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: **July 19, 2017**
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

CALL TO ORDER – Erick Cheung, M.D., Chairman

INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS
- 5150 Patient Transportation by Lt. Robert Lamborghini

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

1 MINUTES
- March 15, 2017
- May 17, 2017 (Record of Meeting – No Quorum Present)

2 CORRESPONDENCE
- 2.1 (06-22-2017) Kurt Norwood, Fire Chief, Montebello Fire Department: State EMS data requirements and Electronic Patient Care Record (ePCR) implementation.
- 2.2 (06-21-2017) Tony Ramos, City Manager, City of Claremont, et al: The Board of Supervisors approved the Exclusive Operating Areas (EOAs) agreements for 9-1-1 response.
- 2.3 (06-21-2017) Roger J. Lewis, MD, PhD, Chair, Harbor-UCLA Medical Center: Appointment for Dr. Nichole Bosson as EMS Fellowship Program Director.
- 2.4 (06-12-2017) Bill Walker, Fire Chief, Santa Monica Fire Department: Termination of the Community Paramedicine Alternate Patient Destination pilot project.
- 2.5 (06-02-2017) Fax/E-mail Distribution: Los Angeles Pride Musical Festival and Resist march.
- 2.6 (05-30-2017) BJ Bartleson, RN, MS, NEA-BC, California Hospital Association: EMS Agency supports the Emergency Care System Initiative (ECSI).
- 2.7 (05-25-2017) Distribution: Inappropriate utilization of 9-1-1 for inter-facility transfers (IFT).
- 2.8 (07-06-2017) Lou Meyer, Project Manager, EMS Authority: Interest in participating in the Community Paramedicine Pilot Project.

3. COMMITTEE REPORTS

3.1 Base Hospital Advisory Committee
3.2 Data Advisory Committee
3.3 Education Advisory Committee – No Quorum
3.4 Provider Agency Advisory Committee

4. POLICIES

4.1 Reference No. 227: Dispatching of Emergency Medical Services
4.2 Reference No. 411: Provider Agency Medical Director
4.3 Reference No. 420: Private Ambulance Operator Medical Director
4.4 Reference No. 517: Private Provider Agency Transport/Response
4.5 Reference No. 519.3: Multiple Casualty Incident Transportation Management
4.6 Reference No. 816: Physician at the Scene
4.7 Reference No. 911: Public Safety First Aid (PSFA) and Basic Tactical Casualty Care (BTCC)
4.8 Reference No. 302: 9-1-1 Receiving Hospital Requirements
4.9 Reference No. 838: Application of Patient Restraints

5. BUSINESS

Old:

5.1 Community Paramedicine *(July 18, 2012)*

5.2 Prehospital Care of Mental Health and Substance Abuse Emergencies Report
- Recommendation Action Plan

5.3 Ad Hoc Committee (Wall Time/Diversion)

5.4 Cannabis Data Submission

New:

5.5 Measure B (Motion from Supervisor Barger)

6. COMMISSIONERS COMMENTS/REQUESTS

7. LEGISLATION

8. EMS DIRECTOR'S REPORT

9. ADJOURNMENT

(To the meeting of September 20, 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
July 19, 2017

1. MINUTES

- March 15, 2017

2. CORRESPONDENCE

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2.7 (05-25-2017) Distribution: Inappropriate utilization of 9-1-1 for inter-facility transfers (IFT).
2.8 (07-06-2017) Lou Meyer, Project Manager, EMS Authority: LA County interest in participating in the Community Paramedicine Pilot Project.

3. COMMITTEE REPORTS

3.1 Base Hospital Advisory Committee
3.2 Data Advisory Committee
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4. POLICIES

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March 15, 2017

	COMMISSIONERS	ORGANIZATION	EMS AGENCY STAFF	POSITION
☑	Ellen Alkon, M.D.	So. CA Public Health Assn.	Cathy Chidester	Director, EMS Agency
☑	Robert Barnes	LAC Police Chiefs Assn	Kay Fruhwirth	Asst. Director, EMS Agency
☑	Lt. Brian S. Bixler	Peace Officers Assn. of LAC	Richard Tadeo	Asst. Director, EMS Agency
☑	Erick H. Cheung, M.D.	So. CA Psychiatric Society	Nichole Bosson, MD	Asst. Medical Director, EMS Agency
*	Marc Eckstein, M.D.	L.A. County Medical Assn	Amelia Chavez	Acting Commission Liaison
☑	John Hisserich	Public Member, 3rd District	Cathlyn Jennings	Staff
☑	Clayton Kazan, M.D.	CAL/ACEP	Lucy Hickey	"
*	James Lott	Public Member, 2nd District		
☑	Robert Ower	LAC Ambulance Association		
*	Margaret Peterson, PhD	HASC		
☑	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, 5th District		

GUESTS

Samantha Vergas-Gates	Long Beach Medical Center
Victoria Hernandez	Los Angeles Co. Fire Dept.
Jaime Garcia	HASC
Kevin Millikan	Torrance Fire Department
Dr. Clayton Kazan	Los Angeles Co. Fire Dept.

(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, CA. 90670. The meeting was called to order at 1:06 PM by Chairman, Erick Cheung. A quorum was present with 12 Commissioners in attendance.

ANNOUNCEMENTS/PRESENTATIONS:

Self-introductions were made starting with EMSC members and followed by EMS Agency Staff.

CONSENT CALENDAR:

Chairman Erick Cheung, M.D., called for approval of the Consent Calendar.

M/S/C Commissioner Hisserich/Snyder to approve the Consent Calendar. Once motion took place, Ms. Cathy Chidester, EMSC Executive Director, wished to make an announcement in reference to item 2.6 as follows:

2.6 Commissioner Frank Binch has been replaced by a newly appointed person who will be representing the Fourth Supervisorial District. Mr. Binch was very active in our commission and he took us in some very good directions; a thank you letter was sent to him for his commitment and time with the commission.

