# EMERGENCY MEDICAL CARE COMMITTEE MEETING AGENDA

Thursday, June 17th, 2020 at 8:30 A.M.
Virtual Meeting ONLY
ZOOM LINK

https://slohealth.zoom.us/j/93069006167?pwd=djU2WDJKc2pHb2NLQVdDRi9KeThXUT09

**MEMBERS**
CHAIR Dr. Rachel May, *Emergency Physicians*, *2018-22*
VICE CHAIR Jonathan Stornetta, *Public Providers, 2020-24*
Bob Neumann, *Consumers*, *2018-22*
Matt Bronson, *City Government, 2020-24*
Alexandra Kohler, *Consumers, 2020-24*
Chris Javine, *Pre-hospital Transport Providers, 2018-22*
Michael Talmadge, *EMS Field Personnel, 2020-24*
Jay Wells, *Sheriff's Department, 2020-24*
Julia Folgelson, *Hospitals*, *2020-22*
Jennifer Sandoval, *MICNs*, *2018-22*
Dr. Tom Hale, *Physicians*, *2018-22*

**EX OFFICIO**
Vince Pierucci, *EMS Division Director*
Dr. Tom Ronay**,** *EMS Medical Director*

**STAFF**
Rachel Oakley *EMS Coordinator*
Kyle Parker, *EMS Coordinator*
Michael Groves, *EMS Coordinator*
Amy Mayfield, *Administrative Assistant*
Denise Yi, *PHEP Program Manager*

| AGENDA | ITEM | LEAD |
|---|---|---|
| Call to Order | Introductions | R. May |
| | Public Comment | |
| Action/Discussion | Approval of minutes: March 2021 Minutes (*attached)* | R. May |
| | • Draft Policy #157 FP-C/CCP-C Unified Scope of Practice<br>• Amend Policy #205 and #209, addition of Wildland Engine as ALS<br>• Ambulance Patient Offload Times (APOT) | V. Pierucci / K. Parker<br>M. Groves<br>M. Groves |
| | • COVID Update | V. Pierucci |
| Staff Reports | • Health Officer<br>• EMS Agency Staff Report<br>• EMS Medical Director Report<br>• PHEP Staff Report | P. Borenstein<br>V. Pierucci<br>T. Ronay<br>D. Yi |
| Committee Members Announcements or Reports | Opportunity for Board members to make announcements, provide brief reports on their EMS-related activities, ask questions for clarification on items not on the agenda, or request consideration of an item for a future agenda (Gov. Code Sec. 54954.2[a][2]) | Committee Members |
| Adjourn | Next Meeting: Thursday September 16, 2021, 0830 Venue TBA | |

*Draft*

Emergency Medical Care Committee
Meeting Minutes
Thursday March 18, 2021
Meeting Held Virtually via ZOOM

Members
- ☒ CHAIR Dr. Rachel May, *Emergency Medicine Physicians*
- ☒ VICE CHAIR Jonathan Stornetta, Public Providers
- ☒ Bob Neumann, *Consumers*
- ☒ Alexandra Kohler, *Consumers*
- ☒ Matt Bronson, *City Government*
- ☒ Chris Javine, Pre-Hospital Transport Providers
- ☐ Michael Talmadge, *EMS Field Personnel*
- ☐ Dr. Tom Hale, *Physicians*
- ☐ Jay Wells, *Sheriff's Department*
- ☐ Julia Fogelson, *Hospitals*
- ☒ Jennifer Sandoval, *MICNs*

Ex Officio
- ☒ Vince Pierucci, *EMS Division Director*
- ☒ Dr. Thomas Ronay, *LEMSA Medical Director*

Staff
- ☒ Rachel Oakley, EMS Coordinator
- ☒ Mike Groves, EMS Coordinator
- ☒ Kyle Parker, EMS Coordinator
- ☒ Denise Yi, *PHEP Program Manager*
- ☐ Amy Mayfield, Administrative Assistant

Guests – Chris Aten Cal Star, Luke Riley Mercy Air, Lisa Epps Mercy Air, Mike McDonough Rob Jenkins, CalFire

| AGENDA ITEM / DISCUSSION | ACTION |
|---|---|
| CALL TO ORDER | Rachel May at 0835 |
| Approval of November Meeting Minutes and recent bulletin. | Jonathan Stornetta |
| *REPORTS & DISCUSSION/ACTION ITEMS* | |
| In favor of continuing meets criteria for COVID suspected patients because of awareness purposes.<br>V. Pierucci is ok with this.<br>M. Groves to revise and resend another bulletin.<br>*08:40 lost connection to the server.*<br>*08:50 back online*<br>V. Pieruuci – Discussed staff coverage for the pandemic efforts.<br>• 60,000 vaccinations given at county sites, hospitals, and pharmacies.<br>• County is administering 1,000/day at Cuesta and Paso sites. AG is at 800/day, has parking restraints.<br>• County is doing 10,000/week, would like to increase to 15,000/week.<br>• Mike and Amy are in the office; Mike is working with EOC and EMSA. Kyle just got back to EMSA, working to get Rachel back as well.<br>• Question re: Quality Improvement Meetings over Zoom. Must go over with County Council, as there are HIPPA sensitive information shared at the meetings.<br>V. Pierucci - met with the governor's office regarding SLO Co low case numbers and best practices. It is a combined effort, that made SLO Co stand out.<br>T. Ronay - Recalled talking to Chris Javine regarding Paramedic Vaccinators, which enabled our community to be prepared for these current efforts.<br>D. Yi - Farm Workers outreach tomorrow, Friday March 19th in AG and next Friday as well.<br>• Trying to get Johnson & Johnson, which are just one dose for this population.<br>• Have 600 for tomorrow, unsure of the count for next Friday. | Jonathan Stornetta |
| Next Regular Meeting<br>Next meeting will be held Thursday, April 15, 2021. | Meeting adjourned |

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
PUBLIC HEALTH DEPARTMENT
**Mike Hill** *Health Agency Director*
**Penny Borenstein, MD, MPH** *Health Officer/Public Health Director*

| | |
|---|---|
| MEETING DATE | Virtual June 17, 2021 |
| STAFF CONTACT | Kyle Parker<br>805.788.2513 kparker@co.slo.ca.us |
| SUBJECT | Local Optional Scope of Practice (LOSOP) Unified Scope for Qualified Providers<br>Draft Policy #157 FP-C / CCP-C Unified Scope of Practice |
| SUMMARY | In late 2017 and through 2018 a State committee was formed to address paramedics working for air medical agencies having to hold multiple local emergency medical service agency (LEMSA) accreditations while flying within several counties. The committee consisted of members from both Emergency Medical Directors Association of California (EMDAC), Emergency Medical Administrators Association of California (EMSAAC), and the Emergency Medical Service Authority (EMS Authority).<br><br>The State committee developed the Unified Scope which falls under the paramedic LOSOP and may be adopted by a LEMSA with their Medical Director's approval. The Unified Scope only applies to providers with Commission on Accreditation of Medical Transport Systems (CAMTS) accreditations and allows qualified paramedics accompanied by a qualified transport nurse to perform the following skills:<br>1. Pediatric intubations<br>2. Rapid sequence induction (RSI)<br>3. Video laryngoscopy<br>4. Supraglottic airways<br>5. Ventilator initiation, maintenance, and management<br>6. Intraosseous access (IO) for both adults and pediatrics<br><br>In 2020 Mercy Air established an air base within San Luis Obispo County and is under contract to provide 911 air transport. At Mercy Air's request, the County of SLO Emergency Medical Service Agency (EMS Agency) submitted a Unified Scope LOSOP to the State EMS Authority for approval in May of 2021.The LOSOP contains Mercy Air's protocols for the six skills that make up the Unified Scope. The protocols have been reviewed and approved by the EMS Agency Medical Director.<br><br>Draft Policy #157 FP-C / CCP-C Unified Scope of Practice directly reflects the Unified Scope in both detail and Quality Assurance. Draft policy #157 was created to codify the Unified Scope into local policy. No dissention by the Operations Sub Committee members present on June 4 , 2021. |

| | |
|---|---|
| REVIEWED BY | EMS Staff, Dr. Ronay, Vince Pierucci |
| RECOMMENDED ACTION(S) | Approval of Policy # 157 FP-C / CCP-C Unified Scope of Practice |
| ATTACHMENT(S) | Draft Policy #157 |

# POLICY # 157 FP-C / CCP-C Unified Scope of Practice

## I. PURPOSE

A. To establish a uniform approach to patient care as delivered from qualified transport program paramedics throughout California. Qualified Transport Programs (Ground or flight crews) that cross regional boundaries may qualify for this scope with approval by the County of San Luis Obispo Emergency Medical Service Agency (EMS Agency) in conjunction with the California EMS Authority.

