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Robert Flashman, M.D.

LA County Medical Association

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Emergency Nurses Association

Mr. Colin Tudor

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Chief David White

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American College of Surgeons

Southern California Public Health Assn.

Executive Director

Cathy Chidester, Director, EMS Agency

(562) 347-1604

cchidester@dhs.lacounty.gov

Acting Commission Liaison

Amelia Chavez

(562) 347-1606

Achavez@dhs.lacounty.gov

**COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION**

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

(562) 347-1604 FAX (562) 941-5835

<http://ems.dhs.lacounty.gov/>

DATE: November 16, 2016

TIME: 1:00 – 3:00 PM

LOCATION: Los Angeles County EMS Agency

10100 Pioneer Blvd., EMSC Hearing Room – 1st Floor
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 Commission Chair as time permits.

NOTE: Please SIGN IN if you would like to address the Commission.

AGENDA – Updated Nov. 9, 2016

CALL TO ORDER – Clayton Kazan, M.D., Chairman

INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

CONSENT CALENDAR (Commissioners/Public may request that an item be held for discussion.)

1 MINUTES

- September 21, 2016

2 CORRESPONDENCE

- 2.1 (10-20-2016) Michael Lang, Fire Chief, Arcadia Fire Department: Hemostatic Dressing Program Approved.
- 2.2 (10/06/2016) Medical Directors, Each Provider Agency, Prehospital Care Coordinators, Paramedic Coordinators, EMS Coordinators: Utilization of Automated Dispensing Systems for Controlled Substances.
- 2.3 (10-04-2016) Chief Executive Officer, Hospital Preparedness Program (HPP) Participant, Non-Emergency Department Approved for Pediatrics: Pediatric Readiness – Integrating Every Day Pediatric Readiness into your Emergency Department Program.
- 2.4 (09-28-2016) Fire Chief, Each Fire Department, CEO/President, Each Ambulance Company: Standardized Length-Based Resuscitation Tape.
- 2.5 (09-20-2016) Supervisor Hilda L. Solis, Chair, Supervisor Mark Ridley-Thomas, Supervisor Sheila Kuehl, Supervisor Don Knabe, Supervisor Michael D. Antonovich: Report on the Evaluation of Countywide Emergency Medical Services Capacity.
- 2.6 (09-20-2016) Sean Stokes, EMS Administrator, Beverly Hills Fire Department: Temporary Implementation of EMT Bicycle Unit.
- 2.7 (09-19-2016) James Burke, MD., Medical Director, Adventist Health Urgent Care: Completion of the Community Paramedicine Alternate Patient Destination Pilot Project.

CORRESPONDENCE – CONTINUED

- 2.8 (09/14/2016) Participating and New Enrollment Physicians: Physicians Services for Indigents Program (PSIP) Reimbursement Rate for Fiscal Year 2016-2017.

3. COMMITTEE REPORTS

- 3.1 Base Hospital Advisory Committee
- 3.2 Data Advisory Committee
- 3.3 Education Advisory Committee
- 3.4 Provider Agency Advisory Committee

4. POLICIES

- 4.1 Reference No. 911: Public Safety First Aid (PSFA) and Basic Tactical Casualty Care (BTCC) Training Program Requirements

5. BUSINESS

Old:

- 5.1 Community Paramedicine (*July 18, 2012*) – Attachment
- 5.2 EMSC Ad Hoc Committee Report (*May 20, 2015*)
- 5.3 Education Advisory Committee (*July 20, 2016*)

New:

- 5.4 EMSC Annual Report – 2015/2016 – Attachment
- 5.5 Appointment of Nominating Committee

6. COMMISSIONERS COMMENTS/REQUESTS

7. LEGISLATION

8. EMS DIRECTOR'S REPORT

9. ADJOURNMENT

(To the meeting of January 18, 2017)

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 noncompliance exists.

CONSENT CALENDAR

November 16, 2016

MINUTES

- September 21, 2016

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September 21, 2016

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cchidester@dhs.lacounty.gov

Acting Commission Liaison

Amelia Chavez

(562) 347-1606

Achavez@dhs.lacounty.gov

COMMISSIONERS	ORGANIZATION	EMS AGENCY STAFF	POSITION
☑ Robert Barnes	LAC Police Chiefs Assn	Cathy Chidester	Director, EMS Agency
☑ Frank Binch	Public Member, 4 th District	Kay Fruhwirth	Asst. Dir., EMS Agency
☑ Lt. Brian S. Bixler	Peace Officers Assn. of LAC	Marianne Gausche-Hill, MD	Medical Director, EMS Agency
☑ Erick H. Cheung, M.D.	So. CA Psychiatric Society	Nichole Bosson, MD	Asst. Medical Director, EMS Agency Staff
☑ Robert Flashman, M.D.	L.A. County Medical Assn	Marilyn Rideaux	
☑ John Hisserich	Public Member, 3 rd District	Amelia Chavez	"
☑ Clayton Kazan, M.D.	CAL/ACEP	Michelle Williams	"
* James Lott	Public Member, 2 nd District	David Wells	"
☑ Robert Ower	LAC Ambulance Association	Lucy Hickey	"
* Margaret Peterson, PhD	HASC	Sara Rasnake	"
☑ Paul S. Rodriguez	CA State Firefighters' Assn.		
* Nerses Sanossian, M.D.	American Heart Assn.		
* Carole Snyder	Emergency Nurses Assn.		
☑ Colin Tudor	League of California Cities		
☑ Chief David White	LA Chapter-Fire Chiefs Association		
☑ Gary Washburn	Public Member, 5 th District		

GUESTS

Michael Murrey	Manhattan Beach FD	Jaime Garcia	HASC
Mike Hansen	Torrance Fire Department	Laurie Mejia	Long Beach Memorial
Chad Richardson	LAFD		

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

CALL TO ORDER:

The Emergency Medical Services Commission (EMSC) meeting was held in the EMS Commission Hearing Room, 10100 Pioneer Blvd, Santa Fe Springs, 90670. The meeting was called to order at 1:16 PM by Chairman, Clayton Kazan. A quorum was present with 12 Commissioners in attendance.

ANNOUNCEMENTS/PRESENTATIONS:

Dr. Kazan recognized Ms. Marilyn Rideaux, Commission Liaison, and extended his congratulations to her on her upcoming retirement. Dr. Kazan requested a moment of silence to honor Ventura County Fire Fighter, Ryan Osler, who lost his life in a rollover crash.

Consent Calendar:

Commissioner Binch reported that the Education Advisory Committee (EAC), one of the four Commission's Committees met in August without a quorum (informational only). As Chair of the EAC committee, he conducted an anonymous voting member and Committee Staff survey that should help clarify the mission and effectiveness of the EAC, the positive quality of EMS in Los Angeles County and overall its function and functionality. Commissioner Binch shared the survey responses with the EMSC members and announced the next EAC meeting will be held in October; he also extended an invitation to the EMSC members to attend any of the four

Committee's meetings.

Dr. Marianne Gausche-Hill highlighted the following items included in the Agenda's correspondence:

2.1 Standardized Drug Formulary: Drug doses for children can be a real challenge. By having a standard formulary, the number of milliliters can be pre-calculated based on children's body weight. Part of the idea is for the Base Hospitals to talk to paramedics and provide instructions for the delivery of medications for children both in milligrams and milliliters to decrease the error rate. The education is going out in November to all the provider agencies and will include all three components; the formulation, and milligrams and the number of milliliters to be delivered.

This is the largest patient safety issue recognized by National Quality Forum for Children, it has been presented to the EMS Medical Directors Association of California (EMDAC) as well, and a number of other Agencies are looking to us to provide this particular tool.

2.2 Pediatric Readiness: The Los Angeles County Emergency Medical Services (EMS) Agency is embarking on Los Angeles Pediatric Readiness Project (LA Peds Ready); a project aimed at improving the readiness of hospitals to care for pediatric patients. This project's targeted audience is 9-1-1 receiving centers that do not participate in the Emergency Department Approved for Pediatrics (EDAP) Program.

An LA Peds Ready kick-off meeting has been scheduled. Hospitals have been asked to designate a pediatric emergency care coordinator (an ED Physician and/or Nurse) to attend this meeting and to work on the coordination of the project.

2.3 Interfacility Transfers Utilizing 9-1-1 Transport: The overall intent is to provide an expectation to the system of when to call for 9-1-1 transports and to avoid overburdening 9-1-1 providers with these transports.

A written memorandum of understanding (MOU) with the closest STEMI receiving center (SRC), delineating the transfer procedure, will help reduce delays and ensure appropriate 9-1-1 utilization.

M/S/C: Commissioner Hisserich/Washburn to approve the Consent Calendar.

5. OLD BUSINESS

5.1 Community Paramedicine (July 18, 2012)

Cathy Chidester reported that Glendale Fire Department is unable to continue with the Pilot Project that includes the Alternate Destination (ALTRANS) and the Congestive Heart Failure (CHF) programs due to insufficient funding to support needed staff, but Santa Monica Fire Department is continuing with the ALTRANS program. Glendale Fire dropped out after a year of participation and the data gathered from the programs will be utilized by Helath Workforce Pilot Project Program (OSHDP) and by the State in making final decisions at a later time. The Community Paramedic programs will continue for another year under OSHDP.

Ms. Chidester stated she will be one of the speakers at State Community Paramedicine Conference on Thursday, September 22, in San Diego, CA.

5.2 EMSC Ad Hoc Committee Report (May 20, 2015)

Cathy Chidester reported that twenty one members, including members of the EMS Commission participated in the EMS Ad Hoc Committee and the tremendous work done by this committee is very helpful to multiple entities to understand how the EMS System, Law Enforcement and the Department of Mental Health (DMH) interact in providing prehospital care to persons with mental health and substance abuse. Ms. Chidester recognized Commissioner Cheung and Ms. Kay Fruhwirth's work on this project. A presentation of the report will be conducted today by Commissioner Cheung but the voting for approval will be in November.

Commissioner Kazan joined Cathy Chidester in recognizing Commissioner Cheung and Kay Fruhwirth for their amazing work ensuring the completion of this report.

Commissioner Cheung provided a presentation of the Ad Hoc Committee on the Prehospital Care of Mental Health and Substance Abuse Emergencies final report. The report included Introduction, Background, Committee Objectives, MH/SA Field Response Maps, Principles, Committee Observations, Recommendations for Change, A Future Vision, Concluding Remarks, Appendix and References.

Commissioner Cheung highlighted the collaboration of Commissioner Kazan, Committee Members, those listed in the report and he thanked Kay Fruhwirth for the amount of data added to the report and Dr. Marianne Gausche-Hill and Cathy Chidester, who synthesized it by being very highly active on revisions related to the report.

Action: Vote for Approval in November.

Responsibility: EMS Commission

NEW BUSINESS

5.4 EMSC Annual Report – 2015/2016

Ms. Chidester announced that the EMSC Annual Report has been completed and it has been posted in the EMS Agency's website. It will be reviewed at the EMSC meeting in November. Hard copies of the report were shared with the Commission members at the meeting.

Action: Tabled until the November Meeting.

Responsibility: EMS Commission

6. Commissioners Comments/Requests

Commissioner Kazan requested for Commission members and representatives from other Agencies to review the Ad Hoc report. There will be a full discussions at the meeting in November in which approval of the report will be on the Agenda.

Cathy Chidester suggested discussing the report prior to the next meeting and come out with ideas from the EMS Agency and from the Commission members about the Ad Hoc Committee next steps and asking the Commission for their direction.

Action: Schedule a meeting

Responsibility: EMS Agency

7. Legislation

The legislative session is closed for 2016. SB 867 was approved. This bill extends the original SB 1773 - authorizes counties to collect an additional \$2 penalty assessment for every \$10 in traffic base fines for purposes of providing for emergency medical services, requires revenue generated from the assessment to be deposited into the Maddy Emergency Medical Services Fund (Maddy EMS Fund), with 15 percent designated for pediatric trauma centers, and allows for up to 10 percent to be used for administrative costs, and sunsets the provisions of this bill January 1, 2027.

The SB 1300 - Medi-Cal: Emergency Medical Transport Providers: Quality Assurance Fee is with the Governor's for approval; it is unclear if it will be signed.

8. Director's Report

There was an incident in Los Angeles City where there was SPICE, a synthetic marijuana that was distributed in the skid row area. People using the drug marijuana became sick and patients were distributed throughout that area. LAC+USC received more than half of the patients, White Memorial, Good Samaritan, CAL, and Kaiser received the rest of the patients. The issue was brought to the attention of the Board of Supervisors. The Board was concerned about the effect on the EMS system and the patients. There was report from Public Health to the Board of Supervisors at the Board Meeting on Tuesday, September 13, 2016. Through a motion, the Board asked for additional information from the EMS Agency to work with LA City Fire Department, LA County Fire Department and the Hospital Association on the capacity of emergency medical services County-wide and how it would respond in a large scale MCI disaster. The report was submitted to the Board of Supervisors and Dr. Mitchell Katz included information in a presentation on the Health Agency at the Board meeting on September 20, 2016. Further information was requested by the Board on the Surge Plan Activities.

9. Adjournment

The Meeting was adjourned by Chairman Clayton Kazan at 2:40 PM. The next meeting will be held on November 16, 2016.

Next Meeting: Wednesday, November 16, 2016
EMS Agency
10100 Pioneer Blvd.
Santa Fe Springs, CA 90670

Recorded by:
Amelia Chavez
Acting, EMSC Liaison



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Marianne Gausche-Hill, MD
Medical Director

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Fax: (562) 941-5835

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CORRESPONDENCE 2.1

October 20, 2016

Michael Lang, Fire Chief
Arcadia Fire Department
710 S. Santa Anita Ave
Arcadia, CA 91006

Dear Chief Lang:

HEMOSTATIC DRESSING PROGRAM APPROVED

This is to inform you that Arcadia Fire Department (AF) has been approved by the Los Angeles County Emergency Medical Services (EMS) Agency for the utilization of QuikClot® Combat Gauze™ in patients with traumatic external hemorrhage not amenable to other methods of control.

The approved quality improvement process required for implementation and tracking the utilization of hemostatic dressings will be reviewed during your annual Program Review or as deemed necessary by the EMS Agency. Additionally, AF may be required to submit data to the EMS Agency for purposes of system evaluation and aggregate reporting on the use of hemostatic dressings.

Please contact me at (562) 347-1600 or Susan Mori at (562) 347-1681 for any questions or concerns.

Sincerely,


Marianne Gausche-Hill, MD
Medical Director

MGH:sm
10-17

c: Director, EMS Agency
EMS Director, AF
Paramedic Coordinator, AF
Medical Director, AF
Nurse Educator, AF



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CORRESPONDENCE 2.2

October 6, 2016

TO: Medical Directors, Each Provider Agency
Prehospital Care Coordinators
Paramedic Coordinators
EMS Coordinators

FROM: Marianne Gausche-Hill, MD, Medical Director

**SUBJECT: UTILIZATION OF AUTOMATED DISPENSING SYSTEMS
FOR CONTROLLED SUBSTANCES**

This is in follow-up to a letter the Emergency Medical Services (EMS) Agency sent to Louis Milione, Deputy Assistant Administrator, Drug Enforcement Administration (DEA), requesting Los Angeles County approved EMS provider agencies be given a waiver from Title 21, Code of Federal Regulations, Controlled Substance Act, §1301.27 authorizing the utilization of automated dispensing systems (ADS) for storage and dispensing of controlled substances.

This waiver was approved by the DEA in a letter dated August 22, 2016, partially stating:

"Nothing, within 21 C.F.R. § 1301.27 would prevent the EMS, acting as your agent, from utilizing some form of automated machinery to facilitate the handling of controlled substances at any registered location so long as the use of such machinery did not interfere with agencies duty to comply with all record-keeping and security requirements imposed under current regulations. Further, registrant must retain responsibility for the controlled substances handled by such machinery and may not delegate or otherwise abrogate responsibility concerning the substances."

Although utilization of an ADS for controlled substance storage and dispensing is not being mandated by the EMS Agency, its use is highly recommended because it provides added security by limiting and documenting access to controlled substances by means of various biometric technology.

The EMS Agency is in the process of updating Ref. No. 702, Controlled Drugs Carried on ALS Units, to include ADS language. If your agency is planning to update to an ADS, please be cognizant of the following:

Each site where narcotics will be delivered/stored, must be registered with the DEA, regardless of whether ADS or conventional means of storage will be used. If you plan to distribute greater than 5% of your schedule II controlled substances (on an annual basis), to another registered site within your system, you must be registered with the DEA as a distributor.

If you have any questions or concerns, please feel free to contact me directly at (562) 347-1500 or John Telmos, Chief Prehospital Operations at (562) 347-1677.

MGH:jt
10-06

c. Director, EMS Agency



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CORRESPONDENCE 2.3

October 4, 2016

TO: Chief Executive Officer
Hospital Preparedness Program (HPP) Participant
Non-Emergency Department Approved for Pediatrics

FROM: Marianne Gausche-Hill, MD 
Medical Director

**SUBJECT: PEDIATRIC READINESS - INTEGRATING EVERY DAY
PEDIATRIC READINESS INTO YOUR EMERGENCY
MANAGEMENT PROGRAM**

Los Angeles County (LAC) Emergency Medical Services (EMS) Agency is embarking on a Pediatric Readiness project aimed at improving the readiness of hospitals to care for pediatric patients. The target audience is hospitals that are 9-1-1 receiving centers that do not participate in the Emergency Department Approved for Pediatrics (EDAP) program.

In 2012, a national assessment of pediatric readiness was conducted with 72 of the 73 (99%) hospitals that are 9-1-1 receiving centers in Los Angeles County participating in this assessment. The median readiness score was 70 out of 100, which was consistent with the national median score of 69. Of interest was that hospitals designated as EDAPs had a mean score of 91.8, indicating that verification of hospitals by the EMS Agency improved day-to-day readiness of hospital emergency departments to care for children.

Given the success of the EDAP program in LAC, the EMS Agency is requesting that you join us in working to improve the readiness of all hospitals for both day-to-day pediatric patients and disaster preparedness. The program called the Los Angeles Pediatric Readiness Project (LA Peds Ready) will identify pediatric champions from EDAP or Pediatric Medical Center (PMC) hospitals to establish partnerships with your hospital to assist in improving your pediatric readiness. These Pediatric Champions will work with you and hospital staff to identify gaps in pediatric readiness. Based on the gap analysis, tools and materials will be provided to assist your organization with developing pediatric policies and the program will provide training to enhance clinicians' pediatric assessment and procedural skills.

A meeting to kick-off the LA Peds Ready project was held on September 29, 2016. We are now ready to move to the next step in determining whether your hospital will participate in this exciting program. If you decide to participate there is an expectation that you would complete the activities as defined in the attached Scope of Work. Funding, provided through the Hospital Preparedness Program, in the amount of \$5,000 will be provided to off-set some of the costs associated with your participation.

Please complete the attached participation form indicating whether or not your hospital will participate and return it to the EMS Agency no later than October 27, 2016. We know that not every hospital attended the kick-off meeting in September; therefore if you have questions about the program and need additional information to assist in your decision to participate, please contact Laurie Lee-Brown at LLeeBrown6@dhs.lacounty.gov and she will assist in answering your questions. For those facilities that choose to participate, once you return your participation form, the Pediatric Champion assigned to your facility will reach out to the designated emergency department pediatric champion(s) to begin the work on this project.

Again, the EMS Agency and Pediatric Champions are excited about this program and look forward to working with your staff to improve the care to the pediatric population.

