EMERGENCY MEDICAL CARE COMMITTEE MEETING AGENDA

Thursday, May 21st, 2026, 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, 2024-2028*
Dr. Brad Knox, *Physician*, *2022-2026*
Bob Neumann, *Consumers*, *2022-2026*
Alexandra Kohler, *Consumers, 2024-2028*
Jonathan Stornetta, *Public Providers, 2024-2028*
Michael Talmadge, *EMS Field Personnel, 2024-2028*
Jay Wells, *Sheriff's Department, 2024-2028*
Julia Fogelson, *Hospitals*, *2024-2028*
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: January 15th, 2026, Minutes (*attached)*	C. Javine
Action/Discussion	**Policy Revision/Development:** • 154 Hospital Diversion • 158 APOT • 124 Documentation • 222 Mechanical CPR Device	R. Rosander
Action/Discussion	**Policy/Policy Attachment Revision:** • 205 Attachment A • 212 Tiered Response	W. Mulkerin
Action/Discussion	**EMCC Membership Discussion**	R. Rosander
Action/Discussion	**EMCC Election of Officers**	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: July 16th, 2026**	C. Javine

Emergency Medical Care Committee

DRAFT Meeting Minutes
8:30 AM January 15th, 2026
2995 McMillan Way, Suite 178
San Luis Obispo, CA 93401

MINUTES

MEMBERS PRESENT:
Chair Chris Javine, Pre-Hospital Transport Providers
Vice Chair Matt Bronson, City Government
Bob Neumann, Consumers
Rachel May, Emergency Physicians
Jonathan Stornetta, Public Providers
Brad Knox, Physicians
Julia Fogelson, Hospitals
Michael Talmadge, EMS Field Personnel

MEMBERS ABSENT:
Diane Burkey, MICNs
Alexandra Kohler, Consumers
Jay Wells, Sheriff's Department

EMS AGENCY STAFF PRESENT:
Rachel Oakley, EMSA
Kaitlyn Blanton, EMSA
Alyssa Vardas, EMSA

PUBLIC COMMENTORS:
Rob Jenkins, CALFIRE
Michelle Brimer, SVRMC

EX OFFICIO:
Bill Mulkerin, EMSA
Ryan Rosander, EMSA

1. CALL TO ORDER

Chair Chris Javine called the meeting to order at 8:30 a.m.

2. REVIEW AND APPROVAL OF November 20th, 2025, MINUTE

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Action: Rachel May moved to approve the minutes with changes, Brad Knox is second to approve, all approved, no opposition.

The meeting discussed the implementation of a Narcan policy for EMS teams, allowing them to leave behind Narcan for overdose or opioid use disorder patients. The policy includes kits provided by the opioid safety coalition, with no cost to providers. The committee approved the policy and discussed the need for standardized training materials. They also reviewed the opioid withdrawal protocol, noting a two-month delay in buprenorphine supply. The committee approved several other policies, including updates to the drowning protocol, atrial fibrillation management, and fluid administration guidelines. They also discussed the potential for a centralized Narcan distribution system. The meeting discussed several key protocol updates and equipment needs. The 20-minute cool running water policy was highlighted, with Kevin Mackey's data suggesting significant benefits. The team debated the necessity of the Ken device and pediatric spine board, opting to make the latter optional. They also discussed the need for more saline bags (increasing from 2 to 6 for ALS transports) and the inclusion of specific medications like magnesium sulfate and buprenorphine. Future agenda items include updating the MCI policy, trauma steps, and potentially a crush injury protocol. The importance of timely transport and the use of dive emergency protocols was emphasized.

3. Protocols/Policies for Review:

Narcan Policy

Discussion:

Suggestion on the need for training on the scene, signs, symptoms, and good Samaritan protection, with mentioning standard kits with information sheets.

Inquiries about the number of kits to be distributed.

Confirmation that the county will provide the kits.

Opioid Withdrawal

Discussion:

Discussion on the opioid withdrawal protocol, noting the addition of leaving behind Narcan in the notes section.

Mention of issues with getting buprenorphine, with a two-month delay reported by San Luis ambulance.

Confirmation of the go-live date for the policy as January 1, acknowledging supply unpredictability.

Discussion on the types of tablets and films, with a suggestion of clarifying the language in the formulary.

SGA

Discussion:

Policy 718, which adds pediatric SGA as a standard scope for paramedics and an optional scope for BLS providers.

Discussion on the need for additional training for BLS providers, mentioning the five-hour state requirement.

It was suggested to add padding under the shoulder for pediatric SGA, noting higher failure rates in infants under 10 kilograms.

Airway Management

Discussion:

Discusses protocol 602, which includes changes to the superglottic airway and optional skills for BLS providers.

Discussion on the use of airway forms and image trend for data collection, with the suggestion of moving away from airway forms.

Emphasizes the importance of QI learning for advanced airway skills, especially with the addition of pediatric SGA.

Drowning

Discussion:

Explains the importance of focusing on respiratory and oxygenation in drowning cases, with specific guidelines for cardiac arrest.

Discussion on the need for high-flow oxygen and avoiding rough handling of hypothermic patients.

Mention of a training event in May to provide approved SGA training and drowning protocol education.

Agrees to remove references to scuba emergencies from the drowning protocol, as a separate protocol is being developed.

Atrial Fibrillation Protocol and SVT Adjustments

Discussion:

Introduces policy 645, which separates atrial fibrillation with rapid ventricular response (AFib with RVR) from other supraventricular tachycardias (SVT).

Discussion on the need for synchronized cardioversion at an appropriate AFib dose for patients in extremes.

Suggestion for including Flutter in the AFib with RVR protocol.

Suggestion of removing cardioversion sequences from the protocol, which is agreed upon.

Mention of the need to adjust the SVT protocol to include an escalating shock pattern, with further discussion planned.

Fluid Administration and Sepsis

Discussion:

Discusses policy 619, which liberalizes fluid administration to allow for a repeat bolus in early shock or fluid down.

Discussion on the need for provider judgment in giving fluids before hypotension occurs.

Confirms the specific change to allow for a 500-milliliter bolus, which may be repeated once.

Motion for approval with changes by Jonathan Stornetta and Jay Wells is second to approve. All in approval, no opposition.

4. STAFF REPORTS/ANNOUNCEMENTS

Health Officer Update - Dr. Borenstein was out.

EMS Director Update – Ryan Rosander was out.

EMS Medical Director Update - Dr. Mulkerin - mentions that we are working through the update class.

PHEP Program Manager Update - Maya discussed the POD that was in October and that they are planning for a surge exercise.

5. FUTURE AGENDA ITEMS

Burn Protocol, Dive Emergency Protocol, MCI Policy

6. ADJOURNMENT

Action:

Chair Javine adjourned the meeting at 9:41 a.m.