## II. SCOPE

A. This Unified Optional Scope provides a standardized scope of practice for qualified Paramedics who practice either on rotor or fixed wing aircraft or on ground ambulances which are CAMTS ECC level certified. The goal for this optional scope is to allow a uniform practice environment for Qualified Transport Program teams and their patients that remains consistent throughout California and across regional boundaries and helps ensure that our patients receive the best critical care possible on both scene calls and interfacility transports.

B. The EMS Agency Medical Director shall ensure that each Qualified Transport Program for which an application is made has appropriate medical oversight for the program, and that crew configuration for aeromedical programs consists of a qualified transport nurse and either a FP-C or a CCP-C with additional education in flight and altitude physiology, and for ground ambulances consists of a qualified transport nurse and either a FP-C or CCPC.

## III. DEFINITIONS

- **CAMTS**: Commission on Accreditation of Medical Transport Systems
- **CAMTS ECC Level Certification**: CAMTS recognizes both the CCP-C and the FP-C for the Emergency Critical Care (ECC) accreditation level. This CAMTS "ECC" level also requires a qualified nurse partner and is required for programs participating in this optional scope - see CAMTS current edition.
- **CCP-C:** A "Critical Care Paramedic" is a paramedic educated and trained in critical care transport, whose scope of practice is in accordance to the standards prescribed in Title 22 - Division 9 - Chapter 4, holds a current certification as a CCP by the Board for Critical Care Transport Paramedic Certification (BCCTPC), has a valid license issued pursuant to Title 22 - Division 9 - Chapter 4, practices within a Qualified Transport Program, and is accredited by a LEMSA. The CCP-C in training must take the CCP-C exam within 6 months and pass the exam by the end of their first year with the Qualified Transport Program. See Appendix and the following link: http://www.emsa.ca.gov/Media/Default/PDF/Chapter4Effctive2816.pdf
- **Emergency Medical Services (EMS) Medical Directors Association of California** (**EMDAC):** Is an association which is advisory to the EMS Authority on issues of scope of practice (SOP).

- **FP-C:** A “Certified Flight Paramedic” is a paramedic educated and trained in critical care transport and flight medicine, holds a current certification as an FP-C by the Board for Critical Care Transport Paramedic Certification (BCCTPC), has a valid license issued pursuant to Title 22 - Division 9 - Chapter 4, practices within a Qualified Transport Program, and is accredited by a LEMSA. The FP-C in training must take the FP-C exam within 6 months and pass the exam by the end of their first year with the Qualified Transport Program. See Appendix and the following link: http://www.emsa.ca.gov/Media/Default/PDF/Chapter4Effctive2816.pdf The FP-C examination consists of 125 questions and takes 2.5 hours to complete. See Appendix
- **Qualified Flight Paramedic:** A certified and LEMSA accredited EMT-P that meets the requirements for participating in this Unified Optional Scope. These Qualified FP-C or CCP-C paramedics have at least 3 years of critical care experience and have completed the Qualified Flight Program’s initial academy training and fall into one of these categories: FP-C, or FP-in training, or CCP-C or CC- in training with additional education in flight and altitude physiology as specified in the attached Appendix, and are working for a Qualified Transport Program and are paired with a Qualified Transport Nurse as required in the “ECC level” of CAMTS current edition standards.
- **Qualified Transport Program:** a ground or aeromedical transport program that has met the requirements to participate in this optional scope program by meeting CAMTS Emergency Critical Care (ECC) current edition level Accreditation (if aeromedical program) or equivalent and demonstrates the required training, education, competencies, Quality Improvement (QI) and Medical Direction required.
- **Qualified Transport Nurse:** A Registered Nurse with at least 3 years of critical care experience, who has completed the Qualified Transport Program training and is working toward the Certified Emergency Nurse (CEN), Critical Care Registered Nurse (CCRN), Certified Flight Registered Nurse (CFRN) or Certified Transport Registered Nurse (CTRN) as required by the CAMTS ECC Accreditation. The Qualified Transport Nurse is employed by and practicing with the Qualified Transport Program. (For aeromedical nurses, see CAMTS current edition Accreditation Standard)
- **Qualified Transport Program Medical Director:** The Qualified Transport Program Medical Director is Board certified or eligible in Emergency Medicine by American Board of Emergency Medicine or the American Board of Osteopathic Medicine, and if the Medical Director directs an aeromedical service, meets CAMTS ECC level requirements for Medical Director.
- **Qualified Transport Program Physician:** A physician who is affiliated with the Qualified Transport Program as an associate or consultant, is not the Medical Director, but also is Board certified or eligible by an American Board of Medical Specialties board in emergency medicine or in the specialty appropriate for the scope of service (e.g., pediatrics, critical care). For aeromedical service meet all the CAMTS requirements for Medical Director.
- **FP-C in training:** These Paramedics have completed the Qualified Transport Program’s initial academy training and are fully functional Paramedics for the program but have not yet completed their FP-C testing/certificate. The FP-C in

training must take the FP-C exam within 6 months and pass the exam by the end of their first year with the Qualified Transport Program.

## IV. PROCEDURE

A. All treatments may be performed on standing order, unless noted. Any treatment required that is not included in the protocols is at the discretion of the base hospital physician at the base hospital in direct radio communication providing medical direction. Unified Paramedic Optional Scope of Practice items include:

1. Pediatric Intubations
2. Rapid Sequence Induction (RSI) medication administration including: sedatives, paralytics, analgesics, and induction agents
3. Video laryngoscopy (indirect laryngoscopy)
4. Supraglottic airways
5. Ventilator initiation, maintenance, and management
6. Intraosseous Access (IO) for both adult and pediatrics

B. Qualified Transport Program Requirements for Participation in this Optional Scope

1. The Transport Program must be CAMTS ECC level certified.
2. The Qualified Transport Program must provide enhanced training, education and competency verification consistent with the requirements of this optional scope, for CAMTS current edition ECC level, and as necessary for the FP-C /CC-P.
3. The Qualified Transport Program must provide all 6 Unified Paramedic Optional Scope of Practice items, appropriate Quality Improvement (QI) and all LEMSA required metrics, providing a uniform report approved by EMDAC/SOP and delivered biannually to the EMS Agency. See Attachment A
4. The Qualified Transport Program must provide ALL policies, protocols, and procedures associated with the 6 Unified Paramedic Optional Scope of Practice items to the EMS Agency for review.
5. The Program Medical Director must meet requirements as a “Qualified Transport Program Medical Director” must be board certified/ eligible in Emergency Medicine and for flight programs includes CAMTS current edition ECC level requirements for the Medical Director.

C. Qualified Paramedic Requirements for Participation in this Optional Scope.

1. The Qualified Paramedic must be employed by a Qualified Transport Program (and working with the program during any transports where these optional scope items are utilized).

