	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	4521.01
	PROGRAM DOCUMENT: **Triage to Alternate Destination Training Curriculum**	Initial Date:	TBD
		Last Approval Date:	TBD
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EMS Medical Director

EMS Administrator

Triage to Alternate Destination Training Curriculum

Length_	Topic
30 Min	**Introduction and Reason for Training** • State and Sacramento County EMS Agency Requirements • Overview of training
45 min	**Understanding Mental Illness** • Mental Illness Defined • Stigma and Its Effect on Attitudes and Behaviors
60 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
60 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
60 min	**Treatment, Triage, and Transport Parameters** • Review of SCEMSA PD# 2004 – Patient Privacy • Review of SCEMSA PD# 2101 – Patient Initiated Refusal of EMS Assessment, Treatment, and Transport • Review of SCEMSA PD# 2522 – Electronic Health Record and Data Policy • Review of SCEMSA PD# 5050 – Destination • Review of SCEMSA PD# 5203 – Transport Guidelines-Sobering Center Facility • Review of SCEMSA PD# 5205 – Transport Guidelines-Mental Health Facility • Review of SCEMSA PD# 8004 – Suspected Narcotic Overdose • Review of SCEMSA PD# 8062 – Behavioral Crisis-Restraint • Review of SCEMSA PD# 8069 – Buprenorphine • EMS Documentation • EMTALA and EMS, what EMS providers need to know.

Cross References: PD# 2004 – Patient Privacy
PD# 2101 – Patient Initiated Refusal of EMS Assessment, Treatment, and Transport
PD# 2522 – Electronic Health Record and Data Policy
PD# 5050 – Destination
PD# 5203 – Transport Guidelines-Sobering Center
PD# 5205 – Transport Guidelines-Mental Health Facility
PD# 8004 – Suspected Narcotic Overdose
PD# 8062 – Behavioral Crisis-Restraint
PD# 8069 – Buprenorphine

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	5200.01
	PROGRAM DOCUMENT: **Triage to Alternate Destination Program Requirements**	Initial Date:	TBD
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		Review:	TBD

EMS Medical Director

EMS Administrator

Purpose:

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

B. 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 EMS system; provide high-quality patient care; and empower health systems to provide care more effectively and efficiently.

Authority:

A. California Health and Safety Code, Division 2.5, Sections 1797.220, 1798,

B. Title 22, California Code of Regulations, Section 100170 (a) (5).

Definitions and Scope:

A. Alternate Destination Facility is defined as a treatment location that is an:
   1. Authorized mental health facility (Health and Safety Code Section 1812).
   2. Authorized sobering center (Health and Safety Code Section 1813).
   3. Authorized local Veterans Administration Emergency Department (ED) (Health and Safety Code Section 1819 (a) (3)).

B. A TAD program also includes providing transport services for patients who identify as veterans and desire transport to a local Veterans Administration ED.

C. Advanced Life Support (ALS) paramedics shall not transport patients to destinations not approved as Receiving Facilities, Standby Facilities, or Alternate Destinations.

D. TAD Provider:
   1. ALS provider authorized by Sacramento County Emergency Medical Agency (SCEMSA) to provide ALS TAD assessments as part of an approved TAD program specialty.

E. TAD Program:
   1. A program developed by SCEMSA and approved by the California Emergency Medical Systems Authority (EMSA) to provide triage paramedic assessments.

F. TAD Paramedic:
   1. A Paramedic who has completed the curriculum for TAD services and receives SCEMSA TAD accreditation.

Medical Direction:

A. A TAD paramedic shall utilize the approved SCEMSA Medical Director patient assessment protocols described in SCEMSA policies. This includes utilizing general TAD scope and other approved scopes while transporting to alternate destinations.

Documentation and Continuous Quality Improvement:

A. TAD paramedics shall complete and submit electronic patient records under the California Code of Regulations Title 22 Section 100171.
B. TAD paramedic shall document destination facilities with standardized facility codes per the California Emergency Medical Services Information System (CEMSIS)
C. TAD programs shall have a written Continuous Quality Improvement (CQI) plan approved by SCEMSA. The CQI plan shall complement the EMS Provider's existing CQI plan. CQI plans shall include provisions for continuing education, including types of activities, frequency, and required hours.
D. TAD programs shall exchange electronic patient health information between TAD providers and facilities.
E. SCEMSA does not store electronic health care records and does not have an established policy for the collection, utilization, storage, and secure transmission of interoperable electronic health records. This is managed by the individual providers.
F. SCEMSA shall submit quarterly summaries of specific data to EMSA due on the thirtieth (30th) of January, April, July, and October to EMSA.
G. SCEMSA shall submit an annual summary of specific TAD facility data to EMSA due January 30.

Local Implementation:

A. TAD programs shall be reviewed, submitted, and implemented within SCEMSA's EMS Plan under California Health and Safety Code 1797.250.
B. SCEMSA shall provide medical control and oversight for TAD programs.
C. SCEMSA with TAD Providers shall facilitate agreements to ensure the delivery of TAD services.
D. SCEMSA shall review TAD training programs, providers, and facilities annually to ensure compliance with all requirements.
E. SCEMSA will continue to use and coordinate with any emergency medical transport providers operating within the jurisdiction of SCEMSA and shall not in any manner eliminate or reduce the services of the emergency medical transport providers.
F. SCEMSA shall notify EMSA of any complaints or unusual occurrences for approved TAD programs within seventy-two (72) hours with supporting documentation.
G. SCEMSA shall approve and establish the effective date of the program approval in writing upon the program's satisfactory meeting and documenting compliance with all program requirements.
H. SCEMSA shall notify the requesting training program in writing of program approvals or deficiencies with the application within ninety (90) days of receiving the training program's request for approval.
I. Training program approval shall be valid for four (4) years ending on the last day of the month it was issued and may be renewed every four (4) years.
J. SCEMSA shall notify EMSA in writing of the training program approval, including the program director's and medical director's names and contact information and the program's effective date.
K. The training program shall provide any documents and materials annually to support SCEMSA's EMS Plan submission to maintain the continuity of TAD programs.

TAD Provider/Facility Oversight:

A. SCEMSA will approve, annually review and facilitate any necessary agreements with one or more TAD providers for the delivery of TAD destination services within its jurisdiction.

B. TAD Provider or TAD Facility's failure to comply with the provisions of statute, regulation, and/or additional SCEMSA requirements may result in denial, probation, suspension, or revocation of approval by SCEMSA.
C. The noncompliance process is listed in the California Code of Regulations (CCR) §100184.

Training Program Approval

A. TAD Training Program Approval:
   1. SCEMSA-approved TAD Training Programs must keep the training fee payment current to maintain TAD Training Program approval.
   2. The applicant's legal place of business and primary training site shall be within Sacramento County's geographical jurisdiction.
   3. SCEMSA shall approve or deny a TAD Training Program approval request within thirty (30) working days of receipt. If the provider submits an incomplete request, missing information will be requested.
   4. SCEMSA shall write to the requesting TAD Training Program to approve or disapprove the program after receiving all required documentation. This time period shall not exceed three (3) months.
   5. SCEMSA shall establish the effective date of program approval in writing upon satisfactory documentation of compliance with all program requirements.
   6. TAD training program approval shall be for four (4) years following the effective date of approval and may be renewed every four (4) years, subject to the program approval procedure specified in this policy.

B. Procedure for TAD Training Program Approval:
   1. SCEMSA shall receive and review the following before program approval:
   2. For TAD training programs, a statement verifying that the course content meets the requirements contained in the United States (U.S.) Department of Transportation (DOT) National Education Standards (DOT HS 811 077A January 2009).
   3. An outline of course objectives.
   4. Performance objectives for each skill.
   5. The name and qualifications of the training program course director, program medical director, and principal instructors.
   6. Provisions for supervised hospital clinical training include student evaluation criteria and standardized forms for evaluating TAD students and, if applicable, monitoring of preceptors by the training program.
   7. The location at which the courses are to be offered and their proposed dates.
   8. If applicable, written agreements between the TAD training program, a hospital(s), and other clinical settings (s) for student placement for clinical education and training.
   9. If applicable, Written contracts or agreements between the TAD training program and provider agencies for student placement for field internship training.
   10. Samples of written and skills examinations administered by the training program for periodic testing.
   11. A final written examination administered by the training program.
   12. Evidence that the training program provides adequate facilities, equipment, examination security, and student record keeping.

C. The TAD Training Program shall be responsible for submitting the SCEMSA TAD Training Application for renewal at least sixty (60) days before expiration to maintain continuous approval.
D. TAD Training Program approval is non-transferable.
E. SCEMSA shall submit to the California EMS Authority (EMSA) an outline of program objectives and eligibility for each proposed training program for approval to allow the EMSA to make the determination required by § 1797.173 of the California Health and

Safety Code. Upon request by the EMSA, any or all materials submitted by the training program shall be submitted to the EMSA.

Training Program Requirements

A. Program Medical Director:

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 are not limited to, the following:
2. Review and approve educational content, standards, and curriculum, including training objectives, local protocols, and clinical and field instruction policies, to certify its ongoing appropriateness and medical accuracy.
3. Review and approve the quality of medical instruction, supervision, and evaluation of the students in all areas of the program.
4. Review and approve the quality of medical instruction, supervision, and student evaluation in all program areas.

B. Approval of Instructor(s)

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.

C. Program Director

1. Each training program shall have a program director who shall meet the following requirements:
   a. Has knowledge or experience in local EMS protocol and policy.
   b. Is a board-certified or board-eligible California licensed emergency medicine physician, registered nurse, paramedic, or individual with a baccalaureate degree in a related health field or education.
   c. Has education and experience in methods, materials, and evaluation of instruction, including:
      - A minimum of one (1) year experience in an administrative or management-level position, and
      - A minimum of three (3) years of academic or clinical experience in prehospital care education.
2. Duties of the program director shall include, but are not limited to, the following:
   a. Administration, organization, and supervision of the educational program.
   b. In coordination with the program medical director, approve the instructor(s), teaching assistants, field and hospital clinical preceptors, clinical and internship assignments, and coordinate curriculum development, including instructional objectives and all evaluation methods.
   c. Ensure training program compliance with this chapter and other related laws.
   d. Ensure that all course completion records include a signature verification.
   e. Ensure the preceptor(s) are training according to the subject matter being taught.

D. Instructors

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:
   a. Be a physician, registered nurse, physician assistant, nurse practitioner, or paramedic currently certified or licensed in California.
   b. 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 baccalaureate degree, and

c. Be knowledgeable in the course content of the U.S. DOT National Emergency Medical Services Education Standards, and
d. 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 the individual, and
e. Be qualified by education and experience, with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and instruction evaluation.
f. An instructor may also be the program medical director or program director.

Minimum Training and Curriculum Requirements

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

Training Program Oversight

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

Cross References: PD# 4302 – Continuing Education Provider
PD# 5202 – Sobering Center Designation Policy
PD# 5204 – Mental Health Facility Designation Policy

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	5201.01
	PROGRAM DOCUMENT: **Triage to Alternated Destination Paramedic Eligibility Requirements**	Initial Date:	TBD
		Last Approved Date:	TBD
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		Review:	TBD

EMS Medical Director

EMS Administrator

Purpose:

A. To establish standards for Triage to Alternate Destination (TAD) paramedic eligibility requirements

Authority:

A. Title 22, California Code of Regulations, Sections 100135 through 100441.1 and 100192.

Initial Accreditation Requirements:

A. The applicant shall submit to the SCEMSA an application with the following eligibility criteria for review:
   1. Proof of an active, unrestricted California-issued paramedic license.
   2. Proof of an active, unrestricted Sacramento County-issued paramedic accreditation.
   3. Social Security Number or Individual Tax Identification Number.
   4. SCEMSA-approved TAD paramedicine course completion certificate.

B. TAD paramedic accreditation will be registered in the Central Registry public look-up database within five (5) business days of accreditation for EMS personnel in TAD and Community Paramedicine (CP) programs.

C. An initial TAD paramedic accreditation is deemed effective when recorded in the Central Registry public look-up database.

D. SCEMSA has thirty (30) days to respond to this application with an approval or denial.

E. Certification expires on the last day of the month, two (2) years from the effective date.

Renewal Eligibility:

A. To be eligible for renewal, the applicant shall submit to the SCEMSA TAD program an application with the following eligibility criteria for review:
   1. Proof of a current, unrestricted California-issued paramedic license, **AND**
   2. Proof of an active, unrestricted Sacramento County-issued paramedic accreditation **AND,**
   3. Proof of completion of four (4) hours approved TAD paramedicine-related continuing education (CE).

B. SCEMSA has thirty (30) days to respond to this application with an approval or denial.

Reinstatement Eligibility – Expiration Date within the last twelve (12) months:

A. To be eligible for reinstatement of a TAD paramedic accreditation that has expired for a period of twelve (12) months or less, the applicant shall submit to the SCEMSA TAD program an application with the following eligibility criteria for review:
   1. Proof of a current, unrestricted California-issued paramedic license, **AND**
   2. Proof of an active, unrestricted Sacramento County-issued paramedic accreditation **AND** Proof of completion of five (5) hours of approved local TAD-related CE.

