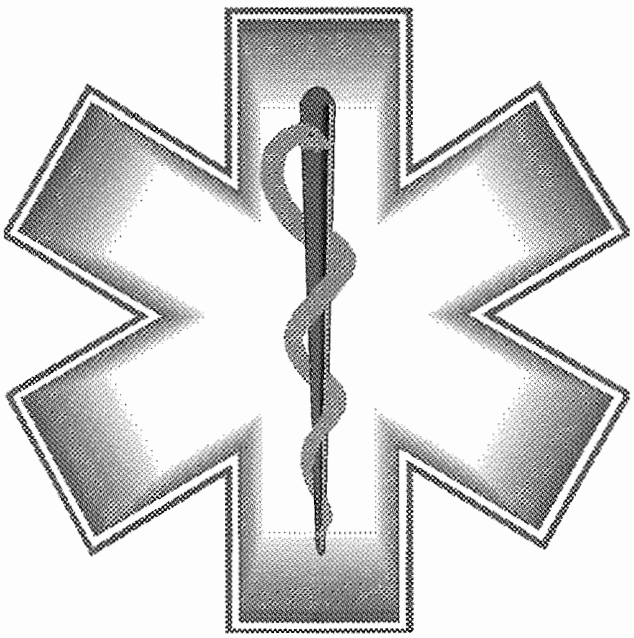
Mountain-Valley
Emergency Medical Services Agency

EMERGENCY MEDICAL SERVICES SYSTEM PLAN



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EXECUTIVE SUMMARY

The Mountain-Valley Emergency Medical Services Agency (MVEMSA) was formed through a joint powers agreement in 1981 and currently serves the counties of Alpine, Amador, Calaveras, Mariposa, and Stanislaus. The MVEMSA's primary responsibility is to plan, implement and evaluate an emergency medical services (EMS) system which meets the minimum standards developed by the California EMS Authority.

State law requires EMS agencies to develop plans for the delivery of emergency medical services (paramedic treatment, ambulance transport, trauma services, etc.) to the victims of sudden illness or injury within the geographic area served by the EMS agency. These plans must be consistent with state standards and address the following components: manpower and training, communications, transportation, assessment of hospitals and critical care centers, system organization and management, data collection and evaluation, public information and education and disaster response.

Major changes have taken place in the EMS system since the MVEMSA last adopted an EMS plan in 1985. Among these changes are: the availability of advanced life support (paramedic) and 9-1-1 services in all parts of the EMS system, the development of specialized policies and services for critically ill and injured children, the creation of an EMS database management system, the formation of exclusive operating areas (EOAs) for ambulance service in Amador and Stanislaus Counties, the adoption of a regional Policy and Procedure Manual and the withdrawal of San Joaquin and Merced Counties from the JPA.

The process of assessing system needs and developing plan objectives revealed that although major improvements have been made in the EMS system since 1985, several components of the EMS system remain unchanged or undeveloped. As an example, despite tremendous improvements in communications technology the communications system, the series of mountain top repeaters and radio frequencies used to dispatch ambulances to emergencies and for paramedics to contact base hospital physicians and nurses for medical advice, has not been updated or significantly modified since 1985. However, the component most noticeably absent from the A-ML-SJ EMS system is that of a formal trauma care system designed to triage and transport major trauma victims to designated trauma care hospitals. This omission exists in spite of three major trauma planning efforts conducted by the MVEMSA in 1981-83, 1988-90 and 1992-93.

The A-ML-SJ EMS system currently meets or exceeds 84 of the State's 121 minimum standards and recommended guidelines. However, the EMS System Plan does more than just focus on the current deficiencies in the EMS system; it attempts to identify objectives for creating an **optimal** EMS system. In order to accomplish the task of creating an "optimal" system, an EMS Plan Task Force, comprised of representatives from hospitals, ambulance providers, first response agencies, and the insurance industry, was formed. The task force met over the course of several months and created the "Local EMS System Model." The concepts included in this document, such as a single 9-1-1 dispatch center in each county, were used as guides in developing the objectives of the EMS System Plan.

The "System Needs and Plan Objectives" section is the heart of the EMS System Plan. This section describes the current status, needs, objectives and time-line of each component of the EMS system. The needs and the objectives listed in the EMS System Plan were identified and developed by comparing our current EMS system with the California EMS Authority's EMS System Standards and Guidelines and following the concepts presented in the "Local EMS System Model" developed by the EMS Plan Task Force.

Some of the major objectives of the MVEMSA EMS System Plan include:

- Studying the feasibility of ALS first response services and other ALS alternatives as described in the EMS system model;
- Determining the feasibility of establishing county-wide exclusive operating areas for ambulance providers and non-transporting paramedic providers;
- Developing agreements with cities and fire districts regarding ambulance response zones in their areas;
- Developing standardized first response agreements;
- Creating a single EMS dispatch center and an integrated dispatch system for each county;
- Developing a better method to triage medical emergencies and dispatch appropriate resources;
- Updating and repairing the communications system;
- Identifying the optimal roles and responsibilities of EMS system participants;
- Establishing a single system-wide on-line medical control point;
- Developing protocols to allow paramedics to treat and release patients from scene;
- Developing a process to identify preventable morbidity and mortality;
- Developing a mechanism to use non-hospital medical facilities to receive some EMS patients;
- Developing a trauma care system;
- Developing prehospital triage and transfer protocols;
- Developing a pediatric plan.

The objectives listed in the EMS System Plan will be used to guide the MVEMSA in monitoring and improving the EMS system over the next 5 years.

ASSESSMENT OF SYSTEM

Summary of System Status

This section provides a summary of how the Mountain-Valley Emergency Medical Services System meets the State of California's EMS Systems Standards and Guidelines. An "x" placed in the first column indicates that the current system does not meet the State's minimum standard. An "x" placed in the second or third column indicates that the system meets either the minimum or recommended standard. An "x" is placed in one of the last two columns to indicate the time-frame the agency has established for either meeting the standard or revising the current status.

A complete narrative description of each standard along with the objective for establishing compliance is included in the System Needs and Plan Objectives Section of this plan.

System Organization and Management

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
1.01 LEMSA Structure		X	NA	X	X
1.02 LEMSA Mission		X	NA		X
1.03 Public Input		X	NA		X
1.04 Medical Director		X	X		
1.05 System Plan		X	NA	X	X
1.06 Annual Plan Update		X	NA	X	
1.07 Trauma Planning	X				X
1.08 ALS Planning		X	NA	X	X
1.09 Inventory of Resources		X	NA	X	
1.10 Special Populations	X			X	X
1.11 System Participants		X		X	X
1.12 Review & Monitoring		X	NA	X	X

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
1.13 Coordination		X	NA		X
1.14 Policy & Procedures Manual		X	NA		X
1.15 Compliance w/ Policies		X	NA	X	X
1.16 Funding Mechanism		X	NA	X	X
1.17 Medical Direction		X	NA	X	X
1.18 QA / QI		X	X	X	X
1.19 Policies, Procedures, Protocols		X	X	X	X
1.20 DNR Policy		X	NA		X
1.21 Determination of Death		X	NA		X
1.22 Reporting of Abuse		X	NA		X
1.23 Inter-facility Transfer		X	NA	X	X
1.24 ALS Systems		X		X	X
1.25 On-Line Medical Direction		X		X	X
1.26 Trauma System Plan					X
1.27 Pediatric System Plan	X		NA		X
1.28 EOA Plan		X		X	X

Staffing and Training

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
2.01 Assessment of Needs		X	NA	X	X
2.02 Approval of Training		X	NA	X	X
2.03 Personnel		X	NA		X
2.04 Dispatch Training	X		X	X	X
2.05 First Responder Training	X				X
2.06 Response	X		NA	X	X
2.07 Medical Control	X		NA		X
2.08 EMT-I Training		X	NA		X
2.09 CPR Training		X	NA		X
2.10 Advanced Life Support		X			X
2.11 Accreditation Process		X	NA		X
2.12 Early Defibrillation		X	NA		X
2.13 Base Hospital Personnel		X	NA	X	

Communications

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
3.01 Communication Plan		X		X	X
3.02 Radios		X	X	X	X
3.03 Inter-facility Transfer		X	NA		X
3.04 Dispatch Center		X	NA	X	X
3.05 Hospitals		X	X		X
3.06 MCI/Disasters		X	NA		X
3.07 9-1-1 Planning/ Coordination		X	X	X	X
3.08 9-1-1 Public Education		X	NA		X
3.09 Dispatch Triage		X	X	X	X
3.10 Integrated Dispatch	X			X	X

Response and Transportation

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
4.01 Service Area Boundaries		X		X	X
4.02 Monitoring		X		X	X
4.03 Classifying Medical Requests		X	NA	X	X
4.04 Pre-scheduled Responses		X	NA		X
4.05 Response Time Standards	X			X	X

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
4.06 Staffing		X	NA		X
4.07 First Responder Agencies	X		NA		X
4.08 Medical & Rescue Aircraft		X	NA		X
4.09 Air Dispatch Center		X	NA		X
4.10 Aircraft Availability		X	NA	X	X
4.11 Specialty Vehicles	X				X
4.12 Disaster Response		X	NA		X
4.13 Intercounty Response		X			X
4.14 Incident Command System		X	NA		X
4.15 MCI Plans		X	NA		X
4.16 ALS Staffing		X			X
4.17 ALS Equipment		X	NA	X	
4.18 Compliance		X	NA		X
4.19 Transportation Plan		X	NA	X	X
4.20 "Grandfathering"		X	NA		X
4.21 Compliance		X	NA		X
4.22 Evaluation		X	NA	X	X

Facilities and Critical Care

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
5.01 Assessment of Capabilities		X		X	
5.02 Triage & Transfer Protocols	X		NA		X
5.03 Transfer Guidelines	X		NA	X	
5.04 Specialty Care Facilities	X		NA	X	X
5.05 Mass Casualty Management		X	X		X
5.06 Hospital Evacuation	X		NA	X	
5.07 Base Hospital Designation		X	NA	X	X
5.08 Trauma System Design					X
5.09 Public Input					X
5.10 Pediatric System Design	X		NA		X
5.11 Emergency Departments		X	X		X
5.12 Public Input		X	NA		X
5.13 Specialty System Design					X
5.14 Public Input					X

Data Collection and System Evaluation

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
6.01 QA/QI Program		X	X	X	X
6.02 Prehospital Records		X	NA	X	
6.03 Prehospital Care Audits		X	X	X	X
6.04 Medical Dispatch		X	NA		X
6.05 Data Management System		X	X	X	X
6.06 System Design Evaluation		X	NA	X	X
6.07 Provider Participation		X	NA	X	X
6.08 Reporting		X		X	
6.09 ALS Audit		X	X	X	X
6.10 Trauma System Evaluation					X
6.11 Trauma Center Data					X

Public Information and Education

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
7.01 Public Information Materials		X	X	X	X
7.02 Injury Control		X	X		X
7.03 Disaster Preparedness	X				X
7.04 First Aid & CPR Training		X		X	X

Disaster Medical Response

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
8.01 Disaster Medical Planning		X	NA	X	
8.02 Response Plans		X	X	X	X
8.03 HazMat Training		X	NA	X	X
8.04 Incident Command System		X	X	X	X
8.05 Distribution of Casualties		X		X	X
8.06 Needs Assessment		X	X	X	X
8.07 Disaster Communications	X		NA		X
8.08 Inventory of Resources	X			X	X
8.09 DMAT Teams	X				X
8.10 Mutual Aid Agreements	X		NA		X
8.11 CCP Designation	X		NA		X
8.12 Establish CCPs	X		NA		X
8.13 Disaster Medical Training		X	X	X	X
8.14 Hospital Plans		X	X	X	X
8.15 Inter-hospital Communications		X	NA		X
8.16 Prehospital Plans		X	X		X
8.17 ALS Policies		X	NA		X
8.18 Specialty Cntr Roles					X
8.19 Waiving Exclusivity		X	NA		X

System Needs and Plan Objectives

This section of the EMS Plan lists each standard included in the State of California's EMS Systems Standards and Guidelines and describes the:

- current status of the MVEMSA system as it relates to the individual standard;
- efforts to coordinate resources and services with other local EMS agencies (LEMSAs) as required by the California EMS Authority;
- need of the MVEMSA system as it relates to the individual standard;
- objective(s) for meeting the minimum standard, upgrading toward the recommended guidelines, or improving the efficiency or effectiveness of the EMS system.
- assignment of each objective to the annual work plan, long range plan, or both.

The needs and objectives of the EMS plan are designed to address both the EMS Systems Standards and Guidelines and the MVEMSA's EMS System Model. Most of the objectives are written as general statements such as Objective 1.01 which states: "Develop secure funding sources to adequately finance agency operations and personnel requirements." Many of these objectives may need to be refined when they are included in annual work plan, pediatric plan, transportation plan, or trauma plan.

1.01 LEMSA STRUCTURE

MINIMUM STANDARDS:
Each local EMS agency shall have a formal organization structure which includes both agency staff and non-agency resources and which includes appropriate technical and clinical expertise.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The agency is managed by a five-person Board of Directors, whose members are elected supervisors from each of the member counties. Agency staff is comprised of a Medical Director, who is Board Certified in Emergency Medicine, an Executive Director, a Deputy Director and an additional 8 FTE employees. Other non-agency resources include: base hospital medical directors, base hospital nurse liaisons, provider QA coordinators and provider training coordinators.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
A) A data analyst/programmer to oversee the data management systems and programs.

OBJECTIVE:
Develop secure funding sources to adequately finance agency operations and personnel requirements.

TIME FRAME FOR MEETING OBJECTIVE:
X Short-Range Plan (one year or less)
Long-Range Plan (more than one year)

1.02 LEMSA MISSION

MINIMUM STANDARDS:
Each local EMS agency shall plan, implement, and evaluate the EMS system. The agency shall use its QA/QI and evaluation processes to identify system changes.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
"The mission of the Mountain-Valley EMS Agency is *to appropriately provide quality prehospital care services to the public in a cost effective manner as an integrated part of the overall health care system.*" A comprehensive emergency medical services system has been established and continuously evaluated by the MVEMSA since 1981. The agency's QA/QI program was revised in 1994, to involve all system participants with the primary purpose of evaluating the EMS system and determining system needs.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure continued evaluation of system performance against established benchmarks.

OBJECTIVE:
Use the agency's QA/QI process and public evaluations by the Regional Advisory Committee, county Emergency Medical Care Committees and other review bodies to identify needed system changes.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

1.03 PUBLIC INPUT

MINIMUM STANDARDS:
Each local EMS agency shall have a mechanism (including EMCCs and other sources) to seek and obtain appropriate consumer and health care provider input regarding the development of plans, policies and procedures, as described in the State EMS Authority's EMS Systems Standards and Guidelines.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Each member county has a functioning Emergency Medical Care Committee which reviews local operations, policies and practices. A Regional Advisory Committee (RAC) comprised of three persons from each member county meets bi-monthly and reviews all MVEMSA plans, policies and procedures before they are submitted to the Board of Directors (BOD) for consideration. All meetings of the BOD, RAC and county EMCCs are open to the public with time allocated on each agenda for open public comments. Additionally, impacted groups are routinely notified and provided with an opportunity to provide input in advance of issues being brought before RAC and the BOD.

COORDINATION WITH OTHER EMS AGENCIES:
None.

NEED(S):
Ensure that appropriate consumer and health care provider input is obtained regarding the development of plans, policies and procedures.

OBJECTIVE:
Monitor and amend, as needed, the structure of the agency's advisory committees to best meet the needs of the EMS system while continuing to provide a mechanism for public input concerning EMS system design and performance.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

1.04 MEDICAL DIRECTOR

MINIMUM STANDARDS:
Each local EMS agency shall appoint a medical director who is a licensed physician who has substantial experience in the practice of emergency medicine.

RECOMMENDED GUIDELINES:
The local EMS agency medical director should have administrative experience in emergency medical services systems.

Each local EMS agency medical director should establish clinical specialty advisory groups composed of physicians with appropriate specialties and non-physician providers (including nurses and prehospital providers), and/or should appoint medical consultants with expertise in trauma care, pediatrics, and other areas, as needed.

CURRENT STATUS:
The agency Medical Director possesses Board Certification in Emergency Medicine and previous experience as a base hospital medical director.

The regional Quality Liaison Committee comprised of base hospital and ambulance providers provides medical oversight of the agency's QA/QI processes. Ad hoc committees for trauma care and pediatrics have been formed and disbanded as needed.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure medical direction of the EMS system.

OBJECTIVE:
Monitor and amend, as needed, the structure of the agency's medical advisory committees to best meet the needs of the EMS system.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.05 SYSTEM PLAN

MINIMUM STANDARDS:
Each local EMS agency shall develop an EMS System Plan, based on community need and utilization of appropriate resources, and shall submit it to the EMS Authority.

The plan shall:

a) assess how the current system meets these guidelines,
b) identify system needs for patients within each of the targeted clinical categories (as identified in Section II), and
c) provide a methodology and time-line for meeting these needs.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Completion of this plan fulfills the requirements of this standard.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Participate in an Urban Trial Study program designed to evaluate the effectiveness of system changes developed under the EMS 2000 system model. Ensure that the EMS System plan meets community needs and provides for the appropriate utilization of resources.

OBJECTIVE
Monitor and amend the EMS system plan, as needed.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.06 ANNUAL PLAN UPDATE

MINIMUM STANDARDS:
Each local EMS agency shall develop an annual update to its EMS System Plan and shall submit it to the EMS Authority. The update shall identify progress made in plan implementation and changes to the planned system design.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Completion of this plan fulfills the requirements of this standard.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Annually evaluate the EMS system plan to determine progress in meeting plan objectives and system changes.

OBJECTIVE:
Submit an annual update of the EMS system plan to the State EMS Authority, which reflects system changes and progress made in meeting plan objectives.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long -Range Plan (more than one year)

1.07 TRAUMA PLANNING

MINIMUM STANDARDS:
The local EMS agency shall plan for trauma care and shall determine the optimal system design for trauma care in its jurisdiction.

RECOMMENDED GUIDELINES:
The local EMS agency should designate appropriate facilities or execute agreements with trauma facilities in other jurisdictions.

CURRENT STATUS:
Although major planning efforts were conducted in 1981-83, 1988-90 and 1992-93, a trauma system has not been established in the MV EMS system.

COORDINATION WITH OTHER EMS AGENCIES:
The demographics and geography of the MV EMS system requires all specialty care planning to consider adjoining systems when determining resource availability and catchment areas.

NEED(S):
Ensure the availability of trauma services for critically injured patients.

OBJECTIVE:
Develop a trauma care system, which may include facility designation, before the end of the century.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.08 ALS PLANNING

MINIMUM STANDARDS:
Each local EMS agency shall plan for eventual provision of advanced life support services throughout its jurisdiction.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Advanced life support ambulance services are provided as the minimum standard for emergency (9-1-1) medical requests in each county in the EMS system.

COORDINATION WITH OTHER EMS AGENCIES:
Alpine County's ALS ambulance service is delivered by providers stationed in Amador, Calaveras and El Dorado counties as well as the State of Nevada. Continuation-of-call agreements have been developed with some neighboring EMS systems. Separate agreements have been executed with Merced County EMS and San Joaquin County EMS concerning the utilization of base hospital medical control and disaster control by each other's providers. Additionally, formal arrangements have been made with Merced County EMS creating ambulance response zones which serve populations in both EMS jurisdictions.

NEED(S):
Ensure the optimal provision of ALS services throughout the EMS system.

OBJECTIVE:
Study the feasibility of ALS first response services and other ALS alternatives as described in the EMS system model, including the development of exclusive operating areas for non-transporting ALS service providers. Make changes as necessary to ensure the optimal provision of ALS services.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.09 INVENTORY OF RESOURCES

MINIMUM STANDARDS:
Each local EMS agency shall develop a detailed inventory of EMS resources (e.g., personnel, vehicles, and facilities) within its area and, at least annually, shall update this inventory.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Completion of this plan fulfills the requirements of this standard.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the accurateness of the resource directories included in this plan.

OBJECTIVE:
Periodically update the resource directories included in this plan.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long-Range Plan (more than one year)

1.10 SPECIAL POPULATIONS

MINIMUM STANDARDS:
Each local EMS agency shall identify population groups served by the EMS system which require specialized services (e.g., elderly, handicapped, children, non-English speakers).

RECOMMENDED GUIDELINES:
Each local EMS agency should develop services, as appropriate, for special population groups served by the EMS system which require specialized services (e.g., elderly, handicapped, children, non-English speakers).

CURRENT STATUS:
The creation of an Emergency Medical Services for Children sub-system is the only work performed in this area by the EMSA.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Begin the process of identifying population groups served by the EMS system which may require special services. Ensure that all population groups know how to access and appropriately utilize the EMS system.

OBJECTIVE:
Identify population groups served by the EMS system which require specialized services. Work with other agencies, both county and private, to identify and develop care plans for population groups requiring specialized services.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.11 SYSTEM PARTICIPANTS

MINIMUM STANDARDS:
Each local EMS agency shall identify the optimal roles and responsibilities of system participants.

RECOMMENDED GUIDELINES:
Each local EMS agency should ensure that system participants conform with their assigned EMS system roles and responsibilities, through mechanisms such as written agreements, facility designations, and exclusive operating areas.

CURRENT STATUS:
The roles and responsibilities of many system participants is based primarily on historical involvement and willingness to cooperate with the agency. Formalization of roles and responsibilities has only been conducted with base hospitals, ALS transport services and dispatch centers.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Identify the optimal roles and responsibilities of all system participants based on the EMS system model and public input. Ensure that system participants conform with assigned EMS system roles and responsibilities.

OBJECTIVE:
Participate in the CSUS Research project to *Identify the optimal roles and responsibilities of system participants.* Identify the optimal roles and responsibilities of EMS system participants and develop mechanisms, such as agreements, facility designations and exclusive operating areas to ensure compliance.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.12 REVIEW AND MONITORING

MINIMUM STANDARDS:
Each local EMS agency shall provide for review and monitoring of EMS system operations.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
In 1994, the agency adopted an EMS System Quality Assurance/Quality Improvement (QA/QI) Plan which formed a multi-disciplinary Quality Liaison Committee (QLC) comprised of base hospital medical directors, base hospital nurse liaisons, ambulance provider quality coordinators, first response quality coordinators and dispatch quality coordinators to assist the agency Medical Director in providing oversight and evaluation of the EMS system. Local Q.I. groups, consisting of members of an operational area, have also been formed to evaluate response, care and transport, and to identify system problems and seek solutions.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the continued review and monitoring of EMS system operations. Work with EMSAAC and the State EMSA to develop standard statewide indicators for EMS system evaluation.

OBJECTIVE:
Implement structural indicators and compliance mechanisms, developed for Base Hospitals, ALS providers, EMD Centers and CE providers. Modify the process of review and monitoring of the EMS system, as needed. Continue to work with statewide planning groups to develop standardized processes and indicators.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.13 COORDINATION

MINIMUM STANDARDS:
Each local EMS agency shall coordinate EMS system operations.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
EMS system operations are coordinated through written agreements with providers, facilities and counties; policies and procedures; training standards; quality improvement programs and other mechanisms. This plan identifies those components of the MVEMSA system.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure coordinated system operations.

OBJECTIVE:
Evaluate EMS system operations and make changes as needed to ensure optimal system performance.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.14 POLICY & PROCEDURES MANUAL

MINIMUM STANDARDS:
Each local EMS agency shall develop a policy and procedures manual which includes all EMS agency policies and procedures. The agency shall ensure that the manual is available to all EMS system providers (including public safety agencies, ambulance services, and hospitals) within the system.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A policy and procedure manual has been developed and distributed to system providers. Policies and procedures are also made available through the Agency website.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the availability of a policy and procedure manual for system providers.

OBJECTIVE:
Monitor the process of policy and procedure manual availability and make changes as necessary.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.15 COMPLIANCE WITH POLICIES

MINIMUM STANDARDS:
Each local EMS agency shall have a mechanism to review, monitor, and enforce compliance with system policies.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Written agreements, county ordinances, inspections, unusual occurrence reporting, investigations and quality improvement programs have been established as mechanisms to review, monitor and enforce compliance with system policies.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure compliance with system policies.

OBJECTIVE:
Implement structural indicators and compliance mechanisms, developed for Base Hospitals, ALS providers, AED providers, EMD Centers, and CE providers. Evaluate and improve compliance with system policies.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.16 FUNDING MECHANISM

MINIMUM STANDARDS:
Each local EMS agency shall have a funding mechanism which is sufficient to ensure its continued operation and shall maximize use of its Emergency Medical Services Fund.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The EMSA relies on local/county contributions, State general fund grants, PHHS project grants, service contracts with other LEMSAs and user fees as a fund base for agency operations. A decrease in funding for FY95-96 required the agency to leave 2.5 FTE employee position unfilled. State general fund augmentation was obtained in FY98-99, allowing agency to potentially fill the Data Analyst/Programmer position in FY99-00.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Identify stable funding sources.

OBJECTIVE:
Maintain existing funding sources and seek alternative or new funding sources. Continue to work with the Emergency Medical Services Administrators Association of California (EMSAAC), the Emergency Medical Services Medical Directors Association of California (EMDAC), State EMS Vision working groups, and the State EMSA to maintain federal, state and local funding of EMS systems. Continue to investigate ways for the Mountain-Valley EMS agency and system to function for cost effectively.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.17 MEDICAL DIRECTION

MINIMUM STANDARDS:
Each local EMS agency shall plan for medical direction within the EMS system. The plan shall identify the optimal number and role of base hospitals and alternative base stations and the roles, responsibilities, and relationships of prehospital and hospital providers.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
Currently all seven hospitals in the EMS system have been designated as base hospitals. However, with the inclusion of provider QA/QI and an increase in standing orders, there may not be the need for the number base hospitals in their current roles.

COORDINATION WITH OTHER EMS AGENCIES:
Arrangements have been made with Merced County and Tuolumne County EMS to allow Mariposa ambulance providers to access Merced County base hospitals for medical control and disaster control functions. Arrangements have been made to allow San Joaquin County EMS personnel to contact MVEMSA base hospitals for medical direction.

NEED(S):
The establishment of a single medical control point has been identified by system participants as a major part of the EMS system model adopted by the agency. A process needs to be developed for selecting a single medical control point and identifying its optimal configuration and responsibilities.

OBJECTIVE:
Evaluate the feasibility of a single medical control point.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.18 QA/QI

MINIMUM STANDARDS:
Each local EMS agency shall establish a quality assurance/quality improvement program. This may include use of provider-based programs which are approved by the local EMS agency and which are coordinated with other system participants.

RECOMMENDED GUIDELINES:
Prehospital care providers should be encouraged to establish in-house procedures which identify methods of improving the quality of care provided.

CURRENT STATUS:
In 1994, the agency adopted an EMS System Quality Assurance/Improvement (QA/QI) Plan which formed a multi-disciplinary Quality Liaison Committee (QLC) comprised of base hospital medical directors, base hospital nurse liaisons, ambulance provider quality coordinators, first response quality coordinators and dispatch quality coordinators to assist the agency Medical Director in providing oversight and evaluation of the EMS system. Local Q.I. groups, consisting of members of an operational area, have also been formed to evaluate response, care and transport. Most aspects of the previous clinical review (medical auditing) program were lost with the transition to the new QA/QI program.

COORDINATION WITH OTHER EMS AGENCIES:
None

NEED(S):
Establishment of a process to identify preventable morbidity and mortality. Reinstitution of medical audit process. Development of a process to provide feedback to prehospital personnel on patient outcomes as described in the EMS system model. Ensure that the QI/QI process meets system needs and State standards.

OBJECTIVE:
Develop a process to: identify preventable morbidity and mortality; conduct medical auditing and; provide feedback to prehospital personnel on patient outcomes. Continue to monitor and amend the QA/QI program to meet system needs.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long -Range Plan (more than one year)

1.19 POLICIES, PROCEDURES, PROTOCOLS

MINIMUM STANDARDS:
Each local EMS agency shall develop written policies, procedures, and/or protocols including, but not limited to:

a) triage,
b) treatment,
c) medical dispatch protocols,
d) transport,
e) on-scene treatment times,
f) transfer of emergency patients,
g) standing orders,
h) base hospital contact,
i) on-scene physicians and other medical personnel, and
j) local scope of practice for prehospital personnel.

RECOMMENDED GUIDELINES:
Each local EMS agency should develop (or encourage the development of) pre-arrival/post dispatch instructions.

CURRENT STATUS:
ALS treatment protocols, including complete sections on standing orders are being revised. Policies, protocols or policy statements regarding medical dispatch, transport, on-scene times, transfer of emergency patients, on-scene physicians and other medical personnel and local scope of practice have been established but require evaluation and revision. Policies on triage and patient destination have not been developed.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Develop and revise polices to meet state minimum standards and the EMS system model.

OBJECTIVE:
1) Review and revise polices, as needed, to meet minimum standards and the EMS System Model. 2) Develop policies for transport of patients to facilities appropriate for their injuries or illness. 3) Evaluate and modify the ALS scope of practice as needed.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.20 DNR POLICY

MINIMUM STANDARDS:
Each local EMS agency shall have a policy regarding "Do Not Resuscitate (DNR)" situations in the prehospital setting, in accordance with the EMS Authority's DNR guidelines.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A comprehensive DNR policy was created and implemented in 1992, with the assistance of the Stanislaus County Medical Society, the Medic-Alert Foundation and the San Diego County EMSA. This DNR program, with minor revisions, was adopted by the State EMSA and the California Medical Association as a State Standard in 1993.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the DNR policy continues to meet standards and system needs.

OBJECTIVE:
Monitor the utilization of the DNR policy and amend as needed. Improve the dissemination of DNR program materials throughout the EMS system.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.21 DETERMINATION OF DEATH

MINIMUM STANDARDS:
Each local EMS agency, in conjunction with the county coroner(s) shall develop a policy regarding determination of death, including deaths at the scene of apparent crimes.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A determination of death policy was created and implemented with the concurrence of the county coroners in 1992 and revised in 1994. Several system participants have expressed a desire to expand the criteria used to determine death in the field.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the determination of death policy continues to meet system needs.

OBJECTIVE:
Evaluate the possibility of expanding the criteria used for determining death in the field.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.22 REPORTING OF ABUSE

MINIMUM STANDARDS:
Each local EMS agency shall ensure that providers have a mechanism for reporting child abuse, elder abuse, and suspected SIDS deaths.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
No EMS policies have been developed regarding the reporting of abuse or suspected SIDS deaths. Agency staff has served on a county Domestic Violence Task Force for the purpose of establishing a standardized multi-disciplinary approach for addressing domestic violence.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that a mechanism exists for the reporting of abuse or suspected SIDS deaths.

OBJECTIVE:
Create EMS policies regrading the reporting of abuse or suspected SIDS deaths. Work with other public, private agencies to increase awareness of abuse cases and reporting among prehospital personnel.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.23 INTERFACILITY TRANSFER

MINIMUM STANDARDS:
The local EMS medical director shall establish policies and protocols for scope of practice of prehospital medical personnel during interfacility transfers.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
A policy delineating the scene and interfacility transfer scope of practice of paramedics is being revised. Established policies and procedures for use of Heparin and Nitroglycerin as an expanded scope for interfacility transfers.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Evaluate the need for further developing a BLS and ALS interfacility scope of practice.

OBJECTIVE:
Evaluate the need for developing a BLS and ALS interfacility scope of practice.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.24 ALS SYSTEMS

MINIMUM STANDARDS:
Advanced life support services shall be provided only as an approved part of a local EMS system and all ALS providers shall have written agreements with the local EMS agency.

RECOMMENDED GUIDELINES:
Each local EMS agency, based on state approval, should, when appropriate, develop exclusive operating areas for ALS providers.

CURRENT STATUS:
All ALS services currently provided in the EMS system are done so with Agency approval and written agreements. Exclusive operating areas (EOAs) have been established in 2 counties.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that ALS services are provided only as an approved part of the EMS system. Determine the feasibility of establishing county-wide EOAs as described in the EMS system model.

OBJECTIVE:
Maintain written agreements with all ALS providers and monitor compliance. Determine the feasibility of establishing county-wide EOAs, including emergency ambulance providers and non-transporting ALS service providers. When a county-wide EOA for either emergency ambulance or non-transporting ALS service providers are not feasible then multiple EOAs should be established to ensure appropriate emergency and ALS response.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long -Range Plan (more than one year)

1.25 ON-LINE MEDICAL DIRECTION

MINIMUM STANDARDS:
Each EMS system shall have on-line medical direction, provided by a base hospital (or alternative base station) physician or authorized registered nurse/mobile intensive care nurse.

RECOMMENDED GUIDELINES:
Each EMS system should develop a medical control plan which determines:

a) the base hospital configuration for the system,
b) the process for selecting base hospitals, including a process for designation which allows all eligible facilities to apply, and
c) the process for determining the need for in-house medical direction for provider agencies.

CURRENT STATUS:
Currently all seven hospitals in the EMS system have been designated as base hospitals. However, with the inclusion of provider QA/QI and an increase in standing orders, there may not be the need for the number of base hospitals in their current roles. A study to evaluate alternatives for medical control is to be conducted in FY99-00.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
The establishment of a single medical control point has been identified by system participants, through the planning process, as a major part of the EMS system model adopted by the agency. A process needs to be developed for selecting a single medical control point and identifying its optimal configuration and responsibilities. A comprehensive plan for medical control including a process of determining the need for in-house medical control for provider agencies needs to be developed.

OBJECTIVE:
Evaluate feasibility of establishing a single medical control point. Develop a comprehensive medical control plan which meets standards and system needs.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.26 TRAUMA SYSTEM PLAN

MINIMUM STANDARDS:
The local EMS agency shall develop a trauma care system plan, based on community needs and utilization of appropriate resources, which determines:

a) the optimal system design for trauma care in the EMS area, and
b) the process for assigning roles to system participants, including a process which allows all eligible facilities to apply.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Although major planning efforts were conducted in 1981-83, 1988-90 and 1992-93, a trauma system has not been established for the MVEMSA system. Trauma and specialty care planning was identified by the Regional Advisory Committee and other groups as a top priority for the agency and is included in the EMS system model adopted by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
None

NEED(S):
Develop a trauma system and other specialty care system as appropriate.

OBJECTIVE:
Develop a trauma system, which may include facility designation, before the end of the century.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.27 PEDIATRIC SYSTEM PLAN

MINIMUM STANDARDS:
The local EMS agency shall develop a pediatric emergency medical and critical care system plan, based on community needs and utilization of appropriate resources, which determines:

a) the optimal system design for pediatric emergency medical and critical care in the EMS area, and
b) the process for assigning roles to system participants, including a process which allows all eligible facilities to apply.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A Pediatric Emergency Medical and Critical Care System was developed and implemented in 1993-1995 as part of two special project grants awarded to the MV EMSA by the California EMS Authority. The pediatric system addresses the major Emergency Medical Services for Children (EMSC) components identified by the California EMS Authority as required of an EMSC system.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the Pediatric Emergency Medical and Critical Care System and the pediatric services provided by the EMS system meets the needs of critically ill and injured children within the MV EMS system.
Develop a Pediatric System Plan which describes the current EMSC system and identifies the optimal system design.

OBJECTIVE:
Evaluate the effectiveness of the EMS system at meeting the needs of critically ill and injured children.
Develop a pediatric system plan.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.28 EOA Plan

MINIMUM STANDARDS:

The local EMS agency shall develop, and submit for State approval, a plan, based on community needs and utilization of appropriate resources, for granting of exclusive operating areas which determines: a) the optimal system design for ambulance service and advanced life support services in the EMS area, and b) the process for assigning roles to system participants, including a competitive process for implementation of exclusive operating areas.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Existing exclusive operating areas were designed to solidify the provision of ALS transport and emergency response with those historic providers who met the eligibility requirements for "grandfathering" under Health and Safety Code. The optimal system design for ALS ambulance and the process for assigning roles to system participants is described in the Transportation Plan included with this document and is based on the EMS system model adopted by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that system design continues to meet community needs.

OBJECTIVE:
Evaluate Agency position regarding the inclusion of all ALS and emergency calls within EOAs and update Transportation Plan. Monitor system design and make changes as required.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

2.01 ASSESSMENT OF NEEDS

MINIMUM STANDARDS:
The local EMS agency shall routinely assess personnel and training needs.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Current training institutions appear to meet system needs considering the abundance of certified EMT-Is, accredited paramedics and MICNs within the EMS system. First response agencies in Amador, Calaveras, and Mariposa counties are assessed yearly regarding certification and recertification training needs.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure a sufficient amount of personnel are trained to meet EMS system demands.

OBJECTIVE:
Monitor and ensure system personnel and training needs, including continuing education.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

2.02 APPROVAL OF TRAINING

MINIMUM STANDARDS:
The EMS Authority and/or local EMS agencies shall have a mechanism to approve EMS education programs which require approval (according to regulations) and shall monitor them to ensure that they comply with state regulations.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Procedures are in place to approve First Responder, EMD, EMT-D, EMT-I, EMT-P, and MICN training programs. Monitoring of training programs is done by periodic auditing of courses and completion of course evaluation forms by students.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that EMS education programs comply with State regulations and local policies for continued program approval.

OBJECTIVE:
Conduct random compliance evaluations of local programs. Monitor EMS education programs and take steps to ensure compliance to standards and other course requirements.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

2.03 PERSONNEL

MINIMUM STANDARDS:
The local EMS agency shall have mechanisms to accredit, authorize, and certify prehospital medical personnel and conduct certification reviews, in accordance with state regulations. This shall include a process for prehospital providers to identify and notify the local EMS agency of unusual occurrences which could impact EMS personnel certification.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Policies have been adopted regarding emergency medical dispatcher certification, first responder certification, EMT-I certification, paramedic accreditation and MICN authorization.

Procedures have been developed for the reporting of unusual occurrences which could impact EMS personnel certification.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):

OBJECTIVE:
Monitor all EMS personnel policies and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

2.04 DISPATCH TRAINING

MINIMUM STANDARDS:
Public safety answering point (PSAP) operators with medical responsibility shall have emergency medical orientation and all medical dispatch personnel (both public and private) shall receive emergency medical dispatch training in accordance with the EMS Authority's Emergency Medical Dispatch Guidelines.

RECOMMENDED GUIDELINES:
Public safety answering point (PSAP) operators with medical dispatch responsibilities and all medical dispatch personnel (both public and private) should be trained and tested in accordance with the EMS Authority's Emergency Medical Dispatch Guidelines.

CURRENT STATUS:
Level II emergency medical dispatching, with pre-arrival instructions, has been adopted as the minimum standard for all PSAPs and dispatch centers providing or responsible for medical dispatching.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure all medical dispatchers maintain Level II EMD training standards.

OBJECTIVE:
Encourage the passage of dispatcher immunity legislation. Investigate and develop, as appropriate, more cost effective means of providing EMS dispatch services to include emergency and non-emergency call screening as outlined in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

2.05 FIRST RESPONDER TRAINING

MINIMUM STANDARDS:
At least one person on each non-transporting EMS first response unit shall have been trained to administer first aid and CPR within the previous three years.

RECOMMENDED GUIDELINES:
At least one person on each non-transporting EMS first response unit should be currently certified to provide defibrillation and have available equipment commensurate with such scope of practice, when such a program is justified by the response times for other ALS providers.

At least one person on each non-transporting EMS first response unit should be currently certified at the EMT-I level and have available equipment commensurate with such scope of practice.

CURRENT STATUS:
While it is assumed that all of the first response agencies serving the MVEMSA system comply with State regulations requiring a minimum of first aid and CPR training, this cannot be ensured in the absence of written agreements.

EMT-I training is widely available within the EMS system and the staffing of first response units with at least one certified EMT-I is encouraged. Greater than 80% of the population of the MVEMSA system is served by an early defibrillation first response provider.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure minimum training standards and encourage adherence to recommended guidelines. Establish minimum training standards for first response providers.

OBJECTIVE:
Identify the optimal roles and responsibilities of all system participants based on the EMS system model and public input.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

2.06 RESPONSE

MINIMUM STANDARDS:
Public safety agencies and industrial first aid teams shall be encouraged to respond to medical emergencies and shall be utilized in accordance with local EMS agency policies.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The roles and responsibilities of most system participants are based primarily on historical involvement and willingness to cooperate with the agency.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Identify the optimal roles and responsibilities of all system participants based on the EMS system model and public input. Ensure that system participants conform with assigned EMS system roles and responsibilities.

OBJECTIVE:
Develop/revise first responder and BLS treatment guidelines. Identify the optimal roles and responsibilities of EMS system participants based upon the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

2.07 MEDICAL CONTROL

MINIMUM STANDARDS:
Non-transporting EMS first responders shall operate under medical direction policies, as specified by the local EMS agency medical director.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Considering the small number of first response agencies who voluntarily participate in the QA/QI program, we are unable to determine the compliance to medical control policies for most of the non-transporting EMS first responders in the region.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that first responders operate under the medical direction of the EMS system.

OBJECTIVE:
Continue to work with first response agencies to encourage participation in the agency QA/QI program.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

2.08 EMT-I TRAINING

MINIMUM STANDARDS:
All emergency medical transport vehicle personnel shall be currently certified at least at the EMT-I level.

RECOMMENDED GUIDELINES:
If advanced life support personnel are not available, at least one person on each emergency medical transport vehicle should be trained to provide defibrillation.

CURRENT STATUS:
By policy, the minimum staffing level of all emergency medical transport vehicles (ambulances), is one licensed paramedic and one certified EMT-I. However, a BLS ambulance, staffed with a minimum of two EMT-Is may be used to respond to emergency requests during times of disaster and system overload when all available ALS resources have been depleted.

BLS ambulance personnel do not perform defibrillation, nor has their training in this procedure been encouraged by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the availability of trained transport personnel to meet the needs of the EMS system.

OBJECTIVE:
Monitor and adjust ambulance staffing requirements to meet EMS system needs and the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

2.09 CPR TRAINING

MINIMUM STANDARDS:
All allied health personnel who provide direct emergency patient care shall be trained in CPR.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Hospital employees working in the emergency department are routinely required to be certified in CPR. However, no mechanism exists to ensure compliance with this standard for personnel not under the jurisdiction of the MVEMSA.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Encourage the training of allied health personnel in CPR.

OBJECTIVE:
Monitor EMS system personnel and take appropriate measures to ensure training in CPR.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

2.10 ADVANCED LIFE SUPPORT

MINIMUM STANDARDS:
All emergency department physicians and registered nurses who provide direct emergency patient care shall be trained in advanced life support.

RECOMMENDED GUIDELINES:
All emergency department physicians should be certified by the American Board of Emergency Medicine.

CURRENT STATUS:
Current base hospital agreements require base hospital physicians and MICNs to be certified in advanced cardiac life support (ACLS). All emergency department physicians are encouraged to be Board certified in emergency medicine or be certified in prehospital EMS management through such courses as prehospital trauma life support (PHTLS) and pediatric advanced life support (PALS).

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure training in ALS for emergency department physicians and nurses who provide emergency patient care.

