EMS Policy No. 3202 and 3202 A MPDS Use and Assignments
45 Day Public Comment Period
March 2, 2023 to March 17, 2023

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3202 II D	Bryan Carr, Division Chief – Stockton Fire Department	Per the International Academies of Emergency Dispatch (IAED), Protocol 38 - Advanced SEND (Secondary Emergency Notification Dispatch), was developed for "Police, Security, Military, and Federal Agents" when calling in from the field. The protocol does not include off duty personnel. The questioning is structured with the specific understanding that it is a field responder who is on scene with the patient. The Protocol has been expanded on a case-by-case basis to include on duty fire personnel who are on scene in the field with patients, but does not at any time include off duty personnel. This information was confirmed by Darren Judd of Priority Dispatch on 3/11/23. Use of Protocol 38 requires additional licensing that is only provided by Priority Dispatch upon verification that all field responders and EMDs have been trained in the use of the protocol. IAED also explicitly states that "Protocol 38 can only be used in conjunction with the Advanced SEND card and cannot function independently as a stand-alone interrogation of scene officers requesting an EMS response." Should the Advance SEND Protocol be utilized within the county for on duty personnel (not off duty, as this is not permitted within protocol), it is unrealistic to expect training for all first responders and EMDs to occur prior to the proposed April 1st effective date of the policy.	SEND Protocol has been removed from draft policy.
3202 V	Bryan Carr, Division Chief – Stockton Fire Department	"Allowing BLS staffed and equipped ambulances to respond to requests for service in the EMS system" should be the exception, not the rule. This policy as written in draft form, radically increases the number of MPDS determinants that a BLS ambulance shall respond to. Please see the attached document previously submitted in relation to policy #5104	Tiered responses utilizing both BLS and ALS ambulance from the medical priority dispatch system (MPDS) are commonly used throughout the country and internationally. Many LEMSAs have been safely using tiered responses

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		concerning the use of BLS ambulances in the 911 system. In addition, the LEMSA did not describe or outline the methodology on how they determined what calls for service a BLS response could be used. Fire EMR non-transport agencies would like to see the methodology that was used to change the determinants in 3202A to allow a BLS ambulance response. Second, we would like to see the criteria or evaluation method that has been created to evaluate these changes in the future and whether the changes to these MPDS responses is appropriate. Finally, related specifically to section V., the ability for SJCEMSA to modify response and priority mode, should be subject to the same requirements listed in section II. B. - 10 (ten) day notice with the response plan and methodology provided - as is being required of Fire based EMR agencies.	throughout California for many years. International Academies of Emergency Dispatch (IAED) methodologies have been well established based on continued extensive research and ongoing quality improvement (QI) efforts. The improved outcomes for patients and EMS personnel are well documented. There is also research outside of IAED looking into tiered responses and, specifically, MPDS' ability to identify and respond appropriately high acuity patients. NAEMSP (National Association of EMS Physicians) embraces the use of tiered responses using both BLS and ALS from MPDS and using CQI to provide real time and ongoing evaluation of EMS systems. As said in Emergency Medical Services Evidence-based System Design White Paper for EMSA, authored by the Tulsa Fire Department Medical Directors. These implementation efforts will be done in conjunction with close monitoring and evaluation of these changes. The EMS Advisory Committee and MPDS QI Committee are stakeholder represented bodies created to advise on these types of issues and to provide input to the EMS Medical Director and SJCESMA.

