CONTRA COSTA
HEALTH SERVICES

Emergency Medical Services Agency

EMS Plan Annual Update
2004/2005

October 2005

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SECTION I: SUMMARY OF CHANGES TO EMS PLAN

All State Standards for local EMS systems have been met. During our initial EMS planning process, higher or more specific local standards were identified for many of the State Standards. The majority of these local standards have been addressed as well.

The EMS Agency obtained a nationally recognized EMS Consultant Firm to evaluate how fire services could increase their paramedic staffing levels at no additional cost to the County, and to assist with a request-for-proposal (RFP) process for emergency ambulance and related services. The RFP was designed to eliminate a subsidy for emergency ambulance services, to redefine the minimum-staffing configuration, to establish response time and performance standards with associated fines for non-performance, and to establish a number of additional EMS enhancements in a variety of areas.

As a result of this process, there have been major changes in how emergency medical services are being provided. In the coming months, we will continue to re-evaluate local standards to further define our EMS system plan for the future.

SECTION II: UPDATES OF SPECIFIC INFORMATION

EMSA TABLE 2 - SYSTEM ORGANIZATION AND MANAGEMENT

1. Percentage of population served by each level of care by county:

a. Basic Life Support (BLS)	____%
b. Limited Advanced Life Support (LALS)	____%
c. Advanced Life Support (ALS)	100 %

2. Type of agency: b

a. Public Health Department
b. County Health Services Agency
c. Other (non-health) County Department
d. Joint Powers Agency
e. Private Non-profit Entity
f. Other:____

3. Person responsible for day-to-day EMS Agency activities reports to: b

a. Public Health Officer
b. Health Services Agency Director/Administrator
c. Board of Directors
d. Other:____

4. Indicate the non-required functions that are performed by the Agency

Implementation of exclusive operating areas (ambulance franchising)	X
Designation of trauma centers/trauma care system planning	X
Designation/approval of pediatric facilities	X
Designation of other critical care centers	
Development of transfer agreements	X
Enforcement of local ambulance ordinance	X
Enforcement of ambulance service contracts	X
Operation of ambulance service	
Continuing education	X
Personnel training	X
Operation or oversight of EMS dispatch center	
Non-medical disaster planning	
Administration of critical incidents stress debriefing (CISD) team	
Administration of disaster medical assistance team (DMAT)	X
Administration of EMS Fund [Senate Bill (SB) 12/612]	
Other: Tracking and monitoring hospital emergency and critical care capacity	X
Other: Procuring and monitoring emergency ambulance services countywide	X
Other: Implementing EMS program enhancements funded under County Service Area EM-1	X
Other: Planning for/coordinating disaster medical response at local/regional levels	X

EMSA TABLE 2 - System Organization & Management (cont.)

5. EMS Agency budget FY 04/05

a. EXPENSES

Salaries and benefits	$	1,071,223
Contract Services		115,971
Operations (e.g. copying, postage, facilities)		342,951
Travel		4,814
Fixed assets		-
Indirect expenses (overhead)		670,461
Ambulance subsidy		558,760
EMS Fund payments to physicians/hospital		1,291,726
Dispatch center operations (non-staff)		240,057
Training program operations		-
Other: 1st Responder Enhancements		1,391,068
Other: HazMat		150,000
TOTAL EXPENSES	$	5,837,031

EMSA TABLE 2 - System Organization & Management (cont.)

b. SOURCES OF REVENUE FY 04/05

Special project grant(s) [from EMSA]		
Preventive Health and Health Services (PHHS) Block Grant	$	222,913
Office of Traffic Safety (OTS)		-
State general fund		142,149
County general fund		593,778
Other local tax funds (e.g., EMS district)		4,597,287
County contracts (e.g. multi-county agencies)		-
Certification fees		11,657
Training program approval fees		-
Training program tuition/Average daily attendance funds (ADA)		
Job Training Partnership ACT (JTPA) funds/other payments		-
Base hospital application fees		-
Base hospital designation fees		-
Trauma center application fees		-
Trauma center designation fees		75,000
Pediatric facility approval fees		-
Pediatric facility designation fees		-
Other critical care center application fees		-
Type:		
Other critical care center designation fees		-
Type:		
Ambulance service/vehicle fees		26,000
Contributions		-
EMS Fund (SB 12/612)		1,579,972
Other grants:		446,641
Other:		1,500
TOTAL REVENUE	$	6,794,531

Note: Difference between expenditures and revenues due to surplus in County Service Area EM-I funds.

EMSA TABLE 2 - System Organization & Management (cont.)

6. Fee structure for 04/05

First responder certification	$ 0
EMS dispatcher certification	
EMT-I certification	30
EMT-I recertification	30
EMT-defibrillation certification	0
EMT-defibrillation recertification	0
EMT-II certification	NA
EMT-II recertification	NA
EMT-P accreditation	50
Mobile Intensive Care Nurse/ Authorized Registered Nurse (MICN/ARN) certification	0
MICN/ARN recertification	0
EMT-I training program approval	0
EMT-II training program approval	NA
EMT-P training program approval	0
MICN/ARN training program approval	0
Base hospital application	0
Base hospital designation	0
Trauma center application	10,000
Trauma center designation	75,000
Pediatric facility approval	NA
Pediatric facility designation	NA
Other critical care center application	
Other critical care center designation	
Ambulance service license	NA
Ambulance vehicle permits	
Non-emergency ambulance (three year permit)	1,500
Emergency ambulance (three year permit per ERA)	1,500
Other: Helicopter classification	250
Other: Helicopter authorization (2 year permit)	1,800
Other: CE Provider (authorization and reauthorization)	100
Other: Replacement EMT certification card	10
Other: CCT P Program	
Other: Non-Emergency Paramedic Transfer Program (plus $50/transfer after 1st 50)	3,000

7. The following tables are for the fiscal year 04/05

EMSA TABLE 2 - System Organization & Management (cont.)

CATEGORY	ACTUAL TITLE	FTE POSITIONS (EMS ONLY)	TOP SALARY BY HOURLY EQUIVALENT[1]	BENEFITS (% of salary)	COMMENTS
EMS Admin/Coord/Dir	EMS Director	1	$49.70	37%	
Asst. Admin/Admin Asst/Admin Mgr.	EMS Assistant Director	1	$44.93	37%	
ALS Coord/Field Coord/Trng Coord	1. 1st Responder Prog/Training Coord	1	$41.38	37%	
Prog Coord/Field Liaison (Non-clinical)	1. Prehosp Care Coord. Personnel/MIS 2. RDMHS (Grant)	1 1	$41.38 $41.38	37% 37%	
Trauma Coord.	EMS Trauma Coordinator	1	$41.38	37%	
Med. Director	EMS Medical Director	0.5	$79.71	37%	
Other MD/Med Consult					
Disaster Med. Planner	Health Services Disaster Mgr	1	$42.93	37%	
Dispatch Super.					
Medical Planner					
Dispatch Super.					
Data Evaluator/Analyst					
QA/QI Coordinator (RN)	EMS QI Specialist (contract position)	0.8	$43.50		
Public Info. & Ed. Coord.					
Ex. Secretary					
Other Clerical	1. Clerk - Senior	1	$20.99	37% 37%	
Data Entry Clerk					
Other: Administrative Assistant	Training Consortium Coordinator - Adm.	1	$20.60		

[1] Salary as of 9/1/05

EMSA TABLE 3 - PERSONNEL/TRAINING

	EMT-I's	EMT - II's	EMT- P's	MICN's	EMS Dispatchers
Total certified/accredited/authorized	276	-	203	31	
Number of newly certified this year	N/A	-	N/A	NA	
Number of certified this year	N/A	-	N/A	NA	
Total number of accredited personnel on July 1 of 2005	N/A	-	N/A	N/A	
Number of certificate reviews resulting in:					
a) formal investigations	-		-	-	
b) probation	-		-	-	
c) suspensions	-		-	-	
d) revocations	-		-	-	
e) denials	-		-	-	
f) denials	-		-	-	
g) no action taken	-		-	-	
h) referred to EMSA	-		-	-	

1. Number of EMS dispatchers trained to EMSA standards: 52

2. Early defibrillation:

   a) Number of EMT-I (defib) certified 551
   b) Number of public safety (defib) certified (non-EMTI) 71

3. Do you have a first responder training program? yes X no _____

EMSA TABLE 4 - COMMUNICATIONS

1. Number of primary Public Service Answering Points (PSAP) — 10
2. Number of secondary PSAP's — 2
3. Number of dispatch centers directly dispatching ambulances — 3
4. Number of designated dispatch centers for EMS aircraft — 3
5. Do you have an operational area disaster communication system? — Yes x No ___
   a. Radio primary frequency

      MEDARS (T-Band) 4 channel

   b. Other methods

      Alternate telephone system; Local government radio frequencies; ReddiNet microwave communications among hospitals, ambulance dispatch centers and EMS Agency.

   c. Can all medical response units communicate on the same disaster communications system? — Yes x No ___
   d. Do you participate in OASIS? — Yes x No ___
   e. Do you have a plan to utilize RACES as a back up communication system? — Yes x No ___
      1) Within the operational area? — Yes x No ___
      2) Between the operational area and region and/or state? — Yes x No ___
6. Who is your primary dispatch agency for day-to-day emergencies?

   Three designated fire/medical dispatch centers

7. Who is your primary dispatch agency for a disaster?

   Sheriff's Communications

EMSA TABLE 5 - RESPONSE/TRANSPORTATION

Transporting Agencies

1.	Number of exclusive operating areas		5
2.	Percentage/population covered by Exclusive Operating Areas		100%
3.	Total number responses in 2004		67,966
a)	Number of emergency responses	(Code 2: expedient, Code 3: lights/siren)	67,966
b)	Number of non-emergency responses	(Code 1: normal)	unknown
4.	Total number of transports in 2004		49,314
a)	Number or emergency transports	(Code 2: expedient, Code 3: lights/siren)	49,314
b)	Number of non-emergency transports	(Code 1: normal)	unknown

Early Defibrillation Programs

5.	Number of public safety defibrillation programs	6
	a) Automated	6
	b) Manual	0
6.	Number of EMT-Defibrillation programs	8
	a) Automated	8
	b) Manual	0

Air Ambulance Services

7.	Total number or responses	unknown
	a) Number of emergency responses	unknown
	b) Number of non-emergency responses	unknown
8.	Total number of transports in 2004	302
	a) Number of emergency (scene) responses	302
	b) Number of non-emergency responses	unknown

EMSA TABLE 5 - Response/Transportation (cont.)

System Standard Response Times (90th Percentile) for 2004.

Enter the response times in the appropriate boxes.	METRO/URBAN	SUBURBAN/RURAL	WILDERNESS	SYSTEM WIDE
1. BLS and CPR capable first responder.	Varies by local jurisdiction	N/A	N/A	Varies by local jurisdiction
2. Early defibrillation capable responder.	Varies by local jurisdiction	N/A	N/A	Varies by local jurisdiction
3. Advanced life capable responder.	8.01 minutes[1]	N/A	N/A	N/A
4. EMS transport unit.	8.01 minutes[2]	N/A	N/A	N/A

[1] Time is for paramedic on the transport ambulance; the majority of patient responses include a fire first responder paramedic. Although written agreements with fire services include response time standards, response times are not currently collected by the EMS Agency.

[2] Official response performance standard are 10 minutes 95% of the time. Providers average the above performance.

EMSA TABLE 6 - FACILITIES/CRITICAL CARE

Trauma care system

Trauma patients for 2004:

1.	Number of patients meeting trauma triage criteria	2,439
2.	Number of major trauma victims transported directly to a trauma center by ambulance	911
3.	Number of major trauma patients transferred to a trauma center	130
4.	Number of patients meeting triage criteria who weren't treated at a trauma center	18

Emergency departments:

1.	Total number of emergency departments	8
	a) Number of referral emergency services	0
	b) Number of standby emergency services	0
	c) Number of basic emergency services	8
	d) Number of comprehensive emergency services	0

Receiving Hospitals

1.	Number of receiving hospitals with agreements	0
2.	Number of base hospitals with agreements	1

EMSA TABLE 7 - DISASTER MEDICAL

System Resources

1. Casualty Collections Points (CCP)
   a. Where are your CCP's located? — On file at the EMS Agency
   b. How are they staffed? — No staffing plan
   c. Do you have a supply system for supporting them for 72 hours? — Yes x No
2. CISD
   Do you have a CISD provider with 24-hour capability? — Yes x No
3. Medical Response Team - DMAT CA-6
   a. Do you have any team medical response capability? — Yes x No
   b. For each team, are they incorporated into your local response plan? — Yes x No
   c. Are they available for statewide response? — Yes x No
   d. Are they part of a formal out-of state response system? — Yes x No
4. Hazardous materials
   a. Do you have any HAZMAT trained medical response teams? — Yes x No
   b. At what HAZMAT level are they trained? — First Responder
   c. Do you have the ability to do decontamination in an emergency room? — Yes x No
   d. Do you have the ability to do decontamination in the field? — Yes x No

Operations

1. Are you using a standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? — Yes x No
2. What is the maximum number of local jurisdiction EOC's you will need to interact with in a disaster? — 20
3. Have you tested your MCI Plan this year in a:
   a. Real event? — Yes x No
   b. Exercise? — Yes x No
4. List all counties with which you have written medical aid agreement. — none
5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response? — Yes x No
6. Do you have a formal agreement with community clinics in your operational areas to participate in disaster planning and response? — Yes x No
7. Are you part of a multi-county EMS system for disaster response? — Yes x No
8. Are you a separate department or agency? — Yes No x
9. If not, to whom do you report? — Contra Costa Health Services
10. If not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department? — Yes n/a No

EMSA TABLE 8 - PROVIDERS

American Medical Response			2350 Whitman Rd. Suite F Concord, CA 94518		Leslie Mueller, Director of Operations, CCC 925-602-1300	
Written Contract: x Yes ____ No	Service: x Ground ____ Air ____ Water	x Transport x Non-Transport	Air Classification: ____ Auxiliary rescue ____ Air ambulance ____ ALS rescue ____ BLS rescue	If Air: ____ Rotary ____ Fixed Wing	# of personnel providing services: ____ PS ____ PS-Defib. 117 BLS ____ EMT-D ____ LALS 188 ALS	
Ownership: ____ Public x Private	Medical Director: x Yes ____ No	If Public: ____ Fire ____ Law ____ Other Explain: ____	If Public: ____ City ____ County ____ State ____ Fire district ____ Federal	System available 24 hours? x Yes ____ No	Number of Ambulances: 71	

San Ramon Valley Fire Protection District			1500 Bollinger Canyon Road San Ramon, CA 94583		Debbie Meier, EMS Program Manager 925-838-6691	
Written Contract: x Yes ____ No	Service: x Ground ____ Air ____ Water	x Transport x Non-Transport	Air Classification: ____ Auxiliary rescue ____ Air ambulance ____ ALS rescue ____ BLS rescue	If Air: ____ Rotary ____ Fixed Wing	# of personnel providing services: ____ PS 29 PS-Defib. ____ BLS 138 EMT-D ____ LALS 53 ALS	
Ownership: x Public ____ Private	Medical Director: x Yes ____ No	If Public: x Fire ____ Law ____ Other Explain: ____	If Public: ____ City ____ County ____ State x Fire district ____ Federal	System available 24 hours? x Yes ____ No	Number of Ambulances: 8	

EMSA TABLE 8 - Providers (cont.)

