describe the risk factors, signs and symptoms, and mitigation strategies for bites and stings in the tactical setting
- Describe appropriate medical care or self/buddy-aid for a bite or sting

### **Competency 13.2: Identification and management of severe allergic reactions (anaphylaxis)**

13.2.1: Describe signs, symptoms and treatment of anaphylaxis

- Identify skin, airway, breathing and systemic findings of a severe allergic reaction
- Describe severe allergic reaction with epinephrine, anti-histamines, IVF, and steroids

## **Domain 14: Mechanisms and Patterns of Injury**

### **Competency 14.1: Recognition and treatment of blunt, penetrating, thermal, electrical, blast, and crush injuries.**

14.1.1: Describe the clinically and tactically significant injuries that could result from blunt, penetrating, thermal, electrical, blast, and crush trauma and treatment within the tactical medical provider's scope of practice

- Identify the mechanisms unique to the tactical environment (e.g., blast) that may cause severe injuries (e.g., spinal injuries, traumatic brain injury, external and internal hemorrhage, and difficulty breathing, thoracic injuries, and burns)

### **Competency 14.2: Recognition and treatment of injury associated with less-lethal weapons**

14.2.1: Describe the medical risks associated with less-lethal weapons

- Describe the risks and injury pattern associated with chemical munitions (including secondary exposure), electrical conductive weapons, impact weapons, and distraction devices
- Describe the potential exacerbation of pre-existing medical conditions associated with less-lethal weapons
- Describe when less-lethal technology may be contraindicated based on medical intelligence

## **Domain 15: Legal Aspects of TEMS**

**Competency 15.1: Medical Legal issues (including proportional use of force, search, seizure, detention and arrest, obligations of the police to a person in custody or arrest, medical evaluation on an arrestee prior to detention, implication of using sworn versus civilian personnel)**

15.1.1: Describe the legal aspects of their participation in law enforcement operations.

- Describe the general principles of local, state and federal laws related to their participation in law enforcement operations

**Competency 15.2: Prevent the destruction and/or contamination of evidence when rendering medical care during a law enforcement operation and maintaining the chain of custody**

15.2.1: Describe the medical provider role in proper evidence preservation and maintaining chain of custody

- Describe how a civilian TEMS medical provider should integrate preserving evidence and maintaining chain of custody while caring for a casualty

**Competency 15.3: Privacy of protected health information**

15.3.1: Describe how to protect health information during a tactical operation

- Describe with whom and under what circumstances unique to tactical operations it is appropriate to disclose protected health information including consideration of the legal and ethical issues

**Competency 15.4: Definition of scope of practice**

15.4.1: Describe the scope of medical care that they can provide in a tactical situation and under whose authority they are providing that care

- Describe why medical care outside of training and/or authorization should not be preformed
- Describe under which protocols and whose authority they are providing care when operating in the tactical setting

### **Competency 15.5: Issues related to practicing in a different jurisdiction**

15.5.1: Describe how local, state, and federal laws affect the jurisdictions where they can provide care and what care can be provided

- Describe how local, state, and federal laws affect the jurisdictions where they can provide care and what care can be provided

## **Domain 16: Hazardous Materials Management**

### **Competency 16.1: Recognition of potential presence of chemical, biological, and radiological hazards**

16.1.1: Identify potential chemical, biological, and radiological hazards within your area of operations, and list signs and symptoms of accidental exposure

- Recognize common signs and symptoms from chemical, biological, and radiological exposures
- Describe how to identify potential chemical, biological, and radiological hazards within your response area
- Describe how you would protect yourself and your team from possible exposure to chemical, biological, and radiological hazards
- Describe prophylaxis and post-exposure treatments for persons exposed to hazardous chemical, biological, and radiological materials

16.1.2: During mission planning/ medical threat assessment identify potential chemical, biological, and radiological threats

- Describe how to incorporate identified chemical, biological, and radiological hazards into your mission planning
- Describe procedures to mitigate potential chemical, biological, and radiological hazards including requesting assistance with isolating and securing a hazard (e.g., HAZMAT teams, WISER).
- Identify Local and regional resources to utilize in the event of an anticipated or actual chemical, biological, and radiological exposure

### **Competency 16.2: Selecting appropriate personal protective equipment (PPE)**

16.2.1: Describe the importance of selecting and using the appropriate level of PPE for an anticipated encounter with a chemical, biological, or radiological hazard

- Describe the importance of selecting and using the appropriate level of PPE for an anticipated encounter with a chemical, biological, or radiological hazard
- Describe operational limitations related to using PPE for an anticipated encounter with a chemical, biological, or radiological hazard
- Describe the importance of pre- and post- PPE physical assessments

### **Competency 16.3: Performing field expedient decontamination**

16.3.1: Describe field expedient decontamination

- Describe the equipment and techniques that may be used for appropriate field expedient decontamination
- Describe when dry versus wet decontamination is appropriate
- Describe the potential implications of equipment decontamination

**Competency 16.4: Immediate clinical interventions for the victims of chemical, biological, and radiological exposures**

16.4.1: Describe the selection and appropriate use of clinical interventions after chemical, biological, and radiological exposure

- Describe the different types of clinical interventions for chemical, biological, and radiological exposure that might be needed in a tactical scenario
- Identify signs/symptoms of exposure
- Identify indications for clinical interventions
- Describe the different types of auto injectors and demonstrate the use of an auto injector
- Describe when operators should carry auto-injectors and how to provide just in time training for their use

**Domain 17: Mass Casualty Triage**

**Competency 17.1: Mass casualty triage**

17.1.1: Utilize a mass casualty triage scheme

- Describe the unique aspects of a mass casualty incident in a tactical environment
- Demonstrate proficiency at communicating the pertinent details of the situation to the chain of command

**Competency 17.2: Casualty Collection Point (CCP) setup and control**

17.2.1: Demonstrate proficiency at establishing and managing a CCP

- Describe the location, organization, and function of a CCP in a tactical setting
- Demonstrate the ability to establish and manage all aspects of a CCP including the ability to communicate the needed resources to other team members and other agencies

**Competency 17.3: Evacuation prioritization**

17.3.1: Demonstrate proficiency prioritizing casualty evacuation

- Describe why evacuation prioritization is important and when evacuation can occur during an ongoing tactical operation
- Describe the medical provider's role in helping to ensure safe evacuation

- Describe the various modes of evacuation specific to tactical operations and how to utilize them safely, including safely identifying a helicopter landing zone

#### **Competency 17.4: Incident command and interface with other agencies**

17.4.1: Describe how incident command and other agencies are integrated into tactical operations

- Describe the Incident Command System
- Describe how to integrate other agencies into tactical operations

### **Domain 18: Tactical Familiarization**

#### **Competency 18.1: Tactical team operations, objectives, and team structure**

18.1.1: Describe TEMS and how it differs from conventional EMS

- Describe TEMS
- Describe the basic difference between TEMS operations and daily EMS operations

