AGENDA

MONO COUNTY
EMERGENCY MEDICAL CARE COMMITTEE

January 25, 2022

0900

Zoom Meeting

Purpose: Information Sharing

Meeting Facilitator: Chris Mokracek

AGENDA ITEM		PERSON(S)	DISCUSSION/ACTION
I.	CALL TO ORDER	Chris Mokracek	
II.	APPROVAL OF MINUTES	Chris Mokracek	Action
III.	DISCUSSION/ACTION ITEMS		
	A. ICEMA Update	Amber Anaya	Discussion
	B. ICEMA Committees (MAC)	Chris Mokracek	Discussion
	C. Mono County Board of Supervisors EMS Ad Hoc Committee Report Update	Chris Mokracek	Discussion
	D. Healthcare Coalition Update	Brianne Chappell - McGovern	Information
	E. Tri Valley Project Update	White Mountain Fire	Information
	F. ICEMA Policy Update 1. 4040 - STEMI Critical Care System Designation 2. 4070R1 - Stroke Critical Care System Designation 3. 8050 - Requests for Ambulance Redirection and Hospital Diversion 4. 8110 - EMS Aircraft Utilization 5 9010 - Continuation of Care	Loreen Gutierrez	Discussion
IV.	EMS SYSTEM MANAGEMENT REPORTS • Base Hospital Report • ePCR Report Reports available at: http://www.sbcounty.gov/ICEMA/mono_reports.aspx		Information
V.	PUBLIC COMMENT PERIOD		
VI.	REQUESTS FOR AGENDA ITEMS		
VII.	NEXT MEETING DATE: April 26, 2022		
VIII.	ADJOURNMENT		

The Mono County Emergency Medical Care Committee (EMCC) meeting facility is accessible to persons with disabilities. If assistive listening devices or other auxiliary aids or services are needed in order to participate in the public meeting, requests should be made through the Inland Counties Emergency Medical Agency at least three (3) business days prior to the EMCC meeting. The telephone number is (909) 388-5823, and the office is located at 1425 South "D" Street, San Bernardino, CA 92408.

MINUTES

MONO COUNTY
EMERGENCY MEDICAL CARE COMMITTEE

October 26, 2021
0900

AGENDA ITEM		DISCUSSION/FOLLOW UP	RESPONSIBLE PERSON(S)
I.	CALL TO ORDER	Meeting called to order at 0904.	
II.	APPROVAL OF MINUTES	The April 26, 2021, minutes were approved. Motion to approve. MSC: Ales Tomaier/Jessica Wagner APPROVED Ayes: Lori Baitx, Jessica Wagner, Ales Tomaier, Chris Mokracek	Ales Tomaier
III.	DISCUSSION/ACTION ITEMS		
	A. ICEMA Update	Tom Lynch has announced his retirement will be March 2022. Amber Anaya has been promoted to EMS Assistant Administrator. ICEMA also continues to hire staff.	Loreen Gutierrez
	B. ICEMA Committees (MAC and SAC)	No update.	Chris Mokracek
	C. Mono County Board of Supervisors EMS Ad Hoc Committee Report Update	Mono County EMS stated a possible request for proposal for billing transports. One staffing vacancy.	Chris Mokracek
	D. EMCC Membership Update	Allison Miller has been added to the committee members.	Chris Mokracek
	E. Healthcare Coalition Update	Coalition will be looking at redundant communications. Inyo County has highest percentage of COVID in the State. Pediatric and Burn Surge Plans will be included in the 2022 drills.	Brianne Chappel-McGovern
	F. Tri Valley Project Update	No update.	Chris Mokracek
	G. 2022 Meeting Dates	Meeting dates for 2022 were included in agenda packet.	Chris Mokracek
IV.	EMS System Management Reports	• Base Hospital Reports • ePCR Reports Reports available at: http://www.sbcounty.gov/ICEMA/sbcounty_reports.aspx	
V.	PUBLIC COMMENT PERIOD		
VI.	REQUEST FOR AGENDA ITEMS	- ICEMA Policy Update	
VII.	NEXT MEETING DATE	January 25, 2022	
VIII.	ADJOURNMENT	Meeting adjourned at 0948.	

