COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
(562) 378-1604 FAX (562) 941-5835
http://ems.dhs.lacounty.gov

DATE: **January 20, 2021**
TIME: **1:00 – 3:00 PM**
LOCATION: **Zoom Video Conference Meeting**
Join Zoom Meeting:
https://zoom.us/j/97565380793?pwd=L1dhaUVybnMyK2tiZE95Q29jK3RDdz09
Meeting ID: 975 6538 0793 / Passcode: 991629

One tap mobile
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The Commission meetings are open to the public. You may address the Commission on any agenda item before or during consideration of that item, and on other items of interest which are not on the agenda, but which are within the subject matter jurisdiction of the Commission. Public comment is limited to three (3) minutes and may be extended by Commission Chair as time permits.

NOTE: Please INPUT YOUR NAME if you would like to address the Commission.

AGENDA

I. CALL TO ORDER – John Hisserich, Dr.PH, Chairman
Instructions for Zoom:
1) Please use your computer to join the Zoom meeting to see documents.
2) Join Zoom meeting by computer (preferable) or phone.
3) Input your name when you first join so we know who you are.
4) You can join Zoom by one tap mobile dialing.
5) Join meeting by landline using any of the "dial by location" numbers and manually entering the Meeting ID and following # prompts.
6) Mute and unmute yourself by clicking on the microphone icon at the bottom of computer screen, or *6 by phone.
7) Volume is adjusted by using the little arrow next to the microphone icon.

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

III. NOMINATION COMMITTEE
Nomination of Chair and Vice Chair (Vote Required)
Standing Committee Nominees

IV. CONSENT AGENDA (Commissioners/Public may request that an item be held for discussion. All matters are approved by one motion unless held.)

1. MINUTES
November 18, 2020

2. CORRESPONDENCE
2.1 (11-17-20) Marc Eckstein: Field-Initiated Telemedicine for Alternate Destination Pilot Program Approval
2.2 (11-18-20) From EMS Authority: STEMI Critical Care System Plan Update Approved
2.3 (11-18-20) From EMS Authority: Stroke Critical Care System Plan Update Approved

2.4 (12-15-20) COVID-19 Surge and Delays in Emergency Department Ambulance Patient Offload Times (APOT)
2.5 (12-18-20) Distribution: EMS Transport of Pediatric Patients (17 Yrs. And Younger) to Pediatric Medical Centers (Directive #1)
2.6 (12-22-20) Distribution: Suspension of Service Area Boundaries (Ref. Nos. 509, 509.1 & .1a, 509.2 & .2a, 509.3 & .3a, 509.4 & .41) (COVID-19 Surge Directive #3)
2.7 (12-23-20) Distribution: EMS Offload of ALS and BLS Patients to the Emergency Department Waiting Room (Directive #4)
2.8 (12-23-20) Distribution: Diversion of ALS Patients Due to E.D. Saturation (Directive #5)
2.9 (01-04-21) Distribution: Revised: EMS Transport of Patients in Traumatic and Non-Traumatic Cardiac Arrest (Directive #6)
2.10 (01-04-21) Distribution: EMS Use of Oxygen (Directive #7)
2.11 (01-04-21) Distribution: Revision #3 – 9-1-1 Transportation of Patients with a Polst and Comfort-Focused Care Directive (COVID-19 Surge Directive #2)
2.12 (01-12-21) Distribution: Shoring up for the Surge of COVID-19 Patients

3. COMMITTEE REPORTS
3.1 Base Hospital Advisory Committee
3.2 Data Advisory Committee – Cancelled for December 7, 2020
3.3 Provider Agency Advisory Committee

4. POLICIES
4.1 Reference No. 228: ReddiNet® Utilization
4.2 Reference No. 518: Decompression Emergencies/Patient Destination
4.3 Reference No. 804: Fireline Emergency Medical Technician – Paramedic (FEMP)
4.4 Reference No. 815: Honoring Pre-Hospital Do Not Resuscitate Orders, Physician Orders for Life Sustaining Treatment and End of Life Option (Aid-in-Dying Drug)
4.5 Reference No. 830: EMS Pilot and Scientific Studies

END OF CONSENT AGENDA

V. BUSINESS

BUSINESS (OLD)
5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies
5.1.1 Ad Hoc Workgroup on the Pre-Hospital Care of Mental Health and Substance Abuse Emergencies – Recommendation Eight
5.2 Ambulance Patient Offload Time (APOT)
5.3 EMS Personnel Administering Vaccinations
5.4 LA County COVID-19 Modeling – EMS Agency Data

BUSINESS (NEW)
5.5 EMS Agency Directives
5.6 Letter from Jonathan E. Sherin, MD, PhD: Transportation and Destination of Individuals on Behavioral Health Holds
5.7 Downgrade of Services Notification – Olympia Medical Center

VI. COMMISSIONERS' COMMENTS / REQUESTS

VII. LEGISLATION

VIII. EMS DIRECTOR'S REPORT (Handouts)
APOD Handout
Criminal History Impact on EMT Certification

IX. ADJOURNMENT
To the meeting of March 17, 2021

EMERGENCY MEDICAL SERVICES COMMISSION
STANDING COMMITTEE NOMINEES
2021

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

COMMITTEE	2019	2020	2021
Provider Agency Advisory Committee ***PAAC***	*Chair:* ***Paul Rodriguez*** *Vice Chair:* ***Dave White*** *Commissioners:* *Brian Bixler* *Gene Harris* *Staff:* ***Gary Watson***	*Chair:* ***Paul Rodriguez*** *Vice Chair:* ***Dave White*** *Commissioners:* *Brian Bixler* *Gene Harris* *Staff:* ***Gary Watson***	*Chair:* ***Robert Ower, RN*** *Vice Chair:* ***Kenneth Powell*** *Commissioners:* *Gene Harris* *Paul Rodriguez* *Brian Bixler* *John Hisserich* *Staff:* ***Gary Watson***
Base Hospital Advisory Committee ***BHAC***	*Chair:* ***Robert Ower, RN*** *Vice Chair:* ***Erick Cheung, MD*** *Commissioners:* *Atilla Uner, MD, MPH* *Margaret Peterson, PhD* *Staff:* ***Lorrie Perez***	*Chair:* ***Robert Ower, RN*** *Vice Chair:* ***Carole Snyder, RN*** *Commissioners:* *Joe Salas* *Staff:* ***Lorrie Perez***	*Chair:* ***Carol Meyer*** *Vice Chair:* ***Carole Snyder, RN*** *Commissioners:* *Atilla Uner, MD, MPH* *Lydia Lam, MD* *Diego Caivano, MD* *Erick Cheung, MD* *Garry Olney* *Staff:* ***Lorrie Perez***
Data Advisory Committee ***DAC***	*Chair:* ***Nerses Sanossian, MD*** *Vice Chair:* ***Pajmon Zarrineghbal*** *Commissioners:* *Lydia Lam, MD* *James Lott, PsyD* *Colin Tudor* *Staff:* ***Sara Rasnake***	*Chair:* ***Nerses Sanossian, MD*** *Vice Chair:* ***Pajmon Zarrineghbal*** *Commissioners:* *Lydia Lam, MD* *James Lott, PsyD* *Staff:* ***Sara Rasnake***	*Chair:* ***Jeffrey Rollman*** *Vice Chair:* ***Joe Salas*** *Commissioners:* *Nerses Sanossian, MD* *James Lott, PsyD* *Gloria Molleda* *Gary Washburn* *Staff:* ***Sara Rasnake***
Education Advisory Committee EAC	*Chair:* ***Carole Snyder, RN*** *Vice Chair:* ***Marc Eckstein, MD*** *Commissioners:* *Ellen Alkon, MD* *Gary Washburn* *Staff:* ***David Wells***	***Education Advisory Committee (EAC) Dissolved September 18, 2019***	***Education Advisory Committee (EAC) Dissolved September 18, 2019***

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
(562) 378-1604 FAX (562) 941-5835
http://ems.dhs.lacounty.gov/

MINUTES
NOVEMBER 18, 2020
Zoom Meeting

☒ Lt. Brian S. Bixler	Peace Officers' Assn. of LAC	Cathy Chidester	Executive Director
☒ Diego Caivano, M.D.	L.A. County Medical Assn.	Denise Watson	Commission Liaison
☒ Erick H. Cheung, M.D.	So. CA Psychiatric Society	Marianne Gausche-Hill	EMS Medical Director
☐ *Chief Eugene Harris	LAC Police Chiefs' Assn.	Nichole Bosson	Asst. Medical Director
☒ John Hisserich, Dr.PH	Public Member, 3rd District	Roel Amara	Assistant Director
☐ *Lydia Lam, M.D.	So. CA Chapter American College of Surgeons	Richard Tadeo	Assistant Director
☒ James Lott, PsyD, MBA	Public Member, 2nd District	Kay Fruhwirth	Nursing Director
☒ Carol Meyer, RN	Public Member, 4th District	John Telmos	EMS Staff
☒ Gloria Molleda	League of CA Cities/LA County	Michelle Williams	EMS Staff
☒ Robert Ower	LAC Ambulance Association	Sara Rasnake	EMS Staff
☒ Margaret Peterson, PhD	Hospital Assn. of So. CA	Denise Whitfield	EMS Staff
☒ Kenneth Powell	LA Area Fire Chiefs' Assn.	Christine Clare	EMS Staff
☒ Paul S. Rodriguez	CA State Firefighters' Assn.	Natalie Greco	EMS Staff
☒ Jeffrey Rollman	So. CA Public Health Assn.	Millicent Wilson	EMS Staff
☒ Joseph Salas	Public Member, 1st District	Terry Crammer	EMS Staff
☒ Nerses Sanossian, M.D.	American Heart Association	Christine Zaiser	EMS Staff
☒ Carole A, Snyder, RN	Emergency Nurses Assn.	Gary Watson	EMS Staff
☒ Atilla Uner, M.D., MPH	American College of Emergency Physicians CAL-ACEP	Lorrie Perez	EMS Staff
		Jennifer Calderon	EMS Staff
☒ Gary Washburn	Public Member, 5th District	Cathlyn Jennings	EMS Staff
		David Wels	EMS Staff
		Jacqueline Rifenburg	EMS Staff
		Adrian Romero	EMS Staff

GUESTS

Clayton Kazan, MD	LA County Fire Department	Jennifer Nulty	Torrance Fire Dept.
Jaime Garcia	Hospital Assn. Southern Cal.	Ken Liebman	AMR
Shelly Trites	Torrance Memorial	Andy Reno	
Puneet Gupta, MD	Harbor-UCLA MC	Matt Armstrong	Jordon A.
Samantha Verga-Gates	Long Beach Memorial	Brit Alton	Robert Aragon

(Ab) = Absent; (*) = Excused Absence

I. CALL TO ORDER

The Emergency Medical Services Commission (EMSC) meeting was held via Zoom Video Communications Conference Call due to the California Statewide Safer at Home Order related to the Coronavirus (COVID-19) pandemic. The meeting was called to order at 1:00 p.m. by Chairman John Hisserich. A quorum was present with 17 Commissioners on the call.

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

Executive Director Cathy Chidester did roll-call of the Commissioners, acknowledged members of the public and EMS Agency staff. General Instructions to mute/unmute and to make public comments using Zoom were provided to participants. Commissioners were asked to state their names when making a motion/second.

III. CONSENT AGENDA

Chairman Hisserich called for approval of the Consent Agenda and opened the floor for discussion.

Motion/Second by Commissioners Lott/Salas to approve the Consent Agenda was approved and carried unanimously.

1. MINUTES

September 16, 2020 Minutes were approved.

2. CORRESPONDENCE

2.1 (09-14-20) Lisa Galindo: EMS System Plan Update (FY 2018-9)
2.2 (09-16-20) From Medical Directors: APOT Letter of Support
2.3 (09-17-20) Distribution: 9-1-1 Trauma Re-Triage
2.4 (10-13-20) David Frankle, M.D.: Letter of Thanks PRAC Service
2.5 (10-21-20) Phil Davis, Chief Executive Officer: King LTS(D) Airway Program Approval for Specialty Care Transport
2.6 (10-21-20) David Eisner, MD: Paramedic Vaccination Program Approval
2.7 (10-22-20) Distribution: Withdrawal from Perinatal Destination and Closure of Neonatal Intensive Care Unit (NICU)
2.8 (10-28-20) Marc Cohen, MD, Medical Director, El Segundo Fire: Paramedic Vaccination Program Approval
2.9 (10-28-20) Marc Cohen, MD, Medical Director, Torrance Fire: Paramedic Vaccination Program Approval
2.10 (10-28-20) Marc Cohen, MD, Medical Director, Manhattan Beach Fire: Paramedic Vaccination Program Approval
2.11 (11-03-20) Ruben Balayan: King LTS(D) Airway Program Approval for Specialty Care Transport

3. COMMITTEE REPORTS

3.1 Base Hospital Advisory Committee
3.2 Data Advisory Committee – Cancelled for October 14, 2020
3.3 Provider Agency Advisory Committee

4. POLICIES

4.1 Reference No. 1013: EMS Continuing Education (CE) Provider Approval and Program Requirements

END OF CONSENT AGENDA

IV. BUSINESS

BUSINESS (OLD)

5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies
5.1.1 Ad Hoc Workgroup on the Pre-Hospital Care of Mental Health and Substance Abuse Emergencies – Recommendation Eight

Discussion
Commissioner Erick Cheung gave an update on the ad hoc workgroup meetings from the September 16, 2020 EMSC Motion to create or reconvene a workgroup to review EMS policies and procedures regarding the management of agitation, and to make any recommendations for change or improvement to aid with reduction in use of force or restraints that enhance patient and provider safety.

The ad hoc workgroup met twice and the tasks were categorized into three areas and subgroups to address the following:

1. Current review of policies and discussion to make updates prudent for policies and procedures and medical control guidelines or pretreatment protocols pertinent to field management of agitation. This includes mental health restraints policy, psychiatric and behavioral health management policy, and excited delirium policy;
2. Appropriate expansion of medication treatment which is pharmacologic treatment of agitation, including a review of current medication midazolam, with the opportunity to investigate other agents such as olanzapine; and
3. Review Long Beach Police and Fire Departments' current 9-1-1 dispatch processes and develop dispatch protocols that allow for a co-response team of EMS and law enforcement for field emergencies.

5.2 Ambulance Patient Offload Time (APOT)

Discussion
Richard Tadeo, EMS Assistant Director, reported on the October 15, 2020 APOT workgroup meeting, and addressed follow-up items from the previous EMSC meeting:

1. Nevada legislation has no monetary repercussions for offload time;
2. EMS Agency has no specific authority to impose bills and fines for offload time. County Counsel has advised that the EMS Agency contract with 9-1-1 receiving hospitals and build in a mechanism to bill for the providers for excessive offload times;
3. LA County Ordinance Title 7 allows for wait time billing only when the patient is being picked-up from a hospital, but not when delivering patient to the hospital; and
4. Billing for ambulances in emergency department. There is no specific carved out billing for offload times.

Action
1. EMS Agency will start requesting Corrective Action Plans for hospitals with excessive Ambulance Patient Offload Delays (APOD) with patient surge considerations;
2. 9-1-1 Receiving Hospital Designation Agreement will include APOD mitigation strategies, diversion of specialty care center patients when APOD threshold is exceeded, and mechanism for billing the hospital for the ambulance crew's time waiting to offload patients;
3. Diversion Policy review/revisions;
4. Develop an APOT/APOD policy utilizing Riverside County's current policy as a reference; and
5. Identify system issues, and Identify hospital issues.

The October 15, 2020 APOT Committee minutes will be distributed to commissioners. Next APOT meeting is December 7, 2020.

Commissioner Jim Lott noted that some APOT issues are EMTALA violations, and the EMSC may want to look at that.

Ken Liebman, Regional Director with American Medical Response (AMR), gave a presentation on APOD that he also presented to the Hospital Association of Southern California (HASC) hospital CEO members.

Mr. Liebman reported that the State of California's standard for APOD is 20 minutes 90% of the time, and is the threshold to measure data. This sometimes is extended to 30 minutes to build in for margin of error. He discussed the impact of offload delays to the community, patient, staff and ambulance company, and provided substantial factors that contribute to APOD.

Further clarification on APOD is that ambulances have electronic patient care record (ePCR) devices, and when the patient gets a bed they report that and that is where these times come from.

Jaime Garcia, Regional Vice-Present of HASC, commented that this presentation raises issues on what impacts a hospital's APOD, which are sometimes beyond the control of the hospital, such as mental health patients and 5150 holds and amount of time these patients spend in the emergency department. A recent survey by HASC found that on average, over a 24-hour period, hospitals are holding 5150s between four-to-five hours. While not receiving medical care, they do require supervision and do occupy an emergency department bed. HASC is working with the EMS Agency and other stakeholders on this issue. HASC will continue to address systems issues.

5.3 Criteria for 9-1-1 Receiving Center Designation (Tabled)

5.4 Patient Refusal of Treatment/Transport (Reference No. 834 – Sub Committee Report)

Discussion
Dr. Gausche-Hill reported that the Reference No. 834 committee has one more meeting scheduled, and that there is some agreement on what type of patient could be assessed and referred. The key is to improve safety and add additional quality controls, to ensure documentation is there to understand who is a public assist, a lift assist, is a medical condition now resolved or a patient who chooses not to go to emergency department. There is concern about paramedics feeling comfortable releasing patients at the scene which will require education.

Action
The next steps include sending the draft policy to the Provider Agencies and Base Hospital Advisory committees in December 2020.

5.5 EMS Personnel Administering Vaccinations

Discussion
Dr. Gausche-Hill reported that she sent letters to fire departments for expansion of Local Optional Scope for vaccinations, and have five fire departments, to date, requesting to expand their scope of practice to give COVID-19 vaccine to their workforce.

Dr. Gausche-Hill noted that all hospitals receiving the vaccine will have to agree to give it to their own workforce and the public based on the four-phase vaccination plan developed by the Advisory Committee on Immunization Practices. Healthcare workers, which includes EMS personnel and residents of Skilled Nursing Facilities are in the first tier of the first phase to receive the first doses of COVID-19 vaccine.

Los Angeles County has approximately 12,000 EMTs and paramedics. MICNs are about 900 somewhere in that range. The EMS Agency will be working with the EMS Providers both public and private to ensure they all have access to COVID-19 vaccine.

Action
The EMS Agency will be working with the EMS Providers, both public and private, to ensure they all have access to COVID-19 vaccine.

The EMS Agency will work with law enforcement in the planning to include them for the vaccine when this sector is eligible to receive vaccine.

5.6 LA County COVID-19 Modeling – EMS Agency Data

Discussion
Dr. Gausche-Hill reported on the latest COVID-19 modeling report. The modeling team uses the data that hospitals report to the EMS Agency daily.

Dr. Gausche-Hill shared hospital data graphs showing patients admitted to non-ICUs, noting an uptick in cases. There is also a bit of an uptick in the numbers admitted to ICU beds. There has never been an issue with ventilators. Some hospitals in the beginning required additional ventilators, but no problems since. Antelope Valley, San Gabriel, and East Region are impacted a little more than South and West, as was released today.

Dr. Gausche-Hill noted on November 10, 2020, the FDA approved an Emergency Use Authorization (EUA) for a monoclonal antibody, Bamlanivimab. This is for treating outpatients. Bamlanivimab is an antibody that helps clear the virus. It turns out it does. It binds to the receptor biding domain for the spike protein and that's how the virus enters the cell. In the initial BLAZE-1 trial, found it decreased hospitalizations by 5% to 10%, but must be given within first 10 days of illness. EUA approved for children 12 year of age or older, 40 kg. Not authorized for adults or children who are hospitalized?

A letter from Dr. Gausche-Hill to hospitals, regarding the distribution of Bamlanivimab, is included in the EMS Commission packet. The amount of drug allocated to each hospital is based on COVID-19 burden.

BUSINESS (NEW)

5.7 EMS Commission Annual Report FY 2019-20 – Vote Required to Approve and Move onto the Board of Supervisors

Motion/Second by Commissioners Ower/Bixler to approve the EMS Commission Annual Report FY 2019-20 was approved and carried unanimously with minor correction noted.

5.8 Nominating Committee – Vote Required

The Nominating Committee for Chair and Vice-Chair recommendations for EMS Commission 2021 is Commissioner Carole Snyder, Commissioner Carol Meyer and Commissioner Robert Ower. The Committee will meet prior to the January 20, 2021, EMS Commission meeting and present their recommendations.

Motion/Second by Commissioners Peterson/Uner to approve the EMS Commission Nominating Committee was approved and carried unanimously.

V. COMMISSIONERS' COMMENTS / REQUESTS

Commissioner Margaret Peterson expressed appreciation and support to the EMS Commission and to HASC, and reported this will be her last EMS Commission meeting as she now works in Orange County. The HASC replacement is Garry Olney.

Commissioner Brian Bixler reported that the suicide diversion funding is now available, and thanked the Commission for supporting this effort. The 9-1-1 calls into LAPD will be given immediately to Didi Hirsch Suicide Hotline rather than going directly to LAPD.

VI. LEGISLATION

No legislative report.

VII. EMS DIRECTOR'S REPORT

Ms. Chidester expressed hand claps for the implementation of the suicide hotline program with LAPD, and thanked Dr. Peterson for her work on the EMS Commission.

VIII. ADJOURNMENT:

Adjournment by Chairman Hisserich at 3:00 pm to the meeting of January 20, 2021.

Next Meeting: Wednesday, January 20, 2021, 1:00-3:00pm
Join by Zoom Videoconferencing

Join Zoom Meeting
https://zoom.us/j/97565380793?pwd=L1dhaUVybnMyK2tiZE95Q29jK3RDdz09
Meeting ID: 975 6538 0793
Passcode: 991629

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Recorded by:
Denise Watson
Secretary, Health Services Commission

Lobbyist Registration: Any person or entity who seeks support or endorsement from the EMS Commission on official action must certify that they are familiar with the requirements of Ordinance No. 93-0031. Persons not in compliance with the requirements of the Ordinance shall be denied the right to address the Commission for such period of time as the non-compliance exists.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 378-1500
Fax: (562) 941-5835

November 17, 2020

Marc Eckstein, MD, Medical Director
Los Angeles Fire Department
200 N. Main Street
Los Angeles, California 90012

CERTIFIED

Dear Dr. Eckstein:

FIELD-INITIATED TELEMEDICINE for ALTERNATE DESTINATION PILOT PROGRAM APPROVAL

This letter is to confirm that Los Angeles Fire Department (Ci) has been approved by the Emergency Medical Services (EMS) Agency for the Field-Initiated Telemedicine Alternate Destination pilot for 12 months at which time the pilot will be re-evaluated for efficacy and feasibility.

The quality improvement plan for implementation of the pilot requires CI to submit quarterly reports to the EMS Agency containing at minimum, the following items:

- Number of telemedicine provider (TMP) contacts and Provider Impressions
- Number of TMP contacts transported to mental health urgent care and sobering center
- Number of TMP contacts transported to the emergency department (ED) via CI ambulance and taxi or rideshare
- Number of TMP contacts declined transport to the alternate destination
- Number of TMP contacts with treat and refer in place
- Number of TMP contacts refusing care against medical advice (AMA)
- Outcome data for patients not transported to the ED, to include the following:
  - Treat and refer in place, no transport and AMA
  - Transport to a mental health urgent care or sobering center
- Number of rekindles requiring ALS intervention and/or hospitalization; if this exceeds 5% at any time report to the EMS Agency within 72 hours
- Appropriate statistical evaluation

In addition to the above requirements, please report all sentinel events within 24 hours of occurrence.

The quarterly reports are due thirty (30) days after the end of each quarter and should be addressed to me at MGausche-Hill@dhs.lacounty.gov (cc Susan Mori at sumori@dhs.lacounty.gov).

Sincerely,

Marianne Gausche-Hill

Marianne Gausche-Hill, M.D.
Medical Director

MGH:JT:sm
10-25

c. Director, EMS Agency
Fire Chief, Los Angeles Fire Department
EMS Director, Los Angeles Fire Department

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY
GAVIN NEWSOM, *Governor*

EMERGENCY MEDICAL SERVICES AUTHORITY
10901 GOLD CENTER DR., SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

November 18, 2020

Cathy Chidester, RN, MSN, Administrator
Los Angeles County EMS Agency
10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670

Dear Cathy,

The EMS Authority (EMSA) has approved the Los Angeles County EMS Agency's STEMI Critical Care System Plan update. The information provided in the plan update is in compliance with the California Code of Regulations, Title 22, Chapter 7.1 STEMI Critical Care Systems.

In accordance with Section 100270.122 of the STEMI Regulations, the next annual plan update of your STEMI Critical Care System will be consistent and part of your annual EMS plan submission, which shall include, at a minimum, all the following:

(1) Any changes in a STEMI critical care system since submission of the prior annual plan update or a STEMI Critical Care System Plan addendum.
(2) The status of a STEMI critical care system goals and objectives.
(3) The STEMI critical care system quality improvement activities.
(4) The progress on addressing action items and recommendations provided by the EMS Authority within the STEMI Critical Care System Plan or status report approval letter if applicable.

Please contact Farid Nasr, M.D. at (916) 431-3685 or farid.nasr@emsa.ca.gov for any questions and technical assistant.

Sincerely,

Tom McGinnis, EMT-P
Chief, EMS Systems Division

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY
GAVIN NEWSOM, *Governor*

EMERGENCY MEDICAL SERVICES AUTHORITY
10901 GOLD CENTER DR., SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

November 18, 2020

Cathy Chidester, RN, MSN, Administrator
Los Angeles County EMS Agency
10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670

Dear Cathy,

The EMS Authority (EMSA) has approved the Los Angeles County EMS Agency's Stroke Critical Care System Plan update. The information provided in the plan update is in compliance with the California Code of Regulations, Title 22, Chapter 7.2 Stroke Critical Care Systems.

In accordance with the Stroke regulations Section 100270.221, the next annual plan update of your Stroke Critical Care System will be consistent and part of your annual EMS plan submission, which shall include, at a minimum, all the following:

(1) Any changes in a stroke critical care system since submission of the prior annual plan update or the Stroke Critical Care System Plan addendum.
(2) The status of the Stroke Critical Care System Plan goals and objectives.
(3) Stroke critical care system performance improvement activities.
(4) The progress on addressing action items and recommendations provided by the EMS Authority within the Stroke Critical Care System Plan or status report approval letter, if applicable.

