

Operations Subcommittee

of the Emergency Medical Care Committee



Meeting Agenda:

9 A.M., October 1st, 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, *Med-Com*
 Clayton Cullen, *Med-Com*
 Adam Forrest, M.D., *Hospitals*
 Kris Strommen, *Ambulance Providers*
 Erin Nash-Fairfax, *Fire Service*
 Kelly Neronde, **Interim** - *Air Ambulance Providers*
 Jon Ontiveros, *CHP*
 Deputy Chief Sammy Fox, *Fire Service*
Vacant, *Law Enforcement*
Vacant, *Fire Service*
 Chief Dan McCrain, *Fire Service*
 Anthony Gutierrez, *Field Provider-Paramedic*
 Chief Scott Hallett, *Fire Service*

Staff

STAFF LIAISON, Ryan Rosander, *EMS Director*
 William Mulkerin, M.D., *Medical Director*
 Kaitlyn Blanton, *EMS Coordinator*
 Rachel Oakley, *EMS Coordinator*
 Eric Boyd, *EMS Coordinator*
Vacant, *Administrative Assistant*

AGENDA	ITEM	LEAD
Call to Order	Introductions	Jay Wells
	Public Comment	
Summary Notes	Review of Summary Notes June 4, 2026	
Discussion	Protocol & Policy Revisions: - Protocol #650 Childbirth - Protocol #652 Obstetric Emergencies – Eclampsia, Preeclampsia and Severe Hypertension - Protocol #653 Post-partum hemorrhage - Magnesium Sulfate Formulary - Midazolam Formulary - TXA Tranexamic Acid Formulary - Lidocaine Formulary - Policy #212 Tiered Response Program for Medical Facilities	Kaitlyn Blanton Dr. William Mulkerin
Discussion	Policy Attachment Revision: - Policy #212 Attachment A - Policy #212 Attachment B	Kaitlyn Blanton Dr. William Mulkerin

Adjourn	Declaration of Future Agenda Items: - Roundtable	Jay Wells
	Next Meeting Date: December 3 rd , 2026 Location: SLOEMSA Conference Room 2995 McMillan Ave, STE #178, San Luis Obispo	

Operations Subcommittee

Meeting June 4, 2026
2995 McMillan Way, Suite 178
San Luis Obispo, CA 93401



MINUTES

MEMBERS PRESENT:

Chair Jay Wells, Sheriff's Department
Scott Hallett, Fire Service
Dan McCrain, Fire Service
Kris Strommen, Ambulance Providers
Casey Bryson, Fire Service

MEMBERS ABSENT:

Tim Nurge, Ambulance Providers
Jon Ontiveros, CHP
Adam Forrest, Hospitals
Dennis Rowley, Air Ambulance providers
John Pearl, Fire Service
Scotty Jalbert, OES
Clayton Cullen, Med-Com
Anthony Gutierrez, Fire Service

EMS AGENCY STAFF PRESENT:

Alyssa Vardas, EMS Administrative Assistant
Rachel Oakley, EMSA
Bill Mulkerin, EMS Medical Director
Kaitlyn Blanton, EMSA
Eric Boyd, EMSA

EMS AGENCY STAFF ABSENT:

Ryan Rosander, EMSA

PUBLIC COMMENTORS:

None

1. CALL TO ORDER

Chair Jay Wells called the meeting to order at 9:02 a.m. He led the review of the meeting protocols and the meeting agenda.

2. REVIEW AND APPROVAL OF April 2nd, 2026, MINUTES

Action: Dan McCrain moved approval of October 2, 2025, Operations Subcommittee Meeting Minutes. Scott Hallett seconded. The motion carried unanimously with no abstentions.

3. Protocols/Policies

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.

Discussion:

- Suggest changing the wording of Judicial Hanging. Maybe adding a specific height to it
- Suggestion of adding wording to Trauma Consult Section. "if you are closest to out of county trauma center go there."

4. ADJOURNMENT

- 5. Action: Dan McCrain moved to approve. Casey Bryson seconded. The motion carried unanimously.**

Adjourned the meeting at 9:34 a.m.