Attendees:

NAME	REPRESENTING	EMS AGENCY STAFF	POSITION
☐ Vacant	Mono County Health Officer	☐ Tom Lynch	EMS Administrator
☒ Lori Baitx, RN	Mammoth Hospital EMS Manager	☒ Amber Anaya	EMS Specialist
☒ Jessica Wagner	Mammoth Hospital PLN		
☒ Ales Tomaier	Mono County Fire Chiefs Association Representative		
☒ Chris Mokracek	Mono County EMS Manager		

GUESTS	
Lisa Davis	Sierra Lifeflight
Brianne Chappel-McGovern	Mono/Inyo Healthcare Coalition
Mike Patterson	Sierra Lifeflight
Ralph Serrano	Regional Specialist
Ray McGrale	Mono County EMS

ST ELEVATION MYOCARDIAL INFARCTION CRITICAL CARE SYSTEM DESIGNATION ~~(San Bernardino County Only)~~

I. PURPOSE

To establish standards for the designation of an acute care hospital as a ST Elevation Myocardial Infarction (STEMI) Receiving Center.

II. POLICY

Hospital requirements for Inland Counties Emergency Medical Agency (ICEMA) STEMI Receiving Center designation:

- Must be a full service general acute care hospital approved by ICEMA as a 9-1-1 receiving hospital.
- Must have a licensure as a Cardiac Catheterization Laboratory (Cath Lab).
- Must be accredited by the American College of Cardiology (ACC) as a Chest Pain Center with Primary Percutaneous Coronary Intervention (PCI).
- Must have a Cardiovascular surgical services permit.
- Must be in compliance with all requirements listed in the California Code of Regulations, Title 22, Division 9, Chapter 7.1, STEMI Critical Care System Regulations.

III. STAFFING REQUIREMENTS

The hospital will have the following positions filled prior to becoming a STEMI Receiving Center:

- Medical Directors

  The hospital shall designate two (2) physicians as co-directors who are responsible for the medical oversight and ongoing performance of the STEMI Receiving Center program. One (1) physician shall be a board certified interventional cardiologist with active Percutaneous Coronary Intervention (PCI) privileges. The co-director shall be a board certified emergency medicine physician with active privileges to practice in the emergency department.

- STEMI Program Manager

  The hospital shall designate a qualified STEMI Program Manager. This individual is responsible for monitoring and evaluating the care of STEMI patients, the coordination of performance improvement and patient safety programs for the STEMI critical care system in conjunction with the STEMI medical director. The STEMI Program Manager must be trained or certified in critical care nursing or have at least two (2) years dedicated STEMI patient management experience.

- On-Call Physician Consultants and Staff

  On-call physicians consultants and staff must be promptly available within 30 minutes from notification. A daily roster must include the following on-call physician consultants and staff:

- Interventional Cardiologist with privileges in PCI procedures.
- Cardiovascular Surgeon with privileges in Coronary Artery Bypass Grafting.
- Cath Laboratory Team.
- Intra-aortic balloon pump nurse or technologist.

- Registrar

  To ensure accurate and timely data submission, hospitals must have a dedicated registrar to submit required data elements.

  - Depending on the volume this position may be shared between specialty cares.
  - Failure to submit data as outlined above, may result in probation, suspension, fines or rescission of STEMI Receiving Center Designation.

IV. INTERNAL STEMI RECEIVING CENTER POLICIES

The STEMI Receiving Center must have:

- The capability to provide STEMI patient care 24 hours per day, seven (7) days per week.
- A single call alert/communication system for notification of incoming STEMI patients, available 24 hours per day, seven (7) days per week (i.e., in-house paging system).
- A process for the treatment and triage of simultaneously arriving STEMI patients.
- A fibrinolytic therapy protocol to be used only in unforeseen circumstances when PCI of a STEMI patient is not possible.
- Prompt acceptance of STEMI patients from STEMI Referral Hospitals that do not have PCI capability. To avoid prolonged door to intervention time the STEMI base hospitals are allowed to facilitate redirection of STEMI patients to nearby STEMI receiving centers Physician to physician contact must be made when redirecting patients.
- Acknowledgement that STEMI patients may **only** be diverted during the times of Internal Disaster in accordance to ICEMA Reference #8050 - Requests for Ambulance Redirection and Hospital Diversion (San Bernardino County Only).

