

IMPERIAL COUNTY DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES AGENCY

EMS SYSTEM OVERVIEW

General characteristics: Imperial County (4284 square miles) is an arid desert region with approximately 18% of the area irrigated agricultural land. The major industry is agriculture followed by geothermal plants and gold mining. Day time temperatures range from a comfortable 60-70 degrees during the winter months to over 120 degrees in the summer. Stable population of 130,000 which is markedly increased by three factors: vehicle & pedestrian crossing at the border (85,000 per day according to U.S. Border Patrol), influx of "Snowbirds" during winter months (80,000 annually), and off-road vehicle enthusiasts who frequent the sand dunes (100,000 during Thanksgiving weekend alone). The federal government owns a large proportion of the land (managed by the Bureau of Land Management). The military also owns a large section of the county and has restricted access for artillery and aerial bombing ranges. The opening of a second Port of Entry in Calexico has recently been completed and established Imperial County as a major thoroughfare for trade between the U.S. and Mexico.

Prior to the establishment of an EMS Agency 7 years ago, there was a lack of cooperation and coordination between public and private providers - which was particularly noticeable during annual disaster drills. There was no data collection, no system-wide QA/CQI in the prehospital arena, no central agency to address concerns of all providers, and no driving force to improve the EMS system.

Current System Design:

Zone 1: Consists of a tiered system. Each town has a Fire Department with First Responders ranging in capabilities from BLS - Limited ALS - ALS responding to most 911 medical aid calls. The ALS Transport Provider, (Gold Cross) who operates under an EOA contract, has 5 ALS units that respond from stations in Brawley and El Centro. Presently, both first responders and an ambulance are dispatched to all medical aids as there is no call priority system - however, EMD has just been implemented and includes this option.

Zone 2: Calexico Fire Department provides ALS ambulance service within their service area. They may choose to send an engine along with the ambulance based on situation needs.

Zone 3: West Shores Ambulance Service, a non-profit organization supported largely by subscriptions and donations, provides ambulance service to the community of Salton Sea (the west bank). The department employs one full time paramedic, one Expanded-Scope EMT, and four full-time EMT-D's and a few part-time EMT-I's. Most EMS calls in this area are responded to by West

a reduction of winter visitors these past few years.

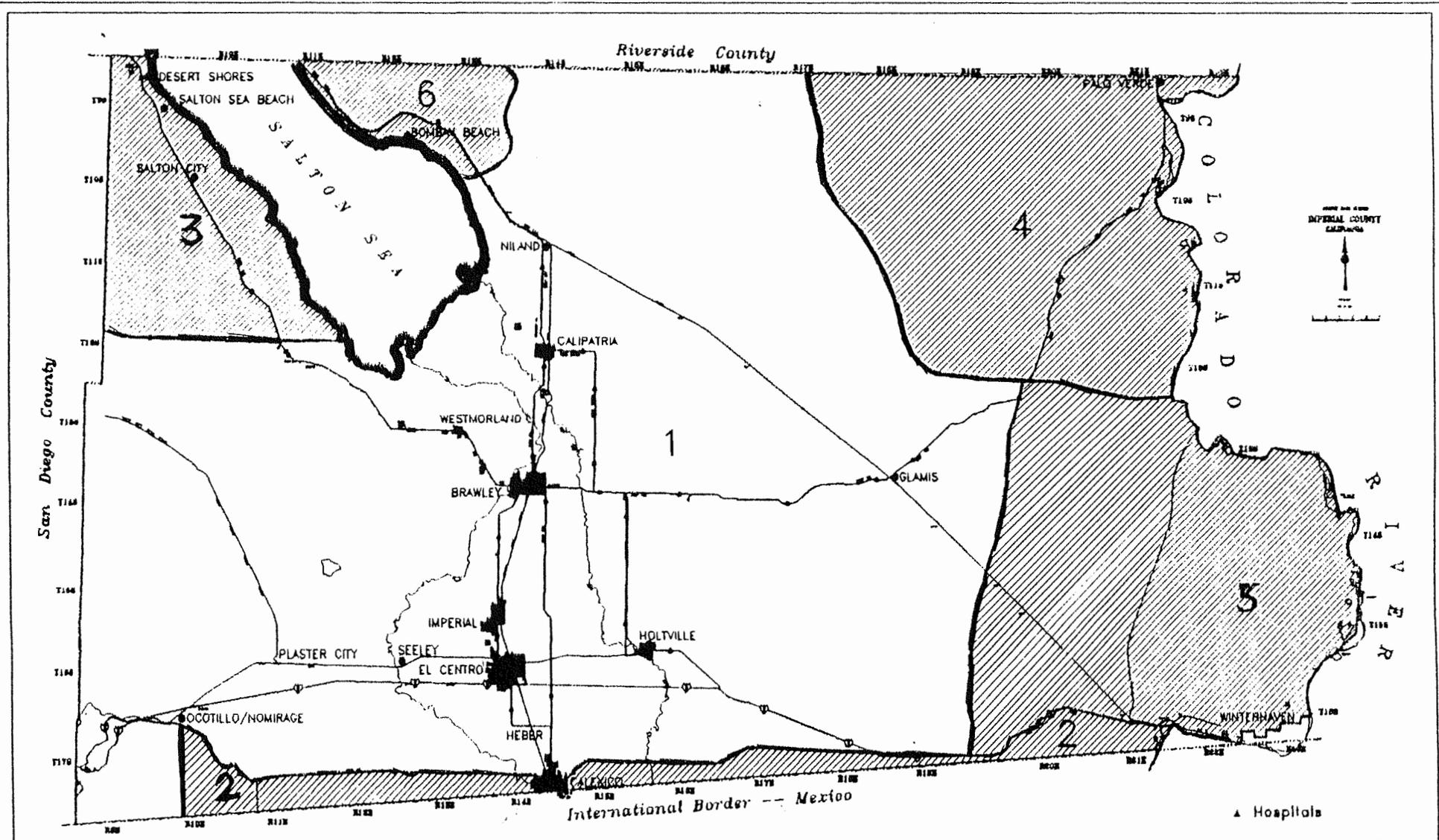
Managed Care has had minimal impact on ambulance service in the County. Pacific Care is the largest HMO in the area (only about 6% of the population to include state prison employees, Wal Mart, Gold Cross and hospital employees, and a few others).

Due to an interference prone, antiquated & obsolete communication system (150 MHz), all public safety and EMS providers are unable to effectively communicate. In 1993, the San Diego and Imperial County Regional Communication System was created that would allow for the pooling of resources and cost sharing with the development and implementation of an 800 MHz communication system. Imperial County is in the process of securing a funding mechanism for their share of the costs.

Several projects have been implemented to improve the quality of pre-hospital care and have been developed with Block Grant Funding:

- EMS Agency Development
- EMS Data Collection System
- Implementation of EMS Agency Training Programs
- Expanded-Scope EMT Trial Study Program
- Emergency Medical Dispatch Program
- Trauma Study
- EMS System-wide QA/CQI Program
- EMS Agency Continuing Education Program
- EMS System Plan

1. Coin Cross
2. Mexico Fire
3. WestShores
4. Blythe
5. Rural Metro
6. Barbey Beach



IMPERIAL COUNTY (AMBULANCE DISTRICTS) - 1994

Imperial County Planning/Building Department
County of Imperial, California (1994)

IMPERIAL COUNTY EMS AGENCY

AEMT REPORT 1996

This report summarizes activity of the Advanced EMT program for the first year of operation, December 27, 1995-December 31, 1996.

Initial training occurred in October-November, 1995. Six candidates were accepted into the program, and five graduated successfully. Provider agencies included Niland Fire Department (NFD), Bombay Beach Rescue Service (BBRS), and West Shores Ambulance Service(WSAS). A second round of training occurred in October-November, 1996. An additional six AEMTs completed the training, and Calipatria Fire Department began offering AEMT service in January, 1997.

There have been no problems with AEMT providers, although turnover is beginning to occur. One individual has left both WSAS and BBRS.

Program Activity

AEMT Responses	105
NFD	50
BBRS	29
WSAS	26

Chief Complaint

Chest Pain	38
Chest Pain w/ Respiratory Distress	12
Respiratory Distress	32
Cardiopulmonary Arrest	10
Altered Mental Status	8
Anaphylaxis	3
Poisoning/Ingestion	2
Near-Drowning	0

Medications Administered

Nitroglycerin	54
Albuterol	38
Aspirin	14
Glucagon	7
Epinephrine	3
Naloxone	1
Activated Charcoal	1

Skills

Combitube	
Attempt	10
Placed	9 (90%)
AED	
Applied	9
Shock delivered	3

Complications

One case of hypotension resulted from nitroglycerin administration in sitting position (systolic blood pressure dropped from 140 to 110 to 80 mm Hg). This resolved after placing patient in supine position. One suspected pneumothorax occurred in COPD patient receiving CPR with Combitube in place.

Errors

None noted. Education addressed cases of glucagon administration in alert patients who complained of confusion or weakness. AEMTs did not report rales heard later by paramedics in several cases.

Patient Disposition

Admitted	39
Dead on-scene	4
AMA	2

Patient Improvement: 63/105 (60%) of patients demonstrated evidence they were improved by the field treatment.

Mean time to ALS (available 99/105 cases): 42 minutes.

Examples

A 34-year-old woman was found unconscious by her family (GCS=7). AEMT blood glucose was 42 mg/dL. After glucagon 1 mg the patient became verbal and regained consciousness. Repeat glucose was 68 mg/dL. AEMT response time was 2 minutes; ALS response time 34 minutes. A six-year-old with diabetes was noted to have altered mental status during exertion at school. AEMTs found a confused child (GCS=11) with blood glucose of 48 mg/dL. One mg of glucagon resulted in improved mental status and blood glucose of 92 mg/dL. AEMT response time was one minute; time to ALS response was 39 minutes.

Bystanders found a 75-year-old man unresponsive in a car; they called 911 and started CPR. AEMTs found patient in cardiac arrest with shockable rhythm. One shock delivered, Combitube placed. Normal vital signs on-scene. Patient discharged from hospital alive with normal mental status. (Later died of unwitnessed arrest). AEMT response time one minute; ALS response time 23 minutes.

A 13-year-old complained of difficulty breathing after eating shrimp. He was "tripoding" on AEMT arrival with a rash and bilateral wheezes. The blood pressure was normal. Epinephrine resulted in distress going from 8/10 to 3-4/10. AEMT response time 4 minutes; ALS response time 31 minutes.

A 56-year old man presented with difficulty breathing. He had a history of hypertension and heart disease. Difficulty was rated as 8/10. He was found to have bilateral rales and wheezes, blood pressure 274/110 mm Hg, pulse 120/min, respirations 32/min. After treatment with nitroglycerin and albuterol he reported feeling "a lot better." BP was 202/100, pulse 88, and respirations 24. ALS response time 30 min.

A 40-year-old man was noted to be unresponsive after using drugs. AEMTs found him unconscious (GCS=3) with cyanosis and respirations 4/min. Naloxone 2 mg IM resulted in return of normal respirations and mental status. The patient signed out AMA. AEMT response time 3 minutes; ALS response time 32 minutes.

Observations

1. AEMTs accurately assess patients, and successfully provide advanced procedures well before ALS would otherwise be available.
2. Patients show evidence of improvement in their clinical condition. This is most evident with easily evaluated conditions such as allergic reactions, hypoglycemia and overdose. Chest pain and respiratory distress patients showed improvement as well. The single survivor of cardiac arrest was remarkable in these areas, although many patients experience unwitnessed arrest or have other unfavorable factors for successful resuscitation.
3. There is limited specificity in treatment of chest pain, although it is unclear if it is any worse than paramedic evaluation and treatment. There is some reluctance to treat patients with multiple doses of nitroglycerin, and it was some time before aspirin was used on a regular basis. Many respiratory distress patients receive "shotgun" therapy for both congestive heart failure (nitroglycerin) and reactive airway disease (albuterol), although many patients had histories and medication profiles consistent with combined disease. Base contact frequently contributed to shotgun therapy, rather than specific therapy.
4. There have been no significant complications or errors. Education and feedback modify and improve performance, including specificity of treatment.
5. Public reaction is favorable based on comments by providers.

Conclusions

1. The AEMT program should continue and be expanded into additional areas.
2. The impact of the program on patient outcome can only be determined by a randomized trial.



ACKNOWLEDGMENTS

This document was prepared by the Imperial County Emergency Medical Services Agency and reviewed by the Department of Public Health Services and the Emergency Medical Care Committee.

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IMPERIAL COUNTY

EMERGENCY MEDICAL SERVICES AGENCY

EMS SYSTEM PLAN

TABLE OF CONTENTS

	<u>Page</u>
Section One - Introduction	
Statement of Board Approval.....	i
Executive Summary.....	ii
Section Two - Assessment of System	
Table 1: Summary of System Status.....	1
System Assessment Narrative.....	15
Section Three - System Resources and Operations	
Tables 2-7.....	108
Section Four - Resource Directories	
Tables 8-11b.....	123
Section Five - Description of Plan Development Process.....	132
Section Six - Appendix	
AB 3153 Compliance (Exclusive Operating Zone).....	133

SECTION ONE
INTRODUCTION

IMPERIAL COUNTY
Emergency Medical Services (EMS) Agency

EMS PLAN EXECUTIVE SUMMARY

Imperial County, an arid desert region located along the U.S./Mexican border in the southeastern corner of California, is one of the nation's leading agricultural areas as a result of an extensive irrigation system fed by the Colorado River. The County has a sparse population (130,000) spread across a large geographic area (4500 square miles) with several small, isolated communities. In addition to having the lowest per capita income and the highest unemployment in the state, the County's low income, elderly, and minority population have limited resources to receive medical care. The adjacent Mexican border creates many issues that magnify public health problems and make solutions difficult.

Imperial County is saddled with unique EMS problems. There is a large influx of elderly visitors "Snowbirds" who come to stay during our mild winter months. Off-road vehicle enthusiasts flood into desolate areas of the county on holiday weekends and throughout the winter season. Rural highways are often the scene of major vehicle accidents. Serious illness and injury are common and frequently occur in the rural remote areas of the county far from local hospitals.

Emergency medical services is a cooperative relationship between numerous agencies - fire department first responders, ambulance providers, hospitals and others, all working together to provide the best patient care possible. The EMS system in Imperial County has made much progress in recent years. The Board of Supervisors is committed to the system. The EMS Agency, working from a new structure, developed new treatment guidelines for paramedics and other emergency medical technicians. Prehospital care protocols for all providers were revised, updated and expanded as needed. Rural EMS providers and others who are directly or indirectly involved with EMS now use the agency as a technical resource. A data system has been installed allowing us to gather information for quality improvement. Early defibrillation is now provided by first responders in our rural communities and a new trial study program has been implemented to test the use of advanced techniques by Basic Life Support (BLS) providers in small communities that do not have paramedics.

Despite these accomplishments, many challenges (outlined in the EMS Plan) remain for all participants in the EMS System. We will briefly summarize several of the most pressing in this brief overview.

The provision of emergency care in rural areas will remain a concern. Emergency Medical Technician (EMT) training is needed for rural providers, to include initial basic training and continuing education. Innovative programs, like the Expanded Scope EMT program, will help bring advanced skills into rural communities whose first

responder agencies are unable to attract paramedics. Medical oversight of BLS services needs to be strengthened and implemented in some areas. New BLS Treatment Guidelines are nearing completion. Emergency Medical Dispatch (EMD) training is needed for all dispatchers enabling them to classify medical emergencies and send the appropriate medical response, and provide pre-arrival instructions to families or bystanders (such as CPR instructions) over the phone until EMS providers arrive.

