9-1-1 ADVANCED LIFE SUPPORT BASE CONTACT, STANDING ORDER, HOSPITAL CONTACT, AND TRANSPORT CRITERIA

I. AUTHORITY:

California Health and Safety Code, Division 2,5, Sections 1797.220, 1797.222, 1797.250, 1797.257, 1798.0, and 1798.2.

II. APPLICATION:

This policy defines when 9-1-1 dispatched advanced life support units (ALS), including ALS air rescue units, must make base contact for EMS system coordination and medical direction of field patient care. It extends the definition to include Comprehensive Children's Emergency Receiving Center (pediatric base) contact when responding to a patient under 15 years of age. This policy also provides authorization and criteria for use of Standing Orders (SO), Treatment Guidelines, and Procedures Prior to Base Contact by 9-1-1 ALS personnel and requirements for transportation of patients from the field to Emergency Receiving Centers (ERC). This policy also authorizes device options for hospital contact when base contact is not required.

III. CRITERIA:

BASE HOSPITAL CONTACT:

Base Hospital contact is encouraged and appropriate at any time an OCEMS 9-1-1 dispatched paramedic determines there is a benefit or need to do so.

Base Hospital (BH) contact is required for the following types of cases:

- Adult patients with unstable vital signs for whom there is not an applicable Standing Order or Treatment Guideline. Unstable vital signs are defined as:

	Adult/Adolescent
Pulse (bpm)	<50 or >130
Respirations (resp/min)	<12 or > 26
Systolic blood pressure (mm Hg)	<90

- All persons identified in Standing Orders or Treatment Guidelines as requiring base contact. Base contact must be enacted prior to the initiation of transport when required by Standing Order or Treatment Guideline.
- Patients (adult and pediatric) on whom an ALS procedure is performed who subsequently request to sign out AMA for transport to an appropriate receiving center. ALS procedures are defined in the California Code of Regulations Title 22, section 100146 and include:
  - Utilization of electrocardiograms, including 12-lead ECGs
  - Performance of defibrillation, synchronized cardioversion, and external cardiac pacing
  - Removal of airway foreign bodies using a laryngoscope and Magill forceps
  - Pulmonary ventilation using a supraglottic airway or endotracheal intubation
  - Use of continuous positive pressure ventilation (CPAP)
  - Placement of IV catheters, IO needles/catheters, and saline locks as well as administration of medications through pre-existing vascular access sites
  - Obtaining venous blood samples

- Use of capnography for prehospital screening and assessment or use of glucometers when readings are less than 60 or greater than 400.
- Use of the Valsalva maneuver to attempt heart rate control
- Performance of needle thoracostomy
- Performance of nasogastric and orogastric tube insertion and suction
- Administration of OCEMS-approved medications or solutions by IV, IN, IM, IO, subcutaneous, inhalation, transcutaneous, sublingual, endotracheal, or oral routes.

NOTE: Medication administered solely by non-911 providers will not trigger base hospital contact

- Mass Casualty Incidents (MCI) for receiving ERC/TC destination, unless the Orange County Communications Center (OCC) is determined by field protocol as communication point for destination assignments.
- Cardiovascular Receiving Center (CVRC) patients to determine destination for an open cardiac catheterization laboratory. Indications for CVRC transport include:
  - Return Of Spontaneous Circulation (ROSC)
  - Automatic Implantable Cardioverter Defibrillator "firing" or defibrillating two or more times in less than fifteen minutes.
  - 12 lead EKG reading of acute MI
  - Patient with symptomatic bradycardia
  - Patient with a Left Ventricular Assist Device (LVAD)
- Patients who meet Trauma (see T-005) or Replant Criteria (see SO-T-015).
- Patients who meet Stroke-Neurology Center criteria (see SO-M-025).
- Burn Center (see E-005) patients to determine which center is available for receiving acute cases.
- Triage decisions in which Base Hospital contact may assist field personnel, such as ALS level refusal of care when there is a question of patient mental capacity.
- Patients who self-administered epinephrine.
- Field transport by helicopter to an ERC

Comprehensive Children's Emergency Receiving Center (CCERC) contact is encouraged and appropriate at any time a paramedic determines there is a benefit or need to do so.