Reinstatement Eligibility – Expiration Date Greater than twelve (12) months:

A. To be eligible for reinstatement of a SCEMSA TAD paramedic accreditation that has expired for more than twelve (12) months, the applicant shall submit to the SCEMSA TAD program the following eligibility criteria for review:
   1. Proof of a current, unrestricted California-issued paramedic license **AND**,
   2. Proof of an active, unrestricted Sacramento County-issued paramedic accreditation **AND,**
   3. Proof of successful completion of a SCEMSA-approved TAD training course within the last year from the submission date of the reinstatement application.

NOTE: Triage Paramedics are subject to the discipline proceedings and standards described in Title 22 California Code of Regulations Sections 100135 through 100144.1.

Cross References: PD# 4050 – Certification-Accreditation Review Process
PD# 4400 – Paramedic Accreditation to Practice

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	5202.01
	PROGRAM DOCUMENT: **Sobering Center Designation**	Initial Date:	TBD
		Last Approved Date:	TBD
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		Review:	TBD

EMS Medical Director

EMS Administrator

Purpose:

A. To establish minimum standards for the designation of Sobering Centers (SC)

Authority:

A. California Health and Safety Code, Division 2.5, Sections 1797.220, 1798, 1843,1206 (b) 1317 (b).
B. Title 22, California Code of Regulations, Section 100170 (a) (5).

Definitions:

A. **Under the Influence of a mental status-altering substance:** A patient who appears to be impaired from a range of possible substances (alcohol, THC, stimulants, CNS depressants, etc.), demonstrated by diminished physical and mental control and without other acute medical or traumatic cause. Being "under the influence" is typically associated with one or more of the following:
   1. Speech disturbance – incoherent, rambling, slurring.
   2. Decline in cognitive function – confusion, inappropriate behavior, impaired decision-making capacity.
   3. Imbalance – unsteady on feet, staggering, swaying.
   4. Poor coordination – impaired motor function, inability to walk a straight line, fumbling for objects.
   5. Agitation (for stimulants) or CNS depression (alcohol, CNS depressants).
B. **Emergency Medical Condition:** A condition or situation in which an individual immediately needs medical attention. Abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure—except isolated asymptomatic hypertension—and oxygen saturation) are also indications of an emergency medical condition.
C. **SC EMS Liaison Officer:** A qualified administrative personnel appointed by the SC to coordinate all activities related to receiving patients triaged by paramedics whose primary provider impression is being under the influence of a mental status-altering substance.
D. **Authorized Sobering Center (SC):** A non-correctional facility that is staffed at all times with at least one registered nurse (RN) that provides a safe, supportive environment for intoxicated individuals to become sober, that is identified as an alternated destination in a plan developed pursuant to Section 1843 of the Health and Safety Code, and that meets any of the following requirements in this policy.

Policy:

General Requirements:

A Designated SC Shall:

A. Be a facility that is a federally qualified health center, including a clinic described in subsection (b) of Section 1206 of the Health and Safety Code.
B. Be certified by the State Department of Health Care Services, Substance Use Disorder Compliance Division, to provide outpatient, nonresidential detoxification services.
C. Accommodate private, commercially insured, Medi-Cal, Medicare, and uninsured patients.
D. The SC is required to notify SCEMSA of changes in the status of the facility within twenty-four (24) hours.

A Designated SC May:

A. Be designated by a city or county to provide a safe, supportive environment for intoxicated individuals to become sober.
B. Operate twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year.
C. Provide and maintain adequate parking for ambulances to ensure access to the SC.
D. Appoint an SC EMS Liaison Officer to act as a liaison between SCEMSA and the designated SC.
E. Accept all patients triaged by paramedics regardless of the patient's ability to pay.
F. Maintain General Liability Insurance as follows:
    1. General aggregate: Two (2) Million Dollars.
    2. Products/completed operations aggregate: One (1) Million Dollars.
    3. Personal and advertising injury: One (1) Million Dollars
    4. Each occurrence: One (1) Million Dollars.
    5. Sexual misconduct: Two (2) Million Dollars per claim and Two (2) Million Dollars aggregate.
    6. Worker's Compensation and Employers Liability: One (1) Million Dollars per accident.

SC Leadership and Staffing Requirements:

A. SC EMS Liaison Officer Responsibilities:
    1. Implement and ensure compliance with the SC Standards.
    2. Maintain direct involvement in developing, implementing, and reviewing SC policies and procedures related to receiving patients triaged by paramedics to the SC.
    3. Serve as the key personnel responsible for addressing variances in care and sentinel events related to patients triaged by paramedics to the SC.
    4. Liaison with SCEMSA, designated Triage to Alternate Destination (TAD) EMS providers and law enforcement agencies.
    5. Serve as the contact person for SCEMSA and be available upon request to respond to county business.
B. A registered nurse licensed in the State of California shall be on-site at all times.
C. Staffing may be augmented by licensed nurse practitioners, licensed vocational nurses, social workers, and other mental health professionals.
D. All medical and nursing staff shall have current Cardiopulmonary Resuscitation (CPR) certification through the American Heart Association or American Red Cross.

Develop, maintain, and implement policies and procedures that address the following:

A. Receipt, immediate evaluation, short-term management, and monitoring of patients who meet SC triage inclusion criteria.
B. Timely transfer of patients who require a higher level of care to an acute care hospital utilizing a non-911 ambulance provider is possible.
C. Immediate transfer of patients with an emergency medical condition to the most accessible Advanced Life Support (ALS) receiving facility/emergency department.
D. Record keeping of EMS Report Forms.
E. Alternate destination facilities shall submit to SCEMSA, at minimum, a quarterly summary of patient outcomes with a California Emergency Medical Services Authority (EMSA) provided template, including but not limited to the following data:
    1. Total number of patients evaluated who were transported by EMS.
    2. The total number of patients admitted to another care facility.
    3. The total number of patients transferred to an acute care emergency department.
    4. The total number of patients admitted to another care facility.
    5. The total number of patients who experienced an adverse event resulting from services provided under this program.
F. Procedure for notifying SCEMSA of patient transfers from SC requiring 911 transport for an emergency medical condition.

Equipment and Supplies:

A. A dedicated telephone line to facilitate direct communication with EMS personnel.
B. EMResource capability to communicate the facility's real-time capacity status.
C. A public Access Device/Layperson Automated External Defibrillator on site with staff trained on its proper use.
D. An up-to-date community referral list of services and facilities available to patients.

Procedure for Approval to be a designated alternate destination SC facility for a TAD program:

A. Submit a written request to the Director of the TAD program to include:
    1. The rationale for the request to be a designated SC.
    2. A document verifying that a city or county has designated the facility to provide a safe, supportive environment for intoxicated individuals to become sober.
    3. The proposed date the SC will open to accept patients triaged by paramedics to the SC.
    4. Copies of the policies and procedures outlined in this policy.
    5. Proposed Staffing.
    6. Hours of operation.
B. Site Visit:
    1. Once all General Requirements are met, the TAD program leadership will coordinate a site visit to verify compliance with all the requirements.
    2. Administrative and field personnel from SCEMSA provider agencies will be invited to exchange contact information and familiarize themselves with the facility's physical layout.

C. Other Requirements:

1. The agreement with the SC requires the facility to operate in accordance with Section 1317 of the Health and Safety Code, which states In no event shall the provision of emergency services and care be based upon, or affected by, the person's ethnicity, citizenship, age, preexisting medical condition, insurance status economic status, ability to pay for medical services, or any other characteristic.
2. 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 the facility's use as part of the TAD destination program.
3. SCEMSA will approve, annually review and facilitate any necessary agreements with the SC within SCEMSA jurisdiction.
4. The TAD program Sacramento County EMS Agency staff reserves the right to perform scheduled site visits or request additional data from the SC at any time.

Cross References: PD# 4003 – EMS Liaison Officer
PD# 5200 – Triage to Alternate Destination Program Requirements
PD# 5203 – Transport Guidelines-Sobering Center
PD# 7600 – Quality Improvement Program

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	5203.01
	PROGRAM DOCUMENT: **Transport Guidelines to Sobering Center Facility**	Initial Date:	TBD
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		Review:	TBD

EMS Medical Director

EMS Administrator

Purpose:

A. To establish guidelines for the transport of patients with a primary provider impression of intoxication to the most appropriate facility that is staffed, equipped, and prepared to administer medical care appropriate to the needs of the patient.

Authority:

A. California Health and Safety Code, Division 2.5, Sections 1797.220, 1798.
B. Title 22, California Code of Regulations, Section 100170 (a)(5).

Definitions:

A. **Under The Influence Of A Mental Status Altering Substance:** A patient who appears to be impaired from a range of possible substances (Alcohol, THC, Stimulants, CNS Depressants, etc.), demonstrated by diminished physical and mental control and without other acute medical or traumatic cause. Being "under the influence" is typically associated with one or more of the following:
   a. Speech disturbance – incoherent, rambling, slurring.
   b. Decline in cognitive function – confusion, inappropriate behavior, impaired decision-making capacity.
   c. Imbalance – unsteady on feet, staggering, swaying.
   d. Poor coordination – impaired motor function, inability to walk a straight line, fumbling for objects.
   e. Agitation (for stimulants), or CNS depression (alcohol, CNS depressants).
B. **Emergency Medical Condition:** A condition or situation in which an individual immediately needs medical attention. The presence of abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure – except isolated asymptomatic hypertension, and oxygen saturation) are also indications of an emergency medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital notification are also considered to have an emergency medical condition.
C. **Authorized Sobering Center (SC):** A non-correctional facility staffed at all times with at least one registered nurse, providing a safe, supportive environment for intoxicated individuals to become sober. Licensed Vocational Nurses, Social Workers, and other mental health professionals may augment staffing. It is identified as an alternate destination in a plan developed pursuant to Section 1843 of the Health and Safety Code.

Principles:

A. EMS provider agencies must be approved by the Sacramento County Emergency Medical Services Agency (SCEMSA) to triage patients under the influence of a mental status-altering substance to an alternate destination (SCEMSA-approved Sobering Center).

B. Paramedics who have completed the curriculum for triage paramedic services adopted pursuant to paragraph two (2) of subsection (d) of Section 1830 of the Health and Safety Code and have been accredited by SCEMSA 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 (TAD) program, are the only EMS personnel authorized to utilize this policy.
C. In instances where there is a potential for the patient to harm self or others, EMS personnel shall consider seeking assistance from law enforcement.
D. In all cases, the patient's health and well-being are the overriding considerations in determining the patient's destination. Factors to be considered include the severity and stability of the patient's illness or injury, the status of the receiving facility, anticipated transport time, requests by the patient, family, guardian, or physician, and EMS personnel and Base Hospital judgment.
E. In an instance where any patient who meets the triage criteria for transport to a TAD facility but who requests to be transported to an Emergency Department (ED) of a general acute care hospital, EMS personnel shall transport the patient immediately to the ED of an acute care hospital.
F. In instances where a patient is transported to a TAD facility and, upon assessment, is found no longer to meet the criteria for admission, EMS personnel shall transport the patient immediately to the ED of a general acute care hospital.

Policy:

Responsibilities of the Paramedic:

A. Retain and provide proof of an active, unrestricted California-issued paramedic license.
B. Retain and provide proof of an active, unrestricted Sacramento County-issued paramedic accreditation
C. Proof of completion of SCEMSA-approved triage paramedicine course.
D. Comply with all patient destination policies established by SCEMSA.
E. The transporting Paramedic shall give a Patient report to a licensed health care provider or physician at the SC to ensure continuity of care and efficient transfer of care.

EMS Provider Agency Requirements and Responsibilities:

A. Submit a written request to the Administrator of SCEMSA for approval to triage patients who meet SC Inclusion Criteria. The written request shall include the following:
   1. Date of proposed implementation.
   2. Scope of deployment (identify response units).
   3. Course/Training Curriculum addressing all items in PD# 4521 – Triage to Alternate Destination Training Curriculum.
   4. Identify a representative to act as the liaison between SCEMSA, designated SC(s), and the EMS Provider Agency.
   5. Policies and procedures listed in Section B. below.
B. Develop, maintain, and implement policies and procedures that address the following:
   1. Completion of one Medical Clearance Criteria Screening Tool for each patient.
   2. Pre-arrival notification of the SC.
   3. Confirmation that SC has the capacity to accept the patient prior to transport.
C. Develop a Quality Improvement Plan or Process to review variances and adverse events.
D. Comply with data reporting requirements established by SCEMSA.

Sobering Center Patient Triage Criteria:

A. Inclusion Criteria – patients who meet the following criteria may be triaged for transport to an authorized SC, provided the facility can be accessed within SCEMSA-approved transport time:

1. Provider impression of being under the influence of a mental status-altering substance.
2. Age ≥ 18 years and < 65 years old.
3. Vital signs:
   - Heart rate ≥ 50 bpm and < 110 bpm.
   - Respiratory rate ≥ 10 rpm and < 20 rpm.
   - Pulse Oximetry ≥ 94% on room air.
   - Systolic Blood Pressure (SBP) ≥ 100 and ≤ ~~180~~ 200 mmHg.
   - Diastolic Blood Pressure ≤ ~~110~~ 120 mmHg.
   - Glasgow Coma Score ≥ 14.
4. Voluntarily or implied consent (when oriented to give verbal consent) to go to the SC.
5. Cooperative and does not require restraints.
6. Ambulatory does not require a wheelchair.
7. If there is a history of Diabetes Mellitus, no evidence of Ketoacidosis, and a blood glucose ≥ 60 mg/dl and < 350 mg/dl.