18.1.2: Understand the tactical team member roles and the types of situations to which they may respond

- Describe the tactical considerations for various scenarios (e.g., serving high risk warrants, barricaded subject, active shooter, hostage situation, protective detail)
- Describe the various roles within a tactical team (e.g., team commander, TEMS provider, breacher, sniper, entry)
- Describe Rescue Task Force operations

#### **Competency 18.2: Tactical team command and control and communication**

18.2.1: Describe a typical team structure and chain of command

- Describe a typical team structure and chain of command

18.2.2: Describe the use of verbal and non-verbal communications and how they are appropriately employed within the tactical environment

- Describe various means of communication within the tactical team (e.g., radio communication, non-verbal)
- Describe various means of communication across the barricade (e.g., “throw phone”)

18.2.3: Importance of operational security and the potential for compromise

- Describe appropriate use of communication to maintain security
- Describe the risks of social networking
- Describe the security of various forms of communication

- Define operational security

### **Competency 18.3: Description of tactical team equipment**

18.3.1: Give examples of specialized equipment and its use in tactical operations and TEMS

- Describe tactical PPE and uniforms
- Describe breaching and diversionary equipment
- Describe firearms and weapons including less-lethal weapons
- Describe the importance of having the ability to make weapons safe and secure during a tactical response
- Describe the types of vehicles used for tactical operations
- Describe equipment used for remote assessment
- Describe night observation and target acquisition equipment
- Describe specialized medical and rescue equipment for tactical operations

### **Competency 18.4: Situational awareness and basic tactical movement**

18.4.1: Understand situational awareness and basic tactical movement techniques and their importance to team safety

- Define the term situational awareness
- Demonstrate individual tactical movements (e.g., high crawl, low crawl, rush, and skylining)
- Demonstrate tactical team movements (e.g., stack, wedge, clearing threats)
- Describe immediate action drills (IAD's) for evolving tactical scenarios
- Describe the importance of the medical providers not revealing team location (noise and light discipline)
- Describe the difference between cover and concealment
- Describe the process for securing a suspect (i.e., the 5 S's: seize, secure, search, segregate, speed to the rear)

# 5

## TRAINING PROGRAM REQUEST FOR APPROVAL FORM

**California Tactical Casualty Care Training Program**  
**Request for Approval**

Applicant: \_\_\_\_\_

Date of Application: \_\_\_\_\_

Program Director: \_\_\_\_\_

Contact Information: \_\_\_\_\_

All statewide public safety agencies shall submit a written request for training program approval to the California EMS Authority. All other prospective training programs shall submit a written request to their local EMS agency.

All requests shall include the following:

- Course being requested for Approval
  - Tactical First Aid/FRO – minimum 4 hour course
  - Tactical Life Saver/Technician – minimum 40 hour course
  
- Class Schedule with Hourly distribution
  
- Course outline and curriculum
  
- List of psychomotor skills and tactical medical scenarios
  
- Written and skills competency examinations
  
- Written course safety policy
  
- Instructor resume

Form#TCCApp  
Effective September 2016

# 6

## RESOURCE GUIDE 1: CALIFORNIA TACTICAL CASUALTY CARE GUIDELINES



**BASIC TACTICAL CASUALTY CARE (TCC)  
CALIFORNIA QUICK REFERENCE GUIDE**

<p><b>HOT ZONE / DIRECT THREAT CARE (DTC) / CARE UNDER FIRE (CUF)</b></p>
<ol style="list-style-type: none"> <li>Mitigate any threat and move to a safer position.</li> <li>Direct the casualty to stay engaged in operation, if appropriate.</li> <li>Direct the casualty to move to a safer position and apply self-aid, if appropriate.</li> <li>Casualty Extraction. Move casualty from unsafe area, to include using manual drags or carries, or use a soft litter or SKEDCO as needed.</li> <li><b>STOP LIFE-THREATENING EXTERNAL HEMORRHAGE</b>, using appropriate PPE, if tactically feasible:             <ul style="list-style-type: none"> <li>Apply effective tourniquet for hemorrhage that is anatomically amenable to tourniquet application.</li> </ul> </li> <li>Consider quickly placing casualty in position to protect airway, Recovery Position, if unable to move patient immediately and tactically feasible.</li> </ol>
<p><b>WARM ZONE / INDIRECT THREAT CARE (ITC) / TACTICAL FIELD CARE (IFC)</b></p>
<ol style="list-style-type: none"> <li>Law Enforcement casualties should have weapons made safe once the threat is neutralized or if mental status is altered.</li> <li><b>AIRWAY MANAGEMENT</b>:             <ol style="list-style-type: none"> <li>Unconscious patient without airway obstruction:                 <ul style="list-style-type: none"> <li>Chin lift or jaw thrust maneuver.</li> <li><b>Nasopharyngeal airway</b>, if approved by LEMSA as an optional skill</li> </ul> </li> <li>Patient with airway obstruction or impending airway obstruction:                 <ul style="list-style-type: none"> <li>Chin lift or jaw thrust maneuver.</li> <li><b>Nasopharyngeal Airway</b>, if approved by LEMSA as an optional skill</li> </ul> </li> </ol> </li> <li>Allow patient to assume position that best protects the airway, including sitting up.</li> <li>Place unconscious patient in Recovery Position.</li> </ol>
<ol style="list-style-type: none"> <li><b>BREATHING</b>:             <ol style="list-style-type: none"> <li>All open and/or sucking chest wounds should be treated by applying a Vented Chest Seal or non-vented occlusive seal to cover the defect and securing it in place. Monitor for development of a tension pneumothorax.</li> </ol> </li> <li><b>BLEEDING</b>:             <ol style="list-style-type: none"> <li>Assess for unrecognized hemorrhage and control all sources of bleeding. If not already done, use a tourniquet, and appropriate pressure dressing.</li> <li>For compressible hemorrhage not amenable to tourniquet use, apply a California EMS-approved hemostatic dressing with a pressure bandage.</li> <li>Reassess all tourniquets that were applied during previous phases of care. Consider exposing the injury and determining if a tourniquet is needed. If a tourniquet is not needed, use other techniques to control bleeding and remove TQ.</li> <li>Apply Emergency Bandage or direct pressure to the wound, if appropriate.</li> <li>For hemorrhage that cannot be controlled with a tourniquet, apply California EMSA-Approved Hemostatic Dressing.</li> </ol> </li> </ol>