5. BUSINESS (old)

5.1 Community Paramedicine (July 18, 2012)

The pilot projects have been operational for over a year. There has been a request from the State to the Office of Statewide Health Planning and Development (OSHPD) to extend the pilot projects that are continuing. In the meantime, Dr. Mitchell Katz, Director, Health Agency, is interested in patients being taken to sobering centers and to the psychiatric urgent care centers by paramedics from the field, as it was addressed it in the Mental Health/Substance Abuse Ad Hoc Committee report. Furthermore, Supervisor Hahn has made a motion for the Board of Supervisors to sponsor state legislation that would allow local EMS Agencies to promulgate rules and regulations that would enable this practice.

The County Legislative Advocates have been working with Senator Gipson on AB 820, a place holder legislation specifically on paramedic destination to sobering centers and psychiatric urgent cares. They have also scheduled a meeting in Sacramento with a stake holder group on March 24, 2017. Entities that have been invited to attend this meeting include, Emergency Medical Services Administrators Association of California (EMSAAC) members, which are the local EMS agency Directors from throughout the state and the Hospital, Ambulance and Nursing Associations. Ms. Chidester will be attending the hearing.

Commissioner Paul Rodriguez asked for a list of Community Paramedic pilot projects that are operating in the County. Ms. Chidester said there are two in existence; one from Glendale Fire Department on Congestive Heart Failure Program and the second from Santa Monica Fire Department on Alternate Destination.

Action: ***Provide a list of the pilot programs in the County to Commissioner Rodriguez.***
Responsibility: ***EMS Agency***

Public Comment:
Dr. Clayton Kazan, Medical Director, Los Angeles County Fire Department and former EMS Commissioner representing California American College of Emergency Physicians (CAL/ACEP), shared that CAL/ACEP has taken the stance that virtually every patient that contacts 9-1-1 or that EMS providers coming in contact with, per the word of the president, deserves a medical screen exam by an emergency physician in the emergency department. In his opinion, this is completely unrealistic

when you look at the growth of patient volume and bed capacity in emergency departments. CAL/ACEP's argument was that there was a lack of evidence to say that patients can be safely transported to other destinations and until they see published trials that demonstrate the safety of alternative destinations, CAL/ACEP will not support any change to legislation

Dr. Kazan adds that his argument was "show me a published study showing that a paramedic could provide any care in the field in 1969, when the system was established," it did not exist; it was based on community's needs. When people keep describing that paramedics are doing these assessments in the field, should keep in mind that paramedics are doing so under the guidance and regulations of emergency physicians and the EMS Agency, who are not just emergency physicians but are double boarded in emergency medicine and EMS, and are practicing under the medical direction of mostly EMS double boarded emergency medicine physicians as well that create the parameters under which the paramedics can do the medical screens. Furthermore, there is law enforcement who is not medically trained at all, doing similar screening in similar situations. National ACEP supports the idea of alternative destination of community paramedicine and mobile integrated health; it is CAL/ACEP who has taken the firm stance and opposed.

Dr. Kazan added that data is being analyzed every day in our systems, not everything is published in medicine, we look for quality improvement data for every project we are working on, and we know our system very well. It is fair to say we can be trusted to continue to monitor our systems. If a step is taken and it is realized to be erroneous, it can quickly be corrected. The system needs a bit more flexibility to work on day-to-day and month-to-month to continue to operate successfully.

5.2 Standing Committee Proposed Appointments

Cathy Chidester informed the Commissioners that because of the changes that affected the commission membership, some other changes were made to the Standing Committee appointments; one was to appoint Commissioner Marc Eckstein, MD., to Chair the Base Hospital Advisory Committee (BHAC) and second to appoint Commissioner Carole Snyder to Chair the Education Advisory Committee (EAC).

5.3 Ad Hoc Committee (Mental Health and Substance Abuse)

Chairman Cheung announced that the EMS Agency solicited feedback from multiple stakeholders many, which already had representatives on the Ad Hoc Committee. The comments received were from Jackie Lacey from the District Attorney's Office; Destiny Castro on behalf of CEO Risk Management; Mario Salcedo on behalf of Dr. Gary Tsai, Medical Director of the Los Angeles County Department of Public Health, Substance Abuse Prevention and Control Division; Mitchell Katz, Director, Health Agency; Curley Bonds, M.D., on behalf of California Psychiatric Society; Brittney Weissman, Executive Director, National Alliance on Mental Illness (NAMI), and Los Angeles Area Fire Chief's Association (LAAFCA). In reviewing the comments received, they were largely supportive. LAAFCA itemized their comments and indicated what they supported and the recommendations they didn't support.

Commissioner Dave White added that LAAFCA's Fire Chiefs reviewed the report and they are mostly very supportive of the items but their concern has to do with the impact on some of the proposed changes on ambulance resources and the need to identify some other resources to be able to expand transport capabilities; it is hard to

justify sending someone using a paramedic ambulance to a hospital because they are on 5150 hold but they do not have any other medical issue, and then not have that resource be available to the community.

Kay Fruhwirth, Assistant Director, EMS Agency added that the next steps will be for discussion with the commission members to either bring the Ad Hoc committee members back together to begin working on the various recommendations.

Chairman Cheung proposed for the Ad Hoc Committee to reconvene by meeting with the various entities for discussion of the various next steps and the specific recommendations to pursue.

Public Member Request:
Dr. Clayton Kazan informed the Commission that he is scheduled to t present the Ad Hoc Committee Report to the Permanent Steering Committee for the Office of Diversion and Re-Entry (ODR) on April 19, 2017 and asked for approval to do this. Dr. Kazan is a member of this committee and they are also addressing mental health and substance abuse issues related to access to care and he is a member of that committee

Chairman Cheung stated there are no oppositions for Dr. Kazan as the Chair of the Ad Hoc Committee to present.

