SAN JOAQUIN COUNTY

EMERGENCY MEDICAL SERVICES AGENCY

Jared Bagwell, *Director*
Dr. Katherine Shafer MD, *EMS Medical Director*

Thursday, August 21, 2025
0900 – 1100
Robert Cabral Agriculture Center
2101 E. Earhart Ave, Stockton CA 95206
Assembly Room 2

SJC EMS ADVISORY COMMITTEE

AGENDA

I. CALL TO ORDER/INTRODUCTIONS

II. APPROVAL OF PAST EMS ADVISORY COMMITTEE MEETING MINUTES:

a. Review and approval of May 8, 2025, EMS Advisory Committee meeting minutes

III. OLD BUSINESS:

a. Paramedic Training Program	Update
b. Emergency Ambulance RFP	Update
c. Nurse Navigation at EMS Dispatch	Update

IV. NEW BUSINESS:

a. 2025 EMS Advisory Committee designations	Info
b. EMS Advisory Committee representation	Info
c. Maddy Funds Request Process	Info
d. EOA Provider Compliance Committee (RFP)	Info

V. EMS SYSTEM PROGRAMS / REPORTS:

a. Ambulance Patient Offload Times (APOT)	
i. AB 40 CCR Regulations	Info
ii. 2025 YTD APOT times	Report
iii. Weekly Reports	Info
iv. Observations	Info
b. Specialty Care Reports	
i. STEMI Program	Report
1. 2024 CARES	
ii. Stroke Program	N/A
iii. Trauma Program	N/A

c. CQI
    i. Trauma Protocol revisions

VI. ANNOUNCEMENTS/GOOD OF THE ORDER:

VII. NEXT MEETING:

a. The next regularly scheduled EMS Advisory Committee meeting is scheduled for November 13, 2025.

VIII. ADJOURNMENT

Attachments:

EMS Advisory Committee Meeting minutes – May 8, 2025 – Draft
EMS Policy 1400, EMS Advisory Committee
EMS Policy 1110, Use and Approval of EMS Maddy Fund Other
AB 40
APOT Reports YTD
CARES Reports

EMS Advisory Committee

Thursday, May 8th, 2025, at 0900

MINUTES

Members	Membership Representing	Present	Absent
Jared Bagwell (Co-Chair)	SJCEMSA	X	
Dr. Katherine Shafer (Co-Chair)	SJCEMSA	X	
Charla Barney	ED RN – Base Hospital - SJGH	X	
Cheryl Heaney-Ordez	ED RN – Receiving Hospital –St. Joseph's Medical Center	X	
Erica Lowry	ED RN – Receiving Hospital – Sutter Tracy Community Hospital	X	
Brian Hajik	EOA emergency ambulance provider – American Medical Response		X
Vanessa Herrero	EOA emergency ambulance provider – Escalon Community Ambulance		X
John Andrews	EOA emergency ambulance provider – Manteca District Ambulance		X
Pat Burns	EOA emergency ambulance provider – Ripon Fire Ambulance	X	
Steven Islas	Representative of an ALS fire dept./district – Stockton Fire Department	X	
Ken Johnson	BLS fire departments or districts – Lodi Fire Department	X	
Vince Stroup	Paramedic Non Fire-based ALS emergency ambulance providers – Manteca District Ambulance	X	
Lucas Mejia	EMT Non Fire-based ALS emergency ambulance providers – Manteca District Ambulance	X	
Eric DeHart	Fire-based emergency ambulance provider – Ripon Fire	X	

Anna Trindade	Emergency Medical Dispatcher – SFD ECD	X	
Nicholas Taiariol	Law Enforcement – San Joaquin County Sheriff		X
Alternate members			
Raeann Pfann	San Joaquin General Hospital		X
Kyle Naes	American Medical Response	X	
George McKelvie	Manteca District Ambulance	X	
Jeremy Abundiz	Ripon Fire Department		X
Jeremy Bishop	Stockton Fire Department	X	
Jennifer Flowers	Sutter Tracy Community Hosp.		X
EMS Agency Staff	**Title**	**Present**	**Absent**
Christine Tualla	EMS Analyst		X
Matthew Esposito	EMS Coordinator	X	
Paul Harper	Pre Hospital Care Coordinator	X	
Nasir Khan	Specialty Care Coordinator	X	
Jeff Costa	Specialty Care Coordinator	X	
Leon Brown	EMS Analyst	X	
Anita Tenscher	Office Technician Coordinator	X	
Guests			
Genevieve Valentine	Health Care Services	X	
Anthony Nguyen	NorCal Ambulance	X	
John Crystalinas	Alpha One Ambulance	X	
David Ziolkowski	St. Joseph's Medical Center	X	

Meeting called to order at 0900 by Co-Chair EMS Director Jared Bagwell.

I. INTRODUCTIONS:

Committee member introductions.

II. APPROVAL OF PAST EMS ADVISORY COMMITTEE MEETING MINUTES:

a. J. Bagwell asked committee to review minutes from last advisory committee meeting. A. Trindade moved to approve, C. Heaney-Ordez seconded.

III. OLD BUSINESS:

a. Paramedic Training Program: Committee members were updated on progress of current NCTI/SJCEMSA paramedic class. SJCEMSA is partnering with Delta college and is currently looking for a facility for the training program while the EMS training facility is built. Looking to have the first cohort begin Fall of 2026.
b. Emergency Ambulance RFP: Committee members were updated on the current and expected progress of the emergency ambulance RFP which is to take effect May 2026. The RFP was submitted to EMSA on January 6 of this year and received verbal approval yesterday. With this update the RFP could be published May 27 of this year and go to the board January of 2026.
c. Nurse Navigation at EMS Dispatch: J. Bagwell informed committee that the Nurse Navigation system was budgeted for and will work ASAP to implement this FY.
d. County Wide Ambulance System Status Deployment: SJEMSA is working on a policy and discussing more effective ways for zone assistance for the EOA's.

IV. NEW BUSINESS:

a. 2025 EMS Award of Excellence: J. Bagwell awarded J. Bishop the 2025 EMS Award of Excellence.
b. EMS Week 2025: J. Bagwell informed the committee that the EMS Week Proclamation will go before the San Joaquin County Board of Supervisors Tuesday, May 13th. He also encouraged the committee to share any events they have planned for EMS week.

V. EMS SYSTEM PROGRAM/REPORTS:

a. Ambulance Patient Offload Times (APOT): J. Bagwell presented the 2025 APOT data to the committee.
    i. 2025 APOT times: The committee was reminded the importance of accuracy for reporting APOTs. Overall there have been improvements in APOT times.
    ii. Weekly Reports: J. Bagwell informed the committee that weekly APOT reports continue to be sent out and posted on the EMS website.
    iii. Observations: J. Costa went over findings from the observations that he and N. Khan have noticed. They are seeing changes in behaviors in transfer of care and seeing more accurate times.
        1. C. Heaney-Ordez stated that they are seeing better patient off loading and transfer of care times at St. Josephs. They are looking at weekly APOT reports and have added an EMS nurse to help with offloads.
        2. D. Ziolkowski informed committee the updates being made to St. Josephs Medical Center will help with ED holds and free up bed in the ED for patients. Working on APOT times is a top priority.
        3. C. Barney said the nurses at San Joaquin General are focusing on make sure their APOT signature times are accurate.
        4. V. Stroup stated he is noticing nurses asking for signatures, which he hasn't seen before.

5. J. Bagwell reminded the committee that the APOT standard is twenty minutes, we will be looking at the data and discussing if changes need to be made to that standard.

b. Specialty Crae Reports: J. Costa presented the 2024 Specialty Care Reports to the committee.
   i. STEMI Program- J. Costa presented 2024 STEMI QI Reports to the committee.
   ii. Stoke Program- J. Costa presented 2024 Stroke QI Reports to the committee.
   iii. Trauma Program- J. Costa presented 2024 Trauma QI Reports and the trauma protocol for San Joaquin General Hospital. Stated that the prehospital care crews' onsite times make a big difference on patients' survival. N. Khan explained the Trauma Tiers 0-2.

c. CQI: P. Harper presented the following trail studies to the committee.
   i. TXA Dosing: TXA was implemented into the field July 2024. Trauma surgeons requested the dosage be increased from 1g to 2gs; this took affect May of this year.
   ii. Zofran Trial Study: San Joaquin county has been approved to participate in this trial study; it will begin July 2025.
   iii. IV Acetaminophen and Ketorolac: This will begin July 2025.

VI. ANNOUNCEMENTS/GOOD OF THE ORDER:

a. E. Lowry informed the committee that Sutter Tracy is opening more primary care clinics and specialty care clinics to hopefully lessen the load on the ED.
b. C. Heaney-Ordez met with joint commission last week and St. Joseph's will be having a food truck for EMS week on 5/19. St. Joseph is also starting construction for new additions to the hospital and a new tower for the ED.
c. K. Johnson updated the committee on the new manager that was hired as well as a new CQI nurse.
d. K. Naes stated they have their boat and bike team established and ready for summer.
e. J. Crystalinas is new to the EMS Advisory Committee and Alpha One is new to San Joaquin County.
f. G. Mckelvie updated the committee on the issues MDA has had with their new monitors.
g. V. Stroup stated he was impressed by the San Joaquin General Hospital's trauma team.
h. C. Barney informed committee that San Joaquin General Hospitals towers is no longer being used for patients, and they are working on reconstructing the ED.
i. G. Valentine introduced herself as the new HCS director. She informed the committee that Lodi Adventist will no longer be accepting Health Plan of San Joaquin/ Medi-cal patients. She is working on getting funding for a new behavioral health campus, looking to open 9/2027.

VII. NEXT MEETING:

a. The next regularly scheduled meeting is scheduled for August 21, 2025.

VIII. ADJOURNMENT:

Meeting adjourned 1100.

TITLE: **EMERGENCY MEDICAL SERVICES ADVISORY COMMITTEE** EMS Policy No. **1400**

PURPOSE:

The purpose of this policy is to establish membership, roles, responsibilities, process, and structure of the San Joaquin County Emergency Medical Services Advisory Committee (EMS Advisory Committee).

AUTHORITY:

Health and Safety Code, Division 2.5, Section 1797.220

POLICY:

The EMS Advisory Committee is a multi-disciplinary, stakeholder represented committee established to discuss, review, provide input, and make recommendations to the EMS Medical Director and the San Joaquin County Emergency Medical Services Agency (SJCEMSA) on matters related to policy and procedures with the purpose to enhance the delivery and effectiveness of prehospital emergency medical services.

PROCEDURE:

I. EMS Advisory Committee Responsibilities:

A. Reviewing draft SJCEMSA policies and reviewing comments on draft policies submitted during any policy review period.

B. Serve as a forum for pre-hospital stakeholder engagement related to the SJCEMSA EMS System.

II. EMS Advisory Committee Membership:

A. Only properly affiliated San Joaquin County EMS system stakeholders shall hold membership in the EMS Advisory Committee.

