



# County of Santa Cruz

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## HEALTH SERVICES AGENCY

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EMERGENCY MEDICAL  
SERVICES

June 28, 2006

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EMS Systems Analyst  
EMS Authority  
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Santa Cruz County EMS Plan - Annual Update 2004-2005

Enclosed is the annual EMS plan for Santa Cruz County and a copy of the "Request for Proposals" which ultimately established our current Emergency Ambulance Services contract.

There have been no significant changes to the Santa Cruz County EMS system since the last plan submission. Staffing remains the same, providers haven't been changed.

If you have any questions, please do not hesitate to call me at (831) 454-4751.

Sincerely,

Celia Barry  
EMS Manager

CB  
Enclosure

## **ANNUAL UPDATE WORKPLAN FORMAT and CONTENTS**

The annual update will consist of the following sections:

**Summary of System Status** - Table 1

**Summary of Changes** - any changes that your agency has made to the original EMS Plan. Provide a narrative description of any changes which have occurred in your system, such as changing providers, designating new centers, changing key personnel, etc.

**Updates of Specific Information** - provided on Tables 2-11.

**Changes made on a Standard** - any changes made on a standard that are different from the previous plan submission, need to be completed on the System Assessment Form (see Appendix 1). Note your agency's progress towards short and long range plans.

### **Ambulance Zone Summary Form**

In order to evaluate the nature of each area or subarea, an Ambulance Zone Form needs to be completed for each zone, whether exclusive or non-exclusive. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

**TABLES**

**NOTE: THESE TABLES ARE TO BE INCLUDED IN THE EMS PLAN AND UPDATED EACH YEAR AS NECESSARY IN THE ANNUAL WORKPLAN.**

**TABLE 1: Summary of System Status**

Place an "x" in the appropriate boxes for each standard. Complete a System Assessment form (Attachment 1) for each standard. For those items from Table 1 that are followed by an asterisk, describe on the Assessment form how resources and/or services are coordinated with other EMS agencies in meeting the standards. Table 1 and the System Assessment form are to be reported by agency.

The last two columns of Table 1 refer to the time frame for meeting the objective. Put an "x" in the "Short-range Plan" column if the objective will be met within a year. Put an "x" in the "Long-range Plan" column if the objective will take longer than a year to complete. If the minimum or recommended standard is currently met no "x" is required in either column.

## A. SYSTEM ORGANIZATION AND MANAGEMENT

2004-05

		Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
<b>Agency Administration:</b>						
1.01	LEMSA Structure		X			
1.02	LEMSA Mission		X			
1.03	Public Input		X			
1.04	Medical Director		X	X		
<b>Planning Activities:</b>						
1.05	System Plan		X			
1.06	Annual Plan Update		X			
1.07	Trauma Planning*		X	X		
1.08	ALS Planning*		X			
1.09	Inventory of Resources		X			
1.10	Special Populations		X			
1.11	System Participants		X	X		
<b>Regulatory Activities:</b>						
1.12	Review & Monitoring		X			
1.13	Coordination		X			
1.14	Policy & Procedures Manual		X			
1.15	Compliance w/Policies		X			
<b>System Finances:</b>						
1.16	Funding Mechanism		X			

## SYSTEM ORGANIZATION AND MANAGEMENT (continued)

2004-05

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
<b>Medical Direction:</b>					
1.17	Medical Direction*	X			
1.18	QA/QI	X			
1.19	Policies, Procedures, Protocols	X			
1.20	DNR Policy	X			
1.21	Determination of Death	X			
1.22	Reporting of Abuse	X			
1.23	Interfacility Transfer	X			
<b>Enhanced Level: Advanced Life Support</b>					
1.24	ALS Systems	X	X		
1.25	On-Line Medical Direction	X	X		
<b>Enhanced Level: Trauma Care System:</b>					
1.26	Trauma System Plan	X			
<b>Enhanced Level: Pediatric Emergency Medical and Critical Care System:</b>					
1.27	Pediatric System Plan	X			
<b>Enhanced Level: Exclusive Operating Areas:</b>					
1.28	EOA Plan	X			

**B. STAFFING/TRAINING**

		<b>Does not currently meet standard</b>	<b>Meets minimum standard</b>	<b>Meets recommended guidelines</b>	<b>Short-range plan</b>	<b>Long-range plan</b>
<b>Local EMS Agency:</b>						
2.01	Assessment of Needs		X			
2.02	Approval of Training		X			
2.03	Personnel		X			
<b>Dispatchers:</b>						
2.04	Dispatch Training		X	X		
<b>First Responders (non-transporting):</b>						
2.05	First Responder Training			X		
2.06	Response		X			
2.07	Medical Control		X			
<b>Transporting Personnel:</b>						
2.08	EMT-I Training		X	X		
<b>Hospital:</b>						
2.09	CPR Training		X			
2.10	Advanced Life Support		X	X		
<b>Enhanced Level: Advanced Life Support:</b>						
2.11	Accreditation Process		X			
2.12	Early Defibrillation		X			
2.13	Base Hospital Personnel		X			