Please contact Farid Nasr, M.D. at (916) 431-3685 or farid.nasr@emsa.ca.gov for any questions.

Sincerely,

Tom McGinnis, EMT-P
Chief, EMS Systems Division

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Holly J. Mitchell
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 378-1500
Fax: (562) 941-5835

To advance the health of our communities by ensuring quality emergency and disaster medical services."

Health Services
http://ems.dhs.lacounty.gov

December 15, 2020

TO: CEO, 9-1-1 Receiving Hospital **VIA E-MAIL**

FROM: Cathy Chidester
Director, EMS Agency

SUBJECT: **COVID-19 SURGE AND DELAYS IN EMERGENCY DEPARTMENT AMBULANCE PATIENT OFFLOAD TIMES (APOT)**

In light of the current surge of COVID related illness, the Emergency Medical Services (EMS) system is severely compromised by prolonged ambulance patient offload times (APOT) in many of our 9-1-1 Receiving Hospitals. This has placed the 9-1-1 EMS response system in jeopardy as emergency ambulance resources are kept at emergency department hallways and ambulance parking ramps waiting to transfer care to hospital personnel (upwards from 2 to 8 hours). This is compromising the ability to send EMS resources to the next 9-1-1 call from the community in a timely manner.

We recognize that hospitals have started to implement their surge plans and are equally challenged in obtaining resources to meet the healthcare demands during this current surge of COVID patients but the current practice of utilizing EMS personnel to provide monitoring and patient care in emergency department hallways and parking lots have placed the communities your hospitals serve at risk for not having adequate and timely 9-1-1 emergency medical services.

Please implement the following actions immediately to assist with the delayed ambulance patient offload times:

- For Basic Life Support (BLS) patients who are stable and are not at risk for fall, ambulatory or able to ambulate with assistance - direct the EMS crew to your ED triage area for transfer of care and or waiting room.
- Ensure your facility has the general staffing waiver from CDPH – acquire additional gurneys for the emergency department (i.e., relocate from other areas within the facility – PACU, same day surgery, etc.)
- Hire EMTs or CNAs to monitor patients that are currently waiting for ED beds – this will release EMS responders back to the community to respond to the next 9-1-1 call. If you are interested in hiring EMTs, please contact Jacqueline Rifenburg at jrifenburg@dhs.lacounty.gov.

All hospitals should be implementing their surge plans which include the utilization of tents and other alternative care sites to triage and off load patients.

If your ED is severely impacted, ED Diversion should be requested via ReddiNet®. However, if every hospital in the immediate area is on diversion, all hospitals in the area are expected to continue to accept ALS patients regardless of the diversion request. The EMS Agency is also working with individual hospitals to assist with redirecting 9-1-1 patients to hospitals with greater capacity as appropriate.

The EMS Agency/Medical Alert Center has begun assisting hospitals to coordinate interfacility transfers as necessary. Please ensure that your facility has the information regarding the procedure.

We will continue to work with you to ensure safe patient care and access during this historically difficult period. Thank you for your attention to this matter and your support of the EMS system. If you have any questions or concerns, feel free to contact me at (562) 378-1604.

CC:cac
12-15

Distribution: Medical Director, EMS Agency
Jaime Garcia, Hospital Association Southern California
ED Director, 9-1-1 Receiving Hospitals
ED Medical Director, 9-1-1 Receiving Hospitals
HASC

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 378-1500
Fax: (562) 941-5835

"To advance the health of our communities by ensuring quality emergency and disaster medical services."

December 18, 2020

TO: Distribution **VIA E-MAIL**

FROM: Cathy Chidester, MSN
Director, EMS Agency

SUBJECT: ***REVISED -*** **EMS TRANSPORT OF PEDIATRIC PATIENTS (17 YRS. AND YOUNGER) TO PEDIATRIC MEDICAL CENTERS**

As a continued effort to assist with the current overcrowding of emergency departments in Los Angeles County, the EMS Agency is providing the following temporary revision to the pediatric patient destination policy.

Effective immediately (until further notice), patients who are 17 years old and younger, regardless of provider impression, shall be transported to the following Pediatric Medical Centers (PMC) if transport time from the incident location to the PMC is within 30 minutes:

- Children's Hospital Los Angeles
- Children's Hospital of Orange County
- Cedars-Sinai Medical Center
- Dignity Health – Northridge Hospital Medical Center
- LAC Harbor/UCLA Medical Center
- LAC+USC Medical Center
- MemorialCare Long Beach Medical Center / Miller Children's Hospital
- Providence Cedars-Sinai Tarzana Medical Center
- Ronald Reagan UCLA Medical Center
- Valley Presbyterian Hospital

Patients who meet Trauma Center Criteria and/or Guidelines (Ref. 506) shall continue to be transported to the closest Trauma Center. Patients who meet PMC Guidelines (Ref. 510) shall continue to be transported to the closest PMC. If transport time is greater than 30 minutes, pediatric patients who do not meet PMC Guidelines shall be transported to the most accessible Emergency Department Approved for Pediatrics (EDAP).

Thank you for your attention to this matter and your support of the EMS system. If you have any questions or concerns, feel free to contact me at (562) 378-1604 or Richard Tadeo, Assistant Director at (562) 378-1610.

CC:rt

Distribution: Medical Director, EMS Agency
Fire Chief, Each Public EMS Provider Agency
CEO, Ambulance Companies
Medical Director, Each EMS Provider Agency
Paramedic Coordinator, Each EMS Provider Agency
Jaime Garcia, Hospital Association Southern California
CEO, Pediatric Medical Centers

December 22, 2020

Directive #3

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 378-1500
Fax: (562) 941-5835

"To advance the health of our communities by ensuring quality emergency and disaster medical services."

TO: Distribution **VIA E-MAIL**

FROM: Cathy Chidester, MSN
Director, EMS Agency

SUBJECT: **SUSPENSION OF SERVICE AREA BOUNDARIES**
Ref. Nos. 509, 509.1 & .1a, 509.2 & .2a, 509.3 & .3a, 509.4 & .4a
COVID SURGE DIRECTIVE #3

Effective immediately, the Emergency Medical Services (EMS) Agency is suspending all Service Area boundaries as a continued effort to assist with the current overcrowding of emergency departments in Los Angeles County. This revision will be effective until January 31, 2021.

This patient destination change will affect the following defined service areas:

- Shared Service Area for Dignity Health California Hospital Medical Center and PIH Health Good Samaritan Hospital
- Adventist Health White Memorial Medical Center
- Centinela Hospital Medical Center

Patient destination within these service area boundaries will be based on Ref. No. 502, Patient Destination. Diversion of patients requiring advanced life support (ALS) level of care shall continue to comply with Ref. No, 503, Guidelines for Hospital Requesting Diversion of ALS patients. Hospitals within these service area boundaries may request diversion of ALS patients utilizing the ReddiNet system.

In severe ED overcrowding and extensive ambulance patient offload times, consideration will be given on a case-by-case basis by the EMS Agency Administrator on Duty (AOD), to allow diversion of patients who only require a basic life support (BLS) level of care. This level of diversion may be requested by the hospital or the EMS provider by contacting the Medical Alert Center at (866) 940-4401.

Thank you for your attention to this matter and your support of the EMS system. If you have any questions or concerns, feel free to contact me at (562) 378-1604 or Richard Tadeo, Assistant Director at (562) 378-1610.

CC:rt

Distribution:
Medical Director, EMS Agency
Medical Alert Center
Fire Chief, Each Public EMS Provider Agency
CEO, Ambulance Companies
Medical Director, Each EMS Provider Agency
Paramedic Coordinator, Each EMS Provider Agency
Hospital Association Southern California
Prehospital Care Coordinators, Each Paramedic Base Hospital
CEO & ED Director, Adventist Health White Memorial Medical Center
CEO & ED Director, Centinela Hospital Medical Center
CEO & ED Director, Community Hospital of Huntington Park
CEO & ED Director, Dignity Health California Hospital Medical Center
CEO & ED Director, East Los Angeles Doctor's Hospital
CEO & ED Director, PIH Health Good Samaritan Hospital

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

December 23, 2020

Directive #4

10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 378-1500
Fax: (562) 941-5835

"To advance the health of our communities by ensuring quality emergency and disaster medical services."

TO: Distribution **VIA E-MAIL**

FROM: Cathy Chidester, MSN
Director, EMS Agency

SUBJECT: **EMS OFFLOAD OF ALS AND BLS PATIENTS TO THE EMERGENCY DEPARTMENT WAITING ROOM (DIRECTIVE #4)**

Effective immediately, in an effort to reduce ambulance patient offload times (APOT), EMS providers will offload their patients to the waiting room with notification of the triage nurse for patients meeting **ALL** the following criteria:

1. APOT estimate is ≥30 minutes
2. Age ≥18 years; or pediatric patients if accompanied by an adult
3. Normal mental status (GCS 15)
4. Normal vital signs per MCG 1380 for adults:
   - SBP ≥90mmHg
   - HR 60-100
   - RR 12-20
   - O_2 ≥94% on room air
   - Or per MCG 1309 for pediatric patients
5. Ambulatory with steady gait without assistance (as appropriate for age)
6. Not suicidal or not on psychiatric hold (5150)
7. No chest pain, syncope or acute neurologic symptoms (e.g., focal weakness, dizziness/vertigo)

EMS will initially present to ambulance triage. If the APOT estimate is ≥30 minutes, and the patient meets all criteria as above, EMS personnel will transport the patient to the waiting room for offload. EMS personnel shall notify the triage nurse of the patient's arrival and provide a transfer of care report.

Emergency Departments should inform triage staff of this new procedure so that they are prepared to receive ambulance patients.

EMS should document in the electronic patient care record: 1) the criteria met, 2) the time of transfer, and 3) the name of the person to whom notification was provided. If a detailed report is declined, this should be documented as well. The nurses' signature may be obtained when possible, but is not required for patient offload.

Thank you once again for your support of the EMS system in these challenging times. If you have any questions or concerns, feel free to contact me at (562) 378-1604.

CC:nb
12-18

Distribution: Medical Director, EMS Agency
Fire Chief, Each Public EMS Provider Agency
CEO, Ambulance Companies
Medical Director, Each EMS Provider Agency
Paramedic Coordinator, Each EMS Provider Agency
Hospital Association Southern California
CEO, Each 9-1-1 Receiving Hospital
ED Medical Directors, Each 9-1-1 Receiving Hospital
ED Director, Each 9-1-1 Receiving Hospital
Prehospital Care Coordinator, Each Base Hospital
Prehospital Base Physician, Each Base Hospital

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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Health Services
http://ems.dhs.lacounty.gov

December 23, 2020

TO: Distribution **VIA E-MAIL**

FROM: Cathy Chidester, MSN
Director, EMS Agency

SUBJECT: **DIVERSION OF ALS PATIENTS DUE TO ED SATURATION (DIRECTIVE #5)**

Effective immediately, Ref. No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients (Attached) is revised to allow a longer period of diversion due to ED Saturation. The current 1 hour period of diversion has been extended to 2 hours. At the end of the two-hour diversion, ReddiNet will automatically re-open the facility to all 9-1-1 traffic. The hospital may request additional ED diversion time in two-hour increments.

If you have any questions, please contact Richard Tadeo, Assistant Director at (562) 378-1610.

CC:rt

Attachment: Ref. No. 503

Distribution: Medical Director, EMS Agency
CEO, Each 9-1-1 Receiving Hospitals
ED Medical Directors, Each 9-1-1 Receiving Hospital
Prehospital Care Coordinator, Each Base Hospital
Base Hospital Medical Director, Each Base Hospital
Fire Chief, Each Public EMS Provider Agency
CEO, Ambulance Companies
Medical Director, Each EMS Provider Agency
Paramedic Coordinator, Each EMS Provider Agency
Hospital Association Southern California

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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Fax: (562) 941-5835

"To advance the health of our communities by ensuring quality emergency and disaster medical services."

Directive #6

January 4, 2021

TO: Distribution **VIA E-MAIL**

FROM: Marianne Gausche-Hill, MD
Medical Director, EMS Agency

SUBJECT: **REVISED: EMS TRANSPORT OF PATIENTS IN TRAUMATIC AND NONTRAUMATIC CARDIAC ARREST (DIRECTIVE #6)**

Effective immediately, due to the severe impact of the COVID-19 pandemic on EMS and 9-1-1 Receiving Hospitals, **adult** patients in blunt traumatic and nontraumatic out-of-hospital cardiac arrest (OHCA) **shall not be transported if return of spontaneous circulation (ROSC) is not achieved in the field**. Please see below for specific guidance according to the mechanism of the arrest. Note that this directive supersedes Reference 814, Determination/Pronouncement of Death in the Field.

Nontraumatic OHCA:
For patients who do not meet Ref 814 criteria for immediate determination of death, EMS shall continue to initiate resuscitation and manage OHCA per TP 1210, Cardiac Arrest-Non-Traumatic. Resuscitation shall be continued for a minimum of 20 minutes or until futility is reached. For patients who do not meet Termination of Resuscitation (TOR) criteria Ref II.A., paramedics will continue to consult with the Base Physician regarding the duration of the resuscitation prior to pronouncement. Patients who do not achieve field ROSC and maintain spontaneous perfusion after initiation of post-ROSC care (minimum 5 minutes), shall not be transported. For patients in persistent ventricular fibrillation, the ECMO pilot has been suspended, so resuscitate as per TP 1210, Cardiac Arrest – Non-Traumatic.

Blunt and Penetrating Traumatic Full Arrest:
Patients in traumatic full arrest who meet current Ref 814 criteria for determination of death shall not be resuscitated and shall be determined dead on scene and not transported.

Patients who do not meet Ref 814 criteria should receive on scene resuscitation and interventions to address any potential immediately reversible causes, i.e., bilateral needle thoracostomies, tourniquet placement, fluid resuscitation and defibrillation of shockable rhythm, per TP 1243 Traumatic Arrest.

For penetrating torso trauma only, paramedics will contact the Trauma Center while initiating resuscitation to determine if immediate transport is advised. All other patients who do not achieve ROSC within 10 minutes of on scene interventions should be determined dead on scene and not transported.

Patients for whom there are scene safety issues may be transported.

EMS should continue to transport patients who arrest en route to the receiving facility. For patients who are transported, usual destination policies apply.

If you have any questions or concerns, feel free to contact me at (562) 378-1600 or MGausche-Hill@dhs.lacounty.gov.

Distribution:

Fire Chief, Each Public EMS Provider Agency
CEO, Ambulance Companies
Medical Director, Each EMS Provider Agency
Paramedic Coordinator, Each EMS Provider Agency
Hospital Association Southern California
CEO, Each 9-1-1 Receiving Hospitals
ED Medical Directors, Each 9-1-1 Receiving Hospitals
Prehospital Care Coordinator, Each Base Hospital
Prehospital Base Physician, Each Base Hospital

EMERGENCY MEDICAL SERVICES AGENCY
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"To advance the health of our communities by ensuring quality emergency and disaster medical services."

January 4, 2021

TO: Distribution **VIA E-MAIL**

FROM: Marianne Gausche-Hill, MD
Medical Director, EMS Agency

SUBJECT: **EMS USE OF OXYGEN (DIRECTIVE #7)**

Given the acute need to conserve oxygen, **effective immediately**, EMS should only administer supplemental oxygen to patients with oxygen saturation below 90%. For patients with hypoxia (O_2 saturation <90%), the minimum amount of oxygen necessary to maintain the oxygen saturation at or just above 90% shall be administered. An oxygen saturation of 90% is sufficient to maintain normal tissue perfusion in most patients.

Considerations for exceptions:

- Oxygen for the purposes of medication administration and CPAP may be used when needed. Per TP 1245, these interventions should be limited to those patients in severe respiratory distress.
- Patients requiring positive-pressure ventilation due to respiratory failure should continue to receive 100% oxygen.
- Titrated oxygen with a higher target of 94% is recommended for the following specific conditions: carbon monoxide poisoning, suspected pneumothorax, shock, traumatic brain injury.

If you have any questions or concerns, feel free to contact me at (562) 378-1600 or MGausche-Hill@dhs.lacounty.gov.

Distribution:

Fire Chief, Each Public EMS Provider Agency
CEO, Ambulance Companies
Medical Director, Each EMS Provider Agency
Paramedic Coordinator, Each EMS Provider Agency
Hospital Association Southern California
CEO, Each 9-1-1 Receiving Hospitals
ED Medical Directors, Each 9-1-1 Receiving Hospitals
Prehospital Care Coordinator, Each Base Hospital
Prehospital Base Physician, Each Base Hospital

Directive #2

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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Medical Director

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"To advance the health of our communities by ensuring quality emergency and disaster medical services."

January 4, 2021

TO: Distribution **VIA E-MAIL**

FROM: Cathy Chidester, MSN
Director, EMS Agency

SUBJECT: **REVISION #3 - 9-1-1 TRANSPORTATION OF PATIENTS WITH A POLST AND COMFORT- FOCUSED CARE DIRECTIVE (COVID SURGE DIRECTIVE #2)**

In a continued effort to assist with the current overcrowding of the emergency departments in Los Angeles County and the additional burden being placed upon EMS providers, the EMS Agency is providing the following temporary revision to Ref. No. 815, Honoring Prehospital Do Not Resuscitate Orders (DNR), Physician Orders for Life Sustaining Treatment (POLST) and End of Life Option (Aid-In-Dying Drug).

Effective immediately and until further notice, all 9-1-1 patients that have a **POLST requesting only comfort-focused care**, and whose **acute needs are related to end-of life care**, will not be transported by 9-1-1 providers to an acute care facility.

APPLICATION:

1. **This directive only applies to patients who are currently in their end-of-life phase and are in a hospice facility, home hospice, skilled nursing or long term care facilities.**
2. This does not apply to patients who would otherwise require transport because of an emergency medical condition that is not related to terminal illness but happen to have a DNR or POLST.

EMS providers will perform a complete assessment including baseline status, and will review existing Advanced Health Care Directive or POLST with staff/caregivers/family to determine goals of care. For patients who fall within this directive, comfort measures (e.g., re-positioning, suctioning) based on need will be performed in their current location (i.e., home hospice, hospice facility, skilled nursing facility, long term care facility).

If there is a discrepancy regarding transportation of a patient, or the patient has no identified family or Power of Attorney for Healthcare Decisions, the base hospital is to be contacted and will determine patient disposition.

Please review this directive with your staff to ensure understanding and appropriate application. Thank you for your support of the EMS system in these extraordinary times. If you have any questions or concerns, feel free to contact me at (562) 378-1604, or Richard Tadeo, Assistant Director at (562) 378-1610.

Distribution:
Director, Each Skilled Nursing Facility
Director, Each Hospice Agency
Medical Director, EMS Agency
Fire Chief, Each Public EMS Provider Agency
CEO, Ambulance Companies
Medical Director, Each EMS Provider Agency
Paramedic Coordinator, Each EMS Provider Agency
Hospital Association Southern California
Prehospital Care Coordinator, Each Base Hospital
Prehospital Base Physician, Each Base Hospital

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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Santa Fe Springs, CA 90670

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To advance the health of our communities by ensuring quality emergency and disaster medical services.

Health Services
http://ems.dhs.lacounty.gov

January 12, 2021

TO: Chief Executive Officer
Each General Acute Care Hospital

FROM: Cathy Chidester
Director

SUBJECT: **SHORING UP FOR THE SURGE OF COVID-19 PATIENTS**

Over the past weeks, hospitals have experienced an unprecedented surge in COVID-19 cases straining hospital staffing, space and other resources. Most recently, the number of hospitalized COVID-19 cases have plateaued; however, there is a concern of another surge from the holiday gatherings. In preparation for this potential surge, this memo is to remind hospitals to continue their focus on surge planning addressing the following issues:

Staffing

- Reach out to your contracted registries including travelers to obtain additional staffing resources specifically, ICU RNs and Respiratory Therapists.
- Continue to use the CDPH Waiver process to expand nursing ratios to extend your available staffing to care for additional patients.
- Consider supplementing your staffing with the use of emergency medical technicians and paramedics.
- If the above actions do not result in meeting your staffing needs, submit a resource request via the ReddiNet system for needed staff.

Space

- Ensure all areas within the walls of the hospital that can be used to care for patients are explored and plans developed on what type of patients could be cared for in each area and the resources needed to convert these spaces.
- Fully utilize the tent facilities located on your hospital campus and ensure plans are developed on what type of patients can be cared for in the tent facilities.
- Give special attention to use of tents outside of your emergency department for the offloading of ambulance crews to release the EMS providers back to field. See Reference No. 855: *Hospital EMS Surge Assistance Plan* for details (attached).
- If tent facilities are needed, submit a resource request via the ReddiNet system.

Stuff

- Ensure adequate PPE is available to protect the workforce caring for the COVID-19 patients. Procure needed supplies from your normal vendors. If unable to procure in a timely manner or quantity needed, submit a resource request via the ReddiNet system.

- Evaluate the equipment that would be needed to care for additional patients to include patient monitoring equipment, IV pumps, feeding tube pumps, ventilators, high flow O2 delivery systems and supplies. Work with your medical vendors to procure these items now. If unable to procure in a timely manner or quantity needed, submit a resource request via the ReddiNet system.
- Evaluate the capacity of your liquid oxygen delivery system and, working with your oxygen vendor, develop plans to mitigate any issues that increased demand could place on the system.
- Ensure that all portable oxygen tanks are routinely refilled by your oxygen gas provider and determine if additional large H tanks are needed and work to procure these. If emergent needs for oxygen tank refills are needed, the State and the EMS Agency are setting up tank refilling stations (Oxygen Depots) to supplement your vendor's capabilities.

The EMS Agency appreciates all the work each hospital is doing to deal with the surge. Your continued vigilance with a focus on shoring up your facility's capabilities will help mitigate the impact.

CC:kf

Attachment

c: Each General Acute Care Hospital Emergency Management Officer

County of Los Angeles • Department of Health Services
Emergency Medical Services Agency

BASE HOSPITAL ADVISORY COMMITTEE MINUTES

December 9, 2020

MEMBERSHIP / ATTENDANCE
VIA ZOOM

	REPRESENTATIVES		EMS AGENCY STAFF
☒	Robert Ower, RN., Chair	EMS Commission	Dr. Marianne Gausche-Hill
☐	Carole Snyder, RN., Vice Chair	EMS Commission	Dr. Nichole Bosson
☐	Joe Salas	EMS Commission	Richard Tadeo
☒	Rachel Caffey	Northern Region	Christine Clare
☒	Melissa Carter	Northern Region	Jackie Rifenburg
☒	Charlene Tamparong	Northern Region, Alternate	Michelle Williams
☐	Samantha Verga-Gates	Southern Region	Paula Rashi
☒	Laurie Donegan	Southern Region	Cathy Jennings
☒	Shelly Trites	Southern Region	Susan Mori
☒	Christine Farnham, APCC Pres. Elect.	Southern Region, Alternate	David Wells
☒	Paula Rosenfield	Western Region	Christy Preston
☒	Ryan Burgess	Western Region	Christine Zaiser
☒	Susana Sanchez	Western Region, Alternate	Gary Watson
☒	Erin Munde	Western Region, Alternate	John Telmos
☒	Laurie Sepke	Eastern Region	Sara Rasnake
☒	Alina Candal	Eastern Region	Natalie Greco
☒	Jenny Van Slyke	Eastern Region, Alternate	Olester Santos
☒	Lila Mier	County Hospital Region	Dr. Denise Whitfield
☒	Emerson Martell	County Hospital Region	
☒	Yvonne Elizarraz	County Hospital Region, Alternate	
☒	Antoinette Salas	County Hospital Region, Alternate	**GUESTS**
☒	Alec Miller	Provider Agency Advisory Committee	Dr. Saman Kashani, LACoFire
☒	Jennifer Nulty	Provider Agency Advisory Committee, Alt.	Dr. Ashley Sanello, Compton Fire
☒	Laarni Abdenoja	MICN Representative	
☒	Jennifer Breeher	MICN Representative, Alt.	
☒	Heidi Ruff	Pediatric Advisory Committee	

	PREHOSPITAL CARE COORDINATORS				
☒	Gloria Guerra (QVH), APCC Pres.	☒	Heidi Ruff (HMN)	☒	Lorna Mendoza (SFM)
☐	Karyn Robinson (GWT)	☒	Jessica Strange (SJS)	☒	Chad Sibbett (SMM)
☒	Coleen Harkins (AVH)	☒	Michael Natividad (AMH)		

1. **CALL TO ORDER:** The meeting was called to order at 1:01 P.M. by Robert Ower, Chairperson.

2. **APPROVAL OF MINUTES**: The meeting minutes for October 14, 2020, were approved as submitted.

   M/S/C (Burgess/Sepke)

3. INTRODUCTIONS/ANNOUNCEMENTS:

- Welcome back Laarni Abdenoia as the MICN Representative
- Richard Tadeo: In response to the recent COVID surge and inundation of emergency rooms across Los Angeles County, the following diversion changes may be temporarily implemented:
  - Diversion of BLS Patients for ED saturation, on a case by case basis, for up to 30-minute transport time. To request BLS diversion, contact the MAC.
  - For providers requesting to place a hospital on diversion, the EMS supervisor will evaluate the situation and contact the MAC to request the hospital be placed on ED diversion. If diversion is authorized, the MAC will notify hospital administration that hospital has been placed on diversion.
  - Diversion of specialty care center diversion (STEMI, Stroke, Trauma), will be considered on a case-by-case basis based on current hospital capacity and capabilities of surrounding hospitals. If specialty center diversion is applied by the MAC, administration of said hospital will be notified.

4. REPORTS & UPDATES:

4.1 EMS Update 2021

Train the Trainer has been moved to Thursday, April 29th, (AM & PM session), and Thursday, May 6th, (AM session). EMS Update will be presented in an online format and content will include: adult and pediatric out of hospital medical and traumatic cardiac arrest, Patient Refusal of Treatment/Transport and Treat and Release at Scene (Ref. No. 834), QI topics relating to sepsis and anaphylaxis, data element collection for Cardiac Arrest Registry to Enhance Survival (CARES), recontact for patient condition change, and a module on infection control.

4.2 EmergiPress

EmergiPress will continue to be offered monthly. The November/December edition is now available online. Please continue to submit feedback and suggestions for future topics to Dr. Denise Whitfield at, dwhitfield@dhs.lacounty.gov.