MEETING DATE	May 21, 2026
STAFF CONTACT	Ryan Rosander, EMS Director 805.788.2512 rrosander@co.slo.ca.us
SUBJECT	Hospital Diversion, APOT Monitoring, Mechanical CPR Devices, Documentation of Prehospital Care
SUMMARY	Policy 154 was updated to modernize the County of San Luis Obispo Emergency Medical Services Agency's hospital diversion standards by replacing the 2018 policy with clearer definitions, stronger EMS Agency oversight authority, improved accountability measures, and more specific criteria for when diversion may be requested. The revised policy clarifies diversion categories, strengthens requirements for hospital internal mitigation prior to diversion, reinforces expectations for continuous availability at specialty care centers, and establishes clearer communication and quality improvement reporting requirements. These updates were necessary to align diversion practices with current EMS system performance expectations, improve consistency across hospitals, reduce inappropriate diversion use stemming from operational throughput issues, and ensure the EMS Agency maintains appropriate regulatory oversight to protect patient access and system reliability. Policy #158 was revised to clarify EMS Agency oversight, strengthen the link between ambulance patient offload times and overall EMS system performance, and emphasize a collaborative quality-improvement approach with system partners. The APOT standard was also updated from 20 minutes to 30 minutes to better align with surrounding California LEMSAs of similar size and ensure a realistic and regionally consistent performance benchmark. Policy #222 was previously reviewed by Operations and approved. During the Clinical Advisory Committee meeting, the policy was temporarily deferred to allow discussion of potential Quality Improvement (QI) software options and associated costs. This policy was brought through the Committee process to review any operational or fiscal impacts before returning to CAC and onward to EMCC. Policy #124 was revised to strengthen documentation standards within the County of San Luis Obispo EMS system by replacing the 2023 policy with clearer minimum documentation expectations, improved legal protections for medical records, defined documentation timelines, and stronger EMS Agency oversight authority. The updated policy improves upon the prior version by simplifying definitions, removing outdated

	technology references, clarifying documentation as a condition of EMS system participation, strengthening amendment and audit trail requirements, and better aligning documentation practices with current CEMSIS and NEMSIS data standards. These revisions were necessary to modernize documentation expectations, improve data integrity, reduce ambiguity for EMS providers, and ensure documentation supports quality improvement, regulatory compliance, and EMS system performance monitoring consistent with current statewide EMS data management practices.
REVIEWED BY	Dr. William Mulkerin, SLOEMSA Staff, Operations, and Clinical Advisory
RECOMMENDED ACTION(S)	Recommended the following for approval by EMCC and moved for adoption Policy #154: Hospital Diversion, Policy #158: APOT Monitoring, Policy #222: Mechanical CPR Devices, Policy #124: Documentation of Prehospital Care
ATTACHMENT(S)	Policy #154, Policy #158, Policy #222, Policy #124

POLICY #154: HOSPITAL DIVERSION

I. PURPOSE

A. To establish standardized criteria and procedures for hospital ambulance diversion within the County of San Luis Obispo to ensure patient safety, preserve uninterrupted access to emergency and specialty care, and maintain EMS system stability.

II. POLICY

A. Ambulance diversion is a temporary measure used when a hospital's ability to safely receive additional ambulance patients is significantly compromised.

B. Diversion shall be limited in scope and duration and used only after internal mitigation efforts have been implemented.

C. Specialty Care Center cannot go on diversion for patients in their area of designation.

D. Specialty care destination policies (trauma, STEMI) remain in effect at all times unless conditions described in Section V are met.

E. SLOEMSA retains authority to, at any time, approve, deny, modify, place on, suspend, or terminate diversion status to preserve patient safety and system access.

F. SLOEMSA shall consider overall EMS system status, regional hospital capacity, ambulance availability, and patient access impacts when evaluating diversion requests

III. DIVERSION CATEGORIES

A. INTERNAL DISASTER (COMPLETE DIVERSION)

A hospital may request diversion when a declared internal disaster prevents safe patient reception.

Examples include, but are not limited to:

- Fire
- Structural damage
- Power outage affecting patient care
- Hazardous materials contamination
- Active security threat
- Critical system failure impacting patient safety

Staffing shortages, boarding, or inpatient bed unavailability alone do not qualify.

B. EMERGENCY DEPARTMENT SATURATION

A hospital may request ED Saturation diversion when:

1. All ED treatment spaces appropriate for unstable patients are occupied; AND
2. Additional ambulance arrivals would compromise safe monitoring or treatment; AND
3. The hospital has implemented internal surge and mitigation measures; AND
4. The on-call hospital administrator and ED physician concur.

ED Saturation Diversion:

1. Requires consultation with and approval by the SLOEMSA Duty Officer;
2. May be approved for up to two (2) hours;
3. After two (2) hours, must be reassessed and reapproved by SLOEMSA Duty Officer prior to continuation, unless otherwise stated by the SLOEMSA Duty Officer;
4. Shall be terminated once safe receiving capacity is restored.

ED Saturation diversion shall not be declared solely for inpatient bed unavailability unless it directly results in unsafe ED conditions.

C. CAPABILITY-SPECIFIC (PARTIAL) DIVERSION

A hospital may request diversion for a defined patient category when critical emergency, diagnostic, or treatment capabilities are temporarily unavailable.

Examples include, but are not limited to:

- CT scanner unavailable, affecting acute stroke or significant head injury evaluation;
- Required specialty physician coverage unavailable for emergency intervention.

Partial diversion applies only to patients requiring the unavailable capability.

Scheduled maintenance affecting key services shall be communicated to the SLOEMSA Duty Officer in advance, or as soon as possible thereafter.

IV. CLINICAL EXCEPTIONS

EMS shall transport to the closest appropriate facility regardless of diversion status when, in the paramedic's judgment or base hospital direction, bypass would increase patient risk.

Examples include, but are not limited to:

- Cardiac arrest
- Unstable airway
- Uncontrollable bleeding with rapidly deterioration of vital signs
- Extremis

Units already on hospital property or enroute after base hospital contact shall not be diverted.

V. SPECIALTY CARE CENTERS

A. Designated Specialty Care Centers, including the Trauma Centers, and the STEMI Receiving Center, shall maintain continuous capability consistent with designation requirements.

B. Specialty Care Centers may declare diversion for patients under their area of designation only under one of the following circumstances:

1. A declared Internal Disaster; OR
2. Complete and temporary loss of the designated specialty capability such that the hospital is unable to provide required emergency stabilization and specialty intervention for patients meeting designation criteria.

C. Partial limitation that does not eliminate the hospital's ability to provide emergency stabilization and specialty care shall not constitute grounds for diversion.

D. If a designated Specialty Care Center declares diversion due to Internal Disaster, the facility shall immediately notify the nearest like specialty care center(s) and SLOEMSA.

