Stanislaus County
Emergency Medical Services Agency

Stanislaus EMS Agency

Paramedic Triage to Alternate Destination

Application for Approval

Application for Approval to the California Emergency Medical Services Authority

And

Amendment to the EMS Plan

November 27, 2023

Stanislaus County
Emergency Medical Services Agency

November 26, 2023

Tom McGinnis, Chief
EMS Systems Division
Emergency Medical Services Authority
11120 International Dr. 2nd Floor
Rancho Cordova, CA 95670

Re: Stanislaus EMS Triage to Alternate Destination EMS Plan Amendment

Chief McGinnis,

The Stanislaus EMS Agency is hereby submitting and attaching plan documents required under the Community Paramedicine or Triage to Alternate Destination Act of 2020, specifically California Health and Safety Code (HSC) §§ 1835,1840-1843 and California Code of Regulations (CCR), Title 22, § 100190 for the implementation of a Triage to Alternate Destination program to authorize transport of patients from the scene of a 911 call to either behavioral health crisis center, a sobering center or a local veterans administration emergency department.

Since 2014, Stanislaus County has had the opportunity to participate in the EMS Authority's Community Paramedicine Health Workforce Pilot Project #173. The success of the program cannot be overstated. Over the last several years, behavioral health budget cuts have resulted in a system-wide surge of patients that have ultimately impacted our local emergency departments. These patients, by nature, require a significant number of resources, in particular nursing time, which draws resources away from regular emergency department operations. As emergency department volumes continue to escalate, help is needed to mitigate the emergency department crowding conditions and permit considerably more efficient use of resources by using is a model of care that leverages the skills of paramedics and enables the EMS System to address care gaps identified through the health care needs within Stanislaus County.

Under HSC § 1812, the Stanislaus County Behavioral Health Crisis Center is being submitted as a Triage to Alternate Destination Facility as an authorized behavioral health center.

Under HSC § 1843, all 911 Ambulance Service providers are being submitted as Triage to Alternate Destination Providers. The Triage to Alternate Destination training program will be administered by American Medical Response.

With the ability to restart the County's Triage to Alternate Destination program, Stanislaus EMS remains dedicated to our mission of oversight through directing, planning, monitoring, and evaluating Stanislaus County's EMS System. For any questions, concerns, or requests for additional information regarding our submission, please do not hesitate to contact me directly.

Sincerely,

//ss// *Chad Braner*

Chad Braner EMS Director

Stanislaus County
Emergency Medical Services Agency

Triage to Alternate Destination

EMS Plan Amendment

Table of Contents

Stanislaus County
Emergency Medical Services Agency

Policy: 954.30
Supersedes: Policy 954.10
Title: Triage to Alternate Destination Program Requirements

Review Date: XXXX

Effective Date: XXXX

APPROVAL SIGNATURES ON FILE AT EMS AGENCY OFFICE

1. AUTHORITY

1.1. **Community Paramedicine or Triage to Alternate Destination Act of 2020; California Health and Safety Code, Division 2.5, Chapter 13; California Code of Regulations (CCR), Title 22, Division 9, Chapter 5**

2. PURPOSE

2.1. Triage to Alternate Destination (TAD) programs are community focused extensions of traditional emergency response transportation and recognized as an emerging model of care to meet an unmet need within the community.

2.2. Authorized TAD Paramedics, working under medical oversight, will deliver TAD services to improve coordination among providers of medical service, behavioral health services and sobering centers; preserve and protect the underlying 911 EMS system; provide high quality patient care; and empower heath systems to provide care more effectively and efficiently.

3. DEFINITIONS AND SCOPE

3.1. Alternate Destination Facility is defined as a treatment location that is an:

- 3.1.1. Authorized mental health facility (Health and Safety Code § 1812)
- 3.1.2. Authorized sobering center (Health and Safety Code § 1813)
- 3.1.3. Authorized local veteran's administration emergency department (Health and Safety Code § 1819(a)(3)

3.2. A TAD program also includes providing transport services for patients who identify as veterans and desire transport to a local veteran's administration emergency department for treatment.

3.3. Advanced Life Support (Paramedics) shall not transport patients to any destinations not approved as a Receiving Facility, Standby Facility, or Alternate Destination.

3.4. TAD Provider

- 3.4.1. Advanced Life Support provider authorized by the EMS Agency to provide Advanced Life Support triage paramedic assessments as part of an approved triage to alternate destination program specialty.

3.5. TAD Program

- 3.5.1. Program developed by the EMS Agency and approved by the EMS Authority (State) to provide triage paramedic assessments.

3.6. TAD Paramedic

- 3.6.1. Paramedic who has completed the curriculum for triage paramedic services and receives local TAD Accreditation.

4. MEDICAL DIRECTION

4.1. A TAD Paramedic shall utilize the approved EMS Agency Medical Director patient assessment protocols as described in EMS Agency **Policy #XXXX**This includes utilizing general paramedic scope and other approved scopes while transporting to alternate destinations, providing care to discharged patients, providing vaccinations, and through other conditions as identified in TAD programs.

5. DOCUMENTATION AND CONTINUOUS QUALITY IMPROVEMENT

5.1. TAD Paramedics shall complete and submit electronic patient records in accordance with 22 CCR § 100171, and document destination facility with standardized facility codes per the California Emergency Medical Services Information System (CEMSIS).

5.2. TAD program shall have a written Continuous Quality Improvement (CQI) plan approved by the EMS Agency. The CQI plan shall complement the EMS Provider's existing CQI plan (Appendix D Policy 620.10). CQI plans shall include provisions for continuing education including types of activities, frequency, and required hours.

5.3. TAD programs shall exchange electronic patient health information between TAD providers and facilities.

6. LOCAL IMPLEMENTATION

6.1. TAD programs shall be reviewed, submitted, and implemented within the EMS Agency's EMS Plan under Ca. Health and Safety Code § 1797.250.

6.2. EMS Agency shall provide medical control and oversight for TAD programs.

6.3. The EMS Agency with TAD Providers shall facilitate agreements to ensure delivery of TAD services.

6.4. The EMS Agency shall annually review TAD training programs, providers, and facilities to ensure compliance with all requirements.

6.5. The EMS Agency shall notify the EMS Authority of any complaints or unusual occurrences for approved TAD programs within seventy-two (72) hours with supporting documentation.

6.6. The EMS Agency shall approve and establish the effective date of program approval in writing upon the program satisfactory meeting and documenting compliance with all program requirements.

6.7. Notification of program approval or deficiencies with the application shall be made in writing by the EMS Agency to the requesting training program within ninety (90) days of receiving the training program's request for approval.

6.8. Training program approval shall be valid for four (4) years ending on the last day of the month in which it was issued and may be renewed every four (4) years.

6.9. The EMS Agency shall notify the EMS Authority in writing of the training program approval, including the name and contact information of the program director, medical director, and effective date of the program.

6.10. Training Program shall provide any documents and materials on an annual basis to support EMS Agency EMS Plan submission to maintain continuity of TAD programs.

7. TAD PROVIDER/FACILITY OVERSIGHT

7.1 TAD Provider/Facility's failure to comply with the provisions of statute, regulation, and/or any additional EMS Agency requirements may result in denial, probation, suspension, or revocation of approval by the EMS Agency.

7.2 The process for noncompliance is listed in 22 CCR § 100184.

8. TRAINING PROGRAM REVIEW AND APPROVAL

8.1. TAD training programs shall submit a written request for training program approval to the EMS Agency

8.2. The EMS Agency shall receive and review the following documentation prior to program approval:

8.3 A statement verifying that the course content meets the requirements contained in the current version of the United States Department of Transportation (U.S. DOT) National EMS Education Standards as required by Section 1831(c)(2) of the Health and Safety Code.

8.3.1 An outline of course objectives and curriculum

8.3.2 Performance objectives for each skill.

8.3.3 The names and qualifications of the training program director, program medical director, and instructors.

8.3.4 The proposed location(s) and date(s) for courses.

8.3.5 Written contract or agreements between the training program and a hospital(s) and other clinical setting(s), if applicable, for student placement for clinical education and training.

8.3.6 Written contracts or agreements between the training program and a provider agency(ies) for student placement for field internship training.

8.3.7 Samples of written and skills examinations administered by the training program.

8.3.8 Evidence that training program facilities, equipment, examination securities, and student record keeping are compliant with the provisions of statute, regulation, and EMS Agency requirements.

9. TRAINING PROGRAM REQUIREMENTS

9.1. Program Medical Director

9.1.1. Each training program shall have a program medical director who is a board certified, or board eligible emergency medical physician currently licensed in the State of California, who has experience in emergency medicine and has education or experience in methods of instruction. Duties of the program medical director shall include, but not be limited to the following:

9.1.2. Review and approve educational content, standards, and curriculum; including training objectives and local protocols and policies for clinical and field instruction, to certify its ongoing appropriateness and medical accuracy.

9.1.3. Review and approve the quality of medical instruction, supervision, and evaluation of the students in all areas of the program.

9.1.4. Review and approve hospital clinical and field internship experience provisions.

9.2. Approval of instructor(s).

9.2.1. The program medical director will certify that guest educators invited by primary instructors to provide instruction or facilitation have the appropriate expertise to deliver the proposed educational content.

9.3. Program Director

9.3.1. Each training program shall have a program director who shall meet the following requirements:

9.3.1.1. Has knowledge or experience in local EMS protocol and policy,

9.3.1.2. Is a board certified or board eligible California licensed emergency medicine physician, registered nurse, paramedic, or an individual who holds a baccalaureate degree in a related health field or in education, and

9.3.1.3. Has education and experience in methods, materials, and evaluation of instruction including:

9.3.1.4. A minimum of one (1) year experience in an administrative or

management level position, and

9.3.1.5. A minimum of three (3) years academic or clinical experience in prehospital care education

9.3.2. Duties of the program director shall include, but not be limited to the following:

9.3.2.1. Administration, organization, and supervision of the educational program.

9.3.2.2. In coordination with the program medical director, approve the instructor(s), teaching assistants, field and hospital clinical preceptors, clinical and internship assignments, and coordinate the development of curriculum, including instructional objectives, and all methods of evaluation.

9.3.2.3. Ensure training program compliance with this chapter and other related laws.

9.3.2.4. Ensure that all course completion records include a signature verification.

9.3.2.5. Ensure the preceptor(s) are trained according to the subject matter being taught.

9.4. Instructors

9.4.1. Each training program shall have instructor(s), who are responsible for areas including, but not limited to, curriculum development, course coordination, and instruction and shall:

9.4.1.1. Be a physician, registered nurse, physician assistant, nurse practitioner, paramedic, who is currently certified or licensed in the State of California,

9.4.1.2. Have six (6) years' experience in an allied health field or community paramedicine, or four (4) years of experience in an allied health field and an associate degree or two (2) years of experience in an allied health field and a baccalaureate degree, and

9.4.1.3. Be knowledgeable in the course content of the U.S. DOT National Emergency Medical Services Education Standards, and

9.4.1.4. Be able to demonstrate expertise and a minimum of two (2) years of experience within the past five (5) years in the subject matter being taught by that individual, and

9.4.1.5. Be qualified by education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction.

9.4.1.6. An instructor may also be the program medical director or program director.

10. MINIMUM TRAINING AND CURRICULUM REQUIREMENTS

10.1. TAD program shall meet or exceed minimum testing, training and curriculum requirements as listed in 22 CCR §§ 100189(e)(2), 100189(f), and 100189(h). (Appendix B)

11. TRAINING PROGRAM OVERSIGHT

11.1. A TAD program's failure to comply with the provisions of statute, regulation, and/or any additional EMS Agency requirements may result in denial, probation, suspension, or revocation of approval by the EMS Agency.

11.2. The EMS Agency may conduct onsite visits, inspect, investigate, and discipline approved training programs for any violations or for failure to fulfill any additional requirements.

11.3. The requirements of training program noncompliance notification and actions are as follows:

11.3.1. The EMS Agency shall provide written notification of noncompliance with state and/or local standards and requirements to the training program provider. The notification shall be in writing by certified mail.

11.3.2. Within fifteen (15) days from receipt of the noncompliance notification, the training program shall submit in writing to the EMS Agency one of the following:

11.3.2.1. Evidence of compliance with the provisions of state and/or local standards and requirements, as applicable, or a plan to comply with the provisions of state and/or local standards and requirements, as

applicable, within sixty (60) days from the day of receipt of the notification of noncompliance.

11.3.2.2. Within fifteen (15) days from receipt of the training program's response, or within thirty (30) days from the mailing date of the noncompliance notification, if no response is received from the training program, the EMS Agency shall issue a decision letter by certified mail to the EMS Authority and the training program. The letter shall identify the EMS Agency's decision to take one or more of the following actions:

- Accept the evidence of compliance provided.
- Accept the plan for meeting compliance provided.
- Place the training program on probation.
- Suspend or revoke the training program approval.

11.3.2.3 The decision letter shall also include, but need not be limited to, the following information:

- Date of the EMS Agency's decision,
- Specific provisions found noncompliant by the EMS Agency
- The probation or suspension effective and ending date
- The terms and conditions of the probation or suspension
- The revocation effective date

11.3.2.4 The EMS Agency shall establish the probation, suspension, or revocation effective dates.

12. TAD DESTINATION REVIEW AND APPROVAL REQUIREMENTS

12.1. Must be an Alternate Destination as defined in Section 3 above.
12.2. Notify the EMS Agency review via written request for facility review.
12.3. Review and approval by the EMS Agency including site visit.
12.4. Facility must maintain all requirements including, but not limited to:
12.4.1. Qualified staff to care for the degree of a patient's injuries and needs.
12.4.2. Standardized medical and nursing procedures for nursing staff.
12.4.3. Necessary equipment and services at the Alternate Destination facility to care for patients including, but not limited to an automatic external defibrillator and at least one bed per individual patient.
12.4.4. Facility shall maintain an agreement with the EMS Agency to ensure compliance with provisions in statute, regulations, and local policies including operation in accordance with Ca. Health and Safety Code § 1317. Failure to operate under § 1317 will result in immediate termination of the facility as part of the TAD facility.
12.4.5. Facilities participating as an alternate destination shall accommodate privately or commercially insured, Medi-Cal, Medicare, and uninsured patients.

Note: The EMS Agency will prohibit triage and assessment protocols or triage paramedic's decision to authorize transport to an alternate destination facility from being based on, or affected by, a patients ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, or any other characteristic listed or defined in subsection (b) or € of Section 51 of the Civil Code, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provisions of appropriate medical care to the patient (CCR 100183(4)

13. TAD ACCREDITATION

13.1. The process and requirements for local TAD Accreditation are located within EMS Agency Policy 254.30 – Triage Paramedic Accreditation.
13.2. A TAD paramedic shall only utilize TAD skills when accredited by the Stanislaus EMS Agency as a TAD paramedic within Stanislaus County and when employed by

an EMS Agency-approved TAD Provider.

13.3. The EMS Agency shall register the triage paramedic accreditation in the Central Registry public look-up database within five (5) business days of the triage paramedic accreditation application being approved.

13.4. A TAD accreditation is deemed effective when recorded in the Central Registry public look-up database.

13.5. The EMS Agency shall review the submitted eligibility criteria for TAD Accreditation and notify the applicant in writing within thirty (30) business days from the date of submission that:

13.5.1. The submission is incomplete or illegible and required corrective action or

13.5.2. The accreditation request has been approved and the accreditation data entered in the Central Registry public look-up database.

13.5.3. The accreditation request has been denied; including the reason and notification of the applicant's right to appeal.

13.6. The process for Accreditation action and appeal for a TAD Accreditation is the same process as ALS Local Accreditation and as listed in EMS Agency Policy 254.00 and is consistent with Ca. Health and Safety Code § 1797.194.

14. TAD DATA SUBMISSION

14.1. EMS Agency and TAD Provider shall submit the minimum data requirements on required intervals as listed in 22 CCR § 100185.

14.2. EMS Agency shall submit to the Authority a summary data report of authorized personnel no later than the thirtieth (30th) calendar day of January, April, July, and October.

POLICY: 620.30
TITLE: Provider Agency Data Requirements

EFFECTIVE: 12/12/18
REVIEW: 12/2023
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PROVIDER AGENCY DATA REQUIREMENTS

I. AUTHORITY

Health and Safety Code, Division 2.5, Section 1797.220

II DEFINITIONS

A. Agency" means Stanislaus County EMS Agency

B. "CAD" means Computer Aided Dispatch

C. "CEMSIS" means California Emergency Medical Services Information System which currently uses the NEMSIS version 3 Data Dictionary.System

D. NEMSIS" means the National Emergency Medical Services Information System as defined by the NEMSIS Organization at www.nemsis.org

E. "ePCR" means Electronic Patient Care Report

F. Provider Agency" means:

1. A Communications Center that provides Emergency Medical Dispatch, including pre arrival instructions or an Air Ambulance Dispatch Center, or;

2. Pre Hospital Care Agency that provides:

a. Advanced Life Support First Response (also known as "First Response Advance Life Support or FRALS) or;

b. Limited Advanced Life Support First Response or;

c. A ground ambulance or;

d. An air ambulance provider.

G. "XML" means Extensible Markup Language, a set of rules for encoding documents electronically.

III PURPOSE

To establish the standard data specifications for Computer Aided Dispatch and patient care records maintained by provider agencies for submission to Stanislaus County EMS Agency.