4.3 ECMO Pilot

The ECMO Pilot is ongoing. County Fire has obtained additional LUCAS devices and will be expanding to additional units in the Inglewood area. Enrolled patients from that area will be transported to UCLA as the ECMO Center.

4.4 Data Collaboratives

STEMI/SRC, Stroke, and Pediatric Data Collaborative: Projects are ongoing, we will keep you posted.

For current publications and publications relevant to the EMS system please visit the EMS Agency website, https://dhs.lacounty.gov/more-dhs/departments/ems/resources/ems-system-publications1/

5. OLD BUSINESS:

None

6. NEW BUSINESS:

6.1 Ref. No. 228, Reddinet® Utilization

Approved as presented.

M/S/C (Burgess/Sepke)

6.2 Ref. No. 508, Sexual Assault Patient Destination

Policy was returned for additional revision, will be returned at next BHAC meeting for review and approval.

6.3 Ref. No. 518, Decompression Emergencies/Patient Destination

Approved as presented.

M/S/C (Guerra/Van Slyke)

6.4 Ref. No. 834, Patient Refusal of Treatment or Transport

Policy is under review and will be presented at future BHAC meeting. 834 Task Force will meet again to discuss circumstances that warrant generating an Electronic Patient Care Record (EPCR), and opportunities to improve safety and quality improvement in the pre-hospital care setting.

7. OPEN DISCUSSION:

Dr. Nichole Bosson: Double Sequential Defibrillation (DSD) is the use of two defibrillators simultaneously to deliver the maximum energy to convert a shockable rhythm to ROSC. Anecdotal reports had suggested that there are benefits to using DSD; however, observational trials have shown that there is no benefit. There is an ongoing randomized controlled trial by Sheldon Cheskes in Toronto, comparing single defibrillation (anterior/posterior pad placement) vector change defibrillation and DSD, this is a new study and enrollment has just begun.

There are concerns that implementation of DSD would delay/interrupt interventions known to benefit the patient and risk damaging the defibrillator/monitor due to simultaneous release of energy. Currently DSD is not an evidence-based standard and is not included in the Prehospital Care Treatment Protocols for Los Angeles County. Base hospital physicians should not be ordering DSD.

8. NEXT MEETING: BHAC's next meeting is scheduled for **February 10, 2021**, location is to be determined.

ACTION: Meeting notification, agenda, and minutes to be distributed electronically prior to the meeting.

ACCOUNTABILITY: Lorrie Perez

9. ADJOURNMENT: The meeting was adjourned at 1:55 P.M.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 378-1500
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EMERGENCY MEDICAL SERVICES COMMISSION
DATA ADVISORY COMMITTEE

MEETING NOTICE

Date & Time: Wednesday, December 9, 2020 10:00 A.M.
Location: Zoom Meeting

DATA ADVISORY COMMITTEE
DARK FOR DECEMBER 2020

County of Los Angeles
Department of Health Services

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

EMERGENCY MEDICAL SERVICES COMMISSION

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, October 21, 2020

Due to the ongoing COVID-19 pandemic and to comply with regulations on Social Distancing, this meeting was conducted via ZOOM conference call-in. General public and Committee Members' attendance was verified by presence of name on the participant list. Quorum was reached and meeting continued.

MEMBERSHIP / ATTENDANCE

MEMBERS	ORGANIZATION
☑ Paul Rodriquez, Chair	EMSC, Commissioner
☐ VACANT, Vice-Chair	EMSC, Commissioner
☐ Eugene Harris	EMSC, Commissioner
☐ Brian Bixler	EMSC, Commissioner
☑ Sean Stokes	Area A
☐ Justin Crosson	Area A, Alt. *(Rep to Med Council, Alt)*
☑ Dustin Robertson	Area B
☑ Clayton Kazan, MD	Area B, Alt.
☐ Victoria Hernandez	Area B, Alt. *(Rep to Med Council)*
☐ Ken Leasure	Area C
☑ Lyn Riley	Area C, Alt.
☑ Ivan Orloff	Area E
☑ Kurt Buckwalter	Area E, Alt.
☑ Wade Haller	Area F
☐ Brenda Bridwell	Area F, Alt.
☑ Alec Miller	Area G *(Rep to BHAC)*
☑ Jennifer Nulty	Area G, Alt. *(Rep to BHAC, Alt.)*
☑ Doug Zabilski	Area H
☐ Anthony Hardaway	Area H, Alt.
☑ Matthew Potter	Area H, Alt. *(Rep to DAC)*
☑ Julian Hernandez	Employed Paramedic Coordinator
☐ Tisha Hamilton	Employed Paramedic Coordinator, Alt.
☑ Rachel Caffey	Prehospital Care Coordinator
☐ Jenny Van Slyke	Prehospital Care Coordinator, Alt.
☐ Andrew Respicio	Public Sector Paramedic
☑ Daniel Dobbs	Public Sector Paramedic, Alt.
☐ Maurice Guillen	Private Sector Paramedic
☐ Scott Buck	Private Sector Paramedic, Alt.
☑ Ashley Sanello, MD	Provider Agency Medical Director
☐ Vacant	Provider Agency Medical Director, Alt.
☑ Andrew Lara	Private Sector Nurse Staffed Ambulance Program
☐ Gary Cevello	Private Sector Nurse Staffed Ambulance Program, Alt.
☑ Michael Kaduce	EMT Training Program
☑ Scott Jaeggi	EMT Training Program, Alt.
☑ David Mah	Paramedic Training Program
☐ David Fillip	Paramedic Training Program, Alt.

EMS AGENCY STAFF (Virtual)

Marianne Gausche-Hill, MD	Denise Whitfield, MD
Richard Tadeo	Chris Clare
Terry Cramer	Elaine Forsyth
Natalie Greco	Cathlyn Jennings
Susan Mori	Christy Preston
Paula Rashi	Jacqueline Rifenburg
John Telmos	Gary Watson
David Wells	Michelle Williams
Christine Zaiser	

Public Attendees (Virtual)

Adrienne Roel	Culver City FD
Anathea Gordon	LAFD
Andy Reno	Long Beach FD
Benjamin Esparza	LAFD
Britney Alton	Burbank FD
Caroline Jack	Beverly Hills FD
Chris Backley	San Gabriel FD
Christine Eclarino	LA County Public Health
Dave Smith	Redondo Beach FD
Drew Bernard	Emergency Ambulance
Jack Ewell	LA County Sheriff's Office
Ken Powell	Culver City FD
Nanci Medina	LA County FD
Roger Braum	Culver City FD
Tina Ziolkowski	LAFD
Bryan Wells	LA County FD
Puneet Gupta, MD	LA County FD
Sheryl Gradney	LA County FD

LACAA – Los Angeles County Ambulance Association LAAFCA – Los Angeles Area Fire Chiefs Association BHAC – Base Hospital Advisory Committee DAC – Data Advisory Committee

1. **CALL TO ORDER:** 1:00 p.m.: Chair, Paul Rodriguez, called meeting to order.

2. **INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS**

2.1 Committee's New Membership
Chairman Paul Rodriquez introduced the following new members to our Committee:

- Kurt Buckwalter, Captain, Santa Fe Springs Fire Rescue: Alternate Representative for Area E
- Matthew Potter, Captain, Los Angeles Fire Department: Alternate Representative for Area H
- David Mah, Paramedic Program Director, Mount San Antonio College, Representative for Paramedic Training Programs.
- David Fillip, Paramedic Program Director, UCLA Center for Prehospital Care, Alternate Representative for Paramedic Training Programs.

2.2 PTI Medical Director *(Marianne Gausche-Hill, MD)*
Dr. Gausche-Hill introduced Dipesh Patel, MD, as the new Medical Director for the EMS Agency's Paramedic Training Institute.

2.3 EpiRite™ Syringe *(John Telmos)*

- Epi-Rite™ Syringe has easy to read markings which allows the EMT a fast and easy dosing of the medication epinephrine, during the treatment of allergic reactions.
- Survey monkeys have been sent out to all providers to determine the number of providers who would be interested in implementing this product.
- Survey monkey link and YouTube video on this product was posted on the ZOOM Chat during this meeting.
- Those interested in more information may contact John Telmos at jtelmos@dhs.lacounty.gov

2.4 Fireline Paramedic – Documentation *(John Telmos)*

- Reminder to all providers, when a fireline medic has a patient contact during deployment, a copy of the patient care record (PCR) is to be sent into the EMS Agency; either mailed or hand delivered to the EMS Agency's Director or Medical Director. This is in addition to your normal PCR submission process.
- More information on this process can be found in Reference No. 804, Fireline Emergency Medical Technician – Paramedic (FEMP).

3. **APPROVAL OF MINUTES (Kazan/Jaeggi)** August 19, 2020 minutes were approved as written.

4. **REPORTS & UPDATES**

4.1 COVID-19 Update *(Marianne Gausche-Hill, MD)*

- Provider Impressions related to COVID-19 (Cold/Flu and Shortness of Breath) continue to decrease.
- The EMS Agency continues with the weekly Monday morning COVID-19 Updates (via ZOOM conference call). Participants include provider agencies, Medical Directors and hospitals.
- Recently, the EMS Agency has received approval from the EMS Authority for a local Optional Scope of Practice for paramedics to administer influenza vaccine.
- If providers are interested in participating in this influenza vaccination program, please contact Susan Mori at sumori@dhs.lacounty.gov

- The EMS Agency and the Los Angeles County Public Health, COVID-19 are collaborating to develop a distribution plan when the vaccine becomes available. It is unknown when a vaccine will be available. Updates will be provided during the Monday morning COVID-19 Update meetings.

4.2 Disaster Services Update

- Health Office order: Annual Influenza Immunization Program *(Marianne Gausche-Hill, MD)*
  - On September 18, 2020, the Los Angeles County Health Office, Dr. Mantu Davis, released the Health Office Order requiring all EMS providers to receive this year's influenza vaccine. Dr. Gausche-Hill emphasized the importance of this, especially during the COVID-19 pandemic.
  - Providers were reminded that all healthcare personnel should continue utilizing masks, gowns and gloves while providing care to [all] patients; and the utilization of N95 masks during any aerosolized procedures.

4.3 EMS Update 2020 & 2021 *(Denise Whitfield, MD and Jacqueline Rifenburg)*

- Completion deadline for EMS Update 2020 was September 1, 2020. More than 6000 EMS personnel have completed this year's Update. County-wide only 60 paramedics have not completed; mainly because of being off work due to injury or leave of absences.
- Due to high amount of positive feedback, EMS Update 2021 will remain on the same electronic format as EMS Update 2020.
- The EMS Update 2021 Workgroup met for the first time on Monday, October 19, 2020. The current plan is to have Train-the-Trainer classes beginning in March 2021. Topics for the EMS Update 2021 include: management of Out of Hospital Cardiac Arrests (OHCA); Treat and Refer procedures; best practices for infection control; and identifying anaphylaxis and sepsis.

4.4 EmergiPress Update *(Denise Whitfield, MD)*

- EmergiPress is now available on an additional e-learning software platform called "SCORM" (Shareable Content Object Reference Model).
- An email from Dr. Whitfield will go out soon, which will provide access to a drop box folder with all course material and will include the "SCORM" folder, if desired.
- EmergiPress training material continue to be available on the EMS Agency's webpage.
- Questions regarding EmergiPress can be directed to Dr. Whitfield at dwhitfield@dhs.lacounty.gov

4.5 PHAST-TSC Trial *(Marianne Gausche-Hill, MM)*

- Trial involved a medication that helped bring oxygen to the body tissues and was implemented in Los Angeles County, with four patients being enrolled.
- Due to the COVID-19 pandemic, the pharmaceutical company stopped the trial to shift their resources to address the pandemic.
- Trial has ceased and will be revisited once the COVID crisis has passed.

4.6 ECMO Pilot *(Marianne Gausche-Hill, MD)*

- This Pilot/Trial is continuing, with 1-2 patient enrollments thus far.
- Hospitals that are involved include Cedars-Sinai Medical Center and Ronald Reagan UCLA Medical Center. (LAC+USC Medical Center's IRB approval is pending).
- As a reminder to all providers and hospitals participating in this pilot, transportation for enrolled patients does not change. Providers are not to bypass the most accessible STEMI-Receiving Center (SRC).

4.7 CPR Techniques in the Prehospital Setting *(Denise Whitfield, MD)*

- Committee members were asked which CPR technique (Continuous CPR vs. the 30 compressions/2 ventilations ratio) was being utilized in the prehospital setting.
- Responses were received through this meeting's chat box or can be sent to Dr. Whitfield via email at dwhitfield@dhs.lacounty.gov

4.8 Out of Hospital Cardiac Arrest (OHCA) Task Force *(Marianne Gausche-Hill, MD)*

- Task force has been meeting regularly to answer questions on OHCA use of epinephrine, airway management, chest compressions vs. ventilation ratios, vascular access and others.
- Goal is to complete this review by December 2020, make changes to Treatment Protocols by early January 2021; and then provide education on these changes during EMS Update 2021.

4.9 Reference No. 834 Task Force *(Marianne Gausche-Hill, MD)*

- Taskforce has been meeting regularly and will be completing a draft of the revised policy.
- The plan is to have provider track the utilization of this policy and develop quality improvement.

4.10 12-Lead Transmissions and Hospital Notifications *(Marianne Gausche-Hills, MD)*

- Providers are reminded that it is imperative to provide immediate SRC notification and to transmit all 12-Lead ECG showing STEMI immediately to the receiving SRC. Providers should not wait to provide an attached ECG with their electronic patient care record prior to transmitting the STEMI ECG.
- Dr. Gausche-Hill also reminded providers to notify the receiving facility if there are changes in patient status during transport.

4.11 Side Walk CPR *(Susan Mori)*

- This year's Side Walk CPR will transition from a Community-based Training program to an on-line/virtual training program.
- The EMS Agency is working on a hands-only CPR training video and will be presented to this Committee when complete.

5. UNFINISHED BUSINESS

There was no unfinished business.

6. NEW BUSINESS

6.1 Reference No. 515, Honoring Prehospital Do Not Resuscitate Orders, Physician Orders for Life Sustaining Treatment and End Of Life Option (Aid-In Dying Drug) *(Richard Tadeo)*

Policy reviewed and approved as written.

M/S/C (Miller/Kazan) Approved Reference No. 515, Honoring Prehospital Do Not Resuscitate Orders, Physician Orders For Life Sustaining Treatment And End Of Life Option (Aid-In Dying Drug).

6.2 Reference No. 830, EMS Pilot and Scientific Studies *(Richard Tadeo)*

Policy reviewed and approved with the following recommendation:

- Page 1, Definition, Pilot or Scientific Study: add the following language to second sentence: "using system-wide data".

M/S/C (Dobbs/Mah) Approved Reference No. 830, EMS Pilot and Scientific Studies, with above recommendation.

6.3 Reference No. 1108, Chempack Deployment for Nerve Agent Release *(Terry Cramer)*

Policy reviewed and approved as written.

M/S/C (Kazan/Miller) Approved Reference No. 1108, Chempack Deployment for Nerve Agent Release.

6.4 Reference No. 1138, Burn Resource Center (BRC) Designation and Activation (*Richard Tadeo)*

Policy reviewed and approved with the following recommendation:

- Page 1, Definitions, Burn Injury: add words "Adult" and "Pediatric" to the following sentences:
  "Adult patients (equal to or greater than 15 years of age) …"
  "Pediatric patients (less than or equal to 14 years of age) …"

M/S/C (Kazan/Zabilski) Approved Reference No. 1138, Burn Resource Center (BRC) Destination and Activation, with above recommendation.

6.5 Reference No. 1337, Medical Control Guideline: Naloxone Distribution by EMS Providers (Leave Behind Naloxone) *(Denise Whitfield, MD)*

Policy reviewed and approved as written.

M/S/C (Kaduce/Kazan) Approved Reference No. 1337, Medical Control Guideline: Naloxone Distribution by EMS Providers (Leave Behind Naloxone).

6.5 Reference No. 1241, Treatment Protocol: Overdose/Poisoning/Ingestion *(Richard Tadeo)*

Policy reviewed and approved with the following recommendation:

- Number 5: Beginning of sentence, add wording similar to: "For providers who participate in the Leave Behind Naloxone program"…

M/S/C (Kazan/Kaduce) Approved Reference No. 1337, Medical Control Guideline: Naloxone Distribution by EMS Providers (Leave Behind Naloxone), with above recommendation.

7. OPEN DISCUSSION:

7.1 Health Data Exchange *(Richard Tadeo)*

- Information was provided regarding a Health Data Exchange program, which would allow those who participate to have access to a bi-directional exchange of preselected information between provider agencies and hospitals.
- Further discussion with Fire Chiefs and Hospital CEOs is being planned.
- This Committee will be presented with more information in the future.

7.2 MCI Terminology *(John Telmos)*

Committee member recommended that the EMS Agency make changes to ensure Incident Command System (ICS) positions/names are consistent within the training at the Paramedic Training Institute, Los Angeles County Prehospital Care Manual, and Firescope's Field Operations Guide (FOG) Manual.

7.3 Reuse of Metered Dose Inhaler (MDI) with Spacers *(John Telmos)*

- Committee member asked if MDIs can be reused on multiple patients if the spacers are replaced between each patient; rather than disposing of the MDI after each use or giving to patient in the emergency department.
- It was reported that some spacers have a one-way valve that would prevent cross contamination of the MDI.
- Dr. Gausche-Hill stated she will research this topic and respond back to the Committee.

7.4 Influenza Survey Monkey *(John Telmos)*

Announcement was given at previous Committee meeting and reminded today that a survey monkey will be sent out to all providers at the end of this influenza season.

7.5 COVID-19 Vaccination Program *(Elaine Forsyth)*

- The EMS Agency is working with the Los Angeles County Public Health Department on a distribution plan for a COVID-19 vaccine.
- An email will be sent out next week to providers, with information on a survey monkey to determine the amount of vaccine needed for distribution.

8.0 NEXT MEETING: December 16, 2020

9.0 ADJOURNMENT: Meeting adjourned at 2:47 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HEALTHCARE FACILITIES, EMT, PARAMEDIC, MICN)

SUBJECT: **REDDINET® UTILIZATION**

REFERENCE NO. 228

PURPOSE: To provide guidelines to Los Angeles County ReddiNet® System users for communication and coordination of hospital diversion status, facility services available, multiple casualty incidents (MCI), disaster assessment polls, messages, and bed availability reporting activities.

PRINCIPLES:

1. The ReddiNet® System is the designated emergency and disaster communication system established for facilities and agencies within Los Angeles County's medical and health system.

2. It is the responsibility of each facility or organization to ensure its ReddiNet® System is maintained per the ReddiNet® Users' Master Agreement and to ensure that it remains online at all times.

3. The ReddiNet® visual and audible alarms are to be maintained at an adequate level to alert staff within a facility at all times. The System shall be placed in a location easily accessible to personnel within each facility.

4. The use of the ReddiNet® computer should be limited to the operation of the ReddiNet® System and access to Emergency Medical Service(s) (EMS) educational materials only. Accessing the internet or other applications on this computer is not recommended.

5. Each facility is responsible for adequately training and annually verifying personnel's competency and having at least one staff member who is knowledgeable in the use of the ReddiNet® System on duty at all times.

6. Release of protected health information (PHI) shall be in accordance with each facility's internal policies.

POLICY

I. Emergency Department Diversion Status

Hospitals will utilize the ReddiNet® System to update all diversion status pursuant to Ref. No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients.

II. Management of Multiple Casualty Incidents

During an MCI, the Medical Alert Center (MAC) or designated paramedic base hospital will coordinate patient destination activities pursuant to Ref. No. 519, Management of Multiple Casualty Incidents.

APPROVED: _____ _____
Director, EMS Agency Medical Director, EMS Agency

III. Bed Availability

Health facilities will follow the guidelines for reporting bed availability pursuant to Ref. No. 1122, Bed Availability Reporting.

IV. Assessment Polls

A. To assist with the coordination of emergency resource management, the MAC sends assessment polls to health care facilities to complete and return. Assessment polls ask health care facilities specific questions and require a response.

B. In the event of a Countywide or regional disaster, health care facilities should anticipate the initiation of a ReddiNet® Facility Status assessment poll.

C. Healthcare facilities must respond to the assessment polls within the timeframe specified on the assessment poll.

V. Messages

A. All facilities are expected to utilize the ReddiNet® messages function to communicate appropriate information about their facility to other facilities, the EMS Agency, and the Department of Public Health (DPH).

B. All messages that are appropriate for dissemination to other staff are to be printed or otherwise shared with affected staff.

C. Users are to limit sent messages and message replies to affected parties only.

1. Messages and message replies should be short, concise, and relevant.

2. Since the ReddiNet® network includes hospitals, clinics, EMS and Public Health agencies, fire, ambulance, law enforcement, and other related agencies, each ReddiNet® user is expected to be very selective when sending messages, as not all messages are intended for all network users.

3. Replies to messages should be limited to the creator of the message unless necessary to copy others. If copies are deemed necessary, users need to open the menu selections and individually select recipients from the recipient list.

D. ReddiNet® can support message attachments, which allows users to attach electronic files.

E. All communications exchanged via the ReddiNet® messages function that contain protected health information (PHI) must comply with Health Insurance Portability and Accountability Act (HIPAA) privacy rules.

VI. Bioterrorism and Health Surveillance

A. DPH may initiate disease surveillance programs utilizing ReddiNet®. These will be in the form of assessment polls that ask for specific information.

B. Each facility is to ensure that these assessments are answered promptly. This will likely require involvement of Infectious/Communicable Disease staff at each facility. This does not replace the obligation of health care providers to report certain diseases on a Confidential Morbidity Report (CMR) pursuant to Title 17, California Code of Regulations, §2500 (rev. 1996).

C. Each 9-1-1 receiving facility must provide daily value data to DPH which includes: Total ED Visits, Total Admissions, Total ICU Admissions, and Total Deaths.

VII. MCI Reported Patients

A. During multiple casualty incidents and disasters, facilities that received patients can enter patient information under the “Add Patients” button in the ReddiNet® module on the MCI tab. During an incident, facilities shall promptly enter the following data: patient’s first and last name, gender, age, status, and disposition. The MCI module will aid facilities with family reunification activities and in locating patients. This data is considered PHI for HIPAA purposes.

B. The exchange of PHI between facilities and counties for disaster relief purposes would be permitted under HIPAA without express patient authorization. However, this exception still requires the covered entity to provide the individual an opportunity to agree or object to such disclosure unless, under the circumstances, in the exercise of professional judgment, the covered entity determines that trying to get such consent would interfere with its ability to respond to the emergency.

C. In the absence of a situation invoking the disaster relief authority of the County, it is permissible to share information that would otherwise be in the facility’s directory. Assuming the patient does not object, the information would include their name, location, and general condition. If the patient is deceased, that information may also be disclosed. The information regarding the patient’s gender and age would generally not be subject to disclosure except, in the professional judgment of the covered entity, when it is necessary to aid in identifying the patient by a family member.

D. When accessing the Reported Patients information, the following is recommended:

1. Request the patient’s permission whenever possible.

2. Solicit identifying information from the calling party instead of giving information to the calling party to the extent that it allows confirmation of the victim’s location as entered on the Reported Patients screen.

E. Each facility’s Reported Patient tab will show all data fields for that facility’s data entry; however, the condition will be suppressed for other facilities’ patients entered on the screen. Only name, gender, age, and location for patients in other facilities will be visible.

VIII. Non - Hospital Users

A. Community clinics, long term care facilities, ambulatory surgery centers, dialysis centers, home health and hospice agencies and paramedic providers with ReddiNet® access shall incorporate ReddiNet® communications into their facility disaster and emergency response plans.

B. Healthcare facilities shall respond to assessment polls (drills or actual events) within 60 minutes of receipt. Responses will be aggregated by the EMS Agency or according to sector-specific emergency response protocols.

IX. Resource Requests

A. ReddiNet® allows healthcare entities to submit and track medical resource requests. It is the preferred resource tracking system employed by the County.

B. Resource requests can be entered in the Resource Request tab, by selecting the 'New Resource Request" button and completing the required information, to include: Mission and/or Tasks; Order type; and verifying that the three (3) requirements outlined on the form are completed; as well as management review and verification was completed before submitting the request.

C. Current resource request status can be seen in the second column. Further detail is visible when the specific resource request is highlighted.

D. If any questions arise during the processing of the request, communication regarding the progress of the request can be seen in the comments section when the specific resource request is highlighted in the Resource Requests column.

X. ReddiNet® System Failure or Disruptions

If the ReddiNet® System is not functioning, facilities are to utilize the following procedure:

A. Attempt to resolve the problem at the computer. Check for correct power and internet connections as well as correct log-in and password.

B. Notify the facility ReddiNet® coordinator or IT department according to facility policy.

C. Access the 24-hour ReddiNet® Help Line number at 1-800-440-7808 as needed.

D. Notify other facilities and the EMS Agency of the status of the ReddiNet® System and the anticipated return to service. Updates should be provided every 8 hours until the system is functional. Facilities should make arrangements with another facility or the EMS Agency to notify ReddiNet® System participants of the disruption as well as perform any functions in ReddiNet® on their behalf as described in the above section of this policy, until service is restored.

E. Notify other facilities and the EMS Agency when the ReddiNet® System is fully operational.

CROSS REFERENCES

Prehospital Care Manual

Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Patients**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 1122, **Bed Availability Reporting**

Reference No. 228, ReddiNet® Utilization

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	12/16/2020	12/16/2020	N
	Base Hospital Advisory Committee	12/09/2020	12/09/2020	N
	Data Advisory Committee			
	Education Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

***** See **Summary of Comments** (Attachment B)

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDICS, MICN)

SUBJECT: **DECOMPRESSION EMERGENCIES/ PATIENT DESTINATION** REFERENCE NO. 518

PURPOSE: To provide a procedure for transporting patients with potential decompression emergencies to the most appropriate and accessible medical facility.

POLICY:

I. Responsibilities of the Provider Agency:

A. Contact assigned base hospital for any patient suspected of having a decompression emergency.

B. Obtain dive incident history of the patient and dive partner, if possible. This includes:

1. Maximum dive depth

2. Time spent at depth

3. Rate of ascent

4. Number of dives

5. Surface interval

6. Gas(es) used

C. Coordinate patient transportation to the appropriate receiving facility.

Transportation of patients with potential decompression emergencies may involve the United States Coast Guard (USCG) helicopter which does not include paramedic level staffing. In some circumstances, the USCG helicopter may be able to accommodate a Los Angeles County paramedic to accompany the patient to the receiving facility. If this is not possible and rapid transport is in the best interest of the patient, care may be transferred from the paramedics handling the call to the USCG medical personnel.

