

Clinical Advisory Subcommittee of the Emergency Medical Care Committee



Meeting Agenda

10:15 A.M. Thursday, June 19th, 2025

Location: SLOEMSA Conference Room

2995 McMillan Ave, Ste 178

San Luis Obispo, CA 93401

Members

CHAIR: Dr. Stefan Teitge, *County Medical Society*
 Dr. Heidi Hutchinson, *ED Physician Adventist*
 Dr. Kyle Kelson, *ED Physician Adventist*
 Dr. Lucas Karaelias, *ED Physician Dignity*
 Diane Burkey, *MICNs*
 Rob Jenkins, *Fire Service Paramedics*
 Nate Otter, *Ambulance Paramedics*
 Paul Quinlan, *Fire Service EMTs*
 Lisa Epps, *Air Ambulance*
 Jeffrey Hagins, *Air Ambulance*
 Arneil Rodriguez, *Ambulance EMTs*
 Casey Hidle, *Lead Field Training Officer*
 VACANT, *Medical Director Appointee*

Staff

STAFF LIAISON: Ryan Rosander, *EMS Division Director*
 Kaitlyn Blanton, *EMS Coordinator*
 Dr. William Mulkerin, *Medical Director*
 Rachel Oakley, *EMS Coordinator*
 Eric Boyd, *EMS Coordinator*
 Alyssa Vardas, *EMS Admin Assistant III*

AGENDA	ITEM	LEAD
Call to Order	Introductions	Dr. Teitge
	Public Comment	
Summary Notes	Review of Summary Notes April 17 th , 2025	
Discussion	Protocol and Formulary Revisions: <ul style="list-style-type: none"> Protocol #XXX Opioid Withdrawal Suboxone Formulary 	Ryan Rosander
	Policy Revisions: <ul style="list-style-type: none"> Policy #203 Patient Refusal Policy #341 Emergency Medical Technician Paramedic Accreditation Policy #342 Emergency Medical Technician Paramedic Reccreditation 	Ryan Rosander Rachel Oakley
Adjourn	Declaration of Future Agenda Items <ul style="list-style-type: none"> Roundtable 	Dr. Teitge
	Next meeting date – August 21st, 2025 1015 hrs – EMSA Conference Room 2995 McMillan Ave. Suite 178 San Luis Obispo, CA 93401	

Clinical Advisory Subcommittee of the Emergency Medical Care Committee

DRAFT Meeting Minutes

10:15 AM April 17, 2025

2995 McMillan Way, Suite 178

San Luis Obispo, CA 93401



MINUTES

MEMBERS PRESENT:

Chair Dr. Stefan Teitge, *County Medical Society*
Casey Hidle, *Lead Field Training Officer*
Dr. Heidi Hutchison, *ED Physician*
Rob Jenkins, *Fire Service Paramedics*
Nate Otter, *Ambulance Paramedics*
Lisa Epps, *Air Ambulance*
Tim Nurge, *Medical Director Appointee*

MEMBERS ABSENT:

Dr. Kyle Kelson, *ED Physician*
Dr. Lucas Karaelias, *ED Physician Dignity*
Diane Burkey, *MICNs*
Paul Quinlan, *Fire Service EMTs*
Jeffrey Hagins, *Air Ambulance*
Arneil Rodriguez, *Ambulance EMTs*
Casey Hidle, *Lead Field Training Officer*

EMS AGENCY STAFF PRESENT:

Alyssa Vardas, *EMS Administrative Assistant*
Ryan Rosander, *EMSA*
Rachel Oakley, *EMSA*
Kaitlyn Blanton, *EMSA*

EMS AGENCY STAFF ABSENT:

Eric Boyd, *EMSA*
Bill Mulkerin, *EMS Medical Director*

1. CALL TO ORDER

Ryan Rosander called the meeting to order at 10:28 a.m. He led the reviewing of the meeting protocols and meeting agenda.

2. REVIEW AND APPROVAL OF December 19th, 2024, Summary Notes

Action: Nate Otter moved approval of the February 20, 2024, Clinical Advisory Committee Meeting Minutes. Rob Jenkins seconded. Motion carried unanimously with no abstentions.