OBJECTIVE:
Monitor, evaluate and update base hospital agreements as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

2.11 ACCREDITATION PROCESS

MINIMUM STANDARDS:
The local EMS agency shall establish a procedure for accreditation of advanced life support personnel which includes orientation to system policies and procedures, orientation to the roles and responsibilities of providers within the local EMS system, testing in any optional scope of practice, and enrollment into the local EMS agency's quality assurance/quality improvement process.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Policies and procedures exist to accredit and orient ALS personnel.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Continue to ensure that ALS personnel are appropriately oriented to the EMS system and capable of performing the expanded scope of practice procedures.

OBJECTIVE:
Monitor and amend the ALS accreditation process as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

2.12 EARLY DEFIBRILLATION

MINIMUM STANDARDS:
The local EMS agency shall establish policies for local accreditation of public safety and other basic life support personnel in early defibrillation.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Policies and procedures exist to accredit personnel as early defibrillation technicians.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Continue to ensure policies and procedures for early defibrillation training and certification meet EMS system needs.

OBJECTIVE:
Evaluate existing policies and procedures for early defibrillation training and certification to determine that system needs are being met.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

2.13 BASE HOSPITAL PERSONNEL

MINIMUM STANDARDS:
All base hospital/alternative base station personnel who provide medical direction to prehospital personnel shall be knowledgeable about local EMS agency policies and procedures and have training in radio communications techniques.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Policies and agreements specify that only mobile intensive care nurses, who have been authorized by the MV EMSA Medical Director, or base hospital physicians, who have been judged knowledgeable in prehospital policies and protocols by the Base Hospital Medical Director, shall provide medical direction to EMS personnel.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that only adequately trained nurses and physicians provide medical direction to EMS personnel.

OBJECTIVE:
Monitor compliance to ensure that base hospital personnel who provide medical direction are knowledgeable about EMS policies and procedures. Evaluate feasibility of a centralized medical control point.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long-Range Plan (more than one year)

3.01 COMMUNICATIONS PLAN

MINIMUM STANDARDS:
The local EMS agency shall plan for EMS communications. The plan shall specify the medical communications capabilities of emergency medical transport vehicles, non-transporting advanced life support responders, and acute care facilities and shall coordinate the use of frequencies with other users.

RECOMMENDED GUIDELINES:
The local EMS agency's communications plan should consider the availability and use of satellites and cellular telephones.

CURRENT STATUS:
The current system of dispatch, field and hospital medical communication was developed more than ten years ago and has recently been evaluated. Most components of the system have been upgraded and repaired. Communications Directory was updated in 1998/99.

COORDINATION WITH OTHER EMS AGENCIES:
The Assignment of communications frequencies and the locations of radio repeaters was performed in conjunction with adjacent EMS systems.

NEED(S):
Several of the repeaters need to be replaced. Comprehensive statewide communications plan. Improved and alternative communications systems (e.g. sattelite) should be explored. The communications plan should ensure that an adequate number of frequencies exist for dispatch, scene management, patient dispersal, and medical control.

OBJECTIVE:
Prioritize system repairs and upgrades. Evaluate necessary changes to comply with the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long -Range Plan (more than one year)

3.02 RADIOS

MINIMUM STANDARDS:
Emergency medical transport vehicles and non-transporting advanced life support responders shall have two-way radio communications equipment which complies with the local EMS communications plan and which provides for dispatch and ambulance-to-hospital communication.

RECOMMENDED GUIDELINES:
Emergency medical transport vehicles should have two-way radio communications equipment which complies with the local EMS communications plan and which provides for vehicle-to-vehicle (including both ambulances and non-transporting first responder units) communication.

CURRENT STATUS:
All emergency medical transport vehicles have two-way radio equipment capable of performing field to dispatch, field to field, and field to hospital communications. However, communications "dead-spots" exist through out the system.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard

NEED(S):
Several of the repeaters need to be replaced. Comprehensive statewide communications plan should be developed. Improved and alternative communications systems (e.g. sattelite) should be explored. The communications plan should ensure that an adequate number of frequencies exist for dispatch, scene management, patient dispersal, and medical control.

OBJECTIVE:
Prioritize system repairs and upgrades and make necessary changes.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long -Range Plan (more than one year)

3.03 INTERFACILITY TRANSFER

MINIMUM STANDARDS:
Emergency medical transport vehicles used for interfacility transfers shall have the ability to communicate with both the sending and receiving facilities. This could be accomplished by cellular telephone.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The current system of dispatch, field and hospital medical communication was developed more than ten years ago and has recently been evaluated. Most components of the system have been upgraded and repaired.

COORDINATION WITH OTHER EMS AGENCIES:
Communications frequencies and the locations of radio repeaters was performed in conjunction with adjacent EMS systems.

NEED(S):
Ensure the availability of medical communications.

OBJECTIVE:
Prioritize system repairs and upgrades and make necessary changes.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

3.04 DISPATCH CENTER

MINIMUM STANDARDS:
All emergency medical transport vehicles where physically possible, (based on geography and technology), shall have the ability to communicate with a single dispatch center or disaster communications command post.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The current system of dispatch, field and hospital medical communication was developed more than ten years ago and has recently been evaluated. Most components of the system have been upgraded and repaired.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard

NEED(S):
The establishment of a single medical dispatch center was identified by system participants as a major part of the EMS system model adopted by the EMSA. Further study needs to be conducted to determine the optimal configuration and responsibilities of a single medical dispatch center by county or region.

OBJECTIVE:
Establish agreement with Mariposa CDF as an EMS dispatch center. Perform a study to determine the required number of medical dispatch centers and their optimal configurations and responsibilities.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

3.05 HOSPITALS

MINIMUM STANDARDS:
All hospitals within the local EMS system shall (where physically possible) have the ability to communicate with each other by two-way radio.

RECOMMENDED GUIDELINES:
All hospitals should have direct communications access to relevant services in other hospitals within the system (e.g., poison information, pediatric and trauma consultation).

CURRENT STATUS:
Hospitals within Stanislaus County can communicate with each other through a dedicated BLAST phone system. The current system of dispatch, field and hospital medical communication was developed more than ten years ago and has recently been evaluated. Most components of the system have been upgraded and repaired.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Maintain the availability of medical communications, including back-up systems.

OBJECTIVE:
Prioritize system repairs and upgrades and make necessary changes.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

3.06 MCI/DISASTERS

MINIMUM STANDARDS:
The local EMS agency shall review communications linkages among providers (prehospital and hospital) in its jurisdiction for their capability to provide service in the event of multi-casualty incidents and disasters.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The county disaster control facilities (DCF) and the regional DCF use regular telephone, facsimile lines, and EMS radios when determining the capabilities of area hospitals during MCIs and disasters. The only alternate communications capability for hospital-to-hospital transmissions is the amateur radio system.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the availability of medical communications during disaster and multi-casualty incidents to include: common dispatch and travel frequencies; tactical frequencies coordinated with local public safety agencies; a mechanism for patient dispersal; and medical control communications.

OBJECTIVE:
Prioritize system repairs and upgrades and make necessary changes consistent with system needs and the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

3.07 9-1-1 PLANNING/COORDINATION

MINIMUM STANDARDS:
The local EMS agency shall participate in ongoing planning and coordination of the 9-1-1 telephone service.

RECOMMENDED GUIDELINES:
The local EMS agency should promote the development of enhanced 9-1-1 systems.

CURRENT STATUS:
All counties in the MVEMSA system have enhanced 9-1-1 telephone service.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Continued participation in ongoing planning and coordination of 9-1-1 telephone service.

OBJECTIVE:
Participate in ongoing planning and coordination of 9-1-1 telephone service and encourage the development of PSAPs as described in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

3.08 9-1-1 PUBLIC EDUCATION

MINIMUM STANDARDS:
The local EMS agency shall be involved in public education regarding the 9-1-1 telephone service as it impacts system access.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Education concerning 9-1-1 access is provided to children through EMS youth projects and to the general public at health fairs and other promotional events.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Determine public education needs, based upon any changes made to the EMS system.

OBJECTIVE:
In coordination with other public safety agencies and primary health care organizations provide for public education concerning appropriate utilization and system access as outlined in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

3.09 DISPATCH TRIAGE

MINIMUM STANDARDS:
The local EMS agency shall establish guidelines for proper dispatch triage which identifies appropriate medical response.

RECOMMENDED GUIDELINES:
The local EMS agency should establish an emergency medical dispatch priority reference system, including systemized caller interrogation, dispatch triage policies, and pre-arrival instructions.

CURRENT STATUS:
Emergency medical dispatch priority reference systems, including systemized caller interrogation, and pre-arrival instructions are being utilized. Currently, an ALS ambulance is dispatched to all 9-1-1 medical requests. First response agencies currently determine their own dispatch criteria.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Develop and implement standardized (first response/ambulance) dispatch triage criteria as described in the EMS system model.

OBJECTIVE:
Develop and implement standardized (first response/ambulance) dispatch triage criteria as described in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

3.10 INTEGRATED DISPATCH

MINIMUM STANDARDS:
The local EMS system shall have a functionally integrated dispatch with system-wide emergency services coordination, using standardized communications frequencies.

RECOMMENDED GUIDELINES:
The local EMS agency should develop a mechanism to ensure appropriate system-wide ambulance coverage during periods of peak demand.

CURRENT STATUS:
Integrated dispatch has not been developed in the MVEMSA system. Providers are required by agreement to ensure the availability of ambulances within their own zones at all times.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Develop an integrated dispatch system as described in the EMS system model.

OBJECTIVE:
Evaluate the feasibility of developing an integrated dispatch system as described in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.01 SERVICE AREA BOUNDARIES

MINIMUM STANDARDS:
The local EMS agency shall determine the boundaries of emergency medical transportation service areas.

RECOMMENDED GUIDELINES:
The local EMS agency should secure a county ordinance or similar mechanism for establishing emergency medical transport service areas (e.g., ambulance response zones).

CURRENT STATUS:
Emergency medical transportation service areas have been determined for all five counties in the EMS system.

An ordinance or similar mechanism has been established in Stanislaus, Mariposa, Calaveras, Tuolumne, Alpine and Amador Counties that provides for the establishment of ambulance response zones. However, the appropriateness of these zones has not been evaluated in several years.

COORDINATION WITH OTHER EMS AGENCIES:
An agreement has been reached with Merced County EMS creating ambulance response zones which encompass portions of both Merced and Stanislaus counties. An agreement has been reach with El Dorado County EMS and the State of Nevada to have providers from their jurisdictions respond to emergencies in parts of Alpine County.

NEED(S):
Ensure that ambulance response zones provide optimal ambulance response and care by periodically evaluating the emergency medical transportation service areas.

OBJECTIVE:
Establish/review/revise local ambulance ordinances in Stanislaus and Amador counties.

Develop agreements with cities and fire districts regarding ambulance response zones in their areas.
Monitor ambulance response zone boundaries and make changes as needed to optimize system response.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long -Range Plan (more than one year)

4.02 MONITORING

MINIMUM STANDARDS:
The local EMS agency shall monitor emergency medical transportation services to ensure compliance with appropriate statutes, regulations, policies, and procedures.

RECOMMENDED GUIDELINES:
The local EMS agency should secure a county ordinance or similar mechanism for licensure of emergency medical transport services. These should be intended to promote compliance with overall system management and should, wherever possible, replace any other local ambulance regulatory programs within the EMS area.

CURRENT STATUS:
The minimum standard is met through written agreements, auditing, inspections and investigation of unusual occurrences.

The recommended guideline is met within all counties except Alpine. Alpine County depends upon ambulance response from providers based in the surrounding counties of El Dorado, Amador, Calaveras and Douglas, NV. Ambulance response zones are based upon the closest available mutual aid response.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that providers comply with statutes, regulations, policies and procedures.

OBJECTIVE:
Conduct random compliance evaluations of ALS providers. Work closely with cities and fire agencies to ensure that their EMS concerns are addressed in both day to day operations and during ambualnce provider agreement negotiations. Monitor providers for compliance to standards. Modify county ambulance ordinances as needed.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.03 CLASSIFYING MEDICAL REQUESTS

MINIMUM STANDARDS:
The local EMS agency shall determine criteria for classifying medical requests (e.g., emergent, urgent, and non-emergent) and shall determine the appropriate level of medical response to each.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
An emergency medical dispatch priority reference system has been developed. Currently, some type of classification criteria is used by all dispatch centers with an ALS ambulance being sent to all 9-1-1 medical requests as a minimum response.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Implementation of an emergency medical dispatch system as described in the EMS system model.

OBJECTIVE:
Evaluate the feasibility of level III dispatch.

Develop and implement an emergency medical dispatch system as described in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.04 PRESCHEDULED RESPONSES

MINIMUM STANDARDS:
Service by emergency medical transport vehicles which can be prescheduled without negative medical impact shall be provided only at levels which permit compliance with local EMS agency policy.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Ambulance provider agreements specify parameters for utilization of emergency medical transport vehicles for prescheduled calls. These parameters require that the last ALS ambulance not be utilized for prescheduled calls.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the availability of a sufficient number of emergency medical transport vehicles to meet EMS system demands.

OBJECTIVE:
Monitor ambulance availability and take corrective action as necessary.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.05 RESPONSE TIME STANDARDS

MINIMUM STANDARDS:

Each local EMS agency shall develop response time standards for medical responses. These standards shall take into account the total time from receipt of call at the primary public safety answering point (PSAP) to arrival of the responding unit at the scene, including all dispatch time intervals and driving time.

RECOMMENDED GUIDELINES:

Emergency medical service areas (response zones) shall be designated so that, for ninety percent of emergency responses, response times shall not exceed:

	Metropolitan - Urban Area	Suburban - Rural Area	Wilderness Area
BLS First Responder	5 minutes	15 minutes	ASAP
Early Defib. First Responder	5 minutes	ASAP	ASAP
ALS Responder or Ambulance	8 minutes	20 minutes	ASAP
EMS Transportation Unit	8 minutes	20 minutes	ASAP

CURRENT STATUS:

Meets recommended standards in Amador, Calaveras, Mariposa, and Stanislaus counties.

COORDINATION WITH OTHER EMS AGENCIES:

Agreements have been made with Merced, El Dorado and Douglas counties for the utilization of ambulance service which cross county lines.

NEED(S):

Ensure the ability to measure response times from the primary PSAP to arrival on scene for ambulance and first response vehicles. Further development of response time standards for Alpine County. Development of a mechanism to measure or collect response times for first response agencies and the establishment of response time goals or standards for first response agencies.

OBJECTIVE:

Create a mechanism to measure response times from receipt of call at primary PSAP to arrival on scene. Establish response time standards for Alpine County.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.06 STAFFING

MINIMUM STANDARDS:
All emergency medical transport vehicles shall be staffed and equipped according to current state and local EMS agency regulations and appropriately equipped for the level of service provided.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Ground ambulance minimum staffing requirements are as follows:

1. BLS Ambulance - Two EMT-1s currently certified in the State of California.

2. ALS Ambulance - One EMT-P accredited by the Agency and one EMT-1 currently certified in the state of California.

3. CCT Ambulance - One EMT-1 currently certified in the state of California, and one attendant who must be either a physician or a Registered Nurse (R.N.) with a minimum of two (2) years of critical care experience, and current certificate of completion from an Advanced Cardiac Life Support course. One attendant must be authorized to provide nasotracheal and orotracheal intubation Providers are required to maintain a minimum drug and equipment inventory on all in-service ambulances as specified by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure compliance with standard.

OBJECTIVE:
Monitor providers for compliance to standards and take corrective action as necessary.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.07 FIRST RESPONDER AGENCIES

MINIMUM STANDARDS:
The local EMS agency shall integrate qualified EMS first responder agencies (including public safety agencies and industrial first aid teams) into the system.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
The roles and responsibilities of most system participants are based primarily on historical involvement and willingness to cooperate with the agency.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Formal integration of first responder agencies into the EMS system.

OBJECTIVE:
Identify the optimal roles and responsibilities of first response agencies as described in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.08 MEDICAL & RESCUE AIRCRAFT

MINIMUM STANDARDS:
The local EMS agency shall have a process for categorizing medical and rescue aircraft and shall develop policies and procedures regarding:

a) authorization of aircraft to be utilized in prehospital patient care,
b) requesting of EMS aircraft,
c) dispatching of EMS aircraft,
d) determination of EMS aircraft patient destination,
e) orientation of pilots and medical flight crews to the local EMS system, and
f) addressing and resolving formal complaints regarding EMS aircraft.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
A process has been established for categorizing medical and rescue aircraft as required in a-f above.

COORDINATION WITH OTHER EMS AGENCIES:
Services classified by other LEMSAs are used to supplement resources based in the MVEMSA system.

NEED(S):
Ensure that medical and rescue aircraft incorporated into the EMS system meet system needs and adhere to agency requirements.

OBJECTIVE:
Monitor providers for compliance to standards and take corrective action as necessary.

TIME FRAME FOR MEETING OBJECTIVE:

Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.09 AIR DISPATCH CENTER

MINIMUM STANDARDS:
The local EMS agency shall designate a dispatch center to coordinate the use of air ambulances or rescue aircraft.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
One dispatch center per county has been identified as an EMS aircraft resource center. The two air ambulance providers operating within the MVEMSA system each provide flight following dispatch services and currently provide for the coordination of EMS aircraft in the entire EMS system on a rotating basis. A toll-free number was established for county air resource centers to use when requesting EMS medical aircraft.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Evaluate and improve the current system for requesting and dispatching EMS aircraft. Determine the feasibility of creating a single air ambulance dispatch center, as described in the EMS system model.

OBJECTIVE:
Evaluate and improve the current system for requesting and dispatching EMS aircraft. Determine the feasibility of creating a single air ambulance dispatch center, as described in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.10 AIRCRAFT AVAILABILITY

MINIMUM STANDARDS:
The local EMS agency shall identify the availability and staffing of medical and rescue aircraft for emergency patient transportation and shall maintain written agreements with aeromedical services operating within the EMS area.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The MVEMSA has identified medical and rescue aircraft for emergency patient transportation for aeromedical services operating within the EMS area. Written agreements between MVEMSA and all such aeromedical services are in place with the exception of the Reno's Care Flight program.

COORDINATION WITH OTHER EMS AGENCIES:
Reno's Care Flight program is under the direct control of the EMS agency in Reno, NV.

NEED(S):
Ensure the availability and appropriate staffing of EMS medical and rescue aircraft to meet the demands of the EMS system. Complete written agreements with Reno's Care Flight.

OBJECTIVE:
Monitor providers to ensure that system demands are being met and take corrective action as necessary. Develop an exclusive operating area or other mechanism to ensure optimal system design and providers compliance with agreements and policy.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.11 SPECIALTY VEHICLES

MINIMUM STANDARDS:
Where applicable, the local EMS agency shall identify the availability and staffing of all-terrain vehicles, snow mobiles, and water rescue and transportation vehicles.

RECOMMENDED GUIDELINES:
The local EMS agency should plan for response by and use of all-terrain vehicles, snow mobiles, and water rescue vehicles areas where applicable. This plan should consider existing EMS resources, population density, environmental factors, dispatch procedures and catchment area.

CURRENT STATUS:
No resource directory of specialty vehicles has been developed by the EMS agency. However, individual counties with specialty vehicle needs have developed resource lists and procedures for requesting and dispatching these specialty vehicles.

COORDINATION WITH OTHER EMS AGENCIES:
Work with adjacent EMS agencies to ensure the availability of specialty vehicles.

NEED(S):
Development of a region-wide resource directory and response plan for specialty vehicles.

OBJECTIVE:
Develop a resource directory of specialty vehicles and research the feasibility and need for developing a response plan for specialty vehicles.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

4.12 DISASTER RESPONSE

MINIMUM STANDARDS:
The local EMS agency, in cooperation with the local office of emergency services (OES), shall plan for mobilizing response and transport vehicles for disaster.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The OES Region IV MCI Plan has been formally adopted, by the Board of Directors of the Mountain-Valley EMSA and the Boards of Supervisors of each of the member counties, as the plan to be used for medical disaster management. The Mountain-Valley EMSA has been designated as the Operational Area Disaster Medical/Health Coordinator for the counties of Alpine (west slope), Amador, Calaveras, and Stanislaus. Standard procedures for mobilizing response and transport vehicles were developed among the counties of OES Region IV.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Continue to work with other OES Region IV counties in developing standard procedures for mobilizing response and transport vehicles for disasters.

OBJECTIVE:
Continue to work with other OES Region IV counties in developing standard procedures for mobilizing response and transport vehicles for disasters.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.13 INTERCOUNTY RESPONSE

MINIMUM STANDARDS:
The local EMS agency shall develop agreements permitting intercounty response of emergency medical transport vehicles and EMS personnel.

RECOMMENDED GUIDELINES:
The local EMS agency should encourage and coordinate development of mutual aid agreements which identify financial responsibility for mutual aid responses.

CURRENT STATUS:
Ambulance provider agreements require providers to arrange for day-to-day mutual-aid from neighboring providers stationed both inside and outside the MVEMSA system.

COORDINATION WITH OTHER EMS AGENCIES:
Continuation of call agreements have been executed with adjacent LEMSAs.

NEED(S):
Statewide medical mutual-aid agreement.

OBJECTIVE:
Continue to monitor day-to-day mutual-aid and continuation of call incidents and take action as necessary. Develop mutual-aid agreements with El Dorado and Sacramento counties for Amador County.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.14 INCIDENT COMMAND SYSTEM

MINIMUM STANDARDS:
The local EMS agency shall develop multi-casualty response plans and procedures which include provision for on-scene medical management using the Incident Command System.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The OES Region IV MCI Plan has been formally adopted, by the Board of Directors of the MVEMSA and the Boards of Supervisors of each of the member counties, as the plan to be used for medical disaster management. The OES Region IV MCI Plan is based on the Incident Command System. Completion of ICS 100 and a 4-hour hospital or 8-hour field MCI course is the minimum standard for EMS personnel.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the MCI plan continues to meet the needs of on-scene medical management.

OBJECTIVE:
Monitor the utilization of the MCI plan and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.15 MCI PLANS

MINIMUM STANDARDS:
Multi-casualty response plans and procedures shall utilize state standards and guidelines.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The OES Region IV MCI Plan has been formally adopted, by the Board of Directors of the MVEMSA and the Boards of Supervisors of each of the member counties, as the plan to be used for medical disaster management. The OES Region IV MCI Plan is based on the Incident Command System. Completion of ICS 100 and a 4-hour hospital or 8-hour field MCI course is the minimum standard for EMS personnel.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the MCI plan continues to meet the needs of on-scene medical management.

OBJECTIVE:
Monitor the utilization of the MCI plan and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.16 ALS STAFFING

MINIMUM STANDARDS:
All ALS ambulances shall be staffed with at least one person certified at the advanced life support level and one person staffed at the EMT-I level.

RECOMMENDED GUIDELINES:
The local EMS agency should determine whether advanced life support units should be staffed with two ALS crew members or with one ALS and one BLS crew member.

On an emergency ALS unit which is not staffed with two ALS crew members, the second crew member should be trained to provide defibrillation, using available defibrillators.

CURRENT STATUS:
By policy, the minimum staffing level of all emergency medical transport vehicles (ambulances), is one licensed paramedic and one certified EMT-I. However, a BLS ambulance, staffed with a minimum of two EMT-Is may be used to respond to emergency requests during times of disaster and system overload when all available ALS resources have been depleted.

BLS ambulance personnel do not perform defibrillation nor has their training in this procedure been encouraged by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that ambulance staffing meets minimum standards and system needs.

OBJECTIVE:
Evaluate the feasibility and need of staffing ambulances with a combination of paramedics, registered nurses and physician assistants (PAs or LPNs) as outlined in the EMS System Model.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.17 ALS EQUIPMENT

MINIMUM STANDARDS:
All emergency ALS ambulances shall be appropriately equipped for the scope of practice of its level of staffing.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Providers are required to maintain a minimum drug and equipment inventory on all in-service ambulances as specified by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the availability of drugs and equipment on ambulances to meet patient and system needs.

OBJECTIVE:
Monitor drug and equipment requirements and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long-Range Plan (more than one year)

4.18 COMPLIANCE

MINIMUM STANDARDS:
The local EMS agency shall have a mechanism (e.g., an ordinance and/or written provider agreements) to ensure that EMS transportation agencies comply with applicable policies and procedures regarding system operations and clinical care.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Written agreements, county ordinances, inspections, unusual occurrence reporting, investigations and quality improvement programs have been established as mechanisms to review, monitor and enforce compliance with system policies for operations and clinical care.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure compliance with system policies.

OBJECTIVE:
Evaluate and improve compliance with system policies.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.19 TRANSPORTATION PLAN

MINIMUM STANDARDS:
Any local EMS agency which desires to implement exclusive operating areas, pursuant to Section 1797.224, H&S Code, shall develop an EMS transportation plan which addresses: a) minimum standards for transportation services; b) optimal transportation system efficiency and effectiveness; and c) use of a competitive bid process to ensure system optimization.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A Transportation Plan which meets standards is included in the plan appendix.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the Transportation Plan meets the needs of the EMS system.

OBJECTIVE:
Evaluate Agency position regarding the inclusion of all ambulance calls within EOAs and update Transportation Plan. Implement and monitor the requirements of the Transportation Plan and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.20 "GRANDFATHERING"

MINIMUM STANDARDS:
Any local EMS agency which desires to grant an exclusive operating permit without use of a competitive process shall document in its EMS transportation plan that its existing provider meets all of the requirements for non-competitive selection ("grandfathering") under Section 1797.224, H&SC.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The enclosed Transportation Plan documents those providers which meet the requirement for "grandfathering" under Section 1797.224, H&S into exclusive operating areas.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the Transportation Plan meets the needs of the EMS system.

OBJECTIVE:
Monitor the requirements of the Transportation Plan and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.21 COMPLIANCE

MINIMUM STANDARDS:
The local EMS agency shall have a mechanism to ensure that EMS transportation and/or advanced life support agencies to whom exclusive operating permits have been granted, pursuant to Section 1797.224, H&SC, comply with applicable policies and procedures regarding system operations and patient care.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Written agreements, county ordinances, inspections, unusual occurrence reporting, investigations and quality improvement programs have been established as mechanisms to review, monitor and enforce compliance with system policies for operations and clinical care.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure compliance with system policies.

OBJECTIVE:
Evaluate and improve compliance with system policies.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.22 EVALUATION

MINIMUM STANDARDS:
The local EMS agency shall periodically evaluate the design of exclusive operating areas.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A formal process evaluating the design of exclusive operating areas has not been established. However, the performance standards required of providers operating within EOAs is routinely monitored and corrective action is taken to address deficiencies.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that EOA design meets the needs of the EMS system and is consistent with the EMS system model.

OBJECTIVE:
Develop a formal mechanism, consistent with the EMS system model, for evaluating EOA design. Continue to monitor performance standards and take corrective action as needed.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

5.01 ASSESSMENT of CAPABILITIES

MINIMUM STANDARDS:
The local EMS agency shall assess and periodically reassess the EMS related capabilities of acute care facilities in its service area.

RECOMMENDED GUIDELINES:
The local EMS agency should have written agreements with acute care facilities in its service area.

CURRENT STATUS:
Facility Assessment Profiles were last completed in 1989. The Emergency Facilities Self-Assessment Instrument, which is used to develop Facility Assessment Profiles, was revised in 1995. At the request of the hospitals, the agency's plans for using the assessment instrument were put on hold in July 1995.
The agency has written base hospital agreements with all seven hospitals in the MVEMSA system.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
To conduct an assessment of area hospitals to determine EMS capabilities to assist the agency in developing triage and destination policies.

OBJECTIVE:
In conjunction with area hospitals and the medical community, determine hospital capabilities through completion of a facility assessment instrument.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long -Range Plan (more than one year)

5.02 TRIAGE & TRANSFER PROTOCOLS

MINIMUM STANDARDS:
The local EMS agency shall establish prehospital triage protocols and shall assist hospitals with the establishment of transfer protocols and agreements.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
Prehospital triage protocols have not been implemented. Transfer protocols and model transfer agreements have been developed and implemented.

COORDINATION WITH OTHER EMS AGENCIES:
Work with adjacent EMS systems to establish standard triage and transfer protocols as practical.

NEED(S):
Prehospital triage protocols must be developed in order to ensure that patients receive an appropriate level of care, i.e.: transport to the closest hospital capable of meeting the patient's treatment needs; transport to the patient's preferred health care provider; treat and release at scene, etc. The development of patient destination policies has been identified by the Regional Advisory Committee and other groups as a top priority.

OBJECTIVE:
Develop prehospital triage and transfer protocols based on medical need and preferred transport which ensure the delivery of patients to appropriate facilities. Explore the concept of treat and release at scene and alternative treatment and transport modalities as identified in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

5.03 TRANSFER GUIDELINES

MINIMUM STANDARDS:
The local EMS agency, with participation of acute care hospital administrators, physicians, and nurses, shall establish guidelines to identify patients who should be considered for transfer to facilities of higher capability and shall work with acute care hospitals to establish transfer agreements with such facilities.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Pediatric Trauma and Critical Care Transfer Guidelines have been developed and forwarded to each acute care hospital for adoption. Transfer guidelines have not been developed for trauma or any other patient group identified by the State of California as requiring special consideration.

COORDINATION WITH OTHER EMS AGENCIES:
The pediatric guidelines are consistent with guidelines adopted by other LEMSA that have implemented EMS-C subsystems. Any future transfer policies or agreements will be coordinated with affected LEMSAs.

NEED(S):
Develop transfer guidelines for trauma and other specialty patient groups as tools to be used by emergency department physicians in determining an appropriate disposition for EMS patients.

OBJECTIVE:
Develop transfer policies, protocols and guidelines for trauma and other specialty patient groups.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long-Range Plan (more than one year)

5.04 SPECIALTY CARE FACILITIES

MINIMUM STANDARDS:
The local EMS agency shall designate and monitor receiving hospitals and, when appropriate, specialty care facilities for specified groups of emergency patients.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A receiving hospital policy was adopted in 1992, but has not been implemented. Agreements have been developed with those facilities providing Pediatric Critical Care Center and Pediatric Trauma Center services to the EMS system.

COORDINATION WITH OTHER EMS AGENCIES:
The recognition agreements with centers located outside of our region were performed with the approval of the local EMS agencies who had originally designated the centers.

NEED(S):
Ensure a process exists to designate and monitor receiving hospitals and specialty care facilities for specified groups of emergency patients.

OBJECTIVE:
Update transfer policies, protocols and guidelines

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

5.05 MASS CASUALTY MANAGEMENT

MINIMUM STANDARDS:
The local EMS agency shall encourage hospitals to prepare for mass casualty management.

RECOMMENDED GUIDELINES:
The local EMS agency should assist hospitals with preparation for mass casualty management, including procedures for coordinating hospital communications and patient flow.

CURRENT STATUS:
A Disaster Control Facility has been designated in each county. All hospitals within the EMS system participate in mass casualty incidents in accordance with the OES Region IV MCI Plan. The MVEMSA provides hospitals with disaster training which includes coordinating hospital communications and patient flow.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure adherence to MCI plan requirements.

OBJECTIVE:
Monitor capability of system hospitals to respond to mass casualty incidents and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

5.06 HOSPITAL EVACUATION

MINIMUM STANDARDS:
The local EMS agency shall have a plan for hospital evacuation, including its impact on other EMS system providers.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A model plan for hospital evacuation is currently being developed by the counties of OES Region IV.

COORDINATION WITH OTHER EMS AGENCIES:
The member counties of OES Region IV have and continue to work together for the development and adoption of standardized multi-casualty incident plans and other medical disaster plans.

NEED(S):
Develop, adopt and implement a standardized hospital evacuation plan and community impact evaluation.

OBJECTIVE:
Development and implement an impact evaluation tool for hospital closures.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long-Range Plan (more than one year)

5.07 BASE HOSPITAL DESIGNATION

MINIMUM STANDARDS:
The local EMS agency shall, using a process which allows all eligible facilities to apply, designate base hospitals or alternative base stations as it determines necessary to provide medical direction of prehospital personnel.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
Currently, all seven hospitals in the EMS system have been designated as base hospitals. However, with the inclusion of provider QA/QI and an increase in standing orders, there may not be a need for the number of base hospitals in their current roles.

COORDINATION WITH OTHER EMS AGENCIES:
Arrangements have been made with Merced County EMSA to allow Mariposa ambulance providers to access Merced County base hospitals for medical control and disaster control functions. Arrangements have been made to allow San Joaquin County EMS personnel to contact EMSA base hospitals for medical direction.

NEED(S):
The establishment of a single medical control point has been identified by system participants as a major part of the EMS system model adopted by the agency. A process needs to be developed for selecting a single medical control point and identifying its optimal configuration and responsibilities.

OBJECTIVE:
Conduct a feasibility study for establishment of a single medical control point.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

5.08 TRAUMA SYSTEM DESIGN

MINIMUM STANDARDS:
Local EMS agencies that develop trauma care systems shall determine the optimal system (based on community need and available resources) including, but not limited to:

a) the number and level of trauma centers (including the use of trauma centers in other counties),
b) the design of catchment areas (including areas in other counties, as appropriate), with consideration of workload and patient mix,
c) identification of patients who should be triaged or transferred to a designated center, including consideration of patients who should be triaged to other specialty care centers,
d) the role of non-trauma center hospitals, including those that are outside of the primary triage area of the trauma center, and
e) a plan for monitoring and evaluation of the system.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
Although major planning efforts were conducted in 1981-83, 1988-90 and 1992-93, a trauma system has not been established in the MVEMSA system. Trauma and specialty care planning were identified by the Regional Advisory Committee and other groups as a top priority for the agency and is included in the EMS system model adopted by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the availability of specialized trauma services to critically injured patients.

OBJECTIVE:
Develop a trauma system which includes facility designation promoting the availability of specialized trauma services to critically injured patients.

TIME FRAME FOR MEETING OBJECTIVE:

Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

5.09 PUBLIC INPUT

MINIMUM STANDARDS:
In planning its trauma care system, the local EMS agency shall ensure input from both prehospital and hospital providers and consumers.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
Although major planning efforts were conducted in 1981-83, 1988-90 and 1992-93, a trauma system has not been established for the MVEMSA system. Trauma and specialty care planning was identified by the Regional Advisory Committee and other groups as a top priority for the agency and is included in the EMS system model adopted by the agency.

All previous trauma planning efforts have included numerous opportunities for public input and special interest lobbying.

COORDINATION WITH OTHER EMS AGENCIES:
None.

NEED(S):
Ensure an open process for trauma system development.

OBJECTIVE:
Keep the process used for developing a trauma system open to hospital, prehospital and public input.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

5.10 PEDIATRIC SYSTEM DESIGN

MINIMUM STANDARDS:
Local EMS agencies that develop pediatric emergency medical and critical care systems shall determine the optimal system, including:

a) the number and role of system participants, particularly of emergency departments,
b) the design of catchment areas (including areas in other counties, as appropriate), with consideration of workload and patient mix,
c) identification of patients who should be primarily triaged or secondarily transferred to a designated center, including consideration of patients who should be triaged to other specialty care centers,
d) identification of providers who are qualified to transport such patients to a designated facility,
e) identification of tertiary care centers for pediatric critical care and pediatric trauma,
f) the role of non-pediatric specialty care hospitals including those which are outside of the primary triage area, and
g) a plan for monitoring and evaluation of the system.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
A Pediatric Emergency Medical and Critical Care System was developed and implemented in 1993-1995 as part of two special project grants awarded to the EMSA by the California EMS Authority. The pediatric system addresses the major Emergency Medical Services for Children (EMSC) components identified by the California EMS Authority as required of an EMSC system.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the Pediatric Emergency Medical and Critical Care System and the pediatric services provided by the EMS system meets the needs of critically ill and injured children within the EMS system. Develop a Pediatric System Plan which describes the current EMSC system and identifies the optimal system design.

OBJECTIVE:
Evaluate the effectiveness of the EMS system at meeting the needs of critically ill and injured children
Develop a pediatric system plan.

TIME FRAME FOR MEETING OBJECTIVE:

Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

Data Collection and System Evaluation

5.11 EMERGENCY DEPARTMENTS

MINIMUM STANDARDS:
Local EMS agencies shall identify minimum standards for pediatric capability of emergency departments including:

a) staffing,
b) training,
c) equipment,
d) identification of patients for whom consultation with a pediatric critical care center is appropriate,
e) quality assurance/quality improvement, and
f) data reporting to the local EMS agency.

RECOMMENDED GUIDELINES:
Local EMS agencies should develop methods of identifying emergency departments which meet standards for pediatric care and for pediatric critical care centers and pediatric trauma centers.

CURRENT STATUS:
Emergency Department Pediatric Guidelines were adopted in 1994 and implemented through voluntary consultation visits with 10 of 11 acute care hospital in the region. Agreements were executed in 1995 with five pediatric critical care centers and pediatric trauma centers located outside the MVEMSA system recognizing their LEMSA designations as PCCCs and PTCs and incorporating them into the MVEMSA system.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Evaluate the usefulness of the pediatric guidelines and each emergency department's voluntary adherence to the guidelines. Determine the need for identifying emergency departments approved for pediatrics (EDAPs).

OBJECTIVE:
Monitor the usefulness of the pediatric guidelines and each emergency departments voluntary adherence to the guidelines and make changes as necessary. Identify EDAPs, as needed, to ensure adherence to pediatric E.D. guidelines.

TIME FRAME FOR MEETING OBJECTIVE:

Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

5.12 PUBLIC INPUT

MINIMUM STANDARDS:
In planning its pediatric emergency medical and critical care system, the local EMS agency shall ensure input from both prehospital and hospital providers and consumers.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A regional Quality Liaison Committee evaluates both the pediatric and adult emergency medical and critical care delivery throughout the system.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Continue public input and evaluation of the pediatric emergency medical and critical care system.

OBJECTIVE:
Ensure continued public input and evaluation of the pediatric emergency medical and critical care system.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

5.13 SPECIALTY SYSTEM DESIGN

MINIMUM STANDARDS:
Local EMS agencies developing specialty care plans for EMS-targeted clinical conditions shall determine the optimal system for the specific condition involved, including:

a) the number and role of system participants,
b) the design of catchment areas (including inter-county transport, as appropriate) with consideration of workload and patient mix,
c) identification of patients who should be triaged or transferred to a designated center,
d) the role of non-designated hospitals including those which are outside of the primary triage area, and
e) a plan for monitoring and evaluation of the system.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
Trauma and specialty care planning was identified by the Regional Advisory Committee and other groups as a top priority and is included in the EMS system model adopted by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
None

NEED(S):
Ensure the availability of trauma and other specialty care services to critically ill and injured patients.

OBJECTIVE:
Develop and implement trauma and other specialty care systems in accordance with the EMS system model and State guidelines, as appropriate.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

5.14 PUBLIC INPUT

MINIMUM STANDARDS:
In planning other specialty care systems, the local EMS agency shall ensure input from both prehospital and hospital providers and consumers.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
Trauma and specialty care planning was identified by the Regional Advisory Committee and other groups as a top priority and is included in the EMS system model adopted by the agency. All previous specialty care planning efforts have included numerous opportunities for public input and special interest lobbying.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure an open process for specialty care system development.

OBJECTIVE:
Keep the process used for developing a specialty care system open to public input.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

6.01 QA/QI PROGRAM

MINIMUM STANDARDS:
The local EMS agency shall establish an EMS quality assurance/quality improvement (QA/QI) program to evaluate the response to emergency medical incidents and the care provided to specific patients. The programs shall address the total EMS system, including all prehospital provider agencies, base hospitals, and receiving hospitals. It shall address compliance with policies, procedures, and protocols, and identification of preventable morbidity and mortality, and shall utilize state standards and guidelines. The program shall use provider based QA/QI programs and shall coordinate them with other providers.

RECOMMENDED GUIDELINES:
The local EMS agency should have the resources to evaluate response to, and the care provided to, specific patients.

CURRENT STATUS:
In 1994, the agency adopted an EMS System Quality Assurance/Quality Improvement (QA/QI) Plan which formed a multi-disciplinary Quality Liaison Committee (QLC) comprised of base hospital medical directors, base hospital nurse liaisons, ambulance provider quality coordinators, first response quality coordinators and dispatch quality coordinators. The purpose of the QLC is to assist the agency Medical Director in providing oversight and evaluation of the EMS system. Local Q.I. groups, consisting of members of an operational area, have also been formed to evaluate response, care and transport. Aspects of the clinical review have been re-established. Region-wide monitoring has been re-established via new clinical indicators. Continuing to work with statewide organizations and EMSA to develop and implement statewide EMS system evaluation program and standards.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Development of a process to provide feedback to prehospital personnel on patient outcomes, as described in the EMS system model. Ensure that the QA/QI process meets system needs and State standards.

OBJECTIVE:
Develop a process to: provide feedback to prehospital personnel on patient outcomes. Continue to monitor and amend the QA/QI program to meet system needs and statewide standards.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long -Range Plan (more than one year)

6.02 PREHOSPITAL RECORDS

MINIMUM STANDARDS:
Prehospital records for all patient responses shall be completed and forwarded to appropriate agencies as defined by the local EMS agency.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Policy requires patient care records (PCRs) to be completed for all patients, with copies of the report being submitted to the receiving hospital, provider and agency. All ground ambulance providers use a standardized PCR for documenting patient care. Air ambulance providers are providing monthly electronic patient care information to the EMS agency. Local QI groups have implemented a Rapid Cycle Improvement project to improve the timely PCR submission to the receiving facilities.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure completeness and timely submission of patient care records.

OBJECTIVE:
Continue to evaluate completeness and timely submission of patient care records with Rapid Cycle Improvement. Monitor providers to ensure adherence to policy and take corrective action as necessary.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long -Range Plan (more than one year)

6.03 PREHOSPITAL CARE AUDITS

MINIMUM STANDARDS:
Audits of prehospital care, including both system response and clinical aspects, shall be conducted.

RECOMMENDED GUIDELINES:
The local EMS agency should have a mechanism to link prehospital records with dispatch, emergency department, in-patient and discharge records.

CURRENT STATUS:
The agency and individual local Q.I. groups have been formed to conduct prehospital care audits regarding system operations. A regional Quality Liaison Committee providers and base hospital liaisons evaluates clinical care on an ongoing basis.

The agency has a database capable of linking prehospital, dispatch, emergency department, and discharge records. The agency receives the following data:

Data Category	Sources Currently Providing Data
Prehospital	All ground and air ambulance service providers in jurisdiction. Compliance with standards varies.
Dispatch	Two dispatch centers that handle the EMS requests in Stanislaus County.
Emergency Department	Information on all ALS scene patients and some BLS scene patients from the hospitals designated as base hospitals.
In-Patient	Two largest Stanislaus County Hospital providing electronic outcome information.

COORDINATION WITH OTHER EMS AGENCIES:
None.

NEEDS:
Work with provider agencies to improve emergency department and hospital outcome data submission. Measure response times from receipt of call at the primary PSAPs.

OBJECTIVE:
Work with provider agencies to improve emergency department and hospital outcome data submission.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

6.04 MEDICAL DISPATCH

MINIMUM STANDARDS:
The local EMS agency shall have a mechanism to review medical dispatching to ensure that the appropriate level of medical response is sent to each emergency and to monitor the appropriateness of prearrival/post dispatch directions.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Approved level II EMD centers are required by policy to establish an in-house QA program which includes the auditing of pre-arrival instructions.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that an appropriate level of medical response is sent to each emergency. Ensure the appropriateness of prearrival/post dispatch directions. Integrate dispatch centers into the regional QA/QI program.