D. In rare instances, EMTs may determine destination to the Catalina Hyperbaric Chamber when ALS level of care is not immediately available in remote locations (e.g., offshore oil and gas platforms), and patient is found either unconscious, apneic, pulseless or exhibiting symptoms of suspected decompression illness due to premature ascent and failure to complete required underwater decompression stops. In such cases, notification shall be made by the on-scene personnel (or notification relayed by US Coast Guard directly to the Catalina Hyperbaric Chamber) as follows:

APPROVED: _____ _____
Director, EMS Agency Medical Director, EMS Agency

1. Catalina Hyperbaric Chamber at (310) 510-1053

2. Los Angeles County Baywatch Isthmus lifeguard paramedics (if not already aware of the incident)

3. Medical Alert Center (MAC)

E. Retrieve patient's dive equipment (e.g., dive computer, regulator, tank, buoyancy compensator, gauges and weight belt) and transport with patient. If the transporting unit cannot accommodate the equipment, the provider agency shall take custody of it and notify the receiving facility of the dive equipment location

As a general rule, the integrity of the dive equipment should be maintained and not tampered with except by investigating authorities.

II. Responsibilities of the Base Hospital Physician or Mobile Intensive Care Nurse (MICN):

A. Contact the Medical Alert Center (MAC) by dialing the general number (866) 940-4401; select Option 1 for emergency or consultation. The MAC will arrange a call between the hyperbaric chamber physician on call and the base hospital. If the hyperbaric physician has not responded within 10 minutes, the base hospital should re-contact the MAC.

B. Provide medical orders for patient care.

C. In consultation with the hyperbaric chamber physician on call (arranged through the MAC), determine if the patient should be transported directly from the incident location to a hyperbaric chamber or to the most accessible receiving facility (MAR). The following guidelines should be considered for any patient with a history of recent underwater compressed gas use:

1. Transport to a MAC-listed hyperbaric chamber (Immediate):

a. Unconscious, or

b. Apneic, or

c. Pulseless; or

d. Premature ascent with reported failure to complete any required underwater decompression stop(s) (omitted decompression) with or without symptoms.

2. Transport to a MAC-listed hyperbaric chamber and/or the MAR after consultation with the hyperbaric chamber physician (Emergent):

a. Any neurological symptoms, or

b. Severe dyspnea, or

c. Chest discomfort

3. Transport to the MAR with potential secondary transfer to a hyperbaric chamber after consultation with the hyperbaric chamber physician (Non-Emergent):

   a. Delayed symptoms after flying, or

   b. Delayed minor symptoms after 24 hours

4. Patient destination for patients with decompression emergencies shall be determined by the hyperbaric chamber physician on call.

III. Responsibilities of the MAC:

A. Contact the hyperbaric chamber physician on call at LAC+USC Medical Center and arrange communications between the physician and the base hospital directing the call. If there has been no response from the LAC+USC hyperbaric physician within 10 minutes, the MAC will call the next hyperbaric physician on the list.

B. Following consultation with the hyperbaric physician on call, determine which hyperbaric chamber is most appropriate to the needs of the patient. Factors to be considered include distance; altitude; weather; ETA of available transportation; the limitations of various aircraft and the condition of the patient.

C. Inform the appropriate receiving facility of the patient's condition and ETA.

D. Coordinate the hyperbaric chamber personnel's transportation to the chamber.

E. Coordinate secondary transfers from the receiving facility as needed.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 502, **Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 516, **Return of Spontaneous Circulation (ROSC) Patient Destination**
Ref. No. 814, **Determination/Pronouncement of Death in the Field**

Reference No. 518 - Decompression Emergencies/Patient Destination

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	12/09/2020	12/09/2020	N
	Base Hospital Advisory Committee	12/16/2020	12/16/2020	N
	Data Advisory Committee			
	Education Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

***** See **Summary of Comments** (Attachment B)

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC)

SUBJECT: **FIRELINE EMERGENCY MEDICAL TECHNICIAN – PARAMEDIC (FEMP)** REFERENCE NO. 804

PURPOSE: To establish procedures for Fireline paramedic response from and to agencies within or outside Los Angeles County EMS Agency jurisdiction when requested through the statewide Fire and Rescue Mutual Aid System, to respond to and provide Advance Life Support (ALS) care on large scale incidents.

AUTHORITY: California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.220
California Code of Regulations, Title 22, Division 9, Sections 100166 and 100167
California Fire Service and Rescue Emergency Mutual Aid System, Mutual Aid Plan, (3-2002).

DEFINITION:

Fireline Emergency Medical Technician-P (FEMP): A paramedic who meets all pre-requisites established by FIRESCOPE and is authorized by their department to provide Advanced Life Support (ALS) treatment on the fireline.

PRINCIPLES:

1. When authorized by the Incident Commander or designee at an incident a paramedic may utilize the scope of practice for which they are trained and accredited according to the policies and procedures established by their accrediting local EMS agency.

2. These guidelines are not intended to replace existing regional EMS policies or circumvent the established response of EMS in the local County.

3. Upon initial request by an agency for FEMP support, the sending provider agency shall notify the EMS Agency by contacting the Medical Alert Center (MAC) at (562) 378-1789 to provide the MAC operator with the following information: First and last name of the paramedic, State paramedic number, local accreditation number, name and location of the incident where they are being sent. Upon assignment completion, the provider agency shall also notify the MAC of the FEMP's return.

4. Upon arrival, the FEMP is expected to check in and obtain a briefing from the Logistics Section Chief, or the Medical Unit Leader or Incident Commander.

POLICY:

I. Under the authority of State regulations, a paramedic may render ALS care during emergency operations as long as the following conditions are met:

   A. The paramedic is currently licensed by the State of California and is accredited by a County EMS Agency within California.

   B. The paramedic is currently employed and on duty with an approved ALS provider and possesses the requisite wildland fireline skills and equipment.

APPROVED: _____ _____
Director, EMS Agency Medical Director, EMS Agency

C. The paramedic does not exceed the scope of practice or medical control policies from their county of origin.

II. The Los Angeles County FEMP will function within Ref. No. 1200, Treatment Protocols, et al. When communication capability is available, the Medical Alert Center (MAC) shall be contacted at (562) 378-1789 for the EMS Agency Medical Director or designee approval for all procedures. The FEMP may also provide the following treatment(s):

A. Additional doses of morphine sulfate may be administered to patients with a pain level of seven (7) or greater as follows: if respiratory rate >10 per minute and SBP>100mmHg, 2mg slow intravenous (IV) push. May repeat every 5 minutes to a maximum total dose of 20mg.

B. Additional doses of fentanyl may be administered to patients with a pain level of seven (7) or greater as follows: if respiratory rate >10 per minute and SBP>100 mmHg, 50-100mcg titrate to pain relief to a maximum adult dose of 200mcg. FOR APPROVED PROVIDERS ONLY.

C. Additional dose(s) of midazolam may be administered to actively seizing patients: 2-5mg slow IV push until the seizure stops or to a maximum total dose of 10mg.

D. Additional doses of epinephrine 0.5mg IM may be administered to patients with anaphylaxis, whose symptoms persist or recur, repeat every 20 minutes to a maximum of 3 doses.

E. Diphenhydramine can be administered to those patients with hives and itching due to an allergic reaction and have adequate perfusion. It may be given as 50mg slow IV push or deep IM.

F. Fluid resuscitate in 250cc increments of normal saline to maximum of two liters for dehydration or shock (with the exception of cardiogenic shock). May repeat once as needed.

G. An additional dose of ondansetron may be administered for nausea and/or vomiting, 4mg IV or IM or ODT (Orally Disintegrating Tablet). The 4mg dose may be repeated one time after 10 minutes if initial dose not effective.

III. Controlled drugs will be obtained, secured and inventoried as per Ref. No. 702, Controlled Drugs Carried on ALS Units. Controlled drugs shall be inventoried by two paramedics at least daily and anytime there is a change in staff as soon as a second paramedic is available to co-sign.

IV. Documentation of patient care will be completed as per Ref. No. 606, Documentation of Prehospital Care and legible copies of Patient Care Records (PCR) shall be distributed as follows:

A. For incidences occurring within Los Angeles County, the FEMP shall ensure copies of PCRs (independent of normal daily PCRs), are forwarded to the Los Angeles County EMS Agency, Attention: Medical Director.

B. For incidences occurring outside Los Angeles County, the LA County accredited FEMP shall provide copies of PCRs to the on-scene Medical Unit Leader for distribution to the jurisdictional Local Emergency Medical Services Agency of the incident. Additionally, it is the LA County accredited FEMP's responsibility to provide copies of PCRs to Los Angeles County EMS Agency through the mechanism outlined above.

V. Upon arrival at the incident the FEMP shall present their credentials (paramedic license and department identification) to the Medical Unit Leader, who will forward the information (deployment date and location) to the local EMS Agency as soon as possible.

VI. County accredited FEMP shall respond with the ALS/BLS inventory as per Ref. No. 719, Fireline Paramedic ALS Pack Inventory as a minimum standard in their pack while on the fireline. The inventory shall be supplied by the FEMP Provider Agency. (Based on FEMP operation assignments the inventory may be adjusted at the discretion of the Incident Medical Unit Leader).

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**
Ref. No. 719, **Fireline Paramedic ALS Pack Inventory**
Ref. No. 1006, **Paramedic Accreditation**
Ref. No. 1200, **Treatment Protocols**, et al.

FIRESCOPE

Reference No. 804 - Fireline Emergency Medical Technician-Paramedic (FEMP)

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	12/09/2020	12/09/2020	N
	Base Hospital Advisory Committee	12/16/2020	12/16/2020	N
	Data Advisory Committee			
	Education Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

***** See **Summary of Comments** (Attachment B)

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **HONORING PREHOSPITAL DO NOT RESUSCITATE ORDERS, PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT AND END OF LIFE OPTION (AID-IN-DYING DRUG)**

REFERENCE NO. 815

PURPOSE: To allow EMS personnel to honor valid Do Not Resuscitate (DNR) orders or Physician Orders for Life-Sustaining Treatment (POLST) and other patient designated end-of-life directives in the field and act in accordance with the patient's wishes when death appears imminent.

AUTHORITY: California Health and Safety Code, Division 1, Part 1.8, Section 442 – 443
California Health and Safety Code, Division 2.5, Section 1797.220 and 1798
California Probate Code, Division 4.7 (Health Care Decisions Law)

DEFINITIONS:

Advance Health Care Directive (AHCD): A written document that allows an individual to provide healthcare instructions and/or appoint an agent to make healthcare decisions when unable or prefer to have someone speak for them. AHCD is the legal format for healthcare proxy or durable power of attorney for healthcare and living will.

Aid-in-Dying Drug: A drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to terminal illness. The prescribed drug may take effect within minutes to several days after self-administration.

Basic Life Support (BLS) measures: The provision of treatment designed to maintain adequate circulation and ventilation for a patient in cardiac arrest without the use of drugs or special equipment. Examples include:

- Assisted ventilation via a bag-mask device
- Manual or automated chest compressions
- Automated External Defibrillator (AED) – only if an EMT is on scene prior to the arrival of paramedics

Comfort measures: Medical interventions used to provide and promote patient comfort. Comfort measures applicable to the End of Life Option Act may include airway positioning and suctioning.

Do Not Resuscitate (DNR): DNR is a request to withhold interventions intended to restore cardiac activity and respirations. For example:

- no chest compressions
- no defibrillation
- no endotracheal intubation

APPROVED: _____ _____
Director, EMS Agency Medical Director, EMS Agency

- no assisted ventilation
- no vasoactive drugs

End of Life Option Act: This California state law authorizes an adult, eighteen years or older, who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease to make a request for an "aid-in-dying drug" prescribed for the purpose of ending his or her life in a humane and dignified manner.

Physician Orders for Life Sustaining Treatment (POLST): A signed, designated physician order form that addresses a patient's wishes about a specific set of medical issues related to end-of-life care. May be used for both adult and pediatric patients.

Resuscitation: Interventions intended to restore cardiac activity and respirations, for example:

- cardiopulmonary resuscitation
- defibrillation
- drug therapy
- other life saving measures

Standardized Patient-Designated Directives: Forms or medallion that recognizes and accommodates a patient's wish to limit prehospital treatment at home, in long term care facilities or during transport between facilities. Examples include:

- Statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form, (Ref. No. 815.1)
- Physician Orders for Life-Sustaining Treatment (POLST, Ref. No.815.2)
- State EMS Authority-Approved DNR Medallion

Supportive Measures: Medical interventions used to provide and promote patient comfort, safety, and dignity. Supportive measures applicable for POLST and AHCD may include but are not limited to:

- Airway maneuvers, including removal of foreign body
- Suctioning
- Oxygen administration
- Hemorrhage control
- Oral hydration
- Glucose administration
- Pain control (i.e., morphine)

Valid DNR Order for Patients in a Licensed Health Care Facility:

- A written document in the medical record with the patient's name and the statement "Do Not Resuscitate", "No Code", or "No CPR" that is signed and dated by a physician, or
- A verbal order to withhold resuscitation given by the patient's physician who is physically present at the scene and immediately confirms the DNR order in writing in the patient's medical record, or
- POLST with DNR checked, or
- AHCD when the instructions state resuscitation should be withheld/discontinued

Valid DNR Order for Patients at a Location Other Than a Licensed Facility:

- EMSA/CMA Prehospital Do Not Resuscitate Form, fully executed, or
- DNR medallion, or
- POLST with DNR checked, or
- AHCD when the instructions state resuscitation should be withheld/discontinued

PRINCIPLES:

1. The right of patients to refuse unwanted medical intervention is supported by California statute.

2. Withhold or discontinue patient resuscitation if a valid AHCD or standardized patient-designated directive is provided.

3. If the patient's personal physician will sign the death certificate, invasive equipment (i.e., intravenous line, endotracheal tube) used on the patient may be removed.

4. Patients are encouraged to utilize one of the standardized patient-designated directives to ensure that end-of-life wishes are easily recognizable. If the patient is in a private home, the DNR or POLST should be readily accessible or clearly posted.

5. Photocopies of all the patient-designated directives are acceptable.

6. After a good faith attempt to identify the patient, EMS personnel should presume that the identity is correct.

7. A competent person may revoke their patient-designated directive at any time.

8. An adult individual, eighteen years or older, who has the capacity to make medical decisions and has a terminal illness may receive a prescription for an aid-in-dying drug and self-administer the aid-in-dying drug in order to end his or her life in a humane and dignified manner.

9. A health care provider, including EMS personnel, shall not be subject to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating in good faith compliance with the End of Life Option Act.

POLICY:

I. General Procedures for EMS Personnel for Patients with a DNR, POLST or AHCD

   A. Confirm the patient is the person named in the patient-designated directive. This will normally require either the presence of a form of identification or a witness who can reliably identify the patient.

   B. Initiate BLS measures immediately on patients in cardiopulmonary arrest pending verification of a valid patient-designated directive or the criteria for discontinuing resuscitative measures outlined in Ref. No. 814, Determination/ Pronouncement of Death in the Field, Policy I, C, have been met.

C. Begin resuscitation immediately and contact the base hospital for further direction if family members/caretakers disagree or object to withholding resuscitation, or if EMS personnel have any reservations regarding the validity of the DNR directive.

D. Transport to the facility designated by the physician or family members if the patient‘s condition deteriorates during transport and they have a valid DNR. This includes 9-1-1 and non-9-1-1 transports.

E. For DNR Patients who have been discharged from hospital to home or skilled nursing facility and expire (cessation of respirations and no palpable pulses) during transport:

1. Do not initiate any resuscitation efforts.
2. Notify discharging hospital.
3. Transport back to discharging hospital.

F. Documentation of a DNR incident shall include, but is not limited to, the following:

1. Check the “DNR” box on the EMS Report Form.

2. Describe the care given. Print the base hospital physician’s name, if consulted, and the date of the DNR directive.

3. Note the removal of any invasive equipment.

4. Document DNR orders written in the medical record of a licensed facility, including, the date signed, physician name, and other appropriate information or provide a copy of the DNR with the EMS Report Form.

5. Provide a copy of the AHCD and/or other patient-designated directive with the EMS Report Form, when possible.

II. Directive-Specific Procedures

A. AHCD

1. A valid AHCD must be:

a. Completed by a competent person age 18 or older
b. Signed, dated, and include the patient’s name
c. Signed by two witnesses or a notary public
d. Signed by a patient advocate or ombudsman if the patient is in a skilled nursing facility

2. If the situation allows, EMS personnel should make a good faith effort to review the AHCD and/or consult with the patient advocate.

3. Base contact is required for any AHCD instructions other than withholding

resuscitation.

4. If the agent or attorney-in-fact is present, they should accompany the patient to the receiving facility.

B. State EMS Authority-Approved DNR Medallion

1. A medallion or bracelet attached to the patient is considered the most accurate form of identification for anyone not in a licensed facility.

2. Medallions are issued only after a copy of the DNR or POLST is received from an applicant. There are three (3) medallion providers approved in California; contact information:

a. Medic Alert Foundation
2323 Colorado Avenue
Turlock, CA 95382
Phone: 24-hour Toll Free Number (888) 633.4298
Toll Free FAX: (800) 863-3429
www.medicalert.org

b. Caring Advocates
2730 Argonauta Street
Carlsbad, CA 92009
Phone: 1-800-647-3223
www.caringadvocates.org

c. StickyJ Medical ID
10801 Endeavour Way #B
Seminole, FL 33777
Phone: 1-866-497-6265
www.stickyj.com

3. If the medallion is engraved “DNR”, treat in accordance with Ref. No. 815.1, Prehospital Do Not Resuscitate Form.

4. If the medallion is engraved “DNR/POLST” and the POLST is available, treat as indicated on the POLST.

5. If the medallion is engraved “DNR/POLST” and the POLST is **not available**, treat in accordance with the DNR until the valid POLST is produced.

3. Physician Orders for Life Sustaining Treatment (POLST)

1. The POLST must be signed and dated by the physician, and the patient or the legally recognized decision maker. No witness to the signatures is necessary.

2. The POLST is designed to supplement, not replace an existing AHCD. If the POLST conflicts with the patient's other health care instructions or advance directive, then the most recent order or instruction governs.

3. In general, EMS personnel should see the written POLST unless the patient's physician is present and issues a DNR order.

4. There are different levels of care in Sections A and B of the POLST. Medical interventions should be initiated, consistent with the provider's scope of practice and POLST instructions.

5. Contact the base hospital for direction in the event of any unusual circumstance.

III. End of Life Option Act

A patient who has obtained an aid-in-dying drug has met extensive and stringent requirements as required by California law. The law offers protections and exemptions for healthcare providers but is not explicit about EMS response for End of Life Option Act patients. The following guidelines are provided for EMS personnel when responding to a patient who has self-administered an aid-in-dying drug.

A. Within 48 hours prior to self-administering the aid-in-dying drug, the patient is required to complete a "Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner". However, there is no mandate for the patient to maintain the final attestation in close proximity of the patient. If a copy of the final attestation is available, EMS personnel should confirm the patient is the person named in the final attestation. This will normally require either the presence of a form of identification or a witness who can reliably identify the patient.

B. There are no standardized "Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner" forms but the law has required specific information that must be in the final attestation (see sample Ref. No. 815.3). If available, EMS personnel should make a good faith effort to review and verify that the final attestation contains the following information:

1. The document is identified as a "Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner"

2. Patient's name, signature, and dated

C. Provide comfort measures (airway positioning, suctioning) and/or airway/ventilation measures when applicable.

D. Withhold resuscitative measures if patient is in cardiopulmonary arrest. If a POLST or AHCD is present, follow the directive as appropriate for the clinical situation.

E. The patient may at any time withdraw or rescind his or her request for an aid-in-dying drug regardless of the patient's mental state. In this instance, EMS personnel shall provide medical care based on the discussion with the patient and as per standard protocols. EMS personnel are encouraged to consult with their base hospital in these situations.

F. Family members may be at the scene of a patient who has self-administered an aid-in-dying drug. If there is objection to the End of Life Option Act, inform the family that comfort measures will be provided and consider Base Hospital contact for further direction.

G. Obtain a copy of the final attestation and attach it with the EMS Report Form, when possible.

CROSS REFERENCE:

Prehospital Care Manual

Ref. No. 502, **Patient Destination**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 814, **Determination/Pronouncement of Death in the Field**
Ref. No. 815.1, **EMSA/CMA Prehospital Do Not Resuscitate (DNR) Form**
Ref. No. 815.2, **Physician Orders for Life-Sustaining Treatment (POLST) Form**
Ref. No. 815.3, **Sample - Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner**
Ref. No. 815.4, **End of Life Option Field Quick Reference Guide**

Emergency Medical Services Authority #311: Do Not Resuscitate (DNR) and Other Patient-Designated Directives. EMS Personnel Guideline Limiting Prehospital Care, 6th Revision, October 2018

POLICY REVIEW – COMMITTEE ASSIGNMENT REFERENCE NO. 202.1
(ATTACHMENT A)

Ref. No. 815, DO NOT RESUSCITATE ORDERS, PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT AND END OF LIFE OPTION (AID-IN-DYING DRUG)

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	10/14/20	10/14/19	Y
	Data Advisory Committee			
	Provider Agency Advisory Committee	10/21/20	10/21/20	
	Medical Council			
OTHER COMMITTEES / RESOURCES	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California – EHS Committee	11/09/20	11/09/20	
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

*****See Ref. No. 202.2, **Policy Review - Summary of Comments**

POLICY REVIEW - SUMMARY OF COMMENTS REFERENCE NO. 202.2
(ATTACHMENT B)

Ref. No. 815, DO NOT RESUSCITATE ORDERS, PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT AND END OF LIFE OPTION (AID-IN DYING DRUG)

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy I. E.3	BHAC 10-14-2020	Add after "…discharging hospital" the phrase "unless otherwise specified through discharge instructions or request from family to continue transport to home in the event patient expires"	Change Made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EMS PILOT AND SCIENTIFIC STUDIES** REFERENCE NO. 830

PURPOSE: To provide a uniform procedure for acquiring authorization to conduct a pilot or a scientific study to perform additional prehospital treatment procedures or administer additional drugs not currently a part of the paramedic scope of practice.

AUTHORITY: Health & Safety Code, Division 2.5, Sections 1797.221, 24170-24179.5
California Code of Regulations, Title 22, Division 9, Chapter 4, Section 100146
Federal Policy for the Protection of Human Subjects, DHHS Regulations 45 CRF 46, FDA Regulations-CRF Title 21

DEFINITION:

Pilot or Scientific Study: For the purposes of this policy, a pilot or scientific study is an evaluation or assessment of a study population in which a medication, device, assessment process, or treatment procedure is introduced or withheld. Descriptive or observational studies that do not introduce or withhold a drug, device, assessment process, or treatment procedure using EMS systemwide data may require, at the discretion of the Emergency Medical Services (EMS) Agency Medical Director, a data use approval as per Ref. Nos. 622, 622.1 through 622.5 and/or Institutional Review Board (IRB) submission/approval prior to implementation.

PRINCIPLES:

1. All pilot or scientific studies must be submitted for review and approval by the EMS Agency Medical Director or designee prior to implementation.

2. The EMS Agency Medical Director may approve or conduct any pilot or scientific study of the efficacy of the prehospital emergency use of any medication, device, or treatment procedure within the local EMS system, utilizing any level of prehospital emergency medical care personnel. The study shall be consistent with any requirements established by the California EMS Authority for pilot or scientific studies conducted within the prehospital emergency medical care system, and, where applicable, with the California Health and Safety Code, Division 104, Part 5, Chapter 6, Article 5, Section 111550-111610.

3. No medication, device, or treatment procedure that is specifically excluded by the California EMS Authority from usage in the EMS system shall be included in a pilot or scientific study without the approval of the EMS Agency Medical Director and the Director of the California EMS Authority.

4. All proposed pilot or scientific studies shall not be implemented prior to approval by the EMS Agency Medical Director.

5. If applicable, IRB review may be required for approval at the discretion of the EMS Agency Medical Director.

APPROVED: _____ _____
Director, EMS Agency Medical Director, EMS Agency

6. Any pilot, scientific study, descriptive or observational study using data or information under the authority of, or maintained and managed by, the EMS Agency must be approved by the EMS Agency Director and Medical Director. Requests for use of such data must be made in writing to the EMS Agency (refer to to Ref. Nos. 622, 622.1 through 622.5).

POLICY:

I. A pilot or scientific study proposal shall include the following information:

A. A letter of request addressed to the EMS Agency Medical Director which includes the following:

1. A statement of the pilot or scientific study objective(s) and a description of the proposed procedure(s) or medication(s), the medical conditions for which they are to be utilized, and the target population

2. Timeline for study implementation, and duration of the study based on anticipated uses/enrollment

3. Specific, measurable outcome(s) that will be used to evaluate the success of the study

B. Study's outcome measure/data analysis which include:

1. Quality improvement plan for evaluating efficacy and safety

2. Defined outcome measures

3. Data collection tool(s)

4. Approved IRB application, applicable if intent to publish results of the study

C. Recommended policies and procedures to be instituted by the EMS Agency regarding the use and medical control of the procedure(s) or medication(s) used in the study, if necessary.

D. A description of the training and competency testing required to implement the study. The study should have a primary instructor who is knowledgeable, skilled and current in the subject matter of the educational material relevant to the proposed study.

E. Statement of costs to patient or providers.

F. Statement of legal authority for the use of the proposed drug(s) or procedure(s).

G. Letters from provider agencies participating in the study indicating their willingness to participate.

H. Letters from hospitals participating in the study indicating willingness to participate, and review by their IRB when applicable.

II. Upon approval of a pilot or scientific study, the investigator shall:

A. In collaboration with the EMS Agency, notify all hospitals, EMS provider agencies, and appropriate private entities or political jurisdictions involved or affected by the study.

B. Conduct training sessions for all hospitals, EMS provider agencies and personnel involved in the study, if necessary.

C. Submit quarterly updates to the EMS Agency Medical Director on the progress of the study, number of patients studied, beneficial effects and adverse reactions or complications, and appropriate interim analysis, whenever applicable. The investigator(s) may be requested to present study results/findings to the Medical Advisory Council.

