Public Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Agenda	March 12, 2020 9:30 a.m.
I.	**Introductions**	
II.	**Approve Agenda**	
III.	**Minutes**	
IV.	**Medical Issues**	
	A. Coronavirus Update	Dr. Shepherd/Steve Carroll
V.	**New Business**	
	A. Education – Policy Development Sub-Committee	Chris Rosa/Andrew Casey
	B. Fentanyl Atomizer	Dr. Shepherd
VI.	**Old Business**	
	A. 736 – Naloxone Policy	Dr. Shepherd
VII.	**Informational/Discussion Topics**	
	A. 402 – Patient Diversion	Karen Beatty
	B. 430 - STEMI	Karen Beatty
	C. 440 - Code STEMI Interfacility Transfer	Karen Beatty
VIII.	**Policies for Review**	
	A. 604 – Transport and Destination Guidelines	
	B. 613 - DNR	
IX.	**Agency Reports**	
	A. Fire Departments	
	B. Ambulance Providers	
	C. Base Hospitals	
	D. Receiving Hospitals	
	E. Law Enforcement	
	F. ALS Education Program	
	G. EMS Agency	
	H. Other	
X.	**Closing**	

Ventura County Fire Dept. Classroom A and B 165 Durley Avenue Camarillo, CA 93010	Pre-hospital Services Committee Minutes	January 16, 2020 9:30 a.m.

Topic	Discussion	Action	Approval
II. Approve Agenda		Approved	Motion: Ira Tilles Seconded: Kristen Shorts Passed unanimous
III. Minutes		Approved	Motion: Barry Parker Seconded: Heather Ellis Passed unanimous
IV. **Medical Issues**			
A. None			
V. New Business			
A. Fentanyl Related Policies			
1. 310 – Paramedic Scope of Practice		Approved	Motion: Heather Ellis Seconded: Adriane Stefansen Passed unanimous
2. 504 – ALS and BLS Equipment		Approved with Changes. Fentanyl added Replace “ampule” with concentration	Motion: Heather Ellis Seconded: Adriane Stefansen Passed unanimous
3. 705.06 - Burns		Approved with changes. Refer to the “pain control” policy 705.19 for medication and dosage. Remove MS from “Additional Information” and replace with Fentanyl.	Motion: Heather Ellis Seconded: Adriane Stefansen Passed unanimous
4. 705.09 – Chest Pain		Approved with Changes. Amiodarone & push dose Epi moved to standing order Pain control 705 referenced for Fentanyl No more communication failure orders	Motion: Heather Ellis Seconded: Adriane Stefansen Passed unanimous
5. 705.19 – Pain Control	Tom O’Conner asked that we try to streamline this policy.	Approved with changes.	Motion: Heather Ellis Seconded: Adriane Stefansen Passed unanimous

		Combine Adult and Peds columns because it is weight based. Dr. Shepherd and Andrew will work on correct dosage. Add Ondansetron to each area that Morphine is listed.	
6. 710 – Airway Management		Approved with changes. TBI contraindication removed Use of approved SGA when ETT placement not successful. Dr. Chase discussed equipment and EtCO2 waveform changes. Dr. Shepherd will review and follow up with Dr. Chase.	Motion: Ira Tilles Seconded: Tom O'Connor Passed unanimous
7. 705.24 - Bradycardia		Approved with changes. Pain control 705 referenced for Fentanyl	
B. Naloxone Policy	Chris presented the draft Naloxone Policy titled "Leave at home Naloxone Program". After a lengthy conversation, it was decided that Chris and Dr. Shepherd would work to address the concerns mentioned today and e-mail to the committee for review.	Tabled	
VI. Old Business			
A. None			
VII. Informational/Discussion Topics			
A. 452 – TCASC Standards			
VIII. Policies for Review			
A. 705.28 – Smoke Inhalation		Approved	
B. 1602 – PSFA Optional Skills Approval and Training		Tabled	

	C. 1605 – PSFA Optional Skills Naloxone Administration		Tabled	
X.	**Agency Reports**			
	A. Fire departments	**VCFPD** – This is Barry Parkers last PSC meeting. He will be replaced by Joe Williams. Good luck to Barry and welcome Joe!! **VCFD-** none **OFD** – none **Fed. Fire** – none **SPFD** – none **FFD** – none		
	B. Transport Providers	**LMT – none** **AMR/GCA** – . **AIR RESCUE –** none		
	C. Base Hospitals	**SAH** – Emergency Room construction is complete. **LRRMC** – E.R expansion starts in Quarter 2. **SJRMC –** none **VCMC** – none		
	D. Receiving Hospitals	**PVH –** none **SPH** – none **CMH** – Completed their first year in the new building. **OVCH** – none		
	E. Law Enforcement	**VCSO –**none **CSUCI PD –** none		
	F. ALS Education Programs	**Ventura –** There are 28 students on clinical rotation. Ride alongs will begin in February. Thank you to all the providers for taking the students. There are 32 applicants for next class.		
	G. EMS Agency	**Steve –** County counsel approved the Stroke Contracts. Hospitals will be asked to sign the contracts in the next few weeks. Hoping to be completed by July 1st. **Dr. Shepherd –** none **Chris** – none **Katy** –none **Karen** – none **Julie** –none **Randy** – none		
	H. Other			
	XI. Closing	**Meeting adjourned at 11:30**		