NOTE: Isolated mild to moderate hypertension (i.e., SBP ≤ ~~180~~ 200 mmHg with no associated symptoms such as headache, neurological changes, chest pain, or shortness of breath) in a patient with a history of hypertension is not a reason to exclude referral to a SC.

B. Exclusion Criteria—Patients who meet the following conditions shall not be triaged to an authorized SC: (The patient's destination shall be in accordance with SCEMSA PD# 5050—Destination or appropriate Specialty Care Center (i.e., Trauma Center, STEMI Center, or Stroke Center).

1. Any emergent medical condition.
2. ~~Patients who have suffered a fall with head injury ≥ 65 years of age or if on a blood thinning medication inclusive of Aspirin.~~
3. Active chest pain of suspected cardiac origin.
4. Bruising or hematomas above the clavicles.
5. Shortness of breath, abdominal pain, pelvic pain.
6. Has complaint of syncope.
7. Has received Naloxone from EMS, law enforcement, or a bystander.
8. Has received a narcotic analgesic.
9. Ingested a toxin or medication with the intent to self-harm.
10. Focal weakness.
11. Open wounds or bleeding, including hemoptysis or GI bleeding.
12. Known or Suspected pregnancy.
13. Requires special medical equipment.
14. Intellectual or developmental disability.
15. Exhibits active dangerous behavior/ severe agitation.
16. EMS personnel feel the patient is not stable enough for an authorized SC facility.

Cross References: PD# 2305 – EMS Patient Care Report-Completion and Distribution
PD# 2522 – Electronic Health Care Record and Data Policy
PD# 2525 – Prehospital Notification
PD# 4521 – Triage to Alternate Destination Training Curriculum
PD# 5050 – Destination

MEDICAL CLEARANCE CRITERIA FOR SOBERING CENTER

A. The paramedic shall assess and evaluate the patient using all the criteria listed below.
B. If ALL criteria are Yes (Gray), triage the patient to an Authorized Sobering Center.
C. If ANY criterion is **No (Orange)** – triage the patient to the most accessible Advanced Life Support (ALS) receiving hospital.

Provider Impression of Patient Under the Influence of a mental status altering substance	Yes ☐	No ☐
Verbalizes consent	Yes ☐	No ☐
Cooperative and do not require restraints	Yes ☐	No ☐
Ambulatory does not require a wheelchair	Yes ☐	No ☐
No emergent medical condition	Yes ☐	No ☐
Age ≥ 18 years old and < 65 years	Yes ☐	No ☐
Heart Rate ≥50 and <110 beats per minute	Yes ☐	No ☐
Respiratory Rate ≥10 and <20 respirations per minute	Yes ☐	No ☐
Pulse Oximetry ≥ 94% on room air	Yes ☐	No ☐
SBP ≥100 and ≤ ~~180~~ 200 mmHg and DBP < ~~110~~ 120	Yes ☐	No ☐
Glasgow Coma Score ≥14	Yes ☐	No ☐
If diabetes, glucose ≥60 and <350mg/dL	Yes ☐	No ☐
No injury meeting TC criteria or guidelines	Yes ☐	No ☐
No complaint of chest pain, SOB, Abdominal or pelvic pain, or syncope	Yes ☐	No ☐
No open wounds or bleeding, including any hemoptysis or GI bleed	Yes ☐	No ☐
~~Not on anticoagulants*~~	Yes ☐	No ☐
Not pregnant (known or suspected)	Yes ☐	No ☐
Not requiring special medical equipment		
No bruising or hematoma above the clavicles	Yes ☐	No ☐
No intellectual or developmental disability	Yes ☐	No ☐
No dangerous behavior		
No signs and symptoms of Agitated Delirium		
EMS Personnel feel the patient is stable for Authorized Sobering Center	Yes ☐	No ☐

~~* Common Anticoagulants: Warfarin/Coumadin, Clopidogrel/Plavix, Enoxaparin/Lovenox,~~

~~— daxa, Apixaban/Eliquis, Edoxaban/Savaysa, Fondaparinux/Arix~~

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	5204.01
	PROGRAM DOCUMENT: **Mental Health Facility Designation**	Initial Date:	TBD
		Last Approved Date:	TBD
		Effective Date:	TBD
		Review:	TBD

EMS Medical Director

EMS Administrator

Purpose:

A. To establish minimum standards for the designation of an Authorized Mental Health Facility.

Authority:

A. California Health and Safety Code, Division 2.5, Sections 1797.220, 1798, 1843, 1206 (b), 1317 (b)..
B. Title 22, California Code of Regulations, Section 100170 (a)(5).

Definitions:

A. **Behavioral/Psychiatric Crisis:** A provider impression for patients who are having a mental health crisis or mental health emergency. This is not for anxiety or agitation secondary to medical etiology.
B. **Emergency Medical Condition:** A condition or situation in which an individual immediately needs medical attention. The presence of abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure – except isolated asymptomatic hypertension, and oxygen saturation) are also indications of an emergency medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital notification are also considered to have an emergency medical condition.
C. **Authorized Mental Health (MH) Facility:** 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.
D. **Psychiatric Urgent Care Center (PUCC):** A mental health facility authorized by the Department of Mental Health and approved by SCEMSA by meeting the requirements in the Psychiatric Urgency Care Center standards.

Policy:

General Requirements

An Authorized Mental Health Facility shall:

A. Be a licensed or certified as a mental health treatment facility or a hospital, as defined in subsection (a) or (b) of Section 1250 of the California Health and Safety Code, and may include, but is not limited to:
   1. A licensed psychiatric hospital.
   2. A licensed health facility.
   3. A certified crisis stabilization unit.
   4. A psychiatric health facility licensed by the State Department of Health Care Services.

B. Accommodate private, commercially insured, Medi-Cal, Medicare, and uninsured patients.
C. The MH facility is required to notify SCEMSA of changes in the status of the facility within twenty-four (24) hours.

The Authorized Mental Health Facility should:

A. Provide and maintain adequate parking for ambulance vehicles to ensure access to the facility.
B. Appoint an EMS Liaison Officer to act as a liaison between Sacramento County Emergency Medical Services Agency (SCEMSA) designated Triage to Alternate Destination (TAD) EMS providers and law enforcement agencies.
C. Accept all patients triaged by paramedics regardless of the patient's ability to pay.
D. Maintain General Liability Insurance as follows:
   1. General aggregate: Two (2) Million Dollars.
   2. Products/completed operations aggregate: One (1) Million Dollars.
   3. Personal and advertising injury: One (1) Million Dollars.
   4. Each occurrence: One (1) Million Dollars.
   5. Sexual Misconduct: Two (2) Million Dollars.
   6. Worker's Compensation and Employers Liability: One (1) Million Dollars per accident.

Authorized Mental Health Facility Leadership and Staffing:

EMS Liaison Officer:

A. Responsibilities:
   1. Implement and ensure compliance with the facility standards.
   2. Maintain direct involvement in developing, implementing, and reviewing facility policies and procedures related to receiving patients triaged by paramedics through the Triage to Alternate Destination (TAD) program.
   3. Serve as the key personnel responsible for addressing variances in the care and sentinel events related to patients triaged by paramedics to the facility.
   4. Liaison with designated TAD EMS Provider Agencies and law enforcement agencies.
   5. Serve as the contact person for SCEMSA and be available upon request to respond to County business.
B. A registered nurse licensed in the State of California shall always be on site.
C. Staffing may be augmented by licensed psychiatric nurse practitioners, licensed vocational nurses, social workers, and other mental health professionals.
D. All medical and nursing staff shall have current Cardiopulmonary Resuscitation (CPR) certification through the American Heart Association or American Red Cross.

Policies and Procedures:

Develop, maintain, and implement policies and procedures that address the following:

A. Receipt, immediate evaluation, short-term management, and monitoring of patients who meet PUCC triage inclusion criteria.
B. Timely transfer of patients who require a higher level of care to an acute care hospital utilizing a non-911 ambulance provider if possible.
C. Immediate transfer of patients with emergency medical conditions to the most accessible Advanced Life Support (ALS) receiving facility/emergency department.
D. Record keeping of EMS Report Forms.
E. Data reporting requirements established by SCEMSA, including but not limited to the following data:
   1. Total number of patients evaluated who were transported by EMS.

2. Total number of patients that were treated and released.
3. Total number of patients transferred to an acute care emergency department.
4. Total number of these patients admitted to another care facility.
5. Total number of patients who experienced an adverse event resulting from services provided under this program.

F. Procedure for notifying SCEMSA of patient transfers from facility requiring 911 transport for an emergency medical condition.

Equipment and Supplies:

A. Dedicated telephone line to facilitate direct communication with EMS personnel.
B. EMResource capability to communicate the facility's real-time capacity status.
C. Public Access Device/Layperson Automated External Defibrillator on site with staff trained on its proper use.
D. An up-to-date community referral list of services and facilities available to patients.

Procedure for Approval to be a designated alternate destination MH facility for a TAD program:

A. Submit a written request to the Director of the TAD program to include:
   1. The rationale for the request to be a TAD facility.
   2. A document verifying that the facility has been approved as an authorized mental health facility as defined in subsection (a) or (b) of Section 1250 of the Health and Safety Code by the State Department of Public Health.
   3. The facility's proposed date will open to accept patients triaged by paramedics.
   4. Copies of the policies and procedures required in this document under Policy and Procedures.
   5. Proposed staffing.
   6. Hours of operation.

Site Visit:

A. Once all general requirements are met, the TAD program will coordinate a site visit to verify compliance with all the requirements.
B. The TAD program Sacramento County EMS Agency staff reserves the right to perform scheduled site visits or request additional data from the SC at any time.
C. Administrative and field personnel from local EMS provider agencies will be invited to exchange contact information and familiarize themselves with the facility's physical layout.

Other Requirements:

A. The agreement with the MH facility is required to operate in accordance with Section 1317 of the Health and Safety Code, which states In no event shall the provision of emergency services and care be based upon, or affected by, the person's ethnicity, citizenship, age, preexisting medical condition, insurance status economic status, ability to pay for medical services, or any other characteristic.
B. 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 the facility's use as part of the TAD destination program.
C. SCEMSA will approve, annually review, and facilitate any necessary agreements with the MH facility within SCEMSA jurisdiction.

Cross References: PD# 4003 – EMS Liaison Officer
PD# 5200 – Triage to Alternate Destination Program Requirements
PD# 5205 – Transport Guidelines-Mental Health Facility
PD# 7600 – Quality Improvement Program

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	5205.01
	PROGRAM DOCUMENT: **Transport Guidelines – Mental Health Facility Designation**	Initial Date:	TBD
		Last Approved Date:	TBD
		Effective Date:	TBD
		Review:	TBD

EMS Medical Director

EMS Administrator

Purpose:

A. To establish guidelines for transporting patients with a primary provider impression of Behavioral/Psychiatric Crisis to the most appropriate approved facility that is staffed, equipped, and prepared to administer medical care appropriate to the patient's needs.

Authority:

A. California Health and Safety Code, Division 2.5, Sections 1797.220, 1798.
B. Title 22, California Code of Regulations, Section 100170 (a)(5).

Definitions:

A. **Behavioral/Psychiatric Crisis:** A provider impression for patients who are having a mental health crisis or mental health emergency. This is not for anxiety or agitation secondary to medical etiology.
B. **Emergency Medical Condition:** A condition or situation in which an individual immediately needs medical attention. The presence of abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure – except isolated asymptomatic hypertension, and oxygen saturation) are also indications of an emergency medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital notification are also considered to have an emergency medical condition.
C. **Mental Health Crisis:** A non-life-threatening situation in which an individual is exhibiting extreme emotional disturbance or behavioral distress, causing an inability to function or care for themselves. Individuals suffering from a mental health crisis may also consider harm to self or others. Examples of a mental health crisis include but are not limited to:
    1. Talking about suicide threats.
    2. Talking about threatening behavior.
    3. Self-injury needing immediate medical attention.
    4. Alcohol or substance abuse.
    5. Highly erratic or unusual behavior.
    6. Eating disorders.
    7. Not taking prescribed psychiatric medications.
    8. Emotionally distraught, depressed, angry, or anxious.
D. **Mental Health Emergency:** This is a life-threatening situation in which an individual is imminently threatening harm to self or others. Individuals may be disoriented, distraught, and lack the ability to care for themselves. Examples of a mental health emergency include:
    1. Acting on a suicide threat.
    2. Homicidal or threatening behavior.
    3. Self-injury needing immediate medical attention.
    4. Severely impaired by drugs or alcohol.

5. Highly erratic or unusual behavior that indicates very unpredictable behavior and/or inability to care for themselves.