2. The Qualified Paramedic must be partnered with a Qualified Transport Nurse, Qualified Program Medical Director or Qualified Program Physician during transports utilizing these optional scope items.
3. Be accredited by the EMS Agency.
4. Must remain competent/proficient in these 6 optional scope procedures by passing competency testing provided by the Qualified Transport Program with the frequency required and noted here:
    a. Pediatric Intubation Quarterly
    b. Rapid Sequence Intubation Quarterly
    c. Video Laryngoscopy Quarterly
    d. Supraglottic Airway Quarterly
    e. Ventilator Management Annually
    f. Intraosseous Access Annually
5. Must have completed a minimum of 200 hours of training and all requisite training by the Qualified Transport Program and meet the requirements as outlined in definitions for one of the following:
    a. CC-P in training
    b. FP-C in training
    c. CCP-C
    d. FP-C

D. Medical Control

1. Medical Control shall remain the primary responsibility of the EMS Agency and is delivered in conjunction with the qualified transport program's policies and procedures when they are approved by the EMS Agency:
    a. Online Medical Control as per current regulation via direct access to base hospitals
    b. Offline Medical Control through the policies, procedures, scope of practice and optional scopes of practice of the EMS Agency.
    c. During an interfacility transport Online Medical Control may be obtained from the sending or receiving physician if on duty at a designated base hospital.

E. Quality Assurance Program

1. Collaborative process between Emergency Medical Services Medical Directors Association of California (EMDAC), EMS Agency, and the Qualified Transport Program for on-going quality assurance (QA), data analysis, and performance improvement.
    a. Provide EMDAC and the EMS Agency with a standardized database report consistent with current national guidelines to be agreed upon

in a collaborative process between EMDAC, EMS Agency and the Qualified Transport Programs.

b. Quality Improvement reporting will be delivered biannually and include all pertinent aspects of service and care surrounding the 6 items in this optional scope as well other critical care bundles.

c. There will be QA reports submitted to the EMS Agency and EMDAC on a scheduled basis (biannually)

d. Data collection will be consistent with the EMDAC derived metrics.

## V. QUALITY IMPROVEMENT

There will be QI reports submitted to the LEMSA and EMDAC/SOP on a scheduled basis (biannually), to include at minimum the following systemwide aggregate data:

1) **Pediatric intubation** (frequency, success and adverse events).

a) Percent successful placement of ETI by age

i) Numerator: # successful attempts = yes, Denominator: # of patients in whom ETI placement was attempted (defined as placement of a laryngoscope with intent of performing ETI)

b) Percent first-attempt success.

i) Numerator: # successful attempts = yes with attempts =1, Denominator: # of patients in whom ETI placement was attempted

c) Percent of each complication (emesis, trauma, hypoxia, dislodgement) and of total complications.

i) Numerator: # with complication = yes, Denominator: # of patients in whom ETI placement was attempted

d) Median time to insertion (if collected)

2) **Rapid Sequence Induction** (RSI) medication administration including: sedatives, paralytics, analgesics, and induction agents - Frequency of use, success rate by age, and adverse events) – as per section a. Pediatric intubation

3) **Supraglottic airways** (SGA): Frequency as primary and rescue airway, success and adverse events).

   a) Percent used as primary versus rescue airway

   b) Percent successful placement of SGA by age

      i) Numerator: # successful attempts = yes, Denominator: # of patients in whom SGA placement was attempted (defined as placement of a laryngoscope with intent of performing ETI)

   c) Percent first-attempt success.

      i) Numerator: # successful attempts = yes with attempts =1, Denominator: # of patients in whom SGA placement was attempted

   d) Percent of each complication (emesis, trauma, hypoxia, dislodgement) and of total complications.

      i) Numerator: # with complication = yes, Denominator: # of patients in whom SGA placement was attempted

   e) Median time to insertion (if collected)

4) **Video laryngoscopy** (indirect laryngoscopy): Frequency as primary and rescue airway, success, and adverse events as per ETI.

5) **I/O (intraosseous**): Frequency of use, overall success rate and adverse events

6) **Ventilator initiation**, maintenance and management: Frequency and adverse events

Data collection will be consistent with the EMDAC derived metrics for endotracheal intubation and supraglottic airway placement:

1) Pediatric intubation, RSI and Video laryngoscopy

a) Rescue device? – yes / no / not documented

*Rescue device* is defined as a device used after failure of the initial device attempted for secondary airway management, after bag-mask-ventilation.

b) Successful placement? – yes / no / not documented

*Successful placement* is defined as the ability to ventilate the patient with minimal or no air leak, confirmed primarily with $ETCO_2$ measurement with capnography. Secondary confirmation methods include visible chest rise during ventilation and air movement on pulmonary auscultation.

c) Number of attempts – numeric in integers / not documented

*Attempt* is defined as insertion of the laryngoscope in the mouth with the purpose of ETI.

d) Time to insertion *(optional)* – numeric in seconds / not documented

*Time to insertion* is defined as the time from insertion of the laryngoscope into the mouth for the first attempt until the time of the first successful ventilation with minimal or no air leak.

e) Complications

i) Regurgitation/emesis? – yes / no / not documented

*Regurgitation/emesis* is defined as the presence of gastric contents noted in the oropharynx or on device during or after placement.

ii) Bleeding/trauma? – yes / no / not documented

*Trauma/bleeding* is defined as the presence of blood noted in the oropharynx or on the device during or after placement, or any abrasion, laceration, dental trauma or other trauma occurring during placement or repositioning of the device. This excludes bleeding or trauma present prior to attempted device placement.

iii) Hypoxia? – yes / no / not documented

*Hypoxia* is defined as any $O_2$ saturation ≤ 90% during or after placement in a patient previously normoxic prior to placement.

iv) Dislodgement? – yes / no / not documented

*Dislodgement* is defined as loss of the ability to adequately ventilate the patient after successful placement was achieved.

v) Cardiovascular effects? – yes/ no/ not documented

*If yes,*
*Hypotension yes/ no/ not documented*
*Bradycardia yes/ no / not documented*
*Cardiopulmonary arrest yes / no/ not documented*

f) If dislodgement after placement, successful replacement?

yes / no / not documented / not applicable

*Successful replacement* is defined the as the ability to ventilate the patient with minimal or no air leak, after dislodgement and replacement of the same device, confirmed primarily with $ETCO_2$ measurement with capnography. Secondary confirmation methods include visible chest rise during ventilation and air movement on pulmonary auscultation.

2) Supraglottic airway:

a) Rescue device? – yes / no / not documented

*Rescue device* is defined as a device used after failure of the initial device attempted for secondary airway management, after bag-mask-ventilation.

b) Successful placement? – yes / no / not documented

*Successful placement* is defined as the ability to ventilate the patient with minimal or no air leak, confirmed primarily with $ETCO_2$ measurement with capnography. Secondary confirmation methods include visible chest rise during ventilation and air movement on pulmonary auscultation.

c) Number of attempts – numeric in integers / not documented

*Attempt* is defined as insertion of the supraglottic airway device (SAD) into the mouth.

d) Time to insertion *(optional)* – numeric in seconds / not documented

*Time to insertion* is defined as the time from insertion of the supraglottic airway device into the mouth for the first attempt until the time of the first successful ventilation with minimal or no air leak.

e) Complications

i) Regurgitation/emesis? – yes / no / not documented

*Regurgitation/emesis* is defined as the presence of gastric contents noted in the oropharynx or on device during or after placement.

ii) Bleeding/trauma? – yes / no / not documented

*Trauma/bleeding* is defined as the presence of blood noted in the oropharynx or on the device during or after placement, or any abrasion, laceration, dental trauma or other trauma occurring during placement or repositioning of the device. This excludes bleeding or trauma present prior to attempted device placement.

iii) Hypoxia? – yes / no / not documented

*Hypoxia* is defined as any $O_2$ saturation ≤ 90% during or after placement in a patient previously normoxic prior to placement.

iv) Dislodgement? – yes / no / not documented

*Dislodgement* is defined as loss of the ability to adequately ventilate the patient after successful placement was achieved.

f) If dislodgement after placement, successful replacement? – yes / no / not documented / not applicable

*Successful replacement* is defined the as the ability to ventilate the patient with minimal or no air leak, after dislodgement and replacement of the same device, confirmed primarily with $ETCO_2$ measurement with capnography. Secondary confirmation methods include visible chest rise during ventilation and air movement on pulmonary auscultation.