Moraga-Orinda Fire Protection District			1280 Moraga Way Moraga, CA 94556		Bob Cox, EMS Chief 925-258-4599	
Written Contract: x Yes ____ No	Service: x Ground ____ Air ____ Water	x Transport x Non-Transport	Air Classification: ____ Auxiliary rescue ____ Air ambulance ____ ALS rescue ____ BLS rescue	If Air: ____ Rotary ____ Fixed Wing	# of personnel providing services: ____ PS 1 PS-Defib. ____ BLS 29 EMT-D ____ LALS 30 ALS	
Ownership: x Public ____ Private	Medical Director: x Yes ____ No	If Public: x Fire ____ Law ____ Other Explain: ____	If Public: ____ City ____ County ____ State x Fire district ____ Federal	System available 24 hours? x Yes ____ No	Number of Ambulances: 2 (plus 1 BLS backup, 1 ALS backup)	

Contra Costa County Fire Protection District			2010 Geary Road Pleasant Hill, CA 94523		Alan Hartford, EMS Chief 925-939-3400	
Written Contract: x Yes ____ No	Service: x Ground ____ Air ____ Water	____ Transport x Non-Transport	Air Classification: ____ Auxiliary rescue ____ Air ambulance ____ ALS rescue ____ BLS rescue	If Air: ____ Rotary ____ Fixed Wing	# of personnel providing services: ____ PS ____ PS-Defib. ____ BLS 194 EMT-D ____ LALS 84 ALS	
Ownership: x Public ____ Private	Medical Director: x Yes ____ No	If Public: x Fire ____ Law ____ Other Explain: ____	If Public: ____ City ____ County ____ State x Fire district ____ Federal	System available 24 hours? x Yes ____ No	Number of Ambulances: 0	

EMSA TABLE 8 - Providers (cont.)

Crockett-Carquenez Fire Protection District			746 Loring Avenue Crockett, CA 94525		G. Littleton, Jr., Fire Chief 510-787-2717	
Written Contract: ___ Yes x No	Service: x Ground ___ Air ___ Water	___ Transport x Non-Transport	Air Classification: ___ Auxiliary rescue ___ Air ambulance ___ ALS rescue ___ BLS rescue	If Air: ___ Rotary ___ Fixed Wing	# of personnel providing services: 11 PS 17 PS-Defib. ___ BLS 30 EMT-D ___ LALS ___ ALS	
Ownership: x Public ___ Private	Medical Director: x Yes ___ No	If Public: x Fire ___ Law ___ Other Explain: ___	If Public: ___ City ___ County ___ State x Fire district ___ Federal	System available 24 hours? x Yes ___ No	Number of Ambulances: 0	

East Contra Costa Fire Protection District			134 Oak Street Brentwood, CA 94513		Jake Gonzalez, Ops Chief 925-240-2133	
Written Contract: ___ Yes x No	Service: x Ground ___ Air ___ Water	___ Transport x Non-Transport	Air Classification: ___ Auxiliary rescue ___ Air ambulance ___ ALS rescue ___ BLS rescue	If Air: ___ Rotary ___ Fixed Wing	# of personnel providing services: ___ PS ___ PS-Defib. 21 BLS 72 EMT-D ___ LALS ___ ALS	
Ownership: x Public ___ Private	Medical Director: x Yes ___ No	If Public: x Fire ___ Law ___ Other Explain: ___	If Public: ___ City ___ County ___ State x Fire district ___ Federal	System available 24 hours? x Yes ___ No	Number of Ambulances: 0	

EMSA TABLE 8 - Providers (cont.)

El Cerrito Fire Department			10900 San Pablo Avenue El Cerrito, CA 94530		Mark Scott, Fire Chief 510-215-4450	
Written Contract: x Yes ____ No	Service: x Ground ____ Air ____ Water	____ Transport x Non-Transport	Air Classification: ____ Auxiliary rescue ____ Air ambulance ____ ALS rescue ____ BLS rescue	If Air: ____ Rotary ____ Fixed Wing	# of personnel providing services: ____ PS ____ PS-Defib. ____ BLS 24 EMT-D ____ LALS 8 ALS	
Ownership: x Public ____ Private	Medical Director: x Yes ____ No	If Public: x Fire ____ Law ____ Other Explain: ____	If Public: x City ____ County ____ State ____ Fire district ____ Federal	System available 24 hours? x Yes ____ No	Number of Ambulances: 0	

Pinole Fire Department			880 Tennent Avenue Pinole, CA 94564		Jim Parrott, Fire Chief 510-724-8970	
Written Contract: ____ Yes x No	Service: x Ground ____ Air ____ Water	____ Transport x Non-Transport	Air Classification: ____ Auxiliary rescue ____ Air ambulance ____ ALS rescue ____ BLS rescue	If Air: ____ Rotary ____ Fixed Wing	# of personnel providing services: ____ PS 24 PS-Defib. 24 BLS ____ EMT-D ____ LALS 4 ALS	
Ownership: x Public ____ Private	Medical Director: x Yes ____ No	If Public: x Fire ____ Law ____ Other Explain: ____	If Public: x City ____ County ____ State ____ Fire district ____ Federal	System available 24 hours? x Yes ____ No	Number of Ambulances: 0	

EMSA TABLE 8 - Providers (cont.)

Richmond Fire Department			330 25th Street Richmond, CA 94804		Clyde Tucker, Fire Chief 510-307-8031	
Written Contract: __x__ Yes _____ No	Service: __x__ Ground _____ Air _____ Water	_____ Transport __x__ Non-Transport	Air Classification: _____ Auxiliary rescue _____ Air ambulance _____ ALS rescue _____ BLS rescue	If Air: _____ Rotary _____ Fixed Wing	# of personnel providing services: _____ PS _____ PS-Defib. _____ BLS 74 EMT-D _____ LALS _____ ALS	
Ownership: __x__ Public _____ Private	Medical Director: __x__ Yes _____ No	If Public: __x__ Fire _____ Law _____ Other Explain: _____	If Public: __x__ City _____ County _____ State _____ Fire district _____ Federal	System available 24 hours? __x__ Yes _____ No	Number of Ambulances: 0	

Rodeo-Hercules Fire Protection District			1680 Refugio Valley Road Hercules, CA 94547		Gary Boyles, Fire Chief 510-799-4561	
Written Contract: _____ Yes __x__ No	Service: __x__ Ground _____ Air _____ Water	_____ Transport __x__ Non-Transport	Air Classification: _____ Auxiliary rescue _____ Air ambulance _____ ALS rescue _____ BLS rescue	If Air: _____ Rotary _____ Fixed Wing	# of personnel providing services: _____ PS _____ PS-Defib. _____ BLS 20 EMT-D _____ LALS 3 ALS	
Ownership: __x__ Public _____ Private	Medical Director: __x__ Yes _____ No	If Public: __x__ Fire _____ Law _____ Other Explain: _____	If Public: __x__ City _____ County _____ State _____ Fire district _____ Federal	System available 24 hours? __x__ Yes _____ No	Number of Ambulances: 0	

EMSA TABLE 9 - APPROVED TRAINING PROGRAMS

Los Medanos College 2700 East Leland Road Pittsburg, CA 94565		Jennifer Warden (925) 439-2181 ext 3352
Student Eligibility: Open to the general public.	Cost of Program $28.00/unit Basic: Approx. $250 - $500 Refresher: Approx $35	Program Level: EMT Training Number of students completing training per year: Initial training: 100 - 200 Refresher: 50 - 75 Cont. Education: NA Expiration Date: 11/30/07 Number of courses: Initial training: 4 Refresher: 2 Cont. Education: NA

Contra Costa College 2600 Mission Bell Drive San Pablo, CA 94806		Michael J. Frith 510-235-7800 x4229
Student Eligibility: Open to the general public.	Cost of Program Basic: $156 Refresher: Approx $26.00	Program Level: EMT Training Number of students completing training per year: Initial training: 50 Refresher: 25 Cont. Education: 50 Expiration Date: 8/31/07 Number of courses: Initial training: 2 Refresher: 2 Cont. Education: As needed

EMSA TABLE 9 - Approved Training Programs (cont.)

Mt. Diablo Adult Education 1266 San Carlos Avenue Concord, CA 94518	Susan Garske 925-685-7340, #2734

Student Eligibility:	Cost of Program	Program Level: EMT Training
Open to the general public.	Basic: $150 - 1st responder $520 - EMT $100 - EMT Challenge Refresher: Approx $72	Number of students completing training per year: Initial training: 40 Refresher: 0 Cont. Education: 16 Expiration Date: 8/31/09 Number of courses: Initial training: 2 Refresher: Cont. Education: 1

Contra Costa County Fire – EMS Division 2945 Treat Blvd. Concord, CA 94518	Alan Hartford (925) 941-3640

Student Eligibility:	Cost of Program	Program Level: EMT Training
District Personnel Only	No charge to Fire District Employees In-house training only.	Number of students completing training per year: Initial training: 0 Refresher: 0 Cont. Education: 30 Expiration Date: 6/30/07 Number of courses: Initial training: 0 Refresher: 0 Cont. Education: 12

EMSA TABLE 9 - Approved Training Programs (cont.)

Health Career College 2300 Clayton Road, Suite 110 Concord, CA 94520	Fernando Garcia (925) 687-9668

Student Eligibility:	Cost of Program	Program Level: EMT Training
Open to the general public. (Note: 1st class begins November 2005 so no previous stats available)	Basic: $950 Refresher: Not yet established	Number of students completing training per year: Initial training: 0 Refresher: 0 Cont. Education: 0 Expiration Date: 6/30/09 Number of courses: Initial training: 0 Refresher: 0 Cont. Education: 0

Moraga/Orinda Fire Protection District 33 Orinda Way Orinda, CA 94563	Batt. Chief Bob Cox (925) 253-4770

Student Eligibility:	Cost of Program	Program Level: EMT Training
District Personnel Only	No charge to Fire District Employees In-house training only.	Number of students completing training per year: Initial training: 0 Refresher: 0 Cont. Education: 60 Expiration Date: 6/30/06 Number of courses: Initial training: 0 Refresher: 0 Cont. Education: 12

EMSA TABLE 10 - FACILITIES

Contra Costa Regional Medical Center	2500 Alhambra Avenue Martinez, CA 94553 (925) 370-5000			Primary Contact: Administration
Written Contract: ____ Yes __x__ No	Referral emergency service ____ Standby emergency service ____ Basic emergency service __x__ Comprehensive emergency service ____		Base Hospital: ____ Yes __x__ No	Pediatric Critical Care Center: * ____ Yes __x__ No
EDAP: ** ____ Yes __x__ No	PICU: *** ____ Yes __x__ No	Burn Center: ____ Yes __x__ No	Trauma Center: ____ Yes __x__ No	If Trauma Center what Level: **** _____

Doctors' Medical Center, San Pablo	2000 Vale Road San Pablo, CA 94806 510-235-7000			Primary Contact: Administration
Written Contract: ____ Yes __x__ No	Referral emergency service ____ Standby emergency service ____ Basic emergency service __x__ Comprehensive emergency service ____		Base Hospital: ____ Yes __x__ No	Pediatric Critical Care Center: * ____ Yes __x__ No
EDAP: ** ____ Yes __x__ No	PICU: *** ____ Yes __x__ No	Burn Center: __x__ Yes ____ No	Trauma Center: ____ Yes __x__ No	If Trauma Center what Level: **** _____

* Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*.
** Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards.
*** Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards.
**** Levels I, II, III and Pediatric.

EMSA TABLE 10 - Facilities (cont.)

John Muir Medical Center	1601 Ygnacio Valley Road Walnut Creek, CA 94598 925-939-3000			Primary Contact: Administration
Written Contract: __x__ Yes ____ No	Referral emergency service ____ Standby emergency service ____ Basic emergency service __x__ Comprehensive emergency service ____		Base Hospital: __x__ Yes ____ No	Pediatric Critical Care Center: * ____ Yes __x__ No
EDAP: ** ____ Yes __x__ No	PICU: *** ____ Yes __x__ No	Burn Center: ____ Yes __x__ No	Trauma Center: __x__ Yes ____ No	If Trauma Center what Level: **** __Level II__

Kaiser Medical Center-Richmond	1330 So. Cutting Blvd. Richmond, CA 94801 510-307-1500			Primary Contact: Administration
Written Contract: ____ Yes __x__ No	Referral emergency service ____ Standby emergency service ____ Basic emergency service __x__ Comprehensive emergency service ____		Base Hospital: ____ Yes __x__ No	Pediatric Critical Care Center: * ____ Yes __x__ No
EDAP: ** ____ Yes __x__ No	PICU: *** ____ Yes __x__ No	Burn Center: ____ Yes __x__ No	Trauma Center: ____ Yes __x__ No	If Trauma Center what Level: **** _____

* Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*.
** Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards.
*** Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards.
**** Levels I, II, III and Pediatric.

EMSA TABLE 10 - Facilities (cont.)

Kaiser Medical Center-Walnut Creek	1425 South Main Street Walnut Creek, CA 94596 925-295-4000			Primary Contact: Administration
Written Contract: ____ Yes __x__ No	Referral emergency service ____ Standby emergency service ____ Basic emergency service __x__ Comprehensive emergency service ____		Base Hospital: ____ Yes __x__ No	Pediatric Critical Care Center: * ____ Yes __x__ No
EDAP: ** ____ Yes __x__ No	PICU: *** ____ Yes __x__ No	Burn Center: ____ Yes __x__ No	Trauma Center: ____ Yes __x__ No	If Trauma Center what Level: **** _____

Mt. Diablo Medical Center	2540 East Street Concord, CA 94524 925-682-8200			Primary Contact: Administration
Written Contract: ____ Yes __x__ No	Referral emergency service ____ Standby emergency service ____ Basic emergency service __x__ Comprehensive emergency service ____		Base Hospital: ____ Yes __x__ No	Pediatric Critical Care Center: * ____ Yes __x__ No
EDAP: ** ____ Yes __x__ No	PICU: *** ____ Yes __x__ No	Burn Center: ____ Yes __x__ No	Trauma Center: ____ Yes __x__ No	If Trauma Center what Level: **** _____

* Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*.
** Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards.
*** Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards.
**** Levels I, II, III and Pediatric.

EMSA TABLE 10 - Facilities (cont.)

San Ramon Regional Medical Center	6001 Norris Canyon Road San Ramon, CA 94583 925-275-9200			Primary Contact: Administration
Written Contract: ____ Yes __x__ No	Referral emergency service ____ Standby emergency service ____ Basic emergency service __x__ Comprehensive emergency service ____		Base Hospital: ____ Yes __x__ No	Pediatric Critical Care Center: * ____ Yes __x__ No
EDAP: ** ____ Yes __x__ No	PICU: *** ____ Yes __x__ No	Burn Center: ____ Yes __x__ No	Trauma Center: ____ Yes __x__ No	If Trauma Center what Level: **** _____

Sutter Delta Medical Center	3901 Lone Tree Way Antioch, CA 94509 925-779-7200			Primary Contact: Administration
Written Contract: ____ Yes __x__ No	Referral emergency service ____ Standby emergency service ____ Basic emergency service __x__ Comprehensive emergency service ____		Base Hospital: ____ Yes __x__ No	Pediatric Critical Care Center: * ____ Yes __x__ No
EDAP: ** ____ Yes __x__ No	PICU: *** ____ Yes __x__ No	Burn Center: ____ Yes __x__ No	Trauma Center: ____ Yes __x__ No	If Trauma Center what Level: **** _____

* Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*.
** Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards.
*** Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards.
**** Levels I, II, III and Pediatric.

