STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY GAVIN NEWSOM, *Governor*

EMERGENCY MEDICAL SERVICES AUTHORITY
10901 GOLD CENTER DR., SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

February 23, 2020

Travis Kusman, EMS Director
San Mateo County EMS Agency
801 Gateway Blvd 2nd Floor
South San Francisco, CA 94080

Dear Travis,

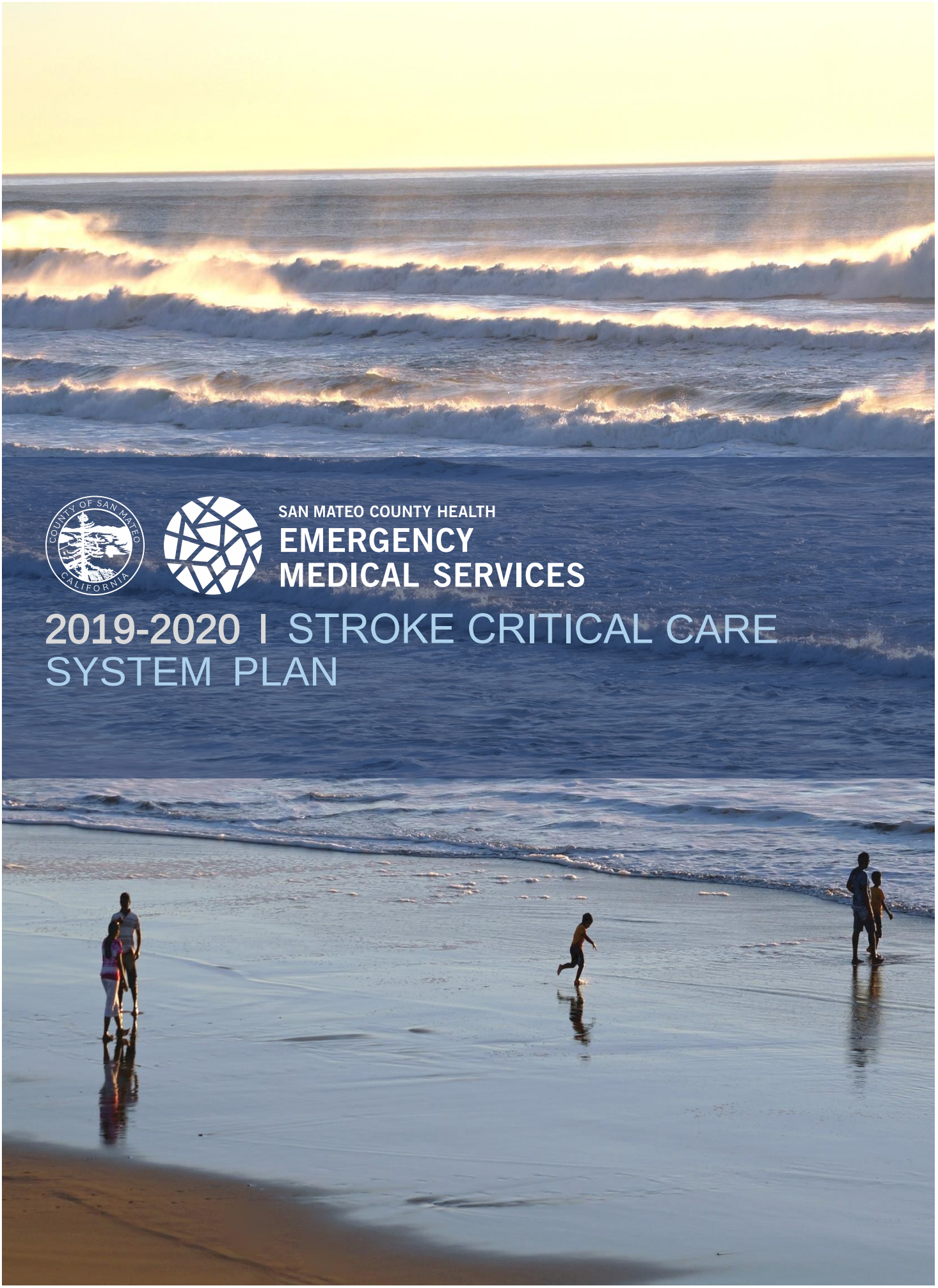
The EMS Authority (EMSA) has reviewed the San Mateo EMS Agency's Stroke Critical Care System Plan submitted in accordance with the California Code of Regulations, Title 22, Chapter 7.2 Stroke Critical Care Systems. The San Mateo EMS Agency's Stroke system plan is in compliance with the Stroke regulations and is approved.

In accordance with Section 100270.221, your Stroke System Status Report will be due by February 23, 2021.

Please contact Farid Nasr, M.D. at (916) 431-3685 or farid.nasr@emsa.ca.gov for any questions.

Sincerely,

Tom McGinnis, EMT-P
Chief, EMS Systems Division



SAN MATEO COUNTY HEALTH

EMERGENCY MEDICAL SERVICES

2019-2020 I STROKE CRITICAL CARE SYSTEM PLAN

Table of Contents

Introduction

San Mateo County has a well-developed stroke specialty care program. As one of the first counties in California to establish a tiered destination policy based on last known well time (LWKT), San Mateo County has been a leader in stroke care. Patients originating from San Mateo County were enrolled in the landmark DEFUSE 3 AND DAWN clinical trial studies via our stroke receiving hospitals. We continue to evolve and pursue potential new therapies. Currently, we are participating in a mobile stroke unit (MSU) clinical trial known as the Benefits of Stroke Treatment Delivered Using Stroke Unit Compared to Standard Management by EMS referred to as the BESTMSU study.

San Mateo County's destination policy is designed to quickly deliver patients to the most appropriate hospital for definitive care. Paramedics have the ability to identify patients as having a stroke and alert the hospitals of their arrival via a "stroke alert." Three hospitals serve San Mateo County patients as primary stroke centers (PSC), one as a recently approved thrombectomy capable stroke center or (TSC) and two are recognized as comprehensive centers (CSC). The tiered system allows patients to receive assessment and treatment at either a primary, thrombectomy capable, or comprehensive center, depending on the time of symptom onset and the type of stroke.

San Mateo County's Stroke System Committee is comprised of San Mateo County EMS Agency (SMC LEMSA) personnel, physicians, stroke coordinator nurses, and American Heart Association (AHA) staff, all of whom participate in the stroke system and work together to improve quality. The committee reviews care and makes recommendations to the EMS Medical Director on best practices for stroke care.

Relatively recent system enhancements include the designation of a thrombectomy-capable stroke center and the implementation of a pilot study involving the use of a mobile stroke unit to quickly determine if a patient is having a stroke and provide definitive therapy if indicated. The MSU has the ability to either meet the patient at the scene of the emergency or at a pre-planned rendezvous site if it would expedite the overall care of the patient. The extension of our system's defined stroke window to a 24-hour period was based on the DEFUSE trial and a collaborative discussion with and agreement amongst our stroke system partners.

Mission Statement

San Mateo County Stroke System

Mission: Improve stroke care outcomes in the SMC Stroke System through data review, quality improvement, education, and innovation.

Committee Purpose: Serve as an advisory committee to the EMS Agency regarding stroke.

Goals:

Goal	Objectives	Responsible Party(ies)	Target Date	Evaluation/Outcome
1. Improve the quality and service delivered to stroke patients.	1. Collect and analyze SMC EMS system data over the continuum of care. 2. Identify best practices and implement appropriate actions as needed. 3. Recognize clinical excellence in stroke care. 4. Facilitate inter-facility transfers between hospitals and stroke centers.	San Mateo County Receiving Hospitals Designated Stroke Centers EMS Provider Agencies EMS Agency	Continually	Implemented Get With The Guidelines for data collection. Structure of meetings to focus on CQI with data. Stroke regulations are routed for the public comment period. EMS has participated in Joint Commission visits. Operations 29 has facilitated Interfacility Transfer (IFT) for stroke.
2. Provide education to professionals and community members and measure the effectiveness of public awareness campaigns.	1. Deliver up-to-date and relevant education to health care professionals. 2. Raise public awareness regarding the signs and symptoms of stroke, the importance of activation of the 911 system, and provide education to identified target groups.	San Mateo County Receiving Hospitals Designated Stroke Centers EMS Provider Agencies EMS Agency Pacific Stroke Association	Quarterly	2019 Stroke conference completed. Looking at new and innovative ways to promote & provide education. Flyers handed out at BART and transit stations in May. AHA community outreach.
3. Conduct, evaluate, and research relevant clinical and system factors having an impact on the stroke system.	1.Collect and analyze research data. 2. Participate in research studies to assist in developing and promoting evidence-based standards of excellence and innovation.	QI Committee Stroke stakeholders	Annually	Mobile Stroke Unit (MSU) BESTMSU study ongoing.

Stroke CQI Committee - Organizational Description, Structure, and Members

The San Mateo County Stroke Continuous Quality Improvement Committee (Stroke CQI Committee) serves in an advisory capacity to the SMC LEMSA.