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3202 V	Bryan Carr, Division Chief – Stockton Fire Department	Regarding the draft policy of 3202/3202A: IF or WHEN a BLS ambulance is sent to a 911 call for service, could be seen as contrary to the spirit and intent of all ALS transport providers requirements and a violation of existing MOU's, State law and County ordinances. There must be clear policy and direction stating what specific data points will be considered to determine response to specific MPDS determinants that may allow for BLS response to a specific determinant in exigent circumstances. There must also be clear policy and direction for all EMS stakeholders -transport providers; non-transport providers; Medical Directors - having input in the process. San Joaquin County Code of Ordinances, Section 4.l0(F)(l), states, "All emergency ambulances in regular service shall be staffed and equipped at the advanced life support level", setting the standard and expectation for ALS care in the County. In addition, the contract granted to AMR West as the exclusive operating ambulance in Zone X, is replete with statements and language that require them to staff an appropriate level of ambulances with advance life support services. In addition, section 2.2 D of the contract states in part: This Agreement requires the highest levels of performance and reliability, and mere demonstration of effort, even diligent and well-intentioned effort, shall not substitute for performance results. If the Contractor fails to perform to the Agreement standards, Contractor may be found to be in major breach of its Agreement and promptly replaced in order to protect the public health and safety. (County of San Joaquin/American Medical	There are no laws or ordinances being violated. The Agreement between AMR and SJCEMSA has been amended to be aligned with BLS response to low acuity calls and is the appropriate thing to do. BLS response to low acuity calls keeps ALS resources available for the high acuity calls in which their services are designed for and needed most. SJCMSA is dedicated and responsible for the quality improvement efforts that will continue to monitor the EMS System for safety and effectiveness. The EMS Advisory Committee is a stakeholder represented body created to advise on these types of issues and to provide input to the EMS Medical Director and SJCESMA.

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		Response-West Emergency and ALS Ambulance Agreement 2021, page 9). A BLS crew on scene Is not the appropriate resource to do an ALS assessment and determine what level of care is needed. A call that is coded as ALS by MPDS should have an ALS transport response sent to that determinant. Anything other than this is contrary to the contract between AMR West and SJCEMSA on providing ALS transport services to the residents of the City and County. ALS care and immediate transport is appropriate for the best patient care and patient outcomes. The concern, however, is ALS non-transport agreements with the LEMSA specifically state they shall provide non-transport ALS and BLS emergency medical service response. In essence, under this draft policy, an ALS non-transport provider would be providing transport services in violation of their MOU with the LEMSA. In addition, requiring an ALS non-transport paramedic to supplement an ALS transport provider paramedic would subject the non-transport paramedic to APOT and possible APOD's at local Emergency Departments. It would also subject the non-transport ALS provider to additional costs for equipment, medications, and staff time used during the transport. There is no current mechanism in place to recover these costs. This policy must add as an additional mandate under this section that if a non-transport ALS provider is needed to transport with a BLS crew, the LEMSA requires an MOU between the transport provider who has the EOA and the public agency serving as an ALS transport provider with the BLS crew, to provide for a process of cost recovery, OR the ALS	

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		non-transport provider has a direct agreement with the County of San Joaquin for cost recovery. In addition, the following concerns were submitted on line 3/17 /23 in comment to 3202 changes: • What methodology was used by SJCEMSA to make these changes? • How will these changes be tracked to determine impact on 911 system? • Policy must require ten (10) day notice requirement apply to SJCEMSA when making changes to 3202.	
3202 A	Brian Hajik, Regional Director, AMR	Protocol 6 vs Protocol 26 • Protocol 6 – Response for determinant 6-C-1 is NRLS • Protocol 26 – Response for determinant 26-C-02 is RLS These are actually identical complaints. The only difference is that with 26C02, abnormal breathing wasn't identified at Case Entry #3. It was identified in Key Questions. I feel that these determinants should be the same since they're technically for the exact same complaint. It doesn't shunt to Protocol 6 from Protocol 26 when abnormal breathing is identified in Key Questions because the thought is that if a breathing problem was their main concern, they would have mentioned it at CE #3. With the way 3202 is now, patient's are getting a code 2 response for calling specifically due to abnormal breathing, but they're getting a code 3 response when they report abnormal breathing after they're questioned about their breathing. Protocol 28 First we have a suffix "T", which doesn't exist. I'm assuming they mean "T = greater than 8 hours", where it now reads "suffix H, K, T, greater than 8 hrs". Suffix D isn't included. Per 3202, if a patient has partial evidence of a stroke and	Corrected Protocol 6 and Protocol 26 response to Charlie Level discrepancy. Removed the non-existing Stroke Suffix of "T".