B. The EMS Advisory Committee membership shall be comprised of thirteen (13) designated members representing each of the following:

1. EMS Administrator – permanent member.
2. EMS Medical Director – permanent member.
3. (1) One Emergency Department Registered Nurse Liaison member representing the Base hospital, designated by the San Joaquin

County Base Hospital.

4. (2) Two Emergency Department Registered Nurse Liaison members representing all of San Joaquin County receiving hospitals.
5. (1) One member representing the San Joaquin County exclusive operating area (EOA) emergency ambulance provider, designated by the EOA provider.
6. (1) One member representing Fire-based emergency ambulance provider(s), designated by the San Joaquin County Fire Chiefs Association.
7. (1) One member representing Advanced Life Support (ALS) fire departments or districts, designated by the San Joaquin County Fire Chiefs Association.
8. (1) One member representing Basic Life Support (BLS) fire departments or districts, designated by the San Joaquin County Fire Chiefs Association.
9. (1) One San Joaquin County accredited paramedic member representing Non Fire-based ALS emergency ambulance providers, designated by the Non Fire-based ALS emergency ambulance providers.
10. (1) One EMT member representing Non Fire-based ALS emergency ambulance providers, designated by the Non Fire-based ALS emergency ambulance providers.
11. (1) One Emergency Medical Dispatcher (EMD) member representing authorized Medical Priority Dispatch System (MPDS) dispatch centers, designated by the authorized MPDS dispatch centers.
12. (1) One member representing law enforcement agencies within San Joaquin County, designated by the San Joaquin County Law Chiefs Council.

C. EMS Advisory Committee members shall serve a term of two (2) years and not limited to term limits.

D. Membership for representatives 3 through 7 shall expire on July 1 of even years and membership for representatives 8 through 13 shall expire on July 1 of odd years.

III. EMS Advisory Committee Membership Designation:

A. All EMS Advisory Committee member designations must be submitted in writing to the EMS Administrator.

B. Member designation requires a consensus of different organizations for member representatives #9, #10, and #11. If consensus is not achieved, or if more designations are received than allotted for a particular membership, the EMS Administrator shall designate a properly affiliated member.

C. Re-designation of membership representation is required at the end of a member's two (2) year term, or in the event of a member no longer meets the requirements for membership or resigns.

IV. EMS Advisory Committee Membership Seating and Vacancy:

A. EMS Advisory Committee members may be removed by the EMS Administrator who are disruptive to committee business or who do not attend at least 75% of scheduled EMS Advisory Committee meetings annually. A member removed based on either of these reasons shall be deemed ineligible for future membership and the membership position shall be deemed vacant.

B. EMS Advisory Committee members may be ineligible for a membership position and their membership position deemed vacant due to change of employment status, change in license or certification status, or other reasons.

C. An EMS Advisory Committee member may request a regular alternate member to attend a meeting. Such requests must be made in advance and in writing to the EMS Administrator for approval.

V. EMS Advisory Committee Proceedings:

A. The EMS Administrator or the EMS Medical Director will serve as the chairperson for each meeting.

B. EMS Advisory Committee members shall notify the SJCEMSA in advance of any meeting they will be unable to attend.

C. The EMS Advisory Committee shall meet no less than quarterly on a schedule to be determined by the EMS Administrator in coordination with

EMS Advisory Committee members.

D. The SJCEMSA will provide administrative and clerical support to maintain records of each meeting including agendas, minutes, and attendance records.

E. All meetings of the EMS Advisory Committee, including all documents pertaining to the proceedings, are public documents and are subject to public review pursuant to the California Public Records Act, California Government Code, Section 6240 et. seq.

SAN JOAQUIN COUNTY
EMERGENCY MEDICAL SERVICES AGENCY

TITLE: **MADDY FUNDS USE AND APPROVAL PROCESS** EMS Policy No. **1110**

PURPOSE: The purpose of this policy is to establish a process for the local approval and disbursement of Maddy EMS Fund – Other, that is consistent with Health and Safety Code 2.5, Section 1797.98a.

AUTHORITY: California Code, Government Code, §76000, Health and Safety Code, Division 2.5, Sections 1797.220 and 1797.98a.

DEFINITIONS: See SJCEMSA Policy Definitions

BACKGROUND:

The San Joaquin County Board of Supervisors established through resolution the Maddy EMS Fund in San Joaquin County (B-92-396 and B-92-763). The Maddy EMS Fund is administered through the San Joaquin County Emergency Medical Services Agency (SJCEMSA) and funded through local levied penalty assessments on criminal offenses, forfeitures, and vehicle code violations. Maddy EMS Funds are divided into three distinct purposes: 1.) reimbursement to physicians and surgeons for uncompensated emergency services, 2.) to hospitals for uncompensated trauma care services, and 3.) for other emergency medical services purposes as approved by SJCEMSA.

POLICY:

It is the policy of SJCEMSA to use the seventeen percent Maddy EMS Fund – Other consistent with the intent of Health and Safety Code Section 1797.98a (5)(C) which is designated for other emergency medical services purposes to support or enhance the San Joaquin County EMS System.

PROCEDURE:

I. EMS Fund – Other Request Requirements

A. Funding requests shall be made for other EMS purposes as reviewed and accepted by SJCEMSA and approved by the San Joaquin County EMS Advisory Committee and may be used for equipment purchases or capital projects only to the extent that these expenditures support the provision of emergency medical service.

B. Funding requests shall only be eligible to authorized San Joaquin County EMS system providers/organizations. Authorized EMS system

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providers/organizations include EMS emergency ambulance dispatch or EMS call processing centers, emergency and non-emergency ambulance providers, fire first responders, and acute care hospitals.

C. Funding requests shall be made as either “EMS Agency Funded” or “Reimbursement” for properly approved future purchases made that are consistent with this policy.

D. Funding request or funding appropriated for the purposes of this policy shall not be used to supplant funding for existing levels of service and shall only be used as approved.

E. Authorized EMS system providers/organizations shall accept the item(s) approved at no cost but with the institutional responsibility to maintain the equipment in accordance with guidance from the SJCEMSA, to replace equipment lost or damaged due to negligence or improper use, to ensure that personnel using the equipment are properly trained in its use, maintain an accurate inventory in the WebEOC Resource Request and Deployment Module (RRDM), and submit annual inventory reports to the SJCEMSA by June 15 of subsequent years.

F. Funding request, approval process, and disbursement of funds shall require a two (2) fiscal year cycle (July 1- June 30).

G. A maximum of $400,000 in total award can be approved by the EMS Advisory Committee each fiscal year in accordance with this policy.

H. No single request for funding shall exceed $200,000.

I. One (1) funding request per authorized San Joaquin County EMS system provider/organization shall be allowed per fiscal year.

II. Maddy EMS Fund – Other Request Process:

A. Request for funding shall be made in writing to the SJCEMSA Director no later than September 1 of each year and shall include, at minimum, the following:
   1. Name and type of organization;
   2. Name and Title of requestor representing the organization;
   3. Type of funding request (capital project, equipment purchase etc.);

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4. Detailed description of capital project or equipment;
5. Detailed purpose and justification request;
6. Detailed description how the purchase will support the provision of the EMS system;
7. Name and Title of organizations approval authority;
8. Quotation for total expenditure.

B. Once a funding request has been received, it will be reviewed by the SJCEMSA Director to ensure it is aligned with state law and this policy.

C. Once a funding request has been reviewed and approved or denied, a notice will be sent back to the requestor no later than October 1. If the funding request is approved, the notice shall require the requesting organization to attend and present at the November EMS Advisory Committee meeting.

D. Approved funding requests will be agendized for the November EMS Advisory Committee for final presentation and approval of the Committee by simple majority vote.

E. Once a funding request has been approved or denied by the EMS Advisory Committee, the SJCEMSA Director shall send appropriate notice back to requestor no later than December 1 with additional instructions and details of the funding process.

F. If a funding request approval was for “Reimbursement”, proof of purchase with receipts and invoice shall be received by SJCEMSA before May 30 of the second fiscal year of the approval.

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Title 22. Social Security
Division 9. Pre-hospital Emergency Medical Services
Chapter 1.2 Delivering Equitable and Person-Centered Care - Ambulance Patient Offload Time

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ARTICLE 1: General Provisions.

§ 100001.01 Authority and Application of this Chapter

(a) This chapter, adopted pursuant to Health and Safety Code Section 1797.120.7, applies to all general acute care hospitals (GACHs) with emergency departments that receive ambulance-transported patients, as well as local EMS agencies (LEMSAs) and EMS transport provider agencies subject to ambulance patient offload time (APOT) monitoring and reporting under Sections 1797.120.5, 1797.120.6, and 1797.120.7. The purpose of this chapter is to establish statewide standards, protocols, and tools designed to improve the accuracy, efficiency, and timeliness of APOT within California's emergency medical services (EMS) system.

(b) This regulation establishes requirements and procedures for the Emergency Medical Services Authority (hereinafter "EMSA"), LEMSAs, GACHs with an emergency department, and EMS transport provider agencies when standard APOT is exceeded.

Note: Authority cited: 1797.1,1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.

ARTICLE 2: Definitions

§ 100002.01 Ambulance Patient Offload Delay (APOD).

"Ambulance patient offload delay" or "APOD" is defined as an APOT, measured from the arrival of an ambulance patient at an emergency department ambulance bay (NEMSIS element eTimes.11) to the time that patient care is transferred to an emergency department gurney, bed, chair, or other acceptable location and the emergency department assumes responsibility for the care of the patient (NEMSIS element eTimes.12), which exceeds the APOT standard set by the LEMSA within whose jurisdiction the receiving GACH with an emergency department is located.

Note: Authority cited: 1797.1,1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.

§100002.02 Ambulance Patient Offload Time (APOT).

"Ambulance patient offload time" or "APOT" is defined as the interval between the arrival of an ambulance patient at an emergency department ambulance bay (NEMSIS element eTimes.11) and the time that patient care is transferred to an emergency department gurney, bed, chair, or other acceptable location and the emergency department assumes responsibility for care of the patient (NEMSIS element eTimes.12). The technical specification for calculating APOT (APOT-1) is defined in Technical Specification to Calculate Ambulance Patient Offload Time (APOT) (Rev. 04/2025), which is incorporated by reference.

Note: Authority cited: 1797.1,1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.

§ 100002.03 Ambulance Patient Offload Time (APOT) Reduction Protocol.

"Ambulance patient offload time reduction protocol" or "APOT reduction protocol" is a protocol developed by a GACH with an emergency department pursuant to Section 1791.120.6 of the Health and Safety Code that identifies specific criteria for activation of the protocol and contains actionable steps to decrease APOD as described in section 100005.01 of this chapter.