VI. AUTHORITY

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

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
PUBLIC HEALTH DEPARTMENT
**Mike Hill** *Health Agency Director*
**Penny Borenstein, MD, MPH** *Health Officer/Public Health Director*

| | |
|---|---|
| MEETING DATE | June 17, 2021 0900 Virtual |
| STAFF CONTACT | Mike Groves, 805.788.2514 mgroves@co.slo.ca.us |
| SUBJECT | Amend Policy #205 and 205 Attachment A to include ALS Wildland Engine<br>Amend Policy #209 and 209 Attachment A |
| SUMMARY | San Luis Obispo City FD has requested their Wildland Engine be added as an ALS capable unit. Fire Captain/Paramedic Nick Hoover worked with Kyle Parker to come up with proposed changes to Policy 205 and 205 Attachment A (EMS Equipment and Supply List).<br><br>The changes to the inventory list and policies have been highlighted in yellow. The starting reference was "ALS Special Use Medic Minimum" (the column just to the left of the proposed change). Nick and Kyle also used a similar policy from San Diego County to help determine what should be included.<br><br>While not directly related to Policy #205, the changes to 205 revealed the need for some minor updates to Policy #209 Guidelines for Use of Co of SLO Paramedics Outside the Co of SLO and 209 Attachment A Fireline Medic Controlled Substance Inventory. The updates added Fentanyl and Midazolam as the primary controlled drugs currently in the ALS inventory.<br><br>Operations sub-committee reviewed the policies and recommended moving it to EMCC for approval. There were no dissenting votes among the committee members present. |
| REVIEWED BY | EMS Staff, Dr. Ronay, Vince Pierucci, Operations Committee members |
| RECOMMENDED ACTION(S) | Recommend approval. |
| ATTACHMENT(S) | Draft policies 205, 205 Attachment A, 209, 209 Attachment A |

# POLICY #: 205 ADVANCED LIFE SUPPORT AND BASIC LIFE SUPPORT EQUIPMENT AND SUPPLY

## I. PURPOSE

A. To establish the minimum requirement of equipment and supplies to be available on ALS ambulances, BLS and ALS First Responder units including ALS Wildland Engines, and for ALS Special Use Medic in the County of San Luis Obispo.

## II. POLICY

A. Ambulances, ALS and BLS First Responder Units, ALS Wildland Engines, and ALS Special Use Medic personnel authorized to operate in the County of San Luis Obispo must, at a minimum, have the equipment and supplies available in the unit/at the event as referenced in Attachment A of this document.

## III. AUTHORITY

- California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.206 and 1797.220
- California Code of Regulations, Title 22, Section 100167 (a) 3

## IV. ATTACHMENTS

A. EMS Equipment and Suppy List

| Description | Strength/Size | ALS Transport Minimum | ALS First Responder Minimum | ALS Special Use Medic Minimum | ALS Wildland Unit Minimum | BLS First Responder Minimum † *Elective skills as required* |
|---|---|---|---|---|---|---|
| **MEDICATIONS** | | | | | | |
| Activated charcoal | 50 gm bottle (aqueous solution) | 1 | 1 | 0 | 0 | 0 |
| Adenosine | 6 mg/2 mL | 5 | 3 | 3 | 3 | 0 |
| Albuterol unit dose | 2.5 mg/3 mL solution | 4 | 2 | 2 | 2 | 0 |
| Aspirin | 81 mg nonenteric coated chewable | 1 bottle | 1 bottle | 4 tablets | 4 tablets | 1 bottle |
| Atropine | 1 mg/10 mL | 2 | 2 | 2 | 2 | 0 |
| Atropine | 8 mg multi-dose vial | 1 | 1 | 0 | 0 | 0 |
| Calcium Chloride 10% | 1 gm/10 mL | 1 | 1 | 0 | 0 | 0 |
| Dextrose 10% | 25 gm/250 mL bag | 2 | 2 | 1 | 1 | 0 |
| *Dextrose 50% | 25 gm/50 mL | 2 | 2 | 1 | 0 | 0 |
| Diphenhydramine | 50 mg/1 mL | 2 | 2 | 2 | 2 | 0 |
| Epinephrine | 1:1,000 1 mg/1 mL | 4 | 2 | 2 | 2 | 0 |
| †Epinephrine Auto-Injector | Pediatric and Adult | 0 | 0 | 0 | 0 | †1 each |
| Epinephrine | 1:10,000 1 mg/10 mL (10 mL preload) | 8 | 6 | 3 | 6 | 0 |
| Fentanyl | 100 mcg/2 mL | 2 | 2 | 2 | 2 | 0 |
| Glucagon | 1 mg/1 mL | 1 | 1 | 0 | 0 | 0 |
| Glucose gel | 15 gm | 2 tubes | 2 tubes | 2 tubes | 2 tubes | 2 tubes |
| Lidocaine 2% | 100 mg/ 5 mL | 6 | 4 | 3 | 3 | 0 |
| Midazolam | 5 mg/1 mL | 2 | 1 | 1 | 1 | 0 |
| Naloxone | 2 mg (vial or pre-load) | 2 | 2 | 2 | 2 | 0 |
| †Naloxone IN Kit | §2 mg pre-load and Atomizer | 0 | 0 | 0 | 0 | †2 |
| Nitroglycerine | SL tablets or spray | 2 | 1 | 1 | 1 | 0 |
| Nitro Paste 2% | 1 gm single dose packet | 3 | 3 | 0 | 0 | 0 |
| Ondansetron | 4 mg /2 mL injectable | 3 | 3 | 0 | 0 | 0 |
| | 4 mg dissolvable tablets | 3 | 3 | 1 | 1 | 0 |
| Sodium Bicarbonate | 50 mEq/50 mL | 2 | 2 | 0 | 0 | 0 |
| Tranexamic Acid (TXA) | 100 mg/1 mL 10 mL vial | 2 | 1 | 0 | 1 | 0 |
| **Because variations in medication supply occur, equivalent total dosage quantities may be substituted** | | | | | | |
| **Variations in the concentration of medications being stocked, due to medication supply shortages, must be approved by Medical Director** | | | | | | |
| ***Dextrose D50 is being phased out in favor of Dextrose D10** | | | | | | |
| **†Elective skills equipment required for participating agencies** | | | | | | |
| | | | | | | |
| **Alternate Medications to be Stocked ONLY with Medical Director Approval** | | | | | | |
| §Other pre-packaged single dose intranasal naloxone delivery devices that may be used with Medical Director Approval | | 0 | 0 | 0 | 0 | †2 |
| Diazepam (alternate to be stocked by order of Med Dir **ONLY**) | 10 mg | 2 | 1 | 1 | 1 | 0 |
| Morphine (alternate to be stocked by order of Med Dir **ONLY**) | 10 mg | 3 | 2 | 2 | 2 | 0 |
| | | | | | | |
| | | | | | | |