V. DATA COLLECTION

All required data elements shall be collected and entered in an ICEMA approved STEMI registry on a regular basis and submitted to ICEMA for review. All hospitals including STEMI receiving centers must participate in Cardiac Arrest Registry to Enhance Survival (CARES).

VI. CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRAM

STEMI Receiving Centers shall develop an on-going CQI program which monitors all aspect of treatment and management of suspected STEMI patients and identify areas needing improvement. The program must, at a minimum, monitor the following parameters:

- Morbidity and mortality related to procedural complications.

- Detail review of cases requiring emergent rescue Coronary Artery Bypass Graph (CABG).
- Tracking of door-to-dilation time and adherence to minimum performance standards set by ICEMA policy, contractual agreement, California Regulations, and the ACC.
- Detailed review of cases requiring redirection of EMS STEMI patients to other STEMI Receiving Centers as a result of over capacity and prolonged delay of door-to-intervention time.
- Active participation in each ICEMA STEMI CQI Committee and STEMI regional peer review process. This will include a review of selected medical records as determined by CQI indicators and presentation of details to peer review committee for adjudication.
- Provide Continuing Education (CE) opportunities twice per year for emergency medical services (EMS) field personnel in areas of 12-lead ECG acquisition and interpretation, as well as assessment and management of STEMI patients.
- Programs in place to promote public education efforts specific to cardiac care.

VII. PERFORMANCE STANDARD

Designated STEMI Receiving Centers must comply with the California Code of Regulations, Title 22, Division 9, Chapter 7.1, STEMI Critical Care System, ICEMA policies, and the ACC performance measures, that exist and may change in the future.

VIII. DESIGNATION

- The STEMI Receiving Center applicant shall be designated after satisfactory review of written documentation, a potential site survey by ICEMA, and completion of a board approved agreement between the STEMI Receiving Center and ICEMA.
- Initial designation as a STEMI Receiving Center shall be in accordance with terms outlined in the agreement.
- Failure to comply with the approved agreement, or ICEMA policy may result in probation, suspension, fines or rescission of STEMI Receiving Center designation.

IX. REFERENCES

Number	Name
8050	Requests for Ambulance Redirection and Hospital Diversion ~~(San Bernardino County Only)~~

STROKE CRITICAL CARE SYSTEM DESIGNATION ~~(San Bernardino County Only)~~

I. PURPOSE

To establish standards for the designation of an acute care hospital as a Stroke Receiving Center.

II. POLICY

Hospital requirements for Inland Counties Emergency Medical Agency (ICEMA) Stroke Receiving Center designation:

- Must be a full service general acute care hospital approved by ICEMA as a 9-1-1 receiving hospital.
- Must have certification as an Acute Ready, Primary, Thrombectomy Capable, or Comprehensive Stroke Center by The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP), or Det Norske Veritas (DNV) and proof of re-certification every two (2) years.
- Must be in compliance with all requirements listed in the California Code of Regulations, Title 22, Division 9, Chapter 7.2, Stroke Critical Care System for the requested level of designation.

III. STAFFING REQUIREMENTS

The hospital will have the following positions filled for all levels of designation prior to becoming a Stroke Receiving Center.

- Medical Directors

  The hospital shall designate two (2) physicians with hospital privileges as co-directors who are responsible for the medical oversight and ongoing performance of the Stroke Receiving Center program. One (1) physician shall be board certified or board eligible by the American Board of Medical Specialties or American Osteopathic Association, neurology or neurosurgery board. The co-director shall be a board certified or board eligible emergency medicine physician.

- Stroke Program Manager

  The hospital shall designate a qualified Stroke Program Manager. This individual is responsible for monitoring and evaluating the care of Stroke patients, the coordination of performance improvement and patient safety programs for the Stroke critical care system in conjunction with the Stroke medical director. The Stroke Program Manager must be trained or certified in critical care nursing or have at least two (2) years dedicated to Stroke patient management experience.