Note: Authority cited: 1797.1,1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.

§ 100002.04 Ambulance Patient Offload Time (APOT) Standard.

"Ambulance Patient Offload Time Standard" or "APOT standard" means the maximum length of time permitted for APOT, not to exceed thirty (30) minutes, 90% of the time, that is developed and adopted by each LEMSA to be applicable within its jurisdiction.

Note: Authority cited: 1797.1,1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.

§ 100002.05 Audit Tool.

"Audit tool" means a standardized process utilizing a protected health information (PHI)-secure electronic portal developed and implemented by EMSA that is used by EMSA, GACHs with an emergency department, and LEMSAs for the purpose of evaluating and verifying data related to the transfer of care from EMS personnel to emergency department medical personnel. The audit tool includes mechanisms for validation by GACHs with an emergency department and LEMSAs and is capable of identifying discrepancies, ensuring data integrity, and supporting compliance with established APOT standards.

Note: Authority cited: 1797.1,1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.

§ 100002.06 Bi-Weekly.

"Bi-weekly" means an interval of two weeks between occurrences.

Note: Authority cited: 1797.1,1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.

§ 100002.07 California Emergency Medical Services Information System or CEMSIS.

"California Emergency Medical Services Information System" or "CEMSIS" means the secure, standardized, and centralized electronic information and data collection system administered by EMSA which is used to collect statewide EMS and trauma data.

Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, 1797.122, and 1797.176 Health and Safety Code.
Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.

§ 100002.08 Electronic Patient Care Record (ePCR)

"Electronic patient care record" or "ePCR" means a real-time, patient care record that make information available securely to authorized users in a digital format capable of being shared electronically across more than one health care organization or within an electronic health record system.

Note: Authority cited: 1797.107, 1797.122, 1797.176, 1831, Health and Safety Code

Reference: Section: 1797.72, 1797.78, 1797.90, 1797.98e, 1797.122, 1797.125.09, 1797.227, 1798.175, 1831, Health and Safety Code.

§ 100002.09 Electronic Signature.

"Electronic signature," means a secure, electronic method of authentication in the form of an electronic signature used to confirm patient arrival (NEMSIS element eTimes.11) as well as the transfer of care time from EMS personnel to emergency department medical personnel (NEMSIS element eTimes.12) and populate a time stamp in NEMSIS element eOther.19. The time stamp is collected within the ePCR and the electronic signature is provided by emergency department medical personnel at the time of transfer of care.

Note: Authority cited: 1797.1, 1797.107, 1797.120, and 1797.120.5 Health and Safety Code.
Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.

§ 100002.10 Emergency Department.

"Emergency department" means facilities which have been licensed by the California Department of Public Health (CDPH) as having an emergency department service level of "basic, comprehensive, or standby" and, for the purposes of this Chapter, includes any location within the GACH with an emergency department where ambulance patients are received.

Note: Authority cited: 1797.1, 1797.107,1797.120, and 1797.120.5 Health and Safety Code.
Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6 and 1797.120.7 Health and Safety Code.

§ 100002.11 Emergency Department Ambulance Bay.

"Emergency department ambulance bay" means a designated location where ground transport ambulances park to offload patients at a GACH emergency department or ambulance receiving area for the purposes of transferring, triaging, or admitting patients. In addition to a GACH emergency department, this also includes other locations authorized by the GACH to receive arriving ambulance patients.

Note: Authority cited: 1797.1, 1797.107, 1797.120, and 1797.120.5 Health and Safety Code.
Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6 and 1797.120.7 Health and Safety Code.

Note: Authority cited: 1797.1, 1797.107,1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.195 Health and Safety Code.

§ 100002.17 Thirty (30) minutes.

"Thirty (30) minutes" for the purpose of APOT standard is defined as 1800 seconds.

Note: Authority cited: 1797.1, 1797.107,1797.120, 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6 and 1797.120.7 Health and Safety Code.

§ 100002.18 Transfer of care.

"Transfer of care" means when an ambulance patient, who has arrived at the emergency department ambulance bay, is physically transferred to an emergency department gurney, bed, chair, or other acceptable location, and emergency department medical personnel receives the report and confirms the transfer of patient care with an electronic signature within the ePCR (NEMSIS element eOther.19).

Note: Authority cited: 1797.1, 1797.107,1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6 and 1797.120.7 Health and Safety Code.

§ 100002.19 Volunteer EMS Transport Provider Agency.

"Volunteer EMS transport provider agency" means an EMS transport provider agency that is staffed primarily by unpaid or volunteer EMS personnel.

Note: Authority cited: 1797.1, 1797.107,1797.120, 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6 and 1797.120.7 Health and Safety Code.

ARTICLE 3. AUDIT TOOL FOR VERIFICATION OF CEMISIS DATA USED FOR APOT AND APOD REPORTING

§ 100003.01 Verification of CEMSIS Data Used for APOT and APOD.

(a) The ePCR shall serve as the legal record for all APOT and APOD data within the California EMS system.

(b) The audit tool and verification process consist of the following:

(1) EMSA shall make CEMSIS APOT and APOD data available to each licensed GACH with an emergency department, through EMSA's PHI-secure electronic portal.

(A) The GACH shall only have access to records within the PHI-secure electronic portal that pertains to patients transported to its emergency department.

(B) The GACH shall have view-only access to the following NEMSIS data elements from the ePCR for the purpose of matching an ePCR to the hospital's corresponding electronic health record (EHR) and validating patient arrival and transfer of care time data:

(i) EMS transport provider agency name (NEMSIS element dAgency.03)

(ii) LEMSA

(iii) Incident run number (NEMSIS element eResponse.03)

(iv) Incident date (earliest eTimes element in the ePCR)
(v) Receiving facility name (NEMSIS element eDisposition.01)
(vi) Receiving facility code (NEMSIS element eDisposition.02)
(vii) Patient first name (NEMSIS element ePatient.03)
(viii) Patient last name (NEMSIS element ePatient.02)
(ix) Patient date of birth (NEMSIS element ePatient.17)
(x) Patient gender (NEMSIS element ePatient.13)
(xi) Patient arrival at destination date/time (NEMSIS element eTimes.11)
(xii) Patient transfer of care date/time (NEMSIS element eTimes.12)
(xiii) Signature date/time (NEMSIS element eOther.19)
(xiv) Unit back in service date/time (NEMSIS element eTimes.13)
(xv) Type of person signing (NEMSIS element eOther.12)

(2) If the GACH identifies any discrepancies between the CEMSIS-reported patient arrival (NEMSIS element eTimes.11) or transfer of care time (NEMSIS element eTimes.12) and the GACH's EHR, the GACH shall notify the relevant LEMSA and EMS transport provider agency or agencies of the discrepancy.

(3) Upon receipt of the notification from the GACH, the LEMSA shall coordinate a collaborative review with the GACH and relevant EMS transport provider agency or agencies.

(4) If the LEMSA and EMS transport provider agency or agencies agree with the discrepancy identified by the GACH, the relevant EMS transport provider agency shall correct the ePCR and resubmit the revised record by the 15th calendar day of the month following the reporting month.

(5) For unresolved discrepancies:

(A) The APOT value shall default to the CEMSIS data patient arrival time (NEMSIS element eTimes.11), and transfer of care time (NEMSIS element eTimes.12), as defined in the Technical Specification to Calculate Ambulance Patient Offload Time (APOT) (Rev. 04/2025).

(B) The GACH shall also enter the hospital-verified values for patient arrival (NEMSIS element eTimes.11) and transfer of care time (NEMSIS element eTimes.12) into the PHI-secure electronic portal using the designated fields so that EMSA can analyze discrepancies and assess their impact on APOT calculations.

(c) The audit tool shall serve as a quality assurance and data validation instrument, in addition to a data collection tool.

Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, 1797.122, and 1797.176 Health and Safety Code.
Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.

ARTICLE 4. LOCAL EMS AGENCY ROLES AND RESPONSIBILITIES FOR APOT

§ 100004.01 The Local EMS Agency.

Each LEMSA shall:

(a) Develop and adopt a local APOT standard. The APOT standard shall not exceed thirty (30) minutes, ninety percent (90%) of the time. If a LEMSA has not adopted a local APOT standard, the standard shall be deemed to be thirty (30) minutes for ninety percent (90%) of ambulance patient offloads for the purposes of APOT reporting and compliance under this Chapter;

(b) Within thirty (30) calendar days of the effective date of the APOT standard, submit a copy of the APOT standard to EMSA to the email address: apot@emsa.ca.gov with the subject line: "LEMSA APOT Standard Submission – [LEMSA Name]" in an electronic format as either a PDF or Microsoft Word document;
(c) Include the APOT standard and any related APOT policies, protocols, or procedures in the Response and Transportation section of its annual EMS plan submission to EMSA;
(d) Submit any updates or revisions to the APOT standard occurring independent of the annual EMS plan submission to EMSA as an amendment to the local EMS plan within thirty (30) calendar days of the effective date of the update or revision;
(e) When directed by EMSA, participate in EMSA-hosted bi-weekly APOT coordination calls, as referenced in Article 7 of this Chapter;
(f) In coordination with the relevant GACH(s) with an emergency department, EMS transport provider agency or agencies, and any other relevant LEMSA(s), review and validate APOT and APOD data submitted to CEMSIS by EMS transport provider agencies to resolve any discrepancies in the APOT or APOD data no later than the 15th calendar day of each month for data submitted in the preceding calendar month.

Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, 1797.122, and 1797.176 Health and Safety Code.
Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.

ARTICLE 5. GENERAL ACUTE CARE HOSPITAL WITH AN EMERGENCY DEPARTMENT ROLES AND RESPONSIBILITIES FOR APOT

§ 100005.01 General Acute Care Hospital (GACH) with an Emergency Department

The GACH with an emergency department shall:
(a) At the time the emergency department medical personnel receives the physical transfer of patient care and report from EMS personnel, the emergency department medical personnel shall provide an electronic signature within the ePCR that confirms the transfer of care (NEMSIS element eTimes.12). The date/time stamp for this signature is captured within the ePCR as the NEMSIS element eOther.19;
(b) Develop and submit an APOT reduction protocol to EMSA. Submission shall be made electronically to the email address: apot@emsa.ca.gov with the subject line: "APOT Reduction Protocol – [Hospital Name]" in an electronic format as either a PDF or Microsoft Word document. The APOT reduction protocol shall be submitted to EMSA annually on or before June 30th and shall include all required data elements and action plans defined in Ambulance Patient Offload Time (APOT) Reduction Protocol Checklist for General Acute Care Hospitals (GACH) with an Emergency Department (Rev. 04/2025), which is incorporated by reference;
(c) Implement the APOT reduction protocol within 10 business days of receiving email notification and direction from EMSA to do so.
(d) Notify EMSA no later than twenty-four (24) hours after implementation of the APOT reduction protocol by email at: apot@emsa.ca.gov, to confirm compliance.
(e) When directed by EMSA, participate in EMSA-hosted bi-weekly calls to update and discuss implementation of the protocol and the outcomes.

Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, and 1797.176 Health and Safety Code.

Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7, Health and Safety Code.

ARTICLE 6. EMS TRANSPORT PROVIDER AGENCY ROLES AND RESPONSIBILITIES FOR APOT

§ 100006.01 EMS Transport Provider Agency

An EMS transport provider agency shall:

(a) No later than 60 days from the effective date of these regulations, collect an electronic signature within the ePCR (NEMSIS element eOther.19) from emergency department medical personnel at the point of transfer of care for each patient transported to a GACH emergency department.

(b) Ensure the date and time entered for the "destination transfer of care" time (NEMSIS element eTimes.12) is viewable to the emergency department medical personnel.

(c) Be permitted to use GPS vehicle tracking technology or automatic vehicle location (AVL) technology to automatically populate or retrospectively verify the 'patient arrival at destination date/time' (NEMSIS element eTimes.11) documented within the ePCR. GACHs with an emergency department may validate GPS data annually in coordination with the EMS transport provider agency.

(d) When directed by EMSA, participate in EMSA-hosted bi-weekly calls to update and discuss implementation of the protocol and the outcomes.

Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, 1797.122, and 1797.176 Health and Safety Code.
Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.

ARTICLE 7. EMERGENCY MEDICAL SERVICES AUTHORITY ROLES AND RESPONSIBILITIES FOR APOT

§ 100007.01 Monthly Monitoring of APOT Data

EMSA shall:

(a) Monitor monthly APOT data submitted by GACH(s) with an emergency department.

(b) Utilize data submitted to CEMSIS or the PHI-secure electronic portal to evaluate compliance with the APOT standards established by LEMSAs pursuant to Section 1797.120.5, subdivision (b).

Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, 1797.122, and 1797.176 Health and Safety Code.
Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.

§ 100007.02 Exceedance of APOT Standards - Required Actions

If a GACH with an emergency department reports an APOT that exceeds the LEMSA's adopted standard for the preceding month, EMSA shall initiate the following actions:

(a) Electronically notify the relevant LEMSA and the Commission on Emergency Medical Services of the exceedance within five (5) business days of verification;

(b) Direct the LEMSA to issue a notification to all EMS transport provider agencies operating within its jurisdiction regarding the GACH's APOT exceedance;

(c) Direct the GACH to immediately implement its APOT reduction protocol no later than five (5) business days after notification;
(d) Convene and host bi-weekly coordination calls and/or virtual meetings with designated representatives from hospital administration, emergency department leadership, hospital employees, the LEMSA(s), and the affected EMS transport provider agency or agencies;
(1) These EMSA-hosted bi-weekly meetings shall be used to review APOT reduction protocol implementation, address operational barriers, monitor outcomes, review the data validation tool, and propose corrective actions;
(2) Meetings shall continue until such time as the GACH demonstrates sustained compliance with the adopted APOT standard for two (2) consecutive reporting periods, or as otherwise determined by EMSA.

Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, 1797.122, and 1797.176 Health and Safety Code.
Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.

§ 100007.03 Technical Assistance Program

(a) EMSA shall establish and maintain a technical assistance program to support eligible small rural hospitals and volunteer EMS transport provider agencies in meeting the requirements of Section 1797.120.5, including:
(1) Implementation of electronic signature systems;
(2) Integration with CEMSIS;
(3) Deployment of the audit tool.
(b) Requests for technical assistance must be submitted using Form EMSA-TA-Request-1 (Rev. 04/2025), which is incorporated by reference.

Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, 1797.122, and 1797.176 Health and Safety Code.
Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.

§ 100007.04 Funding Support

(a) Subject to appropriation by the Legislature, EMSA shall administer a grant support program to provide financial assistance to eligible small rural hospitals and volunteer EMS transport provider agencies;
(b) Grant funds may be used for:
(1) The purchase or upgrade of electronic data systems;
(2) Personnel training for electronic signature or audit tool use;
(3) System integration or compliance consulting services;
(4) Costs associated with participation in mandatory meetings under this Chapter.
(c) Eligible entities shall apply using Form EMSA-APOT-Grant-1(Rev. 04/2025), which is incorporated by reference, and must include the following information:
(1) Proof of eligibility as defined in Sections 100002.16 and 100002.19 of this Chapter (See section I of the form);
(2) A brief description of current capabilities and needs (See section II.1 and IV of the form);
(3) A budget proposal and implementation timeline (See section II.2, II.3 and IV of the

form).

(d) Funding shall be awarded based on the availability of appropriated funds and will take into consideration the entity's geographic needs, call volume, and the extent of its volunteer or under-resourced status, as well as the total number of entities that have requested funding support.

(e) Recipients shall submit a post-award compliance and performance report using Form EMSA-Grant-Report-1 (Rev. 04/2025), which is incorporated by reference, within 90 days of project completion.

Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, 1797.122, and 1797.176 Health and Safety Code.
Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.

§ 100007.05 Oversight and Accountability

(a) EMSA may audit any recipient of grant funding to ensure the funds are used in accordance with approved applications;

(b) Misuse of funds or failure to comply with reporting requirements may result in:

(1) Requirement to return funds;

(2) Disqualification from future support programs;

(3) Referral to the appropriate oversight entity.

Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, and 1797.120.5 Health and Safety Code.
Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.

Technical Specification to Calculate Ambulance Patient Offload Time (APOT)

The technical specification to calculate APOT provides standardized guidance on data elements, inclusion/exclusion criteria, and calculation methodologies to ensure statewide uniformity in reporting and analysis.

MEASURE SET	Ambulance Patient Offload Time (APOT)	
SET MEASURE ID #	APOT-1	
PERFORMANCE MEASURE NAME	Ambulance Patient Offload Time for Emergency Patients	
Description	Does the GACH meet the APOT standard 90% of the time?	
Type of Measure	Process	
Reporting Value and Units	Time (Minutes and Seconds)	
Continuous Variable Statement (Population)	Time (in minutes and seconds) from time ambulance arrives at the emergency department ambulance bay until the patient is transferred to GACH emergency department care. All emergency ambulance transports to the GACH emergency department with available eTimes are included.	
Inclusion Criteria	Criteria in NEMSIS 3.5	Data Elements--NEMSIS 3.5
	• All events for which eResponse.05 "type of service requested" has values recorded of **2205001** "Emergency Response (Primary Response Area)", • **2205003** "Emergency Response (Intercept)", • **2205009** "Emergency Response (Mutual Aid)", • **2205005** "Hospital-to-Hospital Transfer" AND • All events in eDisposition.30 "Transport Disposition" with the value of o **4230001** "Transport by This EMS Unit (This Crew Only)" or o **4230003** "Transport by This EMS Unit, With a Member of Another Crew" AND • All events in eDisposition.21 "Type of	• Type of Service Requested (eResponse.05) • Transport Disposition (eDisposition.30) • Type of Destination (eDisposition.21) • Patient Arrived at Destination Date/Time (eTimes.11) • Destination Patient Transfer of Care Date/Time (eTimes.12) • Type of Person Signing (eOther.12) • Signature Reason (eOther.13) • Type of Patient

	Destination" with the value of **4221003**, "Hospital-Emergency Department"; AND • eTimes.11 "Patient Arrived at Destination Date/Time" values are logical and present AND • eTimes.12 "Destination Patient Transfer of Care Date/Time" values are logical and present AND • All events in eOther.12 "Type of Person Signing" with the value of **4512005** "Healthcare Provider" AND • All events in eOther.13 "Signature Reason" with the value of **4513007** "Transfer of Patient Care" AND • All events in eOther.14 "Type of Patient Representative" o with the value of 4514025 "MD/DO" or o 4514029 "Nurse (RN)" or o 4514031 "Nurse Practitioner (NP), or o 4514033 "Other Care Provider", or o 4514037 "Physician's Assistant (PA)AND • All events in eOther.15 "Signature Status" with the value of or o **4515031** "Signed" or o **4515033** "Signed-Not Patient" AND • All events in eOther.19 "Date/Time of Signature" values are logical and present	Representative (eOther.14) • Signature Status (eOther.15) • Date/Time of Signature (eOther.19)

Exclusion Criteria	Criteria	Data Elements
	• eDisposition.02 is "Blank, Not Available, Not Recorded, Not Applicable, or Null" • All records where the difference between eOther.19 "Date/Time of Signature" and eTimes.11 "Patient Arrived at Destination Date/Time" is negative • All records where eTimes.13 "Unit Back in Service Date/Time" is recorded as taking place prior to eOther.19 "Date/Time of Signature"	• Destination/Transferred To, Code (eDisposition.02) • Patient Arrived at Destination Date/Time (eTimes.11) • Date/Time of Signature (eOther.19) • Unit Back in Service Date/Time (eTimes.13)
Indicator Formula Numeric Expression	The formula is the 90th Percentile of the given numbers or distribution in their ascending order.	
Example of Final Reporting Value (number and units)	19 minutes, 34 seconds (19:34)	
Sampling	No	
Aggregation	Yes	
Minimum Data Values	Not Applicable	
Data Collection Approach	• Retrospective data sources for required data elements include administrative data and pre-hospital care records. • Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.	
Suggested Statistical Measures	• 90th percentile measurement. • Aggregate measure of central tendency and quantile (fractile) measurement to determine the span of frequency distributions.	
Reporting Notes	• Report monthly aggregate values by LEMSA (aggregate of total of offloads and 90th Percentile offload time) Report the 90th percentile time calculated and the denominator (number of emergency transports with data available).	

Ambulance Patient Offload Time (APOT) Reduction Protocol Checklist for General Acute Care Hospitals (GACHs) with an Emergency Department

The purpose of this document is to establish requirements for the development and implementation of the Ambulance Patient Offload Time (APOT) Reduction Protocol by General acute care hospitals (GACHs) with an emergency department (hereinafter referred to as "Hospital"). This protocol aims to ensure timely and efficient transfer of care for patients arriving by emergency medical services (EMS) to improve operational efficiency and reduce ambulance patient offload time, in accordance with local Emergency Medical Services Agency (LEMSA) standards.

The information contained herein is intended to assist GACHs in meeting regulatory requirements, enhancing hospital coordination, and improving patient care outcomes through improved ambulance patient offload practices.