VI. ACTIVATION AND COMMUNICATION

A hospital requesting diversion shall:

1. Contact the SLOEMSA Duty Officer, MEDCOM, and all County of San Luis Obispo Hospitals;
2. Enter diversion status via ReddiNet;
3. Identify diversion category;
4. Provide estimated duration;
5. Identify the approving hospital authority.

Diversion status shall automatically expire after two (2) hours unless renewed with SLOEMSA approval or unless otherwise stated by the SLOEMSA Duty Officer.

No two hospitals may simultaneously declare diversion without notifying and coordinating with the SLOEMSA Duty Officer.

If ReddiNet is not properly updated, a hospital will not be considered on diversion.

VII. OVERSIGHT AND QUALITY IMPROVEMENT

SLOEMSA shall monitor diversion frequency and duration and may:

1. Audit diversion events in person or remotely;
2. Require corrective action;

3. Modify or suspend diversion privileges when use is excessive or inconsistent with policy.

Hospitals must email a detailed synopsis of any diversion and the actions taken to resolve it. For ED saturation, this includes a comprehensive account of internal surge responses. This should cover timelines, critical decisions, and any staffing or protocol adjustments made. The email should be sent to PH_EMSA@co.slo.ca.us within 24 hours of the diversion.

VIII. AUTHORITY

- California Health and Safety Code, Division 2.5
- California Code of Regulations, Title 22, Division 9

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

POLICY #158 AMBULANCE PATIENT OFFLOAD TIME (APOT) MONITORING:

I. PURPOSE

A. To establish standardized methodologies for collecting and reporting Ambulance Patient Offload Time (APOT) data to the County of San Luis Obispo Emergency Medical Services Agency (SLOEMSA) and to support continuous monitoring of EMS system performance, hospital patient flow, ambulance availability, and support data-driven EMS system improvements. APOT monitoring also supports EMS system reliability and emergency response readiness within San Luis Obispo County

II. DEFINITIONS

- Ambulance Arrival at ED: The time the ambulance wheels stop at the designated hospital ED offload location.
- Ambulance Patient Offload Time (APOT): The interval between the arrival of an ambulance patient at an emergency department (ED) and the time when the patient is transferred to an ED gurney, bed, chair, or other suitable location, at which point the ED assumes responsibility for the patient's care.
- Ambulance Patient Offload Delay (APOD): Any delay in ambulance patient offload time that exceeds the local standard for ambulance patient offload time, which is 30 minutes. This is synonymous with “non-standard patient offload time” in the Health and Safety Code.

III. POLICY

A. EMS field personnel are obligated to continue delivering and documenting patient care until the patient is transferred (off EMS gurney and transfer signature obtained) to the hospital's Emergency Department (ED) medical personnel. The medical control and management of the EMS system, including EMS field personnel, remain under the jurisdiction of the SLOEMSA medical director. All patient care provided must adhere strictly to the treatment protocols and policies outlined by SLOEMSA.

B. Ambulance Patient Offload Times should be minimized to ensure efficient transfer of patient care and timely return of EMS resources to service. APOT exceeding 30 minutes shall be classified as an Ambulance Patient Offload Delay (APOD).

C. Hospitals and EMS field personnel shall follow the APOD Mitigation Procedures detailed in Section IV of this policy when an APOD event occurs.

D. SLOEMSA may review APOT and APOD events as part of its EMS system quality improvement responsibilities and may request data or information from hospitals or EMS providers necessary to evaluate system performance and patient care transitions.

E. SLOEMSA maintains oversight of APOT as a system performance indicator and may review delays to identify opportunities to improve EMS system efficiency and patient care transitions. System factors impacting APOT may be considered when evaluating overall EMS system performance.

IV. PROCEDURE

A. Direction of EMS Field Personnel

1. Ambulance Patient Offload Time (APOT) Monitoring

a. If the transfer of care and patient offloading from the ambulance gurney exceeds the 30-minute standard, it will be documented and tracked as an APOD.

b. The transporting EMS field personnel are not responsible for continuing to monitor the patient or provide care within the hospital setting after the patient's care has been transferred to ED medical personnel.

2. APOD Mitigation Procedures

a. Hospitals are responsible for ensuring policies and processes facilitate the rapid and appropriate transfer of patient care from EMS field personnel to ED medical personnel.

b. If APOD does occur, the hospital should make every attempt to:

i. Provide a safe area in the ED within direct sight of ED medical personnel where the ambulance crew can temporarily wait while the hospital's patient remains on the ambulance gurney.

ii. Inform the attending paramedic or EMT of the anticipated time for the offload of the patient.

iii. Provide information to the EMS Field Supervisor regarding the steps the hospital is taking to resolve APOD.

c. If requested, hospitals will provide written details to SLOEMSA of policies and procedures that have been implemented to mitigate APOD and assure effective communication with affected partners:

i. Processes for the immediate notification of the following hospital staff through their internal escalation process of the occurrence of APOD, including but not limited to:

- ED Attending Physician
- ED Nurse Manager/Director or Designee (i.e. Charge Nurse) House Supervisor
  Administrator on-call

ii. Processes for ED medical personnel to immediately respond to and provide care for the patient if the attending EMS field personnel alert the ED medical personnel of a decline in the condition of a patient being temporarily held on the ambulance gurney.

iii. EMS field personnel are directed to do the following to prevent APOD:

- Notify the hospital ED as soon as possible (call-in) that a patient is being transported to their facility.
- Contact the EMS Field Supervisor for direction if the ED medical personnel do not offload the patient within the 30-minute ambulance patient offload time standard.
- Work cooperatively with the hospital staff to transition patient care within the timeframes established in this policy.

d. System Performance Monitoring

i. SLOEMSA may evaluate APOD trends to identify opportunities for system improvement. Hospitals experiencing ongoing APOD events may be asked to participate in collaborative improvement discussions or submit mitigation strategies to improve patient offload efficiency.

V. AUTHORITY

- California Health and Safety Code, Division 2.5
- California Code of Regulations, Title 22, Division 9

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

POLICY #124: DOCUMENTATION OF PREHOSPITAL CARE

I. PURPOSE

A. To establish minimum standards for EMS patient care documentation within the County of San Luis Obispo to ensure accurate documentation, regulatory compliance, quality improvement, and EMS system oversight.