The Stroke CQI Committee has the following values:

- Patient & community-oriented system
- Provide a caring environment to inspire and produce teamwork
- Our work is based on research, scientific examination, and focused process improvement
- Promotion of candor, integrity, and mutual respect
- Multidisciplinary partnerships with our system stakeholders help us produce excellence
- Promote and provide community education on stroke prevention and treatment

The Stroke CQI Committee is a confidential committee and meets quarterly. The committee is comprised of receiving hospital stroke medical directors, receiving hospital stroke coordinators, ED physicians, the American Heart Association, and the EMS Agency Medical Director and staff.

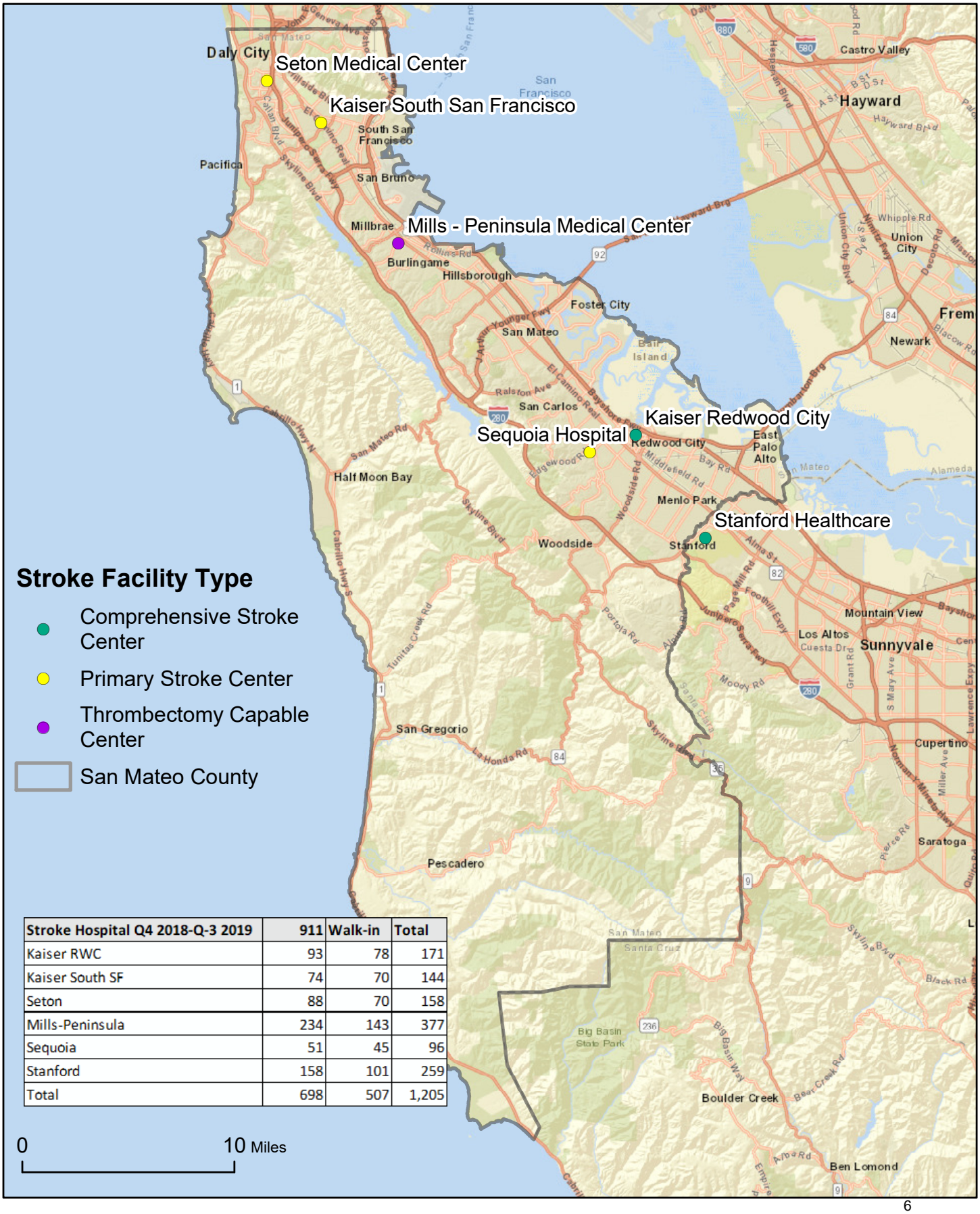
Implementing the recent EMSA regulations, the committee reviews cases, discusses policy and best practices, and makes recommendations to enhance systems of care. San Mateo County was one of the first to implement a tiered destination policy to either a comprehensive, thrombectomy capable, or primary stroke center based on last known well time (LKWT). The committee reviewed and supported a “drip and ship” model for hospitals to expedite transfers to a higher level of care. Enhancements to our stroke system during the last year include the designation of a thrombectomy-capable stroke center and, as described earlier, a pilot study involving a Mobile Stroke Unit or (MSU) is ongoing.

Get With The Guidelines (GWTG) ® has been implemented supporting the EMS Agency’s evaluation of our system’s performance and enabling benchmarking at a national level.

Names and Titles of LEMSA Personnel and Their Role in the Stroke Critical Care System

Travis Kusman, MPH, Paramedic, EMS Agency Director
Gregory H. Gilbert, MD, FAAEMS, EMS Medical Director
Linda Allington RN, MPH, MPA, FACHE, EMS Clinical Services Manager
Chad Henry, MBA, Paramedic, EMS Operations Manager
Garrett Fahey, MBA, EMS Office Manager

Stroke Receiving Hospitals in San Mateo County



Stroke Hospital Q4 2018-Q-3 2019	911	Walk-in	Total
Kaiser RWC	93	78	171
Kaiser South SF	74	70	144
Seton	88	70	158
Mills-Peninsula	234	143	377
Sequoia	51	45	96
Stanford	158	101	259
Total	698	507	1,205

Stroke Destination Policy

Our stroke destination policy, Operations 29, was developed in collaboration with receiving hospital stroke program medical directors and is based on the patient's last known well time. Additionally, the decision was made to take all stroke patients, even if the symptom onset was > 24 hours to a stroke center because wrap-around services would be available to the patient and their support system, even if acute therapeutic interventions were no longer indicated.

In accordance with our system's general medical treatment protocol (page 3) the transporting amublance provides the receiving hospital with a pre-notification "Stroke Alert" and corresponding pertinent information via a "ring down".

COUNTY OF SAN MATEO
EMERGENCY
MEDICAL SERVICES

POLICY NO:	OPS-29
DATE ISSUED:	6/2007
DATE REVISED:	11/2018
DATE TO BE REVIEWED:	10/2021

STROKE SYSTEM TRIAGE AND PATIENT DESTINATION

Purpose: To describe the San Mateo County stroke system and triage policy and provide an overview of data collection and system quality improvement for the San Mateo County stroke system.

This system is designed to provide timely, appropriate care to patients who have symptoms of acute stroke.

Acute stroke patients will be transported to a Primary Stroke Center (PSC), Thrombectomy Capable Stroke Center (TSC), or a Comprehensive Stroke Center (CSC) in accordance with San Mateo County EMS policy.

Authority: Health and Safety Code, Division 2.5, Section 1797.220 and 1798.

Definitions:

1. Acute stroke patient is defined as a patient who meets assessment criteria for an acute stroke in accordance with San Mateo County's patient care protocols, and last known well time (LKWT) is within 24 hours.
2. Primary Stroke Center (PSC) is a hospital that has successfully completed and maintains The Joint Commission accreditation as a PSC and enters into a memorandum of understanding (MOU) with San Mateo County relative to be a PSC. These centers have the ability to treat stroke patients less than 3.5 hours.
3. A Comprehensive Stroke Center (CSC) is a hospital that has successfully completed and maintains The Joint Commission accreditation as a CSC and enters into an MOU with San Mateo County relative to be a stroke center. These centers have the ability to treat both ischemic and hemorrhagic stroke beyond the 3.5-hour window.
4. A Thrombectomy Capable Stroke Center (TSC) is a primary stroke center with the ability to perform mechanical thrombectomy for an ischemic stroke patient and meets the designation requirements by The Joint Commission and enters into an MOU with San Mateo County relative to be a TSC. These centers have the ability to treat ischemic strokes beyond 3.5 hours.
5. Mobile Stroke Unit (MSU) is an organized group of healthcare providers with highly specialized equipment, who are available to respond and provide a higher level on-scene stroke care. A MSU is approved by the EMS Agency to be deployed in the prehospital setting to provide rapid assessment of a suspected stroke patient utilizing a mobile computed tomography (CT) scanner able to transmit images to a remote hospital site. If indicated, the MSU may also administer intravenous tissue plasminogen activase (Alteplase), hemostatic agents, blood pressure medications and other treatments.

