# COUNTY OF LOS ANGELES EMERGENCY MEDICAL SERVICES COMMISSION

**10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670**
**(562) 378-1610 FAX (562) 941-5835**
**http://ems.dhs.lacounty.gov**

DATE: May 8, 2024
TIME: 1:00 – 3:00 PM
LOCATION: 10100 Pioneer Boulevard, First Floor
Cathy Chidester Conference Room 128
Santa Fe Springs, CA 90670

***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 the Commission Chair as time permits.***

**NOTE: Please *sign in* if you would like to address the Commission.**

## AGENDA

**1. CALL TO ORDER – Commissioner Carole Snyder, Chair**

**2. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS**
2.1 EMSAAC Annual Conference May 29-30, 2024

**3. CONSENT AGENDA:** *Commissioners/Public may request that an item be held for discussion. All matters are approved by one motion unless held.*

3.1 **Minutes**
3.1.1 March 20, 2024

3.2 **Committee Reports**
3.2.1 Base Hospital Advisory Committee
3.2.2 Provider Agency Advisory Committee

3.3 **Policies**
3.3.1 Reference No. 316: Emergency Department Approved for Pediatric (EDAP) Standards
3.3.2 Reference No. 318: Pediatric Medical Center (PMC) Standards
3.3.3 Reference No. 324: SART Standards
3.3.4 Reference No. 815: Honoring Prehospital Do Not Resuscitate Orders, Physician Orders for Life Sustaining Treatment and End of Life Option (Aid-in-Dying Drug)

**END OF CONSENT AGENDA**

---

**4. BUSINESS**

**Business (Old)**
4.1 Field Evaluation of Suicidal Ideation and Behavior
4.2 Ambulance Patient Offload Time (APOT)
4.3 Interfacility Transports (IFT) Workgroup

**Business (New)**

4.4 EMS Commission Ordinance Update

## 5. LEGISLATION

## 6. DIRECTORS' REPORTS

6.1 Richard Tadeo, EMS Agency Director / EMSC Executive Director

**Correspondence**

- 6.1.1 (4/18/24) New Medical Director – Monrovia Fire: Salvador Lorenzo Rios, MD
- 6.1.2 (4/11/24) Continuous Positive Airway Pressure, Intraosseous, and Transcutaneous Pacing Program Approval
- 6.1.3 (4/08/24) Physician Services for Indigents Program Reimbursement Rate 2023-24
- 6.1.4 (4/04/24) Name Change for West Hills Hospital and Medical Center and Los Alamitos Medical Center
- 6.1.5 (4/02/24) Name Change for Lakewood Regional Medical Center
- 6.1.6 (4/01/24) Triage to Alternate Destination Program Requirements to Advance Practice Response Unit (APRU) – LACoFD
- 6.1.7 (3/26/24) Triage to Alternate Destination Program Requirements – Santa Monica FD
- 6.1.8 (3/26/24) Triage to Alternate Destination Program Requirements – Culver City FD
- 6.1.9 (3/27/24) Closure of Emergency Medical Technician (EMT), Paramedic, and Continuing Education (CE) Training Programs – University of Antelope Valley

6.2 Nichole Bosson, MD, EMS Agency Medical Director

- 6.2.1 Physician Updates
- 6.2.2 Reference No. 1307.4: EMS and Law Enforcement Co-Response (ELCoR)
- 6.2.3 Hospital Emergency Response Training (HERT) Video

## 7. COMMISSIONERS' COMMENTS / REQUESTS

## 8. ADJOURNMENT

To the meeting of July 17, 2024

# COUNTY OF LOS ANGELES
# EMERGENCY MEDICAL SERVICES COMMISSION

**10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670**
**(562) 378-1610 FAX (562) 941-5835**
**http://ems.dhs.lacounty.gov/**

## MINUTES
## March 20, 2024

| | | | |
|---|---|---|---|
| ☒ Diego Caivano, M.D. | LACo Medical Association | Richard Tadeo | Executive Director |
| ☒ Jason Cervantes | CA Professional Firefighters | Denise Watson | Commission Liaison |
| ☐ *Erick H. Cheung, M.D. | So. CA Psychiatric Society | Nichole Bosson, MD | EMS Staff |
| ☒ Paul Espinosa, Chief | LACo Police Chiefs' Assn. | Denise Whitfield, MD | EMS Staff |
| ☒ Tarina Kang, M.D. | Hospital Assn. of So. CA | Jacqui Rifenburg | EMS Staff |
| ☒ Carol Kim | Public Member, 1st District | Christine Clare | EMS Staff |
| ☒ Lydia Lam, M.D. | American College of Surgeons | Kelsey Wilhelm, MD | EMS Staff |
| ☒ Kenneth Liebman | LACo Ambulance Association | Jake Toy, MD | EMS Staff |
| ☒ James Lott, PsyD, MBA | Public Member, 2nd District | Michael Kim, MD | EMS Staff |
| ☐ *Carol Meyer, RN | Public Member, 4th District | Mark Ferguson | EMS Staff |
| ☐ *Kenneth Powell | LA Area Fire Chiefs' Assn. | Shira Schlesinger MD | EMS Staff |
| ☒ Brian Saeki | League of CA Cities/LA Co | Sara Rasnake | EMS Staff |
| ☒ Stephen G. Sanko, MD | American Heart Association | David Wells | EMS Staff |
| ☒ Carole A, Snyder, RN | Emergency Nurses Assn. | Jennifer Calderon | EMS Staff |
| ☒ Saran Tucker | So. CA Public Health Assn. | Christine Zaiser | EMS Staff |
| ☒ *Atilla Uner, M.D., MPH | CAL-ACEP | Ami Boonjaluksa | EMS Staff |
| ☐ *Gary Washburn | Public Member, 5th District | Laura Leyman | EMS Staff |
| ☐ Vacant | Peace Officers Association | Lily Choi | EMS Staff |
| ☐ Vacant | Public Member 3rd District | Tracy Harada | EMS Staff |
| | | Hanna Kang | EMS Staff |
| | | Gerard Waworundeng | EMS Staff |

### GUESTS

| | | |
|---|---|---|
| Rafael De La Rosa, HASC | Laurie Donegan, LBM/APCC | Jennifer Nulty/Torr FD |
| Clayton Kazan, MD, LACoFD | Chad Druten, SCAA | Matt Armstrong PA |
| Puneet Gupta, MD, LACoFD | Bill Weston, SCAA | Victor Lemus, ComFD |
| Catherine Borman/SMFD | Dave Molyneux/AMW Amb | Deana Josing/LACFD |

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

## 1. CALL TO ORDER

The Emergency Medical Services (EMS) Commission (EMSC) meeting was held at the EMS Agency at 10100 Pioneer Boulevard, First Floor, Cathy Chidester Conference Room 128, Santa Fe Springs, CA 90670. Chair Carole Snyder called the meeting to order at 1:00 p.m. Roll was taken by Commission Liaison Denise Watson. There was a quorum of 13 commissioners present.

## 2. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

2.1 Richard Tadeo, EMS Agency Director/EMSC Executive Director, welcomed Dr. Stephen Sanko to the EMS Commission representing the American Heart Association.

.

2.2 The Emergency Medical Services Administrators' Association of California's (EMSAAC) Annual Conference is May 29–30, 2024, in San Diego, California and open for registration.

2.3 Bill Weston presented on behalf of the Southern California Ambulance Association (SCAA), which is the official name change of Los Angeles County Ambulance Association to their original former name and the merger with the Ambulance Association of Orange County, effective February 8, 2024. The SCAA is requesting EMSC support as follows:

a. Need more Ambulance Strike Team (AST) leaders and wants to work with the State EMS Authority to identify training requirements for certification that are not so difficult to obtain.
b. Identify how to get more narcotics for ambulances when cache runs out.
c. Requesting age waiver for four-wheel drive ambulances (oversized vans) that are timed out to be allowed for use during large deployments beyond the 10 years.
d. Doesn't believe a nerve agent antidote is needed when leaving the County for a large wildfire but wants to find a better use for some of the more expensive medications to secure and keep.

There was discussion regarding consideration of using DuoDote, the formation of ASTs and the impact on personnel in the 9-1-1 system, past experiences and challenges with transport vehicles and APOT, holding staff beyond their regular assignments, staff shortages, and overall success of having enough ambulance units to respond with ASTs while maintaining enough ambulances to staff the exclusive operating areas. For wildfires or large-scale incidents, the number of ambulances sent are between five (5) to 10 in total countywide.

**3. CONSENT AGENDA** – *All matters approved by one motion unless held.*
Chair Snyder called for approval of the Consent Agenda and opened the floor for discussion.

3.1 **Minutes**
3.1.1 January 17, 2024

3.2 **Committee Reports**
3.2.1 Base Hospital Advisory Committee
3.2.2 Provider Agency Advisory Committee

3.3 **Policies**
3.3.1 Reference No. 424: Triage to Alternate Destination Program
3.3.2 Reference No. 502: Patient Destination
There was a request to include "general acute care hospitals" in the language. It was explained that the policy needs to be consistent and compliant with the current statute which is limited to psychiatric urgent care centers and sobering centers, and this patient destination policy is not a policy that identifies the facility or the criteria to be designated to receive 9-1-1 traffic. No changes will be made.
3.3.3 Reference No. 606: Documentation
Clarification was provided on electronic EMS patient care record sequence number capturing for public and private provider calls that get cancelled prior to ambulance arrival on scene.
3.3.4 Reference No. 913: Triage to Alternate Destination (TAD) Paramedic Training Program

***Motion/Second by Commissioners Cervantes/Caivano to approve the Consent Agenda was carried unanimously.***

**END OF CONSENT AGENDA**

## 4. BUSINESS

### Business (Old)

4.1 Prehospital Care of Mental Health and Substance Abuse Emergencies (Reconvene Workgroup)

Jacqueline Rifenburg, EMS Agency Assistant Director, reported this workgroup met and agreed to reconvene under the name, "Field Evaluation of Suicidal Ideation and Behavior." The first meeting will be April 3, 2024, and will consist of representatives from the Base Hospital Association, Provider Association, both at the captain level and at the Field Paramedic level, Department of Mental Health, LA County Sheriffs Department MET team, Psychiatric residents from UCLA, as well as EMS staff and representative from the Pediatric Advisory Committee and EMS Commission.

4.2 Ambulance Patient Offload Time (APOT)

Christine Clare, EMS Agency Nursing Director for EMS Programs, advised that the EMS Agency is still working to get data from providers for fourth quarter 2023 APOT, and anticipates having the first quarter 2024 APOT report by May 2024 EMSC meeting.

Director Tadeo reported Assembly Bill (AB) 40 from the State EMS Authority is on hold because it did not get funded. All requirements of the State to develop the emergency regulations, start running reports from the data that local EMS agencies (LEMSAs) submit, as well as requiring hospitals with APOT problems to come up with mitigating strategies, are also on hold. The Hospital Association of Southern California (HASC) has created a workgroup to help hospitals establish best practices to address APOT so they are prepared to implement mitigating strategies should they have APOT problems.

4.3 Interfacility Transports (IFT) Workgroup

Ms. Clare reported the IFT workgroup met in February 2024, and the focus was on finalizing the hospital checklist for 9-1-1 re-triage utilization for patients meeting current policy requirements for 9-1-1 re-triage for STEMI and trauma. We have met with HASC to discuss rolling this out to the non-specialty centers and educating them on the utilization of this checklist to ensure that 9-1-1 is being utilized appropriately for IFTs. The workgroup's next focus will be to build a hospital and provider survey to get an overview of the problem, identify possible causes and severity, develop plans to help mitigate the delays in getting IFTs, determine if it is the hospital side or difficulty in getting the patient to the appropriate hospital with accepting physicians or certain specialties. Also, if it is certain times of day, certain days of the week, or CCT versus ALS versus BLS. The plan is to have a community education via webinar or conference call to educate smaller community hospitals. We have been meeting one on one with some of the smaller hospital systems like Pipeline Health, and the bigger ones like Kaiser Permanente to discuss some of the challenges and help guide them to the resources that they need. The next monthly meeting is April 22, 2024.

Commissioner Uner recommended the workgroup include wall time as another important focus for the future.

Director Tadeo noted the complexities involved with IFTs in that it is a system issue, and reported the group is hopeful that the survey will provide a better understanding of where they can actually make an impact and see the root causes of this problem. Funding is an important issue as well.

Commissioner Diego Caivano recommended including emergency physicians, admitting physicians, and cardiologists because oftentimes a patient in the Emergency Department that is already admitted develops a STEMI while they are holding the wall, and now there is the dilemma of not having services in a community hospital and having a receiving facility that can handle this patient who is now admitted. So, this is really where we need to educate not just the community emergency physicians, but also the cardiologists as well as the internal medicine admitting physicians.

4.4 EMSC Workplan (Goals/Objectives for 2024

Director Tadeo asked if new Commissioners had a chance to look at developing more goals before moving forward. No new goals were established.

4.5 EMSC Meeting Schedule for May 2024 (Date Change to May 8th)

Chair Snyder reminded everyone the next meeting will be May 8th which is one week earlier than usual due to calendar conflicts.

## 5. LEGISLATION

Director Tadeo reported on the following bills:

AB 40: Emergency Medical Services bill – On hold due to no funding.
AB 716: Balanced billing – Did not get funded.
AB 767: Community Paramedicine – Waiting for funding for State to move on requirements.
AB 2225: Rodriguez – EMSAAC supports this bill regarding the extension of 1157 Evidence Code – Protects QI materials. This is currently limited to hospitals and will extend to EMS providers so they are not subject to evidence for litigation.
AB 2859: Patterson: EMTs: Peer-to-peer support – EMSAAC supports this bill.
AB 2469: Mutual aid between states. There is a clause that sunsets in 2029 and the change will remove the sunset date so it will be in perpetuity in terms of indefinite mutual aid between California and its neighboring states like Nevada, Arizona and Oregon.
AB 2973: Spot bill that cleans up language – Specific language EMS is concerned with says the EMS Agency Medical Director, Assistant Medical Director, and administrative staff shall be supervised by the Board of Supervisors (Board). Current statute designates the County to designate an EMS Agency and provides directives in terms of being the health department of public health wherein the EMS Agency resides. This complicates the bill by having the local EMS Agency report directly to the Board which has a lot of implications. There is a lot of discussion throughout the State in terms of medical authority for elected officials to oversee the complex medical supervision of physicians, as well as Medical Directors.
SB 6973: Emergency Departments to develop mechanisms to address human trafficking or victims of human trafficking who self-identify. There are reforms for the Emergency Department to monitor and provide social support and resources.
AB 977: Expands the penalties to violence experienced by EMS personnel. Current law only allows for Emergency Department personnel to get prosecuted. This bill expands penalties to the violent person who attacked personnel in the Emergency Department. This will be extended to EMS personnel, paramedics or EMTs, that are functioning outside.

## DIRECTOR'S REPORT

6.1 Richard Tadeo, EMSC Executive Director, EMS Agency Director

6.1.1 Director's Report

**Correspondence**

6.1.2 (3/06/24) Countywide Sidewalk CPR Day June 6, 2024

The EMS Agency is considering social media as a potential avenue to future community education on Sidewalk CPR

6.1.3 (2/29/24) Public Works Alliance: EMS Corps Support
6.1.4 (2/29/24) Arcadia Fire: Basic Life Support Program Implementation
6.1.5 (2/27/24) Symbiosis: Continuous Airway Pressure and Intraosseous Approval
6.1.6 (1/24/24) CEO Letter to Board: MBAB Recommendations for Funding

Director Tadeo highlighted a few recommendations for funding:

1. LACoFD – Develop through ReddiNet an App determining in real time the number of ambulances in the 9-1-1 system that triggers when fire department will have mitigating strategies to ensure ambulances are not delayed.
2. HASC – Funded.
3. EMS Agency Projects – Health Data Exchange: bi-directional communication of migrating the discrete data elements of the prehospital care records into the hospital EMR. Consequently, the program software will pull the outcome data from the hospital EMR into a repository that can be accessed by EMS providers and the EMS Agency implementation. The plan is to be in phases. First, get contract with current vendor, then move forward with trauma hospitals (15 trauma centers), then the Base Hospitals (7 Base hospitals that are not trauma centers), then move to STEMI centers, and stroke centers. The last phase would be for community hospitals. So ultimately, the goal is to get 100% outcome data from all 9-1-1 transports from the hospitals including ALS, BLS specialty care centers.
4. Los Angeles Fire Air Operations – Funding the replacement of patient loading equipment for helicopter ambulances that are aging.
5. LACoFD – Funded for 180 video laryngoscopes.
6. Public Health – Allows for continued stockpiling of necessary and important antibiotics through a partnership with pharmacies to rotate them and avoid expiration.
7. Ambulance Association – Funding for Automated External Defibrillators.
8. Regents of UCLA – Development of a Difficult Airway Management course.

6.2 Nichole Bosson, MD, EMS Agency Medical Director

6.2.1 Medical Director's Report

Dr. Bosson welcomed Dr. Shira Schlesinger to the EMS Agency as the new Director of Education and Innovation.

A slide presentation was given on the National Institute of Health's Pediatric Prehospital Airway Resuscitation Trial (Pedi-PART) on optimization of airway management to identify which method is best as the primary strategy in managing critically ill children up to the age of 18. The EMS Agency is currently engaged in the community consultation phase and is leading up to launching this trial in LA County. This is a five-year trial but anticipated to finish early and will start in May 2024. This is included in the EMS Update training.

PediDOSE: How do we dose midazolam for pediatric seizures. We are transitioning from current protocols from weight-based dosing to age-based dosing for pediatric seizures with the goal to standardize dosing and streamline treatment of seizures. This five-year trial will be effective July 1, 2024. Adult patient dosing will continue.

Hospital Emergency Response Teams (HERT) training was held on February 29, 2024. Emergency and professional personnel were trained and utilized from LA County Fire and the Paramedic Training Institute (PTI). The near-final version of the film will be screened at the next Commission meeting.

Office of Traffic Safety (OTS) grants includes leveraging the Health Data Exchange (HDE) to project some of our data to support initiatives in reducing motor vehicle fatalities in injury prevention. We will bring agenda to construct a research agenda around crash-care advancements and prevention of injury.

Protocol Application is being worked on by Dr. Denise Whitfield, Assistant Medical Director, EMS Agency, for all paramedics and MICNs to roll out by October 2024, as well as Just-in-Time training videos. The EMS Agency has applied for additional OTS funding to continue these initiatives.

A new initiative that LA County Fire Department (LACoFD) wants to potentially pilot is the prehospital blood transfusion for the treatment of hemorrhagic shock. The National Association of EMS Physicians and American College of Surgeons Committee on Trauma have come out with a joint position statement that if you have a hemorrhagic patient in the field, and you have the ability to deliver blood products, that should be done.

The EMS Agency will engage first in a feasibility assessment to explore what it might mean and how we might implement in LA County. Dr. Kelsey Wilhelm, EMS Agency, will gather the resources to understand the implications of such a pilot and whether or not we could move forward. We are in stages of information gathering. Trauma Advisory and Medical Advisory Councils have spoken with them.

Dr. Whitfield reported on EMS Update, Pedi-PART, and PediDOSE looking at pediatric seizures using age-based dosing rather than the current method of weight-based dosing.