<ol style="list-style-type: none"> <li><b>ASSESS FOR HEMORRHAGIC SHOCK</b> <ol style="list-style-type: none"> <li>Elevate Lower Extremities if patient in shock.</li> </ol> </li> <li><b>PREVENTION OF HYPOTHERMIA</b>:             <ol style="list-style-type: none"> <li>Minimize patient's exposure to the elements. Keep protective gear on if feasible.</li> <li>Replace wet clothing with dry if possible. Place onto an insulated surface ASAP.</li> <li>Cover the casualty with self-heating Blanket or rescue blanket to torso. Place hypothermia prevention cap on the patient's head. Use dry blankets, poncho liners, sleeping bags, or anything that will retain heat and keep the patient dry.</li> </ol> </li> <li><b>PENETRATING EYE TRAUMA</b>:             <p>If a penetrating eye injury is noted or suspected: a) perform a rapid field test of visual acuity; b) cover the eye with a rigid eye shield (NOT a pressure patch).</p> </li> <li><b>ASSESS CASUALTY AND TREAT OTHER CONDITIONS AS NECESSARY</b>:             <ol style="list-style-type: none"> <li>Complete Secondary Survey checking for additional injuries or conditions. Inspect and dress known wounds that were previously deferred.</li> <li>Consider Splinting known/suspected fracture or Spinal Immobilization, if indicated.</li> <li>Use <b>Nerve Agent Auto-Injector</b> (ie Duo-Dote) for Nerve Agent Intoxication, if approved by LEMSA as an optional skill.</li> <li>Use <b>EpiPen</b> for Anaphylactic Reaction, if approved by LEMSA as an optional skill.</li> </ol> </li> <li><b>BURNS</b>:             <ol style="list-style-type: none"> <li>Aggressively monitor airway and respiratory status for casualties with smoke inhalation or facial burns, including oxygen or cyanide antidote treatment when significant symptoms are present.</li> <li>Estimate TBSA and cover burn area with dry, sterile dressings.</li> </ol> </li> <li><b>MONITORING</b>:             <p>Apply monitoring devices or diagnostic equipment if available. Obtain vital signs.</p> </li> <li><b>PREPARE CASUALTY FOR MOVEMENT</b>:             <ul style="list-style-type: none"> <li>Move packaged patient to site where evacuation is anticipated.</li> <li>Monitor airway, breathing, bleeding, and reevaluate the patient for shock.</li> </ul> </li> <li><b>COMMUNICATE WITH THE PATIENT IF POSSIBLE</b>:             <ul style="list-style-type: none"> <li>Encourage, reassure, and explain care.</li> </ul> </li> <li><b>CARDIOPULMONARY RESUSCITATION (CPR) AND AED</b>:             <p>Resuscitation in the tactical environment for victims of blast or penetrating trauma who have no pulse or respirations should only be treated when resources and conditions allow.</p> </li> <li><b>DOCUMENTATION</b>:             <p>Document clinical assessments, treatments rendered, and changes in the patient's status. Forward this information with the patient to the next level of care.</p> </li> </ol>
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California EMS Authority (2015 Revision)

BLUE—Authorized Basic Skills for Public Safety First Aid Providers and EMTs  
RED—Local Optional Skill which may be added by the Local EMS Agency Medical Director

# 7

## **RESOURCE GUIDE 2: MEDICAL PLANNING AND THREAT ASSESSMENT QUICK REFERENCE GUIDE**

**TACTICAL MEDICAL PLANNING AND THREAT ASSESSMENT QUICK REFERENCE GUIDE**



MEDICAL INTELLIGENCE (MISSION AND PATIENTS)
1. Mission Type?
2. Number of Potential Patients?
3. Ages of Potential Patients?
4. Pre-Existing Conditions?
5. Special Populations? (Pediatric, Elderly, Language)
6. Other

MEDICAL THREAT ASSESSMENT (TEAM)
1. Weather, including Temperature, (Cold, Hot) and Precipitation (Rain, Snow)? - Wind? Wind Direction? - Health Considerations?
2. Hazardous Materials? Explosive Threats? - Chemical? - Nuclear/Radiological? - Improvised Explosive Devices?
3. Biological Threats?
4. Animal Threats?
5. Plant Threats?
6. Regional Specific Threats?
7. Personal Protective Equipment Needed (Ballistic Vest, Helmet, Mask)? - As locally determined

MEDICAL PLANNING AND RESOURCES
1. Communication - Tactical Frequency _____ - Base Hospital _____
2. Location of Key Areas - Staging Area _____ - Casualty Collection Point(s) _____ - Triage Area/Treatment Area _____
3. Hospital - Closest Hospital _____ - Trauma Center/Burn Center _____
4. EMS Transport - Ground Ambulance _____ Standby Location? - Air Ambulance _____ Landing Zone, Lat/Long?
5. Support Services - Poison Control System 1-800-222-1222 - Veterinary Services? Animal Control? - Mental Health/Chaplain? - Social Services/CP? ? - Public Works?

TEAM HEALTH CONSIDERATIONS
1. Completed Team Medical Records? - Access to Records?
2. Exposure Protection
3. Hydration
4. Food/Nutrition
5. Extended Operations, Inc. Sleep/Fatigue
6. Need for Rehabilitation Station/First Aid Station - Medical Equipment - OTC Meds
7. Other

California EMS Authority (2015 Revision)

# 8

## RESOURCE GUIDE 3: ACTIVE SHOOTER QUICK REFERENCE GUIDE

EMS INTEGRATION WITH LAW ENFORCEMENT  
DURING ACTIVE SHOOTER  
EVENTS QUICK REFERENCE GUIDE



<b>PREPARATORY PHASE</b>
<ol style="list-style-type: none"> <li>1. ARRIVE AND REPORT to Staging Area in Secure Area</li> <li>2. REPORT TO UNIFIED COMMAND                     <ul style="list-style-type: none"> <li>- Notify UC that an EMS Team/Rescue Group is ready, staged, and awaiting direction.</li> </ul> </li> <li>3. PPE (Ballistic Vest, Ballistic Helmet)</li> <li>4. Ensure Clear IDENTIFICATION of Rescue personnel</li> <li>5. Prepare MEDICAL EQUIPMENT (Tourniquets, Trauma Kit, Soft Stretcher/Skedco)</li> <li>6. Perform Brief MEDICAL INTEL AND THREAT ASSESSMENT                     <ul style="list-style-type: none"> <li>- Identify Hot, Warm, and Cold Zone Areas</li> </ul> </li> <li>7. Establish COMMUNICATION with respective on-scene medical, fire, and law enforcement                     <ul style="list-style-type: none"> <li>- Determine and Broadcast Response Routes for Additional Responding Resources</li> <li>- Obtain Duress Code</li> </ul> </li> </ol>
<b>RESCUE TASK FORCE FORMATION AND PRIORITY SETTING PHASE</b>
<ol style="list-style-type: none"> <li>1. Form Rescue Task Force, minimum                     <ul style="list-style-type: none"> <li>- 2 LE Officers</li> <li>- 2 EMS Personnel</li> <li>- Designate a team leader</li> </ul> </li> <li>2. Follow Direction of law enforcement officer assigned as RTF leader                     <ul style="list-style-type: none"> <li>- Know Hot, Warm, and Cold Zone Areas</li> <li>- Follow Protected Access Routes</li> </ul> </li> <li>3. Brief objective and direction of movement                     <ul style="list-style-type: none"> <li>- Identify initial Emergency Egress Routes</li> <li>- Identify secure Extraction Lane</li> <li>- Identify Initial Safe Refuge Area</li> <li>- Identify Rally Point</li> <li>- "Mayday" operations emergency evacuation</li> </ul> </li> <li>4. Identify Casualty Collection Points, both Dynamic and Static</li> <li>5. Reinforce Mission Priorities (THREAT)                     <ul style="list-style-type: none"> <li>- T - Threat suppression</li> <li>- H - Hemorrhage control</li> <li>- RE - Rapid Extrication to safety</li> <li>- A - Assessment by medical providers</li> <li>- T - Transport to definitive care</li> </ul> </li> </ol>