OBJECTIVE:
Develop a mechanism to review medical dispatching to ensure that the appropriate level of medical response is sent to each emergency and to monitor the appropriateness of prearrival/post dispatch directions. Integrate dispatch centers into the regional QA/QI program. Evaluate effectiveness of in-house QA/QI programs.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long-Range Plan (more than one year)

6.05 DATA MANAGEMENT SYSTEM

MINIMUM STANDARDS:
The local EMS agency shall establish a data management system which supports its system-wide planning and evaluation (including identification of high risk patient groups) and the QA/QI audit of the care provided to specific patients. It shall be based on state standards.

RECOMMENDED GUIDELINES:
The local EMS agency should establish an integrated data management system which includes system response and clinical (both prehospital and hospital) data.

The local EMS agency should use patient registries, tracer studies, and other monitoring systems to evaluate patient care at all stages of the system.

CURRENT STATUS:
The MVEMSA created and implemented an integrated data management system which meets and exceeds state standards, and includes system response and clinical (both prehospital and hospital) data. QA/QI benchmarks and the utilization of data for system evaluation has been developed.

COORDINATION WITH OTHER EMS AGENCIES:
This data management system has been made available to all other local EMS agencies and is in use in Imperial, Santa Clara, San Joaquin, Sacramento, and Tuolumne EMS systems and is being considered for use in several others. Agency staff continues to work with EMSAAC, EMDAC and State EMSA on developing benchmarks and quality indicators.

NEEDS:
Improve access to existing hospital data regarding the outcomes of prehospital patients. Work with EMSA to work toward statewide data management system.

OBJECTIVE:
Improve access to existing hospital data regarding the outcomes of prehospital patients. Work with EMSA to work toward statewide data management system.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long -Range Plan (more than one year)

6.06 SYSTEM DESIGN EVALUATION

MINIMUM STANDARDS:
The local EMS agency shall establish an evaluation program to evaluate EMS system design and operations, including system effectiveness at meeting community needs, appropriateness of guidelines and standards, prevention strategies that are tailored to community needs, and assessment of resources needed to adequately support the system. This shall include structure, process, and outcome evaluations, utilizing state standards and guidelines.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
In 1994, the agency adopted an EMS System Quality Assurance/Quality Improvement (QA/QI) Plan which formed a multi-disciplinary Quality Liaison Committee (QLC) comprised of base hospital medical directors, base hospital nurse liaisons, ambulance provider quality coordinators, first response quality coordinators and dispatch quality coordinators. The purpose of the QLC is to assist the agency Medical Director in providing oversight and evaluation of the EMS system. Local Q.I. groups, consisting of members of an operational area, have also been formed to evaluate response, care and transport. Aspects of the clinical review have been re-established. Region-wide monitoring has been re-established via new clinical indicators. Continuing to work with statewide organizations and EMSA to develop and implement statewide EMS system evaluation program and standards.

Additionally, each member county has a functioning Emergency Medical Care Committee which reviews local operations, policies and practices. A Regional Advisory Committee (RAC) comprised of three persons from each member county meets bi-monthly and reviews all MV EMSA plans, policies and procedures before they are submitted to the Board of Directors (BOD) for consideration. All meetings of the BOD, RAC and county EMCCs are open to the public with time allocated on each agenda for open public comments. Additionally, impacted groups are routinely notified in advance of issues before RAC and the BOD.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Creation of indicators which can be used for evaluating the efficiencies and customer satisfaction of the EMS system, considering community needs, system demands and current constraints.

OBJECTIVE:
Participate in statewide standardized system evaluation project. Evaluate EMS response alternatives as outlined in the EMS 2000 document.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long -Range Plan (more than one year)

6.07 PROVIDER PARTICIPATION

MINIMUM STANDARDS:
The local EMS agency shall have the resources and authority to require provider participation in the system-wide evaluation program.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
ALS providers are required by policy and agreement to participate in the agency system-wide evaluation program. BLS providers are not required to (but may voluntarily) participate in the agency system-wide evaluation program.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure participation of all providers within the agency QA/QI program.

OBJECTIVE:
Address the role/composition of the local EMCC in Stanislaus County. Encourage first responder, dispatch and other system provider participation by restructuring the QA/QI programs.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long -Range Plan (more than one year)

6.08 REPORTING

MINIMUM STANDARDS:
The local EMS agency shall, at least annually, report on the results of its evaluation of EMS system design and operations to the Board(s) of Supervisors, provider agencies, and Emergency Medical Care Committee(s).

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The agency currently produces ad hoc reports for the entities listed above.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEEDS:
Produce periodic aggregate data reports that can be provided to the above entities.

OBJECTIVE:
At least annually report the results of the system evaluation, design and operations to the Board(s) of Supervisors, provider agencies, and Emergency Medical Care Committee(s).

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long -Range Plan (more than one year)

6.09 ALS AUDIT

MINIMUM STANDARDS:
The process used to audit treatment provided by advanced life support providers shall evaluate both base hospital (or alternative base station) and prehospital activities.

RECOMMENDED GUIDELINES:
The local EMS agency's integrated data management system should include prehospital, base hospital, and receiving hospital data.

CURRENT STATUS:
In 1994, the agency adopted an EMS System Quality Assurance/Quality Improvement (QA/QI) Plan which formed a multi-disciplinary Quality Liaison Committee (QLC) comprised of base hospital medical directors, base hospital nurse liaisons, ambulance provider quality coordinators, first response quality coordinators and dispatch quality coordinators. The purpose of the QLC is to assist the agency Medical Director in providing oversight and evaluation of the EMS system. Local Q.I. groups, consisting of members of an operational area, have also been formed to evaluate response, care and transport. Aspects of the clinical review have been re-established. Region-wide monitoring has been re-established via new clinical indicators. Continuing to work with statewide organizations and EMSA to develop and implement statewide EMS system evaluation program and standards.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Development of a process to provide feedback to prehospital personnel on patient outcomes, as described in the EMS system model. Ensure that the QA/QI process meets system needs and State standards.

OBJECTIVE:
Develop a process to: provide feedback to prehospital personnel on patient outcomes. Continue to monitor and amend the QA/QI program to meet system needs and statewide standards.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long -Range Plan (more than one year)

6.10 TRAUMA SYSTEM EVALUATION

MINIMUM STANDARDS:
The local EMS agency, with participation of acute care providers, shall develop a trauma system evaluation and data collection program, including: a trauma registry, a mechanism to identify patients whose care fell outside of established criteria, and a process for identifying potential improvements to the system design and operation.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The agency developed a draft trauma system evaluation and data collection program which was reviewed by the acute care providers in the EMS region. The program has not been implemented since the agency lacks a formal trauma system plan with designated trauma facilities.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
The formal adoption of a trauma system plan with designated trauma facilities and the implementation of a trauma system evaluation and data collection program.

OBJECTIVE:
Create a formal trauma system, then implement the evaluation process developed by the MVEMSA, which includes the use of trauma registries, tracer studies and a Trauma Audit Committee.

TIME FRAME FOR MEETING THE OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

6.11 TRAUMA CENTER DATA

MINIMUM STANDARDS:
The local EMS Agency shall ensure that designated trauma centers provide required data to the EMS agency, including patient specific information which is required for quality assurance/quality improvement and system evaluation.

RECOMMENDED GUIDELINES:
The local EMS agency should seek data on trauma patients who are treated at non-trauma center hospitals and shall include this information in their QA/QI and system evaluation program.

CURRENT STATUS:
No mechanism exists for the collection of trauma center and trauma patient information due to the lack of a formal trauma system in the EMS region.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
The formal adoption of a trauma system plan with designated trauma facilities and the implementation of a trauma system evaluation and data collection program.

OBJECTIVE:
Create a formal trauma system, then develop standards for trauma center data collection which are capable of meeting the needs required for system evaluation and QA.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

7.01 PUBLIC INFORMATION MATERIALS

MINIMUM STANDARDS:
The local EMS agency shall promote the development and dissemination of information materials for the public which addresses:

a) understanding of EMS system design and operation,
b) proper access to the system,
c) self-help (e.g., CPR, first aid, etc.),
d) patient and consumer rights as they relate to the EMS system,
e) health and safety habits as they relate to the prevention and reduction of health risks in target areas, and
f) appropriate utilization of emergency departments.

RECOMMENDED GUIDELINES:
The local EMS agency should promote targeted community education programs on the use of emergency medical services in its service area.

CURRENT STATUS:
MVEMSA has developed and disseminated information on basic first aid, CPR, system design and access, disaster planning, and bicycle and skate board safety. The agency has created the following children's education programs: Student Activities for Emergencies (S.A.F.E.) and the EMS Youth Program, which are designed to teach emergency awareness, system access and basic first aid skills.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Creation of education materials and programs regarding system access and utilization as described in the EMS system model.

OBJECTIVE:
In coordination with primary care providers and other public safety agencies, develop and present education materials and programs regarding system access and utilization as described in the EMS system model. In partnership with other agencies, address the educational needs of culturally diverse communities.

Review and make modifications, as needed, to the EMS Youth Program.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

7.02 INJURY CONTROL

MINIMUM STANDARDS:
The local EMS agency, in conjunction with other local health education programs, shall work to promote injury control and preventive medicine.

RECOMMENDED GUIDELINES:
The local EMS agency should promote the development of special EMS educational programs for targeted groups at high risk of injury or illness.

CURRENT STATUS:
The agency has not designed programs specifically for injury prevention or injury control. However, the agency routinely participates in public safety (health) fairs at various locations throughout the EMS region promoting system understanding. No work has been conducted to promote the development of EMS education programs for high risk groups.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Development and promotion of injury control education programs and programs targeted at high risk groups.

OBJECTIVE:
Coordinate the development and promotion of injury control education programs and programs targeted toward the general public and high risk groups with providers, hospitals and other organizations.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

7.03 DISASTER PREPAREDNESS

MINIMUM STANDARDS:
The local EMS agency, in conjunction with the local office of emergency services, shall promote citizen disaster preparedness activities.

RECOMMENDED GUIDELINES:
The local EMS agency, in conjunction with the local office of emergency services (OES), should produce and disseminate information on disaster medical preparedness.

CURRENT STATUS:
The MVEMSA developed Project S.A.F.E. (Student Activities for Emergencies) designed to teach middle school children emergency awareness, system access, basic first aid skills and disaster preparedness. No other work has been performed towards this objective.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Promote citizen disaster preparedness activities.

OBJECTIVE:
In conjunction with county OES coordinators, Red Cross and other public safety agencies, develop and promote citizen disaster preparedness activities.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

7.04 FIRST AID & CPR TRAINING

MINIMUM STANDARDS:
The local EMS agency shall promote the availability of first aid and CPR training for the general public.

RECOMMENDED GUIDELINES:
The local EMS agency should adopt a goal for training of an appropriate percentage of the general public in first aid and CPR. A higher percentage should be achieved in high risk groups.

CURRENT STATUS:
The agency provides CPR manikins and other first aid training equipment to community CPR and first aid instructors. A list of available CPR and first aid classes is usually maintained and citizen inquires are directed to sponsoring agencies or instructors.

No citizen training goals have been established.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Establishment of citizen CPR and first aid training goals.

OBJECTIVE:
Determine the need for establishing citizen CPR and first aid training goals.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.01 DISASTER MEDICAL PLANNING

MINIMUM STANDARDS:
In coordination with the local office of emergency services (OES), the local EMS agency shall participate in the development of medical response plans for catastrophic disasters, including those involving toxic substances.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
The OES Region IV MCI Plan has been formally adopted, by the Board of Directors of the EMSA and the Boards of Supervisors of each of the member counties, as the plan to be used for medical disaster management. A response plan specific to toxic substance management has not been developed.

COORDINATION WITH OTHER EMS AGENCIES:
The OES Region IV MCI Plan was developed as a joint project with representation from all 11 counties in OES Region IV.

NEED(S):
Ensure that the OES Region IV MCI Plan continues to meet the disaster medical response needs of the EMS system.

OBJECTIVE:
Monitor the efficiency and utilization of the MCI plan and make changes as needed. Determine the need for developing a medical response plan for hazardous material incidents.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long-Range Plan (more than one year)

8.02 RESPONSE PLANS

MINIMUM STANDARDS:
Medical response plans and procedures for catastrophic disasters shall be applicable to incidents caused by a variety of hazards, including toxic substances.

RECOMMENDED GUIDELINES:
The California Office of Emergency Services' multi-hazard functional plan should serve as the model for the development of medical response plans for catastrophic disasters.

CURRENT STATUS:
The OES Region IV MCI Plan has been formally adopted, by the Board of Directors of the EMSA and the Boards of Supervisors of each of the member counties, as the plan to be used for medical disaster management. A response plan specific to toxic emergencies has not been developed.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the OES Region IV MCI Plan continues to meet the disaster medical response needs of the EMS system.

OBJECTIVE:
Assist with the update of regional MCI Field Instructors through an annual conference/meeting. Monitor the efficiency and utilization of the MCI plan and make changes as needed. Determine the need for developing a medical response plan specific to hazardous material incidents.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

8.03 HAZMAT TRAINING

MINIMUM STANDARDS:
All EMS providers shall be properly trained and equipped for response to hazardous materials incidents, as determined by their system role and responsibilities.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The agency has not formally established a role for EMS personnel regarding hazardous material incidents. The minimum hazardous material training standards for EMS personnel are those standards established by OSHA/Cal-OSHA.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Establish the roles and responsibilities for EMS personnel regarding hazardous materials incidents.

OBJECTIVE:
Determine the roles and responsibilities for EMS personnel regarding hazardous materials incidents.
Determine hazardous material training needs of EMS personnel.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.04 INCIDENT COMMAND SYSTEM

MINIMUM STANDARDS:
Medical response plans and procedures for catastrophic disasters shall use the Incident Command System (ICS) as the basis for field management.

RECOMMENDED GUIDELINES:
The local EMS agency should ensure that ICS training is provided for all medical providers.

CURRENT STATUS:
The OES Region IV MCI Plan adopted by the MVEMSA is based on the Incident Command System. Completion of ICS 120 and a 4-hour hospital or 8-hour field MCI course is the minimum standard for EMS personnel. However, the agency only ensures the training of paramedic and MICN personnel. A process for training all EMS personnel in the requirements of the State's Standardized Emergency Management System (SEMS) is currently being drafted.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that all EMS personnel are trained in ICS, MCI and SEMS.

OBJECTIVE:
Modify existing processes and agreements to ensure that all EMS personnel, including EMTs, first responders and dispatchers are trained in ICS, MCI and SEMS. Monitor compliance to training standards and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.05 DISTRIBUTION OF CASUALTIES

MINIMUM STANDARDS:
The local EMS agency, using state guidelines, shall establish written procedures for distributing disaster casualties to the medically most appropriate facilities in its service area.

RECOMMENDED GUIDELINES:
The local EMS agency, using state guidelines, and in consultation with Regional Poison Centers, should identify hospitals with special facilities and capabilities for receipt and treatment of patients with radiation and chemical contamination and injuries.

CURRENT STATUS:
Distribution of patients is addressed in Module II of the OES Region IV MCI Plan used in each of our counties. County Disaster Control Facilities (DCFs) determine hospital capabilities and distribute patients accordingly. The Regional DCF is activated when two or more counties cannot accommodate the number of patients to be distributed.

COORDINATION WITH OTHER EMS AGENCIES:
The OES Region IV MCI Plan was developed as a joint project with representation from all 11 counties in OES Region IV.

NEED(S):
Ensure that the procedures for distributing disaster casualties functions effectively. Update the Facilities Assessment Profiles and OES Region IV map, which identifies facilities and facility specialties.

OBJECTIVE:
Monitor the distribution of disaster casualties, and make changes as needed, to ensure that patients are distributed to appropriate facilities. Update the Facilities Assessment Profiles and OES Region IV map, which identifies facilities and facility specialties.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.06 NEEDS ASSESSMENT

MINIMUM STANDARDS:
The local EMS agency, using state guidelines, shall establish written procedures for early assessment of needs and shall establish a means for communicating emergency requests to the state and other jurisdictions.

RECOMMENDED GUIDELINES:
The local EMS agency's procedures for determining necessary outside assistance should be exercised yearly.

CURRENT STATUS:
General procedures to be used by Medical Operational Area Coordinators were adopted by the counties in OES Region IV. These procedures included a process for assessing and communicating needs to OES Region IV and State OES. Local disaster exercises are conducted yearly.

SOPs for the activation of the Medical OAC and the Emergency Operations Center (EOC) are in place.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the procedures for assessing medical needs in a disaster function effectively.

OBJECTIVE:
Monitor compliance to training standards and make changes as needed. Monitor the ability to effectively assess medical needs in a disaster and make changes to the process as needed.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.07 DISASTER COMMUNICATIONS

MINIMUM STANDARDS:
A specific frequency (e.g., CALCORD) or frequencies shall be identified for interagency communication and coordination during a disaster.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The current system of dispatch, field, and hospital medical communication was developed more than ten years ago and is in need of evaluation, upgrade and repair.

Most transporting and non-transporting emergency medical response vehicles in the EMS system have CALCORD capabilities. However, no frequency has been officially designated for disaster medical communications.

COORDINATION WITH OTHER EMS AGENCIES:
Communications frequencies and the locations of radio repeaters was performed in conjunction with adjacent EMS systems.

NEED(S):
Ensure the availability of common medical communications during disasters.

OBJECTIVE:
Continue to work with region and state agencies to standardize the medical communications plan.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

8.08 INVENTORY OF RESOURCES

MINIMUM STANDARDS:
The local EMS agency, in cooperation with the local OES, shall develop an inventory of appropriate disaster medical resources to respond to multi-casualty incidents and disasters likely to occur in its service area.

RECOMMENDED GUIDELINES:
The local EMS agency should ensure that emergency medical providers and health care facilities have written agreements with anticipated providers of disaster medical resources.

CURRENT STATUS:
Resource Directory updated each year with the Annual EMS Plan update.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Annually update the Disaster Medical Resource Directory.

OBJECTIVE:
Update the Disaster Medical Resource Directory. Encourage emergency medical providers and health care facilities to have written agreements with anticipated providers of disaster medical resources.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.09 DMAT TEAMS

MINIMUM STANDARDS:
The local EMS agency shall establish and maintain relationships with DMAT teams in its area.

RECOMMENDED GUIDELINES:
The local EMS agency should support the development and maintenance of DMAT teams in its area.

CURRENT STATUS:
No DMAT teams exist within OES Region IV.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Develop a relationship with DMAT Teams as they are formed.

OBJECTIVE:
Develop a relationship with DMAT Teams as they are formed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

8.10 MUTUAL AID AGREEMENTS

MINIMUM STANDARDS:
The local EMS agency shall ensure the existence of medical mutual aid agreements with other counties in its OES region and elsewhere, as needed, which ensure that sufficient emergency medical response and transport vehicles, and other relevant resources will be made available during significant medical incidents and during periods of extraordinary system demand.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Providers are required by their agreements to execute day-to-day mutual aid agreements with neighboring providers. The member counties of OES Region IV are currently working on a "regional" master medical mutual aid agreement to be executed between counties and/or LEMSAs.

COORDINATION WITH OTHER EMS AGENCIES:
As stated above.

NEED(S):
Adoption of a master medical mutual aid agreement for medical resources.

OBJECTIVE:
Continue the process of developing and adopting a master medical mutual aid agreement.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than)

8.11 CCP DESIGNATION

MINIMUM STANDARDS:
The local EMS agency, in coordination with the local OES and county health officer(s), and using state guidelines, shall designate casualty collection points (CCPs).

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Several sites for CCPs or Field Treatment Sites have been identified, by individual counties. However, no formal plans have been developed for their activation, staffing or outfitting.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Formally identify CCPs and establish plans regarding activation, staffing and outfitting.

OBJECTIVE:
In conjunction with county OES offices, identify CCPs and establish plans regarding activation, staffing and outfitting.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

8.12 ESTABLISHMENT OF CCPs

MINIMUM STANDARDS:
The local EMS agency, in coordination with the local OES, shall develop plans for establishing CCPs and a means for communicating with them.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Several sites for CCPs have been identified throughout the EMS region. However, no formal plans have been developed for their activation, staffing or outfitting.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Identify CCPs and establish plans regarding activation, staffing and outfitting.

OBJECTIVE:
In conjunction with county OES offices, identify CCPs and establish plans regarding activation, staffing and outfitting.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

8.13 DISASTER MEDICAL TRAINING

MINIMUM STANDARDS:
The local EMS agency shall review the disaster medical training of EMS responders in its service area, including the proper management of casualties exposed to and/or contaminated by toxic or radioactive substances.

RECOMMENDED GUIDELINES:
The local EMS agency should ensure that EMS responders are appropriately trained in disaster response, including the proper management of casualties exposed to or contaminated by toxic or radioactive substances.

CURRENT STATUS:
Completion of ICS 120 and a 4-hour hospital or 8-hour field MCI course is the minimum standard for EMS personnel. A process for training all EMS personnel in the requirements of the State's Standardized Emergency Management System (SEMS) is currently being drafted. The minimum hazardous material training standards for EMS personnel are those standards established by OSHA/Cal-OSHA.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure a standard of training for EMS personnel in disaster medical response/management hazardous materials awareness.

OBJECTIVE:
Ensure an adequate number of Field, Hospital and Dispatch MCI courses are made available. Monitor and modify policies, provider agreements, and conduct drills to ensure a standard of training for EMS personnel in disaster medical response/management hazardous materials awareness.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.14 HOSPITAL PLANS

MINIMUM STANDARDS:
The local EMS agency shall encourage all hospitals to ensure that their plans for internal and external disasters are fully integrated with the county's medical response plan(s).

RECOMMENDED GUIDELINES:
At least one disaster drill per year conducted by each hospital should involve other hospitals, the local EMS agency, and prehospital medical care agencies.

CURRENT STATUS:
EMSA staff are available to all hospitals for in-service and training in ICS and MCI plan standards. Hospitals are also incorporated into county-wide disaster exercises on an annual basis.

COORDINATION WITH OTHER EMS AGENCIES:
Many of the county-wide disaster exercises involve activation of the Regional Disaster Control Facility and/or the Regional Disaster Medical/Health Coordinator.

NEED(S):
All hospitals should adopt some form of ICS as the basis for their facility's disaster plan.

OBJECTIVE:
Continue to work with and encourage hospitals to use the Hospital Emergency Incident Command System (HEICS). Ensure that at least one inter-agency disaster drill is conducted in each member county. Monitor compliance to the OES Region IV MCI Plan and take corrective action as necessary.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.15 INTERHOSPITAL COMMUNICATIONS

MINIMUM STANDARDS:
The local EMS agency shall ensure that there is an emergency system for interhospital communications, including operational procedures.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Hospitals within Stanislaus County can communicate with each other through a dedicated BLAST phone system. Common radio frequencies between hospitals within the EMS system have not been established.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the availability of inter-hospital medical communications.

OBJECTIVE:
Revise the communications plan, prioritize system repairs and upgrades and make necessary changes.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

8.16 PREHOSPITAL AGENCY PLANS

MINIMUM STANDARDS:
The local EMS agency shall ensure that all prehospital medical response agencies and acute-care hospitals in its service area, in cooperation with other local disaster medical response agencies, have developed guidelines for the management of significant medical incidents and have trained their staffs in their use.

RECOMMENDED GUIDELINES:
The local EMS agency should ensure the availability of training in management of significant medical incidents for all prehospital medical response agencies and acute-care hospital staffs in its service area.

CURRENT STATUS:
The OES Region IV MCI Plan has been formally adopted, by the Board of Directors of the EMSA and the Boards of Supervisors of each of the member counties, as the plan to be used for medical disaster management. Completion of ICS 120 and a 4-hour hospital or 8-hour field MCI course is the minimum standard for EMS personnel.

COORDINATION WITH OTHER EMS AGENCIES:
All eleven counties within OES Region IV have cooperatively maintained a standardized field response plan and disaster patient distribution system.

NEED(S):
Ensure that providers and hospitals continue to effectively use the MCI plan when managing MCIs and medical disasters. Ensure that all EMS personnel receive the minimum level of disaster medical training.

OBJECTIVE:
Monitor compliance to MCI plan standards and take corrective action as necessary. Develop a process to ensure that all EMS personnel receive required ICS, MCI and Hazmat training.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

8.17 ALS POLICIES

MINIMUM STANDARDS:
The local EMS agency shall ensure that policies and procedures allow advanced life support personnel and mutual aid responders from other EMS systems to respond and function during significant medical incidents.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Procedures have been established with adjacent EMS systems through mutual aid agreements. For other counties, the OES Region IV MCI Plan directs ALS, LALS and BLS personnel to act under their own system's standing orders during an MCI or medical disaster.

COORDINATION WITH OTHER EMS AGENCIES:
All eleven counties within OES Region IV have cooperatively maintained a standardized field response plan and disaster patient distribution system.

NEED(S):
Ensure that policies and procedures exist to allow advanced life support personnel and mutual aid responders from other EMS systems to respond and function during significant medical incidents.

OBJECTIVE:
Monitor and modify the policies and procedures which allow EMS personnel from other EMS systems to respond and function during significant medical incidents and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

8.18 SPECIALTY CENTER ROLES

MINIMUM STANDARDS:
Local EMS agencies developing trauma or other specialty care systems shall determine the role of identified specialty centers during a significant medical incidents and the impact of such incidents on day-to-day triage procedures.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
A map depicting all of the acute care facilities within OES Region IV with their various specialties was produced and distributed to all of the Disaster Control Facilities within the region in 1993.

COORDINATION WITH OTHER EMS AGENCIES:
All eleven counties within OES Region IV have cooperatively maintained a standardized field response plan and disaster patient distribution system.

NEED(S):
Determine the role of identified specialty centers during significant medical incidents and the impact of such incidents on day-to-day triage procedures. Update the facilities map distributed through the OES Region IV MCI grant project.

OBJECTIVE:
When specialty centers are identified, develop a process to determine the role of identified specialty centers during significant medical incidents and the impact of such incidents on day-to-day triage procedures.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

8.19 WAIVING EXCLUSIVITY

MINIMUM STANDARDS:
Local EMS agencies which grant exclusive operating permits shall ensure that a process exists to waive the exclusivity in the event of a significant medical incident.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
All exclusive operating area agreements contain language allowing the MVEMSA to waive the exclusivity of an area in the event of a significant medical incident.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that a process exists for the waiving of exclusivity in EOAs in the event a significant medical incident.

OBJECTIVE:
Monitor the process for waiving exclusivity and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

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SYSTEM RESOURCES AND OPERATIONS

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Table 2: System Organization and Management

EMS System: Mountain-Valley EMS Agency Reporting Year: 1999-2000

NOTE: Number (1) below is to be completed for each county. The balance of Table 2 refers to each agency.

1. Percentage of population served by each level of care by county:

   (Identify for the maximum level of service offered; the total of a, b, and c should equal 100%.)

County: Alpine, Amador, Calaveras, Mariposa, and Stanislaus

a. Basic Life Support (BLS)	0%
b. Limited Advanced Life Support (LALS)	0%
c. Advanced Life Support (ALS)	100%

2. Type of agency — d
   - a - Public Health Department
   - b - County Health Services Agency
   - c - Other (non-health) County Department
   - d - Joint Powers Agency
   - e - Private Non-profit Entity
   - f - Other: _____

3. The person responsible for day-to-day activities of EMS agency reports to: — c
   - a - Public Health Officer
   - b - Health Services Agency Director/Administrator
   - c - Board of Directors
   - d - Other: _____

4. Indicate the non-required functions which are performed by the agency:

Implementation of exclusive operating areas (ambulance franchising)	X
Designation of trauma centers/trauma care system planning	X
Designation/approval of pediatric facilities	X
Designation of other critical care centers	n/a
Development of transfer agreements	X

Table 2 - System Organization & Management (cont.)

Enforcement of local ambulance ordinance	X
Enforcement of ambulance service contracts	X
Operation of ambulance service	n/a
Continuing education	X
Personnel training	X
Operation of oversight of EMS dispatch center	n/a
Non-medical disaster planning	n/a
Administration of critical incident stress debriefing (CISD) team	n/a
Administration of disaster medical assistance team (DMAT)	n/a
Administration of EMS Fund [Senate Bill (SB) 12/612]	n/a
Other: _____	
Other: _____	
Other: _____	

5. EMS agency budget for FY: 1999-2000

A. EXPENSES

Salaries and benefits (all but contract personnel)	$563,735
Contract Services (e.g. medical director)	$353,949
Operations (e.g. copying, postage, facilities)	$179,164
Travel	$54,000
Fixed assets	_____
Indirect expenses (overhead)	_____
Ambulance subsidy	_____
EMS Fund payments to physicians/hospital	_____
Dispatch center operations (non-staff)	_____
Training program operations	_____
Other: Training/Education	40,092
TOTAL EXPENSES	$1,190,940

Table 2 - System Organization & Management (cont.)

B. SOURCES OF REVENUE

Special project grant(s) [from EMSA]	
Preventive Health and Health Services (PHHS) Block Grant	$214,745
Office of Traffic Safety (OTS)	_____
State general fund	$358,853
County general fund	_____
Other local tax funds (e.g., EMS district)	_____
County contracts (e.g. multi-county agencies)	$226,522
Certification fees	$40,000
Training program approval fees	_____
Training program tuition/Average daily attendance funds (ADA), Job Training Partnership ACT (JTPA) funds or other payments	$123,704
Base hospital application fees	_____
Base hospital designation fees	_____
Trauma center application fees	_____
Trauma center designation fees	_____
Pediatric facility approval fees	_____
Pediatric facility designation fees	_____
Other critical care center application or designation fees	_____
Type:_____	
Ambulance service/vehicle fees	$47,250
Contributions	_____
EMS Fund (SB 12/612)	_____
Other (specify): Fines	$20,000
Contracts with other LEMSAs for DBS services	
Miscellaneous	$159,866
TOTAL REVENUE	$1,190,940

Table 2 - System Organization & Management (cont.)

6. Fee structure for FY 1999-2000

_____ We do not charge any fees

X Our fee structure is:

First responder certification	$30.00
EMS dispatcher certification	$15.00
EMT-I certification	$30.00
EMT-I recertification	$30.00
EMT-defibrillation certification	no charge
EMT-defibrillation recertification	no charge
EMT-P accreditation (new or expired)	$50.00
Mobile Intensive Care Nurse(MICN) authorization	$25.00
MICN re-authorization	$20.00
MICN Radio Skills Exam	$15.00
EMT-P/MICN Field Experience Evaluation	$1.00/hr
EMT-I training program approval	no charge
EMT-II training program approval	no charge
EMT-P training program approval	no charge
MICN training program approval	no charge
Base hospital application	no charge
Base hospital designation	no charge
Trauma center application	n/a
Trauma center designation	n/a
Pediatric facility approval	n/a
Pediatric facility designation	n/a

Table 2 - System Organization & Management (cont.)

Other critical care center application or designation fees	none
Type: n/a	
Ambulance service license	established separately by each member county
Ambulance vehicle permits	established separately by each member county
BLS Ambulance Special Event Coverage	$25.00
ALS Ambulance Special Event Coverage	$25.00
Air Ambulance Authorization Fees (unit based in the region)	$3500.00
Each additional ship	$250.00
Air Ambulance Authorization Fees (unit based outside the region)	$200.00
Each additional ship	$50.00
Advanced Life Support Treatment Protcols (large book)	$10.00
Advanced Life Support Treatment Protcols (small book)	$5.00
Basic Life Support Treatment Guidelines	$5.00
EMT-I Workbook	$6.50
Adminsitrative Fee	$25.00/hr
Copying	.50¢ for 1st page and .10¢ for each additional page
Other:	

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Table 2 - System Organization & Management (cont.)

EMS System: Mountain-Valley EMS Agency

Reporting Year: 1999-2000

CATEGORY	ACTUAL TITLE	FTE POSITIONS (EMS ONLY)	TOP SALARY BY HOURLY EQUIVALENT	BENEFITS (% of Salary)	COMMENTS
EMS Admin./ Coord./Dir.	Executive Director	1 FTE	$33.64	31%	
Asst. Admin./ Admin. Asst./ Admin. Mgr.	Deputy Director	1 FTE	$30.62	31%	
ALS Coord./ Field Coord./ Trng Coord.	Manpower and Training Coordinator	1 FTE	$23.93	31%	
Program Coord./Field Liaison (Non-clinical)	Field Liaison, Transportation Coordinator, Communications Coordinator	2 FTE	$23.93	31%	
Trauma Coord.					
Med. Director	Medical Director	.25 FTE	$38.50	n/a	
Other MD/ Med. Consult./ Trng. Med. Dir.					
Disaster Med. Planner	Disaster Coordinator	.15 FTE	$23.93	31%	Position unfilled this fiscal year

Include an organizational chart of the local EMS agency and a county organizational chart(s) indicating how the LEMSA fits within the county/multi-county structure.

Table 2 - System Organization & Management (cont.)

CATEGORY	ACTUAL TITLE	FTE POSITIONS (EMS ONLY)	TOP SALARY BY HOURLY EQUIVALENT	BENEFITS (% of Salary)	COMMENTS
Dispatch Supervisor					
Data Evaluator/ Analyst	Data Analyst/Programmer	.5 FTE	$22.77	31%	
QA/QI Coordinator	Medical Quality Coordinator	.5 FTE	$24.51	31%	
Public Info. & Ed. Coord.	Health Educator	.3 FTE	$14.40	31%	
Ex. Secretary	Executive Secretary	1 FTE	$16.03	31%	
Other Clerical	Receptionist, Secretary I	1 FTE	$12.62	31%	
Data Entry Clerk	Data Entry Clerk	1 FTE	$12.28	31%	
Other	Management Services Asst.	1 FTE	$19.16	31%	

Include an organizational chart of the local EMS agency and a county organizational chart(s) indicating how the LEMSA fits within the county/multi-county structure.

TABLE 3: Personnel/Training

EMS System: Mountain-Valley EMS Agency

Reporting Year: 1998-99

	EMT - I	EMT - II	EMT - P	MICN	EMS Dispatchers
Total certified	1172	0		179	46
Number newly certified this year	272	0		7	3
Number recertified this year	339	0		79	26
Total number of accredited personnel on July 1 of the reporting year			188		
Number of certification reviews resulting in:					
a) formal investigations					
b) probation					
c) suspensions					
d) revocations					
e) denials					
f) denials of renewal					
g) no action taken					

1. Number of EMS dispatchers trained to EMSA standards: 46
2. Early defibrillation:
   a) Number of EMT-I (defib) certified 112
   b) Number of public safety (defib) certified (non-EMT-I) 33
3. Do you have a first responder training program? yes

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TABLE 4: Communications

EMS System: Mountain-Valley EMS Agency

County: Alpine

Reporting Year: 1999-2000

Note: Table 4 is to be answered for each county.

1.	Number of primary Public Service Answering Points (PSAP)	1
2.	Number of secondary PSAPs	0
3.	Number of dispatch centers directly dispatching ambulances	0
4.	Number of designated dispatch centers for EMS Aircraft	0
5.	Do you have an operational area disaster communication system?	yes
	a. Radio primary frequency	153.800
	b. Other methods:	RACES
	c. Can all medical response units communicate on the same disaster communications system?	yes
	d. Do you participate in OASIS?	yes
	e. Do you have a plan to utilize RACES as a back-up communication system?	yes
	1) Within the operational area?	yes
	2) Between the operational area and the region and/or state?	yes

TABLE 4: Communications

EMS System: Mountain-Valley EMS Agency

County: Amador

Reporting Year: 1999-2000

Note: Table 4 is to be answered for each county.

1.	Number of primary Public Service Answering Points (PSAP)	1
2.	Number of secondary PSAPs	0
3.	Number of dispatch centers directly dispatching ambulances	1
4.	Number of designated dispatch centers for EMS Aircraft	0
5.	Do you have an operational area disaster communication system?	yes
	a. Radio primary frequency	467.975
	b. Other methods:	RACES
	c. Can all medical response units communicate on the same disaster communications system?	yes
	d. Do you participate in OASIS?	yes
	e. Do you have a plan to utilize RACES as a back-up communication system?	yes
	1) Within the operational area?	yes
	2) Between the operational area and the region and/or state?	yes

TABLE 4: Communications

EMS System: Mountain-Valley EMS Agency

County: Calaveras

Reporting Year: 1999-2000

Note: Table 4 is to be answered for each county.

1.	Number of primary Public Service Answering Points (PSAP)	1
2.	Number of secondary PSAPs	1
3.	Number of dispatch centers directly dispatching ambulances	1
4.	Number of designated dispatch centers for EMS Aircraft	0
5.	Do you have an operational area disaster communication system?	yes
	a. Radio primary frequency	467.950 and 155.280
	b. Other methods:	RACES
	c. Can all medical response units communicate on the same disaster communications system?	yes
	d. Do you participate in OASIS?	yes
	e. Do you have a plan to utilize RACES as a back-up communication system?	yes
	1) Within the operational area?	yes
	2) Between the operational area and the region and/or state?	yes

TABLE 4: Communications

EMS System: Mountain-Valley EMS Agency

County: Mariposa

Reporting Year: 1999-2000

Note: Table 4 is to be answered for each county.

1.	Number of primary Public Service Answering Points (PSAP)	1
2.	Number of secondary PSAPs	1
3.	Number of dispatch centers directly dispatching ambulances	1
4.	Number of designated dispatch centers for EMS Aircraft	1
5.	Do you have an operational area disaster communication system?	yes
	a. Radio primary frequency	159.390
	b. Other methods:	None
	c. Can all medical response units communicate on the same disaster communications system?	yes
	d. Do you participate in OASIS?	No
	e. Do you have a plan to utilize RACES as a back-up communication system?	No
	1) Within the operational area?	No
	2) Between the operational area and the region and/or state?	No

TABLE 4: Communications

EMS System: Mountain-Valley EMS Agency

County: Stanislaus

Reporting Year: 1999-2000

Note: Table 4 is to be answered for each county.

1.	Number of primary Public Service Answering Points (PSAP)	5
2.	Number of secondary PSAPs	2
3.	Number of dispatch centers directly dispatching ambulances	2
4.	Number of designated dispatch centers for EMS Aircraft	2
5.	Do you have an operational area disaster communication system?	No
	a. Radio primary frequency	467.975 and 154.145
	b. Other methods:	RACES
	c. Can all medical response units communicate on the same disaster communications system?	No
	d. Do you participate in OASIS?	yes
	e. Do you have a plan to utilize RACES as a back-up communication system?	yes
	1) Within the operational area?	yes
	2) Between the operational area and the region and/or state?	yes

TABLE 5: Response/Transportation

EMS System: Mountain-Valley EMS Agency

Reporting Year: 1999-2000

Transporting Agencies

1.	Number of exclusive operating areas	6
2.	Percentage of population covered by Exclusive Operating Areas (EOA)	77%
3.	Total number responses	unknown
	a) Number of emergency responses (Code 2: expedient, Code 3: lights and siren)	26,622
	b) Number non-emergency responses (Code 1: normal)	unknown
4.	Total number of transports	unknown
	a) Number of emergency transports (Code 2: expedient, Code 3: lights and siren)	20,618
	b) Number of non-emergency transports (Code 1: normal)	unknown

Early Defibrillation Providers

5.	Number of public safety defibrillation providers	
	a) Automated	10
	b) Manual	0
6.	Number of EMT-Defibrillation providers	
	a) Automated	0
	b) Manual	0

Air Ambulance Services

7.	Total number of responses	1,178
	a) Number of emergency responses	971
	b) Number of non-emergency responses	207
8.	Total number of transports	602
	a) Number of emergency (scene) responses	395
	b) Number of non-emergency responses	207

TABLE 5: Response/Transportation (cont'd.)

EMS System: Mountain-Valley EMS Agency

Reporting Year: 1999-2000

County: Stanislaus[1]

System Standard Response Times (90th percentile)

Enter the response times in the appropriate boxes.	METRO/URBAN	SUBURBAN/RURAL	WILDERNESS	SYSTEMWIDE
1. BLS and CPR capable first responder.	n/a[2]	n/a	n/a	n/a
2. Early defibrillation responder.	n/a	n/a	n/a	n/a
3. Advanced life support responder.	8	14	20	9
4. Transport Ambulance.	8	14	20	9

[1]Stanislaus is the only county in the region for whom response time standards have been implemented.

[2]No mechanism exists for the collection of response time date for first response agencies.

TABLE 6: Facilities and Critical Care

EMS System: Mountain-Valley EMS Agency

Reporting Year: 1999-2000

Trauma

Trauma patients:

a) Number of patients meeting trauma triage criteria	N/A[1]
b) Number of major trauma victims transported directly to a trauma center by ambulance	N/A
c) Number of major trauma patients transferred to a trauma center	N/A
d) Number of patients meeting triage criteria who weren't treated at a trauma center	N/A

Emergency Departments

Total number of emergency departments	7
a) Number of referral emergency services	0
b) Number of standby emergency services	1
c) Number of basic emergency services	6
d) Number of comprehensive emergency services	0

Receiving Hospitals

1. Number of receiving hospitals with written agreements	0
2. Number of base hospitals with written agreements	7

[1]A trauma system has not been implemented in the Mountain-Valley EMS System.

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TABLE 7: Disaster Medical

EMS System: Mountain-Valley EMS Agency

County: Alpine

Reporting Year: 1999-2000

SYSTEM RESOURCES

1. Casualty Collections Points (CCP)
   a. Where are your CCPs located? Alpine County does not have a CCP
   b. How are they staffed? n/a
   c. Do you have a supply system for supporting them for 72 hours? n/a

2. CISD
   Do you have a CISD provider with 24 hour capability? yes

3. Medical Response Team
   a. Do you have any team medical response capability? no
   b. For each team, are they incorporated into your local response plan? n/a
   c. Are they available for statewide response? n/a
   d. Are they part of a formal out-of-state response system? n/a

4. Hazardous Materials
   a. Do you have any HazMat trained medical response teams? no
   b. At what HazMat level are they trained? n/a
   c. Do you have the ability to do decontamination in an emergency room? n/a
   d. Do you have the ability to do decontamination in the field? n/a

OPERATIONS

1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? yes
2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? 1

Table 7: Disaster Medical - Alpine County (cont.)

3. Have you tested your MCI Plan this year in a:
   a. real event? yes
   b. exercise? yes

4. List all counties with which you have a written medical mutual aid agreement. Amador; El Dorado; Douglas County, Nevada

5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response? no

6. Do you have formal agreements with community clinics in your operational area to participate in disaster planning and response? no

7. Are you part of a multi-county EMS system for disaster response? yes

8. If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department? yes

TABLE 7: Disaster Medical

EMS System: Mountain-Valley EMS Agency

County: Amador

Reporting Year: 1999-2000

SYSTEM RESOURCES

1. Casualty Collections Points (CCP)
   a. Where are your CCPs located? Amador County does not have a CCP
   b. How are they staffed? n/a
   c. Do you have a supply system for supporting them for 72 hours? n/a

2. CISD
   Do you have a CISD provider with 24 hour capability? yes

3. Medical Response Team
   a. Do you have any team medical response capability? no
   b. For each team, are they incorporated into your local response plan? n/a
   c. Are they available for statewide response? n/a
   d. Are they part of a formal out-of-state response system? n/a

4. Hazardous Materials
   a. Do you have any HazMat trained medical response teams? yes
   b. At what HazMat level are they trained? awareness
   c. Do you have the ability to do decontamination in an emergency room? yes
   d. Do you have the ability to do decontamination in the field? yes

OPERATIONS

1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? yes
2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? 1

Table 7: Disaster Medical - Amador County (cont.)