E. **Most Accessible Receiving Facility (MAR):** The geographical closest (by distance) Advanced Life Support (ALS) receiving hospital approved by Sacramento County Emergency Medical Services Agency (SCMESA) to receive patients with emergency medical conditions from the emergency medical services (EMS) system.

F. **Authorized Mental Health Facility (MH):** A facility that is licensed or certified as a mental health treatment facility or a hospital, as defined in subdivision subsection (a) or (b) or 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.

Principles:

A. The SCEMSA must approve EMS provider agencies to triage behavioral/psychiatric crisis patients to a SCEMSA-approved mental health facility.

B. Paramedics who have 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 have been accredited by SCEMSA 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 (TAD) program, are the only EMS personnel authorized to utilize this policy.

C. Patients exhibiting mental health crisis who meet Mental Health inclusion criteria may also be released at the scene to the local law enforcement agency.

D. Paramedics shall document on the EMS Report Form to whom the patient was released.

E. In instances where there is a potential for the patient to harm self or others, EMS personnel shall consider seeking assistance from law enforcement.

F. In all cases, the health and well-being of the patient are the overriding considerations in determining the patient's destination. Factors to be considered include severity and stability of the patient's illness or injury; status of the receiving facility; anticipated transport time; requests by the patient, family, guardian, or physician; and EMS personnel and Base Hospital judgment.

G. In an instance where any patient who meets the triage criteria for transport to a TAD facility but who requests to be transported to an Emergency Department (ED) of a general acute care hospital, EMS personnel shall transport the patient immediately to the ED of an acute care hospital.

H. In instances where a patient is transported to a TAD facility and, upon assessment, is found no longer to meet the criteria for admission, EMS personnel shall transport the patient immediately to the ED of a general acute care hospital.

Policy:

Responsibilities of the Paramedic:

A. Retain and provide proof of an active, unrestricted California-issued paramedic license.

B. Retain and provide proof of an active, unrestricted Sacramento County-issued paramedic accreditation.

C. Completion of SCEMSA-approved triage paramedicine course completion certificate.

D. Comply with all patient destination policies established by SCEMSA.

E. The transporting Paramedic shall give a Patient report to a licensed health care provider or physician at the SC to ensure continuity of care and efficient transfer of care.

EMS Provider Agency Requirements and Responsibilities:

A. Submit a written request to the Administrator of SCEMSA for approval to triage patients who meet MH Inclusion Criteria. The written request shall include the following:
   1. Date of proposed implementation.
   2. Scope of deployment (identify response units).
   3. A course/Training Curriculum that addresses all items in PD# 4521—Triage to Alternate Destination Training Curriculum.
   4. Identify a representative to act as the liaison between SCEMSA, designated MH facility(s), and the EMS Provider Agency.
   5. Policies and procedures listed in Section B. below.

B. Develop, maintain, and implement policies and procedures that address the following:
   1. Completion of one Medical Clearance Criteria Screening Tool for each patient.
   2. Pre-arrival notification of the MH facility.
   3. Patient report to a licensed health care provider or physician at the MH facility.
   4. Confirmation that MH facility has the capacity to accept the patient prior to transport.

C. Develop a Quality Improvement Plan or Process to review variances and adverse events.

D. Comply with data reporting requirements established by SCEMSA.

Authorized Mental Health Facility Patient Triage Criteria:

A. Inclusion Criteria – patients who meet the following criteria may be triaged for transport to an authorized mental health facility, provided the facility can be accessed within SCEMSA-approved transport time:
   1. Provider impression of behavior/psychiatric crisis; and
   2. Voluntarily consented or 5150 hold.
   3. Ambulatory does not require the use of a wheelchair; and
   4. No emergent medical condition or trauma (except for ground-level fall with injuries limited to minor abrasions below the clavicle).
   5. Age ≥ 18 years and < 65 years old.
   6. Vital signs:
      - Heart rate ≥ 50 bpm and < 110 bpm.
      - Respiratory rate ≥ 10 rpm and < 20 rpm.
      - Pulse Oximetry ≥ 94% on room air.
      - Systolic Blood Pressure (SBP) ≥ 100 and ≤ 180 mmHg.
      - Diastolic Blood Pressure < 110 mmHg.
   7. Glasgow Coma Scale (GCS) Score of ≥ 14.
   8. If there is a history of Diabetes Mellitus, no evidence of Ketoacidosis, and a blood glucose ≥ 60 mg/dl and < 350 mg/dl.

NOTE: Isolated mild to moderate hypertension (i.e., SBP ≤ 180 mmHg with no associated symptoms such as headache, neurological changes, chest pain, or shortness of breath) in a patient with a history of hypertension is not a reason to exclude referral to a Psychiatric Urgent Care Center (PUCC).

B. Exclusion Criteria—Patients who meet the following conditions shall not be triaged to an authorized mental health facility:(The patient's destination shall be in accordance with SCEMSA PD# 5050—Destination or appropriate Specialty Care Center (i.e., Trauma Center, STEMI Center, or Stroke Center).
   1. Any emergency medical condition.
   2. Patients who have suffered a fall with head injury ≥ 65 years of age or if on a blood thinning medication inclusive of Aspirin.
   3. Active chest pain of suspected cardiac origin.

4. Bruising or hematomas above the clavicles.
5. Shortness of breath, abdominal pain, pelvic pain.
6. Has a history suggestive of Syncope.
7. Has received Naloxone from EMS, law enforcement, or a bystander.
8. Has received a narcotic analgesic.
9. Ingested a toxin or medication with the intent to self-harm.
10. Focal weakness.
11. Open wounds or bleeding, including hemoptysis or GI bleeding.
12. Known or Suspected pregnancy.
13. Requires special medical equipment.
14. Intellectual or developmental disability.
15. Exhibits active dangerous behavior/ severe agitation.
16. EMS personnel feel the patient is not stable enough for an authorized MH facility.

Cross References: PD# 2305 – EMS Patient Care Report-Completion Distribution
PD# 2522 – Electronic Health Care Record and Data Policy
PD# 2525 – Prehospital Notification
PD# 4521 – Triage to Alternate Destination Training Curriculum
PD# 5050 – Destination

MEDICAL CLEARANCE CRITERIA FOR MENTAL HEALTH

A. Paramedic shall assess and evaluate the patient using all criteria listed below.
B. If ALL criteria are **YES** (Gray) – triage the patient to a designated authorized mental health facility.
C. If ANY criterion is **NO** (Orange) – triage the patient to the most accessible 911 receiving hospital.

Provider Impression of Behavioral/Psychiatric Crisis	Yes ☐	No ☐
Voluntarily consented or 5150 hold	Yes ☐	No ☐
Ambulatory, does not require wheelchair	Yes ☐	No ☐
No emergent medical condition	Yes ☐	No ☐
Age ≥ 18 years old and < 65 years	Yes ☐	No ☐
Heart Rate ≥50 and <110 beats per minute	Yes ☐	No ☐
Respiratory Rate ≥10 and <20 respirations per minute	Yes ☐	No ☐
Pulse Oximetry ≥94% on room air	Yes ☐	No ☐
SBP ≥100 and <180 mmHg and DBP <110	Yes ☐	No ☐
Glasgow Coma Score ≥14	Yes ☐	No ☐
If diabetes, glucose ≥60 and <350mg/dL	Yes ☐	No ☐
No injury meeting TC criteria or guidelines	Yes ☐	No ☐
No complaint of chest pain, SOB, Abdominal or pelvic pain, or syncope	Yes ☐	No ☐
No open wounds or bleeding	Yes ☐	No ☐
Not pregnant (known or suspected)	Yes ☐	No ☐
Not requiring special medical equipment	Yes ☐	No ☐
No intellectual or developmental disability	Yes ☐	No ☐
No dangerous behavior	Yes ☐	No ☐
No signs and symptoms of Agitated Delirium	Yes ☐	No ☐
EMS Personnel feel patient is stable for Authorized Mental Health Facility	Yes ☐	No ☐

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	2521.07
	PROGRAM DOCUMENT: **Ambulance Patient Offload Time (APOT) Data Collection and Reporting**	Initial Date:	10/10/16
		Last Approved Date:	12/12/24
		Effective Date:	05/01/25
		Next Review Date:	12/01/26

Signature on File	Signature on File
EMS Medical Director	EMS Administrator

Purpose:

A. To establish standardized methodologies for Ambulance Patient Offload Time (APOT) data collection and reporting to Sacramento County Emergency Medical Services Agency (SCEMSA) in accordance with California Health and Safety Code Division 2.5, Section 1797.225.
B. Use statewide standard methodology for calculating and reporting APOT developed by California Emergency Medical Services Authority (EMSA).
C. Establish criteria for the reporting of, and quality assurance follow-up for a non-standard patient offload time.

Authority:

A. California Health and Safety Code, Division 2.5 Section 1797.120 and 1797.225

Background:

A. California Health and Safety Code, Division 2.5, Section 1797.120 requires EMSA to develop a standard methodology for calculation of, and reporting by, a Local Emergency Medical Services Agency (LEMSA) of ambulance patient offload time.
B. California Health and Safety Code Division 2.5, Section 1797.225 establishes that a LEMSA may adopt policies and procedures for calculating and reporting ambulance offload times. Those policies and procedures must be based on the statewide standard methodology developed pursuant to California Health and Safety Code, Division 2.5, Section 1797.120. LEMSAs that adopt patient off-loading policies and procedures must also establish criteria for reporting and quality assurance follow-up for a non-standard patient off load time.

Definitions:

A. **Ambulance arrival at the Emergency Department (ED)** – The time an ambulance stops at the location outside the hospital ED where the patient will be unloaded from the ambulance.
B. **Ambulance Patient Offload Time (APOT)** – the time interval between the arrival of an ambulance patient at an ED and the time the patient is transferred to the ED gurney, bed, chair or other acceptable location and the emergency department assumes the responsibility for care of the patient .
C. **Ambulance Patient Offload Time (APOT) Standard** – The time interval standard established by the LEMSA within which an ambulance patient that has arrived in an ED should be transferred to an ED gurney, bed, chair or other acceptable location and the ED assumes the responsibility for care of the patient.
D. **Non-Standard Patient Offload Time** – The ambulance patient offload time for a patient exceeds a period of time designated by the LEMSA. (See Standards below).

E. **Ambulance Transport** – The transport of a patient from the prehospital EMS system by ambulance to an approved EMS receiving hospital. This includes Inter-facility transports, 7-digits response, and other patient transports to the ED.
F. **APOT 1** – An ambulance patient offload time interval process measure. This metric is a continuous variable measured in minutes and seconds then aggregated and reported at the 90th percentile.
G. **APOT 2** – An ambulance patient offload time interval process measure. This metric demonstrates the incidence of ambulance patient offload times that exceed a twenty (20) minute reporting goal reported in reference to 60, 120 and 180 minute time intervals, expressed as a percentage of total EMS patient transports.
H. **APOT 3** – The cumulative time, expressed in hours, for patient offload times in excess of 20 minutes. This metric demonstrates the time EMS personnel spend at hospitals awaiting transfer of care to hospital staff, in hours, in excess of the twenty (20) minute target for patient offload.
I. **Ambulance Patient Offload Delay (APOD)** – The occurrence of a patient remaining on the ambulance gurney and/or the emergency department has not assumed responsibility for patient care beyond the LEMSA approved APOT standard. (Synonymous with non-standard patient offload time).
J. **Clock Start** – The time that captures when APOT begins. This is captured in the current version of NEMSIS data set as the time the patient/ambulance arrives at destination/receiving hospital (eTimes.11) and stops at the location outside the hospital ED where the patient will be unloaded from the ambulance.
K. **Clock Stop** – The time that captures when APOT ends. This is captured in the current version of NEMSIS data set as destination patient transfer of care date/time (eTimes.12).
L. **Emergency Department (ED) Medical Personnel** – An ED physician, mid-level practitioner (e.g. Physician Assistant, Nurse Practitioner) or Registered Nurse (RN).
M. **EMS Personnel** – Public Safety First Responders, EMTs, AEMTs, EMT-II and/or paramedics responsible for out of hospital patient care and transport consistent with the scope of practice as authorized by their level of credentialing.
N. **Transfer of Patient Care** – The transition of patient care responsibility from EMS personnel to receiving hospital ED medical personnel. (See criteria below in Measurement Methods).
O. **Verbal Patient Report** – The face to face verbal exchange of key patient information between EMS personnel and ED medical personnel provided that is presumed to indicate transfer of patient care.
P. **Written EMS Report** – The written report supplied to ED medical personnel that details patient assessment and care that was provided by EMS personnel. Electronic report (ePCR) is required by Health and Safety Code 1797.227.

Standard Offload Time APOT:
Receiving hospitals have a responsibility to ensure policies and processes are in place that facilitates the rapid and appropriate transfer of patient care from EMS personnel to the ED medical personnel within 20 minutes of arrival at the ED.