| Description | Strength/Size | ALS Transport Minimum | ALS First Responder Minimum | ALS Special Use Medic Minimum | ALS Wildland Unit Minimum | BLS First Responder Minimum † *Elective skills as required* |
|---|---|---|---|---|---|---|
| **IV SOLUTIONS/EQUIPMENT** | | | | | | |
| 0.9% Normal Saline | 1,000 mL bag (or equivalent total | 6 | 4 | 2 | 4 | 0 |
| 100 mL Saline Delivery Equipment | 0.9% NS 100 mL bag **OR** Burette | 2 | 1 | 0 | 0 | 0 |
| 0.9% Normal Saline | 10 mL Vials/Flush | 5 | 5 | 2 | 2 | 0 |
| IV Tubing | 60gtt/mL | 4 | 2 | 0 | 0 | 0 |
| IV Tubing | 10-20gtt/mL | 6 | 3 | 2 | 2 | 0 |
| IV Catheters | Sizes 14, 16, 18, 20, 22, 24 gauge | 2 each | 2 each | 2 each | 2 each | 0 |
| Syringes | Assorted - 1mL, 3mL, 6mL-20mL | 2 each | 2 each | 1 each | 1 each | 0 |
| Needles Assorted | - ½", 1", 1 ½" - 18-30 gauge | 2 each | 2 each | 2 each | 2 each | 0 |
| Intraosseous (IO) single needle device | (FDA approved) adult and pediatric | 1 each | 1 each | 1 each | 1 each | 0 |
| Tourniquets (for IV start) | | 2 | 2 | 2 | 2 | 0 |
| Saline locks | | 4 | 2 | 2 | 2 | 0 |
| Luer-Lock adaptors | (Not required but recommended for use with STEMI patients) | 2 | 2 | 0 | 0 | 0 |
| Alcohol and betadine swabs | | 10 each | 10 each | 10 each | 10 each | †10 each |
| | | | | | | |
| **TRAUMA** | | | | | | |
| Bandages and bandaging supplies: | | | | | | |
| Bandaids | Assorted | 10 | 10 | 5 | 5 | 10 |
| Sterile bandage compresses or equivalent | 4"x4" | 12 | 10 | 10 | 10 | 10 |
| Trauma dressing | 10"x30" or larger universal dressing | 2 | 2 | 2 | 2 | 2 |
| Roller gauze | 3" or 4" | 12 rolls | 8 rolls | 2 rolls | 2 rolls | 8 rolls |
| Cloth adhesive tape | 1, 2, or 3" | 1 roll | 1 roll | 1 roll | 1 roll | 1 roll |
| Triangular bandages with safety pins | | 4 | 2 | 1 | 1 | 2 |
| Tourniquet | See approved list for commercial | 2 | 2 | 1 | 1 | 2 |
| Vaseline gauze | 3"x8", or 5"x9" | 2 | 2 | 1 | 1 | 2 |
| Tongue blade or bite stick | | 2 | 2 | 2 | 2 | 2 |
| Burn Sheets (sterile or clean) – | may be disposable or linen (with date of sterilization indicated) | 2 | 2 | 0 | 2 | 2 |
| Cervical collars | Stiff. Sizes to fit all patients over one year old | 1each | 1 each | 1 each | 1 each | 1 each |
| Cold packs | | 2 | 2 | 2 | 2 | 2 |
| Irrigation equipment and supplies: | | | | | | |
| Saline, sterile | 250mL | 4 | 2 | 1 | 2 | 2 |
| Long spine board and light weight head immobilizer blocks | (or equivalent immobilization device) | 2 | 1 | 0 | 0 | 1 |
| Straps to secure patient to boards | | 2 sets | 1 set | 0 | 0 | 1 set |
| Splints, traction | Adult and pediatric (or a single device suitable for both) | 1 each | 1 each | 0 | 0 | 1 each |

| Description | Strength/Size | ALS Transport Minimum | ALS First Responder Minimum | ALS Special Use Medic Minimum | ALS Wildland Unit Minimum | BLS First Responder Minimum † *Elective skills as required* |
|---|---|---|---|---|---|---|
| **TRAUMA CONT.** | | | | | | |
| Splints, cardboard or equivalent | arm and leg splint | 2 each | 2 each | 1 each | 2 each | 2 each |
| K.E.D. or equivalent | | 1 | 1 | 0 | 0 | 0 |
| Pediatric spinal immobilization board | (or equivalent immobilization device) | 1 | 1 | 0 | 0 | 0 |
| Sheet or commercial pelvic binder | | 1 | 1 | 0 | 0 | 1 |
| | | | | | | |
| **Infection Control** | | | | | | |
| **Meet the minimum requirement per crew member as stated in the California Code of Regulations Title 8 (All Providers)** | | | | | | |
| | | | | | | |
| **Transportation Equipment** | | | | | | |
| Collapsible gurney cot with adjustable contour feature | | 1 | 0 | 0 | 0 | 0 |
| Stair chair or equivalent device | | 1 | 0 | 0 | 0 | 0 |
| Sheets, pillow, pillow case, towels, blankets (cloth or disposable) | | 2 | 0 | 0 | 0 | 0 |
| Scoop stretcher with straps | | 1 | 0 | 0 | 0 | 0 |
| Flat vinyl/canvas stretchers with | | 1 | 0 | 0 | 0 | 0 |
| | | | | | | |
| **MISCELLANEOUS** | | | | | | |
| Blood pressure cuffs (portable): | Adult | 1 | 1 | 1 | 1 | 1 |
| | Large adult or thigh | 1 | 1 | 0 | 0 | 1 |
| | Pediatric | 1 | 1 | 0 | 1 | 1 |
| Obstetrical kit - sterile, prepackaged | | 1 | 1 | 0 | 0 | 1 |
| Restraints - non-constricting wrist and ankle | | 1 set each | 1 set each | 0 | 0 | 1 set each |
| Stethoscope | | 1 | 1 | 1 | 1 | 1 |
| Trash bags/receptacles | | 2 | 2 | 1 | 1 | 2 |
| Blanket | Disposable | 1 each | 1 each | 1 each | 1 each | 1 each |
| Bandage scissors (heavy duty) | | 1 | 1 | 1 | 1 | 1 |
| Emesis basins or emesis bags with containers | | 2 | 2 | 1 | 1 | 2 |
| Water, potable | | 1 liter | 1 liter | 0 | 1 liter | 1 liter |
| Maps, entire county | | 1 | 1 | 0 | 0 | 1 |
| Penlight | | 1 | 1 | 1 | 1 | 1 |
| Triage tags | | 20 | 20 | 20 | 20 | 20 |
| Bed pan | | 1 | 0 | 0 | 0 | 0 |
| Urinal | | 1 | 0 | 0 | 0 | 0 |
| †Glucometer | with ≥10 test strips, lancets, and other appropriate supplies | 1 | 1 | 1 | 1 | †1 |
| Puncture proof sharps container | small | 2 | 2 | 1 | 1 | †1 |
| Thermometer | | 1 | 1 | 0 | 0 | 0 |
| Automatic External Defibrillator | With AED pads | * For EMT-D Provider Agencies (1) | | | | |

| Description | Strength/Size | ALS Transport Minimum | ALS First Responder Minimum | ALS Special Use Medic Minimum | ALS Wildland Unit Minimum | BLS First Responder Minimum † *Elective skills as required* |
|---|---|---|---|---|---|---|
| | | | | | | |
| **AIRWAY** | | | | | | |
| Endotracheal tubes: | sizes-3.0, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5, 9.0 | 1 each | 1 each | 1 each | 1 each | 0 |
| Laryngoscope handles, with extra batteries | | 2 | 2 | 1 | 1 | 0 |
| Laryngoscope blades: | Miller # 0, 1, 2, 3, 4 Macintosh # 1, 2, 3, | 1 each | 1 each | 1 each | 1 each | 0 |
| Magill forceps (pediatric and adult) | | 1 each | 1 each | 1 each | 1 each | 0 |
| Adult stylets | | 2 each | 1 each | 1 each | 1 each | 0 |
| 10-20 mL syringe, sterile lubricant | | 2 each | 1 each | 1 each | 1 each | 0 |
| Needle Cricothyrotomy kit with: | 10 or 12 ga needle, 10-20 mL syringe, alcohol and betadine wipes and oxygen supply adapter | 1 | 1 | 1 | 1 | 0 |
| | Or other FDA approved percutaneous cricothyrotomy kit | 1 | 1 | 1 | 1 | 0 |
| Capnography Device | Qualitative or Quantitative | 1 | 1 | 1 | 1 | 0 |
| Hand held nebulizer for inhalation therapy | | 2 | 2 | 1 | 1 | 0 |
| Medrafter or equivalent | | 1 | 1 | 0 | 0 | 0 |
| Portable, battery powered, cardiac monitor-defibrillator with 12-lead ECG capability with the ability to perform computerized ECG readings and provide hard copy ECG tracings, with: | | 1 | 1 | 1 | AED w.manal defib and w/EKG | 0 |
| | Patient ECG cable | 1 | 1 | 1 | 0 | 0 |
| | ECG recording chart paper | 1 | 1 | 1 | 0 | 0 |
| | Adult ECG electrodes | 4 sets | 4 sets | 2 sets | 2 sets | 0 |
| | Defibrillation pads or equivalent - Adult and Pediatric | 1 set each | 1 set each | 1 set each | 1 set each | 0 |
| | Conductive defibrillation pads, | 4 | 4 | 2 | 2 | 0 |
| | or tubes of conductive gel | 2 | 2 | 1 | 1 | 0 |
| IV catheter for pleural decompression | 10 gauge/3 inch | 2 | 2 | 1 | 1 | 0 |
| Asherman chest seal or equivalent open wound dressing | | 1 | 1 | 1 | 1 | 1 |
| Pulse oximeter | | 1 | 1 | 1 | 1 | 1 |
| †Continuous Positive Airway Pressure (CPAP) Ventilator | portable/adjustable pressure settings, FDA Approved with an oxygen supply | 1 | 1 | 0 | 0 | †1 |
| Nasopharyngeal airways (soft rubber) | Medium and Large adult sizes | 2 each | 2 each | 1 each | 1 each | 2 each |
| Lubricant, water-soluble jelly (K-Y) | | 2 | 2 | 2 | 2 | 2 |
| Oropharyngeal airways | (sizes 5.5 – 12 or equivalent) | 2 each | 1 each | 1 each | 1 each | 1 each |
| Adult non-rebreather masks | | 2 | 2 | 1 | 1 | 2 |
| Pediatric/infant non-rebreather mask | | 2 | 2 | 1 | 1 | 2 |
| Adult nasal cannula | | 4 | 2 | 1 | 1 | 2 |

