CITY AND COUNTY OF SAN FRANCISCO

COMMUNITY PARAMEDICINE (CP) & TRIAGE TO ALTERNATE DESTINATION (TAD) PROGRAMS

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PROGRAM STANDARDS – APPLICABLE TO BOTH TRIAGE TO ALTERNATE DESTINATION (TAD) AND COMMUNITY PARAMEDICINE (CP)

1. PURPOSE

1.1. Community Paramedicine (CP) and Triage to Alternate Destination (TAD) programs are community focused extensions of traditional emergency response transportation and recognized as an emerging model of care to meet an unmet need within the community.

1.2. Authorized CP and TAD Paramedics, working under medical oversight, will deliver CP and TAD services to improve coordination among providers of medical service, behavioral health services, and social services; preserve and protect the underlying 911 EMS system; provide high quality patient care; and empower heath systems to provide care more effectively and efficiently.

(Community Paramedicine or Triage to Alternate Destination Act of 2020; California Health and Safety Code, Division 2.5, Chapter 13; California Code of Regulations (CCR), Title 22, Division 9, Chapter 5)

2. MEDICAL DIRECTION

2.1. A CP and TAD Paramedic shall utilize the paramedic scope of practice, approved EMS Agency local optional scope and trial study scope as described in EMS Agency policy and protocols. This includes utilizing general paramedic scope and other approved scopes while transporting to alternate destinations, providing care to discharged patients, providing vaccinations, and through other conditions as identified in CP and TAD programs.

3. DOCUMENTATION AND CONTINUOUS QUALITY IMPROVEMENT

3.1. CP and TAD Paramedics shall complete and submit electronic patient care records in accordance with 22 CCR § 100171, and document destination facility with standardized facility codes per the California Emergency Medical Services Information System (CEMSIS).

3.2. A CP and TAD program shall have a written Continuous Quality Improvement (CQI) plan approved by the EMS Agency. The CQI plan shall complement the EMS Provider's existing CQI plan. CQI plans shall include provisions for continuing education including types of activities, frequency, and required hours.

3.3. CP and TAD programs shall exchange electronic patient health information between CP/TAD providers and facilities unless a wavier is obtained under 22 CCR § 100185(c).

4. LOCAL IMPLEMENTATION

4.1. CP and TAD programs shall be reviewed, submitted, and implemented within the EMS Agency's EMS Plan under Ca. Health and Safety Code § 1797.250.

4.2. EMS Agency shall provide medical control and oversight for CP and TAD programs.

4.3. The EMS Agency with CP and TAD Providers shall facilitate agreements to ensure delivery of CP and TAD services.

4.4. The EMS Agency shall annually review CP and TAD training programs, providers, and facilities to ensure compliance with all requirements.

4.5. The EMS Agency shall notify the EMS Authority of any complaints or unusual occurrences for approved CP and TAD programs within seventy-two (72) hours with supporting documentation. The local process for reporting an unusual occurrence is detailed in EMSA Policy 6020 – Incident Reporting.

4.6. CP and TAD Providers, Training Programs, TAD Facilities and Accreditation Applicants must pay all associated fees.

5. CP AND TAD PROVIDER/FACILITY OVERSIGHT

5.1. CP and TAD Provider/Facility's failure to comply with the provisions of statute, regulation, and/or any additional EMS Agency requirements may result in denial, probation, suspension, or revocation of approval by the EMS Agency.

5.2. The process for noncompliance is listed in 22 CCR § 100184.

6. TRAINING PROGRAM REVIEW AND APPROVAL

6.1. CP and TAD training programs shall submit a written request for training program approval to the EMS Agency

6.2. The EMS Agency shall receive and review the following documentation prior to program approval:

5.2.1. A statement verifying that the course content meets the requirements contained in the current version of the United States Department of Transportation (U.S. DOT) National EMS Education Standards as required by Section 1831(c)(2) of the Health and Safety Code.

5.2.2. An outline of course objectives and curriculum

5.2.3. Performance objectives for each skill.

5.2.4. The names and qualifications of the training program director, program medical director, and instructors.

5.2.5. If the training program includes supervised clinical training, then provisions for supervised clinical training including student evaluation criteria and standardized forms for evaluating CP students; and monitoring of preceptors by the training program shall be included.

5.2.6. If the training program includes supervised field internship, then provisions for supervised field internship including CP student evaluation criteria and standardized forms for evaluating students; and monitoring of preceptors by the training program shall be included.