COUNTY OF SAN LUIS OBISPO

DEPARTMENT OF PUBLIC HEALTH

Suzanne Jed, MSN, RN *Director of Public Health*

Rick Rosen, MD, MPH *Interim County Health Officer*

MEETING DATE	October 1st, 2026
STAFF CONTACT	Kaitlyn Blanton, EMS Coordinator kblanton@co.slo.ca.us
SUBJECT	New OB Emergency Protocols & Update of Tiered Response Program
SUMMARY	As we continue moving San Luis Obispo County forward with the shared goal of improving patient care, SLOEMSA is introducing two new protocols for field EMS providers: Protocol #652 – Obstetric Emergencies: Eclampsia, Pre-eclampsia, and Severe Hypertension and Protocol #653 – Obstetric Emergencies: Postpartum Hemorrhage. With the addition of Magnesium Sulfate to the County formulary in 2026, EMS providers now have an expanded ability to provide evidence-based care to patients experiencing obstetric emergencies. These protocols reflect current best practices identified by the June 2026 EMDAC Medical Advisory Committee and incorporate ACOG recommendations where applicable to the EMS setting. Updates to Policy #212 Tiered Response Program for Medical Facilities (formerly “Skilled Nursing Facilities”) provide SLOEMSA with additional oversight and corrective action capabilities for facilities that under-triage or otherwise inappropriately triage critically ill patients. The revised policy also expands eligibility beyond skilled nursing facilities to include other medical facilities, such as urgent care centers. Attachments A and B provide more detailed triage guidance to support appropriate patient assessment and ensure patients receive the appropriate level of care.
REVIEWED BY	Dr. William Mulkerin, SLOEMSA Staff
RECOMMENDED ACTION(S)	Recommended the following for approval by Operations to move forward to the Clinical Advisory agenda: Protocol #652 & Protocol #653 with associated formularies
ATTACHMENT(S)	Protocol #652, Protocol #653, Protocol #650 Magnesium Sulfate Formulary, Midazolam Formulary, TXA Formulary, Lidocaine Formulary, Policy #212, Policy #212 Attachment A, Policy #212 Attachment B

Emergency Medical Services

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

www.slocounty.gov/emsa

OBSTETRIC EMERGENCIES: ECLAMPSIA, PREECLAMPSIA, SEVERE HYPERTENSION	
ADULT	PEDIATRIC (≤34 KG)
BLS	
• Universal Protocol #601 • Pulse Oximetry - O2 administration per Airway Management Protocol #602	
ALS	
Severe Hypertension/Preeclampsia • Magnesium Sulfate 4Gm in 100mL NS IV over 10 minutes if: ○ More than 20 weeks gestation or up to 6 weeks post-partum ○ SBP ≥140-159 or DBP ≥90-109 mmHg <u>combined with</u> any of the following: ▪ Severe headache ▪ Blurred vision ▪ RUQ pain or Epigastric pain OR ○ SBP ≥160mmHg or DBP ≥110mmHg If unable to obtain IV access: • Magnesium Sulfate 10Gm IM ○ To lessen discomfort – <u>two</u> 2.5Gm IM injections in each buttock for a TOTAL of 5Gm per buttock Eclampsia (Active Seizure) • Midazolam 5mg IV/IM • Magnesium Sulfate 4Gm in 100mL NS IV over 10 minutes If unable to obtain IV access: • Magnesium Sulfate 10Gm IM ○ 5Gm in each buttock	
Base Hospital Orders Only	
• As needed	• As needed
Notes	
• Mainstay treatment for preeclampsia and eclampsia is Magnesium Sulfate. The majority of eclamptic seizures resolve quickly on their own and do not typically last longer than 5 minutes.	

- If a patient is still actively seizing upon arrival of EMS, due to dispatch to response time, an EMS witnessed seizure is likely meeting status epilepticus criteria.
 - Order of administration should be Midazolam first, Magnesium Sulfate second in Eclampsia.
- Check blood pressure frequently – at least every 10 minutes
- Eclampsia and Preeclampsia can affect patients up to 6 weeks post-partum
- For IM injection - consider mixing 20 mg of 2% Lidocaine (see Lidocaine formulary) with 10 Gm of Magnesium Sulfate due to volume of injection that may cause pain or discomfort.