<b>INDIRECT THREAT/WARM ZONE/YELLOW ZONE OPERATIONS PHASE</b>
<ol style="list-style-type: none"> <li>1. Maintain Cover and Concealment as directed by Rescue Task Force Leader (LE)</li> <li>2. Utilize Principles of Tactical Casualty Care (TCC)                     <ul style="list-style-type: none"> <li>- Triage as required</li> </ul> </li> <li>3. Finalize Direction of movement based upon prevailing conditions                     <ul style="list-style-type: none"> <li>- Identify Emergency Egress Routes</li> <li>- Identify secure Extraction Lane</li> <li>- Identify Safe Refuge Area</li> </ul> </li> <li>4. Maintain Situational Awareness for Secondary devices at main and secondary scenes</li> <li>5. Identify Dynamic Casualty Collection Points, as necessary</li> <li>6. Move casualties to identified Casualty Collection Points or Cold Zone Treatment Area                     <ul style="list-style-type: none"> <li>- Preference is movement from Warm Zone to Cold Zone Treatment Area</li> <li>- Transfer care to additional medical providers for treatment and transport</li> </ul> </li> <li>7. Prepare to re-enter Warm Zone</li> </ol>

<b>POST INCIDENT PHASE</b>
<ol style="list-style-type: none"> <li>1. Ensure Rescue Task Force accountability</li> <li>2. Collect any incident management records and unit logs</li> <li>3. Determine and announce an incident debriefing strategy</li> <li>4. Assess mental and physical health of the responders                     <ul style="list-style-type: none"> <li>- Determine and announce a stress debrief plan</li> </ul> </li> <li>5. Manage a formal unit-release process</li> </ol>

California EMS Authority (2015)

# 9

## RESOURCE GUIDE 4: INDIVIDUAL FIRST AID KIT RECOMMENDATIONS

Each individual on a team should minimally carry the following individual first aid equipment, or have it readily accessible.

Quantity	Type of Equipment
1	Medical Pouch
6	Gloves (Trauma, latex-free, 3 pair)
1	Tourniquet, CoTCCC-Recommended
1	Emergency Bandage
1	Hemostatic Dressing, California EMSA approved
1	Nasopharyngeal Airway (28f size with water-based lubricant), if approved by the local EMS agency Medical Director
1	Chest Seal
1	Pen, Permanent Marker
1	Rescue Blanket (disposable-consider thermal reflective material)
1	Shears, Trauma
1	Gauze, Roller Bandage or Elastic Bandage

# 10

## REFERENCES

### Further Suggested Reading on Best Practices

- Refer to the Tactical Emergency Casualty Care guidelines for information on trauma care: [http://c-tecc.org/images/content/TECC\\_Guidelines\\_-\\_JUNE\\_2014\\_update.pdf](http://c-tecc.org/images/content/TECC_Guidelines_-_JUNE_2014_update.pdf)
- Refer to Hartford Consensus II for national consensus strategies on improving survivability for mass casualty shooting events: [http://www.naemt.org/Files/LEFRTCC/Hartford\\_Consensus\\_2.pdf](http://www.naemt.org/Files/LEFRTCC/Hartford_Consensus_2.pdf)
- Refer to study from the American College of Surgeons for more information on management of prehospital trauma care: <http://informahealthcare.com/doi/pdf/10.3109/10903127.2014.896962>
- Refer to FEMA.gov for guidance on the incident command system: <https://www.fema.gov/incident-command-system-resources>
- Refer to the following documents for guidance on integrated response:
  - <http://www.cffjac.org/go/jac/media-center/video-gallery/tcm-active-shooter-scenario/>
  - [https://www.usfa.fema.gov/downloads/pdf/publications/active\\_shooter\\_guide.pdf](https://www.usfa.fema.gov/downloads/pdf/publications/active_shooter_guide.pdf)
- Assembly Bill No. 1598 [http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320140AB1598](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB1598)
- FBI Study of Active Shooter Incidents - <http://www.fbi.gov/news/stories/2014/september/fbi-releases-study-on-active-shooter-incidents/pdfs/a-study-of-active-shooter-incidents-in-the-u.s.-between-2000-and-2013>
- FBI Resources for Active Shooter/MCI Incidents - <http://www.fbi.gov/about-us/cirg/active-shooter-and-mass-casualty-incidents>

- Firescope-Emergency Response to Law Enforcement Incidents ICS 701 <http://www.firescope.org/docs-operational-guidelines/ics%20701.pdf>
- Texas State University Study of Active Shooter Events 2000 - 2010 - <http://alerrt.org/files/research/ActiveShooterEvents.pdf>
- POST/EMSA Tactical Medicine Guidelines: <http://lib.post.ca.gov/Publications/TacticalMedicine.pdf>
- C-TECC- IAFF position paper <http://www.jsomonline.org/TEMS/1401CTECC%20Update.pdf>

Training Standards for  
Basic Tactical Casualty Care  
and  
Coordination with EMS during Terrorism Incidents

**Edmund G. Brown Jr.**  
**Governor**  
**State of California**

**Diana S. Dooley**  
**Secretary**  
**Health and Human Services Agency**

**Howard Backer, MD, MPH, FACEP**  
**Director**  
**Emergency Medical Services Authority**

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[www.emsa.ca.gov](http://www.emsa.ca.gov)

**EMERGENCY MEDICAL SERVICES AUTHORITY**

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**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
Director

**PREPARED BY:** Laura Little, EMT  
Transportation Coordinator

**SUBJECT:** Ambulance Patient Offload Time (APOT) Methodology Guidelines

**RECOMMENDED ACTION:**

Approve matrix regarding ambulance patient offload time methodology.

**FISCAL IMPACT:**

None.

**DISCUSSION:**

AB 1223 went into effect on January 1, 2016 and mandated that the EMS Authority (EMSA) develop a statewide methodology for calculating and reporting by a local EMS agency (LEMSA) ambulance patient offload times. This statewide, standard methodology will be based on input received from stakeholders, including but not limited to: hospitals, LEMSAs, public and private EMS providers and must be approved by the Commission on EMS.

