Operations Subcommittee
of the Emergency Medical Care Committee

Meeting Agenda:
9 A.M., June 4th, 2026
Location: SLOEMSA Conference Room
2995 McMillan Ave, STE #178, San Luis Obispo

Members
Jay Wells, *Sheriff's Department, CHAIR*
Tim Nurge, *Ambulance Providers*
Scotty Jalbert, *Office of Emergency Services*
Jennifer Mebane/Clayton Cullen, *Med-Com*
Adam Forrest, M.D., *Hospitals*
Kris Strommen, *Ambulance Providers*
Erin Nash-Fairfax/John Pearl*, Fire Service*
Dennis Rowley, *Air Ambulance Providers*
Jon Ontiveros, *CHP*
Deputy Chief Sammy Fox, *Fire Service*
Vacant, *Law Enforcement*
Chief Casey Bryson, *Fire Service*
Chief Dan McCrain, *Fire Service*
Anthony Gutierrez, *Field Provider-Paramedic*
Chief Scott Hallett, Fire Service

Staff
STAFF LIAISON, Ryan Rosander*, EMS Director*
Bill Mulkerin, M.D., *Medical Director*
Rachel Oakley, *EMS Coordinator*
Kaitlyn Blanton, *EMS Coordinator*
Eric Boyd, *EMS Coordinator*
Alyssa Vardas, *Administrative Assistant*

AGENDA	ITEM	LEAD
Call to Order	Introductions Public Comment	Jay Wells
Summary Notes	Review of Summary Notes April 2, 2026	
Discussion	**Policy Revisions:** • 153 Trauma Patient Triage and Destination	Kaitlyn Blanton
Discussion	**Policy Attachment Revision:** • 153 Attachment A	Kaitlyn Blanton

Adjourn	Declaration of Future Agenda Items: - Roundtable Next Meeting Date: August 6, 2026 Location: SLOEMSA Conference Room 2995 McMillan Ave, STE #178, San Luis Obispo	Jay Wells

Operations Subcommittee

Meeting April 2, 2026
2995 McMillan Way, Suite 178
San Luis Obispo, CA 93401

MINUTES

MEMBERS PRESENT:
Chair Jay Wells, Sheriff's Department
John Pearl, Fire Service
Scotty Jalbert, OES
Scott Hallett, Fire Service
Clayton Cullen, Med-Com
Dan McCrain, Fire Service

Kris Strommen, Ambulance Providers
Anthony Gutierrez, Fire Service
Casey Bryson, Fire Service

MEMBERS ABSENT:
Tim Nurge, Ambulance Providers
Jon Ontiveros, CHP
Casey Bryson, Fire Service
Adam Forrest, Hospitals
Dennis Rowley, Air Ambulance providers

EMS AGENCY STAFF PRESENT:
Alyssa Vardas, EMS Administrative Assistant
Rachel Oakley, EMSA
Ryan Rosander, EMSA
Bill Mulkerin, EMS Medical Director
Kaitlyn Blanton, EMSA
Eric Boyd, EMSA

PUBLIC COMMENTORS:
None

1. CALL TO ORDER

Chair Jay Wells called the meeting to order at 8:56 a.m. He led the review of the meeting protocols and the meeting agenda.

2. REVIEW AND APPROVAL OF December 4, 2025, MINUTES

Action: Rob Jenkins moved approval of October 2, 2025, Operations Subcommittee Meeting Minutes. Dusty Renner seconded. The motion carried unanimously with no abstentions.

3. Protocols/Policies

- 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.

APOT Monitoring:

- Discussed that the state doesn't differentiate between 20 and 30 minutes.
- Stated how we would still like hospitals to try and make 20 minutes but changing to 30 so the hospitals don't get nasty emails about missing the mark.
- Explained how the missed times typically happen around noon or 1:00 when we end up with an hour or more wait times.
- Explained how there is not much consequence for the hospital but that the state will meet with the EMSA and the hospitals.

- 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.

Documentation of Prehospital Care:

- Asked if there are legal concerns regarding patient refusal and who determines the primary.
- Mentions that it should clearly state if there was a transfer of care then they would be the primary.
- Mentions we should adjust the language to make sure everyone completes an ePCR.
- States that putting information in the narrative is still the way to go.
- Asked if both are on a call and it is overlapping, should we be documenting that?
- Mentioned that having a summary version in the narrative would be the best way to do it and that we shouldn't have two people documenting at the same time.
- Stated that in the field there needs to be a transfer of care with documentation.
- This will be tied into the scene management policy.

