

TABLE 1: Summary of System Status

Include the items from Table 1 that are followed by an asterisk on the System Assessment form. Describe on the form how resources and/or services are coordinated with other EMS agencies in meeting the standards. Table 1 is to be reported by agency.

A. SYSTEM ORGANIZATION AND MANAGEMENT

| Agency Administration | Does not currently meet standard | Meet minimum standard | Meet recommended guideline | Annual Implementation | Long-range Plan |
|-----------------------|----------------------------------|-----------------------|----------------------------|-----------------------|-----------------|
| 1.01 LEMSA Structure | | X | | | |
| 1.02 LEMSA Mission | | X | | | |
| 1.03 Public Input | | X | | | |
| 1.04 Medical Director | | X | X | | |

Planning Activities

| | | | | | |
|-----------------------------|--|---|---|---|---|
| 1.05 System Plan | | X | | | |
| 1.06 Annual Plan Update | | X | | X | |
| 1.07 Trauma Planning* | | X | | X | |
| 1.08 ALS Planning* | | X | | | |
| 1.09 Inventory of Resources | | X | | | |
| 1.10 Special Populations | | X | | | X |
| 1.11 System Participants | | X | X | | |

| Regulatory Activities | Does not currently meet standard | Meet minimum standard | Meet recommended guideline | Annual Implementation | Long-range Plan |
|---------------------------------|---|------------------------------|-----------------------------------|------------------------------|------------------------|
| 1.12 Review & Monitoring | | X | | | |
| 1.13 Coordination | | X | | | |
| 1.14 Policy & Procedures Manual | | X | | | |
| 1.15 Compliance w/ Policies | | | | | |

System Finance

| | | | | | |
|------------------------|--|---|--|--|--|
| 1.16 Funding Mechanism | | X | | | |
|------------------------|--|---|--|--|--|

Medical Direction

| | | | | | |
|--------------------------------------|--|---|--|--|--|
| 1.17 Medical Direction * | | X | | | |
| 1.18 QA/ QI | | X | | | |
| 1.19 Policies, Procedures, Protocols | | X | | | |
| 1.20 DNR Policy | | X | | | |
| 1.21 Determination of Death | | X | | | |
| 1.22 Reporting of Abuse | | X | | | |
| 1.23 Interfacility Transfer | | X | | | |

Enhanced Level: Advanced Life Support

| | | | | | |
|--------------------------------|--|---|---|--|--|
| 1.24 ALS Systems | | X | X | | |
| 1.25 On-Line Medical Direction | | X | X | | |

| Enhanced Level: Trauma Care System | Does not currently meet standard | Meet minimum standard | Meet recommended guideline | Annual Implementation | Long-range Plan |
|---|---|--------------------------------------|---|----------------------------------|----------------------------|
| 1.26 Trauma System Plan | | X | | | |

Enhanced Level: Pediatric Emergency & Critical Care System

| | | | | | |
|-------------------------------|--|-----|--|--|--|
| 1.27 Pediatric System Plan | | N/A | | | |
|-------------------------------|--|-----|--|--|--|

Enhanced Level: Exclusive Operating Areas

| | | | | | |
|---------------|--|---|--|--|--|
| 1.28 EOA Plan | | X | | | |
|---------------|--|---|--|--|--|

B. STAFFING / TRAINING

| Local EMS Agency | Does not currently meet standard | Meet minimum standard | Meet recommended guideline | Annual Implementation | Long-range Plan |
|---------------------------|----------------------------------|-----------------------|----------------------------|-----------------------|-----------------|
| 2.01 Assessment of Needs | | X | | | |
| 2.02 Approval of Training | | X | | | |
| 2.03 Personnel | | X | | | |

Dispatchers

| | | | | | |
|------------------------|--|---|--|--|--|
| 2.04 Dispatch Training | | X | | | |
|------------------------|--|---|--|--|--|

First Responders (non-transporting)

| | | | | | |
|-------------------------------|--|---|--|--|---|
| 2.05 First Responder Training | | X | | | X |
| 2.06 Response | | X | | | X |
| 2.07 Medical Control | | X | | | |

Transporting Personnel

| | | | | | |
|---------------------|--|---|--|--|--|
| 2.08 EMT-I Training | | X | | | |
|---------------------|--|---|--|--|--|

Hospital

| | | | | | |
|----------------------------|--|---|--|--|---|
| 2.09 CPR Training | | X | | | |
| 2.10 Advanced Life Support | | X | | | X |

| Enhanced Level: Advanced Life Support | Does not currently meet standard | Meet minimum standard | Meet recommended guideline | Annual Implementation | Long-range Plan |
|--|---|--------------------------------------|---|----------------------------------|----------------------------|
| 2.11 Accreditation Process | | X | | | |
| 2.12 Early Defibrillation | | X | | | |
| 2.13 Base Hospital Personnel | | X | | X | X |

C. COMMUNICATIONS

| Communications Equipment | Does not currently meet standard | Meet minimum standard | Meet recommended guideline | Annual Implementation | Long-range Plan |
|------------------------------|----------------------------------|-----------------------|----------------------------|-----------------------|-----------------|
| 3.01 Communication Plan* | | X | X | X | |
| 3.02 Radios | | X | X | | |
| 3.03 Interfacility Transfer* | | X | | | |
| 3.04 Dispatch Center | | X | | | |
| 3.05 Hospitals | | X | | | |
| 3.06 MCI/Disasters | | X | | | |

Public Access

| | | | | | |
|----------------------------------|--|---|--|--|---|
| 3.07 9-1-1 Planning/Coordination | | X | | | |
| 3.08 9-1-1 Public Education | | X | | | X |

Resource Management

| | | | | | |
|--------------------------|--|---|---|--|--|
| 3.09 Dispatch Triage | | X | | | |
| 3.10 Integrated Dispatch | | X | X | | |

D. RESPONSE / TRANSPORTATION

| | Does not currently meet standard | Meet minimum standard | Meet recommended guideline | Annual Implementation | Long-range Plan |
|-----------------------------------|----------------------------------|-----------------------|----------------------------|-----------------------|-----------------|
| Universal Level | | | | | |
| 4.01 Service Area Boundaries* | | X | X | | X |
| 4.02 Monitoring | | X | | | X |
| 4.03 Classifying Medical Requests | | X | | | |
| 4.04 Prescheduled Responses | | X | | | |
| 4.05 Response Time Standards* | | X | | | X |
| 4.06 Staffing | | X | | | |
| 4.07 First Responder Agencies | | X | | | |
| 4.08 Medical & Rescue Aircraft* | | X | | | |
| 4.09 Air Dispatch Center | | X | | | |
| 4.10 Aircraft Availability* | | X | | | |
| 4.11 Specialty Vehicles* | | X | X | | |
| 4.12 Disaster Response | | X | | | |
| 4.13 Intercounty Response* | | X | X | | |
| 4.14 Incident Command System | | X | X | | |
| 4.15 MCI Plans | | X | X | | |

Enhanced Level: Advanced Life Support

| | | | | | |
|-------------------|--|---|--|--|---|
| 4.16 ALS Staffing | | X | | | X |
| | | | | | |

| | | | | | |
|--------------------|--|---|--|--|--|
| 4.17 ALS Equipment | | X | | | |
|--------------------|--|---|--|--|--|

| Enhanced Level: Ambulance Regulation | Does not currently meet standard | Meet minimum standard | Meet recommended guideline | Annual Implementation | Long-range Plan |
|---|---|--------------------------------------|---|----------------------------------|----------------------------|
| 4.18 Compliance | | X | | | |

Enhanced Level: Exclusive Operating Permits

| | | | | | |
|--------------------------|--|---|---|--|--|
| 4.19 Transportation Plan | | | X | | |
| 4.20 Grandfathering | | | X | | |
| 4.21 Compliance | | X | | | |
| 4.22 Evaluation | | X | | | |

E. FACILITIES / CRITICAL CARE

| | Does not currently meet standard | Meet minimum standard | Meet recommended guideline | Annual Implementation | Long-range Plan |
|-----------------------------------|----------------------------------|-----------------------|----------------------------|-----------------------|-----------------|
| Universal Level | | | | | |
| 5.01 Assessment of Capabilities | | X | | | X |
| 5.02 Triage & Transfer Protocols* | | X | | | X |
| 5.03 Transfer Guidelines* | | X | | | X |
| 5.04 Specialty Care Facilities* | | X | | | X |
| 5.05 Mass Casualty Management | | X | | | |
| 5.06 Hospital Evaluation* | | X | | | |

Enhanced Level: Advanced Life Support

| | | | | | |
|---------------------------------|--|---|--|--|--|
| 5.07 Base Hospital Designation* | | X | | | |
|---------------------------------|--|---|--|--|--|

Enhanced Level: Trauma Care System

| | | | | | |
|---------------------------|--|---|--|--|--|
| 5.08 Trauma System Design | | X | | | |
| 5.09 Public Input | | X | | | |

Enhanced Level: Pediatric Emergency & Critical Care System

| | | | | | |
|------------------------------|--|-----|--|--|--|
| 5.10 Pediatric System Design | | N/A | | | |
| 5.11 Emergency Departments | | N/A | | | |
| 5.12 Public Input | | N/A | | | |

Enhanced Level: Other Speciality Care System

| | | | | | |
|-------------------------------|--|-----|--|--|--|
| 5.13 Speciality System Design | | N/A | | | |
| 5.14 Public Input | | N/A | | | |

F. DATA COLLECTION / SYSTEM EVALUATION

| | Does not currently meet standard | Meet minimum standard | Meet recommended guideline | Annual Implementation | Long-range Plan |
|-------------------------------|----------------------------------|-----------------------|----------------------------|-----------------------|-----------------|
| Universal Level | | | | | |
| 6.01 QA/QI Program | | X | | | |
| 6.02 Prehospital Records | | X | | | |
| 6.03 Prehospital Care Audits | | X | | | X |
| 6.04 Medical Dispatch | | X | | | |
| 6.05 Data Management System* | | X | | | X |
| 6.06 System Design Evaluation | | X | | | X |
| 6.07 Provider Participation | | X | | | |
| 6.08 Reporting | | X | | | X |

Enhanced Level: Advanced Life Support

| | | | | | |
|----------------|--|---|--|--|---|
| 6.09 ALS Audit | | X | | | X |
|----------------|--|---|--|--|---|

Enhanced Level: Trauma Care System

| | | | | | |
|-------------------------------|--|---|--|--|--|
| 6.10 Trauma System Evaluation | | X | | | |
| 6.11 Trauma Center Data | | X | | | |

G. PUBLIC INFORMATION AND EDUCATION

| | Does not currently meet standard | Meet minimum standard | Meet recommended guideline | Annual Implementation | Long-range Plan |
|-----------------------------------|----------------------------------|-----------------------|----------------------------|-----------------------|-----------------|
| Universal Level | | | | | |
| 7.01 Public Information Materials | | X | | | X |
| 7.02 Injury Control | | X | | | X |
| 7.03 Disaster Preparedness | | X | | | X |
| 7.04 First Aid & CPR Training | | X | | | X |

H. DISASTER MEDICAL RESPONSE

| Universal Level | Does not currently meet standard | Meet minimum standard | Meet recommended guideline | Annual Implementation | Long-range Plan |
|-----------------------------------|----------------------------------|-----------------------|----------------------------|-----------------------|-----------------|
| 8.01 Disaster Medical Planning* | | X | | | |
| 8.02 Response Plans | | X | | | |
| 8.03 HazMat Training | | X | | | X |
| 8.04 Incident Command System | | X | X | | |
| 8.05 Distribution of Casualties* | | X | | | |
| 8.06 Needs Assessment | | X | X | | |
| 8.07 Disaster Communications* | | X | | | |
| 8.08 Inventory of Resources | | X | | | X |
| 8.09 DMAT Teams | | X | | | |
| 8.10 Mutual Aid Agreements* | | X | | | |
| 8.11 CCP Designation* | | X | | | |
| 8.12 Establishment of CCPs | | X | | | |
| 8.13 Disaster Medical Training | | X | X | | |
| 8.14 Hospital Plans | | X | | | |
| 8.15 Interhospital Communications | | X | X | | |
| 8.16 Prehospital Agency Plans | | X | X | | |

Enhanced Level: Advanced Life Support

| | | | | | |
|-------------------|--|---|--|--|--|
| 8.17 ALS Policies | | X | | | |
|-------------------|--|---|--|--|--|

| Enhanced Level: Specialty Care Systems | Does not currently meet standard | Meet minimum standard | Meet recommended guideline | Annual Implementation | Long-range Plan |
|--|----------------------------------|-----------------------|----------------------------|-----------------------|-----------------|
| 8.18 Specialty Center Roles | | X | | | |
| 8.19 Waiving Exclusivity | | X | | | |

APPENDIX 1: System Assessment Form

An example of a completed System Assessment form follows this page.

STANDARD:

(THE STANDARDS FROM THE EMS SYSTEM STANDARDS AND GUIDELINES ARE AVAILABLE ON DISK.)

CURRENT STATUS:

COORDINATION WITH OTHER EMS AGENCIES:

NEED(S):

OBJECTIVE:

TIMEFRAME FOR OBJECTIVE:

Annual Implementation Plan

Long-range Plan

1. **SYSTEM ORGANIZATION AND MANAGEMENT -- AGENCY ADMINISTRATION**

A. **AGENCY ADMINISTRATION**

1.01 **UNIVERSAL STANDARD**

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

The EMS Agency has a formal organizational structure which includes an **EMS Manager**, EMS Medical Director, and an office assistant. The EMS Agency is designated by the Imperial County Board of Supervisors. This structure is a division of the Imperial County Department of Health Services and is included in the county structure which delineates other county resources including, the Health Officer, County Counsel, Risk Management and administrative personnel. Non-agency resources include a contract training coordinator through the local community college.

NEED(S): None

1.02 **UNIVERSAL STANDARD**

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

CURRENT STATUS

The agency is active in each of the above areas. The Continuous Quality Improvement (CQI) and evaluation process is used to identify needed system changes. A new web-based data system has been implemented that will facilitate data collection and evaluation of prehospital patient care in Imperial County.

NEED(S): None

OBJECTIVE 1.02: The EMS Agency has developed QI audits of prehospital patient care that can be generated on a periodic as well as ad hoc basis from the web-based data system.

NEED(S): None

1.03 UNIVERSAL STANDARD

Each local EMS agency shall actively seek and shall have a mechanism (including the emergency medical care committee(s) 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

Health care providers, including a broad array of prehospital providers, are represented and active at EMCC meetings. Informal communications are important also in this small county. Proposed system changes are taken to the Emergency Medical Care Committee (EMCC) and circulated among system participants, including EMTs and medics at Base Hospital meetings.

The public is less well represented and aware of system function and changes, except for local ambulance company boards. A member of the Board of Supervisors frequently attends EMCC meetings and is aware of issues, and can provide public input.

NEED(S): None at this time.

B. PLANNING ACTIVITIES

1.05

UNIVERSAL STANDARD

Each local EMS agency shall develop an EMS System Plan and shall submit it to the EMS Authority. The plan shall:

- a) assess how the current system meets these 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

The first EMS plan was developed and submitted by Imperial County in 1996. The plan included evaluation of patients in clinical target groups, and methodology and time line for addressing identified needs.

NEED(S): None.

1.06

UNIVERSAL STANDARD

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

This is our first plan update since the original plan was approved in 1996.

NEED(S): Yearly updates of EMS plan.

OBJECTIVE 1.06: Revise and submit to the EMS Authority annual updates of the Imperial County EMS plan.

