EMERGENCY MEDICAL CARE COMMITTEE MEETING AGENDA

Thursday, July 17th, 2025, at 8:30 A.M.
2995 McMillan Ave, Ste #178, San Luis Obispo

MEMBERS
CHAIR Chris Javine, *Pre-hospital Transport Providers, 2022-2026*
VICE – CHAIR Matt Bronson, *City Government, 2020-2024*
Dr. Brad Knox, *Physician*, *2022-2026*
Bob Neumann, *Consumers*, *2022-2026*
Alexandra Kohler, *Consumers, 2020-2024*
Jonathan Stornetta, *Public Providers, 2020-2024*
Michael Talmadge, *EMS Field Personnel, 2020-2024*
Jay Wells, *Sheriff's Department, 2020-2024*
Julia Fogelson, *Hospitals*, *2022-2024*
Diane Burkey, *MICNs*, *2022-2026*
Dr. Rachel May, *Emergency Physician*, 2022-2026

EX OFFICIO
Ryan Rosander, *EMS Director*
Dr. Bill Mulkerin, *EMS Medical Director*
Penny Borenstein, *Health Officer*

STAFF
Maya Craig-Lauer, PHEP Representative
Rachel Oakley, *EMS Coordinator*
Eric Boyd, *EMS Coordinator*
Kaitlyn Blanton, *EMS Coordinator*
Alyssa Vardas, *Administrative Assistant*

AGENDA	ITEM	LEAD
Call To Order	Introductions Public Comment	C. Javine
Action/Discussion	Approval of minutes: March 20th and May 15th, 2025, Minutes (*attached)*	C. Javine
Action/Discussion	Policy Revisions: • 341- Emergency Medical Technician Paramedic • 342-Emergency Medical Technician Paramedic Reaccreditation • 203-Patient Refusal	R. Oakley
Action/Discussion	Protocol Revisions: • XXX- Opioid Withdrawal • 704-Needle Cricothyrotomy	R. Rosander
Action/Discussion	Formulary Revisions: • Buprenorphine	R. Rosander
Staff Reports	• Health Officer • EMS Agency Director Report • EMS Medical Director Report • PHEP Staff Report	P. Borenstein R. Rosander B. Mulkerin M. Craig-Lauer
Committee Members' Announcements or Reports	Opportunity for Board members to make announcements, provide brief reports on their EMS-related activities, ask questions for clarification on items not on the agenda, or request consideration of an item for a future agenda (Gov. Code Sec. 54954.2[a][2])	Committee Members
Adjourn	**Next Meeting: September 18th, 2025**	C. Javine

Emergency Medical Care Committee

DRAFT Meeting Minutes
8:30 AM May 15th, 2025
2995 McMillan Way, Suite 178
San Luis Obispo, CA 93401

MINUTES

MEMBERS PRESENT:
Chair Chris Javine, Pre-Hospital Transport Providers
Vice Chair Matthew Bronson, City Government
Dr. Brad Knox, Physicians
Bob Neumann, Consumers
Jonathan Stornetta, Chief, City of Paso Robles Fire
Rachel May, Emergency Physicians

MEMBERS ABSENT:
Alexandra Kohler, Consumers
Jay Wells, Sheriff's Department
Michael Talmadge, EMS Field Personnel
Julia Fogelson, Hospitals
Diane Burkey, MICNs

EMS AGENCY STAFF PRESENT:
Alyssa Vardas, EMS Administrative Assistant
Rachel Oakley, EMSA
Eric Boyd, EMSA

PUBLIC COMMENTORS:
Rob Jenkins, CALFIRE

EX OFFICIO:
Ryan Rosander, EMSA
Bill Mulkerin, EMS Medical Director
Dr Penny Borenstein, County Health Officer

1. CALL TO ORDER

Chair Chris Javine called the meeting to order at 8:32 a.m. He then led the review of the meeting protocols and agenda.

2. REVIEW AND APPROVAL OF March 20th, 2025, MINUTES

Action: Minutes were not included in the packet and were tabled until the next meeting.

3. Protocols/Policies

Ambulance Patient Offload Time (APOT) Monitoring: Ambulance Patient Offload Time (APOT) is the interval from when an ambulance arrives at an emergency department (ED) to when the patient is transferred to hospital staff and the ambulance is available for the next call. Excessive APOT negatively impacts EMS system efficiency, delays emergency responses, and contributes to ambulance shortages.
California Health and Safety Code Section 1797.225 mandates that LEMSA monitor and report APOT data. The California EMS Authority (EMSA) has established standardized reporting requirements and defined "excessive offload delay" as patient transfer times exceeding 30 minutes after arrival at the ED.

Discussion:

Rachel May asks if these times get reported to the hospital?

Chris Javine asks if we have the time to share.

Matthew Bronson asks what they are averaging now.

Ryan Rosander answered that we can send the data out and make it public on the website.

Brad Knox says that they did this at Adventist and that it wasn't an issue.

Rachel May says that in terms of language, it says Base Hospital and asks if we should change it to Receiving Hospital.

Ryan Rosander says that we can change it.

Rachel May says that in Image Trend, they can log the time the wheel stops at the hospital, but then they can't continue documenting treatment.

Chris Javine says that he heard they were then documenting in the narrative.

Chris Javine asks what constitutes a transfer under section 3A, where it talks about patient transfer.

Rachel May says she would support a change in that language and that the hospitals need to step up here.

Matthew Bronson asks if the hospitals have weighed in on this?

Ryan Rosander answered that they have and that they have no issues as it stands.

Rachel May says that she thinks French Hospital would need to weigh in.

Jonathan Stornetta asks what the holdback is at French.

Rachel May says that she thinks some of it is demographic and that some of it is how they do things.

Brad Knox says that they are also seeing more patients there.

Matt Bronson mentions that once the data is public, we could have a conversation here.

Jonathan Stornetta asks if we have seen where the ambulance charges the

hospital for time spent at the hospital.