MGH:kf

Attachments

- c: Emergency Management/Disaster Planner, Each Non-EDAP Hospital
- Emergency Department Manager, Each Non-EDAP Hospital
- Emergency Department Medical Director, Each Non-EDAP Hospital
- Hospital Association of Southern California



**EMERGENCY MEDICAL
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LOS ANGELES COUNTY

CORRESPONDENCE 2.4

September 28, 2016

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TO: Fire Chief, Each Fire Department
CEO/President, Each Ambulance Company

FROM: Marianne Gausche-Hill, MD, FACEP, FAAP
Medical Director, LA County EMS Agency

SUBJECT: STANDARDIZED LENGTH-BASED RESUSCITATION TAPE

This is to provide you advanced notice that the Emergency Medical Services (EMS) Agency has approved the standardization of two length-based resuscitation tapes. This standardization is vital to ensure pediatric weights are determined in kilograms and color code of children less than or equal to 14 years of age.

All Los Angeles EMS providers must include in their inventory the most current Broselow™ 2011 Edition A or ©Pedia Tape December 2011 standard version.

In preparation for this change, we request that your department/company either purchase the approved length-based resuscitation tape or ensure that your providers are already supplied with the approved length-based resuscitation tape. The length-based resuscitation tape must be readily available in each Provider unit by November 1, 2016.

If you have any questions or need additional information, please do not hesitate to contact me or Richard Tadeo, Assistant Director, at (562) 347-1610.

MGH:kr

- c. Director, EMS Agency
- Assistant Medical Director, EMS Agency
- Chief, Prehospital Care Operations, EMS Agency
- Medical Director, Each EMS Provider Agency
- Nurse Educator, Each EMS Provider Agency
- Prehospital Care Coordinator, Each Base Hospital
- EMS Commission



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September 20, 2016

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TO: Supervisor Hilda L. Solis, Chair
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Mitchell H. Katz, M.D. *Mitchell Katz*
Director

**SUBJECT: REPORT ON THE EVALUATION OF COUNTYWIDE
EMERGENCY MEDICAL SERVICES CAPACITY**

Mitchell H. Katz, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Medical Officer

Christina R. Ghaly, M.D.
Chief Operations Officer

On September 6, 2016, the Board of Supervisors directed the Department of Health Services, Emergency Medical Services (EMS) Agency, in partnership with the County and City of Los Angeles (LA) Fire Departments and the Hospital Association of Southern California, to evaluate the capacity of emergency medical services responders and emergency room capacity throughout the County and report back with a plan to address massive threats to public health and safety, in addition to routine health care delivery.

Background

The State of California Health and Safety Code Division 2.5, requires that any County that develops an EMS program designate an EMS Agency. The primary responsibility of the local EMS Agency is to coordinate the EMS system on a day-to-day basis and during medical disasters. As part of the Department of Health Services, the EMS Agency works closely with the seventy-four (74) 9-1-1 receiving hospitals, thirty-two (32) fire departments and thirty-six (36) licensed ambulance companies to ensure coordinated, quality care on a daily basis, during Multiple Casualty Incidents (MCI) and major disasters.

Below is a brief overview of the capacity of the EMS system and highlights of the preparedness planning activities that ensure the ability to increase capacity (surge) in the event of MCI or disaster event.

Hospital Capacity

The EMS Agency maintains data on the number of hospitals with Emergency Departments (EDs) and the number of treatment bays per hospital. In 2015, the treatment bay capacity at the 74 EDs was 2,002 compared to 1,351 treatment bays in 2000 and these EDs treated over 3.5 million patients. The increase in capacity is due to the expansion of individual hospital EDs and the approval of newly licensed emergency departments, such as St. Vincent Medical Center and Martin Luther King, Jr. Community Hospital.

Individual hospitals are required to have internal policies for responding to an unexpected influx of patients during MCIs or disaster. This preplanned response adds capacity to care for additional sick and injured above their normal daily census.

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DHS facilities and through
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Additionally, to facilitate coordination of the EMS system, each 9-1-1 receiving hospital is required to have a ReddiNet® system, which provides a 24/7 communication link with the Departments' Medical Alert Center (MAC), EMS providers and other hospitals. This system allows the MAC to poll the hospitals for their bed capacity and availability of services during routine day-to-day operations and during an MCI or disaster.

EMS (Fire Department/Ambulance) Capacity

LA County EMS providers respond to over 700,000 EMS related calls per year and transport over 513,000 patients to hospitals. The County is divided into jurisdictional areas for the provision of 9-1-1 medical services, all operated by fire departments as the first response. LA County Fire District and 31 independent cities, such as LA City, Glendale, Long Beach, and Downey provide EMS. Each department has mutual aid agreements with surrounding departments to assist when EMS resources are encumbered. Along with additional paramedic resources, departments can call for additional ambulances through the LA County Fire District dispatch, in their capacity as the Fire Operational Area Coordinator (FOAC). The County's normal daily activities would be treated as large scale MCIs in other systems that do not have the extensive resources.

EMS, as part of the Los Angeles Regional Interoperable Communications System (LA-RICS) will soon be able to improve mobile coverage, deploy in-vehicle routers and Automatic Vehicle Locator software and mobile applications that aggregate data in a meaningful way for rapid response and appropriate resource deployment.

The City of Los Angeles Fire Department (LAFD) is the jurisdictional provider for the Skid Row area where the Spice incident occurred on August 19 and 22. Their administration reports that they are the second busiest EMS provider agency, responding to over 350,000 EMS incidents annually. LAFD staffs 93 Advanced Life Support (ALS/paramedic) ambulances and 41 Basic Life Support (BLS) ambulances, which transport over 600 patients to area hospitals each day. The LAFD is tasked with responding to largescale incidents or increased demands for EMS service on a very frequent basis. They have the ability to increase the number of dispatchers on duty to handle and process a surge in 9-1-1 calls. They can also increase capacity for additional call volume by moving firefighters from truck companies to ready reserve ambulances as the need arises.

During an MCI, LAFD may dispatch EMS Captains to area hospitals to facilitate the movement of ambulances to be ready for the next call. LAFD would access the FOAC to request additional ambulances if necessary. The LAFD works seamlessly with the surrounding fire departments and the EMS Agency to handle any surge in EMS calls or large scale incidents. This ability has been demonstrated many times over the past twenty years.

Healthcare Disaster Preparedness and Planning

Over the past 14 years, the EMS Agency has engaged the healthcare community in emergency preparedness and response activities to enhance LA County's medical surge capacity and capabilities. This planning is supported through Measure B funds for EMS Agency disaster preparedness staff and federal grant funds from the United States (U.S.) Department of Health and Human Services under the Hospital Preparedness Program (HPP) and the U.S. Department of Homeland Security under the Homeland Security Grant Program.

The complexity of LA County's healthcare community makes medical surge planning extremely challenging. There are 100 acute care hospitals, 74 of which have EDs that are designated by the EMS Agency as 9-1-1 receiving facilities, two Department of Veterans Affairs medical centers, 400 skilled nursing facilities, 800 home health care and hospice agencies, 166 dialysis centers, 444

ambulatory surgery centers, 250 community health centers, 35 private ambulance companies and 32 public paramedic provider agencies.

Medical surge planning is an all hazards approach that identifies key operational steps and coordinated strategies for various healthcare sectors across the healthcare system. The purpose of medical surge planning is to ensure that the healthcare system can maintain operations and surge to provide the healthcare needs to current patients and the victims from the incident. In line with this planning is the LA-RICS program which will allow for the use of technology, voice and data connectivity and mobile applications that will reliably put real-time information in the hands of first responders to allow for rapid and quality decisions during high pressured activities.

Various programs and plans have been developed over the years to address hazard-specific scenarios to enhance the County's medical surge capabilities and capacity: LA County Disaster Healthcare Coalition, Disaster Resource Center Program, Trauma Surge Plan, Burn Surge Plan, Pediatric Surge Plan, 50 in 15 minutes MCI Response Plan, Long Term Care Disaster Resource Guide, and Healthcare Recovery and Continuity planning to name a few.

Other preparedness activities that have been implemented by the EMS Agency and ensure a level of readiness include the following:

- providing hospitals and other healthcare facilities with the ability to perform mass notification and staff recall during emergencies
- emergency preparedness training such as healthcare incident command system programs and Hospital Disaster Management Training courses
- planning and coordinating the County's participation in the annual Statewide Medical and Health exercise to test emergency response plans
- procuring and maintaining a mobile field medical system that is able to support a hospital that has suffered damage and unable to function at full capacity
- procuring and maintaining additional caches of medical supplies to be deployed to augment hospitals and EMS operations.

Beyond the healthcare community, the EMS Agency and LA County Fire District work closely with the Chief Executive Office's Office of Emergency Management (OEM) in planning and exercising for emergency events. All planning includes our County partners such as the Departments of Public Health (DPH), Mental Health (DMH), and the Coroner's Office.

In the event that additional resources are need beyond the County's resources, following statewide plans, there are established mechanisms to procure resources from local counties, referred to as Region I. If the Region I resources are inadequate additional resources from throughout the State could be accessed and this process is clearly delineated in the California Public Health and Medical Emergency Operations Manual.

Plans and Programs

The above initiatives and the leadership of the County have led to many of the emergency response plans and programs being recognized as best practices on both the State and Federal levels, these include the following:

- Multiple Casualty Incident Policy - Since 1992, the EMS Agency has had a MCI policy that provides guidance on the efficient management of a MCI through the coordination of EMS provider agencies, 9-1-1 receiving facilities and the MAC, which allows for maximum

resource allocation and coordinated patient destination. This policy is frequently tested, reviewed and revised with the last revision completed in April 2015.

- Mass Gathering Policy – Prepares hospitals and first responders for planned mass gathering and implement programs that prevent illness and injury and protect hospitals from being overwhelmed by an excessive number of patients.
- Disaster Resource Center Program – Contracted hospitals that coordinate emergency preparedness planning and training within their geographic region. They also store caches of disaster supplies and equipment to support other healthcare facilities during an MCI or disaster.
- Healthcare Surge Planning Guide – Planning guide to assist healthcare entities in developing their emergency operations response plan. The guide is divided into healthcare sectors (acute care hospitals, long term care facilities, community health centers, dialysis centers, ambulatory surgery centers, home health and hospice agencies, and EMS providers) as each sector has their specific surge strategies tailored to their role and expectations.
- Burn Surge Plan – Expands the County's inpatient burn capacity by designating Trauma Centers as Burn Resource Centers during incidents that generate multiple patients with burn injuries. Trauma Centers are provided additional burn supplies and equipment, as well as, management of burn patient training. The plan includes a directory of clinical burn experts to provide consultation to Burn Resource Centers.
- Pediatric Surge Plan – Expands the County's inpatient pediatric bed capacity to address incidents that disproportionately affect the pediatric population. Every acute care hospital in the county was assigned a tier based on their current pediatric bed capacity and capability, 9-1-1 receiving facility designation and Emergency Department Approved for Pediatrics (EDAP) designation. Hospitals that do not normally see patients in their ED (non-EDAP) or those that do not have inpatient pediatric capabilities were provided pediatric equipment and training so they can manage the less acute pediatric patients in a pediatric surge incident.
- Healthcare Recovery and Continuity Planning – Ensures that hospitals and other healthcare entities are able to continue operations during a disaster and develop recovery strategies to effectively and efficiently return to normalcy for the provision of healthcare delivery to the community after a MCI or disaster.
- 50 in 15 minutes MCI Program - A surge response strategy developed to assist hospitals to be ready to accept 50 victims from an MCI or disaster within 15 minutes of the event.
- Communications Connectivity Planning –LA-RICS long term planning for improved mobile coverage and timely dissemination of information such as emergency room capacity, vehicle location, safe and efficient ambulance routes and staging during an MCI or disaster situation.

We are excited to continue to work with our partners in DPH and law enforcement in prevention activities to minimize the number of preventable illness and injuries throughout the County. With a population of greater the 10 million, prevention, preparedness and planning activities are critical. The EMS Agency looks forward to the continued support of your Board as we continue to enhance and refine our preparedness activities.

MHK:cc



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Marianne Gausche-Hill, MD
Medical Director

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CORRESPONDENCE 2.6

September 20, 2016

Sean Stokes
EMS Administrator
Beverly Hills Fire Department
445 North Rexford Dr.
Beverly Hills, CA 90210

Dear Mr. Stokes:

TEMPORARY IMPLEMENTATION OF EMT BICYCLE UNIT

This is in follow-up to your letter dated August 21, 2016, requesting the Emergency Medical Services (EMS) Agency review Beverly Hills Fire Department (BH) implementation plan of an Emergency Medical Technician (EMT) Bicycle Unit(s) to be deployed during preplanned street closure times in the City of Beverly Hills.

This temporary unit(s) will be placed into service in response to the construction of the LA Metro's "purple line" resulting in the planned closure of east and west bound Wilshire Boulevard for 22 consecutive weekends beginning March 2017.

The Emergency Medical Services (EMS) Agency has reviewed and agrees with BH's plan to strategically position EMT bicycle unit(s) in and around the construction zone during Wilshire Boulevard closure times.

Staffing will consist of 2 BH firefighter/EMT personnel on bicycles carrying a modified BLS inventory commensurate with the EMT scope-of-practice. It is further understood that an assessment or paramedic unit will be dispatched to the scene of any patient meeting Ref. No. 808.1, Base Hospital Contact and Transport Criteria Field Reference, Sections 1 or 2, and upon arrival, the paramedic(s) will assume patient care.

If you or your staff have any questions, please contact John Telmos, Chief Prehospital Operations, at (562) 347-1677.

Sincerely,


Cathy Chidester

CC:jt
09-19

- c. Fire Chief, BH
Paramedic Coordinator, BH



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CORRESPONDENCE 2.7

September 19, 2016

James Burke, MD
Medical Director
Adventist Health Urgent Care
1975 Verdugo Blvd.
LaCanada-Flintridge, CA 91011

Dear Dr. Burke:

**COMPLETION OF THE COMMUNITY PARAMEDICINE
ALTERNATE PATIENT DESTINATION PILOT PROJECT**

The Emergency Medical Services (EMS) Agency would like to take this opportunity to acknowledge you and the staff for Adventist Health Urgent Care for their participation in the Community Paramedicine Alternate Patient Destination (ALTrans) Pilot Project.

Adventist Health Urgent Care was approved to participate in the ALTrans Pilot Project by the EMS Agency on September 3, 2015. The Pilot in the Glendale community concluded as of August 31, 2016.

This pilot could not have taken place without the voluntary participation of Adventist Health Urgent Care. Much has been learned during this Pilot, and although there was limited patient enrollment, the framework has been established to support future projects that could benefit the EMS system, Urgent Care Centers and the community.

Again, thank you for your support in this pilot project as the EMS community seeks innovative strategies for delivering safe, effective patient care.

Sincerely,


Cathy Chidester
Director


Marianne Gausche-Hill MD
Medical Director

MGH:CC:jt
09-16

- c. Todd LeGassick, Executive Director, UCLA Center For Prehospital Care



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CORRESPONDENCE 2.8

September 14, 2016

TO: Participating and New Enrollment Physicians

FROM: Cathy Chidester 
Director

**SUBJECT: PHYSICIAN SERVICES FOR INDIGENTS PROGRAM
REIMBURSEMENT RATE FOR FISCAL YEAR 2016-17**

This memo is to inform all participating physicians in the Physician Services for Indigents Program (PSIP) of the reimbursement rates for Fiscal Year (FY) 2016-17. The reimbursement rate for non-trauma claims will be at 13.5% and trauma claims will be 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, 2016 through June 30, 2017.

Additionally, the reimbursement rate for FY 2015-16 trauma claims, which was set at 60% of the OCFS in November 2015 is being increased to 100% of the OCFS. The trauma claim volume for FY 2015-16 is significantly less than projected; therefore we are able to make this adjustment.

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



**EMERGENCY MEDICAL SERVICES COMMISSION
BASE HOSPITAL ADVISORY COMMITTEE
MINUTES
October 12, 2016**



REPRESENTATIVES		EMS AGENCY STAFF
<input checked="" type="checkbox"/> Carole Snyder, RN, Chair	EMS Commission	Dr. Marianne Gausche-Hill
* Margaret Peterson, Ph.D., Vice Chair	EMS Commission	Dr. Nichole Bosson
* Robert Flashman, M.D.	EMS Commission	Richard Tadeo
<input type="checkbox"/> Erick Cheung, Ph.D.	EMS Commission	Christine Clare
<input checked="" type="checkbox"/> Jessica Strange	Northern Region	John Telmos
<input type="checkbox"/> Karyn Robinson	Northern Region	Michelle Williams
<input checked="" type="checkbox"/> Annette Cornell	Northern Region, Alternate	Christy Preston
<input checked="" type="checkbox"/> Kristina Crews	Southern Region	Paula Rashi
<input checked="" type="checkbox"/> Samantha Verga-Gates	Southern Region	Cathy Jennings
<input checked="" type="checkbox"/> Laurie Mejia	Southern Region	Karen Rodgers
<input type="checkbox"/> Natalie Burciago	Southern Region, Alternate	Yvonne Elizarraraz
<input checked="" type="checkbox"/> Christine Farnham	Southern Region, Alternate	Sara Rasnake
<input checked="" type="checkbox"/> Paula Rosenfield	Western Region	Gary Watson
<input checked="" type="checkbox"/> Ryan Burgess	Western Region	Dr. Ashley Sanello
<input checked="" type="checkbox"/> Alex Perez	Western Region, Alternate	
<input checked="" type="checkbox"/> Laurie Sepke	Eastern Region	
<input checked="" type="checkbox"/> Alina Candal	Eastern Region	
<input checked="" type="checkbox"/> Jenny Van Slyke	Eastern Region, Alternate	
<input checked="" type="checkbox"/> Lila Mier	County Hospital Region	
<input checked="" type="checkbox"/> Emerson Martell	County Hospital Region	
<input type="checkbox"/> Jose Garcia	County Hospital Region, Alternate	
<input type="checkbox"/> Mike Hansen	Provider Agency Advisory Committee	
<input checked="" type="checkbox"/> Michael Murrey	Provider Agency Advisory Committee, Alt.	
<input checked="" type="checkbox"/> Jazmin Gonzalez	MICN Representative	
<input type="checkbox"/> Jeff Warsler	MICN Representative, Alt.	
<input checked="" type="checkbox"/> Robin Goodman	Pediatric Advisory Committee	
<input checked="" type="checkbox"/> Kerry Gold-Tsakonas	Pediatric Advisory Committee, Alt.	
PREHOSPITAL CARE COORDINATORS		GUESTS
<input type="checkbox"/> Kevin Lennox (AMH)	<input checked="" type="checkbox"/> Adrienne Roel (AMH)	Jennifer Lee, M.D.- HUCLA
<input checked="" type="checkbox"/> Courtney Derryberry (AVH)	<input type="checkbox"/> Rosie Romero (CAL)	Ian Wilson- PRN Ambulance
<input checked="" type="checkbox"/> Dee Josing (HMN)	<input checked="" type="checkbox"/> Rachel Caffey (NRH)	Victoria Hernandez, LACoFD
<input type="checkbox"/> Heidi Ruff (NRH)	<input type="checkbox"/> Gloria Guerra (QVH)	Susannah Empson, MD- HUCLA
<input checked="" type="checkbox"/> Laura Leyman (SFM)	* Jennifer Hunt (SMM)	

- 1. CALL TO ORDER:** The meeting was called to order at 1:01 P.M. by Carole Snyder, Chairperson.
- 2. APPROVAL OF MINUTES -** The August 10, 2016 meeting minutes were approved with changes to representatives as presented.

M/S/C (Strange/Burgess) Approve the August 10, 2016 meeting minutes with changes.

3. INTRODUCTIONS/ANNOUNCEMENTS

Yvonne Elizarraraz, previously from Harbor-UCLA Medical Center, and Sara Rasnake, previously from LAC+USC Medical Center, were introduced as the new EMS Data System Coordinators working with Michelle Williams in the data section at the EMS Agency.