- On-Call Physicians Specialists/Consultants

  On-Call physicians consultants and staff must be promptly available within 30 minutes from notification. A daily roster must include the following on-call physician consultants and staff:

  - Radiologist experienced in neuroradiologic interpretations.

- On-call Neurologist and /or tele-neurology services available twenty-four (24) hours per day; seven (7) days per week.

- Registrar

  To ensure accurate and timely data submission, hospitals must have a dedicated registrar to submit required data elements.

  - Depending on the volume, this position may be shared between specialty cares.

  - Failure to submit data as outline above, may result in probation, suspension, fines or rescission of Stroke Receiving Center Designation.

IV. INTERNAL STROKE RECEIVING CENTER POLICIES

All levels of designation must have internal policies for the following:

- Stroke Team alert response policy upon EMS notification of a "Stroke Alert".
- Rapid assessment of stroke patient by Emergency and Neurology Teams.
- Prioritization of ancillary services including laboratory and pharmacy with notification of "Stroke Alert".
- Arrangement for priority bed availability in Acute Stroke Unit or Intensive Care Unit (ICU) for "Stroke Alert" patients.
- A process for the treatment and triage of simultaneously arriving stroke patients.
- If neurosurgical services are not available in-house, the Stroke Receiving Center must have a rapid transfer agreement in place with a hospital that provides this service. Stroke Receiving Centers must promptly accept rapid transfer requests. Additionally, the Stroke Receiving Center must have a rapid transport agreement in place with an ICEMA approved EMS transport provider for that Exclusive Operation Area (EOA).
- Acknowledgement that stroke patients may **only** be diverted during the times of Internal Disaster in accordance to ICEMA Reference #8050 - Requests for Ambulance Redirection and Hospital Diversion (San Bernardino County Only).
- Emergent thrombolytic and tele-neurology protocol to be used by Neurology, Emergency, Pharmacy and Critical Care Teams.
- An alert/communication system for notification of incoming stroke patients, available 24 hours per day, seven (7) days per week (i.e., in-house paging system).

V. DATA COLLECTION

Designated Stroke Receiving Centers shall report all required data as determined by ICEMA and the Stroke Committee.

VI. CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRAM

Stroke Receiving Centers shall develop an on-going CQI program which monitors all aspects of treatment and management of stroke patients and identify areas needing improvement. The program must, at a minimum, monitor the following:

- Morbidity and mortality related to procedural complications.
- Review of all transfers.
- Tracking door-to-intervention times and adherence to minimum performance standards.
- Active participation in ICEMA Stroke CQI Committee and Stroke regional peer review process. This will include a review of selected medical records as determined by CQI indicators and presentation of details to peer review committee for adjudication.
- Provide Continuing Education (CE) opportunities twice per year for referral hospitals and EMS field personnel in areas of pathophysiology, assessment, triage and management for stroke patients and report annually to ICEMA.
- Lead public stroke education and illness prevention efforts and report annually to ICEMA.

VII. PERFORMANCE STANDARDS

Designated Stroke Receiving Centers must comply with the California Code of Regulations, Title 22, Division 9, Chapter 7.2, Stroke Critical Care System, ICEMA policies, and the Performance Measures set forth by the accrediting agencies identified in Section II, that exist and may change in the future.

VIII. DESIGNATION LEVELS

- **Acute Stroke Ready Hospital**: A hospital able to provide the minimum level of critical care services for stroke patients in the emergency department, and are paired with one or more hospitals with a higher level of stroke services.
- **Primary Stroke Center:** A hospital that treats acute stroke patients, and identifies patients who may benefit from transfer to a higher level of care when clinically warranted.
- **Thrombectomy-Capable Stroke Center:** A primary stroke center with the availability to perform mechanical thrombectomy for the ischemic stroke patient when clinically warranted.
- **Comprehensive Stroke Center:** A hospital with specific abilities to receive diagnose and treat all stroke cases and provide the highest level of care for stroke patients.

<u>Acute Stroke Ready Hospitals</u>

To be considered for Acute Stroke Ready hospital designation, multiple variables will be taken into consideration and will be determined by the ICEMA Medical Director:

- What are the current needs of the community?
- How will this impact the overall care in the system?
- What is the location of the hospital, is there a prolonged distance to a primary thrombectomy or comprehensive stroke center?