IV. POLICY

A. Communication Centers shall submit CAD data to the Agency in an electronic format acceptable to the Agency on a daily basis, or as otherwise approved by the Agency. CAD data shall include records for all emergency and non-emergency ambulance requests received at the EMD Provider agency. Each computer dispatch record submitted to the Agency shall contain the following fields, as a minimum:

1. Call Date

2. Incident Number
3. Location
4. EMS Map Grid/Zone
5. Call Type (e.g. scene, inter-facility transfer)
6. Emergency Medical Dispatch (EMD) Determinate Code
7. Ambulance Provider
8. Vehicle ID Number
9. Time Call Received
10. Time Call Entered
11. Time Call in Dispatcher Queue
12. Time Dispatched
13. Time En Route
14. Time Arrived Scene
15. Time Patient Contact, if applicable
16. Time Departed Scene.
17. Time Arrived Destination.
18. Time canceled (if applicable)
19. Code of Response
20. Updated Code of Response, if applicable
21. Code of Transport
22. Updated Code of Transport, if applicable
23. Call Disposition, final result of the call for this vehicle or transport status

B. Pre Hospital Care Agencies shall:

1. Submit ePCR data to the Agency in an electronic format acceptable to the Agency on a daily basis, or as otherwise approved by the Agency.

2. The ePCR shall include all fields as documented in Health and Safety Code 1797

3. Comply with patient care record documentation requirements as specified in Agency Documentation Policy # 560.11

4. Triage to alternate destination programs shall exchange electronic patient health information (HIE) between triage to alternate destination providers and health providers and facilities.

5. Use XML format as the approved data format by the Agency with respect to data structures, code sets (i.e. pick list values), and data export capabilities.

C. Agency shall in consultation with EMS providers establish protocols for the collection, utilization, and storage of data in accordance with CCR 100171

D. Agency reserves the right to add additional mandatory data elements as needed.

QUALITY IMPROVEMENT

I. AUTHORITY

Division 2.5 of the California Health and Safety Code, Sections 1797.202, 1797.204, 1797.220, California Code of Regulations, Title 22, Division 9, Chapter 12, Sections 100400 – 100405, California Evidence Code, Section 1040, 1157, 1157.5, 1157.7

II. DEFINITIONS

A. **Local Quality Improvement Group (LQIG)** means an established committee, comprised of multiple provider agencies, which meets regularly to evaluate and act upon quality improvement information and issues within a local community.

B. **Stanislaus County Emergency Medical Services Agency (SCEMSA) Quality Improvement Program Manual** means the document which defines the standardized structure, process, and indicators to be used in performing quality improvement within Stanislaus County.

C. **Outcome Indicator** means the result of structural and process indicators (e.g. cardiac arrest survival rate (outcome) compared to number of AEDs per population (structural) or response times (process).

D. **Process Indicator** means a measurable activity of a system (e.g. IV's, intubations)

E. **EMS Service Provider** means any agency which performs services directly or indirectly to a patient which has received pre-hospital care to include, but not be limited to: dispatch, first responder, ambulance, base hospitals, and receiving facilities.

F. **Provider Improvement Program** means a written program in which an EMS Provider has established an organizational structure and standard operating procedures which allow for the continual evaluation and improvement of services.

G. **Provider Quality Improvement Panel** means an established committee within a local EMS Provider organization which meets regularly to evaluate and act upon quality improvement information and issues within a local provider service area.

H. **Quality Improvement** means an organized and standardized process by which services and products delivered by an EMS System are continuously evaluated and improved based upon accepted benchmark standards.

I. **Quality Indicator** means a measurement of the degree or frequency of compliance with an established standard or benchmark, including both core indicators and ad-hoc indicators, as approved by the EMS Agency Medical Director.

J. **Quality Liaison Committee** (QLC) means an established committee of EMS service providers, which meets regularly to evaluate and act upon quality improvement information and standards within the regional service area.

K. **Structural Indicator** means a physical attribute of a system or the structures in place to ensure quality (e.g. number of hospital or ambulances per population).

III PURPOSE

To provide the structure and process for the continual evaluation and improvement of emergency medical care within Stanislaus County.

IV POLICY

A. **Data Collection & System Evaluation**

EMS Providers shall participate in an organized EMS system evaluation program at each of the following four levels:

1. Regional Level/QLC
   a. All EMS service providers shall collect and report data for core indicators to the EMS Agency on a regular basis.
   b. All EMS service providers shall collect and report ad-hoc indicators to the EMS Agency as recommended by the QLC and approved by the EMS Agency Medical Director.
   c. All EMS service providers shall participate in the regional QLC meetings and processes, which at a minimum provide review and assessment of structural, process, and outcome quality indicators as established within the regional EMS system.

2. Local Level/ LQIG
   a. All EMS service providers shall collect and report data for core indicators to the EMS Agency on a regular basis.
   b. All EMS service providers shall collect and report ad-hoc indicators to the EMS Agency as recommended by the LQIG and approved by the EMS Agency Medical Director.
   c. Each LQIG shall regularly report the results of any system evaluation to the Quality Liaison Committee.
   d. All EMS service providers shall participate in the LQIG meetings and processes, which at a minimum provide review and assessment of core structural, processes, and outcome quality indicators as established within Stanislaus County EMS Agency.

3. Provider Level
   a. All EMS service providers shall establish in writing an internal Data Collection and System Evaluation program, which includes, at a minimum a:
      (1) list of structural, process, and outcome indicators, approved by the EMS AGENCY Medical Director
      (2) procedure for the evaluation of all established indicators

(3) procedure for the regular reporting of core and ad-hoc indicators to the LQIG, QLC, and EMS Agency
(4) procedure for reporting information on any structural, process, or outcome indicator which falls outside the accepted benchmarks to the provider QI liaison
(5) procedure for reporting information on any structural, process, or outcome indicator which falls outside the accepted benchmarks to other agency provider QI liaisons when the information involves another EMS provider
(6) procedure for submitting unusual occurrence reports to the EMS agency for unresolved inter-agency issues.

b. All providers shall immediately provide a written unusual occurrence report to the EMS Agency when any situation could be considered an imminent threat to the public health or safety.

4. Personnel level
a. All EMS personnel who provide pre-hospital medical care for an EMS provider shall participate in a system evaluation program that includes, at a minimum:
(1) collection and documentation of structural, process and outcome indicators as established by the EMS service provider
(2) periodic evaluation of established indicators

b. All EMS personnel shall immediately provide a written situation report to the EMS Agency when any situation could be considered an imminent threat to the public health or safety.

B. **EMS System Improvement Program**

1. EMS Providers shall participate in an organized EMS system improvement program. In cooperation with the EMS agency, providers shall use the following four-step improvement process:

a. **Plan:** Develop a Plan to implement a policy, procedure, or process to improve quality.

b. **Do:** After the plan is developed, DO it by putting the plan into action.

c. **Study**: After the plan has been put into action, STUDY the results to see if the plan has worked.

d. **Act:** After studying the results of the plan, ACT either to stabilize the improvement that occurred or to determine what went wrong if the gains that were planned for did not materialize.

2. EMS Providers shall participate in all training programs identified through the QI process for system improvement and approved by the EMS Agency Medical Director.

3. EMS Providers shall ensure that all personnel who provide prehospital medical care successfully complete training programs identified through the QI process for system improvement and are approved by the EMS Agency Medical Director. Training records shall be maintained for a period of not less than four years and be available to the EMS Agency upon request.

4. All EMS personnel who provide prehospital medical care shall participate in training programs identified through the QI process for system improvement and are approved by the EMS Agency Medical Director.

STANISLAUS COUNTY EMS AGENCY
POLICIES AND PROCEDURES

POLICY: XXXX

TITLE: Triage to Alternate Destination Patient Assessment Protocols

APPROVED: Signature On File In EMS Office
Executive Director

Signature On File In EMS Office
Medical Director

EFFECTIVE DATE:
SUPERSEDES:

REVIEW DATE:
PAGE: 1 of 2

TRIAGE TO ALTERNATE DESTINATION PATIENT ASSSESSMENT PROTOCOLS

I. AUTHORITY

California Code of Regulations, Title 22, Division 9, Chapter 4, Article 5

II. DEFINITIONS

A. "Accreditation" means authorization to practice TAD skills within Stanislaus County

B. "Agency" means Stanislaus County Emergency Medical Services Agency

C. "Provider" means an approved transporting Triage to Alternate Destination provider within Stanislaus County

D. "Triage Paramedic" means an individual who has completed the curriculum for triage paramedic services and received local TAD Accreditation

III. PURPOSE

To establish criteria to provide a medical clearance exam and referral to approved alternative destinations (i.e. transport to a location other than the emergency department) in order to facilitate the most appropriate triage and care for persons with acute mental health concerns.

IV. POLICY

A. Inclusion Criteria: Patients with a primary mental health complaint are eligible for consideration for an alternate destination if ALL the following criteria are met:

1. Patient shall be 18 years of age or older.
2. Patient has no medical complaints or traumatic conditions, other than superficial abrasions that do not require repair (ie: scratches to the wrist).
3. Patient is ambulatory.

4. Patient is cooperative and does not require physical restraint.
5. GCS greater than 14 at baseline.
6. Heart rate greater than 60 and less than 120.
7. SBP 90 – 200 and DBP 60-100. Note: Isolated hypertension (i.e. Hypertension with no associated symptoms such as headache, neurologic changes, chest pain, or shortness of breath) in a patient with a history of hypertension will not be a reason to decline the referral to Behavioral Health.
8. Pulse Oximetry greater than 94%
9. Diabetic patients with no evidence of ketoacidosis AND a blood glucose greater than 60 and less than 300 mg%.

1. Exclusion Criteria: Patients who present with ANY of the following criteria are not eligible for transport to an alternative destination and must be transported to the appropriate emergency department for evaluation:
    a. Patients demonstrating systems of Alcohol Withdrawal
    b. Patients who fail to meet ANY of the INCLUSION criteria outlined above.
    c. Patients who have taken ANY medication, prescribed or over the counter, outside of normal recommended dose.

Stanislaus County
Emergency Medical Services Agency

General Protocols

Policy 554.00

POLICY: 554.00
TITLE: General Protocols

EFFECTIVE: 9/16/2020
REVIEW: 9/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

GENERAL PROTOCOLS

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II. PURPOSE
To serve as the treatment standard for Emergency Medical Responders (EMRs), Emergency Medical Technicians (EMTs), and Paramedics in treating patients.

III. PROTOCOL

A. These are the treatment protocol standards for the Stanislaus County Emergency Medical Services Region. This document is divided into three major sections:

1. **General Procedures**
   a. Contains individual treatment procedures that can be found throughout Stanislaus County EMS Agency protocols.
   b. "ALS" or Advanced Life Support procedures are procedures performed by a Stanislaus County EMS Agency accredited Paramedic.
   c. "BLS" or Basic Life Support procedures are procedures performed by an individual providing care for an Stanislaus County EMS Agency approved or recognized provider. We do not certify all individuals providing BLS care in our system.
   d. "
2. **Treatment Protocols**
   a. Adult – Patient's age 15 and older
   b. Pediatric –Patient's age 14 and younger

3. **Field Specific Policies**
   a. Medication Index
   b. Procedure Index

MEDICAL CONTROL

I. STANDING ORDERS

A. **Standing Orders** are "treatments a licensed and accredited ALS, and/or certified EMT, and/or certified EMR provider can perform without Base Hospital permission".

B. The following are considered **Standing Orders:**

1. All BLS skills and treatment

2. All ALS skills and treatment **EXCEPT** those limited to **Base Physician Orders**

II. BASE PHYSICIAN ORDERS

A. Base Physician Orders are treatment procedures that require a direct order from a Base Hospital Physician. The Base Hospital Physician may order any medications or procedures within the local paramedic scope of practice regardless of the treatment protocol. Verbal orders MUST be signed by the Base Physician and maintained in the patient medical record. The paramedic must call the base hospital to which they are transporting the patient. The physician's name must be documented in the Pre-Hospital Patient Care Report.

B. An MICN may RELAY a verbal "Base Physician Order" from the Base Physician in accordance with any of the approved protocols.

III. ALS WITHOUT BASE HOSPITAL CONTACT FORM

A. If a paramedic cannot make Base Hospital Physician Contact, a paramedic can perform treatments listed under "Base Physician Order".

B. Documentation on an "ALS without Base Hospital Contact Form" must be completed listing any "Base Physician Order" treatments performed. The form must be forwarded to the Mountain-Valley EMS Agency within 24 hours of the call's occurrence.

VASCULAR ACCESS

A. Pre-Vascular Access Device (PVAD) – (e.g., arteriovenous shunt, tunneled catheters, and Peripherally Inserted Central Catheters (PICC lines)

1. A PVAD should only be used when a life-threatening condition requires immediate fluid therapy or IV medications.

2. A Base Hospital MICN or Physician should be consulted if the paramedic is unfamiliar with the type of indwelling catheter.

3. Aseptic technique must be followed.

4. Attempt to withdraw and discard 5 cc of blood from the device prior to infusion. If unable to withdraw, proceed with the infusion.

5. Use a Huber-type non-coring needle, whenever possible.

6. Follow manufacturer recommended settings and insertion techniques

TRANSPORT

I. TRANSPORT

A. Crew judgement based on clinical presentation, weather and roadway conditions

II. Patient Destination:

A. All patients who wish to be transported by ambulance to the hospital should be transported.

B. Patients should be transported to the closest hospital appropriate for their medical needs within a reasonable transport time or as specified in the patient treatment protocols.

C. During a declared MCI– patient destination will be at the direction of the Medical Group Supervisor based on location and availability of services.

D. Patients, not meeting specialty care criteria, i.e. Stroke, STEMI and/or Trauma will be transported to the hospital of their preference within a reasonable request. It is recommended the crew consult with their on-duty supervisor to confirm transports to facilities outside of the county that are not a routine destination.

E. If there are multiple patients in one ambulance, all patients will be transported to the same receiving facility

F. Patients who are eligible to be enrolled in the Triage to Alternate Destination Mental Health program and decline participation, shall be transported to the hospital of their choice.

G. TAD patient Deemed to No Longer Meet TAD Destination eligibility, Shall Be Transported to ED or Acute Care Hospital

H. In the event of a secondary transfer of a TAD patient from an Alternate Destination Facility to an Emergency Department, the Alternate Destination Facility shall send the patient's medical records with the patient to the Emergency Department.

RESPIRATORY GUIDELINES

A. Endotracheal Intubation:

1. Oral endotracheal intubation, stomal endotracheal intubation, and placement of a King-Tube (perilaryngeal airway) or I-Gel (Supraglottic airway) as a rescue airway are standing orders in patients who require advanced airway management. The I-Gel rescue airway, an approved Supraglottic airway device, may be inserted in any patient that fits on to a length based tape designed to estimate weight and/or medication doses (ie: Broselow) only if unable to adequately ventilate with BVM using the jaw thrust method and BLS airway adjuncts. **Endotracheal intubation shall not be performed on any patient that fits on a length based tape designed to estimate weight and/or medication doses (ie: Broselow).**

2. Paramedics must not attempt any form of tracheal intubation more than three (3) times per patient. An attempt to intubate is defined as placement of the laryngoscope blade in a patient's mouth **with the intent to intubate**. A Bougie shall be used as an adjunct to intubation at any time during the intubation procedure. If a total of three attempts are unsuccessful, paramedics will insert an alternative airway (in adults) or use BLS airway techniques (in adults or pediatrics).

3. When appropriate, pediatric patients shall have the appropriate sized I-Gel (Supraglottic airway) inserted following the manufacturers procedure for placing and using the device..

4. Correct tube placement must be confirmed and documented by at least three of the following indicators; Visualize ET tube passing through vocal cords, ET tube fogs with ventilations,, equal breath sounds, absent epigastric sounds, and chest rise and fall. All patients must be assessed immediately after intubation with an end-tidal CO_2 detector, colorimetric or continuous waveform. The number of centimeters at which the tube is secured, confirmatory indicators, and color change or waveform reading must be documented on the Prehospital Care Report. All intubated patients must be continuously assessed using ETCO2 waveform capnography. Any significant movement, emesis or change in clinical condition should be reassessed using waveform capnography and physical examination. If, at any time, capnography indicates that the tube is not in communication with the trachea, the airway must be immediately removed and re-intubation attempted.

5. All ET tubes and rescue airways should be secured using a commercially available device designed to secure ET tubes. Rescue airways should be secured according to manufacturer recommendations.

MECHANICAL CHEST COMPRESSION DEVICE

I. If available, the approved mechanical chest compression device shall be deployed by an EMT level or higher on any patient that meets the indications listed in this policy when the device is available, and the approved training has been completed.

II. **Indications**:

A. Patients 15 years of age or older

B. Medical and/or Traumatic cardiac arrest where manual CPR is indicated

III. **Contraindications:**

A. Patients 14 years of age or younger

B. If unable to correctly position the device due to size of the patient's chest.

IV. **Procedure:**

A. Initiate resuscitative measures according to "Cardiac Arrest Algorithms" 554.11

B. DO NOT attempt placement of the mechanical chest compression device until the third (3rd) cycle of manual compressions and at least three (3) rescuers are available to limit interruptions in chest compressions. DO NOT delay any interventions such as: Defibrillation, Intravenous or Intraosseous access, and medication administration for placement of the mechanical chest compression device.