Non-Standard Offload Time Extended Delay:
APOD occurs when patient offload time is exceeded. SCEMSA shall collect and report the percentage of patients that are delayed by 20:01-60 minutes, 60:01-120 minutes, 120:01-180 minutes, and delays greater than 180:01 minutes to EMSA.
If APOD occurs the hospital should make every attempt to:

A. Provide a safe area in the ED within direct sight of ED medical personnel where the ambulance crew can temporarily wait while the hospital's patient remains on the ambulance gurney.
B. Inform the attending EMS Personnel of the anticipated time for the offload of the patient.

C. Extended offload times reported during a Mass Casualty Incident (MCI) or other large incident(s) response will be taken into consideration.

EMS personnel are directed to do the following to prevent APOD:

A. Provide the receiving hospital ED with the earliest possible notification that the patient is being transported to their facility.
B. After twenty (20) minutes and every twenty (20) minutes thereafter, check with hospital personnel on status of off-load time.
*Refer to PD# 2524 - Extended Ambulance Patient Off-Load Times (APOT)
C. After sixty (60) minutes of APOT, notify the EMS organization's on duty supervisor.
*Refer to PD# 2524 - Extended Ambulance Patient Off-Load Times (APOT)
D. Obtain a signature from the ED medical personnel as soon as patient care has been transferred.
E. Work cooperatively with the receiving hospital staff to transition patient care within the timeframes established by this policy.
F. EMS personnel are responsible when able, to immediately return to response ready status once patient care has been transferred to ED medical personnel and the patient has been offloaded from the ambulance gurney.

Direction of EMS Personnel:
EMS personnel shall continue to provide patient care prior to the transfer of patient care to the receiving hospital ED medical personnel. All patient care shall be documented according to SCEMSA policies. Medical Control and management of the EMS system, including EMS personnel, remain the responsibility of the LEMSA Medical Director and all care provided to the patient must be pursuant to SCEMSA protocols and policies.[1]
Refer to PD# 2524 - Extended Ambulance Patient Off-Load Times (APOT)

Patient Care Responsibility:
The responsibility for patient care belongs to the receiving hospital once the patient arrives on hospital grounds.[2] Receiving hospitals should implement processes for ED medical personnel to immediately triage and provide the appropriate emergency medical care for ill or injured patients upon arrival to the ED by ambulance.

Transfer of Patient Care:
Upon arrival of patients under the care of EMS personnel the hospital ED medical personnel should make every attempt to accept a verbal patient report and offload the patient to a hospital bed or other suitable sitting or reclining device at the earliest possible time not to exceed 20:01 minutes. During triage by ED medical personnel, EMS personnel will provide a verbal patient report containing any pertinent information necessary for the ongoing care of the patient. Transfer of patient care is completed once:

- ED medical staff has accepted a verbal patient report
- The patient has been transferred to a hospital bed
- A signature obtained from medical ED personnel.

If transfer of care and patient offloading from the ambulance gurney exceeds the 20:01 minute standards, it will be documented and tracked as APOD.

Measurement Methods:

A. Clock Start (eTimes.11):
The time the ambulance arrives at the ED and stops at the location outside the hospital ED where the patient will be unloaded from the ambulance.
B. Clock Stop (eTimes.12):
When the patient is transferred to the ED gurney, bed, chair or other acceptable location and the ED has assumed the responsibility for care of the patient.

[1]Medical Care of EMS patients awaiting transfer of care to hospital staff-Letter Addendum1
[2]Emergency Medical Treatment and Active Labor Act (EMTALA), 42 US Code of Federal Regulations

C. Transfer of Care Criteria:
   - Verbal patient report is given by transporting EMS personnel and acknowledged by ED medical personnel;
   - ED medical personnel signs ePCR or other patient care form (completion of ePCR is not a requirement).

Data Collection and Documentation:

A. EMS providers shall implement digital CAD data migration into ePCR platforms and report data to SCEMSA in real time or at least once per twenty-four (24) hour period.

Reporting to EMSA By SCEMSA:
SCEMSA staff will complete reports to EMSA based on EMSA guidelines.

A. **APOT-1:** The number reported is the APOT in minutes for transfer of care of 90% percentile of ambulance patients and the number of ambulance runs included in the report.
B. **APOT-2:** The number reported is the percentage of ambulance patients transported by EMS personnel that experience an ambulance patient offload delay beyond twenty (20:01) minutes, which has been set as a target standard for statewide reporting consistency and to exclude rapid APOT from being combined with more extended times. Time intervals will be reported by sixty (60:01) minute intervals up to one hundred eighty (180:01) minutes then any APOT exceeding one hundred eighty (180) minutes.

Appendix A: Section 1
Section 1797.225 is added to the Health and Safety Code, to read:
1797.225.
(a) A local EMS agency may adopt policies and procedures for calculating and reporting ambulance patient offload time, as defined in subdivision (b) of Section 1797.120.
(b) A local EMS agency that adopts policies and procedures for calculating and reporting ambulance patient offload time pursuant to subdivision (a) shall do all of the following:
(1) Use the statewide standard methodology for calculating and reporting ambulance patient offload time developed by the authority pursuant to Section 1797.120.
(2) Establish criteria for the reporting of, and quality assurance follow-up for, a nonstandard patient offload time, as defined in subdivision (c).
(c) (1) For the purposes of this section, a “nonstandard patient offload time” means that the ambulance patient offload time for a patient exceeds a period of time designated in the criteria established by the local EMS agency pursuant to paragraph (2) of subdivision (b).
(3) “Nonstandard patient offload time” does not include instances in which the ambulance patient offload time exceeds the period set by the local EMS agency due to acts of God, natural disasters, or manmade disasters.

Appendix B:

Section 1.
Set Measure ID# APOT-1
Section 2.
Set Measure ID# APOT-2

Cross Reference: PD# 2522 – Electronic Health Record and Data Policy
PD# 2524 – Extended Ambulance Patient Off-Load Times (APOT)

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	2523.06
	PROGRAM DOCUMENT: **Administration of Naloxone by First Responders – Public Safety**	Initial Date:	11/17/16
		Last Approved Date:	12/12/24
		Effective Date:	05/01/25
		Next Review Date:	12/01/26

Signature on File
EMS Medical Director

Signature on File
EMS Administrator

Purpose:

A. To establish criteria for first responder/public safety administration of intranasal (IN) Naloxone Hydrochloride (Naloxone) in cases of suspected acute opioid overdose.
B. To provide medical direction and Naloxone administration parameters (approved optional scope) for first responders/public safety in Sacramento County.

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9

Training:

A. Training shall be done as outlined in California Code of Regulations, Title 22, Division 9, Chapter 1.5. First Aid and CPR Standards and Training for Public Safety Personnel, including the optional skills administration of IN Naloxone for suspected narcotic overdose.
B. The Training Officer/Coordinator or other designated individual, shall be responsible for the following:
    1. Ensuring the Naloxone is current and not expired.
    2. Proper and efficient deployment of Nasal Naloxone for use.
    3. Replacement of any Naloxone that is damaged, unusable, expired or deployed.
    4. Ensuring all personnel that will be using Naloxone has received appropriate training.
    5. Replacing the Naloxone and ensuring that there is an adequate supply available for use.
    6. Keep record of all documented use, restocking, damaged, and unusable or expired Naloxone.

Definitions:

A. Opioid (narcotic) overdose: The result of an individual's intentional/accidental exposure to narcotic pharmacological substance(s), e.g. heroin, morphine, oxycodone, hydrocodone, fentanyl, methadone, opium, dilaudid, and Demerol.
B. Naloxone: Naloxone is an antagonist **ONLY** to opioid narcotics and is not effective with other medications. It will **NOT** reverse non-opiate drug exposures, e.g. benzodiazepines, sedative hypnotics, alcohol or other class of drugs.

Indications:

A. Suspected or confirmed opiate overdose
    1. Environment is suspicious of illegal or prescription use of opiates, AND
    2. Victim is unconscious/poorly responsive and respiratory (breathing) rate appears slow (< 8) or shallow/inadequate; or victim is unconscious and not breathing.
B. Need for complete or partial reversal of Central Nervous System and respiratory depression induced by opioids.
C. Decreased sensorium of unknown origin

D. Law Enforcement personnel or First Responders with known or suspected Opiate exposure (Fentanyl) AND signs and symptoms of Opiate overdose.

Contraindications:

A. Allergy to Naloxone

Relative Contraindications:

A. Use with caution in opiate-dependent patients and in neonates of opiate addicted mothers; opiate-dependent patients who receive Naloxone may experience acute withdrawal reaction syndrome. Opiate withdrawal symptoms in the opiate-dependent patient include:
   1. Agitation
   2. Tachycardia
   3. Hypertension
   4. Seizures
   5. Dysrhythmias
   6. Nausea, vomiting, and/or diarrhea
   7. Diaphoresis

Protocol:

A. IN Naloxone Administration:
   1. Ensure EMS has been activated using the 9-1-1 system
   2. Maintain standard blood and body fluid precautions, use personal protective equipment.
   3. Check patient/victim for responsiveness.
   4. Open the airway using Basic Life Support techniques.
   5. Perform rescue breathing, if indicated. Perform CPR if pulseless.
   6. Administer IN Naloxone:
      a) **Preload Naloxone, administer 4 mg IN**. If no improvement, consider repeat dose in 2-3 minutes if no response to initial dose (up to a total of three (3) doses) **OR**
      b) **Atomizer Naloxone administer 2 mg IN** (administer ½ of dose to each nostril). Consider repeat dose in 2-3 minutes if no response to initial dose (up to a total of six (6) doses)
   7. If response to naloxone and patient is possibly a chronic opiate user, prepare for possible narcotic reversal behavior or withdrawal symptoms (vomiting and agitation).
   8. Notify transporting EMS personnel of Naloxone administration.

Data Collection:

A. EMS providers shall document the “prior to arrival” administration of Naloxone by law enforcement personnel.
B. Participating law enforcement agencies are **required** to submit any utilization of Narcan to the Overdose Detection Mapping Application Program (ODMAP) website within 48 hours of administration.

Cross Reference: PD # 8831 – Intranasal Medication Administrations

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	4160.05
	PROGRAM DOCUMENT: **Emergency Medical Responder (EMR) Initial Certification and Recertification**	Initial Date:	01/15/19
		Last Approval Date:	12/12/24
		Effective Date:	05/01/25
		Next Review Date:	12/01/26

Signature on File	Signature on File
EMS Medical Director	EMS Administrator

Purpose:

A. To establish the certification/recertification requirements for Emergency Medical Responder (EMR) recognized to practice in Sacramento County, by the Sacramento County Emergency Medical Services Agency (SCEMSA) Medical Director.

Authority:

A. California Health and Safety Code, Division 2.
B. California Code of Regulations, Title 22, Division 9

Procedure:

Candidates and/or their near relatives are not permitted to sign any documentation of proof attesting to the skills, training, or education for that candidate. It is the responsibility of the candidate to ensure impartiality and avoid potential conflicts of interest in any documentation. **Any falsification of documentation is grounds for losing certification for a period of at least twelve (12) months**. All candidates will meet the following certification requirements:

Initial Certification:

A. To be eligible for initial EMR certification in Sacramento County, an individual shall meet/complete the following:
   1. Be eighteen (18) years of age or older
   2. Affiliated with a SCEMSA-authorized EMS Provider
   3. Apply online at Sacramento County EMS eLicensing Application Portal.
B. Meet one of the following training/eligibility requirements:
   1. Possess a course completion record (including skills testing) dated within the past twenty-four (24) months, from a SCEMSA-approved EMR training program, **OR**
   2. Possess an initial course completion record or other documented proof of successful completion, dated within the last twenty-four (24) months, of any initial training program that meets or exceeds the U.S. Department of Transportation Emergency Medical Responder National Emergency Medical Services Educational Standards and Instructional Guidelines, **OR**
   3. A current and valid EMR certification card issued by another certifying entity. Acceptance of an EMR certification card issued by another certifying entity shall be at the sole discretion of SCEMSA.

C. In addition to the above criteria, applications must include the following:
   1. A current government-issued photo ID.
   2. A valid American Heart Association Healthcare Provider-Cardiopulmonary Resuscitation (CPR) card or equivalent (CPR courses must have an instructor-led, hands-on classroom skills component for the certification to be considered valid).
   3. A color passport-style photo of applicant.
   4. Disclosure of any certification or licensure action (completed or pending), conviction of misdemeanor/felony
      - Against any EMR/EMT/AEMT/Paramedic-related certification or license in California, and/or entity per statutes and/or regulations of that state or other issuing entity, including active investigations, **OR**
      - Against an EMR certificate, EMT certificate, AEMT certificate or a Paramedic license, or health-related license, **OR**
      - Any denial of certification by a Local Emergency Medical Service Agency (LEMSA) or in the case of paramedic licensure, a denial by the California EMS Authority.
      - In the event of a certification/licensure action, and/or conviction of misdemeanor/felony, complete and upload the Supplemental Application Form located on the EMR Certification page of the SCEMSA website.

D. Pay the initial certification fee established by SCEMSA, which are non-refundable and non-transferable.

E. Once the above criteria is met, the applicant's provider agency will receive an email verifying applicant's status. When the provider agency verifies status they are agreeing that:
   - Any criminal background history received will be shared with SCEMSA.