The Just-in-Time training videos provide the opportunity to push education and put things at the fingertips of our EMS clinicians. With these videos we are really looking at the most critical procedures that are not done very often like needle thoracostomy, traction splinting, synchronized cardioversion, pacing, as well as childbirth emergencies. Procedures that are not as frequently performed but very time sensitive. These will be a resource they can refer to.

Commissioner Stephen Sanko recommended adding hover and tap to decrease pauses in CPR as a general training resource in those videos as a part of the resuscitation cabinet.

**7. <u>COMMISSIONERS' COMMENTS / REQUESTS</u>**

Commissioner Uner requested that the Medical Council meeting not be mandatory for Base Hospital Medical Directors who attend either PAAC or BHAC sub-committee meetings since policies discussed at EMSC are not discussed at the Medical Council meeting but are discussed at PAAC and BHAC.

Director Tadeo agreed to take this recommendation into consideration, and explained it is important to be very distinct in terms of policies that go into committees. Medical Council focuses on medical issues and the PAAC and BHAC look at the operational impacts of the policies that we change. If there is a clear cross over, we do bring it to the Medical Council, but we will be more cognizant of bringing policies to all the committees.

**8. ADJOURNMENT:**

Adjournment by Chair Snyder at 2:40 p.m. to the meeting of Wednesday, May 8, 2024.

**Next Meeting:** Wednesday, May 8, 2024, 1:00-3:00 p.m.
Emergency Medical Services Agency
10100 Pioneer Boulevard, First Floor
Cathy Chidester Hearing Room 128
Santa Fe Springs, CA 90670

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.

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

# BASE HOSPITAL ADVISORY COMMITTEE MINUTES

**April 10, 2024**

| | REPRESENTATIVES | | EMS AGENCY STAFF |
|---|---|---|---|
| ☑ | Erick Cheung, MD, Chair | EMS Commission | Nichole Bosson, MD |
| ☐ | Diego Caivano, MD, Vice Chair | EMS Commission | Richard Tadeo |
| ☐ | Atilla Under, MD, MPH | EMS Commission | Jacqueline Rifenburg |
| ☐ | Lydia Lam, MD | EMS Commission | Laura Leyman |
| ☐ | Saran Tucker | EMS Commission | Denise Whitfield, MD |
| ☐ | Carol Synder, RN | EMS Commission | Chris Clare |
| ☐ | Tarina Kang, MD | EMS Commission | Lorrie Perez |
| ☐ | Brian Saeki | EMS Commission | Ami Boonjaluksa |
| ☐ | Vacant | EMS Commission | Priscilla Romero |
| ☐ | Rachel Caffey | Northern Region | Sara Rasnake |
| ☑ | Jessica Strange | Northern Region | Sam Calderon |
| ☑ | Michael Wombold | Northern Region, Alternate | David Wells |
| ☑ | Samantha Verga-Gates | Southern Region | Hannah Kang |
| ☑ | Laurie Donegan | Southern Region | Kelsey Wilhelm, MD |
| ☑ | Shelly Trites | Southern Region | Gerard Waworundeng |
| ☑ | Christine Farnham | Southern Region, Alternate | Denise Watson |
| ☑ | Ryan Burgess | Western Region, Alternate | Christine Zaiser |
| ☑ | Travis Fisher | Western Region | Aldrin Fontela |
| ☑ | Lauren Spina | Western Region | Tracy Harada |
| ☑ | Susana Sanchez | Western Region | |
| ☑ | Kate Bard | Western Region | |
| ☑ | Laurie Sepke | Eastern Region | |
| ☑ | Alina Candal | Eastern Region | |
| ☑ | Jenny Van Slyke | Eastern Region, Alternate | |
| ☑ | Lila Mier | County Region | Guests |
| ☑ | Emerson Martell | County Region | Gloria Guerra, LACoFD |
| ☑ | Yvonne Elizarraraz | County Region | Amar Shah, MD (CSM) |
| ☑ | Antoinette Salas | County Region | Shane Cook, LACoFD |
| ☑ | Shira Schlesinger, MD | Base Hospital Medical Director | Salvador Rios, MD (SJS) |
| ☑ | Gabriel Campion, MD | Base Hospital Medical Director, Alternate | Stefan Viera (TFD) |
| ☐ | Adam Brown | Provider Agency Advisory Committee | |
| ☑ | Jennifer Nulty | Prov. Agency Advisor Committee, Alternate | |
| ☐ | Heidi Ruff | Pediatric Advisory Committee Representative | |
| ☐ | Desiree Noel | Ped AC Representative, Alternate | |
| ☑ | John Foster | MICN Representative | |
| ☐ | Vacant | MICN Representative, Alternate | |

| | PREHOSPITAL CARE COORDINATORS | | | | |
|---|---|---|---|---|---|
| ☑ | Melissia Turpin (SMM) | ☑ | Allison Bozigian (HMN) | ☑ | Annette Mason (AVH) |
| ☑ | Jessika Mejia (QVH) | ☑ | Melissa Carter (HCH) | ☑ | Brandon Koulabouth (AMH) |
| ☑ | Thomas Ryan (SFM) | | | | |

1. **CALL TO ORDER:** The meeting was called to order at 1:01 p.m. by Dr. Erick Cheung, EMS Commissioner.

2. **INTRODUCTIONS/ANNOUNCEMENTS:**

2.1 The EMS Agency along with County Fire and Long Beach Fire, will host Sidewalk CPR on Thursday, June 6, 2024, to raise community awareness. There will be information on the EMS Agency website and a QR Code to access additional information.

2.2. EMSAAC 2024 Annual Conference is scheduled to take place in San Diego May 29 and 30, 2024. Guest speakers are Dr. Erick Cheung and Dr. Bosson.

2.3 APOT report update: Due to the transition from prior data standards to the National Standard NEMSIS 3.5, the EMS Agency will not be able to report on the fourth quarter data. Most of the provider data is complete for first quarter 2024 and the report will be coming out shortly.

3. **APPROVAL OF MINUTES**

3.1 The Meeting Minutes for February 7, 2024, were approved as presented.

M/S/C (Spina/Verga-Gates)

4. **REPORTS & UPDATES:**

4.1 EMS Update 2024

The EMS modules for PediDose and Pedi-Part is available to all MICNs and providers. EMS Update training will need to be completed by June 30, 2024. There will be a link for an unlocked course in the Dropbox folder for individuals to access EMS Update for those who do not need tracking for CE.

4.2 EmergiPress

The case of the month is *Pediatric Bradycardia*. Additional education will include an ECG review (adult), and a pediatric GCS module.

4.3 Research Initiatives and Pilot Studies

SRC: The focus is looking at the frequency of CABG after transport for STEMI. The query was to see the volume of cases and understand its potential impact on the system. Current data shows the rate to be low. There are no foreseeable plans to change related to this information. The paper is in peer review.
The SRC data collaborative is also looking at the trends over the last ten years as a STEMI system and how it has been able to address inequities and care.
Stroke: The stroke data collaborative has been looking at the last six years of the stroke system's two-tiered routing to see how well LVO (large vessel occlusions) are routed to Thrombectomy-Capable and Comprehensive Stroke Centers. Another focus is looking at the treatment of hemorrhagic strokes and determining what data to collect to initiate further monitoring of treatment and time to treatment.

Peds: The pediatric data collaborative is looking at how to collect pediatric patient outcomes. A plan will be developed over the next four to six months for a pediatric outcome registry.
Trauma: The use of prehospital whole blood or prehospital blood transfusion for hemorrhagic shock is in the exploratory phase. The therapy is used in other systems for medical shock.
ECMO pilot: Currently there are 150 patients enrolled after exclusions. There is a thirty percent (30%) survival with most patients having good neurological outcomes. The plan is to publish the outcomes of the pilot by the end of the year. There is also plans to transition away from pilot and into a systems-based approach.
Thorasite pilot: Looking at the preliminary first quarter data. The goal is to see if the thorasite device can be an optional device for agencies. There have been 27 needle thoracostomy placements thus far and anticipate only piloting this device for one year.
Informational: The I-gel pilot data that led to the I-gel introduction for pediatrics will be presented at the Society for Academic Emergency Medicine Conference in May to share the data with other EMS systems.

4.4 PediDOSE Study

The transition to age-based dosing protocols for pediatric seizures will be posted on the EMS website on July 1, 2024. The goal is to have everyone complete the PediDOSE training by the June 30 deadline before the rollout date.

4.5 Pedi-PART

Igel versus bag-valve-ventilation: Agencies will be activated when they have reached the training threshold and completed the requirements. The soonest a provider agency could be activated is May 15, 2024. The base hospital should communicate with their local providers to determine their go-live dates. The EMS Agency is asking base hospitals to remind providers to follow the correct assignment, enroll the patient, and email the EMS Agency of the enrollment to ensure all patients are captured. After a long discussion, the EMS Agency will create a REDcap and distribute via email so that base hospitals can operationalize the notification through REDcap as they see best.

4.6 ELCoR Task Force

The EMS and Law Enforcement Co-Response Task Force group created a medical control guideline to help tackle co-response to the agitated patient. A draft of a scenario-based education module will be filmed this year to highlight assessing the patient for decision-making capacity and communication between EMS and law enforcement to determine the best patient approach. Additional goals are to formulate a workgroup around pediatric critical calls, develop best practices with education, and understand the use of law enforcement body cameras.

4.7 California Office of Traffic Safety (OTS) Grants

4.7.1 Mobile Protocol Application

Wireframes were created for the mobile application to encompass all policies and protocols ensuring quick accessibility. The application is designed with three main objectives: Rapid access to treatment protocols to provide a concise overview of treatment protocols along with key steps; Quick Reference Guides that offer decision-making points based on medical control guidelines; and just-in-time

videos. The application will have the capability to send notifications to the system, open multiple protocols simultaneously; and bookmark favorite treatment protocols. Pedi-PART and PediDOSE with the color code drug dosing MCG will be integrated into the application. The goal is to launch the mobile application by October 2024.

4.7.2 Health Data Exchange

The first phase of the one-year funding involves developing a trauma dashboard (prototype). A dashboard was created to look at crash characteristics, demographics of victims, and post-crash care in the prehospital and hospital environments to identify areas of improvement. The EMS Agency is developing a curriculum framework to improve post-crash care with plans to present it at the next BHAC meeting.

Health Data Exchange (HDE): The Measure B Advisory Board approved the funding for the implementation of the HDE. Richard Tadeo will meet with hospital CEOs to present the HDE information. If successful, the HDE will be a major step forward for the system. First targeted would be the twenty-one base hospitals and trauma centers. The funding will also go to the provider agencies and hospitals for implementation and first subscription.

**5. Old Business: None**

**6. New Business; No Action Required**

6.1 Ref. No. 815, Honoring Prehospital Do Not Resuscitate Orders, Physician Orders for Life-Sustaining Treatment (POLST) and End-of-Life Option (Aid-In-Dying Drug) Patient Destination

Policy updated to reflect the senate bill passed in 2021. The law no longer requires a signed final attestation for individuals who chose the Aid-In-Dying Drug.

6.2 Ref. No. 1241, Overdose/Poisoning/Ingestion

Added: Naloxone 2-4mg IN(depending on formulation available)

6.3 Ref. No. 1241-P, Overdose/Poisoning/Ingestion

Added the option for administering the pre-packaged nasal spray dose of 2-4mg IN (depending on the formulation available), excluding neonates.

6.4 Ref. No. 1317.29, Drug Reference-Naloxone

Added the option for administering the pre-packaged nasal spray dose of 2-4mg IN (depending on the formulation available), excluding neonates.

6.5 Ref. No. 1307.4, EMS and Law Enforcement Co-Response

(New) policy presented by Dr.Nichole Bosson. This information will be disseminated to law enforcement agencies via the LA Area Police Chiefs Association with plans to build the training module for POST (Peace Officer Standards of Training) so all law enforcement agencies can have this training.
Discussion around whether education will be given before the policy release, possibly through EmergiPress.

6.6 Mechanical Compression Device (MCD) for Traumatic Arrests

Removed the contraindication for mechanical compression devices for traumatic full arrest. The Medical Council Committee and THAC (Trauma Hospital Advisory Committee) agreed to the change. Videos will be created to demonstrate to EMS and hospital staff how to transition a patient with a MCD. The request was made for the videos to be available on a platform to be reviewed by all hospital staff.

**Informational**

6.7 Base Hospital Documentation Manual

6.8 Base Hospital Form 2024

Discussion about adding a Mechanical Compression Device field on the base hospital form.

6.9 Revised Summary of Changes 2024

**7. OPEN DISCUSSION: None**

**8. NEXT MEETING: June 5, 2024**

**9. ADJOURNMENT: The meeting was adjourned at 14:36**

**ACTION:** Meeting notification, agenda, and minutes will be distributed electronically before the next meeting.

**ACCOUNTABILITY:** Laura Leyman

# EMERGENCY MEDICAL SERVICES COMMISSION
# PROVIDER AGENCY ADVISORY COMMITTEE

**MINUTES**

Wednesday, April 17, 2024

## MEMBERSHIP / ATTENDANCE

| MEMBERS IN ATTENDANCE | ORGANIZATION |
|---|---|
| X Kenneth Powell, Chair | EMSC, Commissioner |
| X Paul Espinosa, Vice-Chair | EMSC, Commissioner |
| James Lott, PsyD, MBA | EMSC, Commissioner |
| Ken Lieberman | EMSC, Commissioner |
| Jason Cervantes | EMSC, Commissioner |
| Carol Kim | EMSC, Commissioner |
| Carol Meyer | EMSC, Commissioner |
| Gary Washburn | EMSC, Commissioner |
| X Sean Stokes | Area A *(Rep to Medical Council)* |
| Justin Crosson | Area A, Alternate |
| Keith Harter | Area B |
| Clayton Kazan, MD | Area B, Alternate |
| X Todd Tucker | Area C |
| X Jeffrey Tsay | Area C, Alternate |
| Kurt Buckwalter | Area E |
| X Ryan Jorgensen | Area E, Alternate |
| X Mick Hannan | Area F |
| Andrew Reno | Area F, Alternate |
| Adam Brown | Area G *(Rep to BHAC)* |
| X Jennifer Nulty | Area G, Alternate |
| Matthew Conroy | Area H |
| X David Hahn | Area H, Alternate |
| X Julian Hernandez | Employed Paramedic Coordinator |
| Tisha Hamilton | Employed Paramedic Coordinator, Alt |
| Rachel Caffey | Prehospital Care Coordinator |
| X Jenny Van Slyke | Prehospital Care Coordinator, Alternate |
| Ryan Cortina | Public Sector Paramedic Coordinator |
| X Bryan Sua | Public Sector Paramedic Coordinator, Alt |
| X Maurice Guillen | Private Sector Paramedic |
| Scott Buck | Private Sector Paramedic, Alternate |
| Tabitha Cheng, MD | Provider Agency Medical Director |
| X Tiffany Abramson, MD | Provider Agency Medical Director, Alt |
| X Andrew Lara | Private Sector Nurse Staffed Amb Program |
| Jonathan Lopez | Private Sector Nurse Staffed Amb Program, |
| X Scott Jaeggi | EMT Training Program |
| Albert Laicans | EMT Training Program, Alternate |
| Scott Atkinson | Paramedic Training Program |
| David Filipp | Paramedic Training Program, Alternate |
| X Caroline Jack | EMS Educator |
| *Pending* | EMS Educator, Alternate |

| EMS AGENCY STAFF | EMS AGENCY STAFF |
|---|---|
| Richard Tadeo | Nichole Bosson, MD |
| Denise Whitfield, MD | Shira Schlesinger, MD |
| Kelsey Wilhelm, MD | Michael Kim, MD |
| Jacqueline Rifenburg | Frederick Bottger |
| Jennifer Calderon | Paula Cho |
| Aldrin Fontela | Elaine Forsyth |
| Natalie Greco | Tracy Harada |
| Han Na Kang | Laurie Lee-Brown |
| Laura Leyman | Nnabuike Nwanonenyi |
| Sara Rasnake | Priscilla Riss |
| Andrea Solorio | Denise Watson |
| Gary Watson | David Wells |
| Essence Wilson | Lorna Mendoza |

| GUESTS | ORGANIZATION |
|---|---|
| Puneet Gupta, MD | LACoFD |
| Marc Cohen, MD | LAFD, BH, MB, TF |
| Catherine Borman | Santa Monica FD |
| Jessie Castillo | PRN Ambulance |
| Benjamin Esparza | LAFD |
| Jason Hansen | Pasadena FD |
| Ky Kalousek | LAFD |
| Ivy Valenzuela | LA County Public Health |
| Kristina Crews | LACoFD |
| Theodor Ecklund | Pasadena FD |
| Dave Molyneux | AM West Ambulance |
| Freddy Jimenez | Montebello FD |
| Travis Corr | San Gabriel FD |
| Sergio Zavala | Downey FD |
| Armando Jurado | Lifeline Ambulance |

**1. CALL TO ORDER –** Chair Kennth Powell, called meeting to order at 1:01 p.m.

**2. INTRODUCTIONS AND ANNOUNCEMENTS**

**2.1** PAAC Membership Changes

As Executive Director of the EMS Commission, Richard Tadeo introduced Commissioner Paul Espinosa as Vice-Chair of this Committee. Chief Espinosa is currently the Police Chief for the City of Montebello and represents the Los Angeles Police Chief's Association.

Committee Chair announced the following membership changes:

- Public Sector Paramedic, Representative: Ryan Cortina moved from Alternate to primary Representative, replacing Paul Voorhees.
- Public Sector Paramedic, Alternate: Bryan Sua (Culver City FD), selected to fill this position on Committee.
- EMT Training Program, Representative: Scott Jaeggi moved from Alternate to Primary Representative, replacing Michael Kaduce.

- EMT Training Program, Alternate: Albert Laicans (Citrus College), selected to fill this position on Committee.

**2.2** 2024 Sidewalk CPR *(David Wells)*

- June 1-7, 2024, is National CPR and AED Awareness week.
- On June 6, 2024 (10am-2pm), the EMS Agency is joining Long Beach FD, Los Angeles County FD, Falck Ambulance and MemorialCare Long Beach Medical Center to host a community-based Sidewalk CPR event, located at the El Dorado Park – West (also known as Good Neighbor Park), 2800 Studebaker Road, Long Beach. This area has been identified as having one of the highest numbers of cardiac arrests with the lowest rate in bystander CPR.
- Providers who are interested in having their own community awareness event, may register with Vanessa Gonzalez at vgonzalez3@dhs.lacounty.gov

**2.3** Infection Control Assessment and Response (ICAR) *(Ivy Valenzuela, LA County Public Health)*

- Representative from the Los Angeles County Public Health Department provided information on the importance of infection control prevention and introduced a project where Public Health will be asking providers to participate in an evaluation of their agency's infection control practices.
- Participation is voluntary, non-punitive, and strongly encouraged.
- More information can be obtained from Ivy Valenzuela at ivalenzuela@ph.lacounty.gov

**3. APPROVAL OF MINUTES (Tucker / Rodriquez)** February 14, 2024, minutes were approved as written.

**4. REPORTS & UPDATES**

**4.1** EMS Update 2024 *(Denise Whitfield, MD)*

- Provider agencies continue to provide education to paramedics and MICNs.
- This year's update includes a 2-hour online module. All 9-1-1 providers are required to complete a hands-on portion covering Pedi-PART and PediDOSE skills.
- All training is to be completed by June 30, 2024.