BUSINESS (New)

5.4 Ad Hoc Committee for Wall/Time Diversion

Ms. Chidester reported that at the EMSC meeting held on Wednesday, January 15, 2017, there was a discussion about wall time and how wall time has been captured now with the request through a legislative action to capture how long the ambulances are at the hospital from the time it rolls up to the hospital until the patient is taken off the gurney and a report is given and there is a transfer of care; this being Ambulance Patient Off-load Time (APOT). This is a very important issue that needs to be worked on and the EMS Agency is working very closely with Hospital Association of Southern California (HASC) on this. Commissioner Carole Snyder brought up a concern about how wall time is being captured, who is putting the time in, and how we are validating these times.

The discussion was also on how important it is to get the patient transitioned to care and release the ambulance and field providers to get back to the next 9-1-1 call. There was also a question on the diversion policies as to how they were developed and if they are effective. Furthermore, there was a recommendation to get back together with HASC and have them coordinate a committee to re-look at the diversion policies and wall times and how patients are moved. Another suggestion, however, was to form another Ad Hoc committee of the Commission, like the one formed for the Mental Health/Substance Abuse committee, and for the Ad Hoc Committee on Wall Time/Diversion to make recommendations and change policy to help alleviate the long wait times and get the EMS providers back in the field. There has not been a motion or action taken on this item because it had not been on the EMSC agenda.

Commissioner White stated he had presented this issue to LAAFCA in February 2017 and that members are interested in being part of this Ad Hoc Committee on

Wall Time/Diversion. Commissioner Carol Snyder volunteered to Chari this Ad Hoc Committee.

Chairman Cheung moved to create an Ad Hoc Committee to address diversion and wall time issues.

Motion by Chairman Cheung, Second by Commissioner Hisserich to create a Wall Time/Diversion Ad Hoc Committee. Motion carried unanimously.

6. COMMISSIONERS COMMENTS/REQUESTS

None

7. LEGISLATION

Cathy Chidester shared an EMSAAC Legislative report with commissioners and staff, and provided a report on the following Bills:

- **AB 263 – Emergency medical services workers: Rights and working conditions**
  The position of EMSAAC is to be watching the progress of this Bill. Commissioner Ower added that LACAA is also in the same mind-frame as Ms. Chidester; the Association is opposing.
- **AB 697 – Tolls: Exemption for privately owned emergency ambulances**
  To exempt authorized emergency vehicles from the payment of a toll or charge on a vehicular crossing, toll highway, or high-occupancy toll (HOT) lane, etc.
- **AB 820 – Community paramedicine program**
  It is a place holder Bill for community paramedic program supported by Los Angeles County.
- **AB 896 – Emergency Services**
  To enact legislation relating to the inclusion of all California federally recognized tribes in California's emergency services and disaster preparedness agreements.
- **AB 909 – Emergency response: Public access trauma kits**
  Trying to get trauma kits available in public places much like the Automated External Defibrillator (AED).
- **AB 1650 – Emergency medical services: Community paramedicine**
  Ambulance associations are very interested in this Bill because other community paramedic programs, besides the alternate destination, are allowing for other community paramedic programs to provide more effective, efficient and timely health care and lowering health care costs.
- **SB 185 – Vehicles: Violations**
  Allows the poor to request a waiver to any penalties associated with a violation if the defendant is indigent or feel they cannot pay. This also supports the EMS Agency because $4 of every moving violation goes to the Maddy Fund and these funds are used for the physician billing and some of the hospital activities.
- **SB 443 – Pharmacy: Emergency medical services automated drug delivery**
  This Bill will allow Los Angeles County Fire Department (LACoFD) to use automated pharmaceutical supply machines; the Bill, however, has some activity to make it not specific to the LACoFD only.

8. DIRECTOR'S REPORT

The executive summary of the Vision Zero Report was provided to Commission members and staff present. The Department of Public Health, in completing the report, worked closely with Richard Tadeo, Assistant Director, EMS Agency to include some of the EMS trauma data. The report, which is thorough, well written and fully detailed will be useful for future trauma prevention activities. GIS was used to spot where injuries occurred and to identify where they would go in the next steps. Public Health is also working with the EMS Agency, trauma hospitals in conjunction with their trauma prevention coordinators, and different communities since they have trauma prevention efforts that they do. Public Health has been awarded Measure B funds to continue to work on some of the trauma prevention programs. The report talks about strategies that are being implemented.

Pomona Valley Hospital opened up as a designated Level II Trauma Center on March 1, 2017. Currently, they have a very small catchment area but it will be expanded at the beginning of April 2017 based on their performance in March.

Sidewalk CPR will be held on June 1, 2017; anyone interested in participating must sign up by completing the respective application.

The EMSAAC annual conference will be May 9 -10, 2017, in San Diego, CA.

The State EMS Authority has annual awards presentations in December of each year. Again in 2016, a number of these awards in various categories were granted to Los Angeles County personnel. Ms. Chidester provided a presentation in which each and every awardee, from Los Angeles County, was mentioned in honor of their great achievement.

Dr. Nichole Bosson, Assistant Medical Director, EMS Agency provided an update on the following topics:

- Color Code for Kids pre-calculation of drug in mLs was implemented on February 1, 2017.
- The EMS Agency is moving forward with the two tiered stroke routing system, which will include designating Comprehensive Stroke Centers.
- The EMS Agency is finalizing EMS Update 2017, with a big focus being on provider impression, which was mandated by the State. The train the trainer dates are set for late April 2017.

9. ADJOURNMENT

The Meeting was adjourned by Chairman Erick Cheung at 2:12 PM. The next meeting will be held on May 17, 2017.