II. DEFINITIONS

- Documentation: The recording of patient assessment, treatment, clinical decision-making, and patient disposition in the approved EMS documentation system.
- Electronic Patient Care Report (ePCR): The official electronic medical record documenting prehospital patient care.
- EMS Provider: Any EMT, paramedic, or authorized responder operating within the EMS system under the County of San Luis Obispo Emergency Medical Services Agency (SLOEMSA) authority.
- Primary Provider: The sole EMS provider who has authority for patient health care management.
- Patient: A person who has an actual or suspected injury or illness or who requests or requires medical evaluation, treatment, or transport by EMS personnel.
- Patient Contact: Any encounter in which EMS personnel initiate patient assessment or care.
- Transfer of Care: The formal transfer of patient care responsibility from EMS personnel to receiving medical personnel following patient acceptance, verbal report, and movement of the patient from the EMS gurney to receiving facility equipment. Refer to SLOEMSA Policy #158: Ambulance Patient Offload Time (APOT)
- CEMSIS: The California EMS Information System, the statewide EMS data repository managed by the California EMS Authority.
- NEMSIS: The National Emergency Medical Services Information System (NEMSIS) is the national system used to collect, store and share EMS data from the U.S. and Territories.
- SLOEMSA Data Repository: The EMS data system designated by SLOEMSA for submission, validation, and management of EMS documentation.

III. POLICY.

A. All EMS providers shall complete electronic patient care documentation for all patient contacts using a SLOEMSA-approved documentation system.

B. The electronic patient care report (ePCR) shall serve as the official legal medical record of prehospital care and shall accurately reflect patient assessment, treatment, clinical decision-making, and disposition.

C. Compliance with documentation requirements is a condition of participation in the EMS system.

D. Documentation shall be accurate, complete, objective, timely, and capable of supporting clinical care, quality improvement, EMS system evaluation, and regulatory review.

IV. REQUIRED DOCUMENTATION

A. An electronic patient care report shall be completed for all patient transports, patient contacts, refusals of care, treatment without transport, ALS assessments, cardiac arrest incidents, trauma activations, STEMI alerts, stroke alerts, and any incident in which patient care is provided.

B. Documentation is not required for responses canceled prior to patient contact; however, sufficient incident information shall be recorded to document the response and reason for cancellation.

V. DOCUMENTATION REQUIREMENTS

A. Documentation shall accurately describe the patient encounter and support clinical decision-making.

B. Required documentation elements include incident information, responding unit identification, personnel involved in patient care, response times, patient demographics when obtainable, chief complaint, assessment findings, vital signs, treatments performed, medications administered, procedures performed, patient response to treatment, disposition, and destination facility.

C. Documentation should reflect only care provided. Providers should document care rendered by other responders when known and clinically relevant.

D. All ePCR documentation for patients that are transported to a hospital or receiving facility shall have a minimum of two sets of vitals obtained and documented.

E. All ePCR’s involving specialty care systems (Stroke, STEMI, Trauma, and Cardiac Arrest) shall have vitals obtained and documented every 5 minutes for the duration of the call.

F. If cardiac monitoring is performed, significant ECG findings shall be included in the record.

VI. NARRATIVE REQUIREMENTS

A. The documenting provider shall complete a narrative accurately describing the patient encounter, including patient presentation, chief complaint, relevant history, assessment findings, clinical impression, treatments provided, patient response, and disposition.

B. Documentation shall clearly support clinical decision-making and be written in a manner understandable to other healthcare providers. Common clinical abbreviations or acronyms may be used when documentation remains clear and interpretable.

C. Artificial Intelligence and automatically generated narratives are not permitted.

VII. DOCUMENTATION TIME REQUIREMENTS

A. Documentation for critical patients, including trauma alerts, cardiac arrest patients, STEMI alerts, stroke alerts, and Code 3 transports, shall be completed as soon as practical but no later than 12 hours following transfer of care, or by the end of shift, whichever occurs first.

B. Documentation for all other transports and non-transport patient contacts shall be completed no later than twenty-four hours following the incident or by the end of shift, whichever occurs first.

VIII. DOCUMENTATION OF REFUSALS

A. Documentation of patient refusals shall be completed by the Primary Provider, consistent with SLOEMSA Policy #200: Scene Management. The Primary Provider is responsible for completion of the ePCR, obtaining all required refusal signatures, and documenting all required assessments, pertinent patient information, and patient care information. Other responding agencies shall complete their own ePCR documenting all pertinent patient and patient care information related to their involvement in the incident. While the Primary Provider is the only EMS provider required to obtain refusal signatures and ensure completion of refusal documentation, all EMS providers shall follow their respective agency policies and documentation requirements.

B. When BLS and ALS providers are present, BLS personnel shall complete documentation of all care provided until authority for patient health care management has been transferred to the ALS provider. The ALS provider assuming authority shall be responsible for completion of the refusal documentation and required signatures.

C. For additional refusal documentation requirements and definitions see SLOEMSA Policy #203 Patient Refusal of Treatment and/or Transport.

IX. DOCUMENTATION CORRECTIONS AND AMENDMENTS

A. The ePCR is a legal medical record and shall not be altered in a manner that removes or obscures original documentation.

B. Errors shall be corrected using approved amendment or addendum functions that maintain the original entry and audit trail.

C. Amendments shall include the date, time, person making the correction, and reason for the change.

D. Late entries shall be identified as such and include the reason for delayed documentation.

E. Documentation shall not be altered to misrepresent patient care, conceal errors, or avoid quality improvement or assurance review.

F. Documentation shall not be modified after notification of a complaint, investigation, or legal request except through proper amendment procedures.

G. All documentation shall be completed by the individual who wrote the original ePCR,.

H. Agencies shall ensure documentation integrity through internal review processes.

I. SLOEMSA may require documentation corrections when deficiencies are identified. Patterns of documentation deficiencies may result in a quality improvement or assurance review, a system compliance action, or a participation review.

X. DATA STANDARDS

A. Documentation shall comply with current CEMSIS requirements, NEMSIS standards, and the SLOEMSA data repository required data elements.

B. SLOEMSA may establish or modify documentation requirements as necessary to maintain regulatory compliance, improve data quality, support EMS system oversight, or support quality improvement activities.

C. Documentation may be used for EMS system performance evaluation, regulatory reporting, and state audit review.

XI. TRANSFER OF CARE

A. Documentation shall reflect transfer of patient care, including receiving facility or provider, patient condition at transfer, treatments provided, and significant clinical findings.

B. EMS units shall not return to service prior to appropriate transfer of care unless operational necessity exists.

A. Ambulance patient offload times (APOT) shall be documented per the local standard, as well as any delays in patient turnover of care (APOD) – see SLOEMSA Policy #158 Ambulance Patient Offload Time (APOT) Monitoring

XII. SYSTEM PARTICIPATION

A. Participation in the EMS system requires compliance with all documentation standards.

B. EMS providers and agencies shall submit required documentation, maintain documentation accuracy, meet submission timelines, and participate in documentation review and quality improvement processes.

C. SLOEMSA may review documentation for quality improvement, protocol compliance, system performance monitoring, public health reporting, and regulatory compliance.

D. SLOEMSA may conduct documentation audits to ensure compliance with documentation standards, regulatory requirements, and EMS system participation requirements.

E. SLOEMSA may require corrective action when documentation deficiencies are identified.

F. EMS providers and agencies shall submit required documentation within timelines established by SLOEMSA.

XIII. RECORD RETENTION

A. EMS providers shall comply with applicable medical record retention requirements in accordance with California Code of Regulations Title 22 and applicable law.