C. Limit interruption in chest compressions to 10 seconds or less

D. Remove all clothing from the front and back of patient's torso.

E. Follow all manufacturer recommendations for application and use of the mechanical compression device.

F. Defibrillation can be performed with the mechanical chest compression device in place. There is no need to stop the device for the purpose of defibrillation.

G. In the event of disruption or malfunction of the mechanical chest compression device, immediately revert to manual CPR.

H. If a cardiac arrest patient is transported, the mechanical chest compression device shall remain in place to continue or resume CPR as necessary.

I. Personnel that deploy a mechanical chest compression device shall ensure that a person trained and qualified to use the device accompanies the patient to the hospital, even if they are not the primary patient caregiver.

J. All mechanical compression devices will be set at a rate of 100-120 compressions per minute. Changes will only be made with approval of the Stanislaus County EMS Agency Medical Director.

K. Any device purchased prior to September 1, 2018, follow manufacturer recommendations for operation.

V. **Mechanical Chest Compression Device Maintenance :**

A. The periodic preventative maintenance of all devices shall meet or exceed the criteria recommended by the manufacturer.

B. Providers shall immediately remove from service any device suspected of malfunctioning. Any malfunctioning device shall not be placed back into service until properly serviced or repaired by the manufacturer's authorized service program.

C. Device maintenance records shall be subject to review and inspected by Stanislaus County EMS Agency upon request.

VI. **Quality Improvement:**

A. Documentation and data related to the use of the mechanical chest compression device shall be provided to Stanislaus County EMS Agency upon request.

B. All patient contacts involving the use of the mechanical chest compression device shall undergo chart review by the provider QI personnel. Chart review shall include evaluation for appropriate clinical use and adherence to Stanislaus County EMS Agency policies and treatment protocols.

C. Any concerns or issues involving the use of the mechanical chest compression device shall be reported to Stanislaus County EMS Agency as soon as possible.

Stanislaus County
Emergency Medical Services Agency

Documenta?on of Pa?ent Contact

Policy 560.11

POLICY: 560.11
TITLE: Documentation of Patient Contact

EFFECTIVE: 6/10/20

REVIEW: 6/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

DOCUMENTATION OF PATIENT CONTACT

I. AUTHORITY

California Health and Safety Code, Division 2.5 sections 1797.220 and 1798 a.; and California Code of Regulations, Title 22 Section 100163 (6) (A).

II. DEFINITIONS

A. "Advanced Life Support Call" means any EMS call in which Advanced Life Support Procedures, as defined in Section 1797.52, Division 2.5 of the Health and Safety Code, with the exclusion of cardiac monitoring, are initiated. Cardiac monitoring, in itself, shall not constitute an ALS call unless done in conjunction with other ALS treatments or prescribed by a physician.

B. "Basic Life Support Call" means any EMS call that does not meet the definition for an Advanced Life Support call.

C. "Health Agent" means any person other than a law enforcement officer or coroner whohasauthorityor responsibility for the disposition of a body. A health agent could be a private physician, a home health nurse or a public health nurse.

D. "Patient" means any individual encountered by EMS personnel who upon questioning, requests assessment, treatment or transport or appears to exhibit evidence of illness or injury.

E. “Person” means any competent individual encountered by EMS personnel who upon questioning, denies illness or injury and does not exhibit any evidence of illness or injury. The individual did not call 911 or direct 911 to be called for medical complaint.

F. “Competent Person/Patient” means an individual with a capacity to understand the nature of his/her medical condition, if one exists, and is not impaired by alcohol, drugs/medications, mental illness, traumatic injury, grave disability, or mental abilities diminished due to age.

G. "Patient Contact" means anytime during the course of an EMS call, a person is identified as a patient as defined in this policy.

H. "Patient Care Record" means the form used to document prehospital medical care information according to the current standards established by the Stanislaus County Emergency Medical Services Agency

J. "Triage Tag" refers to the patient documentation tag currently in use within the Stanislaus County EMS system for the prioritization of patients of a disaster or multi-casualty incident.

III PURPOSE

To identify required patient information and to establish a mechanism for gathering, recording, and reporting this information

IV. POLICY

A. A Patient Care Report (PCR) or Triage Tag (when appropriate) shall be completed:

1. On all patients transported by ambulance

2. For Stanislaus County Fire Department providers with a signed agreement with SCEMSA, PCRs shall be completed when patient contact was made prior to the transporting ambulance and if any skill was performed other than basic vital signs.

3. In all cases of pre-hospital death. A completed original PCR or Triage Tag shall be given to the County Coroner, Law Enforcement, or Health Agent with jurisdiction over the scene by the ambulance personnel prior to departing the scene. A Triage Tag may be used to document patient information to be given to the County Coroner, Law Enforcement or Health Agent, if the original PCR is needed for Base Hospital Documentation and it was a confirmed MCI activation.

a. At a minimum the Triage Tag must contain the following information:

1) Patient History, including the criteria used to determine death.

2) Patient Treatment.

3) The time death was determined.

4) The Name of the Ambulance Service Provider.

5) The name and certification number of the EMT-I or EMT-P who performed the patient assessment.

6) The name of the Base Hospital Physician who determined the patient's death, if applicable.

7) The Patient Care Report number of the PCR that documents the entire incident.

4. In all cases where, in the opinion of the prehospital personnel, a patient has signs and symptoms of illness or has experienced a mechanism of injury substantial enough to warrant medical attention but is refusing treatment and/or transportation a Release From Medical Responsibility Form provided by the employer should be completed and signed

5. In all cases where a patient asks not to be transported but to seek medical attention on his/her own and, in the opinion of the prehospital personnel, a patient has signs and symptoms of illness or has experienced a mechanism of injury that is not of a serious enough nature to warrant ambulance transport.

B. The complete medical record copy of all Patient Care Reports and Triage Tags, except as noted in Section A.3. for cases of death, shall be hand delivered, faxed, transmitted or the

Base Liaison shall have direct access to the completed PCR within 2 hours for any patient that was transported code 3 to the receiving hospital and 12 hours for any others. *EMS PCRs contain vital information when deciding a course of treatment, therefore it is important to have the completed PCRs to the receiving hospital within 2 hours for all critical/code 3 transports*

1. If prehospital personnel are dispatched to an emergency call prior to completing required documentation within the timeframe noted above, the documenter shall contact his/her direct supervisor for a reason why the PCR was not completed within the required timeframe if the timeline was not met unless there was an Information Technology (IT) problem that prohibited submission

2. If the PCR cannot be submitted within the policy time requirements, the care provider completing the report must submit a completed "Interim PCR" (Appendix A) prior to the prehospital personnel's departure from the department receiving the patient if requested by the receiving department.

V. Procedure

A. A Patient Care Report shall be completed according to SCEMSA 560.12 -Patient Care Record Instruction Booklet.

B. A photocopy of a completed Triage Tag shall be used to document all victims of a Multi-Casualty Incident whenever the local county Multi-Casualty Incident Plan is utilized.

C. When a triage tag is used, the original triage tag shall become part of the patient record and photocopies shall:

1. Be done in such a way that the triage tag remains on the patient until such time that the hospital patient record is established. If the ambulance crew needs to leave prior to completion of a hospital patient record, the prehospital personnel may remove a perforated section of the Triage Tag which contains the patient I.D. number for later patient documentation.

2. Be photocopied front and back and attached to the PCR. After the photocopy has been made, the original triage tag should be attached to the PCR for medical records.

3. Be made in triplicate for normal distribution.

Appendix A

I. Provider Agencies will use the elements listed below on the EMS Service Interim PCR Form:

A. "Interim Patient Care Report" in bold caps in the header of report

B. Date, Time, Unit number, Provider, and Incident number

C. Incident Address

D. Last and First Name, Age, DOB, Sex of Patient

E. Patient's Address and Phone

F. Chief Complaint

G. Mechanism of Injury/History

H. Vitals Sign Box to include: Time, BP, Pulse, Resp/Rate/Quality, SP02, GCS, EKG Rhythm

I. Treatment Box to include: Time, Treatment/Medications, and Response to Treatment

J. Allergies, Medications, and Medical History Box

K. Pertinent Physical Findings Box

L. Receiving Hospital, Crew/Cert Number and Signature, Person Receiving Care/Title

II. The following page has an example Interim Patient Care Report, which can be used by the provider within the SCEMSA Region.

Stanislaus County EMS Agency

Interim Patient Care Report

Date: _____Time: _____Unit #: _____Provider _____Incident # _____

Incident Address: _____Level of Distress: **Mild Moderate Severe**

Name (Last, First): _____Age: _____DOB: _____Sex: M F

Patient's Address: _____Phone: _____

Chief Complaint:
Mechanism of Injury/History:

Time	BP	Pulse	Resp. Rate/Quality	SPO2	GCS				EKG Rhythm
					Eyes	Motor	Verbal	Total	

Time	Treatment/Medications				Response to Treatment
	Oxygen □ Cannula □ Mask □ BVM Liter Flow _____				
	□ IV I/O □	**Gauge**	**Location**	**Rate**	

Allergies	Medications	Medical History	
		□ Cardiac □ Psych **□ Stroke □ Diabetes** **□ HTN □ CA** **□ COPD □ GI**	**□ Other:**

Pertinent Physical Findings:
Receiving Hospital: **Person Receiving Care/Title:** **Crew/Cert. Number:** **1. 2. 3.**

Stanislaus County
Emergency Medical Services Agency

TAD Paramedic Accredita?on

Policy 254.30

TRIAGE PARAMEDIC ACCREDITATION

I. AUTHORITY

California Code of Regulations, Title 22, Division 9, Chapter 4, Article 5, Section 100183,

II. DEFINITIONS

A. "Accreditation" means authorization to practice TAD skills within Stanislaus County

B. "Agency" means Stanislaus County Emergency Medical Services Agency

C. "Provider" means an approved transporting Triage to Alternate Destination provider within Stanislaus County

D. "Triage Paramedic" means an individual who has completed the curriculum for triage paramedic services and received local TAD Accreditation

III. PURPOSE

To provide a mechanism whereby individuals may acquire and maintain Triage Paramedic accreditation.

IV. POLICY

A. Candidates must meet the following requirements:

1. Current Stanislaus County EMS Agency Paramedic Accreditation

2. Not to be the subject of any outstanding formal prehospital investigation or have any censures including performance improvement plans, suspensions, etc. within the past two (2) years.

3. Successfully complete an Agency approved training program specific to the skills and procedures used during assessment and transport to an approved alternate destination.

4. Be employed by an authorized Triage to Alternate Destination Provider within Stanislaus County.

B. A Triage Paramedic, once accredited by the Agency, shall be considered accredited as long as they:

1. Maintain licensure as a Paramedic, by the State of California.

2. Successfully complete any requirements imposed by the Agency Medical Director for an Agency approved Expanded Scope of Practice Class, and Policy Update Class.

3. Meet any requirements of the System-wide CQI program.

C. An accredited Triage Paramedic must notify the Agency, within thirty (30) days of any change in address, telephone or e-mail contact information.

D. All accredited Triage Paramedics must submit, every two years, an information update sheet and a copy of a newly issued State Paramedic license in order to maintain accreditation.

V. PROCEDURE

A. Submit a completed Triage Paramedic Authorization Application and attach copies of the following:

1. Certificate of Completion of an approved Triage to Alternate Destination Training program.

B. Upon receipt of materials and payment of any applicable fees, the Agency will review all documents to determine the applicant's eligibility.

C. The Agency will notify the individual and employer of the approval or denial within fourteen (14) business days. If accreditation is granted an accreditation card will be issued.

VI. RENEWAL

A. To maintain accreditation the Triage Paramedic must complete and submit, every two years an Information Update Form and a copy of a valid newly issued Paramedic license from the State of California.

B. At least _____ hours of annual Continuing Education, in specialized Triage to Alternate Destination scope of practice as approved by the Agency.

VII. LOSS of TRIAGE PARAMEDIC ACCREDITATION

A. Accreditation may be discontinued for the following reasons:

1. Failure to comply with any provision of this policy.

2. The Agency's Medical Director has determined, based on validated significant negative clinical or performance issues related to the Triage to Alternate Destination Policies is a threat to the safety and wellbeing of the public or patient.

3. Failure to comply with all applicable Federal, State and Local statutes, regulations, ordinances and polices.

B. If accreditation is suspended, or revoked, the affected paramedic shall be entitled to appeal the decision. The process for appeal is outlined in Agency Policy #161.00, Appeals Process.

Stanislaus County
Emergency Medical Services Agency

Paramedic Accredita?on & Renewal

Policy 254.00

Stanislaus County
Emergency Medical Services Agency

POLICY NO. 254.00
Title: Paramedic Accreditation and Renewal

REVIEW DATE: 10.31.2025
EFFECTIVE DATE: 11.01.22

APPROVAL SIGNATURES ON FILE AT EMS AGENCY OFFICE

PARAMEDIC ACCREDITATION AND RENEWAL

I. AUTHORITY

In accordance with §100165 of the California Code of Regulations, the local EMS agency may accredit a California licensed Paramedic to practice in its jurisdiction.

II. DEFINITIONS

A. **"Accreditation"** means authorization to practice Paramedic skills in Stanislaus County under the medical direction of the policies and protocol authorized by Stanislaus County EMS Agency Medical Director.

B. **"Agency"** means the Stanislaus County Emergency Medical Services Agency.

C. **"Field Training Officer (FTO)"** means a senior/appointed medical personnel of an organization that provides mentoring and guidance to new or current Emergency Medical Services personnel and provides refresher and/or remedial training as needed.

D. **"Field Evaluation"** means time spent during a pre-accreditation period, where a Paramedic Accreditation applicant performs ALS assessments and skills while under the supervision of an Agency Approved FTO, who is evaluating the applicant for Stanislaus County EMS Agency protocol knowledge.

III. PURPOSE

A. The purpose of this policy is to provide a process for California State Licensed Paramedics to apply for and maintain a Stanislaus County Paramedic Accreditation.

IV. POLICY

A. The applicant shall possess a valid/current California Paramedic License.

B. The applicant shall apply to the Agency for Stanislaus County Paramedic Accreditation.

C. The applicant shall complete an orientation of the local EMS system, which shall not exceed eight (8) classroom hours prior to the thirty (30) day pre-accreditation period.

D. The applicant must pass a CLOSED book written examination with an 80% or better score on the Agency ALS Treatment Protocols, Policies and Procedures prior to the thirty (30) day pre-accreditation period.

E. The applicant must pay the Stanislaus County EMS Agency Accreditation fee, as described on the Paramedic Accreditation Application.

F. The applicant shall demonstrate proof of present employment or a written commitment for employment by a Stanislaus County designated ALS provider agency.

G. After successful completion of the local orientation and the CLOSED book Paramedic protocol exam, the applicant may schedule ride time with Agency approved Paramedic level service provider to complete a Field Evaluation of 5 ALS contacts under the supervision of an Agency approved Paramedic Field Training Officer

H. The applicant shall be granted a thirty (30) day pre-accreditation period which begins upon completion of local Paramedic accreditation orientation, and notification of Field Evaluation start date.

1. This notification shall be provided to the Agency from the employer of the paramedic accreditation applicant, at a minimum of 5 business days, preceding the identified Field Evaluation start date.

I. If the pre-accreditation requirements have not been met within this thirty-day extension, an additional thirty (30) day extension may be requested by submitting the request in writing to the Agency and by paying another initial accreditation fee.

J. The applicant shall be limited to applying for accreditation up to two (2) times during a twelve-month period.

1. The Agency's Medical Director shall evaluate any applicant who fails to successfully complete the Field Evaluation and or patient contact scenarios and may recommend further evaluation or training as required to ensure the Paramedic has competent knowledge of Agency's field treatment protocols.

K. The applicant shall complete five (5) ALS contacts supervised by an Agency approved Field Training Officer Paramedic.

V. A Paramedic, once accredited by the Agency, shall be considered accredited with the continued requirements of:

A. Maintain licensure as a Paramedic, by the State of California.

B. Successfully complete any requirements imposed by the Agency Medical Director for an Agency approved Expanded Scope of Practice Class, and Policy Update Class.

C. Meet any requirements of the System-wide CQI program.

D. Provide verification of compliance with Agency Policy 853.00- Prehospital Training Standards.

VI. An accredited Paramedic must notify the Agency within five (5) business days of any change in address, telephone or e-mail contact information, or employment status change.

VII. PROCEDURE

A. Prior to the thirty (30) day pre-accreditation period the applicant must complete the following:

1. An orientation of the local EMS system as prescribed by the Agency, which shall not exceed eight (8) classroom hours.

2. Pass a CLOSED book written examination (within 30 days of initial test), with an 80% or better score on the Agency ALS Treatment Protocols, Policies and Procedures.

Applicants that receive less than 80% will be notified which questions they missed. The applicant will be allowed to retest, taking a closed book exam, with a minimum passing score requirement of 80%. Applicants will have a total of two (2) attempts to pass the test.

The applicant may not retest on the same day as the initial exam and must schedule the retest with the Agency. If the Applicant fails both test attempts, they will be required to pay the application fee again. The applicant will be eligible for a third test attempt after 5 business days (M-F).