- 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. The policy is being brought to the Operations Committee to review any operational or fiscal impacts before returning to CAC and onward to EMCC.

Mechanical CPR:

- Mentioned that if the Zoll monitor is recording compression, could that be used with the device?
- Asked if Zoll puck and the Lucas device be utilized at the same time.
- Mentioned that from a commonsense perspective it is going to be a better outcome.

4. ADJOURNMENT

5. Action: Dan McCrain moved to approve. John seconded. The motion carried unanimously.

Adjourned the meeting at 10:16 a.m.

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
PUBLIC HEALTH DEPARTMENT

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

MEETING DATE	June 4, 2026
STAFF CONTACT	Kaitlyn Blanton, EMS Coordinator kblanton@co.slo.ca.us
SUBJECT	Documentation, Trauma Triage Steps
SUMMARY	Policy #153 and #153 - Attachment A, have been updated from the 2017 version in partnership with The American College of Surgeons (ACS) Committee on Trauma (COT) guidelines and San Luis Obispo County's Trauma Center, receiving guidance from their Trauma Medical Director and Trauma Program Manager. Additions to the current Trauma Triage Steps are intended to expand San Luis Obispo County's current field activation criteria as well as better align itself with the Trauma Tiers utilized in-house at the San Luis Obispo County Trauma Center. Implementation is intended to ensure optimal patient outcomes across the continuum of care. Definitions have been simplified to reduce confusion among EMS providers regarding transportation expectations. All Medical Direction remains within San Luis Obispo County.
REVIEWED BY	Dr. William Mulkerin, SLOEMSA Staff
RECOMMENDED ACTION(S)	Recommended the following for approval by Operations and moved to the Clinical Advisory agenda: Policy#153 Trauma Patient Triage and Destination, Policy #153 Attachment A
ATTACHMENT(S)	Policy #153, Policy #153 Attachment A

POLICY #153: TRAUMA PATIENT TRIAGE AND DESTINATION

I. PURPOSE

A. To establish guidelines for EMS personnel to identify and transport "significantly injured" patients who could benefit from the rapid response and specialized services of a trauma center.

II. ~~SCOPE~~

~~A. This policy applies to both adult and pediatric injured patients, unless stated otherwise.~~

III. PROCEDURE

A. Trauma Activation Criteria

1. "STEP 1, STEP 2, or STEP 3 TRAUMA ALERT" - Patient meeting any one of the Physiologic (Step 1) and/or Anatomic criteria (Step 2) and/or Mechanism of Injury (Step 3) following a traumatic event shall be designated a "TRAUMA ALERT" and shall be transported to the closest trauma center. The target off-scene time should be 10 minutes or less for transport personnel.

~~2. "STEP 3 TRAUMA CONSULTATION" - Patient meeting (Step 3) Mechanism of Injury - contact with the County of San Luis Obispo (SLO) Trauma Center for patient destination. The target off-scene time should be 10 minutes or less for transport personnel.~~

3. "STEP 4 TRAUMA CONSULTATION" - A trauma consultation with the County of San Luis Obispo Trauma Center shall be made to determine patient destination when a paramedic identifies a significantly injured patient who does **not** meet Step 1 (Physiologic), Step 2 (Anatomic), or Step 3 (Mechanism of Injury) criteria, but meets one or more Step 4 (Special Patient or System Considerations) criteria, unless the intended destination is already the closest trauma center.

B. Trauma Patient Criteria

~~1. Patients meeting any one of the Physiologic and/or Anatomic and/or Mechanism of Injury criteria following a traumatic event shall be a "TRAUMA ALERT" and transported to the closest trauma center. Patient meeting Mechanism of Injury and/or Special Patient/System Considerations shall be a "TRAUMA CONSULT" and contact the County of SLOTrauma Center for patient destination, unless the patient's intended destination is already a Trauma Center.~~

C. Medical Direction

1. All Base Hospital requests and/or orders, regardless of Trauma Center destination, shall be made to the County of ~~SLO~~ San Luis Obispo Trauma Center.