## C. COMMUNICATIONS

		Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
<b>Communications Equipment:</b>						
3.01	Communication Plan*		X			
3.02	Radios		X	X		
3.03	Interfacility Transfer*		X			
3.04	Dispatch Center		X			
3.05	Hospitals		X	X		
3.06	MCI/Disasters		X			
<b>Public Access:</b>						
3.07	9-1-1 Planning/Coordination		X	X		
3.08	9-1-1 Public Education		X			
<b>Resource Management:</b>						
3.09	Dispatch Triage		X	X		
3.10	Integrated Dispatch		X	X		

**D. RESPONSE/TRANSPORTATION**

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
<b>Universal Level:</b>					
4.01 Service Area Boundaries*		X	X		
4.02 Monitoring		X	X		
4.03 Classifying Medical Requests		X			
4.04 Prescheduled Responses		X	X		
4.05 Response Time Standards*		X			
4.06 Staffing		X			
4.07 First Responder Agencies		X			
4.08 Medical & Rescue Aircraft*		X			
4.09 Air Dispatch Center		X			
4.10 Aircraft Availability*		X			
4.11 Specialty Vehicles*		X	X		
4.12 Disaster Response		X			
4.13 Intercounty Response*		X			
4.14 Incident Command System		X			
4.15 MCI Plans		X			
<b>Enhanced Level: Advanced Life Support:</b>		X			
4.16 ALS Staffing		X	X		
4.17 ALS Equipment		X			



## RESPONSE/TRANSPORTATION (continued)

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
<b>Enhanced Level: Ambulance Regulation:</b>					
4.18 Compliance		X			
<b>Enhanced Level: Exclusive Operating Permits:</b>					
4.19 Transportation Plan		4.20			
4.20 "Grandfathering"		X	X		
4.21 Compliance		X			
4.22 Evaluation		X			

## E. FACILITIES/CRITICAL CARE

		Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
<b>Universal Level:</b>						
5.01	Assessment of Capabilities		X	X		
5.02	Triage & Transfer Protocols*		X			
5.03	Transfer Guidelines*		X			
5.04	Specialty Care Facilities*		X			
5.05	Mass Casualty Management		X	X		
5.06	Hospital Evacuation*		X			
<b>Enhanced Level: Advanced Life Support:</b>						
5.07	Base Hospital Designation*		X			
<b>Enhanced Level: Trauma Care System:</b>						
5.08	Trauma System Design		X		X	
5.09	Public Input		X		X	
<b>Enhanced Level: Pediatric Emergency Medical and Critical Care System:</b>						
5.10	Pediatric System Design		X			
5.11	Emergency Departments		X	X		
5.12	Public Input		X			
<b>Enhanced Level: Other Specialty Care Systems:</b>						
5.13	Specialty System Design		N/A			
5.14	Public Input		N/A			

## F. DATA COLLECTION/SYSTEM EVALUATION

		Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
<b>Universal Level:</b>						
6.01	QA/QI Program		X	X		
6.02	Prehospital Records		X			
6.03	Prehospital Care Audits		X	X		
6.04	Medical Dispatch		X			
6.05	Data Management System*		X	X		
6.06	System Design Evaluation		X			
6.07	Provider Participation		X			
6.08	Reporting		X			
<b>Enhanced Level: Advanced Life Support:</b>						
6.09	ALS Audit		X			
<b>Enhanced Level: Trauma Care System:</b>						
6.10	Trauma System Evaluation		X		X	
6.11	Trauma Center Data		X		X	

**G. PUBLIC INFORMATION AND EDUCATION**

		<b>Does not currently meet standard</b>	<b>Meets minimum standard</b>	<b>Meets recommended guidelines</b>	<b>Short-range plan</b>	<b>Long-range plan</b>
<b>Universal Level:</b>						
7.01	Public Information Materials		X			
7.02	Injury Control		X	X		
7.03	Disaster Preparedness		X	X		
7.04	First Aid & CPR Training		X			