Chris Javine mentions that the ambulance companies have hired staff to stay at the hospital and bill them. The offload times aren't that bad, but there are some cases where they are really bad.

Jonathan Stornetta says that it may not be a problem today, but it could be a problem in the future.

- Opioid Withdrawal – Implementation of Suboxone and County Plan: In conjunction with the County's Strategic Plan for 2025, the introduction of Protocol #XXX (not currently assigned numeric) for Opioid Withdrawal has been drafted. This new protocol will include the addition of Suboxone to our County as an ALS pre-hospital medication with Base Orders. Aligned with the California Bridge Program ideals, this draft protocol has been created to benefit patients experiencing Opioid withdrawal symptoms with the intent of seeking resources for treatment.

  Discussion:

  Chris Javine asks if there are any active screening processes for getting the overdose numbers.

  Ryan Rosander answered that there isn't any active and accurate data.

  Rachel May mentions there is the California Bridge program. If you go to the EMS bridge, there is a good video that talks about how/what/why the program does. They also have a sample protocol.

  Rachel May says that based on data, it is very safe, and there haven't been any bad outcomes. Buprenorphine is cheaper and is the medication that is used. The bridge program uses 8, not 7. It would be nice to have behavioral health stand behind this.

  Brad Knox says that the hospitals stand with this and think it is the right thing to do.

  Ryan Rosander says that Behavioral Health needs to be involved, and that we can add naloxone to it.

  Jonathan Stornetta asks why we didn't go with Buprenorphine.

  Ryan Rosander answered that Bill chose suboxone because there could be abuse with Buprenorphine.

  Rachel May says she also had that question because Buprenorphine is cheaper.

  Ryan Rosander mentions that with refusals, one of the concerns was that they would be called about the medication and would AMA after that. This is a workaround for community paramedics. You could give it to them en route.

Brad Knox says that part of the messaging is that this is the first dose.
Rachel May mentions that the EMS bridge video talks about how buprenorphine works.

Brad Knox mentions that most of these patients are taking it because they are terrified of withdrawals.

Ryan Rosander says the money part is that in order to help this is that they will give $50000 to LEMSA, and LEMSA can help offset costs. This grant has no deliverables, so all ALS agencies have no issues buying it. Grants would be to help offset costs. We can look at Buprenorphine in the future if suboxone doesn't work or if it's too expensive.

Chris Javine asks if we have data on how many people use this?

Rob Jenkins says that there are grants from CDPH for Buprenorphine.

Ryan Rosander says that there is money out there.

Jonathan Stornetta says that he likes how AG is set up with their plan. Two days the county was awarded money for B. H. State awarded money to BH for substance abuse and crisis stabilization centers. We need to make sure the system is set up. This is a first step, and we would look into making it Buprenorphine.

Ryan Rosander mentions that he doesn't think that would be an issue.

Rachel May asks if this is in the local optional scope of practice?

Chris Javine asks for the Formulary-is it supposed to be film and tablet? It says reassess after 10, but the onset is 20 minutes.

Rachel May says you will still see the effect quickly, but yes, that is correct.

Ryan Rosander says the Cows score is in image trend. If we want to change to 8 to match the Bridge program.

Rachel May says she thinks contraindications are the wrong term. The language needs to be changed there. Pregnancy is safe. 18 years is just consent.

Brad Knox says to strike pregnancy, but contraindications are still good to have.

Rachel May Contraindicated is the wrong terminology for under 18.

Brad Knox says he would just give it to adults only.

Rachel May says that she thinks it could be a standing order as well.
Brad Knox mentions that this will be a big culture change.

Jonathan Stornetta says to start a base and then move to standing. I think there will be some paramedics hesitant to give it.

- Opioid Withdrawal – Implementation of Suboxone and County Plan: The Policy 125 revisions were deemed necessary to address issues related to the interpretation of the current obvious death criteria.

  Discussion:
  Brad Knox says 30 seconds is fine.

  Rachel May says the current equipment medics use does not apply.

  Jonathan Stornetta says I am good with changes.

  Eric Boyd says that for obvious death, rigor was moved to physical examination.

4. ANNOUNCEMENTS

Ryan Rosander says CHEMPACK is on June 12th at Sierra Vista, and EOM/MHOAC training is at EMSA on June 13th.

Rachel May says there is an issue with the Brown Act for the Trauma and STEMI groups.

Ryan Rosander mentions that legal counsel says these are not committees, but work groups, so the Brown Act doesn't apply.

5. FUTURE AGENDA ITEMS

Ryan Rosander says we will bring the last meeting's minutes and Needle Cricothyrotomy.

6. ADJOURNMENT

Action: Rachel May approved the changes to the APOT policy. Brad Knox motioned to approve 125 and to move forward with Suboxone and come back with Buprenorphine. Jonathan Stornetta seconded. Motion Carried, with denial from Rachel May for Suboxone until it comes back.

Chair Javine adjourned the meeting at 10:13 a.m.

MEETING DATE	July 17, 2025
STAFF CONTACT	Rachel Oakley
SUBJECT	Paramedic Policy Revisions
SUMMARY	Paramedic policies 341 and 342 for initial accreditation and reaccreditation were last revised on March 1, 2023. Since that time there have been many conversations regarding clarifying information currently in policy and also making a few changes. On December 5th of 2024, EMS personnel policy revisions were discussed with the Operations Subcommittee. The following revisions were brought to our attention and included in the draft policies attached. **Paramedic Accreditation:** • Paramedic Liaison: o To align with other EMS personnel policies, each provider agency will have a designated liaison to submit and track all accreditation and reaccreditation applications with SLOEMSA. • Accreditation Exam: o State that only 2 attempts will be offered. o Provide the procedure if the test is not successfully completed; consult the medical director if accreditee fails both attempts. • Prorated Reaccreditation Requirements: o Upon initial accreditation, and if applicable, any prorated reaccreditation requirements will be communicated. o Internal standardization of prorated requirements is current practice. • PALS: o PALS certification was added to the list of initial application requirements, as paramedics are provided with PALS certification as part of Cuesta's EMS program and most other counties require PALS certification. • Rush Fee: o The rush fee language was changed for requests to process a completed application within 5 business days. o A rush fee will apply for requests to approve accreditation start dates within 5 business days. **Paramedic Reaccreditation:** • Paramedic Liaison:

	○ To align with other EMS personnel policies, each provider agency will have a designated liaison to submit and track all accreditation and reaccreditation applications with SLOEMSA. • Lapse: ○ Remove the 90 day leave of absence from lapse criteria, however, include a 60 day leave notification to EMSA. ○ All leaves and reinstatements under a year will require the provider agency to submit a plan to the SLOEMSA Medical Director for approval. ○ All leaves and reinstatements over a year will include completion of all missed EMS Update Course materials. • Prorated Reaccreditation Requirements: ○ Upon initial accreditation, and if applicable, any prorated reaccreditation requirements will be communicated (skills and base station meetings). ○ Internal standardization of prorated requirements is current practice. • Skills: ○ Remove the advanced airway maneuver form from skills requirements. ○ Clearly state that one "Paramedic Skills Annual Verification Tracking Sheet-Attachment B" is required to be completed within every 12 months. ○ Change the frequency of required intubations and cardiac arrest management so that they are not completed all at once and are spread throughout the 12 months (per sheet). ○ Eliminate requirement for provider agencies to retain "Skills Verification Checklist-Attachment D" for 4 years. Use only for skills verification, and now is attachment C. • Rush Fee: ○ The rush fee language was changed for requests to process a completed application within 5 business days. • Application Fee: ○ An application fee will be required on all lapsed accreditations. **Attachments:** • All attachments will be revised to match policy changes.
REVIEWED BY	EMSA Director and Staff, Medical Director, OPS, and CAC.
RECOMMENDED ACTION(S)	EMCC Approval
ATTACHMENT(S)	Draft policies of: • 341 Emergency Medical Technician Paramedic Accreditation • 342 Emergency Medical Technician Paramedic Reaccreditation

POLICY #341: EMERGENCY MEDICAL TECHNICIAN PARAMEDIC ACCREDITATION

I. PURPOSE

A. To establish criteria as defined by Title 22 of the California Code of Regulations (CCR), for the local accreditation of emergency medical technician paramedics (paramedics) in the County of San Luis Obispo (SLO).

II. SCOPE

A. This policy applies to all current California state licensed paramedics employed by approved County of SLO advanced life support (ALS) providers, wishing to provide ALS patient care in SLO.

III. POLICY

A. Changes in State paramedic regulations will supersede information in this policy upon codification.

B. A current and valid California paramedic license and local accreditation are required to practice as a paramedic in SLO.

C. A paramedic with an expired license may not provide ALS or basic life support (BLS), patient care in the State of California.

D. A paramedic with an expired accreditation may not provide ALS patient care in SLO.

E. Only paramedics with a current license in the State of California may represent themselves as a paramedic. Individuals not currently licensed as a paramedic who represent themselves as such may be subject to disciplinary action and criminal penalties.

F. An individual with an expired paramedic license will be required to apply for license renewal through the State Emergency Medical Services (EMS) Authority prior to applying for local accreditation.

G. Candidates for initial accreditation must apply to SLO Emergency Medical Services Agency (SLOEMSA) and pay the non-refundable accreditation application fee.

H. Candidates whose checks return for insufficient funds may be subject to disciplinary action as outlined in EMS Agency Policy #101: Fee Collection.

I. Each ALS provider shall have a Paramedic Liaison that will be responsible for the coordination of the application and accreditation process for each of the ALS provider's employees.

J. All information on the SLOEMSA accreditation application is subject to verification. Candidates who supply information found to be fraudulent may be subject to disciplinary action for fraudulent procurement of accreditation per Title 22 1798.200 (c)(1).

K. The SLOEMSA Medical Director will evaluate any candidate who fails to complete the field evaluation. The SLOEMSA Medical Director may recommend further evaluation or training as required or take other license review action deemed necessary.

L. If the individual fails to complete remediation recommended by the SLOEMSA Medical Director, the accreditation may be denied for a minimum of one (1) year and up to two (2) years.

M. As a condition of continued accreditation, individuals must attend and pass all mandated training as required by SLOEMSA.

N. Candidates must have sufficient time to accredit. SLOEMSA may require up to thirty (30) calendar days to process a complete application. If a request is made to expedite a completed application within ~~ten~~ five (~~10~~5) business days of the request, a rush fee will apply.

1. Candidates need to allow five (5) business days to be approved to begin the accreditation field evaluation. If the anticipated field evaluation start date is within five (5) business days, a rush fee will apply.

O. Accredited paramedics must follow all laws, regulations, and local policies, procedures, and protocols. Failure to do so may result in disciplinary action.

~~O.~~P. It is the responsibility of the accredited paramedic to notify SLOEMSA within seven (7) days of any arrest or change in their eligibility status. Failure to report such actions may result in disciplinary action.

~~P.~~Q. The SLOEMSA Medical Director must approve exceptions to any accreditation requirement.

IV. PROCEDURE

A. Candidates must complete the SLOEMSA Paramedic Application for County Accreditation – Attachment A and supply documentation establishing eligibility for accreditation as follows:

1. Current government-issued photo identification.
2. Current and valid paramedic license issued by the California EMS Authority.
3. Possess current certification as a Cardiopulmonary Resuscitation (CPR) Provider according to the American Heart Association guidelines for BLS Healthcare Providers or other course approved by the SLOEMSA Medical Director.
4. Proof of current ACLS provider certification issued by the American Heart Association or other course approved by the SLOEMSA Medical Director.

5. Proof of current PALS provider certification issued by the American Heart Association or other course approved by the SLOEMSA Medical Director.