We need to evaluate trauma care for severely injured patients, determine if we are doing the best job possible with our resources, and discover if better coordination, or other system changes will improve care. Pediatric and Geriatric care should be evaluated in similar fashion to see if areas of improvement exist. Some hospitals may need assistance with transfer of patients and specialty care.

A major focus will be the institution of quality improvement mechanisms at all levels - county agency, field providers, hospitals, and others - to evaluate our care and make sure we are doing the best job possible. This will be addressed by a comprehensive Quality Improvement Plan.

Disaster care should be better coordinated. Areas of special concern are developing resource inventories and the designation of sites for field care in the event of a large earthquake. There has been little public information and education provided in the system. This can be improved in the future through disaster preparedness for the public, CPR and first-aid training, injury prevention, and public education regarding the appropriate use of 911.

Finally, the valley is not immune to the larger changes in health care, changes in reimbursement, managed care, etc. These changes will have to be understood and addressed in a way that preserves emergency care for those who need it.

SECTION TWO
ASSESSMENT OF SYSTEM

TABLE 1: Summary of System Status

Include the items from Table 1 that are followed by an asterisk on the System Assessment form. Describe on the form how resources and/or services are coordinated with other EMS agencies in meeting the standards. Table 1 is to be reported by agency.

A. SYSTEM ORGANIZATION AND MANAGEMENT

Agency Administration	Does not currently meet standard	Meet minimum standard	Meet recommended guideline	Annual Implementation	Long-range Plan
1.01 LEMSA Structure		X			
1.02 LEMSA Mission		X		X	X
1.03 Public Input		X		X	
1.04 Medical Director		X	X		X

Planning Activities

1.05 System Plan		X		X	
1.06 Annual Plan Update				X	
1.07 Trauma Planning*	X			X	X
1.08 ALS Planning*		X		X	X
1.09 Inventory of Resources		X		X	
1.10 Special Populations		X			X
1.11 System Participants		X	X	X	

Regulatory Activities	Does not currently meet standard	Meet minimum standard	Meet recommended guideline	Annual Implementation	Long-range Plan
1.12 Review & Monitoring		X		X	
1.13 Coordination		X			
1.14 Policy & Procedures Manual		X		X	X
1.15 Compliance w/ Policies				X	

System Finance

1.16 Funding Mechanism		X		X	X
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Medical Direction

1.17 Medical Direction*		X			X
1.18 QA / QI		X		X	
1.19 Policies, Procedures, Protocols		X		X	X
1.20 DNR Policy		X			
1.21 Determination of Death		X			
1.22 Reporting of Abuse		X		X	
1.23 Interfacility Transfer		X			X

Enhanced Level: Advanced Life Support

1.24 ALS Systems		X	X		X
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1.25 On-Line Medical Direction		X	X		
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Enhanced Level: Trauma Care System	Does not currently meet standard	Meet minimum standard	Meet recommended guideline	Annual Implementation	Long-range Plan
1.26 Trauma System Plan		N/A			

Enhanced Level: Pediatric Emergency & Critical Care System

1.27 Pediatric System Plan		N/A			
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Enhanced Level: Exclusive Operating Areas

1.28 EOA Plan		X			
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B. STAFFING / TRAINING

Local EMS Agency	Does not currently meet standard	Meet minimum standard	Meet recommended guideline	Annual Implementation	Long-range Plan
2.01 Assessment of Needs				X	
2.02 Approval of Training		X		X	X
2.03 Personnel		X			

Dispatchers

2.04 Dispatch Training	X			X	X
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First Responders (non-transporting)

2.05 First Responder Training		X		X	X
2.06 Response		X		X	X
2.07 Medical Control	X			X	

Transporting Personnel

2.08 EMT-I Training		X			
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Hospital

2.09 CPR Training		X			
2.10 Advanced Life Support	X				X

Enhanced Level: Advanced Life Support	Does not currently meet standard	Meet minimum standard	Meet recommended guideline	Annual Implementation	Long-range Plan
2.11 Accreditation Process		X			
2.12 Early Defibrillation		X			
2.13 Base Hospital Personnel		X		X	X

C. COMMUNICATIONS

Communications Equipment	Does not currently meet standard	Meet minimum standard	Meet recommended guideline	Annual Implementation	Long-range Plan
3.01 Communication Plan*		X	X	X	X
3.02 Radios		X	X		X
3.03 Interfacility Transfer*		X			
3.04 Dispatch Center		X			
3.05 Hospitals		X			
3.06 MCI/Disasters		X			X

Public Access

3.07 9-1-1 Planning/Coordination		X			
3.08 9-1-1 Public Education	X				X

Resource Management

3.09 Dispatch Triage	X			X	X
3.10 Integrated Dispatch		X	X		

D. RESPONSE / TRANSPORTATION

Universal Level	Does not currently meet standard	Meet minimum standard	Meet recommended guideline	Annual Implementation	Long-range Plan
4.01 Service Area Boundaries*		X	X	X	
4.02 Monitoring		X			X
4.03 Classifying Medical Requests	X			X	X
4.04 Prescheduled Responses		X		X	
4.05 Response Time Standards*	X				X
4.06 Staffing		X			
4.07 First Responder Agencies		X		X	
4.08 Medical & Rescue Aircraft*		X			X
4.09 Air Dispatch Center		X			
4.10 Aircraft Availability*		X			X
4.11 Specialty Vehicles*		X	X		
4.12 Disaster Response		X			
4.13 Intercounty Response*		X	X	X	
4.14 Incident Command System		X	X		
4.15 MCI Plans		X	X		

Enhanced Level: Advanced Life Support

4.16 ALS Staffing		X			X
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Enhanced Level: Ambulance Regulation	Does not currently meet standard	Meet minimum standard	Meet recommended guideline	Annual Implementation	Long-range Plan
4.18 Compliance		X		X	X

Enhanced Level: Exclusive Operating Permits

4.19 Transportation Plan			X		
4.20 Grandfathering			X		
4.21 Compliance		X			
4.22 Evaluation		X		X	X

E. FACILITIES / CRITICAL CARE

Universal Level	Does not currently meet standard	Meet minimum standard	Meet recommended guideline	Annual Implementation	Long-range Plan
5.01 Assessment of Capabilities		X			X
5.02 Triage & Transfer Protocols*		X			X
5.03 Transfer Guidelines*	X				X
5.04 Specialty Care Facilities*	X				X
5.05 Mass Casualty Management		X			X
5.06 Hospital Evaluation*		X			

Enhanced Level: Advanced Life Support

5.07 Base Hospital Designation*		X			
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Enhanced Level: Trauma Care System

5.08 Trauma System Design		N/A			
5.09 Public Input		N/A			

Enhanced Level: Pediatric Emergency & Critical Care System

5.10 Pediatric System Design		N/A			
5.11 Emergency Departments		N/A			
5.12 Public Input		N/A			

Enhanced Level: Other Speciality Care System

5.13 Speciality System Design		N/A			
5.14 Public Input		N/A			

F. DATA COLLECTION / SYSTEM EVALUATION

Universal Level	Does not currently meet standard	Meet minimum standard	Meet recommended guideline	Annual Implementation	Long-range Plan
6.01 QA/QI Program	X			X	
6.02 Prehospital Records		X			
6.03 Prehospital Care Audits		X		X	X
6.04 Medical Dispatch	X			X	
6.05 Data Management System*		X		X	X
6.06 System Design Evaluation		X		X	X
6.07 Provider Participation		X			
6.08 Reporting		X			X

Enhanced Level: Advanced Life Support

6.09 ALS Audit		X			X
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Enhanced Level: Trauma Care System

6.10 Trauma System Evaluation		N/A			
6.11 Trauma Center Data		N/A			

G. PUBLIC INFORMATION AND EDUCATION

Universal Level	Does not currently meet standard	Meet minimum standard	Meet recommended guideline	Annual Implementation	Long-range Plan
7.01 Public Information Materials	X				X
7.02 Injury Control	X				X
7.03 Disaster Preparedness	X				X
7.04 First Aid & CPR Training	X				X

H. DISASTER MEDICAL RESPONSE

Universal Level	Does not currently meet standard	Meet minimum standard	Meet recommended guideline	Annual Implementation	Long-range Plan
8.01 Disaster Medical Planning*		X			
8.02 Response Plans		X			
8.03 HazMat Training		X		X	X
8.04 Incident Command System		X	X		
8.05 Distribution of Casualties*		X		X	X
8.06 Needs Assessment		X	X		
8.07 Disaster Communications*		X		X	
8.08 Inventory of Resources	X				X
8.09 DMAT Teams	X				X
8.10 Mutual Aid Agreements*		X			
8.11 CCP Designation*	X				X
8.12 Establishment of CCPs	X				X
8.13 Disaster Medical Training		X	X		
8.14 Hospital Plans		X			X
8.15 Interhospital Communications		X	X		
8.16 Prehospital Agency Plans		X	X		

Enhanced Level: Advanced Life Support

8.17 ALS Policies		X			
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Enhanced Level: Specialty Care Systems	Does not currently meet standard	Meet minimum standard	Meet recommended guideline	Annual Implementation	Long-range Plan
8.18 Specialty Center Roles		X			
8.19 Waiving Exclusivity		X			

1. SYSTEM ORGANIZATION AND MANAGEMENT -- AGENCY ADMINISTRATION

A. AGENCY ADMINISTRATION

1.01 UNIVERSAL STANDARD

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

CURRENT STATUS

The EMS Agency has a formal organizational structure which includes an EMS Coordinator, part-time Senior Public Health Analyst, EMS Medical Director, and an office assistant. The EMS Agency is designated by the Imperial County Board of Supervisors. This structure is a division of the Imperial County Department of Health Services and is included in the county structure which delineates other county resources including, the Health Officer, County Counsel, Risk Management and administrative personnel. Non-agency resources include a contract training coordinator through the local community college.

NEED(S): None

1.02 UNIVERSAL STANDARD

Each local EMS agency shall plan, implement, and evaluate the EMS system. The agency shall use its quality assurance/evaluation process to identify needed system changes.

CURRENT STATUS

The agency is active in each of the above areas. The Continuous Quality Improvement (CQI) and evaluation process is used to identify needed system changes. A new data system will contribute to this.

NEED(S): CQI and evaluation process tied in with database.

OBJECTIVE 1.02: The EMS Agency will develop QI audits based on reviews of the computer data base.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

1.03

UNIVERSAL STANDARD

Each local EMS agency shall actively seek and shall have a mechanism (including the emergency medical care committee(s) and other sources) to receive appropriate consumer and health care provider input regarding the development of plans, policies, and procedures, as described throughout this document.

CURRENT STATUS

Health care providers, including a broad array of prehospital providers, are represented and active at EMCC meetings. Informal communications are important also in this small county. Proposed system changes are taken to the Emergency Medical Care Committee (EMCC) and circulated among system participants, including EMTs and medics at Base Hospital meetings.

The public is less well represented and aware of system function and changes, except for local ambulance company boards. A member of the Board of Supervisors frequently attends EMCC meetings and is aware of issues, and can provide public input.

NEED(S): None at this time.

1.04

MINIMUM STANDARD

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 create 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 current medical director is board-certified in emergency medicine and has extensive clinical and administrative experience in emergency medicine and emergency medical services. There is little input into the EMS system by any physicians other than those at the base hospital.

NEED(S): Develop strategies for involving non-base hospital emergency physicians and other physicians in the EMS system.

OBJECTIVE 1.04.1: Develop relationship with non-base hospital physicians and encourage their participation in EMS.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

B. PLANNING ACTIVITIES

1.05 UNIVERSAL STANDARD

Each local EMS agency shall develop an EMS System Plan 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 clinical target groups, and
- c) provide a methodology and time line for meeting these needs.

CURRENT STATUS

This is the first EMS plan developed and submitted by Imperial county. The plan includes evaluation of patients in clinical target groups, and methodology and time line for addressing identified needs.

NEED(S): None.

1.06 UNIVERSAL STANDARD

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.

CURRENT STATUS

This is our first plan, updates were not submitted in the past.

NEED(S): Yearly updates of EMS plan.

OBJECTIVE 1.06: Revise and submit to the EMS Authority annual updates of the Imperial County EMS plan.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

1.07

UNIVERSAL STANDARD

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

RECOMMENDED GUIDELINE

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

CURRENT STATUS

Trauma patients were historically taken to the closest receiving facility. They now go to one of the two hospitals best equipped to handle them. Many seriously injured patients, depending on local availability of resources and type of injury, are transferred to tertiary care centers in San Diego. There has been no evaluation of trauma care or patient outcome. There is no current support for regionalization within the county, and direct field transfer to centers outside the county is not feasible.

COORDINATION WITH OTHER EMS AGENCIES: The idea of evaluating trauma care in Imperial Valley has been discussed with the EMCC. Participating agencies agree that trauma care should be evaluated for consideration of the institution of systemized trauma care.

NEED(S): An evaluation of the care of patients with major injuries, and institution of systemized trauma care.

OBJECTIVE 1.07.1 The EMS Agency should identify major trauma victims, and evaluate their care, through prehospital, hospital and coroner records. If necessary care should be compared to standard outcome measures.

TIME FRAME FOR IMPLEMENTATION:

- [X] Annual Implementation Plan
[X] Long-range Plan

OBJECTIVE 1.07.2 The EMS Agency should identify trauma system components most likely to impact patient care, and develop a trauma plan consistent with Imperial Valley needs and resources.

TIME FRAME FOR IMPLEMENTATION:

- [] Annual Implementation Plan
[X] Long-range Plan

OBJECTIVE 1.07.3 The EMS Agency should lead community discussion about trauma care, present a model proposal, set standards for trauma patient care, and monitor patient care.

TIME FRAME FOR IMPLEMENTATION:

- [] Annual Implementation Plan
[X] Long-range Plan

1.08

UNIVERSAL STANDARD

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

CURRENT STATUS

Advanced life support is currently available on first response to about 40% of the county's population. ALS is available to 90% of the population through our Zone I transport provider. We have sparse population spread across a large geographic area, with numerous physical obstacles. ALS has been inconsistently available in the north part of the county, on both the west and east shores of the Salton Sea. There is also a significant seasonal population in the winter time. Simply maintaining BLS response, and transport or rendezvous capability is difficult.

COORDINATION WITH OTHER EMS AGENCIES: Implementation of an Expanded-Scope EMT-I program to provide rural first responders with limited ALS skills was well supported by EMCC and EMS Task Force members.

NEED(S): County wide ALS, or availability of critical skills.

OBJECTIVE 1.08.1: Develop plan for ALS services in remote areas, including innovative approaches to financial and training barriers.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 1.08.2: Develop capability for ALS skills among BLS providers.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

1.09

UNIVERSAL STANDARD

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.

CURRENT STATUS

An inventory has been prepared for this plan and will be updated annually.

NEED(S): None at this time.

1.10

UNIVERSAL STANDARD

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

Groups that may require or benefit from specialized services include Spanish-speakers and recent immigrants; the elderly, including seasonal residents; children; low-income families. There are no targeted programs for groups who may require specialized services.

Pediatric care is now provided by valley hospitals, with transfer when needed to San Diego, about 120 miles away.

NEED: Identify groups needing specialized services, and, in the future, provide such services.

OBJECTIVE 1.10.1: Develop tool to identify groups needing specialized services, and the types of services needed.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 1.10.2: The EMS Agency shall perform an evaluation of the need for attention to pediatric needs and care, including emergency department care and need for specialty care, and transfer.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

1.11

UNIVERSAL STANDARD

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 of system participants are set in historical patterns. Whether these are the optimal roles and responsibilities is uncertain, as are potential changes in the future. We are convening, under the auspices of the Board of Supervisors, an EMS Task Force to consider these issues. The Task Force will spend 12-18 months studying EMS System issues.

There are written provider agreements.

NEED(S): Evaluation of optimal roles and responsibilities.