If the third test attempt is unsuccessful, the Agency Medical Director will make the final determination of the Paramedic's application status.

B. Upon completion of the items listed above in section "VII. Procedure, subsection A" the applicant shall be granted a thirty (30) day pre-accreditation period, as described in section "IV, subsection H, and 1."

C. The applicant will have a thirty (30) days pre-accreditation period to complete the following:

1. Successfully complete and show competency on five (5) advanced life support contacts during field evaluation with Agency approved Paramedic Field Training Officer. Applicants shall only operate as a Paramedic while in the presence of an approved Paramedic Field Training Officer.

D. Paramedics Accreditation Renewal

1. Active accreditation that are not yet expired:

a) Complete necessary steps as outlined in the Paramedic Accreditation Renewal application.

2. Expired less than 6 months:

    a) Complete necessary steps as outlined in the Paramedic Accreditation Renewal application.
    b) Pay associated late fee.

3. Expired greater than 6 months, but less than 12 months:

    a) Complete necessary steps as outlined in the Paramedic Accreditation Renewal application.

    b) Pay associated late fee.

    c) Attend Paramedic Orientation

    d) Pass a CLOSED book written examination (within 30 days of initial test), with an 80% or better score on the Agency ALS Treatment Protocols, Policies and Procedures.

    Applicants that receive less than 80% will be notified which questions they missed. The applicant will be allowed to retest, taking a closed book exam, with a minimum passing score requirement of 80%. Applicants will have a total of two (2) attempts to pass the test.

    The applicant may not retest on the same day as the initial exam and must schedule the retest with the Agency. If the Applicant fails both test attempts, they will be required to pay the application fee again. The applicant will be eligible for a third test attempt after 5 business days (M-F).

    If the third test attempt is unsuccessful, the Agency Medical Director will make the final determination of the Paramedic's application status.

4. Expired greater than 12 months

    a) Complete necessary steps as outlined in the Paramedic Accreditation Renewal application.

    b) Pay associated late fee.

    c) Complete ALL additional requirements listed in section "VII. Procedure, subsection A, B, and C" of this policy.

E. Upon successful completion of the accreditation requirements, an accreditation card will be issued.

F. The Medical Director of the local EMS Agency may suspend or revoke accreditation if the Paramedic does not maintain current licensure or meet local accreditation requirements.

G. If accreditation is suspended, or revoked, the affected Paramedic shall be entitled to appeal the decision. The process for appeal is outlined in Agency Policy #161.00.

Stanislaus County
Emergency Medical Services Agency

Appeals Process

Policy 161.00

APPEALS PROCESS

1) AUTHORITY

Division 2.5, California Health and Safety Code, sections 1797.220 and 1798; Title 22, California Code of Regulations, Division 9, Chapter 6, Article 2, (Section 100209); Article 3; and Article 4. California Government Code Division 4, Chapter 9.6 and 9.7 (Section 3230 and 3300)

2) DEFINITIONS

a) "Administrative Hearing" is a hearing that takes place outside the judicial process before hearing examiners who have been granted judicial authority specifically for the purpose of conducting such hearings.

b) "Administrative Law Judge" is an official of a federal or state agency who hears, weighs, and decides on evidence in administrative proceedings, and makes recommendations for any necessary legal action.

C. "Appealing Party@ or "Appellant" means any individual or agency which has received notice of denial, probation, suspension, or revocation of certification, accreditation, authorization, or designation from Stanislaus County EMS Agency.

D.. "Investigative Review Panel@ or AIRP@ is a panel appointed and convened by the EMS Agency for the purpose of resolving disputes. The IRP evaluates evidence presented by an Appealing Party and the EMS Agency. An IRP consists of at least three (3) persons knowledgeable in the health care system and EMS Agency policies and procedures specific to the subject matter.

3) PURPOSE

To establish a process to appeal a decision of denial, probation, suspension, or revocation of certification, accreditation, authorization, or designation by the Local EMS Agency and to ensure due process.

4) POLICY

` An Appealing Party whose certification, accreditation, authorization, or designation has been denied, placed on probation, suspended, or revoked by the Local EMS Agency may formally request an IRP, or in the case of a firefighter EMT or public safety officer, an administrative hearing in front of an Administrative Law Judge.

5) PROCEDURE

A. INVESTIGATIVE REVIEW PANEL (IRP),

1. TYPES OF IRPs
Per California Health & Safety Code Section 100211 & 100213, there are the three types of IRP. The following describes these different panels and there applications.

a. Preliminary IRP
Applies only to cases of immediate suspension where the facts have not been reviewed by a ("full") IRP, and must be requested by the appellant. A preliminary IRP is actually a limited form of the formal review process. The Medical Director is not obligated to present all information gathered at that point in the investigation. A request for a preliminary IRP triggers an automatic request for a (post-action) full IRP unless the certificate holder rejects the opportunity.

b. Pre-action (FULL) IRP
This process may be convened only at the discretion of the Medical Director of the local EMS Agency. Its purpose is to assist in establishing the facts of the matter in question. It occurs prior to the Medical Director making a final decision regarding disciplinary action. All information gathered up to the time the IRP is convened must be presented.

c. Post-action (FULL) IRP
This process occurs after the Medical Director has made a decision regarding probation, suspension, revocation, denial or denial of renewal, and has notified the certificate holder / entity of the decision. It occurs either, (a) when requested by the certificate holder, or (b) in cases where there was an immediate suspension and preliminary IRP, it occurs automatically (except when rejected by certificate holder)

B. DENIAL OF IRP

The situations where a certificate holder/entity is NOT entitled to a post-action IRP are as follows:

1. When a Medical Director has denied certification to an individual who does not meet certification requirements.

2. When a pre-action IRP has already been convened in the case and the IRP Panel has made a recommendation to the Medical Director.

A certificate holder / applicant / entity may specify, in writing that they do not want further review of all of the facts in the case. In the event that the certificate holder / entity does not want a IRP, no further action is required by the Local EMS Agency. All actions should be documented and filed.

C. PRE-HEARING PROCEDURES

1. Notification

In the event of a suspension, probation, revocation, denial or denial of renewal of a certificate or other approved program designation, the appellant must be advised of the disciplinary action by certified mail within ten days of the decision of the Medical Director. For EMT-I certificate holders/applicants this letter shall include all information required under Sections 100217, Title 22, California Code of Regulations.

2. Request for IRP

For a *Preliminary* or *Post Action* IRP, the request for an IRP must be received, in writing by the local EMS Agency within fifteen (15) calendar days of the date (certified by mail) the certificate holder/entity received written notice of disciplinary action.

The Local EMS Agency shall convene an IRP no later than 30 calendar days from the receipt of the request unless a request for continuance is requested by the appellant.

3. Appointment of IRP Members

Under the consultation of the Medical Director or Local EMS Agency designee, a minimum of three (3) persons who are knowledgeable in the delivery of medical care and local policies and procedures should be selected to serve on the IRP. One (1) person on the IRP shall be mutually agreed upon by the certificate holder/applicant or entity and the Local EMS Agency, if the certificate holder / applicant / entity should so request. The IRP should not include the Medical Director or staff member of the local EMS Agency, or anyone who submitted allegations or evidence or was directly involved in the case.

Neither the appellant, nor Local EMS Agency staff shall discuss the facts of the case with panel members prior to the IRP.

4. Notification of IRP

Once the IRP Panel members have been identified, the appellant shall be notified by certified mail, at least ten (10) days prior to the IRP, of the following information as required by Sections 100211, Title 22, California Code of Regulations.

a. The date, time, and location of the IRP review;

b. The purpose of the IRP;

c. Names of IRP members and the appellant's right to request disqualification of any one IRP member, for cause. This request, and the specific cause for request of disqualification, must be made to the Local EMS Agency no more that seven days following the receipt of the notification of the IRP;

d. The appellant's right to be present during the presentation of any testimony before the IRP, call witnesses and to cross examine witnesses called by the Local EMS Agency, present an oral and/or written argument, and present and rebut relevant evidence;

e. The appellant's right to be represented by legal counsel at the IRP or to be accompanied to the IRP by any other person of the appellant's choosing to provide advice and support. If the appellant will be represented by legal counsel, the Local EMS Agency must be notified in writing at least five working days prior to the IRP;

f. The appellant's right to request that the IRP be open to the public. If the appellant wishes to have the proceedings open to the public the Local EMS Agency must be notified in writing at least five working days prior to the IRP. However, the Panel may order closure of all, or any part of, the proceedings for any of the following reasons: (a) To satisfy the federal or state Constitution, statute or other law, including but not limited to, laws protecting privileged, confidential, or other protected information; (b) To conduct the proceedings, including the manner of examining witnesses, in a way that is appropriate to protect a minor witness or a witness with a developmental disability, as defined in Section 4512 of the Welfare and Institutions Code, from intimidation or other harm, taking into account the rights of all persons. (CCR §100211(h));

g. A photocopy of Chapter 6, California Code or Regulations;

h. A photocopy of Local EMS Agency Policy and Procedures # 161.00 outlining the IRP Process;

i. Notification that any discussion with any of the panel members regarding the facts of the case prior to the IRP by the appellant, or representative is strictly prohibited.

5. Should the Medical Director convene a Pre-action IRP, the above "Notification of IRP" shall be sent via certified mail at least 10 days, but no more that 30 days prior to the scheduled date of the IRP. If the certificate holder / applicant / entity does not accept the certified letter, or does not contact the Local EMS Agency to request a change in the date and/or time of the IRP, the IRP will be conducted as scheduled even if it is in the absence of the certificate holder / applicant / entity.

6. Prior to the IRP, the appellant may request written, or recorded evidence that the Local EMS Agency intends to present into evidence. (Nothing in this section shall authorize the inspection or copying of any writing or thing that is privileged from disclosure by law or otherwise made confidential or protected as the attorney's work product. (California Government Code § 11507.6)

D. HEARING PROCEDURES

1. A Local EMS Agency staff member shall be assigned as Facilitator to clarify points of order, prior to, and during the proceedings.

2. During the opening of the IRP, the Facilitator will:

   a. Introduce all parties present
   b. Explain the nature of allegations and specific sections of the Health and Safety Code 1798.200 (c) that has allegedly been violated.
   c. Explain the history of the incidents leading up to the IRP and advise if this is a *preliminary, pre action*, or *post action* IRP.
   d. Describe the potential outcomes of the proceedings; (Recommendation for : reinstatement, probation, suspension, revocation, or denial)
   e. Ask the panel members if they have any reason to believe that they cannot provide a fair and impartial review in this case
   f. Ask the panel members if they have discussed this case with the appellant, a representative of the appellant, Local EMS Agency staff, or any other person, as such action may be cause for disqualification.

3. The IRP shall appoint a chair person who will be the primary spokesperson for the group and will be responsible for generating the final report from the panel.

4. The Facilitator shall review the points of order for the proceedings including:

   a. The appellant shall be presumed innocent of all allegations until the evidence presented by the Local EMS Agency shows otherwise.
   b. The burden of proof is upon the Local EMS Agency to demonstrate that the certificate holder / entity has performed their duties in an improper manner or has otherwise acted inappropriately so as to justify disciplinary action.
   c. The IRP is not a legal trial and is thereby not subject to the same rules of technical evidence as a court trial.
   d. Only a Preponderance of Evidence is required for action to be taken.
   e. Hearsay evidence is admissible as long as it is determined by the Panel to be credible and pertinent to the case.
   f. Either party in the case may call witnesses and cross-examine witnesses.
   g. The party offering testimony of any Expert Witnesses shall be required to show evidence of the witnesses' qualification and expertise prior to providing testimony.
   h. All witnesses with the exception of the appellant and presenting Local EMS Agency staff will be excluded from the proceedings until called to testify
   i. All witnesses providing testimony shall be required to provide affirmation that the testimony they are about to give is truthful to the best of their knowledge.
   j. The proceedings will be recorded

5. Presentation of Evidence:

   a. An opening statement by the Local EMS Agency representative
   b. An opening statement for the appellant.
   c. Opportunity for rebuttal
   d. Presentation of evidence and information by the representative of the Local EMS Agency

e. Appellant rebuttal
f. Presentation of evidence and information for the appellant
g. Local EMS Agency rebuttal
h. Final statements by the Local EMS Agency
i. Final statements for the appellant
j. Submission of the matter for written report and recommendation to the IRP Panel.
k. If additional time is required to complete the proceedings of the IRP beyond the original date and time, the IRP may be continued to a date and time mutually agreed upon by the panel and all parties.

6. IRP Findings:

The IRP shall assess all the available information on the matter in order to establish the facts of the case and shall make a written report of its findings and recommendation to the Medical Director. The report shall be submitted to the Medical Director within fifteen (15) days of the date of the IRP review. (CCR §100211(i)). The time of submission may be lengthened by request of the IRP, and at the discretion of the Local EMS Agency Medical Director. The report shall contain, at a minimum, the following information: (1) the findings with respect to the specific allegation(s); and (2) whether the IRP agrees with the Medical Director's decision regarding disciplinary action, and, if not, the recommendation regarding appropriate disciplinary action.

The Medical Director will notify the appellant within ten days of reaching a final decision on the matter. If the action includes a change of action against an EMT-I or EMT-II, a revised *Negative Certification Action Report* will be submitted to the State EMS Authority.

7. If the appealing party is a firefighter, administrative hearing procedures shall be conducted in accordance with the Firefighters Procedural Bill of Rights Act (California Government Code Section 3250 et. Seq.)

8. If the appealing party is a public safety officer, administrative hearing procedures shall be conducted in accordance with the Public Safety Officers Procedural Bill of Rights Act (California Government Code Section 3300 et. Seq.)

Stanislaus County
Emergency Medical Services Agency

Triage to Alternate Des?na?on

Training Curriculum

Triage to Alternate Destination Training Curriculum	
Length_	Topic
15 Min	Introduction and reason for training • State and Stanislaus County LEMSA Requirements • Overview of training
30 min	Understanding Mental Illness • Mental Illness Defined • Stigma and Its Effect on Attitudes and Behaviors
30 min	Mental Health Conditions • Schizophrenia o Signs and Symptoms of Schizophrenia o Common Neuro-Psychiatric Medications Used to Treat Schizophrenia • Mood/Affective Disorders o Signs & Symptoms of Unipolar Depression (Major Depressive Disorder) o Signs & Symptoms of Bi-Polar Disorder o Common Neuro-Psychiatric Medications Used to • Anxiety Disorders o Common Anxiety Disorders o Signs and Symptoms of Anxiety o Common Neuro-Psychiatric Medications Used to Treat Anxiety • Personality Disorders o Personality Disorder Overview o Signs and Symptoms of Personality Disorders o Treatment of Personality Disorders Including Neuro-Psychiatric Medications • Pre-hospital Case Study
30 min	Understanding Suicidal Thoughts and Behaviors • Demographics and Incidence of Suicide • Key Concepts • Contributing Factors to Suicidal Thoughts and Behavior • Warning Signs • Assessing Risk • Intervention • Resources • Pre-hospital Case Review
45 min	Alcohol and substance use disorders • Substance abuse impact on the community • Understanding the difference between mental health disorders, intoxication, and medical emergencies. Common signs and symptoms • Assessment, treatment, and stabilizing of intoxicated patients • Pre-hospital Case Review
45 min	Triage and transport parameters • Review of CCEMSA Policy 547 Patient Destination as it Pertains to Transport of Individuals on 5150s • Exodus/CSC Adult & Youth Default Destination for Anyone in Fresno County on a 5150

	○ Exceptions: Kaiser Members. and Veterans • Review of Triage Criteria • Refusals and patient choice • EMS Documentation • EMTLA and EMS, what EMS providers need to know
30 min	Mental Health Involuntary Hold • Difference between pre-hospital WIC 5150 and an extended 5150 per AB 2275 • Review WIC Sections 5150, Extended 5150 per AB 2275, 5250, and LPS Conservatorship • The Role of EMS on Mental Health Calls • American Ambulance Policy Review - Use of Restraints
60 min	Performance Skills Lab and Scenarios • De-escalation and communication skills • Application of restraints • Tape Review
15 min	Summary and Take-Home Points

Stanislaus County
Emergency Medical Services Agency

Triage to Alternat Des?na?on

Paramedic Service Provider

Leter of Affirma?on

TRIAGE TO ALTERNATE DESTINATION
Paramedic
Service Provider
Letter of
Affirmation

Provider/Department Name: _____

The provider/department named above acknowledges and affirms the following:

1. The EMS Agency has designated the _____ as an authorized alternate destination for prehospital behavioral health patients.

2. We support the Triage to Alternate Destination program and recognize its value in getting behavioral health patients to a facility that can provide them immediate care.

3. We have reviewed the California Code of Regulations, Title 22, Division 9, Chapter 5 as it pertains to Triage to Alternate Destination.

4. EMS policies and procedures provide the criteria necessary to transport a patient directly to the _____.

5. The EMS Agency has authorized this provider/department and its personnel to participate on the Triage to Alternate Destination Program.

6. It is the responsibility of this provider/department to assure that qualified staff receive the required training and continuing education in order to triage patients to the _____.

7. The Triage to Alternate Destination program will be monitored through our EMS continuous quality improvement plan and we will work closely with the EMS agency in future improvements of the program.

8. Electronic patient care reports shall be completed on all patients, including patient transported to the _____. Patient care data will be submitted to CEMSIS.