4. REPORTS & UPDATES

4.1 EMS Update 2017

Alina Candal and Tina Crews will be the representatives for BHAC to the EMS update workgroup. Samantha Verga-Gates and Laurie Sepke will be the alternates. Possible topics for inclusion are:

- Provider Primary Impression
- Protocol revisions to include provider impression and separate pediatric protocols
- Issues surrounding BLS downgrade

4.2 2016 EMS Data Report

The 2016 EMS Data Report is available on the EMS Agency website:
http://file.lacounty.gov/SDSInter/dhs/248671_2016EMSAnnualDataReport.pdf
Forward any suggestions for inclusion in future reports to Richard Tadeo.

4.3 Standardized Pediatric Drug Formulary

Questions have arisen regarding the dilution of sodium bicarbonate prior to administration for patients under 1 year of age. Dr. Gausche-Hill reported that sodium bicarbonate should be 4.2% for patients under one year of age and the concentration in the formulary is 8.4%. Additionally, Dr. Gausche-Hill reported that the usage of sodium bicarbonate in patients under 1 year of age is extremely rare and it should only be administered when ordered by the Base Physician.

A discrepancy has been noted between the dosages of inhaled epinephrine in Reference No. 1249, Treatment Protocol: Respiratory Distress and Reference No. 1309, Color Code Drug Doses- L.A. County Kids. Dr. Gausche-Hill reported that the correct dosages are in Reference No. 1309. Reference No. 1249 will be revised to reflect the change.

5. UNFINISHED BUSINESS

5.1 Electronic Base Form Documentation

Ryan Burgess reported that the real-time electronic base hospital form was tested by the APCC e-form workgroup. Despite some members feeling it would be challenging to complete real-time base form documentation, it was agreed that it should move forward. One challenge identified is the hardware costs that the Base Hospitals would be responsible for.

Ryan has discussed electronic base form documentation with Orange County and is planning a 'field trip' to evaluate what they are doing.

The initial meeting of the Base Hospital data workgroup is October 13, 2016. This workgroup will be evaluating data requirements which may change how data is currently being collected and evaluated.

5.2 Los Angeles County Fire (CF) ePCR Implementation

Richard Tadeo reported that there continues to be issues with CF and their ePCR. Some are operational and are being addressed as they are identified. The majority

are software issues. There was a software update last week that was to address the issue of the sequence numbers changing when the record is shared. The EMS Agency is continuing to have regular conference calls with CF to address issues/concerns.

An issue was brought up regarding incidents involving more than three patients, the system does not generate sequence numbers for any of the patients. Unlike the prior software version of the ePCR (currently used by LAFD) this newer software does not have an MCI module.

6. NEW BUSINESS

6.1 Reference No. 510, Pediatric Patient Destination

Reference No. 510 revisions were reviewed.

Recommended changes:

Page 1, Definitions- add definition for Brief Resolved Unexplained Event (BRUE)

Page 3, Policy II, F, add words “and the” before “previously called”

Page 3, Policy II, add “G. Choking associated with color change, loss of tone or apnea.”

M/S/C (Burgess/Van Slyke) Approve with recommended changes.

6.2 Reference No. 516, Return Of Spontaneous Circulation (ROSC) Patient

Reference No. 516 revisions were reviewed.

Recommended changes:

Page 1, Definitions- add definition for Cardiac Etiology

Page 1, Definitions- Return of Spontaneous Circulation, change the word ‘any’ to “one or more”; add “signs” after “following”; change “and” to “or”

Page 1, Principle, 4- add “3 or more shocks” after refractory; add “with presumed cardiac etiology” after “fibrillation”; and “for consideration for PCI” at end of sentence

Page 2, Policy, II- delete “direction/notification and destination” and replace with “control”

Page 2, Policy III, D- add “cardiac” after witnessed” and add “on-scene” after “despite”

Page 2, Policy III, E- add “on-scene” after “despite”

M/S/C (Burgess/Van Slyke) Approve with recommended changes.

7. OPEN DISCUSSION

Expanded Scope of Practice

With some providers having the ability to use Intraosseous (IO) device for non-cardiac arrest patients, questions have arisen as to how this applies to the Treatment Protocols and how the MICNs are informed of which Providers have expanded scope.

Bases are notified prior to authorization of expended scope for the providers they are assigned to. The EMS Agency, in collaboration with the providers, will be evaluated those cases where expanded IO was utilized and determine if the utilization should be expanded County-wide.

The EMS Agency will evaluate the possibility of posting the list of which departments have expanded scope on the website.

MICN Development Course Workgroup

First meeting was held on October 11, 2016. Developed and approved guiding principles. Next meeting will be held in approximately one month.

Behavioral and Agitated Delirium Complaints

Concerns regarding the usage of the Behavioral and Agitated Delirium complaints being used inappropriately by the paramedics. Request to include as an EMS Update topic.

Case of the Month

Dr. Bosson requested any interesting or educational runs be forwarded to her for inclusion in the case of the month. The tapes will be de-identified.

8. NEXT MEETING: December 14, 2016

9. ADJOURNMENT: The meeting was adjourned at 2:24 P.M.



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COMMITTEE REPORTS 3.2

EMERGENCY MEDICAL SERVICES COMMISSION DATA ADVISORY COMMITTEE

MEETING NOTICE

Date & Time: Wednesday, October 12, 2016 10:00 A.M.
Location: EMS Agency, First Floor Hearing Room
10100 Pioneer Boulevard
Santa Fe Springs, 90670-3736

DATA ADVISORY COMMITTEE DARK FOR OCTOBER 2016



Health Services
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County of Los Angeles
Department of Health Services



**EMERGENCY MEDICAL SERVICES COMMISSION
EDUCATION ADVISORY COMMITTEE MINUTES**

Wednesday, October 19, 2016

Attendance

Members

- ☒ Frank Binch, Chair
- ☐ Gary Washburn, Vice-Chair
- ☒ Alina Candal, RN
- ☒ Tina Crews, RN
- ☐ VACANT, RN
- ☒ Joanne Dolan, RN
- ★ Susan Hayward, RN
- ☒ Sean Stokes, RN
- ☒ Adam Richards, PM
- ☒ Jim Karras, EMT
- ☒ Kim Mutaw, PM
- ☐ Mark Ferguson, RN
- ☒ Jacqueline Rifenburg, RN
- ☒ Tina Ziolkowski, RN
- ☐ Kelly Sherwood, RN
- ☐ Heather Davis, PM
- ☒ Stanley Bakey, PM
- ☒ Sean Lyons, PM
- ☒ Aaron Aumann, PM
- ☒ Jeff Warstler, RN
- ☐ Jennifer Webb, RN
- ☐ Charles Drehsen, MD
- ☐ VACANT
- ☒ Ken Leasure, PM
- ☐ James Altman, PM
- ☐ Scott Buck, PM
- ☒ William Gonzales, PM
- ☒ Anthony Mendoza, PM
- ☐ VACANT
- ☐ Jeff Pollakoff, EMT
- ☒ Scott Jaeggi, PM
- ☒ Ryan Carey, EMT

Organization

- EMSC/Public Member 4th District
- EMSC/Public Member 5th District
- APCC
- APCC
- APCC - alternate
- LAAFCA
- LAAFCA
- LAAFCA - alternate
- LACAA
- LACAA
- LACAA - alternate
- PTI Paramedic Education
- PTI Paramedic Education- alternate
- Mt SAC Paramedic Education
- Mt SAC Paramedic Education - alternate
- UCLA Paramedic Education
- UCLA Paramedic Education - alternate
- UAV Paramedic Education
- UAV Paramedic Education - alternate
- MICN
- MICN - alternate
- Med Council
- Med Council - alternate
- LAAFCA
- LAAFCA - alternate
- LACAA
- LACAA - alternate
- EMS Educator – Non PD
- EMS Educator – Non PD - alternate
- EMT Program Director
- EMT Program Director
- EMT Program Director - alternate

EMS Agency Staff Present

- Richard Tadeo, RN
- Erika Reich, RN
- Susan Mori, RN
- David Wells, RN

Position

- Assistant Director
- Program Approvals
- Systemwide QI
- Program Approvals

Others Present

- Ben Esparza

Agency/Representing

- LAFD

★ - Excused

1. CALL TO ORDER - F. Binch, Chair called the meeting to order at 10:00 a.m.

2. APPROVAL OF MINUTES - October 21, 2015 minutes approved by committee.

3. INTRODUCTIONS AND ANNOUNCEMENTS

3.1 EMS System Annual Data Report (Tadeo)

The annual report is published on the EMS Agency website.

3.2 Color Code Drug Dosages LA County Kids (Tadeo)

Ref. No. 1309 has been updated with standardized concentrations and dosages. Notification of training and implementation have been distributed to all providers and base hospitals. An addendum will be sent to the EMS community to clarify epinephrine, atropine, sodium bicarbonate, and naloxone changes.

4. REPORTS & UPDATES

4.1 California Prehospital Program Directors (CPPD) (Ziolkowski)

No report

4.2 California Council of EMS Educators (C²E²) (Karras)

No Report. Organization may have commented on the EMT Regulations.

4.3 Association of Prehospital Care Coordinators (APCC) (Candal)

APCC submitted a prioritized list of recommended topics for EMS Update 2017 to Dr. M. Gausche-Hill. The top three were: 1) Case review of inappropriate downgrades, 2) MCI management with focus on destination, and 3) Head-to-Toe assessment with general impression.

4.4 California Association of Nurses and EMS Professionals (CALNEP) (Dolan)

No report

4.5 Disaster Training Unit (Eads)

No report

4.6 EMS Quality Improvement Report (Mori)

LEMSA Coordinators CQI developed and hosted a successful training for EMS quality improvement managers in Northern California. Training is scheduled in Southern California on November 17th and 18th at the EMS Agency. Contact S. Mori if you are interested in attending as registration is required. Public Safety providers are evaluating the use of waveform capnography in adult cardiac arrest patients with bag-mask-ventilation and may start to review stroke assessment specifically for mLAPSS and LAMS. Private providers are evaluating transfer of care vital signs and wall time for non 9-1-1 transports.

4.7 EMT Program Update (Reich)

Public comment to EMSA for the EMT Regulations is closed. A second public comment with responses to the initial public comment period should be released by EMSA in the near future. Potential changes include an increase in primary training hours, tactical casualty care first aid, and administration of naloxone and epinephrine.

4.8 EMS Update (Tadeo)

EMS Update 2017 content is in the early development stages. PCCs and Nurse Educators will be offered the opportunity to participate in the workgroup. The current topics will include: provider impression and pediatric protocols. Additional topics are currently being evaluated. The Agency is investigating online education delivery and developing an application for EMS protocols.

5.UNFINISHED BUSINESS

No Unfinished Business

6.NEW BUSINESS

6.1 Committee Self Review and Recommendations (Commissioner Binch)

Commissioner Binch reported that his review of the Education Advisory meeting minutes since 2007, found this committee has mostly met for information sharing. Question to the members of the Committee: Do we continue as in the past or develop a more active role to support the commission? The committee was presented with the results of the anonymous survey distributed by Commissioner Binch at the August meeting and via email to committee members. R. Tadeo presented information regarding historical changes of EMS Commission subcommittees. Members discussed the Commission's goals for this subcommittee, meeting frequency, membership structure, and community education such as Public Access bleeding control kits, AEDs, drowning prevention and community CPR. Commissioner Binch identified two options: the subcommittee could remain in its existing state or as an ad hoc committee at the will of the Commission to address specific issues. Several members expressed their interest in maintaining this subcommittee.

Three motions were brought forward by members.

1st motion by K. Leasure: Maintain Education Advisory committee with the current meeting schedule. Second by A. Aumann. Motion carried by unanimous vote of eligible members.

2nd motion by K. Leasure: In principle, maintain the current membership of the Education Advisory committee and expand the current membership by adding Provider Agency position representatives not already included in the current structure. Second by R. Carey. Motion carried by unanimous vote of eligible members.

3rd motion by J. Karras: Expand this committee's mission and role to include review and recommendations of public education initiatives related to EMS in addition to its current related functions. Second by R. Carey. Motion carried by unanimous vote of eligible members.

Commissioner Binch thanked the committee members for their time and participation. A second anonymous survey was distributed and requested to submit today in person, by mail or email.

7.OPEN DISCUSSION

No Discussion

8.ADJOURNMENT - The meeting adjourned at 11:57 a.m. Next meeting: Wednesday, December 21, 2015 at 10:00 a.m.

My role on the Education Advisory Committee is:

___ Member

___ Alternate

___ Staff

October 19, 2016

Questions for discussion followed by individual survey response:

- What is the actual role now of the official, permanent, Education Advisory Committee of Los Angeles County's Emergency Medical Services Commission? Please base your answer not on what's in the Pre-hospital Care Policy Manual or other official sources, but on your first-hand knowledge of how the Committee actually spends time.

___ % on _____

___ % on _____

___ % on _____

- What is your opinion of what the Committee's actual role (in other words, how it should spend it's time) should be?

1. _____

2. _____

3. _____

Examples of How Time
Might Be Spent

- Sharing info
- Planning
- Evaluating
- Decision-making/
recommending

Comments:

LOS ANGELES COUNTY EMS COMMISSION'S EDUCATIONAL ADVISORY COMMITTEE
VOTING MEMBER SURVEY (ANONYMOUS) August 17, 2016 - 6 (six) RESPONSES

<i>Do you agree or disagree with these statements?</i>	<i>-2 Strongly Disagree</i>	<i>-1 Disagree</i>	<i>0 No Opinion</i>	<i>+1 Agree</i>	<i>+2 Strongly Agree</i>	<i>Comments (optional) PAAC = (EMS Commission's) Provider Agency Advisory Committee</i>
I am clear about what is the mission of the EMS Commission's Educational Advisory Committee		✓	✓	✓✓	✓✓	Not clear on mission Not clear on mission and purpose Forward agenda items to PAAC and Commission
I believe that the time I spend as a committee member is a good use of my time		✓✓	✓	✓✓✓		Appreciate information of developing changes in education When there's a quorum and education is discussed However, telecommuting or online forums would increase productivity (I'm a) New member. Most of the information I receive here, I have received from other committees or groups Due to attendance, move items to PAAC
I think the Committee is effective as a whole in getting its work done	✓		✓✓✓✓	✓		Without clearer mission, hard to judge Not in its current state, but it has great potential Effective from EMS Agency standpoint. If few attend, time conceivably could better used. (I'm a) New member PAAC can accomplish
I believe this work makes a positive difference in the quality of EMS in L.A. County		✓	✓	✓✓✓	✓	I have not seen any effect on L.A. EMS I believe it can. Education is key for our providers & MICN's. Needs could be suggested at Base & Provider Advisory Committee mtgs. PAAC and Commission can direct

LOS ANGELES COUNTY EMS COMMISSION'S EDUCATIONAL ADVISORY COMMITTEE
COMMITTEE STAFF SURVEY (ANONYMOUS) August 17, 2016 - 5 (five) RESPONSES

<i>Do you agree or disagree with these statements?</i>	<i>-2 Strongly Disagree</i>	<i>-1 Disagree</i>	<i>0 No Opinion</i>	<i>+1 Agree</i>	<i>+2 Strongly Agree</i>	<i>Comments (optional)</i> <i>PAAC = (EMS Commission's) <u>P</u>rovider <u>A</u>gency <u>A</u>dvisory <u>C</u>ommittee)</i>
I am clear about what is the mission of the EMS Commission's Educational Advisory Committee			✓	✓✓✓	✓	I need to review the mission statement I believe that Education Advisory Committee has lost its mission resulting in decreased attendance. Mission has changed over the years
I believe that the time I spend as a committee member is a good use of my time		✓✓	✓✓	✓		Could be a good use of my time
I think the Committee is effective as a whole in getting its work done *	✓	✓✓		✓		Scope of work will need to change to meet mission All work done by Agency staff Not utilized for getting work done
I believe this work makes a positive difference in the quality of EMS in L.A. County*		✓	✓✓	✓		Can be positive effect after given project I believe it could make a difference if utilized differently When focused back on education, I believe the Committee is worthwhile

* One person did not respond to this particular question.

PRESCRIBED MISSION OF THE L. A. COUNTY EMS COMMISSION'S
EDUCATIONAL ADVISORY COMMITTEE
QUESTIONS & ANSWERS

Q 1. What is the assigned mission of the Educational Advisory Committee?

- A 1. Prehospital Care Policy Manual reference No. 207, dated 7/1/2014 and signed as "APPROVED" by the EMS Agency Director and Medical Director, reads in part:**

"SUBJECT: EMS COMMISSION ADVISORY COMMITTEES"

"Purpose:" (of the EMS Commission's Advisory Committees) "to establish a forum for exchange of ideas regarding prehospital care continuing education programs, training programs, certification and accreditation issues, policy development and operational issues involving prehospital care."

.....

"IV. Education Advisory Committee A. Mission: This committee is responsible for all matters regarding issues and policies pertinent to EMS curriculum and program development, implementation and evaluation.

State law (Health & Safety Code or HSC) & County Ordinance, however, mandates or authorizes the EMS Commission, among other things, to at least annually review and report on the operations of:

- | | |
|--------------|---|
| HSC 1797.274 | (b) Emergency medical care offered within the county, including programs for training large numbers of people in cardiopulmonary resuscitation and lifesaving first aid techniques. |
| | (c) First aid practices in the county. |
| HSC 1797.276 | Every emergency medical care committee shall, at least annually, report to the authority, and the local EMS agency its observations and recommendations relative to its review of . . . emergency medical care, and first aid practices, and programs for training people in cardiopulmonary resuscitation and lifesaving first aid techniques, and public participation in such programs in that county. The emergency medical care committee shall submit its observations and recommendations to the county board or boards of supervisors which it serves and shall act in an advisory capacity to the county board or boards of supervisors which it serves, and to the local EMS agency, on all matters relating to emergency medical services as directed by the board or boards of supervisors. |

From: https://www.municode.com/library/ca/los-angeles-county/codes/codes-of-ordinances?nodeId=TYE2ADG000_CH3_20EMM1
ESECO

Chapter 3.20 - EMERGENCY MEDICAL SERVICES COMMISSION

- A. The commission shall perform all of the functions of the emergency medical care committee as defined in Health and Safety Code Sections 1750, et seq., . . .

, , , and shall have the following duties:

1. To act in an advisory capacity to the board of supervisors and the director of health services regarding county policies, programs, and standards for emergency medical care services throughout the county, including paramedic services;
2. To establish appropriate criteria for evaluation and to conduct continuous evaluation on the basis of these criteria of the impact and quality of emergency medical care services throughout the county;
3. To conduct studies of particular elements of the emergency medical care system as requested by the board of supervisors, the director of health services or on its own initiative; to delineate problems and deficiencies and to recommend appropriate solutions;
4. To acquire and analyze the information necessary for measuring the impact and the quality of emergency medical care services;
5. To report its finding, conclusions, and recommendations to the board of supervisors at least every 12 months;
6. To review and comment on plans and proposals for emergency medical care services prepared by county departments;
7. To recommend, when the need arises, that the county engage independent contractors for the performance of specialized temporary or occasional services to the commission which cannot be performed by members of the classified service, and for which the county otherwise has the authority to contract;

8. To advise the department of health service and its director on the following matters:
 - a. Policies, procedures, and standards to control the certification of mobile intensive care nurses and paramedics;
 - b. Proposals of any public or private organization to initiate or modify a program of paramedic services or training;
9. To arbitrate differences in the field of paramedic services and training between all sectors of the community, including, but not limited to, county agencies, municipalities, public safety agencies, community colleges, hospitals, private companies, and physicians. *(subject to limitations set forth in Paragraph B of the ordinance)*

(Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (part), 1979: Ord. 11909 § 1, 1979: Ord. 11179 § 1 (part), 1975: Ord. 4099 Art. 107 § 20505, 1942.)

3.20.080 - Self-government—Meetings.