**4.2** Emergi-Press *(Denise Whitfield, MD)*

- The next Emergi-Press will be available towards the end of April 2024.
- Topics include pediatric bradycardia case review, ECG cardiac ischemia, and calculating the pediatric Glascow Coma Scale (GCS).

**4.3** ITAC Update *(Denise Whitfield, MD)*

No updates to report.

**4.4** Research Initiatives and Pilot Studies *(Nichole Bosson, MD, Denise Whitfield, MD, Kelsey Wilhelm, MD)*

Research Initiatives:

- Publications – A publication by Dr. Jake Toy has been submitted on the frequency of coronary-artery-bypass-grafts (CABG) after transfer of patients with ST-elevated myocardial infarctions (STEMI). This publication is looking at the impact of having on-call cardiac surgeons.
- Stroke – In effort to identify ways to optimize the treatment of stroke patients, this collaborative is reviewing data on Los Angeles County's current two-tier routing strategy of stroke patients.
- Pediatric – This collaborative is currently reviewing methods to capture outcome data in which to identify ways to produce a greater impact on improving our pediatric care.

Pilot Studies:

- ECMO – 150 patients enrolled with an overall 30% survival rate. Data is being reviewed to understand the broader impact of this pilot on cardiac arrest survival within our system. This data will be shared once compiled.
- EXG – Pilot study being conducted by Pasadena FD. Data collection continues.

- Thora Site – LA County FD, Compton FD, Torrance FD and Culver City FD continue with this pilot. A total of 27 needle thoracostomies have been placed under this study. 1st Quarter data has been received and will be shared once reviewed.
- Prehospital Blood Transfusion – This study is not active but is being explored as a potential pilot. Kelsey Wilhelm, MD, will be leading this exploration. LA County FD and Compton FD have expressed interest in participating.

**4.5** PediDOSE Trial *(Nichole Bosson, MD)*

- Providers are reminded to continue utilizing the current Treatment Protocol, Ref. No. 1309-P to treat all pediatric seizure patients via color code.
- Effective July 1, 2024, Los Angeles County will transition systemwide to age-based dosing of midazolam for the treatment of pediatric seizures.
- At least 90% of the system-wide 9-1-1 paramedics must be trained prior to implementation.
- Protocols, policies, and mobile applications will be updated to reflect the new treatment algorithm.
- Data collection will continue throughout this transition. Providers were reminded of the importance to complete the paramedic self-reporting (PSR) for each pediatric seizure response.
- Each paramedic submitting a completed PSR will receive an entry into a monthly drawing for one of four Amazon gift cards.

**4.6** Pedi-PART *(Nichole Bosson, MD)*

- Provider agencies may begin enrolling patients into Pedi-PART once:
  - the paramedic has completed the online and skills training and
  - at least 90% of the agency's paramedics have completed the online training and
  - the EMS Agency has approved the Provider Agency to begin enrollment.
- All ALS units (including EOA provider ambulances) participating in this trial, must have a Pedi-PART reminder sheet (EMS Sheet) visibly displayed inside their ALS unit.
  - This Sheet will remind paramedics to "Recognize", "Randomize", and "Report" for Pedi-PART and will contain two QR codes.
  - The first QR code, named "QBBERT", provides the daily airway assignment; and the second QR code, is for paramedic self-reporting (PSR).
- The EMS Agency will be providing all ALS units with a red hand-held device (RALPH) to assist the paramedic in identifying the daily airway assignment.
- Pedi-PART pocket cards (containing the two QR codes) will also be available.
- This study will require 100% completion of the PSR, within 7 days . Each paramedic submitting a completed PSR will receive a $20 gift card.
- Once your agency's training is complete and prior to implementation, Dr. Bosson is requesting a conference call to discuss your implementation of the Pedi-PART study.

**4.7** California Office of Traffic Safety (OTS) Grants

**4.7.1** Mobile Application Grant *(Nichole Bosson, MD)*

- The development and implementation of this project is ongoing.
- It is projected that there will be a working protocol application by October 2024.

**4.7.2** Health Data Exchange *(Nichole Bosson, MD; Shira Schlesinger, MD; Richard Tadeo)*

- The EMS Agency has received grant funding to implement a Health Data Exchange (HDE) system that would support a live dashboard. This dashboard would project the County's injury events and treatment, which would assist with the development of injury prevention strategies during post-crash care.
- One year of preliminary data has been received from the EMS Agency's Trauma and EMS databases; as well as data from a law enforcement database called "SWITRS" (Statewide Integrated Traffic Records System).
- Once the collected data is inserted into the dashboard system, the EMS Agency will be able to view the functionality of the dashboard. A live version of the dashboard is planned to be displayed on the EMS Agency's webpage soon.

- The EMS Agency will be developing focus groups that will look at potential areas needing increased education on post-crash care. To assist with determining the needs, the EMS Agency asked if providers would be willing to share their educational material related to this subject. (Committee had no opposition)
- Richard Tadeo provided a description of two possible processes where electronic patient care data can be uploaded into a hospital's database system.
- The EMS Agency is exploring ways in which hospitals will make the data accessible to the providers, enabling providers to review patient outcome data and ED diagnoses.
- The first phase of implementing the HDE system will be with the trauma and base hospitals. It is anticipated that it would take approximately 4-8 weeks per hospital to implement. Mr. Tadeo will be meeting with hospital CEOs to discuss this integration.

## 5. UNFINISHED BUSINESS

**Policies for Discussion; No Action Required:**

**5.1** Reference No. 1307.4, MCG: EMS and Law Enforcement Co-Response *(Nichole Bosson, MD)*

Policy reviewed as information only.

## 6. NEW BUSINESS

**Policies for Discussion; Action Required:**

None

**Policies for discussion; No Action required:**

**6.1** Reference No. 517, Private Provider Agency Transport/Response Guidelines *(David Wells)*

Policy reviewed as information only.

**6.2** Reference No. 815, Honoring Prehospital Do Not Resuscitate Orders, Physician Orders for Life Sustaining Treatment and End of Life Option (Aid-in Dying Drug) *(David Wells)*

Policy reviewed as information only.

**6.3** Reference No. 1241,Treatment Protocol: Overdose / Poisoning / Ingestion *(Nichole Bosson, MD)*

Policy reviewed as information only.

**6.4** Reference No. 1241-P, Treatment Protocol: Overdose / Poisoning / Ingestion (Pediatric) *(Nichole Bosson, MD)*

Policy reviewed as information only.

**6.5** Reference No. 1317.29, Medical Control Guideline: Drug Reference – Naloxone *(Nichole Bosson, MD)*

Policy reviewed as information only.

**6.6** Mechanical Compression Device for Traumatic Arrests *(Nichole Bosson, MD)*

Policy reviewed as information only.

## 7. OPEN DISCUSSION

**7.1** Hospital Emergency Response Team (HERT) *(Nichole Bosson, MD)*

The Los Angeles County FD and EMS Agency have joined together to create a training module/film that demonstrates the collaboration and coordination between on-scene paramedics, the USAR team, and HERT members during the treatment of a patient. This film will be presented at the next EMS Commission, on May 8, 2024.

**7.2** Assembly Bill 1417, Elder Abuse Reporting – Update *(Denise Whitfield, MD)*

The Assembly Bill addressing elder abuse reporting has been recently changed. The EMS Agency is revising Reference No. 823, Elder Abuse and Dependent Adult Abuse Reporting Guidelines, to reflect the recent changes.

**8. NEXT MEETING** – June 12, 2024

**9. ADJOURNMENT -** Meeting adjourned at 2:45 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES **DRAFT**

SUBJECT: **EMERGENCY DEPARTMENT APPROVED FOR PEDIATRIC (EDAP) STANDARDS**

REFERENCE NO. 316

PURPOSE: To establish minimum standards for the designation of Emergency Departments Approved for Pediatrics (EDAP). These Emergency Departments (ED) provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 14

DEFINITIONS:

**Board Certified (BC):** Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA), including an examination designed to assess the knowledge, skills, and experience necessary to provide quality patient care in a particular specialty.

**Board Eligible (BE):** Successful completion of a residency training program with progression to board certification based on the timeframe as specified by the ABMS or AOA.

**Commercial Sexual Exploitation of Children:** Commercial Sexual Exploitation of Children (CSEC) refers to any range of crimes and activities involving the sexual abuse or exploitation of a child for the financial benefit of any person or in exchange for anything of value (including monetary and non-monetary benefits) given or received by any person. https://dcfs.lacounty.gov/youth/sexual-exploitation/

**Department of Children and Family Services (DCFS):** A mandated component of Emergency Response Services, administered by the Los Angeles County Department of Children and Family Services. The Child Protection Hotline (CPH), 800-540-4000, intake evaluation staff is responsible for assessing any referral, whether verbal or written, which alleges child abuse, neglect, sexual assault, or exploitation, which includes commercial sexual exploitation and human trafficking, to determine whether an in-person investigation and consultation is required.

**Designated Pediatric Consultant:** a qualified specialist in pediatrics and/or pediatric subspecialty.

**Emergency Department Approved for Pediatrics (EDAP):** A licensed basic or comprehensive ED that is designated by the Los Angeles County Emergency Medical Services (EMS) Agency to receive pediatric patients via the 9-1-1 system. These EDs provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures.

**EDAP Medical Director:** A qualified specialist in Emergency Medicine (EM) or Pediatric Emergency Medicine (PEM), also referred to as the Physician Pediatric Emergency Care Coordinator.



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

**Emergency Nursing Pediatric Course (ENPC):** Two-day course developed by the Emergency Nurses Association (ENA) provides core-level pediatric knowledge and psychomotor skills needed to care for pediatric patients in the emergency care setting.

**Pediatric Advanced Life Support (PALS):** Pediatric resuscitation course that is recognized by the EMS Agency and valid for two years (e.g., American Heart Association, American Red Cross).

**Pediatric Advisory Committee (PedAC):** Acts in an advisory capacity to the EMS Agency and is responsible for all matters regarding pediatric care and policy development pertinent to the practice, operation, and administration of prehospital care, emergency departments, and pediatric intensive care units (PICU). The committee reviews, evaluates and makes recommendations on EMS issues impacting the pediatric population.

**Pediatric Emergency Course (PEC):** Two-day course, with topics pre-approved by the EMS Agency, that provides knowledge about the acutely ill and injured child, and a minimum of 14 hours of Board of Registered Nursing (BRN) approved continuing education.

**Pediatric Emergency Medicine (PEM):** A qualified specialist with a subspecialty in pediatrics to provide and manage emergency care in acutely ill or injured infants and children.

**Pediatric Intensivist:** A qualified specialist in Pediatric Critical Care.

**Pediatric Liaison Nurse (PdLN):** A Registered Nurse currently licensed to practice in the State of California and appointed by the hospital to coordinate pediatric emergency care, also referred to as Nurse Pediatric Emergency Care Coordinator (PECC).

**Pediatric Medical Center (PMC):** A licensed acute care hospital that is designated by the EMS Agency to receive **critically ill** pediatric patients via the 9-1-1 system based on guidelines outlined in Ref. No. 510, Pediatric Patient Destination.

**Pediatric Patient:** In the prehospital setting, is a child who is 14 years of age or younger.

**Pediatric Trauma Center** (**PTC):** A licensed acute care hospital that is designated by the EMS Agency to receive **injured** pediatric patients via the 9-1-1 system based on guidelines outlined in Ref. No. 506, Trauma Triage. These centers provide tertiary pediatric care and serve as referral centers for critically injured pediatric patients.

**Promptly Available:** Able to be physically present in the ED within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, should not have a measurable harmful effect on the course of patient management or outcome. Hospital guidelines shall be established that address response time for on-call physicians.

**Qualified Specialist:** A physician licensed in the State of California who has become BC or BE in the corresponding specialty by ABMS or AOA.

**Sexual Assault Response Team (SART) Centers:** A center specializing in forensic examinations in the case of an acute sexual assault/abuse event (defined as occurring within 120 hours), which has the capabilities of providing comprehensive medical and psychological forensic examinations and consist of a knowledgeable staff whose training, expertise, and state-of-the-art equipment exceeds the community standards.

**Telehealth:** The remote delivery of health care services and clinical information using telecommunications technology. This includes a wide array of clinical services using internet, wireless, satellite, and telephone media.

POLICY:

I. EDAP Designation / Re-Designation

A. EDAP initial designation and EDAP re-designation is granted for a period of three years after a satisfactory review by the EMS Agency.

B. The EMS Agency reserves the right to perform scheduled site visits or request additional data of the EDAP at any time.

C. The EDAP shall immediately provide written notice to the Director of the EMS Agency if unable to adhere to any of the provisions set forth in the EDAP Standards, including structural changes, relocation of ED and change in pediatric inpatient resources.

D. The EDAP shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw from the EDAP program.

E. The EDAP shall notify the EMS Agency within 15 days, in writing of any change in status of the EDAP Medical Director, ED Nurse Manager/Director, Designated Pediatric Consultant, or Pediatric Liaison Nurse (PdLN) by submitting the Notification of Personnel Change Form (Ref. No. 621.2).

F. Execute and maintain a Specialty Care Center EDAP Designation Agreement with the EMS Agency.

II. General Hospital Requirements

A. Licensed by the State of California Department of Public Health (CDPH) as a General Acute Care Hospital, and maintain:

1. A special permit for Basic or Comprehensive Emergency Medical Service; and

2. Accreditation from a Centers for Medicare & Medicaid Services (CMS) recognized Hospital Accreditation Organization.

B. Shall appoint an EDAP Medical Director who will be provided non-clinical time to perform duties based on the ED's annual pediatric volume

1. Low <1,800

2. Medium 1,800 – 4,999

3. Medium-High 5,000 – 9,999

4. High >10,000 highly recommend 50% FTE)

C. Shall appoint a PdLN and provide non-clinical time to perform duties based upon the ED's annual pediatric volume:

1. Low <1,800 (10% FTE or 4 hours/ week)

2. Medium 1,800 – 4,999 (25% FTE or 10 hours/ week)

3. Medium-High 5,000 – 9,999 (50% FTE or 20 hours/week)

4. High >10,000 (a minimum of 50% FTE but highly recommend 1 full time equivalent)

D. Hospital shall have a mechanism to track and monitor pediatric continuing education, including PALS, of pertinent staff.

E. Pediatric Interfacility Transfer

Establish and maintain a written Interfacility Consultation and Transfer Agreement for tertiary or specialty care, which shall include, at a minimum, the following:

1. A plan for subspecialty consultation (telehealth or on-site) 24 hours per day.

2. Identification of transferring and receiving hospitals' responsibilities in accordance with Emergency Medical Treatment and Active Labor Act (EMTALA).

3. A process for selecting the appropriately staffed transport service to match the patient's acuity level.

III. EDAP Leadership Requirements

A. EDAP Medical Director

1. Responsibilities:

1. Oversee EDAP quality improvement (QI) program and monitor to ensure adherence to the EDAP standards.

2. Promote and verify adequate skills and current knowledge of ED staff physicians and mid-level practitioners in pediatric emergency care and resuscitation.

3. Participate in a multidisciplinary ED and pediatric committees (if applicable) to ensure that pediatric care needs are addressed and communicated across disciplines.

4. Liaison with PMCs, PTCs, other hospitals, prehospital care providers, and the EMS Agency to ensure pediatric care needs are addressed.

5. Collaborate with the ED Nurse Manager/Director and the PdLN to ensure adherence to the EDAP standards for staffing, medication, equipment, supplies, and other resources for children in the ED.

6. Participate in EMS Agency activities and meetings and attend a minimum of two (2) PedAC meetings per year.

B. Designated Pediatric Consultant

1. Responsibilities:

a. Promptly available for consultation

b. Participate in the development and monitoring of pediatric QI program, and pediatric policies and procedures

c. Collaborate with the EDAP Medical Director and PdLN as needed

d. May also be the EDAP Medical Director

C. ED Nurse Manager/Director

Responsibility: provide organizational oversite and support to meet EDAP requirements and initiatives

D. Pediatric Liaison Nurse (PdLN)

1. Qualifications:

a. At least two years of experience working in pediatrics, or in an ED that provides care for pediatric patients, within the previous five years; and currently working for the ED.

b. Current PALS provider or instructor certification.

c. Completion of a two-day PEC or ENPC every four years.

d. Completion of seven hours of BRN approved pediatric continuing education (CE) every two years.

2. Responsibilities:

a. Collaborate with the EDAP Medical Director, ED Nurse Manager/Director, and Designated Pediatric Consultant to ensure compliance with the EDAP Standards, and policies and procedures established by the EMS Agency.

b. Implement, maintain, and monitor the EDAP QI program.

c. Serve as a liaison and maintain effective lines of communication with:

1) ED management, physicians, and personnel
2) Hospital pediatric management, physicians, and personnel
3) System PdLNs
4) Other EDAPs and PMCs

5) Prehospital care coordinators (PCCs), as needed, to follow up with pediatric treatment/transport concerns
6) EMS providers as needed, to follow up with pediatric treatment and/or transport concerns
7) EMS Agency

d. Serve as a contact person for the EMS Agency and be available upon request to respond to County business.

e. Ensure pediatric ED continuing education and competency evaluation in pediatrics for ED staff.

f. Participate in EMS Agency activities and meetings and attend a minimum of two (2) PedAC meetings per year.

IV. Personnel Requirements

A. ED Physicians

All physicians attending in the ED shall be BC, or BE in EM, or PEM.

B. Pediatricians (applies to EDAPs with associated pediatric admission unit)

There shall be a call panel for telephone consultation and a qualified specialist in pediatrics to be available to the ED twenty-four hours per day.

C. Pediatric Subspecialty Services

Pediatric subspecialty physicians, to include pediatric intensivist, shall be available through in-house call panel, telehealth, or transfer agreements.

D. Advanced Practice Providers (Physician Assistants and Nurse Practitioners)

1. Advanced Practice Providers shall be licensed in the State of California.

2. Advanced Practice Providers assigned to the ED caring for pediatric patients must have PALS provider or instructor certification.

E. Registered Nurses

1. All RN staff in the ED caring for pediatric patients must have a current PALS provider or instructor certification.

2. All nurses assigned to the ED shall attend at least 14 hours of BRN-approved pediatric emergency education (not including PALS) every four years (e.g., PEC or ENPC).

3. At least one RN per shift shall have completed a two-day PEC within the last 4 years and be available for patient care. It is highly recommended that all nurses regularly assigned to the ED complete this course.

V. Two-Day PEC – Continuing Education

A. May be completed in-house or off-site.

B. The interval between Day/Part 1 and Day/Part 2 must be completed within a six-month period. If the interval between Day/Part 1 and Day/Part 2 is greater than six months, this will only fulfill the 14-hour requirement in Section IV.E.2 above.