TIME FRAME FOR IMPLEMENTATION:

Annual Implementation Plan

Long-range Plan

UNIVERSAL STANDARD

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

RECOMMENDED GUIDELINE

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

CURRENT STATUS

Trauma patients are presently taken to the closest emergency facility, which is one of the two local hospitals certified for basic emergency care . Many seriously injured patients, depending on local availability of resources and type of injury, are transferred to tertiary care centers in San Diego or Riverside County. The local EMS Agency received a grant in 2002 from the State EMS Authority to develop and implement a Trauma System Plan. The EMS Agency contracted with a Trauma Consultant and organized a Trauma Advisory Committee. The consultant and the TAC have conducted an evaluation of the EMS system in Imperial County and a needs assessment. The Imperial County Trauma System Plan was approved by the State EMS Authority on 11/5/03. Both local hospitals received Level IV Trauma Center designation. The plan calls for intercounty and interfacility transfer agreements, triage protocols and a trauma registry.

NEED(S): Continue with developing intercounty agreements with both San Diego and Riverside Counties to allow triage of critical trauma patients from the field in Imperial County to higher level trauma centers in both SD and Riverside Counties.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

1.08

UNIVERSAL STANDARD

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

CURRENT STATUS

ALS or LALS is now available throughout Imperial County through EMS transport providers.

COORDINATION WITH OTHER EMS AGENCIES: Implementation of an Expanded-Scope EMT-I program to provide rural first responders with limited ALS skills has made it possible for early limited ALS to be available in most of the remote areas of the county.

NEED(S): None

1.09

UNIVERSAL STANDARD

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

An inventory has been prepared for this plan and will be updated annually.

NEED(S): None at this time.

1.10

UNIVERSAL STANDARD

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

RECOMMENDED GUIDELINES

Each local EMS agency should develop services, as appropriate, for special population groups served by the EMS system, which require specialized services (e.g. elderly, handicapped, children, non-English speakers).

CURRENT STATUS

Groups that may require or benefit from specialized services include Spanish-speakers and recent immigrants; the elderly, including seasonal residents; children; low-income families. There are no targeted programs for groups who may require specialized services.

Pediatric care is now provided by valley hospitals, with transfer when needed to San Diego, about 120 miles away.

NEED: Identify groups needing specialized services, and, in the future, provide such services.

OBJECTIVE 1.10.1: Develop tool to identify groups needing specialized services, and the types of services needed.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 1.10.2: The EMS Agency shall perform an evaluation of the need for attention to pediatric needs and care, including emergency department care and need for specialty care, and transfer.

TIME FRAME FOR IMPLEMENTATION:

Annual Implementation Plan

Long-range Plan

UNIVERSAL STANDARD

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

RECOMMENDED GUIDELINES

Each local EMS agency should ensure that system participants conform with their assigned EMS system roles and responsibilities, through mechanisms such as written agreements, facility designations, and exclusive operating areas.

CURRENT STATUS

The EMS Agency convened an EMS Task Force, under the auspices of the Board of Supervisors, from June - December 1995. The task force met monthly to evaluate system participants, roles and responsibilities, and EMS system design options. The goal of the task force was to develop an EMS model for Imperial County, which provides quality patient care in a cost-effective manner.

The task force agreed on an optimal system design consisting of a tiered response to include Emergency Medical Dispatch, BLS/ALS First Responders, ALS Transport Providers with Exclusive Operating Areas, and the development of specialty trauma centers in Imperial County. All LALS/ALS providers have written provider agreements with the EMS Agency.

NEED(S): None.

C. Regulatory Activities

1.12

UNIVERSAL STANDARD

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

CURRENT STATUS

The EMS Agency recently implemented (May 1, 2004) a web-based data system to facilitate data collection and system evaluation. This has proven to be very efficient and effective allowing for real-time system review and monitoring. The EMS Agency can now generate periodic and ad hoc reports to evaluate prehospital care in Imperial County.

NEED(S): None

1.13

UNIVERSAL STANDARD

Each local EMS agency shall coordinate EMS system operations.

CURRENT STATUS

The agency performs a coordinating function, and is seen as an information resource.

NEED(S): None at this time.

UNIVERSAL STANDARD

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

CURRENT STATUS

The EMS Agency recently completed (Jan. 1. 2003) the development of a comprehensive and contemporary policies, procedures and protocol manual under a grant from the EMS Authority. During the grant period, a task force was convened to review and update existing policies, and to develop new policies as needed. ALS treatment protocols had recently been updated to include the addition of BLS treatment protocols. The policy manual reflects current practice, standards, ethics and law.

Hard copies of the manual have been distributed to all EMS provider agencies (to include public safety agencies, ambulance services and local hospitals) and electronic copies are available upon request to all system participants and other interested parties.

NEED(S): None

1.15

UNIVERSAL STANDARD

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

CURRENT STATUS

The EMS Agency has developed and implemented a system-wide QA/CQI program by which all aspects of the EMS system can be reviewed and monitored to include equipping and staffing of units, EMS responses (to include first response and transport), field care audits, training programs and dispatching.

NEED(S): None

D. System Finances

1.16

UNIVERSAL STANDARD

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

CURRENT STATUS

The agency is funded primarily through county general fund dollars. A fee schedule was approved by the Board of Supervisors to allow the collection of fees for provider certifications and training programs. Funds are also obtained through grant projects implemented by the EMS Agency.

An Emergency Medical Services Fund cannot be established because of statutory limits.

NEEDS: None.

E. Medical Direction

LOCAL EMS SYSTEMS NEED APPROPRIATE MEDICAL DIRECTION. THIS IMPLIES INVOLVEMENT OF THE MEDICAL COMMUNITY AND ENSURES MEDICAL ACCOUNTABILITY IN ALL STAGES OF THE SYSTEM.

1.17

UNIVERSAL STANDARD

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 stations and the roles, responsibilities, and relationships of prehospital and hospital providers.

CURRENT STATUS

The agency is providing medical direction leadership. One base hospital is sufficient and is committed to base hospital operations. The roles of other providers have been defined.

NEED(S): None

MINIMUM STANDARD

Each local EMS agency shall establish a quality assurance/quality improvement program to ensure adherence to medical direction policies and procedures, including a mechanism to review compliance with system policies. This may include use of provider based programs which are approved by the local EMS agency and which are coordinated with other system participants.

RECOMMENDED GUIDELINES

Prehospital care providers should be encouraged to establish in-house procedures which identify methods of improving the quality of care provided.

CURRENT STATUS

Quality assurance for medical direction policies is now performed largely through individual case review performed by the base hospital. This is done by monitoring of base hospital communications and patient care records, and also in response to questions or complaints. The EMS Agency recently implemented a new policy that requires all providers to develop in-house QA/CQI programs. An EMS QA Committee has been convened to help with the development and implementation of in-house programs.

NEED(S): None

MINIMUM STANDARD

Each local EMS agency shall develop written policies, procedures, and/or protocols including, but not limited to

- a) triage,
- b) treatment,
- c) medical dispatch protocols
- d) transport,
- e) on-scene times
- f) transfer of emergency patients,
- g) standing orders,
- h) base hospital contact,
- i) on-scene physicians and other medical personnel, and
- 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

The EMS Agency recently developed, under a grant from the EMS Authority, an updated and comprehensive policies, procedures and protocol manual. The manual includes policies that address all the items listed above.

NEED(S): None

1.20

MINIMUM STANDARD

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

A formal Do-Not-Resuscitate policy was adopted in 1994.

NEED(S): None.

1.21

UNIVERSAL STANDARD

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 an apparent crime.

CURRENT STATUS

A revised Determination of Death policy, was instituted in 1995. We will continue to monitor its impact.

NEED(S): None.

1.22

UNIVERSAL STANDARD

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

CURRENT STATUS

Protocols have been developed for child abuse, elder abuse and SIDS deaths.

NEED(S): None

1.23

UNIVERSAL STANDARD

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

CURRENT STATUS

The ALS/LALS treatment protocols apply to interfacility transfers. An expanded scope of practice for paramedics has been developed for interfacility transfers and includes Nitroglycerin and Heparin IV drips.

NEED(S): None.

Enhanced Level: Advanced Life Support

1.24

MINIMUM STANDARD

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.

RECOMMENDED GUIDELINES

Each local EMS agency, based on state approval, should, when appropriate, develop exclusive operating areas for ALS providers.

CURRENT STATUS

All ALS and LALS providers are approved by the agency and all have signed written agreements to provide service. The county has been divided into five response zones. The county's largest ambulance provider has been operating in the same scope and manner since before 1980, was awarded an Exclusive Operating Area contract in 1986, and granted a four-year extension to that contract by the Board of Supervisors in 1995, in 1999 and again in 2004.

NEED(S): None.

1.25

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

Each EMS system should develop a medical control plan, which determines

- a) The base hospital configuration for the system,
- b) The process for selecting base hospitals, including a process for designation which allows all eligible facilities to apply, and
- c) The process for determining when prehospital providers should appoint an in-house medical director.

CURRENT STATUS

There is a single base hospital. There is no process for application. EMS providers are too small to have their own medical directors at this point.

NEED(S): None at this time.

F. Enhanced Level: Trauma Care System

1.26

UNIVERSAL STANDARD

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 which allows all eligible facilities to apply.

CURRENT STATUS

The EMS Agency completed the development of a trauma system plan for Imperial County, which was approved by the EMS Authority in November 2003. The plan describes the optimal system design for trauma care, designation of trauma centers, triage criteria, transfer agreements, a trauma registry and a QA/CQI program.

NEED(S): Done.

OBJECTIVE: Implement trauma system plan by December 31, 2003. **The plan was activated on April 1, 2004.**

G. Enhanced Level: Pediatric Emergency Medical and Critical Care System

1.27 UNIVERSAL STANDARD

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

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

CURRENT STATUS

There is no pediatric emergency medical plan.

NEED(S): None. There is no plan at this time. See Standard 1.10.2.

H. Enhanced Level: Exclusive Operating Areas

1.28

UNIVERSAL STANDARD

The local EMS agency shall develop, and submit for state approval, a plan 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

The county's largest ambulance provider has been operating in the same scope and manner since before 1980 and was awarded an exclusive operating area in 1986. The Board of Supervisors has continually extended the contract since then.

NEED(S): None

STAFFING/TRAINING

THE LOCAL EMS SYSTEM SHOULD INCLUDE AN ADEQUATE NUMBER OF HOSPITAL AND PREHOSPITAL HEALTH PROFESSIONALS TO PROVIDE EMERGENCY MEDICAL SERVICES ON A TWENTY-FOUR HOUR PER DAY BASIS.

PROVISION SHOULD BE MADE FOR THE INITIAL AND ON-GOING TRAINING OF THESE PERSONNEL UTILIZING CURRICULA CONSISTENT WITH STATE AND NATIONAL STANDARDS.

Minimum Standards

Recommended Guidelines

Universal Level

2. Local EMS Agency

2.01

UNIVERSAL STANDARD

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

CURRENT STATUS

The agency assesses personnel and training needs, although this is not done on a formal basis. The provision of CME has been enhanced, particularly in the rural and remote areas of the county, through the EMS Agencies Continuing Education program. There are now seven (7) CE Providers in the county to include the EMS Agency, Base and Receiving Hospital, Community College, one ALS Transport Provider and two first responder agencies. The EMS Agency has also implemented a new quality assurance/continuous quality improvement program, which calls for the creation of a QA/CQI Committee with representatives of all EMS provider agencies to address relevant issues regarding prehospital care.

NEED(S): None

2.02

UNIVERSAL STANDARD

The EMS Authority and/or local EMS agencies shall have a mechanism to approve EMS education programs, which require approval (according to regulations) and shall monitor them to ensure that they comply with state regulations.

CURRENT STATUS

There is an approval process for the training institution (Imperial Valley College) and a CME provider approval policy. The EMS Agency monitors them for compliance with State regulations.

NEED(S): None

2.03

UNIVERSAL STANDARD

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, which could impact EMS personnel certification.

CURRENT STATUS

There are mechanisms for certification, accreditation and related actions, and a process for prehospital providers to notify the EMS agency of incidents, which could impact system personnel.

NEED(S): None.

A. Dispatchers

2.04

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

Public safety answering point (PSAP) operators with medical dispatch responsibilities and all medical dispatch personnel (both public and private) should be trained and certified in accordance with the EMS Authority's Emergency Medical Dispatch Guidelines.

CURRENT STATUS

The EMS Agency received grant funding from EMSA in 1996 and implemented the APCO Basic EMD Program in Imperial County. Since that time, the Agency has trained and certified over 50 dispatchers as EMDs and some as EMD Instructors. Four local PSAPs are presently EMD providers. However, due to a high rate of attrition, PSAPs are challenged in maintaining adequate staffing and retention of EMDs. The EMD Course has been offered annually to try and maintain adequate staffing of EMDs within the PSAPs.

NEED(S): None.

B. First Responders (non-transporting)

2.05

MINIMUM STANDARD

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 GUIDELINES

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 the response times for other ALS providers.

At least one person on each 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

Most responders on non-transporting EMS first response units are certified to at least the EMT-I level. The outlying volunteer fire departments (Winterhaven, Ocotillo, Salton Sea, and Bombay Beach) each have some EMT-I trained personnel. Beginning in 1995, many of these units have first response EMT-D capability. EMT-D was targeted at rural communities either without continuous ALS service, or that have long ALS response times. All EMS first response units have equipment commensurate with their scope of practice. Work schedules and distance from the community college make it difficult for volunteers from the remote fire departments to attend the local college for EMT training. Providing EMT training for these remote communities has been a problem for the local community college due to insufficient enrollment.

NEED(S): There is a need for EMT-I training in remote communities to compensate for the high turnover of EMT personnel. Many first responders have had CPR and first aid training within the previous three years.

OBJECTIVE 2.05.1: The EMS Agency shall continue to work with all first responder personnel

to help them meet the minimum required certification in CPR and first aid training

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 2.05.2: The EMS Agency shall develop a plan to offer EMT-I, AED, and other training in remote areas.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

2.06

UNIVERSAL STANDARD

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

Agencies are encouraged to respond to medical emergencies, and most first responders respond to all EMS incidents. Due to lack of resources, some first responders limit their responses to defined EMS incidents. They do follow local policies when they respond.

NEED(S): A stable funding source is needed to enable first responders to respond (and continue to respond) to all medical aid requests.

OBJECTIVE 2.06.1: The EMS Agency shall develop mechanisms for funding first responders and obtain a secure funding source.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

2.07

UNIVERSAL STANDARD

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

CURRENT STATUS

The EMS Agency completed and adopted BLS/First Responder Treatment Protocols in 1996.

NEED(S): None.

C. Transport Personnel

2.08

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

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

All transport personnel are certified at least at the EMT-I level. As of the end of June 1995, all BLS transport personnel, where ALS is not available, have been trained to provide defibrillation and have defibrillation equipment.

NEED(S): None.

D. Hospital

2.09

UNIVERSAL STANDARD

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

CURRENT STATUS

This standard is currently met at the two hospitals that receive ALS/LALS patients.

NEED(S): None.

2.10

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

All emergency department physicians should be certified by the American Board of Emergency Medicine.

CURRENT STATUS

Only the Base Hospital emergency department requires their physicians and registered nurses to be trained in advanced cardiac life support. The other receiving facility has a goal to require this training for all emergency department physicians and registered nurses. Many physicians are ABEM certified.

NEED(S): Advanced Cardiac Life Support training for all emergency department physicians and nurses.

OBJECTIVE 2.10.1: ACLS training for all emergency department physicians and nurses.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 2.10.2: ABEM certification of all emergency department physicians.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

E. **Enhanced Level: Advanced Life Support**

2.11

UNIVERSAL STANDARD

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 assurance process.