**H. DISASTER MEDICAL RESPONSE**

2004-05

	<b>Does not currently meet standard</b>	<b>Meets minimum standard</b>	<b>Meets recommended guidelines</b>	<b>Short-range plan</b>	<b>Long-range plan</b>
<b>Universal Level:</b>					
8.01	Disaster Medical Planning*	X			
8.02	Response Plans	X	X		
8.03	HazMat Training	X			
8.04	Incident Command System	X			
8.05	Distribution of Casualties*	X			
8.06	Needs Assessment	X			
8.07	Disaster Communications*	X			
8.08	Inventory of Resources	X			
8.09	DMAT Teams		X		
8.10	Mutual Aid Agreements*	X			
8.11	CCP Designation*	X			
8.12	Establishment of CCPs	X			
8.13	Disaster Medical Training	X	X		
8.14	Hospital Plans	X	X		
8.15	Interhospital Communications	X			
8.16	Prehospital Agency Plans	X	X		
<b>Enhanced Level: Advanced Life Support:</b>					
8.17	ALS Policies	X			
<b>Enhanced Level: Specialty Care Systems:</b>					
8.18	Specialty Center Roles	X			
<b>Enhanced Level: Exclusive Operating Areas/Ambulance Regulations:</b>					
8.19	Waiving Exclusivity	X			

**TABLE 2: SYSTEM RESOURCES AND OPERATIONS****System Organization and Management**EMS System: SANTA CRUZ COUNTY HEALTH SERVICES AGENCYReporting Year: 2004- 2005

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

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

County: SANTA CRUZ

A. Basic Life Support (BLS)	<u>0%</u>
B. Limited Advanced Life Support (LALS)	<u>0%</u>
C. Advanced Life Support (ALS)	<u>100%</u>

2. Type of agency B

a - Public Health Department

b - County Health Services Agency

c - Other (non-health) County Department

d - Joint Powers Agency

e - Private Non-Profit Entity

f - Other: \_\_\_\_\_

3. The person responsible for day-to-day activities of the EMS agency reports to D

a - Public Health Officer

b - Health Services Agency Director/Administrator

c - Board of Directors

d - Other: CHIEF OF PUBLIC HEALTH

4. Indicate the non-required functions which are performed by the agency:

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

**Table 2 - System Organization & Management (cont.)**

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

5. EMS agency budget for FY 2005-06

## A. EXPENSES

Salaries and benefits (All but contract personnel)	\$ <u>260,282</u>
Contract Services (e.g. medical director)	<u>94,940</u>
Operations (e.g. copying, postage, facilities)	<u>18,830</u>
Travel	<u>1,000</u>
Fixed assets	<u>          </u>
Indirect expenses (overhead)	<u>          </u>
Ambulance subsidy	<u>          </u>
EMS Fund payments to physicians/hospital	<u>          </u>
Dispatch center operations (non-staff)	<u>          </u>
Training program operations	<u>          </u>
Other: <u>Attorney</u>	<u>3,480</u>
Other: _____	<u>          </u>
Other: _____	<u>          </u>

**TOTAL EXPENSES**\$ 378,532

**Table 2 - System Organization & Management (cont.)**

**B. SOURCES OF REVENUE**

Special project grant(s) [from EMSA]	
Preventive Health and Health Services (PHHS) Block Grant	\$ _____
Office of Traffic Safety (OTS)	_____
State general fund	_____
County general fund	<u>177,444</u>
Other local tax funds (e.g., EMS district)	_____
County contracts (e.g. multi-county agencies)	_____
Certification fees	<u>50,000</u>
Training program approval fees	_____
Training program tuition/Average daily attendance funds (ADA)	_____
Job Training Partnership ACT (JTPA) funds/other payments	_____
Base hospital application fees	_____
Trauma center application fees	_____
Trauma center designation fees	_____
Pediatric facility approval fees	_____
Pediatric facility designation fees	_____
Other critical care center application fees	_____
Type: _____	
Other critical care center designation fees	_____
Type: _____	
Ambulance service/vehicle fees	<u>1,100</u>
Contributions	_____
EMS Fund (SB 12/612)	<u>132,988</u>
Other grants: <u>  fines for late ambulance response  </u>	<u>17,000</u>
Other fees: _____	_____
Other (specify): _____	_____
<b>TOTAL REVENUE</b>	<b>\$ <u>378,532</u></b>

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



**Table 2 - System Organization & Management (cont.)**6. Fee structure for FY 2004-2005       We do not charge any fees  X   Our fee structure is:

First responder certification	\$ <u>75</u>
EMS dispatcher certification	<u>50</u>
EMT-I certification	<u>75</u>
EMT-I recertification	<u>75</u>
<b>EMT-defibrillation certification</b>	<u>          </u>
EMT-defibrillation recertification	<u>75</u>
EMT-II certification	<u>75</u>
EMT-II recertification	<u>N/A</u>
EMT-P accreditation	<u>N/A</u>
Mobile Intensive Care Nurse/ Authorized Registered Nurse (MICN/ARN) certification	<u>75</u>
MICN/ARN recertification	<u>25</u>
EMT-I training program approval	<u>200</u>
EMT-II training program approval	<u>N/A</u>
EMT-P training program approval	<u>200</u>
MICN/ARN training program approval	<u>N/A</u>
Base hospital application	<u>N/A</u>
Base hospital designation	<u>N/A</u>
Trauma center application	<u>N/A</u>
Trauma center designation	<u>N/A</u>
Pediatric facility approval	<u>400</u>
Pediatric facility designation	<u>N/A</u>
Other critical care center application Type: _____	
Other critical care center designation Type: _____	
Ambulance service license	\$ <u>          </u>
Ambulance vehicle permits	<u>100</u>
Other: <u>Late Fee/Out of County/No Appt Charge; Duplicate Card</u>	<u>25</u>
Other: <u>First Responder Re-Certification/EMT-P Re-Accreditation</u>	<u>75</u>
Other: <u>Out of County EMT-I Certification &amp; Re-Certification</u>	<u>150</u>

2004/2005

7. Complete the table on the following two pages for the EMS agency staff for the fiscal year of 04/05.

2004/2005

**Table 2 - System Organization & Management (cont.)**EMS System: SANTA CRUZ COUNTY HEALTH SERVICES AGENCYReporting year 2004/2005

CATEGORY	ACTUAL TITLE	FTE POSITIONS (EMS ONLY)	TOP SALARY BY HOURLY EQUIVALENT	BENEFITS (%of Salary)	COMMENTS
EMS Admin./Coord./Director	ADMINISTRATOR PROGRAM MANAGER	.5 1.0	\$53.31 \$40.96	21.67% 23.61%	
Asst. Admin./Admin. Asst./Admin. Mgr.					
ALS Coord./Field Coord./ Training Coordinator					
Program Coordinator/ Field Liaison (Non-clinical)					
Trauma Coordinator					
Medical Director	EMS MEDICAL DIRECTOR	.33	\$80.00	0	Services by Contract
Other MD/Medical Consult/ Training Medical Director					
Disaster Medical Planner					

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

Table 2 - System Organization &amp; Management (cont.)

CATEGORY	ACTUAL TITLE	FTE POSITIONS (EMS ONLY)	TOP SALARY BY HOURLY EQUIVALENT	BENEFITS (%of Salary)	COMMENTS
Dispatch Supervisor					
Medical Planner					
Data Evaluator/Analyst	DEPARTMENTAL SYSTEMS ANALYST	1.0	\$32.36	23.61%	
QA/QI Coordinator					
Public Info. & Education Coordinator					
Executive Secretary					
Other Clerical	TYPIST CLERK III	.95	\$20.09	35.89%	
Data Entry Clerk					
Other					

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

**TABLE 3: SYSTEM RESOURCES AND OPERATIONS - Personnel/Training**EMS System: SANTA CRUZ COUNTY HEALTH SERVICES AGENCYReporting Year: 2004/2005**NOTE:** Table 3 is to be reported by agency.

	EMT - Is	EMT - IIs	EMT - Ps	MICN	EMS Dispatchers
Total Certified	599	-	61	9	17
Number newly certified this year	278	-	34	0	4
Number recertified this year	326	-	30	0	14
Total number of accredited personnel on July 1 of the reporting year	258	-	130	9	26
Number of certification reviews resulting in:					
a) formal investigations	0	-	0	0	0
b) probation	0	-	0	0	0
c) suspensions	0	-	0	0	0
d) revocations	0	-	0	0	0
e) denials	0	-	0	0	0
f) denials of renewal	0	-	0	0	0
g) no action taken	0	-	0	0	0

1. Number of EMS dispatchers trained to EMSA standards: 19
2. Early defibrillation:
  - a) Number of EMT=I (defib) certified 258
  - b) Number of public safety (defib) certified (non-EMT-I) 5
3. Do you have a first responder training program  yes  no

**TABLE 4: SYSTEM RESOURCES AND OPERATIONS - Communications**EMS System: SANTA CRUZ COUNTY HEALTH SERVICES AGENCYCounty: SANTA CRUZReporting Year: 2004-2005**Note:** Table 4 is to be answered for each county.