XIV. CONFIDENTIALITY

A. All patient documentation shall comply with HIPAA, the California Confidentiality of Medical Information Act, applicable state regulations, and County privacy policies. Access shall be limited to authorized individuals.

XV. COMPLIANCE

A. Failure to meet documentation requirements may result in quality improvement review, corrective action, or system compliance action.

B. Intentionally falsifying documentation or failing to meet documentation requirements, such as not submitting an ePCR, may lead to an investigation in accordance with the California Health and Safety Code and related regulations.

C. The SLOEMSA may request amendments and documentation correction when improper documentation is found, following the quality improvement or assurance review.

D. Any EMS personnel involved in patient assessment, treatment, or patient contact who fail to complete required documentation may be subject to quality improvement review, quality assurance investigation, or EMS system compliance action.

XVI. AUTHORITY

- California Health and Safety Code Division 2.5
- California Code of Regulations Title 22 Division 9
- California Code of Regulations Title 22 Division 5

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

POLICY #222 MECHANICAL CPR DEVICES:

Purpose

I. PURPOSE

II. To establish standard procedures and clinical criteria for the deployment, operation, training, and documentation of all mechanical cardiopulmonary resuscitation (CPR) devices (e.g., LUCAS, AutoPulse) by EMS personnel in San Luis Obispo County.

III. POLICY

Manual chest compressions are the standard of care for patients in cardiopulmonary arrest. Studies have shown no mortality benefit to support the use of mechanical CPR devices over high-quality manual chest compressions. However, there are situations where manual CPR is challenging or dangerous for the prehospital provider, and mechanical chest compressions are preferred.

A. Mechanical CPR devices may be used in adult, non-traumatic cardiac arrest patients when continuous, high-quality manual chest compressions are not feasible, or when fatigue is a concern.

B. Mechanical CPR devices are not mandatory and should be used at the provider's discretion.

C. Agencies must inform the SLOEMSA Medical Director in writing prior to deploying mechanical CPR devices in the field.

Procedure

IV. PROCEDURE

A. Training & Competency

1. All personnel operating mechanical CPR devices must complete manufacturer-approved initial training and participate in annual refreshers. Training must include indications (listed herein), contraindications (listed herein), device application, troubleshooting, safety, and patient assessment during use.

B. Clinical Indications

1. Prolonged cardiac arrest with ongoing CPR

2. Unsafe environments for manual CPR

3. Limited staffing or when fatigue is a concern
4. If not already placed, prophylactic application prior to transport in patients with ROSC in case of rearrest. The device should only be activated in the event of rearrest
5. Provider discretion

C. Contraindications

1. Pediatric patients
2. Traumatic cardiac arrest
3. Presence of ventricular assist device (VAD)
4. Incompatible patient body size or anatomy
5. Patients who meet SLOEMSA Policy #125: Prehospital Determination of Death / Do Not Resuscitate (DNR) / End of Life Care

D. Device Application

1. Manual CPR should be performed immediately on patient arrival. Do not delay the initiation of chest compressions to place the mechanical CPR device.
2. Apply the device using deployment to minimize interruptions. Please note that the principles of High-~~-~~Performance CPR (HPCPR) ~~are still~~remain the top priority~~. Limit interruptions of compressions to < 5~~, 10 sec. Confirm proper positioning and secure attachment. Monitor for movement, malfunctions, and signs of ROSC.
3. The EMS crew shall use an objective timing method (e.g., monitor/defibrillator event marker and/or a CPR quality data monitoring program) to verify that all pauses in chest compressions are less than 10 seconds. The expectation is that an EMS agency using a mechanical CPR device would be able to provide documented verification of pause length during its application (and ongoing use during management of a patient in cardiac arrest).

~~3.~~4. Follow device-specific manufacturer instructions for application and operation.

E. Documentation

1. Time of device application and removal.
2. Type of device used.
3. Any complications or malfunctions.

~~Authority~~

4. Electronic record for CQI that verifies that the longest pause was < 10 seconds, unless there was a clinical reason to explain a longer pause, such as but not limited to a hazardous scene requiring emergent patient movement, or other unexpected event that would justify a longer pause in compressions.

V. AUTHORITY

- California Health and Safety Code, Division 2.5
- 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

Penny Borenstein, MD, MPH *Health Officer/Public Health Director*

MEETING DATE	May 21, 2026
STAFF CONTACT	Bill Mulkerin, MD; EMS Medical Director 805.788.2515, wmulkerin@co.slo.ca.us
SUBJECT	Policy 205, Attachment A: EMS Equipment and Supply List; Policy 212: Tiered Response Program for Medical Facilities
SUMMARY	Policy 205, Attachment A: Adjusted minimum stock quantities for various medications. Key changes: Ketamine: quantity 1 for ALS transport units (from prior of qty 2). This is based upon infrequent use, waste of unused medications. Nitroglycerine paste: qty 2 for ALS transport units (from prior of qty 3) Adenosine: increased ALS qty to allow for full treatment of 1 patient Burn sheets: made these optional, except for ALS Wildland Long boards: Expectation is 2 for ALS Transport, but still in service with 1 (to allow for some flexibility if they need to have a quick turnaround from ED after a trauma call). Policy 212: Tiered Response Program for Medical Facilities. Changing this policy to allow for a broader range of facilities to utilize for code 2 ambulance-only response, as long as they meet the requirements and are approved by the EMSA. Decision-maker for the request should be an MD/DO, NP, or PA, although the caller can call on their behalf. New language in policy should allow for interested/appropriate urgent cares, memory care facilities, county jail, and homeless shelters that have on-site medical staff to utilize this policy.
REVIEWED BY	Dr. Bill Mulkerin, SLOEMSA Staff
RECOMMENDED ACTION(S)	Recommended the following for approval by EMCC and moved for adoption Policy 205, Attachment A, Policy 221 Policy 212: Tiered Response Program for Medical Facilities
ATTACHMENT(S)	Policy 205, Attachment A: EMS Equipment and Supply List; Policy 212: Tiered Response Program for Medical Facilities