OBJECTIVE 1.11.1: Convene county Task Force to evaluate system participants, roles, and responsibilities.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

C. Regulatory Activities

1.12 UNIVERSAL STANDARD

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

CURRENT STATUS

EMS system operations are reviewed and monitored, although not in as systematic a way as would be desirable.

NEED(S): Improved, systematic review of EMS system operations.

OBJECTIVE 1.12.1: Develop program for systematic review of all system operations. See also Standards 1.18 and 6.01-6.06.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

1.13 UNIVERSAL STANDARD

Each local EMS agency shall coordinate EMS system operations.

CURRENT STATUS

The agency performs a coordinating function, and is seen as an information resource.

NEED(S): None at this time.

1.14

UNIVERSAL STANDARD

Each local EMS agency shall develop a policy and procedures manual which includes all 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.

CURRENT STATUS

A Manual exists, but most sections require revision and updating. The Agency is now in the process of updating ALS and LALS treatment protocols, and adding BLS treatment protocols. Numerous operational policies are quite dated and need revision to reflect current practice, standards, ethics and law.

The manual is not in the hands of all system participants.

NEED(S): Comprehensive, up-to-date manual. Develop revised operational policies and protocols. Improve distribution to system participants.

OBJECTIVE 1.14.1: Revise policy and procedures manual, updating needed policies.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 1.14.2: Poll system participants to assure possession of manual.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

1.15

UNIVERSAL STANDARD

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

CURRENT STATUS

This is now done through review of individual responses, reports from providers and the base hospitals, and through follow-up of inquiries or complaints. We are arranging reports from the Computer Aided Dispatch system to monitor response times better. Few routine audits are performed using QI techniques. There is a response time report generated by the major provider each month. There is also the ability to monitor other system components.

NEED(S): There is a need for the EMS Agency to develop a Continuous Quality Improvement program by which it shall review and monitor all aspects of the EMS system to include (but not limited to) equipping and staffing of units, EMS responses (to include first response and ALS transport), field care audits, training programs, and dispatching.

OBJECTIVE 1.15.1: To develop and implement an EMS CQI program.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long Range Plan

D. System Finances

1.16

UNIVERSAL STANDARD

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

CURRENT STATUS

The agency was supported solely through state Prevention 2000 funding and local matching soft dollars. In 1994 the county, despite its precarious financial condition, began 50% hard dollar match of state funds. Fees are now under consideration by the EMCC, including reimbursement for training. This may be a limited source as many agencies are volunteer and have little access to funds.

An Emergency Medical Services Fund cannot be established because of statutory limits.

NEEDS: Adequate funding for the agency from a variety of sources including continued Prevention 2000 funds, county general fund hard dollar match and user fees.

OBJECTIVE 1.16: A stable long-term commitment of stable funding for the EMS Agency.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

E. Medical Direction

LOCAL EMS SYSTEMS NEED APPROPRIATE MEDICAL DIRECTION. THIS IMPLIES INVOLVEMENT OF THE MEDICAL COMMUNITY AND ENSURES MEDICAL ACCOUNTABILITY IN ALL STAGES OF THE SYSTEM.

1.17

UNIVERSAL STANDARD

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.

CURRENT STATUS

The agency is providing medical direction leadership. One base hospital is sufficient and is committed to base hospital operations. The roles of other providers have been defined.

NEED(S): A defined medical direction plan might be helpful. Base hospital physicians need more awareness of prehospital protocols.

COORDINATION WITH OTHER EMS AGENCIES: The concept of a written and defined medical direction plan was supported by the EMCC.

OBJECTIVE 1.17.1: The EMS agency will write a medical direction plan.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 1.17.2: Orientation to prehospital care policies and protocols for BH physicians.

TIME FRAME OF IMPLEMENTATION:

- Annual Plan
- Long-range Plan

MINIMUM STANDARD

Each local EMS agency shall establish a quality assurance/quality improvement program to ensure adherence to medical direction policies and procedures, including a mechanism to review compliance with system policies. 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

Quality assurance for medical direction policies is now performed largely through individual case review performed by the base hospital. This is done by monitoring of base hospital communications and patient care records, and also in response to questions or complaints. Providers have no formal in-house quality programs, other than response to inquiries or complaints.

NEED(S): Development of standards and performance-based quality improvement programs at the EMS agency, prehospital providers, and hospitals. Development of improved data system and data-driven agency quality improvement. See 6.01-6.09.

OBJECTIVES: See Standards 6.01-6.09.

1.19

MINIMUM STANDARD

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 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

Most of these areas are covered in existing Policies and Procedures or Treatment Guidelines. Many parts of the Policy and Procedure Manual are, however, outdated and the manual is being re-written slowly. New ALS and LALS treatment protocols, including standing orders, were put into place two years ago. BLS treatment protocols are under development for the first time. Problems with ALS/LALS hand-off and "meets" are being addressed in protocols; on-scene times have been addressed through routine QI and follow-up.

The local scope of practice is tailored to this area, but we may need further refinement of the scope of practice to deal with rural and remote needs. This may include modifications of the EMT-II and EMT-I scopes of practice.

Please see Standard 3.09 regarding pre-arrival/post dispatch instructions.

NEED(S): Update Policy manual, treatment guidelines and medical dispatch. See Standard 1.14.

OBJECTIVE 1.19.1 Finish BLS Treatment Guidelines.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

1.20

MINIMUM STANDARD

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

CURRENT STATUS

A formal Do-Not-Resuscitate policy was adopted in 1994.

NEED(S): None at this time.

1.21

UNIVERSAL STANDARD

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 an apparent crime.

CURRENT STATUS

A revised Determination of Death policy, was instituted in 1995. We will monitor its impact.

NEED(S): None.

1.22

UNIVERSAL STANDARD

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

CURRENT STATUS

There are protocols for child abuse, elder abuse, and suspected SIDS death. They will be reviewed this year.

NEED(S): Review of abuse and SIDS policies.

OBJECTIVE 1.22.1: Review child abuse, elder abuse and SIDS death policies in 1995-96.

TIME FRAME FOR IMPLEMENTATION:

Annual Implementation Plan

Long-range Plan

1.23

UNIVERSAL STANDARD

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

CURRENT STATUS

The ALS/LALS treatment protocols apply to interfacility transfers. The major provider has asked for a specific interfacility scope of practice suitable for this community, since most interfacility transfers must be performed by paramedics.

NEED(S): An expanded scope of practice for paramedics during interfacility transfers.

OBJECTIVE 1.23.1: Develop treatment guidelines and scope of practice for interfacility transfers by paramedics.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

Enhanced Level: Advanced Life Support

1.24

MINIMUM STANDARD

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 and LALS providers are approved by the agency and all have signed written agreements to provide service, although some will need revision and updating. The county has been divided into six response zones. The county's largest ambulance provider has been operating in the same scope and manner since before 1980, was awarded an Exclusive Operating Area contract in 1986, and granted a four year extension to that contract by the Board of Supervisors in 1995.

NEED(S): Revised and updated service provider agreements.

OBJECTIVE 1.24.1: EMS agency shall revise and update provider agreements.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

1.25

MINIMUM STANDARD

Each EMS system shall have on-line medical direction, provided by a base hospital (or alternative base station) physician or authorized registered 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 when prehospital providers should appoint an in-house medical director.

CURRENT STATUS

There is a single base hospital. There is no process for application. EMS providers are too small to have their own medical directors at this point. EMT-D was added in 1995 and a separate medical control plan for that program was adopted that includes policies for providers, the base hospital, and the agency.

NEED(S): None at this time. See Standard 1.17.

F. Enhanced Level: Trauma Care System

1.26

UNIVERSAL STANDARD

The local EMS agency shall develop a trauma care system plan 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.

CURRENT STATUS

NEED(S): None. There is no trauma plan at this time.

G. Enhanced Level: Pediatric Emergency Medical and Critical Care System

1.27

UNIVERSAL STANDARD

The local EMS agency shall develop a pediatric emergency medical and critical care system plan 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.

CURRENT STATUS

There is no pediatric emergency medical plan.

NEED(S): None. There is no plan at this time. See Standard 1.10.2.

H. Enhanced Level: Exclusive Operating Areas

1.28

UNIVERSAL STANDARD

The local EMS agency shall develop, and submit for state approval, a plan 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.

CURRENT STATUS

The county's largest ambulance provider has been operating in the same scope and manner since before 1980 and was awarded an exclusive operating area in 1986. The EMCC made a recommendation to the Board of Supervisors to extend this contract (which expired December 31, 1995) for one year and create an EMS Task Force to study system design. The Board of Supervisors opted instead to extend the contract for another four years, although it has appointed a Task Force to evaluate system components.

NEED(S): None

STAFFING/TRAINING

THE LOCAL EMS SYSTEM SHOULD INCLUDE AN ADEQUATE NUMBER OF HOSPITAL AND PREHOSPITAL HEALTH PROFESSIONALS TO PROVIDE EMERGENCY MEDICAL SERVICES ON A TWENTY-FOUR HOUR PER DAY BASIS.

PROVISION SHOULD BE MADE FOR THE INITIAL AND ON-GOING TRAINING OF THESE PERSONNEL UTILIZING CURRICULA CONSISTENT WITH STATE AND NATIONAL STANDARDS.

Minimum Standards

Recommended Guidelines

Universal Level

2. Local EMS Agency

2.01

UNIVERSAL STANDARD

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

CURRENT STATUS

The agency assesses personnel and training needs, although this is not done on a formal basis.

NEED(S): Formal assessment of personnel and training needs. Enhanced continuing education for providers, including EMT-D skills maintenance, re-certification and CME for rural and remote providers.

OBJECTIVE 2.01.1: Perform formal assessment of personnel and training needs.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 2.01.2: Implement improved education and re-certification options for rural and remote providers.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

2.02

UNIVERSAL STANDARD

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.

CURRENT STATUS

There is an approval process for the training institution (Imperial Valley College). The EMT-II, EMT-I, EMT-I Refresher, First Responder, and First Responder Refresher courses were reviewed and approved in 1994. A new CME provider approval policy is in preparation at this time.

Educational programs have not been closely monitored for quality or compliance.

NEED(S): Better monitoring of CME and educational programs.

OBJECTIVE 2.02.1: Finish policy for approval of CME providers.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 2.02.2: Develop and implement plan for monitoring of CME programs.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 2.02.3: Develop and implement plan for monitoring of educational programs.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

2.03

UNIVERSAL STANDARD

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.

CURRENT STATUS

There are mechanisms for certification, accreditation and related actions, and a process for prehospital providers to notify the EMS agency of incidents which could impact system personnel.

NEED(S): None.

A. Dispatchers

2.04

MINIMUM STANDARD

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 certified in accordance with the EMS Authority's Emergency Medical Dispatch Guidelines.

CURRENT STATUS

Most dispatchers do not have medical orientation or emergency medical dispatch training (see also Standards 1.19, 3.10). Two of our PSAP agencies have some personnel trained in emergency medical dispatch procedures. The EMS Agency applied for federal block grant funding to implement an EMD program in FY 1996-1997.

NEED(S): There is a need for emergency medical dispatch training and certification of dispatchers.

OBJECTIVE 2.04.1: The EMS Agency should develop a formal plan with dispatch agencies to provide medical dispatch education and training for medical dispatchers, and dispatch agencies should commit to Emergency Medical Dispatch training to occur by the end of 1996.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 2.04.2: Medical dispatchers should be trained in Emergency Medical Dispatch by the end of 1996.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

**2.05 B. First Responders (non-transporting)
MINIMUM STANDARD**

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 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

Most responders on non-transporting EMS first response units are certified to at least the EMT-I level. The outlying volunteer fire departments (Winterhaven, Ocotillo, Salton Sea, and Bombay Beach) each have some EMT-I trained personnel. Beginning in 1995, many of these units have first response EMT-D capability. EMT-D was targeted at rural communities either without continuous ALS service, or that have long ALS response times. All EMS first response units have equipment commensurate with their scope of practice. Work schedules and distance from the community college make it difficult for volunteers from the remote fire departments to attend the local college for EMT training. Providing EMT training for these remote communities has been a problem for the local community college due to insufficient enrollment.

NEED(S): There is a need for EMT-I training in remote communities to compensate for the high turnover of EMT personnel. Many first responders have had CPR and first aid training within the previous three years.

OBJECTIVE 2.05.1: The EMS Agency shall ensure that all first responder personnel have the minimum required certification in CPR and first aid training

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 2.05.2: The EMS Agency shall develop a plan to offer EMT-I, EMT-D, and other training in remote areas.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

2.06

UNIVERSAL STANDARD

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.

CURRENT STATUS

Agencies are encouraged to respond to medical emergencies, and most first responders respond to all EMS incidents. Due to lack of resources, some first responders limit their responses to defined EMS incidents. They do follow local policies when they respond.

NEED(S): A stable funding source is needed to enable first responders to respond (and continue to respond) to all medical aid requests.

OBJECTIVE 2.06.1: The EMS agency will encourage all agencies to provide first response.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 2.06.1: The EMS Agency shall develop mechanisms for funding first responders and obtain a secure funding source.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

2.07

UNIVERSAL STANDARD

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

CURRENT STATUS

A draft of BLS/First Response treatment guidelines is under development. It was released for comment in August, 1995.

NEED(S): BLS/First Response treatment guidelines.

OBJECTIVE 2.07.1: The EMS Agency should complete and adopt BLS/First Response treatment guidelines by the end of 1995.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

C. Transport Personnel

2.08

MINIMUM STANDARD

All emergency medical transport vehicle personnel shall be 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

All transport personnel are certified at least at the EMT-I level. As of the end of June 1995, all BLS transport personnel, where ALS is not available, have been trained to provide defibrillation and have defibrillation equipment.

NEED(S): None.

D. Hospital

2.09

UNIVERSAL STANDARD

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

CURRENT STATUS

This standard is currently met at the two hospitals that receive ALS/LALS patients.

NEED(S): None.

2.10

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

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

CURRENT STATUS

Only the Base Hospital emergency department requires their physicians and registered nurses to be trained in advanced cardiac life support. The other receiving facility has a goal to require this training for all emergency department physicians and registered nurses. Many physicians are ABEM certified.

NEED(S): Advanced Cardiac Life Support training for all emergency department physicians and nurses.

OBJECTIVE 2.10.1: ACLS training for all emergency department physicians and nurses.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 2.10.2: ABEM certification of all emergency department physicians.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

E. Enhanced Level: Advanced Life Support

2.11 UNIVERSAL STANDARD

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 process.

CURRENT STATUS

The EMS Agency has an accreditation policy for ALS personnel that meets this standard. It was revised in September, 1995. Orientation and necessary training are performed by the Base Hospital in conjunction with the EMS Agency.

NEED(S): None.

2.12 UNIVERSAL STANDARD

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

CURRENT STATUS

Policies for accreditation in defibrillation went into place in April, 1995. They will be revised as needed.

NEED(S): None at this time.

2.13

UNIVERSAL STANDARD

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.

CURRENT STATUS

All MICNs have training in policies and radio communication techniques. Physicians have a formal orientation program, however it is not always implemented by medical staff.

NEED(S): Training or assurance of knowledge of protocols by base hospital physicians.

OBJECTIVE 2.13.1: The EMS Agency should develop a mechanism to ensure training of physicians in treatment protocols and EMS policies.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

3. Communications

THE LOCAL EMS SYSTEM SHOULD MAKE PROVISION FOR TWO-WAY COMMUNICATIONS BETWEEN PERSONNEL AND FACILITIES WITHIN COORDINATED COMMUNICATIONS SYSTEM(S).

THE COMMUNICATIONS SYSTEM SHOULD INCLUDE PUBLIC ACCESS TO THE EMS SYSTEM, RESOURCE MANAGEMENT, AND MEDICAL DIRECTION ON BOTH THE BASIC LIFE SUPPORT AND ADVANCED LIFE SUPPORT LEVELS.