Based on the above legislation, EMSA created, and sent out a document to LEMSA administrators, called "*Interim Guidance for Implementation of AB 1223 related of Ambulance Patient Offload Time Methodology, Reporting, and Criteria.*" This document gave guidance on current statutes relating to APOT (Health and Safety Code Sections 1797.120 and 1797.225), definitions and data elements, indicator specific sheets (ISS), recommendations to LEMSAs for APOT, along with process and methodology for reporting data.

In February, EMSA convened a working group, based on a past metrics workgroup, to come up with ideas and recommendations based upon a the draft document "*Ambulance Patient Offload Metrics Development*" that addressed data testing issues for the NEMSIS 3.4 elements and determined how to collect data. This group has met multiple times and has created two Indicator Specific Sheets (ISS) APOT -1 and APOT – 2 and will serve as the statewide standard methodology to extract and report APOT data.

***APOT – 1: What is the 90<sup>th</sup> percentile for on Ambulance Patient Offload Time at the Hospital Emergency Department?***

- Report aggregate values by:
  - 1) LEMSA (using total denominator),
  - 2) Broken out by individual hospital
- Report the 90 percentile time calculated and the denominator (number of transports)
- Report Quarterly

***APOT – 2: Extended Ambulance Patient Offload Time greater than 1 hour***

2.1: What percentage of patients transported by EMS personnel experience a transfer of care within 60 minutes of arrival at the Hospital Emergency Department?

2.2: What percentage of patients transported by EMS personnel experience a transfer of care between 61-120 minutes after arrival at the Hospital Emergency Department?

2.3: What percentage of patients transported by EMS personnel experience a transfer of care between 121-180 minutes after arrival at the Hospital Emergency Department?

2.4 What percent of patients transported by EMS personnel experience a transfer of care more than 180 minutes after arrival in the Hospital Emergency Department.

- Report aggregate values by:
  - 1) LEMSA (using total denominator),
  - 2) Broken out by individual hospital
- Report the % calculated and the denominator used to calculate (number of runs)
- Report Quarterly

EMSA is currently collaborating with EMSAAC in the creation of a best practices document for implementing APOT data collection.

In the near future, we will have determined the best method to display and publish APOT data on the EMSA website.

EMSA is requesting that the Commission approve APOT – 1 and APOT – 2 for use by local EMS agencies in determining ambulance patient offload times.

The Commission will be kept informed of the status of the APOT Methodology Guidelines as progress continues.

## AMBULANCE PATIENT OFFLOAD TIME

<b>MEASURE SET</b>	Ambulance Patient Offload Time	
<b>SET MEASURE ID #</b>	APOT-1	
<b>PERFORMANCE MEASURE NAME</b>	Ambulance Patient Offload Time for Emergency Patients	
<b>Description</b>	What is the 90 <sup>th</sup> percentile for on Ambulance Patient Offload Time at the Hospital Emergency Department?	
<b>Type of Measure</b>	Process	
<b>Reporting Value and Units</b>	Time (Minutes and Seconds)	
<b>Continuous Variable Statement (Population)</b>	Time (in minutes) from time ambulance arrives at the hospital until the patient is transferred to hospital emergency department care.	
<b>Inclusion Criteria</b>	<b><u>Criteria</u></b>	<b><u>Data Elements</u></b>
	<ul style="list-style-type: none"> <li>All events for which eResponse.05 "type of service requested" has value 2205001 "911 response (Scene),";</li> <li>All events in eDisposition.21 was Transport to Hospital-Emergency Department was made and has value of 4221003;</li> <li>eTimes.11 "Patient Arrived at Destination Date/Time" values are logical and present</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>All events for which eResponse.05 "type of service requested" has value 2205001 "911 response (Scene),";</li> <li>eTimes.11 "Patient Arrived at Destination Date/Time" values are logical and present</li> </ul>	<ul style="list-style-type: none"> <li>Type of Service Requested (eResponse.05)</li> <li>Type of Destination (eDisposition.21)</li> <li>Patient Arrived at Destination Date/Time (eTimes.11)</li> <li>Destination Patient Transfer of Care Date/Time (eTimes.12)</li> </ul>
<b>Exclusion Criteria</b>	<b><u>Criteria</u></b>	<b><u>Data Elements</u></b>
	None	
<b>Indicator Formula Numeric Expression</b>	The formula is the 90 <sup>th</sup> Percentile of the given numbers or distribution in their ascending order.	
<b>Example of Final Reporting Value (number and units)</b>	19 minutes, 34 seconds (19:34)	

<b>Sampling</b>	No
<b>Aggregation</b>	Yes
<b>Minimum Data Values</b>	Not Applicable
<b>Data Collection Approach</b>	<input type="checkbox"/> Retrospective data sources for required data elements include administrative data and pre-hospital care records. <input type="checkbox"/> Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.
<b>Suggested Display Format &amp; Frequency</b>	Process control or run chart by month
<b>Suggested Statistical Measures</b>	90 <sup>th</sup> Percentile Measurement. Aggregate measure of central tendency and quantile (fractile) measurement to determine the span of frequency distributions.
<b>Trending Analysis</b>	Yes
<b>Benchmark Analysis</b>	(TBD)
<b>Reporting Notes</b>	<p>Report aggregate values by:</p> <ol style="list-style-type: none"> <li>1) LEMSA (using total denominator),</li> <li>2) Broken out by individual hospital</li> </ol> <p>Report the 90 percentile time calculated and the denominator (number of transports)</p> <p>Report Quarterly, within 2 months of the end of the quarter:</p> <ul style="list-style-type: none"> <li>• June 1 for period of January 1 through March 31;</li> <li>• September 1 for period of April 1 through June 30;</li> <li>• December 1 for period of July 1 through September 30;</li> <li>• March 1 for period of October 1 through December 31</li> </ul> <p>Statute allows the LEMSA to set their standard target time; however, the workgroup recommends a target time of 20 minutes, which EMSA will use for the data display.</p>

**AMBULANCE PATIENT OFFLOAD TIME—EXTENDED DELAY**

<b>MEASURE SET</b>	Extended Ambulance Patient Offload Time	
<b>SET MEASURE ID #</b>	APOT-2	
<b>PERFORMANCE MEASURE NAME</b>	Duration of Ambulance Patient Offload Time for Emergency Patients	
<b>Description</b>	<p>2.1: What percentage of patients transported by EMS personnel experience a transfer between 20-60 minutes of arrival at the Hospital Emergency Department?</p> <p>2.2: What percentage of patients transported by EMS personnel experience a transfer of care between 61-120 minutes after arrival at the Hospital Emergency Department?</p> <p>2.3: What percentage of patients transported by EMS personnel experience a transfer of care between 121-180 minutes after arrival at the Hospital Emergency Department?</p> <p>2.4: What percent of patients transported by EMS personnel experience a transfer of care more than 180 minutes after arrival in the Hospital Emergency Department.</p>	
<b>Type of Measure</b>		
<b>Reporting Value and Units</b>	(%) Percentage	
<b>Denominator Statement (population)</b>	Number of patients who were transported to a hospital emergency department by EMS Personnel.	
<b>Denominator Inclusion Criteria</b>	<b><u>Criteria</u></b>	<b><u>Data Elements</u></b>
	<ul style="list-style-type: none"> <li>All events for which eResponse.05 “type of service requested” has value 2205001 “911 response (Scene),”;</li> <li>All events in eDisposition.21 was Transport to Hospital-Emergency Department was made and has value of 4221003;</li> <li>eTimes.11 “Patient Arrived at Destination Date/Time” values are logical and present</li> </ul>	<ul style="list-style-type: none"> <li>Type of Service Requested (eResponse.05)</li> <li>Type of Destination (eDisposition.21)</li> <li>Patient Arrived at Destination Date/Time (eTimes.11)</li> </ul>
<b>Exclusion Criteria</b>	<b><u>Criteria</u></b>	<b><u>Data Elements</u></b>
	None	