5.2.7. The proposed location(s) and date(s) for courses.

5.2.8. Written contract or agreements between the training program and a hospital(s) and other clinical setting(s), if applicable, for student placement for clinical education and training.

5.2.9. Written contracts or agreements between the training program and a provider agency(ies) for student placement for field internship training.

5.2.10. Samples of written and skills examinations administered by the training program.

5.2.11. Evidence that training program facilities, equipment, examination securities, and student record keeping are compliant with the provisions of statute, regulation, and EMS Agency requirements.

6.3. The EMS Agency shall approve and establish the effective date of program approval in writing upon the program satisfactory meeting and documenting compliance with all program requirements.

6.4. Notification of program approval or deficiencies with the application shall be made in writing by the EMS Agency to the requesting training program within ninety (90) days of receiving the training program's request for approval.

6.5. Training program approval shall be valid for four (4) years ending on the last day of the month in which it was issued and may be renewed every four (4) years

6.6. The EMS Agency shall notify the EMS Authority in writing of the training program approval, including the name and contact information of the program director, medical director, and effective date of the program.

6.7. Training Program shall provide any documents and materials on an annual basis to support EMS Agency EMS Plan submission to maintain continuity of CP and TAD programs.

7. TRAINING PROGRAM REQUIREMENTS

7.1. Program Medical Director

7.1.1. Each training program shall have a program medical director who is a board certified or board eligible emergency medical physician currently licensed in the State of California, who has experience in emergency medicine and has education or experience in methods of instruction. Duties of the program medical director shall include, but not be limited to the following:

7.1.2. Review and approve educational content, standards, and curriculum; including training objectives and local protocols and policies for the clinical and field instruction, to certify its ongoing appropriateness and medical accuracy.

7.1.3. Review and approve the quality of medical instruction, supervision, and evaluation of the students in all areas of the program.

7.1.4. Approval of hospital clinical and field internship experience provisions.
7.1.5. Approval of instructor(s).
7.1.6. The program medical director will certify that guest educators invited by primary instructors to provide instruction or facilitation have the appropriate expertise to deliver the proposed educational content.

7.2. Program Director

7.2.1. Each training program shall have a program director who shall meet the following requirements:
7.2.1.1. Has knowledge or experience in local EMS protocol and policy,
7.2.1.2. Is a board certified or board eligible California licensed emergency medicine physician, registered nurse, paramedic, or an individual who holds a baccalaureate degree in a related health field or in education, and
7.2.1.3. Has education and experience in methods, materials, and evaluation of instruction including:
7.2.1.4. A minimum of one (1) year experience in an administrative or management level position, and
7.2.1.5. A minimum of three (3) years academic or clinical experience in prehospital care education

7.2.2. Duties of the program director shall include, but not be limited to the following:
7.2.2.1. Administration, organization, and supervision of the educational program.
7.2.2.2. In coordination with the program medical director, approve the instructor(s), teaching assistants, field and hospital clinical preceptors, clinical and internship assignments, and coordinate the development of curriculum, including instructional objectives, and all methods of evaluation.
7.2.2.3. Ensure training program compliance with this chapter and other related laws.
7.2.2.4. Ensure that all course completion records include a signature verification.
7.2.2.5. Ensure the preceptor(s) are trained according to the subject matter being taught.

7.3. Instructors

7.3.1. Each training program shall have instructor(s), who are responsible for areas including, but not limited to, curriculum development, course coordination, and instruction and shall:
7.3.1.1. Be a physician, registered nurse, physician assistant, nurse practitioner, paramedic, who is currently certified or licensed in the State of California,
7.3.1.2. Have six (6) years' experience in an allied health field or community paramedicine, or four (4) years of experience in an allied health field and an associate degree or two (2) years of experience in an allied health field and a baccalaureate degree, and
7.3.1.3. Be knowledgeable in the course content of the U.S. DOT National Emergency Medical Services Education Standards, and
7.3.1.4. Be able to demonstrate expertise and a minimum of two (2) years of experience within the past five (5) years in the subject matter being taught by that individual, and
7.3.1.5. Be qualified by education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction.
7.3.1.6. An instructor may also be the program medical director or program director.

8. MINIMUM TRAINING AND CURRICULUM REQUIREMENTS

8.1. TAD program shall meet or exceed minimum training and curriculum requirements as listed in 22 CCR §§ 100189(e)(2), 100189(f), and 100189(h).