CURRENT STATUS

The EMS Agency has an accreditation policy for ALS personnel that meets this standard. It was revised in September, 1995. Orientation and necessary training are performed by the Base Hospital in conjunction with the EMS Agency.

NEED(S): None.

2.12

UNIVERSAL STANDARD

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

CURRENT STATUS

Policies for accreditation in defibrillation went into place in April, 1995 and were revised in 2003.

NEED(S): None at this time.

2.13

UNIVERSAL STANDARD

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

All MICNs have training in policies and radio communication techniques. Physicians have a formal orientation program, however it is not always implemented by medical staff.

NEED(S): Training or assurance of knowledge of protocols by base hospital physicians.

OBJECTIVE 2.13.1: The EMS Agency should develop a mechanism to ensure training of physicians in treatment protocols and EMS policies.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

3. Communications

THE LOCAL EMS SYSTEM SHOULD MAKE PROVISION FOR TWO-WAY COMMUNICATIONS BETWEEN PERSONNEL AND FACILITIES WITHIN COORDINATED COMMUNICATIONS SYSTEM(S).

THE COMMUNICATIONS SYSTEM SHOULD INCLUDE PUBLIC ACCESS TO THE EMS SYSTEM, RESOURCE MANAGEMENT, AND MEDICAL DIRECTION ON BOTH THE BASIC LIFE SUPPORT AND ADVANCED LIFE SUPPORT LEVELS.

Minimum Standards

Recommended Guidelines

Universal Level

A. Communications Equipment

3.01

MINIMUM STANDARD

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 in accordance with the EMS Authority's Communications Plan (when it is available).

RECOMMENDED GUIDELINES

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

CURRENT STATUS

The EMS Agency is actively involved with other system participants in the development and implementation of an 800-MHz system. The EMS Manager currently serves on the board of the Imperial Valley Emergency Communications Authority (IVECA), a JPA with representatives from

the County and all cities in the county. IVECA oversees the implementation of the 800 MHz Regional Communication System, which is an extension of the 800 MHz communication system in San Diego County. This system now provides interoperability to all public safety and EMS providers in both Imperial and San Diego Counties, all along the California/Baja Mexico border. The first phase of the communication system was operational by the end of 2003. The EMS Agency was awarded a \$1.25 million grant from EMSA to purchase user equipment for many of the police, fire and EMS providers in the county.

NEED(S): Develop formal EMS System communications plan.

TIME FRAME FOR IMPLEMENTATION

- Annual Implementation Plan
- Long-range Plan

3.02

MINIMUM STANDARD

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 GUIDELINES

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

CURRENT STATUS

All ambulances in the county and many of the law enforcement and first responder units have been equipped with the new 800 MHz radios. Training with the new radios has been ongoing and all EMS and Public Safety providers will be using the new system by the end of 2004.

NEED(S): None.

3.03

UNIVERSAL STANDARD

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

CURRENT STATUS

Emergency transport vehicles can access sending and receiving facilities on the 800 MHz Medical Communication talkgroups.

COORDINATION WITH OTHER EMS AGENCIES: Both hospitals in Imperial County maintain radio/telephone equipment in order to communicate with ambulances.

NEED(S): None at this time.

3.04

UNIVERSAL STANDARD

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

All EMS transport vehicles have the capability to communicate with a single dispatch center, which would coordinate operations in a disaster.

NEED(S): None at this time.

3.05**MINIMUM STANDARD**

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

RECOMMENDED GUIDELINES

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

Both hospitals can communicate with each other on the 800 MHz RCS Medical Communication System. As the RCS now extends across both San Diego and Imperial Counties, local hospitals now have the ability to communicate with hospitals in San Diego County via two-way radio communication.

NEED(S): None at this time.

3.06**UNIVERSAL STANDARD**

The local EMS agency shall review communications 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

The implementation of the 800 MHz Regional Communication System utilizing Motorola SmartZone capability will provide EMS providers and local hospitals with the capability to communicate effectively during disaster operations. In addition, providers can communicate via the VHF and UHF radio systems and via cell phone communications. The local amateur radio group also provides back up communication capabilities if needed via ham radio operators.

NEED(S):

None at this time.

B. Public Access

3.07 UNIVERSAL STANDARD

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

CURRENT STATUS

The local EMS Agency works with the county's "911 Coordinator" with the on going planning and coordination of the enhanced 911 system.

NEED(S): None.

3.08 UNIVERSAL STANDARD

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

CURRENT STATUS

The agency has done minimal public education regarding 911.

NEED(S): A public awareness campaign about the appropriate use of 911.

OBJECTIVE 3.08.1: The EMS Agency, in cooperation with other system participants, should perform public education regarding the use of 911.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

C. Resource Management

3.09

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

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

CURRENT STATUS

The APCO EMD Program was implemented in 1996 and includes Basic EMD training for dispatchers, a dispatch priority reference system, dispatch triage policies, and prearrival instructions. Four PSAPs currently provide EMD service in the county.

NEED(S): None

3.10

MINIMUM STANDARD

The local EMS system shall have a functionally integrated dispatch with system wide emergency services coordination, using standardized communications frequencies which comply with the EMS Authority's Communications Plan (when it is available).

RECOMMENDED GUIDELINES

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

CURRENT STATUS

There is a mechanism to integrate EMS responses.

There is a mechanism in place to identify peak demand periods with the primary provider, who can adjust ambulance coverage accordingly.

NEED(S): None.

4. Response/Transportation

THE LOCAL EMS SYSTEM SHOULD INCLUDE ADEQUATE GROUND, AIR, AND WATER VEHICLES MEETING APPROPRIATE STANDARDS REGARDING LOCATION, DESIGN, PERFORMANCE, EQUIPMENT, PERSONNEL, AND SAFETY.

4.01 MINIMUM STANDARD:

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

RECOMMENDED GUIDELINES

The local EMS agency should secure a county ordinance or similar mechanism for establishing emergency medical transport service areas (e.g. ambulance response zones).

CURRENT STATUS

There is a county ordinance (although it is in need of revision) in which six service areas for emergency medical transport are designated by The Board of Supervisors: 1. The central valley (including the cities of El Centro, Imperial, and Brawley) with 80% of the valley's population; 2. Calexico and the unincorporated area south of highway 98; 3. the southeast corner of the county to the Arizona border (includes the town of Winterhaven); 4. the northeast corner of the county to the Riverside County line and the Arizona border; 5. the western shore of the Salton Sea and surrounding communities; and, 6. the community of Bombay Beach [see map]. There is an exclusive contract for the Zone I service area only.

COORDINATION WITH OTHER EMS AGENCIES: The EMCC supports the revision and updating of the ambulance ordinance and will participate in the review process.

NEED(S): A revised and updated county ordinance for ambulance service is needed.

OBJECTIVE 4.01.1: Revise & update county ordinance for ambulance service.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

The local 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 should, wherever possible, replace any other local ambulance regulatory programs within the EMS area.

CURRENT STATUS

The EMS Agency monitors transport services through informal monitoring, evaluation of complaints and incidents reports, and by monitoring through the Base Hospital. Response times are monitored for the Zone I contractor only. There is a licensing procedure through the Sheriff's office.

NEED(S): Improved monitoring with periodic inspections. An updated ambulance ordinance is needed.

OBJECTIVE: 4.02.1: Develop county ordinance for licensure and monitoring of transport services.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

4.03

UNIVERSAL STANDARD

The local EMS agency shall determine criteria for classifying medical requests (e.g. emergent, urgent, and non-emergent) and shall determine the appropriate level of medical response (e.g. ALS/BLS, ground/air, first responder) to each.

CURRENT STATUS

Criteria for classifying medical requests was established with the implementation of the EMD program in the county. Criteria calls for a Priority I response (lights & sirens) for suspected medical emergency and Priority II (no lights and sirens) response for non-emergency. Criteria also establishes response configuration to include BLS and ALS first responders and transport providers (both air and ground).

NEED(S): None

4.04

UNIVERSAL STANDARD

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

CURRENT STATUS

Pre-scheduled or unscheduled non-emergency response is handled by the major provider. The system is monitored for any negative impact, including effect on response times, which is unusual. The EMS Agency will continue to monitor provision of non-emergency transport for negative impact on the emergency system.

NEED(S): None identified.

MINIMUM STANDARD

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 GUIDELINES

Emergency medical service areas (response zones) shall be designated so that, for ninety percent of emergent responses:

- a. The response time for a basic life support and CPR capable first responder does not exceed:

Metro/urban--5 minutes

Suburban/rural--1-15 minutes

Wilderness--25 minutes

- b. The response time for an early defibrillation capable responder does not exceed:

Metro/urban--5 minutes

Suburban/rural--as quickly as possible

Wilderness--as quickly as possible

- c. The response time for an advanced life support capable responder (not functioning as the first responder above) does not exceed:

Metro/urban--8 minutes

Suburban/rural--20 minutes

Wilderness--45 minutes

- d. The response time for an EMS transportation unit

(not functioning as the first responder, above) does not exceed:

Metro/urban--8 minutes

Suburban/rural--20 minutes

Wilderness--45 minutes

CURRENT STATUS

Current Zone 1 ALS transport response time criteria are Urban, ≤ 10 min., Rural, ≤ 30 min., Wilderness ≤ 60 min. Response time criteria have not been established for other ALS or BLS providers. First-responder response time criteria are not established. Zone 1 ALS response times are monitored by the EMS Agency, but are measured from time of unit dispatch only. Many of these agencies are volunteer, in wilderness areas, and it will be difficult to establish meaningful response time standards.

COORDINATION WITH OTHER EMS AGENCIES: Establishing response time standards for first responder agencies was discussed at the EMCC with mixed response for and against. All agreed it is important for first responders to respond as quickly as possible, but may not be practical to establish standards for volunteer agencies serving the rural/remote areas of the county.

NEED(S): Response time standards for all medical responses, including first-responders, especially ALS, LALS, and EMT-I agencies.

OBJECTIVE 4.05.1 Establish response time standards for medical responses that meet the needs and capabilities of first responder agencies for affected geographic areas.

TIME FRAME FOR IMPLEMENTATION:

Annual Implementation Plan

Long-range Plan

4.06

UNIVERSAL STANDARD

All emergency medical transport vehicles shall be staffed and equipped according to current state and local EMS agency regulations and appropriately equipped for the level of service provided.

CURRENT STATUS

All vehicles are staffed and equipped for the level of service provided. The EMS Agency will ensure that vehicles continue to meet this requirement through annual inspections and the Agency's CQI program.

NEED(S): None.

4.07

UNIVERSAL STANDARD

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

Qualified first-responder agencies are integrated into the system. We have only limited co-response in some areas of the county, however. First responders will respond on all EMS calls when required, according to pre-determined medical dispatch protocols.

NEED(S): None.

4.08

MINIMUM STANDARD

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

- a) authorization of aircraft to be utilized in prehospital patient care,
- b) requesting of EMS aircraft,
- c) dispatching of EMS aircraft,
- d) determination of EMS aircraft patient destination,
- e) orientation of pilots and medical flight crews to the local EMS system, and
- f) addressing and resolving formal complaints regarding EMS aircraft.

CURRENT STATUS

The EMS Agency recently developed a policy that categorized EMS Aircraft in accordance with State guidelines. All EMS Aircraft are authorized by the EMS Agency and dispatched according to county policy. One local air transport provider has an agreement with the County to provide for both fixed wing and rotorcraft. This is a non-exclusive agreement for both interfacility and emergency 911 response. Other EMS aircraft also respond from out of county as needed.

NEED(S): None.

4.09

UNIVERSAL STANDARD

The local EMS agency shall designate a dispatch center to

coordinate the use of air ambulances or rescue aircraft.

CURRENT STATUS

The Sheriff's dispatch serves to dispatch and coordinate EMS aircraft for scene responses.

Interfacility air transfers are common and arranged by individual hospitals.

NEED(S): None.

4.10

MINIMUM STANDARD

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

CURRENT STATUS

Medical and rescue aircraft are identified. Rotorcraft are available from the CHP, Mercy Air, Aeromedevac, and the Marines for scene responses, and from fixed-wing (Schaefer's Air Los Angeles and Aeromedevac. A written agreement was developed with Aeromedevac and an agreement with Mercy Air is pending.

COORDINATION WITH OTHER EMS AGENCIES: Utilization of EMS rotorcraft and fixed-wing aircraft has been discussed with the EMCC and coordinated with dispatch agencies and EMS providers.

NEED(S): None

4.11

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

The local EMS agency should plan for response by and use of all-terrain vehicles, snowmobiles, and water rescue vehicles in areas where applicable. This plan should consider existing EMS resources, population density, environmental factors, dispatch procedures and catchment area.

CURRENT STATUS

The local agency has identified all-terrain vehicles, and these are used for desert rescues by provider and rescue agencies.

NEED(S): None.

4.12

UNIVERSAL STANDARD

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

This is part of the Medical & Health Branch Disaster Plan developed under a grant from EMSA. The plan has been adopted into the Imperial County Emergency Operations Plan.

NEED(S): None.

4.13

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

The local EMS agency should encourage and coordinate development of mutual aid agreements, which identify financial responsibility for mutual aid responses.

CURRENT STATUS

Imperial County is signatory to the Region VI and Region I Mutual Aid Agreements.

NEED(S): None

4.14

UNIVERSAL STANDARD

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

CURRENT STATUS

Multi-casualty plans exist through the Medical Annex of the county Office of Emergency Services disaster plan. This incorporates the Incident Command System and SEMS, and instruction was recently provided to many providers. A countywide disaster drill was conducted in accordance with these standards. On-scene medical management will be according to county EMS Treatment Guidelines.

NEED(S): None.

4.15

STANDARD

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

CURRENT STATUS

The multi-casualty response plans were developed utilizing the State's Standardized Emergency Management System guidelines and in accordance with the Incident Command System procedures.

NEED(S): None.

A. Enhanced Level: Advanced Life Support

4.16

MINIMUM STANDARD

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

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

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

CURRENT STATUS

Some ALS ambulances have split EMT-P/EMT-I teams while others have either two paramedics or a split EMT-P/EMT-II team. In cases where an EMT-I is working with a paramedic, the EMT-I is not trained in defibrillation.

NEED(S): Train EMT-Is in defibrillation.

OBJECTIVE 4.16.1: EMT-Is on ALS/LALS ambulances will be trained to provide defibrillation.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

4.17

UNIVERSAL STANDARD

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

CURRENT STATUS

All ALS ambulances are appropriately equipped for level of staffing.

NEED(S): None.

B. Enhanced Level: Ambulance Regulation

4.18

UNIVERSAL STANDARD

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

All provider agreements have been updated to comply with local policies and procedures regarding system operations and clinical care.

NEED(S): None.

C. Enhanced Level: Exclusive Operating Permits

4.19

UNIVERSAL STANDARD

Any local EMS agency which desires to implement exclusive operating areas 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

Imperial County granted an exclusive contract for Response Zone I in 1986 to its largest ambulance provider who has been operating in the same scope and manner since before 1980. The contract includes minimum standards, transportation system efficiency and effectiveness. This contract was extended for another four years in December 1995, in December 1999 and again in December 2003.

NEED(S): None.

4.20

UNIVERSAL STANDARD

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 "grandfathering" under Section 1797.224, H&SC.

CURRENT STATUS

The Board of Supervisors granted an exclusive contract for Response Zone I medical transportation to Gold Cross Ambulance in 1986. There has been no significant change in the manner and scope of Gold Cross' operation since before 1980.

NEED(S): None.