<p><b>Numerator Statement (sub-population)</b></p>	<p>2.1: Number of patients who were transported to a hospital emergency department by EMS Personnel and had their care transferred within 60 minutes after their arrival to the Emergency Department.</p> <p>2.2: Number of patients who were transported to a hospital emergency department by EMS Personnel and had their care transferred 61-120 minutes after their arrival to the Emergency Department.</p> <p>2.3: Number of patients who were transported to a hospital emergency department by EMS Personnel and had their care transferred 121-180 minutes after their arrival to the Emergency Department.</p> <p>2.4: What percent of patients transported by EMS personnel experience a transfer of care more than 180 minutes after arrival in the Hospital Emergency Department.</p>	
<p><b>Numerator Inclusion Criteria</b></p>	<p><u>Criteria</u></p>	<p><u>Data Elements</u></p>
	<ul style="list-style-type: none"> <li>• All events for which eResponse.05 “type of service requested” has value 2205001 “911 response (Scene),”;</li> <li>• All events in eDisposition.21 was Transport to Hospital-Emergency Department was made and has value of 4221003;</li> <li>• eTimes.11 “Patient Arrived at Destination Date/Time” values are logical and present</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>• eTimes.12 “Destination Patient Transfer of Care Date/Time” values are logical and present</li> </ul> <p>Transferred to hospital care must include:</p> <ul style="list-style-type: none"> <li>• Hospital Emergency Department Triage completed</li> <li>• Patient is moved from the Pre-hospital EMS equipment to the hospital Emergency Department Equipment.</li> </ul>	<ul style="list-style-type: none"> <li>• Type of Service Requested (eResponse.05)</li> <li>• Type of Destination (eDisposition.21)</li> <li>• Patient Arrived at Destination Date/Time (eTimes.11)</li> <li>• Destination Patient Transfer of Care Date/Time (eTimes.12)</li> </ul>
<p><b>Exclusion Criteria</b></p>	<p><u>Criteria</u></p>	<p><u>Data Elements</u></p>
	<p>None</p>	

<b>Indicator Formula Numeric Expression</b>	The formula is to divide (/) the numerator (N) by the denominator (D) and then multiply (x) by 100 to obtain the (%) value the indicator is to report. Therefore the indicator expressed numerically is $N/D = \%$	
<b>Example of Final Reporting Value (number and units)</b>	15%	
<b>Sampling</b>	No	
<b>Aggregation</b>	Yes	
<b>Minimum Data Values</b>	Not Applicable	
<b>Data Collection Approach</b>	<ul style="list-style-type: none"> <li>Retrospective data sources for required data elements include administrative data and pre-hospital care records.</li> <li>Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.</li> </ul>	
<b>Suggested Display Format &amp; Frequency</b>	Process control or run chart by month	
<b>Suggested Statistical Measures</b>	Mean (x); Mode (m)	
<b>Trending Analysis</b>	Yes	
<b>Reporting Notes</b>	<p>Report aggregate values by:</p> <ol style="list-style-type: none"> <li>1) LEMSA (using total denominator),</li> <li>2) Broken out by individual hospital</li> </ol> <p>Report the % calculated and the denominator used to calculate (number of runs)</p> <p>Report Quarterly, within 2 months of the end of the quarter:</p> <ul style="list-style-type: none"> <li>• June 1 for period of January 1 through March 31;</li> <li>• September 1 for period of April 1 through June 30;</li> <li>• December 1 for period of July 1 through September 30;</li> <li>• March 1 for period of October 1 through December 31</li> </ul>	

**EMERGENCY MEDICAL SERVICES AUTHORITY**

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**DATE:** May 18, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
Director

**PREPARED BY:** Heidi Wilkening  
EMS Communications Coordinator

**SUBJECT:** Wireless 9-1-1 Routing

**RECOMMENDED ACTION:**

None.

**FISCAL IMPACT:**

Unknown.

**DISCUSSION:**

The EMS Authority continues to monitor issues related to wireless 9-1-1 call transfers. Specifically under review are issues regarding known delays in timely emergency medical response due to inaccurate wireless call locations, inaccurate routing of wireless calls, and limitations in wireless 9-1-1 call transfer capabilities.

Bill Anderson, Communications Branch Manager, for the Office of Emergency Services (OES) is here to make a presentation on this topic.

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**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
Director

**PREPARED BY:** Teri Harness, Assistant Division Chief  
EMS Systems Division

**SUBJECT:** EMS Systems Regulation Development

**RECOMMENDED ACTION:**

Receive information on the status of the EMS Plan Appeal Regulations.

**FISCAL IMPACT:**

Unknown specific costs to the EMS Authority and local EMS agencies who request the ability to exercise their right to appeal an EMS plan determination made by the EMS Authority.

**DISCUSSION:**

The EMS Plan Appeal Regulations were approved by the Commission at the September 2, 2015 meeting.

Approval of the Economic and Fiscal Impact Statement was received by the Health and Human Services Agency and the Department of Finance (DOF) on January 14, 2016.

The EMS Plan Appeal Regulations were submitted to the Office of Administrative Law (OAL) for review on January 14, 2016. The regulations were approved by OAL and became effective on April 1, 2016. The EMS Authority is currently working with the LEMSAs who have filed appeals to the Commission to get them scheduled for a hearing.

The Commission will be updated on the appeal hearings at future Commission meetings.

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**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
Director

**PREPARED BY:** Adrienne Kim  
CEMSIS Program Coordinator

**SUBJECT:** Data Program and California Emergency Medical Services Information System (CEMSIS) Update

**RECOMMENDED ACTION:**

Receive information on CEMSIS.

**FISCAL IMPACT:**

Changes to adopt the NEMSIS Version 3 data set will have cost to the EMS Authority, local EMS agencies and providers in amounts that are not yet fully determined.

