Coastal Valleys
Emergency Medical Services Agency

Serving the counties of Mendocino, Napa & Sonoma

EMERGENCY MEDICAL SERVICES SYSTEM PLAN

2008-2009

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EXECUTIVE SUMMARY

The Coastal Valleys Emergency Medical Services Agency (CVEMSA) currently serves the counties of Mendocino, Napa and Sonoma. The Agency has served as the regional entity since 1994. This plan represents the sixth updating of the agency's EMS plan. The agency's primary responsibility is to plan, implement and evaluate an emergency medical services (EMS) system which meets the minimum standards developed by the California EMS Authority.

State law requires EMS agencies to develop plans for the delivery of emergency medical services (paramedic treatment, ambulance transport, trauma services, etc.) to the victims of sudden illness or injury within the geographic area served by the EMS agency. These plans must be consistent with state standards and address the following components:

- System organization and management
- Staffing and training
- Communications
- Response & Transportation
- Facilities and critical care
- Data collection and evaluation
- Public information and education
- Disaster medical response

Major changes have taken place since the last EMS Plan update. These changes include:

- The continuing evolution of the Coastal Valleys Emergency Medical Services Region
- Advanced life support (paramedic) services in all of the major population centers of the EMS system.
- Five different region-based EMS aircraft providers to serve the more remote portions of the region.
- Refinement and expansion of a regional EMS database management system.
- The continuing development of the regional trauma system and establishment of a trauma cache at the region's Level II trauma center with EMSA grant funding.
- A continued medical-health disaster preparedness effort in all three member counties through the auspices of HPP and CDC BT grant funding.

The process of assessing system needs and developing plan objectives revealed that major improvements have been made in the overall EMS system since the creation of the respective county LEMSAs in the early 1980's as well as the region itself since the late 1990's. However, several components of the EMS system remain target areas for updating and revision. These areas include, but are not limited to the following: communications systems, trauma system, disaster planning and management as well as data collection. In order to accomplish the task of creating an "ideal" system, the individual member counties have utilized differing methods of collaboration and participation as well as timelines. All three member counties have made tangible progress in transitioning from a sole county perspective to that of a regional vision. As a result, this growing understanding between the CVEMSA members has helped to increase collaborative efforts that have produced the beginning of a true regional data collections system, a region-wide Medical Advisory Committee that has consolidated the Continuous Quality Improvement (CQI) committees of the three member counties. The acknowledgment and prioritization of regional development needs is of course, based on the most pressing needs of the member counties and the respective resources available to each county.

The "System Needs and Plan Objectives" section is the centerpiece of the EMS System Plan. This section describes the current status, needs, objectives and time-line of each component of the EMS system. The needs and the objectives listed in the EMS System Plan were identified and developed by comparing our current EMS system with the California EMS Authority's EMS System Standards and Guidelines and commensurate evaluation and feedback from the EMS Authority. Some of the major objectives of the CVEMSA EMS System Plan include:

- Continued development of the CVEMS region.
- Establishing and maintaining ALS service capability throughout the region.
- Continued development and refinement of the region wide DBMS based CQI program and process.
- Revising and updating EMT and EMT-P field treatment protocols.
- Developing an EMD QI process for the designated EMS Dispatch Centers in the region.
- Continue refinement of triaging medical emergencies and dispatch of appropriate resources, both ground and air.

- Evaluating the respective counties' EMS communications systems.
- Identifying the optimal roles and responsibilities of EMS system participants including the respective counties' EMCC.
- Evaluating roles and number of base and receiving hospitals in each county.
- Continued development of a regional trauma care system, including the development of a North Bay regional system.
- Continued development and refinement of pre-hospital triage and transfer protocols.
- Review and updating of the regional MCI plans.
- Increased participation and involvement with Surge Preparedness planning and operation implementation.

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

ASSESSMENT OF SYSTEM

SUMMARY OF SYSTEM STATUS

This section provides a summary of how the Coastal Valleys Emergency Medical Services System meets the State of California's EMS Systems Standards and Guidelines. An "x" placed in the first column indicates that the current system does not meet the State's minimum standard. An "x" placed in the second or third column indicates that the system meets either the minimum or recommended standard. An "x" is placed in one of the last two columns to indicate the time frame the agency has established for either meeting the standard or revising the current status. A complete narrative description of each standard along with the objective for establishing compliance is included in the System Needs and Plan Objectives Section of this plan.

SYSTEM ORGANIZATION AND MANAGEMENT

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
1.01 LEMSA Structure		X	NA	X	X
1.02 LEMSA Mission		X	NA	X	
1.03 Public Input		X	NA	X	X
1.04 Medical Director		X	X		X
1.05 System Plan		X	NA	X	X
1.06 Annual Plan Update		X	NA	X	
1.07 Trauma Planning		X	X	X	X
1.08 ALS Planning		X	NA		X
1.09 Inventory of Resources		X	NA	X	
1.10 Special Populations		Partial		X	X
1.11 System Participants' Roles & Responsibilities		X	X	X	X
1.12 Review & System Monitoring		X	NA	X	X
1.13 Coordination		X	NA	X	X
1.14 Policy & Procedures Manual*		X	NA	X	X
1.15 Policy Compliance		X	NA		X
1.16 Funding Mechanism		X	NA	X	X
1.17 Medical Direction		X	NA	X	X
1.18 QA / QI		X	X	X	X
1.19 Policies, Procedures, Protocols		X	X	X	X

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
1.20 DNR Policy		X	NA		X
1.21 Determination of Death		X	NA		X
1.22 Reporting of Abuse		X	NA		X
1.23 Inter-facility Transfer		X	NA	X	X
1.24 ALS Systems		X	X	X	X
1.25 On-Line Medical Direction		X		X	X
1.26 Trauma System Plan		X	NA		X
1.27 Pediatric System Plan		X	NA		X
1.28 EOA Plan		X	NA	X	X

STAFFING AND TRAINING

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

COMMUNICATIONS

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

RESPONSE AND TRANSPORTATION

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range Plan	Long-range Plan
4.01 Service Boundaries		X		X	X
4.02 Monitoring		X		X	X
4.03 Classifying Medical Requests		X			X
4.04 Pre-scheduled Responses		X	NA		X
4.05 Response Time Standards		X			X
4.06 Staffing		X	NA		X
4.07 First Responder Agencies		X	NA		X
4.08 Medical & Rescue Aircraft		X	NA	X	X
4.09 Air Dispatch Center		X	NA		X
4.10 Aircraft Availability		X	NA	X	X
4.11 Specialty Vehicles		X			X
4.12 Disaster Response		X	NA	X	X
4.13 Inter-county Response		X		X	X
4.14 Incident Command		X	NA	X	X
4.15 MCI Plans		X	NA	X	X
4.16 ALS Staffing		X			X
4.17 ALS Equipment		X	NA	X	X
4.18 Xport Compliance		X	NA	X	X
4.19 Transportation Plan		X	NA		X
4.20 "Grandfathering"		X	NA		X
4.21 EOA Compliance		X	NA	X	X
4.21 EOA Evaluation		X	NA	X	X

FACILITIES AND CRITICAL CARE

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

DATA COLLECTION AND SYSTEM EVALUATION

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

PUBLIC INFORMATION AND EDUCATION

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

DISASTER MEDICAL RESPONSE

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

SYSTEM NEEDS AND PLAN OBJECTIVES

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

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

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

SYSTEM ORGANIZATION AND MANAGEMENT

1.01 LEMSA STRUCTURE

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Oversight of the Regional EMS Agency is presently provided by a committee comprised of the Directors of Public Health (or Department of Health Services) from Mendocino, Sonoma and Napa counties and the Regional Administrator (Regional Directors Committee -RDC).

The Agency staff is comprised of a Medical Director, who is Board Certified in Emergency Medicine, an EMS Administrator and an additional 9 FTE employees (one FTE is unfilled for FY 08-09). Other non-agency resources include base hospital medical directors, base hospital nurse liaisons, provider QI coordinators and provider training coordinators.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

To identify staffing, review and modify job descriptions and employee classifications to keep with the mission and goals of this Agency and Plan. Maintain a Regional Directors Committee in lieu of a permanent organization of governance (i.e. JPA)

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

Each local EMS agency shall plan, implement, and evaluate the EMS system. The agency shall use its quality assurance/quality improvement (QA/QI) and evaluation processes to identify system changes.

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

The CVEMSA was created in FY 98-99. While individual member counties have comprehensive emergency medical services systems, the regional system continues to be evaluated by the CVEMSA. The continuing evaluation of the system is being accomplished through the writing of the region's updated EMS Plan. Linkage & creation of a region-wide wide QI program is underway through the auspices of the Regional Medical Advisory Committee (MAC) and remains a priority objective.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure continued evaluation of system performance against established benchmarks. Maintain a system wide CQI plan and process.

OBJECTIVE:

Use the agency's MAC and public evaluations by the Regional Advisory Committee, County Emergency Medical Care Committees and other review bodies to identify needed system changes.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.03 PUBLIC INPUT

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Each member county has a functioning Emergency Medical Care Committee / Council that reviews local operations, policies and practices. A Regional Directors Committee (RDC) comprised of one Public Health or Department of Health Services (DHS) administrator from each member county meets bimonthly to review and discuss issues affecting CVEMSA. All meetings of the respective BOS and county EMCCs are open to the public with time allocated on each agenda for open public comments. Additionally, impacted groups are routinely notified and provided with an opportunity to provide input in advance of issues being brought before the respective BOS. All policies and procedures are kept on a public access website, including draft and pending actions. Input is solicited from all interested parties.

COORDINATION WITH OTHER EMS AGENCIES:

None.

NEED(S):

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

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

1.04 MEDICAL DIRECTOR

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

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

CURRENT STATUS: *meets minimum standard*

The agency Medical Director possesses Board Certification in Emergency Medicine and previous experience as a LEMSA Deputy EMS Medical Director. The EMS Medical Director provides medical oversight to all portions of the region.

The regional Medical Advisory Committee has been established. The Medical Director attends MAC meetings and communicates regularly and meets weekly with the regional staff.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure medical direction of the EMS system.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

1.05 SYSTEM PLAN

MINIMUM STANDARDS:

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

The plan shall:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Completion of this annual plan update fulfills the requirements of this standard.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that the EMS System plan meets community needs and provides for the appropriate utilization of resources. Meet the identified and prioritized standards contained within this plan

OBJECTIVE

Monitor and amend the EMS system plan, as needed.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.06 ANNUAL PLAN UPDATE

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Completion of this annual plan update fulfills the requirements of this standard.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Annually evaluate the EMS system plan to determine progress in meeting EMS plan objectives and system changes.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

1.07 TRAUMA PLANNING

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

A Level II Trauma Center and Level III Trauma Center have been established in Sonoma County and Napa County to serve Mendocino, Napa and Sonoma counties, as well as portions of Lake and Marin counties. An updated and revised regional Trauma Plan was submitted to the State during FY 2008/2009. A medical evaluation site visit was conducted by ACS of Trauma Centers (Santa Rosa Memorial - Level II & Napa Queen of the Valley - Level III) in 2002, 2003, 2005 and 2006. A regional Trauma Advisory Committee (TAC) has been reorganized. A regional Trauma Coordinator position has been established and filled. Integration of trauma data into CQI process has been initiated through HRSA grant funding.

COORDINATION WITH OTHER EMS AGENCIES:

The demographics and geography of the CVEMS system requires all specialty care planning to consider adjoining systems when determining resource availability and catchment areas. Collaboration has been initiated with Marin County EMS and SF General Hospital to establish a "regional – North Bay" trauma system via HRSA funding as well.

NEED(S):

Ensure the availability of trauma services for critically injured patients.

OBJECTIVE:

Continue refining a regional trauma care system.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.08 ALS PLANNING

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Advanced life support ambulance services are provided as the minimum standard for emergency (9-1-1) medical requests in each county's major urban centers (and bulk of the respective populations) in the EMS system. 91% of Mendocino is ALS, 90% of Napa is ALS and all of Sonoma County is ALS. BLS service areas in Mendocino and Napa counties are backed up by both ground and air ALS.

COORDINATION WITH OTHER EMS AGENCIES:

North Coast EMS Region, Solano and Marin County EMS provides ALS resource response coordination into certain portions of the CVEMS region.

NEED(S):

Ensure the optimal provision of ALS services throughout the EMS system.

OBJECTIVE:

Study the feasibility of ALS first response services and other ALS alternatives as described in various EMS System Redesign models, including the development of exclusive operating areas for transport and non-transporting ALS service providers. Make changes as necessary to ensure the optimal provision of ALS services.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.09 INVENTORY OF RESOURCES

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Completion of this plan fulfills the requirements of this standard.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

The requirement for a MOHOAC ERD in the 08/09 HPP plan will require updating and refinement. Ensure the accuracy of the resource directories included in this plan. The regional counties have agreed to pool their individual financial recourses and contract with a qualified EMS Consultant to create a revised MHOAC ERD.

OBJECTIVE:

Periodically update the resource directories included in this plan.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.10 SPECIAL POPULATIONS

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *PARTIALLY Meets Standard*

Identification of special population groups has begun but not to the satisfaction of the agency. Establishment of two designated EMS dispatch centers, QI process linkage on a region-wide basis and feedback loops within the respective EMCCs has assisted with better target identification. An EMS-C program was established within the region during FY 2000-2002 and remains active. Additionally, the Agency is working with the respective county Public Health Preparedness groups which are in the process of identifying special populations through HPP and CDC grant funding programs. Efforts have begun to contact and recruit special population advocates along with special population care facilities in developing a coordinated disaster planning process.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Continue the process of identifying population groups served by the EMS system that may require special services. Ensure that all population groups know how to access and appropriately utilize the EMS system.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

1.11 SYSTEM PARTICIPANTS

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

The roles and responsibilities of many system participants are based primarily on historical involvement and willingness to cooperate with the agency. Formalization of roles and responsibilities has been conducted with Base Hospitals, Trauma Centers, EOA transport providers and EMS Dispatch Centers within the region. Mendocino County has formal agreements with most providers. Sonoma has a permit process in place for private providers. Napa has established two EOAs in the county.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Identify the optimal roles and responsibilities of all system participants based on comparative EMS system models and public input. Ensure that system participants conform to assigned EMS system roles and responsibilities.

OBJECTIVE:

Continue the identification of the optimal roles and responsibilities of EMS system participants. Continue developing mechanisms, such as agreements, facility designations and exclusive operating areas to ensure compliance.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.12 REVIEW AND MONITORING

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

There is a region-wide Q.I. program in place. The program's participants - agency staff, provider QI coordinators and hospital liaison QI coordinators as well as medical directors continue to refine the program and its components. A region wide Management Information system (MIS) is now in place. Response time standards are in place in Sonoma and Napa EOA. The respective county EMCCs are continuing to evaluate response, care and transport, and to identify system problems and seek solutions. A region wide Medical Advisory Committee (MAC), comprised of representatives of all system participants, QI coordinators from agencies and facilities from throughout the region has continued to monitor and review system operations with focus on CQI, policy and procedure review and development.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure the continued review and monitoring of EMS system operations. Work with EMSAAC and the State EMSA to develop standard statewide indicators for EMS system evaluation. Continue to refine system wide QI activities and linkage.

OBJECTIVE:

Implement structural indicators and compliance mechanisms in conjunction with a regional QI program implementation. Continue refinement of the region MIS to include Base Hospitals, ALS providers, BLS first responders, EMD Centers and CE providers. Modify the process of reviewing and monitoring of the EMS system, as needed to include a more active role for the regional Medical Advisory Committee which is overseen by the respective EMCCs.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.13 COORDINATION

MINIMUM STANDARDS:

Each local EMS agency shall coordinate EMS system operations.

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

EMS system operations are coordinated through written agreements with providers, facilities and counties; policies and procedures; training standards; quality improvement programs and other review mechanisms. This plan identifies those components of the CVEMSA system, upon which improvement efforts will be focused during the next one to five years.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure coordinated system operations.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

1.14 POLICY & PROCEDURES MANUAL

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

A regional policy and procedure manual has been developed and distributed. These policies and procedures are available to the system providers via the Agency Web site. The Policy Revision Group, comprised of stakeholders from throughout the region, met on a monthly basis to reconcile the respective member counties' policies so that region wide applicability was ensured. A regional web site is maintained, and the region's policies and procedures are posted and available to our region's stakeholders. The Policy Revision Group has since become the regional Medical Advisory Committee (MAC) and meets on a quarterly basis. The various subcommittees, also comprised of regional stakeholders (Education, Data Analysis, Trauma Advisory, PCR Data, Aircraft and MCI / Disaster) meet on a more frequent basis.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Continue to review, revise and synthesize specific county administrative policies into a regional administrative policy manual. Ensure the availability of a policy and procedure manual for system providers. Continue posting EMS policies on the Agency web site.

OBJECTIVE:

Meld the specific county administrative policies into a regional administrative policy manual. Monitor the process of policy and procedure manual availability and make changes as necessary.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.15 COMPLIANCE WITH POLICIES

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Written agreements, county ordinances, inspections, unusual occurrence reporting, investigations and quality improvement programs have been established as mechanisms to review, monitor and enforce compliance with system policies. Not all provider agencies have written agreements with the agency. The Medical Advisory Committee serves as the regional QI committee that will serve as the EMS system's QI clearinghouse.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure compliance with system policies through implementation of written agreements, QI program and MIS.

OBJECTIVE:

Continue to implement compliance mechanisms such as written agreements, QI program and MIS developed for Base Hospitals, ALS providers, BLS first responders, EMD Centers and CE providers. Evaluate and improve compliance with system policies.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.16 FUNDING MECHANISM

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

The CVEMSA relies on local/county contributions, State general fund grants, PHHS project grants, user fees and SB12/612/2132 monies as a fund base for agency operations. A regional certification fee schedule has been established and a centralized accreditation and/or certification process has been established.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Continue to identify funding sources.

OBJECTIVE:

Maintain existing funding sources and continue to seek alternative or new funding sources. Administer SB12/612/2132 funding appropriately in compliance with State recommendations and guidelines. Continue to work with the Emergency Medical Services Administrators Association of California (EMSAAC), the Emergency Medical Services Medical Directors Association of California (EMDAC) and the State EMSA to maintain federal, state and local funding of EMS systems. Continue to investigate ways for the Coastal Valleys EMS agency and system to function more cost effectively.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.17 MEDICAL DIRECTION

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Currently there are 12 hospitals in the EMS system, of which five have been designated as base hospitals. However, with the inclusion of system wide provider QI and an increase in standing orders, the need for the number base hospitals in their current roles is being re-examined.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Develop a process to reengineer the current system of base hospitals, if deemed necessary and viable by system stakeholders. Should a single medical control point in each member county be determined to be desirable, identify optimal configuration and responsibilities.

OBJECTIVE:

Implement base hospital policies and execute base hospital agreements as necessary. Determine feasibility of single medical control points in each county.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.18 QA/QI

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

Pre-hospital care providers should be encouraged to establish in-house procedures, which identify methods of improving the quality of care provided.

CURRENT STATUS: *meets minimum standard*

There is a region wide CQI process in place (Regional Medical Advisory Committee). Local QI representatives in each of the member counties, consisting of respective agency staff, provider QI coordinators, hospital QI coordinators as well as medical directors are functional. A region wide MIS is in place. The respective county EMCCs are continuing to evaluate response, care and transport issues and to identify system problems as well as seek solutions.