Minimum Standards

Recommended Guidelines

Universal Level

A. Communications Equipment

3.01

MINIMUM STANDARD

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 in accordance with the EMS Authority's Communications Plan (when it is available).

RECOMMENDED GUIDELINES

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

CURRENT STATUS

The EMS Agency is actively involved with other system participants planning a proposed 800-mHz system. This would involve transporting and non-transporting EMS units and acute care facilities. Cellular telephones are used by some of the provider agencies and their use will be coordinated in the plan.

COORDINATION WITH OTHER EMS AGENCIES: (see Current Status)

NEED(S): Continued planning for 800-mHz system.

OBJECTIVE 3.01.1: Continue participation in 800-mHz system design.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 3.01.2: Develop formal EMS System communications plan.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

3.02

MINIMUM STANDARD

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 first responder units) communication.

CURRENT STATUS

Historically, all EMS dispatch and base communications occurred on a single VHF frequency. This was recently supplemented by the addition of UHF Med-10 for base communications and communication with receiving facilities. ALS/LALS non-transporting units currently do not have the UHF radios but can still communicate on the VHF frequency and with cell phones. Ambulances and fire first-responder vehicles are not all able to communicate with each other. Ambulances do not have the fire channels (and are unable to acquire them due to fire service regulations) and most fire first responder vehicles do not have the EMS frequency. There is no money for communications upgrades, unless the 800-mHz system is feasible.

NEED(S): Enhanced communications between providers.

OBJECTIVE 3.02.1: To provide enhanced communications between providers.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

3.03

UNIVERSAL STANDARD

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

CURRENT STATUS

Emergency transport vehicles can access sending and receiving facilities on the EMS frequencies.

COORDINATION WITH OTHER EMS AGENCIES: Both hospitals in Imperial County maintain radio/telephone equipment in order to communicate with ambulances.

NEED(S): None at this time.

3.04

UNIVERSAL STANDARD

All emergency medical transport vehicles where physically possible, (based on geography and technology), shall have the capability of communicating with a single dispatch center or disaster communications command post.

CURRENT STATUS

All EMS transport vehicles have the capability to communicate with the single dispatch center, which would coordinate operations in a disaster.

NEED(S): None at this time.

3.05

MINIMUM STANDARD

All hospitals within the local EMS system shall (where physically possible) be able 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

Both hospitals can communicate with each other on designated EMS frequencies (both UHF and VHF).

Specialized services are all outside the county and contacted by telephone. Direct communications, not dependant on the telephone, would be useful during disaster, but unnecessary for everyday use.

NEED(S): None at this time.

3.06

UNIVERSAL STANDARD

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.

CURRENT STATUS

This has recently been reviewed during our annual valley-wide disaster/mass casualty incident drill.

NEED(S): There is a need for enhanced communications between prehospital providers and hospitals.

OBJECTIVE 3.06.1: Develop mechanisms for enhanced disaster communications.

TIME FRAME FOR IMPLEMENTATION:

- Annual implementation plan
- Long range plan

B. Public Access

3.07

UNIVERSAL STANDARD

The local EMS agency shall participate in on-going planning and coordination of the 9-1-1 telephone service.

CURRENT STATUS

The local EMS Agency works with the county's "911 Coordinator" with the on-going planning and coordination of the enhanced 911 system. The local EMS agency also participates as a member of the "800 Users Group".

NEED(S): None.

3.08

UNIVERSAL STANDARD

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

CURRENT STATUS

The agency has done minimal public education regarding 911.

NEED(S): A public awareness campaign about the appropriate use of 911.

OBJECTIVE 3.08.1: The EMS Agency, in cooperation with other system participants, should perform public education regarding the use of 911.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

C. Resource Management

3.09

MINIMUM STANDARD

The local EMS agency shall establish guidelines for proper dispatch triage, identifying 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, pre-arrival instructions.

CURRENT STATUS

Guidelines now exist for first responder assistance when that is available. In many areas, the resources available for a response are limited, so options are few. There is no dispatch priority system, caller interrogation, or pre-arrival instructions. The long response times in some areas might make pre-arrival instructions helpful.

We lack medical dispatch protocols. Currently calls are screened by 7 Public Safety Answering Points (PSAPs) who also dispatch their respective fire first responder agencies. The calls are then forwarded to the Imperial County Sheriff's Office dispatch who is the primary dispatcher of ALS ambulance service. 911 calls from the unincorporated areas of the county are received directly by the Sheriff's dispatch. First responders are sent on most medical aid requests although some departments are limited to selected clinical conditions or call types. None of our local dispatchers have had EMD training and they are not giving prearrival instructions.

NEED(S): EMD training for dispatchers, a dispatch priority reference system, dispatch triage policies, and prearrival instructions.

OBJECTIVE 3.09.1: Provide EMD training for dispatchers and develop guidelines for medical dispatch.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 3.09.2: Obtain agreement with Sheriff's Department, obtain funding and program, and train dispatchers.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 3.09.3: Develop and use pre-arrival/post dispatch instructions.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

3.10

MINIMUM STANDARD

The local EMS system shall have a functionally integrated dispatch with systemwide emergency services coordination, using standardized communications frequencies which comply with the EMS Authority's Communications Plan (when it is available).

RECOMMENDED GUIDELINES

The local EMS agency should develop a mechanism to ensure appropriate systemwide ambulance coverage during periods of peak demand.

CURRENT STATUS

There is a mechanism to integrate EMS responses.

There is a mechanism in place to identify peak demand periods with the primary provider, who can adjust ambulance coverage accordingly.

NEED(S): None.

4. Response/Transportation

THE LOCAL EMS SYSTEM SHOULD INCLUDE ADEQUATE GROUND, AIR, AND WATER VEHICLES MEETING APPROPRIATE STANDARDS REGARDING LOCATION, DESIGN, PERFORMANCE, EQUIPMENT, PERSONNEL, AND SAFETY.

4.01 MINIMUM STANDARD:

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

There is a county ordinance (although it is in need of revision) in which six service areas for emergency medical transport are designated by The Board of Supervisors: 1. The central valley (including the cities of El Centro, Imperial, and Brawley) with 80% of the valley's population; 2. Calexico and the unincorporated area south of highway 98; 3. the southeast corner of the county to the Arizona border (includes the town of Winterhaven); 4. the northeast corner of the county to the Riverside County line and the Arizona border; 5. the western shore of the Salton Sea and surrounding communities; and, 6. the community of Bombay Beach [see map]. There is an exclusive contract for the Zone I service area only; although El Centro Fire Department, citing Health & Safety Code Section 1797.201, has expressed interest in providing ambulance service to the City of El Centro (which is within Zone I).

COORDINATION WITH OTHER EMS AGENCIES:

NEED(S): A revised and updated county ordinance for ambulance service is needed.

OBJECTIVE 4.01.1: Revise & update county ordinance for ambulance service.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

4.02

MINIMUM STANDARD

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 EMS Agency monitors transport services through informal monitoring, evaluation of complaints and incidents reports, and by monitoring through the Base Hospital. Response times are monitored for the Zone I contractor only. There is a licensing procedure through the Sheriff's office.

NEED(S): Improved monitoring with periodic inspections. An updated ambulance ordinance is needed.

OBJECTIVE: 4.02.1: Develop county ordinance for licensure and monitoring of transport services.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

4.03

UNIVERSAL STANDARD

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 (e.g. ALS/BLS, ground/air, first responder) to each.

CURRENT STATUS

The Sheriff's Department has rudimentary criteria for classifying medical requests and determining the appropriate level of response. The criteria used by other dispatch agencies are informal.

NEED(S): Formal policy by each dispatch agency for determining appropriate medical response.

OBJECTIVE 4.03.1: The EMS Agency, together with dispatch agencies, will develop formal criteria for level of medical response.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

4.04

UNIVERSAL STANDARD

Service by emergency medical transport vehicles which can be pre-scheduled without negative medical impact shall be provided only at levels which permit compliance with LEMSA policy.

CURRENT STATUS

Pre-scheduled or unscheduled non-emergency response is handled by the major provider. The system is monitored for any negative impact, including effect on response times, which is unusual.

NEED(S): None identified.

OBJECTIVE 4.04.1: The EMS Agency will continue to monitor provision of non-emergency transport for negative impact on the emergency system.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

MINIMUM STANDARD

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

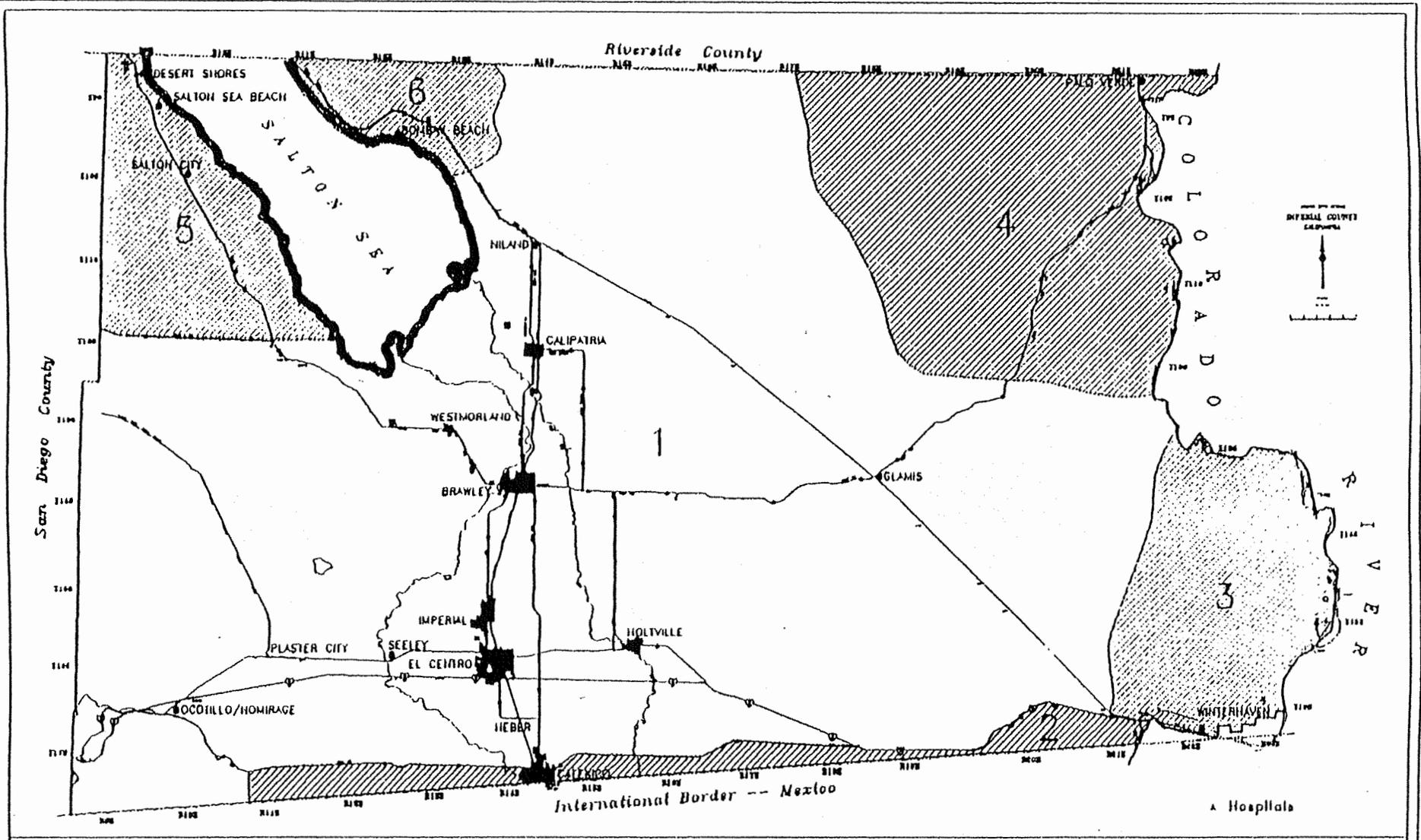
RECOMMENDED GUIDELINES

Emergency medical service areas (response zones) shall be designated so that, for ninety percent of emergent responses:

- a. The response time for a basic life support and CPR capable first responder does not exceed:
 - Metro/urban--5 minutes
 - Suburban/rural--1-15 minutes
 - Wilderness--25 minutes
- b. The response time for an early defibrillation capable responder does not exceed:
 - Metro/urban--5 minutes
 - Suburban/rural--as quickly as possible
 - Wilderness--as quickly as possible
- c. The response time for an advanced life support capable responder (not functioning as the first responder above) does not exceed:
 - Metro/urban--8 minutes
 - Suburban/rural--20 minutes
 - Wilderness--45 minutes
- d. The response time for an EMS transportation unit (not functioning as the first responder, above) does not exceed:
 - Metro/urban--8 minutes
 - Suburban/rural--20 minutes
 - Wilderness--45 minutes

CURRENT STATUS

Current Zone 1 ALS transport response time criteria are Urban, \leq 10 min., Rural, \leq 30 min., Wilderness \leq 60 min. Response time criteria have not been established for other ALS or BLS providers. First-responder response time criteria are not established. Zone 1 ALS response times are monitored by the EMS Agency, but are measured from time of unit dispatch only. Many of these agencies are volunteer, in wilderness areas, and it will be difficult to establish meaningful response time standards.



IMPERIAL COUNTY (AMBULANCE DISTRICTS) - 1994

Imperial County Planning/Building Department
 County of Imperial, California (1994)

COORDINATION WITH OTHER EMS AGENCIES:

NEED(S): Response time standards for all medical responses, including first-responders, especially ALS, LALS, and EMT-D agencies.

OBJECTIVE 4.05.1 Establish response time standards for medical responses that meet EMS Authority standards for affected geographic areas.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

4.06

UNIVERSAL STANDARD

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.

CURRENT STATUS

All vehicles are staffed and equipped for the level of service provided. The EMS Agency will ensure that vehicles continue to meet this requirement through annual inspections and the Agency's CQI program.

NEED(S): None.

4.07

UNIVERSAL STANDARD

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

CURRENT STATUS

Qualified first-responder agencies are integrated into the system. We have only limited co-response in some areas of the county, however. The local community college provides CPR, first aid, and first responder training to all fire departments (as requested) and to other public safety and industrial agencies within the community.

NEED(S): More frequent co-response by first responders in all parts of the county.

OBJECTIVE 4.07.1: First responders will respond on all EMS calls when required, according to pre-determined medical dispatch protocols.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 4.07.2: The Fire Chiefs Association, in cooperation with the EMS agency, will institute specific training for first responders to include CPR, first aid, and first responder training.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

MINIMUM STANDARD

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.

CURRENT STATUS

There is no process for categorizing EMS aircraft. Aircraft are authorized and dispatched according to informal criteria, based on categorization from originating county. Most EMS aircraft are based in other counties and respond here on mutual aid basis (CHP from Riverside, Lifeflight from San Diego, Sun Care from Arizona, and Rescue 1 from the Marine Base in Yuma). Several providers offer interfacility transfer capabilities as well as prehospital response. Fixed wing is used extensively since most out-of-county transfers are more than 120 statute miles.

NEED(S): Formal aircraft policy, including categorization, orientation of crew and incident review policy.

OBJECTIVE 4.08.1: The EMS Agency will develop a formal aircraft policy.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 4.08.2: The EMS Agency will develop an orientation program to the local EMS system.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

4.09

UNIVERSAL STANDARD

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

CURRENT STATUS

The Sheriff's dispatch serves to dispatch and coordinate EMS aircraft for scene responses. Interfacility air transfers are common and arranged by individual hospitals.

NEED(S): None.

4.10

MINIMUM STANDARD

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.