1. Number of primary Public Service Answering Points (PSAP) 1
2. Number of secondary PSAPs 2
3. Number of dispatch centers directly dispatching ambulances 1
4. Number of designated dispatch centers for EMS Aircraft 2
5. Do you have an operational area disaster communication system? Yes  No 
  - a. Radio primary frequency 154.325
  - b. Other methods \_\_\_\_\_
  - c. Can all medical response units communicate on the same disaster communications system?  
Yes  No
  - d. Do you participate in OASIS? Yes  No
  - e. Do you have a plan to utilize RACES as a back-up communication system?  
Yes  No
  - 1) Within the operational area? Yes  No
  - 2) Between the operational area and the region and/or state? Yes  No
6. Who is your primary dispatch agency for day-to-day emergencies?  
SANTA CRUZ CONSOLIDATED EMERGENCY COMMUNICATIONS CENTER
7. Who is your primary dispatch agency for a disaster?  
SANTA CRUZ CONSOLIDATED EMERGENCY COMMUNICATIONS CENTER

**TABLE 5: SYSTEM RESOURCES AND OPERATIONS**  
**Response/Transportation**

EMS System: SANTA CRUZ COUNTY HEALTH SERVICES AGENCY

Reporting Year: 2004-2005

**Note:** Table 5 is to be reported by agency.

**TRANSPORTING AGENCIES**

1.	Number of exclusive operating areas		<u>1</u>
2.	Percentage of population covered by Exclusive Operating Areas (EOA)		<u>100 %</u>
3.	Total number responses		<u>14,797</u>
	a) Number of emergency responses	(Code 2: expedient, Code 3: lights and siren)	<u>14,797</u>
	b) Number non-emergency responses	(Code 1: normal)	<u>0</u>
4.	Total number of		<u>10,156</u>
	a) Number of emergency transports	(Code 2: expedient, Code 3: lights and siren)	<u>10,156</u>
	b) Number of non-emergency transports	(Code 1: normal)	<u>0</u>

**Early Defibrillation Providers**

5.	Number of public safety defibrillation providers		<u>24</u>
	a) Automated		<u>          </u>
	b) Manual		<u>          </u>
6.	Number of EMT-Defibrillation providers		<u>74</u>
	a) Automated		<u>          </u>
	b) Manual		<u>          </u>

**Air Ambulance Services**

7.	Total number of responses		<u>N/A</u>
	a) Number of emergency responses		<u>          </u>
	b) Number of non-emergency responses		<u>          </u>
8.	Total number of transports		<u>234</u>
	a) Number of emergency (scene) responses		<u>92</u>
	b) Number of non-emergency responses		<u>11</u>

**TABLE 5: SYSTEM RESOURCES AND OPERATIONS - Response/Transportation (cont'd.)****SYSTEM STANDARD RESPONSE TIMES (90<sup>TH</sup> PERCENTILE)**

Enter the response times in the appropriate boxes

	<b>METRO/URBAN</b>	<b>SUBURBAN/RURAL</b>	<b>WILDERNESS</b>	<b>SYSTEMWIDE</b>
1.BLS and CPR capable first responder				
2.Early defibrillation responder				
3.Advanced life support responder	8	12	20	8 – 20
4.Transport Ambulance	8	12	20	8 – 20



**TABLE 6: SYSTEM RESOURCES AND OPERATIONS**  
**Facilities/Critical Care**

EMS System: SANTA CRUZ COUNTY HEALTH SERVICES AGENCY

Reporting Year: 2004-2005

**NOTE:** Table 6 is to be reported by agency.

**Trauma**

Trauma patients:

a) Number of patients meeting trauma triage criteria	<u>2,733</u>
b) Number of major trauma victims transported directly to a trauma center by ambulance	<u>234</u>
c) Number of major trauma patients transferred to a trauma center	<u>N/A</u>
d) Number of patients meeting triage criteria who weren't treated at a trauma center	<u>2,499</u>

**Emergency Departments**

Total number of emergency departments	<u>2</u>
a) Number of referral emergency services	<u>0</u>
b) Number of standby emergency services	<u>0</u>
c) Number of basic emergency services	<u>2</u>
d) Number of comprehensive emergency services	<u>0</u>

**Receiving Hospitals**

1. Number of receiving hospitals with written agreements	<u>2</u>
2. Number of base hospitals with written agreements	<u>2</u>

**TABLE 7: SYSTEM RESOURCES AND OPERATIONS -- Disaster Medical**EMS System: SANTA CRUZ COUNTY HEALTH SERVICES AGENCYCounty: SANTA CRUZReporting Year: 2004-2005**NOTE:** Table 7 is to be answered for each county.**SYSTEM RESOURCES**