EMSA TABLE 11 - DISPATCH AGENCIES

Contra Costa Fire Dispatch	2010 Geary Road Pleasant Hill, CA 94523	Brent Finster 925-941-3550

Written Contract: ____ Yes _x_ No	Service: _x_ Ground _x_ Air ____ Water	_x_ Day-to-Day _x_ Disaster	Number of Personnel providing services:	_15_ EMD Trained ____ EMT-D ____ BLS ____ LALS ____ ALS
Ownership: _x_ Public ____ Private	Medical Director: _x_ Yes ____ No	If public: Explain:	_x_ Fire ____ Law ____ Other	____ City ____ County ____ State _x_ Fire District ____ Federal

Richmond Police/Fire Dispatch	401 27th Street Richmond, CA 94804	Lt. Mark Gagan 510-233-1214

Written Contract: ____ Yes _x_ No	Service: _x_ Ground _x_ Air ____ Water	_x_ Day-to-Day ____ Disaster	Number of Personnel providing services:	_28_ EMD Trained ____ EMT-D ____ BLS ____ LALS ____ ALS
Ownership: _x_ Public ____ Private	Medical Director: _x_ Yes ____ No	If public: Explain:_	____ Fire _x_ Law ____ Other	_x_ City ____ County ____ State ____ Fire District ____ Federal

San Ramon Valley Fire Dispatch	1500 Bollinger Canyon Road San Ramon, CA 94583	Chief Chris Suter 925-838-6600

Written Contract: ____ Yes _x_ No	Service: _x_ Ground _x_ Air ____ Water	_x_ Day-to-Day ____ Disaster	Number of Personnel providing services:	_9_ EMD Trained ____ EMT-D ____ BLS ____ LALS ____ ALS
Ownership: _x_ Public ____ Private	Medical Director: _x_ Yes ____ No	If public: Explain:	_x_ Fire ____ Law ____ Other	____ City ____ County ____ State _x_ Fire District ____ Federal

SECTION III: PROGRESS FROM PREVIOUS YEAR

EMSA TABLE 1: SUMMARY OF SYSTEM STATUS

A. System Organization And Management

	Doesn't meet standard	Meets minimum standard	Meets guidelines recommended	Short-range Plan	Long-range Plan
Agency Administration					
1.01 LEMSA Structure		X	n/a	X	
1.02 LEMSA Mission		X	n/a		
1.03 Public Input		X	n/a		
1.04 Medical Director		X	X		
Planning Activities					
1.05 System Plan		X	n/a		
1.06 Annual Plan Update		X	n/a		
1.07 Trauma Planning		X	X		
1.08 ALS Planning		X	n/a		
1.09 Inventory of Resources		X	n/a		
1.10 Special Populations		X	X		
1.11 System Participants		X	X		
Regulatory Activities					
1.12 Review & Monitoring		X	n/a		
1.13 Coordination		X	n/a		
1.14 Policy/Procedures Manual		X	n/a		
1.15 Compliance w/Policies		X	n/a		X
System Finances					
1.16 Funding Mechanism		X	n/a		
Medical Direction					
1.17 Medical Direction		X	n/a		
1.18 QA/QI		X	Being addressed.	X	
1.19 Policies, Procedures, Protocols		X	X		
1.20 DNR		X	X		
1.21 Determination of Death		X	X		
1.22 Reporting of Abuse		X	X	X	
1.23 Interfacility Transfer		X	X		
Enhanced Level: Advanced Life Support					
1.24 ALS System		X	X		
1.25 On-Line Medical Direction		X	X		
Enhanced Level: Trauma Care System					
1.26 Trauma System Plan		X	n/a		
Enhanced Level: Pediatric Emergency Medical and Critical Care System					
1.27 Pediatric System Plan		X	n/a	X	
Enhanced Level: Exclusive Operating Areas					
1.28 EOA Plan		X	n/a		

B. Staffing/Training

	Doesn't meet standard	Meets minimum standard	Meets guidelines recommended	Short-range Plan	Long-range Plan
Local EMS Agency					
2.01 Assessment of Needs		X	n/a		
2.02 Approval of Training		X	n/a		
2.03 Personnel		X	n/a		
Dispatchers					
2.04 Dispatch Training		X	n/a		
First Responder (non-transporting)					
2.05 First Responder Training		X	X	X	
2.06 Response		X	n/a	X	
2.07 Medical Control		X	n/a		
Transporting Personnel					
2.08 EMT-1 Training		X	X		
Hospital					
2.09 CPR Training		X	n/a		
2.10 Advanced Life Support		X	Not planned.		
Enhanced Level: Advanced Life Support					
2.11 Accreditation Process		X	n/a		
2.12 Early Defibrillation		X	n/a		
2.13 Base Hospital Personnel		X	n/a		

C. Communications

	Doesn't meet standard	Meets minimum standard	Meets guidelines recommended	Short-range Plan	Long-range Plan
Communications Equipment					
3.01 Communications Plan		X	X		
3.02 Radios		X	X		
3.03 Interfacility Transfer		X	n/a		
3.04 Dispatch Center		X	n/a		
3.05 Hospitals		X	X	X	
3.06 MCI/Disasters		X	n/a		
Public Access					
3.07 9-1-1 Planning/Coordination		X	X		
3.08 9-1-1 Public Education		X	n/a		
Resource Management					
3.09 Dispatch Triage		X	X		
3.10 Integrated Dispatch		X	X		

D. Response/Transportation

	Doesn't meet standard	Meets minimum standard	Meets guidelines recommended	Short-range Plan	Long-range Plan
Universal Level					
4.01 Service Area Boundaries		X	X		Update planned.
4.02 Monitoring		X	X		
4.03 Classifying Medical Requests		X	n/a		
4.04 Pre-scheduled Responses		X	n/a		
4.05 Response Time Standards		X	Being addressed.		
4.06 Staffing		X	n/a		
4.07 First Responder Agencies		X	n/a		
4.08 Medical & Rescue Aircraft		X	n/a		
4.09 Air Dispatch Center		X	n/a		
4.10 Aircraft Availability		X	n/a	X	
4.11 Specialty Vehicles		X	n/a		
4.12 Disaster Response		X	n/a		
4.13 Intercounty Response		X	X		
4.14 Incident Command System		X	n/a		
4.15 MCI Plans		X	n/a		
Enhanced Level: Advanced Life Support					
4.16 ALS Staffing		X	X		
4.17 ALS Equipment		X	n/a		
Enhanced Level: Ambulance Regulation					
4.18 Compliance		X	n/a		
Enhanced Level: Exclusive Operating Permits					
4.19 Transport Plan		X	n/a		
4.20 "Grand fathering"		X	n/a		
4.21 Compliance		X	n/a		
4.22 Evaluation		X	n/a		

E. Facilities/Critical Care

	Doesn't meet standard	Meets minimum standard	Meets guidelines recommended	Short-range Plan	Long-range Plan
Universal Level					
5.01 Assessment of Capabilities		X	Being addressed.		
5.02 Triage & Transfer Protocols		X	n/a		
5.03 Transfer Guidelines		X	n/a		
5.04 Specialty Care Facilities		X	n/a		
5.05 Mass Casualty Management		X	X		
5.06 Hospital Evacuation		X	n/a		
Enhanced Level: Advanced Life Support					
5.07 Base Hospital Designation		X	n/a		
Enhanced Level: Trauma Care System					
5.08 Trauma System Design		X	n/a		
5.09 Public Input		X	n/a		
Enhanced Level: Pediatric Emergency Medical and Critical Care System					
5.10 Pediatric System Design		X	X		
5.11 Emergency Departments		X	n/a		
5.12 Public Inputs		X	n/a		
Enhanced Level: Other Specialty Care Systems					
5.13 Specialty System Design		X	n/a		
5.14 Public Input		X	n/a		

F. Data Collection/System Evaluation

	Doesn't meet standard	Meets minimum standard	Meets guidelines recommended	Short-range Plan	Long-range Plan
Universal Level					
6.01 QA/QI Program		X	X		
6.02 Prehospital Records		X	n/a		
6.03 Prehospital Care Audits		X	Being addressed.	X	
6.04 Medical Dispatch		X	n/a		
6.05 Data Management System		X	Being addressed.	X	
6.06 System Design Evaluation		X	n/a		
6.07 Provider Participation		X	n/a		
6.08 Reporting		X	n/a		
Enhanced Level: Advanced Life Support					
6.09 ALS Audit		X	Being considered.	X	
Enhanced Level: Trauma Care System					
6.10 Trauma System Evaluation		X	n/a		
6.11 Trauma Center Data		X	X		

G. Public Information And Education

	Doesn't meet standard	Meets minimum standard	Meets guidelines recommended	Short-range Plan	Long-range Plan
Universal Level					
7.01 Public Information Materials		X	n/a		
7.02 Injury Control		X	X	X	
7.03 Disaster Preparedness		X	X		
7.04 First Aid & CPR Training		X	Consider	X	

H. Disaster Medical Response

	Doesn't meet standard	Meets minimum standard	Meets guidelines recommended	Short-range Plan	Long-range Plan
Universal Level					
8.01 Disaster Medical Planning		X	n/a		
8.02 Response Plans		X	X	X	
8.03 HAZMAT Training		X	n/a		
8.04 Incident Command System		X	X		
8.05 Distribution of Casualties		X	No plan.		
8.06 Needs Assessment		X	X		
8.07 Disaster Communication		X	n/a		
8.08 Inventory of Resources		X	No plan.		
8.09 DMAT Teams		X	X		
8.10 Mutual Aid Agreements		X	n/a		
8.11 CCP Designation		X	n/a		
8.12 Establishment of CCP's		X	n/a		
8.13 Disaster Medical Training		X	X		
8.14 Hospital Plans		X	X		
8.15 Inter-hospital Communications		X	n/a	X	
8.16 Prehospital Agency Plans		X	n/a		
Enhanced Level: Advanced Life Support					
8.17 ALS Policies		X	n/a		
Enhanced Level: Specialty Care Systems					
8.18 Specialty Center Roles		X	n/a		
8.19 Waiving exclusivity.		X	n/a		

COMPLETED ASSESSMENT FORMS

Assessment forms have been updated for all standards to simplify and standardize the annual assessment process.

A. System Organization and Management

System Organization and Management
Agency Administration

1.01 LEMSA Structure.

Each local EMS agency shall have a formal organizational structure which includes both agency staff and non-agency resources and which includes appropriate technical and clinical expertise.

CURRENT STATUS: STANDARD MET.

The Contra Costa County Board of Supervisors has designated Contra Costa Health Services as the local EMS Agency. Currently, the EMS Agency has ten staff positions and two contract position including an EMS Director, EMS Medical Director, EMS Program Coordinator, Health Services Emergency Preparedness Manager, two Prehospital Coordinators, Trauma Nurse Coordinator, Training Coordinator, QI Coordinator Administrative Assistant and two clerical staff. Additional staff is being added to work with the expanding first responder paramedic program and data management. Revised 10/05

1.02 LEMSA Mission.

Each local EMS agency shall plan, implement, and evaluate the EMS system. The agency shall use its quality/evaluation process to identify needed system changes.

CURRENT STATUS: STANDARD MET.

The EMS Agency's stated mission is to plan, implement, and evaluate the EMS System. Local data is used to identify necessary system changes, and/or to evaluate the need/effect of recommended changes.

1.03 Public Input.

Each local EMS agency shall actively seek and shall have a mechanism (including the Emergency Medical Care Committee and other sources) to receive appropriate consumer and health care provider input regarding the development of plans, policies, and procedures, as described throughout this document.

CURRENT STATUS: STANDARD MET.

A system of advisory and other EMS related committees including the Emergency Medical Care Committee (EMCC), the EMS Facilities and Critical Care Committee, and the Medical Advisory Committee has developed over the years to provide EMS system related input and recommendations to the Board of Supervisors, the Health Services Department and/or the EMS Agency. Revised 10/05

1.04 Medical Director.

Each local EMS agency shall appoint a medical director who is a licensed physician who has substantial experience in the practice of emergency medicine.

RECOMMENDED GUIDELINES:

Administrative Experience. The local EMS agency medical director should have administrative experience in emergency medical services systems.

Advisory Groups. Each local EMS agency medical director should establish clinical specialty advisory groups composed of physicians with appropriate specialties and non-physician providers, including nurses and prehospital providers.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

The EMS Agency has a full time, well prepared EMS Medical Director who is actively involved in local and statewide EMS related activities. The EMS Medical Director reports directly to the County Health Officer on medical matters, and to the EMS Director on operational issues. Specialty resources, including advisory groups or specialty medical consultants, are in place or are developed to provide input into specialized system issues. Revised 10/05

System Organization and Management
Planning Activities

1.05 System Plan.

Each local EMS agency shall develop an EMS system plan based on community need and utilization of proper resources, and shall submit it to the EMS Authority. The plan shall:

a) Assess how the current system meets guidelines,
b) Identify system needs for patients within each of the clinical target groups, and
c) Provide a methodology and time line for meeting these needs.

CURRENT STATUS: STANDARD MET.

The EMS Plan is the foundation for a process of ongoing planning and implementation for Contra Costa County EMS. Many of the activities directed by this plan focus on target issues and evaluation of the system's performance outcomes.

1.06 Annual Plan Update.

Each local EMS agency shall develop an annual update to its EMS system Plan and shall submit it to the EMS Authority. The update shall identify progress made in plan implementation and changes to the planned system design.

CURRENT STATUS: STANDARD MET.

An approved EMS system plan in the required format has been in place since 11/95. Tables have been updated and have been submitted as required to EMSA.

1.07 Trauma Planning.

The local EMS agency shall plan for trauma care and shall determine optimal system design for trauma care in its jurisdiction.

RECOMMENDED GUIDELINE:

Trauma Center Agreements. The local EMS agency should designate appropriate facilities or execute agreements with trauma facilities in other jurisdictions.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

There is a trauma system and a designated/contract Level II trauma center in Contra Costa County. All essential components of the approved trauma system plan, that was updated to meet new State requirements in 2001, are in place, including criteria for hospital designation, medical control, and data collection. Trauma triage policies have been approved and are periodically reviewed. Integration of all the existing EMS system components into a functional trauma system has been fully completed.

COORDINATION WITH OTHER EMS AGENCIES:

Contra Costa County works closely with neighboring Alameda County with respect to care provided critical trauma patients. Each county recognizes the other's trauma centers, and local critical pediatric trauma is transported/transferred to Children's Hospital Trauma Center in Oakland. There is also an extensive bi-county (Alameda and Contra Costa County) medical review process of trauma patient care. Revised 10/05

1.08 ALS Planning.

Each local EMS agency shall plan for advanced life support services throughout its jurisdiction.

CURRENT STATUS: STANDARD MET.

Advanced life support services are provided countywide. All emergency ambulance services are required to respond ALS resources to emergency medical requests. Innovative rural ALS first response units have been implemented to respond to the identified needs in three rural areas (Byron, Bethel Island and Crockett). Four fire districts and 2 city fire departments, Moraga-Orinda Fire Protection District, San Ramon Valley Fire Protection District, Contra Costa

County Fire Protection District, El Cerrito Fire Department, Rodeo-Hercules Fire District, and Pinole Fire Department, have established ALS first response units.

The EMS Agency has developed and implemented a plan to support fire first response agencies in developing and expanding paramedic first-responder programs throughout the county. This EMS system reconfiguration assures a more rapid paramedic response to emergency medical requests.

As a result of a successful RFP process, the County has entered into a no-subsidy emergency ambulance contract with a private provider, American Medical Response. Subsidy savings are being passed on to fire districts that have elected to provide ALS programs.

COORDINATION WITH OTHER EMS AGENCIES:

Paramedic reciprocity agreements are in place with surrounding counties for situations where paramedics may be dispatched across county lines. Revised 10/05

1.09 Inventory of Resources.

Each local EMS agency shall develop a detailed inventory of EMS resources (e.g., personnel, vehicles, and facilities) within its area and, at least annually, shall update this inventory.

CURRENT STATUS: STANDARD MET.

Inventories exist for personnel, vehicles (air and ground), facilities, and agencies within the jurisdiction of Contra Costa County.

1.10 Special Populations.

Each local EMS agency shall identify population groups served by the EMS system that require specialized service (e.g., elderly, handicapped, children, non-English speakers).

RECOMMENDED GUIDELINES:

Special Services. Each local EMS agency should develop services, as appropriate, for special population groups requiring specialized EMS services as appropriate. (e.g., elderly, handicapped, children, non-English speakers).

CURRENT STATUS: STANDARD MET/RECOMMENDED GUIDELINE BEING ADDRESSED.

Groups served by the EMS system that may require specialized services have been identified. Some targeted specialty population planning has occurred to date particularly in trauma, and in pediatrics.

1.11 System Participants.

Each local EMS agency shall identify the optimal roles and responsibilities of system participants.

RECOMMENDED GUIDELINES:

Formalized EMS System Participation. The local EMS agency should ensure that system participants conform to their assigned EMS system roles and responsibilities, through mechanisms such as written agreements, facility designations, and exclusive operating areas.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

EMS Agency has contracts or letters of understanding with EMS providers that reflect identified roles, responsibilities and performance standards. EMS providers with such agreements include emergency ambulance providers, trauma center, medical dispatch centers, first responder agencies, and emergency helicopter provider, and fire paramedic first responder agencies.