EMS Equipment and Supply List

Description	Strength/Size	ALS Transport Minimum	ALS First Responder Minimum	ALS Special Use Medic Minimum	ALS Wildland Unit Minimum	BLS First Responder Minimum *† Add'l and optional skills as approved*
MEDICATIONS						
Activated charcoal	50 gm bottle (aqueous solution)	1	1	0	0	0
Adenosine	6 mg/2 mL	5	5	5	5	0
Albuterol unit dose	2.5 mg/3 mL solution	4	2	2	2	0
Amiodarone	450mg/9mL (9mL vials)	1	1	1	1	0
	OR					
Amiodarone	150mg/3ml (3ml vials)	3	3	3	3	0
Amiodarone	**Optional** 150mg/100mL NS drip	1	1	1	1	0
†Aspirin	81 mg nonenteric coated chewable	1 bottle	1 bottle	4 tablets	4 tablets	†1 bottle
Atropine	1 mg/10 mL	2	2	2	2	0
Atropine	8 mg multi-dose vial	1	1	0	0	0
Calcium Chloride 10%	1 gm/10 mL	1	1	0	0	0
Dextrose 10%	25 gm/250 mL bag	2	2	1	1	0
*Dextrose 50%	25 gm/50 mL	0	0	0	0	0
Diphenhydramine	50 mg/1 mL	2	2	2	2	0
†Epinephrine	1:1,000 1 mg/1 mL	4	2	2	2	†2
†Epinephrine Auto-Injector	Pediatric and Adult	0	0	0	0	†1 each
Epinephrine	1:10,000 1 mg/10 mL (10 mL preload)	8	6	3	6	0
Fentanyl	100 mcg/2 mL	2	2	2	2	0
Glucagon	1 mg/1 mL	1	1	0	0	0
Glucose gel	15 gm	2 tubes	2 tubes	2 tubes	2 tubes	2 tubes
Lidocaine 2%	100 mg/ 5 mL	1	1	1	1	0
Ketamine	500 mg/ 5mL	1	1	1	1	0
Midazolam	10 mg/ 2 mL	2	1	1	1	0
Naloxone	2 mg (vial or pre-load)	2	2	2	2	0
†Naloxone IN Kit	§2 mg pre-load and Atomizer	0	0	0	0	†2
Nitroglycerine	SL tablets or spray	1 bottle	1 bottle	1 bottle	1 bottle	0
Nitro Paste 2%	1 gm single dose packet	2	2	0	0	0
Ondansetron	4 mg /2 mL injectable	3	3	0	0	0
	4 mg dissolvable tablets	3	3	1	1	0
Sodium Bicarbonate	50 mEq/50 mL	2	2	0	0	0
Magnesium Sulfate	1Gm/2mL	4	4	2	2	0
Ipratropium Bromide	500mcg/3mLsolution	2	2	2	2	0
Buprenorphine	8 mg SL tablet/film	6	3	0	0	0
Tranexamic Acid (TXA)	100 mg/1 mL 10 mL vial	2	1	0	1	0

Variations in the concentration of medications being stocked, due to medication supply shortages, must be approved by Medical Director

†BLS Basic Scope Add'l Skills equipment required for participating agencies

Alternate Medications to be Stocked ONLY with Medical Director Approval and Waiver

EMS Equipment and Supply List

Description	Strength/Size	ALS Transport Minimum	ALS First Responder Minimum	ALS Special Use Medic Minimum	ALS Wildland Unit Minimum	BLS First Responder Minimum † *Add'l and optional skills as approved*
§Other pre-packaged single dose intranasal naloxone delivery devices that may be used with Medical Director Approval		0	0	0	0	†2
Diazepam (alternate to be stocked by order of Med Dir **ONLY**)	10 mg	2	1	1	1	0
Morphine (alternate to be stocked by order of Med Dir **ONLY**)	10 mg	3	2	2	2	0
Lidocaine 2% (alternate to be stocked during Amiodarone shortage by order of Med Dir ONLY)	100mg / 5ml	6	4	3	3	0
IV SOLUTIONS/EQUIPMENT						
0.9% Normal Saline	1,000 mL bag (or equivalent total volume)	6	4	2	4	0
100 mL Saline Delivery Equipment	0.9% NS 100 mL bag	4	2	2	2	0
0.9% Normal Saline	10 mL Vials/Flush	5	5	2	2	0
IV Tubing	10-20gtt/mL	6	3	2	2	0
IV Catheters	Sizes 14, 16, 18, 20, 22, 24 gauge	2 each	2 each	2 each	2 each	0
Syringes	Assorted - 1mL, 3mL, 6mL-20mL	2 each	2 each	1 each	1 each	0
†Syringes BLS only	1mL (draw up epi)	N/A	N/A	N/A	N/A	†2 each
Needles Assorted	½ , 1 , 1 ½ 18-30 gauge	2 each	2 each	2 each	2 each	0
†Needles Assorted BLS only	23 & 25 gauge (draw up epi)	N/A	N/A	N/A	N/A	†2 each
Intraosseous (IO) single needle device	(FDA approved) adult and pediatric	1 each	1 each	1 each	1 each	0
Tourniquets (for IV start)		2	2	2	2	0
Saline locks		4	2	2	2	0
Luer-Lock adaptors	(Not required but recommended for use with STEMI patients)	2	2	0	0	0
†Alcohol and betadine swabs		10 each	10 each	10 each	10 each	†10 each
TRAUMA						
Bandages and bandaging supplies:						
Bandaids	Assorted	10	10	5	5	10
Sterile bandage compresses or equivalent	4"x4"	12	10	10	10	10
Trauma dressing	10"x30" or larger universal dressing	2	2	2	2	2
Roller gauze	3" or 4"	8 rolls	8 rolls	2 rolls	2 rolls	8 rolls
Cloth adhesive tape	1, 2, or 3"	1 roll	1 roll	1 roll	1 roll	1 roll
Triangular bandages with safety pins		4	2	1	1	2
Tourniquet	See approved list for commercial devices	2	2	1	1	2
Vaseline gauze	3"x8", or 5"x9"	2	2	1	1	2

EMS Equipment and Supply List

Description	Strength/Size	ALS Transport Minimum	ALS First Responder Minimum	ALS Special Use Medic Minimum	ALS Wildland Unit Minimum	BLS First Responder Minimum † *Add'l and optional skills as approved*
Tongue blade or bite stick		2	2	2	2	2
Burn Sheets (sterile or clean) –	may be disposable or linen (with date of sterilization indicated)	1	1	0	2	1
Cervical collars	Stiff: Sizes to fit all patients over one year old	1each	1 each	1 each	1 each	1 each
Cold packs		2	2	2	2	2
Irrigation equipment and supplies:						
Saline, sterile	250mL	4	2	1	2	2
Long spine board and light weight head immobilizer blocks	(or equivalent immobilization device)	2	1	0	0	1
Straps to secure patient to boards		2 sets	1 set	0	0	1 set
Splints, traction	Adult and pediatric (or a single device suitable for both)	1 each	1 each	0	0	1 each
Splints, cardboard or equivalent	arm and leg splint	2 each	2 each	1 each	2 each	2 each
K.E.D. or equivalent	*optional*	0	0	0	0	0
Pediatric spinal immobilization board	(or equivalent immobilization device)	1	0	0	0	0
Sheet or commercial pelvic binder		1	1	0	0	1
Infection Control						
Meet the minimum requirement per crew member as stated in the California Code of Regulations Title 8 (All Providers)						
Transportation Equipment						
Collapsible gurney cot with adjustable contour feature		1	0	0	0	0
Stair chair or equivalent device		1	0	0	0	0
Sheets, pillow, pillow case, towels, blankets (cloth or disposable)		2	0	0	0	0
Scoop stretcher with straps		1	0	0	0	0
Flat vinyl/canvas stretchers with straps		1	0	0	0	0
MISCELLANEOUS						
Blood pressure cuffs (portable):	Adult	1	1	1	1	1
	Large adult or thigh	1	1	0	0	1
	Pediatric	1	1	0	1	1
Obstetrical kit - sterile, prepackaged		1	1	0	0	1
Restraints - non-constricting wrist and ankle		1 set each	1 set each	0	0	1 set each
Stethoscope		1	1	1	1	1
Trash bags/receptacles		2	2	1	1	2