Hospital Information

Please provide the following information regarding your specific hospital within your APOT reduction protocol:

Hospital Name:	_____
CDPH Hospital Licensing Number:	_____
Hospital Emergency Department Address:	_____
Chief Executive Officer (CEO):	_____
CEO Email Address:	_____
CEO Phone Number:	_____
Chief Nursing Officer (CNO) or Equivalent:	_____
CNO Email Address:	_____
CNO Phone Number:	_____
Primary Contact (Emergency Department Director or Manager):	_____
Emergency Department Director Email:	_____
Emergency Department Director Phone Number:	_____

APOT Reduction Protocol Checklist

Please check all boxes to confirm that your APOT reduction protocol contains the following requirements:

1. **Consultation & Development:**

   ☐ The APOT reduction protocol was developed in consultation with the emergency department staff and exclusive employee representatives.

2. **Notification to Hospital Staff:**

☐ The APOT reduction protocol includes a process to notify hospital administrators, nursing staff, medical staff, and ancillary services if the LEMSA standard for APOT has been exceeded for one month.

3. **Operational Improvements:**

   ☐ The APOT reduction protocol includes mechanisms to improve hospital operations to reduce APOT. These may include, but are not limited to:

   - Activating the hospital's surge plan
   - Transferring patients to other hospitals
   - Suspending elective admissions
   - Discharging patients
   - Using alternative care sites
   - Increasing supplies
   - Improving triage and transfer systems
   - Adding additional staffing

4. **Hospital Coordination:**

   ☐ The APOT reduction protocol includes systems to improve coordination between the emergency department and other hospital departments, including consults for emergency department patients.

5. **Direct Operational Changes:**

   ☐ The APOT reduction protocol includes direct operational changes designed to facilitate the rapid reduction of APOT to meet the LEMSA standard.

6. **Annual Reporting:**

   ☐ The hospital shall submit its APOT reduction protocol to EMSA and report any revisions annually on or before June 30th. All updates should include required data elements and action plans, as outlined with this document.

Baseline Hospital Data

Please provide the following baseline data for your hospital within your APOT reduction protocol:

Total Number of Licensed Hospital Beds:	_____
Average Number of Staffed Hospital Beds (as a percentage of total licensed beds):	_____
Percentage of Occupied Staffed Beds:	_____
Percentage of Occupied Licensed Beds:	_____

Total Number of Licensed Emergency Department Beds:	
Average Number of Staffed Emergency Department Beds (as a percentage of total licensed ED beds):	
Total Annual Emergency Department Visits:	
Average Number of ED Visits Daily (0000-2359):	
Average Number of Patients Arrived by EMS Daily (0000-2359):	
Average Number of Patients with Behavioral Health Diagnosis Boarding Daily (0000-2359):	
Average Number of Admitted Patients Boarding Daily (0000-2359):	
Average Number of Patients Pending Transfer Boarding Daily (0000-2359):	

APOT Reduction Protocol Action Plan

The APOT reduction protocol action plan must include strategies to manage APOT, including activation of hospital surge plans, utilization of hospital capacity tools, transferring patients, suspending elective admissions, discharging patients, using alternative care sites, increasing supplies, improving triage systems, and adding staff.

Capacity Tool Information

Please provide the following information regarding the use of a hospital capacity tool within your APOT reduction protocol:

Does your hospital utilize a hospital capacity tool (e.g., NEDOCS)?	**Yes ☐ No ☐**
If yes, please provide the name of the hospital capacity tool used:	
If yes, summarize actions for each phase of the capacity tool:	
Level 1 or Green: Normal Operations	
Level 2 or Yellow: Daily Operations	
Level 3 or Orange: Overcrowded	
Level 4 or Red: Overcapacity	
Level 5 or Black: Critical Overcapacity	
If your hospital does not use a hospital capacity tool, please describe your objective overcrowded assessment methods and associated action plans:	

Form EMSA-TA-Request-1

Emergency Medical Services Authority (EMSA)
Technical Assistance Request Form
Pursuant to Health & Safety Code § 1797.120.5(d)

Section I: Applicant Information
Organization Name: _____

Facility Type: ☐ Small Rural Hospital ☐ Volunteer EMS Provider Transport Agency

Primary Contact Name: _____

Title/Position: _____

Phone Number: _____

Email Address: _____

Organization Address: _____

City: _____ Zip Code: _____

Section II: Eligibility Verification
☐ I certify that our organization qualifies as:

A small rural hospital (≤ 50 beds, rural area), or

A volunteer EMS transport provider agency staffed primarily by unpaid or volunteer personnel.

Please attach:
☐ Proof of rural designation (for hospitals)
☐ Staffing summary or volunteer roster, and brief description of current capabilities (for EMS transport provider agencies)

Section III: Technical Assistance Needs (check all that apply)
☐ Electronic Signature System Implementation
☐ Integration with California EMS Information System (CEMSIS)
☐ Audit Tool Deployment
☐ Data Collection and Reporting Training
☐ Workflow/Process Redesign for APOT
☐ Development or Update of APOT Reduction Protocol

(Rev. 04/2025)

☐ Other (describe): _____

Section IV: Description of Request
Provide a brief description (250–500 words) of the assistance needed, operational barriers, how EMSA support will help, and anticipated timeline:

Section V: Certification
I certify the information provided is accurate, and we are committed to implementation in good faith.

Name: _____
Title: _____
Signature: _____
Date: ____/____/_____

Submit Completed Forms To:
Email: APOT@emsa.ca.gov
Mail: EMSA – APOT Assistance Program
11120 Internation Drive, Suite 200, Rancho Cordova CA, 95670

Form EMSA-APOT-Grant-1

Emergency Medical Services Authority (EMSA)
Funding Request Form for APOT Implementation Support

Section I: Applicant Information
Organization Name: _____

Facility Type: ☐ Small Rural Hospital ☐ Volunteer EMS Transport Provider Agency

Primary Contact Name: _____

Phone Number: _____

Email Address: _____

Section II: Project Summary
1. Briefly describe how grant funds will be used:

2. Implementation Timeline:

3. Requested Amount: $_____

Section III: Budget Proposal

Item/Service Estimated Cost Description
Total $_____

Section IV: Attachments
☐ Budget Worksheet
☐ Vendor Quotes or Equipment Specs (if applicable)
☐ Description of Technology Needs
☐ Letter of Commitment from Organizational Leadership

Section V: Certification
I certify that the requested funds will be used solely for APOT implementation as described.

Name: _____
Title: _____
Signature: _____
Date: ____ / ____ / _____

Submit Completed Forms To:
Email: APOT@emsa.ca.gov
Mail: EMSA – APOT Assistance Program
11120 Internation Drive, Suite 200, Rancho Cordova CA, 95670

(Rev. 04/2025)

Form EMSA-Grant-Report-1

Post-Award Grant Reporting Form
Required within 90 days of project completion

Section I: Grantee Information
Organization Name: _____

Contact Person: _____

Phone: _____ Email: _____

Section II: Grant Use Summary
1. Grant Amount Awarded: $_____
2. Total Funds Used: $_____
3. Describe how the funds were used and how implementation goals were achieved:

Section III: Outcome Metrics
Did APOT times improve following the implementation?
☐ Yes ☐ No ☐ Not Yet Determined

If yes, describe the improvement or attach summary data:

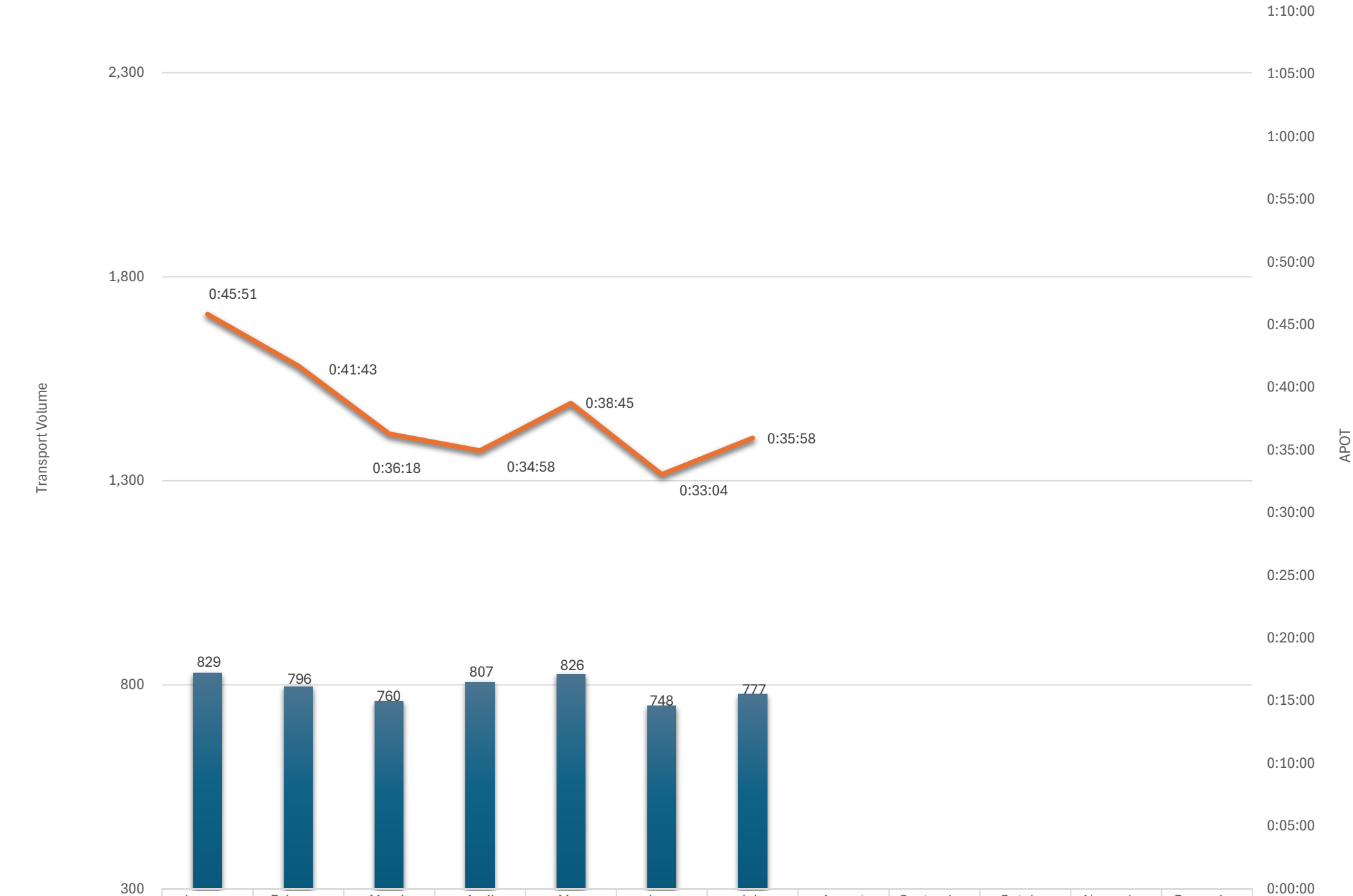
Challenges or barriers encountered:

Section IV: Certification
I certify that the information provided is accurate to the best of my knowledge.