**DISCUSSION:**

The EMS Authority is performing validation reviews on the data being input to CEMSIS. Part of this effort has resulted in the development of statewide data reports. These reports provide a look into the data CEMSIS contains at a statewide level for the first time. The report provides information on the data in the system related to a number of areas that are of interest to both the EMS Authority and the EMS community. The contents of this report can be modified to include other elements the system captures as well. It is our intent to publish this report on an annual basis. Similar reports broken down by each reporting local EMS agency will also be available to those agencies in the near future. The EMS Authority greatly appreciates the work the data advisory group has done in assisting us with getting the first CEMSIS report completed. The report itself is a large document and will be placed on the EMS Authority's website and emailed out to the Commission in PDF format on June 16, 2016.

We are continuing our preparations to adopt NEMSIS Version 3.4 consistent with the requirements of AB 1129 that implemented Health and Safety Code 1797.227 and went into effect on January 1, 2016, The EMSA/EMSAAC/EMDAC data advisory group has been working on establishing a NEMSIS Version 3.4 Data Dictionary for use in California.

This California specific data dictionary uses the minimum data standard NEMSIS Version 3.4 requires for state level reporting but allows us to implement the reporting criteria for data elements in a way best suited to meet our data needs in the State. The California specific data dictionary due to be completed and published by June 1, 2016 makes available relevant data information so providers and software vendors can program their systems with the lists we have developed. AB 1129 specifically requires providers use an electronic health record that is able to report data in a NEMSIS Version 3.4 format to the local EMS agencies.

The EMS Authority has been providing technical assistance to providers and software vendors who have had questions related to the use of NEMSIS Version 3.4. The EMS Authority will fully transition to NEMSIS Version 3.4 effective January 1, 2017 and will no longer accept NEMSIS Version 2.2.1 data past that date consistent with AB 1129's direction for the use of the current version of CEMSIS and NEMSIS. There have been two educational data sessions for local EMS agencies, providers and software vendors related to the transition to version 3.4 and EMSA is planning additional sessions in the near future.

We now have 20 local EMS agencies submitting data in some capacity to CEMSIS EMS. There are approximately 4.1 million records in the current system, extending back to 1990. We will continue to submit data to the University of Utah in the NEMSIS Version 2 format through December 31, 2016.

The EMS Authority has partnered with California Department of Public Health (CDPH) to share a half-time epidemiologist to help us review and analyze the data in CEMSIS, specifically focused on traffic related incidents. This partnership is a result of grant funding from the Office of Traffic Safety. We are looking forward to working with her for some detailed analysis of our data.

The Commission will be kept informed on our progress with the statewide data program.

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**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP  
Director

**PREPARED BY:** Bonnie Sinz, RN, BS  
State Trauma System Coordinator

**SUBJECT:** American College of Surgeons (ACS) State Trauma System Consultation

**RECOMMENDED ACTION**

Receive information regarding the ACS State Trauma System Consultation.

**FISCAL IMPACT**

None.

**DISCUSSION**

On March 22, 2016, an American College of Surgeons (ACS) Review Team arrived in San Diego, at the invitation of the EMS Authority, to conduct a Consultative State Trauma System Review for California. The review process assessed all key areas of a State Trauma System based on national standards. The team members included:

Robert J. Winchell, MD, FACS; Trauma Director, New York-Presbyterian Med. Cntr.  
Shelly D. Timmons, MD, PhD, FACS; Neurosurgeon, Geisinger Med. Center., PA  
Kathy J. Rinnert, MD, MPH, FACEP; Emergency Medicine, University of Texas, Dallas  
Drexdal Pratt; State EMS Director (retired), North Carolina  
Jolene R. Whitney, MPA; State Trauma System Manager, Utah  
Nels D. Sanddal, PhD, REMT (ACS technical advisor)  
Jane W. Ball, RN, DrPH (ACS consultant)

Two months prior to the review, the EMS Authority, with the assistance of technical experts from around the State, completed a Pre-Review Questionnaire (PRQ) for the ACS review team. The PRQ responses reflected California's approach to each of the key State Trauma System components. The PRQ was supplemented with required and other selected supportive documents.

The review process involved ACS team members asking questions based on the information they had reviewed in the PRQ. EMS Authority staff and other subject matter experts from our California trauma system were available to respond to these questions. Trauma partners and constituent groups were invited to all sessions and the ACS team encouraged their participation. The following organizations were represented:

**Local EMS Agencies**

Riverside County  
Los Angeles County  
Sierra-Sacramento Valley EMS  
Inland Counties EMS  
Orange County  
Coastal Valleys EMS  
San Diego County  
Ventura County  
San Benito County  
North Coast EMS  
Yolo County

California Hospital Association  
Hospital Association San Diego/Imperial

**Multiple Trauma Centers**  
**Multiple EMS Provider Agencies**

The first day of the review began with Dr. Howard Backer and Bonnie Sinz giving opening remarks with a brief description of California's trauma system and the EMS system in general. The review began the evening of March 22nd and continued for a full day on the 23rd. From the evening of the 23rd through the morning of the 25th the ACS team reviewed all the information in private and EMS Authority staff provided additional documents on request. On the afternoon of the 25th the ACS team provided a brief summary of their findings and key recommendations in no priority order.

The initial top priority recommendations provided during the visit conclusion include:

**Injury Epidemiology:** Create an injury report template for LEMSAs and coordinate with CDPH Epidemiological Center.

**Statutory Authority:** Revise regulations to be less permissive in certain areas and consistent with State Trauma System Plan; provide for minimum operational standards based on size and resource capabilities delineated by the LEMSAs.

**System Leadership:** Establish basic quality and activity reporting standards for LEMSAs; better define the structure and charge of the trauma regions to solidify their role in the State trauma system.

**Coalition Building and Community Support:** Roll out a media campaign and use any opportunities to educate the public on the State trauma system

**Trauma System Plan:** Obtain approval for the State Trauma Plan.

**Financing:** Seek stable and sustainable funding to support state system planning, oversight, and evaluation; work with local agencies to report on cost and value of the system emphasizing the importance of maintaining readiness.

**Definitive Care Facilities:** Ensure uniform criteria for Trauma Center designation by the LEMSAs, based on a needs assessment; exercise the authority to collect data from all acute care facilities receiving trauma patients.

**System Evaluation and Quality Assurance:** Adopt the draft State Performance Improvement and Patient Safety Plan; monitor performance measures, especially timeliness

to care and address trends in deviation of care; utilize CEMSIS data for reports (despite limitations of completeness and quality)

**Next Steps:**

The draft written report was provided to the EMS Authority May 11, 2016 to allow us to review it for errors, after which the final report will be provided. The final recommendations from ACS will be analyzed extensively by EMS Authority staff and discussed with CHHS to develop strategies to improve California's trauma system in order to provide quality trauma care to our citizens and visitors. The State Trauma Plan will also be reviewed to make sure key ACS recommendations are addressed.

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**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Dr. Howard Backer, Director

**PREPARED BY:** Patrick Lynch, Manager, Response Personnel Unit  
Disaster Medical Services Division

**SUBJECT:** Disaster Healthcare Volunteers Program

**RECOMMENDED ACTION:**

Receive updated information on the State's Disaster Healthcare Volunteers Program.