3. Have you tested your MCI Plan this year in a:
   a. real event? yes
   b. exercise? yes

4. List all counties with which you have a written medical mutual aid agreement. Alpine

5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response? yes

6. Do you have a formal agreements with community clinics in your operational areas to participate in disaster planning and response? no

7. Are you part of a multi-county EMS system for disaster response? yes

8. If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department? yes

TABLE 7: Disaster Medical

EMS System: Mountain-Valley EMS Agency

County: Calaveras

Reporting Year: 1999-2000

SYSTEM RESOURCES

1. Casualty Collections Points (CCP)
   a. Where are your CCPs located? Calaveras County does not have a CCP
   b. How are they staffed? n/a
   c. Do you have a supply system for supporting them for 72 hours? n/a

2. CISD
   Do you have a CISD provider with 24 hour capability? yes

3. Medical Response Team
   a. Do you have any team medical response capability? no
   b. For each team, are they incorporated into your local response plan? n/a
   c. Are they available for statewide response? n/a
   d. Are they part of a formal out-of-state response system? n/a

4. Hazardous Materials
   a. Do you have any HazMat trained medical response teams? yes
   b. At what HazMat level are they trained? operational
   c. Do you have the ability to do decontamination in an emergency room? yes
   d. Do you have the ability to do decontamination in the field? yes

OPERATIONS

1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? yes
2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? 1

Table 7: Disaster Medical - Calaveras County (cont.)

3. Have you tested your MCI Plan this year in a:
   a. real event? yes
   b. exercise? yes

4. List all counties with which you have a written medical mutual aid agreement. none.

5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response? yes

6. Do you have a formal agreements with community clinics in your operational areas to participate in disaster planning and response? no

7. Are you part of a multi-county EMS system for disaster response? yes

8. If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department? yes

TABLE 7: Disaster Medical

EMS System: Mountain-Valley EMS Agency

County: Mariposa

Reporting Year: 1999-2000

SYSTEM RESOURCES

1. Casualty Collections Points (CCP)
   a. Where are your CCPs located? Mariposa County does not have a CCP
   b. How are they staffed? n/a
   c. Do you have a supply system for supporting them for 72 hours? n/a

2. CISD
   Do you have a CISD provider with 24 hour capability? yes

3. Medical Response Team
   a. Do you have any team medical response capability? no
   b. For each team, are they incorporated into your local response plan? n/a
   c. Are they available for statewide response? n/a
   d. Are they part of a formal out-of-state response system? n/a

4. Hazardous Materials
   a. Do you have any HazMat trained medical response teams? yes
   b. At what HazMat level are they trained? Awareness
   c. Do you have the ability to do decontamination in an emergency room? yes
   d. Do you have the ability to do decontamination in the field? yes

OPERATIONS

1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? yes
2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? 1

Table 7: Disaster Medical - Mariposa County (cont.)

3. Have you tested your MCI Plan this year in a:
   a. real event? yes
   b. exercise? yes

4. List all counties with which you have a written medical mutual aid agreement. Madera.

5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response? yes

6. Do you have a formal agreements with community clinics in your operational areas to participate in disaster planning and response? no

7. Are you part of a multi-county EMS system for disaster response? yes

8. If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department? yes

TABLE 7: Disaster Medical

EMS System: Mountain-Valley EMS Agency

County: Stanislaus

Reporting Year: 1999-2000

SYSTEM RESOURCES

1. Casualty Collections Points (CCP)
   a. Where are your CCPs located? Stanislaus County does not have a CCP
   b. How are they staffed? n/a
   c. Do you have a supply system for supporting them for 72 hours? n/a

2. CISD
   Do you have a CISD provider with 24 hour capability? yes

3. Medical Response Team
   a. Do you have any team medical response capability? no
   b. For each team, are they incorporated into your local response plan? n/a
   c. Are they available for statewide response? n/a
   d. Are they part of a formal out-of-state response system? n/a

4. Hazardous Materials
   a. Do you have any HazMat trained medical response teams? yes
   b. At what HazMat level are they trained? awareness
   c. Do you have the ability to do decontamination in an emergency room? yes
   d. Do you have the ability to do decontamination in the field? yes

OPERATIONS

1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? yes
2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? 1

Table 7: Disaster Medical - Stanislaus County (cont.)

3. Have you tested your MCI Plan this year in a:
   a. real event? yes
   b. exercise? yes

4. List all counties with which you have a written medical mutual aid agreement. None.

5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response? yes

6. Do you have a formal agreements with community clinics in your operational areas to participate in disaster planning and response? no

7. Are you part of a multi-county EMS system for disaster response? yes

8. If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department? yes

TABLE 8: Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1997-98

County: Alpine

Name, Address & telephone: Bear Valley Fire Department P.O. Box 5430 Bear Valley, CA 95223 (209)				**Primary Contact:** Scott McKinney	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: _10__ PS _____PS-defib __3__ BLS __6__ EMT-D _____LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☒ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Kirkwood Fire Protection District P.O. Box 247 Kirkwood, CA 95646 (209) 258-4444				**Primary Contact:** Peter Tabacco	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: __4__ PS _____PS-defib ____ BLS __12_ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8: Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1997-98

County: Alpine

Name, Address & telephone: Markleeville Volunteer Fire Department P.O. Box 158 Markleeville, CA 96720 (916) 694-2357				**Primary Contact:** Wayne Thompson	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: __13_ PS _____PS-defib _____ BLS __1__ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☒ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Alpine County EMS 75 Pine Avenue Markleeville, CA 96120 (530) 694-2159				**Primary Contact:** Lynn Doyal	
Written Contract: ☒ yes ☐ no	Service: ☒ Ground ☐ Air ☐ Water	☒ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: _____ PS _____PS-defib _23___ BLS _23 EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☒ yes ☐ no	If public: ☐ Fire ☐ Law ☒ Other: Health	If public: ☐ city ☒ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: 2

TABLE 8: Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1997-98

County: Amador

Name, Address & telephone: American Legion Ambulance P.O. Box 480 Sutter Creek, CA 95685 (209) 223-2963 - Main Office				**Primary Contact:** Al Lennox (209) 267-0268	
Written Contract: ☒ yes ☐ no	Service: ☒ Ground ☐ Air ☐ Water	☒ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib 14 BLS ____ EMT-D ____ LALS 21 ALS
Ownership: ☐ Public ☒ Private	Medical Director: ☐ yes ☒ no	If public: ☐ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: 7

Name, Address & telephone: Amador Fire Protection District 500 Argonaught Lane Jackson, CA 95642 (209) 223-6391				**Primary Contact:** Jim McCart	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: 28 PS 27 PS-defib 19 BLS 19 EMT-D ____ LALS ____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: N/A

TABLE 8: Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1997-98

County: Amador

Name, Address & telephone: California Department of Forestry 11600 Highway 49 Sutter Creek, CA 95685 (209)267-5215				**Primary Contact:** Lee Winton	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: _11__ PS _____PS-defib __5__ BLS _____ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☒ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: City of Ione Fire Department P.O. Box 398 Ione, CA 95640 (209) 274-4548				**Primary Contact:** Ken Mackey	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: __3__ PS _____PS-defib __6__ BLS _____ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☒ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8: Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1997-98

County: Amador

Name, Address & telephone: Jackson Fire Department 33 Broadway Jackson, CA 95642				**Primary Contact:** Jack Quinn	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: __2__ PS ___2_PS-defib __13_ BLS __13_ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☒ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone:				**Primary Contact:**	
Written Contract: ☐ yes ☐ no	Service: ☐ Ground ☐ Air ☐ Water	☐ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: _____ PS _____PS-defib _____ BLS _____ EMT-D _____ LALS _____ ALS
Ownership: ☐ Public ☐ Private	Medical Director: ☐ yes ☐ no	If public: ☐ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☐ yes ☐ no	Number of ambulances: n/a

TABLE 8: Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1997-98

County: Amador

Name, Address & telephone: Lockwood Fire Protection District P.O. Box 221 Volcano, CA 95689 (209) 296-5122				**Primary Contact:** Steven Cuneo	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS __4__ PS-defib ____ BLS __9__ EMT-D ____ LALS ____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Pine Grove Conservation P.O. Box 405 Pine Grove, CA 95665 (209) 296-7591				**Primary Contact:** Tod Dorris	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: __8__ PS ____ PS-defib ____ BLS ____ EMT-D ____ LALS ____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☒ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8: Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1997-98

County: Amador

Name, Address & telephone: Plymouth Volunteer Fire Department P.O. Box 429 Plymouth, CA 95669 (209) 245-4833				**Primary Contact:** Antonio Moreno	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: __1__ PS _____PS-defib __12_ BLS __10_ EMT-D _____LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☒ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Sutter Creek Fire Protection District P.O. Box 365 Sutter Creek, CA 95685 (209) 267-0345				**Primary Contact:** Butch Martin	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: _____ PS _16__PS-defib _____ BLS __9__ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8: Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Calaveras

Name, Address & telephone: American Medical Response 888 E. Lindsay, Stockton, CA 95202 (209) 948-5136				**Primary Contact:** Dale Jones	
Written Contract: ☒ yes ☐ no	Service: ☒ Ground ☐ Air ☐ Water	☒ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib 9 BLS ____ EMT-D ____ LALS 9 ALS
Ownership: ☐ Public ☒ Private	Medical Director: ☒ yes ☐ no	If public: ☐ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: 3

Name, Address & telephone: San Andreas Ambulance P.O. Box 1115 San Andreas, CA 95249 (209) 754-3583				**Primary Contact:** Gail Spann-Pilkington	
Written Contract: ☒ yes ☐ no	Service: ☒ Ground ☐ Air ☐ Water	☒ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib 10 BLS ____ EMT-D ____ LALS 10 ALS
Ownership: ☐ Public ☒ Private	Medical Director: ☐ yes ☒ no	If public: ☐ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: 2

TABLE 8: Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Calaveras

Name, Address & telephone: Valley Springs Ambualnce P.O. Box 399 Valley Springs, CA 95252 (209) 772-2924				**Primary Contact:** Bill McFall	
Written Contract: ☒ yes ☐ no	Service: ☒ Ground ☐ Air ☐ Water	☒ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib 10 BLS ____ EMT-D ____ LALS 8 ALS
Ownership: ☐ Public ☒ Private	Medical Director: ☐ yes ☒ no	If public: ☐ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: 3

Name, Address & telephone: Altaville-Melones Fire Protection District P.O. Box 431 Altaville, CA 95221 (209) 736-2331				**Primary Contact:** Mike Seagle	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib ____ BLS ____ EMT-D ____ LALS ____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8: Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Calaveras

Name, Address & telephone: Blue Mountain Medical Volunteers - West Point Fire Protection District P.O. Box 721 West Point, CA 95255 (209) 293-7000				**Primary Contact:**	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: __1__ PS __0__ PS-defib _____ BLS __4__ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Calaveras County Fire Department 891 Mountain Ranch Road San Andreas, CA 95249 (209) 754-6639				**Primary Contact:** Jim Miner	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: _30__ PS _____PS-defib __25__ BLS _____ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☒ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8: Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Calaveras

Name, Address & telephone: City of Angels P.O. Box 457 Angels, CA 95222 (209) 736-4081				**Primary Contact:** Bette Newcomb	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: __5__ PS _____PS-defib __12__ BLS _____ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☒ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Copperopolis Fire Protection District P.O. Box 131 Copperopolis, CA 95228 (209) 785-2393				**Primary Contact:** Dennis Powers	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ___20_ PS _____PS-defib _____ BLS __10_ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no EMS as MD for AED	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☒ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8: Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Calaveras

Name, Address & telephone: Ebbetts Pass Fire Protection District P.O. Box 66 Arnold, CA 95223-0066 (209) 795-1646 Fax (209) 795-3460				**Primary Contact:** Warren Wilkes	
Written Contract: ☒ yes ☐ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ___ PS _____PS-defib __35__ BLS ___ EMT-D _____ LALS __4__ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☒ yes ☐ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Central Calaveras Fire & Rescue Protection District P.O. Box 2 Mountain Ranch, CA 95246 (209) 754-4330				**Primary Contact:** Don Jensen, Fire Chief	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: __3__ PS _____PS-defib __5__ BLS _____ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8: Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Calaveras

Name, Address & telephone: Jenny Lind Fire Protection District P.O. Box 559 Valley Springs, CA 95252 (209) 786-2227				**Primary Contact:** Michael D. Siligo, Fire Chief	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib ____ BLS ____ EMT-D ____ LALS ____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Mokelumne Hill Fire Protection District P.O. Box 281 Mokelumne Hill, Ca 95245 (209) 286-1389				**Primary Contact:** Ross Aldrich	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: __8_ PS ____ PS-defib __8_ BLS ____ EMT-D ____ LALS ____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8: Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Calaveras

Name, Address & telephone:				**Primary Contact:**	
Written Contract: ☐ yes ☐ no	Service: ☐ Ground ☐ Air ☐ Water	☐ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ___ PS ___PS-defib ___ BLS ___ EMT-D ___ LALS ___ ALS
Ownership: ☐ Public ☐ Private	Medical Director: ☐ yes ☐ no	If public: ☐ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☐ yes ☐ no	Number of ambulances:

Name, Address & telephone: Murphys Fire Protection District P.O. Box 1013 Murphys, CA 95247 (209) 728-3864				**Primary Contact:** Pat Murphy	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ___ PS __7__PS-defib ___ BLS __5__ EMT-D ___ LALS ___ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8: Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Calaveras

Name, Address & telephone: San Andreas Fire Protection District P.O. Box 88 San Andreas, Ca 95221 (209) 754-4693				**Primary Contact:**	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS _11__PS-defib _____ BLS _11__ EMT-D _____ LALS __1___ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Valley Springs Fire Company P.O. Box 193 Valley Springs, CA 95252 (209) 786-2697				**Primary Contact:** Steve Gleason	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: __12_ PS _____PS-defib _____ BLS __6__ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8 Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Mariposa

Name, Address & telephone: Mercy Medical Transport, Inc. P.O. Box 5004 Mariposa, CA 95338-5004				**Primary Contact:** Rick Roesch	
Written Contract: ☒ yes ☐ no	Service: ☒ Ground ☐ Air ☐ Water	☒ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib 13 BLS ____ EMT-D ____ LALS 11 ALS
Ownership: ☐ Public ☒ Private	Medical Director: ☒ yes ☐ no	If public: ☐ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: 5

Name, Address & telephone: California Department of Forestry				**Primary Contact:** Candace Gregory - Unit Chief	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib ____ BLS ____ EMT-D ____ LALS ____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☒ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8 Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Mariposa

Name, Address & telephone: Mariposa County Fire Department P.O. Box 162 Mariposa, CA 95338 (209) 966-4330				**Primary Contact:** Blaine Shultz	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: _58__ PS _____PS-defib __30__ BLS _____ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☒ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Mariposa County Sheriff's Office P.O. Box 276 Mariposa, CA 95338 (209) 966-3615				**Primary Contact:** Pelk Richards, Sheriff/Coroner	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: _25__ PS _____PS-defib __3__ BLS _____ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☐ Fire ☒ Law ☐ Other: _____	If public: ☐ city ☒ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8 Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Mariposa

Name, Address & telephone: Mariposa Utility District P.O. Box 494 Mariposa, CA 95338 (209) 966-2515				**Primary Contact:** James D. Dulcich	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: __16 PS __16_ PS-defib ___4_ BLS _____ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone:				**Primary Contact:**	
Written Contract: ☐ yes ☐ no	Service: ☐ Ground ☐ Air ☐ Water	☐ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: _____ PS _____PS-defib _____ BLS _____ EMT-D _____ LALS _____ ALS
Ownership: ☐ Public ☐ Private	Medical Director: ☐ yes ☐ no	If public: ☐ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☐ yes ☐ no	Number of ambulances:

TABLE 8 Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Name, Address & telephone: American Medical Response P.O. Box 4397 Modesto, Ca 95352 (209) 524-8001				**Primary Contact:** Cindy Woolston	
Written Contract: ☒ yes ☐ no	Service: ☒ Ground ☐ Air ☐ Water	☒ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ___ PS ___ PS-defib 67 BLS ___ EMT-D ___ LALS 59 ALS
Ownership: ☐ Public ☒ Private	Medical Director: ☒ yes ☐ no	If public: ☐ Fire ☐ Law ☐ Other: ___	If public: ☐ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: 25

Name, Address & telephone: Hughson Paramedic Ambulance Company P.O. Box 1719 Hughson, CA 95326				**Primary Contact:** Thomas Crowder	
Written Contract: ☒ yes ☐ no	Service: ☒ Ground ☐ Air ☐ Water	☒ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ___ PS ___ PS-defib 26 BLS ___ EMT-D ___ LALS 6 ALS
Ownership: ☐ Public ☒ Private	Medical Director: ☒ yes ☐ no	If public: ☐ Fire ☐ Law ☐ Other: ___	If public: ☐ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: 7

TABLE 8 Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Name, Address & telephone: Oak Valley District Ambulance 350 South Oak Avenue Oakdale, CA 95361 (209) 847-3011				**Primary Contact:** Ray Leverett	
Written Contract: ☒ yes ☐ no	Service: ☒ Ground ☐ Air ☐ Water	☒ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib 13 BLS ____ EMT-D ____ LALS 14 ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☐ Fire ☐ Law ☒ Other: hospital. district	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: 4

Name, Address & telephone: Patterson District Ambulance P.O. Box 187 Patterson, CA 95353 (209) 892-2618				**Primary Contact:** Craig Grischott	
Written Contract: ☒ yes ☐ no	Service: ☒ Ground ☐ Air ☐ Water	☒ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib 10 BLS ____ EMT-D ____ LALS 14 ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☐ Fire ☐ Law ☒ Other: hospital district	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: 3

TABLE 8 Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Name, Address & telephone: Air Med Team 1441 Florida Avenue Modesto, CA 95350 (209) 576-3939				**Primary Contact:** Graham Pierce	
Written Contract: ☒ yes ☐ no	Service: ☐ Ground ☒ Air ☐ Water	☒ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☒ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☒ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib ____ BLS ____ EMT-D ____ LALS 15 ALS
Ownership: ☐ Public ☒ Private	Medical Director: ☒ yes ☐ no	If public: ☐ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: 3

Name, Address & telephone: Medi-Flight of Northern California 1700 Coffee Road, Modesto, CA 95355 (209) 572-7050				**Primary Contact:** Frank Erdman	
Written Contract: ☒ yes ☐ no	Service: ☐ Ground ☒ Air ☐ Water	☒ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☒ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☒ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib ____ BLS ____ EMT-D ____ LALS 30 ALS
Ownership: ☐ Public ☒ Private	Medical Director: ☒ yes ☐ no	If public: ☐ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: 2

TABLE 8 Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Name, Address & telephone: Denair Fire Distrcit P.O. Box 262 Denair, CA 95316 (209) 632-5032				**Primary Contact:** Duane Larson	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib 14 BLS 2 EMT-D ____ LALS ____ ALS
Ownership: ☐ Public ☒ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone:				**Primary Contact:**	
Written Contract: ☐ yes ☐ no	Service: ☐ Ground ☐ Air ☐ Water	☐ Transport ☐ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS 18 PS-defib ____ BLS 2 EMT-D ____ LALS 1 ALS
Ownership: ☐ Public ☐ Private	Medical Director: ☐ yes ☐ no	If public: ☐ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☐ yes ☐ no	Number of ambulances: n/a

TABLE 8 Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Name, Address & telephone: Keyes Fire Protection District P.O. Box 827 Keyes, CA 95328 (209) 634-7690				**Primary Contact:** Eddie Jones	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: _____ PS _____PS-defib _____ BLS _____ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Modesto City Fire Department 610 Eleventh Street, Modesto, CA 95354 (209) 572-9590				**Primary Contact:** Doug Hannick	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: __29_ PS _____PS-defib _____ BLS _107_ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☒ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8 Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Name, Address & telephone: Mountain View Fire Protection District 9633 Crows Landing Road Crows Landing, CA 95313 (209) 634-4766				**Primary Contact:** Kevin Blount	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: _____ PS _____PS-defib _____ BLS __20_ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Newman Fire Department 1162 North Street Newman, CA 95360 (209) 862-1716				**Primary Contact:** Mel Souza	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: _____ PS _____PS-defib _____ BLS __7_ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☒ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8 Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Name, Address & telephone: Oakdale City Fire Department 325 G Street Oakdale, CA 95361 (209) 847-5904				**Primary Contact:** Mike Wilkinson	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: _____ PS _____PS-defib _____ BLS _17_ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☒ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Oakdale Rural Fire Protection District 1398 East F Street Oakdale, CA 95361 (209) 847-6898				**Primary Contact:** Michael R. Wilkinson	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: _____ PS _____PS-defib _____ BLS _20_ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8 Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Name, Address & telephone: Salida Fire Protection District P.O. Box 1335 Salida, CA 95369 (209) 545-0365				**Primary Contact:** John Brubaker	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: _____ PS _____PS-defib _____ BLS __19_ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Stanislaus Consolidated Fire District 929 Oakdale Road Modesto, CA 95355 (209) 525-4650				**Primary Contact:** Kurt Latipow	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: __23_ PS _____PS-defib _____ BLS __45_ EMT-D _____ LALS _____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: _____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8 Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Name, Address & telephone: Turlock City Fire Department 156 South Broadway, Suite 250 Turlock, CA 95380-5454 (209) 668-5580				**Primary Contact:** Mark Langley	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib 15 BLS 50 EMT-D ____ LALS ____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: ____	If public: ☒ city ☐ county ☐ state ☐ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Turlock Rural Fire Protection District 690 West Canal Drive Turlock, CA 95380 (209) 632-3953				**Primary Contact:** Andy Withington	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: 6 PS ____ PS-defib ____ BLS 21 EMT-D ____ LALS ____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8 Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Name, Address & telephone: Valley Home Fire Protection District P.O. Box 215 Valley Home, CA 95384				**Primary Contact:** Jerry Benedix	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ___ PS ___ PS-defib 4 BLS ___ EMT-D ___ LALS ___ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: ___	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: West Stanislaus Fire Protection District P.O. Box 565 Patterson, CA 95363 (209) 892-5621				**Primary Contact:** Dick Gaiser	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☒ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: 105 PS 25 PS-defib 20 BLS 20 EMT-D ___ LALS ___ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: ___	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

TABLE 8 Providers

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Name, Address & telephone: Westport Fire Protection District 5160 South Carpenter Modesto, CA 95358 (209) 537-1391				**Primary Contact:** Chief Mike Passalaqua	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib 25 BLS 5 EMT-D ____ LALS ____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

Name, Address & telephone: Woodland Avenue Fire Protection District 3300 Woodland Avenue Modesto, CA 95351				**Primary Contact:** Tom Crook	
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☐ Transport ☒ Non-Transport	Air Classification: ☐ auxiliary rescue ☐ air ambulance ☐ ALS rescue ☐ BLS rescue	If Air: ☐ Rotary ☐ Fixed Wing	Number of personnel providing services: ____ PS ____ PS-defib ____ BLS ____ EMT-D ____ LALS ____ ALS
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other: ____	If public: ☐ city ☐ county ☐ state ☒ spec. district ☐ federal	System available 24-hours? ☒ yes ☐ no	Number of ambulances: n/a

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TABLE 9: Approved Training Programs

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Alpine

Training Institution Name and Address		Contact Person and Telephone #
Alpine County Health Dept. P.O. Box 545, Markleeville, CA 96120		Lynn Doyal (530) 694-2159
Student Eligibility: Open	Cost of Program: Basic: None Refresher: None	Program Level: EMT-I Number of Students completing training per year: Initial Training: 20 Refresher: n/a Continuing education: n/a Expiration Date: 3/2000 Number of Courses: Initial training: 1 Refresher: n/a Continuing education n/a

Training Institution Name and Address		Contact Person and Telephone #
Student Eligibility:	Cost of Program: Basic: Refresher:	Program Level: Number of Students completing training per year: Initial Training: Refresher: Continuing education: Expiration Date: Number of Courses: Initial training: Refresher: Continuing education

TABLE 9: Approved Training Programs

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Amador

Training Institution Name and Address	Contact Person and Telephone #
Mountain-Valley EMS Agency 1101 Standiford Avenue, Suite D1, Modesto, Ca. 95350	Marilyn Smith (209) 529-5085
Student Eligibility: Open Cost of Program: Basic $65 plus books. Refresher: $13	Program Level: EMT-I Number of Students completing training per year: Initial Training: 30 Refresher: 50 Continuing education: n/a Expiration Date: 6-30-2001 Number of Courses: Initial training: 1 Refresher: 2 Continuing education n/a

Training Institution Name and Address	Contact Person and Telephone #
Student Eligibility: Cost of Program: Basic: Refresher:	Program Level: Number of Students completing training per year: Initial Training: Refresher: Continuing education: Expiration Date: Number of Courses: Initial training: Refresher: Continuing education

TABLE 9: Approved Training Programs

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Calaveras

Training Institution Name and Address		Contact Person and Telephone #
Mountain-Valley EMS Agency 1101 Standiford Avenue, Suite D1, Modesto, Ca. 95350		Marilyn Smith (209) 529-5085
Student Eligibility: Open	Cost of Program: Basic $65 plus books. Refresher: $13	Program Level: EMT-I Number of Students completing training per year: Initial Training: 50 Refresher: 75 Continuing education: n/a Expiration Date: 6-30-2001 Number of Courses: Initial training: 2 Refresher: 3 Continuing education n/a

Training Institution Name and Address		Contact Person and Telephone #
San Andreas Fire Department P.O. Box 88, San Andreas, CA 95249		Connie Carson (209) 754-4693
Student Eligibility: Open	Cost of Program: Basic: none Refresher: none	Program Level: EMT-I Number of Students completing training per year: Initial Training: 25 Refresher: n/a Continuing education: n/a Expiration Date: 10/2001 Number of Courses: Initial training: 2 Refresher: n/a Continuing education n/a

TABLE 9: Approved Training Programs

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Training Institution Name and Address	Contact Person and Telephone #
Ceres Emergency Services	Danny Davis (209) 538-5709

Student Eligibility: Fire Personnel	Cost of Program:	
	Basic	None.
	Refresher:	None

Program Level: EMT-I

Number of Students completing training per year:

Initial Training:	0
Refresher:	15
Continuing education:	n/a
Expiration Date:	6-30-2001

Number of Courses:

Initial training:	n/a
Refresher:	1
Continuing education	n/a

Training Institution Name and Address	Contact Person and Telephone #
Ceres High School - ROP Program Stanislaus County Dept. of Education, 801 County Center Three, Modesto, Ca. 95355	Carol Perry (209) 538-0130

Student Eligibility: Open	Cost of Program:	
	Basic:	$65 plus books
	Refresher:	$20

Program Level: EMT-I

Number of Students completing training per year:

Initial Training:	60
Refresher:	60
Continuing education:	n/a
Expiration Date:	6-30-2001

Number of Courses:

Initial training:	2
Refresher:	2
Continuing education	n/a

TABLE 9: Approved Training Programs

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Training Institution Name and Address		Contact Person and Telephone #
Newman-Crows Landing School District 890 Main Street, Newman, CA 95360		Barry Hurd 209-862-3205
Student Eligibility: Open	Cost of Program: Basic $175 Refresher: n/a	Program Level: EMT-I Number of Students completing training per year: Initial Training: 50 Refresher: n/a Continuing education: n/a Expiration Date: 8-31-2001 Number of Courses: Initial training: 2 Refresher: 0 Continuing education n/a

Training Institution Name and Address		Contact Person and Telephone #
Modesto Junior College 435 College Avenue, Modesto, Ca. 95350		Rod Brouhard (209) 575-6362
Student Eligibility: Open	Cost of Program: Basic: $60 plus books Refresher: $100	Program Level: EMT-I Number of Students completing training per year: Initial Training: 110 Refresher: 40 Continuing education: n/a Expiration Date: 6-30-2001 Number of Courses: Initial training: 3 Refresher: 2 Continuing education n/a

TABLE 9: Approved Training Programs

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Training Institution Name and Address	Contact Person and Telephone #
Mountain-Valley EMS Agency 1101 Standiford Avenue Suite D1, Modesto, 95350	Marilyn Smith (209) 529-5085
Student Eligibility: Open Cost of Program: Basic $4500 Refresher: n/a	Program Level: EMT-P Number of Students completing training per year: Initial Training: 18 Refresher: n/a Continuing education: n/a Expiration Date: 12/2001 Number of Courses: Initial training: 1 Refresher: n/a Continuing education n/a

Training Institution Name and Address	Contact Person and Telephone #
Abrams College 45 College Avenue, Modesto, CA 95350	Dan Lucky (209) 551-1516
Student Eligibility: Open Cost of Program: Basic: $575 Refresher: None	Program Level: EMT-I Number of Students completing training per year: Initial Training: 75 Refresher: n/a Continuing education: n/a Expiration Date: 7-1-00 Number of Courses: Initial training: 6 Refresher: n/a Continuing education n/a

TABLE 9: Approved Training Programs

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Training Institution Name and Address		Contact Person and Telephone #
Abrams College 45 College Avenue, Modesto, CA 95350		Dan Lucky (209) 551-1516
Student Eligibility: EMT-I	Cost of Program: Basic $5500 Refresher: n/a	Program Level: EMT-P Number of Students completing training per year: Initial Training: 20 Refresher: n/a Continuing education: n/a Expiration Date: 9-30-99 Number of Courses: Initial training: 2 Refresher: n/a Continuing education n/a

Training Institution Name and Address		Contact Person and Telephone #
Student Eligibility:	Cost of Program: Basic: Refresher:	Program Level: Number of Students completing training per year: Initial Training: Refresher: Continuing education: Expiration Date: Number of Courses: Initial training: Refresher: Continuing education

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Table 9.1: Approved EMS Continuing Education Providers **Reporting Year:** 1999-2000

EMS System: Mountain-Valley EMS Agency

County: Alpine

PROVIDER NUMBER	TYPE	NAME OF PROVIDER ADDRESS	CONTACT PERSON	LEVEL OF TRAINING	PROGRAM APPROVAL EXPIRATION DATE
CE 602002	Health Dept.	Alpine County Health Department P.O. Box 545 Markleeville, CA 96120	Rick Botto, M.D. (530) 541-5232	BLS	10-31-99

Table 9.1: Approved EMS Continuing Education Providers **Reporting Year:** 1999-2000

EMS System: Mountain-Valley EMS Agency

County: Amador

PROVIDER NUMBER	TYPE	NAME OF PROVIDER ADDRESS	CONTACT PERSON	LEVEL OF TRAINING	PROGRAM APPROVAL EXPIRATION DATE
CE 60011	Base Hospital	Sutter - Amador Hospital 810 Court Street Jackson, CA 95642	Barabara Steuble, R.N. (209) 223-7500	BLS, ALS	4-30-98
CE 601006	Private	Pioneer-Amador Training Center 26949 Barton Road Pioneer, CA 95666	Patricia Vincent (209) 295-3443	BLS	4-30-99
CE 600231	Fire Dept.	City of Jackson Fire Dept. 33 Broadway Jackson, CA 95642	Geri Saunders (209) 223-1646	BLS	2-28-2001
CE 600231	Ambulance Provider	American Legion Ambulance P.O. Box 480 Sutter Creek, CA 95685	Jenny Rutherford (209) 223-2963	ALS, BLS	4-30-2002

Table 9.1: Approved EMS Continuing Education Providers **Reporting Year:** 1999-2000

EMS System: Mountain-Valley EMS Agency

County: Calaveras

PROVIDER NUMBER	TYPE	NAME OF PROVIDER ADDRESS	CONTACT PERSON	LEVEL OF TRAINING	PROGRAM APPROVAL EXPIRATION DATE
CE 60021	Base Hospital	Mark Twain-St. Joseph's Hospital 768 Mountain Ranch Road San Andreas, CA 95249	Kathy LaBuff, R.N. (209) 754-3521	BLS, ALS	2-28-2001
CE 601007	Private	EMS Taught and Tested 9584 Oak Glenn Drive Valley Springs, CA 95252	Mildred Zyski, EMT-P (209) 786-2425	BLS, ALS	7-31-99
CE 600205	Public Non-Profit	Blue Mountain Medical Volunteers P.O. Box 721 West Point, CA 95255	Bryan Smith (209) 293-7905	BLS	7-31-99
CE 600261	Fire Dept.	San Andreas Fire Department P.O. Box 88 San Andreas, CA 95249	Robert Rhoades (209) 754-4693	BLS	8-31-2001

Table 9.1: Approved EMS Continuing Education Providers **Reporting Year:** 1999-2000

EMS System: Mountain-Valley EMS Agency

County: Mariposa

PROVIDER NUMBER	TYPE	NAME OF PROVIDER ADDRESS	CONTACT PERSON	LEVEL OF TRAINING	PROGRAM APPROVAL EXPIRATION DATE
CE 600071	Base Hospital	John C. Fremont Hospital 5189 Hospital Road Mariposa, CA 95338	Karen Mathes, R.N. (209) 966-3631	BLS, ALS	2-28-2001
CE 602001	Health Dept.	Mariposa County Health Department P.O. Box 5 Mariposa, CA 95338	Phillip Whitson (209) 966-3689	BLS	12-31-98
CE 600072	Hospital	Yosemite Medical Clinic P.O. Box 550 Yosemite National Park, CA 95389	Sandra Saunders, MD (209) 372-4637	10-31-2000	

Table 9.1: Approved EMS Continuing Education Providers **Reporting Year:** 1999-2000

EMS System: Mountain-Valley EMS Agency

County: Stanislaus

PROVIDER NUMBER	TYPE	NAME OF PROVIDER ADDRESS	CONTACT PERSON	LEVEL OF TRAINING	PROGRAM APPROVAL EXPIRATION DATE
CE 601008	Private	Education ETC. 3120 Gayland Drive Modesto, CA 95350	Carlene Bettencourt (209) 544-2928	BLS	1-31-00
CE 600052	Base Hospital	Doctors Medical Center 1441 Florida Avenue Modesto, CA 95350	Candace Tidwell, R.N. (209) 576-3618	BLS, ALS	3-31-2001
CE 600503	Ambulance Provider	American Medical Response Stanislaus County Division P.O. Box 4397 Modesto, CA 95352	Tom Schryer, EMT-P (800) 913-9142	BLS, ALS	10-31-98
CE 600243	Fire Dept.	Modesto City Fire Department 610 11th Street Modesto, CA 95354	Bat. Chief Rich Sasser (209) 578-9591	BLS	12-31-98
CE 601009	Private	Community Education 101 College Avenue Modesto, CA 95354	Patricia Flanigan (209) 551-1516	BLS	2-29-00
CE 600512	Ambulance Provider	Medi-Flight of Northern California Memorial Medical Center 1700 Coffee Road Modesto, CA 95355	Sharon Paulsen, R.N. (209) 572-3292	BLS, ALS	1-31-99
CE 600054	Base Hospital	Memorial Medical Center 1700 Coffee Road Modesto, CA 95355	Vasti DeFreitas, R.N. (209) 526-4500	BLS, ALS	2-28-2001
CE 600264	Fire Dept.	Stanislaus Consolidated Fire Dept. 929 Oakdale Road Modesto, CA 95355	Dep. Chief Dan Reeves (209) 525-4651	BLS	11-30-99
CE 601005	Private	National Ski Patrol System, Inc. 2825 Laramie Drive Modesto, CA 95355	Tom Brennan (209) 521-0209	BLS	1-31-99
CE 600057	Base Hospital	Oak Valley District Hospital 350 South Oak Street Oakdale, CA 95361	Vivian Thompson, R.N. (209) 847-3011	BLS, ALS	2-28-2001

PROVIDER NUMBER	TYPE	NAME OF PROVIDER ADDRESS	CONTACT PERSON	LEVEL OF TRAINING	PROGRAM APPROVAL EXPIRATION DATE
CE 600254	Fire Dept.	Oakdale City Fire Department 325 East "G" Street Oakdale, CA 95361	Dan Cummins, EMT-P (209) 847-5907	BLS	1-28-99
CE 600255	Fire Dept.	Oakdale Rural Fire Protection Dist. 1398 East "F" Street Oakdale, CA 95361	Don Armario, EMT-I (209) 847-6898	BLS	3-31-99
CE 600260	Fire Dept.	Salida Fire Protection District P.O. Box 1335 Salida, CA 95368	Leonard Larsen (209) 545-3840	BLS	2-28-99
CE 600053	Base Hospital	Emanual Medical Center 825 Delbon Avenue Turlock, CA 95380	Debbie Reagor, R.N. (209) 667-5800	BLS, ALS	2-28-2001
CE 600271	Fire Dept.	Turlock Rural Fire District 690 West Canal Drive Turlock, CA 95380	Craig Boothe (209) 632-3953	BLS	10-31-99
CE 600270	Fire Dept.	Turlock City Fire Department P.O. Box 1526 Turlock, CA 95381	Jerry McDaniel (209) 668-5580	BLS	1-28-99
CE600505	Amb. Prov.	Patterson District Ambulance P.O. Box 187 Patterson, CA 95363	Craig Scott, EMT-P (209) 892-8781	ALS/BLS	2-28-2001
CE600206	Fire Dept.	Burbank-Paradise Fire Department 1313 Beverly Drive Modesto, CA 95351	Mark Lockwood (209) 523-1129	BLS	7-31-2001
CE600303	Amb. Prov.	Westside Ambulance 151 So. Highway 33 Newman, CA 95360	Barry Hurd (209) 862-2951	ALS, BLS	9-30-2001
CE601011	School	Ceres Unified School District P.O. Box 307 Ceres, CA 95307	Richard Murdock (209) 538-0150	BLS	7-31-2001
CE601012	Private	Stroup & Associates 1600 Montclair Street Modesto, CA 95350	Craig Stroup (209) 836-0146	ALS, BLS	8-31-2001

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TABLE 10: Facilities

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Amador

Name, Address & telephone: Sutter Amador Hospital 810 Court Street, Jackson, Ca. 95642 (209) 223-6600				**Primary Contact:** Scot Stenberg, Administrator	
Written Contract: ☒ yes ☐ no	Referral Emergency Service: ☐ Standby Emergency Service: ☐ Basic Emergency Service: ☒ Comprehensive Emergency Service: ☐			Base Hospital: ☒ yes ☐ no	Pediatric Critical Care Center: ☐ yes ☒ no
EDAP: ☐ yes ☒ no	PICU: ☐ yes ☒ no	Burn Center: ☐ yes ☒ no		Trauma Center: ☐ yes ☒ no	If Trauma Center, what Level: n/a

Name, Address & telephone:				**Primary Contact:**	
Written Contract: ☐ yes ☐ no	Referral Emergency Service: ☐ Standby Emergency Service: ☐ Basic Emergency Service: ☐ Comprehensive Emergency Service: ☐			Base Hospital: ☐ yes ☐ no	Pediatric Critical Care Center:
EDAP: ☐ yes ☐ no	PICU: ☐ yes ☐ no	Burn Center: ☐ yes ☐ no		Trauma Center: ☐ yes ☐ no	If Trauma Center, what Level: n/a

TABLE 10: Facilities

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Calaveras

Name, Address & telephone: Mark Twain - St. Joseph's Hospital 768 Mountain Ranch Road, San Andreas, Ca. 95249 (209) 754-3521				**Primary Contact:** Michael Lawson, Administrator	
Written Contract: ☒ yes ☐ no	Referral Emergency Service: ☐ Standby Emergency Service: ☐ Basic Emergency Service: ☒ Comprehensive Emergency Service: ☐			Base Hospital: ☒ yes ☐ no	Pediatric Critical Care Center: ☐ yes ☒ no
EDAP: ☐ yes ☒ no	PICU: ☐ yes ☒ no	Burn Center: ☐ yes ☒ no		Trauma Center: ☐ yes ☒ no	If Trauma Center, what Level: n/a

Name, Address & telephone:				**Primary Contact:**	
Written Contract: ☐ yes ☐ no	Referral Emergency Service: ☐ Standby Emergency Service: ☐ Basic Emergency Service: ☐ Comprehensive Emergency Service: ☐			Base Hospital: ☐ yes ☐ no	Pediatric Critical Care Center:
EDAP: ☐ yes ☐ no	PICU: ☐ yes ☐ no	Burn Center: ☐ yes ☐ no		Trauma Center: ☐ yes ☐ no	If Trauma Center, what Level: n/a

TABLE 10: Facilities

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Mariposa

Name, Address & telephone: John C. Fremont Healthcare District 5189 Hospital Road, Mariposa, Ca. 95338 (209) 966-3631				**Primary Contact:** Elnora George, Administrator/CEO/CFO	
Written Contract: ☒ yes ☐ no	Referral Emergency Service: ☐ Standby Emergency Service: ☒ Basic Emergency Service: ☐ Comprehensive Emergency Service: ☐			Base Hospital: ☒ yes ☐ no	Pediatric Critical Care Center: ☐ yes ☒ no
EDAP: ☐ yes ☒ no	PICU: ☐ yes ☒ no	Burn Center: ☐ yes ☒ no		Trauma Center: ☐ yes ☒ no	If Trauma Center, what Level: n/a

Name, Address & telephone:				**Primary Contact:**	
Written Contract: ☐ yes ☐ no	Referral Emergency Service: ☐ Standby Emergency Service: ☐ Basic Emergency Service: ☐ Comprehensive Emergency Service: ☐			Base Hospital: ☐ yes ☐ no	Pediatric Critical Care Center:
EDAP: ☐ yes ☐ no	PICU: ☐ yes ☐ no	Burn Center: ☐ yes ☐ no		Trauma Center: ☐ yes ☐ no	If Trauma Center, what Level: n/a

TABLE 10: Facilities

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Name, Address & telephone:				**Primary Contact:**	
Written Contract: ☐ yes ☐ no	Referral Emergency Service: ☐ Standby Emergency Service: ☐ Basic Emergency Service: ☐ Comprehensive Emergency Service: ☐			Base Hospital: ☐ yes ☐ no	Pediatric Critical Care Center: ☐ yes ☐ no
EDAP: ☐ yes ☐ no	PICU: ☐ yes ☐ no	Burn Center: ☐ yes ☐ no		Trauma Center: ☐ yes ☐ no	If Trauma Center, what Level:

Name, Address & telephone: Doctors Medical Center 1441 Florida Avenue, Modesto, Ca. 95350 (209) 578-1211				**Primary Contact:** Tim Joslin, Chief Executive Officer	
Written Contract: ☒ yes ☐ no	Referral Emergency Service: ☐ Standby Emergency Service: ☐ Basic Emergency Service: ☒ Comprehensive Emergency Service: ☐			Base Hospital: ☒ yes ☐ no	Pediatric Critical Care Center: ☐ yes ☒ no
EDAP: ☐ yes ☒ no	PICU: ☐ yes ☒ no	Burn Center: ☐ yes ☒ no		Trauma Center: ☐ yes ☒ no	If Trauma Center, what Level: n/a