EMS Equipment and Supply List

Description	Strength/Size	ALS Transport Minimum	ALS First Responder Minimum	ALS Special Use Medic Minimum	ALS Wildland Unit Minimum	BLS First Responder Minimum † *Add'l and optional skills as approved*
Blanket	Disposable	1 each	1 each	1 each	1 each	1 each
Bandage scissors (heavy duty)		1	1	1	1	1
Emesis basins or emesis bags with containers		2	2	1	1	2
Water, potable		1 liter	1 liter	0	1 liter	1 liter
Maps, entire county		1	1	0	0	1
Penlight		1	1	1	1	1
Triage tags		20	20	20	20	20
Bed pan		1	0	0	0	0
Urinal		1	0	0	0	0
†Glucometer	with ≥10 test strips, lancets, and other appropriate supplies	1	1	1	1	†1
†Puncture proof sharps container	small	2	2	1	1	†1
Thermometer		1	1	0	0	0
Automatic External Defibrillator	With AED pads	* For EMT-D Provider Agencies (1)				
AIRWAY						
Endotracheal tubes:	sizes-3.0, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5, 9.0	1 each	1 each	1 each	1 each	0
Laryngoscope handles, with extra batteries		2	2	1	1	0
Laryngoscope blades:	Miller # 0, 1, 2, 3, 4 Macintosh # 1, 2, 3, 4	1 each	1 each	1 each	1 each	0
†i-Gel Supraglottic Airways	Size 1, 1.5, 2, 2.5	1 each	1 each	1 each	0	†1 each
†i-Gel Supraglottic Airways	Size 3 and Size 5	1 each	1 each	1 each	1 each	†1 each
†i-Gel Supraglottic Airways	Size 4	2 each	2 each	1 each	1 each	†2 each
Magill forceps (pediatric and adult)		1 each	1 each	1 each	1 each	0
Adult stylets		2 each	1 each	1 each	1 each	0
10-20 mL syringe, sterile lubricant		2 each	1 each	1 each	1 each	0
Needle Cricothyrotomy kit with:	10 or 12 ga needle, 10-20 mL syringe, alcohol and betadine wipes and oxygen supply adapter OR other FDA approved percutaneous cricothyrotomy kit with MD approval	1	1	1	1	0
Capnography Device	Qualitative or Quantitative	1	1	1	1	0
Hand held nebulizer for inhalation therapy		2	2	1	1	0
Medrafter or equivalent		1	1	0	0	0

EMS Equipment and Supply List

Description	Strength/Size	ALS Transport Minimum	ALS First Responder Minimum	ALS Special Use Medic Minimum	ALS Wildland Unit Minimum	BLS First Responder Minimum † *Add'l and optional skills as approved*
Portable, battery powered, cardiac monitor-defibrillator with 12-lead ECG capability with the ability to perform computerized ECG readings and provide hard copy ECG tracings, with:		1	1	1	AED w.manal defib and w/EKG	0
	Patient ECG cable	1	1	1	0	0
	ECG recording chart paper	1	1	1	0	0
	Adult ECG electrodes	4 sets	4 sets	2 sets	2 sets	0
	Defibrillation pads or equivalent - Adult	2 set each	2 set each	1 set each	1 set each	0
	Defibrillation pads or equivalent - Pediatric	1 set each	1 set each	1 set each	1 set each	0
IV catheter for pleural decompression	10 gauge/3 inch	2	2	1	1	0
Asherman chest seal or equivalent open wound dressing		1	1	1	1	1
Pulse oximeter		1	1	1	1	1
Continuous Positive Airway Pressure (CPAP) Ventilator	portable/adjustable pressure settings, FDA Approved with an oxygen supply	1	1	0	0	1
Nasopharyngeal airways (soft rubber)	Medium and Large adult sizes	2 each	2 each	1 each	1 each	2 each
Lubricant, water-soluble jelly (K-Y)		2	2	2	2	2
Oropharyngeal airways	(sizes 5.5 – 12 or equivalent)	2 each	1 each	1 each	1 each	1 each
Adult non-rebreather masks		2	2	1	1	2
Pediatric/infant non-rebreather mask		2	2	1	1	2
Adult nasal cannula		4	2	1	1	2
Oxygen Cylinders	D or E size cylinder with regulator capable of delivering 2-15 LPM	1	1	1	1	1
	M, H, or K cylinder with wall outlet(s) and constant flow regulator(s)	1	0	0	0	0
Oxygen reserve:						
	D or E cylinders	1	1	0	0	1
Face masks for resuscitation (clear)		2	1	1	1	1
Bag-valve mask with O2 reservoir and supply tubing						
	Adult	1	1	1	1	1
	Pediatric	1	1	1	1	1
	Infant	1	1	1	0	1
Suction equipment and supplies:						
Rigid pharyngeal tonsil tip		2	2	0	0	2
Spare suction tubing		1	1	0	0	1
Suction apparatus (portable)		1	1	1	1	1
Suction catheters	at least 2 sizes suitable for adult and	2 each	1 each	1 each	1 each	1 each
	pediatric endotracheal suctioning					

POLICY #: 212 TIERED RESPONSE PROGRAM FOR ~~SKILLED NURSING~~MEDICAL FACILITIES

I. PURPOSE

A. To establish a process through which ~~skilled nursing~~medical facilities may participate in a tiered response level for patients requiring unscheduled non-emergent transportation to a hospital.

II. DEFINITIONS

- On-Site Medical Staff – Licensed medical professionals (Physician, Physician's Assistant [PA], Nurse Practitioner [NP], Registered Nurse [RN])~~, staffing a skill-nursing facility on a 24 hours per day.~~.
- Skilled Nursing Facility (SNF) – A facility that provides healthcare to individuals unable to manage independently in the community, and has licensed medical staff on-site 24 hours per day.
- Urgent Care – A medical care facility that is capable of providing prompt medical care, typically for non-life-threatening illnesses.
- Other medical facility – medical facilities not meeting the above definitions

III. POLICY

A. No ~~SNF~~ Medical Facility will utilize or request tiered response transport unless authorized by the County of San Luis Obispo Emergency Medical Services Agency (EMS Agency) in accordance with this policy.