C. Curriculum should be selected from this broad spectrum of pediatric topics which have been pre-approved by the EMS Agency:

1. Airway management
2. Brief Resolved Unexplained Event (BRUE)
3. Burns
4. Child maltreatment (suspected child abuse, neglect, commercial sexual exploitation, human trafficking and sexual assault) to include the mandated reporting process
5. Coordination of care with a SART Center for an acute suspected sexual assault victim requiring a forensic examination
6. Death
7. Disaster preparedness/Disaster management
8. Fever
9. Female presenting with signs & symptoms of recent delivery and no history of giving birth / newborn abandonment
10. Human trafficking
11. Injury prevention
12. Medical conditions (e.g., diabetic ketoacidosis, inborn errors of metabolism, etc.)
13. Medication safety
14. Neonatal resuscitation
15. Pain management
16. Disaster management
17. Poisonings/overdose
18. Procedural sedation
19. Respiratory emergencies
20. Resuscitation
21. Seizures
22. Sepsis
23. Shock / hypotension
24. SIDS/SUID
25. Special health care needs
26. Submersions
27. Surgical emergencies
28. Trauma
29. Triage

D. A copy of the course flyer, with the agenda, shall be sent electronically to the EMS Agency Pediatric Program Coordinator no later than eight weeks before the scheduled course.

VI. Ancillary Services

A. Respiratory Care Practitioners (RCP)

1. At least one RCP shall be in-house twenty-four hours per day to respond to the ED.

2. All RCPs that work or respond to the ED shall have a PALS provider or instructor certification.

B. Radiology

1. The radiology department shall have pediatric-specific policies and procedures pertaining to imaging studies of children and reducing radiation exposure.

2. Qualified specialist in radiology must be on-call and promptly available twenty-four hours per day.

3. Radiology technician must be in-house twenty-four hours per day.

4. Provide the following services 24 hours per day/seven days per week:

a. Computerized tomography (CT)

b. Ultrasonography

c. Magnetic resonance Imaging (MRI)

C. Laboratory

Laboratory service shall have pediatric-specific policies and procedures pertaining to laboratory studies of children~~,~~ including, but not limited to, obtaining samples, and microtechnique for small or limited sample sizes.

VII. Policies and Procedures

The hospital shall develop and maintain, at minimum, the following policies and procedures pertaining to the emergency department care of children, unless specific to radiology, laboratory or pharmacy practices. Multiple required elements may be incorporated into one policy (e.g., Care of the Pediatric Patient in the ED). All policies should be reviewed minimally every three (3)years and reflect current practice. Any reference to weight should be in the form of kilograms.

A. Weight and Vital Sign Measurement:

1. Vital signs shall be obtained and recorded at triage for all children. The policy shall include age-appropriate methods to obtain temperature, heart rate, respiratory rate, and pain scale.

2. Blood pressure and pulse oximetry monitoring shall be available for children of all ages. Optimally, blood pressure and pulse oximetry should be assessed on all children and shall be measured on all children requiring admission or transfer. Exceptions must be addressed in policy and monitored.

3. All pediatric weights shall be obtained and recorded in kilograms upon

arrival to the ED:

a. For children who require emergency stabilization or those who cannot be safely weighed, a standardized length-based resuscitation tape, approved by the EMS Agency (e.g., Broselow 2011A or newer), may be used to estimate weight in kilograms. The weight shall be recorded in a prominent place on the medical record.

b. Scales used to weigh children must be configured to display weights only in kilograms.

c. Electronic medical records shall only allow for weight entries in kilograms.

B. Pediatric patient safety in the ED

C. Immunization assessment and management of the under immunized patient

D. Mandated reporting of child maltreatment (suspected child abuse, neglect, commercial sexual exploitation, human trafficking and sexual assault) to include:

1. An immediate, or as soon as practically possible, verbal telephone report shall be made to the Child Protection Hotline (CPH). A referral number will be provided by the CPH to initiate a “Create Suspected Child Abuse Report” online in the Child Abuse Reporting Electronic System (CARES).

   a. Suspected Child Abuse Report (SCAR) #8572 report shall be submitted online to the DCFS within 36 hours. https://mandreptla.org/cars.web/CallType.

   b. For a SCAR report is filed electronically, select “Follow-Up Suspected Child Abuse Reports (SS8572)”. The Mandated Reporter (MR) Number and Tracking Number will be generated and both must be documented in the patient’s medical record.

   c. If a “New Non-Emergency Child Abuse/Neglect (CARES) Report” was submitted, document the reference number “ER” followed by 11 digits.

   d. If a “Consultation with ARES number” was provided by CPH, document the reference number “A” followed by 15 digits.

2. Notify the law enforcement agency in the appropriate jurisdiction where the crime occurred. Document the officer’s identification, department, and badge number in the medical record.

3. Collaborative discussion with Social Worker, ED Physician, and RN prior to the patient being discharged to ensure the patient is discharged to the appropriate location or with the appropriate services.

E. A pediatric suspected sexual assault patient requires coordination of care with a SART Center.

1. For an acute sexual assault occurring within the last 120 hours an immediate forensic evidentiary examination may be required.

2. For a sexual assault that occurred over 120 hours, a referral to a SART Center may be appropriate as determined by the forensic examiner.

3. Collaborate with law enforcement to determine a plan of care and/or forensic evidentiary examination or referral.

4. The ED may also contact the forensic examiner for consultation or clarification regarding patient care as it relates to evidence preservation.

5. Document appropriate discharge and referral, include the name of the SART Center(s), location address, hotline telephone number(s), and to whom care was discharged (i.e., law enforcement, family, caregiver, etc.).

F. Pediatric assessment and reassessment include identification of abnormal vital signs according to the age of the patient. If abnormal values are obtained, include a plan/process for the physician notification.

G. Pain assessment, treatment, and reassessment, utilizing developmentally appropriate pain scales (include a description of the tools used for all age levels)

H. Consent and assent for emergency treatment, include situations in which a parent/legal guardian is not immediately available

I. Care of the pediatric patient with Do Not Resuscitate (DNR) orders/ or Physician Orders for Life-Sustaining Treatment (POLST)

J. Death of the child in the ED and care of the grieving family

K. Care and safety for the pediatric patient with mental and/or behavioral health emergencies

L. Physical and chemical restraint of patients

M. Procedural sedation

N. Safe surrender of newborns, include the following:

1. Signage

2. Procedures for accepting a newborn, including a safe surrender packet for the individual relinquishing the newborn

For more information: https://www.cdss.ca.gov/inforesources/Safely-Surrendered-Baby

O. Daily verification of proper location and function of equipment and supplies for the pediatric crash cart with a list and description of all required items in each drawer

P. Family Centered Care, include the following:

1. Supporting appropriate family presence during all aspects of care to include invasive procedures and resuscitation

2. Education of the patient, family, and regular caregivers

3. Discharge planning and instructions

4. Culturally and linguistically appropriate services

Q. Communication with patient's medical home or primary provider based on illness and severity (e.g., aftercare instructions, x-ray results, laboratory studies, as appropriate)

R. Transfer from the ED to another facility

S. Disaster preparedness addressing the following pediatric issues:

1. Minimizing parent-child separation, and methods for reuniting separated children with their families

2. Pediatric surge capacity for both injured and non-injured children

3. Medical and mental health therapies, and social services for children in the event of a disaster

4. Disaster drills that include a pediatric mass casualty incident at least once every two years

5. Decontamination

6. Surge plan for backup personnel (MD and nursing) in the ED

T. Medication safety addressing the following pediatric issues:

1. Medication orders should be written clearly based upon the appropriate units per kilogram and include total dose .

2. Processes for prescribing, safe medication storage, and delivery should be established. Include the use of pre-calculated dosing guidelines for children of all ages.

3. Involve the patient and family in the medication safety process to ensure accurate patient identification. Include patient and family education as to the rationale for the medication.

VIII. Equipment, Supplies, and Medications

A. Pediatric equipment, supplies, and medications shall be easily accessible, labeled, and logically organized. A mobile pediatric crash cart shall be utilized.

B. A locator chart or grid identifying the locations of all required equipment and

supplies shall be developed and maintained in order for staff to easily identify location of all items.

C. Required EDAP equipment, supplies, and medications

1. General Equipment

a. Weight scale measuring only in kilograms for both infants and children

b. Standardized length-base resuscitation tape, approved by the EMS Agency (e.g., Broselow 2011A or newer), or other standardized method to estimate pediatric weights in kilograms

c. Pediatric drug dosage reference material with dosages calculated in milligrams, micrograms, milliequivalents, etc. per kilogram (either posted or readily available)

d. Developmentally appropriate pain scale assessment tools for infants and children

e. Blood and IV fluid warmer (Rapid infuser)

f. Warming and cooling system with appropriate disposable blankets

g. Restraints in various sizes

2. Monitoring Equipment

a. Blood pressure cuffs

1) Neonatal
2) Infant
3) Child
4) Adult arm
5) Adult thigh

b. Vascular Doppler device (handheld)

c. ECG monitor/defibrillator

1) ECG electrodes in pediatric and adult sizes
2) Defibrillator paddles in pediatric and adult sizes, and/or; Hands-free defibrillation device
3) External pacing capability
4) Multifunction pads in pediatric and adult sizes

d. Thermometer with hypothermia capability

3. Airway Management

a. Bag-Mask-Ventilation (BMV) device with self-inflating bag

1) Infant (minimum 450ml)
2) Child
3) Adult

b. BMV clear masks

1) Neonate
2) Infant
3) Child
4) Adult

c. Laryngoscope handle

1) Pediatric
2) Adult

d. Laryngoscope Blades

1) Macintosh/curved: 2, 3
2) Miller/straight: 00, 0, 1, 2, 3

e. Endotracheal Tubes

1) Uncuffed: size mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5
2) Cuffed: size mm 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0

f. Stylets for endotracheal tubes

1) Pediatric
2) Adult

g. Magill Forceps

1) Pediatric
2) Adult

h. Continuous end-tidal CO2 monitoring device for pediatric and adult patients (preferred). If not available, colorimetric CO2 detector may be utilized.

i. Pulse oximeter unit with sensors

1) Infant
2) Pediatric
3) Adult

j. Nasopharyngeal Airways

1) Infant (sizes 12-14)
2) Child (sizes 18-28)
3) Adult (sizes 30-36)

k. Oropharyngeal Airways

1) Infant (size 00)
2) Child (size 0-2)
3) Adult (sizes 3-5)

l. Clear oxygen masks

1) Infant
2) Child
3) Adult

m. Non-rebreather masks

1) Infant (partial non-rebreather)
2) Child
3) Adult

n. Nasal cannulas

1) Infant
2) Child
3) Adult

o. Suction catheters

6, 8, 10, 12 Fr

p. Yankauer suction tips

q. Feeding tubes

5, 8 Fr

r. Nasogastric Tubes

5, 8, 10, 12, 14, 16, 18 Fr

s. Supraglottic Airway Devices

1) Neonatal
2) Infant
3) Child
4) Adult

t. Difficult Airway Kit

u. Tracheostomy trays: optional for EDAP, required for PMC

1) Pediatric
2) Adult

v. Tracheostomy Tubes: optional for EDAP, required for PMC

1) Neonatal: size mm 2.0, 2.5, 3.0, 3.5, 4.0, 4.5
2) Pediatric: size mm 3.0, 3.5, 4.0, 5.0, 5.5, 6.0

4. Vascular Access Equipment

a. Arm boards

1) Infant
2) Child
3) Adult

b. IV administration sets with calibrated chambers

c. IV catheters

16, 18, 20, 22, 24 gauge

d. 3-way stopcocks

e. Device or needle to achieve intraosseous (IO) vascular access, to include needles in the appropriate sizes for pediatric and adult patients

f. IV solutions, 250ml and/or 500ml bags

1) 0.9 NS
2) D5.45NS
3) D5NS
4) D10W

5. Fracture Management Devices

a. Splinting supplies for long bone fractures

b. Cervical spine motion restriction equipment (e.g., cervical collar)

1) Pediatric
2) Adult

c. Spinal board with the appropriate straps

6. Specialized Trays or Kits

a. Newborn delivery kit to include:

1) Bulb syringe
2) Umbilical clamps
3) Towels
4) Scissors

b. Newborn initial resuscitation equipment should be readily available, include:

1) Radiant warmer or warming mattress
2) BMV device with self-inflating bag and clear mask for newborns
3) Umbilical vein catheters, or 5.0 Fr feeding tube

c. Thoracostomy tray

d. Chest drainage system

e. Chest tubes (at least one in each size range)

1) Required for EDAP: (10 – 12) (16 – 24) (28 – 40) Fr
2) Required for PMC: 8, 12, 16, 20, 24, 28, 36 Fr

f. Lumbar Puncture trays and spinal needles

1) 22 g, 3 inch
2) 22-25 g, 1½ inch

g. Urinary catheterization sets and indwelling urinary catheters

5, 8, 10, 12, 14, 16 Fr

7. Pediatric-Specific Resuscitation

a. Immediately available drug calculation resources

b. The following medications must be immediately available:

1) Adenosine
2) Albuterol
3) Amiodarone
4) Atropine
5) Calcium chloride
6) Dobutamine
7) Dopamine
8) Epinephrine 0.1mg/mL **(IV administration**)
9) Epinephrine 1mg/mL (**IM administration**)
10) Epinephrine for inhalation
11) Fentanyl
12) Ipratropium bromide (Atrovent)
13) Ketamine
14) Lidocaine
15) Mannitol or hypertonic saline
16) Naloxone
17) Norepinephrine
18) Neuromuscular blocking agent
19) Procainamide
20) Sedative agent
21) Sodium Bicarbonate 4.2% (or a process to obtain the drug in an emergency situation)

22) Sodium Bicarbonate 8.4%

IX. Quality Improvement (QI) Program Requirements

A QI program shall be developed as per Ref. No. 620, EMS Quality Improvement Program, and monitored by the EDAP Medical Director, ED Nurse Manager/Director, and PdLN, with input as needed from the Designated Pediatric Consultant.

A. Develop a methodology to easily identify pediatric (14 years of age and under) visits to the ED that can clearly delineate between 9-1-1 transport and self-transport.

B. Identification and trending of important aspects of pediatric care requiring improvement shall include:

1. 100% medical record review by physician and PdLN to include physician reviewer's signature(s) and date(s) of the reviews:

a. Deaths in the ED

b. Child Maltreatment (suspected child abuse, neglect, commercial sexual exploitation, human trafficking, and sexual assault) to include the mandated reporting process

c. Transfers to higher level of care

d. Unscheduled/unplanned return visits to the ED within 48 hours and are admitted or transferred for continued acute care

2. System-wide QI projects selected by the EMS Agency and endorsed by the PedAC

a. Participate in the Pediatric Readiness Quality Improvement Collaborative (PRQC) and other endorsed projects.

b. Track and trend one (1) facility indicator (important aspects of patient care) identified by the Medical Director and PdLN.

3. EDAPs not participating and/or sharing data in system-wide QI projects such as PRQC shall track and trend two (2) EMS Agency approved indicators and one (1) additional indicator (important aspects of patient care) identified by the Medical Director and PdLN

4. Quarterly QI review of all suspected child maltreatment cases shall be conducted by Social Services and the ED to ensure the appropriate recognition of, and reporting processes have been completed. A checklist may be utilized to ensure complete documentation and facilitate the review.

C. Submit data as requested by the EMS Agency for quality improvement purposes upon request (e.g., PRQC, Cardiac Arrest Registry to Enhance Survival (CARES), pediatric patient outcomes, physician reviews).

D. Maintain written QI plan, trending and analysis reports, agendas, minutes, and attendance rosters. Upon request, these records shall be readily available to the EMS Agency for review

E. Complete the National Pediatric Readiness Project (NPRP) assessment annually https://www.pedsready.org/, and submit a copy of the NPRP Assessment Gap Analysis to the EMS Agency upon request

X. Data Collection Requirements

A. Participate in the data collection process established the EMS Agency.

B. Submit data to the EMS Agency, within 45 days of patient discharge, which shall include data elements listed in Ref. No. 652, EDAP and PMC Data Dictionary.

CROSS REFERENCE:

Prehospital Care Policy Manual

Ref, No. 216, **Pediatric Advisory Committee (PedAC)**
Ref. No. 318, **Pediatric Medical Center (PMC) Standards**
Ref. No. 324, **SART Center Standards**
Ref. No. 506, **Trauma Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 620, **EMS Quality Improvement Program**
Ref. No. 621.2, **Notification of Personnel Change Form**
Ref. No. 652, **EDAP and PMC Data Dictionary**
Ref. No. 822, **Suspected Child Abuse/Neglect Reporting Guidelines**
Ref. No. 822.2, **Suspected Child Abuse Report (SCAR) #8572**

California Penal Code 11166
Emergency Nursing Pediatric Course (ENPC)
National Pediatric Readiness Project (NPRP)

ACKNOWLEDGEMENTS

The EMS Agency EDAP Standards were first developed by the Committee on Pediatric Emergency Medicine (COPEM), which is made up of representatives from the following organizations: Los Angeles Pediatric Society, Pediatric Liaison Nurses of Los Angeles County, California Chapter of the American College of Emergency Physicians (ACEP), National Emergency Medical Services for Children (EMSC) Resource Alliance, American Academy of Pediatrics (AAP)-California Chapter 2, Emergency Nurses Association (ENA), American College of Surgeons (ACS), and the EMS Agency.

The EDAP Standards have since been revised, endorsed by The Hospital Association of Southern California, and now meet or exceed the 2009 Joint Policy Statement: Guidelines for Care of Children in the Emergency Department which was ratified by the AAP, ACEP, and the ENA.

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

**REFERENCE NO. 316, Emergency Department Approved for Pediatric (EDAP) Standards**

| SECTION | COMMITTEE/DATE | COMMENT | RESPONSE |
|---|---|---|---|
| Definitions | PedAC 12/05/2023 | Within 'Department of Children and Family Services" add wording to include commercial sexual exploitation and labor trafficking" | Adopted |
| Policy II, B. | HASC EHS 9/19/2023 | Remove FTE/hour requirements | Adopted |
| Policy V,C,4 | PedAC 12/05/2023 | Add wording to include, "commercial Sexual exploitation, human trafficking…" | Adopted |
| Policy VII | PedAC 12/05/2023 | Delete "…/emergency…" and add 'unless specific to radiology, laboratory, or pharmacy practices." | Adopted |
| Policy VII | PedAC 12/05/2023 | Add "All policies should be reviewed minimally every three (3) years and reflect current practice. Any reference to weight should be in the form of kilograms." to end. | Adopted |
| Policy VII, D. | PedAC 12/05/2023 | Add "…commercial sexual exploitation, human trafficking…" after neglect | Adopted |
| Policy VII, I | PedAC 12/05/2023 | Remove "Advanced Healthcare Directive" wording, as ACHD only are for adults and add "POLST" | Adopted |
| Policy VII, T, 1 | PedAC 12/05/2023 | Change wording to read, "…clearly based upon the appropriate units per kilogram and include total dose" | Adopted |
| Policy IX,B, 1,b | PedAC 12/05/2023 | Add …"Commercial sexual exploitation, human trafficking…" | Adopted |

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **PEDIATRIC MEDICAL CENTER (PMC) STANDARDS** REFERENCE NO. 318

PURPOSE: To establish minimum standards for the designation of Pediatric Medical Centers (PMC). The PMC will provide an emergency department capable of managing complex pediatric emergencies, a Pediatric Intensive Care Unit (PICU), physicians with pediatric sub-specialties and/or experience in pediatric care, pediatric critical care consultation for community hospitals, and outreach education programs for the Emergency Medical Services (EMS) community.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 14

DEFINITIONS:

**Board Certified (BC):** Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA), including an examination designed to assess the knowledge, skills, and experience necessary to provide quality patient care in a particular specialty.