8.2. CP program shall meet or exceed minimum training and curriculum requirements as listed in 22 CCR §§ 100189(e)(1), 100189(g-h).

9. TRAINING PROGRAM OVERSIGHT

9.1. A CP or TAD program's failure to comply with the provisions of statute, regulation, and/or any additional EMS Agency requirements may result in denial, probation, suspension, or revocation of approval by the EMS Agency.

9.2. The EMS Agency may conduct onsite visits, inspect, investigate, and discipline approved training

programs for any violations or for failure to fulfill any additional requirements.

9.3. The requirements of training program noncompliance notification and actions are as follows:

9.3.1. The EMS Agency shall provide written notification of noncompliance state and/or local standards and requirements to the training program provider. The notification shall be in writing by certified mail.

9.3.2. Within fifteen (15) days from receipt of the noncompliance notification, the training program shall submit in writing to the EMS Agency one of the following:

9.3.2.1. Evidence of compliance with the provisions of state and/or local standards and requirements, as applicable, or a plan to comply with the provisions of state and/or local standards and requirements, as applicable, within sixty (60) days from the day of receipt of the notification of noncompliance.

9.3.2.2. Within fifteen (15) days from receipt of the training program's response, or within thirty (30) days from the mailing date of the noncompliance notification, if no response is received from the training program, the EMS Agency shall issue a decision letter by certified mail to the EMS Authority and the training program. The letter shall identify the EMS Agency's decision to take one or more of the following actions:

- Accept the evidence of compliance provided.
- Accept the plan for meeting compliance provided.
- Place the training program on probation.
- Suspend or revoke the training program approval.

9.3.2.3 The decision letter shall also include, but need not be limited to, the following information:

- Date of the EMS Agency's decision,
- Specific provisions found noncompliant by the EMS Agency
- The probation or suspension effective and ending date
- The terms and conditions of the probation or suspension
- The revocation effective date

9.3.2.4 The EMS Agency shall establish the probation, suspension, or revocation effective dates.

TRIAGE TO ALTERNATE DESTINATION (TAD) – PROGRAM-SPECIFIC STANDARDS

10. DEFINITIONS AND SCOPE

10.1. Alternate Destination Facility is defined as a treatment location that is an:
  10.1.1. Authorized mental health facility (Health and Safety Code § 1812)
  10.1.2. Authorized sobering center (Health and Safety Code § 1813)
10.2. A TAD program also includes providing transport services for patients who identify as veterans and desire transport to a local veterans administration emergency department for treatment.
10.3. Approved alternate destinations are located within EMSA Policy 5000 – Destination Policy.
10.4. Advanced Life Support (Paramedics) shall not transport patients to any destinations not approved as a Receiving Facility, Standby Facility, or Alternate Destination.
10.5. TAD Provider
  10.5.1. Advanced Life Support provider authorized by the EMS Agency to provide Advanced Life Support triage paramedic assessments as part of an approved triage to alternate destination program specialty.
10.6. TAD Program
  10.6.1. Program developed by the EMS Agency and approved by the EMS Authority (State) to provide triage paramedic assessments.
10.7. TAD Paramedic
10.8. Paramedic who has completed the curriculum for triage paramedic services and receives local TAD Accreditation.

11. TAD DESTINATION REVIEW AND APPROVAL REQUIREMENTS

11.1. Must be an Alternate Destination as defined in Section 8 above.
11.2. Notify the EMS Agency review via written request for facility review.
11.3. Pay any associated fees.
11.4. Review and approval by the EMS Agency including site visit.
11.5. Facility must maintain all requirements including, but not limited to:
  11.5.1. Qualified staff to care for the degree of a patient's injuries and needs
  11.5.2. Standardized medical and nursing procedures for nursing staff
  11.5.3. Necessary equipment and services at the Alternate Destination facility to care for patients including, but not limited to an automatic external defibrillator and at least one bed or mat per individual patient
  11.5.4. Facility shall maintain a ReddiNet account, post status, respond to emergency polls and assessments within 5 minutes. Facility shall notify the EMS Agency within 24 hours or less if there are changes in the status of the facility with respect to protocols and the facility's ability to care for patients.
  11.5.5. Facility shall maintain an agreement with the EMS Agency to ensure compliance with provisions in statute, regulations, and local policies including operation in accordance with Ca. Health and Safety Code § 1317. Failure to operate under § 1317 will result in immediate termination of the facility as part of the TAD facility.
  11.5.6. Facilities participating as an alternate destination shall accommodate privately or commercially insured, Medi-Cal, Medicare, and uninsured patients.