TABLE 10: Facilities

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Name, Address & telephone: Emanuel Medical Center 825 Delbon Avenue, Turlock, Ca. 95380 (209) 667-4200				**Primary Contact:** Bob Moen, Administrator	
Written Contract: ☒ yes ☐ no	Referral Emergency Service: ☐ Standby Emergency Service: ☐ Basic Emergency Service: ☒ Comprehensive Emergency Service: ☐			Base Hospital: ☒ yes ☐ no	Pediatric Critical Care Center: ☐ yes ☒ no
EDAP: ☐ yes ☒ no	PICU: ☐ yes ☒ no	Burn Center: ☐ yes ☒ no		Trauma Center: ☐ yes ☒ no	If Trauma Center, what Level: n/a

Name, Address & telephone: Memorial Medical Center 1800 Coffee Road, Modesto, Ca. 95355 (209) 526-4500				**Primary Contact:** David Benn, Chief Executive Officer	
Written Contract: ☒ yes ☐ no	Referral Emergency Service: ☐ Standby Emergency Service: ☐ Basic Emergency Service: ☒ Comprehensive Emergency Service: ☐			Base Hospital: ☒ yes ☐ no	Pediatric Critical Care Center: ☐ yes ☒ no
EDAP: ☐ yes ☒ no	PICU: ☐ yes ☒ no	Burn Center: ☐ yes ☒ no		Trauma Center: ☐ yes ☒ no	If Trauma Center, what Level: n/a

TABLE 10: Facilities

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1999-2000

County: Stanislaus

Name, Address & telephone: Oak Valley District Hospital 350 South Oak Street, Oakdale, Ca. 95361 (209) 847-3011				**Primary Contact:** Norman Andrews, Administrator	
Written Contract: ☒ yes ☐ no	Referral Emergency Service: ☐ Standby Emergency Service: ☐ Basic Emergency Service: ☒ Comprehensive Emergency Service: ☐			Base Hospital: ☒ yes ☐ no	Pediatric Critical Care Center: ☐ yes ☒ no
EDAP: ☐ yes ☒ no	PICU: ☐ yes ☒ no	Burn Center: ☐ yes ☒ no		Trauma Center: ☐ yes ☒ no	If Trauma Center, what Level: n/a

Name, Address & telephone:				**Primary Contact:**	
Written Contract: ☐ yes ☐ no	Referral Emergency Service: ☐ Standby Emergency Service: ☐ Basic Emergency Service: ☐ Comprehensive Emergency Service: ☐			Base Hospital: ☐ yes ☐ no	Pediatric Critical Care Center: ☐ yes ☐ no
EDAP: ☐ yes ☐ no	PICU: ☐ yes ☐ no	Burn Center: ☐ yes ☐ no		Trauma Center: ☐ yes ☐ no	If Trauma Center, what Level:

Table 11: Dispatch Agencies

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1998-99

County: Amador

Name, address & telephone: Amador County Sheriff's Office, Communications Center 700 Court Street, Jackson, Ca. 95642 (209) 223-6513				**Primary Contact:** Darienne Threlkeld
Written Contract: ☒ yes ☐ no	Service: ☒ Ground ☐ Air ☐ Water	☒ Day-to-day ☒ Disaster	Number of personnel providing services: 10-12 EMD Training _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other	
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☐ Fire ☒ Law ☐ Other,_____	If public: ☐ city ☒ county ☐ state ☐spec district ☐ federal	Number of ambulances: 4 ground ambulances 1 ALS squad

Name, address & telephone:				**Primary Contact:**
Written Contract: ☐ yes ☐ no	Service: ☐ Ground ☐ Air ☐ Water	☐ Day-to-day ☐ Disaster	Number of personnel providing services: _____ EMD Training _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other	
Ownership: ☐ Public ☐ Private	Medical Director: ☐ yes ☐ no	If public: ☐ Fire ☐ Law ☐ Other,_____	If public: ☐ city ☐ county ☐ state ☐spec district ☐ federal	Number of ambulances:_____

Table 11: Dispatch Agencies

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1998-99

County: Calaveras

Name, address & telephone: Calaveras County Sheriff's Office, Communications Center Government Center, San Andreas, Ca. 95249 (209) 754-6500				**Primary Contact:** Debby Parsons
Written Contract: ☒ yes ☐ no	Service: ☒ Ground ☐ Air ☐ Water	☒ Day-to-day ☒ Disaster	Number of personnel providing services: _____ EMD Training _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other	
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☐ Fire ☒ Law ☐ Other,_____	If public: ☐ city ☒ county ☐ state ☐spec district ☐ federal	Number of ambulances:_____

Name, address & telephone:				**Primary Contact:**
Written Contract: ☐ yes ☐ no	Service: ☐ Ground ☐ Air ☐ Water	☐ Day-to-day ☐ Disaster	Number of personnel providing services: _____ EMD Training _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other	
Ownership: ☐ Public ☐ Private	Medical Director: ☐ yes ☐ no	If public: ☐ Fire ☐ Law ☐ Other,_____	If public: ☐ city ☐ county ☐ state ☐spec district ☐ federal	Number of ambulances:_____

Table 11: Dispatch Agencies

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1998-99

County: Mariposa

Name, address & telephone: California Department of Forestry, Emergency Communications Center 5366 Highway 49 North, Mariposa, Ca. 95338 (209) 966-3622				**Primary Contact:** Dave Burroughs - BC
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☒ Day-to-day ☒ Disaster	Number of personnel providing services: 12 EMD Training ____ EMT-D ____ ALS ____ BLS ____ LALS ____ Other	
Ownership: ☒ Public ☐ Private	Medical Director: ☐ yes ☒ no	If public: ☒ Fire ☐ Law ☐ Other,____	If public: ☐ city ☐ county ☒ state ☐spec district ☐ federal	Number of ambulances: 3 ground ambulances

Name, address & telephone:				**Primary Contact:**
Written Contract: ☐ yes ☐ no	Service: ☐ Ground ☐ Air ☐ Water	☐ Day-to-day ☐ Disaster	Number of personnel providing services: ____ EMD Training ____ EMT-D ____ ALS ____ BLS ____ LALS ____ Other	
Ownership: ☐ Public ☐ Private	Medical Director: ☐ yes ☐ no	If public: ☐ Fire ☐ Law ☐ Other,____	If public: ☐ city ☐ county ☐ state ☐spec district ☐ federal	Number of ambulances:____

Table 11: Dispatch Agencies

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1998-99

County: Stanislaus

Name, address & telephone: Air Med Team Communications Center 1441 Florida Avenue, Modesto, Ca. 95350 (209) 576 3939				**Primary Contact:** Graham Pierce
Written Contract: ☒ yes ☐ no	Service: ☐ Ground ☒ Air ☐ Water	☒ Day-to-day ☒ Disaster	Number of personnel providing services: _____ EMD Training _____ EMT-D _____ ALS _____ BLS _____ LALS X_____ Other	
Ownership: ☐ Public ☒ Private	Medical Director: ☐ yes ☒ no	If public: ☐ Fire ☐ Law ☐ Other,_____	If public: ☐ city ☐ county ☐ state ☐spec district ☐ federal	Number of ambulances: 1 air ambulance

Name, address & telephone: Regional Rural Dispatch - Medi-Flight Communications Center 1700 Coffee Road, Modesto, Ca. 95355 (209) 572-7050				**Primary Contact:** Frank Erdman
Written Contract: ☒ yes ☐ no	Service: ☒ Ground ☒ Air ☐ Water	☒ Day-to-day ☒ Disaster	Number of personnel providing services: 12 EMD Training _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other	
Ownership: ☐ Public ☒ Private	Medical Director: ☒ yes ☐ no	If public: ☐ Fire ☐ Law ☐ Other,_____	If public: ☐ city ☐ county ☐ state ☐spec district ☐ federal	Number of ambulances: 2 air ambulances 0 ground ambulances

Table 11: Dispatch Agencies

EMS System: Mountain-Valley EMS Agency **Reporting Year:** 1998-99

County: Stanislaus

Name, address & telephone: Stanislaus County Emergency Medical Communications 801 10th Street, Modesto, Ca. 95354 (209) 238-4801				**Primary Contact:** Kevin Grant
Written Contract: ☐ yes ☒ no	Service: ☒ Ground ☐ Air ☐ Water	☒ Day-to-day ☒ Disaster	Number of personnel providing services: 10-12 EMD Training _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other	
Ownership: ☐ Public ☒ Private	Medical Director: ☐ yes ☒ no	If public: ☐ Fire ☐ Law ☐ Other,_____	If public: ☐ city ☐ county ☐ state ☐spec district ☐ federal	Number of ambulances: 15

Name, address & telephone:				**Primary Contact:**
Written Contract: ☐ yes ☐ no	Service: ☐ Ground ☐ Air ☐ Water	☐ Day-to-day ☐ Disaster	Number of personnel providing services: _____ EMD Training _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other	
Ownership: ☐ Public ☐ Private	Medical Director: ☐ yes ☐ no	If public: ☐ Fire ☐ Law ☐ Other,_____	If public: ☐ city ☐ county ☐ state ☐spec district ☐ federal	Number of ambulances:_____

DESCRIPTION OF THE PLAN DEVELOPMENT PROCESS

The process used to develop the EMS System Plan for the Mountain-Valley EMS Agency was taken directly from the California EMS Authority's EMS System Guidelines: Part III: EMS System Planning Guidelines (June 1994). These guidelines recommend the following three steps in developing an EMS plan: document the current status of the local EMS system *(where we are now)*; develop a model for the future *(where we want to be)*; and develop the specific objectives necessary to move the EMS system from where it is today toward the future model *(getting from where we are to where we want to be)*.

The current status of the MVEMSA system was established using the tables included in the EMS System Planning Guidelines. Agency staff completed initial drafts of Tables 1 through 11 and disseminated these drafts to the Regional Advisory Committee (RAC), each county Emergency Medical Care Committee (EMCC), system participants and other interested parties. The EMCCs and the RAC publicly reviewed and commented on the draft documents at regularly scheduled meetings. Agency staff revised the tables based on the comments received and a final copy of each table was approved by the RAC on May 17, 1995.

The process of developing a model for the future of EMS in the MVEMSA system started with the formation of the EMS Design 2000 Planning Task Force. The membership of the task force was designed to ensure that: there was representation from all system providers, (hospitals, ambulance, first response, payers) and geographic areas; all selected members were well-respected professionals in their field; and each member had the unique ability to set aside their own personal and professional biases and analyze prehospital care and transport from a system perspective.

The mission of the task force was to:

1) identify the need the EMS system would meet in the future;
2) identify the future political, social and economic environment through the use of best guess assumptions;
3) design the optimal EMS system based on the need to be met and future environment; and
4) identify the constraints that would interfere or prohibit the adoption of the optimal EMS system.

The task force met regularly from February through May 1995. Once complete, the EMS Design 2000 Optimal System Model, along with the identified local system constraints were presented to all county EMCCs, the area Hospital Council, various local Fire Chief Associations, and the RAC. All comments and input received during and following these public presentations were presented to RAC for consideration. Based upon the optimal system model, the system constraints, and the recommendations received during the public review process, agency staff drafted the EMS Design 2000: The Local EMS System Model for the Mountain-Valley EMS Region, which was approved by the RAC on July 19, 1995.

The next step in the planning process was to develop the objectives necessary to move the current EMS system from where it is today to the EMS system model of tomorrow.
Agency staff developed a first draft of the EMS plan objectives based on the concepts contained in the EMS Design 2000; The Local EMS System Model for the Mountain-Valley EMS Agency and the California EMS Authority's EMS Systems Standards and Guidelines. Once complete the EMS plan objectives were submitted to the RAC for review to determine if the objectives: 1) addressed each of the minimum EMS standards and recommended guidelines and 2) moved the EMS system in the direction of the EMS system model. Based on this review process revisions were made to the EMS plan objectives.

The Transportation Plan for the MVEMSA system, included here as Appendix 2, was drafted and submitted for public review concurrent with the EMS plan objectives.

An executive summary and a description of the plan development process were written following RAC approval of the EMS plan objectives.

Finally, agency staff brought the separate sections, summary, assessment, objectives, tables, etc., together to create a draft Mountain-Valley Emergency Medical Services Agency Emergency Medical Services System Plan. Since each section was developed separately, the compiled plan was reviewed by agency staff and minor edits were made for grammer, format and consistency. The complete EMS plan, including all modifications and appendices was submitted to the Regional Advisory Committee for approval at a public hearing held on November 15, 1995.

The EMS System Plan including all appendices was approved by the Board of Directors of the Mountain-Valley EMS Agency on December 13, 1995.

APPENDIX

Section 1: Summary of Changes

Major Changes to the EMS System

There were no major structural or process changes to the EMS system during the past fiscal year.

Progress in Meeting 1999-2000 Objectives

System Organization and Management

1. Standard 1.01 LEMSA STRUCTURE: Agency hired a data/analyst programmer to oversee the data management systems and programs. However this person resigned in April 2000.

2. Standard 1.05 SYSTEM PLAN: An agreement was reached with Medical Priorities consultants to conduct a three-phase study to evaluate the feasibility of providing level III dispatch in Stanislaus County. The study was funded by various system participants.

3. Standard 1.06 ANNUAL PLAN UPDATE: This document serves as the annual update of the EMS system plan, submitted to the State EMS Authority, which reflects system changes and progress made in meeting plan objectives.

4. Standard 1.08 ALS PLANNING: A grant to study the feasibility of ALS first response services and other ALS alternatives as described in the EMS system model, including the development of exclusive operating areas for non-transporting ALS service providers was awarded to the agency by the state. However, funding was cut two months into the project. The grant proposal will e resubmitted for next fiscal year.

5. Standard 1.09 INVENTORY OF RESOURCES: The resource directories included in this plan have been updated.

6. Standard 1.10 SPECIAL POPULATIONS: Staff participated in a task force in Stanislaus County to identify population groups served by the EMS system which require specialized services. A work plan was developed by the task force.

7. Standard 1.11 SYSTEM PARTICIPANTS: Agency staff participated in the CSUS Research project and is continuing to meet with several task forces to make recommendations to the Stanislaus County board of supervisors regarding the research project's final report.

8. Standard 1.12 REVIEW AND MONITORING (see 6.01)

9. Standard 1.15 COMPLIANCE WITH POLICIES (see 6.01)

10. Standard 1.16 FUNDING MECHANISM: The Agency maintained existing funding sources and explored several additional grant fund sources, however, no alternative sources of funds were

acquire during this fiscal year.

11. Standard 1.17 MEDICAL DIRECTION: The possibility of centralizing base hospital medical control was included in a feasibility study conducted by Medical Priority consultants. The report will be completed and ready for analysis in early FY00/01.

12. Standard 1.18 QA/AI (see 6.01)

13. Standard 1.19 POLICIES, PROCEDURES, PROTOCOLS: BLS Treatment Protocols updated. ALS protocol revisions begun.

14. Standard 1.23 INTERFACILITY TRANSFER: Met with Hospital Council representative regarding possible revisions or our current interfacility transfer policy.

15. Standard 1.24 ALS SYSTEMS: Maintained written agreements with all ALS providers and monitor compliance. Continued to study the feasibility of establishing county-wide EOAs, including emergency ambulance providers and non-transporting ALS service providers.

16. Standard 1.25 ONLINE MEDICAL DIRECTION (see 5.07)

17. Standard 1.28 EOA PLAN: Monitored design of EOAs.

STAFFING & TRAINING

18. Standard 2.01 ASSESSMENT OF NEEDS: For the past several years, MVEMSA has provided First Responder and EMT-I training programs in Amador and Calaveras Counties, through a contract with Delta College. Effective with the Fall '99 semester, the Agency began offering these courses through a contract with Columbia College, allowing these courses to expand to Mariposa County.

19. Standard 2.02 APPROVAL OF TRAINING: A self-survey document to evaluate contract compliance was developed by MVEMSA and completed by each of the CE providers.

20. Standard 2.03 PERSONNEL: Agency staff processed certification and accreditation for the following personnel during FY 1999/00:

✓	EMD Dispatchers Certified	25
✓	First Responders Certified	185
✓	EMTs Certified	593
✓	EMT-Ps Accredited	112
✓	MICNs Authorized	83

- The third year of our local paramedic training program was successful. The program is a joint effort between a community college, two area hospitals and the agency.

- The Agency conducted mandatory 8-hr Airway Performance Improvement courses, required for all paramedics as part of the QI process.

- The Agency conducted 8-hr Field MCI Course, 4-hour Hospital MCI courses, 16-hour ICS200 courses and an 8-hour HEICS course.

22. Standard 2.04 DISPATCH TRAINING: Encouraged the passage of dispatcher immunity legislation. Continued to investigate more cost effective means of providing EMS dispatch services to include emergency and non-emergency call screening as outlined in the EMS system model.

23. Standard 2.06 RESPONSE: BLS treatment guidelines were revised. The optimal roles and responsibilities of EMS system participants was explored by the Medical Priorities Consultant project.

24. Standard 2.13 BASE HOSPITAL PERSONNEL: The roles of the Base Hospital MICN and MD were addressed in meetings with local base hospitals. No significant change was made to either role.

P.I. & E.

25. Standard 7.01 PUBLIC INFORMATION MATERIALS: In coordination with primary care providers and other public safety agencies, staff participated in several public information and education programs.

26. Standard 7.04 FIRST-AID AND CPR TRAINING: Encouraged establishing citizen CPR and first aid training.

COMMUNICATIONS

27. Standard 3.01 COMMUNICATIONS PLAN: The Agency's communications directory was updated, including repeater sites, radio frequencies used in each of our member counties and frequency licenses. MOU established with Merced County for occasional use of the Med 9 repeater by Stanislaus County providers. New repeater to be purchased for West Stanislaus County to improve coverage.

28. Standard 3.04 DISPATCH CENTER: Self-surveys sent to each of the local EMS dispatch center. Random site surveys conducted to evaluate contract compliance. Agreement reached with Medical Priorities Consultants to conduct a feasability study for level III dispatch. Funding for the study to be shared by various stakeholders.

29. Standard 3.07 9-1-1 PLANNING/COORDINATION: Staff attended several meetings regarding a consolidated dispatch center in Stanislaus County. Agreement reached with Medical Priorities Consultants to conduct a feasability study for level III dispatch.

30. Standard 3.09 DISPATCH TRIAGE: EMD Certification/Recertification policies updated.

31. Standard 3.10 INEGRATED DISPATCH: Evaluated the feasibility of developing an integrated dispatch as described in the EMS System Model.

RESPONSE & TRANSPORT

32. Standard 4.01 SERVICE AREA BOUNDARIES: Local ambulance ordinance developed for Amador County.

33. Standard 4.02 MONITORING: Revised surveys and random compliance evaluations of ALS providers. Worked closely with cities and fire agencies to ensure that their EMS concerns are addressed in both day to day operations and during ambulance provider agreement negotiations.

34. Standard 4.03 CLASSIFYING MEDICAL REQUESTS: [see 3.04]

35. Standard 4.05 RESPONSE TIME STANDARDS: Response time standards reevaluated. Language updated in the Transportation Plan to reflect current state guidelines.

36. Standard 4.10 AIRCRAFT AVAILABILITY: Approved one new air ambulance provider. Reassessed and revised the air ambulance response time maps.

37. Standard 4.17 ALS EQUIPMENT: Emergency policy produced regarding cricothyrotomy airway equipment.

38. Standard 4.19 TRANSPORTATION PLAN: Policies and language regarding ALS first responders updated in the Transportation Plan.

39. Standard 4.22 EVALUATION: Participated on a task force to develop a formal mechanism, consistent with the EMS system model, for evaluating EOA design.

FACILITIES & CRITICAL CARE

40. Standard 5.01 ASSESSMENT OF CAPABILITIES: OES Region IV map updated through the RDMHC and distributed to the Control Facilities, indicating hospitals and specialty services.

41. Standard 5.03 TRANSFER GUIDELINES: Began discussions regarding the development of transfer policies, protocols, and guidelines for trauma and other specialty patient groups.

42. Standard 5.06 HOSPITAL EVACUATION: Developed an impact evaluation policy for hospital

reduction or closure of emergency services.

43. Standard 5.07 BASE HOSPITAL DESIGNATION: Conducted a feasibility study for establishment of a single medical control point.

DATA & SYSTEM EVALUATION

44. Standard 6.01 QA/QI PROGRAM (99-00 Grant Project): Continued to participate in the development of statewide standards and indicators for system evaluation. Conducted a Rapid Cycle Improvement Project regarding immediate submission of patient care records and implemented mandatory training as a result of an Airway Performance Improvement Plan.

45. Standard 6.02 PREHOSPITAL RECORDS: Investigated ways of improving completeness and timely submission of patient care records. Agency sponsored two documentation seminars which were well attended by field personnel.

46. Standard 6.03 PREHOSPITAL CARE AUDITS: Plan developed to include first responder and dispatch agencies in the quarterly regional Quality Liaison Committee.

47. Standard 6.06 SYSTEM DESIGN EVALUATION: (see 6.01)

48. Standard 6.07 PROVIDER PARTICIPATION: Re-established QI groups in Stanislaus and Mariposa Counties. The role/composition of the local EMCC in Stanislaus County being addressed by a task force of the county.

49. Standard 6.08 REPORTING: Reports containing the system evaluation, design, and operations are submitted at least quarterly to the Board(s) of Supervisors and Regional Advisory Committee. Periodic reports also provided to local Emergency Medical Care Committees.

50. Standard 6.09 ALS AUDIT: Local quality improvement groups continue to address local operational and patient care issues within each county. The regional Quality Liaison Committee completed the Airway Performance Improvement project, resulting in mandatory 8-hr class for all paramedics.

DISASTER MEDICAL RESPONSE

51. Standard 8.01 DISASTER MEDICAL PLANNING: Staff led a project funded through EMSA to develop statewide standards for disaster medical response. A second year's funding has been requested to follow the regulation process and develop training standards.

52. Standard 8.02 RESPONSE PLANS: Policy manuals updated with current versions of the field, hospital and mutual-aid MCI modules.

53. Standard 8.03 HAZMAT TRAINING: Staff attended local and regional meetings regarding WMD

and hazmat preparedness.

54. Standard 8.04 INCIDENT COMMAND SYSTEM: Provider agreements modified to ensure that all EMS personnel, including EMTs, first responders and dispatchers are trained in MCI and SEMS.

55. Standard 8.05 DISTRIBUTION OF CASUALTIES: Updated the Facilities Assessment Profiles and OES Region IV map, which identifies facilities and facility specialties.

56. Standard 8.06 NEEDS ASSESSMENT: Attended quarterly meetings with the RDMHC and other OADMHC personnel from throughout OES Region IV. Participated in two statewide communications/mutual aid drills.

57. Standard 8.13 DISASTER MEDICAL TRAINING: Seven 8-hour field MCI Course were taught, totaling more than 100 students. Three 4-hour hospital MCI course were taught, totaling more than 30 students. Two 16-hour ICS-200 courses were taught, totaling more than 40 students.

58. Standard 8.14 HOSPITAL PLANS: Continued to work with Hospital Council Disaster Subcommittee and local hospitals to implement HEICS. Monthly hospital Emergency Preparedness Coordinators meetings were begun.

Plan Objectives for 2000-2001

1. Standard 1.01 LEMSA STRUCTURE: Hire a Information Systems Analyst to oversee the data management systems and programs.

2. Standard 1.05 SYSTEM PLAN: Participate in Stanislaus County Evaluation Study program designed to evaluate the effectiveness of system changes developed under the EMS 2000 system model.

3. Standard 1.06 ANNUAL PLAN UPDATE: Submit an annual update of the EMS system plan to the State EMS Authority, which reflects system changes and progress made in meeting plan objectives.

4. Standard 1.08 ALS PLANNING: Study the feasibility of ALS first response services and other ALS alternatives as described in the EMS system model, including the development of exclusive operating areas for non-transporting ALS service providers. Make changes as necessary to ensure the optimal provision of ALS services.

5. Standard 1.09 INVENTORY OF RESOURCES: Annually update the resource directories included in the EMS Plan.

6. Standard 1.10 SPECIAL POPULATIONS: Work with Stanislaus County task force and other agencies, both county and private, to complete work plan developed last fiscal year for multi-cultural public education.

7. Standard 1.11 SYSTEM PARTICIPANTS: Participate in the Stanislaus County project to *Identify the optimal roles and responsibilities of system participants.*

8. Standard 1.12 REVIEW AND MONITORING (see 6.01)

9. Standard 1.13 COORDINATION: Evaluate EMS system operations and make changes as needed to ensure optimal system performance.

10. Standard 1.14 POLICY & PROCEDURE MANUAL: Monitor the process of policy and procedure manual availability and make changes as necessary.

11. Standard 1.15 COMPLIANCE WITH POLICIES (see 6.01)

12. Standard 1.16 FUNDING MECHANISM: Maintain existing funding sources and seek alternative or new funding sources. Continue to evaluate agency cost efficiency.

13. Standard 1.17 MEDICAL DIRECTION (see 6.01)

14. Standard 1.18 QA/QI (see 6.01)

15. Standard 1.19 POLICIES, PROCEDURES, PROTOCOLS: 1) Review and revise polices, as needed, to meet minimum standards and the EMS System Model. 2) Develop policies for transport of patients to facilities appropriate for their injuries or illness. 3) Evaluate and modify the ALS scope of practice as needed.

16. Standard 1.23 INTERFACILITY TRANSFER: Evaluate the need for revising or further developing the interfacility forms and documents.

17. Standard 1.24 ALS SYSTEMS: Maintain written agreements with all ALS providers and monitor compliance. Determine the feasibility of establishing county-wide EOAs, including emergency ambulance providers and non-transporting ALS service providers.

18. Standard 1.25 ONLINE MEDICAL DIRECTION (see 5.07)

19. Standard 1.28 EOA PLAN: Monitor design of EOAs and make changes as required.

STAFFING & TRAINING

20. Standard 2.01 ASSESSMENT OF NEEDS: Evaluate training needs of system participants.

21. Standard 2.02 APPROVAL OF TRAINING: Continue surveys and random compliance evaluations of local programs.

22. Standard 2.04 DISPATCH TRAINING: Encourage the passage of dispatcher immunity legislation. Investigate and develop, as appropriate, more cost effective means of providing EMS dispatch services to include emergency and non-emergency call screening as outlined in the EMS system model.

23. Standard 2.05 FIRST RESPONDER TRAINING: Continue to offer First Responder and EMT training as needed.

24. Standard 2.06 RESPONSE: Continue to work with the Stanislaus County task force to identify the optimal roles and responsibilities of EMS system participants.

25. Standard 2.08 EMT-I TRAINING: Provide AED training for all EMTs.

26. Standard 2.12 EARLY DEFIBRILLATION: Evaluate and revise existing policies and procedures for early defibrillation training and certification to determine that system needs are being met.

27. Standard 2.13 BASE HOSPITAL PERSONNEL: Review and revise the roles of the Base Hospital MICN and MD as needed.

COMMUNICATIONS

28. Standard 3.01 COMMUNICATIONS PLAN: Revise the communications plan, prioritize system repairs and upgrades and make necessary changes to comply with the EMS system model.

29. Standard 3.04 DISPATCH CENTER: Perform a study to determine the required number of medical dispatch centers and their optimal configurations and responsibilities.

30. Standard 3.07 9-1-1 PLANNING/COORDINATION: Participate in ongoing planning and coordination of 9-1-1 telephone service and encourage the development of PSAPs as described in the EMS system model.

31. Standard 3.09 DISPATCH TRIAGE: Develop and implement standardized (first response/ambulance) dispatch triage criteria as described in the EMS system model.

32. Standard 3.10 INTEGRATED DISPATCH: Evaluate the feasibility of developing an integrated dispatch as described in the EMS System Model.

RESPONSE & TRANSPORT

33. Standard 4.01 SERVICE AREA BOUNDARIES: Establish/review/revise local ambulance ordinances as needed. Evaluate response times to and from neighboring areas to ensure optimal service area boundaries.

34. Standard 4.02 MONITORING: Continue surveys and random compliance evaluations of ALS providers. Work closely with cities and fire agencies to ensure that their EMS concerns are addressed in both day to day operations and during ambulance provider agreement negotiations.

35. Standard 4.03 CLASSIFYING MEDICAL REQUESTS: Evaluate the feasibility of developing a dispatch system as described in the EMS System Model.

36. Standard 4.05 RESPONSE TIME STANDARDS: Create a mechanism to measure response times from receipt of call at primary PSAP to arrival on scene.

37. Standard 4.07 FIRST RESPONDER AGENCIES: Identify the optimal roles and responsibilities of first response agencies as described in the EMS system model.

38. Standard 4.10 AIRCRAFT AVAILABILITY: Monitor providers to ensure that system demands are being met and take corrective action as necessary.

39. Standard 4.16 ALS STAFFING: Evaluate the feasibility and need of staffing ambulances with a combination of paramedics, registered nurses and physician assistants (PAs or LPNs) as outlined in the EMS System Model.

40. Standard 4.17 ALS EQUIPMENT: Monitor drug and equipment requirements and make changes as needed.

41. Standard 4.19 TRANSPORTATION PLAN: Evaluate Agency position regarding inclusion of all ambulance calls within EOAs and update Transportation Plan.

42. Standard 4.22 EVALUATION: Develop a formal mechanism, consistent with the EMS system model, for evaluating EOA design. Continue to monitor performance standards and take corrective action as needed.

FACILITIES & CRITICAL CARE

43. Standard 5.01 ASSESSMENT OF CAPABILITIES: In conjunction with area hospitals and the medical community, determine hospital capabilities through completion of a facility assessment instrument.

44. Standard 5.02 TRIAGE & TRANSFER PROTOCOLS: Develop prehospital triage and transfer protocols based on medical need and preferred transport.

45. Standard 5.03 TRANSFER GUIDELINES: Develop/update transfer policies, protocols and guidelines for trauma and other specialty patient groups.

46. Standard 5.05 MASS CASUALTY MANAGEMENT: Ensure adherence to MCI plan requirements.

47. Standard 5.07 BASE HOSPITAL DESIGNATION: Conclude a feasibility study for establishment of a single medical control point.

DATA & SYSTEM EVALUATION

48. Standard 6.01 QA/QI PROGRAM Participate in the development of statewide standards and indicators for system evaluation. Continue to monitor and amend the QA/QI program to meet system needs.

49. Standard 6.02 PREHOSPITAL RECORDS: Investigate ways of improving completeness and timely submission of patient care records. Monitor providers to ensure adherence to policy and take corrective action as necessary.

50. Standard 6.03 PREHOSPITAL CARE AUDITS: Work with provider agencies to improve data submission.

51. Standard 6.06 SYSTEM DESIGN EVALUATION: (see 6.01)

52. Standard 6.07 PROVIDER PARTICIPATION: Continue to encourage system provider participation in local QI groups and the regional Quality Liaison Committee.

53. Standard 6.08 REPORTING: At least annually, report the results of the system evaluation, design and operations to the Board(s) of Supervisors, provider agencies, and Emergency Medical Care Committee(s).

54. Standard 6.09 ALS AUDIT: Conduct medical auditing and; provide feedback to prehospital personnel on patient outcomes. Continue to monitor and amend the QA/QI program, as needed, to meet system needs.

P.I. & E.

55. Standard 7.01 PUBLIC INFORMATION MATERIALS: In coordination with primary care providers and other public safety agencies, develop and present education materials and programs regarding system access and appropriate utilization of the 911 system.

DISASTER MEDICAL RESPONSE

56. Standard 8.01 DISASTER MEDICAL PLANNING: Continue to work with member county OES coordinators and local medical/health providers to incorporate the EOC Medical/Health Branch Manual into local plans.

57. Standard 8.02 RESPONSE PLANS: Assist with the update of regional MCI Field Instructors through an annual conference/meeting.

58. Standard 8.03 HAZMAT TRAINING: Continue to work with local providers and agency representatives to determine the roles and responsibilities of EMS personnel regarding hazardous materials incidents.

59. Standard 8.04 INCIDENT COMMAND SYSTEM: Modify existing processes to ensure that all EMS personnel, including EMTs, first responders and dispatchers are trained in MCI and SEMS. Monitor compliance to training standards and make changes as needed.

60. Standard 8.05 DISTRIBUTION OF CASUALTIES: Update the Facilities Assessment Profiles and OES Region IV map, which identifies facilities and facility specialties.

61. Standard 8.06 NEEDS ASSESSMENT: Monitor the ability to effectively assess medical needs in a disaster and make changes to the process as needed.

62. Standard 8.13 DISASTER MEDICAL TRAINING: Ensure an adequate number of Field, Hospital and Dispatch MCI courses are made available.

63. Standard 8.14 HOSPITAL PLANS: Continue to work with Hospital Council and local hospitals to implement HEICS. Ensure that at least one inter-agency disaster drill is conducted in each member county.

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EXECUTIVE SUMMARY

The Mountain-Valley Emergency Medical Services Agency (MVEMSA) was formed through a joint powers agreement in 1981 and currently serves the counties of Alpine, Amador, Calaveras, Mariposa, and Stanislaus. The MVEMSA's primary responsibility is to plan, implement and evaluate an emergency medical services (EMS) system which meets the minimum standards developed by the California EMS Authority.

State law requires EMS agencies to develop plans for the delivery of emergency medical services (paramedic treatment, ambulance transport, trauma services, etc.) to the victims of sudden illness or injury within the geographic area served by the EMS agency. These plans must be consistent with state standards and address the following components: manpower and training, communications, transportation, assessment of hospitals and critical care centers, system organization and management, data collection and evaluation, public information and education and disaster response.

Major changes have taken place in the EMS system since the MVEMSA last adopted an EMS plan in 1985. Among these changes are: the availability of advanced life support (paramedic) and 9-1-1 services in all parts of the EMS system, the development of specialized policies and services for critically ill and injured children, the creation of an EMS database management system, the formation of exclusive operating areas (EOAs) for ambulance service in Amador and Stanislaus Counties, the adoption of a regional Policy and Procedure Manual and the withdrawal of San Joaquin and Merced Counties from the JPA.

The process of assessing system needs and developing plan objectives revealed that although major improvements have been made in the EMS system since 1985, several components of the EMS system remain unchanged or undeveloped. As an example, despite tremendous improvements in communications technology the communications system, the series of mountain top repeaters and radio frequencies used to dispatch ambulances to emergencies and for paramedics to contact base hospital physicians and nurses for medical advice, has not been updated or significantly modified since 1985. However, the component most noticeably absent from the A-ML-SJ EMS system is that of a formal trauma care system designed to triage and transport major trauma victims to designated trauma care hospitals. This omission exists in spite of three major trauma planning efforts conducted by the MVEMSA in 1981-83, 1988-90 and 1992-93.

The A-ML-SJ EMS system currently meets or exceeds 84 of the State's 121 minimum standards and recommended guidelines. However, the EMS System Plan does more than just focus on the current deficiencies in the EMS system; it attempts to identify objectives for creating an **optimal** EMS system. In order to accomplish the task of creating an "optimal" system, an EMS Plan Task Force, comprised of representatives from hospitals, ambulance providers, first response agencies, and the insurance industry, was formed. The task force met over the course of several months and created the "Local EMS System Model." The concepts included in this document, such as a single 9-1-1 dispatch center in each county, were used as guides in developing the objectives of the EMS System Plan.

The "System Needs and Plan Objectives" section is the heart of the EMS System Plan. This section describes the current status, needs, objectives and time-line of each component of the EMS system. The needs and the objectives listed in the EMS System Plan were identified and developed by comparing our current EMS system with the California EMS Authority's EMS System Standards and Guidelines and following the concepts presented in the "Local EMS System Model" developed by the EMS Plan Task Force.

Some of the major objectives of the MVEMSA EMS System Plan include:

- Studying the feasibility of ALS first response services and other ALS alternatives as described in the EMS system model;
- Determining the feasibility of establishing county-wide exclusive operating areas for ambulance providers and non-transporting paramedic providers;
- Developing agreements with cities and fire districts regarding ambulance response zones in their areas;
- Developing standardized first response agreements;
- Creating a single EMS dispatch center and an integrated dispatch system for each county;
- Developing a better method to triage medical emergencies and dispatch appropriate resources;
- Updating and repairing the communications system;
- Identifying the optimal roles and responsibilities of EMS system participants;
- Establishing a single system-wide on-line medical control point;
- Developing protocols to allow paramedics to treat and release patients from scene;
- Developing a process to identify preventable morbidity and mortality;
- Developing a mechanism to use non-hospital medical facilities to receive some EMS patients;
- Developing a trauma care system;
- Developing prehospital triage and transfer protocols;
- Developing a pediatric plan.

The objectives listed in the EMS System Plan will be used to guide the MVEMSA in monitoring and improving the EMS system over the next 5 years.

ASSESSMENT OF SYSTEM

Summary of System Status

This section provides a summary of how the Mountain-Valley Emergency Medical Services System meets the State of California's EMS Systems Standards and Guidelines. An "x" placed in the first column indicates that the current system does not meet the State's minimum standard. An "x" placed in the second or third column indicates that the system meets either the minimum or recommended standard. An "x" is placed in one of the last two columns to indicate the time-frame the agency has established for either meeting the standard or revising the current status.

A complete narrative description of each standard along with the objective for establishing compliance is included in the System Needs and Plan Objectives Section of this plan.

System Organization and Management

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
1.01 LEMSA Structure		X	NA	X	X
1.02 LEMSA Mission*		X	NA		X
1.03 Public Input		X	NA		X
1.04 Medical Director		X	X		
1.05 System Plan*		X	NA	X	X
1.06 Annual Plan Update		X	NA	X	
1.07 Trauma Planning	X				X
1.08 ALS Planning*		X	NA	X	X
1.09 Inventory of Resources		X	NA	X	
1.10 Special Populations*	X			X	X
1.11 System* Participants		X		X	X
1.12 Review & Monitoring*		X	NA	X	X

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
1.13 Coordination*		X	NA		X
1.14 Policy & Procedures* Manual		X	NA		X
1.15 Compliance w/ Policies*		X	NA	X	X
1.16 Funding Mechanism		X	NA	X	X
1.17 Medical Direction*		X	NA	X	X
1.18 QA / QI		X	X	X	X
1.19 Policies, Procedures, Protocols*		X	X	X	X
1.20 DNR Policy		X	NA		X
1.21 Determination of Death		X	NA		X
1.22 Reporting of Abuse*	X		NA		X
1.23 Inter-facility Transfer*		X	NA	X	X
1.24 ALS Systems*	X			X	X
1.25 On-Line Medical Direction*		X		X	X
1.26 Trauma System Plan					X
1.27 Pediatric System Plan	X		NA		X
1.28 EOA Plan		X		X	X

Staffing and Training

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
2.01 Assessment of Needs*		X	NA	X	X
2.02 Approval of Training*		X	NA	X	X
2.03 Personnel*		X	NA		X
2.04 Dispatch Training*	X			X	X
2.05 First Responder Training	X				X
2.06 Response*	X		NA	X	X
2.07 Medical Control	X		NA		X
2.08 EMT-I Training		X	NA		X
2.09 CPR Training		X	NA		X
2.10 Advanced Life Support	X				X
2.11 Accreditation Process		X	NA		X
2.12 Early Defibrillation*		X	NA		X
2.13 Base Hospital Personnel		X	NA	X	

Communications

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
3.01 Communication Plan		X		X	X
3.02 Radios		X	X	X	X
3.03 Inter-facility Transfer		X	NA		X
3.04 Dispatch Center	X		NA	X	X
3.05 Hospitals		X	X		X
3.06 MCI/Disasters		X	NA		X
3.07 9-1-1 Planning/ Coordination*	X			X	X
3.08 9-1-1 Public Education		X	NA		X
3.09 Dispatch Triage*	X		X	X	X
3.10 Integrated Dispatch	X			X	X

Response and Transportation

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
4.01 Service Area Boundaries*		X		X	X
4.02 Monitoring*		X		X	X
4.03 Classifying Medical Requests*	X			X	X
4.04 Pre-scheduled Responses		X	NA		X
4.05 Response Time Standards*	X			X	X

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
4.06 Staffing		X	NA		X
4.07 First Responder Agencies*	X		NA		X
4.08 Medical & Rescue Aircraft		X	NA		X
4.09 Air Dispatch Center		X	NA		X
4.10 Aircraft Availability		X	NA	X	X
4.11 Specialty Vehicles	X				X
4.12 Disaster Response	X		NA		X
4.13 Intercounty Response		X			X
4.14 Incident Command System		X	NA		X
4.15 MCI Plans		X	NA		X
4.16 ALS Staffing		X			X
4.17 ALS Equipment		X	NA	X	
4.18 Compliance	X		NA		X
4.19 Transportation Plan		X	NA	X	X
4.20 "Grandfathering"		X	NA		X
4.21 Compliance		X	NA		X
4.22 Evaluation		X	NA	X	X

Facilities and Critical Care

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
5.01 Assessment of Capabilities*		X		X	
5.02 Triage & Transfer Protocols	X		NA		X
5.03 Transfer Guidelines	X		NA	X	
5.04 Specialty Care Facilities*	X		NA	X	X
5.05 Mass Casualty Management		X	X		X
5.06 Hospital Evacuation	X		NA	X	
5.07 Base Hospital Designation*		X	NA	X	X
5.08 Trauma System Design*					X
5.09 Public Input					X
5.10 Pediatric System Design	X		NA		X
5.11 Emergency Departments		X	X		X
5.12 Public Input		X	NA		X
5.13 Specialty System Design					X
5.14 Public Input					X

Data Collection and System Evaluation

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
6.01 QA/QI Program*		X	X	X	X
6.02 Prehospital Records		X	NA	X	
6.03 Prehospital Care Audits		X	X	X	X
6.04 Medical Dispatch	X		NA		X
6.05 Data Management System		X	X	X	X
6.06 System Design Evaluation*		X	NA	X	X
6.07 Provider Participation		X	NA	X	X
6.08 Reporting		X		X	
6.09 ALS Audit		X	X	X	X
6.10 Trauma System Evaluation					X
6.11 Trauma Center Data					X

Public Information and Education

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
7.01 Public Information Materials		X	X	X	X
7.02 Injury Control		X	X		X
7.03 Disaster Preparedness*	X				X
7.04 First Aid & CPR Training	X			X	X

Disaster Medical Response

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
8.01 Disaster Medical Planning*		X	NA	X	
8.02 Response Plans		X	X	X	X
8.03 HazMat Training*		X	NA	X	X
8.04 Incident Command System		X	X	X	X
8.05 Distribution of Casualties		X		X	X
8.06 Needs Assessment		X	X	X	X
8.07 Disaster Communications	X		NA		X
8.08 Inventory of Resources*	X			X	X
8.09 DMAT Teams*	X				X
8.10 Mutual Aid Agreements	X		NA		X
8.11 CCP Designation*	X		NA		X
8.12 Establish CCPs	X		NA		X
8.13 Disaster Medical Training		X	X	X	X
8.14 Hospital Plans		X	X	X	X
8.15 Inter-hospital Communications		X	NA		X
8.16 Prehospital. Agency Plans*		X	X		X
8.17 ALS Policies		X	NA		X

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
8.18 Specialty Cntr Roles*					X
8.19 Waiving Exclusivity		X	NA		X

* Change from previous year's EMS Plan.

System Needs and Plan Objectives

This section of the EMS Plan lists each standard included in the State of California's EMS Systems Standards and Guidelines and describes the:

- current status of the MVEMSA system as it relates to the individual standard;
- efforts to coordinate resources and services with other local EMS agencies (LEMSAs) as required by the California EMS Authority;
- need of the MVEMSA system as it relates to the individual standard;
- objective(s) for meeting the minimum standard, upgrading toward the recommended guidelines, or improving the efficiency or effectiveness of the EMS system.
- assignment of each objective to the annual work plan, long range plan, or both.