Protocol 704 Needle Cricothyrotomy:

Procedure 704 needle Cricothyrotomy has been updated with language approving ALS providers to follow manufacturers' guidelines for brand-specific instructions on their equipment.

Discussion:

None

Protocol XXX Opioid Withdrawal:

In conjunction with the County's Strategic Plan for 2025, the introduction of Protocol #XXX (no 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

- H. Hutchison says this is great, we will have pushback from medics and hospitals. May want education from bridge program for hospitals. Knowledge that physicians may choose not to use. If base station order, education for physicians. What is the feeling from field staff?
- C. Hidle says that the field staff will have push back as there already is.
- H. Hutchison says that this is a good thing but we might need
- education and resources
- R. Jenkins asks what the potential is to see patient 2 in a day,
- S. Teitge says some might be more hesitant.
- R. Jenkins asks In How often would we use this, how emergent is it that we use it and not hospitals?
- S. Teitge says that it probably wouldn't be given very much.
- N. Otter says This would be successful if there are all the right pieces in place. I think we are premature in getting this onto the ambulances.
- S. Teitge says you will have to collect the data on it. How often that happens depends.
- R. Jenkins says we would have to get information from the hospital about whether that was the correct diagnosis.
- C. Hidle says I've talked to providers who have done this and people will get it from the ambulance and then not go to the hospital.
- K. Blanton says that's why there are those criteria and it's a base order.
- H. Hutchison says we could gather more data on this. There is some data to support. It would be helpful to hear from Bill on this one. What is the benefit of having this with EMS and not just in the hospital. We need a larger discussion with hospitals.

- R. Rosander says that this is something EMCC and the Board of Supervisors have wanted.
- H. Hutchison says All of our people deserve to be brought up to date and also know what kinds of resources our patients will have.
- R. Rosander says Nick Drews has been working on Triage to alternate destinations with Behavioral Health.
- T. Nurge asks if we got a grant for IXA?
- R. Rosander says there is a grant on Suboxone. Some of that grant could go to ALS agencies to help with buying it.
- K. Blanton says there are gaps in education and that causes polarization.
- T. Nurge asks how the policy affects the patient and the system?
- S. Teitge says that from a clinical standpoint it looks good and there is no issues with medicine.
- T. Nurge asks if in other systems is this a base order?
- R. Jenkins asks if we can have dosage say two strips?
- S. Teitge says to change to reassess at 20 minutes.

Policy 125 Determination of Death:

The Policy #125 (last rev. 4/15/2017) revisions were deemed necessary to address issues related to the interpretation of the current obvious death criteria. Proposed changes are intended to clarify procedures on how death is determined in the field, not overhaul current practices.

Discussion

- H. Hutchison asks, can we change one or more joints to an extremity. I don't know if this is capturing the concern.
- T. Nurge mentions that I think a lot of people just go to the jaw and don't check anything else.
- S. Teitge says at that point if they have gone through the other assessments, it should be obvious.
- N. Otter says it should be clearer for our medics. This chart is to be applied to an obvious death? could we add that wording? Make sure that this doesn't apply for every cardiac arrest? I don't want this to make medics not start CPR.
- T. Nurge asks if this table applies to decapitation?
- H. Hutchison asks if the table could be included within C? To put it under signs of life? "Are not expected to" language would allow them to check if circumstances arise.
- N. Otter says page 4 under a, 20min resuscitation allows room to call base before starting 20 minutes. Make it clear that's the goal, but if circumstances come up, they can call.
- R. Rosander says 20 minutes should be a suggestive number.
- R. Oakley mentions that 20 minutes is in other policies which would need to be changed.
- N. Otter asks MCI defined by what? Do they have the number of patients or if do they not have the personnel to handle?
- R. Jenkins says for it to be an MCI, you have to declare an MCI.

158 Ambulance Offload Time: 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. In the County of San Luis Obispo, all prolonged APOT times negatively impact the system due to the number of ambulances available; for this reason, SLOEMSA is seeking stakeholder feedback for a 20-minute standard.