| Description | Strength/Size | ALS Transport Minimum | ALS First Responder Minimum | ALS Special Use Medic Minimum | ALS Wildland Unit Minimum | BLS First Responder Minimum † *Elective skills as required* |
|---|---|---|---|---|---|---|
| Oxygen Cylinders | D or E size cylinder with regulator capable of delivering 2-15 LPM | 1 | 1 | 1 | 1 | 1 |
| | M, H, or K cylinder with wall outlet(s) and constant flow regulator(s) | 1 | 0 | 0 | 0 | 0 |
| **AIRWAY CONT.** | | | | | | |
| Oxygen reserve: | | | | | | |
| | D or E cylinders | 1 | 1 | 0 | 0 | 1 |
| Face masks for resuscitation (clear) | | 2 | 1 | 1 | 1 | 1 |
| Bag-valve mask with O2 reservoir and supply tubing | | | | | | |
| | Adult | 1 | 1 | 1 | 1 | 1 |
| | Pediatric | 1 | 1 | 1 | 1 | 1 |
| | Infant | 1 | 1 | 1 | 0 | 1 |
| Suction equipment and supplies: | | | | | | |
| Rigid pharyngeal tonsil tip | | 2 | 2 | 0 | 0 | 2 |
| Spare suction tubing | | 1 | 1 | 0 | 0 | 1 |
| Suction apparatus (portable) | | 1 | 1 | 1 | 1 | 1 |
| Suction catheters | at least 2 sizes suitable for adult and | 2 each | 1 each | 1 each | 1 each | 1 each |
| | pediatric endotracheal suctioning | | | | | |
| | | | | | | |

# POLICY #209: GUIDELINES FOR USE OF COUNTY OF SAN LUIS OBISPO PARAMEDICS OUTSIDE OF THE COUNTY OF SAN LUIS OBISPO

## I. PURPOSE

A. To establish policy that will permit paramedics accredited in the County of San Luis Obispo (SLO) to practice paramedic-level skills while on duty outside of the County of SLO.

## II. SCOPE

A. This policy applies to any paramedic accredited in the County of SLO who is on duty with a County of SLO approved ALS provider, who is part of an emergency operation provided under circumstances of urgent and extraordinary need for public safety and emergency medical services (EMS) outside of the County of SLO.

## III. DEFINITIONS

- Controlled substance: Any substance listed as a Schedule I through IV drug in the Controlled Substance Act [i.e. Fentanyl, Morphine, Midazolam, and Diazapam].

## IV. POLICY

A. A paramedic may perform paramedic-level skills during emergency operations outside the County of SLO in compliance with the California paramedic scope of practice and in compliance with County of SLO EMS Agency (EMS Agency) policies during the treatment or transportation of a patient or until transfer of that patient to a locally accredited paramedic.

B. Paramedics operating during emergency operations as a fire-line medic shall be subject to the provisions of California OES/FIRESCOPE Position Manual ICS 223-11, and shall comply with ICS-223-11 as applicable to their assignment.

C. It is the intent of this policy to permit the provision of ALS care during emergency operations. It does not replace existing EMS or circumvent the established response of EMS in locations outside the County of SLO.

D. The paramedic must have access to the ALS equipment as required by EMS Agency Policy #205: Advanced Life Support. The EMS Agency Medical Director may vary the complement of required equipment, medication and supplies for special assignments or circumstances (i.e. ICS-223-11 fire-line medic). For controlled substance inventory and security requirements, reference Attachment A of this policy.

## V. PROCEDURE

A. All ALS equipment and supplies are to remain under the direct control of a paramedic at all times. If a paramedic is on an extended assignment (i.e. special event, fire-line) and is relieved of duty and another paramedic does not assume control of the ALS equipment and supplies, all such equipment and supplies must be secured in such a manner as to prevent access by non-paramedic personnel. Controlled substances will be secure per EMS Agency Policy# 211: Management of Controlled Substances.

B. Paramedics shall follow the directions of the Incident Commander or other designated ICS official, as appropriate.

## VI. AUTHORITY

- California Code of Regulations Title 22, Division 9, Section 100165.
- Health and Safety Code, Sections 1797.204, and 1797.206.

## VII. ATTACHMENTS

A. Fire-Line Medic Program – Controlled Substance

# FIRE-LINE MEDIC PROGRAM – CONTROLLED SUBSTANCE INVENTORY

## CONTROLLED SUBSTANCE INVENTORY

As identified in EMS Agency Policy# 205: Advanced Life Support and Basic Life Support Equipment and Supply, ALS responders shall carry a minimum controlled substance inventory. Additionally, FIRESCOPE ICS 223-11 defines recommended inventories of controlled substances, subject to the direction of the EMS Agency Medical Director.

In circumstances requiring the paramedic to deploy to the fire-line on foot, the following controlled substance inventory shall be allowable:

- Midazolam (10 mg) 2 Quantity
- Fentanyl (100 mcg/2 mL) 2 Quantity

All remaining controlled substance inventory shall remain secured in the paramedic vehicle in an EMS Agency approved double-lock system.