APPROVED:

Nancy A. Lapolla, MPH, EMS Director

Gregory H. Gilbert, MD, EMS Medical Director

Stroke Centers Serving San Mateo County

Primary Stroke Centers (PSC):
1. Kaiser Redwood City
2. Kaiser South San Francisco
3. Mills-Peninsula
4. Sequoia Hospital
5. Seton Hospital (Daly City)
6. Stanford Health Care

Thrombectomy-Capable Stroke Center (TSC):
1. Kaiser Redwood City
2. Mills-Peninsula
3. Stanford Health Care

Comprehensive Stroke Centers (CSC):
4. Kaiser Redwood City
5. Stanford Health Care

Procedure:

A. Criteria for the assessment, identification and treatment of an acute stroke patient are based on San Mateo County paramedic protocols.

1. Patients identified by the paramedic/MSU as having a LKWT or at patient's normal baseline within the last 3.5 hours or beyond 9 hours will be transported to a PSC.
2. Patients identified by the paramedic as having a LKWT or at patient's normal baseline time between the past 3.5 hours and 9 hours will be transported to a CSC or TSC. Where patients usually get their care can be considered in destination.
3. If there is any question as to the status of the patient with acute symptoms of a stroke transport to the nearest PSC.
4. If the LKWT is unknown or exceeds 24 hours, the patient should be transported to the closest or requested stroke center, either primary, thrombectomy capable, or comprehensive.
5. Obtain best family contact and cell phone number to be provided to the stroke center.

B. Notification of the Stroke Center

1. The EMS crew shall notify the Stroke Center as soon as possible during the call.
2. EMS verbal report: As soon as feasible, the crew from the scene will contact the intended stroke center and inform them an acute stroke patient is enroute to that facility. It is recommended that the report be started with the statement "This is a Stroke Alert".
3. The report shall include EMS Stroke/ALOC ringdowns per Routine Medical Care Protocol.

C. Diversion by a Stroke Center

1. Stroke centers will not close to acute stroke patients except for the following:
   a. Failure of all CT scanners in the Stroke Center
   b. Declared internal disaster

2. If a Stroke Center must close to stroke patients, the nurse leader or equivalent will call San Mateo County Public Safety Communications (SMC-PSC) at (650) 363-4981 and request a system wide notification.

D. Documentation

1. A completed patient care record (ePCR) shall be left at the Stroke Center for all stroke patients before the paramedic leaves the receiving hospital.

E. Transferring an acute stroke patient to a higher level of care. See also the Inter-facility (Facilities 4) policy.

1. Patients found to have a large vessel occlusion (LVO) should be expeditiously transferred to a CSC or TSC if the patient meets inclusion criteria for clot retrieval.
2. In the event that an acute stroke patient needs to be transferred to a higher level of stroke care, the emergency department should:
   a. Provide appropriate assessment and emergency treatment.
   b. Notify the receiving CSC or TSC of the intent to transfer the patient, using the term "SIR" (Stroke Interventional Radiology) and provide as complete a report as possible.
   c. Use the microwave line and request an interfacility transport. If unable to use the microwave line, San Mateo County PSC can be contacted at (650) 363-4981. Request a paramedic ambulance to transport the patient to the receiving CSC or TSC. The ambulance will arrive shortly.
3. If initiated patient care exceeds the paramedic scope of practice, qualified medical or nursing staff should accompany the patient in the 911 ambulance or a Critical Care Transport (CCT) unit is required.
   a. It is recommended that the medical staff or RN perform a neurological exam every 15 minutes enroute and follow their routine hospital procedures for care of the patient.
4. Provide the ambulance crew with as complete a record as possible (verbal essential, written if possible). Do not delay transport of the patient. A complete written patient report can be faxed to the receiving stroke center prior to patient arrival at CSC or TSC.
5. In the event that a non-stroke center emergency department receives an acute stroke patient by 911 ambulance, the hospital should notify the EMS agency.

F. Stroke System Quality Improvement (See Stroke System Mission and Purpose Statement)

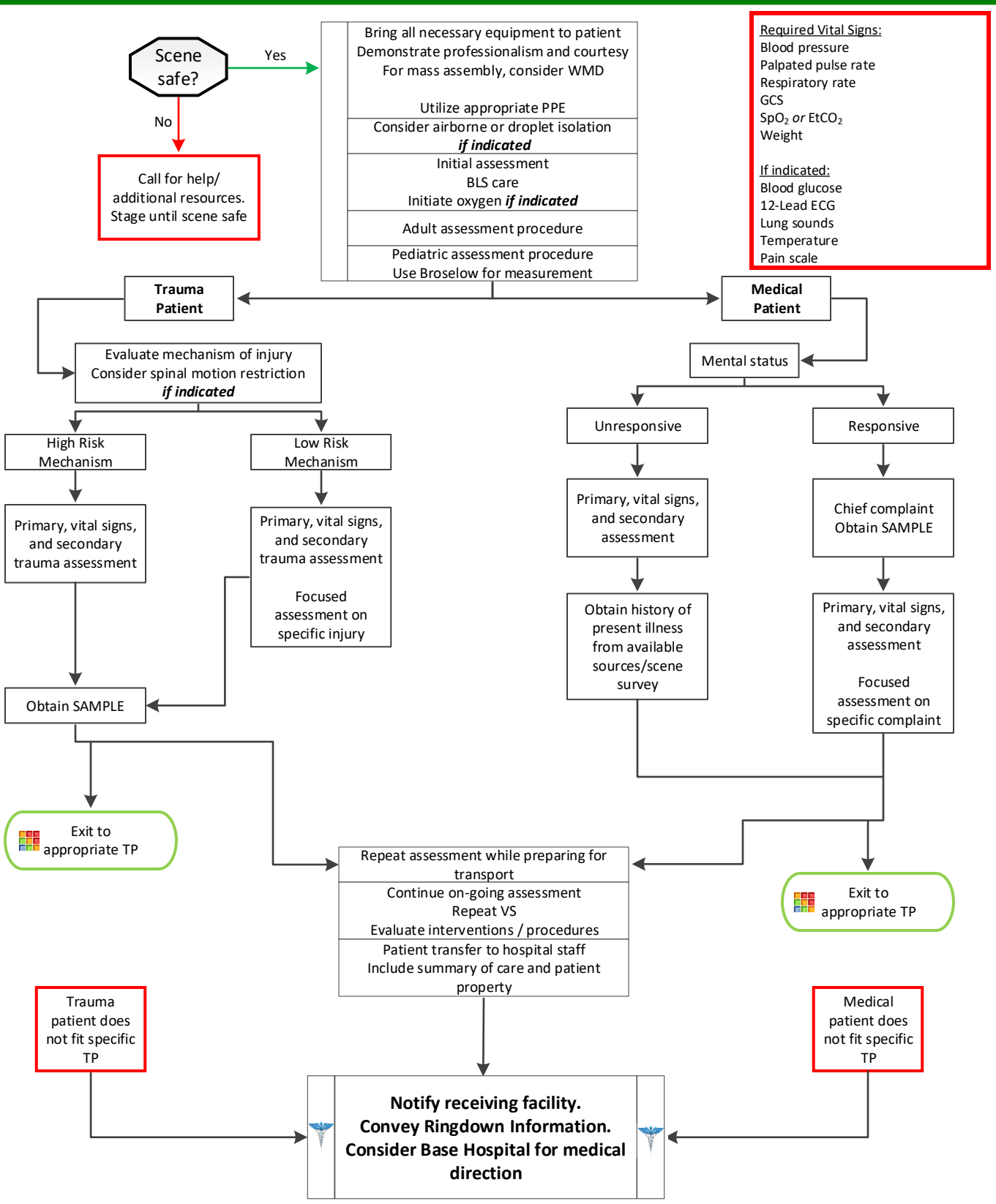
1. Each designated stroke hospital, EMS system participant, and the EMS agency will have representatives on the Stroke Quality Improvement Committee.

G. Data Collection

1. Hospitals should input data into Get with the Guidelines or equivalent.
2. EMS agency staff will review hospital and EMS data and provide reports to be presented to the Stroke Quality Improvement Committee.

San Mateo County Emergency Medical Services

Routine Medical Care



General Treatment Protocol

Routine Medical Care

Scene Safety Evaluation: Identify potential hazards to prehospital providers, patient, and public. Identify the number of patients and utilize triage protocol if indicated. Observe patient position and surroundings.

General: All patient care must be appropriate to the provider level of training and documented in the ePCR. The ePCR narrative should be considered a story of the circumstances, events, and care of the patient and should allow the reader to understand the complaint, assessment, treatment, why procedures were performed, and why indicated procedures were not performed as well as ongoing assessments and response to treatment and interventions.

Adult Patient: An adult should be suspected of being acutely hypotensive when systolic blood pressure is less than 90mmHg. Diabetic patients and women may have atypical presentations of cardiac-related problems such as MI. General weakness can be the symptom of a very serious underlying process. Beta blockers and other cardiac drugs may prevent a reflexive tachycardia in shock with low to normal pulse rates.

Geriatric Patient: Falls, car collisions, hip fractures, and dislocations have high mortality rates. Altered mental status is not always dementia. Always check BGL and assess for signs for stroke, trauma, etc. with any alteration in a patient's baseline mental status. Minor or moderate injury in the typical adult may be very serious in the elderly.