CURRENT STATUS

Medical and rescue aircraft are identified. Rotorcraft are available from the CHP, Lifeflight, and the Marines for scene responses, and from fixed-wing (Critical Air San Diego, Schaefer's Air San Diego, Air-Evac, Sun Care Arizona, and Lifeflight for interfacility transfers. Mercy Air, Riverside, has also expressed an interest in serving our area with both EMS rotorcraft and fixed-wing aircraft. There are no written agreements.

COORDINATION WITH OTHER EMS AGENCIES: Utilization of EMS rotorcraft and fixed-wing aircraft has been discussed with the EMCC and coordinated with dispatch agencies and EMS providers.

NEED(S): Written agreements.

OBJECTIVE 4.10.1: The EMS Agency shall obtain written agreements with aeromedical providers.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

4.11

MINIMUM STANDARD

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 in areas where applicable. This plan should consider existing EMS resources, population density, environmental factors, dispatch procedures and catchment area.

CURRENT STATUS

The local agency has identified all-terrain vehicles, and these are used for desert rescues by provider and rescue agencies.

NEED(S): None.

4.12

UNIVERSAL STANDARD

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

CURRENT STATUS

This is part of the Medical Annex to the Office of Emergency Services disaster plan.

NEED(S): None.

4.13

MINIMUM STANDARD

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

The county has an agreement with San Diego County regarding mutual aid responses and intercounty response of emergency medical transport vehicles for EMS personnel.

COORDINATION WITH OTHER EMS AGENCIES: We are currently negotiating similar agreements with Yuma, Arizona and Riverside County.

NEED(S): Agreements with Yuma and Riverside.

OBJECTIVE 4.13.1: To have agreements in place by December 1996.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

4.14

UNIVERSAL STANDARD

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

CURRENT STATUS

Multi-casualty plans exist through the Medical Annex of the county Office of Emergency Services disaster plan. This incorporates the Incident Command System and SEMS, and instruction was recently provided to many providers. A county-wide disaster drill was conducted in accordance with these standards. On-scene medical management will be according to county EMS Treatment Guidelines.

NEED(S): None.

4.15

STANDARD

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

CURRENT STATUS

The multi-casualty response plans were developed utilizing the State's Standardized Emergency Management System guidelines and in accordance with the Incident Command System procedures.

NEED(S): None.

A. Enhanced Level: Advanced Life Support

4.16

MINIMUM STANDARD

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 members.

On any 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

Some ALS ambulances have split EMT-P/EMT-I teams while others have either two paramedics or a split EMT-P/EMT-II team. In cases where an EMT-I is working with a paramedic, the EMT-I is not trained in defibrillation.

NEED(S): Train EMT-I's on ALS/LALS ambulances in defibrillation.

OBJECTIVE 4.16.1: EMT-I's on ALS/LALS ambulances will be trained to provide defibrillation.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

4.17

UNIVERSAL STANDARD

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

CURRENT STATUS

All ALS ambulances are appropriately equipped for level of staffing.

NEED(S): None.

B. Enhanced Level: Ambulance Regulation

4.18

UNIVERSAL STANDARD

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.

CURRENT STATUS

Written provider agreements are in place with all EMS transportation agencies but require revision and updating to comply with local policies and procedures regarding system operations and clinical care.

NEED(S): Revised and updated provider agreements.

OBJECTIVE 4.18.1: Provider agreements shall be revised and updated by December 1995.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

C. Enhanced Level: Exclusive Operating Permits

4.19

UNIVERSAL STANDARD

Any local EMS agency which desires to implement exclusive operating areas 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 process to ensure system optimization.

CURRENT STATUS

Imperial County granted an exclusive contract for Response Zone I in 1986 to its largest ambulance provider who has been operating in the same scope and manner since before 1980. The contract includes minimum standards, transportation system efficiency and effectiveness. This contract was extended for another four years effective January 1, 1996.

NEED(S): None.

4.20

UNIVERSAL STANDARD

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 "grandfathering" under Section 1797.224, H&SC.

CURRENT STATUS

The Board of Supervisors granted an exclusive contract for Response Zone I medical transportation to Gold Cross Ambulance in 1986. There has been no significant change in the manner and scope of Gold Cross' operation since before 1980.

NEED(S): None.

4.21

UNIVERSAL STANDARD:

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.

CURRENT STATUS

The exclusive contract with the Zone I provider has provisions for compliance with policies and procedures regarding system operations and patient care.

NEED(S): None.

4.22

UNIVERSAL STANDARD

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

CURRENT STATUS

The Board of Supervisors established in 1995 a Task Force to examine the EMS system, including the design of exclusive operating areas.

NEED(S): Examination of exclusive operating areas.

OBJECTIVE 4.22.1: Formal review of exclusive operating areas by January, 1996.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

5.

Facilities/Critical Care

THE LOCAL EMS SYSTEM SHOULD HAVE PROVISION FOR AN APPROPRIATE NUMBER AND LEVEL OF HEALTH FACILITIES TO RECEIVE AND TREAT EMERGENCY PATIENTS. IT SHALL HAVE A SYSTEM OF IDENTIFYING, UNDER MEDICAL DIRECTION, THE MOST APPROPRIATE FACILITY TO MANAGE A PATIENT'S CLINICAL PROBLEM AND ARRANGING FOR TRIAGE AND/OR TRANSFER OF THE PATIENT TO THIS FACILITY.

Minimum Standards

Recommended Guidelines

Universal Level

5.01

MINIMUM STANDARD

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, using state standards (when they exist) should assess, and periodically reassess, and disseminate to EMS providers, information about the EMS-related capabilities of acute care facilities in its services area.

CURRENT STATUS

The agency assesses acute care facilities if there is a significant question about their capability in regard to EMS patients. This information is disseminated to EMS providers.

NEED(S): On-going assessment of all acute care facilities.

OBJECTIVE 5.01.1: The EMS Agency shall assess EMS-related capabilities of acute care facilities in its jurisdiction, and provide those results in an appropriate format to EMS providers.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

5.02

UNIVERSAL STANDARD

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

CURRENT STATUS

Prehospital triage protocols were established for one area, amended for potential transports to one acute care facility based on our assessment of its capabilities. There are only two other acute care facilities, which differ little in their capabilities, and the nearest tertiary care is over 120 miles away.

COORDINATION WITH OTHER EMS AGENCIES: Prehospital triage protocols were developed in coordination with the EMCC.

NEED(S): On-going review of acute care facilities. Assistance for facilities with transfer protocols.

OBJECTIVE 5.02.1: The EMS Agency will review transfer policies and agreements and determine if facilities need agency assistance.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

5.03

UNIVERSAL STANDARD

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.

CURRENT STATUS

Acute care facilities identify patients who should be considered for transfer. This is left to the institutions' evaluation and the availability of specialty physicians (e.g. neurosurgery) in the county at any given time. These institutions utilize their own adopted guidelines for patient transfers.

COORDINATION WITH OTHER EMS AGENCIES: Guidelines for transferring patients to tertiary care centers were discussed at the EMCC.

NEED(S): Review of guidelines for transfer.

OBJECTIVE 5.03.1: The EMS Agency, in cooperation with acute care facilities, will review and develop (as needed) guidelines to identify patients for transfer to higher level care than available in the valley.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

5.04

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

The local EMS agency, using state standards (when they exist), should designate and monitor receiving and, when appropriate, special care facilities for specified groups of emergency patients.

CURRENT STATUS

Receiving facilities are not designated separately from their basic emergency services permit. The limited number of hospitals in the valley may make designation impractical, especially for specialty patients.

COORDINATION WITH OTHER EMS AGENCIES: Designation of receiving facilities was discussed at the EMCC.

NEED(S): Designation of receiving facilities.

OBJECTIVE 5.04.1: The EMS Agency will prepare a document examining the need for designation of emergency facilities.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

5.05

MINIMUM STANDARD

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

The EMS Agency has encouraged hospitals to prepare for mass casualty management. Each of the three acute care hospitals participated in the 1995 mass casualty drill. More training will be offered to prepare system participants.

NEED(S): Hospital preparation for mass casualties.

OBJECTIVE 5.05.1: Hospitals will offer more training to their staff at all three facilities to help prepare them for mass casualty incidents.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

5.06

UNIVERSAL STANDARD

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

CURRENT STATUS

There is currently a plan for hospital evacuation developed in coordination with the local OES.

COORDINATION WITH OTHER EMS AGENCIES: Plans for hospital evacuation were discussed at the EMCC and with the Imperial Valley Fire Chiefs Association Mutual Aid Subcommittee.

NEED(S): None

A. Enhanced Level: Advanced Life Support

5.07

UNIVERSAL STANDARD

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.

CURRENT STATUS

A single base hospital has been designated.

NEED(S): None at this time.

B. Enhanced Level: Trauma Care System

5.08

UNIVERSAL STANDARD

Local EMS agencies that develop trauma care systems shall determine the optimal system, including: a) The number and level of trauma centers, 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 triage or transferred to a designated center, including consideration of patients who should be triage to other critical care centers, d) The role of non-trauma center hospitals, including those that are outside of the primary triage area of the trauma center e) A plan for monitoring and evaluation of the system.

CURRENT STATUS

Presently there is no trauma system in Imperial County. The local EMS Agency is considering implementing a trauma study to evaluate the existing system response to trauma patients and educate the EMS community about the benefits of organized trauma care. During this analysis, if we find opportunities for system improvements, they should be implemented to the degree system participants are willing and able to do so. The EMS Agency has applied for federal block grant funding to implement a trauma study in Imperial County.

NEED(S): To evaluate the existing system response to trauma patients and educate the EMS community about the benefits of organized trauma care.

OBJECTIVE 5.08.1: To implement a trauma study in Imperial County.

TIME FRAME FOR IMPLEMENTATION:

- Annual implementation.
- Long-range plan.

5.09

UNIVERSAL STANDARD

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

CURRENT STATUS

There is presently no trauma system in Imperial County. Upon implementing a trauma study, the EMS Agency should educate and gather input from the EMS community about the benefits of organized trauma care.

NEED(S): See Standard 1.07.

OBJECTIVE 5.09.1 To gather input from EMS community about the benefits of organized trauma care.

TIME FRAME FOR IMPLEMENTATION:

- Annual implementation.
- Long-range plan.

C. Enhanced Level: Pediatric Emergency Medical and Critical Care System

5.10

UNIVERSAL STANDARD

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 triage or secondarily transferred to a designated center, including consideration of patients who should be triage to other critical 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 critical care hospitals including those which are outside of the primary triage area, g) A plan for monitoring and evaluation of the system.

CURRENT STATUS

There is no pediatric system at this time. However, the local EMS Agency may consider doing a study similar to the trauma study to evaluate system response to pediatric care.

NEED(S): See Standard 1.10.2.

5.11**UNIVERSAL STANDARD**

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, 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

See Standard 1.10.2.

NEED(S): None.

5.12**UNIVERSAL STANDARD**

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.

CURRENT STATUS

See Standard 1.10.2.

NEED(S): None at this time.

D.

Enhanced Level: Other Critical Care System

5.13

UNIVERSAL STANDARD

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 triage or transferred to a designated center, d) the role of non-designated hospitals, including those which are outside of the primary triage area, e) a plan for monitoring and evaluation of the system.

CURRENT STATUS

There is no current additional specialty care system. No specialty care plans are under development at this time. These criteria will be addressed when specialty care plans are developed.

NEED(S): None.

5.14

UNIVERSAL STANDARD

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

CURRENT STATUS

There is no critical care system nor the capabilities of providing such services at this time.

NEED(S): None.

Data Collection/System Evaluation

THE LOCAL EMS SYSTEM SHOULD HAVE MECHANISMS TO COLLECT DATA REGARDING OPERATIONAL AND CLINICAL ASPECTS OF THE SYSTEM, COVERING ALL STAGES OF THE SYSTEM. BOTH DAY-TODAY QUALITY ASSURANCE AUDITS AND OVERALL EVALUATIONS OF SYSTEM OPERATIONS ARE NECESSARY.

Minimum Standards Recommended Guidelines

Universal Level

6.01

MINIMUM STANDARD

The local EMS agency shall establish an EMS quality assurance program to evaluate the response to emergency medical incidents and the care provided to specific patients. The program 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 when they exist. The program shall use provider based QA programs and shall coordinate them with other providers.

RECOMMENDED GUIDELINES

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

CURRENT STATUS

Quality assurance is focused on problems identified during routine audit, and by complaints or other information provided to the EMS Agency. The base hospital prehospital care coordinator now performs 100% audit of all calls to the base hospital from ALS and LALS units. We believe most problems and trends are discovered by this system. There is feedback available from the receiving hospitals, but no patient audits. The Agency has limited resources to evaluate care of specific patients.

NEED(S): There is a need for on-going audits involving all providers aimed at a variety of clinical conditions and patient care, adherence with standards, and potential provider and system improvements. Routine patient follow-up is needed. Providers need instruction in QI, and encouragement to begin programs.

OBJECTIVE 6.01.1: The EMS Agency will develop a Quality Improvement Plan for the agency and system participants.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 6.01.2: The EMS Agency will develop a QI process for evaluating patient morbidity and mortality.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 6.01.3: The EMS Agency will develop a QI plan for providers.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

6.02

UNIVERSAL STANDARD

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

CURRENT STATUS

Records of all ALS/LALS responses are forwarded to the base hospital first and then to the EMS Agency. BLS records are forwarded to the EMS Agency.

NEED(S): None

6.03

MINIMUM STANDARD

Audits of prehospital care, including both clinical and service delivery 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

Pre-determined audits are currently performed on a very limited bases by the Base Hospital. A system-wide QI program should be in place soon with all EMS providers performing audits of prehospital care. There is currently no system to link prehospital records to other sources, although it should be in place soon also (see Standard 6.05.).

NEED(S): System-wide audits of prehospital care.

OBJECTIVE 6.03.1: An audit of a selected prehospital problem should be performed during 1995-96.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 6.03.2: Routine audits of prehospital care should be performed.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

6.04

UNIVERSAL STANDARD

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 pre-arrival/post dispatch directions.

CURRENT STATUS

Dispatchers are not currently trained in Emergency Medical Dispatching. There is no mechanism to monitor medical dispatching. The local EMS Agency has applied for federal block grant funding to implement an EMD program to include a QI program to monitor medical dispatching.

NEED(S): EMD training and a mechanism for monitoring medical dispatching.

OBJECTIVE 6.04.1: Provide EMD training for dispatchers and perform routine, periodic audits of medical dispatch.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

6.05

MINIMUM STANDARD

The local EMS agency shall establish a data management system which supports its systemwide planning and evaluation (including identification of high risk patient groups) and the QA audit of the care provided to specific patients. it shall be based on state standards (when they are available).

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 EMS Agency started data entry into the EMS Database System from Alpine, Mother Lode EMS in 1994. Data entry started in the EMS office, although has been quite time consuming, and may not be feasible for continuing long-term. In 1995 computer terminals were placed at the largest ALS provider, and the two major receiving hospitals. Upon completion, direct data entry of prehospital data will be performed by the prehospital provider via modem, and also by Agency personnel. Hospital information, linked to the prehospital data in the EMS database, will be entered via modem by both ALS/LALS receiving hospitals.

COORDINATION WITH OTHER EMS AGENCIES: Data collection has been coordinated with both receiving facilities and the major ALS ambulance provider in the valley.

OBJECTIVE 6.05.1: Complete installation of computer terminals at provider and hospitals and begin data entry.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 6.05.2: The EMS Agency should identify specific patient groups and other categories for specific audits.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 6.05.3: The EMS Agency should assist the base hospital and other providers to perform audits on the database.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 6.05.4: The EMS Agency should establish separate patient registries in the EMS database for evaluation and use.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

6.06

UNIVERSAL STANDARD

The local EMS agency shall establish an evaluation program to evaluate EMS system design and operations. This shall include structure, process, and outcome evaluations, utilizing state standards and guidelines

CURRENT STATUS

There is no on-going evaluation of EMS system design and operations; however, the newly established EMS Task Force will evaluate EMS system design and operations and set the precedent for future evaluations.