Next Meeting: **Wednesday, May 17, 2017**
EMS Agency
10100 Pioneer Blvd. Suite 200
Santa Fe Springs, CA 90670

Recorded by:
Amelia Chavez
Acting, EMSC Liaison

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District
Mark Ridley-Thomas
Second District
Sheila Kuehl
Third District
Janice Hahn
Fourth District
Kathryn Barger
Fifth District

Commissioners
Ellen Alkon, M.D.
Southern California Public Health Assn.
Chief Robert E. Barnes
Los Angeles County Police Chiefs Assn.
Lt. Brian S. Bixler
Peace Officers Association of LA County
Erick H. Cheung, M.D., Chairman
Southern CA Psychiatric Society
Marc Eckstein, M.D.
LA County Medical Association
John Hisserich, Dr. PH.
Public Member (3rd District)
James Lott, PsyD., MBA
Public Member (2nd District)
Mr. Robert Ower
LA County Ambulance Association
Margaret Peterson, Ph.D.
Hospital Association of Southern CA
Paul S. Rodriguez
CA State Firefighters' Association
Nerses Sanossian, MD, FAHA
American Heart Association
Western States Affiliate
Carole A. Snyder, RN
Emergency Nurses Association
Mr. Colin Tudor
League of Calif. Cities/LA County Division
Mr. Gary Washburn
Public Member (5th District)
Chief David White, Vice-Chair
Los Angeles Area Fire Chiefs Association
Pajmon Zarrineghbal
Public Member (4th District)

VACANT
American College of Surgeons
California Chapter-American College of
Emergency Physicians (CAL-ACEP)
Public Member (1st District)

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May 17, 2017

COMMISSIONERS	ORGANIZATION	EMS AGENCY STAFF	POSITION
☑ Ellen Alkon, M.D.	So. CA Public Health Assn.	Cathy Chidester	Director
* Robert Barnes	LAC Police Chiefs Assn.	Kay Fruhwirth	Assistant Director
☑ Lt. Brian S. Bixler	Peace Officers Assn. of LAC	Richard Tadeo	Assistant Director
* Erick H. Cheung, M.D.	So. CA Psychiatric Society	Nichole Bosson, MD	Assistant Medical Dir.
☑ Marc Eckstein, M.D.	L.A. County Medical Assn	Amelia Chavez	Commission Liaison
☑ John Hisserich	Public Member, 3rd District	Lucy Hickey	Staff
☑ Clayton Kazan, M.D.	CAL/ACEP	Cathlyn Jennings	"
* James Lott	Public Member, 2nd District	Susan Mori	"
* Robert Ower	LAC Ambulance Association	Gary Watson	"
* Margaret Peterson, PhD	HASC	David Wells	"
☑ Paul S. Rodriguez	CA State Firefighters' Assn.	Michelle Williams	"
* Nerses Sanossian, M.D.	American Heart Association		
☑ Carole Snyder	Emergency Nurses Assn.		
* Colin Tudor	League of California Cities		
* Gary Washburn	Public Member, 5th District		
☑ Chief David White	LA Chapter-Fire Chiefs Assn.		
☑ Pajmon Zarrineghbal	Public Member, 4th District		
	GUESTS		
Jaime Garcia	HASC		
Samantha Vergas-Gates	Long Beach Medical Center		
Josh Hogan	Long Beach Fire Department		
Dr. Clayton Kazan	Los Angeles Co. Fire Dept.		
Nicole Steeneken	Los Angeles Co. Fire Dept.		
Michael Murrey	Manhattan Beach Fire Dept.		
Caroline Jael	Torrance Fire Department		

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

RECORD OF MEETING
(No Quorum Present)

CALL TO ORDER:

The Emergency Medical Services Commission (EMSC) meeting was held in the EMS Commission Hearing Room, 10100 Pioneer Blvd., Santa Fe Springs, CA. 90670. An informational meeting proceeded at 1:21 PM as there was not a quorum of the commission membership present.

ANNOUNCEMENTS/PRESENTATIONS:

Self-introductions were made starting with EMSC members and followed by EMS Agency Staff. Commissioner Chief White introduced and welcomed Commissioner Pajmon Zarrineghbal, a recently appointed commissioner, who is representing the 4th Supervisorial District.

CONSENT CALENDAR:

Items 2, 3 and 4 will not be covered due to lack of commission quorum.

5. BUSINESS (old)

5.1 Community Paramedicine (July 18, 2012)

Cathy Chidester shared the EMSAAC Legislative Report and reported on the following two Bills, as they relate to Community Paramedicine:

- AB 820, Task Force: Transportation Alternatives
  This Bill is supported by Los Angeles County, and it is specifically on alternate transportation to sobering centers and to psychiatric urgent care centers. The County has one sobering center and there are several psychiatric urgent care centers. This Bill, which did not have broad support, has been a two-year's Bill. The Bill still needs further discussion with constituent groups to better define the process of assessment and determination for a patient to go to an alternate care facility for sobering and/or psychiatric services.

  The main opposition for alternate destination is California American College of Emergency Physicians (CAL/ACEP). Ms. Chidester added that California Professional Firefighters (CPF) position will be consistent with CAL/ACEP. Furthermore, CPF were concerned about liability issues for Paramedics and Emergency Medical Technicians (EMTs) with the Bill going forward as written.

- AB 1650, Emergency Medical Services: Community Paramedicine
  This Bill does not mention Alternate Destination. EMSAAC is watching this Bill to see if there is an opportunity to add language pertaining to alternate destination to sobering centers and psychiatric urgent care centers. The language in this Bill is almost like a pilot project or study for the types of programs that are intended with this Bill; it is not the best avenue to go through since the pilot project with Office of Statewide Health Planning and Development (OSHPD) have been done.

  Ms. Chidester added that the Community Paramedicine pilot projects are still ongoing. The State and San Francisco have implemented an Alternate Destination project taking 9-1-1 patients to their sobering center. Additionally, CAL/ACEP has not taken an opposed or in favor position on this Bill and CPF has not taken a position either.

Dr. Marianne Gausche-Hill, Medical Director, EMS Agency also provided an update on the following Bill:

- SB 443, Pharmacy: Emergency medical services automated drug delivery systems
  Although it is a place holder for now, the Board of Pharmacy has been working with us as well as the Emergency Medical Directors Association of California (EMDAC). There is great desire on moving forward with this Bill to allow for the Pyxis Med-station (automated medication dispensing system) machines-like, to be in fire stations essentially for the storage, delivery and tracking of controlled substances. In speaking with the Health Aid for Senator Hernandez, it appears

that they will work with us on the language allowing all EMS providers and medical directors to oversee these machines.