Prehospital Services Committee 2020

For Attendance, please initial your name for the current month

Agency	LastName	FirstName	1/16/2020	2/13/2020	3/12/2020	4/9/2020	5/14/2020	6/11/2020	7/9/2020	8/13/2020	9/10/2020	10/8/2020	11/12/2020	12/10/2020	%
AMR	Stefansen	Adriane	AS												
AMR	Riggs	Cassie	CR												
CMH - ER	Levin	Ross													
CMH - ER	Querol	Amy													
OVCH - ER	Pulido	Ed	EP												
OVCH - ER	Ferguson	Catherine	CF												
CSUCI PD	Drehsen	Charles	CD												
CSUCI PD	Deboni	Curtis													
FFD	Herrera	Bill	BH												
FFD	Panke	Chad													
GCA															
GCA	Sanders	Mike													
Lifeline	Rosolek	James													
Lifeline	Williams	Joey	JW												
LRRMC - ER	Brooks	Kyle													
LRRMC - ER	Shaner	Meghan	MS												
OFD	Strong	Adam	AS												
OFD	Villa	Jaime	JV												
SJPVH - ER	Hutchison	Stacy													
SJPVH - ER	Sikes	Chris	CS												
SJRMC - ER	Larsen	Todd	TL												
SJRMC - ER	McShea	Kathy													
SVH - ER	Tilles	Ira	IT												
SVH - ER	Shorts	Kristen	KS												
V/College	O'Connor	Tom	TO												
VCFD	Tapking	Aaron	AT												
VCFD	Ellis	Heather	HE												
VNC	Williams	Joseph	JW												
VNC	Schwab	David	DS												
VNC - Dispatch	Gregson	Erica	EG												
VCMC - ER	Chase	David	DC												
VCMC - ER	Gallegos	Tom	TG												

Agency	LastName	FirstName	1/16/2020	2/13/2020	3/12/2020	4/9/2020	5/14/2020	6/11/2020	7/9/2020	8/13/2020	9/10/2020	10/8/2020	11/12/2020	12/10/2020	%
VCMC-SPH	Holt	Carrie													
VCSO SAR	Conahey	Dave	DC												
VCSO SAR	Tolle	Jonathon	JT												
VFF	Lane	Mike													
VFF	Vilaseca	James	JV												
Below names a	**Date Change/cancelled - not counted against member for attendance**														
EMS	Carroll	Steve	SC												
EMS	Frey	Julie	JF												
EMS	Perez	Randy													
EMS	Shepherd	Daniel	DS												
EMS	Rosa	Chris	CR												
EMS	Salvucci	Angelo													
EMS	Hansen	Erik	EH												
EMS	Beatty	Karen	KB												
EMS	Garcia	Martha	MG												
EMS	Casey	Andrew	AC												
LMT	Winter	Jeff													
LMT	Frank	Steve													
AMR/GCA	Gonzales	Nicole													
State Parks	Futoran	Jack													
VCMC	Hill	Jessica													
VCMC	Duncan	Thomas													
CMH	Hall	Elaina	EH												
VNC	James	Lauri													
VNC	Shedlosky	Robin	RS												
VCSO SAR	Hadland	Don													

TEMPORARY
PARKING PASS
Expires March 12, 2020

Health Care Services
2240 E. Gonzales Rd
Oxnard, CA 93036

For use in "Green Permit Parking" Areas only, EXCLUDES Patient parking areas

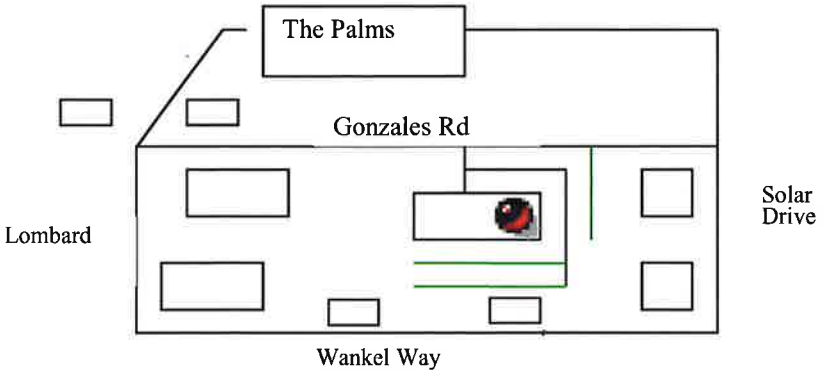
Parking Instructions: Parking at workshop venue is limited. Arrive early to allow for offsite parking if venue parking lot is full.

2240 Gonzales Rd. location
If you park in a designated "green permit parking" slot, fold this flyer in half and place pass face-up on the dash of your car, to avoid receiving a ticket.

2100 Solar Drive
An additional amount of "Green Permit Parking" spaces (only 30) are available in adjacent parking lot, those that back-up against venue parking area, (Enter this parking lot off of Gonzales[3rd driveway] or Solar Drive). Place this flyer on your dash. If all of those stalls are occupied, overflow parking is available at The Palms shopping area or side streets.

The Palms - shopping mall
Enter The Palms at Lombard and Gonzales. Allow for a ten minute walk to venue location.

Additional parking is available on side streets, Lombard, Solar and Wankel Way.



COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Leave at Home Naloxone Program	Policy Number 7XX
APPROVED: Administration: Steve L. Carroll, Paramedic	Date: DRAFT
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: DRAFT
Origination Date: Date Revised: Date Last Reviewed: Review Date:	Effective Date: DRAFT

I. PURPOSE: To authorize ALS prehospital personnel to distribute naloxone kits to patients, or family/friends of patients, with suspected opioid use disorder,- and to delineate the process for distribution of naloxone to Ventura County ALS provider agencies.