NEED(S): On-going evaluation of EMS system design and operations.

OBJECTIVE 6.06.1: On-going evaluations of EMS System.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

6.07

UNIVERSAL STANDARD

The local EMS agency shall have the resources and authority to require provider participation in the systemwide evaluation program.

CURRENT STATUS

The EMS agency welcomes, and requires, provider participation. We believe system participants will want to take part in an evaluation program.

NEED(S): QI Plan, see 6.01, 6.03.

6.08

UNIVERSAL STANDARD

The local EMS agency shall periodically report on EMS system operations to the Board(s) of Supervisors, provider agencies, and Emergency Medical Care Committee(s).

CURRENT STATUS

There is no formal presentation of EMS System operations, other than quarterly reports to the EMCC, which has representatives of providers on it.

NEED(S): Periodic reports on EMS System operations.

OBJECTIVE 6.08.1: The EMS Agency shall prepare and distribute a periodic report on EMS System operations.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

A. Enhanced Level: Advanced Life Support

6.09

MINIMUM STANDARD

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

The integrated data management system will include all these participants. The base hospital is not independently evaluated.

NEED(S): Evaluation of base and prehospital activities.

OBJECTIVE 6.09.1: The EMS Agency shall audit Base Hospital operations.

B. Enhanced Level: Trauma Care System

6.10

UNIVERSAL STANDARD

The local EMS agency shall develop a trauma system evaluation and data collection program, including: a) A trauma registry, b) A mechanism to identify patients whose care fell outside of established criteria, and c) A process of identifying potential improvements to the system design and operation.

CURRENT STATUS

There is no trauma system.

NEED(S): None.

6.11

MINIMUM STANDARD

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 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 quality assurance and system evaluation program.

CURRENT STATUS

There is no trauma system and no designated trauma centers in Imperial County. The EMS Agency is considering doing a trauma study to evaluate system response to trauma patients.

NEED(S): See Standard 1.07.

Public Information and Education

THE LOCAL EMS SYSTEM SHOULD PROVIDE PROGRAMS TO ESTABLISH AN AWARENESS OF THE EMS SYSTEM, HOW TO ACCESS THE SYSTEM AND HOW TO USE THE SYSTEM. PROGRAMS TO TRAIN MEMBERS OF THE PUBLIC IN FIRST AID AND CPR SHOULD BE AVAILABLE.

Minimum- Standards

Recommended Guidelines

Universal Level

7.01

UNIVERSAL STANDARD

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.

CURRENT STATUS

Most agencies (hospitals, transport providers, first responders, and the local community college) offer some programs designed to educate the public in EMS. The EMS Agency has been able to perform only limited public information. A minimal amount of education has been done during EMS week, including public CPR instruction and news articles.

NEED(S): A public information and education program.

OBJECTIVE 7.01.1: The EMS Agency will survey public and private system participants regarding public education activities.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 7.01.2: The EMS Agency shall coordinate or assist in the development of a public information and education program.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

7.02

MINIMUM STANDARD

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 education programs for targeted groups at high risk of injury or illness.

CURRENT STATUS

Minimal injury control and preventive medicine information is disseminated from the EMS Agency at this time.

NEED(S): Injury control and preventive medicine information aimed at high-risk groups.

OBJECTIVE 7.02.1: The EMS Agency shall develop an injury control and preventive medicine program for the EMS system, aimed at high-risk groups.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

7.03

MINIMUM STANDARD

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

These functions are performed by OES and other groups such as the Red Cross.

NEED(S): Public information about medical disaster preparedness.

OBJECTIVE 7.03.1: The EMS Agency shall cooperate with other EMS participants to develop citizen medical disaster preparedness information.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

7.04

MINIMUM STANDARD

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 EMS Agency has promoted first aid and CPR training on a limited basis.

NEED(S): EMS Agency participation in promoting first aid and CPR training.

OBJECTIVE 7.04.1: The EMS Agency will participate in promoting first aid and CPR training.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

Disaster Medical Response

THE LOCAL EMS SYSTEM MUST BE CAPABLE OF EXPANDING ITS STANDARD OPERATIONS TO MEET THE NEEDS CREATED BY MULTI-CASUALTY INCIDENT AND MEDICAL DISASTERS, INCLUDING INTEGRATION OF OUT-OF AREA RESOURCES.

Minimum Standards

Recommended Guidelines

Universal Level

8.01

UNIVERSAL STANDARD

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.

CURRENT STATUS

The EMS Agency participates in the development of medical response plans and training for disasters and hazardous material incidents.

COORDINATION WITH OTHER EMS AGENCIES: Plans were developed in cooperation with the Imperial Valley Fire Chiefs Association Mutual Aid and EMS Subcommittees and OES.

NEED(S): None.

8.02

MINIMUM STANDARD

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 medical response plans are applicable to a variety of hazards, based on OES multi-hazard functional plans.

NEED(S): None.

8.03

UNIVERSAL STANDARD

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

CURRENT STATUS

The training of EMS providers for hazardous incidents is on-going. Fire first-responders and ALS/LALS personnel receive training through their departments. Civilians are receiving State Fire Marshal approved training through the City of El Centro and Imperial County Fire Departments. The community college incorporates Haz Mat training into their EMT and First Responder training. This training is important since there is heavy use of chemicals in agriculture, and chemical transportation to and from Mexico is increasing in volume.

NEED(S): Assure hazardous materials training.

OBJECTIVE 8.03.1: The EMS Agency shall assure the training of all civilian EMS personnel in hazardous materials response.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

8.04

MINIMUM STANDARD

Medical response plans and procedures for catastrophic disasters shall use the Incident Command System 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

ICS is used and all personnel are currently being trained (as of 1995) in its use, pursuant to the SEMS program. This training will be conducted annually by prehospital providers, and EMS Agency personnel.

NEED(S): None.

8.05

MINIMUM STANDARD

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 when they are available, 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

The disaster plan calls for delivering patients to the most appropriate hospitals, although the number of hospitals in the valley is limited. Hospitals have received additional training in chemical incidents.

COORDINATION WITH OTHER EMS AGENCIES: Distribution of casualties during a disaster has been coordinated with the EMCC, I.V. Fire Chiefs Association, and OES.

NEED(S): Improve capability of hospitals in this relatively isolated area to deal with radiation and especially chemical incidents. Identify hospitals with special facilities for possible transfer of patients.

OBJECTIVE 8.05.1: The EMS Agency shall identify capabilities of hospitals to treat radiation and chemical cases, improve those capabilities, and direct patients to those facilities when needed.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 8.05.2: The EMS Agency shall identify out-of-county hospitals with specific expertise in chemical and radiation injury care for possible transfer.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

8.06

MINIMUM STANDARD

The local EMS agency, using state guidelines, shall establish written procedures for early assessment of needs and shall establish an emergency means for communication 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

These procedures exist, are written, and are exercised yearly.

NEED(S): None.

8.07

UNIVERSAL STANDARD

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

CURRENT STATUS

We are currently examining the use of CALCORD by non-fire personnel.

COORDINATION WITH OTHER EMS AGENCIES: Selection of a specific EMS frequency to be utilized during disaster situations will be coordinated with the Fire Chiefs Association, OES, and the EMCC.

NEED(S): Specific disaster frequency.

OBJECTIVE 8.07.1: The EMS Agency will designate a specific inter-agency frequency for medical purposes during a disaster.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

8.08

MINIMUM STANDARD

The local EMS agency, in cooperation with the local OES shall develop an inventory of disaster medical resources.

RECOMMENDED GUIDELINES

The local EMS agency, using state guidelines when they are available, should ensure that emergency medical providers and health care facilities have written agreements with disaster medical resource providers for the provision of appropriate resources to respond to multi-casualty incidents and disasters likely to occur in its service area.

CURRENT STATUS

An inventory of disaster medical resources does not exist.

NEED(S): Disaster medical inventory and supplies.

OBJECTIVE 8.08.1: The EMS Agency will develop a disaster medical inventory.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 8.08.2: The EMS Agency will develop, in cooperation with other system participants, sources of emergency medical supplies, and assist in the development of agreements for provision during a disaster.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

8.09

MINIMUM STANDARD

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

Development of a DMAT (Disaster Medical Assistance Team) team was attempted, but financial problems impeded it.

NEED(S): Liaison with near-by DMATs, and possible team in the future.

OBJECTIVE 8.09.1: The EMS Agency will contact near-by counties about DMAT teams.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

8.10

UNIVERSAL STANDARD

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.

CURRENT STATUS

Imperial sends representatives to Region VI planning meetings, and has access to Region VI for mutual aid.

COORDINATION WITH OTHER EMS AGENCIES: In addition to participation with Region VI, coordination is through the local Fire Chiefs Association Mutual Aid Committee, OES, and the local EMCC and the Yuma, Arizona EMCC.

NEED(S): None.

8.11

UNIVERSAL STANDARD

The local EMS agency, in coordination with the local OES and county health officer(s), and using state guidelines when they are available, shall designate casualty collection points (CCPs).

CURRENT STATUS

The major cities and fire departments in Imperial County have designated CCPs in their respective areas.

COORDINATION WITH OTHER EMS AGENCIES: The EMS Agency along with the local OES and the health officer are working to establish the validity of CCPs in this area.

NEED(S): Designated CCPs where applicable and appropriate.

OBJECTIVE 8.11.1: The EMS Agency, in coordination with local OES, and using state guidelines, shall re-designate (if appropriate) CCPs in this area.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

8.12

UNIVERSAL STANDARD

The local EMS agency shall develop plans for establishing CCPs and a means for communicating with them.

CURRENT STATUS

The local EMS agency has been working with OES to develop plans for establishing CCPs in this area.

NEED(S): Plans for establishing CCPs and a means for communicating with them.

OBJECTIVE 8.12.1: The local EMS agency shall coordinate with local OES to establish plans for CCPs and a means of communicating with them.

TIME FRAME FOR IMPLEMENTATION

- Annual Implementation Plan
- Long Range Plan

8.13

MINIMUM STANDARD

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 and/or contaminated by toxic or radioactive substances.

CURRENT STATUS

EMS responders are appropriately trained in disaster response, hazardous material incidents, and in decontamination procedures.

NEED(S): None.

8.14

UNIVERSAL STANDARD

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).

CURRENT STATUS

Hospitals' plans for disasters are not fully integrated with the county's medical response plans as defined under the OES disaster plan.

NEED(S): Integrate those aspects of the hospitals' plans with the county medical response plans.

OBJECTIVE 8.14.1: The local EMS agency will ensure that the hospitals' plans for disasters are fully integrated with EMS medical response plans.

TIME FRAME FOR IMPLEMENTATION

- Annual Implementation Plan
- Long-range Plan

8.15

UNIVERSAL STANDARD

The local EMS agency shall ensure that there is an emergency system for inter-hospital communications, including operational procedures.

CURRENT STATUS

Inter-hospital communications currently exist between all three area hospitals on the VHF frequency, and both of the acute care receiving facilities (El Centro Regional Medical Center and Pioneers Memorial Hospital) can also communicate on the UHF frequency.

NEED(S): None.

8.16**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

Annual disaster drills are conducted and include all area hospitals, the local EMS agency, and prehospital medical care agencies.

NEED(S): None.

8.17**MINIMUM STANDARD**

The local EMS agency shall ensure that all prehospital medical response agencies and acute-care hospitals in its services area, in cooperation with other local disaster medical response agencies, have developed guidelines management 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

In addition to the disaster/MCI training offered through the local fire services, community college, and CE providers, the local EMS agency also provides annual training to all EMS provider agencies and acute-care hospital staff in its service area.

NEED(S): None.

A. Enhanced Level: Advanced Life Support

8.18 UNIVERSAL STANDARD

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.

CURRENT STATUS

Mutual aid agreements are already in place with San Diego County and presently are being negotiated with both Riverside County and Yuma, Arizona.

NEED(S): None.

B. Enhanced Level: Critical Care Systems

8.19 UNIVERSAL STANDARD

Local EMS agencies developing trauma or other critical 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.

CURRENT STATUS

There are no trauma or critical care systems in Imperial Valley at this time.

NEED(S): None.

C. Enhanced Level: Exclusive operating Areas/Ambulance Regulation

8.20 UNIVERSAL STANDARD

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.

CURRENT STATUS

The exclusive operating permit issued our Zone I provider does allow for mutual aid response during a significant medical incident.

NEED(S): None.

GLOSSARY

advanced life support (ALS)--medically accepted, life sustaining, invasive procedures, provided at the direction of physician or authorized registered nurse.

ambulance service--a qualified provider of medical transportation for patients requiring treatment and/or monitoring due to illness or injury.

ambulance service area (zone)--a designated geographic area contiguous to other such areas and delineated by the local EMS agency for the purpose of ensuring availability or emergency medical transport services at all times by one or more specified providers.

base hospital--one of a limited number of hospitals which, upon entering into written contractual agreement with the local EMS agency, is responsible for directing the advanced life support system or limited advanced life support system assigned to it.

basic life support (BLS)--medically accepted non-invasive procedures used to sustain life.

cardiopulmonary resuscitation (CPR)--opening and maintaining an airway, providing artificial ventilation and artificial circulation by means of external cardiac compression.

casualty collection point (CCP)--a site for the congregation, triage (sorting), preliminary treatment, and evacuation of casualties following a disaster.

catchment area--the geographic area served by a specified health care facility or EMS agency.

centralized EMS dispatch center--a system which is responsible for establishing communications channels and identifying the necessary equipment and facilities to permit immediate management and control of an EMS patient. This operation must provide access and availability to public safety resources essential to the effective and efficient EMS management of the immediate EMS problem.

communication system--those resources and arrangements for notifying the EMS system of an emergency, for mobilizing and dispatching resources, for exchanging information, for remote monitoring of vital indicators, and for the radio transmission of treatment procedures and directions.

definitive care--a level of therapeutic intervention capable of providing comprehensive health care services for a specific condition.

designated facility--a hospital which has been designated by a local EMS agency to perform specified emergency medical services systems functions pursuant to guidelines established by the authority.

dispatch triage--the process of sorting requests for emergency medical assistance based on information provided by the reporting party so the appropriate resources can be sent.

emergency--a situation in which there is a real or perceived need for immediate action, attention or decision making to prevent mortality or to reduce serious morbidity (adjective form--emergent).

emergency air ambulance--an aircraft with emergency medical transport capabilities.

emergency ground ambulance--a surface transportation vehicle that is specially designed, constructed, maintained, supplied, equipped, and intended for exclusive use in emergency transport of the sick and injured.

emergency ambulance service--an emergency medical transport provider operating within an organized EMS system for the purpose of assuring twenty-four (24) hour availability of such services. This pertains to all ground, air or water emergency medical transport.

emergency department--the area of a licensed general acute care facility that customarily receives patients in need of emergent medical evaluation and/or care.

emergency medical services (EMS)-- the provision of services to patients requiring immediate assistance due to illness or injury, including access, response, rescue, prehospital and hospital treatment, and transportation.

EMS plan--a plan for the delivery of emergency medical services.