Pediatric Patient: A pediatric patient is defined by fitting a Length-based Resuscitation Tape, Age $\leq$ 15 years, or weight $\leq$ 49kg. Patients off the Broselow-Luten tape should have weight based medications until age $\geq$ 16 or weight $\geq$ 50kg. Special needs children may require continued use of Pediatric based protocols regardless of age and weight. Initial assessment should utilize the Pediatric Assessment Triangle which encompasses Appearance, Work of Breathing and Circulation to skin. The order of assessment may require alteration dependent on the developmental state of the pediatric patient. Generally the child or infant should not be separated from the caregiver unless absolutely necessary during assessment and treatment.

Special note on oxygen administration and utilization: Oxygen in prehospital patient care is probably over utilized. Oxygen is a pharmaceutical drug with indications, contraindications as well as untoward side effects. Utilize oxygen when indicated, not because it is available. A reasonable target oxygen saturation for most patients is ≥ 94% regardless of delivery device.

Pearls

- Utilize body substance isolation for all patients.
  - **All-hazards precautions** include standard PPE plus airborne and contact precautions. This level of precaution is utilized during the initial phases of an outbreak when the etiology of the infection is unknown or when the causative agent is found to be highly contagious (e.g., Ebola, MERS, SARS).
  - **Airborne precautions** include standard PPE plus a N95 or P100 mask. This level of precaution is utilized for very small germs like tuberculosis, measles, and chicken pox.
  - **Droplet precautions** include standard PPE plus a standard surgical mask for providers who accompany patients in the back of the ambulance and a surgical mask or NRB O_2 mask for the patient. This level of precaution should be utilized when influenza, meningitis, mumps, streptococcal pharyngitis and other illnesses spread via large particle droplets are suspected. A patient with a potentially infectious rash should be treated with droplet precautions.
  - **Contact precautions** include standard PPE plus utilization of a gown, change of gloves after every patient contact and strict hand washing precautions. This level of precaution is utilized when multi-drug resistant organisms (e.g., MRSA and VRE), scabies, herpes zoster (shingles), or other illnesses spread by contact are suspected.
- Timing of transport should be based on the patient's condition and the destination policy.
- Never hesitate to contact the Base Hospital as a high risk refusal resource for any patient who refuses transport.
- SAMPLE: Signs/Symptoms; Allergies; Medications; PMH; Last oral intake; Events leading to injury/illness.

Routine Medical Care

TRAUMA RINGDOWNS

- Unit ID (i.e. M107, San Mateo Medic 42)
- Code 2/3 with **Trauma activation**
- Age
- Gender
- Mechanism of Injury: Blunt vs. penetrating
  - ◊ MVA
    - Restrained vs. unrestrained
    - Location in car
    - Speed
    - Type of MVA (e.g., head on/rear ended/t-bone/rollover)
    - Damage
    - Airbag deployment
  - ◊ FALL
    - Height
    - Surface
    - Taking blood thinners?
  - ◊ ASSAULT
    - Punched, kicked, struck by an object
  - ◊ GSW
    - Wound locations
    - Type of weapon (e.g., shotgun, handgun)
  - ◊ STABBING
    - Wound locations
    - Size of blade
    - Type of blade
- Chief complaint
- A&O status and GCS
- Physical findings
- Vital signs (BP/HR/RR/0_2 sat/BGL)
- Treatments
- ETA
- How do you copy?

STROKE/ALOC RINGDOWNS

- Unit ID (i.e. M107, San Mateo Medic 42)
- Code 2/3 with **STROKE alert**
- Age
- Gender
- Last known well time
- A&O status and GCS
- Chief complaint
- Physical findings
- Vital signs (BP/HR/RR/0_2 sat/BGL/Temp)
- Treatments
- Patient is positive/negative for blood thinners
- MR# or patient name and DOB
- ETA
- How do you copy?

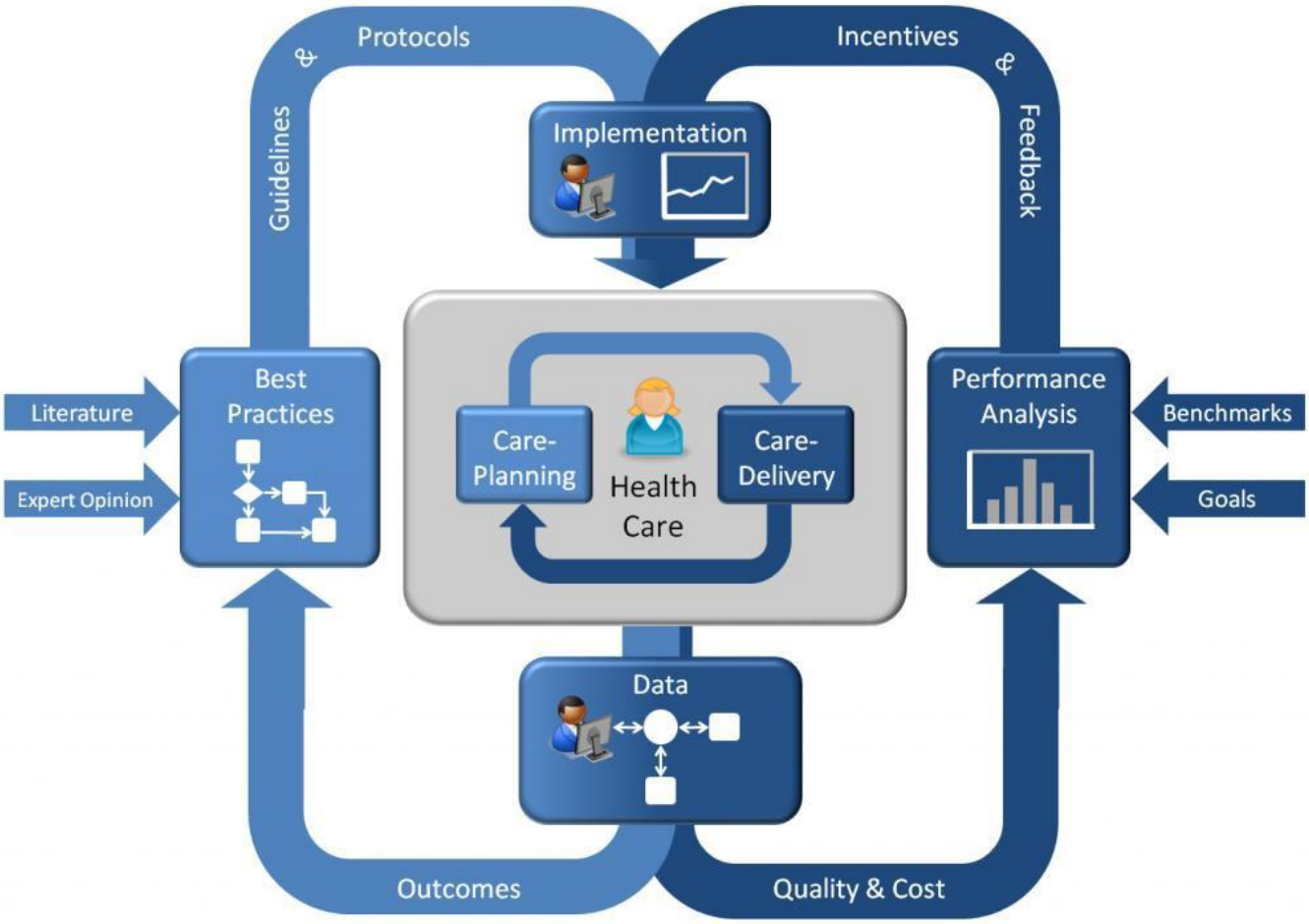
STEMI/MEDICAL RINGDOWNS

- Unit ID (i.e. M107, San Mateo Medic 42)
- Code 2/3 with **STEMI alert**
- Age
- Gender
- Chief complaint
- Physical findings
- Vital signs (BP/HR/RR/0_2 sat/BGL/Temp)
- Treatments
- 12-Lead has been transmitted to your facility
- MR# or patient name and DOB
- ETA
- How do you copy?

Best Family Contact & Phone Number to be gathered on all patients to be reported at Patient Hand Off*

Action to Improve

The EMS Agency working with our clinical system stakeholders largely follows Deming's Circle concept of Plan-Do-Study-Act (PSDA).



Striving to create best practices, the SMC LEMSA focuses on clinical research, recommendations by the International Stroke Committee (ISC) and the American Heart Association (AHA). Recommendations from the International Stroke Conference or ISC are discussed at our quarterly meetings.

Data from GWTG is shared to evaluate and derive system best practices.

Action to Improve

For the past ten years, the SMC LEMSA has hosted a stroke conference for healthcare professionals in the community. For many certified stroke nurses, this conference provides hours toward the requisite joint commission stroke education.

Two years ago, the AHA partnered with the SMC LEMSA in this effort, adding valuable resources. Last year, 175 participants attended the conference. Plans are underway for this year's conference which will be held on March 26, 2020.

Conference topics span the entire spectrum of stroke care, from the prehospital environment, to stroke rehabilitation and post-stroke depression.

Education is also provided to the community throughout the year. During National Stroke Day, healthcare providers personally distribute educational material to the public at BART and Caltrain locations.