5.2 Ad Hoc Committee (Mental Health and Substance Abuse)

Kay Fruhwirth, Assistant Director, EMS Agency shared with members of the commission a table that lists the nine (9) recommendations that came out of the Ad Hoc Committee meeting with Mental Health and Substance Abuse Emergencies. Commissioner Erick Cheung, MD., who is not present at this meeting, has reviewed the list and the documents put together by the Ad Hoc committee as well. Ms. Fruhwirth added that the items with short-term impact have been identified to be worked on now and subsequently will work on those considered to be long-term items (longer than 2 years). The responsible entities to take the short-term projects forward have been identified. The next step is to put small workgroups together of the stakeholder to begin the task.

BUSINESS (New)

5.3 Ad Hoc Committee for Wall/Time Diversion

Richard Tadeo, Assistant Director, EMS Agency reported that he will be meeting with Commissioner Carole Snyder to work on identifying and inviting the membership for the Ad Hoc Committee for Wall/Time Diversion. Commission members will be provided with a list of members, which will include representatives from Fire Departments, with two different categories consisting of City and County, Ambulance Companies and Exclusive Operating Area providers.

5.4 Cannabis Regulation and Licensing – Board Motion

Cathy Chidester shared a copy of the Board of Supervisors' motion dated February 7, 2017. She added that the State had a conference for trauma and invited a speaker from Colorado to discuss how the implementation or legalization of cannabis has affected EMS and trauma in Colorado.

Colorado reported seeing an increase in overdoses with legalization since the potency of marijuana available today is different than what was available in the 1970's and 80's; it has gone from about 5% Tetrahydrocannabinol (THC) to about 30% and the potency can vary with every purchase as there is no standard labeling indicating the potency like there is with alcohol and other drugs. The risk of overdose especially in children comes from edibles that contain THC and the children get access to these edibles or the adults consuming edibles not knowing the potency and overdosing. Colorado also reported an increase of burns which are reported to happen while extracting the "honey oil" and resultant explosions that can and do occur.

Part of the discussion was the importance of the collection of data, which helps to identity what the current system is like, what injuries are currently being identified related to marijuana use and other drug use, versus collecting this same data post legalization in order to measure the impact of legalization. If data is not available, there will not be supportive justification to obtain funding that is generated under the legalization.

6. COMMISSIONERS COMMENTS/REQUESTS

Commissioner Marc Eckstein asked if EMSC will be able to support AB820 as it seems to be very timely while we are talking about emergency departments overcrowding and the wall time being a huge problem for public safety.

Commissioner Brian Bixler stated he would be very interested in supporting AB820 since there has been a huge burden on all resources.

Cathy Chidester responded that the Commission has never taken a position on a Bill and does not know if it possible but will ask County Counsel and will provide feedback at the next meeting.

Action: Verify with County Counsel
Responsibility: Cathy Chidester, Director, EMS Agency

7. LEGISLATION

Cathy Chidester continued her report from the EMSAAC legislative report on the following two Bills, as she already reported for item 5.1 on Community Paramedicine:

- AB 263, Emergency medical services workers: Rights and working conditions
  There is a concern about the impact to the private ambulance companies and the EMS response as the Bill is intended for the employers to provide employees with prescribed rest and meals periods.

- AB 387, Minimum wage: Health professionals: Interns
  This impacts the EMT and Paramedic programs. The intent of the Bill is for Hospitals to pay students in healthcare programs during their clinical internship (i.e. nursing students, radiology students, EMT students, etc.). If hospitals have to pay students to do their internships, that would bring a negative effect on our EMT and paramedic training schools and the availability of EMTs for the Fire Departments and Ambulance Companies. Hospitals have very limited employment for EMT's; therefore, instead of paying, their option may be not provide internships for this level of healthcare personnel.

8. DIRECTOR'S REPORT

- A letter of support was written on behalf of the Commission for a grant application that the EMS Agency submitted requesting funding for the development of a smart device Application for the Color Code Drug Dosages: LA County Kids Application. Dr. Gausche-Hill added that this Application will take Policy No. 1309, which essentially was a collaborative work with Pharmacy colleagues to standardize the formulary, which allows the calculation of the drug dosages in terms of mLs and automate the selection of weight, drug and dose to be delivered.

- June 1st is the annual Sidewalk CPR Day. The press conference will be held at a school in Eagle Rock and the American Heart Association, Los Angeles County Fire Department, Los Angeles City Fire Department and the EMS Agency will be present.

- Agenda item numbered 2.11 from “Correspondence” addressed to the Cities. The contract with private ambulance companies for Emergency Ambulance Transportation Services 9-1-1 Response was extended to support the Los Angeles Fire Departments and several other Fire Departments on transport services. The contested areas were 2, 3, 4 and 5. The protests were reviewed, results were given and the County is ready to go to the Board of Supervisor to award the contracts. The highest score is in area 2, with Schaefer Ambulance; Areas 3, 4 and 5 were Care Ambulance. Currently, Area 3 is Schaefer Ambulance and Area 5 is American Medical Response Ambulance.

9. ADJOURNMENT

The Meeting was adjourned by Vice-Chairman, Chief David White, at 2:08 PM. The next meeting will be held on July 19, 2017.

Next Meeting: **Wednesday, July 19, 2017**
EMS Agency
10100 Pioneer Blvd. Suite 200
Santa Fe Springs, CA 90670

Recorded by:
Amelia Chavez
EMSC Liaison

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

Tel: (562) 347-1500
Fax: (562) 941-5835

To ensure timely, compassionate and quality emergency and disaster medical services.

June 22, 2017

VIA FAX/EMAIL

Kurt Norwood, Fire Chief
Montebello Fire Department
600 N. Montebello Boulevard
Montebello, CA 90640

Dear Chief Norwood:

STATE EMS DATA SYSTEM REQUIREMENTS AND ELECTRONIC PATIENT CARE RECORD (ePCR) IMPLEMENTATION

In 2013, the Emergency Medical Services Agency revised Reference No. 607: *Electronic Submission of Prehospital Data* (Attached), requiring all EMS provider agencies to submit electronic patient care records (ePCR) to the EMS Agency by the end of 2016. This policy change also ensured compliance California State Assembly Bill 1129.