The EMS Medical Director may serve as Medical Director of the fire paramedic program, and EMS staff is involved in program implementation and quality improvement activities. Revised 10/05

1.12 Review & Monitoring.

Each local EMS agency shall provide for review and monitoring of EMS system operations.

CURRENT STATUS: STANDARD MET.

The Board of Supervisors appoints the local Emergency Medical Care Committee. The EMCC provides advice and recommendations on ambulance services and emergency medical care to the County Board of Supervisors, the Health Services Department and the EMS Agency. EMS system operations are monitored and evaluated using data. Written agreements are in place that identify minimum EMS performance standards for system participants. Contra Costa County EMS system's operational performance is evaluated, documented, and reported on a regular basis.

1.13 Coordination.

Each local EMS agency shall coordinate EMS system operations.

CURRENT STATUS: STANDARD MET.

Substantial coordination exists between the EMS Agency and the system providers. System coordination is provided through the Emergency Medical Care Committee and local and multi-county advisory committees. These committees operate with varying missions and meeting schedules based on needs.

1.14 Policy & Procedures Manual.

Each local EMS agency shall develop a policy and procedures manual that includes all EMS agency policies and procedures. The agency shall ensure that the manual is available to all EMS system providers (including public safety agencies, transport services, and hospitals) within the system.

CURRENT STATUS: STANDARD MET.

Comprehensive EMS Agency policies/procedures and prehospital care manuals are available to all EMS system providers on the Contra Costa County EMS website or at the EMS Agency Office. Each EMS Policy is reviewed every three years at a minimum to assure that EMS policies and prehospital care manual are current. Revised 10/05

1.15 Compliance with Policies.

Each local EMS agency shall have a mechanism to review, monitor, and enforce compliance with system policies.

CURRENT STATUS: STANDARD MET.

The EMS Agency has contracts, written agreements or letters of understanding with EMS providers, which include emergency ambulance providers, trauma center, medical dispatch centers, fire paramedic first responder agencies, and emergency helicopter provider agencies. These agreements provide mechanisms to monitor, evaluate and enforce compliance with system policies and regulations with respect to emergency medical services. There is an ambulance ordinance in place that provides limited support to the monitoring and enforcement issues. Revised 10/05

NEED(S):

The current local ambulance ordinance has been in place for a number of years and should be amended or replaced with a new comprehensive ambulance ordinance, as system needs change.

1.16 Funding Mechanism.

Each local EMS agency shall have a funding mechanism that is sufficient to ensure its continued operation and shall maximize use of the Emergency Medical Services Fund.

CURRENT STATUS: STANDARD MET.

EMS Agency and support program funding is derived from several sources: the County Special Benefit Assessment (Measure H), the County general fund, grant funds, certification fees, funds derived from Senate Bill 612, and other fees from EMS system participants. The existing funding sources appear adequate.

1.17 Medical Direction.

Each local EMS agency shall plan for medical direction within the EMS system. The plan shall identify the optimal number and role of base hospitals and alternative base hospitals and the roles, responsibilities, and relationships of prehospital and hospital providers.

CURRENT STATUS: STANDARD MET.

The County has designated a single base hospital to provide medical consultation to prehospital personnel. Roles and responsibilities of the base hospital and base hospital personnel are identified in the County's policies, procedures and protocols manual. ALS Providers, as well as fire first responder agencies participating in the Fire Paramedic First Responder Program and/or a First Responder Defibrillation Program are under the medical direction of the County EMS Medical Director.

1.18 QA/QI.

Each local EMS agency shall establish a quality assurance (QA)/quality improvement (QI) program to ensure adherence to medical direction policies and procedures, including mechanism for compliance review. Provider-based programs approved by the EMS agency and coordinated with other system participants may be included.

RECOMMENDED GUIDELINE:

Provider QA/QI In-house. Prehospital care providers should be encouraged to establish in-house procedures that identify methods of improving the quality of care provided.

CURRENT STATUS: STANDARD MET/RECOMMENDED MET.

A formal system-wide QI plan which integrates/interfaces with prehospital care provider CQI programs is in place. All ALS providers and ALS support providers, have active CQI programs that include data evaluation to the extent possible, case review, and identification of training needs and problem solving. A common data collection set has been established and patient care data from the field is collected electronically, allowing for enhanced CQI processes. An EMS QI committee provides system data review, problem-solving discussion, identification of countywide training needs, and educational case review. A comprehensive, bi-county trauma care review process is also in place. Revised 10/05

NEED(S):

1. Expansion of current QI committee to include representatives from all EMS and dispatch providers.
2. Further development and implementation of electronic capture of patient care data within the fire agencies.
3. Further integration and interface of electronic data to provide expanded capability for EMS system evaluation.

1.19 Policies, Procedures, Protocols.

Each local EMS agency shall develop written policies, procedure, and/or protocols including:

a. Triage,
b. Treatment,
c. Medical dispatch protocols,
d. Transport,
e. On-scene treatment times,
f. Transfer of emergency patients,
g. Standing orders,
h. Base hospital contact,
I. On scene physicians and other medical personnel,
j. Local scope of practice for prehospital personnel.

RECOMMENDED GUIDELINES:

Each local EMS agency should develop (or encourage the development of) pre-arrival/post dispatch instructions.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

Detailed policies, procedures and protocol exist for clinical and operational prehospital situations. County transfer guidelines and a procedure for on-scene physicians and other medical personnel are in place. A Countywide system of emergency medical dispatching that includes pre-arrival instructions is fully implemented. Revised 10/05

1.20 DNR.

Each local EMS agency shall have a policy regarding "Do Not Resuscitate" (DNR) situations, in accordance with the EMS Authority's DNR guidelines.

CURRENT STATUS: STANDARD MET.

An EMS "Do-Not-Resuscitate" policy, developed in accordance with EMSA's DNR guidelines is in place for prehospital personnel. DNA forms are available in English and Spanish.

1.21 Determination of Death.

Each local EMS agency, in conjunction with the County coroner(s) shall develop a policy regarding determination of death, including deaths at the scene of apparent crimes.

CURRENT STATUS: STANDARD MET.

An EMS policy is in place regarding determination of death.

1.22 Reporting of Abuse.

Each local EMS agency, shall ensure that providers have a mechanism for reporting child abuse, elder abuse, and suspected SIDS deaths.

CURRENT STATUS: STANDARD MET.

An EMS Policy is in place for reporting child and elder abuse, and suspected SIDS deaths. The local District Attorney's Office has applied for a grant to provide intensive training in the recognition and reporting of elder abuse and neglect. Revised 10/05

1.23 Interfacility Transfer.

The local EMS medical director shall establish policies and protocols for scope of practice of all prehospital medical personnel during interfacility transfers.

CURRENT STATUS: STANDARD MET.

Policies/procedures have been developed and are in place identifying the scope of practice for prehospital medical personnel during interfacility transfers. A specialized paramedic interfacility transfer program has been developed which includes detailed policies, procedures and QI activities.

1.24 ALS System.

Advanced life support services shall be provided only as an approved part of a local EMS system and all ALS providers shall have written agreements with the local EMS agency.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

Written agreements exist between the EMS Agency and all ALS providers, both transport and first response.

1.25 On-line Medical Direction.

Each EMS system shall have on-line medical direction, provided by a base hospital (or alternative base station) physician or authorized registered nurse.

RECOMMENDED GUIDELINE:

Medical Control Plan. An EMS system should develop a medical control plan that determines:

a) Base hospital configuration for the system;
b) Base hospital selection/designation processes that allow eligible facilities to apply;
c) Process for determining when prehospital providers should appoint an in-house medical director.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

One base hospital has been designated by/for the County, providing on-line medical control by physicians or authorized registered nurses. The base hospital also provides medical control for all trauma cases. There is a base station application and selection process for designation should more than one hospital be interested in being designated as a base hospital.

Prehospital providers that furnish paramedic services are required to have an EMS Medical Director. The EMS Agency Medical Director serves in this capacity for fire agency providers.

Trauma Care System

1.26 Trauma System Plan.

The local EMS agency shall develop a trauma care system plan, which determines:

a) The optimal system design for trauma care in the EMS area, and
b) The process for assigning roles to system participants, including a process that allows all eligible facilities to apply.

CURRENT STATUS: STANDARD MET.

A trauma care system plan was developed and successfully implemented in 1985. One trauma center is optimal for the County, and, following a competitive process, John Muir Medical Center was been designated as the local level II trauma center. The trauma system plan was updated in 2001 to meet new State planning guidelines. Revised 10/05

Pediatric Emergency Medical and Critical Care System

1.27 Pediatric System Plan.

The local EMS agency shall develop a pediatric emergency medical and critical care system plan that determines:

a) Optimal system design for pediatric emergency medical and critical care in EMS area, and
b) Process for assigning roles to system participants, including a process that allows all eligible facilities to apply.

CURRENT STATUS: STANDARD MET.

A comprehensive pediatric emergency medical and critical care system plan is in place that includes triage protocols, criteria for designation of pediatric facilities, and the drafting and execution of agreements between the EMS Agency and the designated receiving and specialty care facilities. Most seriously injured children are transported or interfacility transferred to Children's Hospital Oakland. Pediatric treatment, advanced airway and other prehospital procedures for children have been implemented in the County.

NEED(S):

A review, and if necessary an update, to the Pediatric System Plan.

Exclusive Operating Area

1.28 EOA Plan.

The local EMS agency shall develop, and submit for state approval, a plan based on community needs and utilization of available resources for granting of exclusive operating areas which determines:

a) The optimal system design for ambulance service and advanced life support services in the EMS area, and

b) The process for assigning roles to system participants, including a competitive process for implementation of exclusive operating areas.

CURRENT STATUS: STANDARD MET.

All residents and visitors of Contra Costa County have access to ALS services. The Moraga Fire District is "grandfathered" as an exclusive operating area (EOA) under 1797.201 of the H&S code. Following a highly competitive process for emergency ambulance services in the three EOA's (approximately 90% of the county), which were covered by American Medical Response, the County Board of Supervisors approved a new five year performance based emergency ambulance agreement with American Medical Response. Revised 10/05

B. Staffing/Training

Staffing and Training
Local EMS Agency

2.01 Assessment of Needs.

The local EMS Agency shall routinely assess personnel and training needs.

CURRENT STATUS: STANDARD MET.

The EMS Agency sets standards for training and requires EMS provider agencies to assure that their personnel meet these standards. The local Quality Improvement process is designed to identify areas where training is indicated. EMS routinely assesses training needs when new skills or programs are added to the EMS system.

NEEDS.

With a local EMS system redesign, there are increasing numbers of paramedics in the fire services. Under American Medical Response's (AMR's) new contract with the county, AMR has made training resources available to fire service employees. The fire services have formed a new EMS Training Consortium, which includes representatives of each of the fire providers, AMR and the EMS Agency, to coordinate and standardize available and new training to meet county requirements and to enhance patient care provided in both the public and private sectors. Revised 10/05

2.02 Approval of Training.

The EMS Authority and/or local EMS agencies shall have a mechanism to approve an emergency medical services education programs that require approval (according to regulations) and shall monitor them to ensure that they comply with State regulations.

CURRENT STATUS: STANDARD MET.

Procedures and mechanisms are in place to approve EMS education programs. There is periodic on-site monitoring of teaching activities.

2.03 Personnel.

The local EMS Agency shall have mechanisms to accredit, authorize, and certify prehospital medical personnel and conduct certification reviews in accordance with State regulations. This shall include a process for prehospital providers to identify and notify the local EMS Agency of unusual occurrences that could impact EMS personnel certification.

CURRENT STATUS: STANDARD MET.

Procedures, policies and requirements are in place to credential first responder defibrillator personnel, EMT-I's, EMT-P's, and MICN's. Provisions are included for the Agency to be notified in the event of unusual occurrences that could impact local EMS Agency credentialing. A fingerprint background check process through the California Department of Justice is required of applicants for EMT-I certification.

Dispatchers

2.04 Dispatch Training.

Public safety answering point (PSAP) operators with medical responsibility shall have emergency medical orientation and all medical dispatch personnel (public and private) shall receive emergency medical dispatch training in accordance with the EMS Authority's Emergency Medical Dispatch Guidelines.

RECOMMENDED GUIDELINE:

Training/Certification According to State Standards. Public safety answering point (PSAP) operators with medical dispatch responsibilities and all medical dispatch personnel (both public and private) should be trained and tested in accordance with the EMS Authority's Emergency Medical Dispatch Guidelines.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

Dispatch training standard adopted countywide. Dispatch agency personnel are trained and tested in accordance with EMSA Emergency Medical Dispatch Guidelines.

Staffing and Training

First Responders (non-transporting)

2.05 First Responder Training.

At least one person on each non-transporting EMS first response unit shall have been trained to administer first aid and CPR within the previous three years.

RECOMMENDED GUIDELINE:

Defibrillation. At least one person on each non-transporting EMS first response unit should be currently certified to provide defibrillation and have available equipment commensurate with such scope of practice, when such a program is justified by response times for other ALS providers.

EMT-I. At least one person on each non-transporting EMS first response unit should be currently certified at the EMT-I level and have available equipment commensurate with such scope of practice.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

A first responder master plan which is coordinated by the EMS Agency and which includes policies, procedures and treatment guidelines is in place for the county. First response units are staffed with defibrillation trained, and to a large degree, EMT-I or paramedic personnel. Defibrillation programs for first responders receive ongoing support. Revised 10/05

NEED(S):

Review, and if necessary update, the first responder master plan.

2.06 Response.

Public safety agencies and industrial first aid teams shall be encouraged to respond to medical emergencies and shall be utilized in accordance with local EMS Agency policies.

CURRENT STATUS: STANDARD MET.

All fire services provide first responder services. There are also law enforcement and industrial teams that may respond. A plan for providing increased numbers of paramedics on first-response units is underway.

2.07 Medical Control.

Non-transporting EMS first responders shall operate under medical direction policies, as specified by the local EMS Agency medical director.

CURRENT STATUS: STANDARD MET.

The County EMS Agency policies and procedures manual provides medical protocols for EMS first responders. Monitoring and evaluation of first responder efforts have been incorporated within the County system. Fire first responders complete patient care report forms. Fire agencies provide first responder paramedic services under the medical oversight of the EMS Medical Director.

Transport Personnel

2.08 EMT-I Training.

All emergency medical transport vehicle personnel shall be currently certified at least at the EMT-I level.

RECOMMENDED GUIDELINES:

Defibrillation. If advanced life support personnel are not available, at least one person on each emergency medical transport vehicle should be trained to provide defibrillation.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

All emergency medical transport vehicles are staffed at the EMT-P level. All fire first responder units are staffed and equipped to provide defibrillation. "One and one" staffing (one paramedic and one EMT-I) on ambulances in service areas that are covered by fire first-response paramedics is permitted. Revised 10/05

Staffing and Training
Hospital

2.09 CPR Training.

All allied health personnel who provide direct emergency patient care shall be trained in CPR.

CURRENT STATUS: STANDARD MET.

All first responders, ambulance personnel and hospital personnel who provide direct emergency patient care are trained in CPR.

2.10 Advanced Life Support.

All emergency department physicians and registered nurses that provide direct emergency patient care shall be trained in advanced life support.

RECOMMENDED GUIDELINE:

Board Certification. All emergency department physicians should be certified by the American Board of Emergency Medicine (ABEM).

CURRENT STATUS: STANDARD MET.

All emergency department physicians and registered nurses that provide direct emergency patient care are trained in advanced life support. Most receiving hospitals do require that emergency physician staff be ABEM certified.

Advanced Life Support

2.11 Accreditation Process.

The local EMS Agency shall establish a procedure for accreditation of advanced life support personnel, which includes orientation to system policies and procedures, orientation to the roles, and responsibilities of providers within the local EMS system, testing in any optional scope of practice, and enrollment into the local EMS Agency's quality improvement process.

CURRENT STATUS: STANDARD MET.