12. TAD ACCREDITATION

12.1. The process and requirements for local TAD Accreditation is located within EMSA Policy 2050 – Paramedic Accreditation.
12.2. A TAD paramedic shall only utilize TAD skills when accredited by the San Francisco EMS Agency as a TAD paramedic within San Francisco City and County and when employed by an EMS Agency-approved TAD Provider.
12.3. A TAD accreditation is deemed effective when recorded in the Central Registry public look-up database.
12.4. The San Francisco EMS Agency shall review the submitted eligibility criteria for TAD Accreditation and notify the applicant in writing within thirty (30) business days from the date of submission that:\
  12.4.1. The submission is incomplete or illegible and required corrective action or

12.4.2. The accreditation request has been approved and the accreditation data entered in the Central Registry public look-up database.
12.4.3. The accreditation request has been denied; including the reason and notification of the applicant's right to appeal.

12.5. The process for Accreditation action and appeal for a TAD Accreditation is the same process as ALS Local Accreditation and as listed in EMSA Policy 2070 – Certificate/License Process for Prehospital Personnel and is consistent with Ca. Health and Safety Code § 1797.194.

13. TAD DATA SUBMISSION

13.1. TAD Provider shall submit the minimum data requirements on required intervals as listed in 22 CCR § 100185.

14. TAD EQUIPMENT REQUIREMENTS

14.1. TAD Provider shall ensure all vehicles utilized for TAD transports meet or exceed EMSA Policy 4001 – Vehicle Equipment & Supply List and 4001.a – Minimum Equipment Requirements for First Response and Ambulances.

14.2. TAD transports, with a patient, shall be completed via Medical Response Vehicle - ALS/BLS transport unit and be issued an ambulance permit.

COMMUNITY PARAMEDICINE (CP) – PROGRAM-SPECIFIC STANDARDS

15. PURPOSE

15.1. The San Francisco EMS Agency (EMSA), in collaboration with the San Francisco Fire Department (SFFD) will utilize the Community Paramedicine Program to provide case management services to frequent emergency medical services users in collaboration with, and by providing referral to, existing appropriate community resources.
15.2. The CP programs of the San Francisco Fire Department promote health and social equity among those with unmet medical, mental health and social needs. Frequent users of the EMS system are defined locally as individuals who activate 911 four or more times in a month, 10 times in a year and/or vulnerable populations including persons experiencing behavioral crises, substance use disorders, and/or unsheltered homelessness.

16. PRINCIPLES

16.1. EMS Provider Agency (SFFD) must be approved by the EMS Agency to provide CP services described in Ca. Health and Safety Code § 1815 and must be authorized to provide the CP program specialty pertaining to the provision case management services to frequent EMS users.

17. STAFFING

17.1. Community Paramedic Unit
17.1.1. A minimum of one (1) CP who has completed the curriculum for CP training, received certification in the 'frequent users' program specialty, and has been Accredited to provide CP services.
17.1.2. CP may operate on their own or within Mobile-Integrated-Health teams (listed below) alongside other providers. They may be assigned to operate ALS First Response vehicles which are authorized under EMSA Policy 4001 – Vehicle Equipment & Supply List.
17.2. Community Paramedic Teams
17.2.1. CPs will be organized in teams in order to meet specific CP program goals.
17.2.2. In order to satisfy CP program goals, CPs may be paired with additional providers while engaging individuals. The CP Provider will have agreements with the agencies supplying these non EMS-providers that specifies each non EMS-providers' roles and responsibilities during patient engagements. The management/supervision of the non-EMS staff and their licensure credentials fall under their respective agencies.
17.3. Advanced Provider
17.3.1. Individuals such as Nurse Practitioners, Physician Assistants, Physicians, Licensed Clinical Social Workers, Clinical Psychologists, Marriage and Family Counselors.
17.4. Peer Support Staff
17.4.1. Individuals designated from other City agencies or community-based organizations to provide peer support staff.
17.5. CP Provider shall provide the EMS Agency with a list of all regular staff working on a CP unit and ensure list is updated.
17.6. CP Provider shall retain copies of current and valid credentials for all personnel performing services under this program.

