EMERGENCY MEDICAL CARE COMMITTEE MEETING AGENDA

Thursday, July 16th, 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*
Chris Javine, *Pre-hospital Transport Providers, 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*
Vacant, *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, May 21st, 2026, Minutes (*attached)*	C. Javine
Action/Discussion	**Policy Revision:** • 153 Trauma Patient Triage and Destination	K. Blanton
Action/Discussion	**Policy Attachment Revisions:** • 153 Attachment A	K. Blanton
Action/Discussion	**EMCC Membership Discussion**	R. Rosander
Staff Reports	• Health Officer • EMS Agency Director Report • EMS Medical Director Report • PHEP Staff Report	Vacant R. Rosander B. Mulkerin M. Craig-Lauer
Committee Members' Announcements or Reports	Opportunity for Board members to make announcements, provide brief reports on their EMS-related activities, ask questions for clarification on items not on the agenda, or request consideration of an item for a future agenda (Gov. Code Sec. 54954.2[a][2])	Committee Members
Adjourn	**Next Meeting: September 17th, 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 various policy updates and procedures. Key points included the implementation of a rush fee of $93 for application submissions, effective July 1. The policy on additional skills for EMTs was revised, with specific skills like monitoring intravenous lines and delivering glucose solutions requiring implementation plans. The EMT AED service provider approval policy was updated to ensure all EMTs are oriented to specific AED equipment. The burn protocol was revised to include 20 minutes of cool running water for burns under 30% BSA and to emphasize not delaying transport. The diving emergencies protocol was updated to focus on obtaining dive computers and transporting patients promptly.

3. Protocols/Policies for Review:

Investigation Purposes and Background Checks

Discussion:

Discussed the challenges of contacting people for investigation purposes and mentions the process of analyzing live scans for background checks without applications.

The rush fee for applications is currently $93, and it will be updated on July 1.

Explained the changes in the application form, including the submission information at the bottom.

Additional skills are being separated from optional skills and will be utilized in the county with minimal additional training.

Implementation Plans for Additional Skills

Discussion:

Mentioned that Dr. Mulkerin will work with agencies interested in implementing additional skills safely.

Two skills, monitoring intravenous lines and delivering glucose solutions, might need an implementation plan.

Suggestion that these skills might require a training process.

Note that these skills are not currently an issue and can be monitored as the system changes.

Training and Competency Verifications

Discussion:

Mentioned the removal of Section E for continued competency verifications, as it is now part of basic scope.

Employers may need their own verification or EMS quality improvement programs for certain skills.

Explained that agencies can opt-out of maintaining training on certain skills, such as auto injectors.

Airway Management

Discussion:

Discusses protocol 602, which includes changes to the supraglottic 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.

EMT AED Service Provider Approval

Discussion:

Introduced a new policy for EMT AED service provider approval, treating it as an attestation.

The policy requires that all employee EMTs are oriented to specific AED equipment and maintain their equipment.

Explained that the policy will be revised to provide a list of supplies, reflecting all changes.

Public Safety AED Service Provider Approval

Discussion:

Discussed the revised public safety AED service provider approval policy, which is simplified to reflect the regulation.

The policy requires reporting to pre-hospital personnel for documentation.

Mentioned the challenges of tracking AEDs in private businesses and the need for better structure.

Burn Policy Updates

Discussion:

Presented the updated burn policy, which includes thermal, chemical, and electrical burns, and references burn center referral criteria.

The policy includes the addition of wheezing and treatments from the respiratory protocol.

The policy will be revised to emphasize the importance of not delaying transport and to include specific criteria for burns.

The protocol will be revised to include only the most relevant criteria and to ensure clear communication of destination decisions.

Diving Emergencies Protocol

Discussion:

Introduced the diving emergencies protocol, which includes best practices for diving emergencies and the importance of obtaining a dive computer.

The protocol emphasizes not delaying transport and includes specific criteria for different types of diving emergencies.

Suggested moving the dive computer to the top of the list and adding the onset of symptoms.

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 –

EMS Medical Director Update - Dr. Mulkerin - mentions that we are working on an EMD update and BLS Division

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.