Procedures are in place for accrediting advanced life support personnel that include orientation to system policies and procedures, orientation to roles and responsibilities of providers within the local EMS system, and testing for optional scopes of practice. Provider CQI programs must interface with the county process.

2.12 Early Defibrillation.

The local EMS Agency shall establish policies for local accreditation of public safety and other basic life support personnel in early defibrillation.

CURRENT STATUS: STANDARD MET.

Policies and procedures for first responder defibrillation programs are in place.

2.13 Base Hospital Personnel.

All base hospital/alternative base station personnel who provide medical direction to prehospital personnel shall be knowledgeable about local EMS agency policies and procedures and have training in radio communications techniques.

CURRENT STATUS: STANDARD MET.

Base hospital personnel are prepared to provide consultation to prehospital personnel and are familiar with radio communications techniques.

C. Communications

Communications

Communications Equipment

3.01 Communications Plan.

The local EMS agency shall plan for EMS communications. The plan shall specify the medical communications capabilities of emergency medical transport vehicles, non-transporting advanced life support responders, and acute care facilities and shall coordinate the use of frequencies with other users.

RECOMMENDED GUIDELINE:

Use of Technology. The local EMS agency's communications plan should consider the availability and use of satellite and cellular telephones.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

The EMS communications plan includes common radio frequencies for use by ambulances and hospitals, the use of cell phones by paramedics, fire/ambulance radio communications, and CAD linkages among ambulance, fire and Sheriff's Dispatch centers. All elements of this plan are implemented except for final CAD linkages to one fire dispatch center, which is in progress.

All acute care hospitals, fire medical dispatch centers, ambulance dispatch center, Sheriff's Communications and the EMS Agency have installed the ReddiNet communications system that allows for communications among those agencies. Revised 10/05

3.02 Radios.

Emergency medical transport vehicles and non-transporting advanced life support responders shall have two-way radio communications equipment which complies with the local EMS communications plan and which provides for dispatch and ambulance-to-hospital communication.

RECOMMENDED GUIDELINE:

Enhanced Radio Capability. Emergency medical transport vehicles should have two-way radio communications equipment that complies with the local EMS communications plan and which provides for vehicle-to-vehicle (including both ambulances and non-transporting first responder units) communications.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

Medical transport vehicles are required to have radio capability to communicate with dispatch, with fire agencies, and for ambulance to hospital communication.

3.03 Interfacility Transfer.

Emergency medical transport vehicles used for interfacility transfers shall have the ability to access both sending and receiving facilities. This could be accomplished by cellular telephone.

CURRENT STATUS: STANDARD MET.

Permitted ambulances providing emergency interfacility transfer services have communications capability with sending and receiving facilities through the MEDARS system (T-Band) frequencies and/or by cellular telephone.

3.04 Dispatch Center.

All emergency medical transport vehicles where physically possible (based on geography and technology), shall have the capability of communicating with a single dispatch center or disaster communications command post.

CURRENT STATUS: STANDARD MET.

All ambulances are capable of communicating on the MEDARS radio system.

3.05 Hospitals.

All hospitals within the EMS system shall (where physically possible) be able to communicate with each other by two-way radio.

Communications

RECOMMENDED GUIDELINE:

Access to Services. All hospitals should have direct communications access to relevant services in other hospitals within the system (e.g., poison information, pediatric and trauma consultation).

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

All hospitals, Sheriff's Communications, ambulance dispatch agencies and EMS Agency are part of the ReddiNet computerized communications system. Hospitals use this system on a daily basis to report midnight patient census and to communicate ambulance diversion status. Although the MEDARS system is designed to permit radio communications between hospitals, ambulances and the County, design requires that hospitals communicate via the County Sheriff's Communications Center. An upgrade to the ReddiNet system will be implemented within the next few months that will require training of all users. Revised 10/05

3.06 MCI/Disasters.

The local EMS agency shall review communication linkages among providers (prehospital and hospital) in its jurisdiction for their capability to provide service in the event of multi-casualty incidents and disasters.

CURRENT STATUS: STANDARD MET.

Emergency communications procedures are in place to provide system coordination during a multi-casualty or disaster event. The disaster plan, including the communication component, has been integrated with other agencies within the County. The ReddiNet computer system allows for hospital polling and patient tracking, as well as intra-agency communications.

Public Access

3.07 9-1-1 Planning/Coordination.

The local EMS agency shall participate in on-going planning and coordination of the 9-1-1 telephone service.

RECOMMENDED GUIDELINE:

9-1-1 Promotion. The local EMS agency should promote the development of enhanced 9-1-1- systems.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

Enhanced 9-1-1 has been implemented in Contra Costa County, and is functional throughout the County.

3.08 9-1-1 Public Education.

The local EMS agency shall be involved in public education regarding the 9-1-1-telephone service, as it impacts system access.

CURRENT STATUS: STANDARD MET.

The EMS Agency, along with the EMCC has developed and distributes a 9-1-1-access brochure to assist with the educational process.

Resource Management

3.09 Dispatch Triage.

The local EMS agency shall establish guidelines for proper dispatch triage, identifying appropriate medical response.

RECOMMENDED GUIDELINE:

Priority Reference System. The local EMS agency should establish an emergency medical dispatch priority reference system, including systemized caller interrogation, dispatch triage policies, and pre-arrival instructions.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

A comprehensive Emergency Medical Dispatch program has been implemented Countywide, and is evaluated on an ongoing basis.

3.10 Integrated Dispatch.

The local EMS system shall have functionally integrated dispatch with system-wide emergency services coordination, using standardized communications frequencies.

RECOMMENDED GUIDELINE:

System Status Management. The local EMS agency should develop a mechanism to ensure appropriate system-wide ambulance coverage during periods of peak demand.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

Currently the County Sheriff operates in a radio communication and resource coordination role for emergency ambulances. Fire/ambulance/Sheriff's Dispatch CAD linkages assure coordinated response and enables Sheriff's Dispatch to maintain ambulance unit status.

D. Response and Transportation

Response and Transportation
Universal Level

4.01 Service Area Boundaries.

The local EMS agency shall determine the boundaries of emergency medical transportation service areas.

RECOMMENDED GUIDELINES:

Formalized EOA's. The local EMS agency should secure a county ordinance or similar mechanism for establishing emergency medical exclusive operating areas (e.g., ambulance response zones).

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

The Board of Supervisors has defined exclusive operating areas for EMS ground ambulance providers. These zones remain intact but have been informally restructured for purposes of data reporting.

COORDINATION WITH OTHER EMS AGENCIES.

No impact on other EMS Agencies.

4.02 Monitoring.

The local EMS agency shall monitor emergency medical transportation services to ensure compliance with appropriate statutes, regulations, policies, and procedures.

RECOMMENDED GUIDELINE:

Licensing Mechanism. The EMS agency should secure a county ordinance or similar mechanism for licensure of emergency medical transport services. These should be intended to promote compliance with overall system management and, wherever possible, replace any other local ambulance regulatory programs within the EMS area.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

A County ambulance ordinance and County contracts with emergency ground ambulance providers provide mechanisms for local EMS Agency to permit and monitor medical transportation services. Contracts with emergency ambulance providers include requirements for rigorous evaluation of services provided.

4.03 Classifying Medical Requests.

The local EMS agency shall determine criteria for classifying medical requests (e.g., emergent, urgent, and non-emergent) and shall determine appropriate level of medical response to each.

CURRENT STATUS: STANDARD MET.

Criteria for determining the appropriate level of emergency medical response have been established. Fire/medical dispatchers are trained as emergency medical dispatchers in the Medical Priority system.

4.04 Pre-scheduled responses.

Service by emergency medical transport vehicles, which can be pre-scheduled without negative medical impact, shall be provided only at levels that permit compliance with EMS agency policy.

CURRENT STATUS: STANDARD MET.

Existing ALS provider system status plans do not allow for utilization of emergency resources for pre-scheduled non-emergency use. Policies and procedures are in place that provide a mechanism for interested paramedic provider agencies to establish Paramedic Interfacility Transfer programs. Paramedics staffing these units are required to have additional medical training.

4.05 Response Time Standards.

Each local EMS agency shall develop response time standards for medical responses. These standards shall take into account the total time from receipt of the call at the primary public safety answering point (PSAP) to arrival of the responding unit at the scene, including all dispatch intervals and driving time.

RECOMMENDED GUIDELINE:

Minimum Response Time Standards. Emergency medical service areas designated so that, for 90% of emergent responses, the response time for each of the following does not exceed:

a) BLS/CPR provider	Metro/urban--5 minutes Suburban/rural--15 minutes Wilderness--as quickly as possible
b) First responder defibrillation provider	Metro/urban--5 minutes Suburban/rural-- as quickly as possible Wilderness--as quickly as possible
c) ALS provider (not functioning as first responder)	Metro/urban--8 minutes Suburban/rural--20 minutes Wilderness--as quickly as possible
d) BLS/ALS transport (not functioning as first responder)	Metro/urban--8 minutes suburban/rural--20 minutes Wilderness--as quickly as possible

CURRENT STATUS: STANDARD MET/RECOMMENDED GUIDELINES BEING ADDRESSED.

Emergency ambulance provider contracts and enhanced first responder agreements established by the EMS Agency specify response time standards. Response times are measured from receipt of call at secondary PSAP to arrival on scene. Standards are met for all transport and enhanced first responder providers.

COORDINATION WITH OTHER EMS AGENCIES.

No impact on other EMS Agencies.

4.06 Staffing.

All emergency medical transport vehicles shall be staffed and equipped according to current State and local EMS Agency regulations.

CURRENT STATUS: STANDARD MET.

Adequate regulations, policies and procedures exist to assure that ambulances are staffed and equipped according to current State and local standards.

4.07 First Responder Agencies.

The local EMS agency shall integrate qualified EMS first responder agencies (including public safety agencies and industrial first aid teams) into the system.

CURRENT STATUS: STANDARD MET.

A first responder master plan is in place that includes standards for enhanced first responder programs. Several fire agencies have elected to provide paramedic first responder services and have entered into written agreements with the EMS Agency. Such agreements include standards for quality improvement processes and data collection. The EMS Agency provides some funding to offset the cost of providing paramedic fire first responder services. Revised 10/05

4.08 Medical & Rescue Aircraft.

The local EMS agency shall have a process for categorizing medical/rescue aircraft and shall develop policies/procedures for:

a) Authorizing aircraft to be utilized in prehospital care.
b) Requesting of EMS aircraft.
c) Dispatching of EMS aircraft.
d) Determining EMS aircraft patient destination.

e) Orientation of pilots/flight crews to local EMS system.
f) Addressing and resolving formal complaints regarding EMS aircraft.

CURRENT STATUS: STANDARD MET.

Helicopter guidelines provide a mechanism for emergency helicopter access. Policies and procedures are in place for helicopter classification, authorization, request for, transport criteria and field operations.

COORDINATION WITH OTHER EMS AGENCIES.

No formal coordination with other local EMS agencies.

4.09 Air Dispatch Center.

The local EMS agency shall designate a dispatch center to coordinate the use of air ambulances or rescue aircraft.

CURRENT STATUS: STANDARD MET.

Air medical and air rescue requests are made by the appropriate fire/medical dispatch agency.

4.10 Aircraft Availability.

The local EMS agency shall identify the availability of medical and rescue aircraft for emergency patient transportation and shall maintain written agreements with aeromedical services operating within the EMS system.

CURRENT STATUS: STANDARD MET.

Two air ambulance helicopter services provide emergency helicopter coverage on a daily rotation. Medical helicopters are requested through fire/medical dispatch centers. Procedures to classify and to authorize air medical programs to respond within the County have been developed and implemented. Written agreements are in draft.

COORDINATION WITH OTHER EMS AGENCIES.

No formal coordination with other EMS agencies.

NEED(S):

Enhanced written agreements with agencies providing air medical services.

4.11 Specialty Vehicles.

Where applicable, the local EMS agency shall identify the availability and staffing of all terrain vehicles, snow mobiles, and water rescue and other transportation vehicles.

RECOMMENDED GUIDELINES:

Planning for Response. EMS agency should plan for response by and use of all terrain vehicles, snowmobiles, and water rescue vehicles in areas where applicable, which considers existing EMS resources, population density, environmental factors, dispatch procedures and catchment area.

CURRENT STATUS: STANDARD MET.

Fire and police agencies within the County have rescue capabilities relevant to local areas.

COORDINATION WITH OTHER EMS AGENCIES.

Not applicable.

4.12 Disaster Response.

The local EMS agency, in cooperation with the local office of emergency services (OES) shall plan for mobilizing response and transport vehicles for disaster.

CURRENT STATUS: STANDARD MET.

A comprehensive medical disaster plan following SEMS is in place for the County.

Response and Transportation

4.13 Inter-County Response.

The local EMS agency shall develop agreements permitting inter-county response of emergency medical transport vehicles and EMS personnel.

RECOMMENDED GUIDELINE:

Formal Agreements. Mutual aid agreements and automatic aid agreements that identify the optimal configuration and responsibility for EMS responses are encouraged and coordinated by the county.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

Mutual aid responsibilities met through the California Master Mutual Aid Agreement.

COORDINATION WITH OTHER EMS AGENCIES.

Coordinated through State and Region II medical disaster plans.

4.14 Incident Command System.

The local EMS agency shall develop multi-casualty response plans and procedures that include provisions for on-scene medical management, using the Incident Command System.

CURRENT STATUS: STANDARD MET.

A comprehensive multi-casualty response plan is in place for EMS incidents within the County. The incident command system is utilized for multi-casualty incidents. Hospitals have adopted and trained in the Hospital Emergency Incident Command System.

NEEDS.

The current multi-casualty response plan has been in place for several years, and should be reviewed with revision where necessary. A multidisciplinary multicasualty plan review committee has been designated and is currently reviewing the plan.

4.15 MCI Plans.

Multi-casualty response plans and procedures shall utilize State standards and guidelines.

CURRENT STATUS: STANDARD MET.

Existing State and federal guidelines are used as a basis for the county's multi-casualty plans.

Advanced Life Support

4.16 ALS Staffing.

All ALS ambulances shall be staffed with at least one person certified at the advanced life support level and one person staffed at the EMT-I level.

RECOMMENDED GUIDELINES:

Crew Composition. The local EMS agency should determine whether advanced life support units should be staffed with two ALS crewmembers or with one ALS and one BLS crewmembers.

Defibrillation Capability. On any emergency ALS unit that is not staffed with two ALS crewmembers, the second crewmember should be trained to provide defibrillation, using available defibrillators.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

Ambulances and first responder units are optimally staffed to provide a minimum of two paramedics on scene to provide care for critically ill and injured patients. First responder units are staffed with a paramedic or at least one crewmember trained and equipped to provide defibrillation. Revised 10/05

Response and Transportation

4.17 ALS Equipment.

All emergency ALS ambulances shall be appropriately equipped for the scope of practice of level of staffing.

CURRENT STATUS: STANDARD MET.

Adequate regulations, policies and procedures exist to assure that ALS ambulances are appropriately equipped for the scope of practice of its level of staffing.

Ambulance Regulation

4.18 Compliance.

The local EMS agency shall have a mechanism (e.g., an ordinance and/or written provider agreements) to ensure that EMS transportation agencies comply with applicable policies and procedures regarding system operations and clinical care.

CURRENT STATUS: STANDARD MET.

The county has an ambulance permit process in place which pertains to ground ambulances. The county has written agreements with EMS ground providers that define and require compliance with EMS policies and procedures. The EMS agency has policies and procedures in place for classification and authorization of EMS Aircraft. Written agreements are in draft.

Exclusive Operating Permits

4.19 Transportation Plan.

Any local EMS agency, which desires to implement exclusive operating areas, pursuant to Section 1797.224, H&SC, shall develop an EMS transportation plan which addresses:

a) Minimum standards for transportation services,
b) Optimal transportation system efficiency and effectiveness, and
c) Use of a competitive process to ensure system optimization.

CURRENT STATUS: STANDARD MET.

Contra Costa County Board of Supervisors has approved an EMS ground transportation plan.

4.20 "Grandfathering".