6. Paramedic Field Evaluation Completion Form – Attachment B, is due upon completion of accreditation process and includes:

   a. Orientation to SLO EMS system policies, procedures, and protocols that emphasize the local optional scope of practice.

   b. Ten (10) ALS patient care contacts if the paramedic has been licensed for less than one year, or

   c. Between five (5) and ten (10) ALS patient contacts if the paramedic has a current license and has been licensed for more than one year.

   d. Successfully pass the Accreditation Test with a score of at least 80 percent. Two (2) attempts will be offered. Consult the Medical Director for next steps if accreditee fails both attempts.

   e. The field evaluation will be waived if the candidate successfully completed a paramedic training program internship with SLOEMSA within the previous six (6) months (refer to Policy #340, Paramedic Student Internships, for more information).

7. Provide a letter of employment from a SLO ALS provider indicating employment as a paramedic.

8. Provide the name of the FTO assigned to lead the accreditation process, and the tentative field evaluation start date.

9. Pay the established local non-refundable accreditation fee.

B. Confirmation of application receipt and approval for an accreditation start date will be communicated by email to the applicant and the Paramedic Liaison.

C. Accreditation will be for a maximum of two (2) years, or such time as specified in the current state regulations.

1. The effective date of accreditation will be the date the candidate meets all local requirements and will be communicated by letter of approval.

2. The accreditation will expire on the same date as:

   a. The paramedic license issued by the California EMS Authority, or

   b. The paramedic is no longer employed as a paramedic by a SLO ALS provider, or

   c. The paramedic does not meet accreditation requirements.

D. If the expiration date of the paramedic license is less than two years, the prorated reaccreditation requirements outlined in Policy #342, Emergency Medical Technician Paramedic Reaccreditation, will be communicated upon initial accreditation approval.

V. AUTHORITY

- State of California Code of Regulations, Title 22
- California Health and Safety code, Division 2.5

VI. ATTACHMENTS

A. Paramedic Application for County Accreditation

B. Paramedic Field Evaluation Completion Form

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

POLICY #342: EMERGENCY MEDICAL TECHNICIAN PARAMEDIC REACCREDITATION

I. PURPOSE

A. To establish criteria as defined by Title 22 of the California Code of Regulations (CCR), for the local reaccreditation of emergency medical technician paramedics (paramedics) in the County of San Luis Obispo (SLO).

II. SCOPE

A. This policy applies to all current California state licensed paramedics employed by approved County of SLO advanced life support (ALS) providers, wishing to provide ALS patient care in SLO.

III. DEFINITIONS

- Lapse in Accreditation: A period of time that a paramedic's accreditation is expired.
- Leave of Absence (LOA): A period of time when a paramedic is temporarily excused from work, while maintaining their employment status. This includes medical leave, worker's compensation leave, military leave, personal leave, or a leave for disciplinary reasons.
- Reinstatement: The process whereby a paramedic is restored to active accreditation following a lapse in accreditation.
- Return to Work: The process whereby a paramedic is approved to return to work following a LOA.

IV. POLICY

A. Changes in State paramedic regulations will supersede information in this policy upon codification.

B. A current and valid California paramedic license and local accreditation are required to practice as a paramedic in SLO.

C. A paramedic with an expired license may not provide ALS or basic life support (BLS) patient care in the State of California.

D. A paramedic with an expired accreditation may not provide ALS patient care in SLO.

E. Only paramedics with a current license in the State of California may represent themselves as a paramedic. Individuals not currently licensed as a paramedic and represent themselves as such may be subject to disciplinary action and criminal penalties.

F. An individual with an expired paramedic license will be required to apply for license renewal through the State Emergency Medical Services (EMS) Authority prior to applying for local accreditation.

G. Candidates for reaccreditation must apply to SLO Emergency Medical Services Agency (SLOEMSA) and if applicable, pay the non-refundable reaccreditation application fee.

H. Candidates whose checks return for insufficient funds may be subject to disciplinary action as outlined in EMS Agency Policy #101: Fee Collection.

I. Each ALS provider shall have a Paramedic Liaison that will be responsible for the coordination of the application and accreditation process for each of the ALS provider's paramedic employees.

J. All information on the SLOEMSA accreditation application is subject to verification. Candidates who supply information found to be fraudulent may be subject to disciplinary action for fraudulent procurement of accreditation per Title 22 1798.200 (c)(1).

K. If there is a change in employment ~~status for any reason,~~ function, resulting in an employee no longer acting in the capacity of paramedic, including employees on a LOA, ~~medical leave, workers comp leave, or leave for disciplinary reasons~~, the employer must send SLOEMSA a written notification of the change in function or LOA and expected return date, if known, after 60 days. ~~as soon as practical.~~

L. If a paramedic is no longer employed, the employer must send a written notification to SLOEMSA within three (3) business days after separation of the employee.

M. A paramedic's accreditation is considered expired or lapsed when:

1. They are not currently employed by an ALS provider in SLO.
2. Failure to maintain a California paramedic license.
3. Failure to meet SLO reaccreditation requirements.

N. Once accreditation has lapsed, or in the situation of an employee returning to work after a LOA, the employer must submit to SLOEMSA a written request for employee reinstatement of accreditation or return to work. The written request shall include a plan for any training, skills evaluations, or field training officer (FTO) led observations that the employer deems necessary. The plan will be reviewed and approved by the SLOEMSA Medical Director. This section applies to all LOAs and lapses in accreditation up to one (1) year.

O. All reaccreditation candidates returning to SLO following a lapse or LOA of one year or more must comply with section N of this policy ~~the requirements for initial accreditation as outlined in SLOEMSA Policy #341: Emergency Medical Technician Paramedic Accreditation~~and complete all EMS Update Course materials that were covered during the lapse or LOA.

P. Lapsed reaccreditation requirements due to LOAs may be prorated for a period not to exceed six (6) months. The prorated relief may include a reduction in the number of required advanced skills verifications and base station meetings and will be communicated with the Paramedic Liaison as part of the reinstatement and return to work plan with the employer. All remaining requirements of reaccreditation outlined in the reaccreditation procedures will remain in effect.