D. Closest Trauma Center

The closest Trauma Center for patients being transported within San Luis Obispo County will be defined as follows:

a. A unit on scene of a call that is located within San Luis Obispo County south of El Campo Rd should proceed to Marian Regional Medical Center.

b. A unit on scene of a call that is located within San Luis Obispo County north of El Campo Rd should proceed to ~~Sierra Vista Regional Medical Center~~ the County of San Luis Obispo Trauma Center.

c. In any other area west or east of El Campo Rd, crews should exercise discretion in determining which trauma center is closest or fastest for patient transport.

d. Discretion in all cases should include abnormal traffic patterns, congestion, or other travel factors affecting transport to the closest and fastest Trauma Center

1. **STEP 1 (Physiologic Criteria)**

The target off-scene time should be 10 minutes or less for transport personnel

Adult Injured patients meeting any one of the following criteria:

a. Pre-hospital advanced airway
b. Glasgow Coma Scale ≤13 (based on patient history attributed to injury)
c. Systolic blood pressure <90mmHg
d. Respiratory rate <10 or >29 breaths per minute

Pediatric injured patients (≤34 Kg) meeting any one of the following:

a. Pre-hospital advanced airway
b. Glasgow Coma Scale ≤ 13 (based on patient history ~~and~~ attributed to injury)
c. Evidence of poor perfusion – color, temperature, etc.
d. Respiratory rate
    1. >60 breaths per minute or respiratory distress
    2. <20 breaths per minute in infants <1year
e. Heart rate
    1. ≤5 years (<22Kg) heart rate <60 beats per minute or >180 beats per minute
    2. ≥6 years (23-34Kg) heart rate <60 beats per minute or >160 beats per minute
f. Blood pressure
    1. Newborn (<1 month) systolic blood pressure <60mmHG
    2. Infant (1 month – 1 year) systolic blood pressure <70mmHg
    3. Child (1 year to 10 years) systolic blood pressure <70mmHg + 2X age in years
    4. Child (11-14 years) systolic blood pressure <90mmHg

2. **STEP 2 (Anatomic Criteria)**

The target off-scene time should be 10 minutes or less for transport personnel

Injured patients meeting any one of the following criteria:

a. All significant penetrating injuries to head, neck, torso and extremities proximal to knee or elbow
b. Chest wall instability or deformity (e.g. flail chest)
c. Two proximal long bone fractures (above the elbows and knees)
d. Mangled, degloved, crushed, or pulseless extremity
e. Open or depressed skull fracture
f. Paralysis or suspected spinal cord injury with new onset motor or sensory deficits
g. Pelvic injury with high-risk mechanism of injury (motor vehicle collisions, auto vs. pedestrian accidents, motorcycle collisions, falls from heights)
h. Any extremity amputation excluding digits or phalanges
i. Abdominal seat belt sign
j. Strangulation w/ hard signs (voice changes, bruising, discoloration, subcutaneous emphysema, crepitus)

3. **STEP 3 (Mechanism of Injury Criteria)**

The target off-scene time should be 10 minutes or less for transport personnel

Injured patients meeting any one of the following criteria:

a. Falls
    1. Adults: ~~>20 feet~~ >10 feet (one story is equal to 10 feet)
    2. Pediatric: (≤34 Kg) >10 feet (one story is equal to 10 feet)

       OR 2-3x the child's height
b. High-risk auto crash
    1. Passenger Space Intrusion (PSI) of space: >12 inches occupant patient site; or >18 inches anywhere within the passenger space
    2. Ejection (partial or incomplete) from automobile
c. Auto vs. pedestrian/bicyclist thrown, run over, or with significant impact (>20 mph)
d. Motorcycle or unenclosed transport vehicle crash (>20 mph)
e. Blunt abdominal injury with significant impact
f. Judicial near hanging (fall or jump associated)
g. Pediatric ages 0-9 unrestrained or improperly restrained (MVC)

4. **STEP 4 (Special Patient or System Considerations)**

Age and co-morbid considerations

Injured patients meeting any one of the following criteria:

a. EMS provider judgement
b. Age greater than 65 (SBP <110 mmHg may represent shock)
c. Pediatric (≤34Kg)

d. Pregnancy > 20 weeks

e. Burns with mechanism

f. Vehicle accident with prolonged extrication

g. Submersion event/Drowning with high suspicion or confirmed trauma

h. Anticoagulation therapy (excluding aspirin) or other bleeding disorders with head injury (excluding minor injuries)