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		it's been greater than 8 hours since the onset, it warrants an RLS response. But if a patient has strong or clear evidence of a stroke and it's been greater than 8 hours since the onset, it warrants an NRLS response. Also, suffixes X, Y, and Z are for no test evidence of a stroke less than 8 hours, greater than 8 hours and unknown time frame since onset, yet the response is RLS for no test evidence of a stroke regardless of the time since onset. Protocol 29 – 29B02 vs. 29B03 • 29B02 – MVA: Serious hemorrhage RLS • 29B03 – MVA: Other hazards NRLS What isn't being taken into consideration here is if a serious hemorrhage is reported AND other hazards, it will EMD to 29B03. Should B3 determinant trump a B2 determinant in EMD? Initially I thought maybe that was the case due to there being "other hazards" (scene safety), but "Hazmat" EMD's to 29D04 and the response is RLS. We should not be responding NRLS for a patient(s) with a serious hemorrhage when other hazards are present. Protocol 33 - 33C04 vs. 33C05 • 33C04 – Trans/IFT: Shock – NRLS • 33C05 – Trans/IFT: Possible acute heart problems or MI (heart attack) – RLS What isn't being taken into consideration here is a patient that is having chest pain/possible MI AND shock symptoms will EMD to 33C04 because a 33C04 is actually a higher priority than a 33C05 . So in that case, we're responding NRLS for someone with possible acute heart problems or MI simply because they also have shock symptoms.	
3202 A	Brian Hajik, Regional Director, AMR	Ambulance Level of Service is missing for MPDS determinates 21B03 and 4B01s	Corrected.

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3202	Kevin Meineke, Captain, SSJCFA	IF or WHEN a BLS ambulance is sent to a 911 call for service, could be seen as contrary to the spirit and intent of all ALS transport providers requirements and a violation of existing MOU's, State law and County ordinances. There must be clear policy and direction stating what specific data points will be considered to determine response to specific MPDS determinants that may allow for BLS response to a specific determinant in exigent circumstances. There must also be clear policy and direction for all EMS stakeholders -transport providers; non-transport providers; Medical Directors - having input in the process. San Joaquin County Code of Ordinances, Section 4.l0(F)(l), states, "All emergency ambulances in regular service shall be staffed and equipped at the advanced life support level", setting the standard and expectation for ALS care in the County. In addition, the contract granted to AMR West as the exclusive operating ambulance in Zone X, is replete with statements and language that require them to staff an appropriate level of ambulances with advance life support services. In addition, section 2.2 D of the contract states in part: This Agreement requires the highest levels of performance and reliability, and mere demonstration of effort, even diligent and well-intentioned effort, shall not substitute for performance results. If the Contractor fails to perform to the Agreement standards, Contractor may be found to be in major breach of its Agreement and promptly replaced in order to protect the public health and safety. (County of San Joaquin/American Medical Response-West Emergency and ALS Ambulance Agreement 2021, page 9).	Tiered responses utilizing both BLS and ALS ambulance from the medical priority dispatch system (MPDS) are commonly used throughout the country and internationally. Many LEMSAs have been safely using tiered responses throughout California for many years. International Academies of Emergency Dispatch (IAED) methodologies have been well established based on continued extensive research and ongoing quality improvement (QI) efforts. The improved outcomes for patients and EMS personnel are well documented. There is also research outside of IAED looking into tiered responses and, specifically, MPDS' ability to identify and respond appropriately high acuity patients. NAEMSP (National Association of EMS Physicians) embraces the use of tiered responses using both BLS and ALS from MPDS and using CQI to provide real time and ongoing evaluation of EMS systems. As said in Emergency Medical Services Evidence-based System Design White Paper for EMSA, authored by the Tulsa Fire Department Medical Directors. These implementation efforts will be done in conjunction with close monitoring and evaluation of these changes. The EMS

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3202 A	Rich Silva, Emergency Communications Directors, VRECC	The following protocols are not listed in this document • 24D08 = Possible miscarriage with signs of life • 24D08M = Possible miscarriage with signs of life (multiple birth) • 26C05 = Acute adrenal insufficiency/crisis or Addison's disease • 26O01 = This code is not in use • 17B04 = Unknown status/Other codes not applicable	Added new determinants