The hospital must meet the following minimum criteria:

- Written transfer agreements.

- Written policies and procedures for emergent stroke services to include written protocols and standardized orders.
- A data-driven, continuous quality improvement process.
- Neuro imaging services (CT or MRI) with interpretation of imaging available 24 hours a day, seven (7) days a week, and 365 days a year.
- Laboratory services to include blood testing, electrocardiography, and x-ray services 24 hours a day, seven (7) days a week and 365 days a year.
- Provide IV thrombolytic treatment.
- A clinical Stroke Team available to see patient (in person or by tele-health) within 20 minutes of arrival to ED.

Primary Stroke Centers

- Stroke diagnosis and treatment capacity 24 hours a day, seven (7) days a week.
- A clinical Stroke Team available to see in person or via telehealth, a patient identified as a potential stroke patient within 15 minutes following patient's arrival.
- Neuro imaging services capability that is available 24 hours a day, seven (7) days a week.
- Two (2) CT scanners and one (1) MRI scanner.
- Neuro imaging initiated within 25 minutes following arrival to ED.
- Laboratory services that are available 24 hours a day, seven (7) days a week.

Thrombectomy Capable Centers (in addition to Primary Stroke Center Requirements)

- The ability to perform mechanical thrombectomy for the treatment of ischemic stroke 24 hours a day, seven (7) days a week.
- Neuro interventionalist.
- Neuro radiologist.
- The ability to perform advanced imaging 24 hours a day, seven (7) days a week.

Comprehensive Centers (in addition to Primary and Thrombectomy Center Requirements)

- Neuro-endovascular diagnostic and therapeutic procedures available 24 hours a day, seven (7) days a week.
- Advanced imaging available 24 hours a day, seven (7) days a week.
- A stroke patient research program.

- A neurosurgical team capable of assessing and treating complex stroke and stroke-like syndromes.

- A written call schedule for attending neurointerventionalist, neurologist, or neurosurgeon providing availability 24 hours a day, seven (7) days a week.

IX. DESIGNATION

ICEMA designation as an Acute Stroke Ready Hospital, Primary, Thrombectomy Capable, or Comprehensive Stroke Center will be determined based on need and volume in the community. Designation will not be determined by current accreditation only; however, Stroke Receiving Centers must be accredited at least at an equivalent designation level being requested.

- The Stroke Receiving Center applicant shall be designated by ICEMA after satisfactory review of written documentation, a potential site survey and completion of an agreement between the hospital and ICEMA.

- Documentation of current certification as an Acute Ready Hospital, Primary Stroke Center Thrombectomy Capable Stroke Center or Comprehensive Stroke Center by TJC, HFAP or DNV.

- Initial designation as a Primary, Thrombectomy, Capable or Comprehensive Stoke Center shall be in accordance with terms outlined in the agreement.

- Failure to comply with the approved agreement, or ICEMA policy may result in probation, suspension, fines or rescission of the Stroke Receiving Center designation.

X. REFERENCE

Number	**Name**
8050	Requests for Ambulance Redirection and Hospital Diversion ~~(San Bernardino County Only)~~

REQUESTS FOR AMBULANCE REDIRECTION AND HOSPITAL DIVERSION ~~(San Bernardino County Only)~~

I. PURPOSE

To define policy and procedures for hospitals to request temporary redirection of advanced life support (ALS) ambulances.