Name: _____
Title: _____
Signature: _____
Date: ____ / ____ / _____

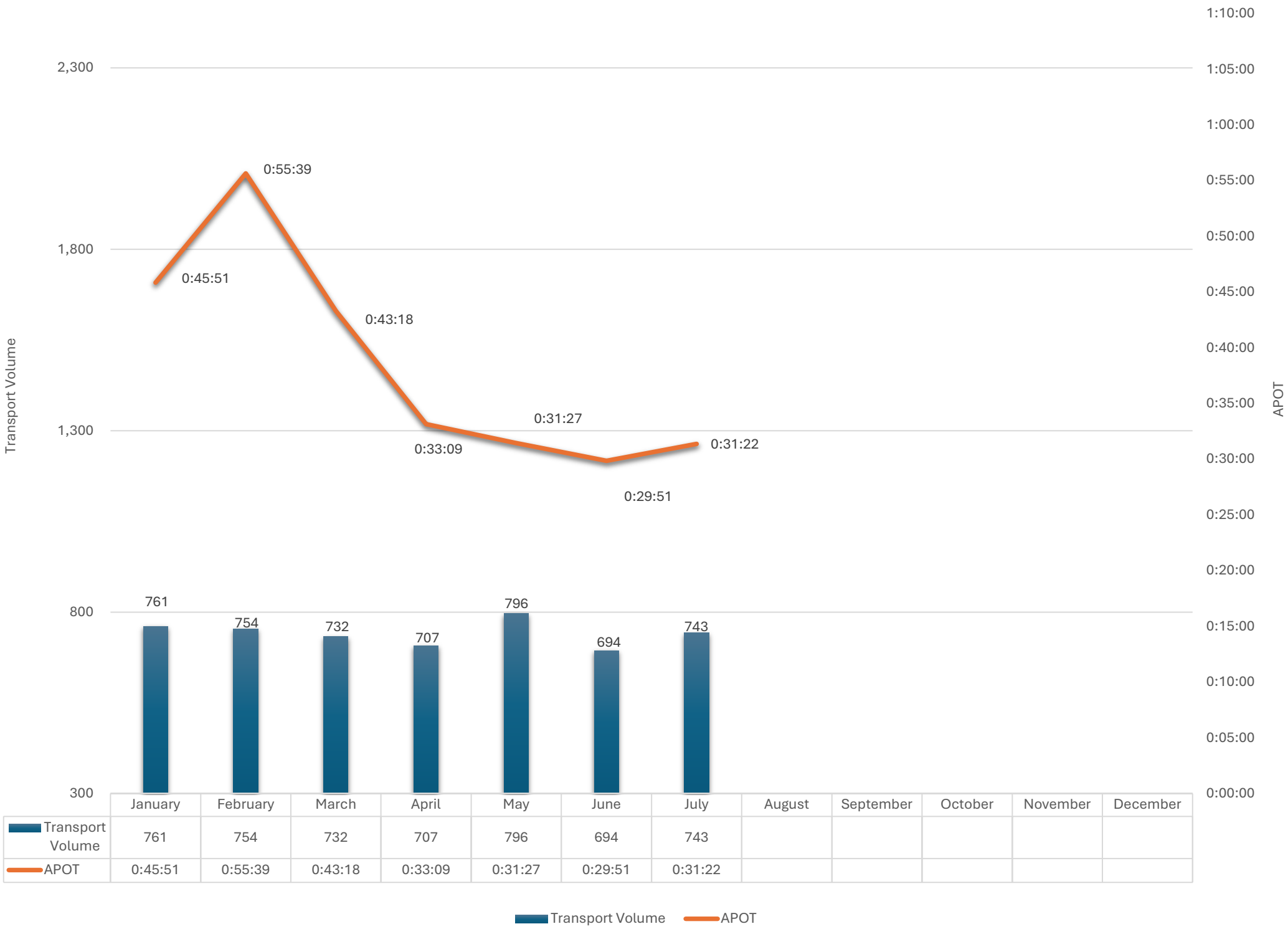
Submit Completed Forms To:
Email: APOT@emsa.ca.gov
Mail: EMSA – APOT Assistance Program
11120 Internation Drive, Suite 200, Rancho Cordova CA, 95670

Adventist Health Lodi Memorial APOT 2025



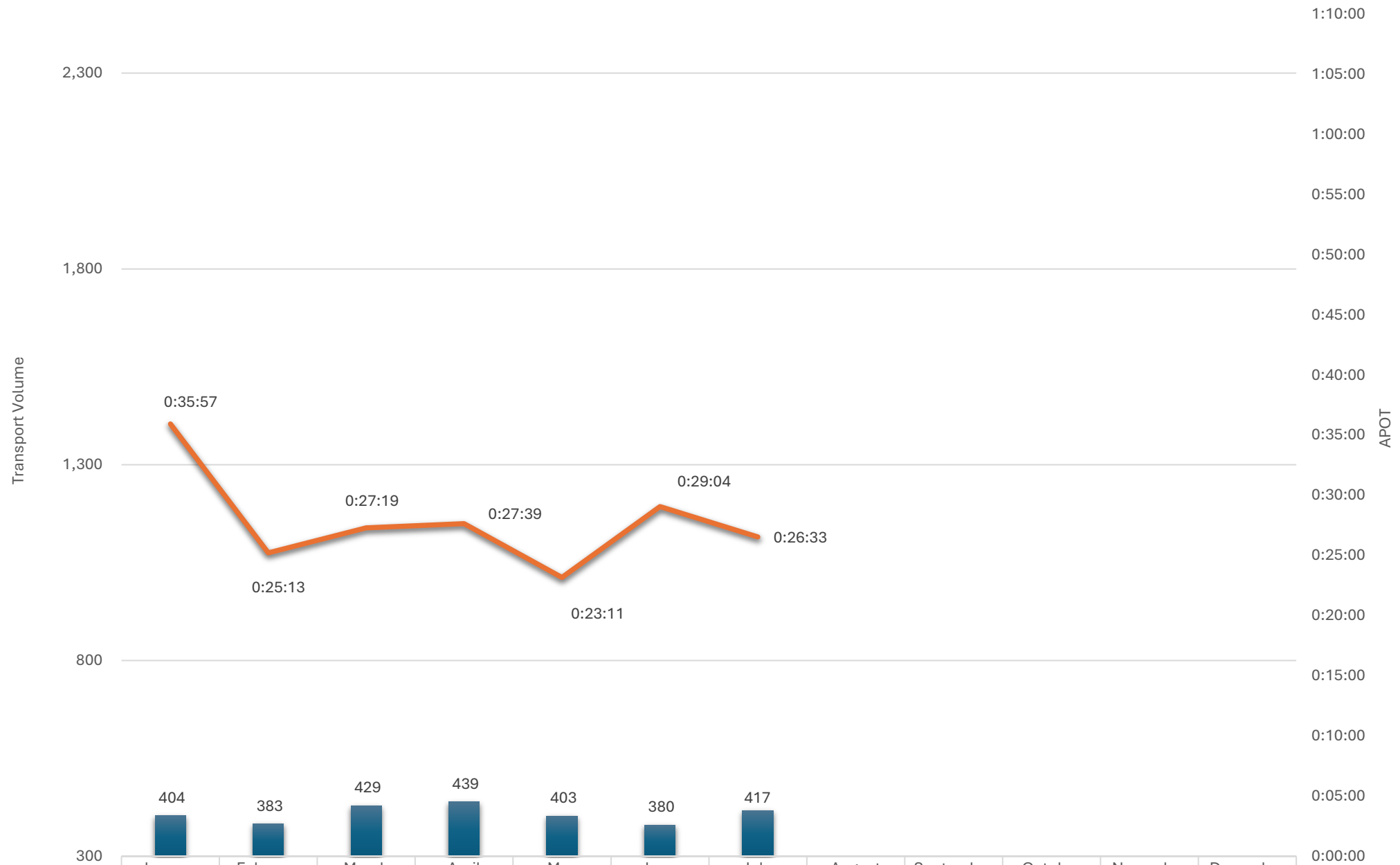
	January	February	March	April	May	June	July	August	September	October	November	December
Transport Volume	829	796	760	807	826	748	777					
APOT	0:45:51	0:41:43	0:36:18	0:34:58	0:38:45	0:33:04	0:35:58					

Dameron Hospital APOT 2025



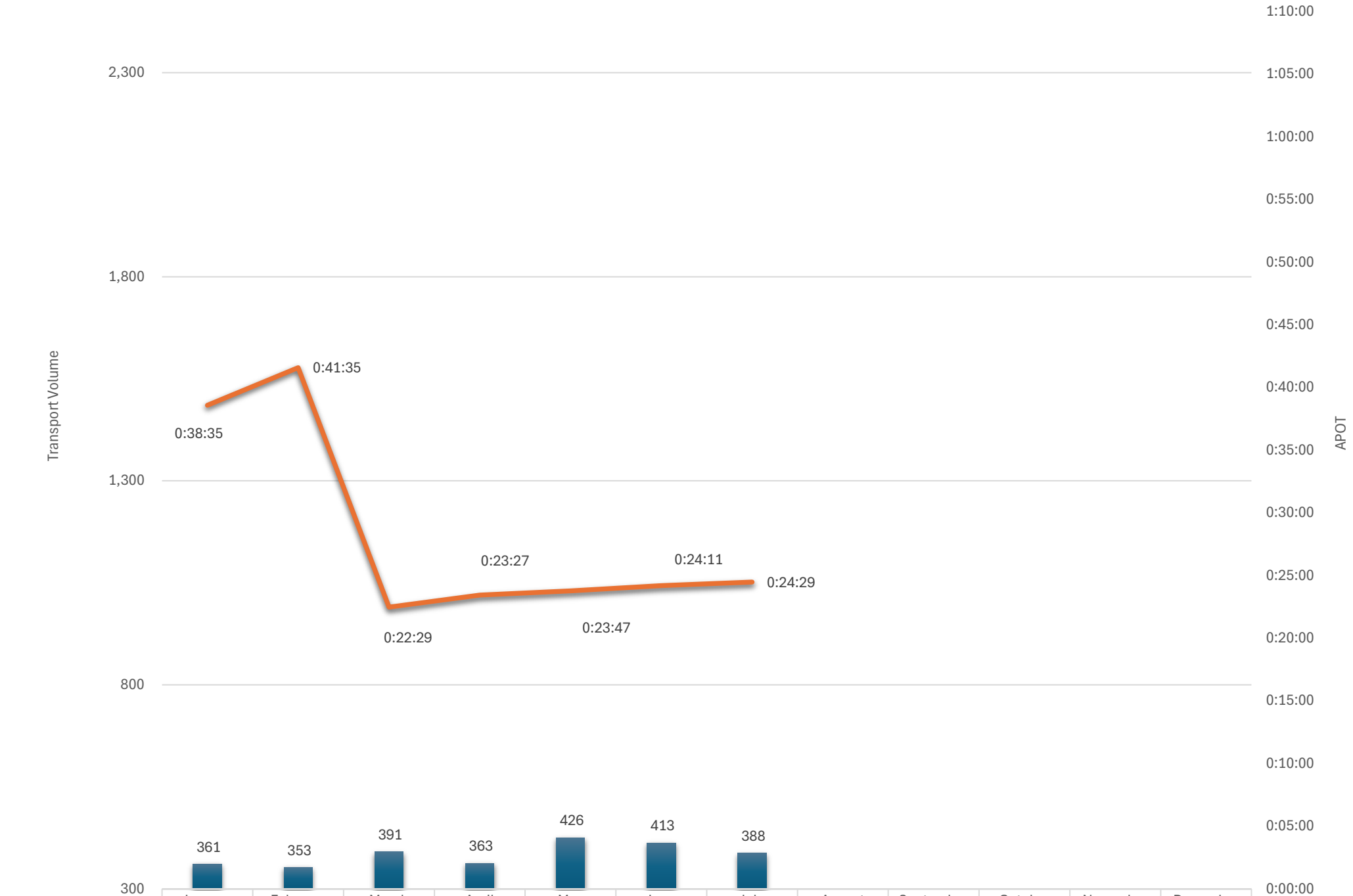
	January	February	March	April	May	June	July	August	September	October	November	December
Transport Volume	761	754	732	707	796	694	743					
APOT	0:45:51	0:55:39	0:43:18	0:33:09	0:31:27	0:29:51	0:31:22					