II. AUTHORITY: California Health and Safety Code, Sections 1797.220 and 1798; California Code of Regulations, Title 22, Sections 100146, 100169, 100170

III. POLICY: The opioid crisis has had a profound impact on communities across the United States. This policy is part of a broader harm reduction strategy that attempts to mitigate the impact of the crisis by increasing the availability of Naloxone. ALS prehospital personnel may distribute naloxone kits- to patients, or the friends/family of patients, with suspected opioid use disorder. The appropriate training must be offered~~provided~~ to the recipient at the time of distribution.

A. Indications

1. Suspected opioid use disorder

2. Patient is not transported~~ and left at scene alive~~

B. Contraindications

1. Patient is transported~~ or determined to be dead~~

IV. PROCEDURE:

A. Treat Patient in accordance with VCEMS policies and procedures

B. Once it has been determined that patient will refuse transport, AMA shall be processed and documented in accordance with VCEMS Policy 603 – Refusal of EMS Services.

C. Once AMA process has been completed, the patient, or the patient's family/friends (must be present on scene) will be offered a leave-at-home naloxone kit.

D. Friends/family can be offered a kit if the patient is determined to be dead. Kits should be offered if the individuals at the scene appear to be at risk for opioid use disorder. For example, they were using drugs with the patient or there is paraphernalia on scene. Document as outlined below.

~~D.~~E. Recipient Training and Education

1. If the naloxone kit is accepted, the patient and/or family and friends will be trained on the recognition of opioid overdose and on the administration of nasal naloxone.
2. At a minimum, the training will consist of the following:
   a) Signs and symptoms of an opioid overdose
   b) Administration of nasal naloxone
   c) Activating the 911 system
   d) Basic~~Hands-only~~ CPR. Instruct the recipient how to perform chest compressions: "place your hands between the nipples and push hard and fast."
3. Printed training materials, written orders from the VCEMS Medical Director, and resources related to ongoing drug treatment services will be left with patient or patient's family/friends at the scene.

~~E.~~F. Documentation

1. Information will be completed for both the patient contact, as well as the refusal of EMS services, in accordance with VCEMS Policy 1000 – Documentation of Patient Care.
2. In addition to the standard ePCR documentation, additional fields related to the leave at home naloxone kit will also be documented via supplemental ePCR fields. At a minimum, these fields will include:
   a) Name of Naloxone Kit Recipient
   b) Recipient relationship to patient
   c) Recipient phone number
   d) Confirmation that training was provided to recipient and family/friends on scene

e) Confirmation that addiction resources were left with recipient

~~F.~~G. Inventory

1. Distribution of leave at home naloxone will be tracked through the ePCR system, which means documentation is very important.
2. Nasal naloxone should not be distributed through standard inventory that is part of the day-to-day equipment (i.e. jump bags, supply cabinets, etc). These kits will be specially marked and tracked outside of the standard inventory process.
3. As nasal naloxone inventory is depleted through the leave at home program, replacement kits will be supplied by VCEMS to agencies on a one-for-one basis.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title Patient Diversion/Emergency Department Closures	Policy Number: 402
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June 1, 2020
APPROVED: Medical Director: Daniel Shepherd	Date: June 1, 2020
Origination Date: January 1990 Revised Date: December 10, 2019 Date Last Reviewed: December 10, 2019 Review Date: June 30, 2023	Effective Date: June 1, 2020

I. PURPOSE: To define the procedures by which Emergency Medical Services (EMS) providers and/or Base Hospitals (BH) may:

A. Transport emergency patients to the most accessible medical facility that is staffed, equipped, and prepared to administer emergency care appropriate to the needs of the patient.

B. Provide a mechanism for a hospital in the Ventura County (VC) EMS system to have patients diverted away from its emergency department when it has been determined that the hospital is not staffed, equipped, and/or prepared to care for additional or specific types of patients.

C. Assure that Advanced Life Support (ALS) units are not unreasonably removed from their area of primary response when transporting patients to a medical facility.

II. AUTHORITY: California Administrative Code, Title 13, Section 1105(c): "In the absence of decisive factors to the contrary, ambulance drivers shall transport emergency patients to the most accessible medical facility equipped, staffed, and prepared to receive emergency cases and administer emergency care appropriate to the needs of the patient".

III. POLICY: Hospitals may divert patients according to the conditions described below. This policy shall not negate prearranged interhospital triage and transport agreements approved by VC EMS Basic Life Support (BLS) patients will be transported to the nearest unless it is closed by internal disaster.

IV. DEFINITIONS:

A. ALS Patient: A patient who meets the criteria for base hospital contact.

B. BLS Patient: A patient whose illness or injury requires BLS care or a patient in a BLS unit, irrespective of the level of care required for the patient's illness or injury.

V. PROCEDURE

A. DIVERSION REQUEST CATEGORIES

A hospital may request that ambulances be diverted for the following reasons using the following terminology:

1. **Internal Disaster**

   Hospital's emergency department cannot receive any patients because of a physical plant breakdown (e.g. fire, bomb threat, power outage, safety issues in the ED, etc.).

   NOTE: Activation of a hospital's internal plan to handle diversions (see Section IV.D) does NOT constitute an internal disaster.

2. **Emergency Department Saturation**

   The hospital's emergency department resources are fully committed to critically and/or seriously ill patients and are not available for additional ALS patients.

3. **Lack of Neurosurgical coverage**

   Hospital is unable to provide appropriate care due to unavailability of a neurosurgeon, and is therefore not an ideal destination for patients likely to require these services.

4. **Intensive Care Unit (ICU) / Critical Care Unit (CCU) Saturation**

   Hospital's ICUs do not have any available licensed beds to care for additional patients, and is therefore not an ideal destination for patients likely to require these services.

5. **CT Scanner Inoperative**

   Hospital's CT scanner is not functioning and therefore not the ideal destination for patients with blunt or penetrating head trauma, truncal trauma, or a prehospital Stroke Alert patient.