4.21

UNIVERSAL STANDARD:

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

The exclusive contract with the Zone I provider has provisions for compliance with policies and procedures regarding system operations and patient care.

NEED(S): None.

4.22

UNIVERSAL STANDARD

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

CURRENT STATUS

The Board of Supervisors established in 1995 a Task Force to examine the EMS system, including the design of exclusive operating areas. A formal review of exclusive operating areas was completed by January 1996.

NEED(S): None.

5. Facilities/Critical Care

THE LOCAL EMS SYSTEM SHOULD HAVE PROVISION FOR AN APPROPRIATE NUMBER AND LEVEL OF HEALTH FACILITIES TO RECEIVE AND TREAT EMERGENCY PATIENTS. IT SHALL HAVE A SYSTEM OF IDENTIFYING, UNDER MEDICAL DIRECTION, THE MOST APPROPRIATE FACILITY TO MANAGE A PATIENT'S CLINICAL PROBLEM AND ARRANGING FOR TRIAGE AND/OR TRANSFER OF THE PATIENT TO THIS FACILITY.

Minimum Standards

Recommended Guidelines

Universal Level

5.01 MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

The local EMS agency, using state standards (when they exist) should assess, and periodically reassess, and disseminate to EMS providers, information about the EMS-related capabilities of acute care facilities in its services area.

CURRENT STATUS

The agency assesses acute care facilities if there is a significant question about their capability in regard to EMS patients. This information is disseminated to EMS providers.

NEED(S): On-going assessment of all acute care facilities.

OBJECTIVE 5.01.1: The EMS Agency shall assess EMS-related capabilities of acute care facilities in its jurisdiction, and provide those results in an appropriate format to EMS providers.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

5.02

UNIVERSAL STANDARD

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

CURRENT STATUS

Prehospital triage protocols were established for one area, amended for potential transports to one acute care facility based on our assessment of its capabilities. There are only two other acute care facilities, which differ little in their capabilities, and the nearest tertiary care is over 120 miles away.

COORDINATION WITH OTHER EMS AGENCIES: Prehospital triage protocols were developed in coordination with the EMCC.

NEED(S): On-going review of acute care facilities. Assistance for facilities with transfer protocols.

OBJECTIVE 5.02.1: The EMS Agency will review transfer policies and agreements and determine if facilities need agency assistance.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

5.03

UNIVERSAL STANDARD

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

CURRENT STATUS

Acute care facilities identify patients who should be considered for transfer. This is left to the institutions' evaluation and the availability of specialty physicians (e.g. neurosurgery) in the county at any given time. These institutions utilize their own adopted guidelines for patient transfers.

COORDINATION WITH OTHER EMS AGENCIES: Guidelines for transferring patients to tertiary care centers were discussed at the EMCC.

NEED(S): Review of guidelines for transfer.

OBJECTIVE 5.03.1: The EMS Agency, in cooperation with acute care facilities, will review and develop (as needed) guidelines to identify patients for transfer to higher level care than available in the valley.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

5.04

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

The local EMS agency, using state standards (when they exist), should designate and monitor receiving and, when appropriate, special care facilities for specified groups of emergency patients.

CURRENT STATUS

The two local hospitals in Imperial County are now designated as receiving facilities for both basic emergency services and Level IV Trauma Centers.

NEED(S): None

5.05

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

The local EMS agency should assist hospitals with preparation for mass casualty management, including procedures for coordinating hospital communications and patient flow.

CURRENT STATUS

Both of the acute care hospitals have developed and implemented the hospital incident command system and have participated in the annual mass casualty exercises.

NEED(S): None.

5.06

UNIVERSAL STANDARD

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

CURRENT STATUS

There is currently a plan for hospital evacuation developed in coordination with the local OES.

COORDINATION WITH OTHER EMS AGENCIES: Plans for hospital evacuation were discussed at the EMCC and with the Imperial Valley Fire Chiefs Association Mutual Aid Subcommittee.

NEED(S): None

A. Enhanced Level: Advanced Life Support

5.07

UNIVERSAL STANDARD

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

A single base hospital has been designated.

NEED(S): None at this time.

B. Enhanced Level: Trauma Care System

5.08

UNIVERSAL STANDARD

Local EMS agencies that develop trauma care systems shall determine the optimal system, including: a) The number and level of trauma centers, b) The 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 triage or transferred to a designated center, including consideration of patients who should be triage to other critical care centers, d) The role of non-trauma center hospitals, including those that are outside of the primary triage area of the trauma center e) A plan for monitoring and evaluation of the system.

CURRENT STATUS

Under a grant from the EMSA, a trauma system plan was developed and was implemented on April 1, 2004. The plan includes identification of two Level IV trauma centers, designated

catchment areas, triage criteria, transfer agreements, policies for QA/CQI and a trauma registry.

NEED(S): Done.

5.09

UNIVERSAL STANDARD

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

CURRENT STATUS

The EMS Agency organized a Trauma Advisory Committee (TAC) to assist with the development of the local trauma system plan. The TAC consisted of representatives from the medical community, public safety and EMS provider agencies. A public hearing was also conducted on the plan.

NEED(S): None

C. Enhanced Level: Pediatric Emergency Medical and Critical Care System

5.10

UNIVERSAL STANDARD

Local EMS agencies that develop pediatric emergency medical and critical care systems shall determine the optimal system, including: a) The number and role of system participants, particularly of emergency departments, b) The 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 primarily triage or secondarily transferred to a designated center, including consideration of patients who should be triage to other critical care centers, d) Identification of providers who are qualified to transport such patients to a designated facility, e) Identification of tertiary care centers for pediatric critical care and pediatric trauma, f) The role of non-pediatric critical care hospitals including those which are outside of the primary triage area, g) A plan for monitoring and evaluation of the system.

CURRENT STATUS

There is no pediatric system at this time. However, the local EMS Agency may consider doing a study similar to the trauma study to evaluate system response to pediatric care.

NEED(S): See Standard 1.10.2.

5.11

UNIVERSAL STANDARD

Local EMS agencies shall identify minimum standards for pediatric capability of emergency departments, 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 GUIDELINES

Local EMS agencies should develop methods of identifying emergency departments which meet standards for pediatric care and for pediatric critical care centers and pediatric trauma centers.

CURRENT STATUS

See Standard 1.10.2.

NEED(S): None.

5.12

UNIVERSAL STANDARD

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

CURRENT STATUS

See Standard 1.10.2.

NEED(S): None at this time.

D. Enhanced Level: Other Critical Care System

5.13 UNIVERSAL STANDARD

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 triage 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 evaluation of the system.

CURRENT STATUS

There is no current additional specialty care system. No specialty care plans are under development at this time. These criteria will be addressed when specialty care plans are developed.

NEED(S): None.

5.14 UNIVERSAL STANDARD

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

CURRENT STATUS

There is no critical care system nor the capabilities of providing such services at this time.

NEED(S): None.

Data Collection/System Evaluation

THE LOCAL EMS SYSTEM SHOULD HAVE MECHANISMS TO COLLECT DATA REGARDING OPERATIONAL AND CLINICAL ASPECTS OF THE SYSTEM, COVERING ALL STAGES OF THE SYSTEM. BOTH DAY-TODAY QUALITY ASSURANCE AUDITS AND OVERALL EVALUATIONS OF SYSTEM OPERATIONS ARE NECESSARY.

Minimum Standards Recommended Guidelines

Universal Level

6.01

MINIMUM STANDARD

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

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

CURRENT STATUS

Quality assurance is focused on problems identified during routine audit, and by complaints or other information provided to the EMS Agency. The base hospital prehospital care coordinator now performs 100% audit of all calls to the base hospital from ALS and LALS units. We believe most problems and trends are discovered by this system. There is feedback available from the receiving hospitals, but no patient audits. The Agency has limited resources to evaluate care of

specific patients.

NEED(S): There is a need for on-going audits involving all providers aimed at a variety of clinical conditions and patient care, adherence with standards, and potential provider and system improvements. Routine patient follow-up is needed. Providers need instruction in QI, and encouragement to begin programs.

OBJECTIVE 6.01.1: The EMS Agency implemented a Quality Improvement Plan for the agency and system participants.

NEED(S): None

OBJECTIVE 6.01.2: The EMS Agency will develop a QI process for evaluating patient morbidity and mortality.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 6.01.3: The EMS Agency will develop a QI plan for providers.

NEED(S): None

6.02 UNIVERSAL STANDARD

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

CURRENT STATUS

Records of all ALS/LALS responses are forwarded to the base hospital first and then to the EMS Agency. BLS records are forwarded to the EMS Agency. Under a grant from EMSA, the EMS

Agency developed a web-based EMS data collection system. The agency used the EPCIS program developed by Marin County as the basis for the web-based program. The new system will allow the EMS Agency Medical Director, EMS Manager and Base Hospital Coordinator the ability for real-time analysis of prehospital patient care.

NEED(S): None

MINIMUM STANDARD

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

The local EMS agency should have a mechanism to link prehospital records with dispatch, emergency department, in-patient and discharge records.

CURRENT STATUS

Pre-determined audits are currently performed on a very limited bases by the Base Hospital. A system-wide QI program should be in place soon with all EMS providers performing audits of prehospital care. There is currently no system to link prehospital records to other sources.

NEED(S): Link prehospital records to other sources and conduct system-wide audits of prehospital care.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

6.04

UNIVERSAL STANDARD

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

The local EMS Agency received a grant from EMSA in 1996 and implemented the APCO EMD program in Imperial County. The EMD program includes a QI program to monitor medical dispatching to include the appropriateness of guidecard use, priority dispatch, and pre-arrival post-dispatch instructions.

NEED(S): None.

MINIMUM STANDARD

The local EMS agency shall establish a data management system which supports its 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 (when they are available).

RECOMMENDED GUIDELINES

The local EMS agency should establish an integrated data management system which includes system response and clinical (both prehospital and hospital) data.

The local EMS agency should use patient registries, tracer studies, and other monitoring systems to evaluate patient care at all stages of the system.

CURRENT STATUS

With the implementation of the new web-based EMS data system, the EMS Agency now has the ability to conduct system wide planning and evaluation (including identification of high risk patient groups) and the QA audit of the care provided to specific patients.

OBJECTIVE 6.05.1: The EMS Agency should identify specific patient groups and other categories for specific audits.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 6.05.2: The EMS Agency should assist the base hospital and other providers to perform audits on the database.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan

Long-range Plan

OBJECTIVE 6.05.4: The EMS Agency should establish separate patient registries in the EMS database for evaluation and use.

TIME FRAME FOR IMPLEMENTATION:

Annual Implementation Plan

Long-range Plan

6.06

UNIVERSAL STANDARD

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

CURRENT STATUS

There is no on-going evaluation of EMS system design and operations; however, the EMS Agency will evaluate EMS system design and operations and set the precedent for future evaluations.

NEED(S): On-going evaluation of EMS system design and operations.

OBJECTIVE 6.06.1: On-going evaluations of EMS System.

TIME FRAME FOR IMPLEMENTATION:

Annual Implementation Plan

Long-range Plan

6.07

UNIVERSAL STANDARD

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

CURRENT STATUS

The EMS agency welcomes, and requires, provider participation. We believe system participants will want to take part in an evaluation program.

NEED(S): QI Plan, see 6.01, 6.03.

6.08

UNIVERSAL STANDARD

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

There is no formal presentation of EMS System operations, other than quarterly reports to the EMCC, which has representatives of providers on it.

NEED(S): Periodic reports on EMS System operations.

OBJECTIVE 6.08.1: The EMS Agency shall prepare and distribute a periodic report on EMS System operations.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

A. Enhanced Level: Advanced Life Support

6.09

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

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

CURRENT STATUS

The integrated data management system will include all these participants. The base hospital is not independently evaluated.

NEED(S): Evaluation of base and prehospital activities.

OBJECTIVE 6.09.1: The EMS Agency shall audit Base Hospital operations.

B. Enhanced Level: Trauma Care System

6.10

UNIVERSAL STANDARD

The local EMS agency shall develop a trauma system evaluation and data collection program, 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

NEED(S): None.

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

The local EMS agency should seek data on trauma patients who are treated at non-trauma center hospitals and shall include this information in their quality assurance and system evaluation program.

CURRENT STATUS

With the activation of the Trauma System plan, designation of local Trauma Centers and implementation of a trauma registry, the EMS Agency is able to collect data on trauma patients and evaluate system response to trauma patient care.

NEED(S): None

Public Information and Education

THE LOCAL EMS SYSTEM SHOULD PROVIDE PROGRAMS TO ESTABLISH AN AWARENESS OF THE EMS SYSTEM, HOW TO ACCESS THE SYSTEM AND HOW TO USE THE SYSTEM. PROGRAMS TO TRAIN MEMBERS OF THE PUBLIC IN FIRST AID AND CPR SHOULD BE AVAILABLE.

Minimum- Standards

Recommended Guidelines

Universal Level

7.01

UNIVERSAL STANDARD

The local EMS agency shall promote the development and dissemination of information materials for the public which 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 and safety habits as they relate to the prevention and reduction of health risks in target areas, and f) appropriate utilization of emergency departments.

CURRENT STATUS

Most agencies (hospitals, transport providers, first responders, and the local community college) offer some programs designed to educate the public in EMS. The EMS Agency has been able to perform only limited public information. A minimal amount of education has been done during EMS week, including public CPR instruction and news articles.

NEED(S): A public information and education program.

OBJECTIVE 7.01.1: The EMS Agency will survey public and private system participants regarding public education activities.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 7.01.2: The EMS Agency shall coordinate or assist in the development of a public information and education program.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

7.02

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

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

CURRENT STATUS

Minimal injury control and preventive medicine information is disseminated from the EMS Agency at this time.

NEED(S): Injury control and preventive medicine information aimed at high-risk groups.

OBJECTIVE 7.02.1: The EMS Agency shall develop an injury control and preventive medicine program for the EMS system, aimed at high-risk groups.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

7.03

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

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

These functions are performed by OES and other groups such as the Red Cross.

NEED(S): Public information about medical disaster preparedness.

OBJECTIVE 7.03.1: The EMS Agency shall cooperate with other EMS participants to develop citizen medical disaster preparedness information.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

7.04

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

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

CURRENT STATUS

The EMS Agency has promoted first aid and CPR training on a limited basis.

NEED(S): EMS Agency participation in promoting first aid and CPR training.

OBJECTIVE 7.04.1: The EMS Agency will participate in promoting first aid and CPR training.

TIME FRAME FOR IMPLEMENTATION:

Annual Implementation Plan

Long-range Plan

Disaster Medical Response

THE LOCAL EMS SYSTEM MUST BE CAPABLE OF EXPANDING ITS STANDARD OPERATIONS TO MEET THE NEEDS CREATED BY MULTI-CASUALTY INCIDENT AND MEDICAL DISASTERS, INCLUDING INTEGRATION OF OUT-OF AREA RESOURCES.

Minimum Standards

Recommended Guidelines

Universal Level

8.01

UNIVERSAL STANDARD

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

The EMS Agency received a grant from the EMS Authority to develop a disaster plan for all medical and health disciplines in Imperial County. A multi-disciplinary task force was organized and resulted in the development of the Imperial County Medical & Health Branch Disaster Plan in 2001. Under the plan, a Medical & Health Departmental Operations Center was also established at the Public Health Department Training Center. Training and exercises have been conducted annually since 2001. The Medical & Health Branch Disaster Plan has been incorporated into the Imperial County Emergency Operations Plan.

NEED(S): None.

8.02

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

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

The Medical & Health Branch Disaster Plan is applicable to a variety of hazards, and is based on OES multi-hazard functional plans.

NEED(S): None.