1. Casualty Collections Points (CCP)
  - a. Where are your CCPs located? not pre-designated
  - b. How are they staffed? Reg II Bay Area DMAT, mutual aid partners
  - c. Do you have a supply system for supporting them for 72 hours?      yes X no \_\_\_\_\_
  
2. CISD
 

Do you have a CISD provider with 24 hour capability?      yes X no \_\_\_\_\_
  
3. Medical Response Team
  - a. Do you have any team medical response capability?      yes X no \_\_\_\_\_
  - b. For each team, are they incorporated into your local response plan?      yes X no \_\_\_\_\_
  - c. Are they available for statewide response?      yes X no \_\_\_\_\_
  - d. Are they part of a formal out-of-state response system?      yes X no \_\_\_\_\_
  
4. Hazardous Materials
  - a. Do you have any HazMat trained medical response teams?      yes X no \_\_\_\_\_
  - b. At what HazMat level are they trained? Technician Specialist
  - c. Do you have the ability to do decontamination in an emergency room?      yes X no \_\_\_\_\_
  - d. Do you have the ability to do decontamination in the field?      yes X no \_\_\_\_\_

**OPERATIONS**

1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure?      yes X no \_\_\_\_\_
  
2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster?      3



**TABLE 8: RESOURCES DIRECTORY -- Providers**

**EMS System:** SANTA CRUZ COUNTY HEALTH SERVICES AGENCY **County:** SANTA CRUZ **Reporting Year:** 2004/2005

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

Name, address & telephone: American Medical Response 116 Hubbard St, Santa Cruz CA 95060; 831/423-7030			Primary Contact: David Zenker, Operations Manager		
Written Contract: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Service: <input checked="" type="checkbox"/> Ground <input type="checkbox"/> Air <input type="checkbox"/> Water	<input checked="" type="checkbox"/> Transport <input type="checkbox"/> Non-Transport	Air classification: <input type="checkbox"/> auxiliary rescue <input type="checkbox"/> air ambulance <input type="checkbox"/> ALS rescue <input type="checkbox"/> BLS rescue	If Air: <input type="checkbox"/> Rotary <input type="checkbox"/> Fixed Wing	Number of personnel providing services: _____ PS _____ PS-Defib _____ BLS _____ EMT-D _____ LALS <u>58</u> ALS
Ownership: <input type="checkbox"/> Public <input checked="" type="checkbox"/> Private	Medical Director: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	If public: <input type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other explain: _____	If public: <input type="checkbox"/> city <input type="checkbox"/> county <input type="checkbox"/> state <input type="checkbox"/> fire district <input type="checkbox"/> Federal	System available 24 hours? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Number of ambulances: <u>9</u>

Name, address & telephone: Calstar, 590 Cohansey, Gilroy CA 95020 408/848-2075			Primary Contact: Scott Weyland		
Written Contract: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Service: <input type="checkbox"/> Ground <input checked="" type="checkbox"/> Air <input type="checkbox"/> Water	<input checked="" type="checkbox"/> Transport <input type="checkbox"/> Non-Transport	Air classification: <input type="checkbox"/> auxiliary rescue <input checked="" type="checkbox"/> air ambulance <input type="checkbox"/> ALS rescue <input type="checkbox"/> BLS rescue	If Air: <input checked="" type="checkbox"/> Rotary <input type="checkbox"/> Fixed Wing	Number of personnel providing services: _____ PS _____ PS-Defib _____ BLS _____ EMT-D _____ LALS <u>14</u> ALS
Ownership: <input type="checkbox"/> Public <input checked="" type="checkbox"/> Private	Medical Director: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	If public: <input type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other explain: _____	If public: <input type="checkbox"/> city <input type="checkbox"/> county <input type="checkbox"/> state <input type="checkbox"/> fire district <input type="checkbox"/> Federal	System available 24 hours? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Number of ambulances: <u>7</u>