6. **STEMI Receiving Center (SRC) Unavailable**

   Hospital is unable to accept a "STEMI Alert" patient due to unavailability of their Cath lab or Cath lab staff. Must state reason in the "comment section" on ReddiNet as to why the Cath lab is unavailable. ROSC patients will not be diverted.

   Thrombectomy Capable Acute Stroke Center (TCASC) Unavailable

7. Hospital is unable to accept an "ELVO Alert" patient due to unavailability of their Cath lab or Cath lab staff. Must state reason in the "comment section" on ReddiNet as to why the Cath lab is unavailable.

B. PATIENT DESTINATION

1. Internal Disaster
   a. A hospital on diversion due to internal disaster shall not receive patients.
   b. Base hospitals shall not direct ALS units to transport patients to any medical facility that has requested diversion of ALS patients due to an internal disaster.
2. Diversion requests will be honored provided that:
   a. The involved ALS unit estimates that it can reach an "open" facility without compromising the patient's condition by extending the Code 3 en route time from the incident location for hospitals on diversion due to:
      1) ICU/CCU saturation,
      2) Emergency Department saturation, or
      3) Neuro/CT scanner limitations for appropriately selected patients.
   b. The patient does not exhibit an uncontrollable problem in the field. An "Uncontrollable Problem" is defined as:
      1) Unstable vital signs
      2) Cardiac Arrest
      3) Severe Respiratory Distress
      4) Unstable Airway
      5) Profound Shock
      6) Status Epilepticus
      7) OB patient with imminent delivery
      8) Life threatening arrythmia
      9) Any Patient that the paramedic on scene or the BH MD feels would likely deteriorate due to diversion.
3. Destination while adjacent hospitals are on diversion
   a. If adjacent hospitals within an area grouping are on diversion for the same diversion category, patients cannot be diverted for that reason, and the patient will be transported to the closest medical facility.
   b. Guidelines for potential diversion destination when a hospital is on diversion based on patient location and estimated transport times are as follows:

Hospital Groupings/Areas

1. **Area 1** (Ojai): Ojai Valley Community Hospital, Community Memorial Hospital, Ventura County Medica lCenter, Santa Paula Memoria lHospital
2. **Area 2** (Santa Paula/Fillmore): Santa Paula Memorial Hospital, Ventura County Medical Center, Community Memorial Hospital, Ojai Valley Community Hospital
3. **Area 3** (Simi Valley): Simi Valley Hospital, Los Robles Hospital and Medical Center, St. Johns Pleasant Valley Hospital
4. **Area 4** (Thousand Oaks): Los Robles Hospital and Medical Center, Simi Valley Hospital, St. Johns Pleasant Valley Hospital
5. **Area 5** (Camarillo): St. Johns Pleasant Valley Hospital, St. Johns Regional Medical Center, Los Robles Regional Medical Center, Simi Valley Hospital, Ventura County Medical Center, Community Memorial Hospital
6. **Area 6** (Oxnard): St. Johns Regional Medical Center, Ventura County Medical Center, Community Memorial Hospital, St. Johns Pleasant Valley Hospital
7. **Area 7** (Ventura): Ventura County Medical Center, Community Memorial Hospital, St. Johns Regional Medical Center, Ojai Valley Community Hospital, Santa Paula Memorial Hospital.

   As needed, an MICN may divert a patient to a hospital outside of Ventura County.

   BLS ambulances shall notify receiving hospitals of their impending arrival.

4. Notwithstanding any other provisions of this policy, and in accordance with VCEMS Policy 604, Patient Transport and Destination, final authority for patient destination rests with the Base Hospital.

C. PROCEDURE FOR REQUESTING DIVERSION OF ALS PATIENTS

1. The hospital administrator or his/her designee must authorize the need for diversion.
2. To initiate, update or cancel a diversion, the Administrator or his/her designee shall make the status change via the ReddiNet system.

a. Hospitals on diversion status shall immediately update their status via the ReddiNet system.

b. Problems with policy and procedure related to diversion notification will be directed to VC EMS during normal business hours or the on-call VC EMS administrator after normal business hours

c. Problems arising during a diversion, requiring immediate action should be directed to VC EMS during normal business hours or the on-call VC EMS administrator after normal business hours.

3. VC EMS staff will perform unannounced site visits to hospitals on diversion status to ensure compliance with these guidelines.

D. Hospitals shall develop internal policies and procedures for authorizing diversion of patients in accordance with this policy. These policies shall include internal activation of backup procedures. These policies and procedures shall be approved according to the hospital policy approval procedure and shall be available to the EMS staff for review.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: STEMI Receiving Center (SRC) Standards and STEMI Referral Hospital (SRH) Standards	Policy Number 430
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June 1, 2020
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: June 1, 2020
Origination Date: July 28, 2006 Date Revised: February 5, 2020 Last Review: February 5, 2020 Review Date: February 28, 2023	Effective Date: June 1, 2020

I. PURPOSE: To define the criteria for designation as a STEMI Receiving Center in Ventura County.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1798, 1798.101, 1798.105, 1798.2 and California Code of Regulations, Title 22, Section 100175, 100270.124 and 100270.125.