The needs and objectives of the EMS plan are designed to address both the EMS Systems Standards and Guidelines and the MVEMSA's EMS System Model. Most of the objectives are written as general statements such as Objective 1.01 which states: "Develop secure funding sources to adequately finance agency operations and personnel requirements." Many of these objectives may need to be refined when they are included in annual work plan, pediatric plan, transportation plan, or trauma plan.

1.01 LEMSA STRUCTURE

MINIMUM STANDARDS:
Each local EMS agency shall have a formal organization structure which includes both agency staff and non-agency resources and which includes appropriate technical and clinical expertise.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The agency is managed by a five-person Board of Directors, whose members are elected supervisors from each of the member counties. Agency staff is comprised of a Medical Director, who is Board Certified in Emergency Medicine, an Executive Director, a Deputy Director and an additional 8 FTE employees. Other non-agency resources include: base hospital medical directors, base hospital nurse liaisons, provider QA coordinators and provider training coordinators.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
A) A data analyst/programmer to oversee the data management systems and programs.

OBJECTIVE:
Develop secure funding sources to adequately finance agency operations and personnel requirements.

TIME FRAME FOR MEETING OBJECTIVE:

	~~Short-Range Plan (one year or less)~~
X	Short-Range Plan (one year or less)
	Long-Range Plan (more than one year)

1.02 LEMSA MISSION

MINIMUM STANDARDS:
Each local EMS agency shall plan, implement, and evaluate the EMS system. The agency shall use its QA/QI and evaluation processes to identify system changes.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
"The mission of the Mountain-Valley EMS Agency is *to appropriately provide quality prehospital care services to the public in a cost effective manner as an integrated part of the overall health care system*." A comprehensive emergency medical services system has been established and continuously evaluated by the MVEMSA since 1981. The agency's QA/QI program was revised in 1994, to involve all system participants with the primary purpose of evaluating the EMS system and determining system needs.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure continued evaluation of system performance against established benchmarks.

OBJECTIVE:
Use the agency's QA/QI process and public evaluations by the Regional Advisory Committee, county Emergency Medical Care Committees and other review bodies to identify needed system changes.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

1.03 PUBLIC INPUT

MINIMUM STANDARDS:
Each local EMS agency shall have a mechanism (including EMCCs and other sources) to seek and obtain appropriate consumer and health care provider input regarding the development of plans, policies and procedures, as described in the State EMS Authority's EMS Systems Standards and Guidelines.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Each member county has a functioning Emergency Medical Care Committee which reviews local operations, policies and practices. A Regional Advisory Committee (RAC) comprised of three persons from each member county meets bi-monthly and reviews all MVEMSA plans, policies and procedures before they are submitted to the Board of Directors (BOD) for consideration. All meetings of the BOD, RAC and county EMCCs are open to the public with time allocated on each agenda for open public comments. Additionally, impacted groups are routinely notified and provided with an opportunity to provide input in advance of issues being brought before RAC and the BOD.

COORDINATION WITH OTHER EMS AGENCIES:
None.

NEED(S):
Ensure that appropriate consumer and health care provider input is obtained regarding the development of plans, policies and procedures.

OBJECTIVE:
Monitor and amend, as needed, the structure of the agency's advisory committees to best meet the needs of the EMS system while continuing to provide a mechanism for public input concerning EMS system design and performance.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

1.04 MEDICAL DIRECTOR

MINIMUM STANDARDS:
Each local EMS agency shall appoint a medical director who is a licensed physician who has substantial experience in the practice of emergency medicine.

RECOMMENDED GUIDELINES:
The local EMS agency medical director should have administrative experience in emergency medical services systems.

Each local EMS agency medical director should establish clinical specialty advisory groups composed of physicians with appropriate specialties and non-physician providers (including nurses and prehospital providers), and/or should appoint medical consultants with expertise in trauma care, pediatrics, and other areas, as needed.

CURRENT STATUS:
The agency Medical Director possesses Board Certification in Emergency Medicine and previous experience as a base hospital medical director.

~~A committeecommittee~~The regional Quality Liaison Committee comprised of ~~all 10 of the~~ base hospital ~~medical directors was recently formed by the MV EMSA for the purpose of providingproviding~~and ambulance providers provides medical oversight of the agency's QA/QI processes. Ad hoc committees for trauma care and pediatrics have been formed and disbanded as needed.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure medical direction of the EMS system.

OBJECTIVE:
Monitor and amend, as needed, the structure of the agency's medical advisory committees to best meet the needs of the EMS system.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

~~1.05 SYSTEM PLAN~~

MINIMUM STANDARDS:
Each local EMS agency shall develop an EMS System Plan, based on community need and utilization of appropriate resources, and shall submit it to the EMS Authority.

The plan shall:

a) assess how the current system meets these guidelines,
b) identify system needs for patients within each of the targeted clinical categories (as identified in Section II), and
c) provide a methodology and time-line for meeting these needs.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Completion of this plan fulfills the requirements of this standard.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Participate in an Urban Trial Study program designed to evaluate the effectiveness of system changes developed under the EMS 2000 system model. Ensure that the EMS System plan meets community needs and provides for the appropriate utilization of resources.

OBJECTIVE
Monitor and amend the EMS system plan, as needed.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.06 ANNUAL PLAN UPDATE

MINIMUM STANDARDS:
Each local EMS agency shall develop an annual update to its EMS System Plan and shall submit it to the EMS Authority. The update shall identify progress made in plan implementation and changes to the planned system design.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Completion of this plan fulfills the requirements of this standard.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Annually evaluate the EMS system plan to determine progress in meeting plan objectives and system changes.

OBJECTIVE:
Submit an annual update of the EMS system plan to the State EMS Authority, which reflects system changes and progress made in meeting plan objectives.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long -Range Plan (more than one year)

1.07 TRAUMA PLANNING

MINIMUM STANDARDS:
The local EMS agency shall plan for trauma care and shall determine the optimal system design for trauma care in its jurisdiction.

RECOMMENDED GUIDELINES:
The local EMS agency should designate appropriate facilities or execute agreements with trauma facilities in other jurisdictions.

CURRENT STATUS:
Although major planning efforts were conducted in 1981-83, 1988-90 and 1992-93, a trauma system has not been established in the MV EMS system. ~~Trauma and specialty care planning was identified by the Regional Advisory Committee and other groups as a top priority for the agency and is included in the EMS system model adopted by the agency.~~

COORDINATION WITH OTHER EMS AGENCIES:
The demographics and geography of the MV EMS system requires all specialty care planning to consider adjoining systems when determining resource availability and catchment areas.

NEED(S):
Ensure the availability of trauma services for critically injured patients.

OBJECTIVE:
Develop a trauma care system, which may include facility designation, before the end of the century.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.08 ALS PLANNING

MINIMUM STANDARDS:
Each local EMS agency shall plan for eventual provision of advanced life support services throughout its jurisdiction.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Advanced life support ambulance services are provided as the minimum standard for emergency (9-1-1) medical requests in each county in the EMS system.

COORDINATION WITH OTHER EMS AGENCIES:
Alpine County's ALS ambulance service is delivered by providers stationed in Amador, Calaveras and El Dorado counties as well as the State of Nevada. Continuation-of-call agreements have been developed with some neighboring EMS systems. Separate agreements have been executed with Merced County EMS and San Joaquin County EMS concerning the utilization of base hospital medical control and disaster control by each other's providers. Additionally, formal arrangements have been made with Merced County EMS creating ambulance response zones which serve populations in both EMS jurisdictions.

NEED(S):
Ensure the optimal provision of ALS services throughout the EMS system.

OBJECTIVE:
Study the feasibility of ALS first response services and other ALS alternatives as described in the EMS system model, including the development of exclusive operating areas for non-transporting ALS service providers. Make changes as necessary to ensure the optimal provision of ALS services.

TIME FRAME FOR MEETING OBJECTIVE:

		X	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)		

1.09 INVENTORY OF RESOURCES

MINIMUM STANDARDS:
Each local EMS agency shall develop a detailed inventory of EMS resources (e.g., personnel, vehicles, and facilities) within its area and, at least annually, shall update this inventory.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Completion of this plan fulfills the requirements of this standard.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the accurateness of the resource directories included in this plan.

OBJECTIVE:
Periodically update the resource directories included in this plan.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long-Range Plan (more than one year)

1.10 SPECIAL POPULATIONS

MINIMUM STANDARDS:
Each local EMS agency shall identify population groups served by the EMS system which require specialized services (e.g., elderly, handicapped, children, non-English speakers).

RECOMMENDED GUIDELINES:
Each local EMS agency should develop services, as appropriate, for special population groups served by the EMS system which require specialized services (e.g., elderly, handicapped, children, non-English speakers).

CURRENT STATUS:
The creation of an Emergency Medical Services for Children sub-system is the only work performed in this area by the EMSA.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Begin the process of identifying population groups served by the EMS system which may require special services. Ensure that all population groups know how to access and appropriately utilize the EMS system.

OBJECTIVE:
Identify population groups served by the EMS system which require specialized services. Work with other agencies, both county and private, to identify and develop care plans for population groups requiring specialized services.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)

X Long-Range Plan (more than one year)

1.11 SYSTEM PARTICIPANTS

MINIMUM STANDARDS:
Each local EMS agency shall identify the optimal roles and responsibilities of system participants.

RECOMMENDED GUIDELINES:
Each local EMS agency should ensure that system participants conform with their assigned EMS system roles and responsibilities, through mechanisms such as written agreements, facility designations, and exclusive operating areas.

CURRENT STATUS:
The roles and responsibilities of many system participants is based primarily on historical involvement and willingness to cooperate with the agency. Formalization of roles and responsibilities has only been conducted with base hospitals, ALS transport services and dispatch centers.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Identify the optimal roles and responsibilities of all system participants based on the EMS system model and public input. Ensure that system participants conform with assigned EMS system roles and responsibilities.

OBJECTIVE:
Participate in the CSUS Research project to *Identify the optimal roles and responsibilities of system participants.* Identify the optimal roles and responsibilities of EMS system participants and develop mechanisms, such as agreements, facility designations and exclusive operating areas to ensure compliance.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.12 REVIEW AND MONITORING

MINIMUM STANDARDS:
Each local EMS agency shall provide for review and monitoring of EMS system operations.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
In 1994, the agency adopted an EMS System Quality Assurance/Quality Improvement (QA/QI) Plan which formed a multi-disciplinary Quality Liaison Committee (QLC) comprised of base hospital medical directors, base hospital nurse liaisons, ambulance provider quality coordinators, first response quality coordinators and dispatch quality coordinators to assist the agency Medical Director in providing oversight and evaluation of the EMS system. Local Q.I. groups, consisting of members of an operational area, have also been formed to evaluate response, care and transport, and to identify system problems and seek solutions.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the continued review and monitoring of EMS system operations. Work with EMSAAC and the State EMSA to develop standard statewide indicators for EMS system evaluation.

OBJECTIVE:
Implement structural indicators and compliance mechanisms, developed for Base Hospitals, ALS providers, EMD Centers and CE providers. Modify the process of review and monitoring of the EMS system, as needed.

Continue to work with statewide planning groups to develop standardized processes and indicators.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.13 COORDINATION

MINIMUM STANDARDS:
Each local EMS agency shall coordinate EMS system operations.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
EMS system operations are coordinated through written agreements with providers, facilities and counties; policies and procedures; training standards; quality improvement programs and other mechanisms. This plan identifies those components of the MVEMSA system~~, upon which improvement efforts will be focused during the next one to five years.~~

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure coordinated system operations.

OBJECTIVE:
Evaluate EMS system operations and make changes as needed to ensure optimal system performance.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.14 POLICY & PROCEDURES MANUAL

MINIMUM STANDARDS:
Each local EMS agency shall develop a policy and procedures manual which includes all EMS agency policies and procedures. The agency shall ensure that the manual is available to all EMS system providers (including public safety agencies, ambulance services, and hospitals) within the system.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A policy and procedure manual has been developed and distributed ~~or made available~~ to ~~all~~ system providers. Policies and procedures are also made available through the Agency website.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the availability of a policy and procedure manual for system providers.

OBJECTIVE:
Monitor the process of policy and procedure manual availability and make changes as necessary.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.15 COMPLIANCE WITH POLICIES

MINIMUM STANDARDS:
Each local EMS agency shall have a mechanism to review, monitor, and enforce compliance with system policies. ~~Evaluate the feasibility of making EMS policies available on the Agency Web Site and electronic distribution of changes to policies.~~

~~**TIME FRAME FOR MEETING OBJECTIVE:**~~
~~X Short-Range Plan (one year or less)~~
~~X Long-Range Plan (more than one year)~~

~~1.15 COMPLIANCE WITH POLICIES~~

~~MINIMUM STANDARDS:~~
~~Each local EMS agency shall have a mechanism to review, monitor, and enforce compliance with system policies.~~

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Written agreements, county ordinances, inspections, unusual occurrence reporting, investigations and quality improvement programs have been established as mechanisms to review, monitor and enforce compliance with system policies.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure compliance with system policies.

OBJECTIVE:
Implement structural indicators and compliance mechanisms, developed for Base Hospitals, ALS providers, AED providers, EMD Centers, and CE providers. Evaluate and improve compliance with system policies.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.16 FUNDING MECHANISM

MINIMUM STANDARDS:
Each local EMS agency shall have a funding mechanism which is sufficient to ensure its continued operation and shall maximize use of its Emergency Medical Services Fund.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The EMSA relies on local/county contributions, State general fund grants, PHHS project grants, service contracts with other LEMSAs and user fees as a fund base for agency operations. A decrease in funding for FY95-96 required the agency to leave 2.5 FTE employee position unfilled. State general fund augmentation was obtained in FY98-99, allowing agency to potentially fill the Data Analyst/Programmer position in FY99-00.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Identify stable funding sources.

OBJECTIVE:
Maintain existing funding sources and seek alternative or new funding sources. Continue to work with the Emergency Medical Services Administrators Association of California (EMSAAC), the Emergency Medical Services Medical Directors Association of California (EMDAC), State EMS Vision working groups, and the State EMSA to maintain federal, state and local funding of EMS systems. Continue to investigate ways for the Mountain-Valley EMS agency and system to function for cost effectively.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.17 MEDICAL DIRECTION

MINIMUM STANDARDS:
Each local EMS agency shall plan for medical direction within the EMS system. The plan shall identify the optimal number and role of base hospitals and alternative base stations and the roles, responsibilities, and relationships of prehospital and hospital providers.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
Currently all seven hospitals in the EMS system have been designated as base hospitals. However, with the inclusion of provider ~~QAQAQA/QI~~ and an increase in standing orders, there may not be the need for the number base hospitals in their current roles.

COORDINATION WITH OTHER EMS AGENCIES:
Arrangements have been made with Merced County and Tuolumne County EMS to allow Mariposa ambulance providers to access Merced County base hospitals for medical control and disaster control functions. Arrangements have been made to allow San Joaquin County EMS personnel to contact MVEMSA base hospitals for medical direction.

NEED(S):
The establishment of a single medical control point has been identified by system participants as a major part of the EMS system model adopted by the agency. A process needs to be developed for selecting a single medical control point and identifying its optimal configuration and responsibilities.

OBJECTIVE:
~~ImplementImplement~~Evaluate the ~~base hospital policy and execute base hospital agreements~~ ~~EstablishEstablish~~feasibility of a single medical control point.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.18 QA/QI (copy 1.12)

MINIMUM STANDARDS:
Each local EMS agency shall establish a quality assurance/quality improvement program. This may include use of provider-based programs which are approved by the local EMS agency and which are coordinated with other system participants.

RECOMMENDED GUIDELINES:
Prehospital care providers should be encouraged to establish in-house procedures which identify methods of improving the quality of care provided.

CURRENT STATUS:
In 1994, the agency adopted an EMS System Quality Assurance/Improvement (QA/QI) Plan which formed a multi-disciplinary Quality Liaison Committee (QLC) comprised of base hospital medical directors, base hospital nurse liaisons, ambulance provider quality coordinators, first response quality coordinators and dispatch quality coordinators to assist the agency Medical Director in providing oversight and evaluation of the EMS system. Local Q.I. groups, consisting of members of an operational area, have also been formed to evaluate response, care and transport. Most aspects of the previous clinical review (medical auditing) program were lost with the transition to the new QA/QI program.

COORDINATION WITH OTHER EMS AGENCIES:
None

NEED(S):
Establishment of a process to identify preventable morbidity and mortality. Reinstitution of medical audit process. Development of a process to provide feedback to prehospital personnel on patient outcomes as described in the EMS system model. Ensure that the QI/QI process meets system needs and State standards.

OBJECTIVE:
Develop a process to: identify preventable morbidity and mortality; conduct medical auditing and; provide feedback to prehospital personnel on patient outcomes. Continue to monitor and amend the QA/QI program to meet system needs.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long -Range Plan (more than one year)

1.19 POLICIES, PROCEDURES, PROTOCOLS

MINIMUM STANDARDS:
Each local EMS agency shall develop written policies, procedures, and/or protocols including, but not limited to:

a) triage,
b) treatment,
c) medical dispatch protocols,
d) transport,
e) on-scene treatment times,
f) transfer of emergency patients,
g) standing orders,
h) base hospital contact,
i) on-scene physicians and other medical personnel, and
j) local scope of practice for prehospital personnel.

RECOMMENDED GUIDELINES:
Each local EMS agency should develop (or encourage the development of) pre-arrival/post dispatch instructions.

CURRENT STATUS:
ALS treatment protocols, including complete sections on standing orders ~~were recently~~recently are being revised ~~and implemented~~. Policies, protocols or policy statements regarding medical dispatch, transport, on-scene times, transfer of emergency patients, on-scene physicians and other medical personnel and local scope of practice have been established but require evaluation and revision. Policies on triage and patient destination have not been developed.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Develop and revise polices to meet state minimum standards and the EMS system model.

OBJECTIVE:
1) Review and revise polices, as needed, to meet minimum standards and the EMS System Model. 2) Develop policies for transport of patients to facilities appropriate for their injuries or illness. 3) Evaluate and modify the ALS scope of practice as needed.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.20 DNR POLICY

MINIMUM STANDARDS:
Each local EMS agency shall have a policy regarding "Do Not Resuscitate (DNR)" situations in the prehospital setting, in accordance with the EMS Authority's DNR guidelines.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A comprehensive DNR policy was created and implemented in 1992, with the assistance of the Stanislaus County Medical Society, the Medic-Alert Foundation and the San Diego County EMSA. This DNR program, with minor revisions, was adopted by the State EMSA and the California Medical Association as a State Standard in 1993.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the DNR policy continues to meet standards and system needs.

OBJECTIVE:
Monitor the utilization of the DNR policy and amend as needed. Improve the dissemination of DNR program materials throughout the EMS system.

TIME FRAME FOR MEETING OBJECTIVE:
X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.21 DETERMINATION OF DEATH

MINIMUM STANDARDS:
Each local EMS agency, in conjunction with the county coroner(s) shall develop a policy regarding determination of death, including deaths at the scene of apparent crimes.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A determination of death policy was created and implemented with the concurrence of the county coroners in 1992 and revised in 1994. Several system participants have expressed a desire to expand the criteria used to determine death in the field.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the determination of death policy continues to meet system needs.

OBJECTIVE:
Evaluate the possibility of expanding the criteria used for determining death in the field.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.22 REPORTING OF ABUSE

MINIMUM STANDARDS:
Each local EMS agency shall ensure that providers have a mechanism for reporting child abuse, elder abuse, and suspected SIDS deaths.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
No EMS policies have been developed regarding the reporting of abuse or suspected SIDS deaths. Agency staff has served on a county Domestic Violence Task Force for the purpose of establishing a standardized multi-disciplinary approach for addressing domestic violence.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that a mechanism exists for the reporting of abuse or suspected SIDS deaths.

OBJECTIVE:
Create EMS policies regrading the reporting of abuse or suspected SIDS deaths. Work with other public, private agencies to increase awareness of abuse cases and reporting among prehospital personnel.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.23 INTERFACILITY TRANSFER

MINIMUM STANDARDS:
The local EMS medical director shall establish policies and protocols for scope of practice of prehospital medical personnel during interfacility transfers.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
A policy delineating the scene and interfacility transfer scope of practice of paramedics ~~has been established~~established is being revised. Established policies and procedures for use of Heparin and Nitroglycerin as an expanded scope for interfacility transfers.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Evaluate the need for further developing a BLS and ALS interfacility scope of practice.

OBJECTIVE:
Evaluate the need for developing a BLS and ALS interfacility scope of practice.

TIME FRAME FOR MEETING OBJECTIVE:

		X	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)		

1.24 ALS SYSTEMS

MINIMUM STANDARDS:
Advanced life support services shall be provided only as an approved part of a local EMS system and all ALS providers shall have written agreements with the local EMS agency.

RECOMMENDED GUIDELINES:
Each local EMS agency, based on state approval, should, when appropriate, develop exclusive operating areas for ALS providers.

CURRENT STATUS:
All ALS services currently provided in the EMS system are done so with Agency approval and written agreements. Exclusive operating areas (EOAs) have been established in 2 counties.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that ALS services are provided only as an approved part of the EMS system. Determine the feasibility of establishing county-wide EOAs as described in the EMS system model.

OBJECTIVE:
Maintain written agreements with all ALS providers and monitor compliance. Determine the feasibility of establishing county-wide EOAs, including emergency ambulance providers and non-transporting ALS service providers. When a county-wide EOA for either emergency ambulance or non-transporting ALS service providers are not feasible then multiple EOAs should be established to ensure appropriate emergency and ALS response.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long -Range Plan (more than one year)

1.25 ON-LINE MEDICAL DIRECTION

MINIMUM STANDARDS:
Each EMS system shall have on-line medical direction, provided by a base hospital (or alternative base station) physician or authorized registered nurse/mobile intensive care nurse.

RECOMMENDED GUIDELINES:
Each EMS system should develop a medical control plan which determines:

a) the base hospital configuration for the system,
b) the process for selecting base hospitals, including a process for designation which allows all eligible facilities to apply, and
c) the process for determining the need for in-house medical direction for provider agencies.

CURRENT STATUS:
Currently all seven hospitals in the EMS system have been designated as base hospitals. However, with the inclusion of provider ~~QAQAQA~~/QI and an increase in standing orders, there may not be the need for the number of base hospitals in their current roles. A study to evaluate alternatives for medical control ~~plan has not been developed~~~~developed~~is to be conducted in FY99-00.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
The establishment of a single medical control point has been identified by system participants, through the planning process, as a major part of the EMS system model adopted by the agency. A process needs to be developed for selecting a single medical control point and identifying its optimal configuration and responsibilities. A comprehensive plan for medical control including a process of determining the need for in-house medical control for provider agencies needs to be developed.

OBJECTIVE:
~~Implement the base hospital policy and execute base hospital agreements. Establish~~~~Establish~~Evaluate feasibility of establishing a single medical control point. Develop a comprehensive medical control plan which meets standards and system needs.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

1.26 TRAUMA SYSTEM PLAN

MINIMUM STANDARDS:
The local EMS agency shall develop a trauma care system plan, based on community needs and utilization of appropriate resources, which determines:

a) the optimal system design for trauma care in the EMS area, and
b) the process for assigning roles to system participants, including a process which allows all eligible facilities to apply.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Although major planning efforts were conducted in 1981-83, 1988-90 and 1992-93, a trauma system has not been established for the MVEMSA system. Trauma and specialty care planning was identified by the Regional Advisory Committee and other groups as a top priority for the agency and is included in the EMS system model adopted by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
None

NEED(S):
Develop a trauma system and other specialty care system as appropriate.

OBJECTIVE:
Develop a trauma system, which may include facility designation, before the end of the century.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.27 PEDIATRIC SYSTEM PLAN

MINIMUM STANDARDS:
The local EMS agency shall develop a pediatric emergency medical and critical care system plan, based on community needs and utilization of appropriate resources, which determines:

a) the optimal system design for pediatric emergency medical and critical care in the EMS area, and

b) the process for assigning roles to system participants, including a process which allows all eligible facilities to apply.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A Pediatric Emergency Medical and Critical Care System was developed and implemented in 1993-1995 as part of two special project grants awarded to the MV EMSA by the California EMS Authority. The pediatric system addresses the major Emergency Medical Services for Children (EMSC) components identified by the California EMS Authority as required of an EMSC system.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the Pediatric Emergency Medical and Critical Care System and the pediatric services provided by the EMS system meets the needs of critically ill and injured children within the MV EMS system. Develop a Pediatric System Plan which describes the current EMSC system and identifies the optimal system design.

OBJECTIVE:
Evaluate the effectiveness of the EMS system at meeting the needs of critically ill and injured children. Develop a pediatric system plan.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

1.28 EOA Plan

MINIMUM STANDARDS:

The local EMS agency shall develop, and submit for State approval, a plan, based on community needs and utilization of appropriate resources, for granting of exclusive operating areas which determines: a) the optimal system design for ambulance service and advanced life support services in the EMS area, and b) the process for assigning roles to system participants, including a competitive process for implementation of exclusive operating areas.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Existing exclusive operating areas were designed to solidify the provision of ALS transport and emergency response with those historic providers who met the eligibility requirements for "grandfathering" under Health and Safety Code. The optimal system design for ALS ambulance and the process for assigning roles to system participants is described in the Transportation Plan included with this document and is based on the EMS system model adopted by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that system design continues to meet community needs.

OBJECTIVE:
Evaluate Agency position regarding the inclusion of all ALS and emergency calls within EOAs and update Transportation Plan. Monitor system design and make changes as required.

TIME FRAME FOR MEETING OBJECTIVE:

		X	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)		

2.01 ASSESSMENT OF NEEDS

MINIMUM STANDARDS:
The local EMS agency shall routinely assess personnel and training needs.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Current training institutions appear to meet system needs considering the abundance of certified EMT-Is, accredited paramedics and MICNs within the EMS system. First response agencies in Amador, Calaveras, and Mariposa counties are assessed yearly regarding certification and recertification training needs.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure a sufficient amount of personnel are trained to meet EMS system demands.

OBJECTIVE:
Monitor and ensure system personnel and training needs, including continuing education.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

2.02 APPROVAL OF TRAINING

MINIMUM STANDARDS:
The EMS Authority and/or local EMS agencies shall have a mechanism to approve EMS education programs which require approval (according to regulations) and shall monitor them to ensure that they comply with state regulations.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Procedures are in place to approve First Responder, EMD, EMT-D, EMT-I, EMT-P, and MICN training programs. Monitoring of training programs is done by periodic auditing of courses and completion of course evaluation forms by students.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that EMS education programs comply with State regulations and ~~requirements~~requirementslocal policies for continued program approval.

OBJECTIVE:
Conduct random compliance evaluations of local programs. Monitor EMS education programs and take steps to ensure compliance to standards and other course requirements.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

2.03 PERSONNEL

MINIMUM STANDARDS:
The local EMS agency shall have mechanisms to accredit, authorize, and certify prehospital medical personnel and conduct certification reviews, in accordance with state regulations. This shall include a process for prehospital providers to identify and notify the local EMS agency of unusual occurrences which could impact EMS personnel certification.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Policies have been adopted regarding emergency medical dispatcher certification, first responder certification, EMT-I certification, paramedic accreditation and MICN authorization.

Procedures have been developed for the reporting of unusual occurrences which could impact EMS personnel certification.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
~~Adopt the procedures used for the certification of first responders~~

~~OBJECTIVE:~~
Monitor all EMS personnel policies and ~~EMT-I and Is~~~~Hs~~make changes as ~~agency policy~~~~policy~~~~needed~~.

~~**OBJECTIVE:**~~
~~**Monitor all EMS personnel policies and make changes as needed.**~~

TIME FRAME FOR MEETING OBJECTIVE:
~~X~~ Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

2.04 DISPATCH TRAINING

MINIMUM STANDARDS:
Public safety answering point (PSAP) operators with medical responsibility shall have emergency medical orientation and all medical dispatch personnel (both public and private) shall receive emergency medical dispatch training in accordance with the EMS Authority's Emergency Medical Dispatch Guidelines.

RECOMMENDED GUIDELINES:
Public safety answering point (PSAP) operators with medical dispatch responsibilities and all medical dispatch personnel (both public and private) should be trained and tested in accordance with the EMS Authority's Emergency Medical Dispatch Guidelines.

CURRENT STATUS:
Level II emergency medical dispatching, with pre-arrival instructions, has been adopted as the minimum standard for all PSAPs and dispatch centers providing or responsible for medical dispatching.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure all medical dispatchers maintain Level II EMD training standards.

OBJECTIVE:
Encourage the passage of dispatcher immunity legislation. Investigate and develop, as appropriate, more cost effective means of providing EMS dispatch services to include emergency and non-emergency call screening as outlined in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

2.05 FIRST RESPONDER TRAINING

MINIMUM STANDARDS:

At least one person on each non-transporting EMS first response unit shall have been trained to administer first aid and CPR within the previous three years.

RECOMMENDED GUIDELINES:

At least one person on each non-transporting EMS first response unit should be currently certified to provide defibrillation and have available equipment commensurate with such scope of practice, when such a program is justified by the response times for other ALS providers.

At least one person on each non-transporting EMS first response unit should be currently certified at the EMT-I level and have available equipment commensurate with such scope of practice.

CURRENT STATUS:

~~All personnel in Tuolumne County receive 40 hours of first response medical training and 8 hours multi-casualty training, in accordance with the written agreements executed with all Tuolumne County first response agencies.~~ While it is assumed that all of the ~~other~~ first response agencies serving the MVEMSA system comply with State regulations requiring a minimum of first aid and CPR training, this cannot be ensured in the absence of written agreements.

EMT-I training is widely available within the EMS system and the staffing of first response units with at least one certified EMT-I is encouraged. Greater than ~~50%~~~~50%~~80% of the population ~~(286,000 people)~~ of the MVEMSA system is served by an early defibrillation first response provider.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure minimum training standards and encourage adherence to recommended guidelines. Establish minimum training standards for first response providers.

OBJECTIVE:

Identify the optimal roles and responsibilities of all system participants based on the EMS system model and public input. ~~Mandate EMT-D training where appropriate.~~

~~OBJECTIVE:~~

~~**Develop and implement standardized first response agreements or other mechanism with all providers which will specify minimum training, staffing and equipment standards.**~~

TIME FRAME FOR MEETING OBJECTIVE:

Short-Range Plan (one year or less)

X Long-Range Plan (more than one year)

2.06 RESPONSE

MINIMUM STANDARDS:
Public safety agencies and industrial first aid teams shall be encouraged to respond to medical emergencies and shall be utilized in accordance with local EMS agency policies.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The roles and responsibilities of most system participants are based primarily on historical involvement and willingness to cooperate with the agency. ~~Formalization of roles and responsibilities has only been conducted with ALS transport services and first response providers within Tuolumne County.~~

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Identify the optimal roles and responsibilities of all system participants based on the EMS system model and public input. Ensure that system participants conform with assigned EMS system roles and responsibilities.

OBJECTIVE:
Develop/revise first responder and BLS treatment guidelines. Identify the optimal roles and responsibilities of EMS system participants ~~and develop mechanisms, such as agreements, facility designations and exclusive operating areas, as appropriate to ensure compliance~~compliancebased upon the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

		X	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)		

2.07 MEDICAL CONTROL

MINIMUM STANDARDS:
Non-transporting EMS first responders shall operate under medical direction policies, as specified by the local EMS agency medical director.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Considering the small number of first response agencies who voluntarily participate in the QA/QI program~~ or who have executed a written agreement with the agency~~, we are unable to determine the compliance to medical control policies for most of the non-transporting EMS first responders in the region.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that first responders operate under the medical direction of the EMS system.

OBJECTIVE:
~~Develop a policypolicy~~Continue to ~~ensure thatthat~~work with first ~~responders operate underunder~~response agencies to encourage participation in the ~~medical direction of the EMS systemsystem~~agency QA/QI program.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

2.08 EMT-I TRAINING

MINIMUM STANDARDS:
All emergency medical transport vehicle personnel shall be currently certified at least at the EMT-I level.

RECOMMENDED GUIDELINES:
If advanced life support personnel are not available, at least one person on each emergency medical transport vehicle should be trained to provide defibrillation.

CURRENT STATUS:
By policy, the minimum staffing level of all emergency medical transport vehicles (ambulances), is one licensed paramedic and one certified EMT-I. However, a BLS ambulance, staffed with a minimum of two EMT-Is may be used to respond to emergency requests during times of disaster and system overload when all available ALS resources have been depleted.

BLS ambulance personnel do not perform defibrillation, nor has their training in this procedure been encouraged by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the availability of trained transport personnel to meet the needs of the EMS system.

OBJECTIVE:
~~Evaluate the need for training BLS ambulance personnel to perform defibrillation.~~ Monitor and adjust ambulance staffing requirements to meet EMS system needs and the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

2.09 CPR TRAINING

MINIMUM STANDARDS:
All allied health personnel who provide direct emergency patient care shall be trained in CPR.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Hospital employees working in the emergency department are routinely required to be certified in CPR. However, no mechanism exists to ensure compliance with this standard for personnel not under the jurisdiction of the MVEMSA.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Encourage the training of allied health personnel in CPR.

OBJECTIVE:
Monitor EMS system personnel and take appropriate measures to ensure training in CPR.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

2.10 ADVANCED LIFE SUPPORT

MINIMUM STANDARDS:
All emergency department physicians and registered nurses who provide direct emergency patient care shall be trained in advanced life support.

RECOMMENDED GUIDELINES:
All emergency department physicians should be certified by the American Board of Emergency Medicine.

CURRENT STATUS:
Current base hospital agreements require base hospital physicians and MICNs to be certified in advanced cardiac life support (ACLS). All emergency department physicians are encouraged to be Board certified in emergency medicine or be certified in prehospital EMS management through such courses as prehospital trauma life support (PHTLS) and pediatric advanced life support (PALS).

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure training in ALS for emergency department physicians and nurses who provide emergency patient care.

OBJECTIVE:
~~Develop policy to ensure that emergency department physicians~~~~physicians~~Monitor, evaluate and ~~nurses are trained to an appropriate ALS level~~~~level~~update base hospital agreements as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

2.11 ACCREDITATION PROCESS

MINIMUM STANDARDS:
The local EMS agency shall establish a procedure for accreditation of advanced life support personnel which includes orientation to system policies and procedures, orientation to the roles and responsibilities of providers within the local EMS system, testing in any optional scope of practice, and enrollment into the local EMS agency's quality assurance/quality improvement process.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Policies and procedures exist to accredit and orient ALS personnel.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Continue to ensure that ALS personnel are appropriately oriented to the EMS system and capable of performing the expanded scope of practice procedures.

OBJECTIVE:
Monitor and amend the ALS accreditation process as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

2.12 EARLY DEFIBRILLATION

MINIMUM STANDARDS:
The local EMS agency shall establish policies for local accreditation of public safety and other basic life support personnel in early defibrillation.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Policies and procedures exist to accredit personnel as early defibrillation technicians.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Continue to ensure policies and procedures for early defibrillation training and certification meet EMS system needs.

OBJECTIVE:
Evaluate existing policies and procedures for early defibrillation training and certification to determine that system needs are being met.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

2.13 BASE HOSPITAL PERSONNEL

MINIMUM STANDARDS:
All base hospital/alternative base station personnel who provide medical direction to prehospital personnel shall be knowledgeable about local EMS agency policies and procedures and have training in radio communications techniques.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Policies and agreements specify that only mobile intensive care nurses, who have been authorized by the MV EMSA Medical Director, or base hospital physicians, who have been judged knowledgeable in prehospital policies and protocols by the Base Hospital Medical Director, shall provide medical direction to EMS personnel.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that only adequately trained nurses and physicians provide medical direction to EMS personnel.

OBJECTIVE:
~~Develop policies requiring base hospital physicians and mobile intensive care nurses~~~~nurses~~Monitor compliance to ~~be trained in providing prehospital~~~~prehospital~~ensure that base hospital personnel who provide medical direction~~, radio communication and~~ are knowledgeable about EMS ~~agency policies~~~~policies~~policies and procedures. ~~Monitor compliance to ensure that base hospital personnel who provide~~~~provide~~Evaluate feasibility of a centralized medical ~~direction are knowledgeable about EMS policies and procedures~~~~procedures~~control point.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long-Range Plan (more than one year)

3.01 COMMUNICATIONS PLAN

MINIMUM STANDARDS:

The local EMS agency shall plan for EMS communications. The plan shall specify the medical communications capabilities of emergency medical transport vehicles, non-transporting advanced life support responders, and acute care facilities and shall coordinate the use of frequencies with other users.

RECOMMENDED GUIDELINES:

The local EMS agency's communications plan should consider the availability and use of satellites and cellular telephones.

CURRENT STATUS:

The current system of dispatch, field and hospital medical communication was developed more than ten years ago and ~~is in need of evaluation, upgrade and repair~~has recently been evaluated. ~~An assessment~~Most components of the ~~communication~~ system ~~was recently performed as a precursor to the development of a revised communications plan~~have been upgraded and repaired.

Communications Directory was updated in 1998/99.

COORDINATION WITH OTHER EMS AGENCIES:

The Assignment of communications frequencies and the locations of radio repeaters was performed in conjunction with adjacent EMS systems.

NEED(S):

~~Ensure the availability~~Several of ~~all necessary EMS dispatch and medical communications.~~

~~OBJECTIVE:~~

~~Revise the communications plan, prioritize system repairs and upgrades and make necessary changes~~the repeaters need to ~~comply with the EMS system model~~be replaced. Comprehensive statewide communications plan. Improved and alternative communications systems (e.g. sattelite) should be explored. The communications plan should ensure that an adequate number of frequencies exist for dispatch, scene management, patient dispersal, and medical control.

OBJECTIVE:

Prioritize system repairs and upgrades. ~~The communications plan should ensure that an adequate number of frequencies exist for dispatch, scene management, patient dispersal and medical control~~Evaluate necessary

changes to comply with the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)

X Long -Range Plan (more than one year)

3.02 RADIOS

MINIMUM STANDARDS:
Emergency medical transport vehicles and non-transporting advanced life support responders shall have two-way radio communications equipment which complies with the local EMS communications plan and which provides for dispatch and ambulance-to-hospital communication.

RECOMMENDED GUIDELINES:
Emergency medical transport vehicles should have two-way radio communications equipment which complies with the local EMS communications plan and which provides for vehicle-to-vehicle (including both ambulances and non-transporting first responder units) communication.

CURRENT STATUS:
All emergency medical transport vehicles have two-way radio equipment capable of performing field to dispatch, field to field, and field to hospital communications. However, communications "dead-spots" exist through out the system ~~especially in the higher elevations of the mountain counties.~~

~~Policies requiring the capability~~COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard

NEED(S):
Several of ~~ambulance and first responder communication have not been established~~the repeaters need to be replaced.

~~COORDINATION WITH OTHER EMS AGENCIES:~~
~~Not applicable for this standard~~

~~NEED(S):~~
~~Ensure the availability of medical communications.~~

~~OBJECTIVE:~~
~~Revise the~~Comprehensive statewide communications plan~~, prioritize system repairs and upgrades and make necessary changes~~ should be developed. Improved and alternative communications systems (e.g. sattelite) should be explored. The communications plan should ensure that an adequate number of frequencies exist for dispatch, scene management, patient dispersal, and medical control.

OBJECTIVE:
Prioritize system repairs and upgrades and make necessary changes.

TIME FRAME FOR MEETING OBJECTIVE:

_____ X Short-Range Plan (one year or less)

X Long -Range Plan (more than one year)

3.03 INTERFACILITY TRANSFER

MINIMUM STANDARDS:
Emergency medical transport vehicles used for interfacility transfers shall have the ability to communicate with both the sending and receiving facilities. This could be accomplished by cellular telephone.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
~~As discussed in 3.01, the~~The current system of dispatch, field and hospital medical communication was developed more than ten years ago and ~~is in need of evaluation, upgrade and repair~~has recently been evaluated. ~~An assessment~~Most components of the ~~communication~~ system ~~was recently performed as a precursor to the development of a revised communications plan~~have been upgraded and repaired.

COORDINATION WITH OTHER EMS AGENCIES:
Communications frequencies and the locations of radio repeaters was performed in conjunction with adjacent EMS systems.

NEED(S):
Ensure the availability of medical communications.

OBJECTIVE:
~~Revise the communications plan, prioritize~~Prioritize system repairs and upgrades and make necessary changes.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

3.04 DISPATCH CENTER

MINIMUM STANDARDS:
All emergency medical transport vehicles where physically possible, (based on geography and technology), shall have the ability to communicate with a single dispatch center or disaster communications command post.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
~~As discussed in 3.01, the~~The current system of dispatch, field and hospital medical communication was developed more than ten years ago and ~~is in need of evaluation, upgrade and repair~~has recently been evaluated. ~~An assessment~~Most components of the ~~communication~~ system ~~was recently performed as a precursor to the development of a revised communications plan~~have been upgraded and repaired.~~—~~

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard

NEED(S):
The establishment of a single medical dispatch center was identified by system participants as a major part of the EMS system model adopted by the EMSA. ~~The~~Further study needs to be conducted to determine the optimal configuration and responsibilities of a single medical dispatch center by county or region.

OBJECTIVE:
Establish agreement with Mariposa CDF as an EMS dispatch center. Perform a study to determine the required number of medical dispatch centers and their optimal configurations and responsibilities.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

3.05 HOSPITALS

MINIMUM STANDARDS:
All hospitals within the local EMS system shall (where physically possible) have the ability to communicate with each other by two-way radio.

RECOMMENDED GUIDELINES:
All hospitals should have direct communications access to relevant services in other hospitals within the system (e.g., poison information, pediatric and trauma consultation).

CURRENT STATUS:
Hospitals within Stanislaus County can communicate with each other through a dedicated BLAST phone system. ~~Common radio frequencies between hospitals within the EMS~~The current system ~~have not~~of dispatch, field and hospital medical communication was developed more than ten years ago and has recently been ~~established~~evaluated.
~~No work has~~Most components of the system have been ~~conducted to provide direct communications access to relevant services between hospitals~~upgraded and repaired.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
~~Ensure~~Maintain the availability of medical communications, including back-up systems.

OBJECTIVE:
~~Revise the communications plan, prioritize~~Prioritize system repairs and upgrades and make necessary changes.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

3.06 MCI/DISASTERS

MINIMUM STANDARDS:
The local EMS agency shall review communications linkages among providers (prehospital and hospital) in its jurisdiction for their capability to provide service in the event of multi-casualty incidents and disasters.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The county disaster control facilities (DCF) and the regional DCF use regular telephone ~~and~~, facsimile lines, and EMS radios when determining the capabilities of area hospitals during MCIs and disasters. The only alternate communications capability for hospital-to-hospital transmissions is ~~RACES~~the amateur radio system.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the availability of medical communications during disaster and multi-casualty incidents to include: common dispatch and travel frequencies; tactical frequencies coordinated with local public safety agencies; a mechanism for patient dispersal; and medical control communications.