**Board Eligible (BE):** Successful completion of a residency training program with progression to board certification based on the timeframe as specified by the ABMS or AOA.

**Certified Registered Nurse Anesthetist (CRNA):** An advanced practice registered nurse (APRN) who has acquired graduate-level education and board certification in anesthesia.

**Children with Special Health Care Needs:** Children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that is required by children generally.

**Commercial Sexual Exploitation of Children (CSEC):** Any range of crimes and activities involving the sexual abuse or exploitation of a child for the financial benefit of any person or in exchange for anything of value (including monetary and non-monetary benefits) given or received by any person. https://dcfs.lacounty.gov/youth/sexual-exploitation/

**Department of Children and Family Services (DCFS):** A mandated component of Emergency Response Services, administered by the Los Angeles County Department of Children and Family Services. The Child Protection Hotline (CPH), (800) 540-4000, intake evaluation staff is responsible for assessing any referral, whether verbal or written, which alleges child abuse, neglect, sexual assault, or exploitation, which includes commercial sexual exploitation and human trafficking, to determine whether an in-person investigation and consultation is required.



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

The CPH operates 24 hours a day, seven days a week. The 24 hour number (1-800-540-4000), staffed by employees of the DCFS, is responsible for screening calls from the community related to issues of child abuse and neglect.

**Emergency Department Approved for Pediatrics (EDAP):** A licensed basic or comprehensive emergency department (ED) that is designated by the Emergency Medical Services (EMS) Agency to receive pediatric patients via the 9-1-1 system. These EDs provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures, as per the guidelines outlined in Ref. No. 316, Emergency Department Approved for Pediatrics (EDAP) Standards.

**Immediately Available:** Unencumbered by conflicting duties or responsibilities, responding without delay when notified, and being physically available to the specified area of the PMC.

**On call:** Agreeing to be available, according to a predetermined schedule, to respond to the Pediatric Medical Center (PMC) in order to provide a defined service.

**Pediatric Advisory Committee (PedAC):** Acts in an advisory capacity to the EMS Agency and is responsible for all matters regarding pediatric care and policy development pertinent to the practice, operation, and administration of prehospital care, emergency departments, and pediatric intensive care units (PICU). Committee reviews, evaluates, and makes recommendations on EMS issues impacting the pediatric population.

**Pediatric Critical Care Education:** Topics in pediatric critical care that addresses fundamental principles for the management of the critically ill pediatric patient, and a minimum of 14 hours of continuing education every four years.

**Pediatric Advanced Life Support (PALS):** Pediatric resuscitation course that is recognized by the EMS Agency and valid for two years (e.g. American Heart Association, American Red Cross).

**Pediatric Experience:** A physician specialty approved by the appropriate hospital body and the PMC Medical Director, based on education, training, and experience to provide care to the pediatric patient.

**Pediatric Intensivist:** A Qualified Specialist in Pediatric Critical Care Medicine.

**Pediatric Liaison Nurse (PdLN):** A Registered Nurse currently licensed to practice in the State of California and appointed by the hospital to coordinate pediatric emergency care required by the EDAP Standards, also referred to as Nurse Pediatric Emergency Care Coordinator.

**Pediatric Medical Center (PMC):** A licensed acute care hospital that is designated by the EMS Agency to receive **critically ill** pediatric patients via the 9-1-1 system based on guidelines outlined in Ref. No. 510, Pediatric Patient Destination.

**PMC Medical Director:** A Qualified Specialist in Pediatric Critical Care Medicine who oversees and directs implementation of these standards within the designated PMC.

**PMC Nurse Coordinator:** A Registered Nurse currently licensed to practice in the State of California and appointed by the Hospital to coordinate pediatric critical care.

**Pediatric Trauma Center** (**PTC):** A licensed acute care hospital that is designated by the EMS Agency to receive **injured** pediatric patients via the 9-1-1 system based on guidelines outlined in Ref. No. 506, Trauma Triage. These centers provide tertiary pediatric care and serve as referral centers for critically injured pediatric patients.

**Promptly Available:** Able to be physically present in the PMC within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, should not have a measurable harmful effect on the course of patient management or outcome. Hospital guidelines shall be established that address response time for on-call physicians not to exceed thirty (30) minutes by telephone and in person within one hour.

**Qualified Specialist:** A physician licensed in the State of California who has become BC or BE in the corresponding specialty by the ABMS or the AOA.

**Senior Resident:** A physician licensed in the State of California who is in training as a member of the residency program at the designated hospital, has completed at least two years of the residency, and is in good standing.

**Sexual Assault Response Team (SART) Centers:** A center specializing in forensic examinations in the case of an acute sexual assault/abuse event (defined as occurring within 120 hours), which has the capabilities of providing comprehensive medical and psychological forensic examinations and consist of a knowledgeable staff whose training, expertise, and state-of-the-art equipment exceeds the community standards.

**Suspected Child Abuse and Neglect (SCAN) Team:** A team of healthcare professionals who are specialists in diagnosing and treating suspected child abuse, neglect, sexual assault, commercial sexual exploitation, and human trafficking.

**Telehealth:** The remote delivery of health care services and clinical information using telecommunications technology. This includes a wide array of clinical services using internet, wireless, satellite, and telephone media.

POLICY:

I. PMC Designation / Re-Designation

A. PMC initial designation and re-designation is granted for a period of three years after a satisfactory review by the EMS Agency.

B. The EMS Agency reserves the right to perform scheduled site visits or request additional data of the PMC at any time.

C. The PMC shall immediately (within 72 hours) provide written notice to the Director of the EMS Agency if unable to adhere to any of the provisions set forth in the PMC Standards including structural changes or relocation of the PICU.

D. The PMC shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw from the PMC program.

E. The PMC shall notify the EMS Agency within 15 days, in writing of any change in status of the PMC Medical Director, PMC Nurse Coordinator, or

PICU Nurse Manager/Director by submitting Ref. No. 621.2, Notification of Personnel Change Form.

F. Have a fully executed Specialty Care Center PMC Designation Agreement with the EMS Agency.

II. General Hospital Requirements

A. Licensed by the State of California Department of Public Health (CDPH) as a General Acute Care Hospital, and

1. Have a special permit for Basic or Comprehensive Emergency Medical Service; and

2. Accredited by a Centers for Medicare & Medicaid Services (CMS) recognized Hospital Accreditation Organization.

B. Designated by the EMS Agency as an Emergency Department Approved for Pediatrics (EDAP).

C. Have a Suspected Child Abuse and Neglect (SCAN) Team.

D. Have a licensed inpatient pediatric unit.

E. Have a Pediatric Intensive Care Unit (PICU).

F. Appoint a PMC Medical Director and a PMC Nurse Coordinator.

III. PMC Leadership Requirements

A. PMC Medical Director

1. Responsibilities:

a. Implement and ensure compliance with the PMC Standards.

b. Serve as chairperson of the PMC Committee or assign a designee.

c. Coordinate medical care across departmental and multidisciplinary committees.

d. Maintain direct involvement in the development, implementation, and maintenance of a comprehensive multidisciplinary QI program.

e. Identify, review, and correct deficiencies in the delivery of pediatric critical care.

f. Review, approve, and assist in the development of transfer guidelines and all PMC policies and procedures.

g. Collaborates with the PMC Nurse Coordinator, ED Medical

Director, and ED Nursing Director to ensure appropriate pediatric critical care education programs are provided to the staff related to the quality improvement findings.

h. Coordinates with PMC Nurse Coordinator to liaison with other PMCs, pediatricians, ED Directors, PdLNs, and community hospitals.

i. Shall have direct involvement in defining the credentialing/privileging criteria/process utilized in determining pediatric experience for the non-boarded physicians.

B. PMC Nurse Coordinator

1. Qualifications:

a. Current PALS provider or instructor certification.

b. Shall have a minimum of three years' experience or specialty certification, in the care of critically ill children, and currently working in the PICU.

c. Shall have education, training, and demonstrated competency in pediatric critical care nursing and attend at least 14 hours of Board of Registered Nursing (BRN) approved pediatric critical care education every four years.

d. May hold other positions in the hospital organization (e.g., PICU staff nurse, PICU Charge Nurse, PICU Nurse Manager/Director).

2. Responsibilities:

a. Ensure the implementation and compliance of the PMC Standards in collaboration with the PMC Medical Director and PICU Nurse Manager/Director.

b. Serve as a member of the PMC Committee.

c. Direct involvement in the development, implementation, and maintenance of comprehensive multidisciplinary QI program.

d. Liaison with other hospital multidisciplinary committees.

e. Ensure appropriate pediatric critical care education programs are provided to the staff.

f. Liaison with other PMCs, hospitals, and PdLNs.

g. Serve as the contact person for the EMS Agency and be available upon request to respond to County business.

h. Participate in EMS Agency activities and meetings and attend

a minimum of two (2) PedAC meetings per year.

i. Maintain joint responsibility with the PICU Medical Director and PICU Nurse Manager/Director for the development and review of policies, procedures, and QI activities in the PICU.

C. PICU Nurse Manager/Director – Shall serve as a member of the PMC committee.

IV. Personnel Requirements

A. Pediatric Intensivist

1. Responsibilities:

a. Shall be on-call and promptly available

b. Shall not be on-call for more than one facility at the same time

c. Participate in all major therapeutic decisions and interventions

B. Anesthesiologist with pediatric experience

1. Responsibilities:

a. Shall be on-call and promptly available

b. Provide oversight for all patients requiring interventions by the senior resident or Certified Registered Nurse Anesthetist (CRNA) and be present for all surgical procedures

C. Specialties who shall be on-call and promptly available:

1. Radiologist with pediatric experience (can be achieved by off-site capabilities)

2. Neonatologist

3. Pediatric Cardiologist

4. General Surgeon with pediatric experience

5. Otolaryngologist with pediatric experience

6. Obstetrics/Gynecologist with pediatric experience

7. Mental health professionals with pediatric experience

8. Orthopedist with pediatric experience

D. Qualified specialists who shall be available 24 hours per day, 7 days per week for consultation which may be met through a transfer and/or telehealth agreement:

1. Pediatric Gastroenterologist
2. Pediatric Hematologist/Oncologist
3. Pediatric Infectious Disease
4. Pediatric Nephrologist
5. Pediatric Neurologist
6. Pediatric Surgeon
7. Cardiac surgeon with pediatric experience
8. Neurosurgeon with pediatric experience
9. Pulmonologist with pediatric experience
10. Pediatric endocrinologist

E. Nursing Personnel on the Pediatric Unit

1. The Pediatric Unit shall be staffed with RNs and Licensed Vocational Nurses (LVNs) who are licensed to practice in the State of California.

2. RNs and LVNs shall have current PALS provider or instructor certification.

3. RNs and LVNs shall have attended at least 14 hours of BRN or Board of Vocational Nursing and Psychiatric Technicians approved pediatric education every four years.

4. Nursing staff shall have experience and demonstrated pediatric clinical competence. The hospital shall have methods for documenting clinical competency (i.e., course completion certificates, course attendance rosters, etc.).

V. Special Services and Resources

The following services may be met by contractual or written transfer agreements:

A. Acute burn care management

B. Urgent dialysis (i.e., hemodialysis)

C. Peritoneal dialysis

D. Pediatric rehabilitation

E. Organ transplantation

F. Home health

G. Reimplantation

H. Hospice

VI. Pediatric Intensive Care Unit

A. General Requirements for the PICU:

1. Shall be a distinct, separate unit within the hospital

2. Provide at minimum, eight licensed beds

3. Admit a minimum of 200 patients per year and a minimum of 40 ventilator days per year.

B. PICU Medical Director

1. Serve as a member of the PMC Committee, and may hold PMC Medical Director position

2. Work with the PMC Medical Director to ensure PMC Standards are met

C. PICU Clinical Nurse Specialist (CNS) shall:

1. Be licensed to practice in the State of California as a CNS

2. Collaborate with the PMC Nurse Coordinator to ensure the PMC Standards are met

3. Develop and oversee pediatric critical care educational programs for the nursing staff in the PICU

D. PICU Staff Nurse shall:

1. Be licensed to practice in the State of California as RN or LVN

2. Have a current PALS provider or instructor certification

3. Have education, training, demonstrated competency in pediatric critical care nursing and have attended at least 14 hours of BRN or Board of Vocational Nursing and Psychiatric Technician approved pediatric education every four years

E. Social Worker shall:

1. Be licensed to practice in the State of California as a Medical Social Worker (MSW)

2. Have a Master's Degree in Social Work

3. Have pediatric experience in psychosocial issues affecting seriously ill children and their families, including management of child abuse, neglect, sexual assault, commercial sexual exploitation, and human trafficking cases

4. Have 4 hours of continuing education every two (2) years in topics related to health, housing and welfare of children (e.g., child abuse reporting)

F. Other professional services with minimum one year pediatric experience shall be available to the PICU:

1. Pharmacist shall be available 24 hours per day, 7 days a week
2. Clinical Registered Dietician
3. Occupational Therapist
4. Physical Therapist
5. Behavioral health specialist to include psychiatrists, psychologists, and nurses

VII. Policies and Procedures

The hospital shall develop and maintain policies and procedures required in Ref. No. 316, Emergency Department Approved for Pediatrics (EDAP) Standards, and those listed below. These policies and procedures shall be reviewed minimally every three (3) years to reflect current practice by the PICU Medical Director in collaboration with the PICU Nurse Manager/Director, and endorsed by hospital administration. All policies and procedures shall be easily accessible in the PICU.

Additional PMC policies and procedures shall address the following:

A. Policies

1. Age appropriate physical environment
2. Credentialing process for physicians who provide care for pediatric patients
3. Do-Not-Resuscitate Orders
4. Family centered care
    a. Care of grieving family and caregivers
    b. Contacting appropriate clergy per request of the parents or primary caregiver
    c. Death of a child in the PICU
5. Infection surveillance and prevention
6. Mechanism and guidelines for bioethical review to include an Ethics Committee
7. Mental health and substance abuse
8. PICU admission, transfer, and discharge criteria and process
9. Referral for rehabilitation

B. Procedures

1. Appropriate use and monitoring of equipment

2. Pain management, includes utilization of developmentally appropriate pain tools

3. Patient care, which include nursing and respiratory management of infants, children, and adolescents

4. Procedural sedation

VIII. PICU Equipment, Supplies, and Medications

A. Pediatric equipment, supplies, and medications shall be easily accessible to PICU staff and may be physically housed in other locations besides the PICU. A mobile pediatric crash cart shall be utilized and available on all units where pediatric patients are treated to include but not limited to, ED, radiology, and in-patient services.

B. A locator chart or grid identifying the locations of all required equipment and supplies shall be developed and maintained in order for staff to easily identify location of all items.

C. Required equipment, supplies, and medications:

1. General Equipment

a. Weight scale measuring only in kilograms for both infants and children, including bed scales

b. Standardized length-base resuscitation tape, approved by the EMS Agency (e.g., Broselow 2011A or newer) to estimate pediatric weights in kilograms

c. Pediatric drug dosage reference material with dosages calculated in milligrams per kilogram (either posted or readily available)

d. Developmentally appropriate pain scale assessment tools for infants and children

e. Blood and IV fluid warmer (rapid infuser)

f. Warming and cooling system with appropriate disposable blankets

g. Restraints in various sizes

2. Monitoring Equipment

a. Blood pressure cuffs

1) Neonatal

2) Infant
3) Child
4) Adult arm
5) Adult thigh

b. Vascular Doppler device (handheld)

c. ECG monitor/Defibrillator/Pacing (Crash cart unit and Transport unit)

1) ECG electrodes in pediatric and adult sizes
2) Defibrillator paddles in pediatric and adult sized, and/or; hands-free defibrillation device
3) External pacing capability
4) Multifunction pads in pediatric and adult

d. Thermometer with hypothermic capabilities

e. Respiration and oxygen saturation monitoring

1) Pulse oximeter unit with sensors
   i. Infant
   ii. Pediatric
   iii. Adult

2) Continuous end-tidal $CO_2$ monitoring device for pediatric and adult

f. Arterial pressure

g. Central venous pressure

h. Intracranial pressure

i. Pulmonary arterial pressure

j. Automated/noninvasive blood pressure modules

3. Airway Management

a. Bag- Mask-Ventilation (BMV) device with self-inflating bag

1) Infant (minimum 450mL)
2) Child
3) Adult

b. BMV clear masks

1) Neonate
2) Infant
3) Child
4) Adult

c. Laryngoscope handle

1) Pediatric
2) Adult

d. Laryngoscope blades

1) Macintosh/curved: 2, 3
2) Miller/straight: 00, 0,1, 2, 3

e. Endotracheal tubes

1) Uncuffed: mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5
2) Cuffed: mm 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0

f. Stylets for endotracheal tubes

1) Pediatric
2) Adult

g. Magill Forceps

1) Pediatric
2) Adult

h. Nasopharyngeal Airways

1) Infant
2) Child
3) Adult

i. Oropharyngeal Airways

1) Infant
2) Child (size 0-2)
3) Adult (size 3-5)

j. Clear oxygen masks

1) Infant
2) Child
3) Adult

k. Non-rebreather masks

1) Infant
2) Child
3) Adult

l. Nasal cannula

1) Infant
2) Child

3) Adult

m. Oxygen capability

n. Suction capability

o. Suction catheters

6, 8, 10, 12 Fr

p. Yankauer suction tips

q. Feeding tubes

5, 8 Fr

r. Nasogastric tubes

5, 8, 10, 12, 14, 16, 18 Fr

s. Supraglottic Airways

1) Neonatal
2) Infant
3) Child
4) Adult

t. Cricothyrotomy Catheter set (pediatric)

u. Tracheostomy trays:

1) Pediatric
2) Adult

v. Tracheostomy Tubes

1) Neonatal: size mm 2.0, 2.5, 3.0, 3.5, 4.0, 4.5
2) Pediatric: size mm 3.0, 3.5, 4.0, 5.0, 5.5, 6.0

4. Vascular Access Equipment

a. Arm boards

1) Infant
2) Child
3) Adult

b. IV volume rate control administration sets with calibrated chambers

c. IV catheters

16, 18, 20, 22, 24 gauge

d. 3-way stopcocks

e. Device or needle to achieve intraosseous (IO) vascular access, to include needles in the appropriate sizes for pediatric and adult patients

f. IV solutions, in 250mL and/or 500mL bags

1) 0.9 NS
2) D5.45NS
3) D5NS
4) D10W
5) Lactated Ringers

g. Ultrasound for facilitating peripheral and central venous access

5. Fracture Management Devices

a. Splinting supplies for long bone fractures

b. Cervical spine motion restriction equipment (e.g. cervical collar)

c. Spinal board with the appropriate straps

6. Specialized Trays or Kits

a. Thoracostomy tray

b. Chest drainage system

c. Chest tubes, one in each size

8, 12, 16, 20, 24, 28, 36 Fr

d. Lumbar Puncture trays and spinal needles

1) 22 g, 3 inch
2) 22-25 g, 1½ inch

e. Urinary catheterization sets and indwelling urinary catheters

5, 8, 10, 12, 14, 16 Fr

f. Central line trays, with one of each catheter size

1) 4.0 Fr
2) 5.5 Fr
3) 7.0 Fr

g. Tray for insertion of ICP monitor

h. Arterial line trays with one of each catheter size

1) 2.5 Fr
2) 4.0 Fr

i. Paracentesis tray

7. Pediatric-Specific Resuscitation

a. Immediately available drug calculation resources

b. The following medications must be immediately available:

1) Adenosine
2) Albuterol
3) Amiodarone
4) Atropine
5) Atrovent
6) Calcium chloride
7) Dobutamine
8) Dopamine
9) Epinephrine 0.1mg/mL **(IV administration**)
10) Epinephrine 1mg/mL (**IM administration**)
11) Epinephrine for inhalation
12) Fentanyl
13) Ketamine
14) Lidocaine
15) Mannitol or hypertonic saline
16) Milrinone
17) Naloxone
18) Norepinephrine
19) Procainamide
20) Prostaglandin E1
21) Neuromuscular blocking agent
22) Sedative agent
23) Sodium Bicarbonate 4.2% (or a process to obtain the drug in an emergency situation)
24) Sodium Bicarbonate 8.4%
25) Vasopressin

8. Portable Equipment (promptly available)

a. Air-oxygen blenders (21-100%)

b. Air Compressor

c. Bilirubin lights

d. Cribs

e. Electrocardiogram (ECG 12 lead)

f. Electroencephalogram (EEG)

g. Echocardiogram (Echo)

h. Oxygen tank

i. Radiant warmer

j. Servo-controlled heating units (with or without open crib)

k. Suction unit

l. Transcutaneous $pCO_2$ monitor

m. Transcutaneous $pO_2$ monitor

n. ECG monitor/Defibrillator/Pacing transport unit

o. Ultrasound

p. Ventilator – pediatric capability

IX. Outreach and Education Program

A. Establish outreach with surrounding facilities to facilitate transfer of pediatric patients.

B. Inform and provide educational programs to EMS providers regarding pediatric patients discharged with special health care needs in their jurisdiction.