Base Hospital (BH) contact (CCERC pediatric base preferred) is required for the following cases:

- Pediatric patients with unstable vital signs for whom there is not an applicable Standing Order or Treatment Guideline. Unstable vital signs are defined as any values outside of the following parameters:

Pediatric Vital Signs by Age

Age	Pulse	Systolic Blood Pressure	Respiratory Rate
Neonate (0-30 days)	100-180	> 60	30-60
Infant (31 days - < 1 yr)	100-160	> 60	30-60
Toddler (1 yr - < 3 yrs)	90-150	> 70	24-40
Pre-school (3 yrs - < 5 yrs)	80-140	> 75	22-34
School Aged (5 yrs - < 10 yrs)	70-120	> 80	18-30
Teen (≥ 10 yrs)	60-100	> 90	12-16

- All persons identified in Standing Orders or Treatment Guidelines as requiring base contact. Base contact must be enacted prior to the initiation of transport when required by Standing Order or Treatment Guideline
- Respiratory distress or labored breathing manifested by:
  - Intercostal retractions,
  - Nasal flaring with inspiration,
  - Respirations less than approximately 12/min or more than approximately 50/min,
  - Cyanosis (particularly of lips and central face area),
  - Complaint of difficulty breathing by child who can communicate
  - Paramedic judgment
- Circulatory compromise manifested by:
  - Poor skin color (pallor, cyanosis)
  - Decreased capillary refill of hypothenar area (3 seconds or greater)
  - Altered mental status or confusion
  - Mottling of skin (darkened or lighter patches)
  - Pale lips or fingernail beds
  - Weak / thready pulse or heart rate less than 60/min or over 200/min
  - Paramedic judgement
- Pediatric patients with acute symptoms of a BRUE (ALTE) below, either observed by EMS personnel or reported by parent or caretaker, even when signs or symptoms are apparently resolved:
  - Apnea episode
  - Color change (cyanosis, pallor, erythema) episode
  - Marked change in muscle tone (limpness, flaccidity) episode
  - Choking or gagging spontaneous, unrelated to food or fluid intake
- Pediatric patients with BRUE (ALTE) symptoms when caretaker requests to sign out AMA for ALS or BLS transport.

- Pediatric patients who meet Trauma (P-015) or Replant Criteria (see SO-P-025).
- Pediatric victims of suspected physical or sexual assault.
- Pediatric patients who had epinephrine self-administered,
- Pediatric patients who meet Stroke Criteria (P-115).
- Pediatric cardiac arrest and/or ROSC
- Pediatric drowning (see P-100)
- Burn Center (see SO-P-095) pediatric patients to determine which center is available for receiving acute cases and to assist with management.

IV. ALS STANDING ORDERS / TREATMENT GUIDELINES (SO): (Applies to ALS provider agencies approved to use Standing Orders or Treatment Guidelines)

- SO/Treatment Guidelines are field medical orders for specific medical conditions. SO/Treatment Guideline may be used by on-duty OCEMS Accredited Paramedics while working for a SO/Treatment Guideline approved ALS provider agency.

- Base Hospital contact should be made when indicated in a specific SO/Treatment Guideline. At times, patients may require care not specified in SO/Treatment Guideline or care beyond that given using SO/Treatment Guideline; when needed, BH contact should be established for further on-line medical direction and orders.

- When BH contact is made, further medical orders come from the BH. If base contact is discontinued after making contact, the appropriate SO/Treatment Guideline may be initiated or resumed as necessary with no further BH contact.

- If a SO/Treatment Guideline does not require BH contact, the paramedic may transport a patient to the appropriate ERC without contacting a BH.

V. TRANSPORT:

- Persons who have stable vital signs or who do not meet Trauma, Burn, Cardiovascular or Stroke-Neurology Receiving Center criteria may request and be transported to their preferred Emergency Receiving Center.

    - Persons who meet Trauma, Burn, Cardiovascular, or Stroke-Neurology Center triage criteria should be ALS transported to an appropriate specialty center as determined by Base Hospital contact.

    - Persons meeting Trauma, Cardiovascular, or Stroke-Neurology Receiving Center triage criteria with stable vital signs and who are mentally competent may sign AMA to be transported to their preferred hospital (if not diverting patients) which may or may not be a TC, CVRC, or SNRC.

- An OCEMS Base Hospital has final authority to determine transport destination to an OCEMS ERC (including determination to route a patient to an ERC or specialty center that has declared it is on diversion).

- Transport any pediatric patient meeting the following criteria directly to a CCERC when:
  - A CCERC is the most appropriate, nearest emergency receiving center (ERC)
  - Parent or caretaker requests transport to a CCERC and transport can reasonably be accomplished
  - Pediatric patient appears to be having an acute stroke or neurologic emergency
  - Pediatric patient is an interfacility transport from a health care facility or provider to a CCERC

VI. RADIO CONTACT PROCESS:

- EMS field units and air rescue units should initiate Base Hospital contact through Orange County Communications (OCC) using standard radio contact and Base assignment procedures. A CCERC Base Hospital is preferred for any pediatric patient.