NOTE: a "TRAUMA CONSULT" is not required for ground/low level impact falls with GCS ≥ 14 or when GCS is normal for patient

E. Contact the Trauma Center

Contact the receiving trauma center early and immediately upon determining the patient meets trauma patient triage criteria with a "TRAUMA ALERT" or "TRAUMA CONSULTATION"

1. "TRAUMA ALERT"

a. A "TRAUMA ALERT" is initiated by ALS personnel when an injured patient meets any one of the Step 1 (Physiologic) or Step 2 (Anatomic) or Step 3 (Mechanism of Injury) Criteria. Consider early notification to the intended receiving Trauma Center~~,~~ Notify from the scene when possible.

b. ~~EMS personnel should provide a "TRAUMA ALERT" early and from the scene when possible to assist in early activation of the trauma team and determination of patient~~ destination.

~~c. ALS personnel must contact the trauma center with the TRAUMA ALERT.~~

d. A "TRAUMA ALERT" report should include the following:

1. "TRAUMA ALERT" meeting trauma triage step criteria "x"
2. Unit and paramedic #
3. ETA to trauma center
4. Report on individual patient (MIVT format):

- Age and sex
- Mechanism of injury and scene
- Injury and complaint
- Vital signs including GCS
- Treatment and response
- Include specific triage findings or considerations that identify the patient as meeting TRAUMA ALERT criteria.
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2. "TRAUMA CONSULTATION"

a. "TRAUMA CONSULTATION" with the ~~SLO County~~ County of San Luis Obispo Trauma Center should be obtained to determine trauma patient destination when ~~Step 3 (mechanism(s) of injury) criteria or~~ Step 4 (special considerations) are present and Step 1 (physiologic), Step 2 (anatomic), and Step 3 (Mechanism of injury) criteria are NOT met AND the intended patient destination is NOT already a designated Trauma Center

b. Only ALS personnel may request a "TRAUMA CONSULTATION" for patient destination

c. A "TRAUMA CONSULTATION" report should include the following:

1. "TRAUMA CONSULTATION" meeting trauma triage step criteria ~~"x"~~ 4
2. Unit and paramedic #
3. ETA to Trauma Center and ETA to closest ED if applicable (When a Trauma center is the closest facility, include that information in radio report)
4. Report on the individual patient: (MIVT format)
   - Patient age and sex
   - Mechanism of injury and scene
   - Injury and complaints
   - Vital signs including GCS
   - Treatment and response
   - Include specific findings or considerations that identify the patient as meeting TRAUMA CONSULTAION criteria
5. Paramedic concerns

d. The Trauma center, when not receiving the patient, shall notify the receiving hospital of the incoming patient and provide that hospital with the prehospital care ~~patient~~ information including any Base Hospital orders given.

e. When practical, a brief updated report should be given to the ~~trauma center~~ receiving Hospital by ALS personnel and include any significant changes in route in vital signs, GCS, physical findings, symptoms or treatments.

f. All Base Hospital orders or requests shall be made to the ~~SLO County~~ County of San Luis Obispo Trauma Center, regardless of destination.

F. Exceptions to Direct Transport to a Trauma Center

Trauma patients will be transported to the closest ED in the following situations:

1. Patient condition deteriorates and ~~necessitates transport to the closest ED, such~~ presents as the following:

   a. Unmanageable airway (Intubation and/or SGA attempts are unsuccessful and an adequate airway cannot be maintained with BVM or other BLS devices)

   b. Uncontrollable bleeding with rapidly deteriorating vital signs

   c. Traumatic cardiac arrest – see ~~EMS Agency Prehospital Determination of Death/Do Not Resuscitate (DNR) End of Life Care Policy #125~~ EMS Agency Policy #125: Prehospital Determination of Death/Do Not Resuscitate (DNR) End of Life Care

2. SLO Trauma Center destination order

3. When a transport unit is directed to an alternate hospital regardless of patient presentation per Incident Command/ Designee (Transportation Unit Leader) during an MCI – see EMS Agency Policy #210: Multi-Casualty Incident Response Plan

4. Patient refusal - see ~~EMS Agency~~ EMS Agency ~~Patient Refusal of Treatment and/or Transport~~ Policy #203: Patient Refusal of Treatment and/or Transport