DRAFT

Magnesium Sulfate**Classification:** Electrolyte, Anticonvulsant, CNS Depressant**Actions:**

1. Blocks peripheral neuromuscular transmission by reduction of acetylcholine release
2. Reduces striated muscle contraction

Indications:

1. Status asthmaticus unresponsive to beta-antagonists or anticholinergics
2. SOB due to COPD exacerbation or asthma
3. Severe hypertension or pre-eclampsia in pregnancy
4. Eclampsia

Contraindications:

Heart blocks – can slow cardiac conduction through the AV node
Acute MI
Hypotension
Hypermagnesemia

Precautions:

Renal Insufficiency
Recent History of MI

Adverse Effects:

Hyporeflexia (decreased reflexes)	Diaphoresis
AV Block/Complete Heart Block	Itching/Rash
Bradycardia	Drowsiness
Respiratory Depression – see notes	Facial Flushing

Administration:**ADULT DOSE****Refractory in Severe Respiratory Distress and Bronchospasm:**

2 Gm IV in normal saline over 20 minutes

- Mixing Instructions: Give 1 Gm in 100 mL normal saline over 10 minutes with immediate repeat for a **total** dose of 2 Gm over 20 minutes
- May repeat once 5 minutes after initial dose has been completed

Severe Hypertension/Preeclampsia

4 Gm in 100mL NS IV over 10 minutes if

- More than 20 weeks gestation and up to 6 weeks post-partum
- SBP $\geq$ 140-159 or DBP $\geq$ 90-109 mmHg combined with any of the following:
 - Severe headache
 - Blurred vision
 - RUQ pain or Epigastric pain

OR

- SBP $\geq$ 160mmHg or DBP $\geq$ 110mmHg
 - If unable to obtain IV access: 10 Gm IM – 5Gm in each buttock
 - To lessen discomfort – TWO 2.5Gm IM injections in each buttock for a TOTAL of 5Gm per buttock

Eclampsia (Active Seizure)

4 Gm in 100mL NS IV over 10 minutes

- If unable to obtain IV access: 10 Gm IM – 5Gm in each buttock

~~Pregnant patients or up to 6 weeks post-partum presenting with active seizure (concern for eclampsia) – Contact Base Hospital for Magnesium Sulfate 4 Gm IV in normal saline over 20 minutes~~

- ~~• Mixing instructions: Give 2 Gm in 100 mL normal saline over 10 minutes with immediate repeat for a total dose of 4 Gm over 20 minutes~~

PEDIATRIC DOSE

Refractory in Severe Respiratory Distress and Bronchospasm:

50mg/kg max of 2Gm

Repeat doses – base order only

Mixing instructions: appropriate weight-based dosing of $\leq$ 1 Gm in 100 mL of NS over 20 minutes. If patient appropriate weight-based dose is $>$ 1 Gm, administer 1 Gm in 100 mL NS over 10 minutes followed by remaining Magnesium Sulfate in additional 100 mL bag over 10 minutes. TOTAL should not exceed 2 Gm

Onset: IV - immediate

Duration: IV - 30-60 minutes

Notes:

- Respiratory depression is more likely with a too-fast IV infusion rate - ensure proper drip rate
- If patient presents with hyporeflexia, discontinue Magnesium Sulfate immediately
- If overdose is suspected consult with Base Hospital immediately to give Calcium Chloride to reverse effects.
- Magnesium Sulfate Overdose Indications:
 - New onset altered mental status
 - New onset of cardiac rate and rhythm changes
 - Respiratory depression
 - Hyporeflexia (Indicated by decreased or loss of deep tendon reflexes)

MIDAZOLAM (Versed®)**Classification:** Benzodiazepine**Actions:**

1. Hypnotic, amnesiac, sedative, anticonvulsant
2. Potent but short-acting, 3-4 times more potent than diazepam
3. Has NO effect on pain

Indications:

1. Active, continuous seizure
2. Status epilepticus
3. Sedation prior to cardioversion
4. Acute behavior disorder (agitated patient danger to self or others)
5. Severe muscle spasms (base physician order only)
6. Eclampsia

Contraindications (Relative):

1. History of hypersensitivity to benzodiazepines
2. Shock with depressed vital signs
3. ALOC of unknown etiology / polypharmacy ingestion
4. Narrow-angle glaucoma
5. Pregnant patients NOT actively seizing
6. Eclampsia (Base Hospital order only)

Adverse Effects (Precautions, Side Effects and Notes):

Midazolam may cause respiratory depression and/or hypotension especially if administered rapidly. Monitor patient closely.