- OCEMS Emergency Receiving Centers (ERCs) and other community hospitals should telephone directly to an ERC/CCERC as a means of communication.

- For ALS transports that don't require Base Hospital contact ("ALS no-contact" calls), EMS field units may communicate with the ERC by:
  a. 800 MHz radio contacting the ERC dedicated ALS receiver, or
  b. an agency-issued mobile phone by calling the emergency department's dedicated ambulance/paramedic phone number(s).

VII. HOSPITAL DIVERSION:

- When a receiving center is known to be on ReddiNet emergency department diversion status, neither BLS nor ALS cases are to be transported to that facility until the facility is off diversion.

- Hospitals that have declared they are on emergency department diversion status are considered unsafe for arrival of further patients, representing a threat to community health and safety.

  Unless the three (3) closest hospitals to the incident scene are on diversion, all field transports including patients with cardiac arrests should be transported to the nearest appropriate hospital that is not on diversion status. If the three (3) hospitals closest to the field scene are on emergency department diversion status, Base Hospital contact may be initiated for ALS level patients at the discretion of the Paramedic to determine which of the 3 hospitals should receive the patient. If Base Hospital contact is not made, the patient should be transported to the nearest Emergency Receiving Center (ERC) regardless of diversion status or to an alternate receiving center determined by the Base Hospital if contacted.

- Patients meeting field triage to a Stroke- Neurology Receiving Center (SNRC) should be transported to the nearest SNRC that is not on neuro diversion. If the two closest SNRCs are on diversion, acute stroke patients should be directed by the Base Hospital to be transported to the nearest SNRC regardless of diversion status.

  Patients meeting field triage to a Cardiovascular receiving Center (CVRC) should be transported to the nearest CVRC that is not on cardiac diversion. If the two closest CVRCs are on diversion, patients with acute cardiac conditions should be directed by the Base Hospital to be transported to the nearest CVRC regardless of diversion status.

- Patients meeting Trauma Triage Criteria (OCEMS Policy # 310.30) should be transported to the nearest Trauma Center that is not on trauma diversion status. If the two closest adult trauma centers are on diversion status, trauma victims should be directed by the Base Hospital to be transported to the nearest adult trauma center regardless of diversion status.

VIII. SPECIAL CIRCUMSTANCES:

- Victims of sexual assault should be transported to the nearest open ERC based on OCEMS triage criteria. If a sexual assault victim has injuries that meet Trauma Triage Criteria, BH Contact should be made with transport to an appropriate trauma center.

- Persons requesting or in need of medical care who are being legally detained will be managed by appropriate OCEMS policies and guidelines. "Medical Clearance" or medical screening requires a complete emergency department or jail intake center medical evaluation and is not a field procedure. Detained persons who are mentally competent may refuse medical care and sign AMA per SO-AMA. Patients in police custody who require emergency medical evaluation should be transported to the nearest Emergency Receiving Center unless the patient meets specialty care (trauma, cardiovascular, or stroke-neurology) criteria.

- First responding BLS units may transport unstable medical cases to the nearest ERC if the estimated time for ALS arrival exceeds BLS transport time to the ERC. First responders may expedite immediate transport of an infant/small child near-drowning victim to the closest ERC.

IX. ALS ESCORT:

- Paramedic escort, with on-going assessment of medical condition, to an appropriate OCEMS facility is required for persons with unstable vital signs (see above), pulse oximetry of 90% or less on room air identified at any time and regardless of improvement with treatment, or as identified in a specific SO/Treatment Guideline.

- Paramedic escort is required when an ALS medication or procedure has been provided under SO/Treatment Guideline (except for special circumstances or specific guidance in SO/Treatment Guideline).

- ALS escort is required for Cardiovascular, Stroke-Neurology, and Trauma triaged specialty patients.

Approved:

Almaas A. Shaikh, MD, MPH FACS
OCEMS Medical Director

Daniel McDonnell MS, MBA, NRP
Director of Emergency Medical Services

Original Date:	02/1992 (previously policy I-40)
Reviewed Date(s):	4/1/2015, 5/02/2018, 02/07/2019, 02/11/2020; 01/2021; 05/23/2023; 04/2026
Revised Date(s):	04/28/2020; 02/11/2021; 10/14/2022; 06/15/2023; 02/28/2025; 04/22/2026
Effective Date:	10/01/2023; 04/01/2025; 04/01/2027