III. DEFINITIONS: Refer to California Code of Regulations, Title 22, Chapter 7.1, Article 1.

III. POLICY:

A. A STEMI Receiving Center (SRC), approved and designated by Ventura County EMS shall meet the following requirements:

1. All the requirements of a Receiving Hospital in VCEMS Policy 420.
2. All the requirements of an SRC in VCEMS Policy 440.
3. The hospital shall have established protocols for triage, diagnosis, and Cath lab activation following field notification.
4. The hospital shall have a single call activation system to activate the Cardiac Catheterization Team directly.
5. Written protocols shall be in place for the identification of STEMI patients.
    - At a minimum, these written protocols shall be applicable in the ICU/Coronary Unit, Cath lab, and the Emergency Department.
6. The hospital shall be available for treatment of STEMI patients 24 hours per day, 7 days a week, 365 days per year.
7. The hospital shall have a process in place for the treatment and triage of simultaneous arriving STEMI patients.
8. SRCs shall comply with the requirements for an annual minimum volume of procedures (25) required for designation by VCEMS.

9. The hospital shall have a STEMI program manager and a STEMI medical director.
10. The hospital shall have job descriptions and organizational structure clarifying the relationship between the STEMI medical director, STEMI program manager, and the STEMI team.
11. Operate a cardiac catheterization lab licensed by the Department of Health Services and approved for emergency percutaneous coronary interventions.
12. A STEMI receiving center without cardiac surgery capability on-site shall have a written transfer plan and agreements for transfer to a facility with cardiovascular surgery capability.
13. The hospital shall maintain daily STEMI team and Cardiac Catheterization team call rosters
14. Have policies for patients to receive emergent angiography or emergent fibrinolysis, based on physician decisions for individual patients.
15. The hospital shall participate in the local EMS agency quality improvement processes related to a STEMI critical care system.
16. The hospital shall submit their data to the STEMI Registry System by the 15th of each month for the previous month patients.
17. Will accept all ambulance-transported patients if the interpretation on the monitor meets the manufacturer guidelines for a POS STEMI ECG, except when on internal disaster or no cardiac catheterization lab is available, regardless of ICU/CCU or ED saturation status.
18. Have policies and procedures that allow the automatic acceptance of any STEMI patient from a Ventura County Hospital upon notification by the transferring physician.
19. The Cardiac Catheterization Team, including appropriate staff, shall be immediately available.
20. Have policies in place for the transfer of STEMI patients.

B. A STEMI Referral Hospital (SRH), approved and designated by Ventura County EMS shall meet the following requirements:

1. All the requirements of a Receiving Hospital in VCEMS Policy 420.
2. All the requirements of an SRH in VCEMS Policy 440.
3. The hospital shall be available for treatment of STEMI patients 24 hours per day, 7 days a week, 365 days per year.
4. Written protocols shall be in place to identify STEMI patients and provide an optimal reperfusion strategy using fibrinolytic therapy.
5. The Emergency Department shall maintain a standardized procedure for the treatment of STEMI patients.
6. The hospital shall have a transfer process through interfacility transfer agreements and have pre-arranged agreements with EMS ambulance providers for rapid transport of STEMI patients to an SRC.
7. The hospital shall have a program to track and improve treatment of STEMI patients.
8. The hospital must have a plan to work with an SRC and VCEMS on quality improvement processes.

B. Designation

1. Application:
   Eligible hospitals shall submit a written request for SRC or SRH approval to the VC EMS, documenting the compliance of the hospital with Ventura County SRC or SRH Standards.
2. Approval:
   SRC or SRH approval or denial shall be made in writing by VCEMS to the requesting Hospital within two weeks after receipt of the request for approval and all required documentation.
3. VC EMS may deny, suspend, or revoke the approval of a SRC or SRH for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Ventura County Board of Supervisors for appropriate action.
4. The VCEMS Medical Director may grant an exception to a portion of this policy upon substantiation of need by the PSC that compliance with the

regulation would not be in the best interests of the persons served within the affected area.

5. SRCs and SRHs shall be reviewed every three years.
   a. SRCs or SRHs shall receive notification of evaluation from VCEMS.
   b. SRCs or SRHs shall respond in writing regarding program compliance.
   c. On-site SRC or SRH visits for evaluative purposes may occur.
   d. SRCs or SRHs shall notify VCEMS by telephone, followed by a letter or email within 48 hours, of changes in program compliance or performance.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: "Code STEMI": Transfer of Patients with STEMI for PCI		Policy Number 440
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: June 1, 2020
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: June 1, 2020
Origination Date: Date Revised: Last Reviewed: Review Date:	July 1, 2007 February 5, 2020 February 5, 2020 February 28, 2023	Effective Date: June 1, 2020

I. PURPOSE: To define the "Code STEMI" process by which patients with a STEMI are transferred to a STEMI Receiving Center (SRC) for emergency percutaneous coronary intervention (PCI).

II. AUTHORITY: Health and Safety Code, Sections 1797.220 and 1798. California Code of Regulations, Title 22, Sections 100147, 100169, 100270.124 and 100270.125

III. DEFINITIONS:

A. STEMI: ST Segment Elevation Myocardial Infarction.

B. STEMI Receiving Center (SRC): an acute care hospital with percutaneous coronary intervention (PCI) services that has been designated according to VC EMS Policy 430.

C. STEMI Referral Hospital (SRH): an acute care hospital in Ventura County that meets the requirements for a receiving hospital in VC EMS Policy 420 and has been designated according to VC EMS Policy 430.

D. PCI: Percutaneous Coronary Intervention.

IV. POLICY:

A. STEMI Referral Hospitals will:

1. Assemble and maintain a "STEMI Pack" in the emergency department to contain all of the following:
   a. Checklist with phone numbers of Ventura County SRCs.
   b. Preprinted template order sheet with recommended prior-to-transfer treatments. Treatment guidelines will be developed with input from the SRH and SRC cardiologists.
   c. Patient Consent/Transfer Forms.
   d. Treatment summary sheet.
   e. Ventura County EMS Code STEMI data entry form.
2. Have policies, procedures, and a quality improvement system in place to minimize door-to-ECG and STEMI-Dx-to-transfer times.