F. Once the above is completed and verified, SCEMSA will process the application, notify applicant if additional information is required, and issue a wallet-sized EMR card. Cards are mailed each Friday (if the Friday falls on a holiday, cards will be mailed the next business day).

Recertification:

A. To apply for EMR recertification, an individual shall meet/complete the following:
   1. Apply online at Sacramento County EMS eLicensing Application Portal.
   2. Possess a current/expired SCEMSA-issued EMR certification.
   3. Meet Continuing Education (CE) requirements:
      - Complete a 12-hour refresher course from an approved EMR training program within 24 months prior to applying for renewal, **OR**
      - Obtain at least 12 hours of prehospital CE within 24 months prior to applying for renewal from an approved CE provider.
   4. A completed EMR Skills Competency Verification Form. Verification of skills competency shall be valid for a maximum of two (2) years.

B. In addition to the above criteria, applications must include the following:
   1. A current government-issued photo ID.
   2. A valid American Heart Association Healthcare Provider-Cardiopulmonary Resuscitation (CPR) care or equivalent (CPR courses must have an instructor-led, hands-on classroom skills component for the certification to be considered valid).
   3. A color passport-style photo of applicant.
   4. Disclosure of an certification or licensure action (completed or pending), conviction of misdemeanor/felony:
      - Against any EMR/EMT/AEMT/Paramedic-related certification or license in California, and/or entity per statutes and/or regulation of that state or other issuing entity, including active investigations, **OR**
      - Against an EMR certificate, EMT certificate, AEMT certificate or a Paramedic license, or health-related license, **OR**
      - Any denial of certification by a Local Emergency Medical Service Agency (LEMSA) or, in the case of paramedic licensure, a denial by the California EMS Authority.
      - In the event of a certification/licensure action and/or conviction of misdemeanor/felony, complete and upload the Supplemental Application Form located on the EMR Certification page of the SCEMSA website.

C. Pay the recertification fee established by SCEMSA, which are non-refundable and non-transferable.

D. Once the above criteria is met, the applicant's provider agency will receive an email notification to login to the Sacramento County EMS eLicensing Application Portal to verify applicant's status. When the provider agency verifies status, they are agreeing that:
   - Any criminal background history received will be shared with SCEMSA.

E. Once the above is completed and verified, SCEMSA will process the application, notify the applicant if additional information is required, and issue a wallet-sized EMR card.

Recertification after a Lapse in Certification:

A. The following recertification requirements shall apply to an individual whose SCEMSA EMR certification has lapsed:
   1. For a lapse of less than six (6) months, the individual shall comply with the recertification requirements listed in the "Recertification" section of this policy.

B. For a lapse of six (6) months or more but less than twelve (12) months, the individual shall comply with the requirements listed in the Recertification section of the policy and:
   1. Successfully complete a twelve (12) hour refresher course from an approved EMR training program, AND an additional 12 hours of CE (24 CE hours total) within 24 months prior to applying for reinstatement, **OR**
   2. Obtain at least 24 hours of CE, within 24 months prior to applying for reinstatement, from an approved CE provider in accordance with the provisions contained in the California Code of Regulations (Title 22, Division 9, Chapter 11).
   3. For a lapse of twelve (12) months or more, the individual shall complete an entire EMR course and comply with all of the requirements listed in the sub-section of the "Initial Certification" section of this policy.

Expiration While Deployed for Active Duty, Cal Fire, Urban Search and Rescue (USAR), or other State/Federal deployed teams:

A. A SCEMSA-certified EMR who is a member of the United States Armed Forces, Cal Fire, USAR, or other State/Federal deployed teams and whose certification expires while deployed on active duty or whose certification expires less than six (6) months from the date they return from active duty deployment with the United States Armed Forces, Cal Fire, USAR, or other State/Federal deployed teams shall have six (6) months from the date they return from active duty deployment to complete the EMR certification renewal requirements. In order to qualify for this exception, the individual shall:
   1. Submit proof of his/her membership in the United States Armed Forces, Cal Fire, USAR, or other State/Federal deployed teams and submit documentation of his or her deployment starting and ending dates.
   2. For the United States Armed Forces, CE credit may be given for documented training that meets the requirements contained in the California Code of Regulations (Title 22, Division 9, Chapter 11) while the individual was deployed on active duty. CE documentation shall include verification from the individual's Commanding Officer attesting to the training.

Additional Provisions:

A. The EMR shall be responsible for notifying SCEMSA of all changes in name using the change of name form, mailing address using change of address form, employer, and/or email, by emailing SCEMSAInfo@saccounty.gov within thirty (30) calendar days of the change.
B. The EMR and the provider agency shall be responsible for notifying the SCEMSA Medical Director and the SCEMSA Administrator within three (3) working days of becoming aware of a reportable incident during the certification period.
C. Application processing may be delayed, and additional information /investigation may be required prior to processing for applicants with criminal backgrounds.
D. A SCEMSA-issued EMR certification may be denied, suspended, or revoked by the SCEMSA Medical Director for any act that is substantially related to the qualifications, functions, and duties of an EMR and is evidence of a threat to the public health and safety (pursuant to California Health and Safety Code, Division 2.5 Section 1798.200).

Recertification Effective Dates:

A. SCEMSA shall issue a wallet-sized EMR certificate card to eligible individuals who apply for an EMR recertification and meet all of the requirements listed in the "Recertification" section of the policy.
B. If the renewal requirements are met within six (6) months prior to the current certification expiration date, the effective date of renewal shall be the date immediately following the expiration date. The certification will expire on the last day of the month two (2) years from the date prior to the effective date.
C. If the EMR renewal requirements are met greater than six (6) months prior to the expiration date, the effective date of renewal shall be the day the certificate is issued. The

certification expiration date will be the last day of the month two (2) years from the effective date.

D. If the EMR renewal requirements are met after six (6) months or more but less than 12 months, the effective date of the renewal shall be the day the certificate is issued. The certification expiration date shall be the last day of the month two (2) years from the effective date.

Cross Reference: PD# 2210 – Emergency Medical Responders (EMR) Scope of Practice
EMR Skills Competency Verification Form
PD# 7600 – Quality Improvement Program
PD# 7602 – Quality Assurance Program

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	4200.18
	PROGRAM DOCUMENT: **Mobile Intensive Care Nurse (MICN): Certification**	Initial Date:	09/01/92
		Last Approved Date:	12/12/24
		Effective Date:	05/01/25
		Next Review Date:	12/01/26

Signature on File	Signature on File
EMS Medical Director	EMS Administrator

Purpose:

A. To establish the requirements for an individual to be certified as a Mobile Intensive Care Nurse (MICN) in Sacramento County.

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9
C. Sacramento County Board of Supervisors, Resolution #2013-0478

Policy:

Candidates and/or their near relatives are not permitted to sign any documentation of proof attesting to the skills, training, or education of that candidate. It is the responsibility of the candidate to ensure impartiality and avoid potential conflicts of interest in any documentation. **Any falsification of documentation is grounds for losing certification for a period of at least twelve (12) months**.

All candidates will meet the following certification requirements:

A. Prerequisite Criteria (Documentation that these criteria have been met) must be submitted online at Sacramento County EMS eLicensing Application Portal.
    1. Provide proof of current licensure as a Registered Nurse in California
    2. Provide proof of current Advanced Cardiac Life Support and Pediatric Advanced Life Support cards according to the standards of the American Heart Association.
    3. Provide proof of completion of a Sacramento County or another California LEMSA MICN course.
        a. If a course is attended outside of Sacramento County, the MICN shall successfully complete the SCEMSA approved MICN exam ~~with a SCEMSA-approved MICN course~~ and taken with a Sacramento County base hospital.
    4. Provide proof of completion of a ground-based SCEMSA-designated Advanced Life Support (ALS) emergency response vehicle observation experience operating within the 911 system or equivalent.
        a. Must consist of at least eight (8) direct observation hours
        b. Must include at least two (2) patient contacts in which the patient is assessed by the EMS Crew.
        - If two (2) patient contacts are not completed, two (2) ALS scenarios will be conducted by the Paramedic within the eight (8) hour observation period.
    5. If a candidate has a valid MICN certification from another LEMSA, provide proof of completion of a ground-based SCEMSA designated Advanced Life Support (ALS) emergency response vehicle observation experience operating within the 911 system.

a. Must consist of at least four (4) observation hours.
b. Must include at least two (2) patient contacts in which the patient is assessed by the EMS Crew.
    - If two (2) patient contacts are not completed, two (2) ALS scenarios will be conducted by the Paramedic within the four (4) hour observation period.

B. Pay all the non-refundable/non-transferable fees established by SCEMSA.
C. Provide a copy of a government-issued Photo ID for identification purposes.
D. Upload a passport-type (2x2) photo.
    a. SCEMSA is available during counter hours to take your photo for the SCEMSA Certification card.
E. Upon successful completion of A-D above, the current base hospital employer will receive an automated email notification to login to the Sacramento County EMS eLicensing Application Portal for verification of both employment and experience* within a SCEMSA base hospital. Once verified, SCEMSA shall certify the candidate as a base hospital MICN for a period of two (2) years from the last day of the month in which all the certification requirements are met.
F. On the first Monday of every month, SCEMSA sends out a Separation from Provider/Roster update reminder. The Base Hospital emergency department prehospital coordinator, or their designee, are responsible for ensuring the roster is accurate and if termination/separation of a MICN has occurred within ten (10) calendar days using the Separation from Provider form on the Sacramento County EMS eLicensing Application Portal.

NOTE: Certification applications that are not completed after one (1) year shall be considered abandoned and shall be discarded.

*Defined as six (6) months as a registered nurse in a base hospital emergency department.

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	4201.20
	PROGRAM DOCUMENT: **Mobile Intensive Care Nurse (MICN): Recertification**	Initial Date:	06/01/92
		Last Approved Date:	12/12/24
		Effective Date:	05/01/25
		Next Review Date:	12/01/26

Signature on File	Signature on File
EMS Medical Director	EMS Administrator

Purpose:

A. To establish the requirements for an individual to be recertified as a Mobile Intensive Care Nurse (MICN) in Sacramento County.

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9
C. Sacramento County Board of Supervisors, Resolution #2013-0478

Policy:

MICNs and/or their relatives are not permitted to sign any documentation of proof attesting to the skills, training, or education of that candidate. It is the responsibility of the candidate to ensure impartiality and avoid potential conflicts of interest in any documentation.
Any falsification of documentation is grounds for losing certification for a period of at least twelve (12) months.

All candidates will meet the following certification requirements:

A. Only MICNs who are currently certified in Sacramento County are eligible for recertification.
B. All recertification MICNs will meet the following requirements and provide documentation to Sacramento County Emergency Medical Services Agency (SCEMSA):

    1. Apply online at Sacramento County EMS eLicensing Portal. Applications/recertification may be completed six (6) months before certification expiration. Applications received less than thirty (30) days before certification expiration shall be assessed a late fee.
    2. Provide a copy of valid and current licensure as a Registered Nurse in California.
    3. Provide a copy of a valid and current Advanced Cardiac Life Support (ACLS) card and Pediatric Advanced Life Support (PALS) card according to the standards of the American Heart Association.
    4. Provide a minimum of 12 hours of CEs, relating to prehospital care. ACLS or PALS may be used for a maximum of six (6) hours CE for reauthorization. Four (4) hours of ride-a-long time on an ALS ambulance may also be used for this CE requirement.
        1) The ALS ride-along requirement shall consist of direct observation with at least two (2) patient contacts during which the patient is assessed with a SCEMSA-designated Advanced Life Support (ALS) emergency response vehicle operating within the 9-1-1 system or equivalent.
            - If two (2) patient contacts are not completed, two (2) ALS scenarios will be conducted by the Paramedic within the four (4) hour observation period.

5. Provide a government-issued Photo ID for identification purposes.
6. Upload a passport-type (2x2) photo of yourself or come into SCEMSA during counter hours, and staff will take your photo for the SCEMSA Certification card.
7. Pay all non-refundable/non-transferable fees established by SCEMSA.

C. Upon successful completion of A-B (1-7) above, the current base hospital employer will receive an automated email notification to login to the Sacramento County EMS eLicensing Portal. for verification of both employment and experience* within a SCEMSA base hospital. Once verified, SCEMSA shall certify the candidate as a base hospital MICN for a period of two (2) years from the last day of the month in which all the certification requirements are met.

D. **For a lapse of MICN** certification from one (1) day to twelve (12) months:
Provide proof of completion of the following:
   1. All required documents per Protocol C 1-7 above and;
      a. Provide proof of completing an additional 1.0 prehospital continuing education hours for each month of lapsed status rounded up to nearest month.
   2. Upon fulfillment the above, the current base hospital employer will receive an automated email for employment verification. Once the current base hospital employer verifies employment, SCEMSA shall recertify the candidate as an MICN for a period of two (2) years from the expiration date on the candidate's current certification card.

E. **For a Lapse of MICN** certification ≥ twelve (12) months, all the initial authorization requirements must be met.

F. On the first Monday of every month, SCEMSA sends out a Separation from Provider/Roster update reminder. The Base Hospital emergency department prehospital coordinator, or their designee, are responsible for ensuring the roster is accurate and if termination/separation of a MICN has occurred within ten (10) calendar days using the Separatin from Provider form on the Sacramento county EMS eLicensing Application Portal.