D. Immediately inform the EMS Agency Medical Director of any unanticipated adverse events or departure from the protocol, including discontinuation of the study, prior to its completion.

E. Provide the final results/data analysis to the EMS Agency at the conclusion of the study (and interim as determined by the EMS Agency Medical Director during the approval process) based on the agreed upon data analysis plan and target outcomes.

III. The EMS Agency shall:

A. Notify the study proposer within 14 days of receiving the request for pilot or scientific study that it was received and request any missing information.

B. Involve the Medical Advisory Council; Innovation, Technology, and Advancement Committee (ITAC); or any other relevant Specialty Care Center Advisory Committee to assist with the evaluation and approval of the proposed study, if warranted.

C. Notify the study proposer within forty-five (45) days from receipt of the complete study proposal of approval or denial of the proposed study.

D. If applicable, submit the pilot or scientific study proposal to the California EMS Authority for approval. The EMS Agency may request assistance from the study investigators to prepare the necessary materials for submission to the California EMS Authority.

E. Notify the research proposer of approval or disapproval of the pilot or scientific study by the California EMS Authority.

F. Submit the research proposer’s written study conclusions or progress report to the California EMS Commission (EMSC) within 18 months of the initiation of the drug, device, or procedure intervention. The conclusion or progress report should include, at a minimum, the study objective(s); number of patients studied; beneficial effects; adverse reactions or complications; appropriate statistical evaluation; and general conclusions. If the trial or scientific study is extended beyond the initially-approved time frame, submit a final report to the California EMSC.

G. Discontinue a study for safety or other concerns at any time at the EMS Agency Medical Director's discretion.

H. Provide a written conclusion based on the results of the study which will include one of the following:

1. Implementation: Suitable for systemwide implementation as directed by the EMS Agency Medical Director

2. Optional Use: EMS provider agencies maintain responsibility for education, training, and oversight of product/procedure/innovation use

3. Pilot: Require that an EMS provider agency continue a specified pilot period and continue to submit pilot study data to the EMS Agency on a quarterly basis

4. Insufficient Data: There is insufficient data to support continuation of the study. Discontinuation of the study indefinitely. This conclusion may change with introduction of new/additional evidence.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 204, **Medical Advisory Council**
Ref. No. 205, **Innovation, Technology, and Advancement Committee (ITAC)**
Ref. No. 622, **Release of EMS Data**
Ref. No. 622.1, **Data Request and Levels of Support**
Ref. No. 622.2, **Limited Data Set Information**
Ref. No. 622.3, **Intended Use of Limited Data Set Information**
Ref. No. 622.4, **Data Use Agreement**
Ref. No. 622.5, **Confidentiality Agreement**

POLICY REVIEW – COMMITTEE ASSIGNMENT REFERENCE NO. 202.1
(ATTACHMENT A)

Ref. No. 830, EMS PILOT AND TRIAL STUDIES

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	10/14/20	10/14/19	
	Data Advisory Committee			
	Provider Agency Advisory Committee	10/21/20	10/21/20	Y
	Medical Council			
OTHER COMMITTEES / RESOURCES	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California – EHS Committee			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

*****See Ref. No. 202.2, **Policy Review - Summary of Comments**

POLICY REVIEW - SUMMARY OF COMMENTS REFERENCE NO. 202.2
(ATTACHMENT B)

Ref. No. 830, EMS PILOT AND SCIENTIFIC STUDIES

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Definition	PAAC 10-21-2020	Add after “Descriptive or observational studies that do not introduce or withhold a drug, device, assessment process or treatment procedure” the phrase “using EMS systemwide data”	Change Made

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
Director

Gregory C. Polk, M.P.A.
Chief Deputy Director

Curley L. Bonds, M.D.
Chief Medical Officer

Lisa H. Wong, Psy.D.
Senior Deputy Director

January 1, 2021

TO: All Los Angeles County Law Enforcement Agencies

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

SUBJECT: **TRANSPORTATION AND DESTINATION OF INDIVIDUALS ON BEHAVIORAL HEALTH HOLDS**

The hospital system within Los Angeles County is experiencing an extreme surge of patients with COVID-19 who require acute care in the emergency departments and hospitals.

In order to assist the Department of Health Service (DHS), the Department of Mental Health (DMH) is requesting that law enforcement agencies transport individuals placed on a 5150 hold and without medical complaints to the following mental health facilities (please see list attached), thereby diverting patients away from hospital emergency departments.

This directive will help to ensure that our hospitals are optimizing their capacity to treat and admit patients with medical conditions. Please direct any questions to Dr. Amanda Ruiz at (213) 294-1297 or Amaruiz@dmh.lacounty.gov.

JES:tld

Attachment

c: Hospital Association of Southern California
Los Angeles Police Chiefs Association
Department of Health Services
EMS Agency
Gregory Polk
Amanda Ruiz

Name of Facility/Address	Point of Contact
San Fernando Valley Olive View Urgent Community Care Services 14659 Olive View Drive Sylmar, CA 91342 Ph: (818) 485-0888	James Coomes jcoomes@dmh.lacounty.gov
(Eastside) Exodus Urgent Care Center 1920 Marengo Street Los Angeles, CA 90033 Ph: (323) 276-6400 Fax: (323) 276-6498 (Westside) Exodus Urgent Care Center 11444 W. Washington Blvd., Suite D Los Angeles, CA 90066-6024 Ph: (310) 253-9494 Fax: (310) 253-9495 MLK Urgent Care Center by Exodus 12021 S. Wilmington Avenue Los Angeles, CA 90059 Ph: (562) 295-4617 Intake: 1-800-829-3923 Harbor Exodus Urgent Care Center 1000 W. Carson Street, Bldg. 2 South Torrance, CA 90502 Ph: (424) 405-5888	Luana Murphy lmurphy@exodusrecovery.com Kathy Shoemaker kshoemaker@exodusrecovery.com
La Casa Mental Health Urgent Care Center 6060 Paramount Boulevard Long Beach, CA 90805 Ph: (562) 790-1860 Fax: (562) 529-2463 (not open 24/7)	David Heffron dheffron@telecarecorp.com
Providence Little Company of Mary Medical Center San Pedro 1300 W. 7th Street San Pedro, CA 90732 Ph: (310) 832-3311	Courtney Harrison courtney.harrison@providence.org Leslie Diaz leslie.diaz@providence.org
Stars Behavioral Health Urgent Care Center 3210 Long Beach Boulevard Long Beach, CA 90807 Ph: (562) 548-6565 Stars Behavioral Urgent Care 18501 Gale Avenue, Suite 100 City of Industry, CA 91748 Ph: (626) 626-4997	Steve Albrect salbrecht@starsinc.com Austina Cho acho@starsinc.com C. Jenks cjenks@starsinc.com

5.5 BUSINESS (NEW)

OLYMPIA MEDICAL CENTER
5900 W. Olympic Boulevard
Los Angeles, California 90036

FAX

Fax Transmittal Form

To

Name: Cathy Chidester, RN, Director, LA County EMS Agency
Fax number: ~~(213-633-5100~~ 562-941-5835

From

Sender's Name: Matt Williams, CEO

Date Sent: December 30, 2020
# of pages including cover page: 6

Urgent _X__
For Review ___
Please Comment __
Please Reply

Message:

See Attached

OLYMPIA MEDICAL CENTER
5900 W. Olympic Boulevard
Los Angeles, California 90036

December 30, 2020

Via Facsimile & Federal Express Heidi Steinecker Deputy Director Center for Health Care Quality California Department of Public Health 1615 Capitol Avenue, Suite 741, MS 0512 Sacramento, CA 95814	Via Facsimile & Federal Express Nwamaka Oranusi Chief, Health Facilities Inspection Division Los Angeles District Office California Department of Public Health 12440 E. Imperial Highway, Suite 522 Norwalk, CA 90650
Via Facsimile & Federal Express Lena Resurrecion Program Manager, Licensing & Certification Acute & Ancillary Unit Los Angeles District Office California Department of Public Health 3400 Aerojet Avenue, #323 El Monte, CA 91731	Via Facsimile & Federal Express Christina R. Ghaly, M.D., Director County of Los Angeles Dept. of Health Services 313 N. Figueroa Street Los Angeles, CA 90012
Via Facsimile & Federal Express Los Angeles County Board of Supervisors c/o Celia Zavala, Executive Officer Los Angeles County Board of Supervisors 500 W. Temple Street, Room 383 Los Angeles, CA 90012	Via Facsimile & Federal Express Cathy Chidester, RN Director, Emergency Medical Services Los Angeles County EMS Agency 10100 Pioneer Boulevard, Suite 200 Santa Fe Springs, CA 90670

Re: Notice of Suspension of Services

Dear All:

To allow for substantial renovations which will allow the Olympia Medical Center facility to better serve the healthcare needs of the community, Olympia Medical Center ("Olympia") has elected to voluntarily suspend all patient care services, as follows:

(1) Emergency Medical Services under Health & Safety Code §1255 will be suspended as of 11:59 p.m. on March 31, 2021, a date which is more than ninety (90) days after this notice as provided for in Health & Safety Code § 1255.1.

(2) All supplemental services will be suspended no later than 11:59 p.m. on March 31, 2021 provided that certain supplemental services may be suspended after January 31, 2021, more than thirty (30) days after this notice as provided for in Health & Safety Code §1255.25 depending on patient volumes, patient safety, and staffing.

(3) All patient care services will be suspended no later than 11:59 p.m. on March 31, 2021.

Depending on patient volumes, staffing, and physician coverage, there may be times prior to the suspension of services that Olympia may need to go on diversion status as it relates to certain services so as to ensure the safe delivery of patient care.

Pursuant to Health & Safety Code §§ 1255.1 and 1255.25, Olympia hereby provides notices that the services to be suspended will include, without limitation, all emergency medical services, all inpatient services, and all outpatient services provided at Olympia located at 5900 W. Olympic Boulevard, Los Angeles, California 90036, and any outpatient services provided by Olympia at 5901 W. Olympic Boulevard, Los Angeles, California 90036. This notice does not apply to and does not affect the practices of those independent providers and physicians who have offices at 5901 W. Olympic Boulevard, Los Angeles, California 90036.

The suspension of services will involve the following:

(1) Suspension of Olympia's inpatient services including 6 licensed coronary care beds, 6 intensive care beds, and 192 unspecified general acute care beds.

(2) Suspension of Olympia's inpatient and outpatient surgical services.

(3) Suspension of Olympia's other approved services including basic emergency medical services, nuclear medicine, physical therapy, respiratory care services, and social services.

(4) Suspension of Olympia's outpatient services including, without limitation, the following services: (a) Wound Care Clinic at 5900 W. Olympic Boulevard; (b) AIDS at Vascular Lab at 5900 W. Olympic Boulevard; (c) AIDS – PT, OT, Speech Therapy at 5901 W. Olympic Boulevard; (d) Behavioral Health at 5901 W. Olympic Boulevard; and (e) Digestive Diseases at 5901 W. Olympic Boulevard; and

(5) The separation of employment for approximately 450 full-time and part-time employees.

The nearest acute care hospitals in the community include:

(1) Southern California Hospital at Culver City
3828 Delmas Terrace, Culver City, California 90232
Serves Medicare and Medi-Cal Patients

(2) Cedars-Sinai Medical Center
8700 Beverly Boulevard
Los Angeles, California 90048
Serves Medicare and Medi-Cal Patients

(3) Ronald Reagan UCLA Medical Center
757 Westwood Plaza
Los Angeles, California 90085
Serves Medicare and Medi-Cal Patients

Interested parties may offer comments with respect to the suspension of services as follows:

(1) Olympia Medical Center
5900 W. Olympic Boulevard
Los Angeles, California 90036
Attn: Administration
(323) 932-5200

(2) Matt Williams
Chief Executive Officer
Olympia Medical Center
5900 W. Olympic Boulevard
Los Angeles, CA 90036

(3) Alecto Healthcare Services
16310 Bake Parkway, # 200
Irvine, California 92618
Attn: Executive Vice-President
(949) 783-3983

Please note that Olympia has also posted a notice in the form of Exhibit A at the entrances to its facilities and on its website on December 31, 2020 so as to reach a significant number of residents in the community serviced by Olympia. Olympia has also provided notice to those health plans with which it contracts.

Please feel free to contact Michael Sarrao, Olympia's Executive Vice-President & General Counsel at (949) 783-3976 with any questions.

Sincerely,

Matt Williams
Chief Executive Officer

Exhibit A

OLYMPIA MEDICAL CENTER

5900 W. Olympic Boulevard
Los Angeles, California 90036

DECEMBER 31, 2020

TO ALLOW FOR SUBSTANTIAL RENOVATIONS WHICH WILL ALLOW THE OLYMPIA MEDICAL CENTER FACILITY TO BETTER SERVE THE HEALTHCARE NEEDS OF THE COMMUNITY, OLYMPIA MEDICAL CENTER ("OLYMPIA") HAS ELECTED TO VOLUNTARILY SUSPEND ALL PATIENT CARE SERVICES INCLUDING THE EMERGENCY DEPARTMENT AND ALL EMERGENCY MEDICAL SERVICES EFFECTIVE AS OF 11:59 P.M. ON MARCH 31, 2021. THE EMERGENCY DEPARTMENT WILL NOT PROVIDE SERVICES AFTER 11:59 PM ON MARCH 31, 2021. CERTAIN SUPPLEMENTAL SERVICES MAY BE SUSPENDED AFTER JANUARY 31, 2021.

THE SUSPENSION OF SERVICES WILL INVOLVE THE FOLLOWING: (1) SUSPENSION OF OLYMPIA'S INPATIENT SERVICES INCLUDING 6 LICENSED CORONARY CARE BEDS, 6 INTENSIVE CARE BEDS, AND 192 UNSPECIFIED GENERAL ACUTE CARE BEDS; (2) SUSPENSION OF OLYMPIA'S INPATIENT AND OUTPATIENT SURGICAL SERVICES; (3) SUSPENSION OF OLYMPIA'S OTHER APPROVED SERVICES INCLUDING BASIC EMERGENCY MEDICAL SERVICES, NUCLEAR MEDICINE, PHYSICAL THERAPY, RESPIRATORY CARE SERVICES, AND SOCIAL SERVICES; (4) SUSPENSION OF OLYMPIA'S OUTPATIENT SERVICES INCLUDING, WITHOUT LIMITATION, THE FOLLOWING SERVICES: (A) WOUND CARE CLINIC; (B) VASCULAR LAB; (C) PT, OT, SPEECH THERAPY; (D) BEHAVIORAL HEALTH; AND (E) DIGESTIVE DISEASES AND (5) THE SEPARATION OF EMPLOYMENT FOR APPROXIMATELY 450 FULL-TIME AND PART-TIME EMPLOYEES.

The nearest acute care hospitals in the community include:

Southern California Hospital at Culver City 3828 Delmas Terrace Culver City, California 90232 Serves Medicare and Medi-Cal Patients	Cedars-Sinai Medical Center 8700 Beverly Boulevard Los Angeles, California 90048 Serves Medicare and Medi-Cal Patients	Ronald Reagan UCLA Medical Center 757 Westwood Plaza Los Angeles, California 90085 Serves Medicare and Medi-Cal Patients

Interested parties may offer comments with respect to the suspension of services as follows:

Olympia Medical Center 5900 W. Olympic Boulevard Los Angeles, California 90036 Attn: Administration (323) 932-5200	Matt Williams Chief Executive Officer Olympia Medical Center 5900 W. Olympic Boulevard Los Angeles, California 90036 (323) 932-5200	Alecto Healthcare Services 16310 Bake Parkway, #200 Irvine, California 92618 Attn: Executive Vice-President (949) 783-3983

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 378-1500
Fax: (562) 941-5835

"To advance the health of our communities by ensuring quality emergency and disaster medical services."

Health Services
http://ems.dhs.lacounty.gov

January 11, 2021

Matt Williams
Chief Executive Officer
Olympia Medical Center
5900 W. Olympic Boulevard
Los Angeles, CA 90036

ELECTRONIC AND CERTIFIED

SUBJECT: CLOSURE OF OLYMPIA MEDICAL CENTER

Dear Mr. Williams:

The Los Angeles (LA) County Emergency Medical Services (EMS) Agency is in receipt of you letter dated December 30, 2020 regarding voluntary suspension of all patient services at Olympia Medical Center (OMC) effective March 31, 2021, which includes the emergency department and all emergency services. Additionally, six (6) coronary care beds, six (6) intensive care beds and 192 unspecified general acute care beds will also be suspended.

As you are aware, the County is in the middle of a crisis due to the effects of COVID-19 which has led to extensive wait times for ambulances to offload patients in local emergency departments, delays in patient care due to a shortage of locations to place sick individuals and the potential implementation of crisis care due to inadequate hospital resources. The voluntary closure of OMC during this crisis is irresponsible and will cause further hardship on the healthcare system.

Additionally, as required by California Health and Safety Code, Section 1300, a public hearing is required to allow the surrounding community and those individuals potentially impacted, to express their opinions or concerns regarding an impending hospital closure. Due to the current COVID-19 crisis, the EMS Agency is unable to conduct an in-person public hearing but instead it would be online. This would decrease the availability of individuals to access/participate and would not meet the intent of the requirement.

As this is a voluntary suspension to allow for facility upgrades that are currently not affecting the ability of OMC to provide patient care, the EMS Agency is requesting that OMC delay suspension of services for a minimum of six (6) months from the original date. This will allow time for the local healthcare system to begin recovering from the current crisis and allow for an in-person public hearing.

Please feel free to contact me at (562) 378-1604 or cchidester@dhs.lacounty.gov with any questions or for further discussion.

Sincerely,

Cathy Chidester
Director

01-04
CC:cac

c: CDPH
Director, Department of Health Services
Hospital Association of Southern California
LA County EMS Commission

Ambulance Patient Offload Delays

Emergency Medical Services Authority

California Health and Human Services Agency

December 2020

Dave Duncan MD, Director

Ambulance Patient Offload Delays

Most Californians have pulled to the side of the road to allow an ambulance to race past them, lights and siren blaring, on its way to a sick or injured patient. Few Californians imagine that, upon arriving at the hospital, not only the patient, but also the ambulance and medical crew that staff it will sometimes wait. Each year, roughly 70,000 Californians wait over an hour on an ambulance gurney once they arrive at the hospital before their care is assumed by the emergency department staff and they are moved to a hospital bed.

Emergency medical services (EMS) systems and hospital emergency departments (ED) are fundamental components of California's health care delivery network. Together they provide the state's safety net for health care with 24/7 access to emergency health services. Unfortunately, especially in California's urban areas, many[1] EMS and hospital partners who provide these vital services have struggled for decades to ensure that ambulances and ED hospital beds are available when patients need them.

This persistent problem has been given a name: "Ambulance Patient Offload Delays," or "APOD," and the method for measuring this phenomenon is called "Ambulance Patient Offload Time" or "APOT." APOD creates extensive, potentially dangerous wait times for patients and results in idle ambulances and ambulance crews that could instead be responding to other emergencies.

For purposes of evaluating APOT across the state, the EMS Authority, in collaboration with EMS system stakeholders, determined that 20 minutes is the maximum time any Californian transported to a hospital by an ambulance should ever wait at any emergency department in the state before being transferred to a hospital bed.[2]

Background

A multiplicity of factors combined cause APODs, and the imperative to better understand these factors has united EMS system participants, and ultimately led to chaptered legislation:

- In 2015, Assembly Bill (AB) 1223 (O'Donnell, Chapter 379) required effective January 1, 2016, that EMSA create a standard methodology for

[1] Graph 1 below identifies the 90th percentile time (i.e. One out of ten patients wait longer than this time) for individual California hospitals as represented within the data available to EMSA. In many cases there are clearly very few APOT times that are extended, in others, APOT times are frequently excessive.
[2] Backer, H., D'Arcy, N., Davis, A., Barton, B., & Sporer, K. (2019). Statewide Method of Measuring Ambulance Patient Offload Times. *Prehospital emergency care : official journal of the National Association of EMS Physicians and the National Association of State EMS Directors*, 23(3), 319-326.

APOT calculation and reporting with stakeholder engagement and approval from the Commission on EMS.

- AB 1223 also permits Local EMS Agencies (LEMSAs) to adopt policies to calculate and report APOT based on the standard methodology outlined in Health and Safety Code (H&SC) 1797.120. However, APOT reporting was not mandated by the bill, and only nine of the 33 LEMSAs provided some APOT information in 2017.
- In 2018, AB 2961(O'Donnell, Chapter 656) required that LEMSAs submit APOT reports quarterly to the EMS Authority effective July 1, 2019. The bill also requires the EMS Authority to calculate APOT times provided by the LEMSAs and provide biannual reports to EMS Commission and a legislative report on or by December 1, 2020.

Table 1: LEMSA Submissions

	2019		2020	
LEMSA	**Q3**	**Q4**	**Q1**	**Q2**
Alameda	11/5/2019	1/2/2020	4/23/2020	7/13/2020
Central California	10/21/2019	1/28/2020		
Coastal Valleys	11/27/2019			
Contra Costa	10/30/2019	2/3/2020	8/12/2020	8/12/2020
El Dorado	11/1/2019	1/15/2020		
Imperial				
Inland Counties	10/18/2019	7/21/2020	7/21/2020	7/16/2020
Kern	10/21/2019	1/22/2020	4/23/2020	8/3/2020
Los Angeles	12/16/2019	5/1/2020	6/25/2020	9/23/2020
Marin	11/19/2019			
Merced	10/4/2019	1/16/2020	4/14/2020	7/2/2020
Monterey	10/31/2019	1/30/2020	6/11/2020	7/30/2020
Mountain Valley	11/1/2019	6/17/2020	6/17/2020	7/13/2020
Napa	10/30/2019	1/18/2020	9/15/2020	9/15/2020
NorCal	10/23/2019	1/15/2020	4/30/2020	7/29/2020
North Coast	10/31/2019	1/15/2020		8/30/2020
Orange	10/8/2019	1/8/2020	4/20/2020	7/7/2020
Riverside	10/22/2019	1/16/2020	4/7/2020	
Sacramento	10/10/2019	1/8/2020	5/7/2020	7/7/2020
San Benito	10/31/2019	1/9/2020	4/7/2020	7/9/2020
San Diego	10/10/2019	1/15/2020	8/14/2020	8/12/2020
San Francisco	11/19/2019	3/16/2020	6/18/2020	8/3/2020
San Joaquin	10/10/2019	1/6/2020	4/10/2020	7/13/2020
San Luis Obispo	10/24/2019	1/22/2020		
San Mateo	10/7/2019	1/2/2020	5/4/2020	7/2/2020

Santa Barbara	11/13/2019	2/11/2020		
Santa Clara	10/30/2019	1/29/2020	4/2/2020	7/29/2020
Santa Cruz	10/30/2019	2/11/2020	4/10/2020	7/7/2020
Sierra-Sac Valley	10/7/2019	1/5/2020	4/3/2020	7/23/2020
Solano	12/20/2019	1/13/2020	4/23/2020	7/28/2020
Tuolumne	12/26/2019			
Ventura	12/3/2019	1/3/2020	4/7/2020	7/13/2020
Yolo	10/30/2019	1/7/2020		

*Updated 10/14/2020

As noted, APOD has been of concern in some jurisdictions for many decades. These issues include, but are not limited to, simple ED overcrowding. "Throughput," or the sum of the services provided by the hospital per unit of time, is considered a significant contributor to APOD. Cited among a long list of identified or likely causes of decreased throughput are increasingly complex patient conditions, a lack of specialty care physicians, a lack of primary care providers, and increased psychiatric holds due to a lack of community mental health resources[3].

Upon arrival at the hospital emergency department, the ambulance crew is required to formally transfer responsibility for the patient's care to a member of the hospital staff who is of equal or higher certification. To do otherwise would endanger the patient and constitute gross negligence per (H&SC) 1798.200. Typically, this individual at the hospital assuming care of the patient is a registered nurse. Until there is a nurse or other hospital staff member available to accept the patient, the ambulance crew must wait, regardless of the length of that wait.

EMS resources are unavailable to respond to another 911 call until the patient is transferred or admitted to the hospital. There are a finite number of ambulances available in any EMS system, and a lack of available ambulances inevitably leads to slower EMS responses with potentially detrimental results for those who require immediate EMS care.