COORDINATION WITH OTHER EMS AGENCIES:

None.

NEED(S):

Ensure that the QA/QI process continues to meet system needs and State standards.

OBJECTIVE:

Continue efforts to refine the formal region wide CQI program including specific clinical indicators and outcome measures. Continue to monitor the performance of the system and amend the QA/QI program and/or processes to meet system needs.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.19 POLICIES, PROCEDURES, PROTOCOLS

MINIMUM STANDARDS:

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

- triage,
- treatment,
- medical dispatch protocols,
- transport,
- on-scene treatment times,
- transfer of emergency patients,
- standing orders,
- base hospital contact,
- on-scene physicians and other medical personnel, and
- local scope of practice for pre-hospital personnel.

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

Updated ALS and BLS treatment protocols, including sections on standing orders are in place. Policies, protocols or policy statements regarding medical dispatch, transport, on-scene times, transfer of emergency patients, on-scene physicians and other medical personnel and local scope of practice have also been updated by the Regional Medical Advisory(MAC) during FY 07-08. Policies on triage and patient destination have been developed. Two of the member county EMS dispatch centers provide both pre-arrival and post dispatch instructions. The dispatch centers utilize Medical Priority Dispatch System protocols.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Continue development and revision of policies to meet state minimum standards and recommended guidelines.

OBJECTIVE:

Continue the review and revision of policies, as needed, to meet minimum standards and the recommended guidelines. Continue development of regional policies for transport of patients to facilities appropriate for their injuries or illness. Evaluate and modify the ALS scope of practice as needed.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.20 DNR POLICY

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

A comprehensive DNR policy based on the DNR State standard was created and implemented in 1993-1994 within the respective counties and was reviewed and updated in FY 08/09. The addition and use of the POLST form has begun region wide in early 2009.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that the DNR policy continues to meet standards and system needs.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

1.21 DETERMINATION OF DEATH

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

A Determination of death policy was created and implemented with the concurrence of the respective county coroners during 1994-1996.

NEED(S):

COORDINATION WITH OTHER EMS AGENCIES:

Ensure that the determination of death policy continues to meet regional system needs.

OBJECTIVE:

Review and update, as necessary, the criteria used for determining death in the field on a regional basis.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.22 REPORTING OF ABUSE

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Regional policies have been developed regarding the reporting of elder abuse along with child abuse and suspected Sudden Unanticipated Death (SUD, in conjunction with the EMS-Children project which was completed in 2002).

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Maintain mechanisms for the reporting of abuse or suspected SUD deaths on a regional basis.

OBJECTIVE:

Review and update, as needed, EMS policies regarding the reporting of abuse or suspected SUD deaths. Work with other public, private agencies to increase awareness of abuse cases and reporting among pre-hospital personnel.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.23 INTERFACILITY TRANSFER

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

A policy delineating the scene and interfacility transfer scope of practice of paramedics has been established on an individual county level. A regional interfacility Transfer Guideline has been completed. Established policies and procedures for use of Heparin, blood products and Nitroglycerin as an expanded scope for interfacility transfers are not instituted region wide but are written and are contingent on individual transport provider training for implementation within individual counties.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Continue development and revision BLS and ALS interfacility scope of practice.

OBJECTIVE:

Maintain a regional BLS and ALS interfacility scope of practice that is compliant with State guidelines.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.24 ALS SYSTEMS

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

All ALS services currently provided in the EMS system are being done with (local) Agency approval. Written agreements, permits and/or contracts are utilized throughout the region. Exclusive operating areas (EOAs) have been established in 2 counties.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that ALS services are provided only as an approved part of the EMS system. Develop regional ALS provider agreements.

OBJECTIVE:

Maintain written agreements with all ALS providers and monitor compliance. .

TIME FRAME FOR MEETING OBJECTIVE:

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

1.25 ON-LINE MEDICAL DIRECTION

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

Each EMS system should develop a medical control plan that determines:

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

CURRENT STATUS: *meets minimum standard*

Currently five out of twelve hospitals in the EMS region have been designated as Base Hospitals. However, with the inclusion of provider QI throughout the region and an increase in standing orders, there may not be the need for the number of base hospitals in their current roles. The financial viability of several smaller facilities continues to be a primary issue of concern, more so than "Base" status. Four facilities have downgraded their Basic ED's to Standby ED's since 2002 and one facility has been eliminated by Sutter Health.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

The issue of a single medical control point in each member county continues to be examined by system participants on a county by county basis. DHS nurse-patient staffing ratios impacts are being assessed by all regional facilities. A process needs to be developed for determining the viability of a single medical control point in each county, when feasible, and identifying its optimal configuration and responsibilities, assuming there is consensus for downsizing the present base hospital network and that geographical barriers are not insurmountable.

OBJECTIVE:

Execute Base Hospital agreements. Establish a single medical control point in each county or where geographically feasible or necessary. Develop a comprehensive medical control plan which meets standards and system needs.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.26 TRAUMA SYSTEM PLAN

MINIMUM STANDARDS:

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

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

A Level II trauma center in Sonoma County (Santa Rosa Memorial Hospital) was designated in FY 99-00. The Sonoma/Mendocino County Trauma Plan was submitted to the State at that time. A Regional Trauma Plan was then developed and submitted to the State during 2002. In Napa County, Queen of the Valley Hospital is a Level III trauma center that has been designated by both Napa County and the State EMS Authority. Both facilities were reviewed 2005-2006 by site teams and deemed compliant. Queen of the Valley was redesignated in 2008. Currently, SRMH is being processed for redesignation in 2009. A regional Trauma Advisory Committee has been established. A regional Trauma Coordinator position has been established and filled. The Agency continues to refine its management of trauma system oversight, based off of recommendations from the site review team reports.

COORDINATION WITH OTHER EMS AGENCIES:

Marin County EMS, North Coast EMS, and Solano County EMS Agency.

NEED(S):

Continue development of the regional trauma system. Continue refinement of the trauma registry for the region. Maintain the trauma audit process and the Trauma Audit Committee. Ensure integration with existing CQI & MIS.

OBJECTIVE:

Maintain and refine current trauma system

TIME FRAME FOR MEETING OBJECTIVE:

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

1.27 PEDIATRIC SYSTEM PLAN

MINIMUM STANDARDS:

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

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: MEETS MINIMUM STANDARDS

The region completed a State funded grant EMS for Children project during 2002, for purposes of developing a formalized EMS for Children system. Pediatric treatment protocols were revised. Pediatric protocols were again updated in 2007-2008. Pediatric specialty centers were identified and transport procedures established. Pediatric related equipment guidelines were reviewed and updated in 2005. Pediatric equipment was purchased and distributed to transport providers and first responder agencies. PEPP classes were introduced for field providers and have been established at local training institutions. A pediatric training equipment library was established.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Continue to support EMS – Children system development in an extremely challenging budget arena.

OBJECTIVE:

Review and revise, as necessary, pediatric treatment protocols.

TIME FRAME FOR MEETING OBJECTIVE:

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

1.28 EOA PLAN

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

The optimal system design for ALS ambulances and the process for assigning roles to system participants are described in the Transportation Plan and is based on the EMS system models examined by the Agency. There are currently three EOAs within the region, which are not totally inclusive within the respective counties (Sonoma & Napa)

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that system design continues to meet community needs. Sonoma EOA #1 has been bid and a vendor selected for service beginning July 1, 2009. Begin system assessment for additional EOA viability in Sonoma, Napa and possibly Mendocino counties and commensurate development of request for proposal process as determined.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

STAFFING AND TRAINING

2.01 ASSESSMENT OF NEEDS

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Current training institutions and approved CE providers appear to be meeting system needs. ALS Update Class for all accredited Paramedics (Previously known as Lesser Used Skills) training platforms have been established on a regional basis and are offered monthly. The development of a training consortium with the training providers is in place. Paramedic training programs now exist in all 3 regional counties. Pediatric coursework (PEPP & PALS) is offered several times a year. Multi-Casualty Incident (MCI) table top training sessions have also been offered in conjunction with LUS classes. Updated regional CE provider's list was established during 2003 and updated quarterly. CE providers are audited and reviewed regularly. All EMT training centers were visited by Agency staff members and the commensurate programs reviewed during FY 2008-2009. A regional training calendar has been added to the Agency's website.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure a sufficient amount of personnel are trained to meet EMS system demands. Continue to refine consortium relationships with local colleges and education providers to capitalize on shared resources, funding and instructors.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

2.02 APPROVAL OF TRAINING

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Procedures are in place to approve First Responder, EMT-I, EMT-II, EMT-P training programs within the region. Monitoring of training programs is done by periodic auditing of courses and completion of course evaluation forms by students. EMS Agency staff for purposes of program compliance visited all training centers during 2008-09 and continue to do so annually. A regional standardization of the respective education approval procedures has been accomplished.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Continue to ensure that EMS education programs comply with State regulations and requirements for continued program approval.

OBJECTIVE:

Conduct random compliance evaluations of local programs. Monitor EMS education programs and ensure compliance to standards and other course requirements. Maintain standardized regional approval policies and compliance process.

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Policies have been adopted regarding emergency medical dispatcher certification requirements within the region as well as first responder certification, EMT-I certification, EMT II certification and paramedic accreditation. Standardizing the EMT certification process on a regional basis has been accomplished, including standardized fee schedules. Procedures have been developed for the reporting of unusual occurrences that could impact EMS personnel certification within all of the member counties.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Review, modify and adopt the procedures and policies used for the certification in the individual member counties for regional use and practice to ensure compliance with EMT regulations by State EMSA.

OBJECTIVE:

Monitor all EMS personnel policies and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

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

2.04 DISPATCH TRAINING

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

Level II emergency medical dispatching, with pre-arrival instructions is online in Mendocino, Napa and Sonoma counties. All three counties have designated EMS Dispatch Centers. There are also city Public Safety Answering Points (PSAP) that dispatch city ambulances (Cloverdale, Petaluma, Ukiah). Ukiah was in the process of adopting MPDS EMD program and procedures. However, Ukiah FD is assessing the viability of moving their fire dispatch operations component to the centralized Fire-EMS dispatch center at Howard Forest CDF-ECC. Petaluma and Cloverdale PSAPs utilize the new joint powers authority consolidated EMS-Fire dispatch Center in Sonoma County (REDCOM) as their “pre-arrival instructions” safety net. REDCOM was established on January 27, 2003. EMS staff members sit on the REDCOM Board of Directors and Dispatch Operations Advisory Group. EMS Agency has purchased the MPDS EMD Continuing Education CD series for the REDCOM dispatch center, which facilitates continuous on-site training for EMD personnel.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Maintain Level II EMD as the minimum standard for all PSAPs and dispatch centers providing or responsible for medical dispatching throughout the region. Ensure all medical dispatchers maintain Level II EMD training standards.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

2.05 FIRST RESPONDER TRAINING

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

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

CURRENT STATUS: *meets minimum standard*

Regional first responder agencies require "first responder" training certificates as a minimum condition of hire. All of the regional first responder agencies possess SAEDs, which were acquired through EMSA grants and corporate donation programs. Distribution of SAEDs and training for the use of SAEDs was accomplished during 2002 in Sonoma County and purchase and distribution of SAEDs for Mendocino County responders was accomplished during the 2003 through a Rural Health Development (RDP) grant. Napa County first responders are SAED equipped.

EMT-I training is widely available within the EMS system and the staffing of first response units with at least one certified EMT-I is a given, since all first responder agencies require EMT certification for paid staff. 100% of the population (650,000 people) of the CVEMSA system are served by an early defibrillation first response provider.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure minimum training standards and encourage adherence to recommended guidelines.

OBJECTIVE:

Develop and implement standardized first response agreements or other mechanism with all providers that will specify minimum training, staffing and equipment standards.

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

The roles and responsibilities of most system participants are based primarily on historical involvement in the EMS system and willingness to serve their respective communities. Formalization of roles and responsibilities has been conducted with the EOA ALS transport services in Napa and Sonoma counties. The region has an extensive first responder system that is primarily fire based. County and State Park rangers as well as certain law enforcement agencies are routinely dispatched to medical aids within their respective jurisdictions. BLS field protocols have been established for region responders and have been updated and revised during CY 2007-08.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Continue to identify the optimal roles and responsibilities of all system participants based on EMS system and models, public input and State standards. Ensure that system participants conform to assigned EMS system roles and responsibilities. Develop expanded scope BLS standards for selected responders in Mendocino County once new State EMT regulations are finalized.

OBJECTIVE:

Identify the optimal roles and responsibilities of EMS system participants and develop mechanisms, such as agreements, to ensure linkage between public, private and industrial EMS stakeholders.

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

There is a revised and updated (CY 2007-2008) BLS field protocol manual for regional first responders. The Agency believes that regional first responders continue to operate under established medical control and policies for BLS personnel. The BLS protocols are available for review or downloading via the Agency Web site. ALS first responders utilize the Agency's ALS protocols as well and there are first responder liaison members on the Regional Medical Advisory Committee (MAC) as well.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that first responders continue to operate under the medical direction of the EMS system. Review, and modify as necessary, BLS field protocols to ensure compliance with new pending State EMT regulations.

OBJECTIVE:

Refine existing methodology to ensure that first responders operate under the EMS Agency's Medical Director.

TIME FRAME FOR MEETING OBJECTIVE:

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

2.08 EMT-I TRAINING

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

By member county policy, the minimum staffing level of all ALS emergency medical transport vehicles (ambulances), is one licensed paramedic and one certified EMT-I. However, a BLS ambulance, staffed with a minimum of two EMT-Is may be used to respond to emergency requests during times of disaster and system overload when all available ALS resources have been depleted or in remote areas where BLS is the primary responder. BLS ambulances are routinely backed by ALS resources (ALS engine companies, Quick Response Vehicles or air ambulances) when being incorporated into the 9-1-1 response system.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure the availability of trained transport personnel to meet the needs of the EMS system. As resources and wherewithal allow, upgrade BLS response capability to BLS enhanced, new EMT-II, optimal scope or ALS.

OBJECTIVE:

Monitor and adjust ambulance staffing requirements to meet EMS system needs and the EMS system recommended guidelines.

TIME FRAME FOR MEETING OBJECTIVE:

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

2.09 CPR TRAINING

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Hospital employees working in the emergency department arena continue to be required to be certified in CPR. However, no mechanism exists to ensure compliance with this standard for personnel not under the jurisdiction of the CVEMSA. CPR training opportunities are listed on the Agency's web site.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Encourage the training of allied health personnel in CPR.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

2.10 ADVANCED LIFE SUPPORT

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

Current base hospital agreements require base hospital physicians to be certified in advanced cardiac life support (ACLS). All emergency department physicians are encouraged to be Board certified in emergency medicine or be certified in pre-hospital EMS management through such courses as pre-hospital trauma life support (PHTLS) and pediatric advanced life support (PALS). With the move to removing the MICN requirements in the region, the ACLS requirement for Registered Nurses will become an employer choice and/or responsibility. Currently no mechanism exists to audit ALS training for ED staff members.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure training in ALS for emergency department physicians and nurses who provide emergency patient care.

OBJECTIVE:

Develop policy to ensure that emergency department physicians and nurses are trained to an appropriate ALS level.

TIME FRAME FOR MEETING OBJECTIVE:

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

2.11 ACCREDITATION PROCESS

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Policies and procedures exist to accredit and orient ALS personnel. ALS Update courses are used as the platform to orient new ALS personnel entering the regional system. Newly accredited paramedics are oriented to policies and procedures, given access to those policies and procedures via the Agency Web site and given an electronic copy of the manual. New medics are assigned access to the region's PCR – MIS and are given an orientation to the region's QI process.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Continue to ensure that ALS personnel are appropriately oriented to the EMS system and capable of performing the expanded scope of practice procedures. Continue to regionalize individual counties' policies.

OBJECTIVE:

Monitor and amend the ALS accreditation process as needed.

TIME FRAME FOR MEETING OBJECTIVE:

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

2.12 EARLY DEFIBRILLATION

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Policies, procedures and training venues exist to support personnel in Public Safety AED (PSAED) programs. The Agency has established an AED program coordination (PSAED and PAD) to support AED usage. An AED programs link has been established on the Agency's Web site.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Continue to ensure policies and procedures for early defibrillation training and certification meet EMS system needs.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

2.13 BASE HOSPITAL PERSONNEL

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Individual member county's policies and agreements specify that only emergency department base hospital physicians who have been authorized by the CVEMSA Medical Director who have been judged knowledgeable in pre-hospital policies and protocols shall provide medical direction to EMS personnel. Paramedic Liaison Nurses (PLN) participate in county/regional QI programs which ensures a feedback loop between field, hospital and Agency. Base hospital personnel are trained in radio usage.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that only adequately trained physicians provide medical direction to EMS personnel.

OBJECTIVE:

Refine policies requiring base hospital physicians to be trained in providing pre-hospital medical direction, radio communication and EMS agency policies. Monitor compliance to ensure that base hospital personnel who provide medical direction are knowledgeable about EMS policies and procedures.

TIME FRAME FOR MEETING OBJECTIVE:

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

COMMUNICATIONS

3.01 COMMUNICATIONS PLAN

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

The current systems of dispatch, field and hospital medical communications within the three member counties range in age from 1 year to 15 years old. Communications capabilities for transport vehicles, ALS responders and facilities are established in each county. There is limited linkage between Sonoma and Napa, and Mendocino and Sonoma, but not between all three counties with the exception of fire based mutual aid frequencies. Mendocino County, with Rural Healthcare Development (RDP) grant funding, has upgraded and established new radio transmitter sites, which connect community health clinics and hospitals with the County communications system. Homeland Security and HRSA/HPP grant funding have facilitated an upgrade in radio equipment for field units. EMResource, an internet based communications system, has been established in all of the region's hospitals, clinics and SNF/Con Homes and Dispatch Centers. ACS (Ham) radios have been established in Sonoma's hospitals.

COORDINATION WITH OTHER EMS AGENCIES:

It is anticipated that coordination with North Coast EMS, NorCal EMS, and Marin County EMS may be either necessary or advantageous when developing a comprehensive communications plan.

NEED(S):

Ensure the availability of all necessary EMS dispatch and medical communications. All three member counties' communications systems are in need of potential upgrade and/or repair. An assessment of the communication systems needs to be performed as a precursor to the development of a regional communications plan. An assessment is contingent on each individual county's communications budget. FCC regulations that propose moving public safety radio systems to new frequency bands are still being modified along with deadline implementation dates. Once FCC establishes these "migration" timelines, the Agency expects that the individual county Communications entities will prepare master plans. The Agency needs to ensure its participation in these planning efforts.

OBJECTIVE:

Create and effect a regional communications plan, prioritize system repairs and upgrades and make necessary changes to comply with regional and/or individual county needs. The communications plan should ensure that an adequate number of frequencies exist for dispatch, scene management, patient dispersal and medical control.