1. Common side effects include drowsiness, hypotension, respiratory depression and apnea. These are more likely to occur in the very young and the very elderly. Rarely, patients may experience paradoxical agitation.
2. Respiratory depression is more likely in patients who have taken other CNS depressant drugs such as opioids, alcohol, other benzodiazepines or barbiturates, or when given rapidly.
3. Midazolam is metabolized in the liver and excreted by the kidneys. **Doses should be adjusted accordingly in patients with underlying hepatic or renal diseases or cardiac diseases with low flow states such as CHF.**
4. GI effects include nausea, vomiting, hiccough/hiccup
5. Pain at injection site (IV/IM), intranasal irritation if given IN

Administration:**ADULT DOSE****1. Seizure:**

- 5 mg SLOW IV or
- 5 mg IM or IN (split dose between nares)

- **May repeat once after 5 minutes for persistent or recurrent seizures**
2. **Agitated patient sedation** (danger to self or others):
 - Up to 5 mg SLOW IV
 - 5 mg IM or IN (IN split dose between nares)
 - **May repeat once after 5 minutes for significant agitation / threat to self or others**
 3. **Pre-cardioversion sedation:**
 - Up to 2 mg SLOW IV
 - 5 mg IM or IN (IN split dose between nares)
 - **May repeat once after 10 minutes**

*****EKG, Pulse oximetry, and ETCO2 (when equipment is available) monitoring will be used at all times.**

PEDIATRIC DOSE

1. **Seizure**
 - 0.2 mg/kg SLOW IV not to exceed 5 mg
 - 0.2 mg/kg IM/IN not to exceed 5 mg
 - **May repeat once after 5 minutes for persistent or recurrent seizures**
 - **Not to exceed 5 mg TOTAL**
2. **Agitated Patient Sedation:**
 - Up to 0.2 mg/kg not to exceed 5 mg
 - Up to 0.2 mg/kg IM/IN not to exceed 5 mg
 - **May repeat once after 5 minutes for significant agitation/threat to self or others**
 - **Not to exceed 5 mg TOTAL**

(IN **volume** for pediatric patient up to 1ml per nostril)

Pediatric maximum **volume** of one (1) mL per nostril per atomization (0.2-0.3 mL per nostril is ideal)

- volumes > 1 mL are more likely to saturate the mucosal surface causing medication runoff into the proximal pharynx

3. **Pre-cardioversion:**
 - 0.1 mg / kg IN or SLOW IV.
 - **Max 2mg**

*****EKG, Pulse oximetry, and ETCO2 (when equipment is available) monitoring will be used at all times.**

Onset:

1.5 - 5 minutes IV
2 - 6 minutes IN

15 minutes IM

Duration: 2 - 6 hours for IV/IN/IM

LIDOCAINE (Xylocaine®)

Classification: Antidysrhythmic agent

Action: Suppresses ventricular ectopy by stabilizing the myocardial cell membrane.

Indications:

1. Cardiac arrest with ventricular fibrillation or pulseless ventricular tachycardia
2. Post conversion or defibrillation of ventricular rhythms with base contact.
3. Ventricular tachycardia with pulse present
4. Symptomatic/malignant ventricular ectopy
5. Pain Management following IO Placement
6. Pain Management for IM injections with Magnesium Sulfate for Preeclampsia and Eclampsia

Contraindications:

1. 2° degree type II heart block
2. 3° degree heart block
3. Junctional bradycardia
4. Ventricular ectopy associated with bradycardia
5. Idioventricular rhythm
6. Known allergy to Lidocaine or sensitivity to other anesthetics (report to base).

Adverse Effects:

Cardiovascular

Bradycardia
Hypotension
Arrest
Blurred vision

Respiratory

Dyspnea
Depression
Apnea

Gastrointestinal

Nausea/vomiting

Neurological

Dizziness
Drowsiness
Paresthesia
Restlessness
Slurred speech
Disorientation
Seizures
Lightheadedness
Tinnitus
Muscle twitching

Administration:

ADULT DOSE

1. **V-Fib/pulseless V-Tach (with SLOEMSA Authorization):** 1.5 mg/kg IVP/IO, repeat every 3-5 minutes, not to exceed 3 mg/kg.
2. **V-Tach with a pulse (with SLOEMSA Authorization):** 1.5 mg/kg IVP, may repeat with 0.75 mg/kg IVP every 5-10 minutes, not to exceed 3 mg/kg.
3. **Pain Management following IO Placement:** 0.5mg/kg (total max dose of 40mg) slow IO push over 60 seconds.