Q. If advanced skills verifications and base station meeting reaccreditation requirements are prorated upon initial or reaccreditation approval, the requirements that were communicated by SLOEMSA at the time of initial or reaccreditation approval will be due when applying for reaccreditation. All remaining requirements of reaccreditation outlined in the reaccreditation procedures will remain in effect.

R. The SLOEMSA Medical Director will evaluate any candidate who fails to meet reaccreditation requirements. The SLOEMSA Medical Director will recommend further evaluation or training as required or take other license review action deemed necessary.

S. Accreditation lapses for failure to meet reaccreditation requirements, for reasons other than a change in employment, will result in suspension of accreditation until such time as the requirements have been met.

~~a. This includes but is not limited to failure to successfully complete any of the advanced skill verifications and failure to maintain required certifications during the two (2) year accreditation cycle.~~

T. Based on the continuous quality improvement and assurance process, the employer or SLOEMSA Medical Director may determine that a paramedic needs additional training, observation, or testing. The employer, the SLOEMSA Medical Director or his/her designee, may create a specific and targeted program of remediation based upon the identified need of the paramedic. If there is disagreement between the paramedic, the employer, and/or the SLOEMSA Medical Director, the decision of the SLOEMSA Medical Director will prevail.

U. If the individual fails to complete this targeted program of remediation the SLOEMSA Medical Director may suspend or revoke the accreditation for a minimum of one (1) year and up to two (2) years.

V. As a condition of continued accreditation, individuals must attend and pass all mandated training as required by SLOEMSA and meet all requirements listed under reaccreditation procedures.

W. Candidates must have sufficient time to reaccredit. SLOEMSA may require up to thirty (30) calendar days to process a complete application. If a request is made to expedite a completed application within ~~ten~~ five (~~10~~5) business days of the request, a rush fee will apply.

X. Accredited paramedics must follow all laws, regulations, and local policies, procedures, and protocols. Failure to do so may result in disciplinary action.

~~X.~~Y. It is the responsibility of the accredited paramedic to notify SLOEMSA within seven (7) days of any arrest or change in their eligibility status. Failure to report such actions may result in disciplinary action.

~~Y.~~Z. The SLOEMSA Medical Director must approve exceptions to any reaccreditation requirement.

PROCEDURE

A. Candidates for paramedic reaccreditation must complete the SLOEMSA Paramedic Application for County Accreditation – Attachment A and supply documentation establishing eligibility for reaccreditation as follows:

V.

1. Current government-issued photo identification.

2. Current and valid paramedic license issued by the California EMS Authority.

3. Possess current certification as a Cardiopulmonary Resuscitation (CPR) Provider according to the American Heart Association guidelines for BLS Healthcare Providers or other course approved by the SLOEMSA Medical Director.

4. Proof of completion of the SLOEMSA EMS Update course from each year of the preceding two (2) year accreditation period.

5. Completion of two (2) Paramedic Skills Annual Verification Tracking Sheet-Attachment B. One (1) sheet of low use / high risk skills shall be completed every 12 months of accreditation either in the field during patient care or under the observation of a FTO or other EMS Agency approved evaluator, using the Skills Verification Checklists-Attachment C.

   a. One (1) adult and one (1) pediatric cardiac arrest management skill shall be verified every six (6) months for a total of four (4) each during the two (2) year accreditation period.

   b. ~~One~~ When possible, one (1) intubation skill should~~all~~ be verified every three (3) months, however two (2) intubations are required every six (6) months, for a total of eight (8) during the two (2) year accreditation period. Intubation requirements exclude supraglottic airway adjunct (SGA) use.

6. A letter of employment from a SLO ALS provider indicating employment as a paramedic.

7. Proof of attendance at four (4) base station meetings in the preceding two (2) year accreditation period.

8. For all lapses in accreditation, pay the established local non-refundable accreditation fee.

B. Reaccreditation will be for a maximum of two (2) years.

1. The effective date of reaccreditation will be the date the candidate meets all local requirements.

2. The reaccreditation will expire on the same date as:

   a. The paramedic license issued by the California EMS Authority, or

b. The paramedic is no longer employed as a paramedic by a SLO ALS provider, or

c. The paramedic does not meet accreditation requirements.

AUTHORITY

- State of California Code of Regulations, Title 22
- California Health and Safety code, Division 2.5

VI. ATTACHMENTS

A. Paramedic Application for County Accreditation

VII. B. Paramedic Skills Annual Verification Tracking Sheet

C. Skills Verification Checklists

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
PUBLIC HEALTH DEPARTMENT
Nicholas Drews *Health Agency Director*
Penny Borenstein, MD, MPH *Health Officer/Public Health Director*

MEETING DATE	July 17, 2025
STAFF CONTACT	Rachel Oakley
SUBJECT	Patient Refusal Policy 203 Revision
SUMMARY	Policy 203, Patient Refusal of Treatment and/or Transport was last revised on April 15th, 2017. This revision was initially requested for a change in definition and language regarding patient "competency" to "mental capacity". Since then, "mental capacity" was further specified to "medical decision making capacity" and a tool or simple process was included to assist EMS personnel in determining a patient's medical decision making capacity. There was a request to remove "against medical advice" or "AMA" from policy at our Operations Committee Meeting. After much discussion, AMA language is thought to be overused and doesn't accurately fit most situations it's being used for. The AMA definition has been removed from policy as requested, and all patient refusals will be documented as a refusal. Procedures remain the same for when ALS services are indicated, however a patient is refusing those services.
REVIEWED BY	EMSA Director/Staff, Medical Director, County Council, OPS, and CAC.
RECOMMENDED ACTION(S)	EMCC Approval
ATTACHMENT(S)	Draft of: • 203 Patient Refusal

POLICY #203: PATIENT REFUSAL

I. PURPOSE

A. To establish policy and procedure for the County of San Luis Obispo (SLO) Emergency Medical Services (EMS) personnel to utilize for a refusal of EMS assessment, treatment, and/or transportation, or to recognize and initiate treatment and/or transportation without explicit consent.