G. Allowance for Active Duty Personnel:
   1. Members of the reserves deployed for active duty during the time when their MICN certification expires may be given an extension of the expiration date for up to six (6) months from the date of their deactivation or release from active duty.
   2. Documentation shall be provided to verify the individual's date of activation and deactivation or release from active duty.

H. Transfer of a SCEMSA MICN certification is permissible from one (1) base hospital to another if the following are met:
   1. Current certification as an MICN.
   2. Within ninety (90) days from when employment ceased.

I. SCEMSA will work, on an individual basis, with the base hospital EMS coordinator for requirements regarding authorized leave of absence.

NOTE: Certification applications that are not completed after one (1) year shall be considered abandoned and shall be discarded.

*Defined as six (6) months as a registered nurse in a base hospital emergency department.

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	4202.01
	PROGRAM DOCUMENT: **Mobile Intensive Care Nurse (MICN) Course**	Initial Date:	9/27/24
		Last Approved Date:	12/12/24
		Effective Date:	11/01/24
		Next Review Date:	9/01/26

Signature on File	Signature on File
EMS Medical Director	EMS Administrator

Purpose:

A. The purpose of this policy is to establish guidelines and requirements for hospitals to develop and implement a Mobile Intensive Care Nurse (MICN) course. This course is essential for certifying nursing staff to provide advanced pre-hospital care and coordinate with emergency medical services (EMS).

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9
C. Sacramento County Board of Supervisors, Resolution #2013-0478

Policy:

A. Any Hospital that utilizes MICNs must establish a MICN course that meets the standards outlined in this policy. The course must be approved by the Sacramento County EMS Agency (SCEMSA) and ensure that participants are adequately trained to perform MICN duties.
B. Course Requirements:
    1. Curriculum:
        a. The MICN course curriculum must cover the following core areas:
            - EMS Overview
            - EMS Legal Matters
            - EMS/MICN Communications
            - Patient Destination
            - Ambulance patient off-load time (APOT)
            - MCI's
            - SCEMSA Treatment Policies
            - Base Hospital Consults
    2. Course Duration:
        a. The course must include a minimum of:
            - Didactic Instruction: minimum of 16 hours **THEN**
            - Practical Training/Shadowing: minimum of 8 hours
                1. All calls / questions answered by MICN shall be given by a licensed MICN
                2. All patient care decisions shall be given by a licensed MICN

3. Instructors:
    a. Course instructors must be:
        - Licensed healthcare professionals with experience in emergency care
        - Certified MICNs or equivalent professionals with expertise in EMS coordination
        - Approved by the hospital's education department and SCEMSA
4. Assessment:
    a. Participants must undergo a comprehensive assessment, which includes:
        - Written examinations covering theoretical knowledge
        - Practical assessments, including simulation-based evaluations
        - Performance reviews during hands-on training sessions
5. Certification:
    a. Upon successful completion of the course and assessments, participants will receive a MICN certification. The certification must be renewed every two years through continuing education and competency assessments.

C. Quality Assurance
1. Course Evaluation:
    a. Hospitals must regularly evaluate the MICN course to ensure its effectiveness and compliance with current standards. Evaluations should include:
        - Participant feedback
        - Performance metrics of certified MICNs
        - Review of course content and instructional methods
2. Continuous Improvement
    a. Based on course evaluations, hospitals must implement improvements to the MICN course. This may include updating curriculum content, enhancing training methods, and incorporating new medical guidelines and technologies.

D. Compliance and Accountability
a. Regulatory Compliance
    - Hospitals must ensure that the MICN course complies with all relevant local, state, and federal regulations. This includes obtaining necessary approvals and maintaining records of compliance.
b. Accountability
    - The hospital’s education department is responsible for the implementation, oversight, and continuous improvement of the MICN course. The department must ensure that all instructors and participants adhere to this policy.
c. Documentation and Records
    - Hospitals must maintain comprehensive records of the MICN course, including:
        i. Participant enrollment and attendance
        ii. Assessment results
        iii. Certification status
        iv. Course evaluations and improvement plans
d. Course and Exam:
    - After completing the course, MICN students must take the SCEMSA approved exam with a passing grade of 80%.
    - Students are permitted to take the exam twice.

i. If they do not pass on the second attempt, they must retake the entire course.
ii. Should they fail the exam two additional times after retaking the course, they will be ineligible to retake the course or the exam for a period of one year.

Cross Reference: 4200 – MICN Certification
4201 – MCIN Recertification

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	4503.06
	PROGRAM DOCUMENT: **Public Safety/Emergency Medical Technician (EMT) Automated External Defibrillation (AED) Service Provider Approval**	Initial Date:	12/17/14
		Last Approved Date:	12/12/24
		Effective Date:	05/01/25
		Next Review Date:	12/01/26

Signature on File	Signature on File
EMS Medical Director	EMS Administrator

Purpose:

A. To establish the training standards and program approval requirements for the use of an Automated External Defibrillator (AED) by any public safety agency employing lifeguards, firefighters, and/or peace officers or EMTs trained in first aid, CPR, and use of an AED.

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9

Definitions:

A. **Automated External Defibrillator (AED)** – An external defibrillator capable of cardiac rhythm analysis that will charge and deliver a shock, either automatically or by user interaction, after electronically detecting and assessing ventricular fibrillation or rapid ventricular tachycardia.

B. **AED Provider** – An organization that employs Public Safety First Aid (PSFA), Emergency Medical Responder (EMR), and/or Emergency Medical Technician (EMT) personnel and who obtains AEDs for the purpose of providing AED services to the general public.

Policy:

A. An AED provider shall be approved by SCEMSA and continually meet all requirements set forth by State law, regulations, and SCEMSA policies. AED provider approval may be revoked or suspended for failure to comply with the requirements of this policy.

Procedure:

A. AED Provider Approval Process:
   1. An EMS prehospital service provider desiring to provide AED services to the the general public shall submit a written request to SCEMSA for approval to provide such services. The written request shall include the following:
      - The organization's name, address, and contact information.
      - A description of the number, type, and location of AEDs being utilized.
      - The organization’s AED equipment orientation training for PSFA, EMR, and/or EMT personnel.
      - The organization’s AED equipment maintenance program.

- The organization’s procedures for collection and retention of AED utilization medical records.
- The organization’s quality improvement (QI) monitoring and oversight processes related to AED utilization.

B. Approved AED Provider Requirements:
   1. Collect and submit the following information as part of the EMS Prehospital services provider’s Emergency Medical Services QI Program annual report:
      - The number of patients with sudden cardiac arrest receiving CPR prior to the arrival of emergency medical care.
      - The total number of patients on whom defibrillator shocks were administered, witnessed (seen or heard), and not witnessed.
      - The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation.
      - A summary of QI issues or concerns related to the organization's AED program
   2. AED providers shall notify SCEMSA by the end of the next business day of any AED equipment malfunction or inappropriate application of an AED.

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	4504.06
	PROGRAM DOCUMENT: **Automated External Defibrillation (AED) Medical Control**	Initial Date:	12/18/14
		Last Approved Date:	12/12/24
		Effective Date:	05/01/25
		Next Review Date:	12/01/26

Signature on File	Signature on File
EMS Medical Director	EMS Administrator

Purpose:

A. To establish medical control criteria for approved Automated External Defibrillation (AED) Service Providers

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9

Policy:

The AED Service Provider will provide evidence of Medical Control. This will include the following:

A. Appointment of a Medical Director, defined as a physician and/or a surgeon, currently licensed in California, who provides medical oversight to the AED Service Provider as set forth in California Code of Regulations, Title 22, Division 9; Prehospital Emergency Medical Services.
    1. The Medical Director will review each incident where emergency care or treatment of a person in cardiac arrest is rendered and ensure the CPR and AED standards were followed
B. Appointment of an AED coordinator, which may be any one of the following:
    1. A physician, registered nurse, physician assistant, paramedic, or EMT.
C. That a mechanism exist assures the continued competency of the CPR and AED-trained individuals in the AED Service Provider's employ to include periodic training and skills proficiency demonstrations.
D. Training on maintenance and use of an AED according to manufacturer's Recommendations.

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	8060.19
	PROGRAM DOCUMENT: **Stroke**	Initial Date:	11/20/96
		Last Approval Date:	12/12/24
		Effective Date:	05/01/25
		Next Review Date:	12/01/26

Signature on File	Signature on File
EMS Medical Director	EMS Administrator

Purpose:

To establish a treatment standard for Emergency Medical Technicians and Paramedics in treating patients showing signs or symptoms of a suspected stroke.

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9

Definitions:

A. **Stroke** - A condition of impaired blood flow to a patient's brain resulting in brain dysfunction, most commonly through occlusion or hemorrhage.
B. **Onset of Symptoms -** The specific date and time when current symptoms were known to have started.
C. **Last Known Normal/Well -** When the "onset of symptom" cannot be reliably determined (no witness or a poor historian), the Last Known Well time is the most recent time a reliable historian can say the patient was at their baseline health without current symptoms.
D. **Wake Up Stroke -** Patient awakens with stroke symptoms that were not present prior to falling asleep.
E. **Suspected Stroke -** Suspected Stroke with one (1) new onset of lateralizing neurological signs; and/or two (2) unexplained new altered level of consciousness (Glasgow Coma Scale < 14) without response to Glucose, Glucagon, or Naloxone (excluding head injury).

Protocol:

A. If possible, document a reliable time of day that the patient was last observed to be normal either by the patient or witness. A patient who wakes up with symptoms is considered as having an **UNKNOWN** time of onset.

BLS
1. Ensure patent airway. 2. Supplemental O_2 as necessary to maintain SPO2 ≥ 94%. Use the lowest concentration and flow rate of O_2 as possible. 3. Perform Blood Sugar determination. 4. Transport.
ALS
1. Advanced airway adjuncts as needed. 2. Cardiac Monitoring. 3. Determine Cincinnati Prehospital Stroke Scale (CPSS). Normal response is 0, Abnormal is 1, Maximum Score is 3. 4. Initiate vascular access. If time allows, without delaying transport, initiate a second access line. Minimum 20g in AC when possible. 5. If CPSS is >0, and "last seen normal" *time, including wake-up Stroke, is twenty-four (24) hours or less, the patient is to be taken to a certified stroke center. 6. Prehospital personnel will contact the receiving hospital and clearly announce: "Stroke Alert" and give the following information if available: • Last time of day observed to be "normal," reported by bystanders. • Patient's name, date of birth, or medical record number, if known. • Baseline Mental Status. 7. When possible and safe to do so, transport a family member or Durable Power of Attorney (DPOA) or obtain and relay to the receiving hospital the name/contact information of the individual(s) who can verify the time of onset of symptoms or last known normal/well time. ***If CPSS is=0, OR "last seen normal" time is > twenty-four (24) hours, the patient is <u>NOT</u> a "stroke alert," and destination is per Policy PD# 5050 – Destination.**

Cross Reference: PD# 2525 – EMS Radio Report Format
PD# 2060 – Hospital Services
PD# 5050 – Destination
PD# 5060 – Hospital Diversion

Cincinnati Prehospital Stroke Scale (CPSS)			
Sign / Symptom	**How tested**	**Normal 0**	**Abnormal + 1**
Facial Droop	Have the patient show their teeth or smile	Both sides of the face move equally	One side of the face does not move as well as the other
Arm Drift	The patient closes their eyes and extends both arms straight out for 10 seconds	Both arms move the same, or both do not move at all	One arm either does not move, or one arm drifts downward compared to the other
Speech	The patient repeats "The sky is blue in Cincinnati"	The patient says correct words with no slurring of words	The patient slurs words, says the wrong words, or is unable to speak

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	8810.13
	PROGRAM DOCUMENT: **Transcutaneous Cardiac Pacing**	Initial Date:	01/07/99
		Last Approval Date:	12/12/24
		Effective Date:	05/01/25
		Next Review Date:	12/01/26

Signature on File	Signature on File
EMS Medical Director	EMS Administrator

Purpose:

A. To establish a procedure standard for utilizing Transcutaneous Cardiac Pacing (TCP).

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9

Indications:

A. Symptomatic Bradycardia per PD# 8024 – Cardiac Dysrhythmias policy:
   - Heart rate < 50 beats per minute (bpm) documented by cardiac monitor
   - Systolic blood pressure < 90 mm Hg,
   - Decreased sensorium
   - Diaphoresis
   - Chest pain
   - Capillary refill > two seconds
   - Cool extremities
   - Cyanosis

Relative Contraindication:

Hypothermia

Procedure:

A. Assemble equipment.
B. Explain the procedure to the patient.
C. Connect the patient to a cardiac monitor and obtain a 12-lead ECG rhythm strip, if possible, or Lead II rhythm strip.
D. Cardiac Monitoring per PD# 8024 – Cardiac Dysrhythmias
E. Select the pacing mode to asynchronous or non-demand mode.
F. Set the pacing rate to 80 bpm.
G. Increase the milliamps (mA) to mechanical capture or lowest setting possible. Activate the pacing device and increase the milliamps as tolerated. Observe the patient and ECG until mechanical capture is achieved. Mechanical capture is the point when the pacemaker produces a pulse with each QRS complex.
H. If needed, provide for patient sedation as described PD# 8024 – Cardiac Dysrhythmia.
I. Continue monitoring the patient and anticipate further therapy.