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard / meets guidelines*

All emergency medical transport vehicles have two-way radio equipment capable of performing field to dispatch, field to field, and field to hospital communications. However, communications "dead-spots" exist throughout the system especially in the valleys of the coastal range mountains. Communications backbone system upgrades have been taking place in both Mendocino and Sonoma counties (2003-2007), with either grant funding or capital improvement funding to lessen the impact of these geographical barriers. The estimated cost to upgrade Sonoma County's communications system to meet projected FCC requirements has been estimated to be in the range of $30M-$40M. The Agency does not and will never have that financial capability. The Agency's intentions are to ensure participation in any strategic communications planning that occurs within each respective member county, as spearheaded by that county's communications / IS department. Fortunately, the infusion of both Homeland Security and HRSA/HPP funding has served as a catalyst for the creation of ad hoc planning groups in the respective counties.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard

NEED(S):

Funding is a critical issue. Ensure the availability of medical communications through development of a regional communications plan. This plan should include linkages between first responders and ambulance providers.

OBJECTIVE:

Develop the communications plan, prioritize system repairs and upgrades and make necessary changes.

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

As discussed in 3.01, the current systems of dispatch, field and hospital medical communications capability have been established for more than ten years. All transport vehicles have two-way radio communication capabilities; cellular phone capability and approximately 25% of the vehicles have Mobile Data Computer communications capability.

COORDINATION WITH OTHER EMS AGENCIES:

Communications frequencies and the locations of radio repeaters may need to be performed in conjunction with adjacent EMS systems.

NEED(S):

Ensure the availability of medical communications. Conduct an assessment of the communication system(s) as a precursor to the development of a regional communications plan. Develop the plan as the State's communications master plan is established and as individual county funding allows.

OBJECTIVE:

Develop the communications plan, prioritize system repairs and upgrades and make necessary changes. Ensure compatibility between regional and state communications plan.

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

As discussed in 3.01, the current system(s) of dispatch, field and hospital medical communication technology have been in use for more than ten years. Designated EMS Dispatch centers have been established in each county. All 9-1-1 system medical transport vehicles have communications linkage with respective Operational Area dispatch centers / ordering points.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard

NEED(S):

An assessment of the communication system(s) needs to be performed as a precursor to the development of a regional communications plan. Commensurate funding from each county has to be established in order to accomplish this. Compatibility with State Master Communications Plan needs to be ensured.

OBJECTIVE:

Maintain and refine standards for system EMS dispatch centers..

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

Hospitals within Sonoma County can communicate with each other through a VHF and HAM radio systems

Not applicable for this standard. . A common radio frequency between hospitals within Mendocino was established with Rural Health Development grant funding in 2005. Napa hospitals utilize a VHF system. All of the hospitals in the region have ACS/RACES/HAM radios and can communicate with each other as well.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard

NEED(S):

Ensure the availability of medical communications as funding becomes available in each county. An alternative communications system, that is internet-based (EMResource), has been established within the region, enabling all hospitals to communicate with each. Ensure linkage between the needs and objectives outlined in Standards 3.01-3.04.

OBJECTIVE:

Develop the communications plan, prioritize system repairs and upgrades and make necessary changes as funding from the individual counties becomes available..

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Hospitals in Sonoma, Mendocino, and Napa counties have VHF radio communications capabilities. Hospitals in Mendocino also have UHF communications linkage (MED-NET). The county base hospitals can use either regular telephone and facsimile lines or the EMResource internet based system when determining the capabilities of area hospitals during MCIs and disasters. All providers have cellular phone capability as well as two-way radio capability with their respective in-county hospitals. Numerous hospitals also have satellite telephone capability. Approximately 25% of the providers have Mobile Data Computer (MDC) capability as well. The latest communications adjunct, EMResource, was established in all regional hospitals. EMResource links hospitals, the EMS Agency and respective county Emergency Operations Centers (EOC). EMResource can be used for MCI/ Disaster response coordination. The only other alternate communications capability for hospital-to-hospital transmissions region wide is Auxiliary Communications System (ACS) and cellular phones. Mendocino, Napa and Sonoma counties' EOCs are respectively linked to ACS operators and utilize regular telephone and facsimile lines as well as the RIMS network.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

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

OBJECTIVE:

Develop the communications plan, prioritize system repairs and upgrades and make necessary changes consistent with system needs and regional communications goals when the individual counties establish system funding.

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

All counties in the CVEMSA system have enhanced 9-1-1 telephone service.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Participate in ongoing planning and coordination of 9-1-1 telephone service.

OBJECTIVE:

Participate in ongoing planning and coordination of 9-1-1 telephone service and encourage the development of secondary EMS PSAPs (designated EMS dispatch centers) as feasible.

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Education concerning 9-1-1 access is provided on an annual basis throughout the region, typically by region providers and first responders. Brochures are distributed to the general public at health fairs and other promotional events.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Determine public education needs from the respective county EMCCs.

OBJECTIVE:

In coordination with other public safety agencies and primary health care organizations, provide for public education concerning appropriate utilization and system access as outlined in various EMS system models.

TIME FRAME FOR MEETING OBJECTIVE:

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

3.09 DISPATCH TRIAGE

MINIMUM STANDARDS:

The local EMS agency shall establish guidelines for proper dispatch triage that identifies appropriate medical response.

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

An emergency medical dispatch priority reference system (MPDS), has been established and is operational in all 3 regional counties.

NEED(S): Maintaining standardized EMD / QI program in then established in the designated EMS dispatch centers.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

OBJECTIVE:

Conduct random compliance evaluation of EMD centers.

TIME FRAME FOR MEETING OBJECTIVE:

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

3.10 INTEGRATED DISPATCH

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

Regional integrated dispatch continues to be developed in the CVEMSA system. Providers are required by agreement/ordinance/permit to ensure the availability of ambulances within their own zones within the respective counties at all times. Sonoma County established a consolidated Fire-EMS dispatch center in 2003. Mendocino has a designated EMS-Fire dispatch center. Napa has a centralized ambulance dispatch system. All 3 counties have designated EMS Aircraft dispatch centers.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Develop an integrated dispatch system in conjunction with the communications plan as individual county funding allows.

OBJECTIVE:

Maintain and refine the current integrated dispatch systems in conjunction with the communications plan.

TIME FRAME FOR MEETING OBJECTIVE:

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

RESPONSE AND TRANSPORTATION

4.01 SERVICE AREA BOUNDARIES

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

Emergency medical transportation service areas have been determined for all three counties in the EMS system. An ordinance or similar mechanism (such as Exclusive Operating Areas) has been established in Mendocino, Napa and Sonoma counties that provides for the establishment of ambulance response zones. Mutual aid procedures have established in each county between transport providers to ensure adequate coverage. The Agency conducted a system assessment during 2008-2009 in conjunction with EOA renewal and/or establishment. That process continues.

COORDINATION WITH OTHER EMS AGENCIES:

Marin, Solano, and North Coast (Lake & Humboldt).

NEED(S):

Ensure that ambulance response zones provide optimal ambulance response and care by periodically evaluating the emergency medical transportation service areas.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

The minimum standard is met through written agreements, permits, EOA contracts, ordinances, auditing, inspections and investigation of unusual occurrences.

There are ordinances in place in Mendocino and Sonoma counties. Sonoma County currently has one EOA provider. Napa has a written agreement with one ALS provider(non-transport) and EOA contracts with an ALS transport provider for the Napa (upper & lower) Valley catchment areas.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that providers comply with statutes, regulations, policies and procedures.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

4.03 CLASSIFYING MEDICAL REQUESTS

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

An emergency medical dispatch priority reference system has been developed and is in use in Napa, Sonoma and Mendocino counties. Currently, classification criteria based off the medical priority dispatch systems is used by all designated EMS dispatch centers with an ALS or BLS ambulance typically being sent to all 9-1-1 medical requests as a minimum response depending on dispatch triage criteria.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure the consistent use of emergency medical dispatch system standards for all (i.e., city PSAP) dispatch centers responsible for dispatching medical resources within the region.

OBJECTIVE:

Maintain emergency medical dispatch system standards in all regional medical resource dispatch centers.

TIME FRAME FOR MEETING OBJECTIVE:

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

4.04 PRESCHEDULED RESPONSES

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

EOA contracts specify system status levels appropriate to accommodating prescheduled responses. Transport unit availability is a provider regulated responsibility, but monitored by the Agency and the various dispatch centers. Mutual aid protocols are in place to ensure an ambulance response to all 9-1-1 system generated calls for service.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure the availability of a sufficient number of emergency medical transport vehicles to meet EMS system demands. EOA system status management principles and standards for all providers.

OBJECTIVE:

Monitor ambulance availability and take corrective action as necessary.

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

	Metropolitan - Urban Area	Suburban - Rural Area	Wilderness Area
BLS First Responder	5 minutes	15 minutes	30 minutes
Early Defib. First Responder	5 minutes	15 minutes	30 minutes
ALS Responder or Ambulance	8 minutes	20 minutes	60 minutes
EMS Transportation Unit	8 minutes	20 minutes	60 minutes

CURRENT STATUS: *meets minimum standard*

Response standards were developed for the EOA ALS ambulance providers in Sonoma County and Napa County EOAs. In Mendocino County, geography, travel distance and resource availability make standards challenging, but recent distribution of AEDs to all first responder agencies in the county have contributed to meeting standards. Additionally, all three counties are serviced by EMS aircraft providers that can reach any point in the respective counties within 30 minutes of lift off from their respective landing pads/hangars. All of the urban corridors within the three counties meet or exceed the ALS/ambulance/transport response standards as listed above. Response times for the EMS transportation unit are measured from the time the secondary PSAP has enough information to send an ambulance (address, complaint, severity) to arrival on scene.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure the ability to measure response times from the primary PSAP to arrival on scene for ambulance and first response vehicles. Development of a mechanism to measure or collect response times for first response agencies and the establishment of response time goals or standards for first response agencies in conjunction with a first responder master plan.

OBJECTIVE:

Create a mechanism and/or process to measure response times from receipt of call at PSAP to arrival on scene for both first responder agencies and transport units. Establish response time standards for non-EOA portions of the region.

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

By policy, the minimum staffing level of all ALS emergency medical transport vehicles (ambulances) is one licensed paramedic and one certified EMT-I. However, a BLS ambulance staffed with a minimum of two EMT-Is may be used to respond to emergency requests during times of disaster, system overload when all available ALS resources have been depleted and in response areas serviced by BLS. LALS staffing requirement is one accredited EMT II and one certified EMT I. Providers are required to maintain a minimum drug and equipment inventory on all in-service ambulances as specified by the agency.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure compliance with standard.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

4.07 FIRST RESPONDER AGENCIES

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

The roles and responsibilities of most system participants are based primarily on a willingness to cooperate with the agency and to serve their communities. The region has an extensive first responder network (70+ agencies) that meets State and local requirements.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Formal integration of first responder agencies into the EMS system through the development of a first responder master plan is a strategic goal..

OBJECTIVE:

Incorporate the optimal roles and responsibilities of first response agencies as described in the first responder master plan.

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

- authorization of aircraft to be utilized in pre-hospital patient care,
- requesting of EMS aircraft,
- dispatching of EMS aircraft,
- determination of EMS aircraft patient destination,
- orientation of pilots and medical flight crews to the local EMS system, and
- addressing and resolving formal complaints regarding EMS aircraft.

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Processes have been established for categorizing medical and rescue aircraft as required in a-f above in the EMS region. All EMS aircraft providers serving the region have completed authorization requirements, a process that was formally instituted in FY 2002-2003. New regional aircraft policies that went into effect in April of 2002 are being revisited and have been revised during FY 2009-2010. Air ambulances have been prioritized as "first-in" to medical calls with Air Rescue units as secondary or first-in when no air ambulances are available. An Aircraft Utilization subcommittee has been established as part of the Agency's Regional Medical Advisory Committee.

COORDINATION WITH OTHER EMS AGENCIES:

Services classified by other LEMSAs are used to supplement resources based in the CVEMSA system.

NEED(S):

Ensure that medical and rescue aircraft incorporated into the EMS system meet system needs and adhere to agency requirements. Maintain and revise, as necessary, EMS Aircraft Utilization policy for regional application.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

4.09 AIR DISPATCH CENTER

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

One dispatch center per county has been identified and designated as an EMS aircraft resource center.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Evaluate and improve the current system for requesting and dispatching EMS aircraft. Update Aircraft Utilization Policy as needed.

OBJECTIVE:

Evaluate and improve the current system for requesting and dispatching EMS aircraft.

TIME FRAME FOR MEETING OBJECTIVE:

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

4.10 AIRCRAFT AVAILABILITY

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

The CVEMSA has identified medical and rescue aircraft for emergency patient transportation for aeromedical services operating within the EMS region. The Agency has either permits or written agreements with the aeromedical services operating in the region, with the exception of the California Highway Patrol, which is exempted. However, CHP and CDF have indicated a desire to cooperatively participate in the CVEMS aeromedical program.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure the availability and appropriate staffing of EMS medical and rescue aircraft to meet the demands of the EMS system. Implement helicopter tracking and statusing interface in the region's EMS Dispatch Centers.

OBJECTIVE:

Monitor providers to ensure that system demands are being met. Ensure providers compliance with agreements and policy.

TIME FRAME FOR MEETING OBJECTIVE:

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

4.11 SPECIALTY VEHICLES

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

Individual counties with specialty vehicle needs have developed resource lists and procedures for requesting and dispatching these specialty vehicles, primarily water rescue vehicles and MCI trailers.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Development of a region-wide resource directory and response plan for specialty vehicles.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

4.12 DISASTER RESPONSE

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Each of the member counties have a current, functional MCI Plan. Each of the member counties have staff members who are part of the respective county disaster team, specifically EOC staff members. As Medical Health Operation Area Coordinators (MHOAC), EMS staff members work closely with the respective county OES organizations. EMS staff members have taken Ambulance Strike Team Leader "Train the Trainer" course during FY 06-07 as well as being compliant with ICS 100-200-300-400, SEMS, and NIMS IS 700-800.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Continue to work with other OES Region II counties in developing standard procedures for mobilizing response and transport vehicles for disasters. Formalize the mutual aid capabilities between the member counties.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

4.13 INTERCOUNTY RESPONSE

MINIMUM STANDARDS:

The local EMS agency shall develop agreements permitting inter-county response of emergency medical transport vehicles and EMS personnel.

RECOMMENDED GUIDELINES:

The local EMS agency should encourage and coordinate development of mutual aid agreements that identify financial responsibility for mutual aid responses.

CURRENT STATUS: *meets minimum standard*

Ambulance provider permits and agreements require providers to arrange for day-to-day auto-aid from neighboring providers stationed both inside and outside the CVEMSA system. Region providers routinely cross county borders to provide emergency response.

When the counties of OES Region II complete the process of finalizing an EMS master-mutual aid agreement, which will identify financial responsibility and request procedures for inter-county mutual aid, CVEMS will apply the agreement procedures to an intercounty response plan.

COORDINATION WITH OTHER EMS AGENCIES:

Formalization of the current day-to-day response configurations between member counties and Marin, Solano, Humboldt and Lake counties is needed.

NEED(S):

Master EMS mutual-aid agreement between the counties of OES Region II. Mutual aid agreement between regional member counties as well as contiguous counties to the region.

OBJECTIVE:

Adoption of a master EMS mutual-aid agreement. Continue to monitor day-to-day mutual-aid and continuation of call incidents and take action as necessary.

TIME FRAME FOR MEETING OBJECTIVE:

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

4.14 INCIDENT COMMAND SYSTEM

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

The MCI Plans currently in use in respective member counties are all based on and utilize the Incident Command System. The Regional Medical Advisory Committee has begun reviewing and updating the respective MCI plans during FY 2008-2009. The group intends to create a regional MCI plan, with specific county annexes. MCI management kits have been purchased and distributed to transport agencies via Homeland Security and HPP grant funding.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that the MCI plan continues to meet the needs of on-scene medical management. Evaluate the viability of establishing a regional MCI Plan. Establish completion of ICS 100-200, NIMS IS 700 and a 4-hour hospital or field MCI course as the minimum standard for EMS personnel.

OBJECTIVE:

Monitor the utilization of the respective MCI plans and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

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

4.15 MCI PLANS

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

The MCI Plans currently in use are ICS, NIMS and SEMS compliant. The Agency has a MCI table top training kit as well as field MCI kit (vests, pocket guides, clipboards) that is available for training exercises for agencies within the region. The Agency has also produced a MCI pocket guide for field responders. The Agency purchased and distributed MCI management kits (along with all-hazard triage tags) to all transport providers via Homeland Security and HPP grant funding.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that the MCI plans continue to meet the needs of on-scene medical management. Evaluate training standards and requirements for MCI planning and response. Update the current MCI Plans and produce a regional MCI plan with county annexes as needed.

OBJECTIVE:

Monitor the utilization of the MCI plans and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

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

4.16 ALS STAFFING

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

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

CURRENT STATUS: *meets minimum standard*

By policy, the minimum staffing level of all ALS ambulances, is one licensed paramedic and one certified EMT-I. However, a BLS ambulance, staffed with a minimum of two EMT-Is may be used to respond to emergency requests during times of disaster, system overload when all available ALS resources have been depleted or in areas presently designated as BLS response zones. All BLS providers are AED certified. Additionally, BLS units are routinely backed up with ALS resources (ALS Engine companies, Quick Response Vehicles or ALS aircraft).

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that ALS ambulance staffing meets minimum standards and system needs.

OBJECTIVE:

Continue to maximize efforts to upgrade emergency medical response capability to ALS region wide.

TIME FRAME FOR MEETING OBJECTIVE:

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

4.17 ALS EQUIPMENT

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Providers are required to maintain a minimum drug and equipment inventory on all in-service ambulances as specified by the agency. Equipment and drug inventory requirements have been revised and updated by the Agency in conjunction with its Regional Medical Advisory Committee during FY 2004-2005 and FY 2005-2006. All providers are inspected annually by the Agency to ensure compliance.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure the availability of drugs and equipment on ambulances to meet patient and system needs. Evaluate and adjust, as necessary, the respective inventories to ensure a regional standard.

OBJECTIVE:

Monitor drug and equipment requirements and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

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

4.18 TRANSPORT COMPLIANCE

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Written agreements, permits, county ordinances, inspections, unusual occurrence reporting, investigations and quality improvement programs have been established as mechanisms to review, monitor and enforce compliance with system policies for operations and clinical care. Not all provider agencies within the region have written agreements (primarily 201 entities). However, these agencies are compliant with system standards. There is now a regional QI program in place.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure compliance with system policies. Establish regional agreement template, investigation process and quality improvement program(s).

OBJECTIVE:

Develop regional templates, standards and policies. Evaluate and improve compliance with system policies.

TIME FRAME FOR MEETING OBJECTIVE:

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

4.19 TRANSPORTATION PLAN

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

The Transportation Plan will undergo a revision/update as needed during FY 2009-2010.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that the Transportation Plan meets the needs of the EMS system.

OBJECTIVE:

Implement and monitor the requirements of the Transportation Plan and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

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

4.20 "GRANDFATHERING"

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

There are currently no grandfathered providers in the region. City of Napa Fire Department has 1797.201 rights for provision of ALS non-transport. City of Petaluma and City of Sonoma Fire Departments have 1797.201 rights for provision of ALS transport. It has been determined that Bells Ambulance in Sonoma County is eligible for "grandfathering". Discussions have begun with 2 of the eligible entities.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

None identified.