II. DEFINITIONS

~~A. Against Medical Advice (AMA) Refusal: The refusal of assessment, treatment, and/or transport by a patient or his/her designated decision maker against the advice of the EMS personnel on scene or of the Base Hospital. This includes patient refusal to be transported to the closest or designated base station.~~

~~B.~~A. Designated Decision Maker (DDM): An individual whom a patient has legally given or implied the authority to make medical decisions concerning the patient's health care.

- Parent, legal guardian, and "attorney-in-fact" through a Durable Power of Attorney for Health Care, or an "agent" through an Advance Health Care Directive.
- ~~o~~

B. Implied Consent: When ~~a patient is not able to make medical decisions for themselves due to mental capacity,~~ the agreement of EMS assessment, treatment, and/or transportation ~~can~~ is ~~be~~ inferred rather than explicitly obtained.

C. Medical Decision Making Capacity: An individual's ability to understand, retain, and use information to make informed decisions about their medical care. It encompasses the cognitive abilities necessary to understand the situation and relevant information, appreciate the consequences of potential decisions, and communicate their choice effectively.

D. Patient: Any person for whom the EMS system has been activated and who meets any of the following criteria:

- Has a chief complaint or suspected illness or injury.
- Requires or requests assessment, treatment, or transportation.
- Is a minor who is not accompanied by a DDM and is or appears to be ill or injured.
- Is not oriented to person, place, time, or event.

~~o~~E. Refusal: The refusal of assessment, treatment, and/or transport by a patient or his/her designated decision maker. This includes patient refusal to be transported to the closest or designated base station.

~~E. Mental Capacity: An individual's ability to understand, retain, and use information to make informed decisions about their own life. It encompasses the cognitive abilities~~

~~necessary to understand the situation and relevant information, appreciate the consequences of potential decisions, and communicate their choice effectively.~~

F. Welfare and Institutions (W&I) 5150 Hold: Holding a patient against his/her will for evaluation under the authority of Welfare and Institutions Code, Section 5150, because the patient is a danger to him/herself, a danger to others, and/or is gravely disabled, e.g., unable to care for self. A law enforcement officer or County Mental Health worker may place a written order.

III. POLICY

A. All patients will be offered treatment and/or transportation following a complete EMS assessment.

B. Adult Patients who can make decisions for themselves have the right to refuse medical assessment, treatment, and/or transportation.

C. An unaccompanied minor who has an illness/injury requiring immediate EMS treatment and/or transportation may not refuse and shall be treated and/or transported by EMS personnel without DDM consent.

~~C.~~D. Except for parents and legal guardians of minors, DDMs will only be used if the patient lacks medical decision making capacity.

E. Decisions made by a DDM shall be treated as though the patient was making the decisions for him/herself.

~~D.~~

IV. PROCEDURE

A. When a~~n AMA~~ refusal exists, complete the following steps:

1. EMS personnel should first determine if there is a patient.

   a. If there is no patient at the scene, there is no refusal. EMS personnel should document why it was determined that there isn't a patient.

2. Next, EMS personnel should determine and document that the patient has medical decision making capacity to refuse services by following these steps:

   a. Ask the patient to explain their understanding of the situation, the options, and their decision.

   b. Observe the patient's demeanor, engagement, and ability to communicate their choice.

   c. Evaluate the patient's understanding: Does the patient comprehend the information provided to them regarding their condition, treatment options, risks, benefits, and alternatives?

   d. Evaluate the patient's appreciation: Does the patient appreciate how the information applies to their specific situation? This means they should

understand the implications of their decision, including the potential impact on their quality of life and well-being.

e. Evaluate the patient's reasoning: Is the patient able to weigh the risks and benefits of different options and make a reasoned decision based on their values and preferences?

f. Evaluate the patient's communication: Is the patient able to express their choice clearly and consistently?

g. If the answer is no for questions in c.-f., the patient may lack medical decision making capacity to refuse services. Follow section E. below.

h. A patient's medical decision making capacity can change, so it's important to reassess as needed.

~~1.~~3. If the patient has a medical condition requiring medical attention, ensure the patient ~~has or is making~~understands that they need to make personal arrangements to seek medical care at a hospital, urgent care, or private physician's office.

~~2.~~4. EMS personnel shall advise the patient of the risks and consequences that may result from refusal of treatment and/~~or~~ transportation including the possible risk of death or disability from any undiagnosed condition being untreated.

~~3.~~5. If the patient still refuses, EMS personnel must attempt to obtain the patient's signature on the EMS provider's refusal ~~of treatment and/or transport~~ form.

~~4.~~6. The signature should be witnessed, preferably by a family member.

~~5.~~7. If the patient refuses to sign the EMS provider's refusal ~~of assessment, treatment, and/or transport~~ form, prehospital personnel must note and initial that the patient refused to sign. EMS personnel or other witnesses present should sign the form.

~~6.~~8. The patient and caregivers shall be advised to seek medical care immediately or call 911 if the patient develops adverse symptoms at any time.

B. Consultation with the Base Hospital or Specialty Care Base physician or MICN will be made for:

1. ~~AMA r~~Refusal cases where ~~EMS~~ ALS interventions are performed or indicated, and the patient is refusing assessment, treatment, and/or transport, which includes transport to the appropriate receiving hospital.

2. Unstable patients, as defined in Universal Protocol # 601, who refuse transport to the nearest appropriate receiving hospital.

C. When Base Hospital physician consultation is indicated, ~~EMS~~ ALS personnel shall advise the physician of all the circumstances while on scene, including indicated care or transportation, reasons for refusal, ~~mental~~ medical decision making capacity, and the patient's plan for follow-up care with his/her own private physician or provider.