The commission shall prepare and adopt rules and regulations for the internal government of its business and designating the time and place of holding its meetings, provided that such rules and regulations are not inconsistent with this or any other ordinance or statute.

(Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (part), 1979: Ord. 11179 § 1 (part), 1975: Ord. 4099 Art. 107 § 20507, 1942.)

3.20.090 - Staff.

The director of health services shall provide the staff for the commission and subcommittees thereof.

(Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (part), 1979: Ord. 11179 § 1 (part), 1975: Ord. 4099 Art. 107 § 20508, 194

Q 2. Based on the above, are the mission and membership set forth in Reference 207 for the EMS Commission's Education Advisory Committee clear, complete, relevant and appropriate?

A 2. They are | are not reasonably clear.

They are | are not reasonably complete,
are | are not relevant
are | are not appropriate

Q 3. Based on the answers to the questions above, what changes (if any) affecting the Education Advisory Committee would best lead to progress for EMS patients and providers?

A 3.



County of Los Angeles
Department of Health Services



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

EMERGENCY MEDICAL SERVICES COMMISSION

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, October 19, 2016

MEMBERSHIP / ATTENDANCE

MEMBERS

- ☒ Dave White, Chair
- ☒ Robert Ower, Vice-Chair
- ☐ LAC Ambulance Association
- ☐ LAC Police Chiefs' Association
- ☒ Jodi Nevandro
 - ☒ Sean Stokes
- ☒ Nick Berkuta
 - ☒ Clayton Kazan, MD
 - ☐ Victoria Hernandez
- ☒ Ken Leasure
 - ☐ Susan Hayward
- ☒ Richard Roman
 - ☐ Mike Beeghly
- ☒ Josh Hogan
 - ☒ Joanne Dolan
- ☐ Mike Hansen
 - ☒ Michael Murrey
- ☐ Corey Rose
 - ☐ Miguel Escobedo
- ☒ Adam Richards
 - ☐ VACANT
- ☐ Jenny Van Slyke
 - ☒ Alina Chandal
- ☒ Andrew Respicio
 - ☐ James Michael
- ☒ Maurice Guillen
 - ☐ Scott Buck
- ☐ Marc Eckstein, MD
 - ☐ Stephen Shea, MD
- ☒ Diane Baker
 - ☐ Vacant

ORGANIZATION

- EMSC, Commissioner
- EMSC, Commissioner
- EMSC, Commissioner
- EMSC, Commissioner
- Area A
- Area A Alt (Rep to Med Council, Alt)
- Area B
- Area B, Alt.
- Area B Alt. (Rep to Med Council)
- Area C
- Area C, Alt
- Area E
- Area E, Alt.
- Area F
- Area F, Alt.
- Area G (Rep to BHAC)
- Area G, Alt. (Rep to BHAC, Alt.)
- Area H (Rep to DAC)
- Area H, Alt.
- Employed EMT-P Coordinator (LACAA)
- Employed EMT-P Coordinator, Alt. (LACAA)
- Prehospital Care Coordinator (BHAC)
- Prehospital Care Coordinator, Alt. (BHAC)
- Public Sector Paramedic (LAAFCA)
- Public Sector Paramedic, Alt. (LAAFCA)
- Private Sector EMT-P (LACAA)
- Private Sector EMT-P, Alt. (LACAA)
- Provider Agency Medical Director (Med Council)
- Provider Agency Medical Director, Alt. (Med Council)
- Private Sector Nurse Staffed Ambulance Program (LACAA)
- Private Sector Nurse Staffed Ambulance Program, Alt (LACAA)

EMS AGENCY STAFF PRESENT

- | | |
|-----------------|--------------------|
| Cathy Chidester | Richard Tadeo |
| Christ Clare | Susan Mori |
| Christy Preston | Paula Rashi |
| David Wells | Cathlyn Jennings |
| Sara Rasnake | Yvonne Elizarraraz |
| Lorrie Perez | Karen Rodgers |
| Gary Watson | |

OTHER ATTENDEES

- | | |
|-------------------|---------------------|
| Kris Thomas | Ambulnz Ambulance |
| Nick Erickson | Ambulnz Ambulance |
| Barry Snyder | LACoFD Life Guard |
| Kyle Power | LACoFD Life Guard |
| Drew Bernard | Emergency Ambulance |
| Ian Wilson | PRN Ambulance |
| Monica Bradley | Culver City FD |
| Tisha Hamilton | AMR Ambulance |
| Julian Zermeno | Santa Monica FD |
| Roger Braum | Culver City FD |
| Ellsworth Fortman | LAFD |
| Caroline Jack | Torrance FD |
| Mike Barilla | Pasadena FD |
| Trevor Stonum | MedCoast Ambulance |
| Nicole Steeneken | LACoFD |
| Yuh Son Kim | LACoFD |
| William Gonzales | AmbuService Amb |
| John Pringle | |
| Ben Esparza | |
| Nanci Medina | |

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

CALL TO ORDER: Chair, Commissioner Dave White called meeting to order at 1:05 p.m.

1. **APPROVAL OF MINUTES: (Berkuta/Leasure)** August 17, 2016 minutes were approved as written.

2. **INTRODUCTIONS / ANNOUNCEMENTS**

None

3. **REPORTS & UPDATES**

3.1 EMS Update 2017 (Richard Tadeo)

- The EMS Agency is requesting representatives from Base Hospital Advisory Committee and Provider Agency Advisory Committee to join a workgroup that will assist with the planning of EMS Update 2017.

- Topics currently being considered include: primary and secondary impressions, pediatric protocols, and development of a mobile app for the treatment protocols,
- Those interested in participating in the EMS Update 2017 workgroup, may contact Richard Tadeo.

3.2 2016 EMS Data Report (Richard Tadeo)

- Recently published Data Report was reviewed.
- This Annual EMS Data Report is currently available on the EMS Agency's webpage; printed copies will soon be available.

3.3 Comprehensive Stroke Center (Richard Tadeo)

- The EMS Agency is currently developing Agreements and Standards for the Comprehensive Stroke Center (CSC).
- CSCs will be required to secure an Agreement with transport providers, which would reduce the need to activate 9-1-1 for secondary transportation.
- Target date to implement CSC is March/April 2017. It is expected that approximately 6-7 hospitals will be ready to participate.

3.4 Standardized Drug Formulary (Richard Tadeo)

3.5 Reference No. 1309, Medical Control Guideline: Color Code Drug Doses (Richard Tadeo)

- Education for these topics have already been distributed.
- Due to concerns identified related to medications, the EMS Agency will be sending out a memo to all providers that will further clarify the following medications: Atropine, Sodium Bicarbonate, Naloxone (Narcan) and Dextrose 10%.
- Committee identified other concerns and requested that the implementation of the Standardized Drug Formulary and Color Code Drug Doses be postponed until EMS Update 2017.
- The EMS Agency will provide notification to all providers on decision to either move forward or postpone the implementation of the Drug Formulary and Reference No. 1309.

4. UNFINISHED BUSINESS

No unfinished business.

5. NEW BUSINESS

5.1 Reference No. 510, Pediatric Destination (Karen Rodgers)

Policy reviewed and approved with the following recommendations:

- Page 3 of 3, Policy II, G: add examples of "Focal neurologic signs", including atypical migraine, pediatric stroke, and small focal/petite mal seizures
- Page 3 of 3, Policy II: add Section H, "Choking associated with cyanosis"
- Include policy in EMS Update 2017

M/S/C (Kazan/Nevandro): Approve Reference No. 510, Pediatric Patient Destination.

5.2 Reference No. 516, Return of Spontaneous Circulation (ROSC) Patient Destination (Paula Rashi)

Policy reviewed and approved as written.

M/S/C (Berkuta/Leasure): Approve Reference No. 516, Return of Spontaneous Circulation (ROSC) Patient Destination.

5.3 Reference No. 911, Public Safety First Aid (PSFA) and Basic Tactical Casualty Care (BTCC) Training Program Requirements (Richard Tadeo, Cathy Chidester, David Wells)

Policy reviewed and approved as written.

M/S/C (Hogan/Murrey): Approve Reference No. 911, Public Safety First Aid (PSFA) and Basic Tactical Casualty Care (BTCC) Training Program Requirements.

6. OPEN DISCUSSION:

None.

7. NEXT MEETING: December 21, 2016

8. ADJOURNMENT: Meeting adjourned at 1:58 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELESSUBJECT: **PUBLIC SAFETY FIRST AID (PSFA) AND
BASIC TACTICAL CASUALTY CARE (BTCC)
TRAINING PROGRAM REQUIREMENTS**

REFERENCE NO. 911

PURPOSE: To establish procedures for public safety agencies in Los Angeles County to obtain approval for a Public Safety First Aid and/or BTCC training program and requirements to maintain program approval.

AUTHORITY: California Code of Regulations, Title 22, Chapter 1.5
Health and Safety Code, Div. 2.5, Section 1797, et seq.
Training Standards for Basic Tactical Casualty Care and Coordination with
EMS during Terrorism Incidents (EMSA #170)

DEFINITIONS:

Approved PSFA and/or BTCC Training Program: A public safety agency in Los Angeles County that has been approved by the EMS Agency or the EMS Authority to train personnel in public safety first aid and/or basic tactical casualty care first aid.

Public Safety Personnel: Firefighter, lifeguard (of a municipality), or peace officer (as defined by section 830 of the Penal Code) not employed as an EMT.

Tamper Resistant: A procedure or technique to prevent alteration, fraud or forgery of a document designed by the PSFA and BTCC training program.

PRINCIPLES:

1. Only public safety agencies that employ public safety personnel are eligible to apply for approval of a PSFA and/or BTCC training program.
2. Training and competency evaluation for all personnel shall meet the minimum requirements set forth by the California EMS Authority and the Los Angeles County EMS Agency.
3. Instructors must have adequate training, credentials and/or experience in educational content and methodology in order to ensure that courses adequately address the educational requirements and needs of the personnel.

POLICY:**I. TRAINING PROGRAM APPROVAL**

The EMS Agency has the primary responsibility for approving and monitoring the performance of Public Safety First Aid and BTCC Training Programs in Los Angeles County to ensure compliance with local policies, statutes, regulations and guidelines.

EFFECTIVE: XX-XX-16
REVISED: New
SUPERSEDES: N/A

PAGE 1 OF 7

APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

A. Approval Process:

1. The EMS Agency shall be the approving agency for non-state public safety agency PSFA and/or BTCC training programs whose headquarters are located within Los Angeles County.
2. The California EMS Authority shall be the approving agency for PSFA and BTCC training programs for state public safety agencies.
3. Program approval may be granted up to four (4) years from the last day of the month in which the application is approved. This approval is not transferable from person to person or organization to organization.

B. Training Program Application Process:

1. Interested public safety agencies shall obtain a PSFA and BTCC training program application packet from the EMS Agency website.
2. Courses shall not be advertised or offered until approval has been granted.
3. The application packet shall contain:
 - a. A complete training program application signed by the program director identifying which program(s) applying for approval.
 - b. Curriculum vitae and copies of applicable licenses and certifications of the program director and instructors.
 - c. A complete training program meeting the requirements set forth in California Code of Regulations, Title 22, Chapter 1.5 and/or EMSA Guideline #170 to include but not limited to:
 - i. Course schedule
 - ii. Instructional objectives
 - iii. Lessons/training
 - iv. Written and skills performance evaluations with:
 1. Answer key
 2. Passing criteria
 - d. A letter or memo, signed by the program director or Chief for the PSFA training program, which states:
 - i. All personnel will be trained in CPR equivalent to BLS for the Healthcare Provider (American Heart Association) or Professional Rescuer (American Red Cross)
 - ii. Training will be competency based and consist of no less than eight hours for retraining.
 - iii. Retraining and evaluation of competency of all personnel will be performed every two years.

- e. A letter or memo, signed by the program director or Chief for the PSFA and BTCC training programs that all personnel shall receive a copy of trauma center locations in Los Angeles County provided by the EMS Agency.
 - f. A copy of the attendance record or description of the on-line registration process and tracking of course completion requirements.
 - g. A copy of the course completion certificate.
 - 4. The EMS Agency shall notify the applicant within thirty (30) days that the application was received and specify missing information. Failure to submit missing information within thirty (30) calendar days of notification will result in denial of the program.
 - 5. The EMS Agency shall notify the applicant in writing within sixty (60) days from the receipt of a complete application of the decision to approve or deny. The application is only considered for approval if it is complete and all requirements are met.
 - 6. The EMS Agency may deny an application for cause as specified in subsection I.C.2.
- C. Denial/Revocation/Probation of a Training Program
- 1. The EMS Agency may, for cause:
 - a. Deny any provider application
 - b. Revoke provider approval
 - c. Place provider on probation
 - 2. Causes for these actions include, but are not limited to the following:
 - a. Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any of the terms of the California Code of Regulations, Title 22, Chapter 1.5; the California Health and Safety Code, Division 2.5, EMSA Guideline #170; or Los Angeles County Emergency Medical Services Prehospital Care Policies.
 - b. Failure to correct identified deficiencies within the specified length of time after receiving written notices from the EMS Agency.
 - c. Misrepresentation of any fact by a provider or applicant of any required information.
 - 3. The EMS Agency may take such action(s) as it deems appropriate after giving written notice and specifying the reason(s) for denial, revocation, or probation.

SUBJECT: **PUBLIC SAFETY FIRST AID AND
BASIC TACTICAL CASUALTY CARE (BTCC)
TRAINING PROGRAM REQUIREMENTS**

REFERENCE NO. 911

-
4. If a program approval is revoked, training provided after the date of action shall be invalid.
 5. A training program is ineligible to reapply for approval following a denial or revocation for a minimum of 6 months.
 6. If a training program is placed on probation, the terms of probation, including approval of an appropriate corrective action plan, shall be determined by the EMS Agency. During the probationary period, prior approval of all courses offered must be obtained. Course documents must be submitted to the EMS Agency at least thirty (30) days prior to each course being offered. Written notification of course approval shall be sent to the training program within fifteen (15) days of the receipt of the request. Renewal of the training program approval is contingent upon completion of the probationary period.

D. Notification

The EMS Agency shall notify the California EMS Authority of each training program approved, denied or revoked within their jurisdiction within thirty (30) days of action.

II. TRAINING PROGRAM RENEWAL

- A. PSFA and BTCC Training Programs shall be renewed if the provider applies for renewal and demonstrates compliance with the requirements of this policy.
- B. The training program must submit a complete application packet for renewal sixty (60) calendar days prior to the expiration date in order to maintain continuous training program approval.

III. TRAINING PROGRAM REQUIREMENTS

- A. Approved training programs shall ensure that:
 1. The content of all PSFA and/or BTCC training is relevant, enhances the practice of prehospital emergency medical care, and is related to the knowledge base or technical skills required for the practice of PSFA and/or BTCC.
 2. All records are maintained as outlined in this policy.
 3. The EMS Agency is notified within thirty (30) calendar days of any change in name, address, telephone number, or program director.
 4. All records are available to the EMS Agency upon request.
 5. The training program is in compliance with all policies and procedures.
- B. A training program may be subject to scheduled site visits by the EMS Agency for program audits.
- C. Individual classes/courses are open for scheduled or unscheduled visits/educational audits by the EMS Agency and/or the local EMS Agency in whose jurisdiction the course is conducted.

IV. TRAINING PROGRAM-STAFF REQUIREMENTS

Each training program shall designate a program director and instructor(s) who meet the requirements. Nothing in this section precludes the same individual from being responsible for more than one function.

A. Program Director

Each training program shall have an approved program director that shall provide administrative direction and is qualified by education and experience in program development, methods, materials and evaluation of instruction.

1. Program director's qualifications by education and experience shall be documented by 40 hours of training in teaching methodology such as:
 - a. Four (4) semester units of upper division credit in educational materials, methods and curriculum development or equivalent OR
 - b. California State Fire Marshall (CSFM) "Training Instructor 1A, 1B, and 1C" OR
 - c. National Association of EMS Educators "EMS Educator Course" OR
 - d. POST Academy Instructor Certificate Program – Level 1

NOTE: New program requests shall meet this requirement upon submission of application for approval. Current approved programs may receive provisional status up to one year in order to meet this requirement with approval for change in personnel.

2. The duties of the program director shall include, but are not limited to:
 - a. Administering the PSFA and/or BTCC program and ensuring adherence to state regulations, guidelines and established EMS Agency policies
 - b. Approving all methods of evaluation
 - c. Approving instructor(s)
 - d. Signing all course completion records and maintaining those records in a manner consistent with this policy
 - e. Attending the mandatory EMS Agency Orientation Program within six (6) months of approval as the program director
 - f. Attending all mandatory PSFA and/or BTCC program updates
 - g. Act as a liaison to the EMS Agency

B. Instructor

Each training program shall submit instructors for approval by the EMS Agency as qualified to teach the topics assigned.

1. Instructor qualifications shall be based on one of the following:
 - a. Currently licensed or certified in their area of expertise, OR
 - b. Have evidence of specialized training which may include, but is not limited to, a certificate of training or advanced education in a given subject area, OR
 - c. Have at least one (1) year of experience, within the last two (2) years, in the specialized area in which they are teaching, OR
 - d. Be knowledgeable, skilled and current in the subject matter of the course or activity

VII. CO-SPONSORING A COURSE

When two or more PSFA and/or BTCC training programs co-sponsor a course, only one approved training program provider shall be used for that course, and that program assumes the responsibility for all training requirements.

X. EDUCATION ATTENDANCE RECORD

- A. An Education Attendance record must be completed for all training provided. Each student must sign an attendance record or register online in order to receive credit.
- B. The information on the Education Attendance Record must contain all the elements set forth in the PSFA and BTCC training program application packet.
- C. Attendees shall sign in or register only for themselves. Signing for another individual is strictly prohibited and subject to action.
- D. The original Attendance Record shall be maintained by the provider. A legible copy (unless the original is requested) of the following attendance records shall be submitted to the Office of Program Approvals within fourteen (14) days of a request unless a specific time frame is specified by the EMS Agency.

XI. COURSE COMPLETION CERTIFICATES AND DOCUMENTS

Providers shall issue a tamper resistant document (method determined by the training program) and contain all the elements set forth in the training program application packet as proof of successful completion of a course within thirty (30) calendar days.

XII. RECORD KEEPING

Each training program shall maintain the following records on file:

- A. Original written and skills performance evaluation and answer key

- B. Course Schedule
- C. Attendance Record.
- D. Curriculum vitae or resume from each instructor providing the course, class or activity, and verification that the instructor is qualified to teach the topics assigned, or have evidence of specialized training which may include, but is not limited to, a certificate of training or an advanced degree in a given subject, or have at least one year of experience within the last two years in the specialized area in which they are teaching, or be knowledgeable, skillful and current in the subject matter of the course, class or activity.
- E. Copies of all program materials and handouts provided
- F. Original or summary of performance evaluations administered
- G. Documentation of course completion certificates issued
- H. All records shall be maintained for four (4) years
- I. All records must be available when audits are conducted or upon request

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 504, **Trauma Patient Destination**

Ref. No. 840, **Medical Support During Tactical Operations**

Los Angeles County EMS Agency, PSFA and BTCC Training Program Application Packet

California EMS Authority, Training Standards for Basic Tactical Casualty Care and Coordination with EMS during Terrorism Incidents, 2016 (EMSA #170)

November 1, 2016



**Los Angeles County
Board of Supervisors**

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Mitchell H. Katz, M.D.
Director, Health Agency

Jonathan E. Sherin, M.D., Ph.D.
Director, Department of Mental Health

Cynthia A Harding, M.P.H.
Interim Director, Department of Public Health

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"The mission of the Los Angeles County Health Agency is to improve health and wellness across Los Angeles County through effective, integrated, comprehensive, culturally appropriate services, programs, and policies that promote healthy people living in healthy communities."