OBJECTIVE:
~~Revise the communications plan, prioritize~~Prioritize system repairs and upgrades and make necessary changes consistent with system needs and the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

3.07 9-1-1 PLANNING/COORDINATION

MINIMUM STANDARDS:
The local EMS agency shall participate in ongoing planning and coordination of the 9-1-1 telephone service.

RECOMMENDED GUIDELINES:
The local EMS agency should promote the development of enhanced 9-1-1 systems.

CURRENT STATUS:
All counties in the MVEMSA system have enhanced 9-1-1 telephone service.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
~~Participate~~Continued participation in ongoing planning and coordination of 9-1-1 telephone service.

OBJECTIVE:
Participate in ongoing planning and coordination of 9-1-1 telephone service and encourage the development of PSAPs as described in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

3.08 9-1-1 PUBLIC EDUCATION

MINIMUM STANDARDS:
The local EMS agency shall be involved in public education regarding the 9-1-1 telephone service as it impacts system access.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Education concerning 9-1-1 access is provided to children through EMS youth projects and to the general public at health fairs and other promotional events.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Determine public education needs, based upon any changes ~~required by~~made to the EMS system ~~model~~.

OBJECTIVE:
In coordination with other public safety agencies and primary health care organizations provide for public education concerning appropriate utilization and system access as outlined in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

3.09 DISPATCH TRIAGE

MINIMUM STANDARDS:
The local EMS agency shall establish guidelines for proper dispatch triage which identifies appropriate medical response.

RECOMMENDED GUIDELINES:
The local EMS agency should establish ~~a~~an emergency medical dispatch priority reference system, including systemized caller interrogation, dispatch triage policies, and pre-arrival instructions.

CURRENT STATUS:
~~An emergency~~Emergency medical dispatch priority reference ~~system~~systems, including systemized caller interrogation, and pre-arrival instructions ~~has been developed~~are being utilized.~~–~~ Currently, an ALS ambulance is dispatched to all 9-1-1 medical requests. First response agencies currently determine their own dispatch criteria.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Develop and implement standardized (first response/ambulance) dispatch triage criteria as described in the EMS system model.

OBJECTIVE:
~~Conduct random compliance evaluation of EMD centers~~Develop and implement standardized (first response/ambulance) dispatch triage criteria as described in the EMS system model.~~–~~

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

3.10 INTEGRATED DISPATCH

MINIMUM STANDARDS:
The local EMS system shall have a functionally integrated dispatch with system-wide emergency services coordination, using standardized communications frequencies.

RECOMMENDED GUIDELINES:
The local EMS agency should develop a mechanism to ensure appropriate system-wide ambulance coverage during periods of peak demand.

CURRENT STATUS:
Integrated dispatch has not been developed in the MVEMSA system. Providers are required by agreement to ensure the availability of ambulances within their own zones at all times.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Develop an integrated dispatch system as described in the EMS system model.

OBJECTIVE:
~~Develop~~Evaluate the feasibility of developing an integrated dispatch system as described in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

X	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.01 SERVICE AREA BOUNDARIES

MINIMUM STANDARDS:
The local EMS agency shall determine the boundaries of emergency medical transportation service areas.

RECOMMENDED GUIDELINES:
The local EMS agency should secure a county ordinance or similar mechanism for establishing emergency medical transport service areas (e.g., ambulance response zones).

CURRENT STATUS:
Emergency medical transportation service areas have been determined for all ~~six~~ five counties in the EMS system.

An ordinance or similar mechanism has been established in Stanislaus, Mariposa, Calaveras, Tuolumne, Alpine and Amador Counties that provides for the establishment of ambulance response zones. However, the appropriateness of these zones has not been evaluated in several years.

COORDINATION WITH OTHER EMS AGENCIES:
An agreement has been reached with Merced County EMS creating ambulance response zones which encompass portions of both Merced and Stanislaus counties. An agreement has been reach with El Dorado County EMS and the State of Nevada to have providers from their jurisdictions respond to emergencies in parts of Alpine County.

NEED(S):
Ensure that ambulance response zones provide optimal ambulance response and care by periodically evaluating the emergency medical transportation service areas.

OBJECTIVE:
Establish/review/revise ~~other~~ local ambulance ordinances ~~as needed~~ ~~needed~~ in Stanislaus and Amador counties.

Develop agreements with cities and fire districts regarding ambulance response zones in their areas. Monitor ambulance response zone boundaries and make changes as needed to optimize system response.

TIME FRAME FOR MEETING OBJECTIVE:

		X	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)		

4.02 MONITORING

MINIMUM STANDARDS:
The local EMS agency shall monitor emergency medical transportation services to ensure compliance with appropriate statutes, regulations, policies, and procedures.

RECOMMENDED GUIDELINES:
The local EMS agency should secure a county ordinance or similar mechanism for licensure of emergency medical transport services. These should be intended to promote compliance with overall system management and should, wherever possible, replace any other local ambulance regulatory programs within the EMS area.

CURRENT STATUS:
The minimum standard is met through written agreements, auditing, inspections and investigation of unusual occurrences.

The recommended guideline is met within all counties except Alpine. Alpine County depends upon ambulance response from providers based in the surrounding counties of El Dorado, Amador, Calaveras and Douglas, NV. Ambulance response zones are based upon the closest available mutual aid response.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that providers comply with statutes, regulations, policies and procedures.

OBJECTIVE:
Conduct random compliance evaluations of ALS providers. Work closely with cities and fire agencies to ensure that their EMS concerns are addressed in both day to day operations and during ambualnce provider agreement negotiations. Monitor providers for compliance to standards. Modify county ambulance ordinances as needed.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.03 CLASSIFYING MEDICAL REQUESTS

MINIMUM STANDARDS:
The local EMS agency shall determine criteria for classifying medical requests (e.g., emergent, urgent, and non-emergent) and shall determine the appropriate level of medical response to each.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
An emergency medical dispatch priority reference system has been developed. Currently, some type of classification criteria is used by all dispatch centers with an ALS ambulance being sent to all 9-1-1 medical requests as a minimum response.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Implementation of an emergency medical dispatch system as described in the EMS system model.

OBJECTIVE:
Evaluate the feasibility of level III dispatch.

Develop and implement an emergency medical dispatch system as described in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.04 PRESCHEDULED RESPONSES

MINIMUM STANDARDS:
Service by emergency medical transport vehicles which can be prescheduled without negative medical impact shall be provided only at levels which permit compliance with local EMS agency policy.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Ambulance provider agreements specify parameters for utilization of emergency medical transport vehicles for prescheduled calls. These parameters require that the last ALS ambulance not be utilized for prescheduled calls.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the availability of a sufficient number of emergency medical transport vehicles to meet EMS system demands.

OBJECTIVE:
Monitor ambulance availability and take corrective action as necessary.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.05 RESPONSE TIME STANDARDS

MINIMUM STANDARDS:

Each local EMS agency shall develop response time standards for medical responses. These standards shall take into account the total time from receipt of call at the primary public safety answering point (PSAP) to arrival of the responding unit at the scene, including all dispatch time intervals and driving time.

RECOMMENDED GUIDELINES:

Emergency medical service areas (response zones) shall be designated so that, for ninety percent of emergency responses, response times shall not exceed:

	Metropolitan - Urban Area	Suburban - Rural Area	Wilderness Area
BLS First Responder	5 minutes	15 minutes	ASAP
Early Defib. First Responder	5 minutes	ASAP	ASAP
ALS Responder or Ambulance	8 minutes	20 minutes	ASAP
EMS Transportation Unit	8 minutes	20 minutes	ASAP

CURRENT STATUS:

~~Response~~~~Response~~Meets recommended standards ~~were developed for ALS ambulance providers~~ in Amador, Calaveras, Mariposa, and Stanislaus counties. ~~In Stanislaus County, response times for the EMS transportation unit are measured from the time the secondary PSAP has enough information to send an ambulance (address, complaint, severity) to arrival on scene.~~

~~Response times for first responders to medical responses are not available in any LEMSA counties.~~

COORDINATION WITH OTHER EMS AGENCIES:

Agreements have been made with Merced, El Dorado and Douglas counties for the utilization of ambulance service which cross county lines.

NEED(S):

Ensure the ability to measure response times from the primary PSAP to arrival on scene for ambulance and first response vehicles. Further development of response time standards for ~~Calaveras~~~~Calaveras~~Alpine County. Development of a mechanism to measure or collect response times for first response agencies and the establishment of response time goals or standards for first response agencies.

OBJECTIVE:

Create a mechanism to measure response times from receipt of call at primary PSAP to arrival on scene. Establish response time standards for ~~Calaveras~~~~Calaveras~~Alpine County.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.06 STAFFING

MINIMUM STANDARDS:
All emergency medical transport vehicles shall be staffed and equipped according to current state and local EMS agency regulations and appropriately equipped for the level of service provided.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
~~By policy, the minimum staffing level of all emergency medical transport vehicles (ambulances), is one licensed paramedic and one certified EMT-I. However, a BLSBLSGround~~ ambulance ~~staffed with a minimum of two EMT-Is may be used to respond to emergency requests during times of disaster and system overload when all available ALS resources have been depleteddepletedminimum~~ staffing requirements are as follows:

1. BLS Ambulance - Two EMT-I's currently certified in the State of California.
2. ALS Ambulance - One EMT-P accredited by the Agency and one EMT-I currently certified in the state of California.
3. CCT Ambulance - One EMT-I currently certified in the state of California, and one attendant who must be either a physician or a Registered Nurse (R.N.) with a minimum of two (2) years of critical care experience, and current certificate of completion from an Advanced Cardiac Life Support course. One attendant must be authorized to provide nasotracheal and orotracheal intubation. Providers are required to maintain a minimum drug and equipment inventory on all in-service ambulances as specified by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure compliance with standard.

OBJECTIVE:
Monitor providers for compliance to standards and take corrective action as necessary.

TIME FRAME FOR MEETING OBJECTIVE:
Short-Range Plan (one year or less)

X Long-Range Plan (more than one year)

4.07 FIRST RESPONDER AGENCIES

MINIMUM STANDARDS:
The local EMS agency shall integrate qualified EMS first responder agencies (including public safety agencies and industrial first aid teams) into the system.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
The roles and responsibilities of most system participants are based primarily on historical involvement and willingness to cooperate with the agency.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Formal integration of first responder agencies into the EMS system.

OBJECTIVE:
Identify the optimal roles and responsibilities of first response agencies as described in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

		X	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)		

4.08 MEDICAL & RESCUE AIRCRAFT

MINIMUM STANDARDS:
The local EMS agency shall have a process for categorizing medical and rescue aircraft and shall develop policies and procedures regarding:

a) authorization of aircraft to be utilized in prehospital patient care,
b) requesting of EMS aircraft,
c) dispatching of EMS aircraft,
d) determination of EMS aircraft patient destination,
e) orientation of pilots and medical flight crews to the local EMS system, and
f) addressing and resolving formal complaints regarding EMS aircraft.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
A process has been established for categorizing medical and rescue aircraft as required in a-f above.

COORDINATION WITH OTHER EMS AGENCIES:
Services classified by other LEMSAs are used to supplement resources based in the MVEMSA system.

NEED(S):
Ensure that medical and rescue aircraft incorporated into the EMS system meet system needs and adhere to agency requirements.

OBJECTIVE:
Monitor providers for compliance to standards and take corrective action as necessary. ~~Develop an exclusive operating area or other mechanism to ensure compliance with standards and optimal system design.~~

TIME FRAME FOR MEETING OBJECTIVE:

Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.09 AIR DISPATCH CENTER

MINIMUM STANDARDS:
The local EMS agency shall designate a dispatch center to coordinate the use of air ambulances or rescue aircraft.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
One dispatch center per county has been identified as an EMS aircraft resource center. The two air ambulance providers operating within the MVEMSA system each provide flight following dispatch services and currently provide for the coordination of EMS aircraft in the entire EMS system on a rotating basis. A toll-free number was established for county air resource centers to use when requesting EMS medical aircraft.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Evaluate and improve the current system for requesting and dispatching EMS aircraft. Determine the feasibility of creating a single air ambulance dispatch center, as described in the EMS system model.

OBJECTIVE:
Evaluate and improve the current system for requesting and dispatching EMS aircraft. Determine the feasibility of creating a single air ambulance dispatch center, as described in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.10 AIRCRAFT AVAILABILITY

MINIMUM STANDARDS:
The local EMS agency shall identify the availability and staffing of medical and rescue aircraft for emergency patient transportation and shall maintain written agreements with aeromedical services operating within the EMS area.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The MVEMSA has identified medical and rescue aircraft for emergency patient transportation for aeromedical services operating within the EMS area. Written agreements between MVEMSA and all such aeromedical services are in place with the exception of the ~~Fresno-based services~~~~services~~Reno's Care Flight program.

COORDINATION WITH OTHER EMS AGENCIES:
Reno's Care Flight program is under the direct control of the EMS agency in Reno, NV.

NEED(S):
Ensure the availability and appropriate staffing of EMS medical and rescue aircraft to meet the demands of the EMS system. Complete written agreements with Reno's Care Flight ~~and Life Flight of U.C. Davis~~.

OBJECTIVE:
Monitor providers to ensure that system demands are being met and take corrective action as necessary. Develop an exclusive operating area or other mechanism to ensure optimal system design and providers compliance with agreements and policy.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.11 SPECIALTY VEHICLES

MINIMUM STANDARDS:
Where applicable, the local EMS agency shall identify the availability and staffing of all-terrain vehicles, snow mobiles, and water rescue and transportation vehicles.

RECOMMENDED GUIDELINES:
The local EMS agency should plan for response by and use of all-terrain vehicles, snow mobiles, and water rescue vehicles areas where applicable. This plan should consider existing EMS resources, population density, environmental factors, dispatch procedures and catchment area.

CURRENT STATUS:
No resource directory of specialty vehicles has been developed by the EMS agency. However, individual counties with specialty vehicle needs have developed resource lists and procedures for requesting and dispatching these specialty vehicles.

COORDINATION WITH OTHER EMS AGENCIES:
Work with adjacent EMS agencies to ensure the availability of specialty vehicles.

NEED(S):
Development of a region-wide resource directory and response plan for specialty vehicles.

OBJECTIVE:
Develop a resource directory of specialty vehicles and research the feasibility and need for developing a response plan for specialty vehicles.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

4.12 DISASTER RESPONSE

MINIMUM STANDARDS:
The local EMS agency, in cooperation with the local office of emergency services (OES), shall plan for mobilizing response and transport vehicles for disaster.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The OES Region IV MCI Plan has been formally adopted, by the Board of Directors of the Mountain-Valley EMSA and the Boards of Supervisors of each of the member counties, as the plan to be used for medical disaster management. The Mountain-Valley EMSA has been designated as the ~~Medical~~ Operational Area Disaster Medical/Health Coordinator for the counties of Alpine (west slope), Amador, Calaveras, and Stanislaus. Standard procedures for mobilizing response and transport vehicles were developed among the counties of OES Region IV.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Continue to work with other OES Region IV counties in developing standard procedures for mobilizing response and transport vehicles for disasters.

OBJECTIVE:
Continue to work with other OES Region IV counties in developing standard procedures for mobilizing response and transport vehicles for disasters.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.13 INTERCOUNTY RESPONSE

MINIMUM STANDARDS:
The local EMS agency shall develop agreements permitting intercounty response of emergency medical transport vehicles and EMS personnel.

RECOMMENDED GUIDELINES:
The local EMS agency should encourage and coordinate development of mutual aid agreements which identify financial responsibility for mutual aid responses.

CURRENT STATUS:
Ambulance provider agreements require providers to arrange for day-to-day mutual-aid from neighboring providers stationed both inside and outside the MVEMSA system.

~~The counties of OES Region IV are in the process of finalizing a master-mutual aid agreement, which identifies financial responsibility and request procedures for intercounty mutual aid.~~

COORDINATION WITH OTHER EMS AGENCIES:
Continuation of call agreements have been executed with adjacent LEMSAs.

NEED(S):
~~Master~~~~Master~~Statewide medical mutual-aid agreement~~ between the counties of OES Region IV~~.

OBJECTIVE:
~~Adoption of a master~~~~master~~Continue to monitor ~~day-to-day~~ mutual-aid ~~agreement~~~~agreement~~and continuation of call incidents and take action as necessary. ~~Continue to monitor day-to-day~~~~day-to-day~~Develop mutual-aid ~~and continuation~~agreements with El Dorado and~~continuation of call incidents and take action as necessary~~ Sacramento counties for Amador County.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.14 INCIDENT COMMAND SYSTEM

MINIMUM STANDARDS:
The local EMS agency shall develop multi-casualty response plans and procedures which include provision for on-scene medical management using the Incident Command System.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The OES Region IV MCI Plan has been formally adopted, by the Board of Directors of the MVEMSA and the Boards of Supervisors of each of the member counties, as the plan to be used for medical disaster management. The OES Region IV MCI Plan is based on the Incident Command System. Completion of ICS ~~120~~120100 and a 4-hour hospital or 8-hour field MCI course is the minimum standard for EMS personnel.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the MCI plan continues to meet the needs of on-scene medical management.

OBJECTIVE:
Monitor the utilization of the MCI plan and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.15 MCI PLANS

MINIMUM STANDARDS:
Multi-casualty response plans and procedures shall utilize state standards and guidelines.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The OES Region IV MCI Plan has been formally adopted, by the Board of Directors of the MVEMSA and the Boards of Supervisors of each of the member counties, as the plan to be used for medical disaster management. The OES Region IV MCI Plan is based on the Incident Command System. Completion of ICS ~~120~~120100 and a 4-hour hospital or 8-hour field MCI course is the minimum standard for EMS personnel.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the MCI plan continues to meet the needs of on-scene medical management.

OBJECTIVE:
Monitor the utilization of the MCI plan and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.16 ALS STAFFING

MINIMUM STANDARDS:
All ALS ambulances shall be staffed with at least one person certified at the advanced life support level and one person staffed at the EMT-I level.

RECOMMENDED GUIDELINES:
The local EMS agency should determine whether advanced life support units should be staffed with two ALS crew members or with one ALS and one BLS crew member.

On an emergency ALS unit which is not staffed with two ALS crew members, the second crew member should be trained to provide defibrillation, using available defibrillators.

CURRENT STATUS:
By policy, the minimum staffing level of all emergency medical transport vehicles (ambulances), is one licensed paramedic and one certified EMT-I. However, a BLS ambulance, staffed with a minimum of two EMT-Is may be used to respond to emergency requests during times of disaster and system overload when all available ALS resources have been depleted.

BLS ambulance personnel do not perform defibrillation nor has their training in this procedure been encouraged by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that ambulance staffing meets minimum standards and system needs.

OBJECTIVE:
Evaluate the feasibility and need of staffing ambulances with ~~two ALS crew members, and of training BLS crew members to perform defibrillation.~~ ~~*Evaluate the feasibility and need of staffing ambulances with*~~ a combination of paramedics, registered nurses and physician assistants (PAs or LPNs) as outlined in the EMS System Model.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.17 ALS EQUIPMENT

MINIMUM STANDARDS:
All emergency ALS ambulances shall be appropriately equipped for the scope of practice of its level of staffing.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Providers are required to maintain a minimum drug and equipment inventory on all in-service ambulances as specified by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the availability of drugs and equipment on ambulances to meet patient and system needs.

OBJECTIVE:
Monitor drug and equipment requirements and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long-Range Plan (more than one year)

4.18 COMPLIANCE

MINIMUM STANDARDS:
The local EMS agency shall have a mechanism (e.g., an ordinance and/or written provider agreements) to ensure that EMS transportation agencies comply with applicable policies and procedures regarding system operations and clinical care.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Written agreements, county ordinances, inspections, unusual occurrence reporting, investigations and quality improvement programs have been established as mechanisms to review, monitor and enforce compliance with system policies for operations and clinical care.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure compliance with system policies.

OBJECTIVE:
Evaluate and improve compliance with system policies.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.19 TRANSPORTATION PLAN

MINIMUM STANDARDS:
Any local EMS agency which desires to implement exclusive operating areas, pursuant to Section 1797.224, H&S Code, shall develop an EMS transportation plan which addresses: a) minimum standards for transportation services; b) optimal transportation system efficiency and effectiveness; and c) use of a competitive bid process to ensure system optimization.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A Transportation Plan which meets standards is included in the plan appendix.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the Transportation Plan meets the needs of the EMS system.

OBJECTIVE:
Evaluate Agency position regarding the inclusion of all ~~ALS and emergency~~~~emergency~~ambulance calls within EOAs and update Transportation Plan. Implement and monitor the requirements of the Transportation Plan and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

4.20 "GRANDFATHERING"

MINIMUM STANDARDS:
Any local EMS agency which desires to grant an exclusive operating permit without use of a competitive process shall document in its EMS transportation plan that its existing provider meets all of the requirements for non-competitive selection ("grandfathering") under Section 1797.224, H&SC.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The enclosed Transportation Plan documents those providers which meet the requirement for "grandfathering" under Section 1797.224, H&S into exclusive operating areas.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the Transportation Plan meets the needs of the EMS system.

OBJECTIVE:
Monitor the requirements of the Transportation Plan and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.21 COMPLIANCE

MINIMUM STANDARDS:
The local EMS agency shall have a mechanism to ensure that EMS transportation and/or advanced life support agencies to whom exclusive operating permits have been granted, pursuant to Section 1797.224, H&SC, comply with applicable policies and procedures regarding system operations and patient care.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Written agreements, county ordinances, inspections, unusual occurrence reporting, investigations and quality improvement programs have been established as mechanisms to review, monitor and enforce compliance with system policies for operations and clinical care.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure compliance with system policies.

OBJECTIVE:
Evaluate and improve compliance with system policies.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

4.22 EVALUATION

MINIMUM STANDARDS:
The local EMS agency shall periodically evaluate the design of exclusive operating areas.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A formal process evaluating the design of exclusive operating areas has not been established. However, the performance standards required of providers operating within EOAs is routinely monitored and corrective action is taken to address deficiencies.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that EOA design meets the needs of the EMS system and is consistent with the EMS system model.

OBJECTIVE:
Develop a formal mechanism, consistent with the EMS system model, for evaluating EOA design. Continue to monitor performance standards and take corrective action as needed.

TIME FRAME FOR MEETING OBJECTIVE:

		X	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)		

5.01 ASSESSMENT of CAPABILITIES

MINIMUM STANDARDS:
The local EMS agency shall assess and periodically reassess the EMS related capabilities of acute care facilities in its service area.

RECOMMENDED GUIDELINES:
The local EMS agency should have written agreements with acute care facilities in its service area.

CURRENT STATUS:
Facility Assessment Profiles were last completed in 1989. The Emergency Facilities Self-Assessment Instrument, which is used to develop Facility Assessment Profiles, was revised in 1995. At the request of the hospitals, the agency's plans for using the assessment instrument were put on hold in July 1995.

The agency has written base hospital agreements with all seven hospitals in the MVEMSA system. ~~The agency has written base hospital agreements with all seven hospitals in the MV EMS system. No agreements or contracts regarding receiving facility status have been developed.~~

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
To conduct an assessment of area hospitals to determine EMS capabilities to assist the agency in developing triage and destination policies.

~~To develop receiving hospital agreements with all hospitals or add receiving hospital language to existing base hospital agreements.~~

OBJECTIVE:
In conjunction with area hospitals and the medical community, determine hospital capabilities through completion of a facility assessment instrument. ~~Develop and execute receiving facility agreements with all area hospitals based on their capabilities.~~

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long -Range Plan (more than one year)

5.02 TRIAGE & TRANSFER PROTOCOLS

MINIMUM STANDARDS:
The local EMS agency shall establish prehospital triage protocols and shall assist hospitals with the establishment of transfer protocols and agreements.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
Prehospital triage protocols have not been implemented. Transfer protocols and model transfer agreements have been developed and implemented.

COORDINATION WITH OTHER EMS AGENCIES:
Work with adjacent EMS systems to establish standard triage and transfer protocols as practical.

NEED(S):
Prehospital triage protocols must be developed in order to ensure that patients receive an appropriate level of care, i.e.: transport to the closest hospital capable of meeting the patient's treatment needs; transport to the patient's preferred health care provider; treat and release at scene, etc. The development of patient destination policies has been identified by the Regional Advisory Committee and other groups as a top priority.

OBJECTIVE:
Develop prehospital triage and transfer protocols based on medical need and preferred transport which ensure the delivery of patients to appropriate facilities. Explore the concept of treat and release at scene and alternative treatment and transport modalities as identified in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

5.03 TRANSFER GUIDELINES

MINIMUM STANDARDS:
The local EMS agency, with participation of acute care hospital administrators, physicians, and nurses, shall establish guidelines to identify patients who should be considered for transfer to facilities of higher capability and shall work with acute care hospitals to establish transfer agreements with such facilities.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Pediatric Trauma and Critical Care Transfer Guidelines have been developed and forwarded to each acute care hospital for adoption. Transfer guidelines have not been developed for trauma or any other patient group identified by the State of California as requiring special consideration.

COORDINATION WITH OTHER EMS AGENCIES:
The pediatric guidelines are consistent with guidelines adopted by other LEMSA that have implemented EMS-C subsystems. Any future transfer policies or agreements will be coordinated with affected LEMSAs.

NEED(S):
Develop transfer guidelines for trauma and other specialty patient groups as tools to be used by emergency department physicians in determining an appropriate disposition for EMS patients.

OBJECTIVE:
Develop transfer policies, protocols and guidelines for trauma and other specialty patient groups.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long-Range Plan (more than one year)

5.04 SPECIALTY CARE FACILITIES

MINIMUM STANDARDS:
The local EMS agency shall designate and monitor receiving hospitals and, when appropriate, specialty care facilities for specified groups of emergency patients.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A receiving hospital policy was adopted in 1992, but has not been implemented. Agreements have been developed with those facilities providing Pediatric Critical Care Center and Pediatric Trauma Center services to the ~~MV~~ EMS system.

COORDINATION WITH OTHER EMS AGENCIES:
The recognition agreements with centers located outside of our region were performed with the approval of the local EMS agencies who had originally designated the centers.

NEED(S):
Ensure a process exists to designate and monitor receiving hospitals and specialty care facilities for specified groups of emergency patients.

OBJECTIVE:
~~Develop~~Update transfer policies, protocols and guidelines ~~for trauma and other specialty patient groups.~~

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

5.05 MASS CASUALTY MANAGEMENT

MINIMUM STANDARDS:
The local EMS agency shall encourage hospitals to prepare for mass casualty management.

RECOMMENDED GUIDELINES:
The local EMS agency should assist hospitals with preparation for mass casualty management, including procedures for coordinating hospital communications and patient flow.

CURRENT STATUS:
A Disaster Control Facility has been designated in each county. All hospitals within the EMS system participate in mass casualty incidents in accordance with the OES Region IV MCI Plan. The MVEMSA provides hospitals with ~~classroom and practical~~ disaster training which includes coordinating hospital communications and patient flow.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure adherence to MCI plan requirements.

OBJECTIVE:
Monitor capability of system hospitals to respond to mass casualty incidents and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

5.06 HOSPITAL EVACUATION

MINIMUM STANDARDS:
The local EMS agency shall have a plan for hospital evacuation, including its impact on other EMS system providers.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A model plan for hospital evacuation is currently being developed by the counties of OES Region IV.

COORDINATION WITH OTHER EMS AGENCIES:
The member counties of OES Region IV have and continue to work together for the development and adoption of standardized multi-casualty incident plans and other medical disaster plans.

NEED(S):
Develop, adopt and implement a standardized hospital evacuation plan and community impact evaluation.

OBJECTIVE:
Development and implement ~~a model~~an impact evaluation tool for hospital ~~evacuation plan~~closures.

TIME FRAME FOR MEETING OBJECTIVE:

	~~Short-Range Plan (one year or less)~~
X	Short-Range Plan (one year or less)
	Long-Range Plan (more than one year)

5.07 BASE HOSPITAL DESIGNATION

MINIMUM STANDARDS:
The local EMS agency shall, using a process which allows all eligible facilities to apply, designate base hospitals or alternative base stations as it determines necessary to provide medical direction of prehospital personnel.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
Currently, all seven hospitals in the EMS system have been designated as base hospitals. However, with the inclusion of provider ~~QA~~QA/QI and an increase in standing orders, there may not be a need for the number of base hospitals in their current roles.

COORDINATION WITH OTHER EMS AGENCIES:
Arrangements have been made with Merced County EMSA to allow Mariposa ambulance providers to access Merced County base hospitals for medical control and disaster control functions. Arrangements have been made to allow San Joaquin County EMS personnel to contact EMSA base hospitals for medical direction.

NEED(S):
The establishment of a single medical control point has been identified by system participants as a major part of the EMS system model adopted by the agency. A process needs to be developed for selecting a single medical control point and identifying its optimal configuration and responsibilities.

OBJECTIVE:
~~Develop and execute receiving facility agreements with all area hospitals based on their capabilities.~~
~~Establish~~Conduct a feasibility study for establishment of a single medical control point.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

5.08 TRAUMA SYSTEM DESIGN

MINIMUM STANDARDS:
Local EMS agencies that develop trauma care systems shall determine the optimal system (based on community need and available resources) including, but not limited to:

a) the number and level of trauma centers (including the use of trauma centers in other counties),
b) the design of catchment areas (including areas in other counties, as appropriate), with consideration of workload and patient mix,
c) identification of patients who should be triaged or transferred to a designated center, including consideration of patients who should be triaged to other specialty care centers,
d) the role of non-trauma center hospitals, including those that are outside of the primary triage area of the trauma center, and
e) a plan for monitoring and evaluation of the system.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
Although major planning efforts were conducted in 1981-83, 1988-90 and 1992-93, a trauma system has not been established in the MVEMSA system. Trauma and specialty care planning were identified by the Regional Advisory Committee and other groups as a top priority for the agency and is included in the EMS system model adopted by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the availability of specialized trauma services to critically injured patients.

OBJECTIVE:
Develop a trauma system which includes facility designation promoting the availability of specialized trauma services to critically injured patients.

TIME FRAME FOR MEETING OBJECTIVE:

Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

5.09 PUBLIC INPUT

MINIMUM STANDARDS:
In planning its trauma care system, the local EMS agency shall ensure input from both prehospital and hospital providers and consumers.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
Although major planning efforts were conducted in 1981-83, 1988-90 and 1992-93, a trauma system has not been established for the MVEMSA system. Trauma and specialty care planning was identified by the Regional Advisory Committee and other groups as a top priority for the agency and is included in the EMS system model adopted by the agency.

All previous trauma planning efforts have included numerous opportunities for public input and special interest lobbying.

COORDINATION WITH OTHER EMS AGENCIES:
None.

NEED(S):
Ensure an open process for trauma system development.

OBJECTIVE:
Keep the process used for developing a trauma system open to hospital, prehospital and public input.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

5.10 PEDIATRIC SYSTEM DESIGN

MINIMUM STANDARDS:
Local EMS agencies that develop pediatric emergency medical and critical care systems shall determine the optimal system, including:

a) the number and role of system participants, particularly of emergency departments,
b) the design of catchment areas (including areas in other counties, as appropriate), with consideration of workload and patient mix,
c) identification of patients who should be primarily triaged or secondarily transferred to a designated center, including consideration of patients who should be triaged to other specialty care centers,
d) identification of providers who are qualified to transport such patients to a designated facility,
e) identification of tertiary care centers for pediatric critical care and pediatric trauma,
f) the role of non-pediatric specialty care hospitals including those which are outside of the primary triage area, and
g) a plan for monitoring and evaluation of the system.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
A Pediatric Emergency Medical and Critical Care System was developed and implemented in 1993-1995 as part of two special project grants awarded to the EMSA by the California EMS Authority. The pediatric system addresses the major Emergency Medical Services for Children (EMSC) components identified by the California EMS Authority as required of an EMSC system.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the Pediatric Emergency Medical and Critical Care System and the pediatric services provided by the EMS system meets the needs of critically ill and injured children within the EMS system. Develop a Pediatric System Plan which describes the current EMSC system and identifies the optimal system design.

OBJECTIVE:
Evaluate the effectiveness of the EMS system at meeting the needs of critically ill and injured children Develop a pediatric system plan.

TIME FRAME FOR MEETING OBJECTIVE:

Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

Data Collection and System Evaluation

5.11 EMERGENCY DEPARTMENTS

MINIMUM STANDARDS:
Local EMS agencies shall identify minimum standards for pediatric capability of emergency departments including:

a) staffing,
b) training,
c) equipment,
d) identification of patients for whom consultation with a pediatric critical care center is appropriate,
e) quality assurance/quality improvement, and
f) data reporting to the local EMS agency.

RECOMMENDED GUIDELINES:
Local EMS agencies should develop methods of identifying emergency departments which meet standards for pediatric care and for pediatric critical care centers and pediatric trauma centers.

CURRENT STATUS:
Emergency Department Pediatric Guidelines were adopted in 1994 and implemented through voluntary consultation visits with 10 of 11 acute care hospital in the region. Agreements were executed in 1995 with five pediatric critical care centers and pediatric trauma centers located outside the MVEMSA system recognizing their LEMSA designations as PCCCs and PTCs and incorporating them into the MVEMSA system.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Evaluate the usefulness of the pediatric guidelines and each emergency department's voluntary adherence to the guidelines. Determine the need for identifying emergency departments approved for pediatrics (EDAPs).

OBJECTIVE:
Monitor the usefulness of the pediatric guidelines and each emergency departments voluntary adherence to the guidelines and make changes as necessary. Identify EDAPs, as needed, to ensure adherence to pediatric E.D. guidelines.

TIME FRAME FOR MEETING OBJECTIVE:

Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

5.12 PUBLIC INPUT

MINIMUM STANDARDS:
In planning its pediatric emergency medical and critical care system, the local EMS agency shall ensure input from both prehospital and hospital providers and consumers.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
A ~~Pediatric Advisory~~regional Quality Liaison Committee ~~comprised of prehospital and hospital advisors, consumers and~~evaluates both the pediatric ~~experts was formed to provide advice and public input on the development of the pediatric~~and adult emergency medical and critical care delivery throughout the system.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Continue public input and evaluation of the pediatric emergency medical and critical care system.

OBJECTIVE:
Ensure continued public input and evaluation of the pediatric emergency medical and critical care system.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

5.13 SPECIALTY SYSTEM DESIGN

MINIMUM STANDARDS:
Local EMS agencies developing specialty care plans for EMS-targeted clinical conditions shall determine the optimal system for the specific condition involved, including:

a) the number and role of system participants,
b) the design of catchment areas (including inter-county transport, as appropriate) with consideration of workload and patient mix,
c) identification of patients who should be triaged or transferred to a designated center,
d) the role of non-designated hospitals including those which are outside of the primary triage area, and
e) a plan for monitoring and evaluation of the system.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
Trauma and specialty care planning was identified by the Regional Advisory Committee and other groups as a top priority and is included in the EMS system model adopted by the agency.

COORDINATION WITH OTHER EMS AGENCIES:
None

NEED(S):
Ensure the availability of trauma and other specialty care services to critically ill and injured patients.

OBJECTIVE:
Develop and implement trauma and other specialty care systems in accordance with the EMS system model and State guidelines, as appropriate.

TIME FRAME FOR MEETING OBJECTIVE:

Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

5.14 PUBLIC INPUT

MINIMUM STANDARDS:
In planning other specialty care systems, the local EMS agency shall ensure input from both prehospital and hospital providers and consumers.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
Trauma and specialty care planning was identified by the Regional Advisory Committee and other groups as a top priority and is included in the EMS system model adopted by the agency. All previous specialty care planning efforts have included numerous opportunities for public input and special interest lobbying.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure an open process for specialty care system development.

OBJECTIVE:
Keep the process used for developing a specialty care system open to public input.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

6.01 QA/QI PROGRAM

MINIMUM STANDARDS:
The local EMS agency shall establish an EMS quality assurance/quality improvement (QA/QI) program to evaluate the response to emergency medical incidents and the care provided to specific patients. The programs shall address the total EMS system, including all prehospital provider agencies, base hospitals, and receiving hospitals. It shall address compliance with policies, procedures, and protocols, and identification of preventable morbidity and mortality, and shall utilize state standards and guidelines. The program shall use provider based QA/QI programs and shall coordinate them with other providers.

RECOMMENDED GUIDELINES:
The local EMS agency should have the resources to evaluate response to, and the care provided to, specific patients.

CURRENT STATUS:
In 1994, the agency adopted an EMS System Quality Assurance/Quality Improvement (QA/QI) Plan which formed a multi-disciplinary Quality Liaison Committee (QLC) comprised of base hospital medical directors, base hospital nurse liaisons, ambulance provider quality coordinators, first response quality coordinators and dispatch quality coordinators. The purpose of the QLC is to assist the agency Medical Director in providing oversight and evaluation of the EMS system. Local Q.I. groups, consisting of members of an operational area, have also been formed to evaluate response, care and transport. ~~Most aspects~~Aspects of the ~~previous~~ clinical review ~~(medical auditing) program were lost with the transition to the new QA/QI program~~have been re-established.—

Region-wide monitoring has been re-established via new clinical indicators. Continuing to work with statewide organizations and EMSA to develop and implement statewide EMS system evaluation program and standards.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
~~Establishment~~Development of a process to ~~identify preventable morbidity and mortality~~provide feedback to prehospital personnel on patient outcomes, as described in the EMS system model. ~~Reinstitution of a medical audit process. Development of a process to provide feedback to prehospital personnel on patient outcomes, as described in the EMS system model.~~ Ensure that the QA/QI process meets system needs and State standards.

OBJECTIVE:
Develop a process to: ~~identify preventable morbidity and mortality; conduct medical auditing and;~~ provide feedback to prehospital personnel on patient outcomes. Continue to monitor and amend the QA/QI program to meet system needs and statewide standards.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)

X Long -Range Plan (more than one year)

6.02 PREHOSPITAL RECORDS

MINIMUM STANDARDS:
Prehospital records for all patient responses shall be completed and forwarded to appropriate agencies as defined by the local EMS agency.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Policy requires patient care records (PCRs) to be completed for all patients, with copies of the report being submitted to the receiving hospital, provider and agency. All ground ambulance providers use a standardized PCR for documenting patient care. ~~Negotiations with the air~~Air ambulance providers ~~regarding patient documentation and the submission of data~~ are ~~continuing~~providing monthly electronic patient care information to the EMS agency.

Local QI groups have implemented a Rapid Cycle Improvement project to improve the timely PCR submission to the receiving facilities.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure completeness and timely submission of patient care records.

OBJECTIVE:
Continue to evaluate completeness and timely submission of patient care records with Rapid Cycle Improvement. ~~Obtain copies of all PCRs from air ambulance providers on approved agency forms or in an approved electronic format.~~

~~**OBJECTIVE:**~~
~~Investigate ways of improving completeness and timely submission of patient care records.~~ Monitor providers to ensure adherence to policy and take corrective action as necessary.

TIME FRAME FOR MEETING OBJECTIVE:
X Short-Range Plan (one year or less)
~~X~~ Long -Range Plan (more than one year)

6.03 PREHOSPITAL CARE AUDITS

MINIMUM STANDARDS:
Audits of prehospital care, including both system response and clinical aspects, shall be conducted.

RECOMMENDED GUIDELINES:
The local EMS agency should have a mechanism to link prehospital records with dispatch, emergency department, in-patient and discharge records.

CURRENT STATUS:
The agency and individual local Q.I. groups have been formed to conduct prehospital care audits regarding system operations. A ~~steering committee comprised of~~regional Quality Liaison Committee providers and base hospital ~~medical directors has been formed to evaluate~~liaisons evaluates clinical care on an ongoing basis.

The agency has a ~~DBMS~~database capable of linking prehospital, dispatch, emergency department, and discharge records. The agency receives the following data:

Data Category	Sources Currently Providing Data
Prehospital	All ground and air ambulance service providers in jurisdiction. Compliance with standards varies.
Dispatch	~~One~~Two dispatch ~~center~~centers that ~~handles~~handle the ~~majority of~~ EMS requests in Stanislaus County.
Emergency Department	Information on all ALS scene patients and some BLS scene patients from the hospitals designated as base hospitals. ~~No information from receiving hospitals.~~
In-Patient	~~None~~Two largest Stanislaus County Hospital providing electronic outcome information.

~~NoneDischarge~~

COORDINATION WITH OTHER EMS AGENCIES:
None.

NEEDS:
~~A wide area network linking first response~~Work with provider agencies~~, ambulance services, dispatch centers, hospitals, and the local EMS agency for the purpose of efficiently recording and linking prehospital, dispatch, emergency department, and discharge records.~~

~~6.03 continued:~~

~~A clinical audit system capable of identifying preventable morbidity and mortality and ensuring adherence~~ to ~~treatment standards~~improve emergency department and hospital outcome data submission. Measure response times from receipt of call at the primary PSAPs.

OBJECTIVE:
~~Develop a Wide Area Network (WAN) or other type of electronic data link to allow access to the EMS Database System for the EMSA, ambulance~~Work with provider agencies to improve ~~base hospitals to facilitate data collection and reporting~~emergency department and hospital outcome data submission.

TIME FRAME FOR MEETING OBJECTIVE:
X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

6.04 MEDICAL DISPATCH

MINIMUM STANDARDS:
The local EMS agency shall have a mechanism to review medical dispatching to ensure that the appropriate level of medical response is sent to each emergency and to monitor the appropriateness of prearrival/post dispatch directions.

~~Develop a process to identify preventable morbidity and mortality and ensure adherence to treatment standards.~~

~~**TIME FRAME FOR MEETING OBJECTIVE:**~~
~~X Short-Range Plan (one year or less)~~
~~X Long-Range Plan (more than one year)~~

~~6.04 MEDICAL DISPATCH~~

~~MINIMUM STANDARDS:~~
~~The local EMS agency shall have a mechanism to review medical dispatching to ensure that the appropriate level of medical response is sent to each emergency and to monitor the appropriateness of prearrival/post dispatch directions.~~

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Approved level II EMD centers are required by policy to establish an in-house QA program which includes the auditing of pre-arrival instructions. ~~However, most dispatch agencies have not been approved as level II EMD centers and are not required to establish an in-house QA program.~~

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that an appropriate level of medical response is sent to each emergency. Ensure the appropriateness of prearrival/post dispatch directions. Integrate dispatch centers into the regional QA/QI program.

OBJECTIVE:
Develop a mechanism to review medical dispatching to ensure that the appropriate level of medical response is sent to each emergency and to monitor the appropriateness of prearrival/post dispatch directions. ~~Execute agreements with all EMD~~Integrate dispatch centers ~~specifying minimum~~into the regional QA/QI ~~standards.~~

~~TIME FRAME FOR MEETING OBJECTIVE:~~
~~Short-Range Plan (one year or less)~~
~~X Long-Range Plan (more than one year)~~

~~6.05 DATA MANAGEMENT SYSTEM~~

~~MINIMUM STANDARDS:~~
~~The local EMS agency shall establish a data management system which supports its system-wide planning and evaluation (including identification of high risk patient groups) and the QA/QI audit of the care provided to specific patientsprogram.~~ Evaluate effectiveness of in-house QA/QI programs.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)

Long-Range Plan (more than one year)

6.05 DATA MANAGEMENT SYSTEM

MINIMUM STANDARDS:
The local EMS agency shall establish a data management system which supports its system-wide planning and evaluation (including identification of high risk patient groups) and the QA/QI audit of the care provided to specific patients. It shall be based on state standards.