Our records indicate that your department is in the process of implementing an ePCR program; however, your department is not currently submitting data electronically and is therefore out of compliance with Reference No. 607.

Please note that Reference No. 607, requires that the data must be transmitted to the EMS Agency in a format that meets the LA-EMS Data Dictionary requirements. Most of the Independent City have selected Digital EMS, which meets this requirement.

Please submit a plan for implementation of an ePCR program, which includes a timeline with major milestones, within 30 business days of receipt of this letter to Michelle Williams, EMS Data Systems Manager.

Please contact Michelle Williams at michwilliams@dhs.lacounty.gov or (562) 347-1658 if you have any questions. Thank you for your attention to this matter.

Sincerely,

Cathy Chidester
Director

CC:mw
01-27

Attachment

c: Paramedic Coordinator, Montebello Fire Department

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **ELECTRONIC SUBMISSION OF PREHOSPITAL DATA** (EMT, PARAMEDIC, MICN) REFERENCE NO. 607

PURPOSE: To establish procedures for the submission of electronic data by prehospital care providers.

AUTHORITY: California Code of Regulations, Title 22, Chapter 4, Sections 100169, 100170
Health Insurance Portability and Accountability Act (HIPAA), 2009
Health and Safety Code, Section 130202
Health Information Technology for Economic and Clinical Health Act (HITECH)

DEFINITIONS:

Electronic Data: Patient care records submitted in electronic format (as per LA-EMS Data Dictionary) or field electronic data capture (ePCR).

PRINCIPLES:

1. All submission of electronic personal health information (PHI) shall be in compliance with HIPAA regulations.

2. Electronic patient care records require redundant back up and emergency down time procedures.

3. The provider agency will ensure that the electronic data is compliant with the EMS Agency's data system requirements.

4. All provider agencies shall submit data electronically, which meets the LA-EMS data requirements, to the EMS Agency by 2016.

POLICY:

I. Provider Agency Responsibilities

A. Prior to Implementation of an Electronic Data System

1. Electronic Data Submission Plan

Submit a plan, approved by the department's Fire Chief, to the EMS Agency for approval which includes:

a. Ability to transmit data to the EMS Agency which meets the LA-EMS Data Dictionary requirements.

b. A mechanism to provide immediate transfer of patient information to additional providers, including the transporting agency (if necessary).

APPROVED: Director, EMS Agency — Medical Director, EMS Agency

c. System to ensure only one patient care record per patient is created, per provider agency, regardless of the number of units an individual provider responds with.

d. A successful mechanism for receiving facilities to have the electronic record available upon the patient's transfer of care and any patient care related revisions made after leaving receiving facility.

e. Back-up system available in case of system failure.

f. Staff member assigned to act as a liaison between the vendor and EMS Agency to identify and correct data issues.

2. Notify the EMS Agency Data System Manager once a vendor has been selected and provide an estimated field implementation date

3. Notify all hospitals that provider transports to, of intent to convert to an ePCR system and the tentative start date.

B. Implementation

1. Ensure the selected vendor contacts the EMS Agency Data System Manager to discuss the data format, transmission procedures and obtain sequence number format.

2. Maintain a staff member to act as liaison between the vendor and the EMS Agency to identify and correct data issues.

3. **If controlled drugs are obtained through a County pharmacy, prior approval by the EMS Agency and County Pharmacy, as to the mechanism for procurement, must be in place.**

4. Submit validated test files, meeting the LA-EMS Data Dictionary and Extensible Markup Language (XML) Schema Definition (XSD) standard that accurately reflect the documentation in the electronic record upon import.

C. Ongoing

1. Transmit validated data to the EMS Agency for import into the TEMIS database within 30 days of the last day of the preceding month. Files with validation errors will be rejected and must be corrected and re-transmitted prior to import.

2. Address and correct data related issues as they arise.

3. Implement annual data field and export program changes within three months of publication

II. EMS Agency Responsibilities

A. Review and approve the electronic data submission plan.

B. Liaison with the provider agency and receiving hospital(s) to establish a mutually agreed upon method by which the receiving hospital(s) will obtain the ePCR.

C. Meet with the provider agency and vendor to review electronic data submission plan and provide the Sequence Number formatting, LA-EMS Data Dictionary, LA-EMS XSD, LA-EMS XSD validator and LA-EMS sample XML.

D. Review validated test files for completeness and accuracy and provides a report to the provider agency and vendor with noted deficiencies.

E. Ongoing

1. Monitor incoming data and notify the provider as issues arise and follow up with provider as needed to ensure data issues are addressed and resolved.

2. Present data field changes annually to the Paramedic Agency Advisory Committee.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 604, **Confidentiality of Patient Information**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 608, **Disposition of Copies of the EMS Report Form**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**

LA-EMS Data Dictionary
LA-EMS Extensible Markup Language (XML) Schema Definition (XSD)
LA-EMS XSD Validator
LA-EMS Sample XML

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

June 21, 2017

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

Tel: (562) 347-1500
Fax: (562) 941-5835

To ensure timely, compassionate and quality emergency and disaster medical services.

Tony Ramos, City Manager
City of Claremont
207 Harvard Avenue
Claremont, CA 91711

Dear Mr. Ramos:

This is to inform you that on June 20, 2017, the Board of Supervisor approved Exclusive Operating Areas (EOAs) agreements for Emergency Ambulance Transportation Services 9-1-1 Response in your area.

The Department of Health Services/Emergency Medical Services (EMS) Agency manages the contracting, with oversight by the State Emergency Medical Services Authority (EMSA), for exclusive rights to Emergency 911 Ambulance Services. Areas of the County that are not Grandfathered under the Health and Safety Code, 1797.224 are required to be defined and contracted by a Request for Proposals (RFP) every ten years.