The Honorable Ed Hernandez
Member, California State Senate
State Capitol, Room 2080
Sacramento, CA 95814

Dear Senator Hernandez,

It was a pleasure to see you at the Partnership for Quality of Care. I enjoyed your presentation and agreed with your perspective on the difficulty of dealing with drug prices at a state level, as well as the challenges of making policy via the voter initiative process.

As I mentioned to you I have been working with the Los Angeles County Medical Society and the broader Emergency Medical Services (EMS) community on trying to enable paramedics/EMTs responding to 9-1-1 calls to take patients to the most appropriate facility in the county. This is particularly important for patients experiencing mental health crises or who are inebriated. Los Angeles County has several mental health urgent care facilities which would be the preferable destination for those with mental health crises that are not complicated by other active medical conditions. We are about to open a sobering center which would be the ideal place for someone who is inebriated. At the current time our ambulances can only take these patients to the emergency department of a hospital, even though this is more expensive, and less appropriate for many patients.

This problem could be resolved at no cost to the state by a bill that said: "Ambulances responding to 9-1-1 calls may take patients to a mental health urgent care or to a sobering center, if available in the county, and if in the judgment of the paramedic/EMT it is the most appropriate setting, subject to each county's EMS destination policy. Counties will ensure that such facilities, if included in their destination plans, have appropriate personnel to triage and arrange transport of any such patients to a hospital, if needed".

You and your staff would know best the likelihood of success of such a bill, but as Chair of the Health Committee, and health professional, I am sure people will be interested in your opinion.

Any guidance or feedback that you or your staff could provide would be welcomed. Meanwhile, I appreciate all the work you do on behalf of Californians.

Best wishes,


Mitchell H. Katz, M.D.
Health Agency Director

MHK:mm

c: Sachi Hamai, Chief Executive Officer
Manuel Rivas, Assistant Chief Executive Officer
Donna Seitz, Legislative Advocate
Cathy Chidester, EMS Agency Director

**ANNUAL REPORT
TO THE
BOARD OF SUPERVISORS**



EMERGENCY MEDICAL SERVICES COMMISSION

JULY 1, 2015 – JUNE 30, 2016

INTRODUCTION

The Emergency Medical Services (EMS) Commission was established by the Board of Supervisors in October 1979 under Ordinance No. 12332 of the County Code, Chapter 3.20. The EMS Commission performs the functions of the Emergency Medical Care Committee as defined in the Health and Safety Code, Section 1797.270, et seq.

The EMS Commission acts in an advisory capacity to the Board of Supervisors and the Director of Health Services regarding County policies, programs, and standards for emergency medical services, including paramedic services throughout Los Angeles County.

The EMS Commission is comprised of 19 members appointed by the Board of Supervisors of which five members are public members representing each of the County Supervisorial Districts. Each of these 19 members serves a four year term at the pleasure of the Board of Supervisors and may not serve more than two consecutive four-year terms as stipulated in the EMS Commission Bylaws. The Board of Supervisors can authorize a commissioner to serve beyond the two-consecutive terms upon request.

The EMS Commission meetings are held on the third Wednesday of each odd month at 1:00 PM in the EMS Commission Hearing Room, 10100 Pioneer Boulevard, 1st Floor, Santa Fe Springs, CA 90670 and are open to the public. The EMS Agency is conveniently located in the same building on the 2nd Floor.

DUTIES

The Commission performs the functions of the Emergency Medical Care Committee as defined in Sections 1750 et seq. of the Health and Safety Code and shall have the following duties:

- Act in an advisory capacity to the Board of Supervisors and the Director of Health Services regarding County policies, programs, and standards for emergency medical care services throughout the County, including paramedic services.
- Establish appropriate criteria for evaluation and conduct continuous evaluations on the basis of these criteria of the impact and quality of emergency medical care services throughout Los Angeles County.
- Conduct studies of particular elements of the emergency medical care system as requested by the Board of Supervisors, the Director of Health Services or on its own initiative; delineate problems and deficiencies and to recommend appropriate solutions.
- Acquire and analyze the information necessary for measuring the impact and the quality of emergency medical care services.
- Report its findings, conclusions and recommendations to the Board of Supervisors at least every twelve months.
- Review and comment on plans and proposals for emergency medical care services prepared by County departments.
- Recommend, when the need arises, that Los Angeles County engage Independent contractors for the performance of specialized, temporary, or occasional services to the Commission which cannot be performed by members of the classified service, and for which the County otherwise has the authority to contract.
- Advise the Director and the Department of Health Services on the Policies, procedures, and standards to control the certification of mobile intensive care nurses and

paramedics. Proposals of any public or private organization to initiate or modify a program of paramedic services or training

EMERGENCY MEDICAL SERVICES COMMISSIONERS



**Clayton Kazan,
M.D.**



**Erick H.
Cheung, M.D.,
Vice Chair**



**Chief Robert E.
Barnes**



**Mr. Frank
Binch**

No
photo

**Lt. Brian S.
Rivler**



**Robert
Flachman**



**John C.
Hisserich, Dr.**



**James Lott,
Psy.D.**

No
photo

**FF/Paramedic
Paul Rodriguez**

No
photo

**Margaret
Peterson Ph.D.**



**Nerses Sanossian,
MD FAHA**



**Carole A.
Snyder, RN**

No
photo

**Fire Chief David
White**



**Mr. Colin
Tudor**



**Mr. Gary
Washburn**

VANCANCIES

Public Member, First Supervisorial
District



**Ms. Cathy
Chidester**



**Ms. Marilyn
Bidgood**

Vacancies

Public Member, First Supervisorial District
Southern California Chapter-American College of Surgeons
Southern California Public Health Association

New Appointments

Mr. Robert Ower (12/15/2015)	L. A. County Ambulance Association
Lt. Brian Scott Bixler (2/23/2016)	Peace Officers Association of LA
County	
Chief David White (1/19/2016)	L.A. Area Fire Chiefs' Association
FF/Paramedic Paul S. Rodriguez (4/5/2016)	CA State Firefighters' Association

Re-Appointments

Mr. Frank Binch
Erick H. Cheung, M.D.
John Hisserich, Dr. PH.
James Lott, PsyD., MBA
Margaret Peterson, PH.D.
Nerses Sanossian, M.D.
Carole Snyder, RN

Resignations

Mr. David Austin (11/19/2015)	L. A. County Ambulance Association
Lt. Andres Ramirez (11/19/2015)	Peace Officers Association of LA
County	
Chief Jon Thompson (11/19/2015)	L.A. Area Fire Chiefs' Association
Chief Raymond Mosack (1/20/2016)	CA State Firefighters' Association
Mr. Bernard Weintraub (4/1/2016)	So CA Public Health Association

Elected Officers

Clayton Kazan, M.D., Chair	1/21/2015 – Present
Erick Cheung, M.D., Vice Chair	1/21/2015 – Present

Areas of Discussion

- Community Paramedicine Pilot Project in the County (ongoing)
- 1+1 Paramedic Staffing Model
- Physician Services for Indigent Program – Proposed increase of the reimbursement rate for Fiscal Year 2015-2016
- Transport of 5150 Patients: The EMSC recommended that an ad hoc committee be identified to develop a blueprint for addressing behavioral emergencies in the prehospital setting. Meeting have been ongoing throughout the year. (ongoing)
- Active legislation of interest to EMS

Accomplishments

- The Los Angeles Surgical Society which is represented on the EMS Commission ceased to exist. The EMS Agency drafted an ordinance change to the Board of Supervisors to fill the vacancy with a practicing trauma surgeon affiliated with the Southern California

Chapter of the American College of Surgeons (ACS). The Ordinance change was adopted by the Board of Supervisors on February 11, 2016.

- A mandatory public hearing was held in conjunction with the September 16, 2015 regular meeting of the EMS Commission to discuss a proposed Physician Services for Indigent Program (PSIP) increase of the reimbursement rate for Fiscal Year 2015-2016
- Approved the 2014-2015 Annual Report of the EMS Commission at the September 16, 2015 meeting
- Recognized key players in the Community Paramedicine pilot project at the November 18, 2015 meeting; also upon his departure from the EMS Commission, Commissioner David Austin, representing the Los Angeles County Ambulance Association was honored for his many years of service to the EMS Commission and the EMS community
- The Commission approved development of an Ad Hoc Committee on November 18, 2015, to address the Prehospital Care of Mental Health and Substance Use. The Ad Hoc Committee has been meeting and working on a report that will provide a *blue print* for management of behavioral emergencies in a prehospital setting.

Recommendations

- The Commission recommended that the EMS Agency work with the Chairman and Vice Chairman of the EMS Commission to identify proper stakeholders to serve on an ad hoc committee to develop recommendations for management of behavioral emergencies in the prehospital setting.

Policies Approved by the Commission

The Commission approved 35 Prehospital Care Policies between July 1, 2015 and May 31, 2016.

Advisory Committees to the EMS Commission

Base Hospital Advisory Committee

MISSION:

The Base Hospital Advisory Committee is responsible for all matters regarding MICN certification and policy development pertinent to the practice, operation and administration of prehospital care.

2015 Commissioners

Carole Snyder- Chair
James Lott- Vice Chair

2016 Commissioners

Carole Snyder- Chair
Margaret Peterson, Ph.D. - Vice Chair

Meetings

August 10, 2015 - Meeting Canceled
October 12, 2015
December 14, 2015
February 10, 2016
April 13, 2016
June 8, 2016

SUMMARY OF COMMITTEE ACTIVITIES

Prehospital Care Policies/Treatment Protocols/Medical Control Guidelines Activity

During this fiscal year, the Base Hospital Advisory Committee (BHAC) reviewed and took action on 34 prehospital care policies. Thirty-three policies were approved and one policy was deleted.

EMS Update 2016

EMS Update 2016 was an instructor-based module.

The final topics compiled by the EMS Update 2016 Work Group included:

- Provider Impression
- Anaphylaxis
- Comprehensive Stroke Centers
- Documentation
- Pediatric Resuscitation
- Ventricular Assist Device
- Hypertension in Pregnancy
- Emerging Infectious Diseases
- Surge Plans
- Hemostatic Agents
- Needle Thoracostomy
- 911 Re-Triage

Stroke Program Update

Revised stroke standards were developed, to include specific standards for Comprehensive Stroke Centers. As of June 30, 2016 there were 43 Primary Stroke Centers approved for transportation of 9-1-1 patients with stroke symptoms, three of which are located outside of Los Angeles County.

Data Advisory Committee

MISSION:

The Data Advisory Committee is responsible for all matters regarding quality of prehospital data, report generation, prehospital research and policy development impacting TEMIS.

2015 Commissioners

Robert Flashman –Chair
Ray Mosack – Vice Chair

2016 Commissioners

Nerses Sanossian – Chair
John Hisserich – Vice Chair

Membership Changes

- New Medical Council representative Dipesh Patel, MD effective July 2015
- New Provider Agency Advisory Committee representative Corey Rose, effective December 2015
- New Hospital Association of Southern California (HASC) representative Ryan Burgess, effective June 2015 and new HASC alternate Nathan McNeil, effective June 2015
- Base Hospital Advisory Committee representative Mark Baltau resigned position, replaced by Gloria Guerra, effective June 2016

Meetings

August 12, 2015
October 14, 2015
December 9, 2015
February 10, 2016
April 13, 2016
June 8, 2016 – Cancelled due to lack of agenda items

SUMMARY OF COMMITTEE ACTIVITIES

Prehospital Care Policies Activity

Reference No. 622-622.5 *Data Requests* and *Data Use Agreement* reviewed

Data submission verification and cleanup

Developed data reports that will be sent to the public providers on a quarterly basis to assist with data verification and cleanup

Education Advisory Committee

MISSION:

The Education Advisory committee is responsible for all matters regarding issues and policies pertinent to EMS curriculum and program development, implementation and evaluation.

2015 Commissioners

Andres Ramirez - Chair
Frank Binch - Vice-Chair
Gary Washburn – Commissioner
Bernard Weintraub -Commissioner

2016 Commissioners

Frank Binch - Chair
Gary Washburn – Vice Chair
Bernard Weintraub -Commissioner

Meetings:

August 19, 2015 – meeting canceled due to lack of agenda items
October 21, 2015
December 16, 2015 – meeting canceled due to lack of agenda items
February 17, 2017 - meeting canceled due to lack of agenda items
April 20, 2016 - meeting canceled due to lack of agenda items
June 15, 2016 – no quorum

SUMMARY OF COMMITTEE ACTIVITIES

Nothing to report. The Education Advisory committee is responsible for issues and policies pertinent to EMS curriculum implementation and evaluation. This advisory committee is scheduled to meet every other month on the even months. In Fiscal Year 2015-2016, the committee met once. Four meetings were canceled due to a lack of agenda items. The June 2016 meeting was scheduled but failed to obtain a quorum. The committee received updates on EMS Update, system-wide QI studies and the California EMS System Core Measures report.

Provider Agency Advisory Committee

MISSION:

The Provider Agency Advisory Committee is responsible for all matters regarding prehospital licensure, certification/accreditation, and policy development (and revision) pertinent to the practice, operation and administration of prehospital care.

2015 Commissioners

Dave Austin - Chair
Robert Barnes - Vice Chair
Jon Thompson - Commissioner
Clayton Kazan, MD - Commissioner

2016 Commissioners

Dave Austin - Chair
Robert Ower – Vice Chair

During the fiscal year, this Committee included six different Commissioners; representatives from each major fire department and the seven public geographic regions. Membership also included one currently employed paramedic coordinator, one prehospital care coordinator; one public sector paramedic; one private sector paramedic; one provider agency Medical Director and one critical care transport nurse coordinator.

Meetings

August 19, 2015
October 21, 2015
December 16, 2015
February 17, 2016
April 20, 2016
June 15, 2016

SUMMARY OF COMMITTEE ACTIVITIES

Prehospital Care Policies/Treatment Protocols/Medical Control Guidelines Activity

During this fiscal year, the Provider Agency Advisory Committee reviewed and took action on 42 prehospital care policies. Forty policies were approved, one policy was deleted and currently, one policy is tabled.

Topics of discussion included issues related to the Middle Eastern Respiratory Syndrome (MERS); Community Paramedicine programs; and the implementation of Comprehensive Stroke Centers within Los Angeles County. This Committee also said good bye to the EMS Agency's Medical Director, William Koenig, MD and welcomed the new Medical Director, Marianne Gausche-Hill, MD.



LOS ANGELES COUNTY
Emergency Medical Services Commission

**Ad Hoc Committee
On
The Prehospital Care of
Mental Health and Substance Abuse Emergencies**

FINAL REPORT

September 2016



Prehospital Care of Mental Health and Substance Abuse Emergencies

Ad Hoc Committee Participants

Frank Binch

EMS Commissioner
Representing the 4th Supervisorial District

Brian Bixler

Los Angeles Police Department
EMS Commissioner
Representing the Peace Officers Association

Annadenise Briz

Los Angeles County Sheriff Department

Miriam Brown

Mental Health Clinical Program Manager III
Los Angeles County Department of Mental Health

Irma Castaneda, Ph.D.

Deputy Director, Emergency Outreach
Los Angeles County Department of Mental Health

Cathy Chidester, RN, MSN

Director, EMS Agency
Executive Director, EMS Commission

Erick Cheung, M.D.

Medical Director, UCLA Psychiatric Emergency Services
Vice Chair, EMS Commission
Representing the Southern California
Psychiatric Society

Herman DeBose, MSW, Ph.D.

Commissioner
Los Angeles County Mental Health Commission

Kay Fruhwirth, RN, MSN

Assistant Director, EMS Agency

Jaime Garcia

Regional Vice President
Hospital Association of Southern California

Larry Gasco

Commissioner
Los Angeles County Mental Health Commission

Marianne Gausche-Hill, M.D., FACEP, FAAP

Medical Director, EMS Agency

Bob Baker

Los Angeles County District Attorney

Clayton Kazan, M.D.

Medical Director, Los Angeles County Fire Department
Chair, EMS Commission
Representing the California Chapter of the American
College of Emergency Physicians

Ken Liebman

General Manager, AMR
Representing Los Angeles Ambulance Association

Sheila Mallet, RN

Nursing Director, Emergency Services
LAC+USC Psychiatric Emergency Services

Rick Moreno

Deputy Chief EMS Bureau
Los Angeles County Fire Department

Luana Murphy, MBA

President/Chief Executive Officer
Exodus Recovery

Martha Mullen, RN, MSN

Emergency Nurses Association

Rita Murray

Member, National Alliance on Mental Illness(NAMI)
Los Angeles County Council
President, NAMI Whittier
Representing NAMI Los Angeles County Council

Roderick Shaner, M.D.

Medical Director
Los Angeles County Department of Mental Health

Kathy Shoemaker, RN

Senior Vice President
Clinical Services/Urgent Care Centers Exodus Recovery

Jim Smith

Police Chief, Monterey Park
Representing Los Angeles Police Chiefs Association

Gary Tsai, M.D.

Medical Director and Science Officer
Substance Abuse Prevention and Control
Los Angeles County Department of Public Health

Dave White

Fire Chief, Culver City
EMS Commissioner
Representing Los Angeles Area Fire Chiefs Association

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Introduction

The Ad Hoc Committee on the Prehospital Care of Mental Health and Substance Abuse ^{a, b} (MH/SA) Emergencies was created by a motion of the Los Angeles County Emergency Medical Services Commission (EMSC) on November 18, 2015 to address two broad goals:

- 1) To evaluate the current manner in which MH/SA emergencies are handled by the 9-1-1 system, and
- 2) To propose a short and long term vision to improve the quality of care and safety for the patients, families, neighbors and first responders.

Among the types of medical problems for which the public calls for an emergency response, MH/SA emergencies are unique as they involve a patchwork of various healthcare providers (not just EMS and paramedics) and law enforcement (LE) agencies.

As the result of the clear challenges in responding to MH/SA emergencies, several of the field response entities in Los Angeles have been developing individualized strategies to cope with the rising volume, complexity, and lack of resources for MH/SA patients. While noble and necessary, this has not resolved the problem of fragmentation of resources, nor the lack of uniform standards in the care provided.

The EMSC Ad Hoc Committee (hereafter referred to as the Committee) was composed of stakeholders from diverse disciplines and agencies through Los Angeles including:

- Los Angeles County Department of Health Services Emergency Medical Services (EMS) Agency
- Los Angeles Police Department (LAPD)
- Los Angeles County Sheriff's Department (LASD)
- Los Angeles Ambulance Association
- National Alliance on Mental Illness (NAMI)
- Los Angeles County Department of Mental Health (DMH)
- Los Angeles County Department of Public Health (DPH)
- California Branch of American College of Emergency Physicians (CAL-ACEP)
- Southern California Psychiatric Society
- Hospital Association of Southern California (HASC)
- LA Care
- HealthNet
- Board of Supervisors
- Exodus Mental Health Urgent Care Center (MHUCC)
- Los Angeles County Fire Department
- Los Angeles Area Fire Chiefs' Association
- Los Angeles County Mental Health Commission
- LAC+USC Medical Center Psychiatric Emergency Services
- Los Angeles County Police Chiefs' Association
- California State Firefighters' Association
- Peace Officers' Association of Los Angeles County
- Emergency Nurses Association

^aThe term substance abuse (SA) as used in this document is interchangeable with the term substance use disorder and both are used to define a dependence on alcohol and/or drugs that is accompanied by intense and sometimes uncontrollable cravings and compulsive behaviors to obtain the substance.

^bWhen using the term mental health and substance abuse (MH/SA) in this document it is acknowledged that the field responder's are providing "impressions" based on the person's exhibited behavior and history and not necessarily providing a diagnosis.

Background

There is substantial evidence to indicate that problems with the emergency care for patients with MH/SA emergencies are aggravated by the lack of coordination and integration of emergency, mental health, and substance abuse services. Experts have written about the significant dysfunction within each of the respective systems.