**TABLE 8: RESOURCES DIRECTORY -- Providers**

**EMS System:** SANTA CRUZ COUNTY HEALTH SERVICES AGENCY **County:** SANTA CRUZ **Reporting Year:** 2004/2005

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

Name, address & telephone:			Primary Contact:		
Stanford Life Flight, 300 Pasteur Dr, Stanford CA 94305 650-723-5578			Agripina Villegas		
Written Contract: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Service: <input type="checkbox"/> Ground <input checked="" type="checkbox"/> Air <input type="checkbox"/> Water	<input checked="" type="checkbox"/> Transport <input type="checkbox"/> Non-Transport	Air classification: <input type="checkbox"/> auxiliary rescue <input checked="" type="checkbox"/> air ambulance <input type="checkbox"/> ALS rescue <input type="checkbox"/> BLS rescue	If Air: <input checked="" type="checkbox"/> Rotary <input type="checkbox"/> Fixed Wing	Number of personnel providing services: _____ PS _____ PS-Defib _____ BLS _____ EMT-D _____ LALS <u>35</u> ALS
Ownership: <input type="checkbox"/> Public <input checked="" type="checkbox"/> Private	Medical Director: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	If public: <input type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other explain: _____	If public: <input type="checkbox"/> city <input type="checkbox"/> county <input type="checkbox"/> state <input type="checkbox"/> fire district <input type="checkbox"/> Federal	System available 24 hours? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Number of ambulances: <u>1</u>

Name, address & telephone:			Primary Contact:		
Written Contract: <input type="checkbox"/> yes <input type="checkbox"/> no	Service: <input type="checkbox"/> Ground <input type="checkbox"/> Air <input type="checkbox"/> Water	<input type="checkbox"/> Transport <input type="checkbox"/> Non-Transport	Air classification: <input type="checkbox"/> auxiliary rescue <input type="checkbox"/> air ambulance <input type="checkbox"/> ALS rescue <input type="checkbox"/> BLS rescue	If Air: <input type="checkbox"/> Rotary <input type="checkbox"/> Fixed Wing	Number of personnel providing services: _____ PS _____ PS-Defib _____ BLS _____ EMT-D _____ LALS _____ ALS
Ownership: <input type="checkbox"/> Public <input type="checkbox"/> Private	Medical Director: <input type="checkbox"/> yes <input type="checkbox"/> no	If public: <input type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other explain: _____	If public: <input type="checkbox"/> city <input type="checkbox"/> county <input type="checkbox"/> state <input type="checkbox"/> fire district <input type="checkbox"/> Federal	System available 24 hours? <input type="checkbox"/> yes <input type="checkbox"/> no	Number of ambulances: _____

2004/2005

**TABLE 9: RESOURCES DIRECTORY -- Approved Training Programs**

Revision #1 [2/16/95]

EMS System: SANTA CRUZ COUNTY HEALTH SERVICES AGENCY County: SANTA CRUZ Reporting Year: 2004/2005

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

**Training Institution Name** Emergency Training Services (ETS) **Contact Person telephone no.** Priscilla Leighton 831/476-8813  
**Address** 3050 Paul Sweet Rd., Santa Cruz CA 95065

<b>Student Eligibility: *</b>	<b>Cost of Program</b>  Basic <u>  \$500  </u>  Refresher <u> \$165 </u>	<b>**Program Level: <u>I</u></b> Number of students completing training per year: Initial training: <u>      </u> Refresher: <u>      </u> Cont. Education <u>      </u> Expiration Date: <u>04/30/08</u> Number of courses: <u>  6  </u> Initial training: <u>  4  </u> Refresher: <u>      </u> Cont. Education: <u>      </u>
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**Training Institution Name** Cabrillo Community College **Contact Person telephone no.** Kris Legge 831/479-5042  
**Address** 6500 Soquel Dr., Aptos CA 95003

<b>Student Eligibility: *</b>	<b>Cost of Program</b>  Basic <u> \$300-375 </u>  Refresher <u> \$300-375 </u>	<b>**Program Level: <u>I</u></b> Number of students completing training per year: Initial training: <u>150</u> Refresher: <u> 20 </u> Cont. Education <u>      </u> Expiration Date: <u>12/31/06</u> Number of courses: <u>   </u> Initial training: <u>  2  </u> Refresher: <u>  2  </u> Cont. Education: <u>      </u>
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- Open to general public or restricted to certain personnel only.
- \*\* Indicate whether EMT-I, EMT-II, EMT-P, or MICN; if there is a training program that offers more than one level complete all information for each level.

**TABLE 10: RESOURCES DIRECTORY -- Facilities**

**EMS System:** SANTA CRUZ COUNTY HEALTH SERVICES AGENCY **County:** SANTA CRUZ **Reporting Year:** 2004/2005

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

<b>Name, address &amp; telephone:</b> Watsonville Community Hospital, 755 Nielson, Watsonville CA 95076; 831/724-4741		<b>Primary Contact:</b> Lisa Angell, MICN		
Written Contract <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Referral emergency service <input type="checkbox"/> Standby emergency service <input type="checkbox"/> Basic emergency service <input checked="" type="checkbox"/> Comprehensive emergency service <input type="checkbox"/>	Base Hospital:  <input checked="" type="checkbox"/> yes <input type="checkbox"/> no		Pediatric Critical Care Center:*  <input type="checkbox"/> yes <input checked="" type="checkbox"/> no
EDAP:** <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	PICU:*** <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Burn Center: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Trauma Center: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	If Trauma Center what Level:**** _____