This newest RFP replaces the 2006-2016 agreements in the 1 through 9 (Attachment). Yesterday, June 20th, the Board of Supervisor's action was to approve agreement with Schaefer Ambulance Company for EOA 2 and Care Ambulance Services for EOAs 3, 4, 5. Services under the new agreements will begin on July 1, 2017 and expire June 30, 2027.

We anticipate a smooth transition between services, many of the employees from Schaefer and AMR have been hired by Care Ambulance Services and will be working in the same areas. The agreements, scope of work, and transition will be closely monitored by the EMS Agency and Los Angeles County Fire District, Monrovia, La Habra Heights, Montebello, and Santa Fe Springs Fire Departments.

The EMS Agency works closely with both Schaefer and Care ambulance companies and is confident that they will provide excellent service in your city. If you wish to contact Care Ambulance, please contact Mr. Bill Weston at (714) 228-3823 or by email at Billw@careambulance.net, or if you have any questions or desire to reach out to us with specific issues to be addressed in your city, please contact me at (562) 347-1604.

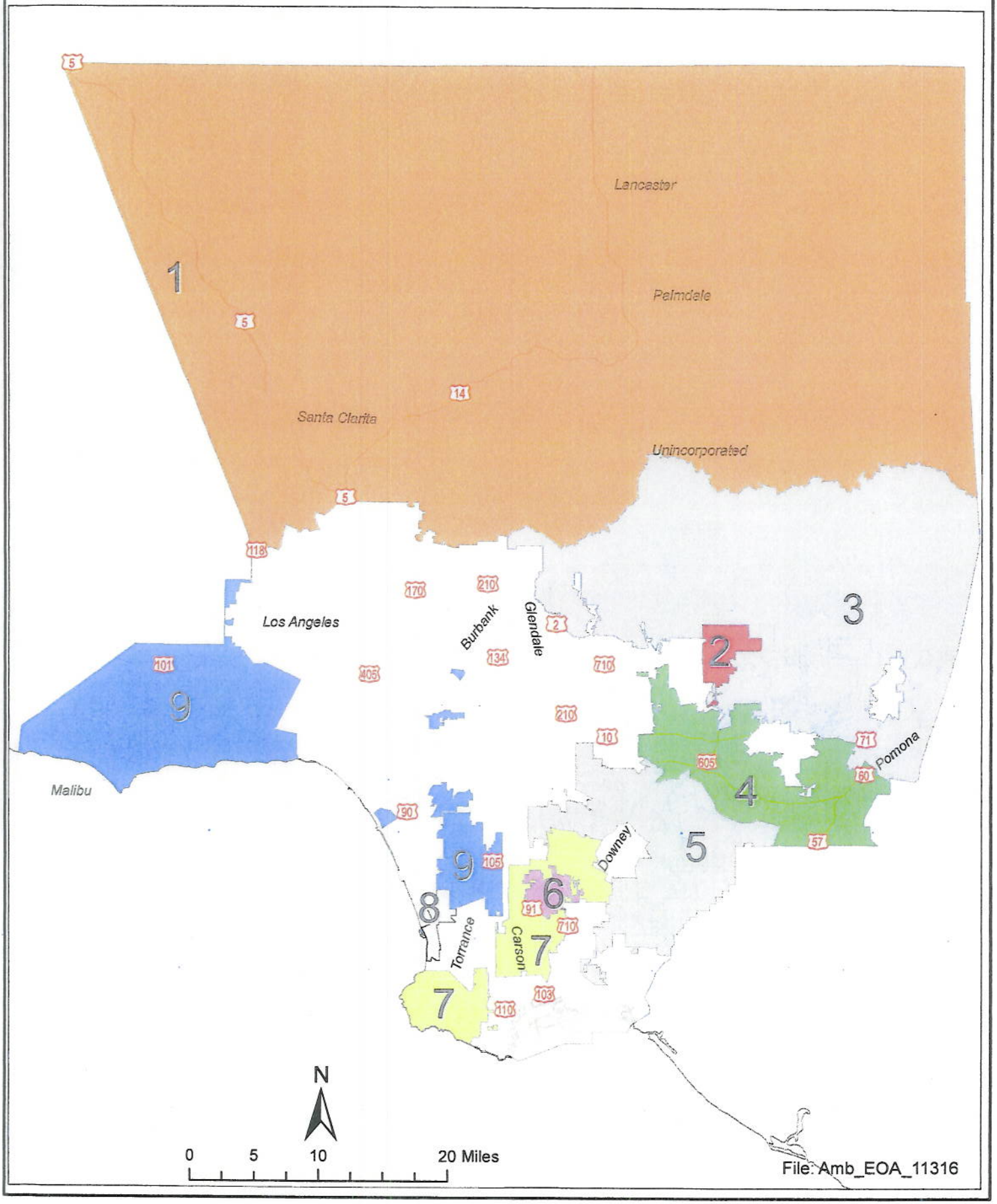
Sincerely,

Cathy Chidester
Director

Attachment

c: Health Deputies
Director, Health Agency
Deputy Director, DHS
EMS Commission
City Mayor

LOS ANGELES COUNTY
9-1-1 AMBULANCE EXCLUSIVE OPERATING AREAS 2016



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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Sheila Kuehl
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Janice Hahn
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Kathryn Barger
Fifth District

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Director

Marianne Gausche-Hill, MD
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To ensure timely, compassionate and quality emergency and disaster medical services.

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

June 21, 2017

Roger J. Lewis, MD, Ph.D
Chair,
Harbor-UCLA Medical Center
Department of Emergency Medicine
roger@emedharbor.edu

Re. Appointment of Nichole Bosson, MD, MPH as EMS Fellowship Program Director as of July 1, 2017

Dear Dr. Lewis, Roger

It gives me great pleasure to announce the appointment of Dr. Nichole Bosson as the new *Program Director for Emergency Medical Services (EMS)* at *Harbor-UCLA Medical Center* and *the Los Angeles County EMS Agency.*

Dr. Bosson brings great experience in EMS to this position, she attended Tufts University School of Medicine for medical training and completed her Emergency Medicine Internship and Residency at NYU Belleview Medical Center in New York. She then joined the Harbor family in 2011 and completed her EMS and Disaster Research Fellowship in 2013. During her fellowship she obtained a Master's in Public Health at the UCLA School of Public Health.