Any local EMS agency which desires to grant an exclusive operating permit without use of a competitive process shall document in its EMS transportation plan that its existing provider meets all of the requirements for "grand fathering" under Section 1797.224, H&SC.

CURRENT STATUS: STANDARD MET.

Exclusive operating areas that have been granted comply with the H&S Code.

4.21 Compliance.

The local EMS agency shall have a mechanism to ensure that EMS transportation and/or advanced life support agencies to whom exclusive operating permits have been granted, pursuant to Section 1797.224, H&SC, comply with applicable policies and procedures regarding system operations and patient care.

CURRENT STATUS: STANDARD MET.

County ordinance, contracts and EMS Agency policies and procedures require compliance of ambulance providers.

4.22 Evaluation.

The local EMS agency shall periodically evaluate the design of exclusive operating areas.

CURRENT STATUS:

Exclusive operating areas are periodically reviewed.

E. Facilities and Critical Care

Facilities and Critical Care

5.01 Assessment of Capabilities.

The local EMS agency shall assess and periodically reassess the EMS-related capabilities of acute care facilities in its service area.

RECOMMENDED GUIDELINE:

Written Agreements. The local EMS agency should have written agreements with acute care facilities in its services area.

CURRENT STATUS: STANDARD MET/RECOMMENDED GUIDELINE BEING CONSIDERED.

The EMS Agency, in conjunction with the Facilities & Critical Care standing committee, has developed and conducts an assessment of receiving hospital capabilities annually.

5.02 Triage & Transfer Protocols.

The local EMS agency shall establish prehospital triage protocols and shall assist hospitals with the establishment of transfer protocols and agreements.

CURRENT STATUS: STANDARD MET.

The local EMS Agency has prehospital triage and transfer protocols.

COORDINATION WITH OTHER EMS AGENCIES.

There is coordination with Alameda County on trauma triage.

5.03 Transfer Guidelines.

The local EMS agency, with the participation of acute care hospital administrators, physicians and nurses, shall establish guidelines to identify patients who should be considered for transfer to facilities of right capability and shall work with acute care hospitals to establish transfer agreements with such facilities.

CURRENT STATUS: STANDARD MET.

The EMS Agency has developed criteria to help identify patients who should be considered for transport or transfer to facilities with specialized or limited capabilities and has assisted in developing transfer agreements among these facilities.

COORDINATION WITH OTHER EMS AGENCIES.

There is no formal coordination with other EMS Agencies.

5.04 Specialty Care Facilities.

The local EMS agency shall designate and monitor receiving hospitals and, when appropriate, specialty care facilities for specified groups of emergency patients.

CURRENT STATUS: STANDARD MET.

The EMS Agency designates and monitors ambulance-receiving facilities, including a specialty care facility for trauma patients. Children are transported to receiving hospitals staffed and equipped to care for pediatric patients.

COORDINATION WITH OTHER EMS AGENCIES.

The local trauma system/center evaluation process is performed in conjunction with neighboring Alameda County's trauma review process.

5.05 Mass Casualty Management.

The local EMS agency shall encourage hospitals to prepare for mass casualty management.

RECOMMENDED GUIDELINE:

Preparation. The local EMS agency should assist hospitals with preparation for mass casualty management, including procedures for coordination of hospital communication and patient flow.

Facilities and Critical Care

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

Contra Costa Health Services has a comprehensive plan in place for managing medical/health emergencies. The EMS Agency administers federal and state grants that provide funding specific for hospital and trauma center preparations for caring for large numbers of patients. The EMS Agency facilitates the Hospital Disaster Forum that provides an opportunity for hospital disaster planners, city disaster medical planners and the EMS Agency to share ideas and information. Individual hospitals have their own disaster and mass-casualty incident plans and have adopted the Hospital Emergency Incident Command System.

5.06 Hospital Evacuation.

The local EMS agency shall have a plan for hospital evacuation, including its impact on other EMS system providers.

CURRENT STATUS: STANDARD MET.

The Bay Area Medical Mutual Aid (BAMMA) Committee developed hospital evacuation guidelines and each hospital has an evacuation plan as required by law. Additionally, the County Multicasualty Incident Plan can be implemented to handle transport and distribution of patients from a hospital being evacuated.

COORDINATION WITH OTHER EMS AGENCIES.

Evacuation guidelines were developed in coordination with the other Bay area counties.

5.07 Base Hospital Designation.

The local EMS agency shall, using a process which allows all eligible facilities to apply, designate base hospitals or alternative base stations as it determines necessary to provide medical direction of prehospital personnel.

CURRENT STATUS: STANDARD MET.

One hospital has been designated as a base hospital in Contra Costa County (John Muir Medical Center). John Muir Medical Center has also been designated to receive all of the trauma system base contacts. All hospitals may apply to provide base hospital services.

COORDINATION WITH OTHER EMS AGENCIES.

Not applicable.

Trauma Care System

5.08 Trauma System Design.

Local EMS agencies that develop trauma care systems shall determine the optimal system, including:

a) Number and level of trauma centers,
b) Design of catchment areas (including areas in other counties, as appropriate), with consideration of workload and patient mix,
c) Identification of patients who should be triaged or transferred to a designated center, including consideration of patients who should be triaged to other critical care centers,
d) Role of non-trauma center hospitals, including those that are outside of the primary triage area of trauma center,
e) Plan for monitoring and evaluation of the system.

CURRENT STATUS: STANDARD MET.

A comprehensive trauma system plan, which addresses the points identified in the standard has been developed and adopted throughout the county. The County has designated one Level II trauma center.

5.09 Public Input.

In planning its trauma care system the local EMS agency shall ensure input from both providers and consumers.

CURRENT STATUS: STANDARD MET.

The local trauma system planning process included broad multidisciplinary input including from consumers through several health services forums for the public and the EMCC.

Facilities and Critical Care

Pediatric Emergency and Critical Care Systems

5.10 Pediatric System Design.

Local EMS agencies that develop pediatric emergency medical and critical care systems shall determine the optimal system, including:

a) Number/role of system participants, particularly ED's,
b) Catchment area design with regard to workload/patient mix,
c) Identification of patients to be primarily triaged or secondarily transferred to designated centers,
d) Role of providers qualified to transport such patients to designated facilities,
e) Identification of tertiary care centers for pediatric critical care and pediatric trauma,
f) Role of non-pediatric, critical care hospitals including those outside the primary triage area,
g) Plan for monitoring and evaluation of the system.

CURRENT STATUS: STANDARD MET.

A comprehensive pediatric system plan that addresses considerations listed in the standard for optimal system design is in place.

COORDINATION WITH OTHER EMS AGENCIES.

Local hospitals transfer most seriously ill pediatric patients to Children's Hospital, Oakland, in neighboring Alameda County. Children's Hospital has been designated as a Pediatric Critical Care Center.

5.11 Emergency Departments.

Local EMS agencies shall identify minimum standards for pediatric capability of an emergency department, including:

a) Staffing,
b) Training,
c) Equipment,
d) Identification of patients for whom consultation with a pediatric critical care center is appropriate,
e) Quality assurance, and
f) Data reporting to the local EMS agency.

RECOMMENDED GUIDELINE:

Identification Procedure. A County EMS procedure for identifying emergency departments that meet standards for pediatric care, for pediatric critical care centers and pediatric trauma centers.

CURRENT STATUS: STANDARD MET.

The County's EMS for Children plan includes standards for hospitals. Revised 10/05

5.12 Public Input.

In planning its pediatric emergency medical and critical care system, the local EMS agency shall ensure input from the prehospital, hospital providers and consumers.

CURRENT STATUS: STANDARD MET.

Public input, including input from prehospital, hospital providers and consumers was obtained through the EMCC, EMS Medical Advisory Committee, Facilities and Critical Care Standing Committee, and others, in developing and implementing a countywide EMS for Children program.

Other Specialty Care Systems

5.13 Specialty System Design.

Local EMS agencies developing specialty care plans for EMS-targeted clinical conditions shall determine the optimal system, for the specific condition involved including:

a) The number and role of system participants,
b) The design of catchment areas (including inter-county transport, as appropriate), with consideration of workload and patient mix,
c) Identification of patients who should be triaged or transferred to a designated center,
d) The role of non-designated hospitals, including those which are outside of the primary triage area,
e) A plan for monitoring and evaluating the system.

CURRENT STATUS: STANDARD MET.

The local EMS Agency has and will continue to consider the points listed in Standard 5.13 in developing specialty care plans.

5.14 Public Input.

In planning other specialty care systems the local EMS agency shall ensure input from both providers and consumers.

CURRENT STATUS: STANDARD MET.

The EMS Agency has and will ensure input from both providers and consumers when planning and developing specialty care systems.

F. Data Collection and System Evaluation

Data Collection and System Evaluation

6.01 QI Program.

The local EMS agency shall establish an EMS quality improvement/assurance program to evaluate response to emergency medical incidents and care provided specific patients. Programs shall address the total EMS system, including all prehospital provider agencies, base and receiving hospitals. It shall address compliance with policies, procedures, and protocols and identification of preventable morbidity and mortality and shall utilize State standards/guidelines. Program shall use provider-based QI/QA programs and shall coordinate them with other providers.

RECOMMENDED GUIDELINE:

Resources to Evaluate. The local EMS agency should have the resources to evaluate response to and the care provided to specific patients.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

The EMS system has a quality improvement program in place that includes and addresses components identified in the minimum standard. Resources are available for the EMS Agency to evaluate response to and the care provided to individual patients. An updated management information system has been implemented by the major ambulance transport provider within the county, and may be accessed by EMS staff. This upgrade provides a significant enhancement to the local QI program. Fire Agencies providing paramedic service are looking at electronic patient care reporting systems similar to that used by the ambulance service provider. Revised 10/05

6.02 Prehospital Records.

Prehospital records for all patient responses shall be completed and forwarded to appropriate agencies as defined by the local EMS agency.

CURRENT STATUS: STANDARD MET.

The EMS Agency has established prehospital care report (PCR) data to be collected by all contract emergency ambulance providers and paramedic first responders. A standard PCR for BLS first responder is in place. Copies of completed ambulance PCR's are submitted routinely to receiving hospitals and base hospital. EMS Agency staff has access to the major ambulance provider's ePCR database, and may print individual PCR's or evaluate aggregate data.

6.03 Prehospital Care Audits.

Audits of prehospital care, including both clinical and service delivery aspects, shall be conducted.

RECOMMENDED GUIDELINES:

Linking Mechanism. The local EMS agency should have a mechanism that links prehospital records with dispatch, emergency department, inpatient and discharge records.

CURRENT STATUS: STANDARD MET/RECOMMENDED GUIDELINE BEING ADDRESSED.

Provider agencies, base hospitals and the EMS Agency perform audits of prehospital care. New access to the large database of patient care information generated through the ambulance providers' ePCR programs is available and is being used. Prehospital records for approximately 90% of the county are electronically linked with dispatch. Dispatch, PCR, emergency department, inpatient, and discharge records are manually collected for critical trauma patients, cardiac arrest situations, and on a case-by-case, request for information basis. Further linkages of this information are being considered.

6.04 Medical Dispatch Evaluation.

The local EMS agency shall have a mechanism to review medical dispatching to ensure that the appropriate level of medical response is sent to each emergency and to monitor the appropriateness of pre-arrival/post dispatch directions.

CURRENT STATUS: STANDARD MET.

The dispatch staffs of all three fire/medical dispatch centers in the county have implemented the Emergency Medical Dispatch program. This program provides for pre-arrival instructions, and for ongoing monitoring and evaluation that is performed in conjunction with the EMS Agency.

6.05 Data Management System.

The local EMS agency shall establish a data management system that supports system-wide planning and evaluation (including identification of high-risk patient groups) and the QA audit of the care provided to specific patients. It shall be based on State standards.

RECOMMENDED GUIDELINES:

Integrated Data Management System. The local EMS agency should establish an integrated data management system that includes system response and clinical (both prehospital and hospital) data. The EMS agency should use patient registries, tracer studies, and other monitoring systems to evaluate patient care at all stages of the system.

CURRENT STATUS: STANDARD MET/RECOMMENDED GUIDELINE BEING ADDRESSED.

Work is being done locally to fully implement a comprehensive data management system. Prehospital ambulance response data is available electronically for all responses, and clinical data is now captured. Current emphasis is on linking information from the various providers and developing programs to evaluate available data. Revised 10/05

6.06 System Design/Operations Evaluation.

The local EMS agency shall establish an evaluation program to evaluate EMS system design and operations. This shall include structure, process, and outcome evaluations, utilizing State standards and guidelines when they exist.

CURRENT STATUS: STANDARD MET.

The EMS Agency has a program to evaluate system components.

6.07 Provider Participation.

The local EMS agency shall have the resources and authority to require provider participation in the system-wide evaluation program.

CURRENT STATUS: STANDARD MET.

Local EMS providers are active participants in EMS system review processes. Such processes include participation on the Emergency Medical Care Committee, the Medical Advisory Committee, the QI/Data Committee, the Facilities and Critical Care Committee and the Hospital Disaster Forum. EMS providers are also active participants on specialized evaluation projects and programs. Contract emergency ambulance providers submit to intense program review. Contracts and written agreements with EMS providers contain provisions that require participation in EMS system evaluation activities. Revised 10/05

6.08 Reporting.

The local EMS agency shall periodically report on EMS system operations to the Board(s) of Supervisors, provider agencies, and Emergency Medical Care Committee(s).

CURRENT STATUS: STANDARD MET.

The EMS Agency reports to the Board of Supervisors, the EMCC and its advisory committees on a regular basis.

6.09 ALS Audit.

The process used to audit treatment provided by advanced life support providers shall evaluate both base hospital (and alternative base station) and prehospital activities.

RECOMMENDED GUIDELINES:

Integrated Data Management System. The local EMS agency's integrated data management system should include prehospital, base hospital, and receiving hospital data.

CURRENT STATUS: STANDARD MET AND RECOMMENDED GUIDELINE BEING CONSIDERED.

An EMS system quality improvement process is used to evaluate care provided by paramedics and by base hospital personnel. The EMS agency's integrated data management system includes dispatch, ambulance (PCR data and dispatch data), first responder, base hospital and trauma system data.

6.10 Trauma System Evaluation.

The local EMS agency shall develop a trauma system including:

a) A trauma registry,
b) A mechanism to identify patients whose care fell outside of established criteria, and
c) A process of identifying potential improvements to the system design and operation.

CURRENT STATUS: STANDARD MET.

The trauma system evaluation process includes a comprehensive trauma registry, a mechanism to identify "under triaged" trauma patients, and methods to assure continued optimal operation.

6.11 Trauma Center Data.

The local EMS agency shall ensure that designated trauma centers provide required data to the EMS agency, including patient specific information that is required for quality assurance and system evaluation.

RECOMMENDED GUIDELINE:

Non-Trauma Center Data. The local EMS agency should seek data on trauma patients who are treated at non-trauma center hospitals and shall include this information in its quality assurance/quality improvement and system evaluation program.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

The EMS Agency collects required trauma registry and system data from the local designated level II trauma center, and seeks necessary trauma related data from the other hospitals that might, on occasion receive critical trauma patients.

G. Public Information and Education

Public Information and Education

7.01 Public Information Materials.

The local EMS agency shall promote the development and dissemination of materials for the public that addresses:

a) Understanding of EMS system design and operation,
b) Proper access to the system,
c) Self help, e.g., CPR, first aid, etc.
d) Patient and consumer rights as they relate to the EMS system,
e) Health/safety habits as they relate to prevention/reduction of health risks in target areas.
f) Appropriate utilization of ED's.

RECOMMENDED GUIDELINE:

Community Education Programs. The local EMS agency should promote targeted community education programs on the use of emergency medical services in its service area.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

The EMS Agency has developed information and materials for dissemination to the public including a 9-1-1 brochure, and has targeted schools countywide for distribution. EMS participants have been involved in the Health Services Division Prevention Programs including Violence Prevention, Drowning Prevention, and in Child Death Review. The EMS Agency has acquired a "1-800-GIVE CPR" telephone number to promote CPR training.