## STORAGE OF CONTROLLED SUBSTANCE INVENTORY

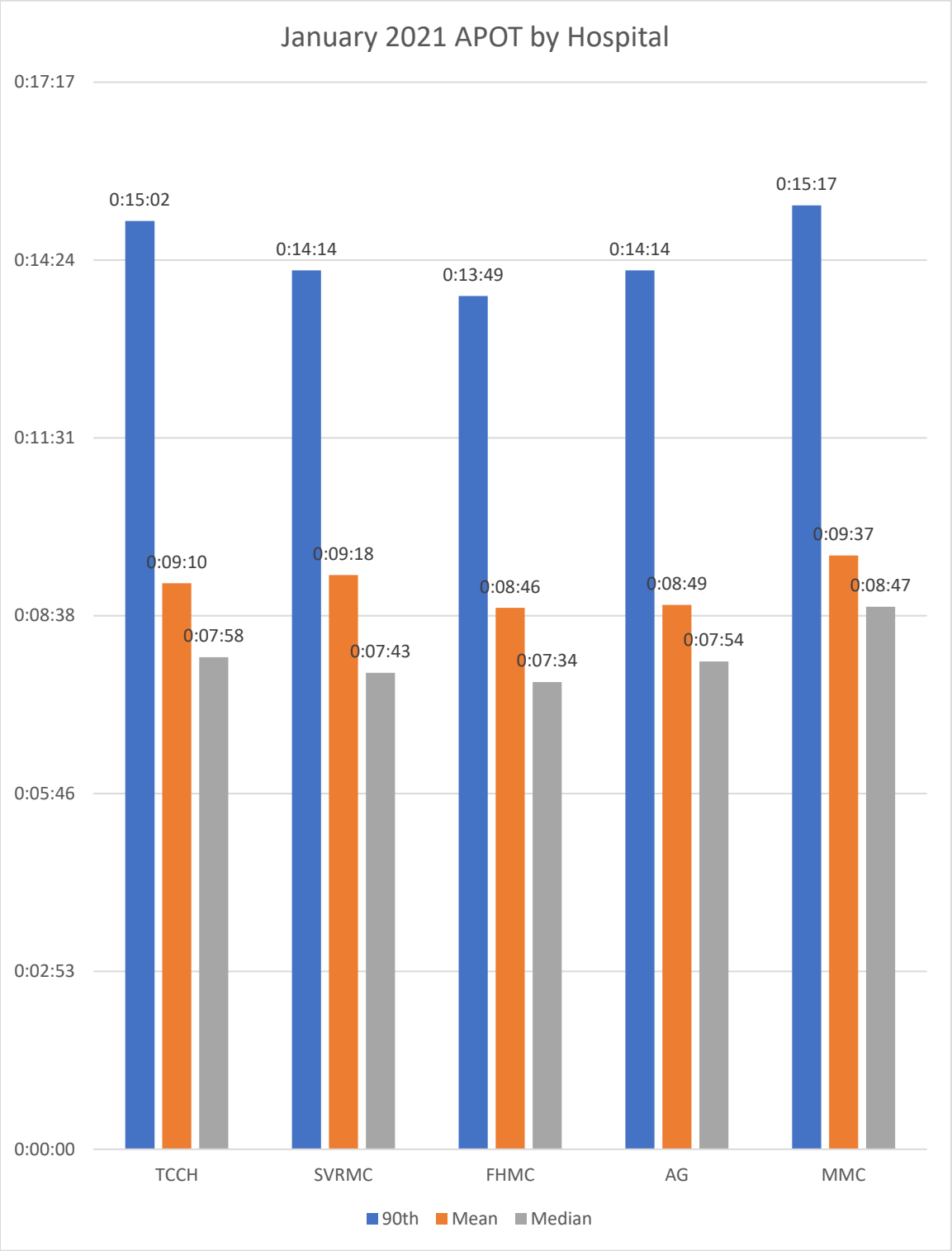
ALS units shall secure controlled substances in compliance with EMS Agency Policy# 211: Management of Controlled Substances. In circumstances requiring the paramedic to deploy to the fire-line on foot, the controlled substance inventory shall be secured as described:

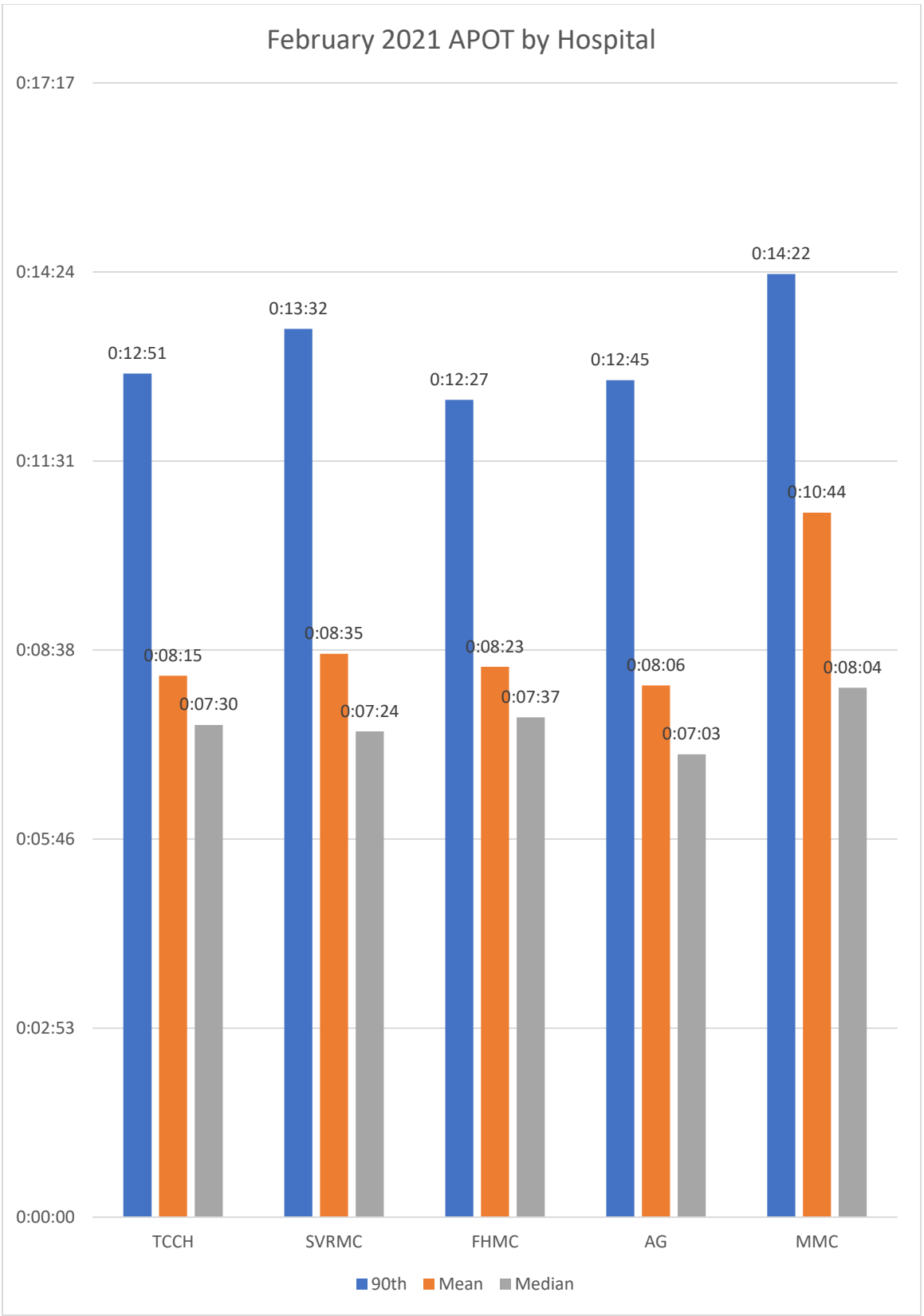
- Fire-line paramedic backpack – Double-locking system with controlled substances secured in a durable container within backpack.
- Fire line paramedic backpack – Must be in constant possession of assigned paramedic

When paramedic returns to their vehicle, controlled substances shall be returned to the vehicle’s double-locking system.

## Ambulance Patient Offload Time (APOT) - 1
## APOT Standard – 20 Minutes

| Hospital | Jan-21 | | Feb-21 | | Mar-21 | |
|---|---|---|---|---|---|---|
| | Transports | 90th Percentile APOT Time | Transports | 90th Percentile APOT Time | Transports | 90th Percentile APOT Time |
| Arroyo Grande Community Hospital | 213 | 14:14 | 182 | 12:45 | 240 | 12:46 |
| French Hospital Medical Center | 213 | 13:49 | 227 | 12:27 | 216 | 12:04 |
| Sierra Vista Regional Medical Center | 308 | 14:14 | 237 | 13:32 | 284 | 12:22 |
| Twin Cities Community Hospital | 345 | 15:02 | 304 | 12:51 | 335 | 12:13 |
| Marian Medical Center (Santa Barbara Co) | 79 | 15:17 | 58 | 14:22 | 73 | 12:26 |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| **EMS System Total (Aggregate)** | 1,158 | 14:37 | 1,008 | 13:00 | 1,148 | 12:17 |


January 2021 APOT by Hospital
0:17:17
0:14:24
0:11:31
0:08:38
0:05:46
0:02:53
0:00:00
0:15:02
0:09:10
0:07:58
0:14:14
0:09:18
0:07:43
0:13:49
0:08:46
0:07:34
0:14:14
0:08:49
0:07:54
0:15:17
0:09:37
0:08:47
TCCH
SVRMC
FHMC
AG
MMC
90th
Mean
Median