3. Establish policies and procedures to make personnel available to accompany the patient during the transfer to the SRC. These policies will include patient criteria for requiring an RN to accompany patient.

B. Ambulance Dispatch Center will:

1. Respond to a “Code STEMI” transfer request by immediately dispatching the closest available ALS ambulance to the requesting SRH.

C. Ambulance Companies

1. Ambulance Companies will:
   a. Respond immediately upon request for “Code STEMI” transfer.
   b. Staff all ambulances with a minimum of one paramedic who has been trained in the use of intravenous heparin and nitroglycerine drips, and the pump being used, according to VC EMS Policy 722.
2. Transports performed according to this policy are not to be considered an interfacility transport as it pertains to ambulance contract compliance.

D. STEMI Receiving Centers will:

1. Maintain accurate status information on ReddiNet regarding the availability of a cardiac catheterization lab.
2. Publish a single phone number, that is answered 24/7, to receive notification of a STEMI transfer.
3. Immediately upon initial notification by a transferring physician at an SRH, accept in transfer all patients who have been diagnosed with a STEMI and who, in the judgment of the transferring physician, require urgent PCI.
4. Authorize the emergency physician on duty to confirm the acceptance in transfer of any patient with a STEMI.
5. Establish an internal communications plan that assures the immediate notification of all necessary individuals, including the cardiac catheterization services staff and on-call interventional cardiologist, of the transfer.
6. Adopt procedures to make an ICU/CCU bed available or to make alternate arrangements for post-PCI care.

V. PROCEDURE:

A. Upon diagnosis of STEMI, and after discussion with the patient, the SRH will:

1. Determine availability of the SRC by checking ReddiNet.
2. Immediately call the Ventura County Fire Communication Center at 805-384-1500 for an ambulance.

3. Identify their facility to the dispatcher and advise they have a Code STEMI transfer to [SRC].
4. After calling for ambulance, the SRH transferring physician will notify the SRC emergency physician of the transfer.
5. Perform all indicated diagnostic tests and treatments.
6. Complete transfer consent, treatment summary, and Code STEMI data forms.
7. Include copies of the ED face sheet and demographic information.
8. Arrange for one or more healthcare staff, as determined by the clinical status of the patient, to accompany the patient to the SRC.
    a. If, because of unusual and unanticipated circumstances, no healthcare staff is available for transfer, the SRH may contact the responding ambulance company to make a paramedic or EMT available.
    b. If neither the SRH or ambulance company has available personnel, a CCT transfer may be requested.
9. Contact SRC for nurse report at the time of, or immediately after, the ambulance departs.

B. Upon request for “Code STEMI” transfer, the dispatch center will dispatch the closest ALS ambulance and verbalize “MEDxxx Code STEMI from [SRH]”. The SRC will be denoted in the Incident Comments, which will display on the Mobile Data Computer (MDC). If a unit does not have an operational MDC, the SRH will advise the responding ambulance personnel of the SRC.

C. Upon notification, the ambulance will respond Code (lights and siren) and the ambulance personnel will notify their ambulance company supervisor of the “Code STEMI” transfer.

D. Ambulance units will remain attached to the incident and FCC will track their dispatch, en-route, on scene, en-route hospital, at hospital, and available times.

E. The patient shall be urgently transferred without delay. Every effort will be made to minimize on-scene time.
1. All forms should be completed prior to ambulance arrival.
2. Any diagnostic test results may be relayed to the SRC at a later time.
3. Intravenous drips may be discontinued or remain on the ED pump.
4. Ambulance personnel will place defibrillation pads on the patient.

F. Upon notification, the SRC will notify the interventional cardiologist and cardiac catheterization staff, who will respond immediately and prepare for the PCI procedure.

G. The SRH and SRC shall review all STEMI transfers within 24 hours for appropriate and timely care and to identify opportunities for improvement. Results will be reviewed and discussed at the Countywide EMS STEMI CQI Committee.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Transport and Destination Guidelines	Policy Number 604
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: June 1, 2016
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: June 1, 2016
Origination Date: June 3, 1986 Date Revised: December 10, 2015 Date Last Reviewed: December 10, 2015 Review Date: December, 2018	Effective Date: June 1, 2016

I. PURPOSE: To establish guidelines for determining appropriate patient destination, so that to the fullest extent possible, individual patients receive appropriate medical care while protecting the interests of the community at large by optimizing use and availability of emergency medical care resources.

II. AUTHORITY: Health and Safety Code, Section 1317, 1797.106(b), 1797.220, and 1798 California Code of Regulations, Title 13, Section 1105(c) and Title 22, Section 100147.

III. POLICY: In the absence of decisive factors to the contrary, patients shall be transported to the most accessible medical facility equipped, staffed, and prepared to receive emergency cases and administer emergency medical care appropriate to the needs of the patients.

IV. PROCEDURE:

A. Hospitals unable to accept patients due to an internal disaster shall be considered NOT "prepared to receive emergency cases".

B. In determining the most accessible facility, transport personnel shall take into consideration traffic obstruction, weather conditions or other factors which might affect transport time.

C. Most Accessible Facility

The most accessible facility shall ordinarily be the nearest hospital emergency department, except for:

1. Base Hospital Direction for ALS patients

a. Upon establishment of voice communication, the Base Hospital is responsible for patient management until the patient reaches a hospital and medical care is assumed by the receiving hospital.

b. The Base Hospital may direct that the patient be transported to a more distant hospital which in the judgment of the BH physician or MICN is more appropriate to the medical needs of the patient.

c. Patients may be diverted in accordance with Policy 402.