[3] From "White Paper: EMS Patient Offload Delays in the ED" on page 12: https://www.gao.gov/new.items/d09347.pdf

EMS Authority APOT Program Activities

In August 2014, the California Hospital Association (CHA), the EMS Authority, and a group of stakeholders published the Toolkit to Reduce Ambulance Patient Offload Delays in the Emergency Department. In part, the publication was intended to help system participants develop metrics to better quantify and understand the problem. In December 2016, the Commission on EMS approved the APOT Standardized Methods for Data Collection and Reporting which established two statewide measurements: APOT-1 and APOT-2. APOT-1 and APOT-2 data are submitted to the EMS Authority by LEMSAs. [4]

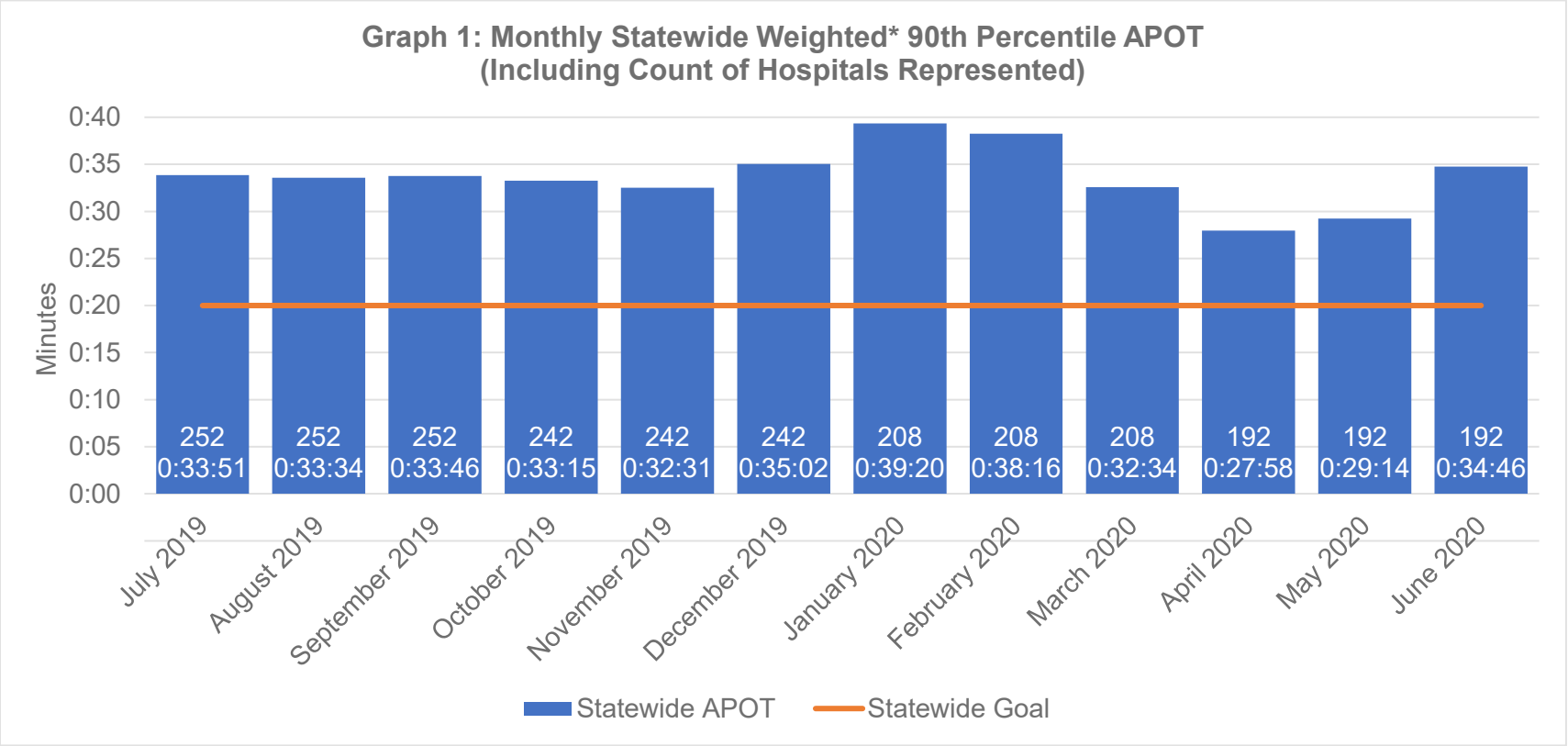
The EMS Authority tracks all APOT submissions and reviews and consolidates the information for analysis. Analysis is performed to determine total hours of delay throughout the state, to identify trends, and to help establish benchmarks. Because the LEMSAs data submissions to EMSA did not include the totality of California' ambulance response areas, not all hospitals are represented in the graphs displayed below.[5]

[4] Additionally, EMSA collects electronic prehospital care patient data from LEMSAs using the California Emergency Medical Services Information System (CEMSIS). EMSA staff has been developing LEMSA-CEMSIS Comparison reports for each LEMSA that has submitted APOT reports and submits data into CEMSIS. This serves as a quality assurance tool for a LEMSA to verify their data submission and show LEMSAs how their APOT within CEMSIS compare with those of other LEMSAs. In the future EMS Authority's will generate all LEMSA APOT reports in CEMSIS to provide data that can be more quickly aggregated and reliably compared, and to reduce an unnecessary replication of effort by LEMSAs.

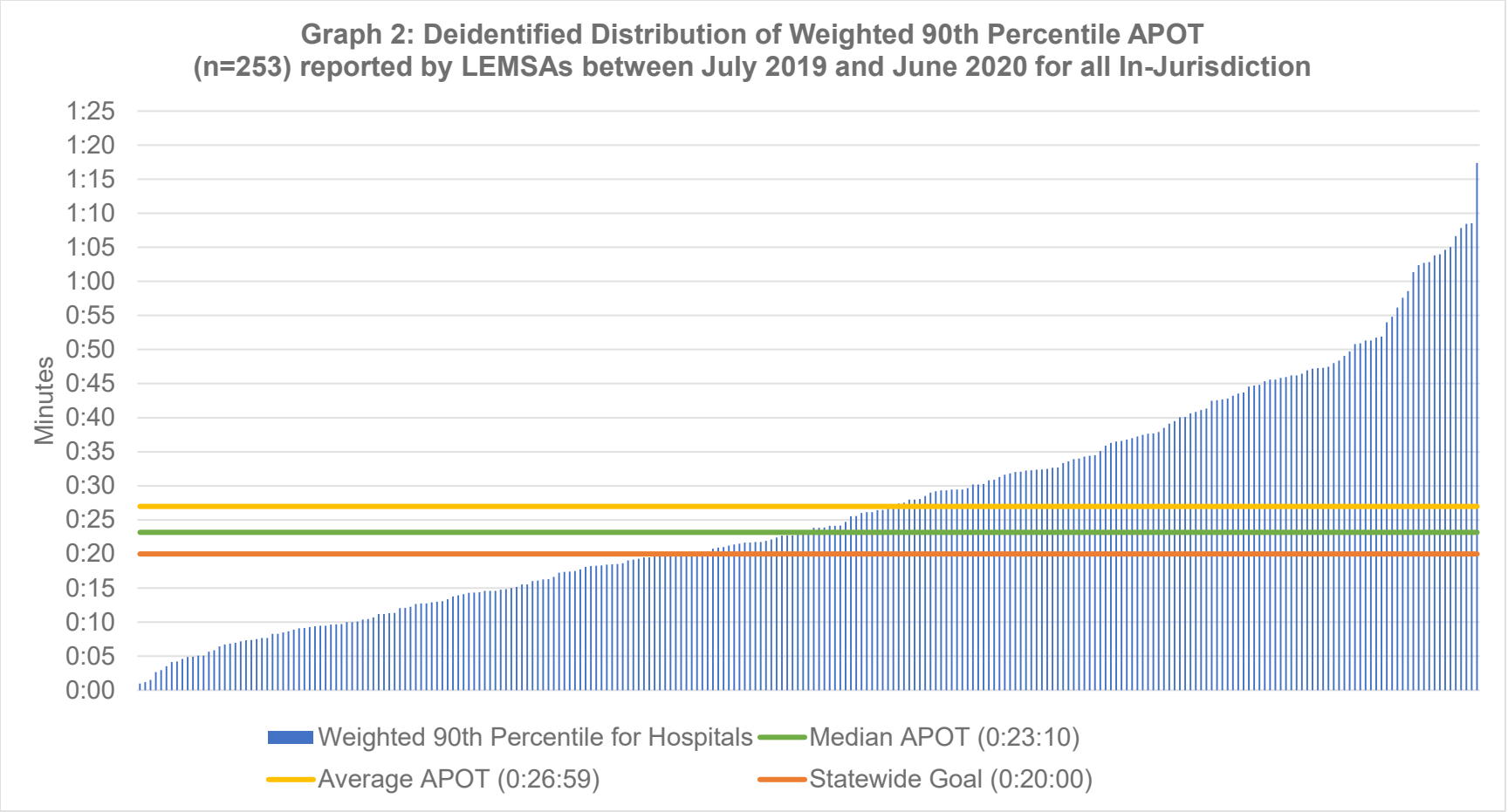
[5] The California Health Care Foundation's 2018 California Health Care Almanac found that "in 2016, 334 acute care hospitals in California operated EDs." P. 2. https://www.chcf.org/wp-content/uploads/2018/08/CAEmergencyDepartments2018.pdf

APOT-1

APOT-1 identifies the number of 911 transports to an emergency department and the 90th percentile time for each hospital. For APOT-1, the weighted 90th percentile is used so all transports hold the same value. This approach allows the opportunity to compare APOT times within a jurisdiction across the state or across multiple months and quarters.



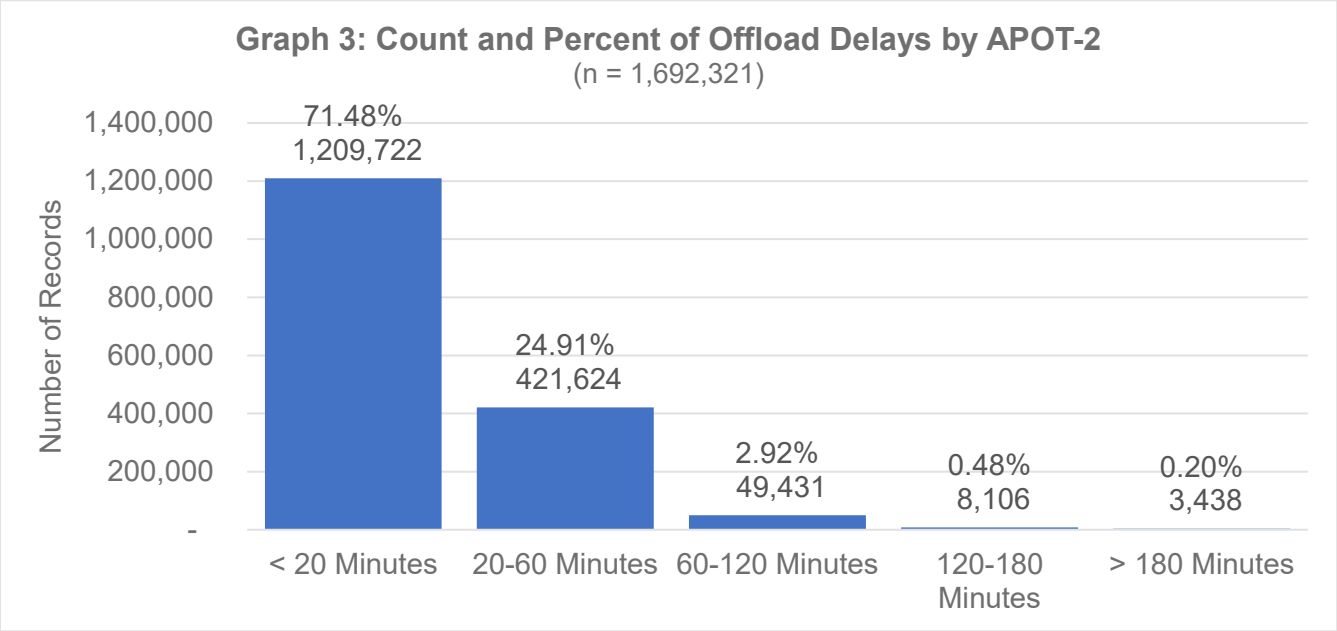
* Graph 1 shows that in July of 2019, the statewide weighted 90th percentile APOT was 33 minutes and 51 seconds, with 252 hospitals included in the data.



*Graph 2 shows the weighted 90th percentile APOT data for all 253 hospitals represented in the data collected between July 2019 and June 2020. Each blue line on the x-axis represents one of the 253 hospitals, with the y-axis representing the average APOT for the duration of the reporting interval.

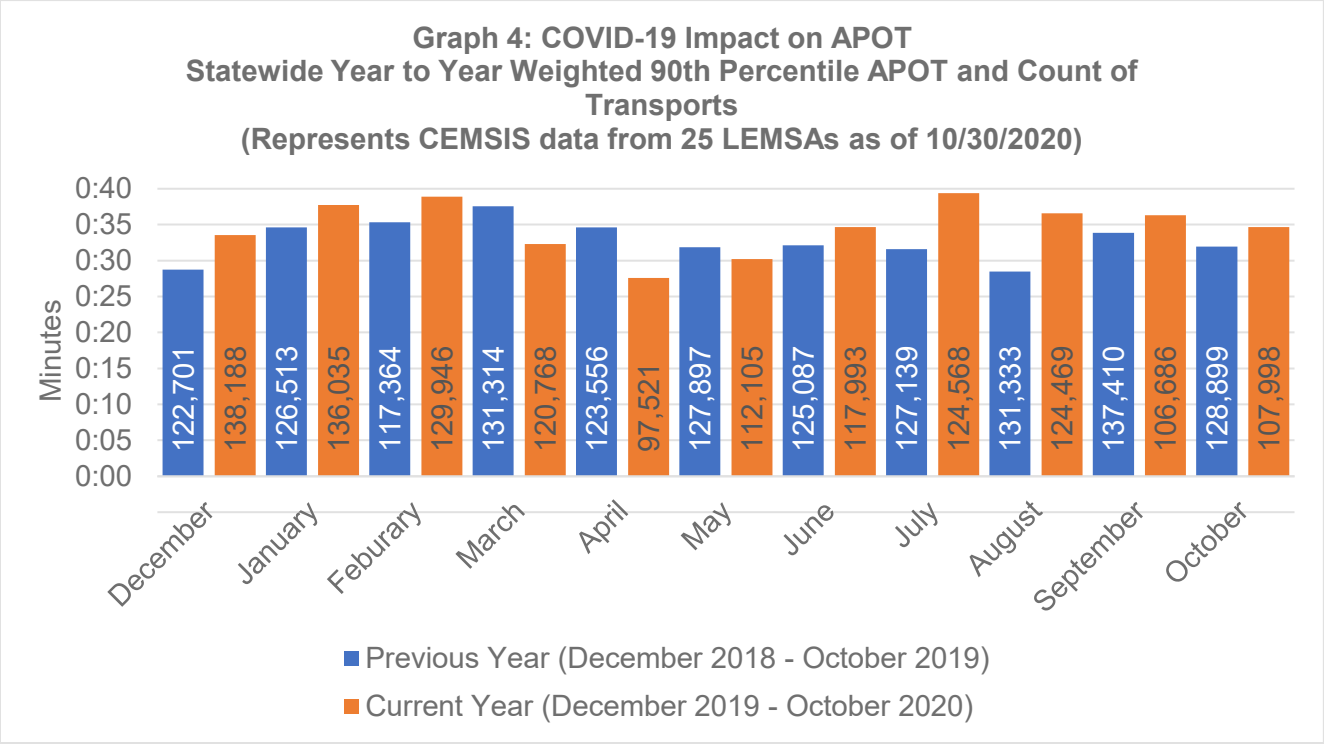
APOT-2

APOT-2 identifies five consecutive time intervals into which transports can be grouped. These time intervals are: Less than 20 minutes, between 20 minutes and 60 minutes, between 60 minutes and 120 minutes, 120 minutes to 180 minutes, and greater than 180 minutes (see Graph 3).



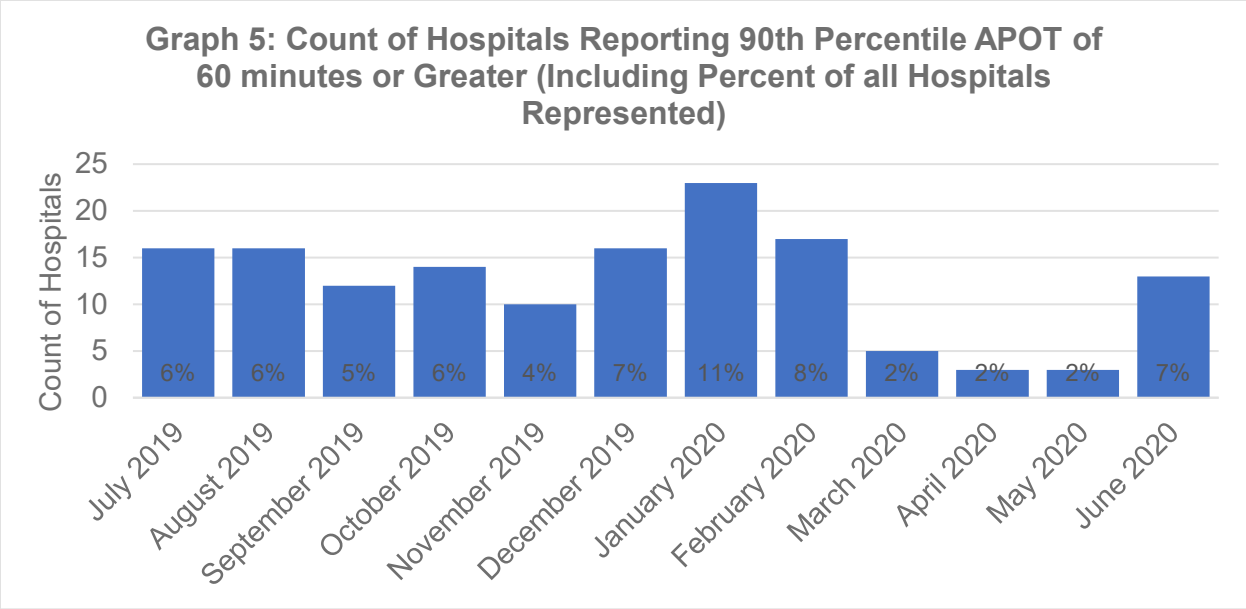
APOT and COVID-19

The EMS Authority has also been tracking the COVID-19 Impact on APOT by running a year-to-year comparison of CEMSIS APOT data from December 2018 to present. EMSA staff continues to monitor, report findings, and identify any trends of 911 transport utilization.[6]

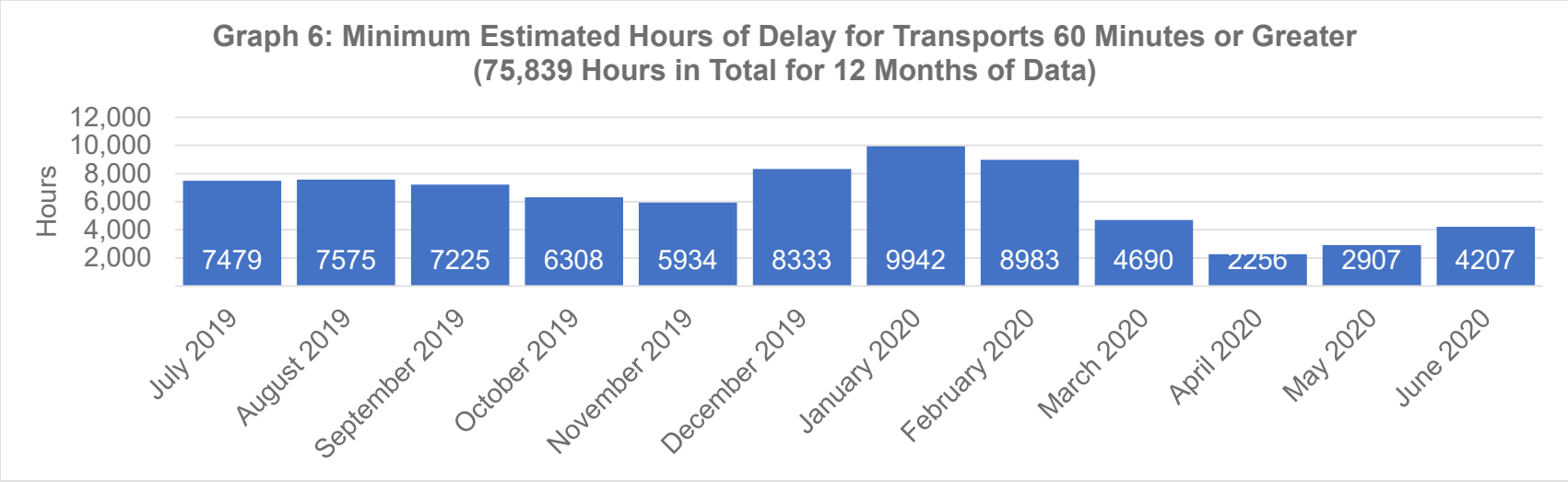


*Graph 4 shows APOT-1 data separated by 12-month intervals within EMSA's data collection period. For example, in February 2019, the statewide APOT-1 was 35 minutes across 117,364 transports. By contrast, February 2020 had an APOT-1 of nearly 40 minutes across 129,946 transports.

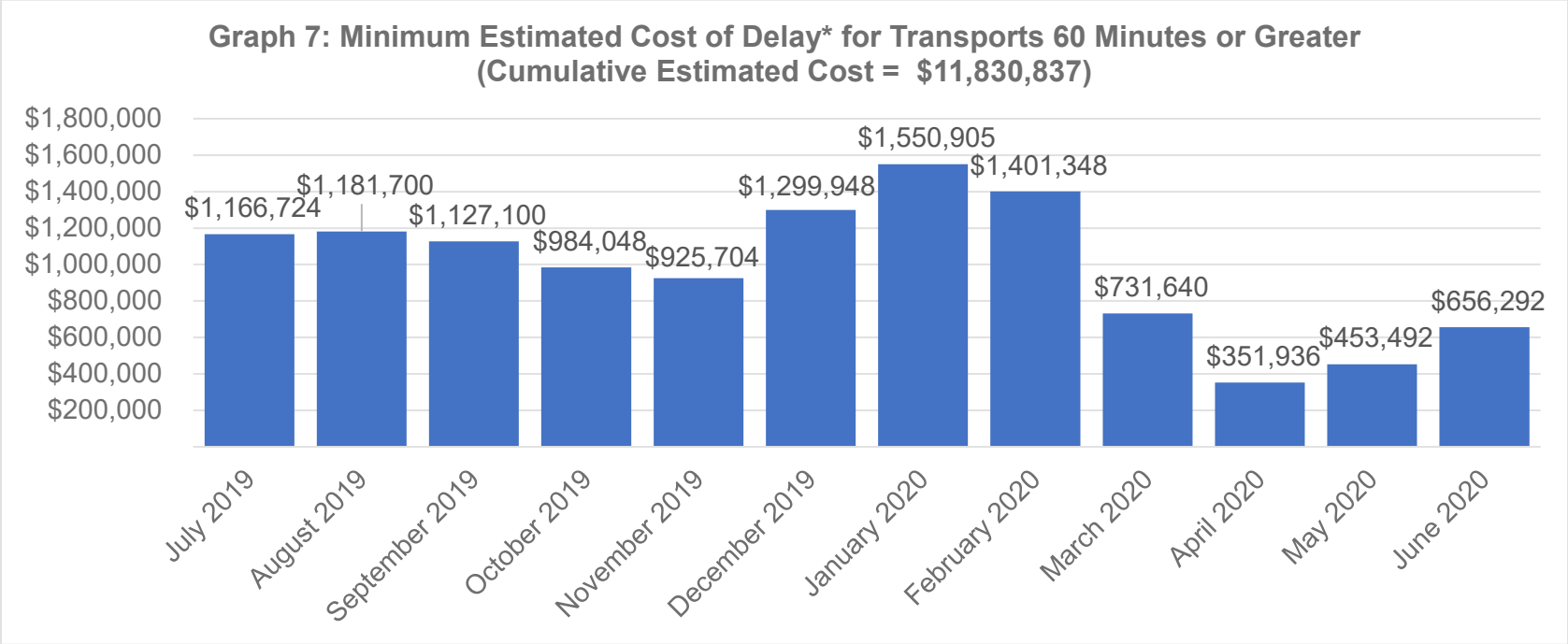
[6] Of the 33 LEMSAs, 32 LEMSAs have provided at least one quarter's worth of data while 22 LEMSAs have provided a full year's worth of data (July 2019-June 2020).



*Graph 5 shows the 90th percentile of ambulance patient offload times that are 60 minutes or greater. For example, in January 2020, LEMSAs reported 11% of offload times were 60 minutes or greater



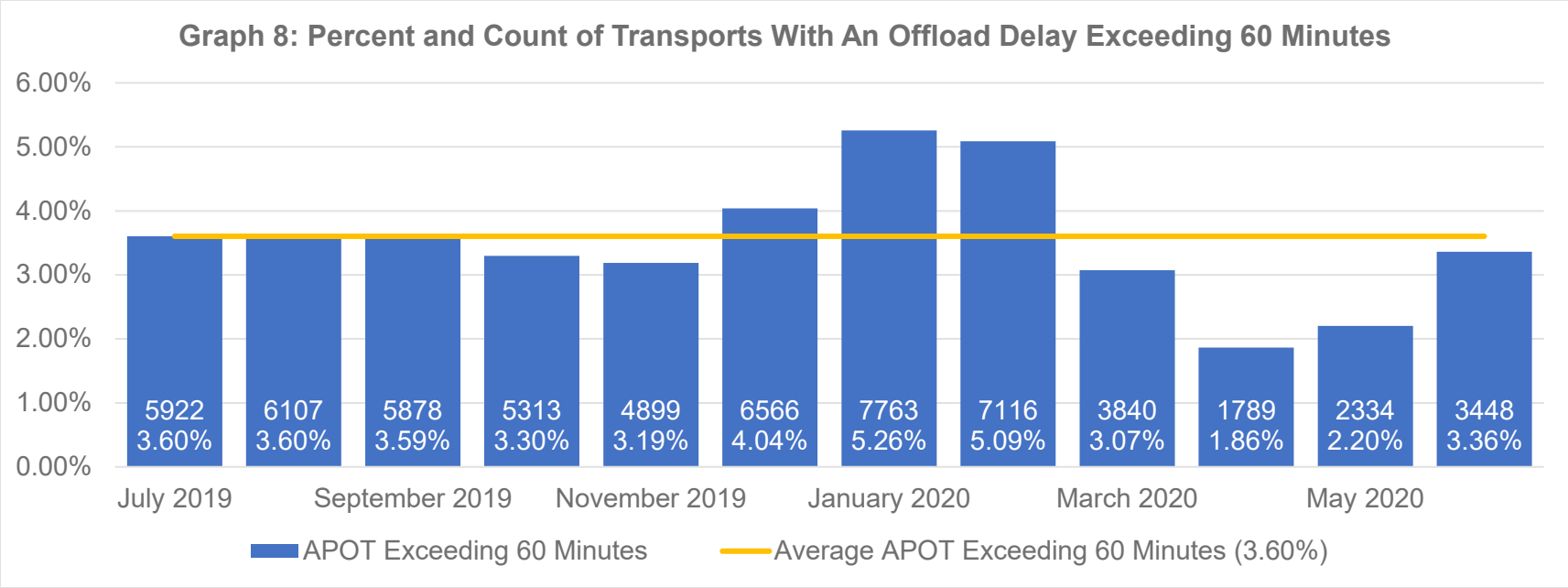
*Graph 6 shows the estimated total hours of delay for all transports occurring between July 2019 and June 2020 that were 60 minutes or greater. For example, in January 2020, the estimated total hours of delay resulting from transports that took 60 or more minutes was 9,942.