EMS system--a coordinated arrangement of resources (including personnel, equipment, and facilities) which are organized to respond to medical emergencies, regardless of the cause.

first responder--the first person (unit) dispatched to the scene of a medical emergency to provide patient care.

health facility--any facility, place or building which is organized, maintained and operated for the diagnosis, care and treatment of human illness or injury, physical or mental, including convalescence, rehabilitation and/or pre- and post-natal care, for one or more persons, to which patients are admitted for twenty-four (24) hours or longer.

hospital--an acute care hospital licensed under Chapter 2 (commencing with Section 1250) of Division 2, Health and Safety Code.

intervener physician--a physician on the scene of a medical emergency who offers to assist advanced life support personnel.

medical control--physician responsibility for the development, implementation, and evaluation of the clinical aspects of an EMS system.

medical disaster--a natural or human-caused event which overwhelms the medical resources within a system. It is characterized by a wide geographic scope and by damage to medical facilities and the transportation system. Because of its wide scope, it must be managed by a centralized, off-scene command system.

medical emergency--an unforeseen situation in which there is a real or perceived need for immediate medical care, based on an injury or other unforeseen acute physical or mental disorder.

medical protocol--pre-established physician authorized procedures or guidelines for medical care of a specified clinical situation, based on patient presentation.

metro--all census places with a population density of greater than 500 persons per square mile; or census tracts and enumeration districts without census tracts which have a population density of greater than 500 persons per square mile.

multi-casualty incident--a natural or human-caused event which may overwhelm the medical resources within a system. It is characterized by a limited geographic scope and can be managed by an on-scene command system.

mutual aid--the furnishing of resources, from one individual or agency to another individual or agency, including but not limited to facilities, personnel, equipment, and services, pursuant to an agreement with the individual or agency, for use within the jurisdiction of the individual or agency requesting assistance.

non-emergency--a situation in which there is a no perceived need for immediate action, attention or decision making to prevent mortality or to reduce serious morbidity (adjective form--non-emergent).

pediatric emergency medical and critical care system--a subsystem within the EMS system designed to manage the treatment of the emergent pediatric patient.

prehospital emergency medical services--a sub-system of the emergency medical services system which provides medical services to patients requiring immediate assistance due to illness or injury, prior to the patient's arrival at an emergency medical facility.

prehospital time--the interval of time between activation of the emergency medical transport response to an emergency incident and arrival of the emergency patient at a receiving facility.

primary transport--transport of an emergency patient from the scene of an emergency incident to a receiving facility.

provider--an organization, institution, or individual authorized to provide direct patient care.

public safety agency--a functional division of a public agency which provides fire fighting, police, medical or other emergency services.

public safety answering point (PSAP)--the location at which an emergency telephone call is answered and, either appropriate resources are dispatched or the request is relayed to the responding agency.

public safety telephone operators--the initial answerer of an emergency call.

quality assurance/quality improvement--a method of evaluation of services provided, which includes defined standards, evaluation methodology(ies), and utilization of evaluation results for continued system improvement.

receiving facility--a general acute care facility which has been assigned a role in the EMS system by the local EMS agency.

response time--the total interval from receipt of a request for medical assistance to the primary public safety answering point (PSAP) to arrival of the responding unit at the scene. This includes all dispatch intervals and driving time.

rural--All census places with a population density of 7 to 50 persons per square mile; or census tracts or enumeration districts without census tracts which have a population density of 7 to 50 persons per square mile.

secondary care--health care beyond the primary. Included are more sophisticated diagnostic methods and techniques, and laboratory facilities. This level of care is nearly available in medical care institutions serving a large population. (SOURCE: Tabors, 16th edition). Contrast with primary and tertiary care.

secondary transport--transport of an emergency patient from an initial receiving facility to a second treatment facility.

service area--the geographic area within which an EMS agency or health care facility provides service.

significant medical incident--a medical incident which is larger than normal. It includes both multicasualty incidents and medical disasters.

statewide EMS system--a network of local EMS systems, integrated and coordinated at the state level.

suburban--All census places with a population density of 51 to 100 persons per square mile; or census tracts or enumeration districts without census tracts which have a population density of 51 to 100 persons per square mile.

transfer agreement--a written agreement between health facilities providing reasonable assurance that transfer of patients will be effected between health facilities whenever such transfer is medically appropriate, as determined by the attending physician.

transport time--the interval of time required for emergency medical transport of an ill or injured person from the scene of an emergency incident to arrival at a receiving facility.

trauma care system--a subsystem within the EMS system designed to manage the treatment of the trauma patient.

triage--the process of sorting the sick and injured on the basis of type and urgency of condition present, so that they may be properly routed to the medical facility most appropriately situated and equipped for their care.

urban--all census places with a population density of 101 to 500 persons per square mile; or census tracts and enumeration districts without census tracts which have a population density of 101 to 500 persons or more per square mile.

urgent--a situation in which there is a real or perceived need for immediate action, attention, or decision making to reduce morbidity, but where no life threatening situation appears to exist.

wilderness--census tracts or enumeration districts without census tracts which have a population of less than seven persons per square mile.

SECTION THREE
SYSTEM RESOURCES AND OPERATIONS

TABLE 2: SYSTEM RESOURCES AND OPERATIONS
System Organization and Management

EMS System: Imperial County Reporting Year: FY 94-95

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: Imperial

- | | |
|---|------------|
| a. Basic Life Support (BLS) | <u>15%</u> |
| b. Limited Advanced Life Support (LALS) | <u>5%</u> |
| c. Advanced Life Support (ALS) | <u>80%</u> |

2. Type of agency

B

- 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

B

- 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) | <u>X</u> |
| Designation of trauma centers/trauma care system planning | |
| Designation/approval of pediatric facilities | |
| Designation of other critical care centers | |
| Development of transfer agreements | |
| Enforcement of local ambulance ordinance | <u>X</u> |
| Enforcement of ambulance service contracts | <u>X</u> |
| Operation of ambulance service | |

Table 2 - System Organization & Management (cont.)

Continuing education	<u>X</u>
Personnel training	<u>X</u>
Operation of oversight of EMS dispatch center	
Non-medical disaster planning	
Administration of critical incident stress debriefing (CISD) team	
Administration of disaster medical assistance team (DMAT)	
Administration of EMS Fund [Senate Bill (SB) 12/612]	
Other:	
Other:	
Other:	

5. EMS agency budget for FY 95

A. EXPENSES

Salaries and benefits (all but contract personnel)	<u>\$ 76,868</u>
Contract Services (e.g. medical director)	<u>37,000</u>
Operations (e.g. copying, postage, facilities)	<u>5,265</u>
Travel	<u>2,110</u>
Fixed assets	<u>2,000</u>
Indirect expenses (overhead)	<u>12,474</u>
Ambulance subsidy	<u>0</u>
EMS Fund payments to physicians/hospital	<u>0</u>
Dispatch center operations (non-staff)	<u>0</u>
Training program operations	<u>0</u>
Other: <u>Meetings</u>	<u>1,500</u>
Other: <u>Funding to increase service level</u>	<u>25,000</u>
Other:	<u>0</u>
TOTAL EXPENSES	\$ <u>162,217</u>

Table 2 - System Organization & Management (cont.)

B. SOURCES OF REVENUE

Special project grant(s) [from EMSA]

Preventive Health and Health Services (PHHS) Block Grant \$ 79,887

Office of Traffic Safety (OTS)

State general fund

County general fund 82,330

Other local tax funds (e.g., EMS district)

County contracts (e.g. multi-county agencies)

Certification fees

Training program approval fees

Training program tuition/Average daily attendance funds (ADA)

Job Training Partnership ACT (JTPA) funds/other payments

Base hospital application fees

Base hospital designation fees

Trauma center application fees

Trauma center designation fees

Pediatric facility approval fees

Pediatric facility designation fees

Table 2 - System Organization & Management (cont.)

Other critical care center application fees

Type:

Other critical care center designation fees

Type:

Ambulance service/vehicle fees

Contributions

EMS Fund (SB 12/612)

Other grants:

Other fees:

Other (specify):

TOTAL REVENUE

\$ 162,217

*TOTAL REVENUE SHOULD EQUAL TOTAL EXPENSES.
IF THEY DON'T, PLEASE EXPLAIN BELOW.*

Table 2 - System Organization & Management (cont.)

6. Fee structure for FY 95

We do not charge any fees

Our fee structure is:

First responder certification \$

EMS dispatcher certification

EMT-I certification

EMT-I recertification

EMT-defibrillation certification

EMT-defibrillation recertification

EMT-II certification

EMT-II recertification

EMT-P accreditation

Mobile Intensive Care Nurse/
Authorized Registered Nurse (MICN/ARN)
certification

MICN/ARN recertification

EMT-I training program approval

EMT-II training program approval

EMT-P training program approval

MICN/ARN training program approval

Base hospital application

Base hospital designation

Trauma center application

Trauma center designation

Pediatric facility approval

Pediatric facility designation

Table 2 - System Organization & Management (cont.)

Other critical care center application

Type:

Other critical care center designation

Type:

Ambulance service license

\$

Ambulance vehicle permits

Other: Optional skills training

Other: Continuing Education training

Other: Special training programs (EMD)

7. Complete the table on the following two pages for the EMS agency staff for the fiscal year of .

Table 2 - System Organization & Management (cont.)

EMS System: Imperial County

Reporting Year: FY 95

CATEGORY	ACTUAL TITLE	FTE POSITIONS (EMS ONLY)	TOP SALARY BY HOURLY EQUIVALENT	BENEFITS (% of Salary)	COMMENTS
EMS Admin./ Coord./Dir.	EMS Coordinator	1	19.56	30%	
Asst. Admin./ Admin. Asst./ Admin. Mgr.					
ALS Coord./ Field Coord./ Trng Coord.	EMS Training Coordinator	.5	19.23		
Program Coord./Field Liaison (Non-clinical)					
Trauma Coord.					
Med. Director	EMS Medical Director	.15	60.00		
Other MD/ Med. Consult./ Trng. Med. Dir.					
Disaster Med. Planner					

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.

114

Table 2 - System Organization & Management (cont.)

CATEGORY	ACTUAL TITLE	FTE POSITIONS (EMS ONLY)	TOP SALARY BY HOURLY EQUIVALENT	BENEFITS (% of Salary)	COMMENTS
Dispatch Supervisor					
Medical Planner					
Dispatch Supervisor					
Data Evaluator/ Analyst					
QA/QI Coordinator					
Public Info. & Ed. Coord.					
Ex. Secretary					
Other Clerical	Office Assistant III	1	11.85	30%	
Data Entry Clerk					
Other					

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: SYSTEM RESOURCES AND OPERATIONS -- Personnel/Training

EMS System: Imperial County

Reporting Year: FY 95

NOTE: Table 3 is to be reported by agency.

	EMT - Is	EMT - IIs	EMT - Ps	MICN	EMS Dispatchers
Total certified	203	12		7	0
Number of newly certified this year	47	1		0	0
Number of recertified this year	156	11		7	0
Number of certificate reviews resulting in:	0	0	0	0	0
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: 0
2. Early defibrillation:
 - a) Number of EMT-I (defib) certified 97
 - b) Number of public safety (defib) certified (non-EMT-I) 0
3. Do you have a first responder training program? yes
 no

TABLE 4: SYSTEM RESOURCES AND OPERATIONS -- Communications

EMS System: Imperial County

County: Imperial

Reporting Year: FY 95

Note: Table 4 is to be answered for each county.

1. Number of primary Public Service Answering Points (PSAP) 6
2. Number of secondary PSAPs 1
3. Number of dispatch centers directly dispatching ambulances 2
4. Number of designated dispatch centers for EMS Aircraft 1
5. Do you have an operational area disaster communication system? yes no
 - a. Radio primary frequency Transmit 154.745 Receive 155.100
 - b. Other methods Fire nets
 - c. Can all medical response units communicate on the same disaster communications system?
yes no
 - d. Do you participate in OASIS? yes no
 - e. Do you have a plan to utilize RACES as a back-up communication system?
yes no
 - 1) Within the operational area? yes no
 - 2) Between the operational area and the region and/or state? yes no
6. Who is your primary dispatch agency for day-to-day emergencies? Imperial County Sheriffs Office
7. Who is your primary dispatch agency for a disaster? Imperial County Fire OES

TABLE 5: SYSTEM RESOURCES AND OPERATIONS
Response/Transportation

EMS System: Imperial County

Reporting Year: FY 95

Note: Table 5 is to be reported by agency.

TRANSPORTING AGENCIES

1. Number of exclusive operating areas	<u>1</u>
2. Percentage of population covered by Exclusive Operating Areas (EOA)	<u>80%</u>
3. Total number responses	<u>8882</u>
a) Number of emergency responses (Code 2: expedient, Code 3: lights and siren)	<u>6618</u>
b) Number non-emergency responses (Code 1: normal)	<u>2264</u>
4. Total number of transports	<u>8349</u>
a) Number of emergency transports (Code 2: expedient, Code 3: lights and siren)	<u>5593</u>
b) Number non-emergency transports (Code 1: normal)	<u>2756</u>

Early Defibrillation Providers

5. Number of public safety defibrillation programs	<u>0</u>
a) Automated	<u>0</u>
b) Manual	<u>0</u>
6. Number of EMT-Defibrillation providers	<u>9</u>
a) Automated	<u>9</u>
b) Manual	<u>0</u>

Air Ambulance Services

7. Total number of responses	<u>N/A</u>
a) Number of emergency responses	<u>N/A</u>
b) Number of non-emergency responses	<u>N/A</u>
8. Total number of transports	
a) Number of emergency (scene) responses	
b) Number of non-emergency responses	

TABLE 5: SYSTEM RESOURCES AND OPERATIONS -- Response/Transportation (cont)

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	N/A	N/A	N/A
2. Early defibrillation capable responder.	N/A	N/A	N/A	N/A
3. Advanced life capable responder.	N/A	N/A	N/A	N/A
4. EMS transport unit.	10 min.	23 min.	32 min.	22 min.

119

TABLE 6: SYSTEM RESOURCES AND OPERATIONS
Facilities/Critical Care

EMS System: Imperial County

Reporting Year: FY 95

NOTE: Table 6 is to be reported by agency.

Trauma care system

1. Trauma patients:

- | | |
|--|------------|
| a) Number of patients meeting trauma triage criteria | <u>N/A</u> |
| b) Number of major trauma victims transported directly to a trauma center by ambulance | <u>N/A</u> |
| c) Number of major trauma patients transferred to a trauma center | <u>N/A</u> |
| d) Number of patients meeting triage criteria who weren't treated at a trauma center | <u>N/A</u> |

Emergency departments:

- | | |
|--|----------|
| 2. Total number of emergency departments | <u>2</u> |
| a) Number of referral emergency services | |
| b) Number of standby emergency services | |
| c) Number of basic emergency services | <u>2</u> |
| d) Number of comprehensive emergency services | |
| 3. Number of receiving hospitals with agreements | <u>2</u> |

TABLE 7: SYSTEM RESOURCES AND OPERATIONS -- Disaster Medical

EMS System: Imperial County

County: Imperial

Reporting Year: FY 95

NOTE: Table 7 is to be answered for each county.

SYSTEM RESOURCES

1. Casualty Collections Points (CCP)

- a. Where are your CCPs located? El Centro (1275 Main & 900 S. Dogwood)
- b. How are they staffed? firefighter/EMT personnel
- c. Do you have a supply system for supporting them for 72 hours? yes no

2. CISD

Do you have a CISD provider with 24 hour capability? yes no

3. Medical Response Team

- a. Do you have any team medical response capability? yes no
- b. For each team, are they incorporated into your local response plan? yes no
- c. Are they available for statewide response? yes no
- d. Are they part of a formal out-of-state response system? yes no

4. Hazardous Materials

- a. Do you have any HazMat trained medical response teams? yes no
- b. At what HazMat level are they trained? Specialist and Technician
- c. Do you have the ability to do decontamination in an emergency room? yes no
- d. Do you have the ability to do decontamination in the field? yes no

OPERATIONS

- 1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? yes no
- 2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? 2

SECTION FOUR
RESOURCE DIRECTORIES

TABLE 8: RESOURCES DIRECTORY -- Providers

NOTE: TABLE 8 ALREADY SUBMITTED TO EMS AUTHORITY (JILL SCHROEDER)

EMS System: Imperial County

County: Imperial

Reporting Year: FY 95

NOTE: Make copies to add pages as needed. Complete information for each provider by county.