Emergency Department Services

The Institute of Medicine, in their landmark series of reports issued in 2006, strongly warned that emergency care in the United States (U.S.) is fragmented, underfunded, under-resourced, over-utilized, and overcrowded (see appendix for IOM key findings fact sheet). The demand for emergency care in the U.S. has grown rapidly; between 1993 and 2003 emergency department (ED) visits increased by 26%¹. Meanwhile the number of EDs declined by 425.

Mental Health Services

At the same time, America's MH/SA systems have seen decades of severe contraction of acute care services (i.e. inpatient psychiatric hospital beds). Well-intentioned efforts to de-criminalize and de-institutionalize mental illness and substance abuse and remove afflicted individuals from jails, and an overall lack of availability and access to timely and appropriate community MH/SA services² compound the demand for services.

It is critical to understand the magnitude of people who suffer from mental illness and/or substance abuse. The burden of mental illness in the U.S. is great. Almost one in four adults suffers from a diagnosable mental disorder in any given year, and between 5% and 7% of adults suffer from a severe mental illness (SMI)^{3,4}. The California Department of Mental Health estimated in 2007 that there were nearly two million people in the State of California in need of mental health services for SMI³. According to the California Health Care Foundation, 1 in 20 California adults suffers from a serious mental illness that causes substantial impairment in carrying out major life activities⁵. Mental illness is a leading cause of disability and suicide, and carries large social, economic, and personal costs^{2,4}.

Pediatric MH/SA Services:

The burden of MH/SA disorders in the pediatric and adolescent population, defined as <18 years of age, is large. In the United States 23% of children and adolescents have a MH/SA disorder and in the emergency settings nearly 70% of children and adolescents screen positive for at least one mental health disorder.^{6,7}

Few emergency care providers have significant clinical experience with evaluating children and adolescents with MH/SA disorders and yet EMS and emergency department physicians are often faced with managing these children, performing a medical clearance evaluation, and referring them to limited inpatient and outpatient psychiatric services. A number of barriers exist to the provision of mental health services to children in emergency care systems. These barriers include knowledge gaps in pediatric psychiatric illness by emergency care providers, limitations of the prehospital and

ED settings to provide comprehensive evaluation, and lack of access to pediatric inpatient and outpatient mental health services.⁸

Substance Use Disorders Services

In California, approximately 2.3 million Californians need substance use disorder treatment, while only about 10% receive such care [Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009-2013]. Meanwhile, the number of people who need access to addiction substance abuse treatment through Medi-Cal is increasing and person with untreated substance use disorders are among the highest users of publicly funded health services. Additionally, billions of dollars are lost every year due to direct and indirect costs of addiction.

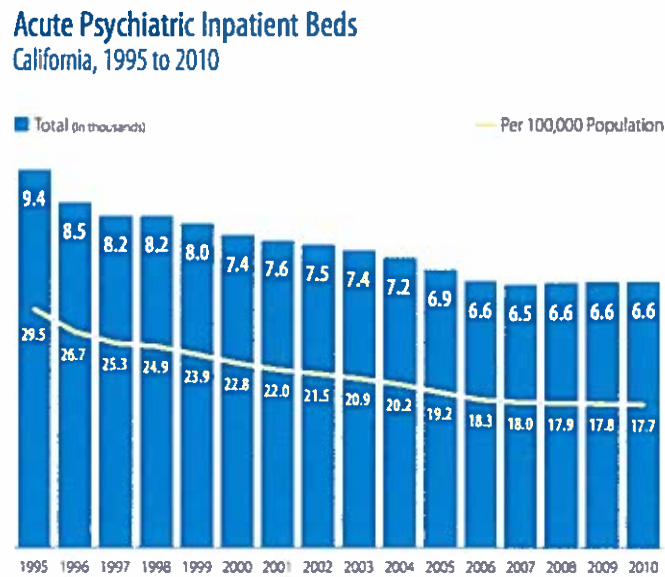
Resources for substance use disorders are limited. There are currently approximately 300 substance use disorder providers located throughout LA County, comprised of approximately 100 residential withdrawal management beds, 1,200 short term residential treatment beds, 3,000 intensive outpatient and outpatient treatment slots and 5,000 opioid treatment program slots (Substance Abuse Prevention and Control, LA County DPH). In LA County, approximately 18% of individuals who might need substance use treatment actually receive treatment. Although this penetration rate is higher than the 10% national average reported by SAMHSA, this data still demonstrates that the vast majority of individuals who would benefit from substance use treatment are not receiving it. Given that individuals with substance use disorders incur two to three times the total medical expenses of people without these conditions¹², and die an average of 26.1 years younger than the general population¹³, this lack of treatment contributes to significant economic and human loss.

MH/SA Services in Emergency Departments

When MH/SA services and supports are unavailable or poorly coordinated, patients with unmet needs turn to the ED and the 9-1-1 system for care⁹. In the current healthcare delivery system, EDs are the only institutional providers required by federal law to evaluate anyone seeking care. In California, 8.4% of the population received care for a mental health problem in an ED in 2005, up from 2.7% in 2001¹⁰.

In a 2010 survey of California EDs, over 75% of respondents reported that lack of inpatient beds was the primary reason for mental health boarding (patients waiting in the ED to be admitted), ED overcrowding, and extended lengths of stay¹¹. Indeed, the reduction in psychiatric inpatient beds has been severe. In California between 1995 and 2011, there was a 30% decrease in psychiatric inpatient beds, from 9,353 to 6,367³. The psychiatric bed-to-population ratio has steadily declined to an all-time low of 16.76 beds per 100,000 California residents, corresponding to a shortfall of 4,000 psychiatric beds^{2,3} (see Figure 1).

Figure 1. Acute Psychiatric Inpatient Beds, California, 1995-2010 ⁵



Estimating the number of annual MH/SA visits to EDs in LA County has been challenging due to inconsistent data reporting. However, the current best estimate is that there are approximately 150,000 MH/SA visits to LA County EDs annually. Additionally, in calendar year 2013 there were 490,701 EMS transports with 21,106 patients having a "behavioral" chief complaint. This number does not include MH/SA patients transported by other responders: LE, psychiatric mobile response teams (PMRT) and psychiatric evaluation teams (PET).

Committee Objectives

Focusing on prehospital care for MH/SA emergencies, the Committee posed a fundamental question: What happens when a person in LA County calls 9-1-1 with a MH/SA emergency?

Unlike the response for medical emergencies, which could be generally characterized as predictably delivered and uniformly regulated^c, the response to MH/SA emergencies is comparatively varied and lacks the same coordinated delivery and regulation. The main source of variation lies in the fact that two very different entities, LE or EMS agencies, may be dispatched as a result of a 9-1-1 call. The LA County DMH “Access Line” is a third entity that may be called by the public to respond to a MH/SA emergency, though notably it is distinctly separate from the 9-1-1 system. A call to the DMH Access Line could potentially trigger specific mental health teams to respond.

A number of questions naturally follow:

- When does LE respond, when does EMS respond, and how is this decided?
- What are the differences or similarities in the LE, EMS and DMH response?
- Is one response better than the other in terms of patient care, or patient preference?
- Do LE and EMS responses lead to different standards of care or outcomes for patients?

It is in this current climate of increased demand and decreased availability of MH/SA and emergency services, that the Committee was tasked to assess the current prehospital care for MH/SA emergencies, as the first step in developing a blue print for system improvement.

The main objectives of the committee focused on:

1. Generating a clear and comprehensive map of the process by which MH/SA emergencies are managed in the LA County EMS system, from a person placing a 9-1-1 call to destination (i.e. where the patient will be transported to).
2. Providing a coherent description of the multiple agencies and entities that can potentially respond to MH/SA emergencies
3. Describing the critical decision points in the MH/SA field responses for LE and EMS
4. Identifying sources of data that demonstrate the availability of services, or lack thereof, and/or data that exemplify the strain on the system
5. Articulating principles for change and improvement in the MH/SA emergency response system in LA County
6. Recommending specific areas for potential intervention by the EMS Agency, LE and EMS agencies, LA County Officials, or others.

MH/SA FIELD RESPONSE MAPS

Figures 2 and 3 display the process for EMS and LE response to MH/SA emergencies. Though the process starts with a call to 9-1-1 in both cases, once a decision has been made to dispatch EMS vs. LE, the processes, decision points, resources, and disposition options are unique to each discipline.

A detailed appendix is located at the end of this document which corresponds to the shaded grey numerals in each field response map, providing descriptions, areas of need, comments, recommendations, and barriers to change.

Figure 2

Los Angeles County Mental Health and Substance Abuse Emergency Response System

Process Map : Law Enforcement Response to MH/SA Emergencies (Approved 06/06/16)

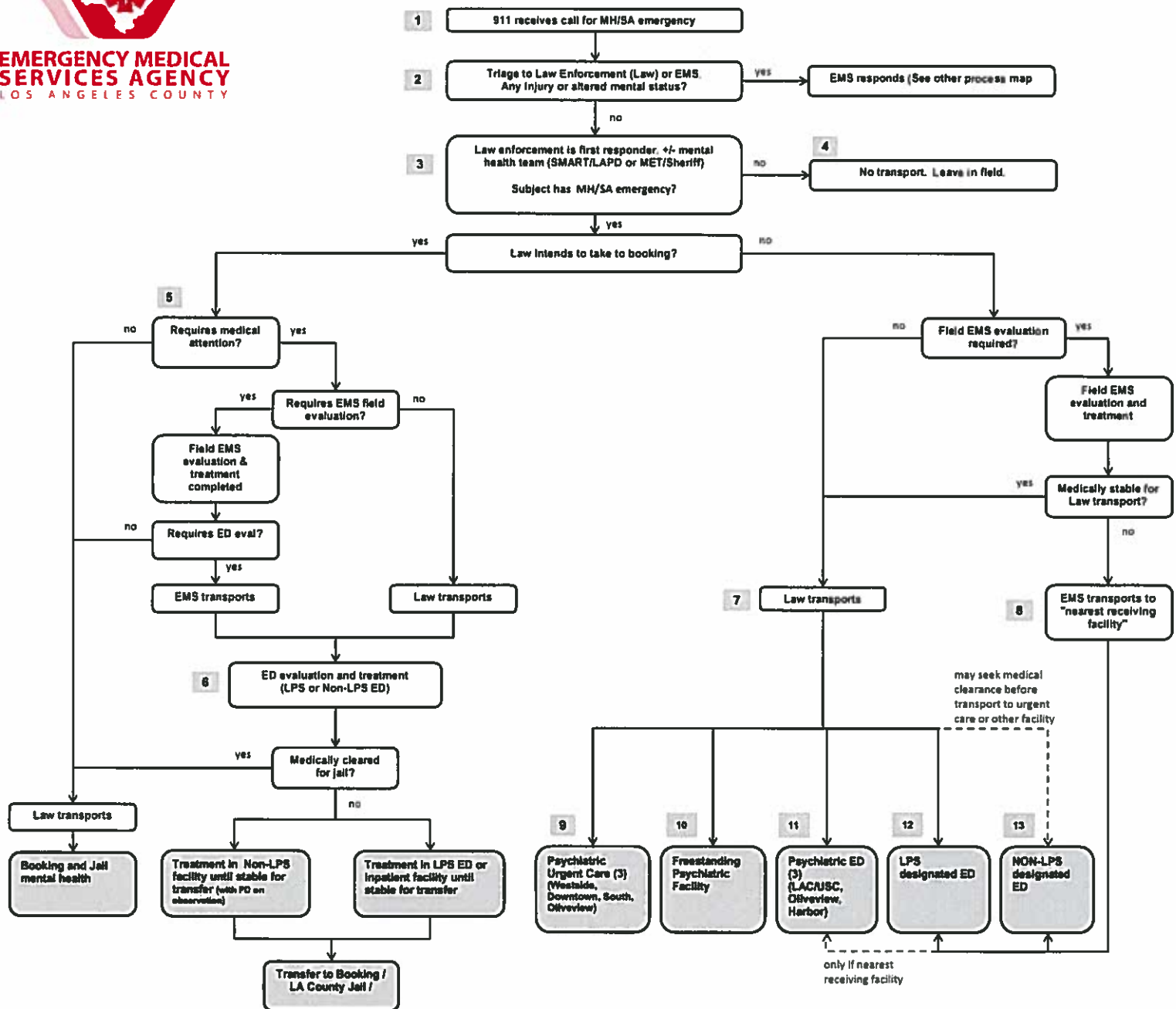
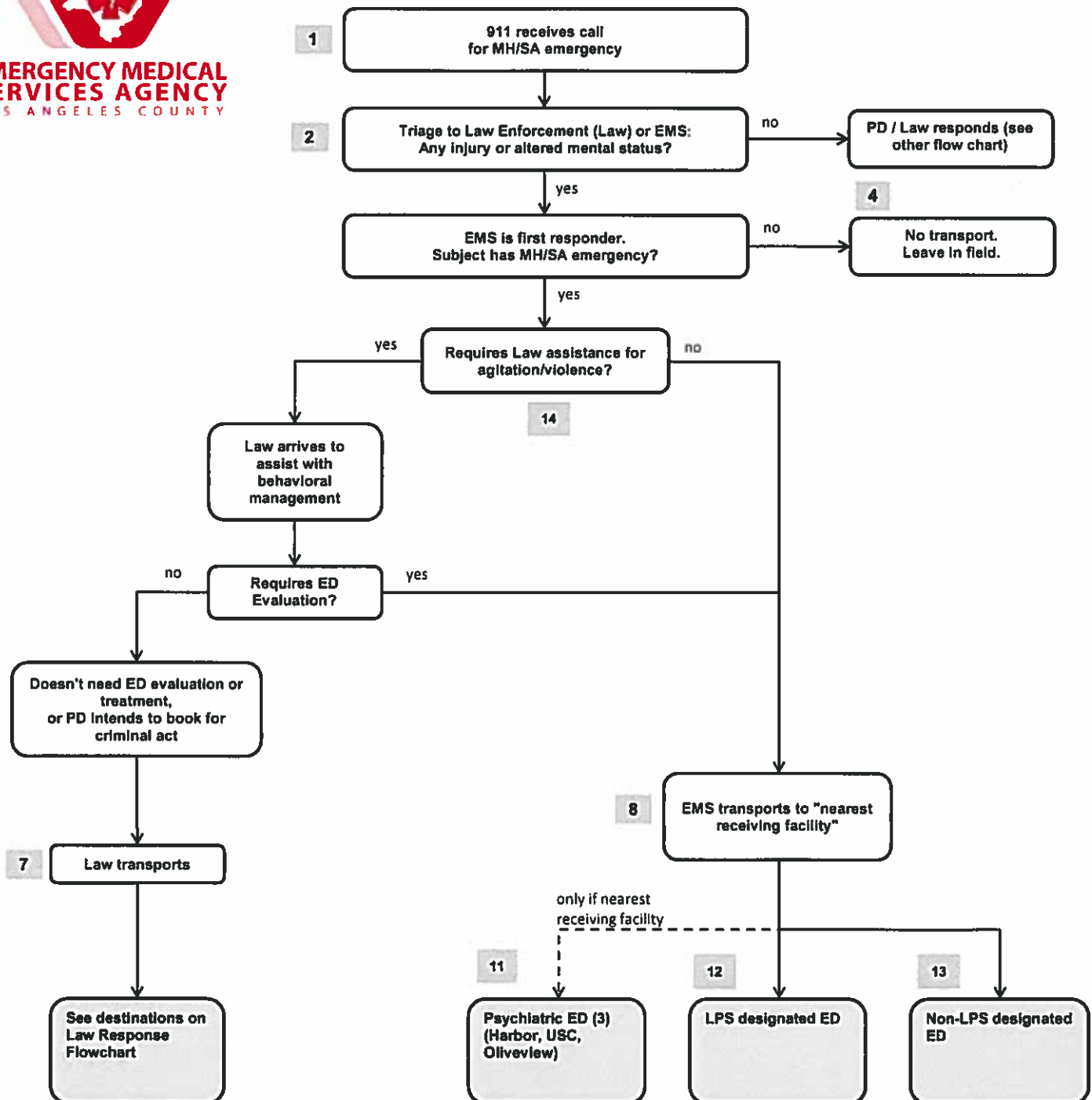


Figure 3

**Los Angeles County Mental Health and Substance Abuse Emergency Response System
Process Map : EMS Response to MH/SA Emergencies (Approved 06/06/2016)**



Abbreviations:

MH/SA: Mental Health and Substance Abuse, also commonly referred to as "behavioral"

Law: Law Enforcement Agency (Police Department, Sheriff's department)

EMS: Emergency medical services

ED: Emergency Department

LPS: Lanterman-petris-short (CA WIC 5150), referring to County designated mental health facilities

Principles for evaluating current MH/SA emergency services and proposed changes

The Committee identified four major themes that should serve as fundamental guiding principles in evaluating both the current system and proposed changes.

1. MH/SA emergencies are medical emergencies, and, as such, are best treated from the point of first contact by medical/clinical personnel trained, equipped, and experienced to evaluate and manage the patient.
2. A proportion of MH/SA emergencies involve acute behavioral agitation, violence, threats of harm to self or others, or criminal activity, in which case they most likely require the combined response of EMS and LE.
3. MH/SA emergencies in adults and children are best treated in emergency facilities (transport destinations) that are appropriately designed and resourced to address MH/SA needs.
4. The system of prehospital care for MH/SA emergency patients should be based on established best practices, which are consistently applied throughout the County regardless of which agencies respond.

In addition to the above principles, the Committee underscored the fact that prehospital care response to MH/SA emergencies are just one component of the larger MH/SA and emergency systems in LA County. As such, this response is intimately related to, and impacted by, the lack of ready access to acute care services (e.g. inpatient psychiatric beds). In addition, it is impacted by patients' access (or lack thereof) to timely resources and treatment for non-emergent MH/SA problems, where case management and wrap-around care are needed to reduce the incidence of MH/SA emergencies

Committee Observations

A number of consensus observations were made by the Committee, with regard to the current MH/SA emergency response system:

1. The current MH/SA emergency field response is variable, and lacks uniformity and a source of central oversight. The dispatch of EMS or LE is based on local customs, and, in many circumstances, may be defaulted to LE as the first responder. LE officers are, therefore, often in a position of conducting clinical evaluations of MH/SA patients with a goal of determining whether the patient needs treatment, and to determine the best destination option, despite the lack of medical training.
2. The LE response, and more specifically the transport of patients in squad cars in handcuffs, has the undesirable effect of “criminalizing” persons with MH/SA emergencies.
3. LE agencies have made, and are continuing to make, valiant efforts to improve officers’ training and interactions with MH/SA patients. Likewise, several agencies have developed MH/SA emergency response teams, staffed with specifically trained law or clinical personnel, to attempt to address the demand and risks of LE’s response. Though an improvement upon the default response of routine LE, the availability of such specialized MH/SA response services remains limited and within the domain of LE (as opposed to within the domain of EMS).
4. The current EMS field treatment protocols for management of the acutely agitated person with a MH/SA emergency are limited to identification of patients with “agitated delirium” and treatment of these patients is limited to using chemical restraint (e.g. midazolam). The use of such agents for chemical restraint in MH/SA emergencies have not been well studied and often lack efficacy.
5. The current LE field protocols for management of the acutely agitated person with a MH/SA emergency are guided by department specific customs or training.
6. The current system provides several destination options to LE that increase the access to appropriate mental health care for patients with MH/SA emergencies (such as options to transport to Mental Health Urgent Care Centers (MHUCCs) or directly to freestanding Psychiatric Hospitals. Conversely, the current EMS destination is limited to emergency departments as per the State of California Health and Safety Code Division 2.5. This regulation appears to limit the timely access to appropriate mental health care for patients with MH/SA emergencies transported by EMS.
7. LA County EMS Agency Prehospital Care Reference No. 502, *Patient Destination* requires transportation to the “most appropriate receiving” facility. Generally, this is the “nearest emergency department”. An exception to going to the nearest emergency

8. department includes transporting a patient to a specialized care center for pre-defined conditions such as stroke, ST elevation myocardial infarction (STEMI) and trauma. To date, there hasn't been the will of the community to create emergency specialty care designations for MH/SA care.
9. Many EDs that currently receive patients from EMS providers lack both sufficient resources and expertise to optimally manage MH/SA patients. Further, facilities that do not have authority to detain patients under WIC 5150 or 5585 (pediatric patients, 18 years of age), face significant barriers in securing a patient's transportation to an inpatient psychiatric hospital, resulting in lengthy patient boarding waiting for an evaluation by a PET or PMRT, then transfer to an available bed.
10. Substance use disorder services are largely unavailable or lack integration into the emergency and acute care system. Specifically LE and EMS providing field assessment and transport do not have acute substance detoxification services readily available as a destination option. Individuals with substance use disorders that arrive at an ED are often discharged with inadequate follow up or referrals to community resources for their addiction, as there are a scarcity of these resources and little to no options for referral. Additionally, EDs do not have an ability to transfer patients to detoxification services as there is limited or no access.
11. EMS providers have not sought LPS authority/certification to write involuntary detainments, though there is nothing prohibiting their application for such authority/certification.