A number of local businesses and other organizations have developed Public Access Defibrillation programs to assure rapid availability of defibrillation. The EMS Agency has worked with public agencies throughout the county during the past year to make available CPR and public access defibrillation training and to distribute 42 defibrillators to public agencies that have developed PAD programs. Revised 10/05

7.02 Injury Control.

The local EMS agency, in conjunction with other local health education programs, shall work to promote injury control and preventive medicine.

RECOMMENDED GUIDELINE:

Programs for Targeted Groups. The local EMS agency should promote the development of special EMS educational programs for targeted groups at high risk of injury or illness.

CURRENT STATUS: STANDARD MET.

The EMS Agency supports and provides resources to injury control efforts including the Child Injury Prevention Coalition of the Health Services Department. The local designated trauma center provides a trauma prevention education program directly and financially supports the county's programs to decrease violence and to prevent injury. The local private emergency ambulance provider will undertake an annual community health research project. Revised 10/05

7.03 Disaster Preparedness Promotion.

The local EMS agency, in conjunction with the local office of emergency services, shall promote citizen disaster preparedness activities.

RECOMMENDED GUIDELINE:

Disaster Preparedness Activities. The local EMS agency, in conjunction with the local office of emergency services (OES), should produce and disseminate information on disaster medical preparedness.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

The EMS Agency works with the Office of Emergency Services and other local agencies in promoting and disseminating information to the public on disaster preparedness.

7.04 First Aid and CPR Training.

The local EMS agency shall promote the availability of first aid and CPR training for the general public.

RECOMMENDED GUIDELINE:

Training Goals: The local EMS agency should adopt a goal for training an appropriate percentage of the general public in first aide and CPR. A higher percentage should be achieved in high-risk groups.

CURRENT STATUS: STANDARD MET.

The EMS Agency has taken a lead in promoting CPR training for the general public by maintaining the "1-800 GIVE-CPR" phone number which, when called, provides information regarding locations of citizen CPR classes. Multiple providers within the County have provided CPR training and are actively promoting such programs. The County included the requirement for a substantial public education commitment in its recent emergency ambulance procurement, and the selected provider has implemented a program to provide CPR training, AED training and distribution. The Emergency Medical Care Committee is particularly interested in CPR training efforts. Revised 10/05

H. Disaster Medical Response

Disaster Medical Response

8.01 Disaster Medical Planning.

In coordination with the local office of emergency services (OES), the local EMS agency shall participate in the development of medical response plans for catastrophic disasters, including those involving toxic substances.

CURRENT STATUS: STANDARD MET.

The EMS Agency is actively involved in medical response planning for the county including bioterrorism response.

8.02 Response Plans.

Medical response plans and procedures for catastrophic disasters shall be applicable to incidents caused by a variety of hazards, including toxic substances.

RECOMMENDED GUIDELINES:

Model Plan. The California Office of Emergency Services' multi-hazard functional plan should serve as the model for the development of medical response plans for catastrophic disasters.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

County Health Services has implemented a comprehensive medical/health emergency plan for the county based on SEMS that interfaces with the County Disaster Plan. Medical response plans under SEMS are in place for a variety of potential disastrous or hazardous incidents.

A Multicasualty Response (MCI) Plan provides for a multidisciplinary response to incidents with multiple victims including hazardous materials medical incidents.

NEED:

A revision of the current local MCI plan to assure the broadest possible scope of response possibilities is covered.

8.03 HAZMAT Training.

All EMS providers shall be properly trained and equipped for response to hazardous materials incidents, as determined by their system role and responsibilities.

CURRENT STATUS: STANDARD MET.

The County's fire departments and the County Health Services Hazardous Materials Division have addressed hazardous materials response. All emergency ambulance providers are required to attend eight hours of HAZMAT training.

8.04 Incident Command System.

Medical response plans and procedures for catastrophic disasters shall use the Incident Command System as the basis for field management.

RECOMMENDED GUIDELINES:

ICS Training. The EMS agency should ensure that ICS training is provided for all medical providers.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

Medical response plans and procedures for catastrophic events use the incident command system (ICS) as the basis for field management and coordination. Training for incident command system activities by ambulance personnel is required in the emergency ambulance contracts.

8.05 Distribution of Casualties.

The local EMS agency, using State guidelines when available, shall establish written procedures for distributing disaster casualties to the most appropriate facilities in its service area.

RECOMMENDED GUIDELINES:

Special Facilities and Capabilities. The local EMS agency, using State guidelines and in consultation with the Regional Poison Center, should identify hospitals with special facilities and capabilities for receipt and treatment of patient with radiation and chemical contamination and injuries.

CURRENT STATUS: STANDARD MET.

Patient distribution procedures are provided for by the County multicasualty plan. Specialized HAZMAT training has been provided to hospital emergency personnel. All basic emergency departments are considered capable of receiving and treating patients with hazardous materials contamination.

8.06 Needs Assessment.

The local EMS agency shall establish written procedures for early assessment of needs and resources and an emergency means for communicating requests to the State and other jurisdictions.

RECOMMENDED GUIDELINE:

Annual Exercises. The local EMS agency's procedures for determining necessary outside assistance in a disaster should be exercised yearly.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

Specific components of the county disaster plan address out-of-county medical mutual aid requests. A comprehensive Regional Disaster Health and Medical Coordination (RDHMC) system is in place in Region II with the CCC EMS Agency as the lead. Local hospitals, ambulance providers and the EMS Agency drill together during the statewide disaster exercise.

8.07 Disaster Communication.

A specific frequency (e.g., CALCORD) or frequencies shall be identified for interagency communication and coordination during a disaster.

CURRENT STATUS: STANDARD MET.

CALCORD is the frequency in the County for interagency coordination at the command level. Fire and emergency ambulance units are capable of unit-to-unit communication, and a single frequency has been identified for this purpose. All paramedic ambulances are equipped with cellular telephones.

8.08 Inventory of Resources.

The local EMS agency, in cooperation with the local OES, shall develop an inventory of appropriate disaster medical resources to respond to multi-casualty incidents and disasters likely to occur in the service area.

RECOMMENDED GUIDELINES:

Medical Resource Provider Agreements. The local EMS agency should ensure that emergency medical providers and health care facilities have written agreements with anticipated disaster medical resource providers.

CURRENT STATUS: STANDARD MET.

Resource directories have been developed by County OES and by the EMS Agency. There are no plans to require emergency medical providers and health care facilities to develop written agreements with anticipated disaster medical resource providers.

The EMS Agency has entered into cooperative agreements with the Health Resources Services Administration (HRSA) to make available funding to hospitals and clinics to achieve preparedness in surge capacity; pharmaceutical caches; personal protection; decontamination; communications and information; and education, preparedness training and terrorism preparedness exercises.

The Health Department and EMS Agency worked with fire, law, and OES to implement the Homeland Security grant which provided communications equipment, radiological detection equipment, and person protective equipment.
Revised 10/05

8.09 DMAT Teams.

The local EMS agency shall establish and maintain relationships with disaster medical assistance teams (DMAT) teams in its area.

RECOMMENDED GUIDELINE:

Local DMAT Team. The local EMS agency supports the development and maintenance of DMAT teams in its area.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

The county supports the OES Region II DMAT team, CA-6.

8.10 Mutual Aid Agreements.

The local EMS agency shall ensure the existence of medical mutual aid agreements with other counties in its OES Region and elsewhere, as needed, to ensure that sufficient emergency medical response and transport vehicles, and other relevant resources will be available during significant medical incidents and during periods of extraordinary system demand.

CURRENT STATUS: STANDARD MET.

Inter-county medical mutual aid planning has been extensive particularly in the EMS Agency's role as the Regional Disaster Medical Health Coordinator (RDMHC). The County is signatory to the California Mutual Aid Agreement.

8.11. CCP Designation.

The local EMS agency, in coordination with local OES and County health officer(s), and using State guidelines when they are available, shall designate casualty collection points (CCP's).

CURRENT STATUS: STANDARD MET.

CCP sites have been designated for all areas of the County.

8.12 Establishment of CCP's.

The local EMS agency shall develop plans for establishing CCP's and a means for communicating with them.

CURRENT STATUS: STANDARD MET.

CCP sites have been designated. There is a plan to dispatch an ambulance to the CCP to communicate with the County EOC.

8.13 Disaster Medical Training.

The local EMS agency shall review the disaster medical training of EMS responders in its service area, including the proper management of casualties exposed to and/or contaminated by toxic or radioactive substance.

RECOMMENDED GUIDELINE:

EMS Responders Appropriately Trained. The EMS agency should assure that EMS responders are appropriately trained in disaster response, including the proper management of casualties exposed to or contaminated by toxic or radioactive substances.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

Policies, procedures, and treatment guidelines for substance specific hazardous material incidents have been developed. EMS Agency requires eight hours of HAZMAT training for all ambulance personnel. EMS providers participate in training exercises.

8.14 Hospital Plans.

The local EMS agency shall encourage all hospitals to ensure that their plans for internal and external disaster are fully integrated with the County's medical response plan(s).

Disaster Medical Response

RECOMMENDED GUIDELINE:

Hospital Disaster Drills. At least one disaster drill per year conducted by each hospital should involve other hospitals, the local EMS agency, and prehospital medical care agencies.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

Hospitals have internal and external disaster plans in place. There is integration with the County's disaster plans. EMS Agency facilitates the Hospital Disaster Forum for hospitals to share ideas and assist each other in disaster planning. Local hospitals, ambulance providers and the EMS Agency participate in the annual EMSA statewide hospital/ambulance disaster exercise held each fall at a minimum.

8.15 Inter-hospital Communications.

The local EMS agency shall ensure that there is an emergency system for inter-hospital communications, including operational procedures.

CURRENT STATUS: STANDARD MET.

ReddiNet, an inter-hospital microwave communications system, links hospitals with each other, the EMS Agency, Sheriff's Communications Center, and all 3 ambulance dispatch centers.

NEED:

Develop a schedule for either Sheriff's Communications staff or EMS Agency staff to hold ReddiNet polling and status drills with the hospitals on a periodic basis on all three nursing shifts (days, evenings, nights).

8.16 Prehospital Agency Plans.

The local EMS agency shall ensure that all prehospital medical response agencies and acute care hospitals in its service area, in cooperation with other local disaster medical response agencies, have developed guidelines for the management of significant medical incidents and have trained their staffs in their use.

RECOMMENDED GUIDELINE:

Prehospital Training. The local EMS agency ensures the availability of training in management of significant medical incidents for all prehospital medical response agencies and acute-care hospital staffs in its service area.

CURRENT STATUS: STANDARD AND RECOMMENDED GUIDELINE MET.

All hospitals and medical response agencies have written policies and procedures for the management of significant medical incidents. Generally, all hospitals participate in multi-agency exercises on an annual basis.

Advanced Life Support

8.17 ALS Policies.

The local EMS agency shall ensure that policies and procedures allow advanced life support personnel and mutual aid responders from other EMS systems to respond and function during significant medical incidents.

CURRENT STATUS: STANDARD MET.

Current policies waive restrictions on responders during disasters. There are reciprocal agreements with surrounding county EMS agencies.

Critical Care System

8.18 Specialty Center Roles.

Local EMS agencies developing trauma or other critical care systems shall determine the role of identified specialty centers during significant medical incidents and the impact of such incidents on day-to-day triage procedures.

CURRENT STATUS: STANDARD MET.

In multiple patient situations, efforts are made to see that patients are transported by ground or air to indicated specialty centers. The local trauma center capacity is being greatly enhanced as the result of a grant providing trauma and burn related equipment and supplies for multicasualty situations. In a significant medical incident, trauma or other specialty center designation may not be taken into consideration in patient triage once trauma resources are overwhelmed.
Revised 10/05

8.19 EOA/Disasters.

Local EMS agencies that grant exclusive operating permits shall ensure that a process exists to waive the exclusivity in the event of a significant medical incident.

CURRENT STATUS: STANDARD MET.

Current policies and County contracts with providers allow exclusivity waiver in the event of disaster and mutual aid requests.

MAJOR SYSTEM CHANGES

EMS SYSTEM MANAGEMENT AND ORGANIZATION

EMS Agency staff functions and assignments have been evaluated and consolidated in light of Plan priorities and goals. Additional staff has been added to support Agency activities.

In May 2004, the Board of Supervisors approved a comprehensive plan for the integration of paramedic first responder and ambulance services in those areas of the county covered by private ambulance services; that is, all areas of the county outside the San Ramon Valley and the Moraga-Orinda Fire Protection Districts. This plan was developed with considerable input from the County Fire Chiefs Association and its Paramedic Engine Task Force and from American Medical Response. The plan was based upon recommendations by Fitch and Associates in a consultant report to the EMS Agency made in October 2003 and recommendations made by the EMCC following a series of public meetings in which the Fitch report recommendation and EMS staff recommendations were reviewed.

The final plan approved by the Board had four objectives: (1) to promote the development of integrated paramedic ambulance and first response services by using existing Measure H funds to support the implementation and expansion of fire paramedic programs; (2) to assure that ambulance response and staffing standards remain unchanged for jurisdictions unable to undertake paramedic first response; (3) to assure that there be no diminution of paramedic services during the transition to an integrated paramedic ambulance/first responder program; and (4) that a measure of equity be maintained in the level of Measure H support for EMS services throughout the county.

As adopted, the plan divides the private ambulance service area into five response zones and sets new ambulance standards for areas with paramedic first responders – one paramedic/one EMT-I staffing and 11:59/90% (later changed to 11:45/90%) urban/suburban response time.

The plan approved by the Board of Supervisors eliminated the prior subsidy for paramedic ambulance service and established subsidies for paramedic engine operational costs and for fire paramedic startup costs. The plan was implemented September 1, 2004.

A Request for Proposal (RFP) for emergency ambulance services, based on the integrated ambulance/first responder paramedic plan, was released in September 2004. The RFP covered those areas currently served by American Medical Response; i.e., all areas of the county except for the San Ramon Valley and Moraga-Orinda Fire Protection Districts. EMS consultant Fitch and Associates provided assistance in proposal solicitation and review. Proposals were received from incumbent provider American Medical Response and StarWest Ambulance, a subsidiary of Arizona-based Southwest Associates.

The review process that had been established by the Board of Supervisors included scoring of proposals by a ten-member Proposal Review Panel. The Proposal Review Panel was comprised of representatives from the Fire Chiefs Association, Hospital Council, Police Chiefs Association, Public Managers Association United Professional Firefighters Association (IAFF Local 1230), Service Employees International Union Local 250, a Contra Costa EMCC consumer member, Contra Costa emergency physician, out-of-county emergency nurse, and out-of-county local EMS agency director selected by the Health Services Director. The Panel met over a three-day period to review and score proposals in accordance with a 1,400 point scoring system. An independent CPA firm was retained to monitor the review process and compile scores from score sheets submitted by the panelists. Each proposer also was able to make an oral presentation to the Panel and answer panelists' questions. The result of the Panel review was that the two proposals received tie scores.

A unique feature of Contra Costa's competitive ambulance selection process was that documents related to the proposals and review were placed on the EMS web site. These included the RFP, proposals, scoring report, preliminary recommendation, appeal and response, final recommendation, and supplementary proposal information requested by the Board.

Following the process set forth in the RFP for preliminary recommendation and appeal, the Health Services Director made a final recommendation, approved by the Board of Supervisors in February 2005, for the selection of AMR. A new five to nine-year ambulance contract was negotiated with AMR that was approved by the Board of Supervisors on June 28, 2005 and became effective on July 1, 2005. Key features of the new contract include:

- No paramedic ambulance subsidy.
- Single paramedic/EMT-I staffing and 11:45 urban/suburban area Code 3 response times for all zones except Richmond, which remains at two-paramedic staffing with a 10-minute response time.
- Response time standards set for each of five response zones and for both emergency and non-emergency response with monetary penalties set for failure to meet standard.
- Four non-transporting, single-paramedic-staffed Quick Response Vehicles provided at no cost to County to augment fire first response in designated areas.
- Upgrade of front line ambulance vehicles from Type II van unit to larger Type III modular unit.
- Specified clinical quality assurance resources.
- Specified disaster response resources, including six non-staffed ambulance units to be positioned at designated fire stations (or equivalent resources).
- Paramedic training for up to 100 firefighters at AMR's Northern California Training Institute.
- Public CPR training – 24 classes per year.
- Public Access Defibrillation – donation of AED's and leadership assistance in County's PAD program.