With the addition of the BEST MSU study, extensive stroke education has been provided to stakeholders including hospitals, nursing staff, fire crews, paramedics and members of our community.

Annual Update

The San Mateo County EMS Agency will continue to plan, implement and evaluate the performance of the EMS system as well as update the Stroke Critical Care System Plan annually and provide it to the California Emergency Medical Services Authority (EMSA).

COUNTY OF SAN MATEO
EMERGENCY MEDICAL SERVICES

POLICY NO:	OPS-29
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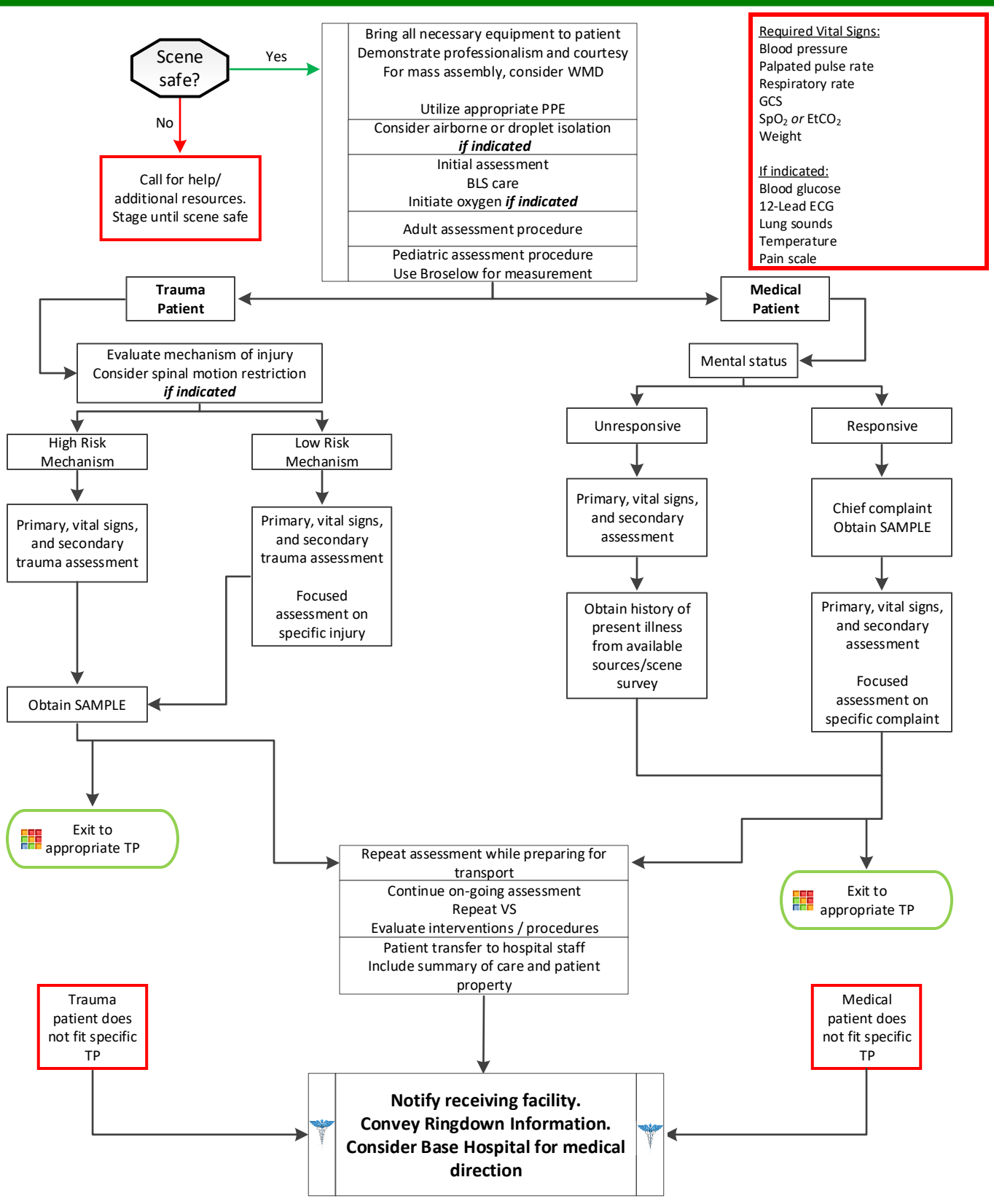
San Mateo County Emergency Medical Services

Routine Medical Care



General Treatment Protocol

COUNTY OF SAN MATEO
EMERGENCY MEDICAL SERVICES

Treatment Protocol G01

Effective March 2019

Routine Medical Care

Scene Safety Evaluation: Identify potential hazards to prehospital providers, patient, and public. Identify the number of patients and utilize triage protocol if indicated. Observe patient position and surroundings.

General: All patient care must be appropriate to the provider level of training and documented in the ePCR. The ePCR narrative should be considered a story of the circumstances, events, and care of the patient and should allow the reader to understand the complaint, assessment, treatment, why procedures were performed, and why indicated procedures were not performed as well as ongoing assessments and response to treatment and interventions.

Adult Patient: An adult should be suspected of being acutely hypotensive when systolic blood pressure is less than 90mmHg. Diabetic patients and women may have atypical presentations of cardiac-related problems such as MI. General weakness can be the symptom of a very serious underlying process. Beta blockers and other cardiac drugs may prevent a reflexive tachycardia in shock with low to normal pulse rates.

Geriatric Patient: Falls, car collisions, hip fractures, and dislocations have high mortality rates. Altered mental status is not always dementia. Always check BGL and assess for signs for stroke, trauma, etc. with any alteration in a patient's baseline mental status. Minor or moderate injury in the typical adult may be very serious in the elderly.

Pediatric Patient: A pediatric patient is defined by fitting a Length-based Resuscitation Tape, Age $\leq$ 15 years, or weight $\leq$ 49kg. Patients off the Broselow-Luten tape should have weight based medications until age $\geq$ 16 or weight $\geq$ 50kg. Special needs children may require continued use of Pediatric based protocols regardless of age and weight. Initial assessment should utilize the Pediatric Assessment Triangle which encompasses Appearance, Work of Breathing and Circulation to skin. The order of assessment may require alteration dependent on the developmental state of the pediatric patient. Generally the child or infant should not be separated from the caregiver unless absolutely necessary during assessment and treatment.

Special note on oxygen administration and utilization: Oxygen in prehospital patient care is probably over utilized. Oxygen is a pharmaceutical drug with indications, contraindications as well as untoward side effects. Utilize oxygen when indicated, not because it is available. A reasonable target oxygen saturation for most patients is ≥ 94% regardless of delivery device.

General Treatment Protocols

Pearls

- Utilize body substance isolation for all patients.
  - **All-hazards precautions** include standard PPE plus airborne and contact precautions. This level of precaution is utilized during the initial phases of an outbreak when the etiology of the infection is unknown or when the causative agent is found to be highly contagious (e.g., Ebola, MERS, SARS).
  - **Airborne precautions** include standard PPE plus a N95 or P100 mask. This level of precaution is utilized for very small germs like tuberculosis, measles, and chicken pox.
  - **Droplet precautions** include standard PPE plus a standard surgical mask for providers who accompany patients in the back of the ambulance and a surgical mask or NRB O_2 mask for the patient. This level of precaution should be utilized when influenza, meningitis, mumps, streptococcal pharyngitis and other illnesses spread via large particle droplets are suspected. A patient with a potentially infectious rash should be treated with droplet precautions.
  - **Contact precautions** include standard PPE plus utilization of a gown, change of gloves after every patient contact and strict hand washing precautions. This level of precaution is utilized when multi-drug resistant organisms (e.g., MRSA and VRE), scabies, herpes zoster (shingles), or other illnesses spread by contact are suspected.
- Timing of transport should be based on the patient's condition and the destination policy.
- Never hesitate to contact the Base Hospital as a high risk refusal resource for any patient who refuses transport.
- SAMPLE: Signs/Symptoms; Allergies; Medications; PMH; Last oral intake; Events leading to injury/illness.

Routine Medical Care

TRAUMA RINGDOWNS

- Unit ID (i.e. M107, San Mateo Medic 42)
- Code 2/3 with **Trauma activation**
- Age
- Gender
- Mechanism of Injury: Blunt vs. penetrating
  - ◊ MVA
    - Restrained vs. unrestrained
    - Location in car
    - Speed
    - Type of MVA (e.g., head on/rear ended/t-bone/rollover)
    - Damage
    - Airbag deployment
  - ◊ FALL
    - Height
    - Surface
    - Taking blood thinners?
  - ◊ ASSAULT
    - Punched, kicked, struck by an object
  - ◊ GSW
    - Wound locations
    - Type of weapon (e.g., shotgun, handgun)
  - ◊ STABBING
    - Wound locations
    - Size of blade
    - Type of blade
- Chief complaint
- A&O status and GCS
- Physical findings
- Vital signs (BP/HR/RR/0_2 sat/BGL)
- Treatments
- ETA
- How do you copy?