OBJECTIVE:

None identified.

TIME FRAME FOR MEETING OBJECTIVE:

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

4.21 EOA COMPLIANCE

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

There are contracts, county ordinances, inspections, unusual occurrence reporting, investigations and quality improvement programs in place which serve to review, monitor and enforce compliance by EOA providers with system policies for operations and clinical care. Napa County instituted a second EOA during 2002, which is reflected in the Transportation Plan. Both Sonoma and Napa counties have EOAs. A system assessment was instituted during FY 2008-2009 to determine the viability of establishing an EOA(s) within Mendocino County. At this time fiscal limitations have precluded further action.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure compliance with system policies

OBJECTIVE:

Evaluate and improve compliance with system policies.

TIME FRAME FOR MEETING OBJECTIVE:

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

4.22 EOA EVALUATION

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

The EMS Agency evaluates the design of EOA in conjunction with EOA contract terms. Sonoma County completed a system redesign process in 98-99 that focused on exclusive operating areas as part of its scope. Napa County completed the design phase of its EOA process during 98-99 as well and has since instituted an EOA. A second Napa county EOA was instituted during 2002 after an extensive evaluation and design process. The performance standards required of providers operating within EOAs are routinely monitored and corrective action is taken to address deficiencies. Work began during FY 2006-2007 to assess the respective EOAs in Napa and Sonoma Counties. In December 2008 Sonoma County entered into a contract for an established EOA (EOA #1) beginning July 1, 2009. Napa continues the process to develop and deploy an EOA in 2010.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that EOA designs meet the needs of the EMS system and is consistent with the EMS system model.

OBJECTIVE:

Continue to monitor performance standards and take corrective action as needed.

TIME FRAME FOR MEETING OBJECTIVE:

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

FACILITIES AND CRITICAL CARE

5.01 ASSESSMENT OF CAPABILITIES

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

Two facilities are designated as Trauma Centers within the region. New triage and patient destination policies have been produced as a result of trauma system planning activities. There are written agreements with the base hospitals within the region. Two facilities that downgraded their ED status from Basic to Standby in Sonoma County (2004-05) were assessed during the impact evaluation process. One receiving facility(Sutter Warrack) was taken off- line in Sonoma County by Sutter Health in 2006. Additionally, two hospitals (Mendocino Coast District Hospital – Mendocino County and St. Helena Hospital – Napa County) downgraded their respective Emergency Departments from Basic to Standby in 2005 and 2006. All of the region's facilities participated in HRSA/HPP grant funding projects during 2008-09 and have increased their respective surge capacity as well decontamination capabilities.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Develop a dynamic assessment process of area hospitals to determine ongoing EMS capabilities.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

5.02 TRIAGE & TRANSFER PROTOCOLS

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Pre-hospital trauma triage protocols have been implemented on a regional basis. Alternate trauma center destination alternatives (John Muir & UC Davis) for air transport trauma patients are in place. An interfacility transfer policy has been established. Transfer protocols with Children's Hospital Oakland (CHO) have been established along with direct air transport procedures for pediatric related field incidents. Transfer agreements are in place at the region's two Trauma Centers with other specialty centers (burn, spinal cord, microsurgery). Additional model transfer procedures for pediatric patients were developed in conjunction with the EMSC project.

COORDINATION WITH OTHER EMS AGENCIES:

Work with adjacent EMS systems(Marin, North Coast) to establish standard triage and transfer protocols as practical.

NEED(S):

Continue development and implementation of pre-hospital triage protocols as needed. Continue to establish linkage platforms for patient transfers to specialty centers outside of the region. Develop a North Bay (Marin, CVEMS) trauma system.

OBJECTIVE:

Ensure timely production of pre-hospital triage and transfer protocols based on medical need and preferred transport.

TIME FRAME FOR MEETING OBJECTIVE:

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

5.03 TRANSFER GUIDELINES

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Transfer protocols with Children's Hospital Oakland (CHO) have been established. An interfacility transfer policy has been established. Transfer agreements are in place at the region's two Trauma Centers with other specialty centers (burn, spinal cord, microsurgery). Additional l transfer procedures for pediatric patients were developed in conjunction with the EMSC project. A review of field trauma triage criteria along with point of entry protocols is being conducted by the Agency's regional Trauma Coordinator. The Trauma Coordinator is responsible for chairing the region's Trauma Advisory Committee (TAC) which is comprised of regional trauma center and receiving hospital representatives along with the regional EMS medical director.

COORDINATION WITH OTHER EMS AGENCIES:

Any future transfer policies or agreements will be coordinated with affected LEMSAs (Marin, North Coast).

NEED(S):

Assist with the development of transfer guidelines for trauma and other specialty patient groups as tools to be used by emergency department physicians in determining an appropriate disposition for EMS patients.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

5.04 SPECIALTY CARE FACILITIES

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

There is a Level II Trauma Center designation located in Sonoma County. There is a Level III Trauma Center in Napa County. Children's Hospital-Oakland has been designated for direct air transport of pediatric patients. Two STEMI receiving facilities are designated in Sonoma County. Two STEMI receiving facilities are designated in Napa County

COORDINATION WITH OTHER EMS AGENCIES:

The designation of specialty care centers located outside of our region was performed with the approval of the local EMS agencies that had originally designated the centers.

NEED(S):

Ensure a process exists to designate and monitor receiving hospitals and specialty care facilities for specified groups of emergency patients. Accomplish the needs portion of Standard 5.01.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

5.05 MASS CASUALTY MANAGEMENT

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

Work is underway in all three counties to establish "surge capacity" in the region's hospitals via HRSA/HPP grant funding. The region's Level II Trauma Center (Santa Rosa Memorial Hospital) was the recipient of EMS Authority trauma cache grant funding and now has the equivalent of two trauma/burn caches. There are Multi-Casualty Incident plans in place in the member counties. All individual facilities within the region have internal disaster management plans. All of the region's facilities have received MCI management kits including multi-hazard triage tags. NIMS training is being conducted. Mass casualty drills are scheduled in conjunction with the EMS Authority's annual statewide hospital disaster drill. The region's hospitals conduct their disaster drills utilizing the HEICS system. The EMResource system has been established in all of the region's hospitals.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure adherence to MCI plan requirements. Continue efforts to assess, establish and maintain a "surge capacity" as defined by federal grant funding programs (HRSA/HPP, CDC)

OBJECTIVE:

Monitor capability of system hospitals to respond to mass casualty incidents and encourage and/or make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

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

5.06 HOSPITAL EVACUATION

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

All regional hospitals have individual evacuation plans in place. County by county and/or regional hospital / healthcare disaster planning group(s) to address the issues of patient evacuation and developing surge capacity have been established, thanks to HRSA/HPP and Homeland Security grant funding. The EMResource system was implemented throughout the region in 2007 to enhance the tracking of available facility beds and for making informed patient destination decisions. Inclusion of Skilled Nursing Facilities (SNF), Clinics and convalescent centers into disaster planning groups within the respective counties began in 2008.

COORDINATION WITH OTHER EMS AGENCIES:

Will most likely be necessary as OES regional evacuation plans are developed.

NEED(S):

Develop, adopt and implement a standardized regional hospital evacuation plan

OBJECTIVE:

Development and implement a model hospital evacuation plan.

TIME FRAME FOR MEETING OBJECTIVE:

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

5.07 BASE HOSPITAL DESIGNATION

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Currently, five of twelve hospitals in the EMS system have been designated as base hospitals. However, with the inclusion of provider QI and an increase in standing orders, there may not be a need for the number of base hospitals in their current roles.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Explore the viability of a single medical control point in each county. A process needs to be developed for selecting a single medical control point, if deemed viable, and identifying its optimal configuration and responsibilities.

OBJECTIVE:

Establish a single medical control point in each county, if deemed viable by system participants.

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

The Agency has established two trauma centers, a Level II in Sonoma County (Santa Rosa Memorial Hospital) and a Level III in Napa County (Queen of the Valley). The catchment area includes all of Sonoma, Mendocino and Napa counties and portions of Lake and Marin counties respectively. Trauma triage criteria has been implemented and the trauma centers have transfer platforms in place for patients needing specialty care outside of the region. Both trauma centers utilize trauma registry software to gather and track trauma patient data. The capabilities of the outlying facilities have been considered and representatives of the various receiving facilities are members of the regional Trauma Advisory Committee (TAC), which meets quarterly. A regional trauma coordinator position has been established to monitor and evaluate the system.

COORDINATION WITH OTHER EMS AGENCIES:

Coordination with Nor-Cal, Marin, and Solano.

NEED(S):

Ensure the availability of specialized trauma services to critically injured patients.

OBJECTIVE:

Maintain and refine a trauma system that effectively serves patients with critical injuries.

TIME FRAME FOR MEETING OBJECTIVE:

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

5.09 PUBLIC INPUT

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

All trauma planning efforts have included numerous opportunities for public, stakeholder and hospital representatives. Trauma planning has included the input of the respective county EMCCs. The EIR process for the Level II Trauma Center included extensive public input. A regional Trauma Advisory Committee has been established and meets quarterly.

COORDINATION WITH OTHER EMS AGENCIES:

Marin

NEED(S):

Ensure an open process for continuing trauma system development.

OBJECTIVE:

Keep the process used for developing a trauma system open to hospital, pre-hospital and public input.

TIME FRAME FOR MEETING OBJECTIVE:

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

5.10 PEDIATRIC SYSTEM DESIGN

MINIMUM STANDARDS:

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

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

The Agency competed an EMSC project grant in 2002. Site visits were conducted at all regional hospitals. Pediatric patient transfer procedures were established and distributed. CHO was identified as the pediatric trauma center of choice, UC Davis has since been added. Catchment areas were identified. Direct transport guidelines for pediatric trauma patients from the field were established. Pediatric transport providers were identified. Pediatric patient flow is monitored via the region's PCR system. The Agency's pediatric field protocols were revised and updated during FY 2005-2006. The EMS Agency regional Trauma Coordinator will be assuming pediatric system planning responsibilities.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Maintain pediatric patient flow surveillance. Establish permanent EMS-C coordinator position and/or responsibilities within the Agency.

OBJECTIVE:

Create permanent EMS-C system coordination responsibilities within the Agency.

TIME FRAME FOR MEETING OBJECTIVE:

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

5.11 EMERGENCY DEPARTMENTS

MINIMUM STANDARDS:

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

- staffing,
- training,
- equipment,
- identification of patients for whom consultation with a pediatric critical care center is appropriate,
- quality assurance/quality improvement, and
- 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: *meets minimum standard*

EMSC project staff conducted site visits at all regional hospitals during 2002. Pediatric equipment was reviewed along with staffing expertise and qualifications. Training needs were identified and grant funding was used to provide ENPC courses for ED nursing staff members. A consultation matrix was developed and distributed. QI procedures were reviewed and suggestions for "standardizing" pediatric review were offered. EMSC equipment review and assessment was reevaluated in 2008-09.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that the pediatric services provided by the EMS system continue to meet the needs of critically ill and injured children within the EMS system.

OBJECTIVE:

Develop continuous pediatric system monitoring capability.

TIME FRAME FOR MEETING OBJECTIVE:

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

5.12 PUBLIC INPUT

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *MEETS MINIMUM STANDARDS*

A Pediatric Advisory Committee comprised of pre-hospital and hospital advisors, consumers and pediatric experts was formed to provide advice and public input on the development of the pediatric emergency medical and critical care system.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Continue public input and evaluation of the pediatric emergency medical and critical care system.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

5.13 SPECIALTY SYSTEM DESIGN

MINIMUM STANDARDS:

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

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Adult and pediatric trauma patients have been identified as patients warranting transfer to designated centers both inside and outside of the region. The Agency has established a transfer policy for burn patients. Four STEMI receiving centers have been designated in the region.

COORDINATION WITH OTHER EMS AGENCIES:

None.

NEED(S):

Ensure the availability of trauma and other specialty care services to critically ill and injured patients.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

5.14 PUBLIC INPUT

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

NOT APPLICABLE FOR THIS STANDARD.

All specialty care planning efforts have included numerous opportunities for public and stakeholder input. The respective counties host EMCCs and the Regional Medical Advisory Committee is comprised of stakeholders (pre-hospital and receiving facilities, and the public). The various committees meet on a quarterly basis.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure an open process for specialty care system development.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

DATA COLLECTION AND SYSTEM EVALUATION

6.01 QA/QI PROGRAM

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

There is a dynamic, compliant regional CQI program in place in Mendocino, Napa and Sonoma counties which is comprised of base hospital medical directors, base hospital nurse liaisons and ambulance provider quality improvement coordinators as well as EMS Agency staff members. There is a region wide DBMS. Alignment of field care policies and protocols utilized in each county has been completed. Representatives from all three counties meet collectively on a quarterly basis. The Agency is undertaking a review and "ground-up review" and reassessment of it's CQI plan and process. An RFP for selecting a CQI Consultant was issued in early 2009 to perform this assessment.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Refine a region wide process to provide feedback to pre-hospital care personnel on patient outcomes. Maintain and refine a region wide CQI process that meets system needs and State standards.

OBJECTIVE:

Maintenance of a region-wide CQI program. Establishment of a process to identify preventable morbidity and mortality. Development of a process to provide feedback to pre-hospital personnel on patient outcomes. Ensure that the CQI process meets system needs and State standards. Expand the CQI process to include first response quality improvement coordinators and dispatch quality control coordinators. Continue to monitor and amend the QA/QI program to meet system needs.

TIME FRAME FOR MEETING OBJECTIVE:

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

6.02 PREHOSPITAL RECORDS

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Policy requires patient care records (PCRs) to be completed for all patients, with copies (hard or electronic) of the report being submitted to the receiving hospital, provider and agency. All ground ambulance providers and ALS first responders use either a standardized bubble form PCR, computerized keyboard entry PCR or a handwritten form for documenting patient care. A system wide PC server based PCR system is in place. The region is part of a multi-agency consortium (NorCal, Coastal Valleys and Imperial) that has utilized grant funding to develop a web-based PCR system that can be accessed by wireless devices.

COORDINATION WITH OTHER EMS AGENCIES:

NorCal, North Coast & Imperial as “user group” participants..

NEED(S):

Ensure completeness and timely submission of patient care records. Continue development efforts to standardize the data collection methodology within the region.

OBJECTIVE:

Investigate ways of improving completeness and timely submission of patient care records. Monitor providers to ensure adherence to policy and take corrective action as necessary.

TIME FRAME FOR MEETING OBJECTIVE:

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

6.03 PREHOSPITAL CARE AUDITS

MINIMUM STANDARDS:

Audits of pre-hospital care, including both system response and clinical aspects, shall be conducted.

RECOMMENDED GUIDELINES:

The local EMS agency should have a mechanism to link pre-hospital records with dispatch, emergency department, in-patient and discharge records.

CURRENT STATUS: *meets minimum standard*

A regional Q.I. group (advisory to the Agency) has been formed to conduct pre-hospital care audits regarding system operations. Each individual County has specific CQI groups that work on County specific issues. These individual; groups constitute the Regional Committee who meet and report at the quarterly held Medical Advisory Committee (MAC) meetings.

COORDINATION WITH OTHER EMS AGENCIES:

None.

NEEDS:

A clinical audit system capable of identifying preventable morbidity and mortality and ensuring adherence to treatment standards.

OBJECTIVE:

Continue development of a Wide Area Network (WAN) or other type of electronic data link to allow access to the EMS Database System for the EMSA, ambulance provider agencies and base hospitals to facilitate data collection and reporting.

Develop a process to identify preventable morbidity and mortality and ensure adherence to treatment standards.

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Approved level II EMD centers are required by policy to establish an in-house QA program that includes the auditing of pre-arrival instructions as well as appropriate call categorization and commensurate resource response.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that an appropriate level of medical response is sent to each emergency. Ensure the appropriateness of prearrival/post dispatch directions.

OBJECTIVE:

Continue development of an oversight process 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.

TIME FRAME FOR MEETING OBJECTIVE:

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

6.05 DATA MANAGEMENT SYSTEM

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

The local EMS agency should establish an integrated data management system which includes system response and clinical (both pre-hospital 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: *meets minimum standard*

There is a region-wide DBMS. Essential audit filters are completed. Additional specialized filters are under development.

COORDINATION WITH OTHER EMS AGENCIES:

NorCal EMS and North Coast EMS agencies are members of the DBMS users group.

NEEDS:

In order to assure that our data management system meets the changing needs of the agencies using it in the future, the tasks of need assessment, revision design, programming and documentation must continue.

Gain access to existing hospital data regarding the outcomes of pre-hospital patients. Establish benchmarks and quality indicators.

OBJECTIVE:

Train system participants to use established QI processes and indicators. Monitor and modify as needed.

TIME FRAME FOR MEETING OBJECTIVE:

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

6.06 SYSTEM DESIGN EVALUATION

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

A Regional Medical Advisory Committee, comprised of local Q.I. coordinators, hospital liaisons and provider representatives has been formed to evaluate response, care and transport. Additionally, each member county has a functioning Emergency Medical Care Committee that reviews local operations, policies and practices. A Regional Directors Committee (RDC) comprised of the three DHS Directors from each member county meets and reviews issues concerning the plans, policies and procedures of the CVEMSA before they are submitted to the respective Board of Supervisors (BOS) for consideration. All meetings of the BOS and county EMCCs are open to the public with time allocated on each agenda for open public comments. Additionally, impacted groups are routinely notified in advance of issues before the EMCCs and the BOS.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Creation of common indicators that can be used for evaluating the effectiveness of the EMS system at meeting community needs and system demands. Maintain and support the regional CQI committee.

OBJECTIVE:

Create common indicators that can be used for evaluating the effectiveness of the EMS system at meeting community needs and system demands. Train local providers in Agency QI processes. Participate in statewide standardized system evaluation projects.

TIME FRAME FOR MEETING OBJECTIVE:

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

6.07 PROVIDER PARTICIPATION

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

ALS providers are required by policy and agreement to participate in the agency system-wide evaluation program. BLS providers in Mendocino County are required to participate in the agency system-wide evaluation program.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure participation of all providers within the agency's regional QA/QI program.

OBJECTIVE:

Investigate the feasibility of requiring first responder, dispatch and other system provider participation in system QA/QI programs.

TIME FRAME FOR MEETING OBJECTIVE:

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

6.08 REPORTING

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Individual member counties have been reporting to their respective BOS and constituent groups on the progress of the regionalization process as well as overall system operations within the respective member counties. The Agency submits quarterly status reports to the EMS Authority.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEEDS:

Analyze data using established QI indicators and benchmarks. Establish reporting cycles.

OBJECTIVE:

Report analyzed data on an annual or quarterly basis. Annually report the results of the system evaluation, design and operations to the respective Board(s) of Supervisors, provider agencies, and Emergency Medical Care Committee(s).

TIME FRAME FOR MEETING OBJECTIVE:

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

6.09 ALS AUDIT

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

The local EMS agency's integrated data management system should include pre-hospital, base hospital, and receiving hospital data.