Discussion

- N. Otter says a component of the crew being responsible in the ER.
- R. Rosander says it is then the hospital's responsibility.
- N. Otter says Its not clear in 3 a. We are doing ER treatment on our gurneys. At what point do they take the patient off gurney? I do have concerns about what we are responsible for and what the ER is responsible.
- H. Hutchison says we can't take a patient if we don't have a bed and nurse but the doctor will go and see the patient. Even if a physician is seeing a patient, its not actually the ER taking the patient.
- S. Teitge asks how much has this been presented to the hospitals?
- H. Hutchison says she just wants to make sure that people are empowered to do the right thing for the patient. Its not usually the charge nurse that can solve the issue in the moment.
- S. Teitge says it's a case-by-case thing that a policy won't work for everyone.
- H. Hutchison says language that this is a goal that we are tracking. Directing this at correct level is key.
- S. Teitge says EMSA needs to talk to the correct hospital directors about it.

3. ITEMS FOR NEXT AGENDA

Review of 203 Patient Refusal, 341, 342 Paramedic Accreditation and Reaccreditation.

4. PUBLIC COMMENT

None

5. ADJOURNMENT

Action: Rob Jenkins moved to move the protocols and policies as amended forward to EMCC. Stefan Teitge seconded. Motion carried unanimously.

Stefan Teitge adjourned the meeting at 11:42 am.



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	June 19, 2025
STAFF CONTACT	Ryan Rosander, EMS Director 805-788-2512 rrosander@co.slo.ca.us
SUBJECT	Procedure #704 Opioid Withdrawal – Medication change from Suboxone to Buprenorphine
SUMMARY	On May 15, 2025, EMCC approved SLOEMSA's Opioid 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.
REVIEWED BY	Dr. William Mulkerin, SLOEMSA Staff, EMCC
RECOMMENDED ACTION(S)	Changes are recommended for CAC approval and move to EMCC agenda.
ATTACHMENT(S)	Protocol # xxx – Opioid Withdrawal Suboxone Formulary

Emergency Medical Services

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OPIOID WITHDRAWAL	
ADULT	PEDIATRIC (≤34 KG)
BLS Procedures	
<ul style="list-style-type: none"> • Universal Algorithm #601 • Pulse Oximetry <ul style="list-style-type: none"> ○ O₂ Administration per Airway Management Protocol #602 	<ul style="list-style-type: none"> • Universal Algorithm
ALS Procedures	
<ul style="list-style-type: none"> • If suspected opioid withdrawals, use “COWS” score to determine if patient meets criteria to receive Suboxone Buprenorphine <ul style="list-style-type: none"> ○ “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 	<ul style="list-style-type: none"> • Suboxone Buprenorphine is not permitted in pediatric patients under 18 16
Base Hospital Orders Only	
<ul style="list-style-type: none"> • Suboxone Buprenorphine 16mg SL film (two strips) – reassess after 20 minutes <ul style="list-style-type: none"> ○ 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 	<ul style="list-style-type: none"> • As needed
Notes	
<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ Recent opioid use ○ Chronic opioid use ○ Evidence of illicit drug use (paraphernalia, needles etc) ○ Prescription narcotics in household or on patient <p style="color: red;">• 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</p>	

Clinical Opioid Withdrawal Scale (COWS)