C. Provide outreach and pediatric education to EDAPs and EMS providers.

X. Ancillary Services

Ancillary services shall have the capabilities and technologist appropriately trained to manage a critically ill pediatric patient. These services shall be in-house and available 24 hours per day.

A. Respiratory Care Practitioners working in the PICU shall:

1. Be license as a Respiratory Car Practitioner (RCP) in the State of California

2. Have current PALS provider or instructor certification

3. Successfully complete additional training in pediatric critical care and attend a minimum of 4 hours of pediatric critical care education annually

B. Radiology

1. Shall have pediatric-specific policies and procedures pertaining to imaging studies of children

2. Radiology technicians must be in-house 24 hours per day, 7 days per week

3. Provide the following services 24 hours per day:

   a. Nuclear medicine on-call and promptly available

   b. Computerized Tomography (CT)

   c. Ultrasound

   d. Magnetic Resonance Imaging (MRI) on-call and promptly available

   e. Angiography (may be provided through a transfer agreement)

C. Clinical laboratory shall have pediatric-specific policies and procedures pertaining to laboratory studies of children, including, but not limited to, obtaining samples by trained phlebotomists, micro technique for small or limited sample sizes, and ability to provide autologous and designated donor transfusions.

XI. PMC Committee

A. The purpose of the Committee is to establish a forum for exchange of ideas regarding the provision of emergency, inpatient, and critical care to the pediatric patient.

B. The membership shall include interdepartmental and multidisciplinary representatives from the emergency department, PICU, pediatric unit, nursing, social services, respiratory services, discharge planning, SCAN team, and other relevant services as applicable, such as: prehospital care, pediatric sub-specialties, and pediatric interfacility transport team.

C. The Committee is responsible for all matters regarding the medical care provided to the pediatric patient which include, but not limited to, the following:

1. Review and recommend revision to policies and procedures to verify compliance with the PMC Standards

2. Review the quality improvement process to identify system-related performance and operational issues, and recommend corrective action plans

D. Meeting Frequency: Quarterly, additional meetings may be held on an as needed basis.

E. Meeting minutes and attendance rosters shall be maintained and made available to the EMS Agency when requested.

XII. Suspected Child Abuse and Neglect

A. Suspected Child Abuse and Neglect (SCAN) Team shall:

1. Consist of a medical director, coordinator, social worker, physician, and/or nurse consultants as applicable.

2. Assist nursing and medical staff in the evaluation of pediatric patients who have alleged to have been abused, neglected, sexually assaulted, commercially sexually exploited, or human trafficked.

3. Have a member on-call and available to all areas of the hospital 24 hours per day.

4. Review cases of suspected child abuse/neglect to verify adequacy of care, reporting, and follow-up.

B. SCAN Team Medical Director

Shall be board certified in Pediatrics and/or Child Abuse Pediatrics:

Responsibilities:

1. Collaborate with the SCAN Team Coordinator:

   a. To monitor the SCAN Team’s activities

   b. Ensure the development of education for nursing and medical staff in the evaluation of children suspected of child abuse, neglect, sexual assault, commercial sexual exploitation, and human trafficking.

2. Serve as a member of the PMC Committee.

3. Oversee the review of suspected child abuse, neglect, sexual assault, commercial sexual exploitation, and human trafficking cases for appropriateness of care, compliance with mandated reporting and appropriateness of follow-up.

C. SCAN Team Coordinator

Shall have experience and training in the management of a child abuse, neglect, sexual assault, commercial sexual exploitation, and human trafficking victim and obtain 14 hours of pediatric education every four years.

Responsibilities:

1. Oversees scheduling to ensure a SCAN Team member is available 24 hours per day/seven day a week.

2. Serve as a member of the PMC Committee.

3. Review cases of suspected child abuse, neglect, sexual assault, commercial sexual exploitation, and human trafficking in consultation with the SCAN Team Medical Director for appropriateness of care,

compliance with mandated reporting, appropriateness of follow-up, and completeness of documentation.

4. Assist nursing and medical staff in the evaluation of children who have alleged to have been abused, neglected, sexually assaulted, commercially sexually exploited, or human trafficked.

5. Develop educational training for medical and nursing staff in the recognition and management of children with suspected child abuse, neglect, sexual assault, commercial sexual exploitation, and human trafficking.

D. Social Worker

1. Qualifications:

a. Licensed to practice as a Medical Social Worker (MSW) by the State of California.

b. Must have experience and training in the management of child abuse, neglect, sexual assault, commercial sexual exploitation, and human trafficking.

c. Have 4 hours of continuing education every two (2) years in topics related to health, housing, and welfare of children (e.g., child abuse reporting).

2. Responsibilities:

a. Assist nursing and medical staff in the evaluation of children alleged to have been abused, neglected, sexually assaulted, commercially sexually exploited, or human trafficked.

b. Provide support and resources for the abused, neglected, sexually assaulted, commercially sexually exploited, or human trafficked children and their family.

E. SCAN Team Physician and/or Nurse Consultants

1. Qualifications:

a. Physicians shall be board certified in Pediatrics, Child Abuse Pediatrics, or Emergency Medicine with medical experience in diagnosing and managing suspected child abuse, neglect, sexual assault, commercial sexual exploitation, and human trafficking cases.

b. Nurse consultant shall have training and experience in evaluating and managing suspected child abuse, neglect, sexual assault, commercial sexual exploitation, and human trafficking cases.

2. Responsibilities:

a. Provide guidance or consultation, as needed, in suspected child abuse, neglect, sexual assault, commercial sexual exploitation, and human trafficking cases.

F. Pediatric Forensic Examination

1. The PMC shall ensure a forensic examination and an interview are completed for acute (defined as occurring within 120 hours) sexual assault/abuse event, or appropriate referral was made for such examination, if the event occurred over 120 hours.

2. If the PMC does not provide the necessary forensic examination, a written consultation and transfer agreement shall exist with an EMS Agency designated SART Center.

XIII. Pediatric Interfacility Transport (PIFT) Program

PMCs shall have a PIFT program or have written agreements to provide PIFT services for the timely transport of patients *in or out* of the PMC. The PIFT program shall have the capability to transport neonatal and pediatric patients. The PIFT program shall also include back-up processes or agreements for the timely transport of patients with time sensitive conditions when the estimated time of arrival of the primary transport team is greater than 1 hour.

A. PMCs with a PIFT program shall have program policies and procedures and composition of PIFT as determined by the level of care needed.

1. The hospital maintaining the PIFT program shall have written agreements with referring and receiving facilities that utilize the program.

2. Agreements should specify the role and responsibilities of the transport program and the hospitals to include the following:

a. Agreement to transfer and receive appropriate pediatric patients when indicated

b. Responsibilities for patient care before, during and after transport

c. Documentation and transferring appropriate information/records

B. If the PMC does not have a PIFT program, written agreements shall exist with agencies or other programs that will provide timely transportation of critically ill pediatric patients to and from the PMC. Written agreements shall be with a PIFT program that meets the specifications outlined in XIII.A.

XIV. Quality Improvement (QI) Program

A. The PMC shall develop a multidisciplinary QI program for the purpose of improving patient outcomes of critically ill children. The QI program shall interface

with the emergency department, PICU, NICU, pediatric unit, SCAN Team, PIFT Program, and EMS providers. The QI program shall also interface with hospital wide and emergency department QI activities.

B. The PMC Medical Director and Nurse Coordinator shall be responsible for the development, implementation, and review of the QI program as it pertains to the care of the pediatric patients transported to the PMC.

C. The PMC's QI program shall meet the requirements stipulated in Ref. No. 620, Section V, QI Program Requirements, which includes, at minimum, the following:

1. QI Plan
2. Identification of indicators
3. Methods to collect data
4. Written results and conclusions
5. Recognition of improvement
6. Action(s) taken (e.g., education of staff or feedback to referring facilities and EMS providers)
7. Assessment of effectiveness of action(s) taken
8. Dissemination of QI information to stakeholders

D. The QI review process shall include, at a minimum, a detailed 100% physician review, tracking, and trending of the following cases:

1. Unexpected deaths in the PICU
2. Unexpected cardiac arrests in the PICU
3. Unexpected transfers for higher level of care
4. Sentinel events
5. Child maltreatment (suspected child abuse, neglect, sexual assault, commercial sexual exploitation, and human trafficking) to include the mandated reporting process
6. Readmissions to the PICU within 48 hours
7. Unexpected admissions from the operating room
8. Unplanned admissions to the PICU

E. The QI process shall include providing feedback, via appropriate process or channels, to referral facilities and/or EMS providers on items that may require commendation, positive reinforcement, fact-finding, case/peer review, and education/competency verification or remediation.

XV. Data Requirement

A. Participate in the data collection process established by the EMS Agency.

B. Submit data to the EMS Agency, within 45 days of patient's discharge, which shall include data elements listed in Ref. No. 652, EDAP and PMC Data Dictionary.

CROSS REFERENCE:

Prehospital Care Policy Manual:

Ref. No. 216, **Pediatric Advisory Committee (PedAC)**
Ref. No. 316, **Emergency Department Approved for Pediatrics (EDAP) Standards**
Ref. No. 324, **SART Center Standards**
Ref. No. 506, **Trauma Triage**
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 508.1, **SART Center Roster**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 620, **EMS Quality Improvement Program**
Ref. No. 621, **Notification of Personnel Change**
Ref. No. 621.2, **Notification of Personnel Change Form**
Ref. No. 652, **EDAP and PMC Data Dictionary**

California Clinical Forensic Medical Training Center, California Sexual Assault Response Team (SART) Manual

California Children's Services: Provider Standards, https://www.dhcs.ca.gov/services/ccs/Pages/ProviderStandards.aspx
ACEP: Emergency Information Form, https://www.acep.org/by-medical-focus/pediatrics/medical-forms/emergency-information-form-for-children-with-special-health-care-needs/
AAP: Emergency Information Form, https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-child-care/Documents/AR_EmergencyInfo.pdf

ACKNOWLEDGEMENTS

The EMS Agency Pediatric Medical Center Standards were first developed by the Committee on Pediatric Emergency Medicine (COPEM), Los Angeles County Pediatric Society, Pediatric Liaison Nurses of Los Angeles County, California Chapter of American College of Emergency Physicians (ACEP) National Emergency Medical Services for Children (EMSC) Resource Alliance, American Academy of Pediatrics California Chapter 2, Emergency Nurses Association, and the EMS Agency.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **SEXUAL ASSAULT RESPONSE TEAM (SART) CENTER STANDARDS** REFERENCE NO. 324

PURPOSE: To establish minimum standards for the designation of Sexual Assault Response Team (SART) Centers. The SART Centers provide care to victims of sexual assault, sexual exploitation, and human trafficking by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures.

The goal of the Los Angeles County Emergency Medical Services (EMS) Agency is to transport these patients to a SART Center, where healthcare practitioners have special training in treating victims of sexual assault/abuse and in the collection of forensic evidence.

DEFINITIONS:

**Board Certified (BC):** Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA), including an examination designed to assess the knowledge, skills, and experience necessary to provide quality patient care in a particular specialty.

**Board Eligible (BE):** Successful completion of a residency program with progression to board certification based on the time frame specified by the ABMS or AOA.

**California Governor's Office of Emergency Service (Cal OES):** Cal OES Public Safety Division provides funding to programs that train law enforcement, court education, victim notification, victim/witness assistance, reducing crime lab backlogs, and post-conviction DNA testing. Cal OES has developed the standardized forensic-medical forms which must be used to document the sexual assault examination.

**Commercial Sexual Exploitation of Children (CSEC):** Any range of crimes and activities involving the sexual abuse or exploitation of a child for the financial benefit of any person or in exchange for anything of value (including monetary and non-monetary benefits) given or received by any person. https://dcfs.lacounty.gov/youth/sexual-exploitation/

**Department of Children and Family Services (DCFS):** A mandated component of Emergency Response Services, administered by the Los Angeles County Department of Children and Family Services. The Child Protection Hotline (CPH), (800) 540-4000, intake evaluation staff is responsible for assessing any referral, whether verbal or written, which alleges child abuse, neglect, sexual assault, or exploitation, which includes commercial sexual exploitation and human trafficking, to determine whether an in-person investigation and consultation is required.

**Patient:** A person who has been sexually assaulted, commercially sexually exploited, or human trafficked. The patient can also be identified as the victim and/or survivor. In the criminal justice system, the patient is identified as a crime victim. For rape crisis centers providing counseling and advocacy, the patient is identified as a survivor.



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

**Qualified Medical Specialist:** A physician licensed in the State of California who is BC or BE in the corresponding specialty by the ABMS or AOA.

**Qualified Health Care Professional:** Any physician or surgeon, or a nurse or a professional registered nurse working in consultation with a physician and surgeon who conducts examinations or provides treatment in a general acute care hospital or in a physicians or surgeon's office pursuant to the California Penal Code 13823.5 (e).

**Rape Crisis Advocate:** An individual who is affiliated with a Rape Crisis Center and functions as a support person for the patient throughout the entire medical/legal process and who meets the requirements of Penal Code 679.04.

**Sexual Assault Forensic Examiner (SAFE) / Sexual Assault Nurse Examiner (SANE):** A specially trained healthcare provider (i.e., physician, nurse practitioner, physician assistant, registered nurse) who independently and competently performs sexual assault forensic medical exams. Examiners are trained healthcare professionals who perform adult and adolescent sexual assault forensic medical examinations, and/or child sexual abuse forensic medical examinations.

**Sexual Assault Response Team (SART):** A coordinated interdisciplinary intervention model between law enforcement, crime laboratory, District Attorney's (DA) Office, medical and advocacy experts to meet the forensic needs of the criminal justice system and the medical and emotional needs of the sexual assault/abuse victim.

**Sexual Assault Response Team (SART) Centers:** A hospital sponsored program that is designated by the EMS Agency to receive patients who are victims of sexual assault/abuse. A SART Center specializes in forensic examinations in the case of an acute sexual assault/abuse event (defined as occurring within 120 hours), which has the capabilities of providing comprehensive medical forensic examinations and psychological support. The center consists of knowledgeable staff whose training, expertise, and state-of-the-art equipment exceeds the community standards.

**Quality Improvement (QI):** The analysis of performance and systematic effort to improve it.

POLICY:

I. SART Center Designation / Re-Designation Agreement:

A. SART Center initial designation and SART Center re-designation is granted for a period of three years after satisfactory review by the EMS Agency.

B. The EMS Agency reserves the right to perform scheduled site visits or request additional data of the SART Center at any time.

C. The SART Center shall immediately provide written notice to the Director of the EMS Agency if unable to adhere to any of the provisions set forth in the SART Center Standards.

D. The SART Center shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw from the SART program.

E. The SART Center shall notify the EMS Agency within 15 days, in writing of any

change in status of the SART Medical Advisor or SART Program Director/Coordinator by submitting the Notification of Personnel Change Form (Reference No. 621.2).