CURRENT STATUS: *meets minimum standard*

There is a regional CQI program in place. Mendocino, Napa and Sonoma counties each have local QI networks which are comprised of base hospital medical directors, base hospital nurse liaisons and ambulance provider quality improvement coordinators in conjunction with Agency staff.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Maintain and enhance a region wide process to provide feedback to pre-hospital care personnel on patient outcomes. Maintain a region wide CQI process that meets system needs and State standards.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

6.10 TRAUMA SYSTEM EVALUATION

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Both trauma centers utilize trauma registry software to gather and track trauma patient data. Quarterly data is submitted to the agency by the Trauma centers. The regional trauma audit committee(Tac) meets quarterly and is responsible for reviewing and evaluating care of major trauma patients in the region. Tac provides an educational platform for both prehospital and hospital personnel. Improvements to system design and operations are identified and recommended by Tac. HRSA/HPP grant funding was used to review and provide recommendations regarding the regions current trauma configuration of acute trauma hospitals. These recommendations offered alternatives for configuration of acute care centers and how they might be modified to better ensure timely access to trauma receiving facilities in the region .

COORDINATION WITH OTHER EMS AGENCIES:

Marin EMS, North Coast EMS.

NEED(S):

Data collection program/system that includes all non-trauma designated receiving facilities in the region that receive trauma patients.

OBJECTIVE:

Continue development of a data collection program/system that encompasses all trauma patients regardless of initial destination. Continue utilizing the trauma registry and Tac to identify potential needs in the system.

TIME FRAME FOR MEETING OBJECTIVE:

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

6.11 TRAUMA CENTER DATA

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

The agency currently collects quarterly data from all trauma centers in the region. Quarterly data is reviewed by all Tac members at its quarterly meetings. Additional information or details of specific cases are provided by the trauma centers as requested by Tac or the agency.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Establish a linkage between prehospital data and the trauma registry data. This should include non-trauma center receiving facilities receiving trauma patients.

OBJECTIVE:

Develop standards for all receiving facilities in the region regarding data collection for trauma patients. Establish data linkage with CA EMSA on trauma data.

TIME FRAME FOR MEETING OBJECTIVE:

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

PUBLIC INFORMATION AND EDUCATION

7.01 PUBLIC INFORMATION MATERIALS

MINIMUM STANDARDS:

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

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

CVEMSA has either developed or disseminated information on basic first aid, CPR, system design and access and disaster planning. The Agency established an internet Web site for public access and review of the EMS system within the respective region's counties. The Agency has established a PIE "traveling kit" that will be used throughout the region at public safety and health oriented public events. PIE materials from the kit will be available for distribution at these events. .

NEED(S):

Continue to develop a regional approach, with linkages between the regions' respective EMCCs, for meeting the components contained within this standard.

OBJECTIVE:

In coordination with primary care providers and other public safety agencies, develop and present education materials and programs regarding system access and utilization as described in the EMS system model.

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

The agency began involvement with injury prevention and/or injury control efforts through its EMSC project. The regional Trauma Coordinator has reestablished liaison with the statewide EMSC coordinator's group. Those efforts have been followed up with the Risk Watch Injury Prevention project and the above-mentioned PIE grant. The Agency participates in the SafeKids program on an ad-hoc basis. The agency and EMS system participants routinely participates in public safety (health) fairs at various locations throughout the EMS region promoting system understanding.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Continued development and promotion of injury control education programs and programs targeted at high risk groups.

Utilize the Education and Training ad hoc committees within the respective member county EMCCs to develop evaluation methodologies and develop training formats/programs.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

7.03 DISASTER PREPAREDNESS

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

The Agency has been involved with the respective OA OES in promoting citizen disaster preparedness. Agency staff members have participated in BT plan development, Homeland Security and HRSA/HPP grant programs as well bolstering the individual counties' disaster response capability. A Disaster Preparedness brochure has been created in conjunction with these activities and will be distributed through the PIE program.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Promote citizen disaster preparedness activities.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

7.04 FIRST AID & CPR TRAINING

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

A list of available CPR and first aid classes is usually maintained within the respective member counties' offices. Additionally, region wide training opportunities (including CPR etc.) are posted on the Agency's website. The Agency has begun taking a lead in promoting CPR and first aid training for respective member County employees as well.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Establishment of citizen CPR and first aid training goals.

OBJECTIVE:

Develop the capacity to either provide or coordinate the provision of CPR and first aid training.

TIME FRAME FOR MEETING OBJECTIVE:

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

DISASTER MEDICAL RESPONSE

8.01 DISASTER MEDICAL PLANNING

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Disaster medical planning has been occurring in each of the member counties. A response plan specific to toxic substance management has not been developed on a regional level, however the Agency has participated in preparation of local counties' WMD plans. Agency staff have been actively participating with local health departments, OES departments and other allied agencies in BT, CBRNE and WMD disaster planning and preparedness. Staff members sit on various focus groups related to Bioterrorism and disaster planning and have actively participated in Homeland Security, Office of Domestic Preparedness and HRSA/HPP grant programs. Agency staff members have also been actively involved in the annual Statewide Health-Hospital Disaster exercises as well.

COORDINATION WITH OTHER EMS AGENCIES:

As needed coordination exists between all Region II MOHOCS and lemsas.

NEED(S):

Ensure that the MCI Plans in place continue to meet the disaster medical response needs of the EMS system.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

Disaster medical planning has been occurring in each of the member counties. Agency staff have been actively participating with local health departments, OES departments and other allied agencies in BT, CBRNE and WMD disaster planning and preparedness. Staff members sit on various focus groups related to Bioterrorism and disaster planning and have actively participated in Homeland Security and HRSA/HPP grant programs. Agency staff members have also been actively involved in the annual Statewide Health-Hospital Disaster exercises as well.

COORDINATION WITH OTHER EMS AGENCIES:

As needed coordination exists between all Region II MOHOCS and lemsas.

NEED(S):

Ensure that the respective member counties' MCI Plans continue to meet the disaster medical response needs of the EMS system.

OBJECTIVE:

Monitor the efficiency and utilization of the MCI plans and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

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

8.03 HAZMAT TRAINING

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

The minimum hazardous material training standards for EMS personnel are those standards established by OSHA/Cal-OSHA. Personal Protection Equipment for EMS providers has been procured through Homeland Security grant funding and distributed accordingly. Additional PPE has been acquired through a EMS Authority administered grant as well. Medical personnel roles have been identified in OA hazmat response plans. In conjunction with the purchase of new all-hazard triage tags, train the trainer courses were conducted for EMS providers and hospital staff. Course content included biological, chemical and explosive incident mitigation.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Continue to maintain training coordination efforts for EMS providers throughout the region.

OBJECTIVE:

Ensure adequate training for EMS personnel regarding hazardous materials incidents. Determine hazardous material training levels or needs of EMS personnel.

TIME FRAME FOR MEETING OBJECTIVE:

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

8.04 INCIDENT COMMAND SYSTEM

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard / meets recommended guidelines*

The MCI Plans utilized by the CVEMSA member counties are based on the Incident Command System. Agency staff members have completed NIMS (is 700-800) training as well as advanced (ICS 300-400) ICS training. The Agency has a certified Ambulance Strike Team Leader on staff.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that all EMS personnel are trained in ICS, MCI, SEMS and NIMS.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

8.05 DISTRIBUTION OF CASUALTIES

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: PARTIALLY MEETS STANDARD

Regional patient distribution planning is underway in conjunction with HPP grant funding. “Surge capacity” grant benchmarks for the region’s hospitals and commensurate are addressing the redistribution of patients to either specialty centers or “disaster” designated facilities. A matrix of available beds is under development, including beds in acute care facilities (licensed vs. staffed as well as area/space for HPP grant acquired military cots), SNF, convalescent centers as well as other government run facilities (Sonoma Developmental Center, Coast Guard Two Rock Base, Napa State Hospital etc.). Potential sites for CCP or FTS activities (Vet’s buildings, fairgrounds etc.) have been identified in Sonoma County. The Agency is reviewing its MCI plan, specifically patient distribution procedures, as part of this process.

COORDINATION WITH OTHER EMS AGENCIES:

Eventual coordination with Marin County EMS, Solano County EMS cooperative, and Region II is anticipated.

NEED(S):

Develop the procedures for distributing disaster casualties that functions effectively. Develop a regional Facilities Assessment Profiles document, which would identify hospitals with special facilities and capabilities for receipt and treatment of patients with radiation and chemical contamination and injuries.

OBJECTIVE:

Monitor the distribution of disaster casualties, and make changes as needed, to ensure that patients are distributed to appropriate facilities. Create a facilities assessment profile for each hospital in the EMS system.

TIME FRAME FOR MEETING OBJECTIVE:

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

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

General written procedures and checklists have been used by Medical-Health OA Coordinators in the counties in CVEMSA throughout the 90's and early 2000's during a series of wet winters. These procedures include a process for assessing and communicating needs to OA EOCs, OES Region II and State OES, DHS and EMSA.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that the procedures for assessing medical needs in a disaster function effectively. Develop regional written procedures for MHOACs .

OBJECTIVE:

Monitor the ability to effectively assess medical needs in a disaster and make changes to the process as needed.

TIME FRAME FOR MEETING OBJECTIVE:

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

8:07 Disaster Communications

MINIMUM STANDARDS:

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

Current Status: Meets Minimum Standard

CALCORD is a commonly held frequency among all regional field providers. There are also EMS field/tactical frequencies as well as several fire field/tactical frequncies held in common, broken down by zones within the respective counties. ACS links all of the regional hospitals and OA EOC's. VHF and UHF frequency networks are in place for hospitals, ambulance providers, first responders and dispatch centers.

Coordination with other EMS Agencies:

Not applicable for this strandard.

Need(s):

Keep abreast of the FCC efforts to reallocate public safety bandwidths. Migrate, on a planned basis, with other public safety agencies in the respective counties to trunked radio systems or wireless cellular systems as technology is established aznd/or upgraded in each county. Work closely with each respective member counties' IS/Communications departments to ensure EMS inclusion in any long range as well as short term communications system infrastructure upgraqdes and enhancements.

Objective:

Maintain a dynamic and viable EMS communications system for use during disasters.

Time Frame for Objective:

Short Range Plan (one year or less)

X Long Range Plan (More than one year)

8.08 INVENTORY OF RESOURCES

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

MCI TRAILERS (25 patient) have been deployed in the respective counties through the auspices of Homeland Security and HRSA grant funding. Individual first responder agencies and EMS transport provider agencies have also been equipped with backboards, trauma kits, triage tags, O2 kits, burn kits and PPE. Additionally, hospital disaster trailers have been purchased via HRSA/HPP and Department of Homeland Security funding for all three counties. A Trauma equipment/supply cache was established in Sonoma County via State EMSA Trauma Cache grant funding (2006)

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Annually update the Disaster Medical Resource Directory.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

8.09 DMAT TEAMS

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

DMAT team within OES Region II is functional. Planning by member counties has occurred at the regional disaster medical coordinators meetings.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Develop a more formal relationship with Region II DMAT Team.

OBJECTIVE:

Develop a relationship with Region II DMAT Team.

TIME FRAME FOR MEETING OBJECTIVE:

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

8.10 MUTUAL AID AGREEMENTS

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *does not currently meet standard*

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

COORDINATION WITH OTHER EMS AGENCIES:

As stated above.

NEED(S):

Adoption of a master (Region II) medical mutual aid agreement. Formalize existing day to day mutual aid operations that currently exist within and between member counties. Develop a CVEMSA regional medical mutual aid agreement.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

8.11 CCP DESIGNATION

MINIMUM STANDARDS:

The local EMS agency, in coordination with the local OES and county health officer(s), and using state guidelines, shall designate Field Treatment Sites (FTS).

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *PARTIALLY meets standard*

Several locations for Casualty Collection Points (CCP) have been identified by individual counties. These sites have multi-use configurations, i.e., shelters, mass prophylaxis etc. Planning efforts are underway to develop a formal regional plan for their activation and staffing. CVEMSA plans to use the State EMSA medical volunteer registry as an adjunct and/or template. Site identification is relatively easy to document, however the issues of staffing and logistical support remain extremely challenging.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Formally identify CCP and establish plans regarding activation, staffing and outfitting.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

8.12 ESTABLISHMENT OF CCP

MINIMUM STANDARDS:

The local EMS agency, in coordination with the local OES, shall develop plans for establishing Casualty Collection Points (CCP) and a means for communicating with them.

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *does not currently meet standard*

Several sites for CCP have been identified throughout the EMS region. However, no formal plans have been developed for their activation, staffing or outfitting as CCP. There are plans in place for utilizing these sites as PODs, general shelters, as well as mass prophylaxis sites. CVEMSA is working with the respective member counties' Health Departments' Disaster Preparedness programs/units

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Identify CCP and establish plans regarding activation, staffing and outfitting.

OBJECTIVE:

In conjunction with county OES offices and Health Departments, establish plans regarding activation, staffing and outfitting of CCP.

TIME FRAME FOR MEETING OBJECTIVE:

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

8.13 DISASTER MEDICAL TRAINING

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

The minimum hazardous material training standards for EMS personnel are those standards established by OSHA/Cal-OSHA. Providers, first responders and training institutions, conduct MCI training. Personal Protection Equipment for EMS providers has been procured through Homeland Security and State EMSA grant funding and distributed accordingly. Medical personnel roles have been identified in OA hazmat response plans. In conjunction with the purchase of new all-hazard triage tags (California Fire Chiefs approved), train the trainer courses were conducted for EMS providers and hospital staff. Course content included biological, chemical and explosive incident mitigation. The Agency's MCI plan is being reviewed and updated to ensure compliance with ICS, SEMS and NIMS.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure a standard of training for EMS personnel in disaster medical response and the management of hazardous materials incidents.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

8.14 HOSPITAL PLANS

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

CVEMSA staff have been working with the respective member counties' Health Departments via CDC and HPP grant programs in conducting and/or providing for in-service hospital training in ICS and CBRNE response. CVEMS and local hospitals conduct disaster exercises on an annual basis. HEICS is the standard for all EMS regional hospitals. Region hospitals are now coordinating annual drills with the statewide EMSA annual hospital drill (and/or Golden Guardian exercise). Side by side comparisons of hospital disaster plans and OA plans are being conducted. The Agency helped establish a "hospital disaster planning group" in Sonoma County, and both Napa and Mendocino counties are developing similar groups.

COORDINATION WITH OTHER EMS AGENCIES:

Coordination of regional (Region II) partners.

NEED(S):

All hospitals should continue to refine respective facility's disaster plans for compatibility with OA disaster plans.

OBJECTIVE:

Continue to work with and encourage hospitals to use the Hospital Emergency Incident Command System (HEICS). Ensure that at least one inter-agency disaster drill is conducted in each member county.

TIME FRAME FOR MEETING OBJECTIVE:

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

8.15 INTERHOSPITAL COMMUNICATIONS

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Hospitals within Sonoma County can communicate with each other through a VHF radio net. Hospitals in Mendocino County have a UHF frequency network established. Hospitals in Napa County communicate via a VHF network. Common radio frequencies (ACS) between hospitals within the regional EMS system is established. EMResource system has been installed in all regional hospitals, thus providing an additional communications system redundancy.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure the availability of inter-hospital medical communications in conjunction with a region-wide communications system assessment and the development of a regional communications plan. Communications department funding from each of the member counties is needed to accomplish these goals.

OBJECTIVE:

Develop the communications plan, prioritize system repairs and upgrades and make necessary changes.

TIME FRAME FOR MEETING OBJECTIVE:

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

8.16 PREHOSPITAL AGENCY PLANS

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

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

CURRENT STATUS: *meets minimum standard*

Disaster medical planning has been occurring in each of the member counties. Individual member counties have MCI Plans that are ICS, SEMS and NIMS compatible. Regional hospitals have acquired significant disaster mitigation supplies, including PPE, triage tags and patient evacuation equipment through HPP grant funding. Prehospital providers and first responder agencies have also been extensively equipped with PPE, triage tags and medical equipment with HRSA and Homeland Security grant funding.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that providers and hospitals continue to effectively use the respective MCI plans when managing MCIs and medical disasters. Consider development of an annual medical/health disaster conference for regional providers and facilities.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

8.17 ALS POLICIES

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Procedures have been established with adjacent EMS systems through day to day mutual aid agreements, and universal ALS protocols have been established on a region-wide basis.

COORDINATION WITH OTHER EMS AGENCIES:

Eventual coordination is anticipated with Marin, Solano and North Coast EMS agencies.

NEED(S):

Ensure that policies and procedures exist to allow advanced life support personnel and mutual aid responders from other EMS systems to respond and function during significant medical incidents. Enact a mutual aid agreement within OES Region II.

OBJECTIVE:

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

TIME FRAME FOR MEETING OBJECTIVE:

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

8.18 SPECIALTY CENTER ROLES

MINIMUM STANDARDS:

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

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

Both trauma centers are base hospitals as well and are charged with coordinating disaster events within their respective counties. The remaining base hospitals coordinate disaster response within their respective catchment areas.

COORDINATION WITH OTHER EMS AGENCIES:

Coordination with Marin, Solano, Alameda and North Coast EMS agencies with regards to specialty centers in their juristiction.

NEED(S):

Continue to refine the role of identified specialty centers during significant medical incidents and the impact of such incidents on day-to-day triage procedures.

OBJECTIVE:

When additional specialty centers are identified, develop a process to determine the role of identified specialty centers during significant medical incidents and the impact of such incidents on day-to-day triage procedures.

TIME FRAME FOR MEETING OBJECTIVE:

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

8.19 WAIVING EXCLUSIVITY

MINIMUM STANDARDS:

Local EMS agencies which grant exclusive operating permits shall ensure that a process exists to waive the exclusivity in the event of a significant medical incident.

RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: *meets minimum standard*

All exclusive operating area agreements contain language allowing the CVEMSA to waive the exclusivity of an area in the event of a significant medical incident.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

Ensure that a process continues to exist for the waiving of exclusivity in EOAs in the event of a significant medical incident occurrence.

OBJECTIVE:

Monitor the process for waiving exclusivity and make changes as needed.

TIME FRAME FOR MEETING OBJECTIVE:

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

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TABLE 2: SYSTEM RESOURCES AND OPERATIONS

System Organization and Management

EMS System: Coastal Valleys
Reporting Year: 2008-2009

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%.)

	Sonoma	Napa	Mendocino
A. Basic Life Support (BLS)	**0** %	**7** %	**3** %
B. Limited Advanced Life Support (LALS)	**0** %	**0** %	**7** %
C. Advanced Life Support (ALS)	**100** %	**93** %	**90** %

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 the EMS agency reports to **A**
a - Public Health Officer
b- Health Services Agency Director/Administrator
c - Board of Directors
d - Other: _____

4. Indicate the non-required functions which are performed by the agency:

Implementation of exclusive operating areas (ambulance franchising)	X
Designation of trauma centers/trauma care system planning	X
Designation/approval of pediatric facilities	
Designation of other critical care centers	X
Development of transfer agreements	X
Enforcement of local ambulance ordinance	X
Enforcement of ambulance service contracts	X
Operation of ambulance service	

Table 2 - System Organization & Management (cont.)