Name, address & telephone:		Primary Contact:			
Written Contract: <input type="checkbox"/> yes <input type="checkbox"/> no	Service: <input type="checkbox"/> Ground <input type="checkbox"/> Air <input type="checkbox"/> Water	<input type="checkbox"/> Transport <input type="checkbox"/> Non-Transport	Air classification: <input type="checkbox"/> auxiliary rescue <input type="checkbox"/> air ambulance <input type="checkbox"/> ALS rescue <input type="checkbox"/> BLS rescue	If Air: <input type="checkbox"/> Rotary <input type="checkbox"/> Fixed Wing	Number of personnel providing services: <input type="checkbox"/> PS <input type="checkbox"/> PS-Defib <input type="checkbox"/> BLS <input type="checkbox"/> EMT-D <input type="checkbox"/> LALS <input type="checkbox"/> ALS
Ownership: <input type="checkbox"/> Public <input type="checkbox"/> Private	Medical Director: <input type="checkbox"/> yes <input type="checkbox"/> no	If public: <input type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other explain: _____	If public: <input type="checkbox"/> city; <input type="checkbox"/> county; <input type="checkbox"/> state; <input type="checkbox"/> fire district; <input type="checkbox"/> Federal	System available 24 hours? <input type="checkbox"/> yes <input type="checkbox"/> no	Number of ambulances: _

123

Name, address & telephone:		Primary Contact:			
Written Contract: <input type="checkbox"/> yes <input type="checkbox"/> no	Service: <input type="checkbox"/> Ground <input type="checkbox"/> Air <input type="checkbox"/> Water	<input type="checkbox"/> Transport <input type="checkbox"/> Non-Transport	Air classification: <input type="checkbox"/> auxiliary rescue <input type="checkbox"/> air ambulance <input type="checkbox"/> ALS rescue <input type="checkbox"/> BLS rescue	If Air: <input type="checkbox"/> Rotary <input type="checkbox"/> Fixed Wing	Number of personnel providing services: <input type="checkbox"/> PS <input type="checkbox"/> PS-Defib <input type="checkbox"/> BLS <input type="checkbox"/> EMT-D <input type="checkbox"/> LALS <input type="checkbox"/> ALS
Ownership: <input type="checkbox"/> Public <input type="checkbox"/> Private	Medical Director: <input type="checkbox"/> yes <input type="checkbox"/> no	If public: <input type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other explain: _____	If public: <input type="checkbox"/> city; <input type="checkbox"/> county; <input type="checkbox"/> state; <input type="checkbox"/> fire district; <input type="checkbox"/> Federal	System available 24 hours? <input type="checkbox"/> yes <input type="checkbox"/> no	Number of ambulances: _

TABLE 9: RESOURCES DIRECTORY -- Approved Training Programs -

EMS System: Imperial County County: Imperial Reporting Year: FY 95

NOTE: Table 9 is to be completed by county. Make copies to add pages as needed.

Training Institution Name / Address		Contact Person telephone no.
Imperial Valley College PO BOX 158, Imperial, CA 92251		Susan Phalen, RN (619) 355-6275 EMS Training Coordinator
Student Eligibility: *	Cost of Program [basic/refresher]:	**Program Level: <u>EMT-I</u> Number of students completing training per year: Initial training: <u>47</u> Refresher: <u>156</u> Cont. Education: Expiration Date: <u>9/96</u> Number of courses: Initial training: <u>2</u> Refresher: <u>2</u> Cont. Education:
Open to general public	Registration - \$ 84.50 Textbooks - 60.00 Malpractice - 35.00	

Training Institution Name / Address		Contact Person telephone no.
Imperial Valley College PO BOX 158, Imperial, CA 92251		Susan Phalen, RN (619) 355-6275 EMS Training Coordinator
Student Eligibility: *	Cost of Program [basic/refresher]:	**Program Level: <u>EMT-II</u> Number of students completing training per year: Initial training: <u>0</u> Refresher: Cont. Education: Expiration Date: <u>9/96</u> Number of courses: Initial training: Refresher: Cont. Education:
Restricted to certain personnel	Registration - \$156.00 Textbooks - 100.00 Malpractice - 35.00	

* Open to general public or restricted to certain personnel only.

** Indicate whether EMT-I, EMT-II, EMT-P, or MICN; if there is a training program that offers more than one level complete all information for each level.

124

TABLE 9: RESOURCES DIRECTORY -- Approved Training Programs

EMS System: Imperial County County: Imperial Reporting Year: FY 95

NOTE: Table 9 is to be completed by county. Make copies to add pages as needed.

Training Institution Name / Address		Contact Person telephone no.
Imperial Valley College PO BOX 158, Imperial, CA 92251		Susan Phalen, RN (619) 355-6275 EMS Training Coordinator
Student Eligibility: *	Cost of Program [basic/refresher]:	**Program Level: <u>EMT-P</u>
Restricted to certain personnel	Registration - \$ 550.00 Textbooks - 150.00 Malpractice - 35.00	Number of students completing training per year: Initial training: <u>15</u> Refresher: Cont. Education: Expiration Date: <u>9/97</u>
		Number of courses: Initial training: <u>1</u> Refresher: <u>0</u> Cont. Education:

Training Institution Name / Address		Contact Person telephone no.
Imperial Valley College PO BOX 158, Imperial, CA 92251		Susan Phalen, RN (619) 355-6275 EMS Training Coordinator
Student Eligibility: *	Cost of Program [basic/refresher]:	**Program Level: <u>MICN</u>
Restricted to certain personnel	Registration - \$1195.00 Textbooks - 100.00 Malpractice - 60.00	Number of students completing training per year: Initial training: <u>7</u> Refresher: Cont. Education: Expiration Date: <u>9/97</u>
		Number of courses: Initial training: Refresher: Cont. Education:

* Open to general public or restricted to certain personnel only.

** Indicate whether EMT-I, EMT-II, EMT-P, or MICN; if there is a training program that offers more than one level complete all information for each level.

125

TABLE 10: RESOURCES DIRECTORY -- Facilities

EMS System: Imperial County

County: Imperial

Reporting Year: FY 95

NOTE: Make copies to add pages as needed. Complete information for each facility by county.

Name, address & telephone: El Centro Regional Medical Center (619) 339-7111 1415 W. Ross Ave., El Centro, CA 92243					Primary Contact: Ted Fox Administrator									
Written Contract	<input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Basic/Comp EMS Permit H&SC Section 1798.101:		<input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Base Hospital:	<input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Pediatric Critical Care Center:*			<input type="checkbox"/> yes <input checked="" type="checkbox"/> no				
EDAP:**					<input type="checkbox"/> yes <input checked="" type="checkbox"/> no	PICU:***		<input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Burn Center:	<input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Trauma Center:	<input type="checkbox"/> yes <input checked="" type="checkbox"/> no	If Trauma Center what Level:****	

Name, address & telephone: Pioneers Memorial Hospital (619) 344-2120 207 W. Legion Rd., Brawley, CA 92227					Primary Contact: Bill Daniels Administrator									
Written Contract	<input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Basic/Comp EMS Permit H&SC Section 1798.101:		<input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Base Hospital:	<input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Pediatric Critical Care Center:*			<input type="checkbox"/> yes <input checked="" type="checkbox"/> no				
EDAP:**					<input type="checkbox"/> yes <input checked="" type="checkbox"/> no	PICU:***		<input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Burn Center:	<input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Trauma Center:	<input type="checkbox"/> yes <input checked="" type="checkbox"/> no	If Trauma Center what Level:****	

126

TABLE 10: RESOURCES DIRECTORY -- Facilities

EMS System: Imperial County

County: Imperial

Reporting Year: FY 95

NOTE: Make copies to add pages as needed. Complete information for each facility by county.

Name, address & telephone:		Calexico Hospital (619) 357-1191 450 Birch Street, Calexico, CA 92231		Primary Contact: Randy Smith Administrator	
Written Contract	<input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Basic/Comp EMS Permit H&SC Section 1798.101:	<input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Base Hospital:	<input type="checkbox"/> yes <input checked="" type="checkbox"/> no
					Pediatric Critical Care Center:*
					<input type="checkbox"/> yes <input checked="" type="checkbox"/> no
EDAP:**	<input type="checkbox"/> yes <input checked="" type="checkbox"/> no	PICU:***	<input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Burn Center:	<input type="checkbox"/> yes <input checked="" type="checkbox"/> no
					Trauma Center:
					<input type="checkbox"/> yes <input checked="" type="checkbox"/> no
					If Trauma Center what Level:****

127

Name, address & telephone:		Primary Contact:			
Written Contract	<input type="checkbox"/> yes <input type="checkbox"/> no	Basic/Comp EMS Permit H&SC Section 1798.101:	<input type="checkbox"/> yes <input type="checkbox"/> no	Base Hospital:	<input type="checkbox"/> yes <input type="checkbox"/> no
					Pediatric Critical Care Center:*
					<input type="checkbox"/> yes <input type="checkbox"/> no
EDAP:**	<input type="checkbox"/> yes <input type="checkbox"/> no	PICU:***	<input type="checkbox"/> yes <input type="checkbox"/> no	Burn Center:	<input type="checkbox"/> yes <input type="checkbox"/> no
					Trauma Center:
					<input type="checkbox"/> yes <input type="checkbox"/> no
					If Trauma Center what Level:****

TABLE 11a: RESOURCES DIRECTORY -- Disaster Medical Responders

EMS System: Imperial County

County: Imperial

Date: 8-3-95

NOTE: Information on Table 11a is to be completed for each county.

County Office of Emergency Services (OES) Coordinator:

Acting Fire Chief Joe Buzo

Work Telephone No.: (619) 355-1191

Home Telephone No.: 353-2822

Office Pager No.: 339-3641

FAX No.: 355-1482

24-HR No.: 355-1164

∞

Alternate's Name:

Robert Carter

Work Telephone No.: (619) 355-1191

Home Telephone No.: 355-4889

Office Pager No.:

FAX No.: 355-1482

24-HR No.: 355-1164

County EMS Disaster Medical Services (DMS) Coordinator:

John Pritting, EMS Coordinator

Work Telephone No.: (619) 339-4468

Home Telephone No.: (619) 352-5664

Office Pager No.: (619) 580-0978

FAX No.: (619) 352-9933

24-HR No.: 339-6311 (Sheriffs Dispatch)

Alternate's Name:

Robin Raecker

Work Telephone No.: (619) 339-4704

Home Telephone No.: 353-3239

Office Pager No.: 339-7857

FAX No.: 352-9933

24-HR No.: (619) 339-6311

TABLE 11a: RESOURCES DIRECTORY -- Disaster Medical Responders (cont)

NOTE: Information on Table 11a is to be completed for each county.

County Health Officer's Name:

Benjamin Lehr, M.D.

Work Telephone No.: (619) 339-4429

Home Telephone No.: 353-4719

Office Pager No.:

FAX No.: 352-9933

24-HR No.: 353-4719

Alternate's Name: None

Work Telephone No.:

Home Telephone No.:

Office Pager No.:

FAX No.:

24-HR No.:

Medical/Health EOC telephone no.: (310) 795-2900

Amateur Radio contact name: Joe Essary (909) 867-9270

Who is the RDMHC for your region? Thomas Prendergast, M.D.

Medical/Health EOC FAX No.: (310) 795-2877

Medical/Health radio frequency used:

NOTE: In the event of an emergency it is critical for the EMSA to have current information on whom to contact. Therefore, please submit name and telephone number changes to Table 11 as they occur.

129

TABLE 11b: RESOURCES DIRECTORY -- Disaster Medical Responders (cont)

OES Region: VI

County: Imperial

Date: 8-3-95

NOTE: Information on Table 11b is to be completed by counties with RDMHC projects.

Regional OES Coordinator:

Sonia Brown

Work Telephone No.: (310) 795-2900

Home Telephone No.:

Office Pager No.:

FAX No.: 795-2877

24-hour No.:

Alternate's Name:

Work Telephone No.:

Home Telephone No.:

Office Pager No.:

FAX No.:

24-HR No.:

Regional Disaster Coordinator:

Stuart Long

Work Telephone No.: (909) 888-7511

Home Telephone No.: 681-5758

Office Pager No.:

FAX No.: 824-7515

24-hour No.: (909) 356-3895

Alternate's Name:

Work Telephone No.:

Home Telephone No.:

Office Pager No.:

FAX No.:

24-HR No.:

NOTE: In the event of an emergency it is critical for the EMSA to have current information on whom to contact. Therefore, please submit name and telephone number changes to Table 11 as they occur.

130

TABLE 11b: RESOURCES DIRECTORY -- Disaster Medical Responders (cont)

NOTE: Information on Table 11b is to be completed by counties with RDMHC projects.

Regional Disaster Medical Health Coordinator:

Thomas J. Prendergast, Jr., M.D.

Work Telephone No.: (909) 387-6219

Home Telephone No.:

Office Pager No.:

FAX No.: (909) 387-6228

24-hour No.: (909) 356-3805

Alternate's Name:

Work Telephone No.:

Home Telephone No.:

Office Pager No.:

FAX No.:

24-HR No.:

Regional Ambulance Transportation Coordinator:

Shelby Helmer

Work Telephone No.: (909) 793-7676

Home Telephone No.:

Office Pager No.: 439-2514

FAX No.: 335-2260

24-hour No.: 793-2666

Alternate's Name:

Work Telephone No.:

Home Telephone No.:

Office Pager No.:

FAX No.:

24-HR No.:

Medical/Health EOC telephone no.: (310) 795-2900

Amateur Radio contact name:

Medical/Health EOC FAX No.:

Medical/Health radio frequency used:

NOTE: In the event of an emergency it is critical for the EMSA to have current information on whom to contact. Therefore, please submit name and telephone number changes to Table 11 as they occur

SECTION FIVE

DESCRIPTION OF PLAN DEVELOPMENT PROCESS

EMS SYSTEM PLAN DEVELOPMENT PROCESS

The EMS Plan was developed by EMS Agency staff after a several-year study of the system and its needs. The draft plan was circulated to system participants for review and comment; and officially reviewed at the county Emergency Medical Care Committee comprised of all provider groups involved with the delivery of prehospital emergency care. After appropriate modifications were made, the plan was reviewed and approved by the Imperial County Board of Supervisors. Updates will be dealt with in similar fashion in the future.

SECTION SIX

APPENDIX

APPENDIX 1: Exclusive Operating Area

The Imperial County EMS Agency is implementing a plan that continues the use of an existing provider (Schaefer's Gold Cross Ambulance Service) within an Exclusive Operating Area (Ambulance Zone I) in the manner and scope in which services have been provided without interruption since January 1, 1981 (Health & Safety Code Section 1797.224).

EMERGENCY MEDICAL SERVICES AUTHORITY

1930 9TH STREET, SUITE 100
SACRAMENTO, CA 95814-7043
(916) 322-4336
FAX (916) 324-2875



May 21, 1997

John Pritting
EMS Administrator
Imperial County EMS
935 Broadway
El Centro, CA 92243

Dear Mr. Pritting:

We received the letter from Dr. Haynes dated March 18, 1997, regarding Section 1.26 of your EMS Plan. Section 1.07 contained the information we were looking for. Your plan is in compliance with the *EMS System Standards and Guidelines and the EMS System Planning Guidelines*. As requested, a member of our disaster staff will send you an example of a detailed disaster component for future plan updates.

Thank you for responding to our request, and if you have any further questions, please call Michele Rains at (916) 322-4336, extension 315.

Sincerely,

A handwritten signature in cursive script that reads "Maureen McNeil".

Maureen McNeil
Chief, EMS Authority

cc: Bruce E. Haynes, M.D.
Medical Director

MM:MR:mr