F. Execute and maintain a Specialty Care Center SART Center Designation Agreement with the EMS Agency.

II. General SART Center Requirements

A. All designated SART Centers shall be sponsored by a hospital and the hospital shall be:

1. Licensed by the State of California Department of Public Health (CDPH) as a General Acute Care Hospital, and

a. Be approved for Basic or Comprehensive Emergency Medical Services

b. Be accredited by a Centers for Medicare & Medicaid Services (CMS) recognized Hospital Accreditation Organization

c. Have a SART team available 24 hours a day, 7 days a week.

d. Have a dedicated private space away from the emergency department that provides a secure area for the examination and interview process

B. SART Center Leadership Requirements:

1. SART Center Medical Advisor

a. Qualifications:

i. BC in Emergency Medicine, Obstetrics/Gynecology, Family Practice or Pediatrics with education and interest in the care of patients/victims of sexual assault, commercial sexual exploitation, and human trafficking.

ii. Completion of the initial SAFE Course for adult/adolescent and pediatrics, minimum of 40-hour curriculum, in compliance with the medical forensic examination standards set forth in the Penal Code 13823.11

iii. Complete eight hours of approved continuing medical education (CME) related to sexual assault forensic examination every three years

b. Responsibilities:

i. Be available for consultation with forensic examiners as needed

ii. Ensure up-to-date knowledge and skills regarding sexual assault forensic medical examination performance and interpretation of findings

iii. Coordinate medical care across departmental and multidisciplinary services as needed

iv. Provide medical oversight in the development, implementation, and maintenance of a comprehensive QI program as it pertains to the care of the sexual assault, commercial sexual exploitation, or human trafficking victim

v. Collaborate with the SART Center Program Director on educational programs: review and ensure content is medically sound and appropriate

vi. Be available for consultation with other SART Centers, EMS providers, EMS Agency, community hospitals (non-SART), local health clinics, law enforcement, local crime laboratory, rape crisis advocacy response groups, DA's Office and forensic examiners.

c. A written job description defining the authority and responsibilities of the SART Center Medical Advisor shall exist

2. SART Program Director

a. Qualifications

i. A Registered Nurse currently licensed to practice in the State of California

ii. Completion of the initial SAFE Course for adult/adolescent and pediatrics, minimum of 40 hours curriculum, in compliance with the medical forensic examination standards set forth in the Penal Code 13823.11

iii. Completion of eight hours of Board of Registered Nursing (BRN) approved continuing education (CE) related to sexual assault forensic examinations every three years

b. Responsibilities

i. Implement and ensure compliance with the SART Center Standards

ii. Ensure that a chairperson is designated for the Multidisciplinary SART Center Committee

iii. Ensure that a QI process is in place to identify, review, and correct deficiencies in the delivery of care to the sexual

assault, commercial sexual exploitation, or human trafficking victim

iv. Ensure that appropriate sexual assault, commercial sexual exploitation, and human trafficking education programs are provided to the SART Center personnel in collaboration with the SART Center Medical Advisor

v. Maintain records of completed continuing education by SART Center personnel

vi. Liaison with other SART Centers, EMS providers, EMS Agency, community hospitals, local health clinics, law enforcement, local crime laboratory, rape crisis advocacy response groups, DA's Office and forensic examiners as needed

vii. Serve as a contact person for the EMS Agency and be available upon request to respond to County business regarding SART Center issues

viii. Ensures the EMS Agency is notified, in writing, when there is a personnel change of the SART Center Medical Advisor or SART Center Program Director

ix. Ensure compliance with SART Center Standards and EMS Agency policies and procedures related to the care of sexual assault/abuse, commercial sexual exploitation, or human trafficking victims

ix. Ensure that the QI reports are presented at applicable SART or hospital committees (e.g.: ED, hospital-wide QI, and/or pediatric committees)

x. Ensures that all SART Center policies and procedures are reviewed at least annually with multidisciplinary committee approval at least triennial

c. A written document defining the authority and responsibilities of the SART Center Program Director shall exist

C. Personnel

1. Sexual Assault Forensic Examiner (SAFE) / Sexual Assault Nurse Examiner (SANE)

a. Qualifications:

i. Licensed as a Physician, RN, or Physician Assistant in the State of California

ii. Completion of the initial SAFE Course for adult/adolescent

and pediatrics, minimum of 40-hour curriculum, in compliance with the medical forensic examination standards set forth in the Penal Code 13823.11

iii. Completion of eight hours of BRN or CME approved CE related to sexual assault forensic examinations every three years

b. A written job description defining the authority and responsibilities of the SAFE/SANE Examiner shall exist

2. Rape Crisis Center Personnel

a. Rape Crisis Center Director provides leadership advocating for the needs and rights of the survivors, provides Cal OES training for rape crisis advocates, and maintains on-call schedules indicating 24-hour, 7 days a week availability

b. Rape Crisis Center Advocate shall have successful completion of a 40-hour training consistent with Cal OES training and in-service requirements set forth in the Penal Code 679.04

c. A written document defining the authority and responsibilities of the Rape Crisis Center Director and Advocate shall exist

III. Competency

Competency of all SART Center examiners shall be evaluated during orientation and at least annually to ensure up-to-date knowledge and skills regarding sexual assault forensic medical exam performance and interpretation of findings to include the following:

A. Consents

1. Explains exam

2. Obtains consents per the Cal OES forms and protocols

3. Assesses patients understanding of explanation

B. Interview – Uses therapeutic approach to information gathering (Assault History)

C. Obtains complete history per Cal OES forms and protocols and clarifies events as needed

D. Examination

1. Physical exam per Cal OES protocol

2. Exam relevant to history or per Cal OES protocol

3. Identifies physical findings

E. Evidence Collection

1. Identifies appropriate areas for collection

2. Collects evidence accurately per Cal OES protocols

3. Handles, labels, and packages evidence properly

4. Demonstrates and maintains chain of custody

F. Equipment – Demonstrates proficiency in use of site specific equipment (alternate light source, camera, digital imaging system, colposcope, etc.)

G. Documentation – Accurately and properly completes the most current Cal OES 2-923 Form to include accurate documentation of injuries

H. Medical Care

1. Assesses and explains risks of sexually transmitted infections and HIV post exposure prophylaxis (PEP), and/or pregnancy

2. Offers appropriate screening and/or diagnostic tests as applicable

3. Appropriately offers and administers medications and/or treatments as indicated

4. Provides and reviews with patient, recommended aftercare instructions

5. Provides appropriate referrals

IV. Multidisciplinary SART Center Committee

A. The multidisciplinary SART Center Committee should meet, at a minimum, on a quarterly basis and more frequently as needed, to review system-related performance issues. The committee members or a designee shall attend at least 50% of the meetings.

B. The multidisciplinary SART Center committee shall include representatives from the following:

1. EMS Provider(s), as applicable

2. Emergency Department

3. Law Enforcement

4. SAFE/SANE

5. Rape crisis advocacy groups

6. Local crime laboratory

7. District Attorney's (DA) Office

C. Responsibilities:

1. Review and ensure compliance with the SART Center Standards

2. Review and ensure the coordination of SART services across departmental and multidisciplinary lines

3. Review and ensure a comprehensive and multidisciplinary quality improvement (QI) program as per Section V

4. Review and discuss the development and implementation of policies and procedures listed in Section VI

5. Maintain attendance rosters and meeting minutes. The minutes shall reflect the review including, when appropriate, the analysis and proposed corrective actions.

V. Quality Improvement (QI) Program Requirements

QI program shall be developed as per Reference No. 620, EMS Quality Improvement Program, and monitored by the SART Center Director and SART Center Medical Advisor.

A. Program shall be an organized multidisciplinary program for the purpose of improving care of the sexual assault, commercial sexual exploitation, and human trafficking victim and ensuring the integrity of evidence collection.

B. A written SART QI Program plan shall be developed, monitored, and reviewed by the SART Center Program Director and Medical Advisor at a minimum of every two years.

C. SART personnel shall interface with EMS, emergency department, law enforcement, SAFE/SANE, local crime laboratory, rape crisis advocate, DA's Office and other relevant services regarding identified QI issues as needed.

D. A written QI plan, tracking and trending reports, agenda, minutes and attendance rosters shall be maintained.

E. Timely QI review should occur following each exam. This review should include:

1. Review of Cal OES examination form documentation

2. Review of forensic digital images which must also be retrievable for summons at the DA's request

3. Evidence collection procedures and management

4. Incorporation of feedback information from the crime laboratory when available

F. Submit data as requested by the EMS Agency for quality improvement purposes to include number of medical examinations, based on the following categories: Adult, Pediatric, Suspects, and DCFS referrals to the Medical Hub as applicable.

VI. Policies

A. There shall be a current SART Center policy manual reviewed and signed by the Program Director and Medical Advisor and readily accessible in the SART Center.

B. SART Centers shall follow the Cal OES protocols and utilize the current Cal OES forms and shall establish specific written policies that address, but are not limited to, the following:

1. Hours of operation, patients served (adults and/or pediatric), provisions for after-hours and mobile examinations

2. Role and responsibilities of the SART members

2. Patient care management to include:

a. Providing examination within 120 hours from time of sexual assault

b. Physician availability and/or consultation of the sexually abused, commercially sexually exploited, or human trafficked patient

c. Patient request for a physician examination

4. Consent for forensic evaluation

5. Unconscious sexual assault patient

6. Strangulation sexual assault patient

7. Alcohol and Drug Facilitated Sexual Assault (DFSA) patient

8. Management of Injuries

9. Family presence during examination

10. SART Activation or “CALL-OUT” procedures

11. Emergency Department Medical Screening Examination

12. Referral of pediatric patients who are victims of sexual assault to hospitals with a pediatric SART, if applicable.

13. Patient referral from non-SART hospitals

14. Treatment recommendations and aftercare instructions for the following:

a. Sexually transmitted infection prophylaxis

b. Pregnancy prophylaxis

c. Healthcare referral and follow up

d. HIV information and referral for immediate HIV PEP

e. First Aid Instructions

f. Referrals for counseling and mental health follow up

15. Medical record storage and release, including digital images

16. Evidence collection and storage, including locked refrigerator storage

17. Routine maintenance and monitoring of equipment

18. Specific populations and their needs, which include but are not limited to the following:

a. Persons with disabilities

b. Hearing impaired

c. Elderly

d. Pregnant

e. Provision foreign language translation

f. Suspect exams:

i. Process ensuring that the victims do not come in contact with the suspect

ii. Back-up-procedure to ensure the same examiner does not perform both the victim and suspect exam whenever possible, and a policy in preventing cross contamination if the same examiner does both exams

g. Lesbian, gay, bisexual, transgender/transsexual, queer/questioning, intersex, and asexual (LGBTQIA)

19. Interface with the other agencies/departments, including:

a. Law enforcement

b. Local crime laboratory

c. County/City DA’s Office

d. Local rape crisis center

e. Other SART centers

f. Adult Protective Services

g. DCFS

h. Shelters for battered women

i. Child abuse and neglect treatment centers

j. County/City Public Health Departments

k. County/City Victim Witness Assistance Programs

l. Local Health Clinics

m. County Mental Health Services

VIII. Space, Equipment, Supplies, and Medications

A. Safety for patients and the SART members, privacy and confidentiality for patients, and comfortable peaceful surroundings are important considerations.

B. SART equipment, supplies, and medications shall be easily accessible, labeled, and logically organized.

C. The following are minimum requirements for space, equipment, supplies, and medications:

1. The SART Center shall be a designated space located away from the emergency department and include:

a. Designated examination room

b. Designated patient bathroom

c. Waiting room for the patients, family members, and friends which ensures privacy

d. Separate waiting area for law enforcement which supports their report writing

e. Evidentiary examination supplies and sexual assault evidence collection kit storage

f. Storage for administrative and forensic medical records

2. The following is the minimum required equipment, supplies, and medications:

a. Locked specimen refrigerator for storage of evidence with chain of custody

b. Sexual assault evidence collection kits from the local crime laboratory

c. Small copier near the exam room

d. Accessible fax machine

e. Videocamera, Camera, or Colposcope with photographic capabilities

f. Alternate light source

g. Swab dryer

h. Digital imaging system

i. Examination table with stirrups

j. Secure area to preserve the chain of custody

k. Locked file cabinets to store forensic records

l. Medications for:

i. Pregnancy prophylaxis

ii. Treatment of sexually transmitted diseases after sexual assault as recommended by current Center for Disease Control and Prevention (CDC) guidelines

CROSS REFERENCE:

Prehospital Care Policy Manual
Reference No. 508, **Sexual Assault Patient Destination**
Reference No. 508.1, **SART Center Roster**
Reference No. 620, **EMS Quality Improvement Program**
Reference No. 621, **Notification of Personnel Change**
Reference No. 621.2, **Notification of Personnel Change Form**
Reference No. 822, **Suspected Child Abuse/Neglect Reporting Guidelines**

REFERENCES:
California Clinical Forensic Medical Training Center California Sexual Assault Response Team (SART) Manual, https://www.ccfmtc.org/
Cal OES 2-923 Adult/Adolescent Sexual Assault Forensic Medical Report
Cal OES 2-924 Abbreviated Adult/Adolescent Sexual Assault Examination Forensic Medical Report, https://www.ccfmtc.org/forensic-medical-examination-forms/
"Sexual Assault and Abuse and STDs -2021 STD Treatment Guidelines." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 23 July 2021, Federal Violence Against Women Act (VAWA).

ACKNOWLEDGEMENTS

The Los Angeles County Sexual Assault Coordinating Council (LACSACC), and the California Coalition Against Sexual Assaults (CALCASA) made significant contributions in the development of these SART Center Standards.

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, Parts 1.8 and 1.85
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. For patients who have a POLST requesting only comfort-focused care, EMS providers shall first attempt to meet the patient's comfort needs on scene by implementing supportive measures. Patients should not be transported unless their comfort needs cannot be met on scene and transport is in accordance with their wishes.

6. 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. While a final attestation is not required, the patient may have one. If a final attestation is available, EMS personnel should confirm the patient is the person named in the final attestation and obtain a copy if possible. This will normally require either the presence of a form of identification or a witness who can reliably identify the patient.

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

C. 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.

D. 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.

E. 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.

F. 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, **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

**ORDINANCE NO._____**

An ordinance amending Title 3 – Advisory and Commissions and Committees of the Los Angeles County Code, relating to the Emergency Medical Services Commission, to require certain commission members to practice and/or work in the County of Los Angeles, and to update other organization and nomination requirements.

The Board of Supervisors of the County of Los Angeles ordains as follows:

**SECTION 1.** Section 3.20.040 is hereby amended to read as follows:

**3.20.040 Composition.**

The ~~c~~Commission shall be composed as follows:

A. An emergency medical care physician who practices in Los Angeles County in a paramedic base hospital and is nominated by the California Chapter of the American College of Emergency Physicians;

B. A ~~cardiologist~~physician who practices in Los Angeles County and is nominated by the American Heart Association, Western States ~~Affiliate~~Region;

C. A Los Angeles County certified mobile intensive care nurse nominated by the ~~California~~Greater Los Angeles County Chapter of the Emergency ~~Department~~ Nurses Association California State Council;

D. A hospital administrator who works in Los Angeles County and is nominated by the ~~Healthcare~~Hospital Association of Southern California;

E. A ~~representative of a public provider agency~~ fire chief nominated ~~by~~ from the membership of the Los Angeles ~~Chapter~~Area ~~of California~~ Fire Chiefs Association;

F. A representative of a ~~private provider agency~~Los Angeles County licensed ambulance service provider nominated by the ~~Los Angeles County~~ Southern California Ambulance Association;

. . .

H. A psychiatrist who practices in Los Angeles County and is nominated by the Southern California Psychiatric Society;

I. A physician who practices in Los Angeles County and is nominated by ~~t~~The Los Angeles County Medical Association;

J. A licensed paramedic who works in Los Angeles County and is nominated by the California Professional Firefighters; ~~California State Firefighters Association, Emergency Medical Services Committee;~~

. . .

L. A law enforcement representative nominated initially by the California Highway Patrol. After the first term of office for this position is completed, the law enforcement representative shall be nominated by the Los Angeles County Professional Peace Officers' Association;

. . .

N. A police chief nominated ~~by~~ from the membership of the Los Angeles County Police Chiefs' Association;

O. A representative who works in Los Angeles County and is nominated by the Southern California Public Health Association

[320040GGCC]

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."*

April 18, 2024

Jeremy Sanchez, Fire Chief
Monrovia Fire Department
415 South Ivy Avenue
Monrovia, California 91016

Dear Chief Sanchez:

**NEWLY APPOINTED MEDICAL DIRECTOR – APPROVAL**
**- SALVADOR LORENZO RIOS, MD**

This letter is to acknowledge that the Emergency Medical Services (EMS) Agency has received notification from Monrovia Fire Department (MF) that effective April 1, 2024, Salvador Lorenzo Rios, M.D., has been appointed as Medical Director and will be providing medical oversight to MF's paramedic and pharmaceutical programs.

Based on the documents provided to the EMS Agency, Dr. Rios meets the requirements as Medical Director set forth in the Los Angeles County Prehospital Care Manual, Reference No. 411, Provider Agency Medical Director.

The EMS Agency has also received the necessary documentation confirming that Dr. Rios has agreed to purchase drugs and medical supplies for MF and will be providing complete oversight to MF's controlled substance program.

If there are any questions during this transition or in the future, please don't hesitate to contact me directly.

Sincerely,

Nichole Bosson, MD, MPH
Medical Director

NB:gw
4-18

c. Medical Director, Monrovia Fire Department
Paramedic Coordinator, Monrovia Fire Department
Nurse Educator, Monrovia Fire Department

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

**Los Angeles County Board of Supervisors**

**Hilda L. Solis**
First District

**Holly J. Mitchell**
Second District

**Lindsey P. Horvath**
Third District

**Janice K. Hahn**
Fourth District

**Kathryn Barger**
Fifth District

**Richard Tadeo**
Director

**Nichole Bosson, MD, MPH**
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."*

April 11, 2024

Amar Shah, MD, Medical Director
Eastwestproto, Inc. dba Lifeline Ambulance
6605 East Washington Blvd
Commerce, California 90040

Dear Dr. Shah,

**CONTINUOUS POSITIVE AIRWAY PRESSURE, INTRAOSSEOUS, AND TRANSCUTANEOUS PACING PROGRAM APPROVAL**

This letter is to confirm Eastwestproto, Inc. dba Lifeline Ambulance (LE) has been approved by the Los Angeles County Emergency Medical Services (EMS) Agency for training and implementation of the following programs:

- Continuous Positive Airway Pressure (CPAP) for the prehospital treatment of moderate to severe respiratory distress.
- Intraosseous cannulation (IO) proximal tibia placement for adult and pediatric patients in cardiopulmonary arrest, shock/poor perfusion, severe burns, and extremis.
- Transcutaneous Pacing (TCP) utilized in the treatment of symptomatic bradycardia.

Validation of delivery of training, the approved quality improvement process and data requirements required for implementation of CPAP, IO, and TCP will be reviewed during LE's annual program review, or as deemed necessary by the EMS Agency. Additionally, LE may be required to submit data to the EMS Agency on CPAP, IO and TCP utilization for purposes of systemwide evaluation and aggregate reporting.

Please contact me at (562) 378-1600 or Greg Klein at (562) 378-1685 for any questions or concerns.

Sincerely,

Nichole Bosson, MD, MPH
Medical Director

NB:gk
04-08

c: Richard Tadeo, Director, EMS Agency
Max Gorin, CEO Lifeline Ambulance.
Dillon Brock, VP of Operations, Lifeline Ambulance

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

**Los Angeles County Board of Supervisors**

**Hilda L. Solis**
First District

**Holly J. Mitchell**
Second District

**Lindsey P. Horvath**
Third District

**Janice K. Hahn**
Fourth District

**Kathryn Barger**
Fifth District

**Richard Tadeo**
Director

**Nichole Bosson, MD, MPH**
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."*

April 8, 2024

TO: Participating Physicians
Physician Services for Indigents Program

FROM: Richard Tadeo
Director

SUBJECT: **PHYSICIAN SERVICES FOR INDIGENTS PROGRAM REIMBURSEMENT RATE FOR FISCAL YEAR 2023-24**

This memo is to inform all participating physicians in the Physician Services for Indigents Program (PSIP) of the reimbursement rates for Fiscal Year (FY) 2023-24. The reimbursement rates will be the same rates used for the past four fiscal years. The non-trauma emergency (ER) claims will be paid at 13.5% and trauma claims will be paid at 100% of the Official County Fee Schedule (OCFS).

These reimbursement rates are effective for all claims that meet the PSIP requirements with service dates of July 1, 2023 through June 30, 2024.

If you have any questions regarding enrollment, please contact the County's Contract Claims Adjudicator, American Insurance Administrators (AIA), at (800) 303-5242.