Doctors Hospital of Manteca APOT 2025



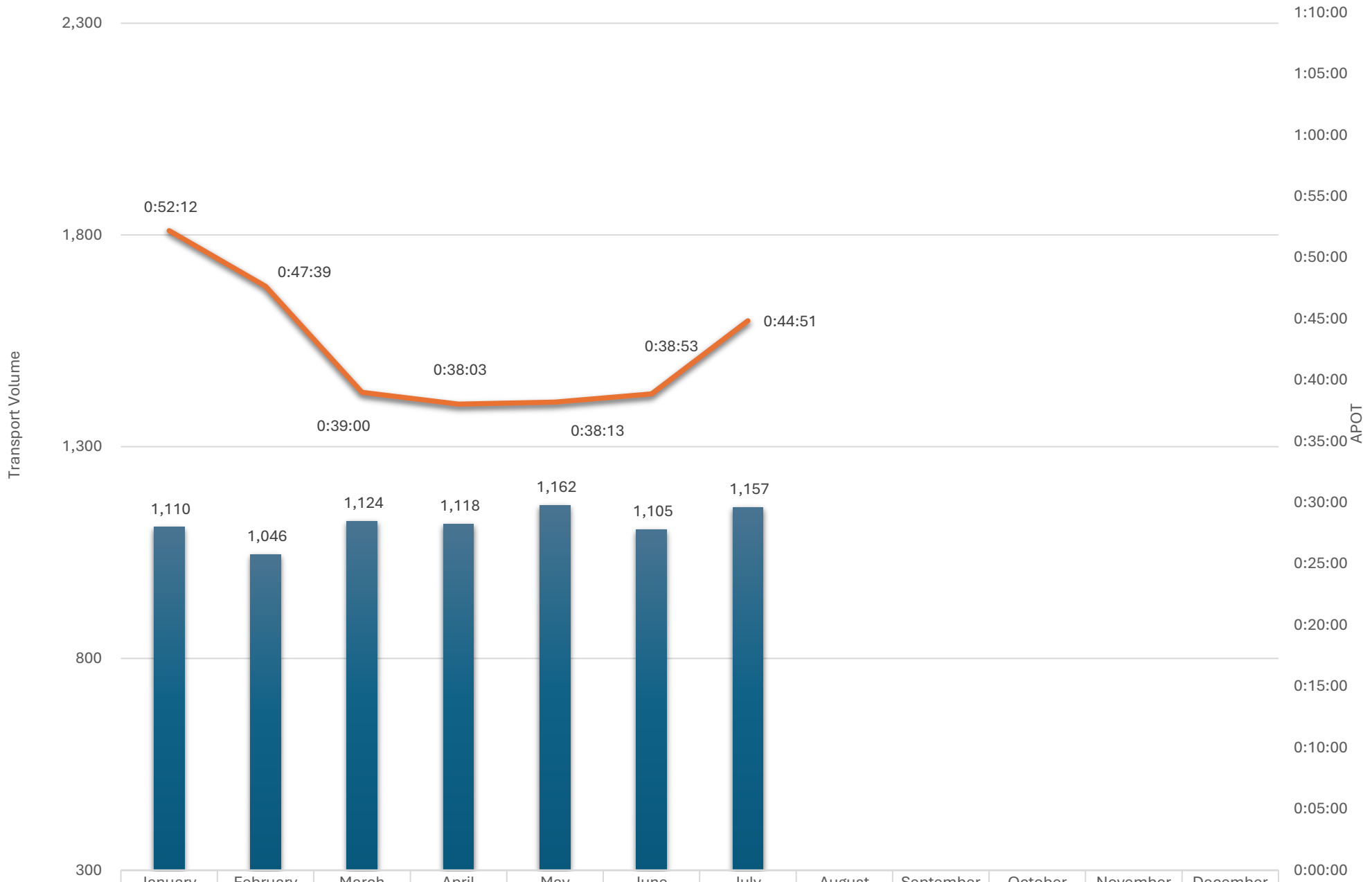
	January	February	March	April	May	June	July	August	September	October	November	December
Transport Volume	404	383	429	439	403	380	417					
APOT	0:35:57	0:25:13	0:27:19	0:27:39	0:23:11	0:29:04	0:26:33					

Kaiser Permanente, Manteca APOT 2025



	January	February	March	April	May	June	July	August	September	October	November	December
Transport Volume	361	353	391	363	426	413	388					
APOT	0:38:35	0:41:35	0:22:29	0:23:27	0:23:47	0:24:11	0:24:29					

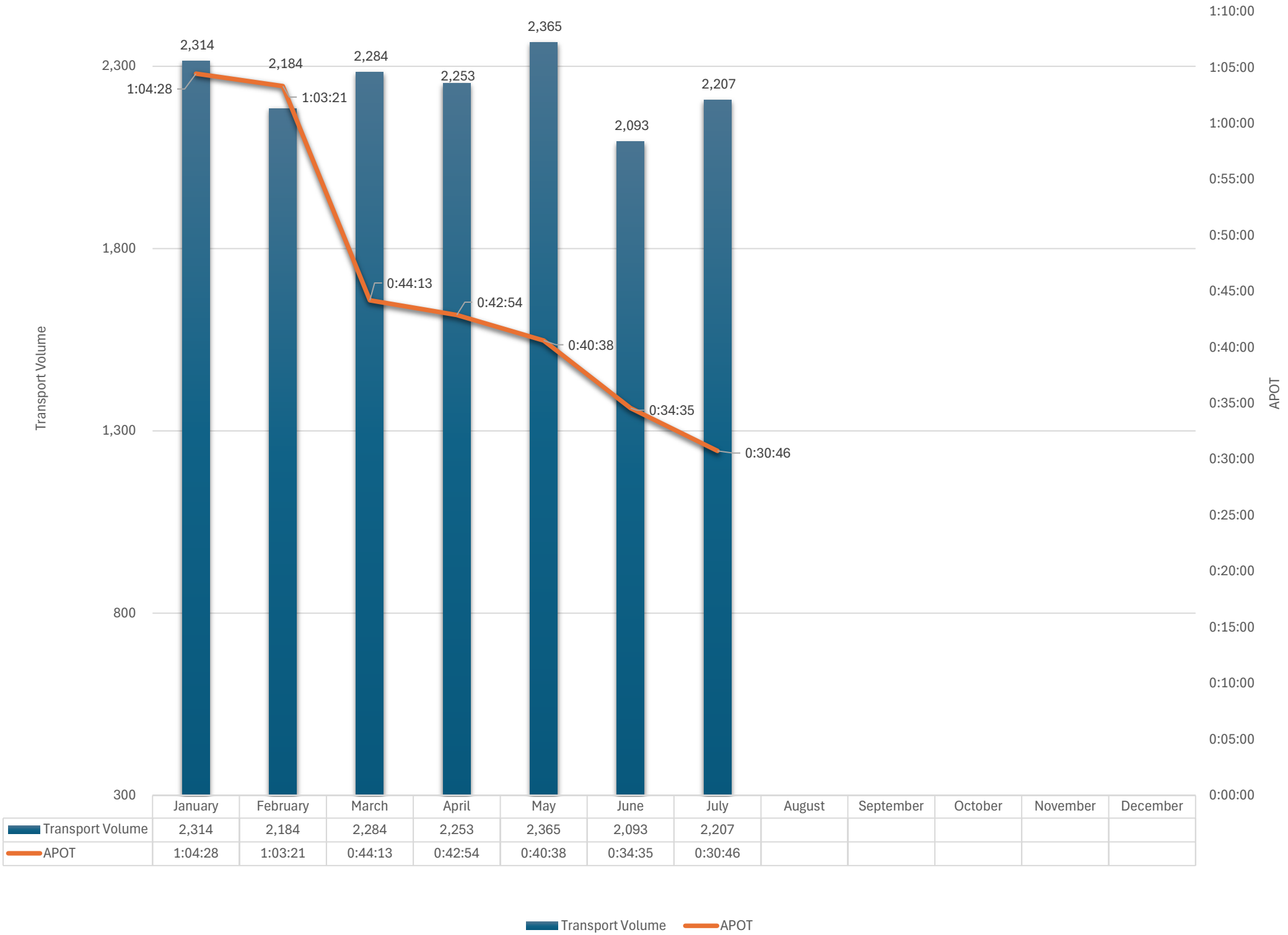
San Joaquin General Hospital APOT 2025



	January	February	March	April	May	June	July	August	September	October	November	December
Transport Volume	1,110	1,046	1,124	1,118	1,162	1,105	1,157					
APOT	0:52:12	0:47:39	0:39:00	0:38:03	0:38:13	0:38:53	0:44:51					