Print Name and Position

Date

Signature

Stanislaus County
Emergency Medical Services Agency

Mountain Valley EMS Agency

Triage to Alternate Des?na?on

Pilot Project Proposal

HWPP #173

012

Mountain-Valley

EMERGENCY MEDICAL SERVICES AGENCY

Stanislaus County

Mobile Integrated Behavioral Health Paramedicine Project 012

A Proposal

To: The California Emergency Medical Services Authority

From: Mountain-Valley Emergency Medical Services Agency

May 8, 2014

Community Paramedics Addressing the Needs of Behavioral Health Patients

Contents

TITLE OF PROJECT

Stanislaus County, Mobile Integrated Behavioral Health Paramedicine, project 012

SCOPE OF PRACTICE CATEGORIES

Stanislaus County will assess the safety and value of modifying the EMT-P Scope of Practice (SOP) to achieve the following goals and objectives:

Goals:

- Reduce utilization of emergency room services by behavioral health (BH) patients within Stanislaus County that would have normally been transported directly to emergency departments through the utilization of trained paramedics to assess, treat, and transport patients meeting specific and pre-identified criteria to appropriate alternative care at behavioral health treatment facilities.

- Demonstrate appropriate utilization of non-traditional alternate destinations for BH patients assessed and treated by paramedics.

- Reduce the utilization of emergency department (ED) services by BH patients within Stanislaus County.

Objectives:

- Designate the general assessment of the trained paramedic as “appropriate” or “inappropriate” in accordance with the established diagnosis by the treating behavioral health professional with 95% accuracy within six hours of admission.

- Less than 5% of BH patients transported to the ED by paramedics ultimately identified as a patient who should have gone directly to an alternative BH facility/service.

- Less than 5% of patients transported to an alternative destination were sent back to the ED within six hours.

- A 20% reduction in ED nursing hour utilization for the care and treatment of BH patients as a result of transporting BH patients to alternate/appropriate BH centers. (Nursing hour reduction per BH patients will be based on existing nursing hour utilization for BH patients transported to an emergency room.)

- Demonstrated competency at a 100% success rate with an average grade of 85% or better will be maintained by paramedics participating in the Community Paramedic Training Program.

- The BH QRV will remain in service 24/7 365 days a year with a minimum of one (1) trained community paramedic 95% of the time.

- 95% of requests for the BH QRV will be met.

- 100% of BH patients not receiving a response by a trained CP within 15 minutes will receive a 911-transport unit response.

- Each trained paramedic will meet community paramedic protocol compliance standards 100% of the time for every patient contact.

DESCRIPTION OF PROPOSED CONCEPT

The development of a Community Paramedic Pilot Project that expands the role and practice of the Emergency Medical Technician-Paramedic (EMT-P) will allow Mountain Valley EMS Agency to utilize leading edge and innovative concepts to address a problem that has not only overwhelmed Stanislaus County, but a multitude of other counties in California. The pilot project will permit the community paramedic, under the direction of the EMS Agency Medical Director, to provide medical clearance exams to behavioral health patients in the pre-hospital setting.

Assessments focused on behavioral health patients provide a medically safe method for the paramedic to transport behavioral health patients that meet specific criteria directly to a behavioral health center, thus avoiding an unnecessary transport to the emergency department. The program concept is aimed to obtain the right level of care to the right patients in an efficient, effective and timely manner.

Benefits of this program will be aimed at reducing hospital and EMS system costs and reducing emergency department overcrowding, thereby allowing for a more efficient use of emergency department resources and reducing secondary transfers between the emergency department and behavioral health centers.

Mountain-Valley EMS Agency will be partnering with AMR, Stanislaus County Hospitals, Stanislaus County Behavioral Health Services, and the Stanislaus County Health Services Agency. Geographically, the project will encompass the cities of Modesto and Turlock with a combined population of approximately 270,000 citizens. The estimated length for the pilot project will be 24 months.

ESTIMATED PROJECT LENGTH

2 years

BACKGROUND INFORMATION

Need for Project:

Over the last several years, behavioral health budget cuts have resulted in a system-wide surge of patients that have ultimately impacted our local emergency departments. This impact on Stanislaus County hospital emergency departments has resulted in regularly scheduled conference calls with system participants to help mitigate the overcrowding effects. Doctors Medical Center Modesto sees an average of 289 behavioral health patients a month, accounting for 1,671 monthly average hours to provide one-to-one care for these patients. The average length of stay for behavioral health patients requiring an evaluation in the emergency department is over 8 hours. Hospital management reports that it is becoming more common to have patients stay in the emergency department longer than 24 hours.

These patients, by nature, require a significant amount of resources, in particular nursing time, which draws resources away from regular emergency department operations. As emergency department volumes continue to escalate, help is needed to mitigate the emergency department crowding conditions and permit considerably more efficient use of resources. Unnecessary utilization of emergency room services can be reduced by transporting medically cleared behavioral health patients to facilities dedicated to their unique needs. This is a model of care that leverages the skills of paramedics and enables the EMS System to address care gaps identified through the health care needs within Stanislaus County.

Similar projects have seen successful prehospital triage methods decrease emergency department visits by this population by 30%, which would result in a reduction of 500 emergency department hours equating to 86 patients per month or 3 patients per day. The appropriate transport destination would have a cost saving benefit for the patient, the hospitals and the EMS provider

AMR data indicated responses to 2,571 behavioral health calls in 2012, which averages out to 7 calls per day. Transporting patients directly to a behavioral health center, following a prescribed and thorough paramedic screening, decreases the impact of interfacility transfers between the emergency departments and behavioral health centers. These transfers are often delayed because of facility security issues. This approach would also allow transport units to remain available for response in the 911 system by utilizing them only when transport is deemed necessary.

Types and Number of Patients Likely to be served:

It is anticipated the trained Community Paramedics will assess and treat 3-5 patients per day or approximately 86 patients per month.

Anticipated Number of Community Paramedics:

We estimate that 12 CPs (excluding the current Field Supervisors) can address 2093 behavior health patients over 2 years, once equipped with the appropriate training and resources.

Employment Opportunities for Community Paramedics:

American Medical Response will serve the entire Stanislaus County exclusive operating area. The lessons learned from CP pilot study will quickly extend to neighboring communities and numerous job opportunities will be created for skilled, empathic paramedics once the pilot verifies the value of the concept.

Other Programs Serving as Models for this Project:

The EMS Agency Medical Director and AMR CES Manager have been corresponding and coordinating with Wake County, North Carolina and San Mateo County, California. Both programs have successfully utilized paramedics to conduct field assessments on behavioral health patients; and have transported qualifying patients to alternative destinations.

PROGRAM MANAGEMENT

Project Leadership and Local Steering Committee:

The project leadership and local steering committee will work in collaboration with the EMSA Community Paramedic Project Manager, Independent Evaluator, and State Community Paramedic Advisory Committee as necessary throughout the duration of the pilot project. Project leadership and local advisory committee members are described below:

Mountain Valley Emergency Medical Services Agency (Dr. Kevin Mackey, Richard Murdock, Sheldon Gilbert, Project Manager); provide project management, regulatory oversight and medical direction.

American Medical Response (Cindy Woolston, Mike Corbin); provide and monitor quality improvement, staffing/funding, training, data collection and analysis.

Doctors Medical Center (Anita Schlenker); serve as the Primary Behavioral Health Services Partner, ED participant, and clinical mentor.

Memorial Medical Center (Mike Taylor); serve as a secondary partner and ED participant.

Kaiser (Chris Neilson); serve as a secondary partner, ED participant, and clinical mentor.

Emanuel Medical Center (Renee Pimentel); serve as a secondary partner and ED participant.

Doctors Behavioral Health Center (Tony Vartan); serve as alternate transport partner and secondary behavioral health expert.

Behavioral Health Resource Center (Cherie Dockery); serve as alternate transport partner and behavioral health expert provider.

Health Care Services Agency (Maria Blanco); serve as a project partner and provide public health oversight and direction.

Stanislaus County Fire Chiefs Association (Dale Skiles); serve as a system first responder stakeholder and function in a support capacity for the project.

Stanislaus County Police Chiefs Association (Adam Christianson); serve as a system first responder/law enforcement stakeholder and function in a support capacity for the project.

Operational Logistics:

American Medical Response, Stanislaus County will provide the community paramedics and logistical support for the CP 012 project. A quick response vehicle (QRV) staffed with a CP trained paramedic will be in service 24/7 to respond to behavioral health incidents anywhere within the exclusive operating area (EOA). In addition, the on duty supervisor will be trained as a CP and serve as a secondary response vehicle for behavioral health responses meeting the CP012 response criteria. Designated CP units will be posted, dispatched and tracked through Life-Com dispatch.

Training and education will be provided through AMR clinical services and augmented by Steering Committee representatives from Doctors Medical Center, Kaiser Permanente Modesto, Sutter Hospital Modesto and Stanislaus County behavioral health services.

The Improvement Process:

The attached Mountain Valley Emergency Medical Services Agency Quality Assurance/Quality Improvement process (Attachment C) will be utilized as the foundational quality program elements. The process has been utilized in the development of the CP 12 Program to define the customer, stakeholder and community opportunities/issues the program will be addressing. The process has ensured that the necessary measurement tools exist for baseline data; paramedic performance measurement; measuring adopted goals/objectives; evaluating program management; and ensuring that adequate physician and behavioral health professional and clinical elements are in place. Data analysis sources, variations and solutions have been identified and are included in the project. In addition, through the quality assurance process, forums such as steering, curriculum, and quality committees have been established to brainstorm, prioritize, and benchmark program elements that result in proposed solutions for improvement. Lastly, the quality improvement process has ensured control mechanisms are in place that pursue error proof solutions; a culture of safety and accountability ("Just Culture"); and sustainable practices that have adequate response plans in place to address findings and necessary changes.

Governance & Medical Control:

The EMS Agency Medical Director will act as the principle investigator and has primary responsibility for medical control. The EMS Agency Executive Director and Community Paramedicine Coordinator will have primary responsibility for the coordination of the pilot project. As project management, they will work closely with the local steering committee, the State EMS Authority Project Manager and

the Independent Evaluator. The steering committee will be tasked to provide feedback, direction, and monitor any program issues that may arise. This increase in medical control and oversight will be necessary to ensure patient safety and for quality assurance. The local steering committee will work in collaboration with the State EMS Authority Project Manager and the Independent Evaluator.

Provisions for Protecting Patients' Safety:

Community Paramedics will complete the core paramedicine curriculum approved by the California EMS Authority and a site-specific training program. A curriculum development sub-committee of the steering committee consisting of the project Medical Director as well as County behavioral health and program management staff developed the on-site training program utilizing national best practice curriculums as a reference. The curriculum presented includes didactic, clinical and field internship components. The training program has been approved by the steering committee, the Project Medical Director, and the County Health Department Behavioral Health Medical Director. It is recognized as being consistent with local and national standards.

The approved curriculum meets or exceeds local and national behavioral health training standards and learning objectives and will address specific patient safety and privacy standards and requirements.

Data Collection and Security:

Patient data will only be transmitted via secure electronic communications. All records will be maintained in a secure location and will only be available for data review by authorized investigators or data abstraction research associates. Mountain Valley EMS Agency will apply for and obtain Institutional Review Board (IRB) approval for this project to ensure the safety and welfare of participants. The protection of patients will further be met through the testing of the protocol and collection of six months of baseline data prior to implementation; use of electronic patient care records for quick identification of problems and generation of reports; monthly quality improvement meetings; hands-on physician oversight; and an active Community Paramedicine Steering Committee.

A weekly review of collected data elements, project objectives and system performance will be conducted by program management staff and reviewed by the Medical Director. Bi-weekly meetings of the steering committee will be conducted. The steering committee will review retrospective and concurrent data and performance in relation to established objectives. The steering committee will propose

recommendations for approval by the Medical Director and implementation by the program management staff. A data dashboard will be established and utilized for real time review of program data, performance, and outcomes.

MOUNTAIN-VALLEY EMS AGENCY
POLICIES AND PROCEDURES

POLICY: 2XX.XX
TITLE: **COMMUNITY PARAMEDICINE**

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE: DRAFT
SUPERSEDES:
REVISED:
REVIEW DATE:

COMMUNITY PARAMEDICINE

I. AUTHORITY: Division 2.5, California Health and Safety Code, §1797.206; 1791.214; 1797.218; 1791.220 and 1791.221. Title 22, California Code of Regulations, §100144 and 100145.

II. DEFINITIONS:

A. "Agency" means the Mountain-Valley Emergency Medical Services Agency.

B. "ALS" means Advanced Life Support, as defined in Section 1797.52, Division 2.5 of the Health and Safety Code

C. "Base Hospital" means a hospital approved and designated by the Agency to provide immediate medical direction and supervision of EMT-I, EMT-II, and EMT-P personnel in accordance with policies and procedures established by the Agency.

D. "Community Paramedic" means a paramedic trained and certified to provide a medical clearance exam and the issuance of a 5150 assessment hold

III. PURPOSE

To establish criteria to provide a medical clearance exam and referral to approved alternative destinations (i.e. transport to a location other than the emergency department) in order to facilitate the most appropriate triage and care for persons with acute mental health or substance abuse concerns.

IV. POLICY

A. Steering Committee
The steering committee will be tasked to monitor as well as provide feedback and direction for any program issues that may arise. This increase in medical control and oversight will be necessary to ensure patient safety and quality improvement.

1. The Agency Medical Director will act as the principal investigator and has primary responsibility for medical control.

2. The local steering committee shall work in collaboration with the State EMS Authority Project Manager and Independent Evaluator.

3. The Steering Committee will include a representative from the following agencies:

    a. Mountain-Valley EMS Agency (Medical Director and Program Coordinator)
    b. Health Services Agency
    c. Memorial Medical Center
    d. American Medical Response
    e. Doctors Medical Center
    f. Kaiser Permanente
    g. Behavioral Health
    h. Law Enforcement

B. QI/Patient Safety Committee

C. Paramedic Eligibility

1. Candidates will have a minimum of 4 years of ALS experience. The possession of an AA/AS degree is preferred but not required.

2. Candidates will be endorsed by the LEMSA Medical Director.

D. Training

1. The Community Paramedic must complete 120-180 additional training hours:

    a. 80 hours of Core Curriculum will be provided by the State EMS Authority.
    b. 80 hours of local training will be provided by the Agency based on local program requirements. This will include:

        (1) Crisis Intervention Training (40 hours)
        (2) Advanced clinical assessment and Breathalyzer training (4 hours)
        (3) Local policy/procedure training and evaluation (4 hours)
        (4) Preceptorship with ED Physician/Clinical Nurse (16 hours)
        (5) Preceptorship with Behavioral Health Clinician (16 hours)

E. Quality Improvement and Data Collection

1. All patients evaluated by the Community Paramedic for referral will be documented on the Patient Care Record (PCR).

2. Specific behavioral health fields will be added to the PCR. These include, but are not limited to:

3. All cases referred to behavioral health facilities will be audited for appropriateness of referral.

4. Any patient who is referred to Behavioral Health and later transferred back within 6 hours to the emergency department will be audited, tracked and trended.

5. Evaluation components will include a process evaluation, qualitative evaluation, impact evaluation, utilization, and an estimate of healthcare cost savings.

6. Agency shall have access to electronic PCR information.

7. All data shall be collected and shared electronically.

8. Monthly reports will developed and maintained by the Agency

9. Monthly reports shall be available for review by the local steering committee, independent evaluators, and the State Advisory Committee through the State EMS Authority's Project Manager.

V. PROCEDURE

A. Inclusion Criteria: Patients with a primary mental health or substance abuse complaint are eligible for consideration for an alternate destination if ALL of the following criteria are met:

1. Patient has no medical complaint or traumatic conditions, other than superficial abrasions that do not require repair (ie: scratches to the wrist).
2. Patient is ambulatory.
3. Patient is cooperative and does not require physical restraint.
4. GCS greater than 13.
5. Heart rate greater than 60 and less than 120.
6. SBP 90 – 200 and DBP 60-100. Note: Isolated hypertension (i.e. Hypertension with no associated symptoms such as headache, neurologic changes, chest pain, or shortness of breath) in a patient with a history of hypertension will not be a reason to decline the referral to Behavioral Health.
7. Pulse Oximetry greater than 94%
8. Diabetic patients with no evidence of ketoacidosis AND a blood glucose greater than 60 and less than 300 mg%.
9. Blood alcohol concentration (BAC) less than 0.3.

B. Exclusion Criteria: Patients who present with ANY of the following criteria are not eligible for transport to an alternative destination and must be transported to the appropriate emergency department for evaluation:

1. Patient who fails to meet ANY of the INCLUSION criteria outlined above
2. Patient who has taken ANY medications, prescribed or over the counter, outside of normal recommended dose.

C. The Community Paramedic must approve and communicate with the behavioral health facility prior to transport in all cases. In any circumstance, transport crews must communicate directly with the Community Paramedic on-scene to ensure that proper notification of the behavioral health center has been made and approved.