IV. PROCEDURE

A. A ~~SNF~~ Medical Facility seeking authorization to participate in the tiered response program must submit a written proposal to the EMS Agency, which includes the following elements:

1. Requesting facility has a licensed medical staff on duty ~~24 hours per day~~at the time of the request.
2. A written letter of support for the request to participate in the program from the jurisdictional Fire Department and Public Safety Answering Point (PSAP) submit to the EMS Agency.
3. The jurisdictional PSAP must be an EMS Agency approved Emergency Medical Dispatch provider agency
4. Requesting facility must provide written documentation detailing process for how staff will handle preparing for the transfer request, including the inclusion of appropriate patient transfer documents, and notification of/coordination with receiving hospitals.
5. Final approval may include a review by an EMS Agency advisory committee(s).
6. The EMS Agency will review each request within 60 days of receipt and will approve request after all requirements have been satisfied:

B. Upon EMS Agency written approval of request:

1. Approved facility must utilize the Patient Assessment Flow Chart (Attachment A) to determine whether to request a Code 2 or Code 3 response
2. Approved facility will utilize the narrative script (Attachment B) when facility contacts the PSAP to request unscheduled patient transport
3. Approved facility will participate in a Quality Improvement program, and provide documentation to the EMS Agency upon request.

V. AUTHORITY

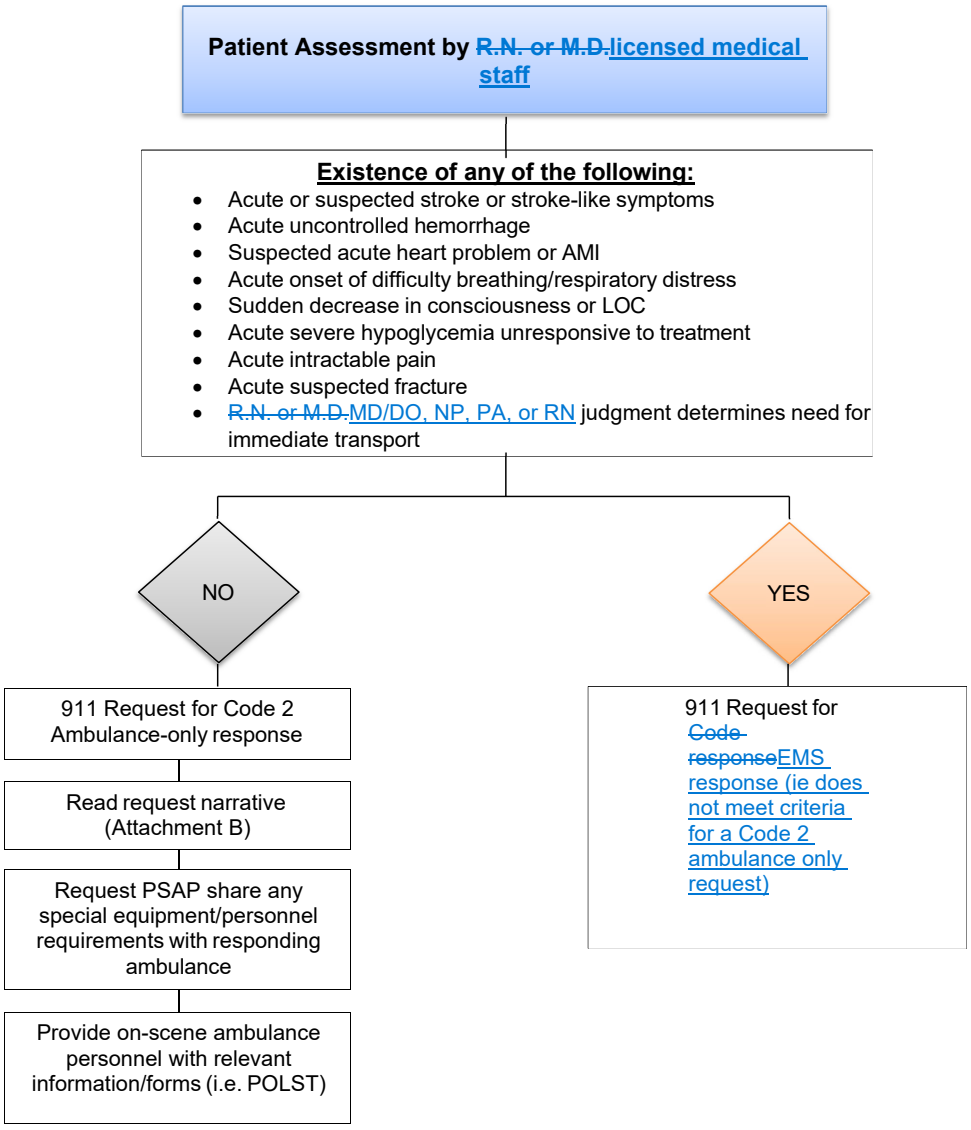
- California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.206, 1797.220, 1797.252, 1798 (a)(b)

VI. ATTACHMENTS

A. Patient Assessment Flow Chart

B. Facility Narrative script

PATIENT ASSESSMENT FLOW CHART



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TIERED RESPONSE PROGRAM FOR SKILLED NURSING FACILITIES REQUESTING FACILITY NARRATIVE

1) Identify the need for a code 2 ambulance-only transfer (Attachment A).

2) Dial 911 to initiate the request

3) State the following:

   "This is _____(Name) from_____(approved facility name) on behalf of _____(~~R.N. or M.D.~~MD/DO/NP/PA name - if not the same as caller), requesting a Code 2 Ambulance-only transfer to _____(Hospital)."

4) Monitor patient for changes which may require an upgrade to a Code 3 response, and dial 911 with such request.

5) Confirm proper transfer documents including code status / POLST are properly prepared and ready to deliver to the transporting crew.

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
PUBLIC HEALTH DEPARTMENT

Penny Borenstein, MD, MPH *Health Officer/Public Health Director*

MEETING DATE	May 21, 2026
STAFF CONTACT	Ryan Rosander, EMS Director 805.788.2512 rrosander@co.slo.ca.us
SUBJECT	Election of Chairperson
SUMMARY	In accordance with the San Luis Obispo County Emergency Medical Care Committee (EMCC) Bylaws, the EMCC shall elect a Chairperson from its voting membership. The Chairperson serves a two-year term beginning July 1 and may not serve more than two consecutive terms in the position. The current Chairperson (Chris Javine) term expires June 30, 2026. Staff recommends the EMCC conduct the election of Chairperson for the upcoming term consistent with the adopted bylaws.
RECOMMENDED ACTION(S)	Conduct the election of the EMCC Chairperson for the upcoming two-year term in accordance with the EMCC Bylaws.