<p><u>ANXIETY OR IRRITABILITY</u> <i>Visually observed during assessment</i></p> <p>0 None 1 Reports increasing irritability or anxiousness 2 Visually irritable or anxious 4 Too irritable to participate or affecting participation</p>	<p><u>RESTING HEART RATE</u> <i>Measured after sitting for one (1) minute</i></p> <p>0 ≤80 bpm 1 81 to 100 bpm 2 101 to 120 bpm 4 >120 bpm</p>
<p><u>BONE OR JOINT ACHES</u> <i>Only new pain attributed to withdrawal is scored</i></p> <p>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</p>	<p><u>RESTLESSNESS</u> <i>Visually observed during assessment</i></p> <p>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</p>
<p><u>SKIN SIGNS</u> <i>Visually or physically observed during assessment</i></p> <p>0 Skin is smooth 3 Piloerection of skin – can be felt or visible arm hairs standing up 5 Prominent piloerection – “Gooseflesh Skin”</p>	<p><u>TREMOR</u> <i>Observation of outstretched hands</i></p> <p>0 No tremors 1 Tremor can be felt but not observed 2 Slight tremor observed 4 Gross tremor or muscle twitching</p>
<p><u>GASTROINTESTINAL UPSET</u> <i>Within past 30 minutes</i></p> <p>0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting</p>	<p><u>SWEATING</u> <i>Over past 30 min – not from environment or activity</i></p> <p>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</p>
<p><u>PUPIL SIZE</u> <i>Visually observed during assessment</i></p> <p>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</p>	<p><u>YAWNING</u> <i>Visually observed during assessment</i></p> <p>0 No Yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times per minute</p>
<p><u>RUNNY NOSE OR TEARING</u> <i>Not accounted for by cold symptoms or allergies</i></p> <p>0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Runny nose or tearing 4 Nose constantly running or tears streaming down face</p>	<p>TOTAL COWS SCORING</p> <p>5 - 12 Mild Withdrawal 13 - 24 Moderate Withdrawal 25 - 36 Moderately Severe Withdrawal >36 Severe Withdrawal</p>

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 \geq 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~~



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	June 19, 2025
STAFF CONTACT	Rachel Oakley
SUBJECT	Patient Refusal Policy 203 Revision
SUMMARY	<p>Policy 203, Patient Refusal of Treatment and/or Transport was last revised on April 15th, 2017.</p> <p>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.</p> <p>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.</p>
REVIEWED BY	EMSA Director/Staff, Medical Director, Operations Committee, and County Council.
RECOMMENDED ACTION(S)	Approve and move to EMCC.
ATTACHMENT(S)	Draft of: <ul style="list-style-type: none">• 203 Patient Refusal

Emergency Medical Services

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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.

~~C.~~

~~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.

~~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 an ~~an 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.

~~4.3.~~ 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	June 19, 2025
STAFF CONTACT	Rachel Oakley
SUBJECT	Paramedic Policy Revisions
SUMMARY	<p>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.</p> <p><u>Paramedic Accreditation:</u></p> <ul style="list-style-type: none"> • Paramedic Liaison: <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ○ State that only 2 attempts will be offered. ○ Provide the procedure if the test is not successfully completed; consult the medical director if accredittee fails both attempts. • Prorated Reaccreditation Requirements: <ul style="list-style-type: none"> ○ Upon initial accreditation, and if applicable, any prorated reaccreditation requirements will be communicated. ○ Internal standardization of prorated requirements is current practice. • PALS: <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ○ The rush fee language was changed for requests to process a completed application within 5 business days. ○ A rush fee will apply for requests to approve accreditation start dates within 5 business days. <p><u>Paramedic Reaccreditation:</u></p> <ul style="list-style-type: none"> • Paramedic Liaison:

Emergency Medical Services

2995 McMillan Ave Ste 178 | San Luis Obispo, CA 93401 | (P) 805-781-2519

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	<ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ○ Remove the 90 day leave of absence from lapse criteria. ○ 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: <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ○ The rush fee language was changed for requests to process a completed application within 5 business days. ● Application Fee: <ul style="list-style-type: none"> ○ An application fee will be required on all lapsed accreditations. <p><u>Attachments:</u></p> <ul style="list-style-type: none"> ● All attachments will be revised to match policy changes.
REVIEWED BY	EMSA Director and Staff, Medical Director, and Operations Committee.
RECOMMENDED ACTION(S)	Approve and move to EMCC.
ATTACHMENT(S)	Draft policies of: <ul style="list-style-type: none"> ● 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 (105) 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.
- 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 accretee 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 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 (405)** 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.

V. 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:

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 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.

VI. AUTHORITY

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

VII. ATTACHMENTS

- A. Paramedic Application for County Accreditation
- B. Paramedic Skills Annual Verification Tracking Sheet
- C. Skills Verification Checklists

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	