18. CP SCOPE OF PRACTICE

18.1. CPs may perform case management of EMS frequent users as defined above.
18.2. CPs may engage patients in emergency and non-emergency encounters (definitions below).
18.3. CPs may perform biopsychosocial assessments of individuals they encounter and provide case management services, in collaboration with, and by providing referral to, existing appropriate community resources.
18.4. CPs may provide referrals to proactive and comprehensive healthcare and social services that meet the specific needs of each patient.
18.5. Only CPs working a CP-specific shift may perform the roles stipulated in this subsection.

19. EXCEPTIONAL SITUATIONS

19.1. Critical Patients and On-views
19.1.1. If a CP identifies someone as a patient, per policy 4040, the CP shall:
19.1.1.1. Notify the dispatch communication center,

19.1.1.2. Provide appropriate patient care as a First Responder, which may include any indicated ALS interventions following appropriate EMS Agency protocols.

19.2. Client Deterioration During Transport

19.2.1. If during a non-emergency transport by a CP unit the client begins to deteriorate after transport has begun, the encounter will become emergency encounter and personnel shall:

19.2.1.1. Provide appropriate care that may include any indicated BLS and ALS interventions following appropriate EMS protocols.

19.2.1.2. Request additional resources from the dispatch communication center as needed.

19.2.1.3. Provide appropriate care while waiting for an ambulance arrival and transfer care to the transport paramedic or EMT.

20. STANDARD OF CARE

20.1. Client Engagement Protocols

20.1.1. Referral Sources

20.1.1.1. Teams receive requests for client engagement from a variety of sources (“referrals”).

20.1.2. 911 System

20.1.2.1. The Department of Emergency Management’s (DEM) Division of Emergency Communications (DEC) may dispatch specific CP teams based on triage criteria.

20.1.3. Radio

20.1.3.1. Referring emergency services personnel may request a team’s support by radio through DEC (“special call”).

20.1.4. Phone

20.1.4.1. In some circumstances, referring parties may contact teams by phone. This referral pathway is not to replace emergent calls for service that should be routed through 911.

20.1.5. Email

20.1.5.1. In some circumstances, parties may refer clients to teams via email. These referrals are exclusively for non-emergent requests.

20.1.6. Self-assign

20.1.6.1. Teams may attach themselves to 911 incidents in progress if believed, based on dispatch notes or radio traffic, that patient or providers on scene may benefit from an additional CP resource.

20.1.7. On-view

20.1.7.1. If teams encounter an individual who may benefit from their services, they will notify DEC via radio and request a new incident be generated and appropriate resources be dispatched. All communications will comply with regulations pertaining to patient confidentiality and privacy.

20.2. CP providers will attempt to respond to requests for service in accordance with response patterns determined by AMPDS and approved by the EMS Agency Medical Director. This requirement pertains to all emergent, urgent, immediate, and/or unscheduled requests for service received by any means.

20.3. Emergency Encounters

20.3.1. The following section outlines emergency encounter guidelines for members of the CP Division. An emergency encounter is defined as an unscheduled interaction when the 911 emergency care system has been activated by an individual or on that individual’s behalf due to a known or suspected medical, mental health or other emergency.

20.3.2. CPs will engage clients during a 911 incident when:

20.3.2.1. Dispatched by the DEC,

20.3.2.2. Special called by a 911 provider,

20.3.2.3. Self-assigned,

20.3.2.4. An on-view incident has occurred, and CP has evaluated the individual to be a patient in accordance with EMSA Policy 4040 – Procedure and Documentation for Non-Transported Patients.

20.3.3. Only an on-duty SFFD-designated CP accredited by EMS Agency, may perform their duties within the CP scope of practice.