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

5. EMS agency budget for FY 2008-2009

EXPENSES

Salaries and benefits (All but contract personnel)	$1,069,176
Contract Services (e.g. medical director)	$109,264
Operations (e.g. copying, postage, facilities)	$170,555
Travel	$21,500
Fixed assets	_____0
Indirect expenses (overhead)	$133,775
Ambulance subsidy	_____0
EMS Fund payments to physicians/hospital	_____*
Dispatch center operations (non-staff)	_____0
Training program operations	_____0
Other: Legal_____	$16,461
Other: _____	_____
Other: _____	_____
TOTAL EXPENSES	$1,520,731

*** EMS Fund disbursement not administered in EMS Agency budget**

Table 2 - System Organization & Management (cont.)

SOURCES OF REVENUE

Special project grant(s) [from EMSA]	
Preventive Health and Health Services (PHHS) Block Grant	$_____0
Office of Traffic Safety (OTS)	_____0
State general fund	$269,269
County general fund	$458,119
Other local tax funds (e.g., EMS district)	_____0
County contracts (e.g. multi-county agencies)	$85,986
Certification fees	$26,000
Training program approval fees	_____0
Training program tuition/Average daily attendance funds (ADA)	_____0
Job Training Partnership ACT (JTPA) funds/other payments	_____0
Base hospital application fees	$58,901
Trauma center application fees	_____0
Trauma center designation fees	$151,953
Pediatric facility approval fees	_____0
Pediatric facility designation fees	_____0
Other critical care center application fees	_____0
Type: _____	
Other critical care center designation fees	_____0
Type: _____	
Ambulance service/vehicle fees	$191,882
Contributions	_____0
EMS Fund (SB 12/612)	$211,341
Other grants: _____	_____0
Other fees: _____	_____0
Other (specify): REDCOM Contract	$67,340
TOTAL REVENUE	$1,520,731

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

Fee structure for FY 2008-2009

_____ We do not charge any fees

__X_ Our fee structure is:

First responder certification	$___0_____
EMS dispatcher certification	___ 0_____
EMT-I certification	___35_____
EMT-I recertification	___25_____
EMT-DEFIBRILLATION CERTIFICATION	_____
EMT-defibrillation recertification	___0_____
EMT-II certification	___50____
EMT-II recertification	___25____
EMT-P accreditation	__100____
Mobile Intensive Care Nurse/ Authorized Registered Nurse (MICN/ARN) certification	___ 50 ___ 0_____
MICN/ARN recertification	___25____
EMT-I training program approval	___0_____
EMT-II training program approval	___ 0_____
EMT-P training program approval	___ 0_____
MICN/ARN training program approval	___0_____
Base hospital application	___0_____
Base hospital designation	__58,901___
Trauma center application	___0_____
Trauma center designation	__151,953_
Pediatric facility approval	____0_____
Pediatric facility designation	____0_____

Other critical care center application

Type: _____

Ambulance service license	(Mendocino Only)	$900.00
Ambulance vehicle permits	(Mendocino Only)	$200.00
Other: Franchise and Fines		$152,674
Other: _____		_____
Other: _____		_____

7. Complete the table on the following two pages for the EMS agency staff for the fiscal year of 08/09

Table 2 - System Organization & Management (cont.)

EMS System: Coastal Valleys Reporting year 2008-2009

CATEGORY	ACTUAL TITLE	FTE POSITIONS (EMS ONLY)	TOP SALARY BY HOURLY EQUIVALENT	BENEFITS (%of Salary)	COMMENTS
EMS Admin./ Coord./Dir.	EMS Administrator	1.0	$ 51.75	39.0%	
Asst. Admin./ Admin. Asst./ Admin. Mgr.					
EMS Coordinator	EMS Coordinator	3.0	$ 41.68	39.%	1.0 FTE assigned to each of the three counties
ALS Coord./ Field Coord./ Trng Coord.	ALS Coordinator	1.0	$35.16	39.7%	
Program Coord./Field Liaison (Non-clinical)	EMS Specialist	1.0	$30.10	39.0%	1.0 FTE assigned to Sonoma
Trauma Coord.	EMS Coordinator	1.0	$41.68	39.%	
Med. Director	Regional EMS Med. Dir.	0.5	$ 77.00	n/a	Contract position, no benefits
Disaster Medical Planner					

Include an organizational chart of the local EMS agency and a county organization chart(s) indicating how the LEMSA fits within the county/multi-county structure.

Table 2 - System Organization & Management (cont.)

CATEGORY	ACTUAL TITLE	FTE POSITIONS (EMS ONLY)	TOP SALARY BY HOURLY EQUIVALENT	BENEFITS (%of Salary)	COMMENTS
Dispatch Supervisor					
Medical Planner					
Data Evaluator/Analyst					
QA/QI Coordinator					
Public Info. & Education Coordinator					
Executive Secretary					
Other Clerical	Office Assistant II	1.0	$25.10	45.4%	Sonoma County office
Other Clerical	Senior Office Assistant	1.0	$22.56	21.9%	Napa County office
Other Clerical	Staff Assistant II	1.0	$15.16	38.9%	Mendocino office

Include an organizational chart of the local EMS agency and a county organization chart(s) indicating how the LEMSA fits within the county/multi-county structure.

TABLE 3: SYSTEM RESOURCES AND OPERATIONS - Personnel/Training Revision #4 (4/20/07)

EMS System: Coastal Valleys

Reporting Year: 2008-2009 NOTE: Table 3 is to be reported by agency.

	EMT - Is	EMT - IIs	EMT - Ps	MICN
Total Certified	2155	0		0
Number newly certified this year	475	0		0
Number recertified this year	710	0		0
Total number of accredited personnel on July 1 of the reporting year	2224	0	341	0
Number of certification reviews resulting in:				
a) formal investigations	2	0		0
b) probation	14	0	0	0
c) suspensions	0	0	0	0
d) revocations	0	0		0
e) denials	0	0		0
f) denials of renewal	0	0		0
g) no action taken	0	0	0	0

1. Number of EMS dispatch agencies utilizing EMD Guidelines: **3**
2. Early defibrillation:
   a) Number of EMT=I (defib) certified **2155**
   b) Number of public safety (defib) certified (non-EMT-I) **320**
3. DO YOU HAVE A FIRST RESPONDER TRAINING PROGRAM **X** YES ☐ NO

TABLE 4: SYSTEM RESOURCES AND OPERATIONS - Communications

EMS System: Coastal Valleys

County: Sonoma

Reporting Year: 2008-2009

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

1. Number of primary Public Service Answering Points (PSAP) _____**9**_____

2. Number of secondary PSAPs _____**1**_____

3. Number of dispatch centers directly dispatching ambulances _____**3**_____

4. Number of designated dispatch centers for EMS Aircraft _____**1**_____

5. Do you have an operational area disaster communication system? Yes __**X**___ No _____
   a. Radio primary frequency ____155.265_____
   b. Other methods ___CalCord, Cell, 2nd VHF (155.100), UHF Med-Net__
   c. Can all medical response units communicate on the same disaster communications system?
   Yes __X__ No _____
   d. Do you participate in OASIS? Yes __X__ No _____
   e. Do you have a plan to utilize RACES as a back-up communication system?
   Yes __X__ No _____

   1) Within the operational area? Yes __X__ No _____
   2) Between the operational area and the region and/or state? Yes __X__ No _____

6. Who is your primary dispatch agency for day-to-day emergencies? REDCOM (Fire-EMS)

7. Who is your primary dispatch agency for a disaster? Sonoma County SO (Law), REDCOM (Fire-EMS)

TABLE 4: SYSTEM RESOURCES AND OPERATIONS - Communications

EMS System: Coastal Valleys

County: Napa

Reporting Year: 2008-2009

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

1. Number of primary Public Service Answering Points (PSAP) ____**3**_____

2. Number of secondary PSAPs ____**1**_____

3. Number of dispatch centers directly dispatching ambulances ____**1**_____

4. Number of designated dispatch centers for EMS Aircraft ____**1**_____

5. Do you have an operational area disaster communication system? Yes __**X**__ No _____
   a. Radio primary frequency ____155.100_____
   b. Other methods _____Cell_____
   c. Can all medical response units communicate on the same disaster communications system?
   Yes __X__ No _____
   d. Do you participate in OASIS? Yes __X__ No _____
   e. Do you have a plan to utilize RACES as a back-up communication system?
   Yes __X__ No _____

   1) Within the operational area? Yes __X__ No _____
   2) Between the operational area and the region and/or state? Yes __X__ No _____

6. Who is your primary dispatch agency for day-to-day emergencies? Napa Central Dispatch Center

7. Who is your primary dispatch agency for a disaster? Napa Central Dispatch Center

TABLE 4: SYSTEM RESOURCES AND OPERATIONS - Communications

EMS System: Coastal Valleys

County: Mendocino

Reporting Year: 2008-2009

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

1. Number of primary Public Service Answering Points (PSAP) _____**3**____

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 _**X**___ No _____
   a. Radio primary frequency ____155.985_____
   b. Other methods ____Cell, Numerous VHF, UHF Med-Net_____
   c. Can all medical response units communicate on the same disaster communications system?
   Yes __X__ No _____
   d. Do you participate in OASIS? Yes __X__ No _____
   e. Do you have a plan to utilize RACES as a back-up communication system?
   Yes __X__ No _____

   1) Within the operational area? Yes __X__ No _____
   2) Between the operational area and the region and/or state? Yes __X__ No _____

6. Who is your primary dispatch agency for day-to-day emergencies? CalFire Howard Forrest (Fire-EMS)
   Mendocino County SO (Law)

7. Who is your primary dispatch agency for a disaster? CalFire Howard Forrest (Fire-EMS)
   Mendocino County SO (Law

TABLE 5: SYSTEM RESOURCES AND OPERATIONS - Response/Transportation

EMS System: Coastal Valleys

Reporting Year: 2008-2009

Note: Table 5 is to be reported by agency.

EARLY DEFIBRILLATION PROVIDERS

1. Number of EMT-Defibrillation providers __76__

SYSTEM STANDARD RESPONSE TIMES (90TH PERCENTILE)

Enter the response times in the appropriate boxes	METRO/URBAN	SUBURBAN/RURAL	WILDERNESS	SYSTEMWIDE
BLS and CPR capable first responder	N/A*	N/A	N/A	N/A
Early defibrillation responder	N/A*	N/A	N/A	N/A
Advanced life support responder	7**	14** / 4-6 min.***	29**	N/A
Transport Ambulance	11**/ <10***	18** / <30***	33** /<60***	N/A

* No mechanism exists for the collection of response time data for first response agencies

** Sonoma's response time standards are only in effect in the EOA portion of Sonoma. Additionally, the response time standards are triggered by EMD call determinants.

*** Napa County's standards

TABLE 6: SYSTEM RESOURCES AND OPERATIONS - Facilities/Critical Care

EMS System: Coastal Valleys

Reporting Year: 2008-2009

NOTE: Table 6 is to be reported by agency.

Trauma

Trauma patients:

a) Number of patients meeting trauma triage criteria ____1734_____

b) Number of major trauma victims transported directly to a trauma center by ambulance ____1557_____

c) Number of major trauma patients transferred to a trauma center ____360_____

d) Number of patients meeting triage criteria who weren't treated at a trauma center ____Unkown_____

Emergency Departments

Total number of emergency departments _____12_____

a) Number of referral emergency services _____1_____

b) Number of standby emergency services _____5_____

c) Number of basic emergency services _____7_____

d) Number of comprehensive emergency services _____0_____

Receiving Hospitals

1. Number of receiving hospitals with written agreements _____7_____

2. Number of base hospitals with written agreements _____5_____

TABLE 7: SYSTEM RESOURCES AND OPERATIONS -- Disaster Medical

EMS System: Coastal Valleys

County: Sonoma

Reporting Year: 2008-2009

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

SYSTEM RESOURCES

1. Casualty Collections Points (CCP)

   a. Where are your CCPs located? Various Veteran's buildings, fairgrounds and high schools throughout the county.

   b. How are they staffed? Medical Reserve Corp, Red Cross, PH Staff, EMS system participants

   c. Do you have a supply system for supporting them for 72 hours? yes ____ no_X_

2. CISD

   Do you have a CISD provider with 24 hour capability? yes _X_ no____

3. Medical Response Team

   a. Do you have any team medical response capability? yes _X_ no ____

   b. For each team, are they incorporated into your local response plan? yes _X_ no ____

   c. Are they available for statewide response? yes _X_ no ____

   d. Are they part of a formal out-of-state response system? yes ____ no _X_

4. Hazardous Materials

   a. Do you have any HazMat trained medical response teams? yes ____ no _X_

   b. At what HazMat level are they trained? _____

   c. Do you have the ability to do decontamination in an emergency room? yes _X_ no ____

   d. Do you have the ability to do decontamination in the field? yes _X_ no ____

OPERATIONS

1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? yes _X_ no ____

2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? ___10____

3. Have you tested your MCI Plan this year in a:

   a. real event? yes _X_ no ____

   b. exercise? yes _X_ no ____

4. List all counties with which you have a written medical mutual aid agreement.

   _____N/A_____

5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response? yes _X_ no ____

6. Do you have a formal agreements with community clinics in your operational areas to participate in disaster planning and response? yes _X_ no ____

7. Are you part of a multi-county EMS system for disaster response? yes _X_ no ____

8. Are you a separate department or agency? yes ____ no _X_

9. If not, to whom do you report? Department of Health Services

8. If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department? N/A

TABLE 7: SYSTEM RESOURCES AND OPERATIONS -- Disaster Medical

EMS System: Coastal Valleys

County: Napa

Reporting Year: 2008-2009

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

SYSTEM RESOURCES

1. Casualty Collections Points (CCP)
   a. Where are your CCPs located? In Process
   b. How are they staffed? NA
   c. Do you have a supply system for supporting them for 72 hours? yes ____ no__X__

2. CISD
   Do you have a CISD provider with 24 hour capability? yes _X__ no____

3. Medical Response Team
   a. Do you have any team medical response capability? yes ____ no _X__
   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 __X_ no ____
   b. At what HazMat level are they trained? Specialist
   c. Do you have the ability to do decontamination in an emergency room? yes ____ no _X__
   d. Do you have the ability to do decontamination in the field? yes _X__ no ____

OPERATIONS

1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? yes _X_ no ____

2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? _____4____

3. Have you tested your MCI Plan this year in a:

   a. real event? yes _X__ no ____

   b. exercise? yes _X__ no ____

4. List all counties with which you have a written medical mutual aid agreement.

   _____None_____

5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response? yes ____ no __X_

6. Do you have a formal agreements with community clinics in your operational areas to participate in disaster planning and response? yes ____ no __X_

7. Are you part of a multi-county EMS system for disaster response? yes __X_ no ____

8. Are you a separate department or agency? yes ____ no __X_

9. If not, to whom do you report? Department of Health Services

8. If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department? yes ____ no ____

TABLE 7: SYSTEM RESOURCES AND OPERATIONS -- Disaster Medical

EMS System: Coastal Valleys

County: Mendocino

Reporting Year: 2008-2009

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

SYSTEM RESOURCES

1. Casualty Collections Points (CCP)
   a. Where are your CCPs located? In Process
   b. How are they staffed? NA
   c. Do you have a supply system for supporting them for 72 hours? yes ____ no__X_

2. CISD
   Do you have a CISD provider with 24 hour capability? yes _X_ no____

3. Medical Response Team
   a. Do you have any team medical response capability? yes ____ no __X_
   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 _X__
   b. At what HazMat level are they trained? _____
   c. Do you have the ability to do decontamination in an emergency room? yes _X__ no ____
   d. Do you have the ability to do decontamination in the field? yes _X__ no ____

OPERATIONS

1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? yes _X__ no ____

2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? ____4_____

3. Have you tested your MCI Plan this year in a:

   a. real event? yes __X_ no ____

   b. exercise? yes __X_ no ____

4. List all counties with which you have a written medical mutual aid agreement.

   _____None_____

5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response? yes _X_ no ____

6. Do you have a formal agreements with community clinics in your operational areas to participate in disaster planning and response? yes _X_ no ____

7. Are you part of a multi-county EMS system for disaster response? yes _X_ no ____

8. Are you a separate department or agency? yes ____ no _X_

9. If not, to whom do you report? Department of Health Services

8. If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department? yes ____ no __

TABLE 8: RESOURCES DIRECTORY -- Approved Training Programs

EMS System: **Coastal Valleys** County: **Sonoma** Reporting Year: 2008-2009

NOTE: Table 8 is to be completed by county. Make copies to add pages as needed.

Training Institution Name: Santa Rosa Junior College
Contact Person telephone no.: Jeff Snow 707-836-2917
Address: 5743 Skylane Blvd., Windsor CA, 95492

Student Eligibility: * Open * course prerequisites required	Cost of Program Basic $26.00 per unit Refresher _____	**Program Level: EMT - Basic Number of students completing training per year: Initial training: 200 Refresher: 300 Cont. Education 500 Expiration Date: 6/1/09 Number of courses: _____ Initial training: 5 Refresher: 5 Cont. Education: _____

Training Institution Name: Santa Rosa Junior College
Contact Person telephone no.: Jeff Snow 707-836-2917
Address: 5743 Skylane Blvd., Windsor CA, 95492

Student Eligibility: * Open *Competitive application process & prerequisites	Cost of Program Basic $26.00 per unit Refresher _____	**Program Level: EMT- Paramedic Number of students completing training per year: Initial training: 20 Refresher: Cont. Education _____ Expiration Date: 7/1/10 Number of courses: 1 Initial training: 1 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.

TABLE 8: RESOURCES DIRECTORY -- Approved Training Programs

EMS System: **Coastal Valleys** County: **Mendocino** Reporting Year: 2008-2009

NOTE: Table 8 is to be completed by county. Make copies to add pages as needed.

Training Institution Name	Mendocino Community College	Contact Person telephone no.	William Webster
Address	1000 Hensley Creek Rd, Ukiah, 95482		(707) 468-3000

Student Eligibility: *Open * course prerequisites required: CPR,HS or GED, EMT-1 current or within 12 months	Cost of Program Basic $1266.50 Refresher _____	**Program Level: EMT-Paramedic Number of students completing training per year: Initial training: 14 Refresher: _____ Cont. Education _____ Expiration Date: 7/1/10 Number of courses: 1 Initial training: 1 Refresher: _____ Cont. Education: _____

Training Institution Name	Mendocino County ROP	**Contact Person telephone no.**	Dottie
Address	2240 Old River Rd. Ukiah, CA 95482		(707) 467-5106

Student Eligibility:	Cost of Program Basic $125.00 Refresher _____	**Program Level: EMT-B Number of students completing training per year: Initial training: 60 Refresher: ____ Cont. Education _____ Expiration Date: 7/1/10 Number of courses: 5 Initial training: 5 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.

TABLE 8: RESOURCES DIRECTORY -- Approved Training Programs

EMS System: **Coastal Valleys** County: **Napa** Reporting Year: 2008-2009

NOTE: Table 8 is to be completed by county. Make copies to add pages as needed.