Emergency Medical Care Committee

DRAFT Meeting Minutes
8:30 AM May 21st, 2026
2995 McMillan Way, Suite 178
San Luis Obispo, CA 93401

MINUTES

MEMBERS PRESENT:
Chair Chris Javine, Pre-Hospital Transport Providers
Alexandra Kohler, Consumers
Jay Wells, Sheriff's Department
Bob Neumann, Consumers
Rachel May, Emergency Physicians
Jonathan Stornetta, Public Providers
Julia Fogelson, Hospitals
Michael Talmadge, EMS Field Personnel

MEMBERS ABSENT:
Diane Burkey, MICNs
Alexandra Kohler, Consumers
Jay Wells, Sheriff's Department
Matt Bronson, City Government
Brad Knox, Physicians

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

PUBLIC COMMENTORS:
Dennis Rowley, Cal Star
Bette Jenkins, Dignity

EX OFFICIO:
Bill Mulkerin, EMSA
Ryan Rosander, EMSA

1. CALL TO ORDER

Chair Chris Javine called the meeting to order at 8:32 a.m.

2. REVIEW AND APPROVAL OF January 15th, 2026, MINUTE

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Minutes were skipped this meeting due to wrong minutes attached.

The meeting focused on updates to the hospital diversion policy, emphasizing the need for clearer communication and consultation with the EMS duty officer. Key changes include addressing ED saturation, partial diversion, and clinical exceptions. The policy now requires consultation with the duty officer for approvals and updates on Ready Net. The APOT monitoring process was reviewed, highlighting the need for better documentation and communication to reduce offload times. The documentation of pre-hospital care was revised to ensure accurate and timely reporting, with a focus on quality improvement and accountability. The discussion also touched on the potential use of AI for documentation consistency. The meeting focused on updates to the hospital diversion policy, emphasizing the need for clearer communication and consultation with the EMS duty officer. Key changes include addressing ED saturation, partial diversion, and clinical exceptions. The policy now requires consultation with the duty officer for approvals and updates on ReadyNet. The APOC monitoring process was reviewed, highlighting the need for better documentation and communication to reduce offload times. The documentation on pre-hospital care was revised to ensure accurate and timely reporting, with a focus on quality improvement and accountability. The discussion also touched on the potential use of AI for documentation consistency.

3. Protocols/Policies for Review:

Hospital Diversion Policy Rework

Discussion:

Explained the need for full policy rework for hospital diversion due to outdated and confusing language.

The new policy includes consultation with the EMS duty officer for hospital diversion, ensuring all parties are on the same page.

The policy now includes ED saturation as a factor, addressing issues raised by the emergency manager for Adventist.

The policy will update to include Ready Net for better communication and partial diversion categories.

Specialty Care Centers and Clinical Exceptions

Discussion:

Discussed the inclusion of specialty care centers in the policy, ensuring they cannot go on diversion unless it's an internal disaster.

Clinical exceptions are added, such as cardiac arrest, unstable airway, and extremities, but not for internal disasters.

The policy now includes complete and temporary loss of designated specialty capability, allowing for flexibility in certain situations.

Activation and communication sections are updated to include entering information on Ready Net for accurate diversion status.

APOT Monitoring and Documentation of Pre-Hospital Care

Discussion:

Revisits the APOT monitoring, adding a QI/QA layer to it and addressing state enforcement issues.

The policy aims to reduce APOT problems by improving hospital offload times and communication.

The documentation of pre-hospital care is reworked to provide medics with a more reasonable timeframe for completing reports.

The policy includes requirements for vitals documentation every five minutes for specialty care systems and minimum two sets of vitals for documentation.

Patient Refusals and Documentation Corrections

Discussion:

The policy addresses patient refusals, requiring one signature from the authority for patient healthcare management.

Providers are encouraged to document care rendered by others when known or clinically relevant.

The policy includes a section on documentation of corrections and amendments, ensuring accurate and complete records.

The discussion highlights the need for a cultural shift away from double documentation and towards more accurate and streamlined records.

Data Sharing and Continuum of Care

Discussion:

The need for data sharing between agencies to improve QI and billing is discussed.

The idea of a master case number for continuum of care is proposed, allowing for better documentation and accountability.

The discussion includes the potential challenges and benefits of sharing narratives and procedural data across agencies.

The importance of having all procedures and medications documented is emphasized for comprehensive QI reviews.

AI in Documentation and Future Considerations

Discussion:

Introduced new AI tools from Image Trend, including Next Gen Reporting and AI checks for documentation consistency.

The potential benefits and challenges of using AI in documentation are discussed, with a focus on maintaining accuracy and accountability.