APPENDIX B – Local Training Curriculum

Proposed Stanislaus County
Community Paramedic Training Curriculum

Didactic Crisis Intervention Instruction (40 hours)

1. Module 1 – Introduction (2 Hour) The student will understand his or her role in the pilot program and able to demonstrate proficiency in the following
   - 1.1. Overview of Community Paramedicine
   - 1.2. Scope of Stanislaus CP Pilot Project
   - 1.3. CIT Program Overview
   - 1.4. Clinical Issues related to Mental Illness

2. Module 2 - Introduction to Behavioral Disorders (8 Hours) The student will become familiar with adult and adolescent mental health disorders to include major behavioral, cognitive, depressive and special focus disorders. Student will demonstrate proficiency with signs and symptom of behavioral Disorders.
   - 2.1. Sever, Persistent Mental Illness
     - 2.1.1. General Psychiatric Diagnosis and Symptoms
     - 2.1.2. Mood Disorders: Bipolar, Depression, Mania
     - 2.1.3. Thought Disorders: Schizophrenia
   - 2.2. Children, Youth and Adolescence
     - 2.2.1. Attention Deficit, Hyperactivity, or Impulse Control Disorders
     - 2.2.2. Autism, Childhood Schizophrenia
     - 2.2.3. Developmental Disabilities: such as Mental Retardation
   - 2.3. Cognitive Disorders
     - 2.3.1. Dementia
     - 2.3.2. Traumatic Brain Injury
     - 2.3.3. Delirium
   - 2.4. Special Focus Issues
     - 2.4.1. Posttraumatic Stress Disorder
     - 2.4.2. Personality, Borderline, Dissociative Disorder
     - 2.4.3. Geriatric Issues
     - 2.4.4. Anxiety Disorders/ Panic Disorders/ Obsessive-Compulsive Disorders
     - 2.4.5. Suicide Issues
3. Module 3 – Neuropharmacology (6 Hours) The student will be able to Identification and common effects of psychotropic medications
   - 3.1. Types of Medications
     - 3.1.1. Antidepressants

        3.1.2. Mood stabilizers
        3.1.3. Anti-anxiety
        3.1.4. Antipsychotics
    3.2. Side Effects
    3.3. Medication Assessments

4. Module 4 – Mental Health Assessments (6Hours) The student will be to review the sociopathic checklist, personality assessments and mental health profiling used in current mental health assessments for inpatient and outpatient care. Learn how to interview the patient using medical history, substance abuse history, social-economic history and mental health examination to determine if the patient has a history or potential to be mentally ill. Learn special considerations for caring for substance/alcohol abuse, incarcerated, children, elderly and suicidal patients. Learn to effectively communicate with the mentally ill. Demonstrate patient risk assessment for the potential for harm.
    4.1. Assessment Tools
        4.1.1. Special Considerations: Alcohol and Drug Abuse
        4.1.2. Special Considerations: The Incarcerated Patient
        4.1.3. Special Considerations: Children and Adolescents
        4.1.4. Special Considerations: The Elderly or Dependent Adult
        4.1.5. Special Considerations: Suicidal Emergencies
    4.2. Therapeutic Communications
        4.2.1. Verbal components
        4.2.2. Non-verbal components
        4.2.3. Factors that influence communication
        4.2.4. Communication statistics
    4.3. Interview Techniques
    4.4. Risk Assessment
        4.4.1. Violence Curve
5. Module 5 – Cross Cultural Considerations (2 Hours) The student will able to identify unique perceptions regarding mental health by various cultures, to include Hispanic, Asian, African American, Eastern European, and Native American cultures. Learn how to utilize appropriate community skills and techniques for individuals from identified cultures. Identify local community resources available to identify cultures.
    5.1. Cultural Awareness
    5.2. Culturally Informed Intervention

6. Module 6 – Legal Issues (2 Hours) The student will be familiar with legal issues regard involuntary civil confinement, 5150/5170 statutes and patient right's.
   6.1. Civil Commitment
   6.2. Voluntary vs Involuntary holds
   6.3. 5150 Statutes

   6.4. Patient Rights

7. Module 7 – Self –Protection and De-escalation Techniques (6 Hours) The student will become familiar with techniques and strategies to use when encountering a crisis and ways to de-escalate the mental patient.
   7.1. Self-protection
   7.2. De-escalation techniques

8. Module 8 – Overview of Community Resources (8 Hours) The student will have the opportunity to tour Behavioral Health facilities and gain insight into intake procedures for each facility. Learn Referral process for APS, CPS and Public Health
   8.1. Referral Process (APS/CPS/HSA)
   8.2. Intake Process (DBHC/BHRC)

9. Module 9 – Clinical Decision Making for the Patient with a Behavioral Emergency (8 Hours) The student will be able to demonstrate competence through the use of pre-staged scenarios to manage behavioral emergencies and properly identify patient care needs. Understand operational procedures and how to integrate into the total system. Learn documentation standards and pilot scope of practice. Demonstrate equipment proficiency. Comprehension of didactic knowledge will be demonstrated by a passing score of eighty percent on a written exam. As well a passing score during hospital and field experience with behavioral health clinitians.
   9.1. Prehospital Management of Behavioral Emergencies
   9.2. Protocol Review
   9.3. Equipment review (Breathalyzer)
   9.4. Documentation (Patient Consent/PCR)
   9.5. Quality Review Process
   9.6. Mental Health Assessment Practice
   9.7. Review and Evaluation

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10. Module 10 - Advanced Clinical Assessment (16 hours) The student will participate in a clinical practicum under the supervision of a ED nurse mentor
    10.1. Clinical Mentor (Doctor's Medical Center)
    10.2. Clinical Mentor (Kaiser Permanente – Modesto)

10.3. Breathalyzer familiarization

11. Module 11 - Clinical Experience with Behavioral Heath Clinician (16 hours)
    The student will participate in a clinical experience under the supervision of a mental health clinician. Patient evaluations will be approved by the MVEMSA Medical Director.
    11.1. Field Assessments

MOUNTAIN-VALLEY EMS AGENCY
POLICIES AND PROCEDURES

POLICY: 620.10
TITLE: **Quality Improvement Program**

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 5/2013
SUPERSEDES:
REVISED:
REVIEW DATE: 5/2018
PAGE: 19 of 23

QUALITY IMPROVEMENT

I. **AUTHORITY**

Division 2.5 of the California Health and Safety Code, Section 1797.107 and California Code of Regulations, Title 22, Section 100027.

II. **DEFINITIONS**

A. **Local Quality Improvement Group (LQIG)** means an established committee, comprised of multiple provider agencies, which meets regularly to evaluate and act upon quality improvement information and issues within a local community.

B. **Mountain-Valley Emergency Medical Services Agency (MVEMSA) Quality Improvement Program Manual** means the document which defines the standardized structure, process, and indicators to be used in performing quality improvement within the MVEMSA member counties' system.

C. **Outcome Indicator** means the result of structural and process indicators (e.g. cardiac arrest survival rate (outcome) compared to number of AEDs per population (structural) or response times (process).

D. **Process Indicator** means a measurable activity of a system (e.g. IV's, intubations)

E. **EMS Service Provider** means any agency which performs services directly or indirectly to a patient which has received pre-hospital care to include, but not be limited to: dispatch, first responder, ambulance, base hospitals, and receiving facilities.

F. **Provider Improvement Program** means a written program in which an EMS Provider has established an organizational structure and standard operating procedures which allow for the continual evaluation and improvement of services.

G. **Provider Quality Improvement Panel** means an established committee within a local EMS Provider organization which meets regularly to evaluate

and act upon quality improvement information and issues within a local provider service area.

H. **Quality Improvement** means an organized and standardized process by which services and products delivered by an EMS System are continuously evaluated and improved based upon accepted benchmark standards.

I. **Quality Indicator** means a measurement of the degree or frequency of compliance with an established standard or benchmark, including both core indicators and ad-hoc indicators, as approved by the EMS Agency Medical Director.

J. **Quality Liaison Committee** (QLC) means an established committee of EMS service providers, which meets regularly to evaluate and act upon quality improvement information and standards within the regional service area.

K. **Structural Indicator** means a physical attribute of a system or the structures in place to ensure quality (e.g. number of hospital or ambulances per population).

III PURPOSE

To provide the structure and process for the continual evaluation and improvement of emergency medical care within the Mountain-Valley EMS system.

IV POLICY

A. **Data Collection & System Evaluation**
EMS Providers shall participate in an organized EMS system evaluation program at each of the following four levels:

1. Regional Level/QLC

    a. All EMS service providers shall collect and report data for core indicators to the EMS Agency on a regular basis.
    b. All EMS service providers shall collect and report ad-hoc indicators to the EMS Agency as recommended by the QLC and approved by the EMS Agency Medical Director.
    c. All EMS service providers shall participate in the regional QLC meetings and processes, which at a minimum provide review and assessment of structural, process, and outcome quality indicators as established within the regional EMS system.

2. Local Level/ LQIG

   a. All EMS service providers shall collect and report data for core indicators to the EMS Agency on a regular basis.
   b. All EMS service providers shall collect and report ad-hoc indicators to the EMS Agency as recommended by the LQIG and approved by the EMS Agency Medical Director.
   c. Each LQIG shall regularly report the results of any system evaluation to the Quality Liaison Committee.
   d. All EMS service providers shall participate in the LQIG meetings and processes, which at a minimum provide review and assessment of core structural, processes, and outcome quality indicators as established within the regional EMS system.

3. Provider Level

   a. All EMS service providers shall establish in writing an internal Data Collection and System Evaluation program, which includes, at a minimum a:

      (1) list of structural, process, and outcome indicators, approved by the EMS AGENCY Medical Director

      (2) procedure for the evaluation of all established indicators

      (3) procedure for the regular reporting of core and ad-hoc indicators to the LQIG, QLC, and EMS Agency

      (4) procedure for reporting information on any structural, process, or outcome indicator which falls outside the accepted benchmarks to the provider QI liaison

      (5) procedure for reporting information on any structural, process, or outcome indicator which falls outside the accepted benchmarks to other agency provider QI liaisons when the information involves another EMS provider

      (6) procedure for submitting unusual occurrence reports to the EMS agency for unresolved inter-agency issues.

   b. All providers shall immediately provide a written unusual occurrence report to the EMS Agency when any situation could be considered an imminent threat to the public health or safety.

4. Personnel level

a. All EMS personnel who provide pre-hospital medical care for an EMS provider shall participate in a system evaluation program that includes, at a minimum:

(1) collection and documentation of structural, process and outcome indicators as established by the EMS service provider
(2) periodic evaluation of established indicators

b. All EMS personnel shall immediately provide a written situation report to the EMS Agency when any situation could be considered an imminent threat to the public health or safety.

B. **EMS System Improvement Program**

1. EMS Providers shall participate in an organized EMS system improvement program. In cooperation with the EMS agency, providers shall use the following four-step improvement process:

a. **Plan:** Develop a Plan to implement a policy, procedure, or process to improve quality.

b. **Do:** After the plan is developed, DO it by putting the plan into action.

c. **Study**: After the plan has been put into action, STUDY the results to see if the plan has worked.

d. **Act:** After studying the results of the plan, ACT either to stabilize the improvement that occurred or to determine what went wrong if the gains that were planned for did not materialize.

2. EMS Providers shall participate in all training programs identified through the QI process for system improvement and approved by the EMS Agency Medical Director.

3. EMS Providers shall ensure that all personnel who provide prehospital medical care successfully complete training programs identified through the QI process for system improvement and are approved by the EMS Agency Medical Director. Training records shall be maintained for a period of not less than four years and be available to the EMS Agency upon request.

4. All EMS personnel who provide prehospital medical care shall participate in training programs identified through the QI process for system improvement and are approved by the EMS Agency Medical Director.

Stanislaus County
Emergency Medical Services Agency

California Code of Regula?ons

Title 22

Division 9

Chapter 5

STATE OF CALIFORNIA
EMERGENCY MEDICAL SERVICES AUTHORITY

ORDER OF ADOPTION

All text is new and being proposed for adoption, therefore it does not contain underlining or strikeout.

CHAPTER 5. COMMUNITY PARAMEDICINE AND TRIAGE TO ALTERNATE DESTINATION

§ 100181. Definitions

(a) "Alternate destination facility" means a treatment location that is an authorized mental health facility, as defined in Section 1812 of the Health and Safety Code or an authorized sobering center as defined in Section 1813 of the Health and Safety Code.

(b) "Authorized mental health facility" means a facility that is licensed or certified as a mental health treatment facility or a hospital, as defined in subsection (a) or (b) of Section 1250 of the Health and Safety Code, by the State Department of Public Health, and may include, but is not limited to, a licensed psychiatric hospital, or licensed health facility, or certified crisis stabilization unit. An authorized mental health facility may also be a psychiatric health facility licensed by the State Department of Health Care Services. The facility shall be staffed at all times with at least one registered nurse.

(c) "Authorized sobering center" a non-correctional facility that is staffed at all times with at least one registered nurse, that provides a safe, supportive environment for intoxicated individuals to become sober, that is identified as an alternate destination in a plan developed pursuant to Section 1843 of the Health and Safety Code, and that meets any of the following requirements:

(1) The facility is a federally qualified health center, including a clinic described in subsection (b) of Section 1206 of the Health and Safety Code.

(2) The facility is certified by the State Department of Health Care Services, Substance Use Disorder Compliance Division to provide outpatient, nonresidential detoxification services.

(3) The facility has been accredited as a sobering center under the standards developed by the National Sobering Collaborative. Facilities granted approval for operation by Office of Statewide Health Planning and Development (OSHPD) before November 28, 2017, under the Health Workforce Pilot Project No. 173,

may continue operation until one year after the National Sobering Collaborative accreditation becomes available.

(d) "Community paramedic" means a paramedic licensed under Division 2.5 of the Health and Safety Code who has completed the curriculum for community paramedic training, has received certification in one or more of the community paramedicine program specialties described in Section 1815 of the Health and Safety Code, and is accredited to provide community paramedic services by a local EMS agency (LEMSA) as part of an approved community paramedicine program.

(e) "Community paramedic training program" means a training program approved by the LEMSA to provide certification of completion of didactic education and clinical experience in this area.

(f) "Community paramedicine program" means a program developed by a LEMSA and approved by the Emergency Medical Services Authority (the Authority or EMSA) to provide community paramedicine services consisting of one or more of the program specialties described in Section 1815 of the Health and Safety Code under medical protocols developed by the LEMSA that are consistent with the minimum medical protocols established by the Authority. Community paramedicine program specialties include:

(1) Providing directly observed therapy (DOT) to persons with tuberculosis in collaboration with a public health agency to ensure effective treatment of the tuberculosis and to prevent spread of the disease.

(2) Providing case management services to frequent emergency medical services users in collaboration with, and by providing referral to, existing appropriate community resources.

(g) "Community paramedicine provider" means an advanced life support (ALS) provider authorized by a LEMSA to provide ALS services who has entered into a contract to deliver community paramedicine services as described in Section 1815 of the Health and Safety Code as part of an approved community paramedicine program developed by a LEMSA and approved by the Authority.

(h) "Public agency" means a city, county, city and county, special district, or other political subdivision of the state that proves first response services, including emergency medical care.

(i) "Triage paramedic" means a paramedic licensed under this Division who has completed the curriculum for triage paramedic services adopted pursuant to paragraph (2) of subsection (d) of Section 1830 of the Health and

Safety Code and has been accredited by a LEMSA in one or more of the triage paramedic specialties described in Section 1819 of the Health and Safety Code as part of an approved triage to alternate destination program.

(j) "Triage paramedic training program" means a training program approved by LEMSA to provide certification of completion of didactic and clinical experience and that includes a final comprehensive competency-based exam to test the knowledge and skills specified in this Chapter to provide triage paramedic services.

(k) "Triage to alternate destination program" means a program developed by a LEMSA and approved by the Authority to provide triage paramedic assessments under triage and assessment protocols developed by the LEMSA that are consistent with the minimum triage and assessment protocols established by the Authority in one or more specialties including:

(1) Providing care and comfort services to hospice patients in their homes in response to 911 calls by providing for the patient's and the family's immediate care needs, including grief support in collaboration with the patient's hospice agency until the hospice nurse arrives to treat the patient.

(2) Providing patient with ALS triage and assessment by a triage paramedic and transportation to an alternate destination facility, as defined in Section 1811 of the Health and Safety Code.

(3) Providing transport services for patients who identify as veterans and desire to transport to a local veteran's administration emergency department for treatment, when appropriate.

(l) "Triage to alternate destination provider" means an advanced life support provider authorized by a LEMSA to provide ALS triage paramedic assessments as part of an approved triage to alternate destination program specialty as described in Section 1819 of the Health and Safety Code.

Note: Authority cited: Sections 1797.107 and 1830, Health and Safety Code. Reference: Sections 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, and 1820, Health and Safety Code.

§100182. General Provisions

(a) A LEMSA that elects to implement a community paramedicine or triage to alternate destination program pursuant to Section 1840 of the Health and Safety Code shall develop and, prior to implementation, submit a plan for that program to the Authority for review and approval.

(b) If a LEMSA within the county elects to develop a community paramedicine or triage to alternate destination program pursuant to Section 1840 of the Health and Safety Code, the county board of supervisors, or in the case of a city and county, the mayor, shall establish an emergency medical care committee to advise the LEMSA on the development of the program and other matters relating to emergency medical services (EMS). Where a committee is already established for the purposes described in this article, the county board of supervisors or the mayor, shall ensure that the membership meets or exceeds the requirements of Section 1797.273, subsection (b) of the Health and Safety Code.