2. Patients transported in BLS ambulances demonstrating conditions requiring urgent ALS care (e.g., unstable vital signs, chest pain, shortness of breath, airway obstruction, acute unconsciousness, OB patient with contractions), shall be transported to the nearest hospital emergency department prepared to receive emergency cases.

D. "Decisive Factors to the Contrary"

Decisive factors to the contrary for BLS or ALS patients include, but are not limited to, the following:

1. Prepaid Health Plans

a. EMS personnel shall not request information on insurance or delay transport or treatment while determining insurance status.

b. A member of a group practice prepayment health care service who volunteers such information and requests a specific facility may be transported according to that plan when the ambulance personnel or the Base Hospital determines that the condition of the member permits such transport. Therefore when the Base Hospital contact is made the Base Hospital must always be notified of the patient’s request.

c. However, when the on duty supervisor determines that such transport would unreasonably remove the ambulance unit from the service area, the member may be transported to the nearest hospital capable of treating the member.

2. Patient Requests

a. When a person or his/her legally authorized representative requests emergency transportation to a hospital other than the most accessible emergency department, which may include out of the county, the request should be honored when ambulance personnel, BH physician or MICN determines that the condition of the patient permits such transport. Therefore when the Base

Hospital contact is made the Base Hospital must always be notified of the patient's request.

b. When it is determined by the on duty supervisor that such transport would unreasonably remove the ambulance unit from the service area, the patient may be transported to the nearest hospital capable of treating him/her.

3. Private Physician's Requests

When a treating physician requests emergency transportation to a hospital other than the most accessible acute care hospital, which may include out of the county, the request should be honored unless it is determined by the on duty supervisor that such transport would unreasonably remove the ambulance from the service area. In such cases:

a. If the treating physician is immediately available, ambulance personnel shall confer with the physician regarding a mutually agreed upon destination.

b. If the treating physician is not immediately available, the patient should be transported to the nearest hospital capable of treating him/her.

c. If Base Hospital contact has been made due to the condition of the patient and the immediate unavailability of the treating physician, and the BH physician or MICN determines that the condition of the patient permits or does not permit such transport, BH directions shall be followed. If communication with the treating physician is possible, the BH should consult with the physician.

4. Physician on Scene per VC EMS Policy 703

When a bystander identifies him/herself as a physician and offers assistance on scene, VC EMS Policy 702 shall be followed.

5. Direct Admits

When a patient's physician has arranged direct admission to a hospital, the patient should be transported to that hospital regardless of Emergency Department diversion status unless the Base Hospital determines that the patient's condition requires that s/he be transported to a more appropriate facility.

E. “Medical facilities equipped, staffed and prepared to administer care appropriate to needs of the patients.”

1. Paramedics treating patients that meet trauma criteria Steps 1-3 in VCEMS Policy 1405 will make Base Hospital contact with a designated Trauma Center. The Trauma Center MICN or ED physician will direct the patient to either the Trauma Center or a non-trauma hospital.
2. Patients who meet STEMI criteria in VC EMS Policy 440 will be transported to a STEMI Receiving Center.
3. Patients who are treated for cardiac arrest and achieve sustained return of spontaneous circulation (ROSC) will be transported to a STEMI Receiving Center.
4. Patients who meet Stroke criteria in VC EMS Policy 451 will be transported to an Acute Stroke Center.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Do Not Resuscitate		Policy Number 613
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: December 1, 2016
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: December 1, 2016
Origination Date: Date Revised: Date Last Reviewed: Review Date:	October 1, 1993 October 13, 2016 October 13, 2016 October, 2018	Effective Date: December 1, 2016

I. PURPOSE: To establish criteria for a Do Not Resuscitate (DNR) Order, and to permit Emergency Medical Services personnel to withhold resuscitative measures from patients in accordance with their wishes.

II. AUTHORITY: California Health and Safety Code, Sections 1797.220, 1798 and 7186 and Division 1, Part 1.85 (End of Life Option Act).
California Probate Code, Division 4.7 (Health Care Decisions Law).
California Code of Regulations, Title 22, Section 100170.

III. DEFINITIONS:

A. "EMS Personnel": All EMTs, paramedics and RNs caring for prehospital or interfacility transfer patients as part of the Ventura County EMS system.

B. "Resuscitation": Medical interventions whose purpose is to restore cardiac or respiratory activity, and which are listed below:

1. External cardiac compression (chest compressions).
2. Defibrillation.*
3. Tracheal Intubation or other advanced airway.*
4. Assisted Ventilation for apneic patient.*
5. Administration of cardiotonic medications.*

C. "DNR Medallion": A permanently imprinted insignia, worn by a patient that has been manufactured and distributed by an organization approved by the California Emergency Medical Services Authority.

D. "DNR Order": An order to withhold resuscitation. A DNR Order shall be considered operative under any of the following circumstances. If there is a conflict between two DNR orders the one with the most recent date will be honored.

* - Defibrillation, advanced airway, assisted ventilation, and cardiotonic medications may be permitted in certain patients using a POLST form. Refer to VCEMS Policy 625.