The policy should allow for flexibility in adopting new AI tools while ensuring they do not compromise the quality of documentation.

The discussion highlights the need for ongoing evaluation and adjustment of documentation policies to keep up with technological advancements.

Mechanical CPR Devices and Policy Clarifications

Discussion:

Discussed the need for clear documentation on mechanical CPR devices and their use.

Explained the challenges in characterizing pauses in CPR using electronic means.

Highlights the potential benefits of mechanical CPR devices for crew safety and effective CPR.

Mentioned the use of mechanical CPR devices in hospitals, especially for fresh sternotomies.

Expressed concerns about the potential harm from mechanical CPR devices.

Emphasized the importance of provider discretion in using mechanical CPR devices.

Suggested that transport providers without training on the devices should not use them.

Inventory Levels and Policy Adjustments

Discussion:

Presents changes in inventory levels for various parts of the system.

Mentioned decreasing the requirement for carrying ketamine and increasing adenosine for first response ALS fire.

Policy 212

Discussion:

Introduced policy 212, which allows nursing skilled nursing facilities to call for a code to ambulance only response.

Suggested expanding this policy to include other medical facilities like urgent cares and jail medical.

Highlighted the need for remediation plans for facilities that miss calls under the current policy.

Expressed concerns about the barriers to entering facilities participating in the program.

Suggested including inclusion and exclusion criteria in the policy.

Pointed out the increased burden on facilities when transporting patients.

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

Election of Officers:

Motion to elect Matt Bronson as Chair by Jonathan Stornetta and Julia Fogelson seconded.

Motion to elect Brad Knox as Vice Chair by Jonathan Stornetta and Rachel May seconded.

4. STAFF REPORTS/ANNOUNCEMENTS

Health Officer Update - Dr. Borenstein was out. Dr. Borenstein will be retiring. The Health

Agency will be splitting into Public Health and Behavioral Health.

EMS Director Update – R. Rosander highlighted the success of the First Responder Roundup. There will be an investigation training course in August for standardized training in investigations.

EMS Medical Director Update - Dr. Mulkerin – mentioned the Airway lab coming up in June.

PHEP Program Manager Update - Maya discussed the MERSE that used Reddinet.

5. FUTURE AGENDA ITEMS

6. ADJOURNMENT

Action:

Chair Javine adjourned the meeting at 10:23 a.m.

MEETING DATE	July 16th, 2026
STAFF CONTACT	Kaitlyn Blanton, EMS Coordinator kblanton@co.slo.ca.us
SUBJECT	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 EMCC. Policy #153 and #153 Attachment A
ATTACHMENT(S)	Policy #153 and #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, 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.

    a. If an out of county trauma center is closer and is the intended destination, no destination consult with the County of San Luis Obispo Trauma Center is necessary. Proceed to out of county trauma center and update in accordance with this policy.

~~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 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~~ the closest Santa Barbara County Trauma 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. Glasgow Coma Scale ≤13 (based on patient history attributed to injury)
b. Systolic blood pressure <90mmHg
c. Respiratory rate <10 or >29 breaths per minute

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

a. Glasgow Coma Scale ≤ 13 (based on patient history and attributed to injury)
b. Evidence of poor perfusion – color, temperature, etc.
c. Respiratory rate
    1. >60 breaths per minute or respiratory distress
    2. <20 breaths per minute in infants <1year
d. 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
e. 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 <90mmH

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 bruising from seat belt ("abdominal seatbelt sign") or significant impact
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 2x 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. Near hanging with fall or jump associated ("Judicial Hanging")
f. 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. Trauma Center Contact

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

2. "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.

3. 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 closest 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 ~~(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

4. When the San Luis Obispo County Trauma Center is not receiving the patient but has had contact with the transporting unit, they shall notify the receiving hospital of the incoming patient and provide that hospital with any prehospital care ~~patient~~ information, including any Base Hospital orders given.

5. 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.

6. 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. Direct destination order from San Luis Obispo County Trauma Center

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 San Luis Obispo Trauma Center is on partial diversion, patients meeting Trauma Triage Criteria shall still be accepted by the 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

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

Pediatric Criteria

- 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 bruising from seatbelt (seatbelt sign) or significant impact
- 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
- Near hanging with jump or fall associated ("Judicial Hanging")
- 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 orders" unless already transporting to a 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