II. POLICY

- Ambulance redirection based on hospital capacity, census or staffing is not permitted in the ICEMA region and will only be permitted as outlined in this policy.
- This policy applies to the 9-1-1 emergency system as a temporary measure and is not intended for utilization to determine destination for interfacility transports, including higher level of care transports.
- If a hospital meets internal disaster criteria, Trauma Center Diversion or any other specialty care centers with unique circumstances, immediate telephone notification must be made to the ICEMA Duty Officer by an administrative staff member who has the authority to determine that criteria has been met for redirection or diversion.
- Hospitals must notify EMS dispatch centers immediately via ReddiNet or available communication modalities.
- Hospitals must maintain a hospital redirection policy that conforms with this policy. The hospital policy shall include plans to educate all appropriate staff on proper utilization of redirection.
- Receiving hospitals cannot redirect an incoming ambulance and diversion/ redirection is only permitted as outlined in this policy.
- Within 72 hours of an incident, the hospital must provide ICEMA with a written after action report indicating the reasons for internal disaster, plans activated, adverse patient consequences and the corrective actions taken. The report must be signed by the CEO or designated responsible individual.
- ICEMA may perform unannounced site visits to hospitals on temporary redirection status to ensure compliance with the request for ambulance redirection.
- ICEMA may randomly audit base hospital records to ensure redirected ambulance patients are transported to the appropriate destination.
- ICEMA staff may contact the hospital to determine the reasons for ambulance redirection, under this policy.
- ICEMA may remove any hospital from redirection status using ReddiNet if it is determined that the request is not consistent with this policy.

III. PROCEDURE

A request for redirection of ALS ambulances may be made for the following approved categories:

- CT Redirection (for Non-Specialty Care Centers).

- When Non-Specialty Care Centers experience CT scanner failure, the hospital can go on ambulance redirection using the ReddiNet system for EMS patients who may require CT imaging.

- Trauma Center Diversion (for use by designated Trauma Centers only)

  - The on duty trauma surgeon must be involved in the decisions regarding any request for trauma diversion.

  - The trauma team and trauma surgeon (both first and second call) and are fully committed to the care of trauma patients in the operating room and are NOT immediately available for any additional incoming patients meeting approved trauma triage criteria.

  - All operating rooms are occupied with critically injured patients that meet trauma triage criteria.

  - All CT Scanners are inoperable due to scanner failure at a designated Trauma Center.

  - Internal disaster.

  NOTE: Diversion is canceled when all designated Trauma Centers are on Trauma Center Diversion.

- **Internal Disaster Diversion**

  - Requests for Internal Disaster Diversion shall apply only to physical plant breakdown affecting the Emergency Department or significant patient services.

    NOTE: Examples of Internal Disaster Diversion include bomb threats, explosions, power outage and a nonfunctional generator, fire, earthquake damage, hazardous materials exposure, incidents involving the safety and/or security of a facility.

  - Internal Disaster Diversion shall not be used for hospital capacity or staffing issues.

  - Internal Disaster Diversion will stop all 9-1-1 transports into the facility.

  - The hospital CEO or AOD shall be notified and notification documented in ReddiNet.

  - If the hospital is a designated base hospital, the hospital should consider immediate transfer of responsibility for on-line direction to another base hospital. Notification must be made to the EMS provider.

  - The affected hospital shall enter Internal Disaster Diversion status into ReddiNet immediately.

IV. EXCEPTIONS TO CT AND TRAUMA DIVERSION ONLY

- Basic life support (BLS) ambulances shall not be diverted.
- Ambulances on hospital property shall not be diverted.
- With the exception of Internal Disaster Diversion involving significant plant failure, patients exhibiting unmanageable problems (i.e., difficult to manage airway, uncontrolled hemorrhage, cardiopulmonary arrest) in the field, shall be transported to the closest emergency department.

EMS AIRCRAFT UTILIZATION ~~(SAN BERNARDINO COUNTY ONLY)~~

I. PURPOSE

To establish 9-1-1 EMS aircraft utilization and medical transportation criteria ~~for San Bernardino County.~~

II. POLICY

- All EMS aircraft requests from the field in ~~San Bernardino County~~ will be coordinated by ICEMA's designated EMS Aircraft Dispatch Center (ADC).
- EMS aircraft may be requested by EMS providers when a patient's condition is of a time sensitive nature and where extended transport times may result in a poor patient outcome. EMS providers must contact ADC to request aircraft.
- At the time of dispatch, the ADC shall utilize the closest available EMS aircraft proximate to the scene of the incident using Automatic Flight Following (AFF) as the determining factor.
- If two (2) or more EMS aircraft are co-located and/or within close distance (less than a mile), the ADC shall institute a rotation system of all EMS aircraft.
- The ADC shall determine the closest EMS aircraft and inform the EMS provider which EMS aircraft will be utilized, this will include an accurate Estimated Time of Arrival (ETA). ETA will be determined by time of dispatch until EMS aircraft is over scene, and includes the total amount of time for crew preparation, flight planning, aircraft pre-flight, take-off, aircraft reconfiguration, and flight time to over scene.
- The destination decision will be made in accordance with established ICEMA policies and protocols, and may be changed by the flight crew in conjunction with the pilot in command based on patient or flight safety concerns including weather conditions.
- All air transports will undergo a Quality Improvement (QI) review following dispatch and transport.