Special Notes:

A. Symptomatic Type II 2nd-degree blocks and 3rd-degree blocks should have TCP implemented without delay.

Cross Reference: PD# 8024 – Cardiac Dysrhythmias
PD# 8018 – Overdose and/or Poisoning

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	8829.11
	PROGRAM DOCUMENT: **Noninvasive Ventilation (NIV)**	Initial Date:	01/25/08
		Last Approval Date:	12/12/24
		Effective Date:	05/01/25
		Next Review Date:	12/01/26

Signature on File	Signature on File
EMS Medical Director	EMS Administrator

Purpose:

A. To establish a guideline for the indications and application of CPAP or BiPAP.

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9

Definitions:

A. Noninvasive Ventilation (NIV): Refers to the administration of ventilatory support without using an invasive artificial airway (endotracheal tube or tracheostomy tube). In prehospital care, this can be provided by either:
    1. Continuous positive airway pressure (CPAP)
    2. Bi-level positive airway pressure (BiPAP)

Indications:

A. Adult and Pediatric patients, > 12 years of age, in moderate to severe respiratory distress being treated under PD# 8026 – Respiratory Distress and PD# 9003 – Pediatric Respiratory Distress Reactive Airway Disease, Asthma, Bronchospasm, Croup, or Stridor: Shortness of Breath and who are:
    1. Spontaneously breathing
    2. Conscious
    3. Indications:
        - Congestive Heart Failure (CHF) with acute pulmonary edema
        - Severe Asthma
        - Chronic Obstructive Pulmonary Disease (COPD)
        - Near Drowning

Contraindications:

A. Agonal respirations or apneic patients
B. Pediatric patients < 12 years of age
C. Systolic Blood Pressure (SBP) < 80 mmHg
D. Cardiac and/or respiratory arrest
E. Suspected pneumothorax
F. Vomiting patients

G. Uncooperative patients after coaching
H. Inability to achieve a good seal with the CPAP or BiPAP facemask
I. Major trauma, especially a head injury or significant chest trauma
J. GCS ≤ 14
K. Inability to maintain airway patency
L. Inability to remain in a sitting position

Special Precautions:

A. Do not delay medication administration to apply a non-invasive ventilatory support device.
B. Patients must be **CONTINUOUSLY** monitored for the development of:
   1. Respiratory failure – Remove device and use Bag Valve Mask (BVM) and/or advanced airway adjunct.
   2. Vomiting – Remove device to prevent aspiration.
   3. Suspected barotrauma – Remove device.
C. Monitor oxygen consumption, especially if nebulizers are being run off the same oxygen supply.
D. If staffing permits, allow one paramedic to focus on setting up, coaching, and monitoring the patient's response to CPAP or BiPAP, and another paramedic responsible for patient care.

Equipment:

A. CPAP or BiPAP pressure generator and circuit.
B. Appropriate sized facemask and straps.
C. Inline nebulizer if required for bronchodilator administration.
D. Oxygen supply.
E. ETCO2 detector (Optional).

Procedure:

A. Assemble equipment.
B. Explain procedure to patient.
C. Assist patient to use and tolerate the mask and circuit.
D. Use straps to maintain CPAP or BiPAP seal if needed.
E. Transport patient in a position that facilitates continuous visual monitoring and minimizes aspiration risk.
F. Document lung sounds before and after application of CPAP or BiPAP frequently or if clinical change.
G. Starting CPAP pressure shall be 5 cm H2O. If using BiPAP set IPAP to 10 cm H2O and EPAP to 5 cm H2O.
H. NIV support pressures may be increased for clinical effect 2.5-5 cm every 5 minutes. Use the lowest NIV pressures which result in clinical improvement to maintain O2 saturation > 90% and improve patient work of breathing.

I. If patient becomes unresponsive or has agonal respirations, remove CPAP or BiPAP and assist ventilations with BVM and airway adjuncts.
J. Monitor patient and response to NIV.
K. Notify hospital that a NIV is in use so that equipment can be made available upon arrival at the hospital to continue.

Medication Administration:

A. FiO2 shall be titrated to the least amount needed to maintain SAO2 ≥ 94%.
B. If indicated for wheezing, Albuterol 5 mg will be administered via in line nebulizer utilizing at least 8 liters per minute.
C. Nitrates, if indicated for CHF, shall be delivered per CHF algorithm via sub lingual Nitroglycerine 0.4mg to 1.2mg prior to application of NIV, then Nitro paste one (1) inch applied to the chest.

Management of Hypotension on NIV:

A. CPAP or BiPAP may introduce transient hypotension via decreased venous return.
B. If SBP < 90 mmHg, for adults, decrease the NIV to no more than 5 cm H2O pressure and administer 500 cc normal saline bolus x 1, if SBP remains < 90 mmHg after fluid bolus then remove device and any Nitro paste.
C. If SBP < 80 mmHg, titrate to a minimal Systolic Blood Pressure (SBP) for the patient's age, decrease CPAP to 5 cm H2O pressure, and administer 20ml/kg normal saline bolus x 1. If SBP remains < 80 mmHg after fluid bolus then remove CPAP.

Cross Reference: PD# 8026 – Respiratory Distress
PD# 9003 – Respiratory Distress: Reactive Airway Disease, Asthma, Bronchospasm, Croup, or Stridor

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	8830.10
	PROGRAM DOCUMENT: **Supraglottic Airway i-Gel®**	Initial Date:	02/18/09
		Last Approved Date:	12/12/24
		Effective Date:	05/01/25
		Next Review Date:	09/01/26

Signature on File	Signature on File
EMS Medical Director	EMS Administrator

Purpose:

A. To establish the Emergency Medical Services (EMS) system standard for the establishment of a supraglottic airway.

B. To describe the situations where a supraglottic airway device may be established

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Authority:

A. California Code of Regulations, Title 22, Division 9
B. California Health and Safety Code, Division 2.5

Indications:
EMT:

A. Cardiac arrest management for age ≥ fifteen (15) years of age.

AEMT and/or Paramedic ONLY:

A. Newborn (≥2 kg) – ADULT
   1. Advanced airway in cardiac arrest airway management.
   2. Respiratory failure.
   3. Backup advanced airway when endotracheal intubation cannot be achieved.
   4. When non-invasive airway management is inadequate.

Approved Supraglottic Airway Devices:

A. I-Gel®

Contraindications:

A. Responsive patients with intact gag reflex
B. Patients with known esophageal disease
C. Ingestion of caustic substance
D. Difficulty in advancing the i-Gel® due to resistance upon insertion attempt
E. Presence of tracheostomy or stoma
F. Burns involving the airway
G. Foreign body airway obstruction

Relative Contraindications:

A. Anatomical disruption of the oropharynx

Procedure:

I-Gel®

A. Lubricate i-gel® with manufacture lubricant
B. Ensure the gag reflex is not intact
C. Place the patient's head in a sniffing or neutral position. Maintain spinal motion restriction if indicated
D. Introduce i-gel into the mouth and advance behind the base of the tongue. Never force the tube into position
E. Advance tube until the base of the connector aligns with teeth or gums
F. Confirm placement by auscultating bilateral breath sounds and end-tidal CO_2 detector. Response to confirmation may be slower than endotracheal intubation
G. Secure the tube using an approved device and ventilate with a BVM and 100% O_2.
H. The tube's position shall be reevaluated after moving the patient
I. No medication is to be administrated through the supraglottic device

Potential Complications:

A. Subcutaneous emphysema
B. Perforated trachea or esophagus
C. Retropharyngeal perforation

Precautions and Special Considerations:

A. Emergency Removal:

In situations where patient combativeness makes continued intubation with a supraglottic airway device dangerous, the presence of a gag reflex, or inadequate ventilation with the supraglottic device, the tube may be removed.

1. Have suction and BVM for assisted ventilations
2. Position the patient to minimize the risk of aspiration
3. Remove the tube
4. Suction and assist ventilations as necessary

B. Airway Management:

Frequently reassess advanced airway placement. Bilateral breath sounds are to be checked after each move of the patient, e.g., placing the patient on the gurney, moving the patient to the ambulance, loading the patient into the ambulance, and unloading the patient at the hospital.

Cross Reference: PD# 8020 – Respiratory Distress: Airway Management Policy.
PD# 9003 – Pediatric Respiratory Distress: Reactive Airway Disease, Asthma, Bronchospasm, Croup, or Stridor.

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	8831.07
	PROGRAM DOCUMENT: **Intranasal Medication Administration**	Initial Date:	04/09/09
		Last Approval Date:	12/12/24
		Effective Date:	05/01/24
		Next Review Date:	12/01/26

Signature on File
EMS Medical Director

Signature on File
EMS Administrator

Purpose:

A. To establish a skill guideline for Intranasal (IN) administration of medications.

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9

Indications:

A. Any patient requiring medication administration which by SCEMSA policy can be given via the intranasal route.

Contraindications:

A. Epistaxis.
B. Nasal Trauma.
C. Nasal septal abnormalities.
D. Nasal congestion or discharge.

Relative Contraindications:

A. Severe hypotension may prevent adequate absorption.
B. Recent use of vasoconstriction medications.

Equipment:

A. Mucosal Atomizer Device (MAD).

Procedure:

A. Patient should be in a supine or recumbent position. If the patient is sitting then compress the nares after administration.
B. Draw up medication into a syringe using appropriate transfer device.
   1. One-half (1/2) the total dose is administered in each nare.
C. Place MAD onto syringe and confirm it is secure.
D. Administer medication by briskly compressing the plunger to expel and atomize the medication administering a maximum of 1cc of solution per nare.
E. Evaluate medication effectiveness and continue with treatment protocol.

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	9019.06
	PROGRAM DOCUMENT: **Pediatric** **Brief Resolved Unexplained Event (BRUE)**	Initial Date:	08/14/15
		Last Approval Date:	12/12/24
		Effective Date:	05/01/25
		Next Review Date:	12/01/26

Signature on File	Signature on File
EMS Medical Director	EMS Administrator

Purpose:

A. To establish the treatment standard for treating pediatric patients with a Brief Resolved Unexplained Event (BRUE).

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9

Definition:
Brief Resolved Unexplained Event (BRUE) is an episode involving an infant less than twelve (12) months of age that is frightening to the observer and there is no explanation for a qualifying event after conducting an appropriate history and physical exam.

A. A qualifying event is characterized by one or more of the following:

1. Apnea (central or obstructive)
2. Color change (cyanosis, pallor, erythema)
3. Marked change in muscle tone
4. Unexplained choking or gagging
5. Altered level of responsiveness

Protocol:

A. EMS personnel shall make every effort to obtain the contact information of the person who witnessed the event. Provide the contact information to the receiving hospital upon patient delivery.

B. Perform a comprehensive exam and obtain a history of event, including duration, severity, what, if any, resuscitative measures were done by the parent or caretaker, and obtain past medical history.

C. If treatment/transport is refused by parent or guardian, contact base hospital to consult prior to leaving and document the refusal of care.

BLS
1. Ensure patent airway. 2. Supplemental O2 as necessary to maintain SPO2 ≥ 94%. Use the lowest concentration and flow rate of O2 as possible. 3. Perform Blood Sugar 4. Transport
ALS
1. Cardiac Monitor

Cross Reference: PD #8837 - Pediatric Airway Management

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	9020.06
	PROGRAM DOCUMENT: **Pediatric** **Nausea and/or Vomiting**	Initial Date:	11/15/15
		Last Approval Date:	12/12/24
		Effective Date:	05/01/25
		Next Review Date:	12/01/26

Signature on File
EMS Medical Director

Signature on File
EMS Administrator

Purpose:

A. To establish a treatment standard for treating pediatric patients with nausea and/or vomiting.

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9

Protocol:

BLS

1. Consider oxygen therapy per PD # 8837 – Pediatric Airway Management.
2. Assess and treat, as appropriate, for underlying causes.
3. Perform blood glucose.
4. Maintain normal body temperature.

ALS

~~1.~~ ~~Cardiac Monitoring~~

2. If vital signs or exam suggests volume depletion, consider:
   a) IV/IO access.
   b) Normal Saline 20 ml/kg ~~x 1~~.
   c) Recheck vitals every 5 minutes.
3. Consider Ondansetron if age > one (1) month and weight ≥ eight (8) kg.

   [8-15 kg]:
   - Dose: 2 mg PO/IM ~~x 1~~; Alt: 0.15 mg/kg/dose IV/IO ~~x 1~~.

   [16-30 kg]:
   - Dose: 4 mg PO/IM ~~x 1~~;
     Max: 4 mg/dose; Alt: 0.15 mg/kg/dose IV/IO ~~x 1.~~

   [> 31 kg]:
   - Dose 4 mg PO/IM ~~x 1~~
     Max: 8 mg/dose PO/IM; Alt: 0.15 mg/kg/dose IV/IO ~~x 1~~.

Cross Reference: PD #8837 – Pediatric Airway Management