**4. Pain Management for IM injections in Preeclampsia or Eclampsia: 20mg
2% Lidocaine (mixed into 10 Gm Magnesium Sulfate for IM injection)**

PEDIATRIC DOSE

- 1. V-Fib/pulseless V-Tach (with SLOEMSA Authorization):** 1 mg/kg IVP/IO.
May repeat every 5 minutes, not to exceed 3 mg/kg.
- 2. V-Tach with a pulse (with SLOEMSA Authorization):** 1 mg/kg IVP/IO, may
repeat with 0.5 mg/kg IVP/IO every 5-10 minutes, not to exceed 3 mg/kg.
- 3. Pain Management following IO Placement:** 0.5mg/kg (total max dose of
40mg) slow IO push over 60 seconds.

Onset: 30 - 90 seconds

Duration: 10 - 20 minutes

Notes:

- Lidocaine may be used as backup to Amiodarone with SLOEMSA authorization (using Policy #205 Attachment C) in cases where Amiodarone stock is unavailable. In cases when Lidocaine is substituted for Amiodarone, the minimum stock of Lidocaine shall mimic the same numbers as Amiodarone.
- In cases of premature ventricular contractions, assess need and treat underlying cause. Needs include: chest pain, syncope, R on T situations, multifocal and paired PVCs, bigeminy and trigeminy, and PVCs at 6-12 per minute. See appropriate protocols as needed.
- Lidocaine is to be administered no faster than 50mg/min, except in patients in cardiac arrest.

OBSTETRIC EMERGENCIES: POST-PARTUM HEMORRHAGE CONTROL	
ADULT	PEDIATRIC (≤34 KG)
BLS	
• Universal Protocol #601 • Pulse Oximetry ○ O2 administration per Airway Management Protocol #602 • Post-Partum Hemorrhage control ○ Perform visual exam to determine site of bleeding ○ For perineal tear (external vaginal area), apply direct pressure to the perineum with sterile dressings. <u>DO NOT place dressings inside the vagina</u> ○ Firmly massage fundus	
ALS	
• Normal Saline up to 500mL IV ○ May repeat X1 to maintain SBP > 90 If immediate post-partum hemorrhage persists despite use of available measures: • TXA 1Gm in 100mL NS IV infusion over 10 minutes ○ Must be within 3 hours post-hemorrhage	
Base Hospital Orders Only	
• As needed	• As needed
Notes	
• Immediate Post-Partum Hemorrhage is significant or ongoing bleeding after delivery. Defined as the loss of 1000mL or more of blood up to 24 hours after delivery, or any blood loss accompanied by signs or symptoms of hypovolemia • Clinical manifestation of blood loss may be delayed until considerable blood loss has occurred in post-partum hemorrhage patients. Consider early fluid resuscitation as indicated under Universal Protocol #601	

CHILDBIRTH	
NORMAL	COMPLICATIONS
BLS	
- Universal Protocol #601 - Pulse Oximetry - O2 administration per Airway Management Protocol #602 Delivery - Patient assessment with visual exam of perineum for crowning - Control head and speed of delivery - Check for cord around neck - Deliver upper, then lower shoulder - Dry, stimulate, and wrap baby - Suction airway as needed - Cut and clamp cord 6" from newborn's umbilicus - Healthy infant to mother's breast - Prepare for delivery of placenta Postpartum Hemorrhage Control - Perform visual exam to determine site of bleeding - For perineal tear, apply direct pressure - Firmly massage fundus - For ongoing/uncontrolled hemorrhage or hemodynamic instability refer to Protocol #653 Obstetric Emergencies: post-partum Hemorrhage	- Universal Protocol #601 - Pulse Oximetry - O2 administration per Airway Management Protocol #602 Initiate Transport Early - Hypertension BP > 180/110 mmHg - Seizures — follow Seizure Protocol #620 - Vaginal bleeding in last trimester <u>not</u> associated with labor may indicate Placenta Previa/Abruptio - Breech/Limb presentation - Prolapsed cord – Place mother in knee-chest position. Feel cord for pulse. With gloved hand, push baby into vagina slightly to take pressure off cord. Maintain this position. Do <u>not</u> attempt to push cord back Newborn Viability - Gestation ≤20 weeks without signs of life (pulseless, not breathing) are not considered viable. Resuscitation may be withheld by first responder - If gestational age is uncertain – initiate resuscitation and contact nearest Base hospital - Provider judgement of scene may also warrant initiation of resuscitation efforts in gestation of ≤ 20 week newborn - If resuscitation initiated - contact nearest Base Hospital
ALS Standing Orders	
Refer to appropriate protocol based on patient's presentation	Refer to appropriate protocol based on patient's presentation
Base Hospital Orders Only	
As needed	As needed