Training Institution Name: Pacific Union College
Contact Person telephone no.: James Robertson
Address: One Angwin Ave, Angwin, CA 95403
(707) 965-7030

Student Eligibility: *	Cost of Program	**Program Level: EMT-B
Enrolled as PUC student. AHA BLS Provider card	Basic $5,348.00 Refresher _____	Number of students completing training per year: Initial training: 15 Refresher: _____ Cont. Education _____ Expiration Date: 6/1/09 Number of courses: _____ Initial training: _____ Refresher: _____ Cont. Education: _____

Training Institution Name: Napa Community College
Contact Person telephone no.: Amy Lapan
Address: 2277 Napa-Vallejo Hwy. Napa, CA 94559
(707) 253-3120

Student Eligibility: *	Cost of Program	**Program Level: EMT-B
	Basic $200.00 Refresher _____	Number of students completing training per year: Initial training: 28 Refresher: ____ Cont. Education _____ Expiration Date: 7/1/10 Number of courses: 2 Initial training: 2 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.

EMS System: **Coastal Valleys** County: **Napa** Reporting Year: 2008-2009

NOTE: Table 8 is to be completed by county. Make copies to add pages as needed.

Training Institution Name	Napa Community College	Contact Person telephone no.	Amy Lapan
Address	2277 Napa-Vallejo Hwy. Napa, CA 94559		(707) 253-3120

Student Eligibility: *	Cost of Program	**Program Level: EMT-Paramedic
	Basic $1,500.00	Number of students completing training per year:
	Refresher _____	Initial training: 14
		Refresher: _____
		Cont. Education _____
		Expiration Date: 7/1/10
		Number of courses: 1
		Initial training: 1
		Refresher: _____
		Cont. Education: _____

Training Institution Name	_____	**Contact Person telephone no.**	_____
Address	_____		

Student Eligibility: *	Cost of Program	**Program Level: _____
	Basic _____	Number of students completing training per year:
	Refresher _____	Initial training: __
		Refresher: ____
		Cont. Education _____
		Expiration Date: _____
		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

TABLE 9: RESOURCES DIRECTORY -- Dispatch Agency

EMS System: Coastal Valleys County: **Sonoma** Reporting Year: 2008-2009

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

Name, address & telephone:			Primary Contact:
REDCOM 2796 Ventura Ave. Santa Rosa, CA 95403 (707) 568-5992			Dick Luttrell
Written Contract: X yes ☐ no	Medical Director: ☐ yes X no	X Day-to-day X Disaster	Number of Personnel providing services: ___30__ EMD Training_____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other
Ownership: X Public ☐ Private		If public: ☐ Fire ☐ Law X Other explain:_JPA_____	If public: ☐ city; ☐ county; ☐ state; ☐ fire district; ☐ Federal Joint Powers Agreement between County, Local and City Fire

Name, address & telephone:			Primary Contact:
City of Petaluma 969 Petaluma Blvd N. Petaluma, CA 94952 (707) 762-4546			Ed Crosby
Written Contract: ☐ yes X no	Medical Director: ☐ yes X no	X Day-to-day X Disaster	Number of Personnel providing services: _____ EMD Training_____ EMT-D _____ ALS __8__ BLS _____ LALS _____ Other
Ownership: XPublic ☐ Private		If public:X Fire X Law ☐ Other explain:_____	If public: X city; ☐ county; ☐ state; ☐ fire district; ☐ Federal

TABLE 9: RESOURCES DIRECTORY -- Dispatch Agency

EMS System: Coastal Valleys County: **Sonoma** Reporting Year: 2008-2009

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

Name, address & telephone:			Primary Contact:
REACH 451 Aviation Blvd. Santa Rosa CA 95403 (800) 338-4045			Chris LeBaudour
Written Contract: ☐ yes X no	Medical Director: X yes ☐ no	X Day-to-day ☐ Disaster	Number of Personnel providing services: _____ EMD Training _____ EMT-D _____ ALS _____ BLS _____ LALS __10__ Other
Ownership: ☐ Public X Private		If public: ☐ Fire ☐ Law ☐ Other explain:_____	If public: ☐ city; ☐ county; ☐ state; ☐ fire district; ☐ Federal

Name, address & telephone:			Primary Contact:
CalFire St. Helena ECC 1199 Big Tree Road St. Helena, CA 94574 (707) 967-1403			Karen Shubin
Written Contract: ☐ yes ☐ no	Medical Director: ☐ yes ☐ no	☐ Day-to-day ☐ Disaster	Number of Personnel providing services: _____ EMD Training _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other
Ownership: ☐ Public ☐ Private		If public: ☐ Fire ☐ Law ☐ Other explain:_____	If public: ☐ city; ☐ county; ☐ state; ☐ fire district; ☐ Federal

TABLE 9: RESOURCES DIRECTORY -- Dispatch Agency

EMS System: Coastal Valleys County: **Mendocino** Reporting Year: 2008-2009

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

Name, address & telephone:			Primary Contact:
CalFire Howard Forest ECC 17501 N. Highway 101 Willits, CA 95490 (707) 459-7403			Jonni Mayberry
Written Contract: X yes ☐ no	Medical Director: ☐ yes X no	X Day-to-day X Disaster	Number of Personnel providing services: ___23__ EMD Training_____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other
Ownership: X Public ☐ Private		If public: X Fire ☐ Law ☐ Other explain:_____	If public: ☐ city; ☐ county; X state; ☐ fire district; ☐ Federal

Name, address & telephone:			Primary Contact:
City of Ukiah 300 Seminary Ave. Ukiah, CA 95482 (707) 463-6262			Chris Dewey
Written Contract: ☐ yes X no	Medical Director: ☐ yes X no	X Day-to-day ☐ Disaster	Number of Personnel providing services: ___8___ EMD Training_____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other
Ownership: X Public ☐ Private		If public: X Fire X Law ☐ Other explain:_____	If public: X city; ☐ county; ☐ state; ☐ fire district; ☐ Federal

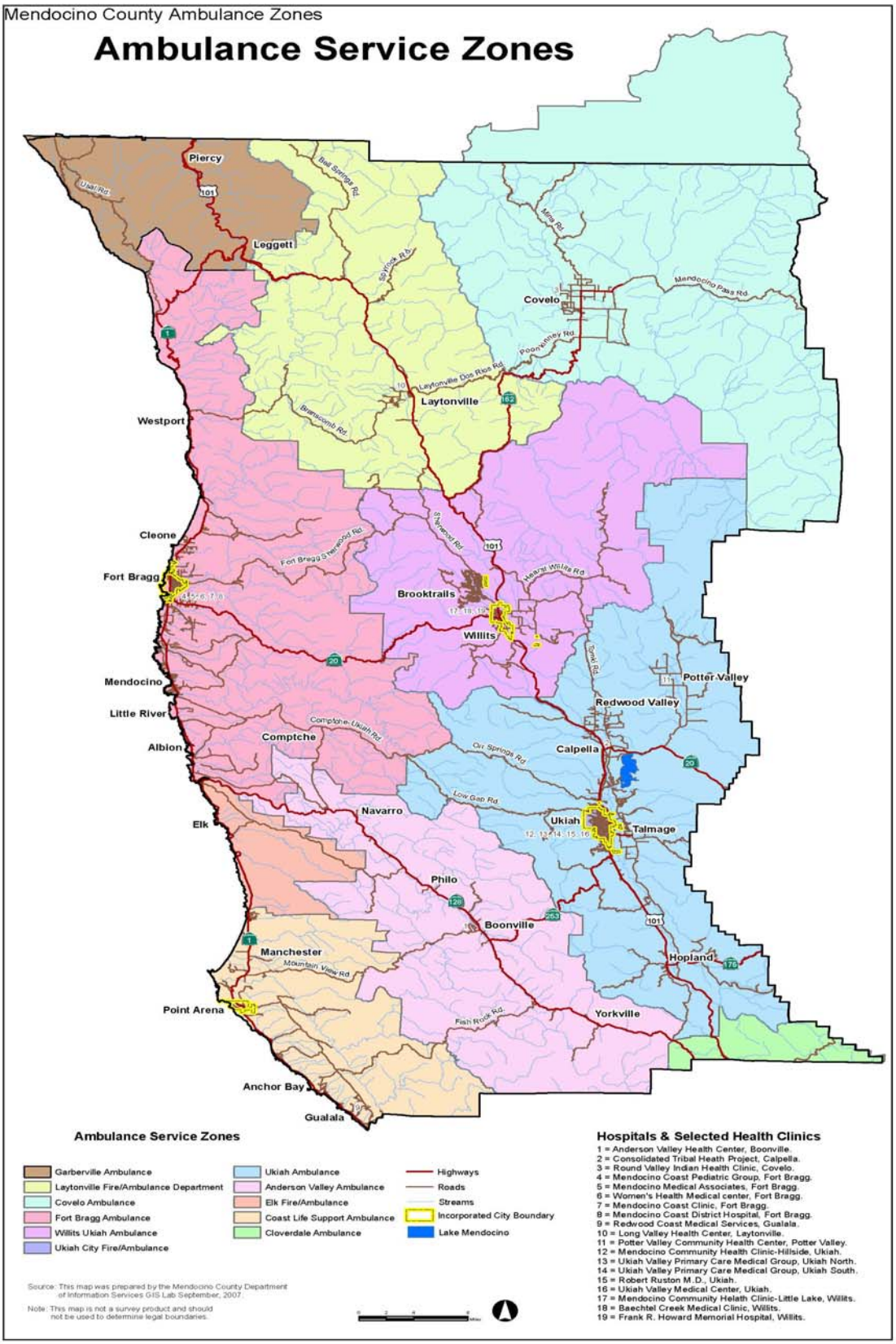
TABLE 9: RESOURCES DIRECTORY -- Dispatch Agency

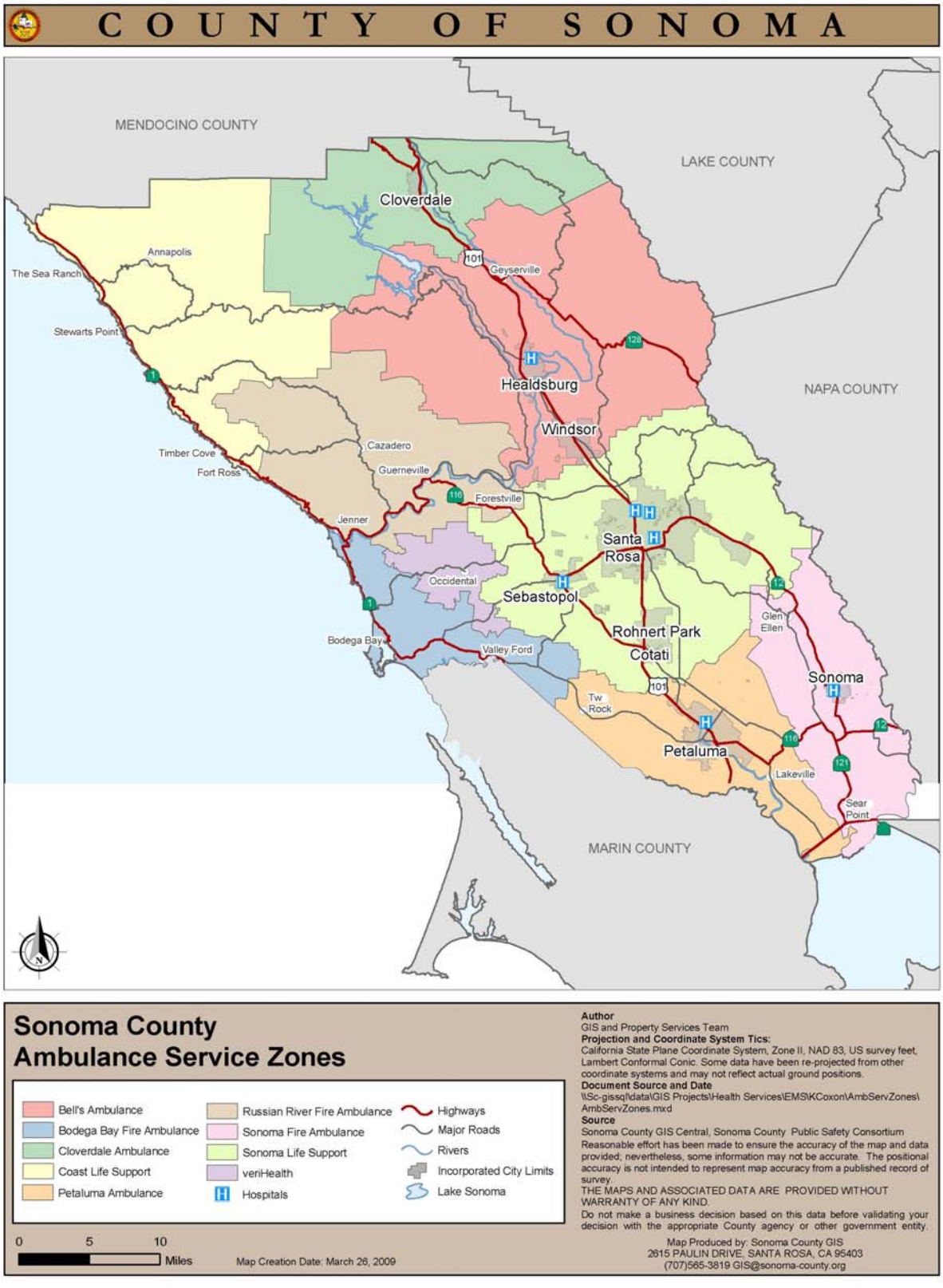
EMS System: Coastal Valleys County: **Napa** Reporting Year: 2008-2009

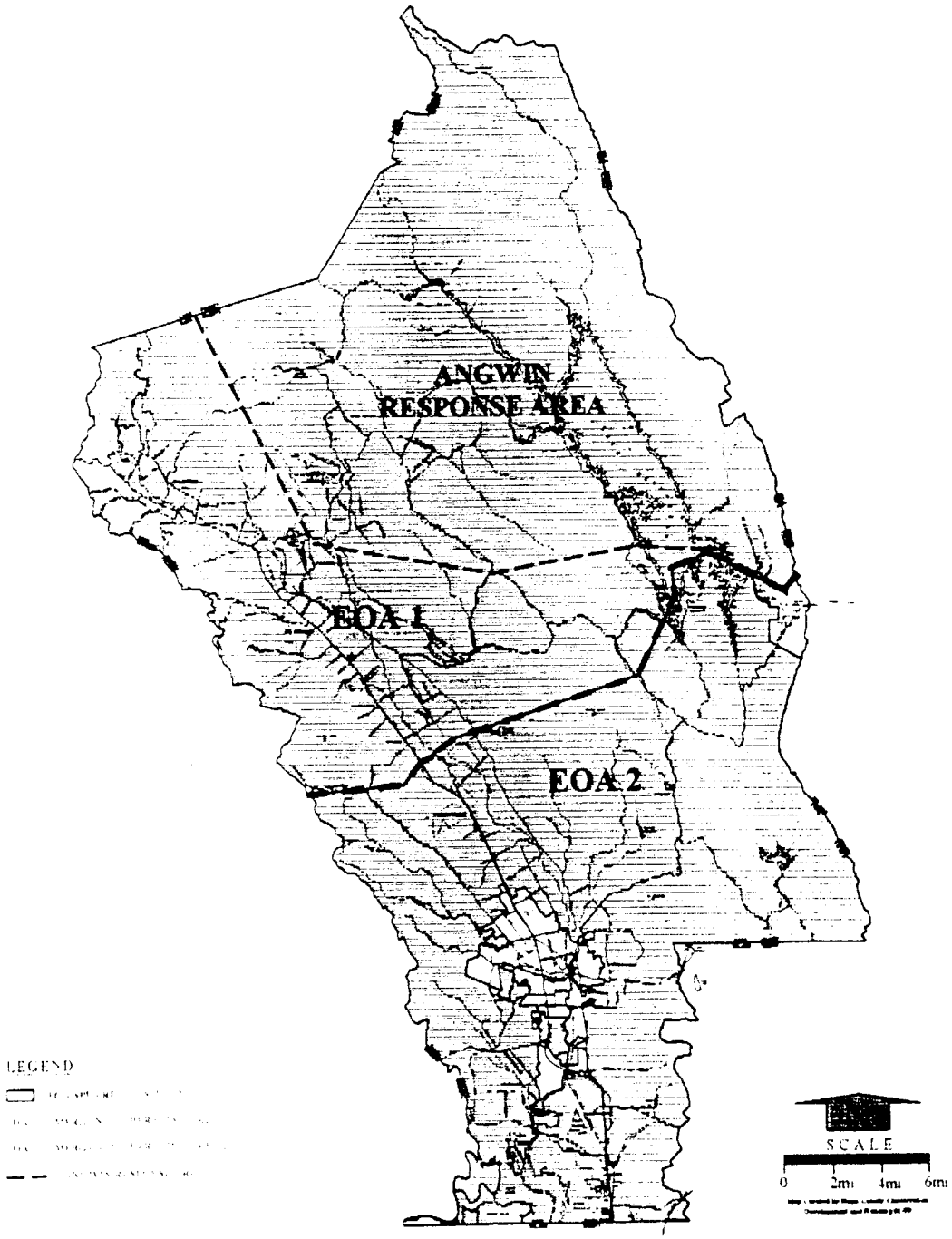
NOTE: Make copies to add pages as needed. Complete information for each provider by county.