STAFFING AND TRAINING

Virtually all fire first responders are trained as EMT-I's at a minimum. Most fire services provide paramedic first response services either part or full time, and the number of paramedics continues to rise. All first responder units carry defibrillators.

At the request of the EMS chiefs of the 2 largest fire first responder agencies, work has begun to establish an EMS Training Consortium that will include representatives from each of the fire first responder agencies, emergency ambulance provider and EMS. The goal of the consortium would be to standardize EMS training throughout the county by working together on developing training plans, providing training aids, and encouraging participation by both public and private personnel working together.

COMMUNICATIONS

Emergency Medical Dispatch (EMD) in accordance with State EMD Guidelines has been adopted countywide and currently all dispatchers are trained and tested according to these standards.

The ReddiNet system, implemented locally in 2001, is a microwave communications link between hospitals. Hospitals and the EMS Agencies in Alameda and Contra Costa Counties are included in our local ReddiNet system. In Contra Costa, Sheriff's Dispatch is the coordination point, and the dispatch centers for all three emergency ambulance providers are also included. On a day-to-day basis, hospitals can receive alert notices and timely incident updates from EMS and from Sheriff's dispatch, post hospital diversion and "census alert" status, and send any important message to other hospitals individually or as a group. During multicasualty incidents, ReddiNet facilitates the reporting of hospital information and tracking ambulance assignments and patient information. During a major disaster, ReddiNet is designed to provide a reliable communication path between hospitals and the counties' disaster operations centers. An updated version of ReddiNet will be implemented in December 2005.

RESPONSE AND TRANSPORTATION

Significant time and effort has been spent reviewing and re-evaluating the model used for response to emergency medical requests. In cooperation with the EMS Agency, several local fire first-responder agencies have implemented and/or expanded first responder advanced life support programs. Changes in ambulance staffing configuration and response time standards have been implemented through the RFP process described above in the System Organization and Management section.

Local EMS aircraft policies and procedures for classification, authorization, request for, transport criteria and field operations have been implemented. Two currently classified and accredited air medical providers are based within the County.

FACILITIES AND CRITICAL CARE

Eight acute care hospitals currently provide Basic Emergency Medical Services. In the past 6 years two other hospitals downgraded services and no longer have emergency departments. A third hospital has increased service from Stand-By Emergency Medical Services to Basic during the same period.

DATA COLLECTION AND SYSTEM EVALUATION

American Medical Response, the County's largest contract emergency ambulance provider, implemented an electronic patient care reporting system which is linked to their dispatch data. Information about at patient including evaluation findings and treatment are documented on a computer. The patient care report (PCR) is printed at the patient's receiving hospital and specified data points are entered into a database. This information can be used for a variety of functions including quality improvement activities. Certain EMS staff has access to this database for countywide QI activities and data evaluation. Fire agencies providing paramedic ambulance and first responder services are evaluating electronic PCR systems to replace existing systems or for initial implementation.

PUBLIC INFORMATION AND EDUCATION

Public education efforts are directed towards 9-1-1 and EMS system awareness through distribution of a brochure designed to inform Contra Costans about their local system. Brochures are distributed at health fairs and other community activities. The EMS Agency maintains its 1-800-GIVECPR phone line that is identified in the health section of local telephone books. This program is designed to advise callers about CPR classes in their neighborhoods.

DISASTER MEDICAL RESPONSE

Disaster planning continues to be a high local priority. EMS Agency staff members participate on the Health Services Bioterrorism Response Planning Committee that provides education and training on biological threats for emergency responders, clinicians, and the public.

In Contra Costa, the Health Services Public Health Division has added a fulltime bioterrorism coordinator, and has established a Bioterrorism Advisory Committee with representation from fire, law enforcement, Red Cross, EMS, and other Health Services divisions. The Bioterrorism Advisory Committee is currently working on plans for receipt and distribution of medical equipment and supplies that may be received from state and federal stockpiles in the event of a disaster and on plans to establish mass inoculation sites in communities throughout the county.

County and other organizations have been involved in the preparation of several grant applications related to bioterrorism and homeland security. Hospitals in the county will receive funding to purchase personal protective equipment for treatment teams and decontamination units through a grant administered by the federal Health Resources and Services Administration (HRSA) through the State EMS Authority. A federal Homeland Security grant administered through State OES will provide funding to Contra Costa fire, law enforcement, and health services for equipment purchases, planning, and exercises. Much of this money was used for personal protective equipment for responders, but funds will also be used for medical supply trailers to treat mass casualty victims and to enhance the capabilities of hazardous materials response teams and the Public Health Laboratory.

The ReddiNet communications system has important features that provide for communications and data collection during disasters.

SPECIFIC OBJECTIVES

Progress From Last Reporting Period

	Standard	Meets State Standard	Objective	Progress
1.08	ALS Planning	Yes	Identify opportunities for interested fire first-responder agencies to provide paramedic services at no additional cost to the county.	Objective met. A plan to support fire first response agencies in developing and expanding paramedic first-responder programs throughout the county has been implemented. Funds, which were historically provided the local private emergency ambulance provider as a subsidy, are being passed on to fire districts providing paramedic services.
1.11	System Participants	Yes	Work with interested fire first-responder agencies in providing paramedic service.	Objective met. The EMS Agency makes available staff support and some funding to all interested fire paramedic providers. The EMS Medical Director serves a medical director for fire agencies providing ALS services. EMS staff provides administrative assistance and quality improvement activities for those fire agencies that do not have this support within their agencies.
1.15	Compliance With System Policies	Yes	Review and update local ambulance ordinance.	Objective not met. Long-term goal.
1.18	QA/QI	Yes	Implement a system-wide CQI plan that is monitored by a quality council and integrates individual provider QI plans.	Objective partially met. A system wide quality improvement program has been implemented. A small quality council composed of paramedic provider agencies and EMS meets to review system performance and address individual provider concerns.
1.28	Exclusive Operating Area Plan	Yes	Review, and if necessary, redesign the EOA system	EOA system reviewed, and no changes will be made at this time.
2.05	First Responders (non-transporting)	Yes	Review recommended guideline with respect to staffing	Objective met. The majority of fire first responder units include a paramedic as part of its staffing. BLS first responder units include at least one EMT-I or first Responder defibrillation trained staff.
4.01	Service Area Boundaries	Yes	See Standard 1.28 EOA Plan	EOA system reviewed, and no changes will be made at this time.
4.05	Response Time Standards	Yes	Consider adjusting response time standards in areas where fire first responder paramedics are dispatched.	Objective met. Response times have been adjusted in those areas where fire first responder paramedics are dispatched.
4.10	Aircraft Availability	Yes	Complete enhanced air ambulance written agreement process.	Objective not met.

4.16	ALS Staffing (ambulance)	Yes	Consider adjusting staffing standards in areas where fire first responder paramedics are dispatched.	Objective met. The ambulance-staffing standard has been changed from 2-paramedic ambulance crew to allow 1 paramedic and 1 EMT-I in those areas where fire first responder paramedics are dispatched.
4.22	EOA Evaluation	Yes	Review EOA design	Objective met. EOA design was reviewed as part of the EMS system design and the emergency ambulance procurement process begun in 2004.
5.01	Assessment of Capabilities	Yes	Consider adjusting the recommended guideline for receiving hospital agreements.	Receiving hospital agreements will not be addressed at this time.
6.03	Prehospital Care Audits	Yes	Develop a plan for routine and special audits	Objective partially met. The quality council is charged with and is in the process of developing an audit schedule.
6.05	Data Management System	Yes	Complete implementation of an integrated data management system.	Objective partially met. Work continues in the development of an integrated data management system. There has been significant progress, but work remains to be done.
6.09	ALS Audit	Yes	Consider ways to integrate first responder and receiving hospital data.	Objective partially met. Some first responder data is available and major first responder agencies are jointly evaluating new data collection systems for first responder data collection. Hospital data is collected for trauma patients, and limited data for cardiac arrest patients and QI cases. There is some resistance on the part of hospitals to provide data routinely, mainly based on how the hospital data collection is done internally and perceived issues around HIPAA regulations.
7.01	Public Information Materials	Yes	Consider adding information about public access defibrillation for distribution to business and other agencies as well as individuals.	Objective met. Public access defibrillation brochure and information packets have been developed and are being distributed.
7.04	First Aid and CPR Training	Yes	Consider expanding public information activities to include public access defibrillation (PAD).	Objective met. The EMS Agency obtained and distributed 42 defibrillators through its newly organized PAD program. EMS staff assisted the recipient public agencies with program development, CPR training and PAD orientation. The private emergency ambulance service provider has committed to providing numerous CPR training classes and to implementing PAD distribution program.
8.02	Response Plans	Yes	Consider revising the current local MCI plan to assure that the broadest possible scope of response possibilities is covered.	Objective partially met. A multidisciplinary committee is currently meeting to review and revise the current MCI plan
8.15	Inter-hospital Communications	Yes	Develop a local ReddiNet polling and status drill procedure with the hospitals.	Objective not met. A new upgraded version of ReddiNet has been developed and will be installed within the next few months. Following training on this new system, routine drill procedures will be put into place.

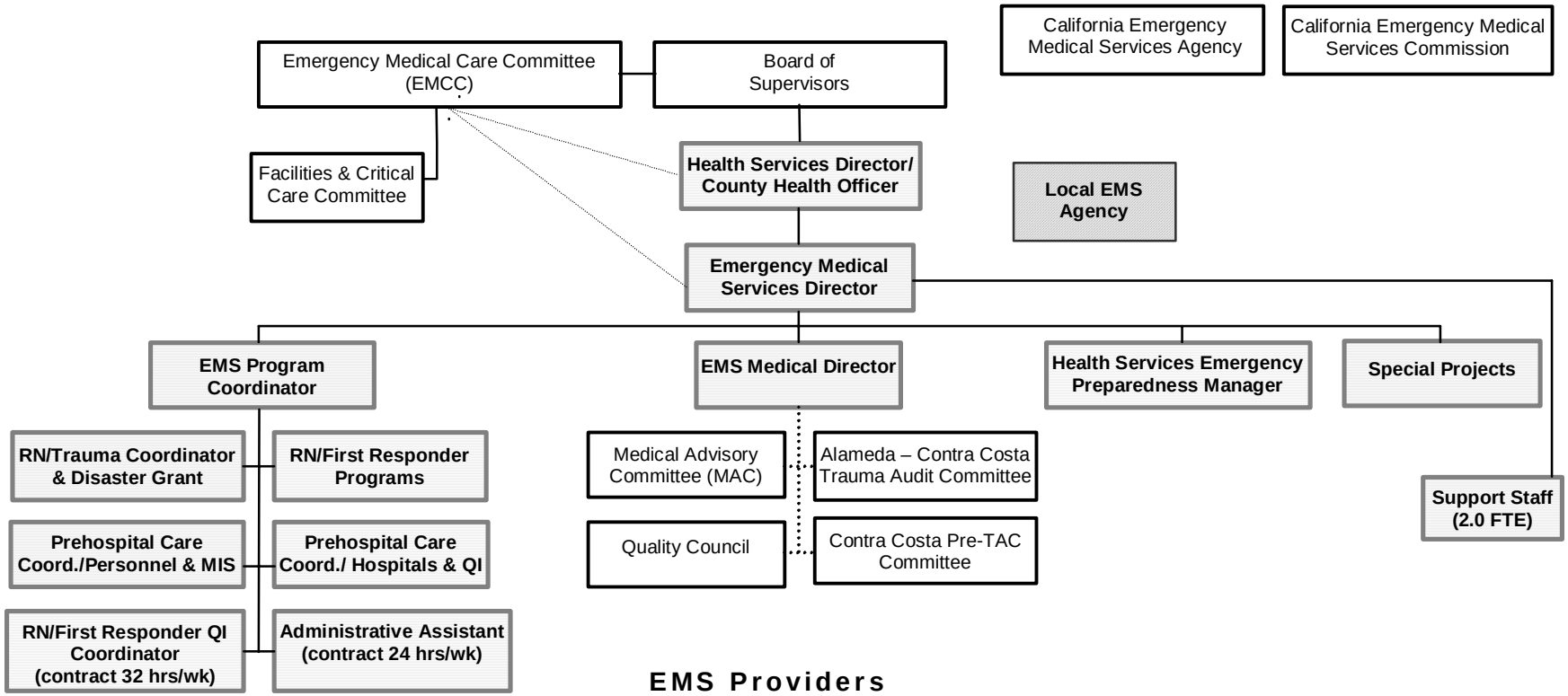
TIMELINE/ACTIONS TO BE ADDRESSED

All State standards have been met. We plan to address or reassess the following objectives.

	Standard	Meets State Standard	Objective	Time Frame
1.01	LEMSA Structure	Yes	Recruit additional staff to work with the expanding first responder paramedic program and data management.	1 year
1.15	Compliance With System Policies	Yes	Review and update local ambulance ordinance.	2 – 3 years
1.18	QA/QI	Yes	Expand current QI committee to include representatives from all EMS and dispatch providers. Further develop and implement electronic capture of patient care data within the fire agencies. Further integrate electronic data to provide expanded capability for EMS system evaluation.	1 – 2 years
1.22	Reporting of Abuse	Yes	Provide special training in abuse recognition and reporting for field personnel.	1 year
1.27	Pediatric System Plan	Yes	Evaluate current pediatric system plan and make changes if indicated.	1 year
2.05	First Responder Training	Yes	Review the first responder master plan and update if necessary in light of the EMS system redesign process.	1 – 2 years
2.06	Response	Yes	Work with interested fire first responder agencies to increase numbers of paramedics on first-response units.	2 – 3 years
3.05	Hospitals	Yes	Assure that emergency department, dispatch and EMS staff are trained and are familiar with the upgraded ReddiNet system when installed.	1 year
4.10	Aircraft Availability	Yes	Complete enhanced air ambulance written agreement process.	1 – 2 years
6.03	Prehospital Care Audits	Yes	Complete a plan for routine and special audits	1 year
6.05	Data Management System	Yes	Continue to work on implementation of an integrated data management system.	1 - 2 years
6.09	ALS Audit	Yes	Continue to work on integrating first responder and receiving hospital data.	1 - 2 years
7.02	Injury Control	Yes	Undertake, through the local private emergency ambulance provider, an annual community health research project.	1 year
7.04	First Aid and CPR Training	Yes	Work with the local private emergency ambulance provider to develop a countywide CPR training project.	1 year
8.02	Response Plans	Yes	Complete the review and revision of the current local MCI plan to assure that the broadest possible scope of response possibilities is covered.	1 - 2 years
8.15	Inter-hospital Communications	Yes	Develop a local ReddiNet polling and status drill procedure with the hospitals.	1 year

ORGANIZATIONAL CHART

Contra Costa Health Services, Emergency Medical Services



EMS Providers

Hospitals
Contra Costa
Doctors
John Muir
Kaiser-Richmond
Kaiser-Walnut Creek
Mt. Diablo
San Ramon
Sutter Delta

EMS Dispatch Centers
Contra Costa Fire
Contra Costa Sheriff
Richmond Police
San Ramon Valley Fire

Trauma Centers
John Muir
Children's (pediatric)

Air Ambulances
CALSTAR
REACH

Emergency Ambulance Services
American Medical Response
Moraga-Orinda Fire
San Ramon Valley Fire

Training Programs
Los Medanos College
Contra Costa College
Mt. Diablo Adult Education
Health Career College

Rescue Aircraft
California Highway Patrol
East Bay Regional Parks

First Responders
Contra Costa Fire
Crockett
East Contra Costa Fire
El Cerrito Fire
Moraga-Orinda Fire
Pinole Fire
Richmond Fire
Rodeo-Hercules
San Ramon Valley Fire