RECOMMENDED GUIDELINES:
The local EMS agency should establish an integrated data management system which includes system response and clinical (both prehospital and hospital) data.

The local EMS agency should use patient registries, tracer studies, and other monitoring systems to evaluate patient care at all stages of the system.

CURRENT STATUS:
The ~~MV EMSA~~MVEMSA created and implemented an integrated data management system which meets and exceeds state standards, and includes system response and clinical (both prehospital and hospital) data. ~~However, the establishment of~~ QA/QI benchmarks and the utilization of data for system evaluation ~~is minimal~~has been developed.

COORDINATION WITH OTHER EMS AGENCIES:
This data management system has been made available to all other local EMS agencies and is in use in Imperial, Santa Clara, San Joaquin, Sacramento, and Tuolumne EMS systems and is being considered for use in several others.

~~Attempts to obtain access to other sources of patient information such as trauma registries and other computerized hospital data have, generally, not been successful.~~

~~**COORDINATION WITH OTHER EMS AGENCIES:**~~
~~This data management system has been made available to all other local EMS agencies and is in use in Imperial, Santa Clara, San Joaquin, San Mateo, and Tuolumne EMS systems and is being considered for use in several others.~~ Agency staff continues to work with EMSAAC, EMDAC and State EMSA on developing benchmarks and quality indicators.

NEEDS:
~~In order~~Improve access to ~~assure that our~~existing hospital data ~~management system meets~~regarding the ~~changing needs of the agencies using it in the future, the tasks of need assessment, revision design, programming and documentation must continue~~outcomes of prehospital patients.
~~Gain access~~Work with EMSA to ~~existing hospital~~work toward statewide data ~~regarding the outcomes of prehospital patients~~management system.

~~Establish benchmarks and quality indicators~~**OBJECTIVE:**
Improve access to existing hospital data regarding the outcomes of prehospital patients.—

Work with EMSA to work toward statewide data management system ~~6.05 continued:~~

~~**OBJECTIVE:**~~
~~Train system participants to use establish QI processes and indicators.~~

~~**Monitor and modify as needed:**~~

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long -Range Plan (more than one year)

6.06 SYSTEM DESIGN EVALUATION

MINIMUM STANDARDS:
The local EMS agency shall establish an evaluation program to evaluate EMS system design and operations, including system effectiveness at meeting community needs, appropriateness of guidelines and standards, prevention strategies that are tailored to community needs, and assessment of resources needed to adequately support the system. This shall include structure, process, and outcome evaluations, utilizing state standards and guidelines.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
In 1994, the agency adopted an EMS System Quality Assurance/Quality Improvement (QA/QI) Plan which formed a multi-disciplinary Quality Liaison Committee (QLC) comprised of base hospital medical directors, base hospital nurse liaisons, ambulance provider quality coordinators, first response quality coordinators and dispatch quality coordinators ~~to assist the agency Medical Director in providing oversight and evaluation of the EMS system~~. The purpose of the QLC is to assist the agency Medical Director in providing oversight and evaluation of the EMS system. Local Q.I. groups, consisting of members of an operational area, have also been formed to evaluate response, care and transport. ~~Local Q.I. groups, consisting~~Aspects of ~~members of an operational area,~~ the clinical review have ~~also been formed to evaluate response, care and transport~~been re-established. Region-wide monitoring has been re-established via new clinical indicators. ~~Most aspects of the previous clinical review (medical auditing) program were lost~~Continuing to work with ~~the transition to the new QA/QI~~statewide organizations and EMSA to develop and implement statewide EMS system evaluation program and standards.—

Additionally, each member county has a functioning Emergency Medical Care Committee which reviews local operations, policies and practices. A Regional Advisory Committee (RAC) comprised of three persons from each member county meets bi-monthly and reviews all MV EMSA plans, policies and procedures before they are submitted to the Board of Directors (BOD) for consideration. All meetings of the BOD, RAC and county EMCCs are open to the public with time allocated on each agenda for open public comments. Additionally, impacted groups are routinely notified in advance of issues before RAC and the BOD.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Creation of ~~common~~ indicators which can be used for evaluating the ~~effectiveness~~efficiencies and customer satisfaction of the EMS system ~~at meeting~~, considering community needs ~~and~~, system demands and current constraints.

OBJECTIVE:
~~Create common indicators which can be used for evaluating the effectiveness of the EMS system at meeting community needs and system demands~~Participate in statewide standardized system evaluation project. ~~Train local providers~~Evaluate EMS response alternatives as outlined in ~~Agency QI processes. Participate in~~

~~statewide standardized system evaluation project~~the EMS 2000 document.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)

X Long -Range Plan (more than one year)

6.07 PROVIDER PARTICIPATION

MINIMUM STANDARDS:
The local EMS agency shall have the resources and authority to require provider participation in the system-wide evaluation program.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
ALS providers are required by policy and agreement to participate in the agency system-wide evaluation program. BLS providers are not required to (but may voluntarily) participate in the agency system-wide evaluation program.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure participation of all providers within the agency QA/QI program.

OBJECTIVE:
~~Re-establish QI groups in Stanislaus County and address~~Address the role/composition of the local EMCC~~:~~ ~~Investigate the feasibility of requiring~~ in Stanislaus County. Encourage first responder, dispatch and other system provider participation ~~in system~~by restructuring the QA/QI programs.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long -Range Plan (more than one year)

6.08 REPORTING

MINIMUM STANDARDS:
The local EMS agency shall, at least annually, report on the results of its evaluation of EMS system design and operations to the Board(s) of Supervisors, provider agencies, and Emergency Medical Care Committee(s).

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The agency currently produces ~~quarterly or semi-annual~~ad hoc reports for the entities listed above~~ that include information about patient populations, response time intervals, scene time intervals, etc. However, these reports only provide aggregate data not system analysis.~~

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEEDS:
~~Analyze~~Produce periodic aggregate data ~~using established~~reports that can be provided to the above entities. ~~QA indicators and benchmarks~~

OBJECTIVE:
~~Report analyzed data on a semi-annual or quarterly basis. Annually~~At least annually report the results of the system evaluation, design and operations to the Board(s) of Supervisors, provider agencies, and Emergency Medical Care Committee(s).

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long -Range Plan (more than one year)

6.09 ALS AUDIT

MINIMUM STANDARDS:
The process used to audit treatment provided by advanced life support providers shall evaluate both base hospital (or alternative base station) and prehospital activities.

RECOMMENDED GUIDELINES:
The local EMS agency's integrated data management system should include prehospital, base hospital, and receiving hospital data.

CURRENT STATUS:
In 1994, the agency adopted an EMS System Quality ~~Improvement/Assurance~~Assurance/Quality Improvement (QA/QI) Plan which formed a multi-disciplinary Quality Liaison Committee (QLC) comprised of base hospital medical directors, base hospital nurse liaisons, ambulance provider quality coordinators, first response quality coordinators and dispatch quality coordinators ~~to assist the agency Medical Director in providing oversight and evaluation of the EMS system. – Local Q.I. groups, consisting~~The purpose of ~~members of an operational area, have also been formed~~the QLC is to ~~evaluate response, care~~assist the agency Medical Director in providing oversight and ~~transport~~evaluation of the EMS system. Local Q.I. groups, consisting of members of an operational area, have also been formed to evaluate response, care and transport. Aspects of the clinical review have been re-established. ~~Most aspects of the previous clinical review (medical auditing) program were lost with the transition to the~~Region-wide monitoring has been re-established via new ~~QA/QI program~~clinical indicators.—

~~The local~~ Continuing to work with statewide organizations and EMSA to develop and implement statewide EMS ~~agency's integrated data management~~ system ~~is capable of tracking prehospital, base hospital,~~evaluation program and ~~receiving hospital data~~standards.
-

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
~~Establish~~Development of a process to ~~identify preventable morbidity and mortality~~provide feedback to prehospital personnel on patient outcomes, as described in the EMS system model. ~~Re-institute~~Ensure that the QA/QI process meets system needs and State standards.

~~**OBJECTIVE:**~~
Develop a ~~medical audit process~~process to: provide feedback to prehospital personnel on patient outcomes.- ~~Develop of a process to provide feedback to prehospital personnel on patient outcomes, as described in the EMS system model. Ensure that the QI/QI process meets system needs and State standards.~~

~~**OBJECTIVE:**~~

~~Develop a process to: identify preventable morbidity and mortality; conduct medical auditing and; provide feedback to prehospital personnel on patient outcomes. Continue to monitor and amend the QA/QI program, as needed, to meet system needs.~~

~~**TIME FRAME FOR MEETING OBJECTIVE:**~~

~~X Short-Range Plan (one year or less)~~

~~Long -Range Plan (more than one year)~~

~~6.10 TRAUMA SYSTEM EVALUATION~~

~~MINIMUM STANDARDS:~~
~~The local EMS agency, with participation of acute care providers, shall develop a trauma system evaluation and data collection program, including: a trauma registry, a mechanism to identify patients whose care fell outside of established criteria, and a process for identifying potential improvements to the system design and operation.~~ Continue to monitor and amend the QA/QI program~~, as needed,~~ to meet system needs and statewide standards.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)

X Long -Range Plan (more than one year)

6.10 TRAUMA SYSTEM EVALUATION

MINIMUM STANDARDS:
The local EMS agency, with participation of acute care providers, shall develop a trauma system evaluation and data collection program, including: a trauma registry, a mechanism to identify patients whose care fell outside of established criteria, and a process for identifying potential improvements to the system design and operation.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The agency developed a draft trauma system evaluation and data collection program which was reviewed by the acute care providers in the EMS region. The program has not been implemented since the agency lacks a formal trauma system plan with designated trauma facilities.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
The formal adoption of a trauma system plan with designated trauma facilities and the implementation of a trauma system evaluation and data collection program.

OBJECTIVE:
Create a formal trauma system, then implement the evaluation process developed by the MVEMSA, which includes the use of trauma registries, tracer studies and a Trauma Audit Committee.

TIME FRAME FOR MEETING THE OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

6.11 TRAUMA CENTER DATA

MINIMUM STANDARDS:
The local EMS Agency shall ensure that designated trauma centers provide required data to the EMS agency, including patient specific information which is required for quality assurance/quality improvement and system evaluation.

RECOMMENDED GUIDELINES:
The local EMS agency should seek data on trauma patients who are treated at non-trauma center hospitals and shall include this information in their QA/QI and system evaluation program.

CURRENT STATUS:
No mechanism exists for the collection of trauma center and trauma patient information due to the lack of a formal trauma system in the EMS region.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
The formal adoption of a trauma system plan with designated trauma facilities and the implementation of a trauma system evaluation and data collection program.

OBJECTIVE:
Create a formal trauma system, then develop standards for trauma center data collection which are capable of meeting the needs required for system evaluation and QA.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

7.01 PUBLIC INFORMATION MATERIALS

MINIMUM STANDARDS:
The local EMS agency shall promote the development and dissemination of information materials for the public which addresses:

a) understanding of EMS system design and operation,
b) proper access to the system,
c) self-help (e.g., CPR, first aid, etc.),
d) patient and consumer rights as they relate to the EMS system,
e) health and safety habits as they relate to the prevention and reduction of health risks in target areas, and
f) appropriate utilization of emergency departments.

RECOMMENDED GUIDELINES:
The local EMS agency should promote targeted community education programs on the use of emergency medical services in its service area.

CURRENT STATUS:
MVEMSA has developed and disseminated information on basic first aid, CPR, system design and access, disaster planning, and bicycle and skate board safety. The agency has created the following children's education programs: Student Activities for Emergencies (S.A.F.E.) and the EMS Youth Program, which are designed to teach emergency awareness, system access and basic first aid skills.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Creation of education materials and programs regarding system access and utilization as described in the EMS system model.

OBJECTIVE:
In coordination with primary care providers and other public safety agencies, develop and present education materials and programs regarding system access and utilization as described in the EMS system model. In partnership with other agencies, address the educational needs of culturally diverse communities.

Review and make modifications, as needed, to the EMS Youth Program.

TIME FRAME FOR MEETING OBJECTIVE:
X Short-Range Plan (one year or less)

X Long-Range Plan (more than one year)

7.02 INJURY CONTROL

MINIMUM STANDARDS:
The local EMS agency, in conjunction with other local health education programs, shall work to promote injury control and preventive medicine.

RECOMMENDED GUIDELINES:
The local EMS agency should promote the development of special EMS educational programs for targeted groups at high risk of injury or illness.

CURRENT STATUS:
The agency has not designed programs specifically for injury prevention or injury control. However, the agency routinely participates in public safety (health) fairs at various locations throughout the EMS region promoting system understanding. No work has been conducted to promote the development of EMS education programs for high risk groups.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Development and promotion of injury control education programs and programs targeted at high risk groups.

OBJECTIVE:
Coordinate the development and promotion of injury control education programs and programs targeted toward the general public and high risk groups with providers, hospitals and other organizations.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

7.03 DISASTER PREPAREDNESS

MINIMUM STANDARDS:
The local EMS agency, in conjunction with the local office of emergency services, shall promote citizen disaster preparedness activities.

RECOMMENDED GUIDELINES:
The local EMS agency, in conjunction with the local office of emergency services (OES), should produce and disseminate information on disaster medical preparedness.

CURRENT STATUS:
The MVEMSA developed Project S.A.F.E. (Student Activities for Emergencies) designed to teach middle school children emergency awareness, system access, basic first aid skills and disaster preparedness. No other work has been performed towards this objective.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Promote citizen disaster preparedness activities.

OBJECTIVE:
In conjunction with county OES coordinators, Red Cross and other public safety agencies, develop and promote citizen disaster preparedness activities.

TIME FRAME FOR MEETING OBJECTIVE:
~~X~~ Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

7.04 FIRST AID & CPR TRAINING

MINIMUM STANDARDS:
The local EMS agency shall promote the availability of first aid and CPR training for the general public.

RECOMMENDED GUIDELINES:
The local EMS agency should adopt a goal for training of an appropriate percentage of the general public in first aid and CPR. A higher percentage should be achieved in high risk groups.

CURRENT STATUS:
The agency provides CPR manikins and other first aid training equipment to community CPR and first aid instructors. A list of available CPR and first aid classes is usually maintained and citizen inquires are directed to sponsoring agencies or instructors.

No citizen training goals have been established.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Establishment of citizen CPR and first aid training goals.

OBJECTIVE:
Determine the need for establishing citizen CPR and first aid training goals.

TIME FRAME FOR MEETING OBJECTIVE:

		X	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)		

8.01 DISASTER MEDICAL PLANNING

MINIMUM STANDARDS:
In coordination with the local office of emergency services (OES), the local EMS agency shall participate in the development of medical response plans for catastrophic disasters, including those involving toxic substances.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
The OES Region IV MCI Plan has been formally adopted, by the Board of Directors of the EMSA and the Boards of Supervisors of each of the member counties, as the plan to be used for medical disaster management. A response plan specific to toxic substance management has not been developed.

COORDINATION WITH OTHER EMS AGENCIES:
The OES Region IV MCI Plan was developed as a joint project with representation from all 11 counties in OES Region IV.

NEED(S):
Ensure that the OES Region IV MCI Plan continues to meet the disaster medical response needs of the EMS system.

OBJECTIVE:
Monitor the efficiency and utilization of the MCI plan and make changes as needed. Determine the need for developing a medical response plan for hazardous material incidents.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
Long-Range Plan (more than one year)

8.02 RESPONSE PLANS

MINIMUM STANDARDS:
Medical response plans and procedures for catastrophic disasters shall be applicable to incidents caused by a variety of hazards, including toxic substances.

RECOMMENDED GUIDELINES:
The California Office of Emergency Services' multi-hazard functional plan should serve as the model for the development of medical response plans for catastrophic disasters.

CURRENT STATUS:
The OES Region IV MCI Plan has been formally adopted, by the Board of Directors of the EMSA and the Boards of Supervisors of each of the member counties, as the plan to be used for medical disaster management. A response plan specific to toxic emergencies has not been developed.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the OES Region IV MCI Plan continues to meet the disaster medical response needs of the EMS system.

OBJECTIVE:
Assist with the update of regional MCI Field Instructors through an annual conference/meeting. Monitor the efficiency and utilization of the MCI plan and make changes as needed. Determine the need for developing a medical response plan specific to hazardous material incidents.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

8.03 HAZMAT TRAINING

MINIMUM STANDARDS:
All EMS providers shall be properly trained and equipped for response to hazardous materials incidents, as determined by their system role and responsibilities.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The agency has not formally established a role for EMS personnel regarding hazardous material incidents. The minimum hazardous material training standards for EMS personnel are those standards established by OSHA/Cal-OSHA.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Establish the roles and responsibilities for EMS personnel regarding hazardous materials incidents.

OBJECTIVE:
Determine the roles and responsibilities for EMS personnel regarding hazardous materials incidents.
Determine hazardous material training needs of EMS personnel.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.04 INCIDENT COMMAND SYSTEM

MINIMUM STANDARDS:
Medical response plans and procedures for catastrophic disasters shall use the Incident Command System (ICS) as the basis for field management.

RECOMMENDED GUIDELINES:
The local EMS agency should ensure that ICS training is provided for all medical providers.

CURRENT STATUS:
The OES Region IV MCI Plan adopted by the MVEMSA is based on the Incident Command System. Completion of ICS 120 and a 4-hour hospital or 8-hour field MCI course is the minimum standard for EMS personnel. However, the agency only ensures the training of paramedic and MICN personnel. A process for training all EMS personnel in the requirements of the State's Standardized Emergency Management System (SEMS) is currently being drafted.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that all EMS personnel are trained in ICS, MCI and SEMS.

OBJECTIVE:
Modify existing processes and agreements to ensure that all EMS personnel, including EMTs, first responders and dispatchers are trained in ICS, MCI and SEMS. Monitor compliance to training standards and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.05 DISTRIBUTION OF CASUALTIES

MINIMUM STANDARDS:
The local EMS agency, using state guidelines, shall establish written procedures for distributing disaster casualties to the medically most appropriate facilities in its service area.

RECOMMENDED GUIDELINES:
The local EMS agency, using state guidelines, and in consultation with Regional Poison Centers, should identify hospitals with special facilities and capabilities for receipt and treatment of patients with radiation and chemical contamination and injuries.

CURRENT STATUS:
Distribution of patients is addressed in Module II of the OES Region IV MCI Plan used in each of our counties. County Disaster Control Facilities (DCFs) determine hospital capabilities and distribute patients accordingly. The Regional DCF is activated when two or more counties cannot accommodate the number of patients to be distributed.

COORDINATION WITH OTHER EMS AGENCIES:
The OES Region IV MCI Plan was developed as a joint project with representation from all 11 counties in OES Region IV.

NEED(S):
Ensure that the procedures for distributing disaster casualties functions effectively. Update the Facilities Assessment Profiles and OES Region IV map, which identifies facilities and facility specialties.

OBJECTIVE:
Monitor the distribution of disaster casualties, and make changes as needed, to ensure that patients are distributed to appropriate facilities. Update the Facilities Assessment Profiles and OES Region IV map, which identifies facilities and facility specialties.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.06 NEEDS ASSESSMENT

MINIMUM STANDARDS:
The local EMS agency, using state guidelines, shall establish written procedures for early assessment of needs and shall establish a means for communicating emergency requests to the state and other jurisdictions.

RECOMMENDED GUIDELINES:
The local EMS agency's procedures for determining necessary outside assistance should be exercised yearly.

CURRENT STATUS:
General procedures to be used by Medical Operational Area Coordinators were adopted by the counties in OES Region IV. These procedures included a process for assessing and communicating needs to OES Region IV and State OES. Local disaster exercises are conducted yearly.

SOPs for the activation of the Medical OAC and the Emergency Operations Center (EOC) are in place.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that the procedures for assessing medical needs in a disaster function effectively.

OBJECTIVE:
Monitor compliance to training standards and make changes as needed. Monitor the ability to effectively assess medical needs in a disaster and make changes to the process as needed.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.07 DISASTER COMMUNICATIONS

MINIMUM STANDARDS:
A specific frequency (e.g., CALCORD) or frequencies shall be identified for interagency communication and coordination during a disaster.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
The current system of dispatch, field, and hospital medical communication was developed more than ten years ago and is in need of evaluation, upgrade and repair.

Most transporting and non-transporting emergency medical response vehicles in the EMS system have CALCORD capabilities. However, no frequency has been officially designated for disaster medical communications.

COORDINATION WITH OTHER EMS AGENCIES:
Communications frequencies and the locations of radio repeaters was performed in conjunction with adjacent EMS systems.

NEED(S):
Ensure the availability of common medical communications during disasters.

OBJECTIVE:
Continue to work with region and state agencies to standardize the medical communications plan.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

8.08 INVENTORY OF RESOURCES

MINIMUM STANDARDS:
The local EMS agency, in cooperation with the local OES, shall develop an inventory of appropriate disaster medical resources to respond to multi-casualty incidents and disasters likely to occur in its service area.

RECOMMENDED GUIDELINES:
The local EMS agency should ensure that emergency medical providers and health care facilities have written agreements with anticipated providers of disaster medical resources.

CURRENT STATUS:
Resource Directory updated each year with the Annual EMS Plan update.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Annually update the Disaster Medical Resource Directory.

OBJECTIVE:
Update the Disaster Medical Resource Directory. Encourage emergency medical providers and health care facilities to have written agreements with anticipated providers of disaster medical resources.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.09 DMAT TEAMS

MINIMUM STANDARDS:
The local EMS agency shall establish and maintain relationships with DMAT teams in its area.

RECOMMENDED GUIDELINES:
The local EMS agency should support the development and maintenance of DMAT teams in its area.

CURRENT STATUS:
No DMAT teams exist within OES Region IV.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Develop a relationship with DMAT Teams as they are formed.

OBJECTIVE:
Develop a relationship with DMAT Teams as they are formed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

8.10 MUTUAL AID AGREEMENTS

MINIMUM STANDARDS:
The local EMS agency shall ensure the existence of medical mutual aid agreements with other counties in its OES region and elsewhere, as needed, which ensure that sufficient emergency medical response and transport vehicles, and other relevant resources will be made available during significant medical incidents and during periods of extraordinary system demand.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Providers are required by their agreements to execute day-to-day mutual aid agreements with neighboring providers. The member counties of OES Region IV are currently working on a "regional" master medical mutual aid agreement to be executed between counties and/or LEMSAs.

COORDINATION WITH OTHER EMS AGENCIES:
As stated above.

NEED(S):
Adoption of a master medical mutual aid agreement for medical resources.

OBJECTIVE:
Continue the process of developing and adopting a master medical mutual aid agreement.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than)

8.11 CCP DESIGNATION

MINIMUM STANDARDS:
The local EMS agency, in coordination with the local OES and county health officer(s), and using state guidelines, shall designate casualty collection points (CCPs).

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Several sites for CCPs or Field Treatment Sites have been identified, by individual counties. However, no formal plans have been developed for their activation, staffing or outfitting.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Formally identify CCPs and establish plans regarding activation, staffing and outfitting.

OBJECTIVE:
In conjunction with county OES offices, identify CCPs and establish plans regarding activation, staffing and outfitting.

TIME FRAME FOR MEETING OBJECTIVE:
~~X~~ Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.12 ESTABLISHMENT OF CCPs

MINIMUM STANDARDS:
The local EMS agency, in coordination with the local OES, shall develop plans for establishing CCPs and a means for communicating with them.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Several sites for CCPs have been identified throughout the EMS region. However, no formal plans have been developed for their activation, staffing or outfitting.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Identify CCPs and establish plans regarding activation, staffing and outfitting.

OBJECTIVE:
In conjunction with county OES offices, identify CCPs and establish plans regarding activation, staffing and outfitting.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

8.13 DISASTER MEDICAL TRAINING

MINIMUM STANDARDS:
The local EMS agency shall review the disaster medical training of EMS responders in its service area, including the proper management of casualties exposed to and/or contaminated by toxic or radioactive substances.

RECOMMENDED GUIDELINES:
The local EMS agency should ensure that EMS responders are appropriately trained in disaster response, including the proper management of casualties exposed to or contaminated by toxic or radioactive substances.

CURRENT STATUS:
Completion of ICS 120 and a 4-hour hospital or 8-hour field MCI course is the minimum standard for EMS personnel. A process for training all EMS personnel in the requirements of the State's Standardized Emergency Management System (SEMS) is currently being drafted. The minimum hazardous material training standards for EMS personnel are those standards established by OSHA/Cal-OSHA.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure a standard of training for EMS personnel in disaster medical response/management hazardous materials awareness.

OBJECTIVE:
Ensure an adequate number of Field, Hospital and Dispatch MCI courses are made available. Monitor and modify policies, provider agreements, and conduct drills to ensure a standard of training for EMS personnel in disaster medical response/management hazardous materials awareness.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.14 HOSPITAL PLANS

MINIMUM STANDARDS:
The local EMS agency shall encourage all hospitals to ensure that their plans for internal and external disasters are fully integrated with the county's medical response plan(s).

RECOMMENDED GUIDELINES:
At least one disaster drill per year conducted by each hospital should involve other hospitals, the local EMS agency, and prehospital medical care agencies.

CURRENT STATUS:
EMSA staff are available to all hospitals for in-service and training in ICS and MCI plan standards. Hospitals are also incorporated into county-wide disaster exercises on an annual basis.

COORDINATION WITH OTHER EMS AGENCIES:
Many of the county-wide disaster exercises involve activation of the Regional Disaster Control Facility and/or the Regional Disaster Medical/Health Coordinator.

NEED(S):
All hospitals should adopt some form of ICS as the basis for their facility's disaster plan.

OBJECTIVE:
Continue to work with and encourage hospitals to use the Hospital Emergency Incident Command System (HEICS). Ensure that at least one inter-agency disaster drill is conducted in each member county. Monitor compliance to the OES Region IV MCI Plan and take corrective action as necessary.

TIME FRAME FOR MEETING OBJECTIVE:

X Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.15 INTERHOSPITAL COMMUNICATIONS

MINIMUM STANDARDS:
The local EMS agency shall ensure that there is an emergency system for interhospital communications, including operational procedures.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Hospitals within Stanislaus County can communicate with each other through a dedicated BLAST phone system. Common radio frequencies between hospitals within the EMS system have not been established.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure the availability of inter-hospital medical communications.

OBJECTIVE:
Revise the communications plan, prioritize system repairs and upgrades and make necessary changes.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long -Range Plan (more than one year)

8.16 PREHOSPITAL AGENCY PLANS

MINIMUM STANDARDS:
The local EMS agency shall ensure that all prehospital medical response agencies and acute-care hospitals in its service area, in cooperation with other local disaster medical response agencies, have developed guidelines for the management of significant medical incidents and have trained their staffs in their use.

RECOMMENDED GUIDELINES:
The local EMS agency should ensure the availability of training in management of significant medical incidents for all prehospital medical response agencies and acute-care hospital staffs in its service area.

CURRENT STATUS:
The OES Region IV MCI Plan has been formally adopted, by the Board of Directors of the EMSA and the Boards of Supervisors of each of the member counties, as the plan to be used for medical disaster management. Completion of ICS 120 and a 4-hour hospital or 8-hour field MCI course is the minimum standard for EMS personnel.

COORDINATION WITH OTHER EMS AGENCIES:
All eleven counties within OES Region IV have cooperatively maintained a standardized field response plan and disaster patient distribution system.

NEED(S):
Ensure that providers and hospitals continue to effectively use the MCI plan when managing MCIs and medical disasters. Ensure that all EMS personnel receive the minimum level of disaster medical training.

OBJECTIVE:
~~Conduct a medical/health conference as a forum to update and communicate current disaster protocols to medical/health community.~~ Monitor compliance to MCI plan standards and take corrective action as necessary. Develop a process to ensure that all EMS personnel receive required ICS, MCI and Hazmat training.

TIME FRAME FOR MEETING OBJECTIVE:
~~X~~ Short-Range Plan (one year or less)
X Long-Range Plan (more than one year)

8.17 ALS POLICIES

MINIMUM STANDARDS:
The local EMS agency shall ensure that policies and procedures allow advanced life support personnel and mutual aid responders from other EMS systems to respond and function during significant medical incidents.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
Procedures have been established with adjacent EMS systems through mutual aid agreements. For other counties, the OES Region IV MCI Plan directs ALS, LALS and BLS personnel to act under their own system's standing orders during an MCI or medical disaster.

COORDINATION WITH OTHER EMS AGENCIES:
All eleven counties within OES Region IV have cooperatively maintained a standardized field response plan and disaster patient distribution system.

NEED(S):
Ensure that policies and procedures exist to allow advanced life support personnel and mutual aid responders from other EMS systems to respond and function during significant medical incidents.

OBJECTIVE:
Monitor and modify the policies and procedures which allow EMS personnel from other EMS systems to respond and function during significant medical incidents and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

8.18 SPECIALTY CENTER ROLES

MINIMUM STANDARDS:
Local EMS agencies developing trauma or other specialty care systems shall determine the role of identified specialty centers during a significant medical incidents and the impact of such incidents on day-to-day triage procedures.

RECOMMENDED GUIDELINES:
None

CURRENT STATUS:
A map depicting all of the acute care facilities within OES Region IV with their various specialties was produced and distributed to all of the Disaster Control Facilities within the region in 1993.

COORDINATION WITH OTHER EMS AGENCIES:
All eleven counties within OES Region IV have cooperatively maintained a standardized field response plan and disaster patient distribution system.

NEED(S):
Determine the role of identified specialty centers during significant medical incidents and the impact of such incidents on day-to-day triage procedures. Update the facilities map distributed through the OES Region IV MCI grant project.

OBJECTIVE:
When specialty centers are identified, develop a process to determine the role of identified specialty centers during significant medical incidents and the impact of such incidents on day-to-day triage procedures.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

8.19 WAIVING EXCLUSIVITY

MINIMUM STANDARDS:
Local EMS agencies which grant exclusive operating permits shall ensure that a process exists to waive the exclusivity in the event of a significant medical incident.

RECOMMENDED GUIDELINES:
None.

CURRENT STATUS:
All exclusive operating area agreements contain language allowing the MVEMSA to waive the exclusivity of an area in the event of a significant medical incident.

COORDINATION WITH OTHER EMS AGENCIES:
Not applicable for this standard.

NEED(S):
Ensure that a process exists for the waiving of exclusivity in EOAs in the event a significant medical incident.

OBJECTIVE:
Monitor the process for waiving exclusivity and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

	Short-Range Plan (one year or less)
X	Long-Range Plan (more than one year)

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non-exclusive forms

EXCLUSIVE OPERATING AREAS
EMS PLAN ZONE SUMMARY

Local EMS Agency or County Name:
Mountain-Valley EMS Agency - Alpine County

Area or subarea (Zone) Name or Title:
Alpine County

Name of Current Provider(s):
The current provider of emergency ground ambulance services in this zone is Alpine County EMS. This provider has provided emergency ambulance services without interruption since June, 1998. Alpine County continues to depend upon mutual aid response for ALS ambulance services. ALS ambulances are dispatched from surrounding counties and either rendezvous with the Alpine County EMS ambulance, arrive on scene, or be canceled.

Area or subarea (Zone) Geographic Description:
See map attached.

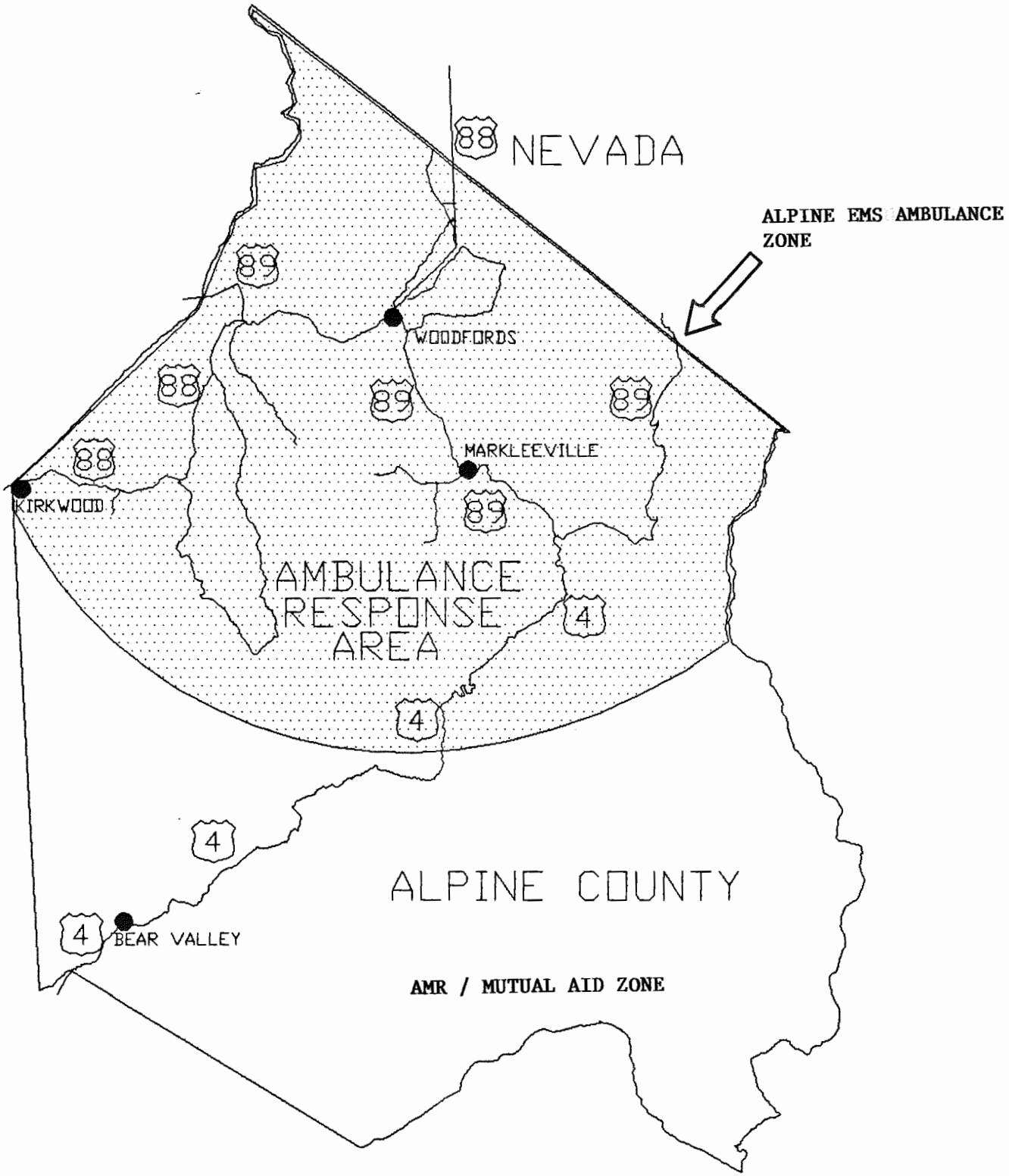
Statement of Exclusivity, Exclusive or Non-Exclusive (HS 1797.6):
There is no ALS or emergency ambulance service exclusivity in Alpine County.

Type of Exclusivity:
None

Method to achieve Exclusivity:
Not applicable

Exhibit - A
Ambulance Response Area

The areas of Hwy 88 (Carson Pass) from the California/Nevada State border to the Alpine/Amador County line. Hwy 89 from the Alpine/Mono county line to the Alpine/El Dorado County line. Hwy 4 (Ebbetts Pass) from Markleeville to the top of Ebbetts Pass. All residential, public and private lands serviced by the above mentioned highway routes.



EXCLUSIVE OPERATING AREAS
EMS PLAN ZONE SUMMARY

Local EMS Agency or County Name:
Mountain-Valley EMS Agency - Calaveras County

Area or subarea (Zone) Name or Title:
Zone One

Name of Current Provider(s):
The current provider of emergency ground ambulance services and Advanced Life Support Services in this zone is Valley Springs Ambulance. This provider has provided emergency ambulance services in this area since January, 1985.

Area or subarea (Zone) Geographic Description:
See map of Calaveras County Ambulance Grids.

Statement of Exclusivity, Exclusive or Non-Exclusive (HS 1797.6):
There is no ALS or emergency ambulance service exclusivity in Calaveras County.

Type of Exclusivity:
None

Method to achieve Exclusivity:
Not applicable

EXCLUSIVE OPERATING AREAS
EMS PLAN ZONE SUMMARY

Local EMS Agency or County Name:
Mountain-Valley EMS Agency - Calaveras County

Area or subarea (Zone) Name or Title:
Zone Two

Name of Current Provider(s):
The current provider of emergency ground ambulance services and Advanced Life Support Services in this zone is San Andreas Ambulance. This provider has provided emergency ambulance services in Calaveras County since 1966, but specifically in this area since January, 1985.

Area or subarea (Zone) Geographic Description:
See map of Calaveras County Ambulance Grids.

Statement of Exclusivity, Exclusive or Non-Exclusive (HS 1797.6):
There is no ALS or emergency ambulance service exclusivity in Calaveras County.

Type of Exclusivity:
None

Method to achieve Exclusivity:
Not applicable

EXCLUSIVE OPERATING AREAS
EMS PLAN ZONE SUMMARY

Local EMS Agency or County Name:
Mountain-Valley EMS Agency - Calaveras County

Area or subarea (Zone) Name or Title:
Zones Three & Four

Name of Current Provider(s):
The current provider of emergency ground ambulance services and Advanced Life Support Services in this zone is American Medical Response (AMR). AMR purchased Cal-Sierra Ambulance, (taking over their ambulance response zone in 1995), which was configured in its current form in 1990.

Area or subarea (Zone) Geographic Description:
See map of Calaveras County Ambulance Grids.

Statement of Exclusivity, Exclusive or Non-Exclusive (HS 1797.6):
There is no ALS or emergency ambulance service exclusivity in Calaveras County.

Type of Exclusivity:
None

Method to achieve Exclusivity:
Not applicable

EXCLUSIVE OPERATING AREAS
EMS PLAN ZONE SUMMARY

Local EMS Agency or County Name:
Mountain-Valley EMS Agency - Calaveras County

Area or subarea (Zone) Name or Title:
Zone Five

Name of Current Provider(s):
The current provider of emergency ground ambulance services and Advanced Life Support Services in this zone is American Legion Ambulance Post 108 (ALA). ALA has responded from Amador County as the first call ambulance to this zone since 1996.

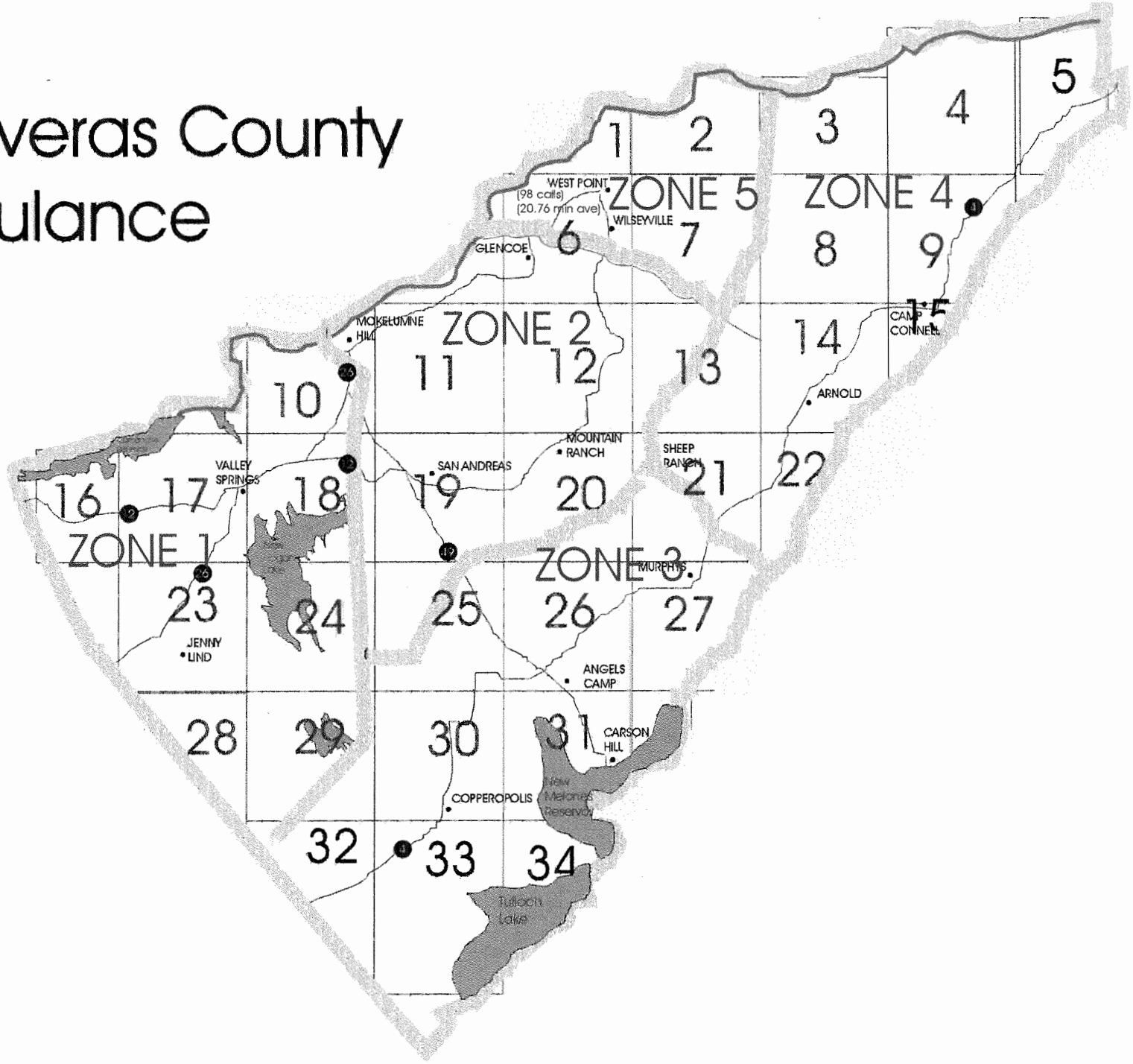
Area or subarea (Zone) Geographic Description:
See map of Calaveras County Ambulance Grids

Statement of Exclusivity, Exclusive or Non-Exclusive (HS 1797.6):
There is no ALS or emergency ambulance service exclusivity in Calaveras County.

Type of Exclusivity:
None

Method to achieve Exclusivity:
Not applicable

Calaveras County Ambulance Grids



EXCLUSIVE OPERATING AREAS
EMS PLAN ZONE SUMMARY

Local EMS Agency or County Name:
Mountain-Valley EMS Agency - Mariposa County

Area or subarea (Zone) Name or Title:
All of Mariposa County

Name of Current Provider(s):
The current provider of emergency ground ambulance services and Advanced Life Support Services in Mariposa County is Mercy Medical Transport (MMT). MMT has provided ambulance services in Mariposa County since January 1, 1994.

Area or subarea (Zone) Geographic Description:
Entire County

Statement of Exclusivity, Exclusive or Non-Exclusive (HS 1797.6):
There is no ALS or emergency ambulance service exclusivity in Mariposa County.

Type of Exclusivity:
None

Method to achieve Exclusivity:
Not applicable