(c) No person or organization shall offer a community paramedicine or triage paramedic training program or hold themselves out as offering a community paramedicine or triage paramedic training program or hold themselves out as providing ALS services utilizing community paramedic personnel for the delivery of community paramedicine care unless that person or organization is authorized by the LEMSA to provide those services as part of a community paramedicine or triage to alternate destination program approved by the Authority in accordance with Section 1835 of the Health and Safety Code.

Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1797.259, 1797.273, 1815, 1830, 1840, and 1851, Health and Safety Code.

§ 100183. Program Requirements and Minimum Standards

(a) A LEMSA that elects to develop a community paramedicine or triage to alternate destination program shall do all the following:

(1) Integrate the proposed community paramedicine or triage to alternate destination program into the LEMSA's EMS plan described in Article 2 (commencing with Section 1797.250) of Chapter 4 of the Health and Safety Code.

(2) Provide medical control and oversight for the program(s).

(3) Approve, annually review, and facilitate any necessary agreements with one or more community paramedicine or triage to alternate destination providers for the delivery of community paramedicine or triage to alternate destination services within the LEMSA's jurisdiction.

(4) Prohibit triage and assessment protocols or a triage paramedic's decision to authorize transport to an alternate destination facility from being based on, or affected by, a patient's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, or any other characteristic listed or defined in subsection (b) or (e) of Section 51 of the Civil Code, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

(5) Facilitate funding discussions between a community paramedicine provider, triage to alternate destination provider, or incumbent emergency medical transport provider and public or private health system participants to support the implementation of the LEMSA's community paramedicine or triage to alternate destination program.

(6) Coordinate, review, and approve any agreements necessary for the provision of community paramedicine specialties as described in Section 1815 of the Health and Safety Code consistent with all the following:

(A) Provide a first right of refusal to the public agency or agencies within the jurisdiction of the proposed program area to provide the proposed program specialties for community paramedicine. If the public agency or agencies agree to provide the proposed program specialties for community paramedicine, the LEMSA shall review and approve any written agreements necessary to implement the program with those public agencies.

(B) Review and approve agreements with community paramedicine providers that partner with a private provider to deliver those program specialties.

(C) If a public agency declines to provide the proposed program specialties pursuant to paragraph (A) or (B), the LEMSA shall develop a competitive process held at periodic intervals to select community paramedicine providers to deliver the program specialties.

(7) Establish a process to verify training and accreditation of community paramedics in each of the proposed community paramedicine program specialties described in subsections (a) and (b) of Section 1815 of the Health and Safety Code, and a process to verify and training and accreditation of triage paramedics in each of the areas described in Section 1819 of the Health and Safety Code.

(8) A LEMSA may exclude an existing ALS provider from the plan if it determines that the provider's participation will negatively impact patient care.

If a LEMSA elects to exclude an ALS provider, the LEMSA shall do both of the following:

(A) Report to the Authority at the time the program is submitted for approval, the specific reasons for excluding an ALS provider.

(B) Inform the ALS provider of the reasons for exclusion.

(9) Facilitate any necessary agreements to ensure continuity of care and efficient transfer of care between the triage to alternate destination provider and the existing emergency medical transport provider to ensure transport to the appropriate facility.

(10) At the discretion of the LEMSA medical director, develop additional triage and assessment protocols commensurate with the need of the local programs authorized under this Chapter.

(11) Secure an agreement with the alternate destination facility that requires the facility to notify the LEMSA within twenty-four (24) hours if there are changes in the status of the facility with respect to protocols and the facility's ability to care for patients.

(12) Secure an agreement with the alternate destination facility that requires the facility to operate in accordance with Section 1317 of the Health and Safety Code. The agreement shall provide that failure to operate in accordance with Section 1317 of the Health and Safety Code shall result in the immediate termination of use of the facility as part of the triage to alternate destination program.

(13) In implementing a triage to alternate destination program specialties described in Section 1819 of the Health and Safety Code, continue to use, and coordinate with, any emergency medical transport providers operating within the jurisdiction of the local LEMSA pursuant to Section 1797.201 or 1797.224 of the Health and Safety Code. The LEMSA shall not in any manner eliminate or reduce the services of the emergency medical transport providers.

(14) Establish a process for training and accreditation of triage paramedics in each of the proposed triage to alternate destination program's specialties described in Section 1819 of the Health and Safety Code.

(15) Approve and annually review community paramedicine and triage to alternate destination training programs.

(16) Coordinate community paramedic personnel and training program(s).

(17) Notify the Authority of any reported complaints or unusual occurrences for any approved community paramedicine or triage to alternate destination program within seventy-two (72) hours of receiving them along with any supporting or explanatory documentation.

(b) The LEMSA shall write into program policy and ensure through program oversight that any patient who meets the triage criteria for transport to an alternate destination facility, but who requests to be transported to an emergency department of a general acute care hospital, shall be transported to the emergency department of a general acute care hospital.

(c) The LEMSA shall require in policy that a patient who is transported to an alternate destination facility and, upon assessment, is found to no longer meet the criteria for admission to an alternate destination facility, be immediately transported to the emergency department of a general acute care hospital.

(d) For any patient requiring secondary transfer from an alternate destination facility to an emergency department, the LEMSA shall require alternate destination facilities to send with each patient at the time of transfer or, in the case of an emergency, as promptly as possible, copies of all medical records related to the patient's transfer. To the extent practicable and applicable to the patient's transfer, the medical records shall include current medical findings, diagnosis, laboratory results, medications provided prior to transfer, a brief summary of the course of treatment provided prior to transfer, ambulation status, nursing and dietary information, name and contact information for the treating provider at the alternate destination facility, and, as appropriate, pertinent administrative and demographic information related to the patient, including name and date of birth. The requirements in this paragraph do not apply if the alternate destination facility has entered into a written transfer agreement with a local hospital that provides for the transfer of medical records.

(e) The LEMSA shall ensure that facilities participating in the triage to alternate destination program shall accommodate privately or commercially insured, Medi-Cal, Medicare, and uninsured patients.

Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1830, 1831, 1841, 1842, and 1843, Health and Safety Code.

§ 100184. Community Paramedicine, Triage to Alternate Destination, and Alternate Destination Facility Providers Program Requirements, Oversight and Withdrawal

(a) LEMSAs that approve a community paramedicine, triage to alternate destination, or alternate destination facility provider~~.~~ shall annually conduct a review of community paramedicine, triage to alternate destination, or alternate destination facility providers programs to ensure compliance with all requirements.

(b) A community paramedicine, triage to alternate destination, or alternate destination facility providers program's failure to comply with the provisions of statute, regulation, and/or any additional LEMSA requirements may result in denial, probation, suspension, or revocation of approval by the LEMSA. Not complying with this subsection is considered noncompliance.

(c) The procedure for notifying a community paramedicine, triage to alternate destination, or alternate destination facility providers programs of noncompliance shall be as follows:

(1) Within ten (10) days of a LEMSA finding noncompliance by a community paramedicine, triage to alternate destination, or alternate destination facility provider, the LEMSA shall provide a written notification of noncompliance to the community paramedicine, triage to alternate destination, or alternate destination facility provider, including the specific requirements they failed to meet. The notification shall be sent by certified mail to the director.

(2) Within fifteen (15) days from receipt of the notification, the community paramedicine, triage to alternate destination, or alternate destination facility provider shall submit, in writing and by certified mail, to the LEMSA one of the following:

(A) Evidence of compliance, or

(B) A plan to comply within sixty (60) days from the day of receipt of the notification of noncompliance.

(3) Within fifteen (15) days from receipt of the community paramedicine, triage to alternate destination, or alternate destination facility provider's response, or within thirty-five (35) days from the mailing date of the notification of noncompliance if no response is received from the community paramedicine, triage to alternate destination, or alternate destination facility provider, the LEMSA shall issue a decision letter by certified mail to the Authority

and the community paramedicine, triage to alternate destination, or alternate destination facility provider. The letter shall identify the LEMSA's decision to take one or more of the following actions based on relevant factors such as severity of noncompliance, actual or potential harm to public health, safety, and welfare, or history of compliance or noncompliance as provided in subsection (b) of this section:

(A) Accept the evidence of compliance provided.

(B) Accept the plan for meeting compliance provided.

(C) Place the community paramedicine, triage to alternate destination, or alternate destination facility provider on probation.

(D) No sooner than five (5) days after the LEMSA's decision suspend or revoke the community paramedicine, triage to alternate destination, or alternate destination facility provider.

(4) The decision letter shall also include, but not be limited to, the following information:

(A) Date of the LEMSA's decision,

(B) Specific requirements that LEMSA found the community paramedicine, triage to alternate destination, or alternate destination facility provider failed to meet,

(C) The probation or suspension effective and ending date, if applicable,

(D) The terms and conditions of the probation or suspension, if applicable, and

(E) The revocation effective date, if applicable.

(5) The LEMSA that approves a community paramedicine, triage to alternate destination, or alternate destination facility provider shall establish the probation, suspension, or revocation effective dates no sooner than five (5) days after the date of the community paramedicine provide community paramedicine, triage to alternate destination, or alternate destination facility provider had been notified under subsection (c)(3) of this Section.

(6) EMSA retains authority to take any necessary action against a community paramedicine, triage to alternate destination, or alternate destination facility provider for failure to meet the requirements of this Chapter or the community

paramedicine or triage to alternate destination program requirements of the LEMSA. Such action may be taken in addition to any actions taken by the LEMSA and may include immediate suspension or revocation.

Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1811, 1812, 1813, 1830, 1831, 1832, 1840, 1841, and 1842, Health and Safety Code.

§ 100185. Documentation and Data Submission

(a) Community paramedics and triage paramedics shall complete and submit electronic patient care records in accordance with Title 22 California Code of Regulations Section 100171.

(b) Community paramedics and triage paramedics providers shall document destination facility with standardized facility codes per the California Emergency Medical Services Information System (CEMSIS).

(c) Community paramedicine or triage to alternate destination programs shall exchange electronic patient health information (HIE) between community paramedicine or triage to alternate destination providers and health providers and facilities. The Authority may grant a one-time temporary waiver based on the proposed plan and timeline to achieve Electronic HIE functionality, not to exceed five (5) years of this requirement for alternate destination facilities that are unable to immediately comply with the electronic patient health information requirement. A plan to establish HIE shall accompany any request for a waiver.

(d) Community paramedicine programs shall submit to the LEMSA at minimum a quarterly summary of patient outcomes, which are due by January 30, April 30, July 30, and October 30 each year, in an EMSA provided template with the following data:

(1) For programs which provide directly observed therapy (DOT) to persons with Tuberculosis:

(A) Total patients enrolled who completed therapy successfully.

(B) Total patients enrolled who are still in the treatment program.

(C) Total number of patients enrolled who did not complete treatment successfully.

(2) For programs which provide case management services to EMS high utilizers, a summary of the reduction in EMS utilization, and any other impacts of the program.

(e) Alternate destination facilities shall submit to the LEMSA at minimum a quarterly summary of patient outcomes with an EMSA provided template, the following data:

(1) Total number of patients evaluated who were transported by EMS.

(2) Total number of these patients who were treated and released

(3) Total number of these patients who were transferred to an acute care emergency department.

(4) Total number of these patients admitted to another care facility.

(5) Total number of these patients who experienced an adverse event resulting from services provided under this program.

(f) LEMSAs shall submit quarterly data reports to the Authority to include:

(1) Quarterly ambulance patient offload times (APOT) for every alternate destination facility.

(2) Quarterly total EMS transports to every alternate destination facility.

(3) Quarterly total number of patients turned away or diverted from every alternate destination facility.

(4) Quarterly total number of patients who require subsequent transfer to an emergency department from an alternate care facility.

(5) A summary of the primary reasons for turning away, diverting, or transferring patients to emergency departments from alternate care facilities.

(6) A summary of feedback about the program from the Emergency Medical Care Committee.

(7) Community paramedicine program summary of outcomes (noted in subsection (d) above).

(8) Alternate destination facility summary of patient outcomes (noted in subsection (e) above).

(g) LEMSAs shall submit a once annual summary, due to EMSA January 30 each year, of all alternate destination facilities that certifies each facility maintains adequate licensed medical and professional staff, facilities, and equipment pursuant to the Authority's regulations and the provisions of this Chapter, which shall include all the following:

(1) Identification of qualified staff to care for the degree of a patient's injuries and needs.

(2) Certification of standardized medical and nursing procedures for nursing staff.

(3) Certification that the necessary equipment and services are available at the alternate destination facility to care for patients, including, but not limited to, an automatic external defibrillator and at least one bed or mat per individual patient.

Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1797.227, 1830, 1831, and 1833, Health and Safety Code.

§ 100186. Quality Improvement

The LEMSA and all participating providers shall include any community paramedicine or triage to alternate destinations program in their existing Quality Improvement programs, and they shall adhere to all sections of Title 22, Division 9, Chapter 12 of the California Code of Regulations.

Note: Authority cited: Section 1797.107, 1830, and 1831, Health and Safety Code. Reference: Section 1830 and 1831, Health and Safety Code.

§ 100187. Approval of Community Paramedic and Triage to Alternate Destination Training Programs

(a) The LEMSA is responsible for approval of training programs within its geographic area. As the approver, the LEMSA has oversight authority to conduct onsite visits, inspect, investigate, and discipline the training program for any violations of this Division or for failure to fulfill any additional requirements established by the LEMSA through denial, probation, suspension, or revocation of the approval.

(b) The LEMSA shall develop policies and procedures for the submission of program applications and requirements based on patient population and EMS system needs.

(c) Eligible training programs shall submit a written request for training program approval to the LEMSA.

(d) The LEMSA shall receive and review the following documentation prior to program approval:

(1) A statement verifying that the course content meets the requirements contained in the current version of the United States Department of Transportation (U.S. DOT) National EMS Education Standards as required by Section 1831(c)(2) of the Health and Safety Code.

(2) An outline of course objectives.

(3) Performance objectives for each skill.

(4) The names and qualifications of the training program director, program medical director, and instructors.

(5) If the training program includes supervised clinical training, then provisions for supervised clinical training including student evaluation criteria and standardized forms for evaluating community paramedic students;-and monitoring of preceptors by the training program shall be included.

(6) If the training program includes supervised field internship, then provisions for supervised field internship including community paramedic student evaluation criteria and standardized forms for evaluating students; and monitoring of preceptors by the training program shall be included.

(7) The proposed location(s) and date(s) for courses.

(8) Written contract or agreements between the training program and a hospital(s) and other clinical setting(s), if applicable, for student placement for clinical education and training.

(9) Written contracts or agreements between the training program and a provider agency(ies) for student placement for field internship training.

(10) Samples of written and skills examinations administered by the training program.

(11) Evidence that training program facilities, equipment, examination securities, and student record keeping are compliant with the provisions of statute, regulation, and LEMSA requirements.

(e) The LEMSA shall approve and establish the effective date of program approval in writing upon the program satisfactory meeting and documenting compliance with all program requirements.

(f) Notification of program approval or deficiencies with the application shall be made in writing by the LEMSA to the requesting training program within ninety (90) days of receiving the training program's request for approval.

(g) Training program approval shall be valid for four (4) years ending on the last day of the month in which it was issued and may be renewed every four (4) years.

(h) The LEMSA shall notify the Authority in writing of the training program approval, including the name and contact information of the program director, medical director, and effective date of the program.

Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1830 and 1831, Health and Safety Code.

§ 100188. Oversight of Training Programs

(a) The LEMSA has oversight authority to conduct onsite visits, inspect, investigate, and discipline approved training programs for any violations of this Division or for failure to fulfill any additional requirements established by the LEMSA through denial, probation, suspension, or revocation of the approval.

(b) The requirements of training program noncompliance notification and actions are as follows:

(1) A LEMSA shall provide written notification of noncompliance with this Division and/or local standards and requirements to the training program provider. The notification shall be in writing and sent by certified mail to the training program director.

(2) Within fifteen (15) days from receipt of the noncompliance notification, the training program shall submit in writing, by certified mail, to the LEMSA one of the following:

(A) Evidence of compliance with the provisions of this Division and/or the local standards and requirements, as applicable, or

(B) A plan to comply with the provisions of this Division and/or the local standards and requirements, as applicable, within sixty (60) days from the day of receipt of the notification of noncompliance.

(3) Within fifteen (15) days from receipt of the training program's response, or within thirty (30) days from the mailing date of the noncompliance notification, if no response is received from the training program, the LEMSA shall issue a decision letter by certified mail to the Authority and the training program. The letter shall identify the LEMSA's decision to take one or more of the following actions:

(A) Accept the evidence of compliance provided.

(B) Accept the plan for meeting compliance provided.

(C) Place the training program on probation.

(D) Suspend or revoke the training program approval.

(4) The decision letter shall also include, but need not be limited to, the following information:

(A) Date of the LEMSA's decision,

(B) Specific provisions found noncompliant by the LEMSA, if applicable,

(C) The probation or suspension effective and ending date, if applicable,

(D) The terms and conditions of the probation or suspension, if applicable, and

(E) The revocation effective date, if applicable.

(5) The LEMSA shall establish the probation, suspension, or revocation effective dates.

Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1830 and 1831, Health and Safety Code.