8.03

UNIVERSAL STANDARD

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

The training of EMS providers for hazardous incidents is on going. Fire first-responders and ALS/LALS personnel receive training through their departments. Civilians are receiving State Fire Marshal approved training through the City of El Centro and Imperial County Fire Departments. The community college incorporates Haz Mat training into their EMT and First Responder training. This training is important since there is heavy use of chemicals in agriculture, and chemical transportation to and from Mexico is increasing in volume.

NEED(S): Assure hazardous materials training.

OBJECTIVE 8.03.1: The EMS Agency shall assure the training of all civilian EMS personnel in hazardous materials response.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

8.04

MINIMUM STANDARD

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

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

CURRENT STATUS

ICS is used and all personnel receive training, in accordance with SEMS program. This training is conducted annually by prehospital providers, the base hospital, local community college, and EMS Agency personnel.

NEED(S): None.

8.05**MINIMUM STANDARD**

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

The local EMS agency, using state guidelines when they are available, and in consultation with Regional Poison Centers, should identify hospitals with special facilities and capabilities for receipt and treatment of patients with radiation and chemical contamination and injuries.

CURRENT STATUS

The disaster plan calls for delivering patients to the most appropriate hospitals, although the number of hospitals in the valley is limited. Hospitals have received additional training in chemical incidents.

COORDINATION WITH OTHER EMS AGENCIES: Distribution of casualties during a disaster has been coordinated with the EMCC, I.V. Fire Chiefs Association, and OES. Local hospitals have participated in training and exercises to improve their capability to deal with chemical, biological, radiological, incendiary and explosion incidents

NEED(S): None.

8.06**MINIMUM STANDARD**

The local EMS agency, using state guidelines, shall establish written procedures for early assessment of needs and shall establish an emergency means for communication requests to the state and other jurisdictions.

RECOMMENDED GUIDELINES

The local EMS agency's procedures for determining necessary outside assistance should be exercised yearly.

CURRENT STATUS

These procedures exist, are written, and are exercised yearly.

NEED(S): None.

8.07

UNIVERSAL STANDARD

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

CURRENT STATUS

With the extension of San Diego's 800 MHz Regional Communication System across Imperial County, we now have specific frequencies (now called talkgroups) for interagency communication and coordination during a disaster.

NEED(S): None.

8.08

MINIMUM STANDARD

The local EMS agency, in cooperation with the local OES shall develop an inventory of disaster medical resources.

The local EMS agency, using state guidelines when they are available, should ensure that emergency medical providers and health care facilities have written agreements with disaster medical

resource providers for the provision of appropriate resources to respond to multi-casualty incidents and disasters likely to occur in its service area.

CURRENT STATUS

An inventory of disaster medical resources does not exist.

NEED(S): Disaster medical inventory and supplies.

OBJECTIVE 8.08.1: The EMS Agency will develop a disaster medical inventory.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

OBJECTIVE 8.08.2: The EMS Agency will develop, in cooperation with other system participants, sources of emergency medical supplies, and assist in the development of agreements for provision during a disaster.

TIME FRAME FOR IMPLEMENTATION:

- Annual Implementation Plan
- Long-range Plan

8.09

MINIMUM STANDARD

The local EMS agency shall establish and maintain relationships with DMAT teams in its area.

RECOMMENDED GUIDELINES

The local EMS agency should support the development and maintenance of DMAT teams in its area.

CURRENT STATUS

Development of a DMAT (Disaster Medical Assistance Team) team was attempted, but financial problems impeded it. However, the Medical & Health Branch Disaster Plan includes plans for identifying the need for and requesting DMATs when local needs exceed the availability of resources.

NEED(S): None

8.10

UNIVERSAL STANDARD

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

CURRENT STATUS

Imperial sends representatives to Region VI planning meetings, and has access to Region VI for mutual aid.

COORDINATION WITH OTHER EMS AGENCIES: In addition to participation with Region VI, coordination is through the local Fire Chiefs Association Mutual Aid Committee, OES, and the

local EMCC and the Yuma, Arizona EMCC.

NEED(S): None.

8.11

UNIVERSAL STANDARD

The local EMS agency, in coordination with the local OES and county health officer(s), and using state guidelines when they are available, shall designate casualty collection points (CCPs).

CURRENT STATUS

The major cities and fire departments in Imperial County have designated CCPs in their respective areas. The EMS Agency along with the local OES are working to establish the validity of CCPs in this area.

NEED(S): None

8.12

UNIVERSAL STANDARD

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

CURRENT STATUS

The Medical & Health Branch Disaster Plan includes plans and checklists for determining the need for and activating CCPs (now called Field Treatment Sites). Communication with FTS will be accomplished via the 800 MHz radio system, cell phones or with the assistance of amateur radio group.

NEED(S): None.

8.13

MINIMUM STANDARD

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 substances.

The local EMS agency should ensure that EMS responders are appropriately trained in disaster response, including the proper management of casualties exposed to and/or contaminated by toxic or radioactive substances.

CURRENT STATUS

Training of EMS responders in disaster response, hazardous material incidents, and in decontamination procedures is on going.

NEED(S): None.

8.14

UNIVERSAL STANDARD

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

CURRENT STATUS

Hospitals' plans for disasters are fully integrated with the county's medical response plans as defined under the OES disaster plan.

NEED(S): None.

8.15

UNIVERSAL STANDARD

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

CURRENT STATUS

Inter-hospital communications currently exist between both local hospitals on the 800 MHz Regional Communication System.

NEED(S): None.

8.16

RECOMMENDED GUIDELINES

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

Annual disaster drills are conducted and include all area hospitals, the local EMS agency, and prehospital medical care agencies.

NEED(S): None.

8.17

MINIMUM STANDARD

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

RECOMMENDED GUIDELINES

The local EMS agency should ensure 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

In addition to the disaster/MCI training offered through the local fire services, community college, and CE providers, the local EMS agency also provides annual training to all EMS provider agencies and acute-care hospital staff in its service area.

NEED(S): None.

A. Enhanced Level: Advanced Life Support

8.18

UNIVERSAL STANDARD

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

Imperial County is signatory to the Region VI Mutual aid agreement, which includes plans for mutual aid responders from other EMS systems to respond and function during significant medical incidents in Imperial County

NEED(S): None.

B. Enhanced Level: Critical Care Systems

8.19

UNIVERSAL STANDARD

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

CURRENT STATUS

The Imperial County EMS Agency activated its Trauma System Plan on April 1, 2004, which includes activation of two Level IV Trauma Centers in the county.

NEED(S): None.

C. Enhanced Level: Exclusive operating Areas/Ambulance Regulation

8.20

UNIVERSAL STANDARD

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

CURRENT STATUS

The exclusive operating permit issued our Zone I provider does allow for mutual aid response during a significant medical incident.

NEED(S): None.

GLOSSARY

advanced life support (ALS)--medically accepted, life sustaining, invasive procedures, provided at the direction of physician or authorized registered nurse.

ambulance service--a qualified provider of medical transportation for patients requiring treatment and/or monitoring due to illness or injury.

ambulance service area (zone)--a designated geographic area contiguous to other such areas and delineated by the local EMS agency for the purpose of ensuring availability of emergency medical transport services at all times by one or more specified providers.

base hospital--one of a limited number of hospitals which, upon entering into written contractual agreement with the local EMS agency, is responsible for directing the advanced life support system or limited advanced life support system assigned to it.

basic life support (BLS)--medically accepted non-invasive procedures used to sustain life.

cardiopulmonary resuscitation (CPR)--opening and maintaining an airway, providing artificial ventilation and artificial circulation by means of external cardiac compression.

casualty collection point (CCP)--a site for the congregation, triage (sorting), preliminary treatment, and evacuation of casualties following a disaster.

catchment area--the geographic area served by a specified health care facility or EMS agency.

centralized EMS dispatch center--a system which is responsible for establishing communications channels and identifying the necessary equipment and facilities to permit immediate management and control of an EMS patient. This operation must provide access and availability to public safety resources essential to the effective and efficient EMS management of the immediate EMS problem.

communication system--those resources and arrangements for notifying the EMS system of an emergency, for mobilizing and dispatching resources, for exchanging information, for remote monitoring of vital indicators, and for the radio transmission of treatment procedures and directions.

definitive care--a level of therapeutic intervention capable of providing comprehensive health care services for a specific condition.

designated facility--a hospital which has been designated by a local EMS agency to perform specified emergency medical services systems functions pursuant to guidelines established by the authority.

dispatch triage--the process of sorting requests for emergency medical assistance based on information provided by the reporting party so the appropriate resources can be sent.

emergency--a situation in which there is a real or perceived need for immediate action, attention or decision making to prevent mortality or to reduce serious morbidity (adjective form--emergent).

emergency air ambulance--an aircraft with emergency medical transport capabilities.

emergency ground ambulance--a surface transportation vehicle that is specially designed, constructed, maintained, supplied, equipped, and intended for exclusive use in emergency transport of the sick and injured.

emergency ambulance service--an emergency medical transport provider operating within an organized EMS system for the purpose of assuring twenty-four (24) hour availability of such services. This pertains to all ground, air or water emergency medical transport.

emergency department--the area of a licensed general acute care facility that customarily receives patients in need of emergent medical evaluation and/or care.

emergency medical services (EMS)-- the provision of services to patients requiring immediate assistance due to illness or injury, including access, response, rescue, prehospital and hospital treatment, and transportation.

EMS plan--a plan for the delivery of emergency medical services.

EMS system--a coordinated arrangement of resources (including personnel, equipment, and facilities) which are organized to respond to medical emergencies, regardless of the cause.

first responder--the first person (unit) dispatched to the scene of a medical emergency to provide patient care.

health facility--any facility, place or building which is organized, maintained and operated for the diagnosis, care and treatment of human illness or injury, physical or mental, including convalescence, rehabilitation and/or pre- and post-natal care, for one or more persons, to which patients are admitted for twenty-four (24) hours or longer.

hospital--an acute care hospital licensed under Chapter 2 (commencing with Section 1250) of Division 2, Health and Safety Code.

intervener physician--a physician on the scene of a medical emergency who offers to assist advanced life support personnel.

medical control--physician responsibility for the development, implementation, and evaluation of the clinical aspects of an EMS system.

medical disaster--a natural or human-caused event which overwhelms the medical resources within a system. It is characterized by a wide geographic scope and by damage to medical facilities and the transportation system. Because of its wide scope, it must be managed by a centralized, off-scene command system.

medical emergency--an unforeseen situation in which there is a real or perceived need for immediate medical care, based on an injury or other unforeseen acute physical or mental disorder.

medical protocol--pre-established physician authorized procedures or guidelines for medical care of a specified clinical situation, based on patient presentation.

metro--all census places with a population density of greater than 500 persons per square mile; or census tracts and enumeration districts without census tracts which have a population density of greater than 500 persons per square mile.

multi-casualty incident--a natural or human-caused event which may overwhelm the medical resources within a system. It is characterized by a limited geographic scope and can be managed by an on-scene command system.

mutual aid--the furnishing of resources, from one individual or agency to another individual or agency, including but not limited to facilities, personnel, equipment, and services, pursuant to an agreement with the individual or agency, for use within the jurisdiction of the individual or agency requesting assistance.

non-emergency--a situation in which there is a no perceived need for immediate action, attention or decision making to prevent mortality or to reduce serious morbidity (adjective form--non-emergent).

pediatric emergency medical and critical care system--a subsystem within the EMS system designed to manage the treatment of the emergent pediatric patient.

prehospital emergency medical services--a sub-system of the emergency medical services system which provides medical services to patients requiring immediate assistance due to illness or injury, prior to

the patient's arrival at an emergency medical facility.

prehospital time--the interval of time between activation of the emergency medical transport response to an emergency incident and arrival of the emergency patient at a receiving facility.

primary transport--transport of an emergency patient from the scene of an emergency incident to a receiving facility.

provider--an organization, institution, or individual authorized to provide direct patient care.

public safety agency--a functional division of a public agency which provides fire fighting, police, medical or other emergency services.

public safety answering point (PSAP)--the location at which an emergency telephone call is answered and, either appropriate resources are dispatched or the request is relayed to the responding agency.

public safety telephone operators--the initial answerer of an emergency call.

quality assurance/quality improvement--a method of evaluation of services provided, which includes defined standards, evaluation methodology(ies), and utilization of evaluation results for continued system improvement.

receiving facility--a general acute care facility which has been assigned a role in the EMS system by the local EMS agency.

response time--the total interval from receipt of a request for medical assistance to the primary public safety answering point (PSAP) to arrival of the responding unit at the scene. This includes all dispatch intervals and driving time.

rural--All census places with a population density of 7 to 50 persons per square mile; or census tracts or enumeration districts without census tracts which have a population density of 7 to 50 persons per square mile.

secondary care--health care beyond the primary. Included are more sophisticated diagnostic methods and techniques, and laboratory facilities. This level of care is nearly available in medical care institutions serving a large population. (SOURCE: Tabors, 16th edition). Contrast with primary and tertiary care.

secondary transport--transport of an emergency patient from an initial receiving facility to a second treatment facility.

service area--the geographic area within which an EMS agency or health care facility provides service.

significant medical incident--a medical incident which is larger than normal. It includes both multicasualty incidents and medical disasters.

statewide EMS system--a network of local EMS systems, integrated and coordinated at the state level.

suburban--All census places with a population density of 51 to 100 persons per square mile; or census tracts or enumeration districts without census tracts which have a population density of 51 to 100

persons per square mile.

transfer agreement--a written agreement between health facilities providing reasonable assurance that transfer of patients will be effected between health facilities whenever such transfer is medically appropriate, as determined by the attending physician.

transport time--the interval of time required for emergency medical transport of an ill or injured person from the scene of an emergency incident to arrival at a receiving facility.

trauma care system--a subsystem within the EMS system designed to manage the treatment of the trauma patient.

triage--the process of sorting the sick and injured on the basis of type and urgency of condition present, so that they may be properly routed to the medical facility most appropriately situated and equipped for their care.

urban--all census places with a population density of 101 to 500 persons per square mile; or census tracts and enumeration districts without census tracts which have a population density of 101 to 500 persons or more per square mile.

urgent--a situation in which there is a real or perceived need for immediate action, attention, or decision making to reduce morbidity, but where no life threatening situation appears to exist.

wilderness--census tracts or enumeration districts without census tracts which have a population of less than seven persons per square mile.

SYSTEM ASSESSMENT (example)

STANDARD

2.xx Public safety telephone operators shall have emergency medical orientation and all medical dispatch personnel shall receive emergency medical dispatch training.

Public safety telephone operators should have emergency medical orientation and all medical dispatch personnel should be trained and certified in accordance with the EMS Authority's Emergency Medical Dispatch Guidelines.

CURRENT STATUS:

No local program exists for training of telecommunications personnel, other than on-the-job training provided by employers.

The County EMS Dispatch Center interrogates reporting parties and uses dispatch triage, but does not provide pre-arrival instructions.

COORDINATION WITH OTHER EMS AGENCIES:

Not applicable for this standard.

NEED(S):

A pre-service training program for EMS dispatchers.

OBJECTIVE:

OBJECTIVE 2-1:

The LEMSA, in conjunction with the Community College should develop and present an EMS Dispatch course meeting the standards of the U.S. Department of Transportation.

TIMEFRAME FOR OBJECTIVE:

Annual Implementation Plan

Long-range Plan

TABLE 2: SYSTEM RESOURCES AND OPERATIONS
System Organization and Management

EMS System: Imperial County Reporting Year: FY 03-04

NOTE: Number (1) below is to be completed for each county. The balance of Table 2 refers to each agency.