STROKE/ALOC RINGDOWNS

- Unit ID (i.e. M107, San Mateo Medic 42)
- Code 2/3 with **STROKE alert**
- Age
- Gender
- Last known well time
- A&O status and GCS
- Chief complaint
- Physical findings
- Vital signs (BP/HR/RR/0_2 sat/BGL/Temp)
- Treatments
- Patient is positive/negative for blood thinners
- MR# or patient name and DOB
- ETA
- How do you copy?

STEMI/MEDICAL RINGDOWNS

- Unit ID (i.e. M107, San Mateo Medic 42)
- Code 2/3 with **STEMI alert**
- Age
- Gender
- Chief complaint
- Physical findings
- Vital signs (BP/HR/RR/0_2 sat/BGL/Temp)
- Treatments
- 12-Lead has been transmitted to your facility
- MR# or patient name and DOB
- ETA
- How do you copy?

Best Family Contact & Phone Number to be gathered on all patients to be reported at Patient Hand Off*

COUNTY OF SAN MATEO
EMERGENCY MEDICAL SERVICES

POLICY NO:	FAC-4
DATE ISSUED:	5/2005
LAST REVIEW:	9/2017
NEXT REVIEW:	9/2020

ED PATIENT INTERFACILITY TRANSFERS

Purpose: To provide guidance for emergency departments on ground ambulance transport of patients that require interfacility transfer at the Basic (EMT), Advanced Life Support (ALS) (Paramedic), or Critical Care Transport (CCT) levels.

Compliance with law

1) All transfers shall comply with mandates contained in Federal and State law.
2) The sending ED physician determines the appropriate level of transportation required. Each ambulance service dispatch center should have call screening mechanisms assisting callers in selecting the most appropriate unit. The dispatch center will identify ALS calls and immediately transfer the call to Public Safety Communications (PSC) for a paramedic response.
3) The sending physician or designee should provide verbal report and transfer documents to arriving crews. These transfer documents must include the name of the sending and receiving physician. Once this has occurred, care for the patient is transferred to the ambulance crew until arrival at the destination and care has been transferred to the staff of the receiving facility.
4) The sending ED physician makes arrangements for the receipt of the patient by another physician at the receiving facility.

Description of Transport Options

CCT-RN Units

1) Type of patient:
   a) Unstable patient or a stable patient that requires care outside of the paramedic scope of practice
   b) Service can be scheduled or unscheduled and can be from any hospital department.
2) Staffing, equipment and authorization for care:
   a) The CCT unit is staffed with at least one (1) Registered Nurse and one (1) additional crew member at no less than the EMT level.

APPROVED:

Nancy A. Lapolla, MPH, EMS Director

Gregory H. Gilbert, MD, EMS Medical Director

b) The transferring physician, receiving physician, or CCT provider agency may suggest additional staff.
c) If specialized equipment is needed details should be discussed at the time the service is requested.
d) Care is provided by the registered nurse under standing orders and standardized procedures authorized by the provider's medical director. Additional orders are provided by the transferring physician.

3) Patient destination is determined by the transferring physician based on patient need.
4) Requesting a CCT Ambulance:
   a) Request CCT Ambulance through private ambulance provider.
   b) Urgent service can be requested if needed.
   c) Do not request a CCT through PSC.

BLS Ambulance

1) Type of patient:
   a) Stable patient unless the BLS ambulance staffing is supplemented by additional health care providers (MD, RN, RT)
2) Staffing:
   a) Basic Life Support ambulances are usually staffed with two (2) Emergency Medical Technicians.
   b) Additional staff may accompany the BLS unit from the transferring hospital if needed and approved by the BLS provider.
   c) Specialized units staffed by EMT providers may accompany teams for critical care transfer of specialized patients.
3) Care During Transports/Scope of Practice:
   a) The EMT will follow standard orders provided by the ambulance provider that are within the state scope of practice (see scope of practice table below).
   b) The transferring facility may provide additional instructions within this scope of practice
   c) If the patient's condition deteriorates during transport requiring treatment not included by the physician orders and EMT scope of practice, ambulance personnel will divert to the closest receiving hospital and notify the receiving hospital prior to arrival. The transferring physician will be notified as soon as possible.
4) Requesting a BLS ambulance:
   a) Service may be scheduled or unscheduled.
   b) Urgent service can be requested if needed.
   c) Do not request a BLS ambulance through PSC.

EMS/911 System Paramedic Ambulance/ALS Ambulance

1) Type of patient:
   a) Unstable or potentially unstable patients from the emergency department transferred to another hospital for specialized or higher level of care. (Examples include: patients identified as major trauma victims by anatomic or physiologic criteria, patients with 3rd trimester obstetrical complications and patients in need of immediate surgical intervention for life threatening events. 911 ambulances may also transfer patients for acute STEMI or stroke care as defined by San Mateo County policy and protocols.)
2) Staffing:
   a) The 911 ambulance is staffed by two health care providers. At least one is a paramedic. The second staff member may be an EMT or paramedic.
3) Care During Transport/Scope of Practice:
   a) The paramedic will follow San Mateo County Emergency Medical Services Policies, Protocols, and Procedures. Any modification must be by a Base Hospital physician and must be within the San Mateo County Scope of Practice (see Scope of Practice chart below)
   b) Patient destination is determined by the sending physician but must comply with San Mateo County policy and protocol.
4) Requesting a 911 system/paramedic ambulance:
   a) Contact San Mateo County PSC by Microwave phone (344) or landline telephone at 650-364-1313.
   b) PSC will ask five screening questions to determine patient condition
   c) The patient should be ready for transfer within 15 minutes of the request to PSC. The ambulance will usually arrive at the hospital within 13 minutes of the request.

Special Considerations

Major Trauma Patient Transfer/Consult (see Trauma Transfer algorithm, next page):

TRAUMA TRANSFER PROCEDURE

STEP 1	Determine appropriate level of transfer using chart below. Contact receiving Trauma Center and confirm acceptance of the patient **Stanford Trauma Center** • **1-650-724-2243 (Emergency)** • **1-650-723-4696 (Urgent – Adult)** • **1-650-723-7342 (Urgent – Pediatric)** **Zuckerberg S.F. General Trauma Center:** • **1-628-206-8111** ****Request to speak to Attending in Charge (AIC) about Trauma Re-Triage Patient****
STEP 2	**As soon as need for transfer is recognized,** request **CODE 3 TRAUMA TRANSFER** using ED to County Communication microwave direct line (#344)
STEP 3	Prepare patient and paperwork for immediate transport before ambulance arrives.
STEP 4	For trauma consults on patients not meeting red or blue box criteria, contact the trauma center and request to speak to the Trauma Attending-In-Charge about Trauma Re-Triage Patient • Stanford Trauma Center: 1-650-723-4696 (Adult) or 1-650-723-7342 (Pediatric) • Zuckerberg SF General Trauma Center: 1-628-206-8111

TRAUMA TRANSPORTATION SELECTION CRITERIA

EMERGENCY TRANSFER PATIENTS: Call Trauma Center PRIOR to Transfer and state RED BOX TRAUMA TRANSFER

Stanford Trauma Center:
- **1-650-724-2243**

Zuckerberg S.F. General Trauma Center:
- **1-628-206-8111**

****Request to speak to Attending in Charge (AIC) about Trauma Re-Triage Patient****

ED physician determines patient requires immediate evaluation/resuscitation by a trauma center

Some indicators:

Blood Pressure
- B/P of <90 or
- Decrease in B/P by 30mmHg following 2 liters of IV crystalloid

Head Injury with Blown Pupil

Penetrating Thoracic or Abdominal Trauma

URGENT TRANSFER PATIENTS: Call Trauma Center PRIOR to Transfer

Stanford Trauma Center:
- **1-650-723-4696 (Adult)**
- **1-650-723-7342 (Pediatric)**

Zuckerberg S.F. General Trauma Center:
- **1-628-206-8111**

****Request to speak to Attending in Charge (AIC) about Trauma Re-Triage Patient****

ED physician determines that the patient requires urgent evaluation by a trauma center based on the following indicators:

Anatomic area	**Related Injuries**
Central Nervous System	• GCS <14 with abnormal CT Scan • Spinal Cord or major vertebral injury
Chest	• Major chest wall injury with >3 rib fractures and/or pulmonary contusion • Cardiac Injury
Pelvis/Abdomen	• Pelvic ring disruption • Solid organ injury confirmed by CT Scan or ultrasound demonstrating abdominal fluid
Major extremity injuries	• Fracture/dislocation with loss of distal pulses and/or ischemia • Open long bone fractures • Two or more long bone fractures • Amputations that require reimplantation
Co-morbid factors	• Adults > 65 y/o • **Pediatric < 6 y/o Transfer to Stanford (Pediatric Trauma Center)** • Pregnancy - >22 weeks gestation • Insulin dependent diabetes • Morbid obesity • Cardiac or Respiratory disease • Immunosuppression • Antiplatelet or anticoagulation agents
Multiple-System Injury	• Trauma with associated burns **Transfer to closest Trauma Center** • Major injury to more than two body regions • Signs of hypoperfusion – Lactate >4 or Base Deficit >4