20.3.4. If the CP is the first provider on the scene of an emergency encounter, they will perform an assessment in accordance with EMSA Policy 4041 – Scene Management, Physician on Scene and Mass Gatherings.
20.3.5. The CP may assist the transporting unit by providing patient care within their scope of practice.
20.3.6. If the patient receives an assessment not resulting in an ambulance transport (either a Patient Declines Transport - PDT or Against Medical Advice - AMA disposition), the CP may engage the individual and perform an assessment of unmet, non-emergent medical, behavioral, social or substance addiction needs via a biopsychosocial assessment.
20.3.7. CPs will offer referrals to appropriate services.
20.3.8. CPs may arrange for non-emergent transport of the client. Non-emergent transport could include public transportation, taxi or other ride service, other city agency transport, or CP non-emergency transport.
20.3.9. Non-emergent transportation will only be provided once the individual or client disengages from the emergency care system using current EMSA Policy 4040 – Procedure and Documentation for Non-Transported Patients.
20.3.10. If the individual remains in the community, CPs will make a reasonable attempt to ensure their safety under EMSA Policy 4040 – Procedure and Documentation for Non-Transported Patients.
20.3.11. CPs may contact the base hospital and/or senior base physician for consultation by radio, telephone, or telemedicine at any time during the encounter regarding the care of the patient if necessary under EMSA Policy 3020 – Field to Hospital Communications.

20.4. Non-Emergency Encounters
20.4.1. A non-emergency encounter is defined as an encounter in which the 911 emergency care system has not been activated and in which there is no known or suspected medical, mental health or other emergency.
20.4.2. During non-emergency encounters, CPs will engage individuals who have been referred to us. CPs will perform a scene size up and global assessment of the individual (EMSA Policy 1.01 -Patient Assessment – Primary Survey).

20.5. If at any point the individual meets the definition of a patient as defined by EMSA Policy 4040 – Procedure and Documentation for Non-Transported Patients, the engagement will become an emergency encounter (refer to section 18.3 Emergency Encounters).
20.6. CPs will engage the individual and perform an assessment of unmet non-emergent medical, behavioral, social, or substance addiction needs (biopsychosocial assessment).
20.7. If the individual accepts placement at a non-emergency resource, the CP will arrange transportation to the resource destination. Non-emergent transport could include public transportation, taxi, other ride service, other city agency transport, or CP non-emergency transport.
20.8. CPs will explain the referral, care coordination, and wraparound services that are offered.
20.9. If the individual remains in the community, CPs will make a reasonable attempt to ensure their safety.
20.10. CPs will contact the medical direction team by radio, telephone, or telemedicine if consultation regarding the care of the client is needed.

21. CP COMPETENCY STANDARDS

21.1. All CPs shall meet the following requirements to maintain their local EMS Agency approval to function with their advanced CP scope of practice:
21.2. Completion of annual in-service CP policy and skills competency education which, at the minimum, shall meet the above Continuing Education requirements for CP reaccreditation.
21.3. Compliance with Paramedic and CP policy and skills competency standards is required to maintain standing as an active CP. Any variance requires approval of the EMS Agency. Skill list may be expanded at the discretion of the local EMS Agency Medical Director.

22. CP ACCREDITATION

22.1. The process and requirements for local CP Accreditation is located within EMSA Policy 2050 – Paramedic Accreditation.

22.2. A CP paramedic shall only utilize CP skills when accredited by the San Francisco EMS Agency as a CP paramedic within San Francisco City and County and when employed by an EMS Agency-approved CP Provider.
22.3. A CP accreditation is deemed effective when recorded in the Central Registry public look-up database.
22.4. The San Francisco EMS Agency shall review the submitted eligibility criteria for CP Accreditation and notify the applicant in writing within thirty (30) business days from the date of submission that:
22.4.1. The submission is incomplete or illegible and required corrective action or
22.4.2. The accreditation request has been approved and the accreditation data entered in the Central Registry public look-up database.
22.4.3. The accreditation request has been denied; including the reason and notification of the applicant's right to appeal.
22.5. The process for Accreditation action and appeal for a CP Accreditation is the same process as ALS Local Accreditation and as listed in EMSA Policy 2070 – Certificate/License Process for Prehospital Personnel and is consistent with Ca. Health and Safety Code § 1797.194.

23. CP DATA SUBMISSION

23.1. CP Provider shall submit the minimum data requirements on required intervals as listed in 22 CCR § 100185.

24. CP EQUIPMENT REQUIREMENTS

24.1. CP Provider shall ensure all vehicles utilized for CP transports meet or exceed EMSA Policy 4001 – Vehicle Equipment & Supply List and 4001.a – Minimum Equipment Requirements for ALS Foot/Bike.
24.2. CP Provider shall ensure equipment for local optional scope or trials, such as Buprenorphine, is added in addition to ALS Foot/Bike requirements.
24.2.1. CP Provider shall provide a checklist of additional list of equipment carried to meet local optional scope or trials.