February 2021 APOT by Hospital
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0:14:24
0:11:31
0:08:38
0:05:46
0:02:53
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0:08:15
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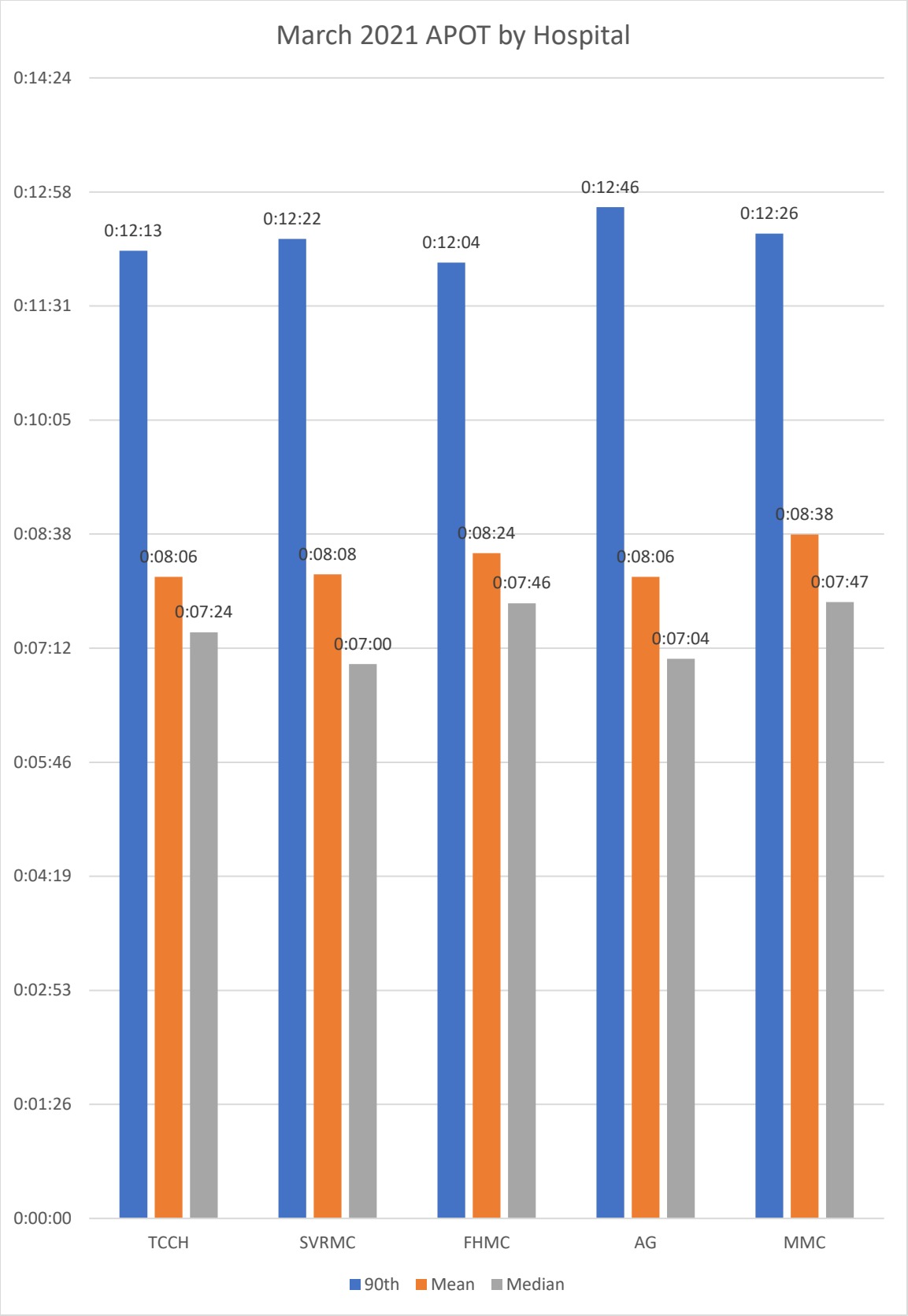
0:08:06
0:07:03
0:14:22
0:10:44
0:08:04
TCCH
SVRMC
FHMC
AG
MMC
90th
Mean
Median


March 2021 APOT by Hospital
0:14:24
0:12:58
0:11:31
0:10:05
0:08:38
0:07:12
0:05:46
0:04:19
0:02:53
0:01:26
0:00:00
0:12:13
0:08:06
0:07:24
0:12:22
0:08:08
0:07:00
0:12:04
0:08:24
0:07:46
0:12:46
0:08:06
0:07:04
0:12:26
0:08:38
0:07:47
TCCH
SVRMC
FHMC
AG
MMC
90th
Mean
Median

**APOT – 2**

**2.1** Number and percentage of transports with transfer of care **within 20 min** of arrival at ED

**2.2** Number and percentage of transport with transfer of care between **21-60 min** of arrival at ED

**2.3** Number and percentage of transports with transfer of care between **61-120 min** of arrival at ED

**2.4** Number and percentage of transports with transfer of care between **121-180** min of arrival at ED

**2.5** Number and percentage of transports with transfer of care **greater than 180 min** of arrival at ED

APOT standard is **20 min**

9-1-1 calls only, no interfacility transfers or long-distance transfers

Includes 9-1-1 transports to Marian Medical Center by SLO County ambulances

**APOT - 2**

| Hospital | Jan-21 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2.1 | | 2.2 | | 2.3 | | 2.4 | | 2.5 | |
| | transp | % | transp | % | transp | % | transp | % | transp | % |
| Arroyo Grande Community Hospital | 206 | 96% | 8 | 4% | 0 | 0% | 0 | 0% | 0 | 0% |
| French Hospital Medical Center | 204 | 95% | 10 | 5% | 0 | 0% | 0 | 0% | 0 | 0% |
| Sierra Vista Regional Medical Center | 292 | 95% | 16 | 5% | 0 | 0% | 0 | 0% | 0 | 0% |
| Twin Cities Community Hospital | 337 | 98% | 8 | 2% | 0 | 0% | 0 | 0% | 0 | 0% |
| Marian Medical Center (Santa Barbara Co) | 77 | 97% | 2 | 3% | 0 | 0% | 0 | 0% | 0 | 0% |

| Hospital | Feb-21 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2.1 | | 2.2 | | 2.3 | | 2.4 | | 2.5 | |
| | transp | % | transp | % | transp | % | transp | % | transp | % |
| Arroyo Grande Community Hospital | 176 | 97% | 6 | 3% | 0 | 0% | 0 | 0% | 0 | 0% |
| French Hospital Medical Center | 223 | 98% | 4 | 2% | 0 | 0% | 0 | 0% | 0 | 0% |
| Sierra Vista Regional Medical Center | 228 | 96% | 9 | 4% | 0 | 0% | 0 | 0% | 0 | 0% |
| Twin Cities Community Hospital | 300 | 99% | 4 | 1% | 0 | 0% | 0 | 0% | 0 | 0% |
| Marian Medical Center (Santa Barbara Co) | 54 | 93% | 4 | 7% | 0 | 0% | 0 | 0% | 0 | 0% |

| Hospital | Mar-21 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2.1 | | 2.2 | | 2.3 | | 2.4 | | 2.5 | |
| | transp | % | transp | % | transp | % | transp | % | transp | % |
| Arroyo Grande Community Hospital | 235 | 98% | 5 | 2% | 0 | 0% | 0 | 0% | 0 | 0% |
| French Hospital Medical Center | 213 | 99% | 3 | 1% | 0 | 0% | 0 | 0% | 0 | 0% |
| Sierra Vista Regional Medical Center | 280 | 99% | 4 | 1% | 0 | 0% | 0 | 0% | 0 | 0% |
| Twin Cities Community Hospital | 332 | 99% | 3 | 1% | 0 | 0% | 0 | 0% | 0 | 0% |
| Marian Medical Center (Santa Barbara Co) | 72 | 99% | 1 | 1% | 0 | 0% | 0 | 0% | 0 | 0% |