D. Consultation with the Base Hospital physician or MICN is not required for isolated injury without potential for significant airway, hemodynamic, orthopedic, or neurological compromise.

E. Implied consent can be inferred when based on the professional judgment of the EMS personnel, a patient lacks medical decision making capacity to refuse services, and a reasonable person would consent to assessment, treatment, and/or transport.

~~E.~~F. If EMS or Base Hospital personnel determine that a patient with an emergency condition lacks ~~mental~~ medial decision making capacity to refuse assessment, treatment, and/or transportation, the following alternatives exist:

1. The patient should be transported to a hospital under implied consent.
2. A Base Hospital physician may determine that it is necessary to transport the patient against his/her will. If the patient resists, or if EMS personnel believe the patient will resist, assistance from law enforcement or County Mental Health shall be requested to assist in the transportation of the patient.
3. Law enforcement or County Mental Health may consider the placement of a W&I 5150 hold on the patient, but this is not required for transport.
4. If EMS personnel believe a DDM of the patient may not be acting in the best interest of the patient in refusing indicated immediate treatment and/or transportation, assistance from law enforcement personnel shall be requested.
5. EMS personnel should never put themselves in danger by attempting to treat and/or transport a patient who refuses. EMS personnel should use good judgment and request appropriate assistance, as needed.

~~Documentation Guidelines:~~

~~F.~~G. A PCR and an EMS provider's patient refusal form shall be completed for each incident of refusal of EMS assessment, treatment, and/or transportation, including transport to the appropriate receiving hospital.

~~1. A PCR shall be completed for individuals meeting the definition of patient.~~

~~2.~~1. Patient information is not required for individuals that did not present with any complaint or illness/injury and advised EMS personnel upon initial contact that they ~~he/she~~ did not want further assessment or evaluation.

~~3. A PCR and an EMS provider's AMA refusal form shall be completed for each incident of refusal of EMS assessment, treatment, and/or transportation, including transport to the appropriate receiving hospital.~~

~~4.~~2. ~~AMA refusal forms~~Refusal documentation in the narrative ~~shall~~ should include:

a. Who activated 9-1-1 and the reason for the call, if known.
b. A complete patient history and assessment.
c. All circumstances pertaining to consent issues during the patient encounter.
d. An assessment ~~mental status examination of the patient~~ that ~~clearly~~ indicates ~~his/her~~ the patient's medical decision making capacity.
e. The presence or absence of any impairment, such as by alcohol or drugs.

f. The reason that the patient is refusing an assessment~~care, evaluation~~, treatment, and/or transportation.

g. A statement that the patient understands the risks and consequences of refusing medical treatment and/or transportation to the appropriate receiving hospital that was offered.

h. All alternatives presented to the patient.

i. That the patient has been informed that they may re-access 9-1-1 as necessary.

j. Base Hospital and/or Base physician contacted if applicable.

k. Signature of patient and EMS personnel on the refusal ~~of treatment and/or transport~~ form.

V. AUTHORITY

G. California Health and Safety Code, Division 2.5

H. California Welfare and Institutions Code 5150

I. Title 22, California Code of Regulations, Division 9

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
PUBLIC HEALTH DEPARTMENT
Nicholas Drews *Health Agency Director*
Penny Borenstein, MD, MPH *Health Officer/Public Health Director*

MEETING DATE	July 17, 2025
STAFF CONTACT	Ryan Rosander, EMS Director 805-788-2512 rrosander@co.slo.ca.us
SUBJECT	Procedure #704 Needle Cricothyrotomy Opioid Withdrawal – Medication change from Suboxone to Buprenorphine
SUMMARY	On May 15, 2025, EMCC approved SLOEMSA's Opiod Withdraw protocol. However, it was recommended that the policy should return to CAC to discuss changing the medication outlined in the protocol from Suboxone to Buprenorphine. Reasoning behind this change was that Buprenorphine is cheaper and more readily available to stock. More importantly, Buprenorphine is more widely studied in an EMS setting than Suboxone. CAC has approved this change to Buprenorphine. Procedure #704 Needle Cricothyrotomy has been updated with language approving ALS providers to follow manufacture guidelines for brand specific instructions on their equipment.
REVIEWED BY	Dr. William Mulkerin, SLOEMSA Staff, OPs, EMCC, CAC
RECOMMENDED ACTION(S)	Changes are recommended for EMCC approval and move to 2025 EMS Update Class agenda.
ATTACHMENT(S)	Protocol # xxx – Opioid Withdrawal Buprenorphine Formulary Procedure #704 Needle Cricothyrotomy

NEEDLE CRICOTHYROTOMY

ADULT	PEDIATRIC (≤34KG)

BLS

- **Universal Protocol #601**
- Attempt BLS maneuvers for airway obstruction
- Pulse Oximetry – O_2 administration per Airway Management Protocol #602

ALS

- Position patient supine
- Identify and clean cricothyroid membrane between thyroid cartilage and cricoid cartilage with povidone-iodine and alcohol
- With finger marking cricothyroid membrane, stabilize the trachea
- Insert large bore IV catheter (maximum 10 Ga.) with a syringe attached at a 45° angle towards the patients feet through the membrane while aspirating. Aspiration of air indicates entry into the trachea
- Withdraw the needle, attach a cut 3 mm endotracheal tube and ventilate with BVM
- Secure tube and manually stabilize through transport
- Assess and reassess lung sounds
- For agencies utilizing commercially available devices:
  - Refer to the manufacturer guidelines and follow specific directions

Base Hospital Orders Only

As needed

Notes

- Indications - upper airway obstruction resulting in severe respiratory distress not relieved by conventional airway maneuvers in accordance to Airway Management Protocol #602
  - Epiglottitis
  - Fractured larynx
  - Facial burns with upper airway involvement
  - Laryngeal edema or spasm
  - Massive facial trauma
- Equipment
  - Large IV catheter (10-12 Ga.) with a syringe
  - 3mm ET tube – cut distal end to make tube approx. 2”
  - Antiseptic products, povidone-iodine/alcohol swabs
- Rapid transport with early notification
- In the event of complications – remove and repeat procedure
- Commercially available devices are allowed for use by County ALS agencies