III. EMS AIRCRAFT TRANSPORT INDICATIONS

- The determination to utilize a 9-1-1 dispatched EMS aircraft must be made with the use of a thorough and appropriate physical assessment by qualified EMS field personnel on scene, and must be made with careful consideration of the following elements:
  - The injury/illness is of a time-sensitive, critical nature requiring Specialty Care Center services.
  - The benefit of EMS aircraft transport is clearly greater than ground transportation. An acceptable standard is a 15 minute time differential in favor of air transportation.
  - The needs of the patient and scene management supersede all other considerations.

Commented [GL1]: Do we need a bullet here that says all ems aircraft from the field in Inyo Mono county will be coordinated by…

Commented [GL2]: Please Review the highlighted bullets to determine if this guidance is appropriate for inyo mono county or do we need a separate bullet on determination of which craft to use in inyo mono?

IV. EMS AIRCRAFT CANCELLATION INDICATIONS

- A dispatched EMS aircraft that responds to a scene, prior to ground transport contact with the patient, will be cancelled if the Incident Commander in consultation with the most medically-qualified first responder determines it is not needed.
  - If ground transport is the first to arrive on scene, and it is determined that air transport is not needed, ground transport may cancel a dispatched EMS aircraft.

V. SPECIAL CONSIDERATIONS

- Transport stable snakebite patients from the field by ground to the closest hospital.
- Mechanism of injury alone is not criteria for transport by air.
- Patients with unmanageable airways shall be transported to the closest hospital for airway stabilization and, on its own, does not constitute an indication for EMS aircraft utilization.
- If a request to transport is denied by the initial dispatched aircraft, the second aircraft shall be notified of the denial, and the reason for the denial.
- If the patient is combative due to suspected traumatic injury, communication with flight personnel is essential.
- Patients with exposure to hazardous materials must be decontaminated on scene before utilizing EMS aircraft.
- Medical transport by EMS aircraft may not be suitable in the following situations:
  - Cardiac arrest when the patient is not responding to prehospital therapy.
  - Patients who are violent or have behavioral emergencies.

Commented [GL3]: Do we need a bullet point here that indicates that if the airship arrives first in inyo mono county and it is determined that the patient is stable for ground transport the crew will await the arrival of ground transport and transfer care

Commented [GL4]: Consider if inyo or mono will require further guidance to ground crews appropriate utilization.

CONTINUATION OF CARE ~~(San Bernardino County Only)~~

I. PURPOSE

To develop a system that ensures the rapid transport of patients upon arrival at a receiving hospital that requires urgent transfer to a higher level of care.

This policy shall only be used for:

- Rapid transport of STEMI, stroke and trauma patients from referral hospitals to the appropriate Specialty Care Center.
- Specialty Care Center to Specialty Care Center when higher level of care is required.
- EMS providers that are transporting unstable patients to a STEMI, Stroke or Trauma Center but need to stop at the closest receiving hospital for airway stabilization before continuing to a Specialty Care Center.

It is not to be used for interfacility transfer of patients.

II. INCLUSION CRITERIA

- Patients meeting ICEMA Reference #9040 - Trauma Triage Criteria, who arrive at a non-trauma hospital.
- Upon recognition of any critically injured patient that require urgent transfer from one trauma receiving center to a higher level of care trauma receiving center.
- Patients requiring subspecialty services that are not a requirement for trauma center designation (i.e., reimplantation, hand surgery, burn, etc.) are not covered by this policy and must be managed through the normal interfacility transfer process compliant with all applicable regulations.
- Any patient with a positive STEMI requiring EMS transport to a STEMI Receiving Center (refer to ICEMA Reference #4040 - ST Elevation Myocardial Infarction Critical Care System Designation).
- Any patient with a positive mLAPSS requiring EMS transport to a Stroke Receiving Center, (refer to ICEMA Reference #4070 - Stroke Critical Care System Designation).
- Any stroke patient identified with a Large Vessel Occlusion (LVO) requiring rapid EMS transport to higher level of care for Endovascular Stroke Treatment.