1. Percentage of population served by each level of care by county:
 (Identify for the maximum level of service offered; the total of a, b, and c should equal 100%.)
 County: Imperial

| | |
|---|------------|
| a. Basic Life Support (BLS) | <u>15%</u> |
| b. Limited Advanced Life Support (LALS) | <u>5%</u> |
| c. Advanced Life Support (ALS) | <u>80%</u> |

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. The person responsible for day-to-day activities of EMS agency 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 which are performed by the agency

| | |
|---|----------|
| Implementation of exclusive operating areas (ambulance franchising) | <u>X</u> |
| Designation of trauma centers/trauma care system planning | <u>X</u> |
| Designation/approval of pediatric facilities | |
| Designation of other critical care centers | |
| Development of transfer agreements | |
| Enforcement of local ambulance ordinance | <u>X</u> |
| Enforcement of ambulance service contracts | <u>X</u> |
| Operation of ambulance service | |

Table 2 - System Organization & Management (cont.)

| | |
|---|----------|
| Continuing education | <u>X</u> |
| Personnel training | <u>X</u> |
| Operation of oversight of EMS dispatch center | |
| Non-medical disaster planning | |
| Administration of critical incident stress debriefing (CISD) team | |
| Administration of disaster medical assistance team (DMAT) | |
| Administration of EMS Fund [Senate Bill (SB) 12/612] | |
| Other: | |
| Other: | |
| Other: | |

5. EMS agency budget for FY 95

A. EXPENSES

| | |
|---|--------------------------|
| Salaries and benefits (all but contract personnel) | <u>\$ 222,000</u> |
| Contract Services (e.g. medical director) | <u>137,000</u> |
| Operations (e.g. copying, postage, facilities) | <u>115,000</u> |
| Travel | <u>8,900</u> |
| Fixed assets | <u>3,500</u> |
| Indirect expenses (overhead) | <u>15,000</u> |
| Ambulance subsidy | <u>0</u> |
| EMS Fund payments to physicians/hospital | <u>0</u> |
| Dispatch center operations (non-staff) | <u>0</u> |
| Training program operations | <u>0</u> |
| Other: <u>Meetings</u> | <u>0</u> |
| Other: <u>Funding to increase service level</u> | <u>0</u> |
| Other: | <u>0</u> |
| TOTAL EXPENSES | <u>\$ 501,400</u> |

Table 2 - System Organization & Management (cont.)

B. SOURCES OF REVENUE

| | |
|---|---------------------|
| Special project grant(s) [from EMSA] | |
| Preventive Health and Health Services (PHHS) Block Grant | <u>\$ 17,827.11</u> |
| Office of Traffic Safety (OTS) | <u>\$</u> |
| State general fund | |
| County general fund | <u>0</u> |
| Other local tax funds (e.g., EMS district) | |
| County contracts (e.g. multi-county agencies) | |
| Certification fees | <u>\$15,610</u> |
| Training program approval fees | |
| Training program tuition/Average daily attendance funds (ADA) | <u>\$2270.00</u> |
| Job Training Partnership ACT (JTPA) funds/other payments | |
| Base hospital application fees | |
| Base hospital designation fees | |
| Trauma center application fees | |
| Trauma center designation fees | |
| Pediatric facility approval fees | |
| Pediatric facility designation fees | |

Table 2 - System Organization & Management (cont.)

Other critical care center application fees

Type:

Other critical care center designation fees

Type:

Ambulance service/vehicle fees

Contributions

EMS Fund (SB 12/612)

Other grants:

Bioterrorism \$522,286.00

Homeland Security \$80,821.36

Other fees:

Child Safety Seat Fund \$38,368.89

Other (specify):

TOTAL REVENUE \$ 677,183.36

*TOTAL REVENUE SHOULD EQUAL TOTAL EXPENSES.
IF THEY DON'T, PLEASE EXPLAIN BELOW.*

Table 2 - System Organization & Management (cont.)

6. Fee structure for FY 03-04

We do not charge any fees

Our fee structure is:

| | |
|---|------|
| First responder certification | \$ |
| EMS dispatcher certification | |
| EMT-I certification | \$10 |
| EMT-I recertification | \$10 |
| EMT-defibrillation certification | |
| EMT-defibrillation recertification | |
| EMT-II certification | \$20 |
| EMT-II recertification | \$20 |
| EMT-P accreditation | \$20 |
| Mobile Intensive Care Nurse/ Authorized Registered Nurse (MICN/ARN) certification | \$20 |
| MICN/ARN recertification | \$20 |
| EMT-I training program approval | |
| EMT-II training program approval | |
| EMT-P training program approval | |
| MICN/ARN training program approval | |
| Base hospital application | |
| Base hospital designation | |
| Trauma center application | |
| Trauma center designation | |
| Pediatric facility approval | |
| Pediatric facility designation | |

Table 2 - System Organization & Management (cont.)

Other critical care center application

Type:

Other critical care center designation

Type:

Ambulance service license

\$

Ambulance vehicle permits

Other: Optional skills training (Advanced EMT Course)

\$3,400

Other: Continuing Education training

\$25/hr

Other: Special training programs (EMD)

\$800

7. Complete the table on the following two pages for the EMS agency staff for the fiscal year of .

Table 2 - System Organization & Management (cont.)

EMS System: Imperial County

Reporting Year: FY 95 03

| CATEGORY | ACTUAL TITLE | FTE POSITIONS (EMS ONLY) | TOP SALARY BY HOURLY EQUIVALENT | BENEFITS (% of Salary) | COMMENTS |
|---|----------------------|--------------------------|---------------------------------|------------------------|----------|
| EMS Admin./ Coord./Dir. | EMS Manager | 1 | 26.47 | 31% | |
| Asst. Admin./ Admin. Asst./ Admin. Mgr. | | | | | |
| ALS Coord./ Field Coord./ Trng Coord. | | | | | |
| Program Coord./Field Liaison (Non-clinical) | | | | | |
| Trauma Coord. | | | | | |
| Med. Director | EMS Medical Director | .15 | 65.00 | N/A | |
| Other MD/ Med. Consult./ Trng. Med. Dir. | | | | | |
| Disaster Med. Planner | | | | | |

Include an organizational chart of the local EMS agency and a county organizational chart(s) indicating how the LEMSA fits within the county/multi-county structure.

Table 2 - System Organization & Management (cont.)

| CATEGORY | ACTUAL TITLE | FTE POSITIONS (EMS ONLY) | TOP SALARY BY HOURLY EQUIVALENT | BENEFITS (% of Salary) | COMMENTS |
|----------------------------|---|--------------------------|---------------------------------|------------------------|----------|
| Dispatch Supervisor | | | | | |
| Medical Planner | | | | | |
| Dispatch Supervisor | | | | | |
| Data Evaluator/ Analyst | Analyst II (Bioterrorism Program) | 1 | 19.28 | 31% | |
| QA/QI Coordinator | | | | | |
| Public Info. & Ed. Coord. | | | | | |
| Ex. Secretary | | | | | |
| Other Clerical | Office Assistant III | 1 | 11.85 | 31% | |
| Data Entry Clerk | | | | | |
| Other | Health Education Spec. (Bioterrorism Program) | 1 | 15.50 | 31% | |

Include an organizational chart of the local EMS agency and a county organizational chart(s) indicating how the LEMSA fits within the county/multi-county structure.

TABLE 3: SYSTEM RESOURCES AND OPERATIONS – Personnel/Training

EMS System: Imperial County

Reporting Year: FY 03-04

NOTE: Table 3 is to be reported by agency.

| | EMT - Is | EMT - IIs | EMT - Ps | MICN | EMS Dispatchers |
|--|----------|-----------|----------|------|-----------------|
| Total certified | 229 | 3 | | 10 | 28 |
| Number of newly certified this year | | | | 0 | 0 |
| Number of recertified this year | | | | | 0 |
| Number of certificate reviews resulting in: a) formal investigations b) probation c) suspensions d) revocations e) denials f) denials of renewal g) no action taken | 0 | 0 | 0 | 0 | 0 |
| | | | | | |

1. Number of EMS dispatchers trained to EMSA standards: 28 (All APCO Certified)
2. Early defibrillation:
 - a) Number of EMT-I (defib) certified 229
 - b) Number of public safety (defib) certified (non-EMT-I) 78 (all Sheriff Deputies)
3. Do you have a first responder training program?

yes

no

TABLE 4: SYSTEM RESOURCES AND OPERATIONS – Communications

EMS System: Imperial County

County: Imperial

Reporting Year: FY 03-04

Note: Table 4 is to be answered for each county.

1. Number of primary Public Service Answering Points (PSAP) 6
2. Number of secondary PSAPs 1
3. Number of dispatch centers directly dispatching ambulances 1
4. Number of designated dispatch centers for EMS Aircraft 1
5. Do you have an operational area disaster communication system? yes no
 - a. Radio primary frequency Transmit 856.075 Receive 856.075
 - b. Other methods Conventional Channels, Cellular Communications, RACES
 - c. Can all medical response units communicate on the same disaster communications system?
yes no
 - d. Do you participate in OASIS? yes no
 - e. Do you have a plan to utilize RACES as a back-up communication system?
yes no
 - 1) Within the operational area? yes no
 - 2) Between the operational area and the region and/or state? yes no
6. Who is your primary dispatch agency for day-to-day emergencies? Imperial County Sheriffs Office
7. Who is your primary dispatch agency for a disaster? Imperial County Sheriffs Office

TABLE 5: SYSTEM RESOURCES AND OPERATIONS
Response/Transportation

EMS System: Imperial County

Reporting Year: FY 03-04

Note: Table 5 is to be reported by agency.

TRANSPORTING AGENCIES

| | | |
|----|---|---------------|
| 1. | Number of exclusive operating areas | <u>5</u> |
| 2. | Percentage of population covered by Exclusive Operating Areas (EOA) | <u>80%</u> |
| 3. | Total number responses | <u>14,318</u> |
| | a) Number of emergency responses (Code 2: expedient, Code 3: lights and siren) | <u>9,555</u> |
| | b) Number non-emergency responses (Code 1: normal) | <u>4,763</u> |
| 4. | Total number of transports | <u>11,526</u> |
| | a) Number of emergency transports (Code 2: expedient, Code 3: lights and siren) | <u>6,763</u> |
| | b) Number non-emergency transports (Code 1: normal) | <u>4,763</u> |

Early Defibrillation Providers

| | | |
|----|---|----------|
| 5. | Number of public safety defibrillation programs | <u>0</u> |
| | a) Automated | <u>3</u> |
| | b) Manual | <u>0</u> |
| 6. | Number of EMT-Defibrillation providers | <u>9</u> |
| | a) Automated | <u>9</u> |
| | b) Manual | <u>0</u> |

Air Ambulance Services

| | | |
|----|--|------------|
| 7. | Total number of responses | <u>67</u> |
| | a) Number of emergency responses | <u>67</u> |
| | b) Number of non-emergency responses | <u>N/A</u> |
| 8. | Total number of transports | <u>67</u> |
| | a) Number of emergency (scene) responses | <u>67</u> |
| | b) Number of non-emergency responses | |

TABLE 5: SYSTEM RESOURCES AND OPERATIONS – Response/Transportation (cont)

SYSTEM STANDARD RESPONSE TIMES (90TH PERCENTILE)

| Enter the response times in the appropriate boxes. | METRO/URBAN | SUBURBAN/RURAL | WILDERNESS | SYSTEMWIDE |
|--|-------------|----------------|------------|------------|
| 1. BLS and CPR capable first responder. | N/A | N/A | N/A | N/A |
| 2. Early defibrillation capable responder. | N/A | N/A | N/A | N/A |
| 3. Advanced life capable responder. | N/A | N/A | N/A | N/A |
| 4. EMS transport unit. | 10 min. | 30 min. | 60 min. | N/A |

TABLE 6: SYSTEM RESOURCES AND OPERATIONS
Facilities/Critical Care

EMS System: Imperial County

Reporting Year: FY 03-04

NOTE: Table 6 is to be reported by agency.

Trauma care system

1. Trauma patients: (Trauma System activated on April 1, 2004, no data available yet)
 - a) Number of patients meeting trauma triage criteria N/A
 - b) Number of major trauma victims transported directly to a trauma center by ambulance N/A
 - c) Number of major trauma patients transferred to a trauma center N/A
 - d) Number of patients meeting triage criteria who weren't treated at a trauma center N/A

Emergency departments:

2. Total number of emergency departments 2
 - a) Number of referral emergency services
 - b) Number of standby emergency services
 - c) Number of basic emergency services 2
 - d) Number of comprehensive emergency services
3. Number of receiving hospitals with agreements 2

TABLE 7: SYSTEM RESOURCES AND OPERATIONS – Disaster Medical

EMS System: Imperial County

County: Imperial

Reporting Year: FY 03-04

NOTE: Table 7 is to be answered for each county.

SYSTEM RESOURCES

1. Casualty Collections Points (CCP)

- a. Where are your CCPs located? The County’s Emergency Operations Plan no longer has designated CCPs. However, under the Medical & Health Branch Disaster Plan, Field Treatment Sites can be set up as needed in many predetermined locations to include community centers and schools throughout the county.
- b. How are they staffed? These sites would be staffed with physicians, nurses, paramedics and EMTs as they become available. When local demand exceeds local resources, the County EOC would submit a request to Region VI for a DMAT team to help provide staff for FTSs and elsewhere as needed.
- c. Do you have a supply system for supporting them for 72 hours? This depends on the demand. We have developed a plan to support FTSs and when the demand exceeds resources, we submit a request for additional resources through Region VI. yes [X] no []

2. CISD

Do you have a CISD provider with 24 hour capability? yes [] no [X]

3. Medical Response Team

- a. Do you have any team medical response capability? (DMAT?) yes [] no [X]
- b. For each team, are they incorporated into your local response plan? yes [] no [X]
- c. Are they available for statewide response? yes [] no [X]
- d. Are they part of a formal out-of-state response system? yes [] no [X]

4. Hazardous Materials

- a. Do you have any HazMat trained medical response teams? yes [X] no []
- b. At what HazMat level are they trained? Specialist and Technician
- 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 EOCs you will need to interact with in a disaster? 9

Table 8: Providers (From EMS System Plan)

Reporting Year: 2004

| | | | | |
|---|---|---|--|---|
| Name, Address & Telephone: Bureau of Land Management 1661 S. 4th St. El Centro, CA 92243 760-337-4400 office; 909-383-5652 dispatch | | Primary Contact: Neil Hamada 760-337-4451 office; 760-996-8415 cell Thomas Sharkey 760-337-4452 office; 760-996-8414 cell | | |
| Written Contract: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Service: <input checked="" type="checkbox"/> Ground (off-highway rescue) <input type="checkbox"/> Air <input type="checkbox"/> Water | <input type="checkbox"/> Transport <input checked="" type="checkbox"/> Non-Transport (BLM transports victims from scene to nearest ambulance) | Air Classification: <input type="checkbox"/> Auxiliary Rescue <input type="checkbox"/> Air Ambulance <input type="checkbox"/> ALS Rescue <input checked="" type="checkbox"/> BLS Rescue | Number of personnel providing Services: <input type="checkbox"/> PS <input type="checkbox"/> BLS <input type="checkbox"/> LALS <input type="checkbox"/> PS-defib <input checked="" type="checkbox"/> 9 EMT-D <input type="checkbox"/> ALS |
| Ownership: <input checked="" type="checkbox"/> Public <input type="checkbox"/> Private | Medical Director: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | If Public: <input type="checkbox"/> Fire <input type="checkbox"/> Law <input checked="" type="checkbox"/> Other: <u>BLM</u> | If Public: <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Spec. <input checked="" type="checkbox"/> Federal <input type="checkbox"/> Dist. | Number of ambulances: 3 off-highway rescue buggies 10 4x4 rescue vehicles 1 mobile rescue medical trailer |

| | | | | |
|---|---|--|---|--|
| Name, Address & Telephone | | Primary Contact: | | |
| Written Contract: <input type="checkbox"/> Yes <input type="checkbox"/> No | Service: <input type="checkbox"/> Ground <input type="checkbox"/> Air <input type="checkbox"/> Water | <input type="checkbox"/> Transport <input type="checkbox"/> Non-Transport | Air Classification: <input type="checkbox"/> Auxiliary Rescue <input type="checkbox"/> Air Ambulance <input type="checkbox"/> ALS Rescue <input type="checkbox"/> BLS Rescue | Number of personnel providing Services: <input type="checkbox"/> PS <input type="checkbox"/> BLS <input type="checkbox"/> LALS <input type="checkbox"/> PS-defib <input type="checkbox"/> EMT-D <input type="checkbox"/> ALS |
| Ownership: <input type="checkbox"/> Public <input type="checkbox"/> Private | Medical Director: <input type="checkbox"/> Yes <input type="checkbox"/> No | If Public: <input type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other: _____ | If Public: <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Spec. <input type="checkbox"/> Federal <input type="checkbox"/> Dist. | Number of ambulances: |