*The hour/cost was derived from the "Toolkit to Reduce Ambulance Patient Offload Delays in the Emergency Department" on page 4: https://emsa.ca.gov/wp-content/uploads/sites/71/2017/07/Toolkit-Reduce-Amb-Patient.pdf

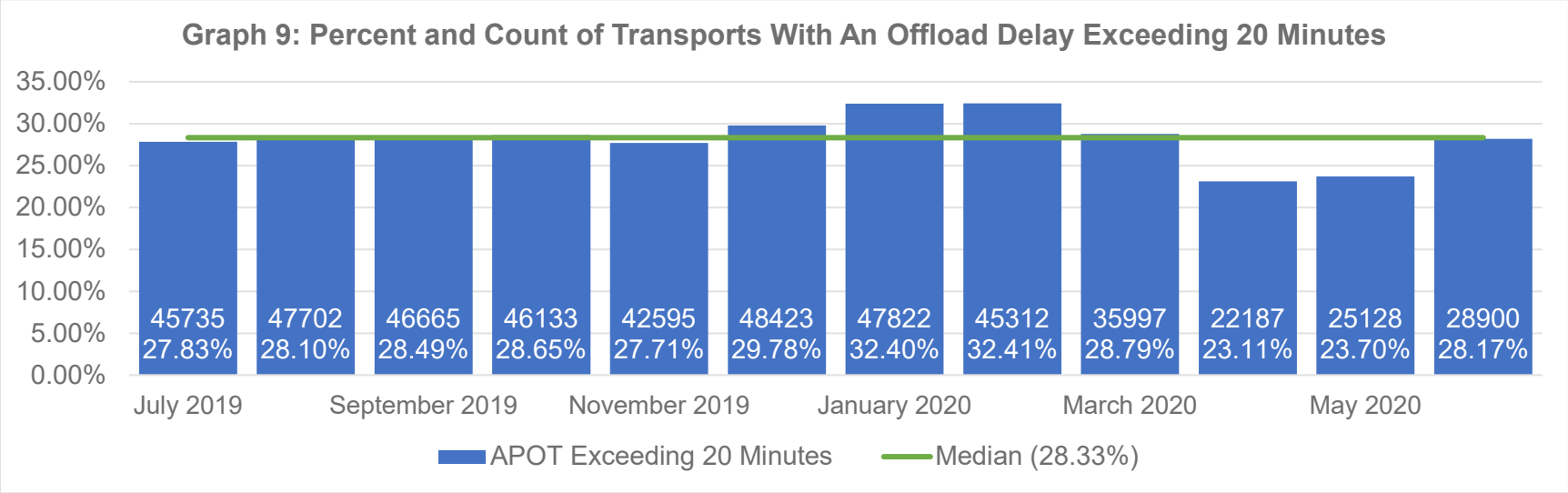
The number of transports to a given hospital seems to directly correlate to their APOT. More transport typically means higher times. Generally, rural counties and their hospitals have significantly lower APOT than urban counties and their hospitals.

During the COVID-19 pandemic, almost all LEMSAs experienced less transport overall but saw an increase in APOT compared to the prior year. Hospitals saw an increased number of patients being admitted and this has resulted in an increase of patient offload time (see Graph 4).



*Graph 8 shows the count of offload times that were more than 60 minutes as well as the percentage of all offload times that were more than 60 minutes. For example, in January 2020, 7763 transports, or 5.25% of all transports, had a delay exceed 60 minutes.

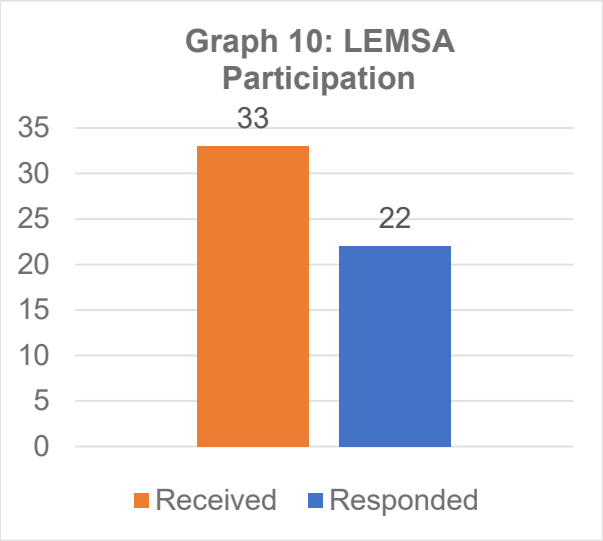
As noted previously, with stakeholder input, EMSA has targeted 20 minutes as a maximum APOT. EMSA estimates that 554,506 annual transports with an offload delay exceed 20 minutes. That represents an annual average of 28.26% of all APOTs; based on LEMSA submitted APOT data from months with the most statewide representation (June 2019 – December 2019).

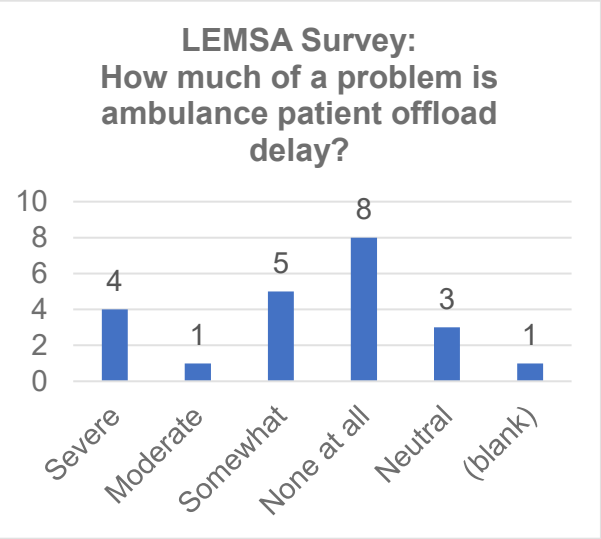


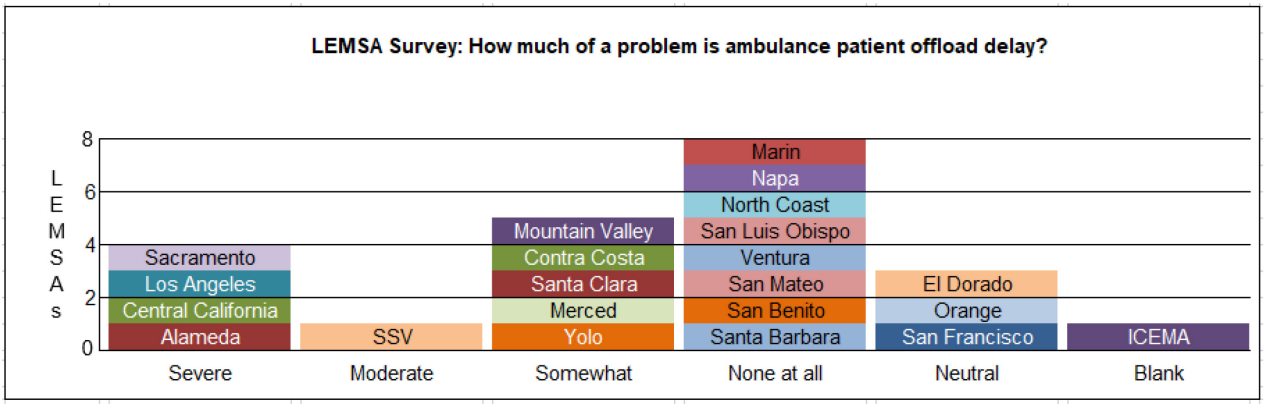
*Graph 9 shows the count and percentages of all offload delays that exceeded 20 minutes. For example, in January 2020, 48,423 transports, or 32.4% of all transports, had an offload delay exceeding 20 minutes.

Survey Report Findings:

In November 2020, LEMSAs were sent a survey about APOT in their jurisdiction. Out of the 33 LEMSAs, EMSA received a response from 22.







Recommendations

With only two years of data derived from disparate sources, it is still premature to draw conclusions about what corrective measures are most practical and acceptable. Although a one-size-fits-all solution to APOD may not exist, at minimum, we must demand a demonstrable effort and sustained incremental improvement. All agree that extended waits cannot be allowed to be a feature of any emergency medical system.

Some jurisdictions have adopted innovative approaches to ensuring EMS provider agencies and their receiving hospitals agree about the times they are

measuring. This is an essential element in building effective partnerships. Unfortunately, these efforts require a high degree of system wide buy-in and the ability and willingness to invest in a long-term quality improvement process.

While the adoption of common APOT definitions has been an important step in understanding the issue, defining the rate of time considered a "delay" is still left up to local jurisdictions and there is currently no statewide standard.

Current data collection efforts need to be extended and reinforced. While virtually all of California's LEMSAs are now providing APOT data, the current data aggregation efforts take weeks or even months and are labor intensive.

The COVID-19 pandemic has pointed to the need for real-time EMS data collection by California's state and local authorities. Real-time data is needed for EMS because it can contribute to overall situational awareness in any disaster. Furthermore, retrospective data collected by EMSA reflected increasing APOT times at the peak of the COVID-19 response. Having this data minute by minute would have provided state decision makers with a particularly important data point in determining the optimal deployment of limited response resources.

Stakeholder cooperation and past legislation have done much to clear a path towards solving the problem of APOD. We remain hopeful that this information will provide additional information to inform this important issue.

Criminal History Impact on EMT Certification 2019

Emergency Medical Services Authority
California Health and Human Services Agency

December 2020

Dave Duncan MD, Director

EXECUTIVE SUMMARY:

In accordance with Health and Safety Code (H&SC) Section 1797.229, the Emergency Medical Services Authority (EMSA) collected 2019 data for all Emergency Medical Technician (EMT) and Advanced Emergency Medical Technician (AEMT) initial certification processing. Data on 9,062 EMT applicants was submitted to EMSA by 65 certifying entities. Of those, 9,026 applicants were approved, 17 applicants were denied and 19 applicants either withdrew their applications or were rejected due to incomplete applications. The common reason listed for applicants with criminal history to withdraw their application was "withdrawn in lieu of denial."

After reviewing the data, EMSA did not readily find evidence that prior criminal history is a frequent obstacle to certification as an EMT in the state of California. Analysis of the data shows that five percent (5%) of all applicants were found to have criminal history on their background check and the majority of those applicants (80%) were approved without restrictions. Less than 1% of all applicants are denied EMT certification due to criminal history. The low number of EMTs denied with criminal backgrounds compared to those approved or approved with restrictions does not suggest that criminal history is an absolute barrier to certification. EMSA was not able to correlate gender, age, or ethnicity to denial or approval of EMT applications.

Certifying entities who oversee the certification of EMTs and AEMTs were tasked with providing data on initial applications including criminal histories, denials, and approvals. Four hundred and thirty-three (433) applicants were found to have criminal history in their background, which represents five percent (5%) of all applicants. The majority of those (347) were approved without restrictions, while 17 were denied. Additionally, 19 withdrew their applications before a decision was made or did not complete the application process and 56 were approved with restrictions. Typical restrictions for EMT applicants is probation for one to three years.

BACKGROUND:

Health and Safety Code Section 1797.229 requires that each local EMS Agency (LEMSA) and other certifying entities (CE) annually submit to the authority data on approvals or denials of EMT I (EMT Basic) or EMT-II (Advanced EMT). Health and Safety Code Section 1797.229 was enacted in 2018 and became effective January 1, 2019. Reporting by all agencies for the calendar year 2019 was due to EMSA by July 1, 2020. Reporting continues annually through July 1, 2024.

SCOPE & METHODOLOGY:
EMSA provided a reporting tool for all agencies to utilize in tracking the required data monthly that could then be submitted annually to EMSA. The reporting tool EMSA provided interlinked via excel all the data points so that final analysis could be conducted, correlations between the denial rates and the demographic data could be considered.

Six of the reporting agencies elected to use their own report in lieu of using the reporting tool provided by EMSA. The reports from these agencies were limited to aggregate totals, which did not permit any further breakdown and analysis. EMSA's ability to analyze the age, gender and ethnicity reflects the limits of these undifferentiated data reports. The specific demographic data of approvals and denials could not be determined. Additionally, two agencies chose not to collect or provide demographic data. This is reflected in subsequent appendixes in this report under the categories "Data Not Provided (by Agency)".

Of the 68 agencies required to provide annual reporting, EMSA found that 55 reports were complete, ten provided reports that were missing varying data points, and three agencies did not report anything. All data received was compiled and analyzed by EMSA and included in this report.

ANALYSIS:
EMSA reviewed the submitted data to determine if criminal background, age, gender or ethnicity may be a significant obstacle toward EMT or AEMT certification. EMSA further reviewed the data to determine if criminal backgrounds were a substantial barrier to certification. An analysis of all criminal history data received shows that while the number of applicants who have a criminal backgrounds was small (433), this background did not pose a significant barrier to certification, with less than one percent (1%) of the applicants being denied. EMSA reviewed the data on applicants with criminal history and determined the following:

- 433 (5%) were found to have criminal history in their background check.
- 347 applicants with criminal history were approved without restrictions.
- 17 applicants with criminal history were denied.
- 14 applicants with criminal history withdrew or had incomplete applications.
- 56 applicants with criminal history were approved with restrictions.
- One applicant without criminal history was denied due to fraud in the procurement of a license and five applicants with no criminal history withdrew or had incomplete applications.
- Less than one percent of the overall EMT applicants (9,062) were denied due to criminal history.

Of the applicants reported to have criminal history, only 28 included additional reasons for the decisions made. Based on the information provided, EMSA was not able identify any trends guiding the decisions.

- Twelve provided additional information on the conviction, but not the reason for the final decision,
- Four reported basing the decision recommended Guidelines for Disciplinary Orders; which are based on statutory requirements,
- Four were denied for lack of response to the statement of issues and investigation requirements,
- Seven reported the applicant withdrew in lieu of denial or prior to investigation being completed,
- One withdrew because it was already certified by another Certifying Entity.

Of the data submitted in a format that allowed stratification, EMSA did not find that gender was a significant factor in denials. EMSA was only able to review the data of 59 certifying entities' submissions for this analysis as the other data sets were submitted in a format that was aggregate and did not allow more granular analysis. While the majority of the applicants that were denied were male, this is consistent with the larger male application total. EMSA could find no correlation that the gender of the applicant was a factor in denial. EMSA reviewed the gender data submitted on all applicants and determined the following:

- 63% of all applicants were male.
- 27% of all applicants were female.
- 10% either chose not to disclose or the gender data was not provided.
- 59% of all denials were male, 6% were female, 35% had no gender data disclosed or provided.
- 41% of all applicants who withdrew or had incomplete applications were male, 11% were female, 48% had no gender data disclosed or provided.
- 54% of all applicants approved with restrictions were male, 13% were female, 33% had no gender data disclosed or provided.

EMSA also collected demographic data for the age of all applicants. For data collected in a format that allowed analysis, EMSA examined the data and determined that age was not a denial factor. EMSA was only able to review the data of 59 certifying entities as the other data sets were in an aggregate format that prevented further analysis. Although most applicants who were denied were age 35 or younger, this is in line with the larger population of applicants as a whole. EMSA could find no evidence that the age of the applicant was a factor in denial. EMSA reviewed the age demographic data submitted on all applicants and determined the following:

- 90% of all applicants were age 35 or younger.

- 76% of all applicants with criminal history were age 35 or younger.
- 53% of all denials were age 35 or younger.
- 56% of all applicants who withdrew or had incomplete applications were over the age of 35.
- 66% of all applicants approved with restrictions were age 35 or younger.

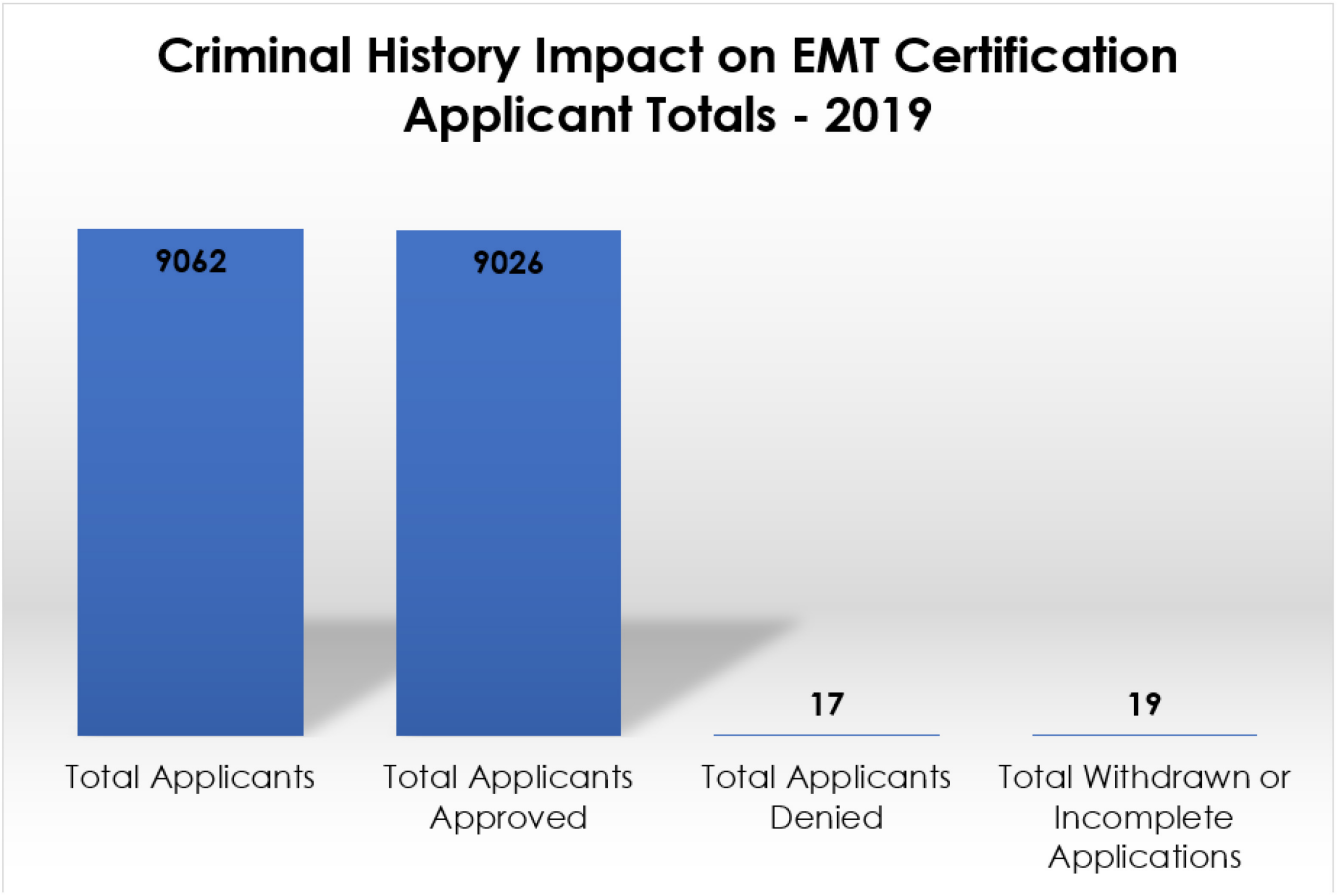
Of the data submitted in a format that allowed analysis, EMSA could not determine that ethnicity or race played any denial factor. EMSA was only able to review the data of 57 certifying entities submissions for this analysis as the other data sets were either submitted in a format that was aggregate or the ethnicity data was not provided at all. Additionally, for 15 of the 17 denials reported the applicant either chose not to identify their ethnicity (ten) or the ethnicity was not specified in the data (five). EMSA could find no correlation that the ethnicity of the applicant was a factor in denial with the data provided. A review of all ethnicity data received showed the following:

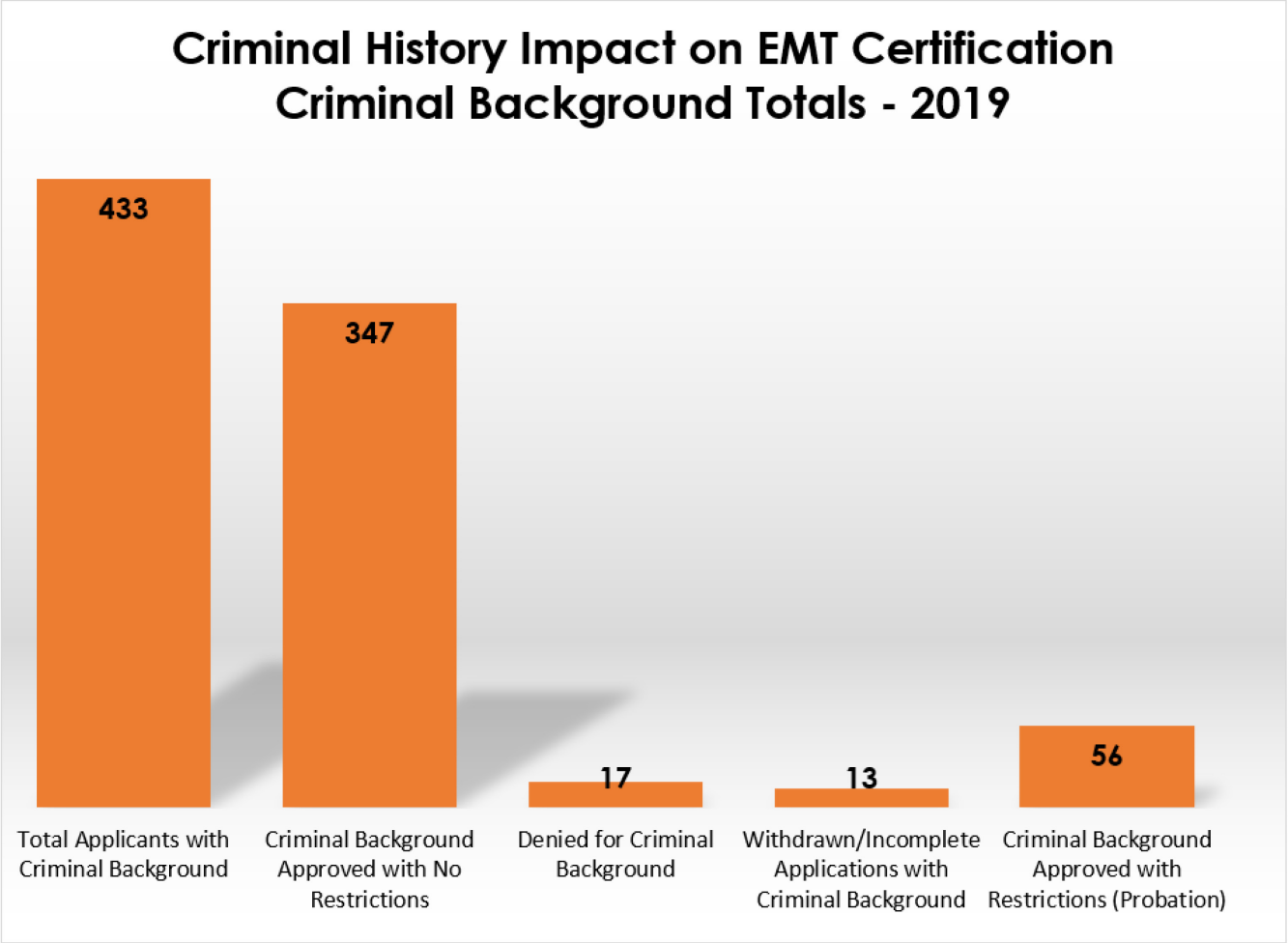
- 43% of applicants identified as was "White/Caucasian".
- 22% of applicants identified as "Hispanic or Latino".
- 14% of applicants chose not to identify.
- 10% of applicants identified as "Asian".
- 5% of applicants had no ethnicity data reported in the data that was submitted.
- 3% identified as "Black/African American".
- Other ethnicities identified in the data were; "American Indian or Alaska Native" 2% and "Native Hawaiian or Other Pacific Islander" 1%.
- 88%, or 15 of the 17 denials reported, either chose not to identify their ethnicity (ten) or the ethnicity was not specified in the data (five).
- 32% of applicants who were approved with restrictions identified as "White/Caucasian".
- 14% of applicants who were approved with restrictions identified as "Hispanic or Latino".