Name, address & telephone:			Primary Contact:
Napa Central Dispatch 1539 First Street Napa, CA 94558 (707) 253-4451			Steve Potter
Written Contract: ☐ yes X no	Medical Director: ☐ yes X no	X Day-to-day X Disaster	Number of Personnel providing services: __16__ EMD Training _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other
Ownership: X Public ☐ Private		If public: ☐ Fire X Law ☐ Other explain:_____	If public: ☐ city; X county; ☐ state; ☐ fire district; ☐ Federal

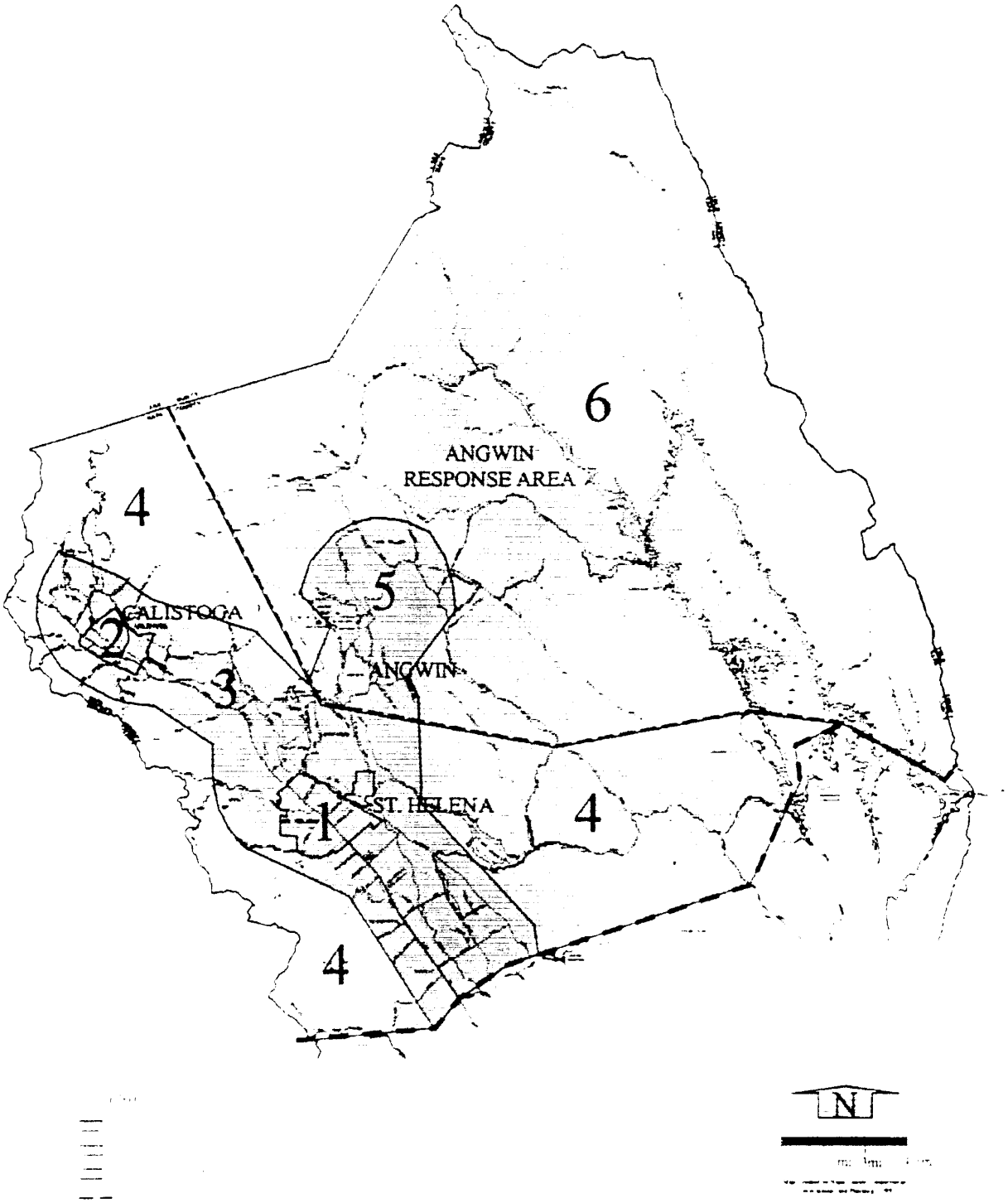
Name, address & telephone:			Primary Contact:
CalFire St. Helena ECC 1199 Big Tree Road St. Helena, CA 94574 (707) 967-1403			Karen Shubin
Written Contract: ☐ yes ☐ no	Medical Director: ☐ yes ☐ no	☐ Day-to-day ☐ Disaster	Number of Personnel providing services: _____ EMD Training _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other
Ownership: ☐ Public ☐ Private		If public: ☐ Fire ☐ Law ☐ Other explain:_____	If public: ☐ city; ☐ county; ☐ state; ☐ fire district; ☐ Federal


Mendocino County Ambulance Zones
Ambulance Service Zones
Piercy
Leggett
Covelo
Laytonville
Westport
Cleone
Fort Bragg
Brooktrails
Willits
Mendocino
Little River
Albion
Comptche
Navarro
Elk
Philo
Boonville
Manchester
Point Arena
Anchor Bay
Gualala
Potter Valley
Redwood Valley
Calpella
Ukiah
Talmage
Hopland
Yorkville
Ambulance Service Zones
Garberville Ambulance
Laytonville Fire/Ambulance Department
Covelo Ambulance
Fort Bragg Ambulance
Willits Ukiah Ambulance
Ukiah City Fire/Ambulance
Ukiah Ambulance
Anderson Valley Ambulance
Elk Fire/Ambulance
Coast Life Support Ambulance
Cloverdale Ambulance
Highways
Roads
Streams
Incorporated City Boundary
Lake Mendocino
Hospitals & Selected Health Clinics
1 = Anderson Valley Health Center, Boonville.
2 = Consolidated Tribal Heath Project, Calpella.
3 = Round Valley Indian Health Clinic, Covelo.
4 = Mendocino Coast Pediatric Group, Fort Bragg.
5 = Mendocino Medical Associates, Fort Bragg.
6 = Women's Health Medical center, Fort Bragg.
7 = Mendocino Coast Clinic, Fort Bragg.
8 = Mendocino Coast District Hospital, Fort Bragg.
9 = Redwood Coast Medical Services, Gualala.
10 = Long Valley Health Center, Laytonville.
11 = Potter Valley Community Health Center, Potter Valley.
12 = Mendocino Community Health Clinic-Hillside, Ukiah.
13 = Ukiah Valley Primary Care Medical Group, Ukiah North.
14 = Ukiah Valley Primary Care Medical Group, Ukiah South.
15 = Robert Ruston M.D., Ukiah.
16 = Ukiah Valley Medical Center, Ukiah.
17 = Mendocino Community Helath Clinic-Little Lake, Willits.
18 = Baechtel Creek Medical Clinic, Willits.
19 = Frank R. Howard Memorial Hospital, Willits.
Source: This map was prepared by the Mendocino County Department of Information Services GIS Lab September, 2007.
Note: This map is not a survey product and should not be used to determine legal boundaries.


COUNTY OF SONOMA
MENDOCINO COUNTY
LAKE COUNTY
NAPA COUNTY
MARIN COUNTY
Cloverdale
Annapolis
The Sea Ranch
Stewarts Point
Geyserville
Healdsburg
Windsor
Cazadero
Timber Cove
Fort Ross
Guerneville
Forestville
Jenner
Santa Rosa
Occidental
Sebastopol
Bodega Bay
Valley Ford
Rohnert Park
Cotati
Glen Ellen
Sonoma
Tw Rock
Petaluma
Lakeville
Sear Point
Sonoma County
Ambulance Service Zones
Bell's Ambulance
Bodega Bay Fire Ambulance
Cloverdale Ambulance
Coast Life Support
Petaluma Ambulance
Russian River Fire Ambulance
Sonoma Fire Ambulance
Sonoma Life Support
veriHealth
Hospitals
Highways
Major Roads
Rivers
Incorporated City Limits
Lake Sonoma
0 5 10
Miles
Map Creation Date: March 26, 2009
Author
GIS and Property Services Team
Projection and Coordinate System Tics:
California State Plane Coordinate System, Zone II, NAD 83, US survey feet, Lambert Conformal Conic. Some data have been re-projected from other coordinate systems and may not reflect actual ground positions.
Document Source and Date
\\Sc-gissql\data\GIS Projects\Health Services\EMS\KCoxon\AmbServZones\AmbServZones.mxd
Source
Sonoma County GIS Central, Sonoma County Public Safety Consortium
Reasonable effort has been made to ensure the accuracy of the map and data provided; nevertheless, some information may not be accurate. The positional accuracy is not intended to represent map accuracy from a published record of survey.
THE MAPS AND ASSOCIATED DATA ARE PROVIDED WITHOUT WARRANTY OF ANY KIND.
Do not make a business decision based on this data before validating your decision with the appropriate County agency or other government entity.
Map Produced by: Sonoma County GIS
2615 PAULIN DRIVE, SANTA ROSA, CA 95403
(707)565-3819 GIS@sonoma-county.org



County of Napa Appendix I
Emergency Ambulance Exclusive Operating Areas



County of Napa Appendix II
Exclusive Operating Area 1 (EOA 1)
Response Time Zones

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Sonoma

Area or subarea (Zone) Name or Title:

EOA #1.

Area includes the cities of Santa Rosa, Rohnert Park, Sebastopol, Cotati. Includes the Rancho Adobe, Bennett Valley, Gold Ridge, Graton and Kenwood Fire Protection Districts. Also includes the Mountain Volunteer Fire Company service area in unincorporated Sonoma County.

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

American Medical Response dba/ Sonoma Life Support. Since July 1, 1999

Area or subarea (Zone) Geographic Description:

See Sonoma County Ambulance Service Zone Map on page #167

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

Exclusive franchise developed and implemented through a competitive RFP process. County BOS approved contract for service. Current Franchise expires 6/30/2009. AMR won the new Franchise beginning 7/1/2009 for a 5year term.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

All ALS (including IFT) and Emergency (911) Ambulance

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

Announcement of RFP June 4, 2008, RFP Document Available July 11, 2008, Deadline for Written Questions July 25, 2008, Pre-Proposal Conference July 31, 2008, 11:00 am, Letter of Interest Due August 7, 2008, Closing Date/Time for Proposals October 2, 2008 – 4:00 pm, Review of Credentials/Proposals October 3 – 9, 2008 Recommendations Made by the Evaluation Committee to the County Director of the EMS Agency October 20, 2008 Notice of Intent to Award by the DHS/Coastal Valleys EMS, Agency of the Successful Proposal October 31, 2008 Last Day to Protest November 11, 2008, Decision on Protest Within 30 calendar days of receipt of the letter of intent to file protest, Contract Negotiation November, 2008, Request Authorization from the Board of Supervisors to Enter into Contract with the EMS Agency's Selected Proposer December 9, 2008, Implementation July 1, 2009.

Full RFP available at: http://www.sonoma-county.org/cvrems/resources/pdf/sonoma/franchise/rfp20080714.pdf

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Sonoma

Area or subarea (Zone) Name or Title:
Petaluma Ambulance Response Area

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
City of Petaluma Fire Department. Since 1980

Area or subarea (Zone) Geographic Description:
See Sonoma County Ambulance Service Zone Map on page #167. Area includes City of Petaluma, portions of Rancho Adobe Fire Protection District, and the Volunteer Fire Companies of Wilmar, Two Rock, San Antonio, and Lakeville.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Sonoma

Area or subarea (Zone) Name or Title:
Bodega Bay Fire Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Bodega Bay Fire Department. Since 1995

Area or subarea (Zone) Geographic Description:
See Sonoma County Ambulance Service Zone Map on page #167. Area includes Bodega Bay Fire Protection District, and the Volunteer Fire Companies of Bodega, Valley Ford, and Bloomfield.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Sonoma

Area or subarea (Zone) Name or Title:
Russian River Fire Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Russian River Fire Protection District. Since 1985

Area or subarea (Zone) Geographic Description:
See Sonoma County Ambulance Service Zone Map on page #167. Area includes the Russian River, Forestville, and Monte Rio Fire Protection Districts. Also includes the Cazadero and Timber Cove Community Service Areas, and the Ft. Ross Volunteer Fire Company.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Sonoma

Area or subarea (Zone) Name or Title:
Occidental Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
veriHealth Ambulance. Since 2006

Area or subarea (Zone) Geographic Description:
See Sonoma County Ambulance Service Zone Map on page #167. Area includes the communities of Occidental and Camp Meeker as well as the Occidental Fire Protection District.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Sonoma

Area or subarea (Zone) Name or Title:
Bells Ambulance Service Area

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Bells Ambulance Service. Since 1956

Area or subarea (Zone) Geographic Description:
See Sonoma County Ambulance Service Zone Map on page #167.
Area includes the Town of Windsor, City of Healdsburg, Windsor Fire Protection District, Fitch Mountain Community Service Area, Dry Creek Volunteer Fire District, Geyserville Fire Protection District, and the Dry Creek Rancheria.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Sonoma

Area or subarea (Zone) Name or Title:
Sonoma Valley Fire Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Sonoma Valley Fire Rescue Authority (SVFRA). Since 1990

Area or subarea (Zone) Geographic Description:
See Sonoma County Ambulance Service Zone Map on page #167.
Area includes City of Sonoma. Also includes the Fire Protection Districts of Valley of the Moon, Schell Vista, and Glen Ellen. Covers the Mayacamas Volunteer Fire Company and Infineon Raceway.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Sonoma

Area or subarea (Zone) Name or Title:
Cloverdale Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Cloverdale Ambulance Service. Since 1986

Area or subarea (Zone) Geographic Description:
See Sonoma County Ambulance Service Zone Map on page #167.
Area includes City of Cloverdale, Cloverdale fire protection district, Lake Sonoma, and portions of Geyserville Fire Protection District. This provider also serves Southern Mendocino County. See separate Ambulance Zone Summary Form.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Sonoma

Area or subarea (Zone) Name or Title:
Coast Life Support Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Coast Life Support District (CLSD). Since 1989

Area or subarea (Zone) Geographic Description:
See Sonoma County Ambulance Service Zone Map on page #167. Area includes the community of Sea Ranch, the Volunteer Fire Companies of Sea Ranch, Annapolis, and portions of Ft. Ross. Also included are portions of Timber Cove Community Service Area. This provider also serves Southern Mendocino County. See separate Ambulance Zone Summary Form.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Napa

Area or subarea (Zone) Name or Title:
EOA #1

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Piner Ambulance Service. Since July 1, 2003

Area or subarea (Zone) Geographic Description:
See Napa County Ambulance Service Zone Map on page #168.
Area includes the Cities of St. Helena and Calistoga. Includes portions of Lake Berryessa.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Exclusive franchise developed and implemented through a competitive RFP process. County BOS approved contract for service. Current Franchise expires 3/30/2010.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).
All Emergency (911) and ALS Calls

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

Competitive bid process. Ratified by County Board of Supervisors. RFP on file at EMSA

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Napa

Area or subarea (Zone) Name or Title:
EOA #2

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Piner Ambulance Service. Since July 1, 2001.

Area or subarea (Zone) Geographic Description:
See Napa County Ambulance Service Zone Map on page #168. Area includes City of Napa, unincorporated area surrounding the City of Napa, Napa State Hospital, American Canyon Fire Protection District, and the community of Yountville.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Exclusive franchise developed and implemented through a competitive RFP process. County BOS approved contract for service. Current Franchise expires 3/30/2010.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).
All Emergency (911) and ALS Calls

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

Competitive bid process. Ratified by County Board of Supervisors. RFP on file at EMSA

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Napa

Area or subarea (Zone) Name or Title:
Angwin Response Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Angwin Ambulance Service. Since 1989

Area or subarea (Zone) Geographic Description:
See Napa County Ambulance Service Zone Map on page #168. Area includes the Community of Angwin, Pacific Union College, and portions of Lake Berryessa.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Mendocino

Area or subarea (Zone) Name or Title:
Garberville Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
City Ambulance dba/Garberbville Ambulance. Since 1992.

Area or subarea (Zone) Geographic Description:
See Mendocino County Ambulance Service Zone Map on page #166. Area includes the Towns of Leggett and Piercy. Also includes the Fire Protection Districts of Leggett and Piercy as well as surrounding SRA in northern Mendocino County. Provider is based in Humboldt County.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Mendocino

Area or subarea (Zone) Name or Title:
Laytonville Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Laytonville Ambulance. Since 1988

Area or subarea (Zone) Geographic Description:
See Mendocino County Ambulance Service Zone Map on page #166. Area includes the communities of Laytonville, Branscomb, Dos Rios, Bell Springs, and portions of Leggett.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Mendocino

Area or subarea (Zone) Name or Title:
Covelo Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Covelo Ambulance. Since 1995

Area or subarea (Zone) Geographic Description:
See Mendocino County Ambulance Service Zone Map on page #166. Includes the community of Covelo and the Round Valley Indian Reservation.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Mendocino

Area or subarea (Zone) Name or Title:
Ft. Bragg Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Mendocino Coast District Hospital (MCDH) Ambulance. Since 1988.

Area or subarea (Zone) Geographic Description:
See Mendocino County Ambulance Service Zone Map on page #166. Area includes the City of Ft. Bragg, Town of Mendocino, and communities of Comptche, Whale Gulch, Albion, Little River, Rockport, and Cleone

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Mendocino

Area or subarea (Zone) Name or Title:
Willits Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Ukiah Ambulance Service dba/Willits Ambulance. Since 1998

Area or subarea (Zone) Geographic Description:
See Mendocino County Ambulance Service Zone Map on page #166. Area includes the city of Willits, the Little Lake Fire Protection District, the Brooktrails Community Service District.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Mendocino

Area or subarea (Zone) Name or Title:
Ukiah City Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
City of Ukiah Fire Department. Since 1994

Area or subarea (Zone) Geographic Description:
See Mendocino County Ambulance Service Zone Map on page #166. Area includes the City of Ukiah.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Mendocino

Area or subarea (Zone) Name or Title:
Ukiah Valley Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Ukiah Ambulance Service. Since 1998

Area or subarea (Zone) Geographic Description:
See Mendocino County Ambulance Service Zone Map on page #166. Area includes City of Ukiah, towns of Redwood Valley, Potter Valley, and Hopland. Also includes Ukiah Valley Fire Protection District and the Hopland/Sanel Valley Community Service District.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Mendocino

Area or subarea (Zone) Name or Title:
Anderson Valley Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Anderson Valley Ambulance. Since 1992

Area or subarea (Zone) Geographic Description:
See Mendocino County Ambulance Service Zone Map on page#166. Area includes the Communities of Boonville, Navarro, and Philo. Also includes the Anderson Valley Fire Protection District.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Mendocino

Area or subarea (Zone) Name or Title:
Elk Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Elk Fire Department. Since 1990

Area or subarea (Zone) Geographic Description:
See Mendocino County Ambulance Service Zone Map on page #166. Area includes the Community of Elk.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS PLAN
AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Mendocino

Area or subarea (Zone) Name or Title:
South Coast Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Coast Life Support District (CLSD). Since 1989

Area or subarea (Zone) Geographic Description:
See Mendocino County Ambulance Service Zone Map on page #166. Area includes the City of Pt. Arena, the Town of Gualala and the South Coast Fire Protection District. This provider also serves northern Sonoma County. See separate Ambulance Zone Summary Form.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

DESCRIPTION OF THE PLAN DEVELOPMENT PROCESS

The process used to develop the EMS System Plan for the Coastal Valleys EMS Agency was taken directly from the California

Local EMS Agency or County Name: Coastal Valleys EMS Agency - Mendocino

Area or subarea (Zone) Name or Title:
Cloverdale Ambulance Service Zone

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.
Cloverdale Ambulance. Since 1986

Area or subarea (Zone) Geographic Description:
See Mendocino County Ambulance Service Zone Map on page #166. Area includes portions of Sanel/Hopland Community Service Area and Anderson Valley Fire Protection District. This provider also serves northern Sonoma County. See separate Ambulance Zone Summary Form.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.
Non Exclusive

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

N/A

Method to achieve Exclusivity, if applicable (HS 1797.224):
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If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

N/A

EMS Authority's EMS System Guidelines; Part III: EMS System Planning Guidelines (June 1994). These guidelines recommend the following three steps in developing an EMS plan: document the current status of the local EMS system *(where we are now)*; develop a model for the future *(where we want to be)*; and develop the specific objectives necessary to move the EMS system from where it is today toward the future model *(getting from where we are to where we want to be)*.

Agency staff developed a first draft of the EMS plan objectives based on the California EMS Authority's EMS Systems Standards and Guidelines. Once complete the EMS plan objectives were submitted to the Regional Directors Committee (RDC) for review to determine if the objectives: 1) addressed each of the minimum EMS standards and recommended guidelines and 2) moved the EMS system in the direction of the EMS system model. Based on this review process revisions were made to the EMS plan objectives.

The Transportation Plan for the CVEMSA system, included here as Appendix 2, was drafted and submitted for public review concurrent with the EMS plan objectives.

An executive summary and a description of the plan development process were written following RDC approval of the EMS plan objectives.

Finally, agency staff brought the separate sections, summary, assessment, objectives, tables, etc., together to create a the Coastal Valleys Emergency Medical Services Agency Emergency Medical Services System Plan. Since each section was developed separately, agency staff reviewed the compiled plan and minor edits were made for grammar, format and consistency

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