<b>Name, address &amp; telephone:</b> Dominican Santa Cruz Hospital, 1555 Soquel Dr., Santa Cruz CA 96065; 831/462-7700		<b>Primary Contact:</b> Terry Lapid, MD/ED Medical Director		
Written Contract <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Referral emergency service <input type="checkbox"/> Standby emergency service <input type="checkbox"/> Basic emergency service <input checked="" type="checkbox"/> Comprehensive emergency service <input type="checkbox"/>	Base Hospital:  <input checked="" type="checkbox"/> yes <input type="checkbox"/> no		Pediatric Critical Care Center:*  <input type="checkbox"/> yes <input checked="" type="checkbox"/> no
EDAP:** <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	PICU:*** <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Burn Center: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Trauma Center: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	If Trauma Center what Level:**** _____

\* Meets EMSA *Pediatric Critical Care Center (PCCC) Standards.*

\*\* Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards.

\*\*\* Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards.

\*\*\*\* Levels I, II, III and Pediatric.

**TABLE 11: RESOURCES DIRECTORY -- Dispatch Agency**

**EMS System:** SANTA CRUZ COUNTY HEALTH SERVICES AGENCY **County:** SANTA CRUZ **Reporting Year:** 2004/2005

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

Name, address & telephone:		Primary Contact: Michael McDougall	
Santa Cruz Consolidated Communications Center, 95 Upper Park Rd., Santa Cruz CA 95065; 831/471-1000			
Written Contract: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Medical Director: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	<input checked="" type="checkbox"/> Day-to-day <input checked="" type="checkbox"/> Disaster	Number of Personnel providing services: _____ EMD Training      _____ EMT-D      _____ ALS _____ BLS                      _____ LALS      _____ 26 Other
Ownership: <input checked="" type="checkbox"/> Public <input type="checkbox"/> Private		If public: <input checked="" type="checkbox"/> Fire <input checked="" type="checkbox"/> Law <input checked="" type="checkbox"/> Other explain: <u>Joint Powers Authority</u>	If public: <input type="checkbox"/> city; <input type="checkbox"/> county; <input type="checkbox"/> state; <input type="checkbox"/> fire district; <input type="checkbox"/> Federal

Name, address & telephone:		Primary Contact:	
Written Contract: <input type="checkbox"/> yes <input type="checkbox"/> no	Medical Director: <input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> Day-to-day <input type="checkbox"/> Disaster	Number of Personnel providing services: _____ EMD Training      _____ EMT-D      _____ ALS _____ BLS                      _____ LALS      _____ Other
Ownership: <input type="checkbox"/> Public <input type="checkbox"/> Private		If public: <input type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other explain: _____	If public: <input type="checkbox"/> city; <input type="checkbox"/> county; <input type="checkbox"/> state; <input type="checkbox"/> fire district; <input type="checkbox"/> Federal



**APPENDIX 1: System Assessment Form**

**STANDARD:**

**CURRENT STATUS:**

**COORDINATION WITH OTHER EMS AGENCIES:**

**NEED(S):**

**OBJECTIVE:**

**TIME FRAME FOR MEETING OBJECTIVE:**

\_\_\_\_\_ Short-range plan (one year or less)

\_\_\_\_\_ Long-range plan (more than one year)

**EMS PLAN  
AMBULANCE ZONE SUMMARY FORM**

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

<p><b>Local EMS Agency or County Name:</b>  <u>Santa Cruz County Health Services Agency</u></p>
<p><b>Area or subarea (Zone) Name or Title:</b>  <u>Santa Cruz County</u></p>
<p><b>Name of Current Provider(s):</b>          Include company name(s) and length of operation (uninterrupted) in specified area or subarea.  <u>American Medical Response</u></p>
<p><b>Area or subarea (Zone) Geographic Description:</b>  <u>Santa Cruz County</u></p>
<p><b>Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):</b>          Include intent of local EMS agency and Board action.  <u>Exclusive</u></p>
<p><b>Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):</b>          Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).  <u>ALS</u></p>
<p><b>Method to achieve Exclusivity, if applicable (HS 1797.224):</b>          If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.           If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.   <u>Competitive, RFP, current agreement is 09/01/03 – 12/31/08, 75 pages, available online at <a href="http://www.santa_cruzhealth.org/pdf/ambulance2002rfp.pdf">www.santa_cruzhealth.org/pdf/ambulance2002rfp.pdf</a></u></p>