III. INITIAL TREATMENT GOALS AT REFERRAL HOSPITAL

- Initiate resuscitative measures within the capabilities of the facility.
- Ensure patient stabilization is adequate for subsequent transport.

- Do not delay transport by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.

  ➢ GUIDELINES FOR USE OF CONTINUATION OF CARE POLICY

  Less than 30 minutes at referral hospital (door-in/door-out).
  Less than 30 minutes to complete ALS continuation of care transport.
  Less than 30 minutes door-to-intervention at Specialty Care Center.
  Less than 60 minutes for rapid identification of a LVO at a primary stroke center.

- Referral hospital shall contact the appropriate Specialty Care Center ED physician directly without calling for an inpatient bed assignment.

- Specialty Care Centers should route requests directly to the ED physician and bypass their transfer center triage process.

- EMS providers shall make contact with Specialty Care Centers to notify of the estimated time of arrival.

- Specialty Care Centers shall accept all referred STEMI, stroke and trauma patients meeting criteria in this policy unless they are on Internal Disaster as defined in ICEMA Reference #8050 - Requests for Ambulance Redirection and Hospital Diversion (San Bernardino County Only).

- The ED physician is the accepting physician at the Specialty Care Center and will activate the STEMI, Stroke or Trauma Team according to internal policies or protocols.

- The referral hospital ED physician will determine the appropriate mode of transportation for the patient.

- Simultaneously call 9-1-1 and utilize the following script to dispatch:

  "This is a continuation of care from ____ hospital to ____ STEMI, Stroke or Trauma Center"

  Fire departments will not be dispatched for 9-1-1 continuation of care calls, the dispatchers will only dispatch transporting ALS ambulances.

- Referral hospital ED physician will provide a verbal report to the ED physician at the Specialty Care Center.

- Referral hospital will send all medical records, test results, radiologic evaluations to the Specialty Care Center. DO NOT DELAY TRANSPORT - these documents may be electronically submitted or faxed to the Specialty Care Center.

IV. SPECIAL CONSIDERATIONS FOR REFERRAL HOSPITALS

- If a patient arrives to a referral hospital via EMS field personnel, a physician may request that the transporting team remain and immediately transport the patient once minimal stabilization is completed.

- If a suspected stroke patient presenting to a non-designated stroke center is outside of the tPA administration window (greater than 4.5 hours from "last seen normal"), consider contacting nearest thrombectomy capable or comprehensive stroke center to determine the best destination. Then follow the 9-1-1 script.

- Unless medically necessary, avoid using medications or IV drips that are outside of the EMT-P scope of practice to avoid delays in transferring of patients.

- The referral hospital may consider sending one of its nurses or physician with the transporting ALS ambulance if deemed necessary due to the patient's condition or scope of practice limitations per ICEMA Reference #8010 - Interfacility Transfer Guidelines.

- Do not call 9-1-1 dispatch if the patient requires Critical Care Transport (CCT) or Specialty Care Transport (SCT). The referral hospital must make direct contact with the EMS Providers Dispatch Center.

- Diversion is not permitted except for Internal Disaster. However, to avoid prolonged door-to-intervention times when STEMI, Stroke and Trauma Centers are over capacity, base hospitals may facilitate alternative STEMI, Stroke or Trauma Centers as the best destination for the patient. Base hospitals must ensure physician to physician contact when facilitating the use of an alternate destination.

V. REFERENCES

Number	Name
4040	ST Elevation Myocardial Infarction Critical Care System Designation ~~(San Bernardino County Only)~~
4070	Stroke Critical Care System Designation ~~(San Bernardino County Only)~~
8010	Interfacility Transfer Guidelines
8050	Requests for Ambulance Redirection and Hospital Diversion ~~(San Bernardino County Only)~~
9040	Trauma Triage Criteria