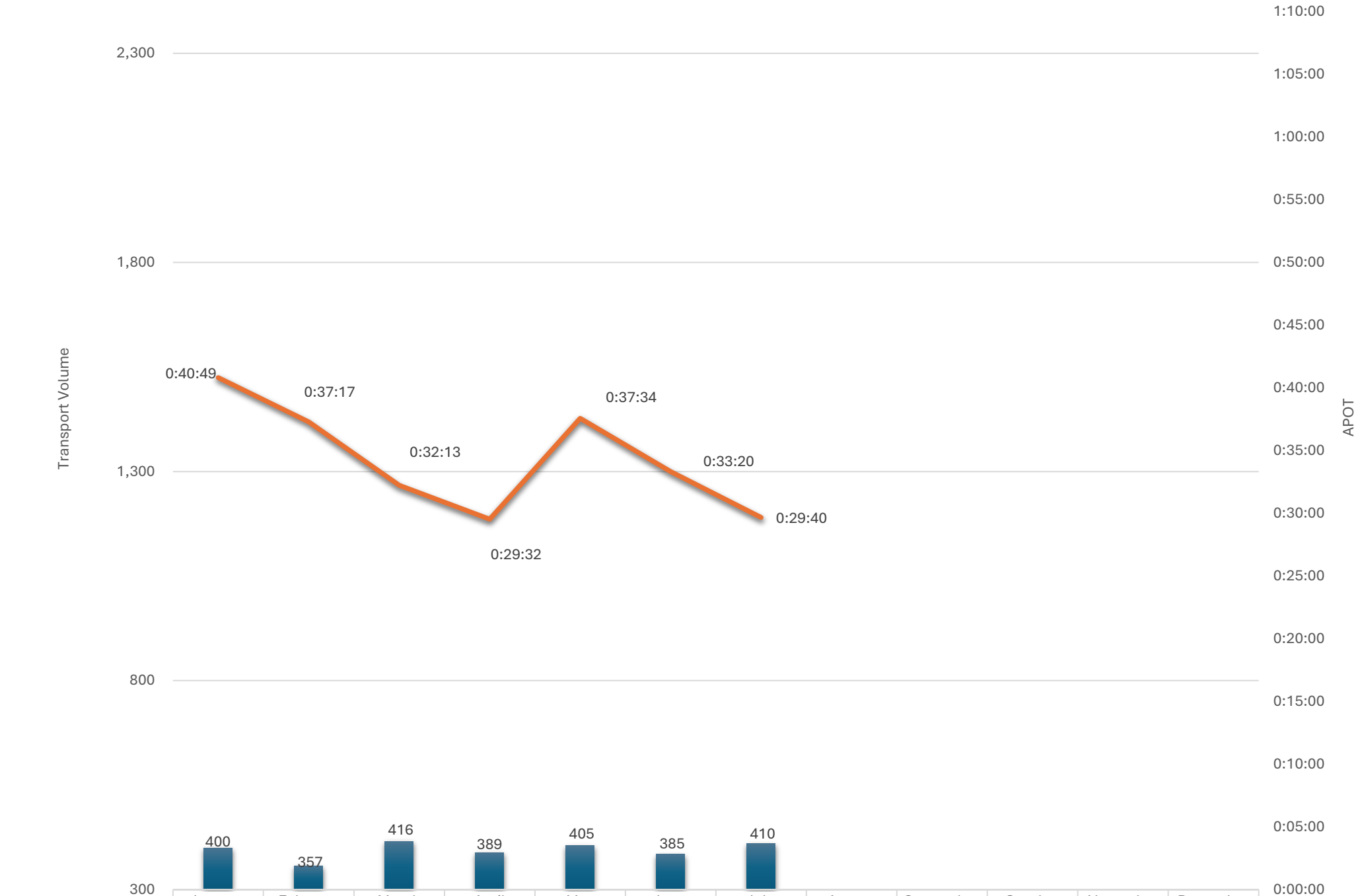
Transport Volume APOT

St. Joseph's Medical Center APOT 2025



	January	February	March	April	May	June	July	August	September	October	November	December
Transport Volume	2,314	2,184	2,284	2,253	2,365	2,093	2,207					
APOT	1:04:28	1:03:21	0:44:13	0:42:54	0:40:38	0:34:35	0:30:46					

Sutter Tracy Community Hospital APOT 2025



	January	February	March	April	May	June	July	August	September	October	November	December
Transport Volume	400	357	416	389	405	385	410					
APOT	0:40:49	0:37:17	0:32:13	0:29:32	0:37:34	0:33:20	0:29:40					

Transport Volume APOT

San Joaquin County
Emergency Medical Services Agency

A DIVISION OF
HEALTH CARE SERVICES
AGENCY

DATE: August 21, 2025

TO: All Interested Parties

FROM: Jeff Costa, RN, EMS Specialty Care Coordinator
Nasir Khan, RN, EMS Specialty Care Coordinator

SUBJECT: Cardiac Arrest Registry to Enhance Survival (CARES) Report for 2024

CARES is a collaborative data collection and analysis that represents approximately fifty-one (51) percent of the United States population and consists of data from more than 2,300 EMS agencies and over 2,500 hospitals nationwide. The goal of CARES is to improve patient survival from sudden cardiac death. CARES uses Utstein style reporting which is a standardized reporting of processes and outcomes, using clear definitions and performance indicators for quality improvement and analysis.

In 2024, San Joaquin County Emergency Medical Services Agency's (SJCEMSA) EMS system experienced on average thirteen (13) medical cardiac arrests each week. According to the CARES data, San Joaquin County's (SJC) Utstein cardiac arrest patient survival rate (patients that were witnessed by bystander and found in shockable rhythm) to hospital discharged was 45.7%. SJC outperformed both the State of California's Utstein survival rate of 31.7% and the National Utstein survival rate of 33.3%. Additionally, SJC's Utstein Bystander survival rate (which includes patients that received bystander interventions such as CPR and or AED) of 41.9% outperforms both the State of California's Utstein Bystander survival rate of 34.8% and National Utstein Bystander survival report rate of 37.6%.

This is a significant achievement considering that more patients in SJC are found with an initial cardiac rhythm of asystole (61.6%) as compared to the state (57.8%) or national (49.4%). Patients presenting with an initial rhythm of asystole have a significantly decreased chance of survival.

In summary, the larger incidence of medical cardiac patients with an initial rhythm of asystole combined with an Utstein of 45.7% and Utstein Bystander of 41.9% demonstrates that the SJCEMSA system (prehospital dispatch centers, first responders, fire departments and districts, ambulance transport providers, hospitals, and specialty care facilities) performs at a high capacity and provides superior cardiac survival outcomes.

SJCEMSA CARES Data	2020 Complete		2021 Complete		2022 Complete		2023 Complete		2024 Complete		California 2024 Data		National 2024 Data	
Overall Survival	5.1%		7.2%		7.1%		7.3%		8.8%		8.7%		10.5%	
Inclusion criteria: An out-of-hospital cardiac arrest where resuscitation is attempted by a 911 responder (CPR and/or defibrillation). This would also include patients that received an AED shock by a bystander prior to the arrival of 911 responders.														
Utstein	31.0%		29.3%		40.6%		41.7%		45.7%		31.7%		33.3%	
**** Defined by CARES to include **ONLY** patients that were witnessed by bystander and found in shockable rhythm ****														
Utstein Bystander	26.9%		33.3%		51.3%		45.5%		41.9%		34.8%		37.6%	
**** Defined by CARES to include ONLY patients that were witnessed by bystander, found in shockable rhythm AND received some bystander intervention (CPR and/or AED) ****														
Total Number of Cases Non-Traumatic Etiology	**900**		**977**		**858**		**797**		**701**		**24,278**		**141,096**	
Initial rhythm VF/VT	112	12.4%	114	11.7%	107	12.5%	99	12.4%	97	13.8%	3791	15.6%	24835	17.6%
Percentage of Discharged alive	24.1%		24.6%		35.5%		30.3%		30.9%		28.2%		29.2%	
Initial rhythm Asystole	590	65.6%	663	67.9%	565	65.9%	504	63.2%	432	61.6%	14025	57.8%	69711	49.4%
Percentage of Discharged alive	0.5%		2.4%		1.4%		2.0%		2.3%		2.3%		2.5%	
Initial rhythm Other	198	22.0%	200	20.4%	186	21.7%	194	24.3%	168	23.9%	6192	25.5%	43051	30.5%
Percentage of Discharged alive	8.1%		13.0%		8.6%		9.3%		12.5%		11.8%		12.5%	

Created by: Jeff Costa, RN, EMS Specialty Care Coordinator 7/9/2025
Nasir Khan, RN, EMS Specialty Care Coordinator 7/9/2025

Data Source: The Cardiac Arrest Registry to Enhance Survival Annual Report 2024

2024 CARES Data			San Joaquin County Survivability			California Survivability			National Survivability
Utstein			**45.7%**			31.7%			33.3%
Defined by CARES to include only patients that were witnessed by bystander and found in shockable rhythm.									
Utstein Bystander			**41.9%**			34.8%			37.6%
Defined by CARES to include only patients that were witnessed by bystander, found in shockable rhythm AND received some bystander intervention (CPR and/or AED).									
Bystander CPR rates			**44.7%**			42.0%			41.7%
Public AED use			12.8%			9.9%			12.6%
Overall Survival			8.8%			8.7%			10.5%
Inclusion criteria: All Out-of-hospital cardiac arrest patients where resuscitation is attempted by a 911 responder.									

2024 Total Percentages of Non-Traumatic Etiology Cases									
Initial Rhythm	**Overall Total**	**Inclusion Amount**	**San Joaquin County**	**Overall Total**	**Inclusion Amount**	**California**	**Overall Total**	**Inclusion Amount**	**National**
Ventricular Fibrillation / Ventricular Tachycardia	701	97	13.8%	24278	3791	15.6%	141096	24835	17.6%
Percentage of VF/VT Patients Discharged alive	97	30	**30.9%**	3791	1040	27.4%	24835	7251	29.2%
Percentage of Discharged alive with CPC 1 or 2	30	29	**96.7%**	1040	912	87.7%	7251	6299	86.9%
Asystole	701	432	**61.6%**	24278	14025	57.8%	141096	69711	49.4%
Percentage of Asystole Patients Discharged alive	432	10	2.3%	14025	318	2.3%	69711	1774	2.5%
Percentage of Discharged alive with CPC 1 or 2	10	3	30.0%	318	162	50.9%	1774	949	53.5%
Other "ECG" Rhythm	701	168	24.0%	24278	6192	25.5%	141096	43051	30.5%
Percentage of "Other" Patients Discharged alive	168	21	12.5%	6192	730	11.8%	43051	5382	12.5%
Percentage of Discharged alive with CPC 1 or 2	21	15	71.4%	730	525	71.9%	5382	4047	75.2%

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Data Source: The Cardiac Arrest Registry to Enhance Survival Annual Report 2024