Notes



- Knee-chest position for prolapse cord presentation (above)
- General guideline transport in left lateral position Obtain Para/Gravida
- Refer to policy #125 for withholding resuscitation on pre-term fetal delivery ≤ 20 weeks gestation.
- If delivery of neonate with gestational age ≤ 20 weeks without resuscitation efforts, transport of post-partum patient is still encouraged. Use OB-kit swaddle/blanket for transport of neonate with mother.
- If resuscitation of gestational age ≤ 20 weeks is initiated, continue with newborn resuscitation per protocol #641 with early base hospital notification and rapid transport.

Tranexamic Acid (TXA) (Cyklokapron)

Classification:	Antifibrinolytic, plasminogen inactivator
Actions:	Reduces fibrinolysis and clot breakdown; stabilizes clot formation; inhibits conversion of plasminogen to plasmin
Indications:	1. Blunt or penetrating traumatic injury with SBP ≤ 90 2. Significant hemorrhage not controlled by direct pressure, hemostatic agents, or tourniquet application 3. Persistent or uncontrolled post-partum hemorrhage
Contraindications:	• >3 hours post injury • > 3 hours post birth in cases of post-partum hemorrhage • Isolated spinal shock • Isolated head injury • Non-blood loss conditions • Isolated extremity hemorrhage when bleeding has been controlled and if there is a strong expectation for re-implantation • Patients <15 years old • Active Thromboembolic event (within 24 hrs); i.e. CVA, MI, Pulmonary Embolism, or DVT • Hypersensitivity or anaphylactic reaction to TXA • Traumatic Arrest with >5 min of CPR without ROSC • Drowning or hanging victims
Precautions:	• Severe kidney diseases • Pregnancy
Adverse Effects:	<1% • Hypotension with rapid IV infusion • Chest tightness, difficulty breathing • Facial flushing, swelling in hands or feet • Blurred vision • Anaphylactoid reaction <i>Frequency not defined for IV solution</i> • Headache • Musculoskeletal pain
Administration:	Adult Dosage (≥ 15 year old) 1 Gm in 100mL NS IV/IO infused over >10 min <u>No pediatric dose approved</u>
Pharmacology:	Onset: 20 min – 2 hrs Duration: 2 – 8 hrs
Notes:	Rate of administration should not exceed 100 mg/min

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

I. PURPOSE

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

II. DEFINITIONS

- On-Site Medical Staff – Licensed medical professionals (Physician, **Physician's Associate, Nurse Practitioner**, or Registered Nurse). ~~staffing a skill-nursing facility on a 24 hours per day.~~
- Skilled Nursing Facility (SNF) – A facility that provides healthcare to individuals unable to manage independently in the community and has licensed medical staff on-site 24 hours per day.
- **Medical facility – Any licensed or authorized healthcare facility, clinic, center, office, or other location where medical, nursing, diagnostic, rehabilitative, or other healthcare services are provided. For purposes of this policy, the term "medical facility" does not include hospitals.**
- **Urgent Care – A medical care facility that is capable of providing prompt medical care, typically for non-life threatening illnesses.**

III. POLICY

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

IV. PROCEDURE

- A. A ~~SNF~~ **medical facility** seeking authorization to participate in the tiered response program must submit a written proposal to the SLOEMSA, which includes the following elements:
1. Requesting facility has a licensed medical staff on duty ~~24 hours per day~~ **during operating hours.**
 2. A written letter of support for the request to participate in the program from the jurisdictional Fire Department and Public Safety Answering Point (PSAP) submit to SLOEMSA.
 3. The jurisdictional PSAP must be a SLOEMSA approved Emergency Medical Dispatch provider agency.
 4. Requesting facility must provide written documentation detailing process for how staff will handle preparing for the transfer request, including the inclusion

of appropriate patient transfer documents, and notification of/coordination with receiving hospitals.

5. Final approval may include a review by a SLOEMSA advisory committee(s).
6. SLOEMSA will review each request within 60 days of receipt and will approve request after all requirements have been satisfied:

B. Upon SLOEMSA written approval of request:

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

V. CORRECTIVE ACTION

A. The County of San Luis Obispo EMS Agency, at any time, may request and conduct an audit of any participating facility authorized to utilize this policy.