Recommendations for change to the current MH/SA field response

Provided below is a summary of the final recommendations of the Committee based on their review of the current MH/SA field response maps. Details of these recommendations as they pertain to specific elements within the response maps can be found in the Appendix.

1. Modify and standardize the MH/SA emergency 9-1-1 triage criteria to match the field response (LE vs. EMS) to the type of emergency situation. Specifically: triage LE to patients who may be combative, violent, or exhibiting potential criminal behaviors, and triage EMS to all other MH/SA emergencies, including “agitated delirium”. The net expected effect would be a decrease in responses where LE is the sole responder and a corresponding decrease in criminalization of mental illness and potential use of force, and an increase in the appropriate medicalization of MH/SA emergencies.
2. Investigate the potential of greater integration of co-deployed MH/SA and LE teams into the 9-1-1 first response systems. Consider a tiered approach to the dispatch of patrol units to MH/SA emergencies, such that MH/SA trained officers may preferentially respond to the scene.
3. Develop basic resource materials for persons with MH/SA emergencies who are not transported / left in the field, to increase access to mental health services when appropriate.
4. Standardize training/protocol across the County for all LE agencies regarding what constitutes a need for a medical evaluation by EMS providers.
5. Investigate the pros/cons of establishing MH/SA emergency specialized care centers, akin to the system for STEMI, trauma, stroke, etc., to improve the care for MH/SA emergencies.
6. Determine the feasibility (including regulatory and financial/economic or practical barriers) of alternate destinations to directly transport EMS patients to specialty EDs that demonstrate the capacity and expertise to care for MH/SA patients, to MHUCCs, or to other destinations that can provide the appropriate evaluation and treatment. Investigate and pursue the integration for substance abuse detoxification and rehabilitation services as destination options for EMS, LE and EDs.
7. Support regulatory changes to ensure parity for all populations, including the following key issues. Medi-Cal currently does not reimburse free standing mental health facilities for care to adult recipients. Further, the Drug Medi-Cal Organized Delivery System benefit program being implemented by DPH focuses on outpatient SA treatment and does not provide reimbursement for inpatient services. Finally, the Drug Medi-Cal Organized Delivery System benefit program contains annual limitations on residential treatment for substance use disorders for both youth and adult clients.

8. **Develop additional treatment protocols (non-pharmacologic and pharmacologic) to address combative, agitated or potentially violent behavior in MH/SA adult and pediatric patients. Refer to the EMS Agency Medical Advisory Council to determine whether the EMS Agency should pursue the use of alternate agents for behavioral agitation as the result of acute psychosis, substance intoxication or withdrawal, delirium, and undetermined etiologies.**
9. **Explore the option of Sobering Centers as a patient destination for inebriates as these resources become more available in the community.**

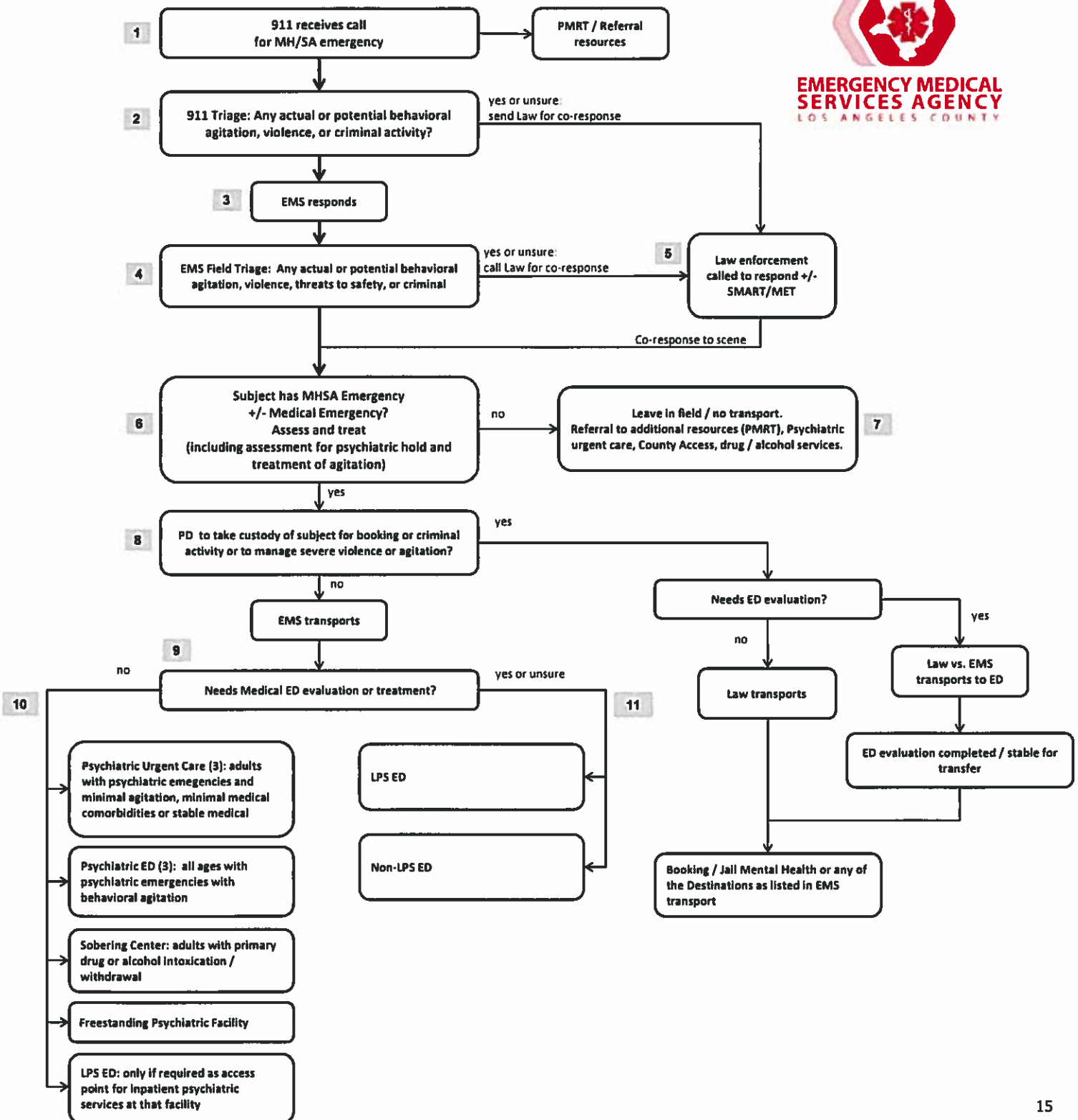
A future vision

Having considered our current model, we shifted our focus to a combined vision of how to improve patient care for persons with MH/SA emergencies taking into account the Committee's principles and observations stated above.

Figure 4 proposes a fundamentally re-designed management algorithm to address MH/SA emergencies, consistent with the articulated principles and a primary focus on delivering higher quality patient care. Again, specific areas of focus are addressed in the appendix that corresponds to Figure 4.

Figure 4

Los Angeles County MH/SA Emergency Response System (Mental Health and Substance Abuse) Process Map : Potential Field Response Map (Approved 6/1/16)



Concluding Remarks

MH/SA problems are prevalent, disabling, at times dangerous, and increasingly the cause for calls to the 9-1-1 system. In LA County, the field response to MH/SA emergencies is highly varied, with either a LE and/or EMS response based on non-uniformly standardized or regulated triage protocols. As a result, a person cannot reliably predict who will respond and how his or her MH/SA emergency will be evaluated and managed in the field, and, furthermore, how or where he or she will be transported to in the event that additional care is needed.

The current system has placed LE personnel frequently in the position of performing clinical evaluations for, and attempting to manage, MH/SA issues in the field. The Committee firmly asserts that MH/SA emergencies are medical emergencies, and as such are best addressed by trained healthcare personnel, whenever possible. Finally, the Committee fully recognizes that MH/SA emergencies are unique in their potential for first responders to encounter adult and pediatric patients who may be acutely agitated or potentially harmful to themselves or others. New protocols and training are necessary to tailor and equip the EMS and LE response to these situations, including training in verbal de-escalation as well as pharmacologic treatment protocols, in order to provide the highest quality of care and to minimize the use of force and potentially disastrous outcomes.

The Committee respectfully submits this analysis of the current field response system, with accompanying principles, observations, and specific recommendations, to the LA County EMSC.

APPENDIX TO FIGURES 2 and 3: LE AND EMS FLOWCHARTS

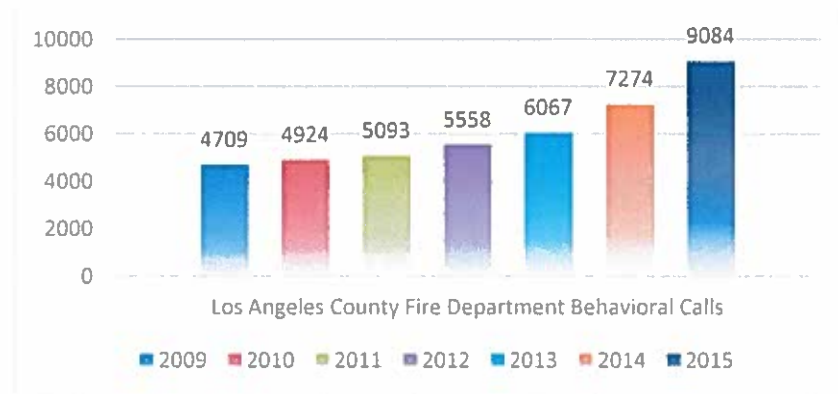
The numerical items below correspond to the flowcharts for the current LE and EMS response to behavioral emergencies. Sub-items are categorized as follows:

- Description
- Area of need
- Comment
- Recommendation
- Barriers to change

1. 9-1-1 receives call for MH/SA emergency:

- Description:** All 9-1-1 calls are routed to the Public Safety Answering Point (PSAP). Most PSAPs are operated by LE, and, if the call taker determines that the call is medical, then they will, in most cases, transfer the call to an EMS call taker. There are a few PSAPs in LA County that handle both LE and EMS calls, but most medical related calls are transferred from LE to EMS call takers. There are more than 40 LE agencies and 13 EMS dispatching centers in LA County.
- Area of Need:** It is unclear how many calls for MH/SA are received per year, or what proportion of all emergency 9-1-1 calls are related to MH/SA problems. The total quantity is difficult to discern because of poor data collection, but the expert consensus is that the demand for emergency services continues to rise.

Below is a graph showing LA County Fire Department (LACoFD) dispatches for behavioral emergencies from 2009 – 2015. From 2013-2015, the department's overall EMS call volume rose by about 20%, while the behavioral emergency calls increased by 50%.



In 2016, the LA Police Department (LAPD) responded to approximately 18,000 MH calls, and the LA Fire Department (LAFD) responded to 11,500 calls. Some of these calls may have had response of both agencies.

2. Triage to LE vs. EMS:

- a. **Description:** The current 9-1-1 system is designed to triage based on the questions posed by the 9-1-1 call taker. In the LAPD, for example, if the caller indicates that the patient is having a MH/SA emergency, then police are dispatched. Only if the caller indicates that there is a medical emergency is there an EMS response.
- b. **Comment:** There is currently no known uniformity in the criteria used to triage the response to LE or EMS. As a result of this triage decision point, the 9-1-1/EMS system likely relies more heavily on the response of LE to MH/SA emergencies than perhaps desired. Concerns are raised about the training, ability and resources of LE to appropriately manage MH/SA emergencies, and such emergencies are likely better addressed by medically trained individuals.
- c. **Area of need:** It is unclear what percentage of 9-1-1 calls are triaged to LE vs. EMS in the current system. This is data that needs to be collected. It is currently unknown if other major counties in California have a triage system for MH/SA emergencies that is similar to Los Angeles, or whether any are designed in a way that reduces the use of LE as first responders.
- d. **Recommendation:** Consider modifying the MH/SA emergency triage criteria to match the field response (LE vs. EMS) to the type of emergency situation, i.e. triage LE specifically to patients who may have agitation, violence, or potential criminal behaviors and triage EMS to all other MH/SA emergencies.
- e. **Barriers to change:** Concerns for safety and training if EMS becomes the default first responder for MH/SA emergencies.

3. The availability of specialized and embedded mental health units ("SMART"/LAPD or "MET"/LA Sheriff) in law enforcement agencies is limited but possibly growing.

- a. **Description:** Mobile crisis units for mental health emergencies have several different monikers which vary based on the department that they are affiliated with:
 - i. SMART (System-wide Mental Assessment Response Team) is associated with LAPD. They have 17 teams available per day on overlapping shifts with 24 hour coverage.
 - ii. MET (Mental Evaluation Team) is associated with Los Angeles County Sheriff Department (LASD). They have eight teams providing coverage 18 hours/day with three additional teams to be added on September 1, 2016 and there are plans to expand to 23 teams over the next three years.
 - iii. LE Teams are associated with 22 other local LE agencies. Eight additional METs affiliated with city police departments will be operational by September 30, 2016. Four additional METs are pending, including on with the LA World Airports. These METs operate according to the needs of each jurisdiction,

with most operating Monday-Friday between 9:00 a.m. until 8:00 p.m. Some METs operate on weekends depending on personnel resources.

- iv. PMRT (Psychiatric Mobile Response Team) is associated with LAC DMH and are field-based teams that operate seven days a week from 8:00 a.m. until 2:00 a.m. These teams are geographically located in eight service areas and each team consists of eight to ten clinicians.
- v. PET (Psychiatric Emergency Team) are associated with freestanding psychiatric hospitals.
- vi. Other: There are other mobile crisis teams, which the LA County Metropolitan Transit Authority Crisis Response Unit (MTA-CRU) is an example of.

Embedded mental health units with LE are generally viewed as favorable responders to MH/SA emergencies, with better training to interact with this population. However, there is limited, or no, outcomes data regarding such entities. The availability of teams is limited by hours of operation, geographical access and mobility.

- b. Comments: SMART and MET teams are not dispatched directly to calls and, thus, are not first responders. The SMART team can self-dispatch based on calls heard on the radio, and they are available on request of first responding patrol units. MET teams are dispatched on request of patrol deputies. The City of Houston Police Department utilizes a tiered response, which is considered a best practice, and is based on the intensity of the call and availability of their units.
 - i. Tier 1 – co-deployed Mental Health/LE team
 - ii. Tier 2 – Patrol unit that has received specialized mental health or crisis intervention training
 - iii. Tier 3 – Standard patrol unit.

It is noted that PMRT and PET are not accessible in the current 9-1-1 system algorithm

It is also noted that some freestanding psychiatric hospitals operate their own PET units, which are usually deployed to emergency departments to perform assessments for 5150 or 5585 (pediatric patients) and to facilitate transfer to their own psychiatric facility.

- c. Recommendation: Investigate the potential of greater integration of co-deployed Mental Health/LE teams into the 9-1-1 first response systems. Consider a tiered approach to the dispatch of patrol units to MH/SA emergencies, such that MH/SA trained officers may preferentially respond to the scene.

- d. **Barriers to change:** The main barrier to a widespread growth and integration of co-deployed teams is cost.

4. No transport, Leave in Field:

- a. **Comment:** Both LAPD and LASD provide a leaflet with resource information for MH/SA services. EMS providers do not have any standard information to give to these patients. DMH offers linkage through their ACCESS system, which funnels patients to their outpatient mental health programs.
- b. **Recommendation:** Investigate the development of basic resource materials for persons with MH/SA emergencies who are not transported, to increase access to mental health services when appropriate.

DMH offered their ACCESS number, (800) 854-7771, to LE and EMS departments that are leaving patients in the field. LA County DMH should produce standard information that can be given out by both LE and EMS agencies outlining available outpatient mental health information and telephone numbers. It is essential that these resources receive patients regardless of payor status, redirecting them when necessary but never turning them away.

- c. **Barriers to change:** None

5. Requires medical attention:

- a. **Comment:** It is unclear what standard criteria are used, if any, by LE to determine whether the patient requires medical attention. LE officers are being asked to make a medical determination without any standardization of training. Current practice is to refer to EMS if there is an apparent injury or if the patient appears ill or has chronic medical problems.
- b. **Recommendation:** Standardization and training across the County for all LE agencies regarding what constitutes a need for a medical evaluation by EMS providers.
- c. **Barriers to change:** Apart from Peace Officer Standards and Training (POST), which is a state organization, there is not an easy way to ensure dissemination and standardization across all law enforcement agencies in LA County. The EMS Agency is part of the Department of Health Services and does not have any jurisdiction over the evaluation performed by peace officers in the field.

6. ED evaluation and treatment, ED at a Lanterman-Petris-Short (LPS) or non-LPS facility:

- a. **Description:** Current California law stipulates that patients on a 5150 or 5585 placed by LE should be brought to an LPS designated facility. Typically, this involves bringing the patient to the ED at an LPS designated facility, though there are some LPS designated hospitals without ED's that receive patients directly from LE under specific circumstances.

- b. **Comments:** In practice, it is unclear how LE determines which ED to transport a patient to. The time from arrival at a specific facility until the facility staff take over the care, often referred to as “wall time” for LE officers is unknown, but may be a factor in determining which facility LE officers transport to. LE officers may generally transport to ED’s that are closest to them, or those ED’s who they have developed relationships or agreements with, or the ED that will lead to the least amount of wall time.

When patients on a 5150 hold are brought to ED’s that are not located at LPS designated hospitals, then this is difficult for both the patient and the ED. These ED’s are frequently ill equipped to manage MH/SA patients, lacking proper space, equipment, training, and experience. This results in poor and potentially unsafe treatment of the patient. Also, because of limited access to psychiatric inpatient bed capacity, these patients may be stuck waiting in an ED for several days for an inpatient bed to open up. This also impacts the ED holding the patient, reducing their available capacity and hampering their ability to provide emergency services to other patients.

7. LE transports:

- a. **Description:** Some LE agencies frequently though not uniformly transport MH/SA patients in handcuffs in the back of a patrol car even if the patient is not aggressive or resistive. For example, LAPD policy requires that all MH/SA patients being transported in a patrol car have handcuffs applied. This is for the safety of the officer and the patient and to reduce use-of-force. LASD frequently utilizes handcuffs as well, but this is not in policy. As depicted in the flow chart, LE officers have a much greater range of destination options compared to EMS personnel. Health and Safety Code Division 2.5 stipulates that EMS personnel can only transport to an ED, and, per LA County EMS Agency policy, they must be transported to the “most appropriate receiving” ED (MAR), which may or may not be part of an LPS designated hospital. LE can transport to any ED, and they can bypass the nearest ED to transport to the nearest LPS designated hospital ED or County PES. Law enforcement can also transport to a MHUCC instead of an ED.
- b. **Comments:** While method of transport is intended to reduce the potential for harm to the patient or the officer, it is a cause for major concern regarding the impact from a medical and patient’s perspective on patients who are suffering MH/SA emergencies.
- c. **Recommendation:** See Appendix item #2. If triage of MH/SA emergencies is re-calibrated to dispatch LE primarily to patients who have potentially combative, violent, or exhibiting criminal behaviors, then the number of transports of patients by LE would likely be reduced, thereby reducing the effect of “criminalization” of mental illness. The Committee believes that, when possible, transportation in an unmarked vehicle or ambulance versus a marked police vehicle is preferable both from patient safety and to reduced stigmatization.