OPIOID WITHDRAWAL

ADULT	PEDIATRIC (≤34 KG)
BLS Procedures	
• Universal Algorithm #601 • Pulse Oximetry ○ O_2 Administration per Airway Management Protocol #602	• Universal Algorithm
ALS Procedures	

• If suspected opioid withdrawals, use "COWS" score to determine if patient meets criteria to receive ~~Suboxone~~ Buprenorphine
  ○ "COWS" ≥ 8 to qualify
  ○ Patient must be agreeable to treatment with goal of seeking resources and counseling
• If believed that patient will benefit from ~~Suboxone~~ Buprenorphine with no contraindications – contact nearest Base Hospital for orders
	• ~~Suboxone~~ Buprenorphine is not permitted in pediatric patients under ~~18~~ 16

Base Hospital Orders Only	

• ~~**Suboxone**~~ **Buprenorphine** 16mg SL film (two strips) – reassess after 10 minutes
  ○ Call for secondary 8mg SL dose for persistent or worsening symptoms after 20 minutes
  ○ Give water to moisten mucus membranes prior to SL film administration
	• As needed

Notes

- **SEE PAGE 2 FOR COWS SCORE ASSESSMENT TOOL**
- If ~~Suboxone~~ Buprenorphine is administered repeat "COWS" score assessment 20 minutes after initial dose and secondary dose if applicable
- Patients should have history of any one of the following:
  - Recent opioid use
  - Chronic opioid use
  - Evidence of illicit drug use (paraphernalia, needles etc)
  - Prescription narcotics in household or on patient

- ~~Naloxone in Suboxone has a negligible SL absorption and should not be factored into dosing totals. Should a patient present in respiratory distress with suspicion of opioid overdose refer to Protocol #618~~

Clinical Opioid Withdrawal Scale (COWS)

ANXIETY OR IRRATIBILITY *Visually observed during assessment* **0** None **1** Reports increasing irritability or anxiousness **2** Visually irritable or anxious **4** Too irritable to participate or affecting participation	RESTING HEART RATE *Measured after sitting for one (1) minute* **0** ≤80 bpm **1** 81 to 100 bpm **2** 101 to 120 bpm **4** >120 bpm
BONE OR JOINT ACHES *Only new pain attributed to withdrawal is scored* **0** Not present **1** Mild, diffuse discomfort **2** Reports severe, diffuse aching of joints/muscles **4** Patient rubbing joints/muscles and unable to be still	RESTLESSNESS *Visually observed during assessment* **0** Able to be still **1** Report difficulty being still, but able to do so **3** Frequent shifting or extraneous movement of legs/arms **5** Unable to be still for more than a few seconds
SKIN SIGNS *Visually or physically observed during assessment* **0** Skin is smooth **3** Piloerection of skin – can be felt or visible arm hairs standing up **5** Prominent piloerection – "Gooseflesh Skin"	TREMOR *Observation of outstretched hands* **0** No tremors **1** Tremor can be felt but not observed **2** Slight tremor observed **4** Gross tremor or muscle twitching
GATROINTESTINAL UPSET *Within past 30 minutes* **0** No GI symptoms **1** Stomach cramps **2** Nausea or loose stool **3** Vomiting or diarrhea **5** Multiple episodes of diarrhea or vomiting	SWEATING *Over past 30 min – **not** from environment or activity* **0** No reports of chills or flushing **1** Subjective report of chills or flushing **2** Flushed or observable moistness to face **3** Beads of sweat on brow or face **4** Sweat streaming off of face
PUPIL SIZE *Visually observed during assessment* **0** Pupil pinned or normal size for ambient light **1** Pupils possibly larger than normal for ambient light **2** Pupils moderately dilated **5** Pupils very dilated	YAWNING *Visually observed during assessment* **0** No Yawning **1** Yawning once or twice during assessment **2** Yawning three or more times during assessment **4** Yawning several times per minute
RUNNY NOSE OR TEARING *Not accounted for by cold symptoms or allergies* **0** Not present **1** Nasal stuffiness or unusually moist eyes **2** Runny nose or tearing **4** Nose constantly running or tears streaming down face	**TOTAL COWS SCORING** **5 - 12** Mild Withdrawal **13 - 24** Moderate Withdrawal **25 - 36** Moderately Severe Withdrawal **>36** Severe Withdrawal

Buprenorphine~~/Naloxone (Suboxone®)~~
(Base Hospital Order Only)

Classification: Narcotic analgesic combination (Class III)

Actions:

1. Buprenorphine; partial mu-receptor opioid agonist
2. ~~Naloxone; opioid antagonist~~

Indications:

1. Management of opioid withdrawal in adults with moderate to severe opioid drug dependence

Contraindications:

1. **Recent methadone use (within 10 days)**
2. **No signs of Opioid withdrawal or COWS ≥ 8**
3. **Altered mental status – unable to give consent**
4. **Severe medical illness – sepsis, respiratory distress, hypoglycemia etc**

Adverse Effects (Precautions, Side Effects and Notes)

1. Headache
2. Nausea/Vomiting
3. Respiratory Depression

Administration:

ADULT DOSE – Base Hospital Order Only

1. ~~**Suboxone**~~ **Buprenorphine –** 16 mg SL film, reassess after 10 minutes
   a. 8 mg SL film secondary dose if ordered by Base Hospital after 10 minute reassessment

PEDIATRIC DOSE

2. **None - Contraindicated in patients under ~~18~~ 16 years of age**

Onset: 10 – 40 minutes
Peak effect 3-4 hours*

Duration: 24+ hours

~~**Notes:** Naloxone has a negligible SL absorption and should not be factored into dosing totals. Should a patient present in respiratory distress with suspicion of opioid overdose refer to Protocol #618~~