RT:jd

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Holly J. Mitchell
Second District

Lindsey P. Horvath
Third District

Janice K. Hahn
Fourth District

Kathryn Barger
Fifth District

Richard Tadeo
Director

Nichole Bosson, MD, MPH
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

**MEMORANDUM**

April 4, 2024

**TO:** Distribution **VIA-EMAIL**

**FROM:** Richard Tadeo
Director

**SUBJECT:** **NAME CHANGE FOR WEST HILLS HOSPITAL AND MEDICAL CENTER AND LOS ALAMITOS MEDICAL CENTER**

Effective Friday, April 12th, 2024 at 0700, the following hospital names will be changed in Reddinet® and all EMS Agency databases:

West Hills Hospital and Medical Center to **UCLA West Valley Medical Center**
Los Alamitos Medical Center to **UCI Health – Los Alamitos**

The 3-letter hospital identification code will remain HWH and LAG respectively.

Please update all systems and ensure personnel are notified of the name change.

If you have any questions, please contact Ami Boonjaluksa, Chief Hospital Programs at (562) 378-1596 or ABoonjaluksa2@dhs.lacounty.gov.

RT:ab
04-09

Distribution:
Medical Director, EMS Agency
Fire Chief, All Public Provider EMS Agencies
Paramedic Coordinators, All Public Provider EMS Agencies
Nurse Educators, All Public Provider EMS Agencies
CEO, All Licensed Private Ambulance Providers
Paramedic Coordinator, All Licensed Private Ambulance Providers
CEO, All 9-1-1 Receiving Hospitals
ED Medical Director, All 9-1-1 Receiving Hospitals
ED Clinical Director, All 9-1-1 Receiving Hospitals
Medical Director, All Paramedic Base Hospitals
Prehospital Care Coordinators, All Paramedic Base Hospitals
Medical Alert Center
ReddiNet®
Hospital Association of Southern California
EMS Commission

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

**MEMORANDUM**

April 2, 2024

**TO:** Distribution **VIA-EMAIL**

**FROM:** Richard Tadeo
Director

**SUBJECT:** **NAME CHANGE FOR LAKEWOOD REGIONAL MEDICAL CENTER**

Effective Friday, April 12th, 2024 at 0700, Lakewood Regional Medical Center's name will be changed to UCI Health – Lakewood in Reddinet® and all EMS Agency databases. The 3-letter hospital identification code will remain as DHL.

Please update all systems and ensure personnel are notified of the name change.

If you have any questions, please contact Ami Boonjaluksa, Chief Hospital Programs at (562) 378-1596 or ABoonjaluksa2@dhs.lacounty.gov.

RT:ab
04-04

Distribution:
Medical Director, EMS Agency
Fire Chief, All Public Provider EMS Agencies
Paramedic Coordinators, All Public Provider EMS Agencies
Nurse Educators, All Public Provider EMS Agencies
CEO, All Licensed Private Ambulance Providers
Paramedic Coordinator, All Licensed Private Ambulance Providers
CEO, All 9-1-1 Receiving Hospitals
ED Medical Director, All 9-1-1 Receiving Hospitals
ED Clinical Director, All 9-1-1 Receiving Hospitals
Medical Director, All Paramedic Base Hospitals
Prehospital Care Coordinators, All Paramedic Base Hospitals
Medical Alert Center
ReddiNet®
Hospital Association of Southern California
EMS Commission

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

April 1, 2024

Anthony Marrone, Fire Chief
Los Angeles County Fire Department
1255 Corporate Center, Suite 212
Monterey Park, California 91754

Dear Chief Marrone,

**TRIAGE TO ALTERNATE DESTINATION PROGRAM REQUIREMENTS AND ADVANCED PRACTICE RESPONSE UNIT (APRU) PILOT**

The Los Angeles County Emergency Medical Services (EMS) Agency has been approved by the EMS Authority to implement the Triage to Alternate Destination (TAD) Program in Los Angeles County. To transition Los Angeles County Fire Department's (CF) TAD destination determination from the Advanced Provider Response Unit pilot to direct field TAD determination, CF must have an approved TAD Paramedic Training Program as per Reference No. 913, Triage to Alternate Destination (TAD) Paramedic Training Program Requirements and meet the program requirements listed in Reference No. 424, Triage to Alternate Destination Paramedic Provider Program.

To begin this process, please complete and submit the following forms to the EMS Agency's Office of Certification and Training Program Approvals at jrcalderon@dhs.lacounty.gov:

1. 1A – Program Application Form
2. 1B – Training Location Form
3. 1D – Medical Director Application
4. 1E – Program Director
5. 1F – Instructor

Additionally, the following will need to be developed by the Program Director and submitted to the EMS Agency with the forms above to complete the application. These can be in any format provided it meets the criteria specified in the attachments.

1. 1C – Attendance Record Checklist
2. 1G – Certificate Checklist
3. 1H – TAD Lesson Plan Sample

For questions regarding the TAD Paramedic Training Program requirements please contact Jennifer Calderon, EMS Training Program Approval Manager at (562) 378-1638 or jrcalderon@dhs.lacounty.gov. For general questions regarding the TAD Program, please contact Ami Boonjaluksa, Chief Hospital Programs at (562) 378-1596 or ABoonjaluksa2@dhs.lacounty.gov.

Sincerely,

Richard Tadeo
Director

Attachments

RT:cc

c: Medical Director, EMS Agency
Chief-Prehospital Care Operations, EMS Agency
EMS Training Program Approval Manager, EMS Agency
EMS Systems Quality Coordinator, EMS Agency
Medical Director, Los County Angeles Fire Department
EMS Deputy Chief, Los Angeles County Fire Department
Paramedic Coordinator, Los Angeles County Fire Department
Nurse Educator-QI Program Coordinator, Los Angeles County Fire Department
(All of the above via email)

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

**Los Angeles County Board of Supervisors**

**Hilda L. Solis**
First District

**Holly J. Mitchell**
Second District

**Lindsey P. Horvath**
Third District

**Janice K. Hahn**
Fourth District

**Kathryn Barger**
Fifth District

**Richard Tadeo**
Director

**Nichole Bosson, MD, MPH**
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."*

March 26, 2024

Wolfgang Knabe, Fire Chief
Santa Monica Fire Department
333 Olympic Drive
Santa Monica, CA 90401

**CERTIFIED**

Dear Chief Knabe,

**TRIAGE ALTERNATE DESTINATION PROGRAM REQUIREMENTS**

The Los Angeles County Emergency Medical Services (EMS) Agency has been approved by the EMS Authority to implement the Triage to Alternate Destination (TAD) Program in Los Angeles County. To transition from the TAD Pilot and into the TAD Program, Santa Monica Fire Department (SMFD) must meet the program requirements listed in Reference No. 424, Triage to Alternate Destination Paramedic Provider Program and Reference No. 913, Triage to Alternate Destination Paramedic Training Program Requirements. Please submit the following forms (attached) to the EMS Agency's Office of Certification and Training Program Approvals at jrcalderon@dhs.lacounty.gov by April 30, 2024:

1. 1A – Program Application Form
2. 1B – Training Location Form
3. 1C – Attendance Record Checklist
4. 1D – Medical Director Application
5. 1E – Program Director
6. 1F – Instructor
7. 1G – Certificate Checklist

A notification of approval or deficiencies with the TAD paramedic accreditation process will be provided by the EMS Agency to SMFD within 60 days of receiving the request for approval.

For questions regarding the TAD Paramedic Training Program requirements, please contact Jennifer Calderon, EMS Training Program Approval Manager at (562) 378-1638 or jrcalderon@dhs.lacounty.gov. For general questions regarding the TAD Program, please contact Ami Boonjaluksa, Chief Hospital Programs at (562) 378-1596 or ABoonjaluksa2@dhs.lacounty.gov.

Sincerely,

Richard Tadeo
Director

Attachments

RT:ab
03-24

c: Medical Director, EMS Agency
Chief-Prehospital Care Operations, EMS Agency
Medical Director, Santa Monica Fire Department
EMS Director, Santa Monica Fire Department
Paramedic Coordinator, Santa Monica Fire Department

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."*

March 26, 2024

Keith Powell, Fire Chief
Culver City Fire Department
9770 Culver Blvd.
Culver City, CA 90232

**CERTIFIED**

Dear Chief Powell,

**TRIAGE ALTERNATE DESTINATION PROGRAM REQUIREMENTS**

The Los Angeles County Emergency Medical Services (EMS) Agency has been approved by the EMS Authority to implement the Triage to Alternate Destination (TAD) Program in Los Angeles County. To transition from the TAD Pilot and into the TAD Program, Culver City Fire Department (CCFD) must meet the program requirements listed in Reference No. 424, Triage to Alternate Destination Paramedic Provider Program and Reference No. 913, Triage to Alternate Destination Paramedic Training Program Requirements. Please submit the following forms (attached) to the EMS Agency's Office of Certification and Training Program Approvals at jrcalderon@dhs.lacounty.gov by April 30, 2024:

1. 1A – Program Application Form
2. 1B – Training Location Form
3. 1C – Attendance Record Checklist
4. 1D – Medical Director Application
5. 1E – Program Director
6. 1F – Instructor
7. 1G – Certificate Checklist

A notification of approval or deficiencies with the TAD Paramedic Training Program application will be provided by the EMS Agency to CCFD within 60 days of receiving the request for approval.

For questions regarding the TAD Paramedic Training Program requirements please contact Jennifer Calderon, EMS Training Program Approval Manager at (562) 378-1638 or jrcalderon@dhs.lacounty.gov. For general questions regarding the TAD Program, please contact Ami Boonjaluksa, Chief Hospital Programs at (562) 378-1596 or ABoonjaluksa2@dhs.lacounty.gov.

Sincerely,

Richard Tadeo
Director

Attachments

RT:ab
03-19

c: Medical Director, EMS Agency
Chief-Prehospital Care Operations, EMS Agency
Medical Director, Culver City Fire Department
EMS Director, Culver City Fire Department
Paramedic Coordinator, Culver City Fire Department

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."*

March 27, 2024

**Email/Certified**

William Barrett
University of Antelope Valley
44055 North Sierra Highway
Lancaster, CA 93534

Dear Mr. Barrett:

**CLOSURE OF EMERGENCY MEDICAL TECHINICAN (EMT), PARAMEDIC, AND CONTINUING EDUCATION (CE) TRAINING PROGRAMS**

The Emergency Medical Services agency received a notice of emergency final decision from the Bureau for Private Postsecondary Education (BPPE) regarding Antelope Valley's (UAV) order to cease all instruction in all institutional programs as of March 22, 2024, close of business. A review of the letter has been completed and I regret to inform you that UAV's Paramedic, EMT, and CE programs are closed effective the same date.

If you have any questions regarding this matter, please contact Sandy Montero at (562) 378-1689 or smontero@dhs.lacounty.gov.

Sincerely,

Richard Tadeo
Director

RT:jc

Cc: Nicole Mixon, California Emergency Medical Services Authority
Nichole Bosson, LA County EMS Agency Medical Director

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

**Medical Control Guideline: EMS AND LAW ENFORCEMENT CO-RESPONSE** **Ref. No. 1307.4**

## DEFINITION

**Agitation:** A hyper-aroused state (ranging in severity from anxious and cooperative to violent and combative) in which the individual exhibits excessive, repeated, and purposeless motor or verbal behaviors (e.g., pacing, fidgeting, clenching fists or teeth, prolonged staring, picking at clothing or skin, responding to internal stimuli such as hallucinations, threatening or carrying out violent acts).

**Decision-Making Capacity:** The ability to understand the nature and consequences of proposed health care. This includes understanding the significant risks and benefits and having the ability to make and communicate a decision regarding the proposed health care in the patient's primary language, if feasible. A person has decision-making capacity if they are able to:

- Communicate the need for treatment, the implications of receiving and of not receiving treatment, and alternative forms of treatment that are available, and
- Relate the above information to their personal values, and then make and convey a decision.

The lack of decision-making capacity may be:

- Temporarily lost (e.g., due to unconsciousness, influence of mind-altering substances, mental illness, or cognitive impairment)
- Permanently lost (e.g., due to irreversible coma, persistent vegetative state, untreatable brain injury, or dementia)
- Never existed (i.e., due to profound neurodevelopmental disorder, those who are deemed by the Court as incompetent or a person under conservatorship)

**Minor**: A person less than eighteen years of age.

## PRINCIPLES:

1. EMS and Law Enforcement often co-respond to the scene when there is an agitated patient perceived to pose risk to themself and/or others.

2. EMS focus is on the duty to the patient, whereas Law Enforcement has a duty to the public. This may result in differences in the approach to scene management.

3. Each situation is unique and dynamic such that no guideline can be comprehensive or specific. The flow diagram below represents a general approach, but must be adapted to the individual circumstances of the response.

4. Early, clear and open communication will facilitate arriving at the best possible outcome for the person. The conflict resolution pathway (Guideline #4) should be employed whenever there is not full agreement between EMS and Law Enforcement on whether to remain engaged.

5. The decision for Law Enforcement to engage, and/or to apply a 5150 or 5585, will be according to their policies, procedures, and the law. While Law Enforcement will ultimately determine if there is an immediate threat, engagement should be a consensus-driven decision based on the assessment of EMS and Law Enforcement on scene. For cases where there is ongoing disagreement and a successful resolution cannot be reached on scene, an after action review shall be undertaken at a later agreed upon date, in collaboration with both agencies.

**GUIDELINES:**

1. Refer to the flow diagram below for guidance.

2. When the agitated person is a minor, apply the guidelines with the following caveats:

    a. If the minor is alone, the general approach will be to engage.
    b. If the minor is in the care of a parent or legal guardian, the principles of capacity assessment are applied to that parent or legal guardian, with consideration for how they can assist in de-escalating the situation and provide an alternative to engagement.
    c. Involve the Department of Child and Family Services as appropriate, https://dcfs.lacounty.gov/, 800-540-4000.
    d. Refer also to Ref. No. 832, Treatment/Transport of Minors.

3. Consider the following Mental Health Resources:

    a. Request response of local jurisdictional resources as available.
    b. Request a Crisis Response Team from the Department of Mental Health Access Center 24/7 Contact Line: 800-854-7771.
    c. For any patient left on scene, inform the patient of the '988' hotline, which provides telemedicine mental health resources.

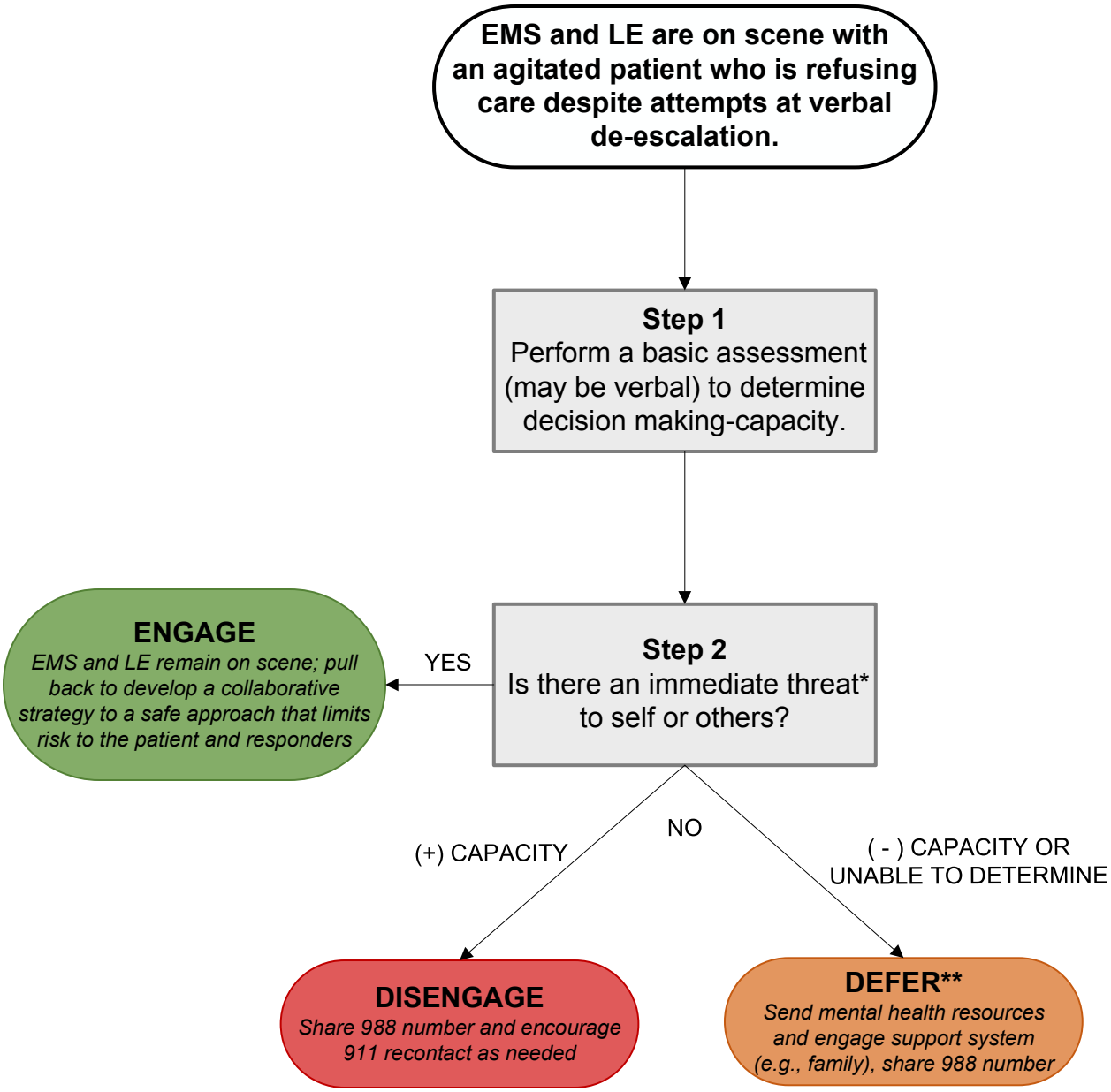
4. For situations where Law Enforcement decision is to disengage or defer and EMS remains concerned about immediate risk to the patient and/or others, the following communication strategy should be employed in a stepwise fashion until a final solution is agreed upon:

    a. The highest ranking EMS and Law Enforcement personnel on scene discuss their rationale for the decision to engage versus disengage.
    b. Mental health resources are identified and requested to the scene to provide alternative methods for de-escalation and management. Consider contacting the Base Hospital for further guidance on resources and strategies.
    c. If not already on scene, the EMS and Law Enforcement supervisors are requested to the scene and discuss face-to-face.
    d. The EMS supervisor speaks with the Law Enforcement Watch Commander.
    e. If no resolution is achieved, EMS shall defer to Law Enforcement and not engage on their own if there is a perceived risk to EMS personnel and/or the patient.

5. Document decision-making and involved personnel on the ePCR including:
    a. All responding agencies on scene
    b. EMS assessment

c. Name and assignment of the highest ranking Law Enforcement Officer involved in the decision-making
d. Reasons for Law Enforcement decision for disengagement when applicable
e. Any follow up plans and resources requested and/or provided to the patient for non-transport decisions

# APPROACH TO THE AGITATED PATIENT REFUSING CARE




*While, determination of immediate threat is ultimately per law enforcement, it should be a consensus-driven decision based on the assessment of both EMS and LE on scene

**If resources are not available, consider risk/benefit of engagement.