- d. Barriers to change: Standardization of management of MH/SA patients by LE across LA County is difficult because of a lack of a local governing body.

Delegation by LE of responsibility for maintaining custody of individuals detained under WIC 5150, aside from transfer of custody directly from LE to an LPS designated facility, is not clearly addressed in regulations. Therefore, EMS are sometimes hesitant to assume such responsibilities.

The Center for Medicare/Medicaid Services (CMS) has ruled that reduced stigmatization of patients does not constitute a medical need for ambulance transport. Thus, ambulance companies may not be reimbursed if this is the sole reason for utilizing ambulance transportation.

Health and Safety Code Division 2.5 and EMS Agency Prehospital Care Reference No. 502, *Patient Destination* limit destinations for emergency ambulance transportation. Any deviation from this could only be achieved through an authorized pilot study from the State EMS Authority (EMSA) or through a legislative change.

8. EMS transports to “most appropriate receiving facility”:

- a. Description: Current EMS Agency Prehospital Care Reference No. 502: *Patient Destination* requires EMS to transport to the nearest receiving facility, regardless of LPS designation status, and regardless of the availability of psychiatrists or appropriate resources (such as specialized facilities and staff for mental health emergencies). The options for patient destination are limited in comparison to law enforcement.
- b. Comments: The EMS Agency has recognized the need for specialized care centers for certain types of medical illnesses (for example stroke, trauma, STEMI, pediatrics), which establishes resources and personnel that are specifically prepared to manage such emergencies.
- c. Recommendation: Investigate the pros and cons of establishing MH/SA emergency specialized care centers to improve the care for MH/SA emergencies.

Consider a tiered system as outlined below:

- i. Comprehensive Psychiatric Center with a PES (adult and pediatric facilities)
 - ii. ED at a LPS designated hospital
 - iii. MHUCC
 - iv. ED at a non-LPS designated hospital
- d. Barriers to change: Hospitals have been reluctant in the past to become designated as psychiatric receiving centers. Federal law currently prohibits the use of federal Medi-Cal dollars for inpatient treatment. Hospitals are not reimbursed for providing SA services and the County’s DPH Drug Medi-Cal programs appear to be focused on outpatient treatment not inpatient care.

9. MHUCC (Exodus Recovery Inc.):

- a. Description: Psychiatric or MHUCC provide intensive crisis services to individuals who would otherwise be taken to EDs. There are currently four 24/7 MHUCC's in Los Angeles County. A report to the LA County Board of Supervisors dated May 17, 2016 from DMH titled *Report Back on Collection of Standardized Urgent Care Center Data* provided April 2016 volumes from MHUCCs and this data is included below. Note that the estimated annualized total number of visits based on this monthly volume is 46,500.

SERVICES DELIVERED

Overall, 3,139 unique individuals were served by UCCs in the month of April. Some individuals received more than one visit; total visits to UCCs for that month was 3,875. Information for each UCC is as follows:

April 2016 Unique Clients Served and Visits to UCCs

Urgent Care Center	Unique Clients	Total Visits
DMH Olive View UCC	578	1,148
Exodus Eastside UCC	1,093	1,154
Exodus MLK UCC	868	937
Exodus Westside UCC	424	449
Telecare MHUCC	176	187
Total	3,139	3,875

Average length of stay in LPS-designated UCCs reflects the time spent in a crisis stabilization service which includes psychiatric evaluation, medication monitoring, case management, and crisis intervention. During April 2016, average time spent in UCCs for the four providing crisis stabilization was:

- Exodus Eastside UCC: 8.43 hours
- Exodus Foundation MLK UCC: 9.08 hours
- Exodus Westside UCC: 11.54 hours
- Olive View UCC: 12.03 hours*

*due to data entry lag, data reflects prior month's (March) length of stay

- b. The number of countywide admissions to acute ED's and psychiatric inpatient units within 30 days of MHUCC visit were 438 (14%). The number of countywide re-admissions to MHUCC's within 30 days of a previous visit were 253 (8%)

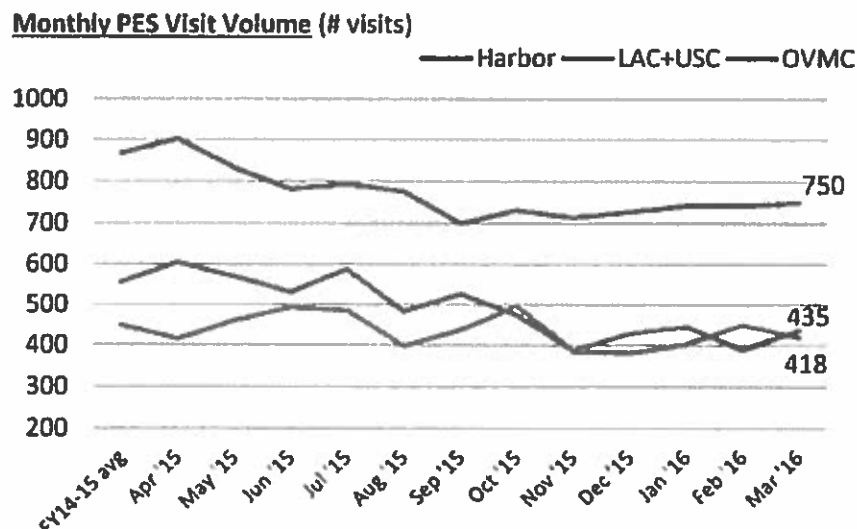
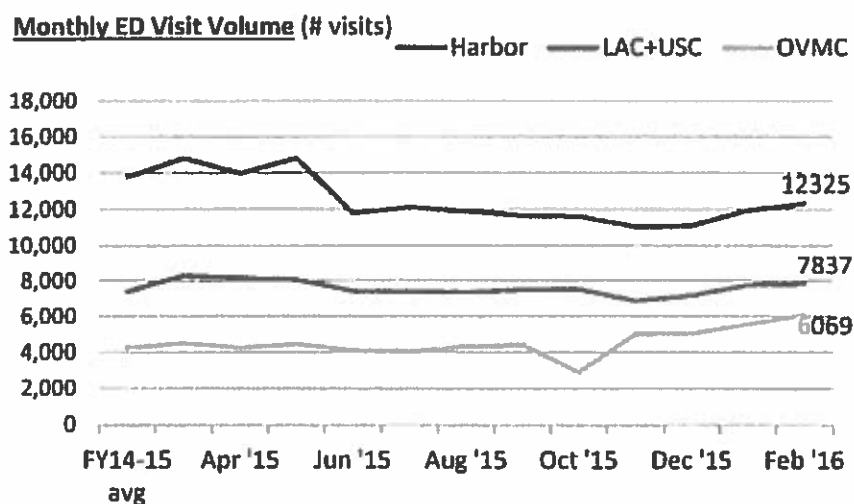
10. Free standing Psychiatric Facility:

- a. Description: There are 11 free standing acute psychiatric hospitals in LA County, with a total licensed bed capacity of 1,334 (as of 2016). Data on the average daily census, average length of stay (ALOS), and beds by age groups was not available from LA County DPH Health Facilities division. According to HASC the ALOS for mental health admissions is eight days.
- b. Free standing psychiatric facilities often work collaboratively with local EDs and LE, in conjunction with their own PETs, to receive admissions to their hospitals. DMH also

has contracts with some of the free standing psychiatric facilities to accept LE transports.

11. PES:

- a. Description: Three County hospitals, Harbor-UCLA Medical Center (Harbor), LAC+USC Medical Center (LAC+USC), and Olive View – UCLA Medical Center (OVMC) provide PES. These hospitals have facilities and staff that are specifically intended to treat MH/SA emergencies (restraint beds, showers, isolation rooms, video surveillance, trained personnel to manage agitated behaviors, mental health social workers, etc.). Monthly data for fiscal year 2015-2016 on ED volumes and PES volumes are shown graphically below. This data is taken from the DHS Dashboard Report published April 2016.



- b. Comment: These facilities are likely the best suited for management of the acutely agitated or potentially violent patients with MH/SA emergencies, given their resources (availability of restraint beds, isolation rooms, and specific mental health staff).

12. ED at LPS designated hospital:

- a. Description: There are 24 general acute care hospitals (including the 3 County hospitals) that are LPS designated and also have basic emergency services and are 9-1-1 receiving facilities. Self-report data on MH/SA ED Visit volumes (2013):

ED	MH/SA ED visits	All visits	% MH/SA visits of all-cause visits
LPS	66,812	1,069,399	6.25%
Non-LPS	71,146	2,113,153	3.37%

b.

ED	Pediatric MH/SA ED visit	% Pediatric MH/SA visits of all-age MH/SA visits
LPS	7,508	11.24%
Non-LPS	3,997	5.62%

ED	MH/SA Admissions	% (Admitted of all MH/SA visits)
LPS	39,500	59.12%
Non-LPS	33,098	46.52%

e availability of psychiatrists and mental health staff in ED's at LPS designated facilities varies. It is presumed, that a patient would be seen by a psychiatrist or mental health professional in a shorter period of time than compared to an ED at a non-LPS designated facility; however if 9-1-1 MH/SA transports were only directed to LPS designated facilities, the increase volume from the non-LPS designated facilities may increase delays.

13. ED at non-LPS designated facility:

- a. **Description:** There are 50 general acute care hospitals that have basic emergency services and are 9-1-1 receiving facilities, but who do not have LPS designation. Self-report data on MH/SA ED Visit volumes (2013) is shown above and compares ED MH/SA visits at LPS and non-LPS designated EDs.
- b. **Comment:** The availability of psychiatrists and mental health staff in ED's at non-LPS designated facilities varies. It is presumed, that most of these facilities do not have on-call psychiatrists and if they have access to on-call psychiatrists there are variable response times to when the patient may be evaluated.

14. Requires LE assistance for agitation / violence:

- a. **Description:** The current EMS protocols only address "agitated delirium," which is insufficient to address the broad spectrum of agitation or violent behaviors that can be manifested from MH/SA emergencies. Most first responders have major concerns regarding persons with MH/SA emergencies who are potentially dangerous, agitated or violent. It remains unclear what is the best response to the agitated or violent patient.
- b. **Area of need:** EMS providers in LA County lack access to any medication that can treat acute psychosis unless it has progressed to the point of agitated delirium. Midazolam, used for agitated delirium, can worsen patients whose agitation is due to acute psychosis.
- c. **Comment:** Further guidance and decision support is needed to improve the management of the agitated or violent patient. It is unclear how much training is provided or required, if any, for LE or EMS in de-escalation techniques
- d. **Recommendation:** Investigate the development of additional treatment protocols (non-pharmacologic and pharmacologic) to address MH/SA emergencies, in adults and children with concomitant agitation or violence. Refer to the EMS Agency Medical Advisory Council to determine whether the LA County EMS Agency should pursue the use of alternate agents for acute psychosis. Literature exists regarding successful prehospital use of neuroleptics and ketamine.
- e. **Barriers to change:** none

APPENDIX TO FIGURE 4: POTENTIAL FIELD RESPONSE MAP

The numerical items below correspond to the flowcharts for the “potential field response map” to MH/SA emergencies.

1. 9-1-1 receives call for MH/SA emergency:
 - a. For cases that do not require immediate LE or EMS evaluation, consider whether it is possible to triage to a mobile crisis response team (SMART, MET, PMRT, PET etc.). The Committee believes that the presence of LE has the potential to escalate the behavioral condition and/or situation of vulnerable patients, and the specialized mobile crisis response teams are highly trained in MH/SA emergencies and behavioral de-escalation.
2. 9-1-1 Triage: any actual or potential behavioral agitation, violence, or criminal activity:
 - a. Description: The current 9-1-1 system is designed to triage based on the following primary question posed by the PSAP 9-1-1 operator: “Does the patient have any injury or altered mental status?” If the answer is “yes” EMS is dispatched to respond. If the answer is “no” LE responds.
 - b. This field response map has the 9-1-1 triage question re-oriented towards having EMS as the default first responder and LE would be triaged to the scene based on the presence or anticipation of agitated or violent behavior, or possible criminal activity.
3. EMS responds:
 - a. EMS always responds to the scene, in keeping with the principle that MH/SA emergencies are a type of medical emergency, as well as to provide potential treatment for mental health emergencies (see appendix item #6).
4. EMS Field Triage:
 - a. When EMS arrives on scene, personnel assessing the situation should attempt to determine if the person has any actual or potential for behavioral agitation, threats to safety, or criminal activity. If the answer is yes, then LE is called to co-respond to the scene to provide additional assistance to ensure the safety of the subject and others.
5. LE called to co-respond (+/- SMART/MET):
 - a. LE is called to respond in cases where the subject has actual or potential behavioral agitation, violence, threats to safety, or criminal activity.
6. Subject has MH/SA emergency +/- other medical emergency:
 - a. EMS will determine if the patient has an MH/SA emergency, and/or another medical emergency.

- b. Field treatment protocol will be updated to address persons with MH/SA emergencies and concomitant agitation or violent behaviors, including de-escalation techniques, pharmacological treatment, and use/avoidance of restraints.
- c. At this stage the subject should also be assessed for the potential need of an involuntary psychiatric hold (WIC 5150 or 5585 for pediatric patients).
 - i. LPS certification may perhaps be extended to EMS providers. The Committee noted that LE officers, with little medical training are permitted to determine the need for involuntary holds, but EMS providers are not. As a long term goal, we believe that EMS providers are capable of safely determining the need for involuntary holds and should be granted that power. The training for both LE and EMS should be a requirement for purposes of consistency and uniformity across the County.

7. Leave in field / no transport:

- a. Resources to community MH/SA services should be made available for persons left in the field, including but not limited to PMRT, MHUCC, County DMH ACCESS, addiction treatment services. Technology advances such as a development of an application that could provide real time information on available MH/SA resources would be a great adjunct.

8. LE to take custody of subject for booking, or to manage severe violence or agitation:

- a. A binary yes/no question to determine most appropriate mode of transport and to reduce the unnecessary use of handcuffs/squad car transport. The Committee recognizes that the placement of handcuffs and the use of a patrol vehicle have the potential to escalate a MH/SA emergency, occasionally with severe negative results. The Committee suggest that LE agencies consider the need to handcuff individuals based on patient behavior rather than policy. The improved response capabilities of specialized LE teams and ongoing MH/SA training of LE officers throughout the County will improve the ability to successfully de-escalate patients prior to transport.

9, 10, 11. Needs medical ED evaluation or treatment:

- a. EMS personnel will determine if the patient requires medical evaluation or treatment, and if yes, then transport to the most appropriate receiving hospital ED, which may be a LPS or non-LPS designated facility. Currently, policy limits the EMS providers to transport only to the nearest receiving facility. Unfortunately, most ED's in LA County are non-LPS EDs, and, thus, they lack expertise, training, and equipment to optimally manage MH/SA patients. When a MH/SA patient presents to that ED and requires an involuntary hold, the process of transferring that patient to an LPS designated facility can take days. The Committee recommends that EMS providers be able to triage MH/SA patients in the field for the possible need for involuntary hold and, when need is determined, transport those patients preferentially to the ED of the nearest LPS

designated hospitals. Patients with MH/SA emergencies that are not believed to require an inpatient psychiatric hospitalization can be effectively managed at any ED, whether or not its hospital has LPS designation. This would provide the perfect opportunity to create a seamless process to transfer patients to a network MHUCC. This network needs to be robust and expanded beyond the current MHUCCs.

- b. If no need for ED medical evaluation, then options for destination need to be expanded to MHUCC, County PES, Sobering Center, freestanding psychiatric facilities, or EDs at LPS designated facilities. A specific plan should be developed to address pediatric patients with MH/SA disorders. The MHUCC system has been shown to be a safe and effective alternative to EDs for LE transports. There is no reason to believe that EMS providers cannot have similar success. The patient benefits from the MH expertise of the MHUCC, the EDs benefit from a lower burden on MH/SA patients, and the EMS providers benefit from rapid offloading of their patients in order to free up resources for the next emergency call.

APPENDIX: IOM Fact Sheet on the Future of Emergency Care: Key Findings and Recommendations (June 2006)

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

FACT SHEET • JUNE 2006

The Future of Emergency Care: Key Findings and Recommendations

KEY FINDINGS

Many EDs and trauma centers are overcrowded.

(Drawn from *Hospital-Based Emergency Care: At the Breaking Point*)

- Demand for emergency care has been growing fast—emergency department (ED) visits grew by 26 percent between 1993 and 2003.
- But over the same period, the number of EDs declined by 425, and the number of hospital beds declined by 198,000.
- ED crowding is a hospital-wide problem—patients back up in the ED because they can not get admitted to inpatient beds.
- As a result, patients are often “boarded”—held in the ED until an inpatient bed becomes available—for 48 hours or more.
- Also, ambulances are frequently diverted from overcrowded EDs to other hospitals that may be farther away and may not have the optimal services. In 2003, ambulances were diverted 501,000 times—an average of once every minute.

Emergency care is highly fragmented. (Drawn from *Emergency Medical Services At the Crossroads*)

- Cities and regions are often served by multiple 9-1-1 call centers.
- Emergency Medical Services (EMS) agencies do not effectively coordinate EMS services with EDs and trauma centers. As a result, the regional flow of patients is poorly managed, leaving some EDs empty and others overcrowded.
- EMS does not communicate effectively with public safety agencies and public health departments—they often operate on different radio frequencies and lack common procedures for emergencies.
- There are no nationwide standards for the training and certification of EMS personnel.
- Federal responsibility for oversight of the emergency and trauma care system is scattered across multiple agencies.

Critical specialists are often unavailable to provide emergency and trauma care. (Drawn from *Hospital-Based Emergency Care: At the Breaking Point*)

- Three quarters of hospitals report difficulty finding specialists to take emergency and trauma calls.
- Key specialties are in short supply. For example, the number of neurosurgeons declined between 1990 and 2002, while the number of trauma visits increased.
- On-call specialists often treat emergency patients without compensation due to high levels of uninsurance.
- These specialists also face higher medical liability exposure than those who do not provide on-call coverage.

The emergency care system is ill-prepared to handle a major disaster. (Drawn from all three reports)

- With many EDs at or over capacity, there is little surge capacity for a major event, whether it takes the form of a natural disaster, disease outbreak, or terrorist attack.
- EMS received only 4 percent of Department of Homeland Security first responder funding in 2002 and 2003.
- Emergency Medical Technicians in non-fire based services have received an average of less than one hour of training in disaster response.
- Both hospital and EMS personnel lack personal protective equipment needed to effectively respond to chemical, biological, or nuclear threats.

EMS and EDs are not well equipped to handle pediatric care. (Drawn from *Emergency Care for Children: Growing Pains*.)

- Most children receive emergency care in general (not children’s) hospitals, which are less likely to have pediatric expertise, equipment, and policies in place for the care of children.
- Children make up 27 percent of all ED visits, but only 6 percent of EDs in the U.S. have all of the necessary supplies for pediatric emergencies.
- Many drugs and medical devices have not been adequately tested on, or dosed properly for, children.
- While children have increased vulnerability to disasters—for example, children have less fluid reserve, which leads to rapid dehydration—disaster planning has largely overlooked their needs.

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