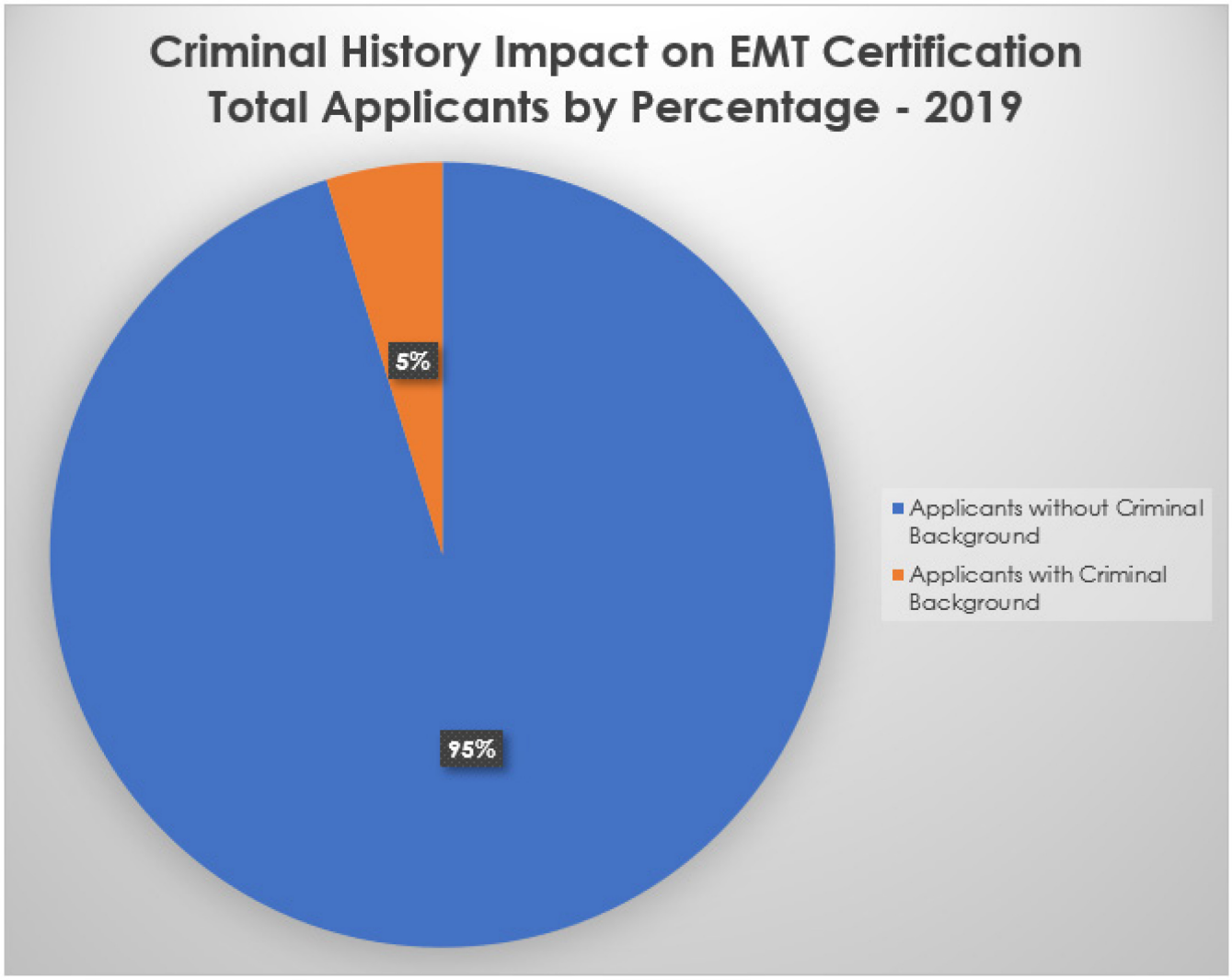
CONCLUSION:

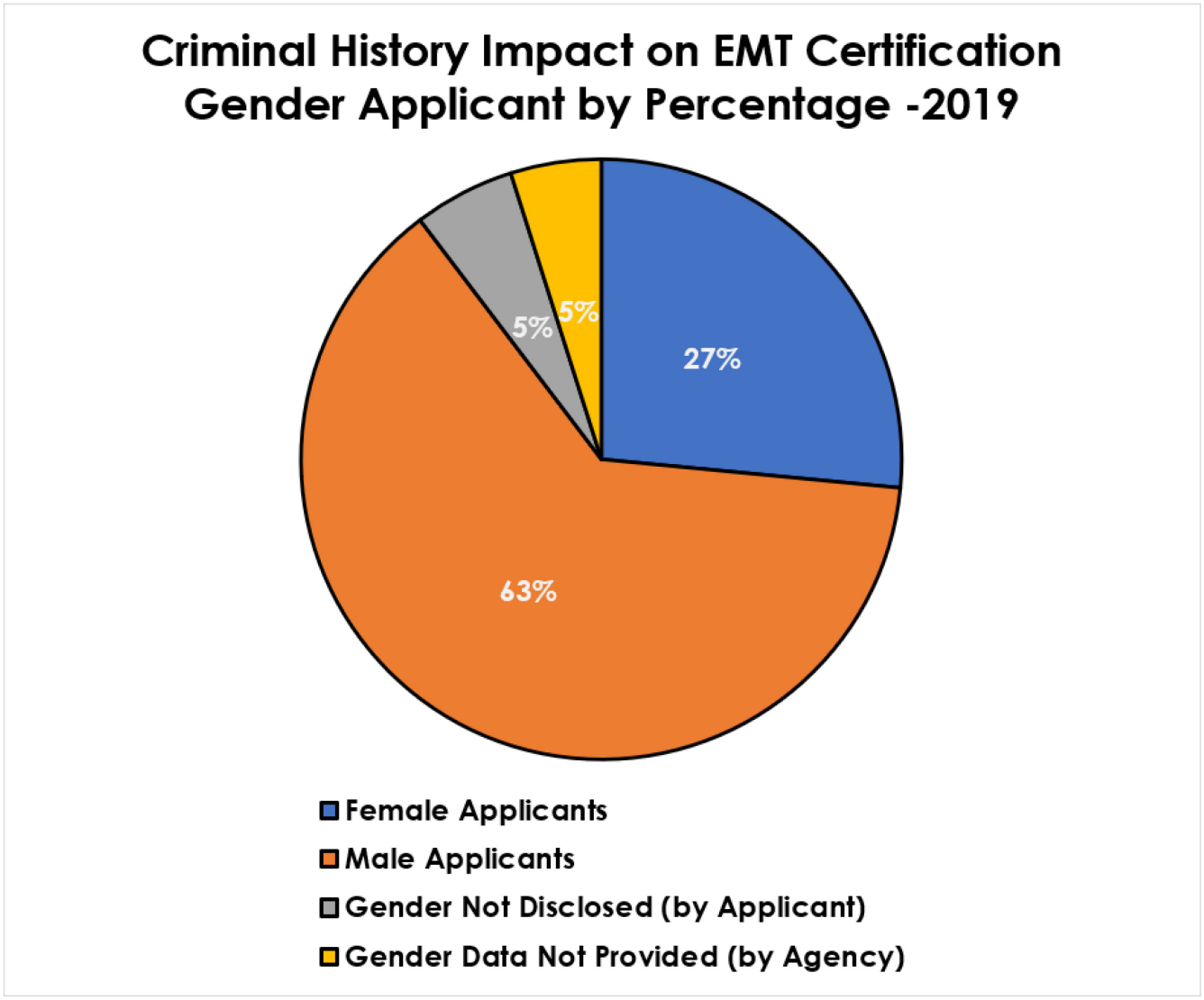
After reviewing and analyzing the EMT certification data collected from 65 certifying entities for 2019, EMSA found that prior criminal history does not appear to represent an obstacle to certification as an EMT in the state of California. The low number of EMTs denied with criminal backgrounds compared to those approved or approved with restrictions indicates that criminal history is not an absolute barrier to certification. EMSA was unable to find a correlation between gender, age and denial or approval of EMT applications. Complete analysis of demographic data was hindered by ten reports that were received and missing varying data points or were submitted in aggregate form.

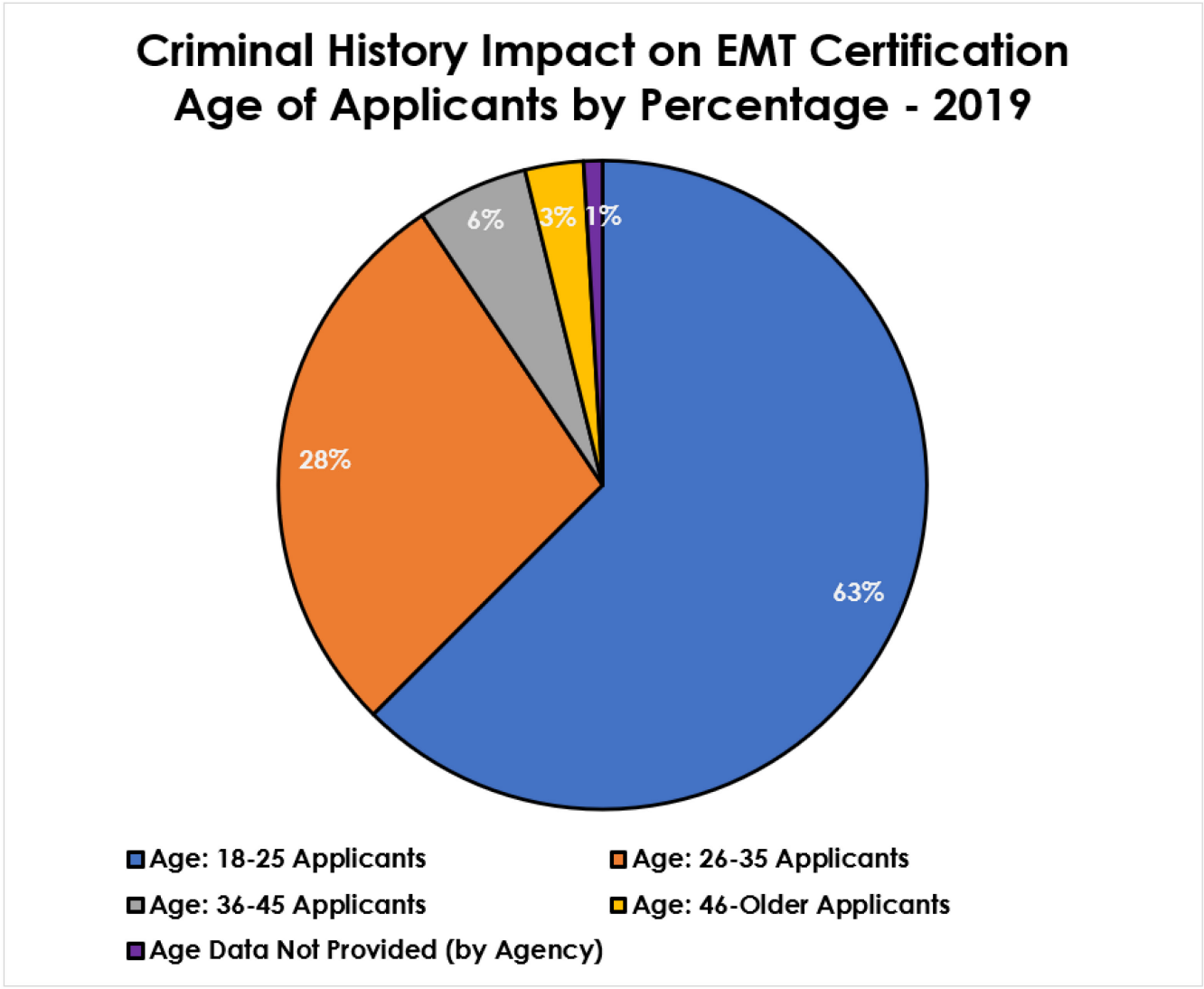
Appendix A: Aggregate Data Sets

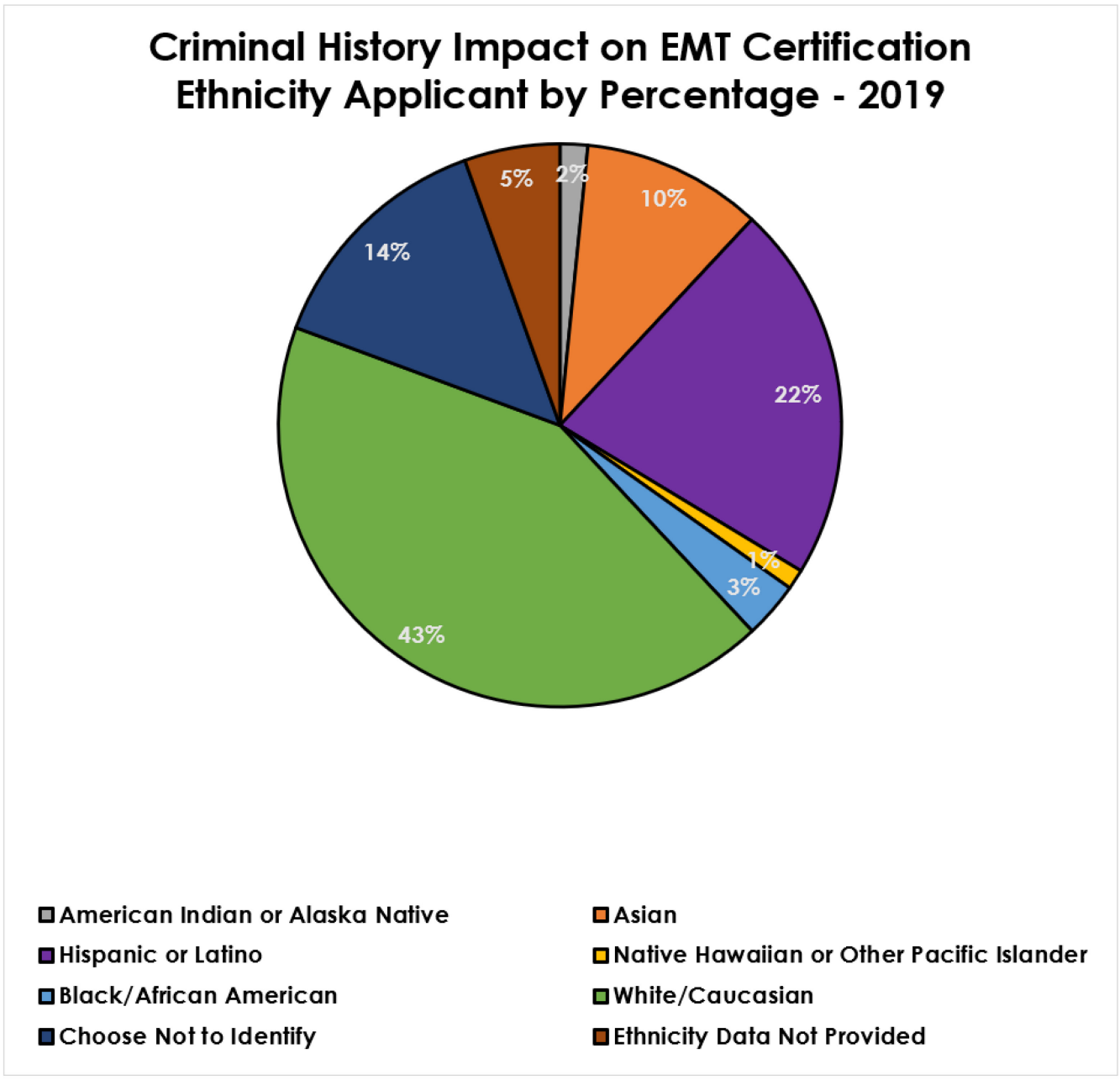



Criminal History Impact on EMT Certification
Criminal Background Totals - 2019
433
347
17
13
56
Total Applicants with Criminal Background
Criminal Background Approved with No Restrictions
Denied for Criminal Background
Withdrawn/Incomplete Applications with Criminal Background
Criminal Background Approved with Restrictions (Probation)

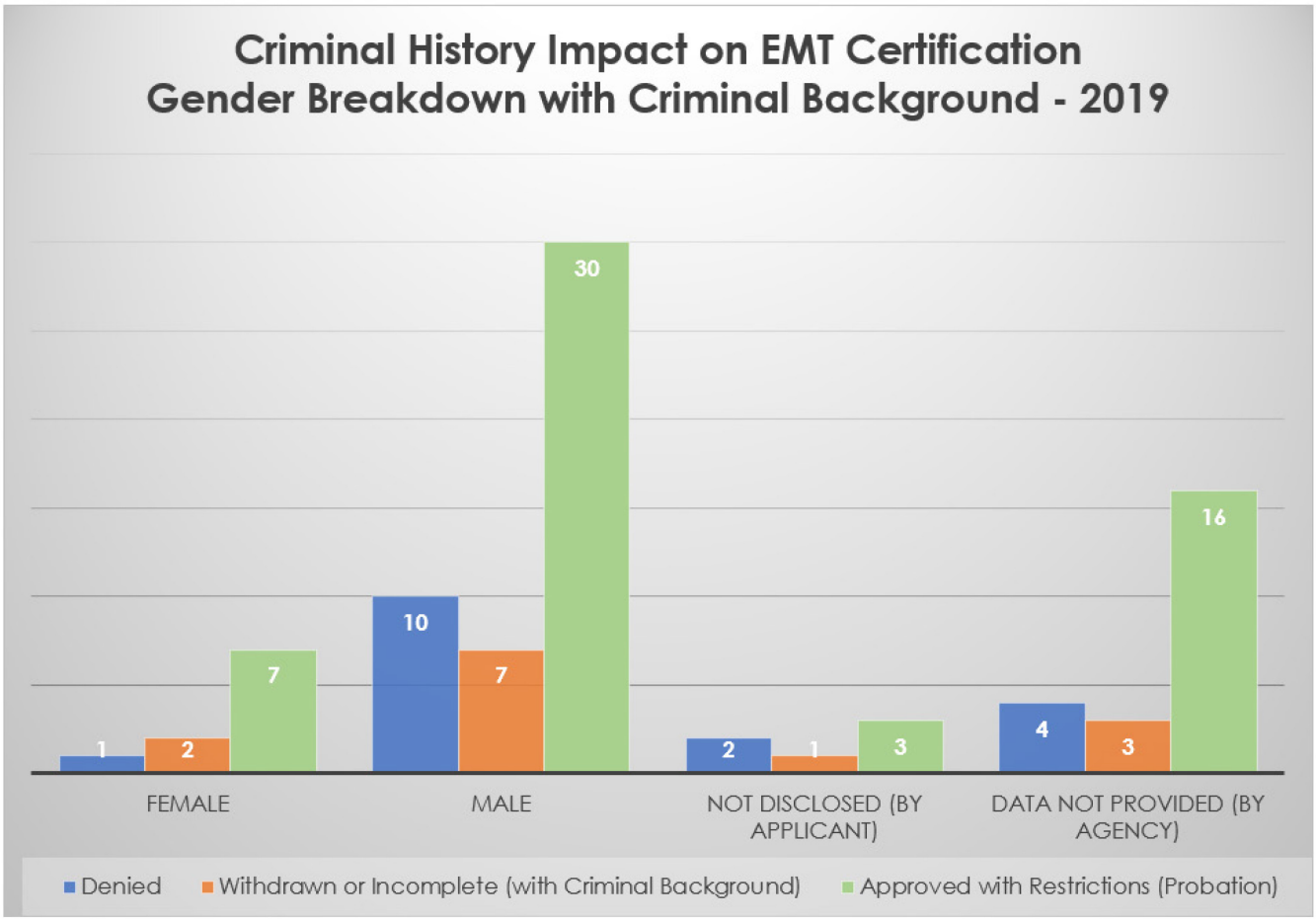

Criminal History Impact on EMT Certification
Total Applicants by Percentage - 2019
5%
95%
Applicants without Criminal Background
Applicants with Criminal Background

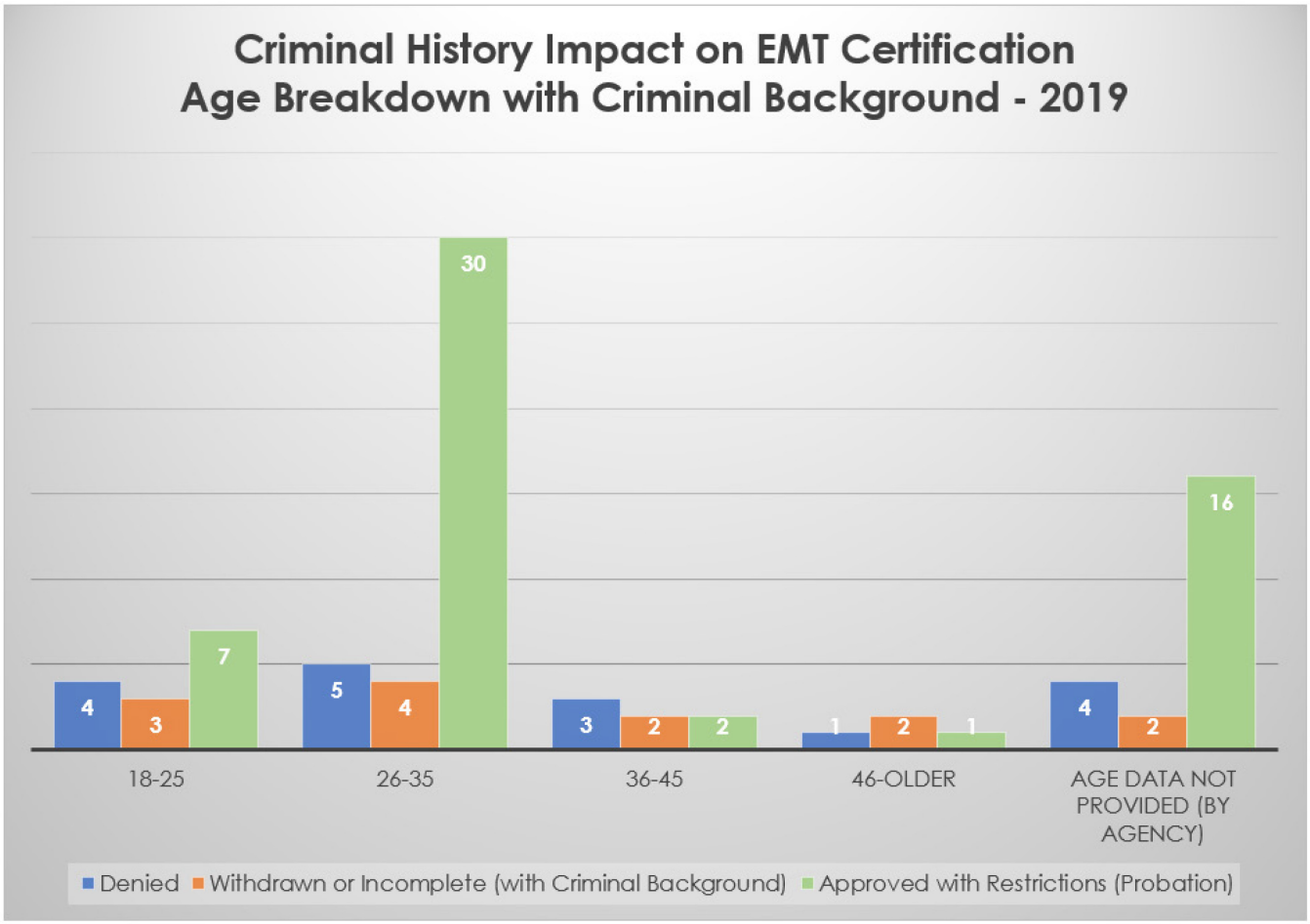

Criminal History Impact on EMT Certification
Gender Applicant by Percentage -2019
27%
63%
5%
5%
Female Applicants
Male Applicants
Gender Not Disclosed (by Applicant)
Gender Data Not Provided (by Agency)

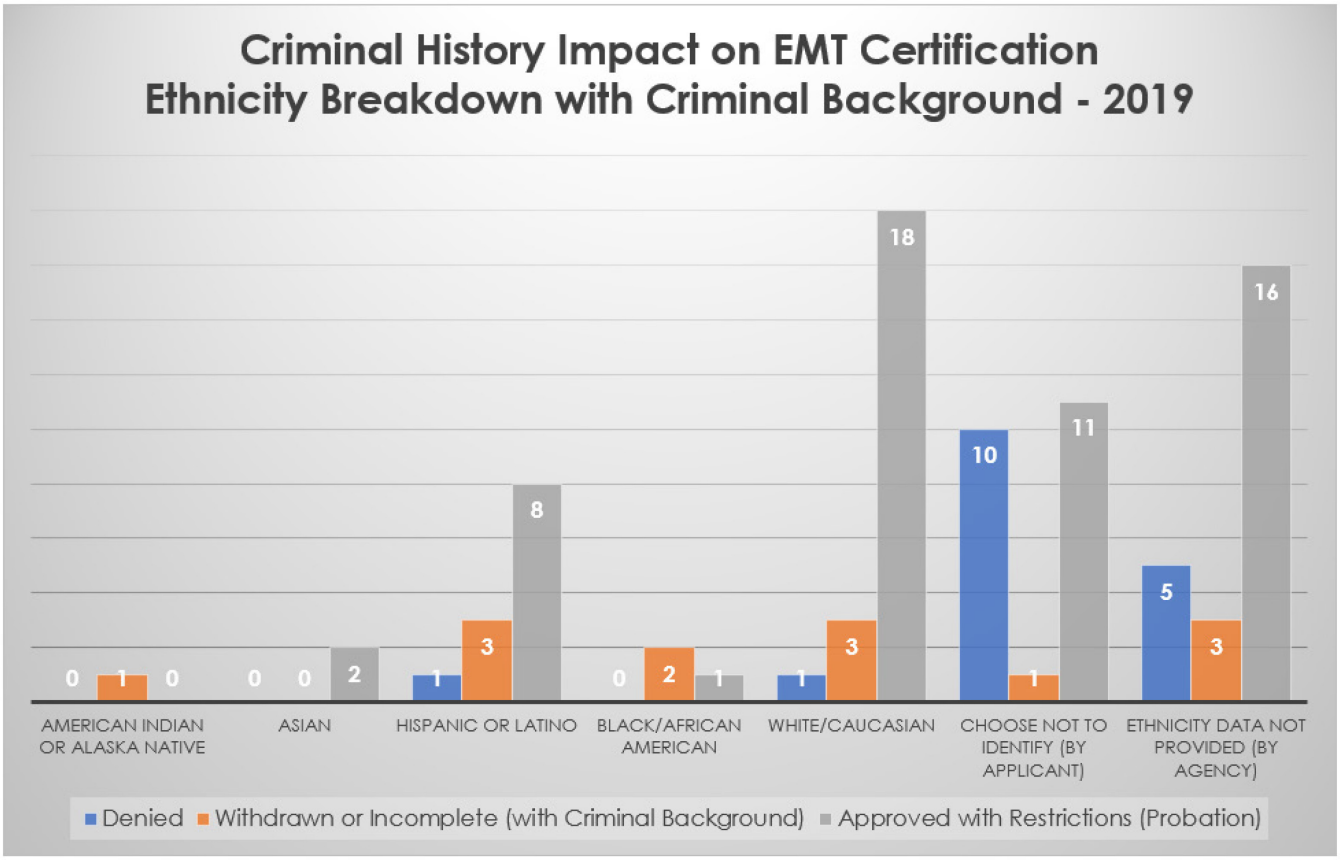

Criminal History Impact on EMT Certification
Age of Applicants by Percentage - 2019
6%
3%
1%
28%
63%
Age: 18-25 Applicants
Age: 26-35 Applicants
Age: 36-45 Applicants
Age: 46-Older Applicants
Age Data Not Provided (by Agency)


Criminal History Impact on EMT Certification
Ethnicity Applicant by Percentage - 2019
2%
10%
22%
1%
3%
43%
14%
5%
American Indian or Alaska Native
Asian
Hispanic or Latino
Native Hawaiian or Other Pacific Islander
Black/African American
White/Caucasian
Choose Not to Identify
Ethnicity Data Not Provided

Appendix B: Graphs and Tables




Criminal History Impact on EMT Certification
Age Breakdown with Criminal Background - 2019
4
3
7
5
4
30
3
2
2
1
2
1
4
2
16
18-25
26-35
36-45
46-OLDER
AGE DATA NOT PROVIDED (BY AGENCY)
Denied
Withdrawn or Incomplete (with Criminal Background)
Approved with Restrictions (Probation)



(Native Hawaiian / Other Pacific Islander not included as all results were zero)