**FISCAL IMPACT:**

None.

**DISCUSSION:**

The Disaster Healthcare Volunteers, (DHV) Program is California's model for the federally mandated Emergency System for Advance Registration of Volunteer Health Professionals, (ESAR-VHP). DHV is administered by the California Emergency Medical Services Authority, (EMSA). The program system operates in coordination with county operational areas and local Medical Reserve Corps (MRC) Units to recruit, register, credential, track, identify, deploy, and maintain currently licensed volunteer healthcare professionals for response to emergencies, disasters, and terrorist incidents in California and throughout the nation.

At the local level, DHV volunteers are coordinated by county (operational area) Medical/Health System Administrators as well as MRC Unit Coordinators. System Administrator training has been provided to all 58 counties as well as 41 MRC Units. Medical Reserve Corps volunteers account for 8,910 of the volunteers in the program. Currently there are over 21,000 active volunteers registered on the system. Of the 21,000 registered volunteers, 19,009 are healthcare professionals. The remaining volunteers provide ancillary services such as logistics, administration, and communications, etc.

DHV verifies the license and credential status nightly of 49 types of healthcare professionals, well beyond the federal guideline of 20 healthcare professions.

EMSA staff conducts ongoing training and technical support for the over 200 local System Administrators as well as quarterly drills on the system and quarterly user group webinars.

EMSA developed and distributed the “DHV Volunteer Handbook” via a web-link to the 21,000+ DHV registered responders. The “DHV Volunteer Handbook” provides information on the DHV Program and its guiding policies, as well as information for the volunteer concerning deployment preparedness, expectations, conduct, and demobilization. A hardcopy pocket guide version was produced and distributed to all of the DHV units and participating MRC units of California.

In an effort to assist local units with recruitment and retention of volunteers, three times a year EMSA staff publishes the “DHV Journal,” a newsletter with articles about the DHV Program, MRC activities, and disaster preparedness and response information for California’s healthcare volunteers.

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**DATE:** June 15, 2016

**TO:** Commission on EMS

**FROM:** Dr. Howard Backer, Director

**PREPARED BY:** Jody Durden, Manager, Plans and Training Unit  
Disaster Medical Services Division

**SUBJECT:** Disaster Medical Services Training and Exercises Update

**RECOMMENDED ACTION:**

Receive updated information on the EMS Authority's Disaster Medical Services Training and Exercise Program.

**FISCAL IMPACT:**

None

**DISCUSSION:**

The EMS Authority is designated as the lead State agency for coordinating disaster medical services in California. In order to be prepared to support local areas in the event of a disaster and to be ready to coordinate information and mutual aid resources, the EMS Authority participates in trainings, drills, and exercises throughout the year.

For every drill, tabletop and/or full-scale exercise that is conducted, an After Action Report (AAR) is created that includes an improvement plan and corrective actions that will be used to improve future responses in disasters.

This year, to date, the EMS Authority has participated in the planning or conduct of the following disaster exercises and trainings:

On **February 24 and 25, 2016** the EMS Authority sponsored Medical Health Operations Center Support Activities (MHOCSA) pilot course was held in Riverside, CA. The MHOCSA course is designed to prepare emergency management personnel that specialize in medical and health operations to provide support to local, operational area, regional and State emergency operation centers (EOCs). The course focuses on four specific positions essential to medical and health support functions within EOCs. The MHOCSA course training includes the California Standardized Emergency Management System (SEMS) and the Public Health and Medical Emergency Operations Manual. Final edits based on the pilot course are being completed. Once finalized, the EMS Authority, in partnership with the California Specialized Training Institute, plans to offer the MHOCSA course twice per year.

On **April 25, 2016**, the EMS Authority participated in the EMS Authority/California Department of Public Health (CDPH) sponsored Cascadia Rising Table Top Exercise. The exercise was designed to prepare participants for the Cascadia Rising functional exercise that followed on **June 2, 2016**. Both exercises were designed to test the Emergency Response Teams procedures and training for the resource requesting process in the Medical Health Coordination Center (MHCC) and State Operations Center.

On **April 30, 2016**, the EMS Authority participated in a local event regarding family preparedness titled "Dare to Prepare". This event was sponsored by Sunrise Market Place which coordinates activities at the Sunrise Mall in Citrus Heights, California. Numerous state and local agencies participated in this Sacramento area event. This event encouraged local families to make a plan, gather and store supplies, develop a family communication plan, and take safe precautions to prepare for and sustain themselves during a disaster or public health emergency. The EMS Authority had a large demonstration area exhibiting the department's mobile medical assets including the Mission Support Team (MST) vehicles, the Command/Communication Vehicle, Ambulance Strike Team (AST) Disaster Medical Support Units (DMSUs), a California Medical Assistance Teams (CAL-MAT) Field Treatment Site with a CAL-MAT healthcare team, and a Disaster Healthcare Volunteer (DHV) booth for recruiting healthcare volunteers.

On **June 7, 8, 9 and 10, 2016**, the EMS Authority participated in an Urban Search and Rescue (US&R) exercise at Moffett Field. The scenario was a 7.3 magnitude earthquake activated along the Hayward fault resulting in catastrophic damage to the area. Search and rescue task forces exercised rescue operations. A CAL-MAT and federal Disaster Medical Assistance Teams (DMATs) tested their ability to establish a field treatment facility to receive and stabilize victims extracted from the rubble by US&R personnel. The EMS Authority also exercised the Mission Support Team communications infrastructure and tested the communications and information technology capabilities.

On **November 17, 2016**, the EMS Authority will participate in the Statewide Medical and Health Exercise (SWMHE) in partnership with the CDPH. The exercise is designed as a multiphase program for participants to test response to a Multi Casualty Incident. The SWMHE will include objectives for Ambulance Services, Behavioral Health, Community Clinics, Coroner/Medical Examiner, Emergency Management, EMS Agencies, Fire

Services, Hospitals, Law Enforcement, Long Term Care Facilities, and Public Health. The discipline-specific objectives were designed to further enhance participants exercise play.

The California Emergency Medical Response to Weapons and Mass Destruction Incidents with Med-Plus, (WMD w/ MED+) is offered throughout California on a **continuous** basis by the EMS Authority as requested. The WMD w/ MED+ course is designed for Emergency Medical Response Personnel. Areas of instruction include the recognition, identification, notification and self-protection knowledge required to safely become aware of and activate the emergency response system in the event of a weapons of mass destruction incident. Senate Bill 1350 passed in 2002, directed California EMS providers to undergo "Terrorism Awareness" training that exceeds that of the federal Office of Domestic Preparedness WMD Response Training Guidelines. This enhanced medical curriculum focuses on the specific signs and symptoms of various Chemical, Biological, Radiological, Nuclear, and Explosive (CBRNE) agents. This course refers to this "enhanced medical" content as "Med-Plus." The WMD w/ MED+ course goal is to provide a safe, organized and effective response for EMS personnel and the people of California in the event of a WMD event.