1. A fully executed original or photocopy of the "Emergency Medical Services Prehospital DNR Form" has been read and reviewed on scene;
2. The patient is wearing a DNR Medallion;
3. A fully executed California Durable Power of Attorney For Health Care (DPAHC) form is seen, a health care agent designated therein is present, and that agent requests that resuscitation not be done;
4. A fully executed Natural Death Act Declaration has been read and reviewed on scene;
5. A fully executed California Advance Health Care Directive (AHCD) has been read and reviewed on scene and:
   a. a health care agent designated therein is present, and that agent requests that resuscitation not be done, or
   b. there are written instructions in the AHCD stating that the patient does not wish resuscitation to be attempted;
6. A completed and signed Physician Orders for Life-Sustaining Treatment (POLST) form has been read and reviewed on scene, and in Section A, "Do Not Attempt Resuscitation/DNR" is selected;
7. A fully executed Final Attestation Form, or;
8. For patients who are in a licensed health care facility, or who are being transferred between licensed health care facilities, a written document in the patient's permanent medical record containing the statement "Do Not Resuscitate", "No Code", or "No CPR," has been seen. A witness from the health care facility must verbally document the authenticity of this document.

E. "California Advance Health Care Directive (AHCD)". As defined in California Probate Code, Sections 4600-4805.

F. "California Durable Power of Attorney for Health Care (DPAHC)": As defined in California Civil Code, Sections 2410-2444.

G. "Natural Death Act Declaration": As defined in the Natural Death Act of California, Health and Safety Code, Sections 7185-7195.

H. "Physician Orders for Life-Sustaining Treatment (POLST)". As defined in California Probate Code, Division 4.7 (Health Care Decisions Law).

I. "Final Attestation Form": As defined in the End of Life Option Act, California Health and Safety Code Section 443.11.

J. Comfort measures: Medical interventions used to provide and promote patient comfort. Comfort measures applicable to the End of Life Option Act may include airway positioning and suctioning.

IV. PROCEDURE:

A. All patients require an immediate medical evaluation.

B. Correct identification of the patient is crucial in this process. If not wearing a DNR Medallion, the patient must be positively identified as the person named in the DNR Order. This will normally require either the presence of a witness or an identification band.

C. When a DNR Order is operative:

1. If the patient has no palpable pulse and is apneic, resuscitation shall be withheld or discontinued.
2. The patient is to receive full treatment other than resuscitation (e.g., for airway obstruction, pain, dyspnea, hemorrhage, etc.).
3. If the patient is taking high doses of opioid medication and has decreased respiratory drive, early base hospital contact should be made before administering naloxone. If base hospital contact cannot be made, naloxone should be administered sparingly, in doses no more than 0.1 mg every 2-3 minutes.
4. If transport has been initiated, continue transporting the patient to the appropriate receiving facility and transfer care to emergency department staff.
    a. If transport has not been initiated, but personnel are still on scene, patient should be left at scene, if not in a sensitive location (place of business, public place, etc.). The situation should be explained to the family or staff at the scene.

D. A DNR Order shall be considered null and void under any of the following circumstances:

1. The patient is conscious and states that he or she wishes resuscitation.
2. In unusual cases where the validity of the request has been questioned (e.g., a family member disputes the DNR, the identity of

the patient is in question, etc.), EMS prehospital personnel may temporarily disregard the DNR request and institute resuscitative measures while consulting the BH for assistance. Discussion with the family member, with explanation, reassurance, and emotional support may clarify any questions leading to validity of a DNR form.

The underlying principle is that the patient's wishes should be respected.

3. There is question as to the validity of the DNR Order.

Should any of these circumstances occur, appropriate treatment should continue or immediately commence, including resuscitation if necessary. Base Hospital contact should be made when appropriate.

E. Other advanced directives, such as informal “living wills” or written instructions without an agent in the California Durable Power of Attorney for Health Care, may be encountered. Should any of these occur, appropriate treatment will continue or immediately commence, including resuscitation if necessary. Base Hospital contact will be made as soon as practical.

F In case of cardiac arrest, if a DNR Order is operative, Base Hospital contact is not required and resuscitation should not be done. Immediate base hospital contact is strongly encouraged should there be any questions regarding any aspect of the care of the patient.

G. If a DPAHC or AHCD agent requests that resuscitation not be done, the EMT shall inform the agent of the consequences of the request.

H. DNR in a Public Place

Persons in cardiac arrest with an operative DNR Order should not be transported. The Medical Examiner’s office should be notified by law enforcement or EMS personnel. If possible, an EMS representative should remain on scene until a representative from law enforcement or the Medical Examiner’s office arrives.

I. For End-of-Life Option Act:

1. The patient may at any time withdraw or rescind his or her request for an aid-in-dying drug regardless of the patient’s mental state. In this instance, EMS personnel will provide medical care as per standard protocols and contact base hospital.

2. Family member(s) or significant other(s) may be at the scene of a patient who has self-administered an aid-in-dying drug. If there is objection to the End of Life Option Act:
    a. BLS personnel will provide BLS airway management and bag-mask ventilation as needed until ALS arrives.
    b. ALS personnel will provide BLS airway management and bag-mask ventilation as needed, or instruct BLS personnel to continue, and consult the base hospital physician.

V. DOCUMENTATION:

For all cases in which a patient has been treated under a DNR Order, the following documentation is required in the Ventura County Electronic Patient Care Report (VCePCR):

A. Name of patient's physician signing the DNR Order.

B. Type of DNR Order (DNR Medallion, Prehospital DNR Form, POLST Form, written order in a licensed health care facility, DPAHC, Natural Death Act Declaration, Final Attestation Form).

C.

D. For all cases which occur within a licensed health care facility, in addition to above, if the DNR Order was established by a written order in the patient's medical record, the name of the physician signing and the witness to that order.

E. If resuscitation is not done because of the request of a healthcare agent designated in a DPAHC or AHCD, document the agent's name in the VCePCR narrative.

Appendix 1: Algorithm, Aid-in-Dying

Appendix 1
Ventura County EMS Policy 613, "Do Not Resuscitate (DNR)

For <u>End of Life Options Act</u> only:

Patient has taken Aid-in-Dying drug, is NOT in cardiopulmonary arrest