Table 8: Providers (From EMS System Plan)

Reporting Year:2004

| | | | | |
|--|--|---|---|---|
| Name, Address & Telephone: Calipatria Fire Department 125 N. Park Calipatria, CA 92233 760-348-4144 | | Primary Contact: Chris Hall, Fire Chief | | |
| Written Contract: <input type="checkbox"/> Yes <input type="checkbox"/> No | Service: <input checked="" type="checkbox"/> Ground <input type="checkbox"/> Air <input type="checkbox"/> Water | <input type="checkbox"/> Transport <input checked="" type="checkbox"/> Non-Transport | Air Classification: <input type="checkbox"/> Auxiliary Rescue <input type="checkbox"/> Air Ambulance <input type="checkbox"/> ALS Rescue <input type="checkbox"/> BLS Rescue | Number of personnel providing Services: <u>0</u> PS <u>0</u> PS-defib <u>0</u> BLS <u>7</u> EMT-D <u>3</u> LALS <u>2</u> ALS |
| Ownership: <input checked="" type="checkbox"/> Public <input type="checkbox"/> Private | Medical Director: <input type="checkbox"/> Yes <input type="checkbox"/> No | If Public: <input checked="" type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other: _____ | If Public: <input checked="" type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Spec. <input type="checkbox"/> Federal Dist. | Number of ambulances: <u>0</u> |

Table 8: Providers (From EMS System Plan)

Reporting Year:2004

| | | | | |
|---|--|---|---|--|
| Name, Address & Telephone: Brawley Fire Department 815 Main St. Brawley, CA 92227 760-344-1234 | | Primary Contact: Frank Contreras, Fire Chief | | |
| Written Contract: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Service: <input checked="" type="checkbox"/> Ground <input type="checkbox"/> Air <input type="checkbox"/> Water | <input type="checkbox"/> Transport <input checked="" type="checkbox"/> Non-Transport | Air Classification: <input type="checkbox"/> Auxiliary Rescue <input type="checkbox"/> Air Ambulance <input type="checkbox"/> ALS Rescue <input type="checkbox"/> BLS Rescue | Number of personnel providing Services: <u>0</u> PS <u>0</u> PS-defib <u>0</u> BLS <u>23</u> EMT-D <u>0</u> LALS <u>0</u> ALS |
| Ownership: <input checked="" type="checkbox"/> Public <input type="checkbox"/> Private | Medical Director: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | If Public: <input checked="" type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other: _____ | If Public: <input checked="" type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Spec. <input type="checkbox"/> Federal Dist. | Number of ambulances: <u>0</u> |

Table 8: Providers (From EMS System Plan)

Reporting Year: 2004

| | | | | |
|---|--|---|---|--|
| Name, Address & Telephone: El Centro Fire Department 775 State Street El Centro, CA 92243 760-337-4530 | | Primary Contact: Bill Dubois, Battalion Fire Chief | | |
| Written Contract: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Service: <input checked="" type="checkbox"/> Ground <input type="checkbox"/> Air <input type="checkbox"/> Water | <input checked="" type="checkbox"/> Transport <input type="checkbox"/> Non-Transport | Air Classification: <input type="checkbox"/> Auxiliary Rescue <input type="checkbox"/> Air Ambulance <input type="checkbox"/> ALS Rescue <input type="checkbox"/> BLS Rescue | Number of personnel providing Services: 0 PS 20 BLS 3 LALS 0 PS-defib 0 EMT-D 10 ALS |
| Ownership: <input checked="" type="checkbox"/> Public <input type="checkbox"/> Private | Medical Director: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | If Public: <input checked="" type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other: _____ | If Public: <input checked="" type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Spec. <input type="checkbox"/> Federal Dist. | Number of ambulances: <u>0</u> |

Table 8: Providers (From EMS System Plan)

Reporting Year: 2004

| | | | | |
|---|--|---|---|--|
| Name, Address & Telephone: Calexico Fire Department 430 E. 5 th St. Calexico, CA 92231 760-768-2150 | | Primary Contact: Chief Carlos Escalante | | |
| Written Contract: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Service: <input checked="" type="checkbox"/> Ground <input type="checkbox"/> Air <input type="checkbox"/> Water | <input checked="" type="checkbox"/> Transport <input type="checkbox"/> Non-Transport | Air Classification: <input type="checkbox"/> Auxiliary Rescue <input type="checkbox"/> Air Ambulance <input type="checkbox"/> ALS Rescue <input type="checkbox"/> BLS Rescue | Number of personnel providing Services: 0 PS 15 BLS 0 LALS 0 PS-defib 0 EMT-D 13 ALS |
| Ownership: <input checked="" type="checkbox"/> Public <input type="checkbox"/> Private | Medical Director: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | If Public: <input checked="" type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other: _____ | If Public: <input checked="" type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Spec. <input type="checkbox"/> Federal Dist. | Number of ambulances: <u>3</u> |

Table 8: Providers (From EMS System Plan)

Reporting Year: 2004

| | | | | |
|---|---|--|--|--|
| Name, Address & Telephone: Gold Cross Ambulance PO Box 1834 El Centro, CA 92243 760-353-3380 | | Primary Contact: John Goodall Work- 760-353-3380 Pager- 760-370-6211 | | |
| Written Contract: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | Service: <input checked="" type="checkbox"/> Ground <input checked="" type="checkbox"/> Air <input type="checkbox"/> Water | <input checked="" type="checkbox"/> Transport <input checked="" type="checkbox"/> Non-Transport | Air Classification: <input type="checkbox"/> Auxiliary Rescue <input checked="" type="checkbox"/> Air Ambulance <input type="checkbox"/> ALS Rescue <input type="checkbox"/> BLS Rescue | Number of personnel providing Services: 0 PS 22 BLS 0 LALS 0 PS-defib 0 EMT-D 14 ALS |
| Ownership: <input type="checkbox"/> Public <input checked="" type="checkbox"/> Private | Medical Director: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | If Public: <input type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other: _____ | If Public: <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Spec. <input type="checkbox"/> Federal Dist. | Number of ambulances: <u>10</u> |

Table 8: Providers (From EMS System Plan)

Reporting Year: 2004

| | | | | |
|--|--|---|---|--|
| Name, Address & Telephone: Holtville Fire Department 121 W. 5th St. Holtville, CA 92250 760-356-2673 | | Primary Contact: Chief David Lantzer | | |
| Written Contract: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Service: <input checked="" type="checkbox"/> Ground <input type="checkbox"/> Air <input type="checkbox"/> Water | <input type="checkbox"/> Transport <input checked="" type="checkbox"/> Non-Transport | Air Classification: <input type="checkbox"/> Auxiliary Rescue <input type="checkbox"/> Air Ambulance <input type="checkbox"/> ALS Rescue <input type="checkbox"/> BLS Rescue | Number of personnel providing Services: 0 PS 10 BLS 0 LALS 0 PS-defib 10 EMT-D 0 ALS |
| Ownership: <input checked="" type="checkbox"/> Public <input type="checkbox"/> Private | Medical Director: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | If Public: <input checked="" type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other: _____ | If Public: <input checked="" type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Spec. <input type="checkbox"/> Federal Dist. | Number of ambulances: <u>0</u> |

Table 8: Providers (From EMS System Plan)

Reporting Year:2004

| | | | | |
|---|--|---|---|--|
| Name, Address & Telephone: Imperial County Fire Department 2514 La Brucherie Rd. Imperial, CA 92251 760-355-1191 | | Primary Contact: Fred Nippens, Assistant Chief | | |
| Written Contract: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Service: <input checked="" type="checkbox"/> Ground <input type="checkbox"/> Air <input type="checkbox"/> Water | <input type="checkbox"/> Transport <input checked="" type="checkbox"/> Non-Transport | Air Classification: <input type="checkbox"/> Auxiliary Rescue <input type="checkbox"/> Air Ambulance <input type="checkbox"/> ALS Rescue <input type="checkbox"/> BLS Rescue | Number of personnel providing Services: 0 PS 0 PS-defib 0 BLS 48 EMT-D 0 LALS 3 ALS |
| Ownership: <input checked="" type="checkbox"/> Public <input type="checkbox"/> Private | Medical Director: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | If Public: <input checked="" type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other: _____ | If Public: <input type="checkbox"/> City <input checked="" type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Spec. <input type="checkbox"/> Federal Dist. | Number of ambulances:0 |

Table 8: Providers (From EMS System Plan)

Reporting Year:2004

| | | | | |
|--|--|---|---|--|
| Name, Address & Telephone: Niland Fire District P.O. Box 40 Niland, CA 92257 760-359-0410 | | Primary Contact: Chief Mike Aleksick | | |
| Written Contract: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Service: <input checked="" type="checkbox"/> Ground <input type="checkbox"/> Air <input type="checkbox"/> Water | <input type="checkbox"/> Transport <input checked="" type="checkbox"/> Non-Transport | Air Classification: <input type="checkbox"/> Auxiliary Rescue <input type="checkbox"/> Air Ambulance <input type="checkbox"/> ALS Rescue <input type="checkbox"/> BLS Rescue | Number of personnel providing Services: 0PS 0PS-defib 0BLS 11EMT-D 3LALS 0ALS |
| Ownership: <input checked="" type="checkbox"/> Public <input type="checkbox"/> Private | Medical Director: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | If Public: <input checked="" type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other: _____ | If Public: <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input checked="" type="checkbox"/> Spec. <input type="checkbox"/> Federal Dist. | Number of ambulances:0 |

Table 8: Providers (From EMS System Plan)

Reporting Year:2004

| | | | | |
|---|--|--|---|--|
| Name, Address & Telephone: West Shores Ambulance Service 83 Desert Shores Drive Desert Shores, CA 92274 760-395-6800 | | Primary Contact: Marcia McKinney, Office Manager Richard Lopez, Paramedic, Supervisor | | |
| Written Contract: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Service: <input checked="" type="checkbox"/> Ground <input type="checkbox"/> Air <input type="checkbox"/> Water | <input checked="" type="checkbox"/> Transport <input type="checkbox"/> Non-Transport | Air Classification: <input type="checkbox"/> Auxiliary Rescue <input type="checkbox"/> Air Ambulance <input type="checkbox"/> ALS Rescue <input type="checkbox"/> BLS Rescue | Number of personnel providing Services: 0 PS 0 BLS 3 LALS 0 PS-defib 2 EMT-D 5 ALS |
| Ownership: <input type="checkbox"/> Public <input checked="" type="checkbox"/> Private | Medical Director: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | If Public: <input type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other: _____ | If Public: <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Spec. <input type="checkbox"/> Federal Dist. | Number of ambulances:4 |

Table 8: Providers (From EMS System Plan)

Reporting Year:2004

| | | | | |
|---|--|---|---|--|
| Name, Address & Telephone: Ocotillo Fire Department PO Box 209 Ocotillo, CA 92259 760-358-7735 | | Primary Contact: Chief James Williams | | |
| Written Contract: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Service: <input checked="" type="checkbox"/> Ground <input type="checkbox"/> Air <input type="checkbox"/> Water | <input type="checkbox"/> Transport <input checked="" type="checkbox"/> Non-Transport | Air Classification: <input type="checkbox"/> Auxiliary Rescue <input type="checkbox"/> Air Ambulance <input type="checkbox"/> ALS Rescue <input type="checkbox"/> BLS Rescue | Number of personnel providing Services: 0PS 5BLS 0LALS 0PS-defib 0EMT-D 0ALS |
| Ownership: <input type="checkbox"/> Public <input checked="" type="checkbox"/> Private | Medical Director: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | If Public: <input checked="" type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other: _____ | If Public: <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Spec. <input checked="" type="checkbox"/> Federal Dist. | Number of ambulances:0 |

TABLE 9: RESOURCES DIRECTORY – Approved Training Programs

EMS System: Imperial County County: Imperial Reporting Year: FY 03-04

NOTE: Table 9 is to be completed by county. Make copies to add pages as needed.

Training Institution Name / Address Contact Person telephone no.

| | | |
|---|---|--|
| Imperial Valley College PO BOX 158, Imperial, CA 92251 | | Jackie Cypher, RN, MSN (760) 355-6275 EMS Training Coordinator |
| Student Eligibility: * | Cost of Program [basic/refreshers]: | **Program Level: <u>EMT-I</u> Number of students completing training per year: Initial training: Refresher: Cont. Education: Expiration Date: <u>9/05</u> |
| Open to general public | Registration - \$ Textbooks - Malpractice - | |
| | | Number of courses: Initial training: <u>2</u> Refresher: <u>2</u> Cont. Education: |

Training Institution Name / Address Contact Person telephone no.

| | | |
|---|---|--|
| Imperial Valley College PO BOX 158, Imperial, CA 92251 | | Jackie Cypher, RN, MSN (760) 355-6275 EMS Training Coordinator |
| Student Eligibility: * | Cost of Program [basic/refreshers]: | **Program Level: <u>Paramedic</u> Number of students completing training per year: Initial training: Refresher: Cont. Education: Expiration Date: <u>1/05</u> |
| Restricted to certain personnel | Registration - \$ Textbooks - Malpractice - | |
| | | Number of courses: Initial training: <u>1</u> Refresher: Cont. Education: |

* Open to general public or restricted to certain personnel only.

** Indicate whether EMT-I, EMT-II, EMT-P, or MICN; if there is a training program that offers more than one level complete all information for each level.