5. Trauma center is on complete diversion – see ~~EMS Agency Hospital Diversion Policy #154: Hospital Diversion.~~ EMS Agency Policy #154: Hospital Diversion

6. If the County of SLO Trauma Center is on partial diversion, patients meeting Trauma Triage Criteria shall still be accepted by the County of San Luis Obispo Trauma Center and shall be transported accordingly – see EMS Agency Policy #154: Hospital Diversion

7. Utilization of EMS helicopters for the response/transport of trauma patients ~~must be in accordance with~~ – see EMS Agency Policy #155: EMS Helicopter Operations

IV. AUTHORITY

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

V. ATTACHMENTS

A. Trauma Triage Matrix

IV. Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

TRAUMA ALERT CRITERIA – transport to nearest TC

STEP 1 - Physiologic

TARGET DEPART SCENE ≤ 10 Min

Adult Criteria

- Pre-hospital advanced airway
- Glasgow Coma Scale ≤ 13
- Systolic blood pressure <90 mmHg
- Respiratory rate <10 or > 29 breathe per minute

Pediatric Criteria

- Pre-hospital advanced airway
- Glasgow Coma Scale≤ 13
- Evidence of poor perfusion – color, temperature, etc.
- Respiratory Rate
  - > 60/min or respiratory distress/apnea
  - < 20/min in infants < 1 yr
- Heart Rate
  - ≤ 5 yrs (<22 kg) < 80 or > 180/min
  - ≥ 6 yrs (23-34 kg) < 60 or > 160/min
- Blood Pressure
  - Newborn (<1 month) SBP < 60mmHg
  - Infant (1mo to 1 yr) SBP <70 mmHg
  - Child (1yr to 10 yrs) SBP < 70mmHg + 2X age in yrs
  - Child (11 to 14 yrs) SBP < 90 mmHg

STEP 2 – Anatomic

TARGET DEPART SCENE ≤ 10 MIN

- All penetrating injuries to head, neck, torso, and extremities proximal to the elbow or knee
- Chest wall instability or deformity (i.e. flail chest)
- Two long bone fractures – proximal to elbow or knee
- Mangled, degloved, crushed or pulseless extremity
- Open or depressed skull fracture
- Paralysis or suspected spinal cord injury with new onset motor or sensory deficits
- Pelvic injury with high-risk mechanism of injury
- Any extremity amputation excluding digits or phalanges
- Abdominal seat belt sign
- Strangulation with hard signs (voice changes, bruising, discoloration, subcutaneous emphysema, crepitus)

STEP 3 – Mechanism

TARGET DEPART SCENE ≤ 10 MIN

- Falls
  - Adults - > ~~20~~ 10 feet (one story equals 10 feet)
  - Children (≤34Kg) - > 10 feet OR 2x the child's height
- High risk auto crash
  - Intrusion of passenger compartment space > 12 inches occupant site or > 18 inches any site including the roof/floor
  - Ejection (partial or complete) from automobile
  - Death in the same vehicle
- Auto vs pedestrian/bicycle thrown, run over, or with significant impact (> 20 mph)
- Motorcycle or unenclosed transport vehicle crash > 20 mph
- Blunt abdominal injury with significant impact
- Judicial near hanging (associated jump or fall)
- Pediatric ages 0-9 unrestrained or improperly restrained (MVC)

If STEPS 1, 2 & 3 not applicable – continue to STEP 4

TRAUMA CONSULT CRITERIA –

Call for destination UNLESS already transporting to TC

STEP 4 – Special Patient and System Considerations

- EMS provider judgement
- Age > 65 yrs or < 14 yrs
- Pregnancy > 20 weeks
- Burns with traumatic mechanism
- Vehicle accident with prolonged extrication
- Submersion event/Drowning with high suspicion or confirmed trauma
- Anticoagulants therapy * (excluding ASA) or other bleeding disorders with head injury (excluding minor injuries)

(*) Trauma Consult is not required for ground level/low impact falls with a GCS ≥ 14 (or GCS is normal for patient) – follow EMS Agency Policy # 151 Destination

Contact TC and Transport to nearest ED with:
-Unmanageable airway
-Uncontrolled bleeding
-Traumatic Arrest

If ALL STEPS not applicable – follow EMS Agency Policy #151 Destination