§100189. Community Paramedic and Transportation to Alternate Destination Training Programs Administration and Faculty Requirements

(a) Each training program shall have a program medical director who is a board certified or board eligible emergency medical physician currently licensed in the State of California, who has experience in emergency medicine and has education or experience in methods of instruction. Duties of the program medical director shall include, but not be limited to the following:

(1) Review and approve educational content, standards, and curriculum; including training objectives and local protocols and policies for the clinical and field instruction, to certify its ongoing appropriateness and medical accuracy.

(2) Review and approve the quality of medical instruction, supervision, and evaluation of the students in all areas of the program.

(3) Approval of hospital clinical and field internship experience provisions.

(4) Approval of instructor(s).

(5) The program medical director will certify that guest educators invited by primary instructors to provide instruction or facilitation have the appropriate expertise to deliver the proposed educational content.

(b) Each training program shall have a program director who shall meet the following requirements:

(1) Has knowledge or experience in local EMS protocol and policy,

(2) Is a board certified or board eligible California licensed emergency medicine physician, registered nurse, paramedic, or an individual who holds a baccalaureate degree in a related health field or in education, and

(3) Has education and experience in methods, materials, and evaluation of instruction including:

(A) A minimum of one (1) year experience in an administrative or management level position, and

(B) A minimum of three (3) years academic or clinical experience in prehospital care education.

(c) Duties of the program director shall include, but not be limited to the following:

(1) Administration, organization, and supervision of the educational program.

(2) In coordination with the program medical director, approve the instructor(s), teaching assistants, field and hospital clinical preceptors, clinical and internship assignments, and coordinate the development of curriculum, including instructional objectives, and all methods of evaluation.

(3) Ensure training program compliance with this chapter and other related laws.

(4) Ensure that all course completion records include a signature verification.

(5) Ensure the preceptor(s) are trained according to the subject matter being taught.

(d) Each training program shall have instructor(s), who are responsible for areas including, but not limited to, curriculum development, course coordination, and instruction and shall:

(1) Be a physician, registered nurse, physician assistant, nurse practitioner, paramedic, who is currently certified or licensed in the State of California,

(2) Have six (6) years' experience in an allied health field or community paramedicine, or four (4) years of experience in an allied health field and an associate degree or two (2) years of experience in an allied health field and a baccalaureate degree, and

(3) Be knowledgeable in the course content of the U.S. DOT National Emergency Medical Services Education Standards, and

(4) Be able to demonstrate expertise and a minimum of two (2) years of experience within the past five (5) years in the subject matter being taught by that individual, and

(5) Be qualified by education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction.

(6) An instructor may also be the program medical director or program director.

(e) Required course content:

(1) The community paramedicine training program medical director and training program director will be required to certify that all delineated education standards are met. In addition, the Authority and the authorizing LEMSA shall assure that each training program curriculum meets the minimum educational standards set forth in this Division and is focused on the knowledge and skills needed to successfully complete the International Board of Specialty Certification (IBSC) examination.

(2) The triage to alternate destination training program medical director shall certify that all delineated triage to alternate destination education standards are met. In addition, the Authority and the authorizing LEMSA shall assure that each training program has a curriculum that meets the minimum educational standards set forth in this division.

(f) Minimum training and curriculum requirements, triage paramedic training:

(1) Triage paramedic training curriculum shall include at a minimum the following:

(A) Screening and responding to mental health and substance use crisis intervention, including co-occurring mental health and substance use disorders to be provided by a licensed physician, surgeon, or licensed addiction medicine specialist with experience in the emergency department of a general acute care hospital.

(B) Mental health conditions.

(C) Assessment and treatment of intoxicated patients.

(D) The prevalence and causes of substance use disorders and associated public health impacts.

(E) Suicide risk factors.

(F) Alcohol and substance use disorders.

(G) Triage and transport parameters.

(H) Health risks and interventions in stabilizing acutely intoxicated patients.

(I) Common medical conditions and infections with presentations similar to psychosis and intoxication which require medical testing and treatment.

(J) Disease process, behavioral emergencies, and injury patterns common to those with chronic alcohol use and other substance use disorders.

(K) LEMSA policies for the triage, treatment, transport, and transfer of care, of patients to an alternate destination facility.

(L) The Emergency Medical Treatment and Labor Act (EMTALA) law as it pertains to psychiatric, and substance use disorder-related emergencies.

(2) LEMSAs shall verify that the participating triage paramedic has completed training in all the following topics:

(A) Psychiatric disorders.

(B) Neuropharmacology.

(C) Alcohol and substance abuse.

(D) Patient consent.

(E) Patient documentation.

(F) Medical quality improvement.

(g) Minimum training and curriculum requirements, community paramedic training:

(1) Foundations of community paramedicine.

(A) Subjects and theories to be learned:

(i) Overview of the United States and California healthcare systems and reimbursement.

(ii) Overview of public health.

(iii) Effect of the Affordable Care Act on development of community paramedicine nationally and in California.

(iv) Roles of the community paramedic.

(v) Community paramedic scope of practice.

(vi) Legal and ethical issues in client- and community-centered care.

(vii) Chronic disease management.

(viii) Subacute disease management.

(ix) Personal safety and wellness.

(x) International Board of Specialty Certification (IBSC).

(xi) Research in evidence-based practice.

(B) Knowledge and abilities acquired include:

(i) Understanding the relationship of the system of care as a community paramedic within public health.

(ii) Advocating for the client and the health care team through an equity lens.

(iii) Maintaining a healthy workplace stressor balance.

(2) Cultural humility, equity and access within community paramedicine and healthcare.

(A) Subjects and theories to be learned:

(i) Social determinants of health.

(ii) Biomedical ethics.

(iii) Equity versus equality.

(iv) Implicit bias in healthcare.

(v) Disparities in healthcare access and health outcomes by age, race, gender, ethnicity, language, ability status, socioeconomic status, mental health, and community.

(vi) Cultural humility as a framework for public health and community paramedic practice.

(vii) Roles of the culturally effective community paramedic.

(viii) Trauma-informed care.

(B) Knowledge and abilities acquired ~~should~~ include:

(i) Examination of potential biases toward clients and/or communities.

(ii) Application of evidence-based tools and models for practicing cultural humility in client-centered care.

(iii) Connect with culturally diverse/aware community partners.

(iv) Application of culturally effective community paramedic as community advocate.

(v) Access qualified interpreter services for language access and communication with clients and community.

(3) Interdisciplinary collaboration and systems of care navigation.

(A) Subjects and theories to be learned:

(i) Healthcare coordination.

(ii) Systems of care navigation.

(iii) Outreach and advocacy for target and at-risk populations.

(iv) Client referral.

(v) Documentation across disciplines.

(vi) Overview of the subject areas of nutrition, palliative care, hospice care, end of life care, home health vs. home care, mental health care, and substance use care.

(B) Knowledge and abilities acquired include:

(i) Collegial communications with interdisciplinary team members.

(ii) Appreciative inquiry with care team members.

(iii) Interdependent relationships with team members.

(iv) Appropriate referrals and system navigation.

(4) Client-centered Care.

(A) Subjects and theories to be learned:

(i) Client approach and the biopsychosocial assessment, including embedding cultural humility practices in client case management.

(ii) Motivational interviewing.

(iii) Interventional techniques.

(iv) Crisis intervention.

(v) Client assessment, referral, and education.

(vi) Creating a care plan.

(vii) Implementing a care plan.

(viii) Resources for client case management.

(ix) Service coordination and client counseling.

(x) Documentation and follow up.

(B) Knowledge and abilities acquired include:

(i) Core proficiency in health assessment, referral, health education, service coordination, and client-centered counseling.

(ii) Create resource map and examine webs of resources.

(iii) Create outreach strategies to connect client/community to resources.

(5) Community and public health.

(A) Subjects and theories to be learned:

(i) Population based care.

(ii) Health equity across populations.

(iii) Epidemiology.

(iv) Public health mission.

(v) Community health/needs assessment.

(vi) Public health disaster response.

(vii) Prevention.

(viii) Isolation and quarantine.

(ix) Public education.

(x) Interagency communications.

(B) Knowledge and abilities acquired include:

(i) Engages in public health planning and implementation.

(ii) Develops resources that aid in public health responses.

(iii) Coordinates and manages mass events.

(h) Community Paramedicine and Triage Paramedic Required Testing:

(1) ISBC community paramedic exam approved paramedic training programs shall include a minimum of two (2) formative examinations and one (1) final comprehensive competency-based examinations to test the knowledge and skills specified in this chapter.

(2) Triage paramedic approved programs shall include a minimum of one (1) final comprehensive competency-based examination to test the knowledge and skills specified in this chapter.

(3) Documentation of successful student clinical and field internship performance, if applicable.

Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1801, 1830, 1831, 1842, and 1843, Health and Safety Code.

§ 100190. Community Paramedicine or Triage to Alternate Destinations Program Approval Process

(a) LEMSA shall submit a written request to the Authority for approval of a community paramedicine or triage to alternate destination program, which shall include the following:

(1) Identification of the community need and recommended solutions.

(2) All program medical protocols and policies to include but not limited to, data collection, transport, patient safety, and quality assurance/improvement process.

(3) All program service provider approval documentation, including written agreements, if any.

(4) All relevant alternate destination facility approval documentation, including agreements, if any.

(5) All relevant documentation outlining policy for collaboration with public health or community resource entities for DOT and EMS high utilizer programs.

(6) Curriculum for program focused training.

(b) The Authority shall review a LEMSA's proposed community paramedicine or triage to alternate destination program using procedures consistent with Section 1797.105 of the Health and Safety Code and review the LEMSA's program protocols to ensure compliance with the statewide minimum protocols developed under Section 1832 of the Health and Safety Code.

(c) The Authority shall impose conditions as part of the approval of a community paramedicine or triage to alternate destination program that the LEMSA is required to incorporate into its program to achieve consistency with the Authority's regulations and statute.

(d) The Authority shall approve or deny in writing the proposed community paramedicine or triage to alternate destination program no later than 30 days after it is submitted by the LEMSA.

(e) Approval of community paramedicine or triage to alternate destination program shall be for twelve (12) months from the date of approval. Renewal of the program shall be completed annually through submission of the Community Paramedicine Annex of the EMS plans process found in Section 1001834.

Note: Authority cited: Section 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1830, 1831, 1832, 1835, and 1836, Health and Safety Code.

§ 100191. Review, Withdrawal, and Revocation of a Community Paramedicine or Triage to Alternate Destination Program

LEMSA shall immediately terminate from participation in the program any alternate destination facility, community paramedicine, or triage to alternate destination provider if it fails to operate in accordance with subsection (b) of Section 1317 of the Health and Safety Code.

Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1830 and 1831, Health and Safety Code.

§ 100192. Paramedic Scope of Practice, Accreditation, and Discipline

(a) Scope of Practice. A community paramedic or triage paramedic shall utilize the paramedic scope of practice, approved LEMSA local optional scope as identified in section 100146 of this division, and trial study scope identified in section 100147 of this Division. This includes utilizing their general paramedic scope and other approved scopes while transporting to alternate destinations, providing care to discharged patients, providing vaccinations, and through other conditions as identified in approved community paramedicine and triage to alternate destination programs.

(b) Community Paramedic Accreditation to Practice.

(1) A community paramedic shall only utilize community paramedicine skills when accredited by the LEMSA as a community paramedic within that LEMSA jurisdiction and when associated with that LEMSA's overseen EMSA approved Community Paramedicine Program(s).

(2) The LEMSA shall register the community paramedic accreditation in the Central Registry public look-up database within five (5) business days of the community paramedic accreditation application being approved.

(3) An initial community paramedic accreditation is deemed effective when recorded in the Central Registry public look-up database.

(4) An initial community paramedic accreditation shall expire on the last day of the month, two (2) years from the effective date of the initial accreditation.

(5) Community paramedic accreditation shall require renewal every two (2) years by the LEMSA that oversees EMSA approved community paramedic program(s) in the jurisdiction in which the community paramedic is associated.

(c) Initial Community Paramedic Accreditation Application Requirements and Process.

(1) To be community paramedic accredited, the applicant shall submit to the community paramedic program(s) LEMSA the following eligibility criteria for review:

(A) Proof of an active, unrestricted California issued paramedic license,

(B) Social Security Number or Individual Tax Identification Number,

(C) LEMSA approved community paramedicine course completion certificate, and

(D) Proof of passing the IBSC community paramedic examination for community paramedics within the last two (2) years of the date of application submission.

(2) The LEMSA shall review the submitted eligibility criteria for community paramedic accreditation and notify the applicant in writing within thirty (30) business days from the date of submission that:

(A) The submission is incomplete or illegible and requires corrective action, or

(B) The accreditation request has been approved and the accreditation data has been entered into the Central Registry public look-up database, or

(C) The accreditation request has been denied; including the reason and notification of the applicant's right to appeal.

(d) Renewal Community Paramedic Accreditation Requirements and Process.

(1) To be eligible for renewal, the applicant shall submit to the community paramedic program(s) LEMSA the following eligibility criteria for review:

(A) Proof of a current, unrestricted California issued paramedic license, and either,

(i) Show proof of completion of eight (8) hours approved community paramedicine related continuing education (CE) every two (2) years, or

(ii) Show proof of continued active, unrestricted IBSC.

(2) The LEMSA shall review the submitted eligibility criteria for community paramedicine accreditation renewal and notify the applicant in writing within thirty (30) business days from the date of submission that:

(A) The submission is incomplete or illegible and required corrective action, or

(B) The accreditation request has been approved and renewal data is updated in the Central Registry public look-up database.

(C) The accreditation request has been denied; including the reason and notification of the applicant's right to appeal.

(e) Reinstatement Community Paramedic Accreditation Requirements and Process.

(1) To be eligible for reinstatement of a community paramedic accreditation that has expired for a period of twelve (12) months or less, the applicant shall submit to the community paramedic program(s) LEMSA the following eligibility criteria for review:

(A) Proof of a current, unrestricted California issued paramedic license, and either,

(i) Proof of completion of eight (8) hours of approved local community paramedicine related CE, or

(ii) Show proof of continued active, unrestricted IBSC.

(2) To be eligible for reinstatement of a community paramedic accreditation that has expired more than twelve (12) months, the applicant shall submit to the community paramedic program(s) LEMSA the following eligibility criteria for review:

(A) Proof of an active, unrestricted California issued paramedic license,

(B) Proof of successful completion of a LEMSA approved community paramedicine course within the last two (2) years from the submission date of the reinstatement application, and

(C) Proof of passing the IBSC Community Paramedic examination within the last two (2) years from the submission date of the reinstatement application.

(3) The LEMSA shall review the community paramedic accreditation application and notify the applicant in writing within thirty (30) business days from the date of submission that the application is:

(A) Incomplete or illegible and requires corrective action, or

(B) The accreditation application has been approved and the accreditation data entered in the Central Registry public look-up database, or

(C) The accreditation request has been denied; including the reason for the denial and notification of the applicant's right to appeal.

(f) Triage Paramedic Accreditation to Practice.

(1) A triage paramedic shall only utilize triage to alternate destination skills when accredited by the LEMSA as a triage paramedic within that LEMSA's jurisdiction and when associated with that LEMSA's approved triage to alternate destination service program(s).

(2) The LEMSA shall register the triage paramedic accreditation in the Central Registry public look-up database within five (5) business days of the triage paramedic accreditation application being approved.

(3) An initial triage paramedic accreditation is deemed effective when recorded in the Central Registry public look-up database.

(4) An initial triage paramedic accreditation shall expire on the last day of the month, two (2) years from the effective date of the initial accreditation.

(5) Triage paramedic accreditation shall require renewal every two (2) years by the LEMSA that oversees EMSA approved triage to alternate destination service program(s) in the jurisdiction in which the triage paramedic is associated.

(g) Initial Triage Paramedic Accreditation Application Requirements and Process.

(1) To be triage paramedic accredited, the applicant shall submit to the triage program(s) LEMSA the following eligibility criteria for review:

(A) Proof of an active, unrestricted California issued paramedic license,

(B) Social Security Number or Individual Tax Identification Number, and

(C) LEMSA approved triage paramedicine course completion certificate.

(2) The LEMSA shall review the submitted eligibility criteria for triage paramedic accreditation and notify the applicant in writing within thirty (30) business days from the date of submission that:

(A) The submission is incomplete or illegible and requires corrective action, or

(B) The accreditation request has been approved and the accreditation data entered in the Central Registry public look-up database, or

(C) The accreditation request has been denied; including the reason for the denial and notification of the applicant's right to appeal.

(h) Renewal Triage Paramedic Accreditation Requirements and Process.

(1) To be eligible for renewal, the applicant shall submit to the triage Paramedicine program(s) LEMSA the following eligibility criteria for review:

(A) Proof of a current, unrestricted California issued paramedic license, and

(B) Proof of completion of four (4) hours of approved local triage paramedicine related CE.

(2) The LEMSA shall review the submitted eligibility criteria for triage paramedic accreditation and notify the applicant in writing within thirty (30) business days from the date of submission that:

(A) The submission is incomplete or illegible and required corrective action, or

(B) The accreditation request has been approved and the accreditation data entered in the Central Registry public look-up database.

(C) The accreditation request has been denied; including the reason and notification of the applicant's right to appeal.

(i) Reinstatement Triage Paramedic Accreditation Requirements and Process.

Stanislaus County
Emergency Medical Services Agency

Documentation of Patient Contact

Policy 560.11