TRAUMA LEVEL OF TRANSPORTATION

CATEGORY	TYPE/STAFF	DESCRIPTION	CAPABILITIES	TYPICAL ETA	PROVIDERS
Emergent ALS	Advanced Life Support	Standard Paramedic transport	Consider for cases meeting **emergency** and **urgent** criteria above, paramedic scope of practice	Approx. 10 min	9-1-1 System
CCT-RN	Critical Care Transport Ground: 1 RN	Critical Care RN Transport	Mechanical ventilation and most medications	60-120 min ETA can be extended	Facility Choice
Air Ambulance	Critical Care Transport Air: 2 RNs	Critical Care RN Transport	Advanced practice RN / expanded scope of practice	ETA can be extended	CALSTAR/REACH; LifeFlight

1) Pediatric Critical Care Center Transfer:
   a) San Mateo County recognizes three Pediatric Critical Care Centers (PCCC).
   b) To contact these centers call their 24 hour consultation line to make transfer and transportation arrangements:
      i) Stanford Health Care Lucile Packard Children's Hospital Dispatch 650-723-7342
      ii) California Pacific Medical Center 888-637-2762 (Transfer Center) or 415-600-0720 (PICU)
      iii) UCSF Benioff Children's Hospital– 877-822-4453 (Transfer Center) or 415-353-1352 (PICU)
   c) If the intended PCCC cannot immediately accept the patient, that PCCC will take responsibility for:
      i) locating an alternate PCCC able to immediately accept the patient, and
      ii) keeping the sending hospital informed as to the success or failure of securing a PCCC able to immediately accept the patient.
      iii) Inform EMS Agency, if PCCC did not assist in finding an alternate PCCC.
2) Scope of Practice Chart – (CCT-RN Scope of Practice is determined by provider's medical director):

Skills/Medication/Procedure	**BLS**	**911 – Paramedic**
Vital signs stable	X	X
Unstable vital signs		X
Oxygen by mask or cannula	X	X
Level of consciousness-stable	X	X
Level of consciousness-unstable		X
Peripheral IV established (no additives) 5 or 10% Dextrose, Saline, Ringer's Lactate or combined solutions	X	X
Peripheral IV established with Lidocaine, Dopamine, or potassium chloride (20 mEq/mL)		X
Mechanical respiratory assistance (patient's vent accompanied by a trained attendant who will do suctioning)	X	X
Intubated patient with BVM ventilation		X
NG, gastric tubes, Foley catheter	X	X
Saline lock, indwelling vascular access device (not infusing fluids or medication)	X	X
Central IV line in place (non-infusing)	X	X
Cardiac monitor		X
Temporary pacemaker in place		X

Standby or anticipated transcutaneous pacing		X
Medication administration in progress or anticipated. IV drips cannot be maintained on a mechanical pump and are only approved as noted. Adenosine Albuterol Atropine Calcium Chloride Dopamine-IV Drip Dextrose Diphenhydramine Midazolam Morphine Sulfate Narcan Nitroglycerine spray or paste Ondansetron Sodium Bicarbonate		X

RECEIVING HOSPITALS

APPROVED: _____ _____

EMS Medical Director | Interim EMS Administrator

1. Purpose: To provide paramedics and EMT-1's with information and guidance about the capability of the receiving facilities in San Mateo County.

2. Definitions:
   - 2.1 Appropriate Receiving Hospital: The receiving hospital that has the capability of treating the anticipated needs of the patient and has no restriction to receiving the patient with the presenting symptoms or complaint.
   - 2.2 Requested hospital: The hospital that the patient, the patient's family or the designated decision maker for the patient requests.
   - 2.3 San Mateo County Receiving Hospital /SMC Receiving Hospitals: Receiving hospitals that participate in the San Mateo County Quality Improvement Program and function as Base Hospitals for physician consultation.
   - 2.4 Basic Emergency Department: An emergency department that is designated by the State Department of Health Services as providing "basic emergency medical service."
   - 2.5 Standby Emergency Department: An emergency department that is designated by the California Department of Public Health as providing "standby emergency medical service."
   - 2.6 Labor and Delivery Patient/Obstetrical patient: Any patient who is suspected of being in labor with a fetus of greater than 20 weeks gestation or who has a known or suspected complication of pregnancy such as placenta abruptio, placenta previa or toxemia of pregnancy.
   - 2.7 Acute Stroke Patient: A patient with the onset of symptoms of a stroke up to 8 hours prior to paramedic contact. Symptoms of a stroke include abrupt changes in mental status, altered speech, gait, behavior, sudden onset of confusion and focal neurological findings.
   - 2.8 Major Burn Patient: Any patient who meets the American Burn Association criteria for a major burn and does not meet the San Mateo County criteria for a major trauma victim.

2.9 Major Trauma Patient: Any patient who meets the Trauma Triage Criteria of San Mateo County
2.10 STEMI Patient: A patient with a documented ST Segment Myocardial Infarction noted on the 12-lead EKG.

3. SMC Receiving Hospitals: The following hospitals routinely receive patients from the SMC emergency medical services system.
   3.1 Kaiser Redwood City
   3.2 Kaiser South San Francisco
   3.3 Palo Alto Veterans Affairs Hospital
   3.4 Peninsula Medical Center
   3.5 San Francisco General Hospital for trauma
   3.6 San Mateo Medical Center
   3.7 Sequoia Hospital
   3.8 Seton Coastside
   3.9 Seton Medical Center
   3.10 Stanford Hospital
   3.11 Dominican Hospital of Santa Cruz may be utilized as a receiving facility from the southwest coastside of the County
      3.11.1 A San Mateo County Base Hospital should be contacted for physician consultation as needed for patients being transported to Dominican Hospital. Stanford Hospital is the usual base hospital for these situations

4. Receiving Hospitals for labor and delivery or obstetrical patients as defined above:
   4.1 Kaiser Redwood City
   4.2 Peninsula Medical Center
   4.3 San Francisco General Hospital
   4.3 Sequoia Hospital
   4.4 Seton Medical Center
   4.5 Stanford Hospital
   4.6 Dominican Hospital Santa Cruz (contact a San Mateo County Base Hospital if physician consult is needed)

5. For destination requests for emergency departments not listed in 3. or 4. above:
   5.1 The on-duty AMR supervisor should be contacted for authorization. At request of the transporting crew or other on scene personnel, Public Safety Communications will page the AMR on-duty supervisor the unit designation, destination request and system levels.
      5.1.1 In general, if the request is due to a clinical need or for continued care it will be granted.

5.1.2 The AMR supervisor may approve or deny the request based upon the number of available in-County ambulances (as an example: 2 or less available ambulances) or the number of active calls.

5.1.3 If the hospital request is denied by the ALS supervisor an incident report will be generated by the ALS supervisor and sent to the AMR Operations Manager or SSFFD EMS Captain. The involved agency will forward the copy of the report to the San Mateo County EMS Clinical Services Manager.

5.2 Patient's facility of preference is defined as the hospital requested by a patient, his/her family, his or her designated medical decision maker or the patient's private physician

5.3 All patients, except those requiring transport to the closest appropriate receiving hospital, will be transported to the hospital of their preference; as long as it is a San Mateo County receiving hospital,

5.4 In addition to the San Mateo County Receiving Hospitals paramedics will routinely transport patients to the following facilities if they are capable of receiving the patient.

5.5 <u>The hospital must be contacted prior to transport to ensure they can receive the patient:</u>

5.5.1 Santa Clara County Hospitals.

5.5.1.1 El Camino Hospital-Mountain View

5.5.2 San Francisco County Hospitals

5.5.2.1 University of California San Francisco Medical Center

5.5.2.2 California Pacific Medical Center

5.5.2.2.1 Pacific Campus of CPMC

5.5.2.2.2 Davies Campus of CPMC

5.5.2.2.3 St. Luke's Campus of CPMC

5.5.2.3 San Francisco General Medical Center for medical complaints

5.5.2.4 Kaiser San Francisco

5.6 <u>The above facilities are not to be contacted as a base hospital for physician consultation</u>

5.7 A patient who does not specify a facility of preference will be transported to the closest appropriate San Mateo County receiving hospital.

5.8 Within the jurisdiction of the South San Francisco Fire Department the paramedic will determine if the request can be granted

6. Sexual Assault.

6.1 San Mateo Medical Center is the designated hospital victims of sexual assault regardless of gender or age. San Mateo Medical Center will not divert suspected sexual assault victims.

6.2 If the victim of sexual assault is a major trauma victim or other specialty hospital care transport will be to the appropriate specialty care center.