1. Should SLOEMSA determine that continued participation is not appropriate or that the facility has failed to comply with the requirements, procedures, or standards within this policy, SLOEMSA may suspend or revoke a facility's authorization to participate in the tiered response program.

B. Following the determination that a facility has been suspended or revoked, SLOEMSA will develop a corrective action and reinstatement plan.

1. Such plans may include, but are not limited to, additional training, education, competency verification, policy review, operational changes, or other corrective measures deemed necessary.
2. Once a facility has completed all requirements specified by SLOEMSA, reinstated approval will be communicated in writing by SLOEMSA.
3. Facilities who have been reinstated may be subject to extended monitoring as outlined in their corrective action plan.
 - a. These facilities will be required to fill out page 2 of Attachment B
 - b. these records must be maintained by the facility for two years.
 - c. SLOEMSA will determine the length of time a facility needs to complete attachment B, page 2. This will be no less than ninety days and no more than two years.

VI. AUTHORITY

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

VII. ATTACHMENTS

- A. Patient Assessment Flow Chart
- B. Facility Narrative Script and Corrective Action Plan Audit Form

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

PATIENT ASSESSMENT FLOW CHART

Patient Assessment by R.N. or M.D.

Transport required for any of the following:

- Blood labs
- Urinary tract infection (with good vital signs within 20 minutes of EMS)
- Dialysis (with good vital signs)
- Radiological appointments
- Wound care
- Outpatient blood transfusion
- Orthopedic appointments
- Vascular access including PIC lines
- Urinary catheter placement or repair

YES

911 Request for Code 2
Ambulance-only response

Read request narrative
(Attachment B)

Request PSAP share any
special equipment/personnel
requirements with responding
ambulance

Provide on-scene ambulance
personnel with relevant
information/forms (i.e. POLST)

NO

Existence of any of the following:

- **Unstable vitals** (O2, BP, HR, Orientation)
- Acute or suspected stroke or stroke-like symptoms
- Sudden decrease in consciousness or LOC (Altered Mental Status)
- Acute onset of difficulty breathing/respiratory distress
- Suspected acute heart problem or AMI
- Acute uncontrolled hemorrhage
- Acute severe hypoglycemia unresponsive to treatment
- Acute intractable pain
- Acute suspected fracture
- R.N. or M.D. judgment determines need for immediate transport
- **Other not listed**

911 Request for immediate transport

- Obtain current vitals for EMS arrival
- Staff remain with pt to assess for additional changes
- Provide on-scene ambulance personnel with relevant information/forms (i.e. POLST) when possible

**TIERED RESPONSE PROGRAM FOR MEDICAL FACILITIES
REQUESTING FACILITY NARRATIVE**

1) Qualified person (M.D., D.O., N.P., P.A.) has identified the need for code 2 ambulance-only transfer (Attachment A).

2) Dial 911 to initiate the request.

3) State the following:

“This is _____ (Name) from _____ (approved facility name) on behalf of _____ (R.N. or M.D., D.O., N.P., P.A., name - if not the same as caller), requesting a Code 2 Ambulance-only transfer to _____ (Hospital).”

4) Monitor patient for changes (see Attachment A) which may require an upgrade to an emergent Code 3 response and dial 911 immediately with updated patient status.

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

If your facility is under a Corrective Action plan, please print and fill out page 2 of this form for each Code 2 request. Once your facility Corrective Action Plan has been completed, as communicated by the County of San Luis Obispo EMS Agency, you may disregard page 2.

Please continue to use the script lines 1-5 on page 1 per Policy# 212 when no Corrective Action Plan is in place.

SLOEMSA Corrective Action Plan Audit Form

Facility Name: _____

Date, Time & Individual making Code 2 Request	Date: _____ Time: _____ Name: _____
Reason for Code 2 Request	
Name of person making Patient assessment	Name: _____ (circle one) M.D. / D.O. / N.P. / P.A. / R.N.
Patient Age & Gender	
Vitals Time Taken: _____	HR: _____ B/P: _____ Oxygen Saturation: _____ Is patient mentation baseline: Y / N
Receiving Facility	

* If facility is on a Corrective Action and Reinstatement plan, fill out the above form in its entirety for each Code 2 Ambulance request. Keep with facility records for two years.