TABLE 10: RESOURCES DIRECTORY – Facilities

EMS System: Imperial County

County: Imperial

Reporting Year: FY 03-04

NOTE: Make copies to add pages as needed. Complete information for each facility by county.

| | | | | | |
|---|--|--|---|---|--|
| Name, address & telephone: | | El Centro Regional Medical Center 1415 W. Ross Ave, El Centro, CA 92243 | | Primary Contact: (760) 339-7111 Administrator: David Green | |
| Written Contract <input checked="" type="checkbox"/> yes (Trauma Center only) <input type="checkbox"/> no | Basic/Comp EMS Permit H&SC Section 1798.101: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no | Base Hospital: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no | Pediatric Critical Care Center: * <input type="checkbox"/> yes <input checked="" type="checkbox"/> no | | |
| EDAP:** <input type="checkbox"/> yes <input checked="" type="checkbox"/> no | PICU:*** <input type="checkbox"/> yes <input checked="" type="checkbox"/> no | Burn Center: <input checked="" type="checkbox"/> no | Trauma Center: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no | If Trauma Center what Level: IV | |

| | | | | | |
|---|--|--|---|---|--|
| Name, address & telephone: | | Pioneers Memorial Healthcare District 207 W. Legion Rd., Brawley, CA 92227 | | Primary Contact: (760) 344-2120 Administrator: Richard Mendoza | |
| Written Contract <input checked="" type="checkbox"/> yes (Trauma Center only) <input type="checkbox"/> no | Basic/Comp EMS Permit H&SC Section 1798.101: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no | Base Hospital: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no | Pediatric Critical Care Center: * <input type="checkbox"/> yes <input checked="" type="checkbox"/> no | | |
| EDAP:** <input type="checkbox"/> yes <input checked="" type="checkbox"/> no | PICU:*** <input type="checkbox"/> yes <input checked="" type="checkbox"/> no | Burn Center: <input checked="" type="checkbox"/> no | Trauma Center: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no | If Trauma Center what Level: IV | |

TABLE 11a: RESOURCES DIRECTORY – Disaster Medical Responders

EMS System: Imperial County

County: Imperial

Date: 8-3-95

NOTE: Information on Table 11a is to be completed for each county.

County Office of Emergency Services (OES) Coordinator:

Acting Fire Chief Fred Nippins

Work Telephone No.: (760) 355-1191

Home Telephone No.:

Cell No.: (760) 996-2921

FAX No.: 355-1482

24-HR No. 355-1164

Alternate's Name:

Work Telephone No.: (619) 355-1191

Home Telephone No.:

Office Pager No.:

FAX No.: 355-1482

24-HR No.: 355-1164

County EMS Disaster Medical Services (DMS) Coordinator:

John Pritting, EMS Manager

Work Telephone No.: (760) 482-4468

Home Telephone No.: (760) 352-5664

Office Pager No.: (760) 370-9913

FAX No.: (760) 482-4519

24-HR No.: 339-6312 (Sheriffs Dispatch)

Alternate's Name:

Robin Raecker, Public Health Director

Work Telephone No.: (760) 482-4704

Home Telephone No.: 353-3239

Cell No.: (760) 996-2357

FAX No.: 352-9933

24-HR No.: (760) 339-6312

NOTE: In the event of an emergency it is critical for the EMSA to have current information on whom to contact. Therefore, please submit name and telephone number changes to Table 11 as they occur.

TABLE 11a: RESOURCES DIRECTORY – Disaster Medical Responders (cont)

NOTE: Information on Table 11a is to be completed for each county.

County Health Officer's Name:

Stephen Munday, M.D.

Work Telephone No.: (760) 482-4429

Home Telephone No.:

Pager No.: (619) 476-4011

FAX No.: (760) 352-9933

24-HR No.:

Alternate's Name: None

Work Telephone No.:

Home Telephone No.:

Office Pager No.:

FAX No.:

24-HR No.:

Medical/Health EOC telephone no.: (310) 795-2900

Amateur Radio contact name: Joe Essary (909) 867-9270

Who is the RDMHC for your region? Thomas Prendergast, M.D.

Medical/Health EOC FAX No.: (310) 795-2877

Medical/Health radio frequency used:

NOTE: In the event of an emergency it is critical for the EMSA to have current information on whom to contact. Therefore, please submit name and telephone number changes to Table 11 as they occur.

TABLE 11b: RESOURCES DIRECTORY – Disaster Medical Responders (cont)

OES Region: VI

County: Imperial

Date: 8-3-95

NOTE: Information on Table 11b is to be completed by counties with RDMHC projects.

Regional OES Coordinator:

Sonia Brown

Work Telephone No.: (310) 795-2900

Home Telephone No.:

Office Pager No.:

FAX No.: 795-2877

24-hour No.:

Alternate's Name:

Work Telephone No.:

Home Telephone No.:

Office Pager No.:

FAX No.:

24-HR No.:

Regional Disaster Coordinator:

Stuart Long

Work Telephone No.: (909) 388-5823

Home Telephone No.: (909)681-5758

Office Pager No.:

FAX No.: (909) 388-5825

24-hour No.: (909) 356-3895

Alternate's Name:

Work Telephone No.:

Home Telephone No.:

Office Pager No.:

FAX No.:

24-HR No.:

NOTE: In the event of an emergency it is critical for the EMSA to have current information on whom to contact. Therefore, please submit name and telephone number changes to Table 11 as they occur.

TABLE 11b: RESOURCES DIRECTORY – Disaster Medical Responders (cont)

NOTE: Information on Table 11b is to be completed by counties with RDMHC projects.

Regional Disaster Medical Health Coordinator:

Thomas J. Prendergast, Jr., M.D.

Work Telephone No.: (909) 387-6219

Home Telephone No.:

Office Pager No.:

FAX No.: (909) 387-6228

24-hour No.: (909) 356-3805

Alternate's Name:

Work Telephone No.:

Home Telephone No.:

Office Pager No.:

FAX No.:

24-HR No.:

Regional Ambulance Transportation Coordinator:

Shelby Helmer

Work Telephone No.: (909) 793-7676

Home Telephone No.:

Office Pager No.: 439-2514

FAX No.: 335-2260

24-hour No.: 793-2666

Alternate's Name:

Work Telephone No.:

Home Telephone No.:

Office Pager No.:

FAX No.:

24-HR No.:

Medical/Health EOC telephone no.: (310) 795-2900

Amateur Radio contact name:

Medical/Health EOC FAX No.:

Medical/Health radio frequency used:

NOTE: In the event of an emergency it is critical for the EMSA to have current information on whom to contact. Therefore, please submit name and telephone number changes to Table 11 as they occur

**EMS PLAN
AMBULANCE ZONE SUMMARY FORM**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

| |
|--|
| <p>Local EMS Agency or County Name: IMPERIAL COUNTY EMS</p> |
| <p>Area or subarea (Zone) Name or Title: Zone I Ambulance District</p> |
| <p>Name of Current Provider(s): Include company name(s) and length of operation (uninterrupted) in specified area or subarea. Schaefer's Gold Cross Ambulance Service has provided uninterrupted ambulance service in Zone I since 1974</p> |
| <p>Area or subarea (Zone) Geographic Description: From the San Diego County line east along the Baja Mexico boarder to the point where a line drawn north meets Highway 98 at No Mirage, then east from No Mirage along an imaginary line drawn through Heber Ave, Heber and continues east to where the line meets with Interstate 8, then follows I-8 to Gordon's Well. North from Gordon's Well to the intersection of Highway 78, then northeast along Highway 78 to the border of the Chocolate Mountain Live Bombing Range, and following the eastern border of the Live Bombing Range to the Riverside County line. West along the Riverside County line to the Salton Sea, then south along the eastern and southern shoreline of the Salton Sea, to a point where a line drawn from Highway 78 meets the Salton Sea, then west along Highway 78 to the San Diego County line. South from Highway 78, along the San Diego County line to the border of Baja Mexico. (see map)</p> |
| <p>Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6): Include intent of local EMS agency and Board action. Exclusive Operating Area awarded by Board of Supervisors. Initial EOA awarded in January 1, 1981 and has been renewed every four years. Last renewal January 1, 2004 by Board Action Minute Order #17 dated 12-16-03.</p> |
| <p>Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85): Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.). All calls requiring emergency ambulance service to include 911 and interfacility transports with combination ALS/BLS.</p> |
| <p>Method to achieve Exclusivity, if applicable (HS 1797.224): If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service. If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers. Grandfathered: Schaefer's Gold Cross Ambulance Service has provided uninterrupted service with no changes to scope and manner of service to Zone I Ambulance District since 1974.</p> |

**EMS PLAN
AMBULANCE ZONE SUMMARY FORM**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

| |
|--|
| Local EMS Agency or County Name: IMPERIAL COUNTY EMS |
| Area or subarea (Zone) Name or Title: Zone 2 Ambulance District |
| Name of Current Provider(s): Include company name(s) and length of operation (uninterrupted) in specified area or subarea. Calexico Fire Department Ambulance Service has provided uninterrupted ambulance service in Zone 2 since 1972 |
| Area or subarea (Zone) Geographic Description: Starting point – on the Baja Mexico boarder at the point where a line drawn north meets Highway 98 at No Mirage, then east from No Mirage along an imaginary line drawn through Heber Ave, Heber and continues east to where the line meets with Interstate 8, then follows I-8 to Gordon's Well. South from Gordon's Well to the border of Baja, Mexico, then west along the Baja Mexico border to the starting point. Service Area includes all areas south of the imaginary line drawn through Heber Ave (not including Heber Ave) and inclusive of all other boundaries. (see map) |
| Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6): Include intent of local EMS agency and Board action. Exclusive Agreement with County |
| Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85): Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.). All calls requiring emergency ambulance service to include 911 and interfacility transports with combination ALS/LALS. |
| Method to achieve Exclusivity, if applicable (HS 1797.224): If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service. If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers. Grandfathered: Calexico Fire Department has provided uninterrupted service with no changes to scope and manner of service to Zone 2 Ambulance District since 1972. |

**EMS PLAN
AMBULANCE ZONE SUMMARY FORM**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

| |
|--|
| Local EMS Agency or County Name: IMPERIAL COUNTY EMS |
| Area or subarea (Zone) Name or Title: Zone 3 Ambulance District |
| Name of Current Provider(s): Include company name(s) and length of operation (uninterrupted) in specified area or subarea. West Shore Ambulance Service has provided uninterrupted ambulance service in Zone 3 since 1979. |
| Area or subarea (Zone) Geographic Description: Starting at the point where Imperial County, San Diego County and Riverside County meet, then east along the Riverside County line, then south along the western shoreline of the Salton Sea, to a point where a line drawn east from Highway 78 meets the Salton Sea, then west along Highway 78 to the San Diego County line and then north to the starting point. Service area includes all areas north of Highway 78 (including Highway 78) and all areas west of the Salton Sea to the county line. (see map) |
| Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6): Include intent of local EMS agency and Board action. Exclusive Agreement with County |
| Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85): Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.). All calls requiring emergency ambulance service with combination ALS/LALS/BLS. |
| Method to achieve Exclusivity, if applicable (HS 1797.224): If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service. If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers. Grandfathered: West Shore Ambulance Service has provided uninterrupted service with no changes to scope and manner of service to Zone 3 Ambulance District since 1979. |

**EMS PLAN
AMBULANCE ZONE SUMMARY FORM**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

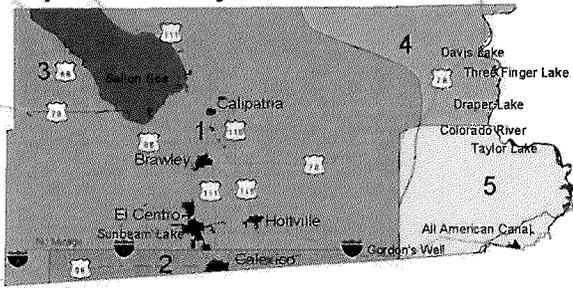
| |
|--|
| Local EMS Agency or County Name: IMPERIAL COUNTY EMS |
| Area or subarea (Zone) Name or Title: Zone 4 Ambulance District |
| Name of Current Provider(s): Include company name(s) and length of operation (uninterrupted) in specified area or subarea. Blythe Ambulance Service has provided uninterrupted ambulance service in Zone 4 since 1979. |
| Area or subarea (Zone) Geographic Description: Starting at the point where Imperial County and Riverside County meet at the Arizona border, then south along the California/Arizona border line to a point where a line drawn west meets at the border of the Chocolate Mountain Live Bombing Range, then north following the eastern border of the Live Bombing Range to the Riverside County line, then east to the starting point. (see map) |
| Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6): Include intent of local EMS agency and Board action. Exclusive Agreement with County |
| Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85): Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.). All calls requiring emergency ambulance service with combination ALS/LALS/BLS. |
| Method to achieve Exclusivity, if applicable (HS 1797.224): If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service. If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers. Grandfathered: Blythe Ambulance Service has provided uninterrupted service to Zone 4 Ambulance District since 1979. They upgraded from LALS/BLS to full ALS in 1994. |

**EMS PLAN
AMBULANCE ZONE SUMMARY FORM**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

| |
|---|
| Local EMS Agency or County Name: IMPERIAL COUNTY EMS |
| Area or subarea (Zone) Name or Title: Zone 5 Ambulance District |
| Name of Current Provider(s): Include company name(s) and length of operation (uninterrupted) in specified area or subarea. Rural/Metro Ambulance Service has provided uninterrupted ambulance service in Zone 5 since 1981. |
| Area or subarea (Zone) Geographic Description: Starting at a point on the US/Mexico Border where a line drawn north passes through Gordon's Well to the intersection of Highway 78, then northeast along Highway 78 to the southern boundary of the Chocolate Mountain Live Bombing Range, and then east to the California/Arizona border; then south along the California/Arizona border to the US/Mexico border, then west along the border to the starting point. |
| Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6): Include intent of local EMS agency and Board action. Exclusive Agreement with County |
| Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85): Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.). All calls requiring emergency ambulance service with ALS. |
| Method to achieve Exclusivity, if applicable (HS 1797.224): If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service. If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers. Grandfathered: Rural/Metro Ambulance Service has provided uninterrupted service with no changes to scope and manner of service to Zone 5 Ambulance District since 1981. |

Imperial County Ambulance Zones



EMERGENCY MEDICAL SERVICES AUTHORITY

1930 9th STREET
 SACRAMENTO, CA 95814-7043
 (916) 322-4336 FAX (916) 324-2875



February 14, 2005

John Pritting
 EMS Manager
 Imperial County EMS Agency
 935 Broadway
 El Centro, CA 92243

Dear Mr. Pritting:

We have completed our review of *Imperial County's 2004 Emergency Medical Services Plan Update*, and have found it to be in compliance with the *EMS System Standards and Guidelines and the EMS System Planning Guidelines*.

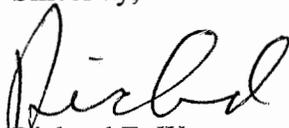
Our reviewers raised some concerns regarding certain sections of the plan. I have listed those sections along with the specific comment below.

| SECTION | COMMENT |
|------------------------------|--|
| 1.27 Pediatric System Plan | Need to perform a study to evaluate pediatric needs and care, including emergency department care and need for specialty care and transfer. |
| 5.10 Pediatric System Design | |
| 2.10 Advanced Life Support | Standard is partially met - Only Imperial's base hospital emergency department requires their physicians and RNs to be trained in advanced cardiac life support (ACLS). Need to have all emergency department physicians and RNs certified in ACLS. Note: Table 1 states standard was met. Please change to partially met. |
| 3.08 9-1-1 Public Education | Standard was not met. The agency needs to perform public education regarding the use of 9-1-1. Note: Table 1 states standard was met. Please change to Does Not Meet the Current Standard. |
| 4.05 Response Time Standards | Standard is partially met - Need response time standards for all medical responses including first responders, ALS and BLS. Note: Table 1 states standard was met. Please change to partially met. |
| 8.08 Inventory of Resources | Standard was not met. EMS Plan states, "An inventory of disaster medical resources does not exist." LEMSA needs to develop an inventory of disaster medical resources. Note: Table 1 states standard was met. Please change to Does Not Meet the Current Standard. |

John Priting
February 14, 2005
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These comments are for your information and may be addressed in your annual update. Your annual update, utilizing the attached guidelines, will be due one year from your approval date. If you have any questions regarding the plan review, please call Sandy Salaber at (916) 322-4336, extension 423.

Sincerely,


Richard E. Watson
Interim Director

REW:SS

Attachments