7. Major Trauma Receiving Hospitals (Refer to Operations 22)
   - 7.1 The following Hospitals are designated to receive major trauma patients:
     - 7.1.1 San Francisco General Hospital
     - 7.1.2 Stanford Hospital

8 Stroke Centers (Refer to Operation 29)
   - 8.1 Primary Stroke Centers
     - 8.1.2 Any hospital recognized by San Mateo County EMS that has been designated as an accredited Primary Stroke Center by the Joint Commission.
       - 8.1.2.1 Seton Medical Center (Daly City)
       - 8.1.2.2 Kaiser South San Francisco Hospital
       - 8.1.2.3 Mills-Peninsula Hospital (Peninsula Campus)
       - 8.1.2.4 Sequoia Hospital
       - 8.1.2.5 Kaiser Redwood City Hospital
       - 8.1.2.6 Stanford Hospital and Clinics
   - 8.2 Primary Stroke Centers with interventional stroke care capability
     - 8.2.2 Kaiser Redwood City Hospital
   - 8.3 Comprehensive Stroke Center
     - 8.3.2 A Comprehensive Stroke Center is a hospital that has successfully completed and maintains Joint Commission Accreditation as a Comprehensive Stroke Center and enters into an MOU with San Mateo County relative to being a stroke center
       - 8.3.2.1 Stanford Hospital and Clinics

9 Major Burn Receiving Hospitals
   - 9.1 St. Francis Hospital (The Bothin Burn Center) San Francisco (415-353-6300)
   - 9.2 Santa Clara Valley Medical Center, San Jose (408-885-3228)

10 STEMI Centers Designated by San Mateo County
   - 10.1 Seton Medical Center
   - 10.2 Peninsula Medical Center
   - 10.3 Sequoia Hospital
   - 10.4 Kaiser Redwood City
   - 10.5 Stanford Hospital

11 5150 Receiving Hospitals: Two hospitals are designated by the Health Services Agency to receive patients under Section 5150 of the Welfare and Institutions Code:
   - 11.1 Peninsula Medical Center: Emergency Department
   - 11.2 San Mateo Medical Center: Emergency Department or Psychiatric Emergency Services (PES)
   - 11.3 Patients on a 5150 hold who are determined to have a potentially life threatening emergency shall be transported to the closest hospital including

those not designated as a 5150 receiving hospital. See Policy Facilities - 5 for definitions of potentially life threatening emergencies.

12. Standby Emergency department in San Mateo County are:
    - 12.2 Seton Coastside
    - 12.3 Patients whom the paramedic reasonably believes will be discharged from the emergency department may be transported to this facility.
    - 12.4 Patients that require emergent stabilization at an emergency department may be transported to a standby emergency department if a basic emergency facility is not within a reasonable distance. These would include patients:
        - 12.4.1 in cardiac arrest with no return of spontaneous circulation (ROSC) in the field
        - 12 4.2 with uncontrolled bleeding from an extremity
        - 12.4.3 with an uncontrolled airway

13. Patients who may require admission to an acute care hospital should not be transported to a standby emergency department. Examples of these patients would include, but are not limited to, patients with:
    - 13.1 Sustained abnormal vitals signs
    - 13.2 A history of head trauma with an abnormal level of consciousness.
    - 13.3 Recent onset (less than 12 hours) of neurological deficit due to suspected stroke.
    - 13.4 Adult patients with seizure of new onset, multiple seizures within a 24-hour period, or sustained alteration in level of consciousness.
    - 13.5 Chest pain or discomfort of known or suspected cardiac origin
    - 13.6 Sustained respiratory distress not responsive to field treatment (adult or pediatric patients)
    - 13.7 Suspected pulmonary edema who are not responsive to field interventions.
    - 13.8 Potentially significant cardiac arrhythmias
    - 13.9 New onset hypertension with diastolic blood pressure >120 Hbg or symptoms of headache, photophobia, or altered mental status.
    - 13.10 Post-Cardiac Arrest patients
    - 13.11 Orthopedic emergencies having deformity, open fractures, or alterations of distal neuro-vascular status.
    - 13.12 Suspected spinal cord injury of new onset.
    - 13.13 Toxic exposure or overdose. If there is a question as to the potential for hospital admission the poison control center or a base hospital physician should be contacted for consultation.
    - 13.14 Major burns as defined in the burn protocol
    - 13.15 Near drowning or suspected barotrauma with any history of loss of consciousness, unstable vital signs, or respiratory problems

13.16 In addition to the preceding, pediatric patients who present with any of the following conditions or should be transported to a facility with a basic emergency department.
- 13.16.1 Children with symptomatic dehydration
- 13.16.2 Children requiring endotracheal intubation and/or ventilator support
- 13.16.3 Children with a serious medical condition having exacerbation of the condition or clinical deterioration
- 13.16.4 Children with long bone fractures or fractures involving the joints
- 13.16.5 Pediatric seizure patients who do not present with fever or who continue to seize longer than 10 minutes.

14. South San Francisco Fire Department Hospital Destination

14.1 South San Francisco Fire Department ambulances will transport patients from their City to the following receiving facilities only:
- 14.1.1 Kaiser South San Francisco
- 14.1.2 Peninsula Medical Center
- 14.1.3 San Francisco General Hospital
- 14.1.4 Seton Medical Center
- 14.1.5 San Mateo Medical Center (5150, in-custody, sexual assault victims only)
- 14.1.6 Kaiser Redwood City for patients with onset of stroke symptoms from 3.5-8 hours prior to paramedic arrival
- 14.1.7 Stanford Hospital for patients with major trauma or onset of stroke symptoms from 2.5-8 hours prior to paramedic arrival
- 14.1.8 St. Francis Hospital (Bothin Burn Center) for major burns
- 14.1.9 STEMI Centers as identified in section 10 above.

15. Jail Inmates

15. 1 Jail inmates being transported code 3 shall be taken to the closest appropriate facility

15. 2 Jail inmates being transported code 2:
- 15.2.1 San Mateo County inmates will be transported to San Mateo Medical Center
- 15.2.2 San Bruno Jail inmates will be transported to San Francisco General Hospital (even if it is on ambulance diversion).

16. Cordilleras Center/Canyon Oaks/Hillcrest Juvenile Facility

16.1 Patients at these facilities being transported code 3 shall be taken to the closest appropriate facility

16.2 Patients at these facilities being transported Code 2 will be transported to San Mateo Medical Center

17. Burn Patients
    - 17.1 Patients who meet the American Burn Association criteria for major burns shall be transported to the closest Burn Receiving Hospital
    - 17.2 Patients who meet the criteria for a Major Trauma Victim shall be transported to the appropriate San Mateo County Trauma Center
    - 17.2 Patients who present with signs of symptoms of acute respiratory distress from smoke inhalation (sore throat, wheezing, coughing, hoarse voice, or stridor) shall be transported to the closest receiving hospital. All other patients with suspected respiratory involvement shall be transported to the closest trauma center.
    - 17.3 Air medical transportation may be considered for those patients with burn injuries who have field transport times exceeding 30 minutes from the burn or trauma center who have extensive body surface area burns, respiratory symptoms, or electrical injuries.

COUNTY OF SAN MATEO

Emergency Medical Services
San Mateo County Health
801 Gateway Blvd., Ste. 200
South San Francisco, CA 94080
smchealth.org/ems

February 19, 2020

Farid Nasr, MD
Specialty Care Systems
California EMS Authority

Via Electronic Mail

Dr. Nasr,

I write in response to your request for supplemental information in relation to the most recent Stroke Critical Care System Plan submitted by the San Mateo County Emergency Medical Services Agency. Please find responses to your inquiry immediately below. Referenced documents have also been attached.

§ 100270.220. Stroke Critical Care System Plan.
(c) The Stroke Critical Care System Plan submitted to the EMS Authority shall include, at a minimum, all of the following components:
(2) The list of stroke designated facilities **with the agreement expiration dates.**

Hospital	Designation	Contract End Date
Kaiser Foundation Hospital - Redwood City	Comprehensive Stroke Center (CSC)	8/31/2021
Stanford Health Care	Comprehensive Stroke Center (CSC)	2/13/2022
Mills-Peninsula Medical Center	Thrombectomy-capable Stroke Center (TCS)	8/31/2021
Kaiser Foundation Hospital - South San Francisco	Primary Stroke Center (PSC)	8/31/2021
Seton Medical Center	Primary Stroke Center (PSC)	12/31/2021
Sequoia Hospital	Primary Stroke Center (PSC)	8/31/2021

(4) A description or a copy of the method of field communication to the receiving hospital-specific to stroke patients, designed to expedite time-sensitive treatment on arrival.

Response: Field communication to the receiving hospital-specific to stroke patients designed to expedite time-sensitive treatment on arrival is by either radio or telephone. The Routine Medical Care field treatment protocol (g01) that was included in the initial submission and is also attached to this email outlines the information given in the "ring down" or notification provided to the receiving facility by prehospital personnel. Please refer to page 3 of this treatment protocol.

(7) A policy or description of how the Local EMS agency integrates a receiving center in a neighboring jurisdiction.

Response: Stanford Healthcare is a San Mateo County EMS system receiving hospital which is physically located in Santa Clara County. Our Facility-1, Receiving Hospitals policy attached to this email governs destinations for patients originating within the San Mateo County EMS system and includes Stanford. Operations 29 which was included in the initial submission and is also attached to this communication is our stroke *policy*. Operations 29 specifically identifies all stroke receiving hospitals serving the San Mateo County EMS system, including Stanford. Stanford actively participates in our quarterly stroke CQI meetings and our Agency provides oversight of its provided services to patients originating within our EMS system.

Please do not hesitate to contact me should the Authority require any additional clarification or information.

Sincerely,

Travis Kusman, MPH, Paramedic
Director

Cc
Linda Allington, Clinical Services Manager