Since the completion of her fellowship she has been active in EMS as the Medical Director for the J. Michael Criley Paramedic Training Institute (PTI) before recruiting Dr. Shira Schlesinger to that position. Dr. Bosson remains as active faculty for PTI and currently serves as the Assistant Medical Director for the Los Angeles County EMS Agency. As the Assistant Medical Director of the Los Angeles County EMS Agency and in that capacity, been active in the Data Advisory Committee, provided education to 4000 paramedics for the numerous EMS Updates, serves as Co-Chair of the Medical Advisory Committee and currently is Chair of our Task Force for ECG Acquisition and Transmission.

On a regional level Dr. Bosson is an active member of the EMS Medical Directors Association of California serving as a member of the Scope of Practice Committee. She also has been active in the California TF2 Urban Search and Rescue Deployable Medical Team since 2014 and was deployed to the Nepal earthquake in April of 2015. On a national level, she has been active in the Society for Academic Emergency Medicine, serving on the International Medicine Interest Group as well as the EMS Interest Group and the Research Committee. Her involvement with National Association of EMS Physicians includes serving on the Research and Educational Committees and as a member of the American College of Emergency Physicians, she is active in the EMS Interest Group.

Dr. Bosson has been extremely prolific in research, having numerous abstracts and scientific presentations. She has 20 Peer Reviewed papers to her credit and has over 15 Abstracts with 5 papers in preparation.

Overall, Dr. Bosson brings many skills to the Program Director position for EMS including an extensive knowledge base, outstanding clinical skills, and an inquisitive mind that continues to produce research to improve the specialty of EMS.

Please join me in congratulating Dr. Nichole Bosson as EMS Fellowship Director, Harbor-UCLA Medical Center and the Los Angeles County EMS Agency.

Sincerely,

Marianne Gausche-Hill, MD, FACEP, FAAP, FAEMS
Medical Director, Los Angeles County EMS Agency
Professor of Clinical Medicine and Pediatrics, David Geffen School of Medicine at UCLA
Clinical Faculty, Harbor-UCLA Medical Center, Department of Emergency Medicine
Investigator, the Los Angeles Biomedical Research Institute at Harbor-UCLA

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562)941-5835

To ensure timely, compassionate and quality emergency and disaster medical services.

June 12, 2017

Bill Walker, Fire Chief
Santa Monica Fire Department
333 Olympic Blvd.
Santa Monica, CA 90401

Dear Chief Walker:

TERMINATION 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 of the Santa Monica Fire Department (SM) for their participation in the Community Paramedicine Alternate Patient Destination (ALTrans) Pilot Project.

The Community Paramedicine Pilot has been discontinued as of June 1, 2017. This pilot could not have taken place without the voluntary participation of SM. The EMS Agency appreciates the time spent training, and motivating your employees. Much has been learned, and although there was limited patient enrollment, the framework has been established to support future projects that could benefit the EMS system, paramedic programs 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:cj
06-09

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

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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Santa Fe Springs, CA 90670

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Fax: (562) 941-5835

To ensure timely, compassionate and quality emergency and disaster medical services.

June 2, 2017

TO: FAX/E-Mail Distribution

FROM: Cathy Chidester
Director

SUBJECT: **LOS ANGELES (LA) PRIDE MUSIC FESTIVAL AND RESIST MARCH**

This is to advise you of the *LA Pride Music Festival and Resist March* scheduled to take place on Saturday, June 10 and Sunday, June 11, 2017 in the City of West Hollywood. The reported event hours are as follows:

- June 10th, 2:00 p.m. to June 11th, 2:00 a.m.
- June 11th, 9:00 a.m. to June 12th, 2:00 a.m.

The estimated number of participants over the course of the weekend is 80,000 with an additional 200,000 on Sunday morning for the Resist March. During last year's LA Pride Music Festival, there were a total of 23 transports from the event to surrounding emergency departments. Event medical treatment stations will be used to help minimize the impact to surrounding hospitals.

The Emergency Medical Services (EMS) Agency encourages Emergency Departments in the area to prepare and staff adequately. The Medical Alert Center (MAC) will conduct a ReddiNet® Multi-Casualty Incident (MCI) poll to manage patient destinations. It is imperative that hospitals complete the MCI poll "Victim List" for patient tracking purposes of all event-related patients, including those who may self-transport.

In advance, please ensure that all affected personnel are properly informed. Should you have any questions or need further information, please contact the MAC Supervisor at (562) 941-1037.

CC:rj

Distribution:

Paramedic Coordinator, Los Angeles County Fire Department
Prehospital Care Coordinator, Each Hospital
Emergency Department Director, California Hospital Medical Center
Emergency Department Director, Cedars-Sinai Medical Center
Emergency Department Director, Centinela Hospital Medical Center
Emergency Department Director, Childrens Hospital of Los Angeles
Emergency Department Director, Encino Hospital Medical Center
Emergency Department Director, Glendale Adventist Med. Center/Adventist Health
Emergency Department Director, Glendale Memorial Hospital and Health Center
Emergency Department Director, Good Samaritan Hospital
Emergency Department Director, Hollywood Presbyterian Medical Center
Emergency Department Director, Kaiser Foundation Hospital – Panorama City
Emergency Department Director, Kaiser Foundation Hospital – Sunset
Emergency Department Director, Kaiser Foundation Hospital – West Los Angeles
Emergency Department Director, LAC+USC Medical Center
Emergency Department Director, Marina Del Rey Hospital
Emergency Department Director, Olympia Medical Center
Emergency Department Director, Providence Saint Joseph Medical Center
Emergency Department Director, Providence Saint John's Health Center
Emergency Department Director, Ronald Reagan – UCLA Medical Center
Emergency Department Director, Saint Vincent Medical Center
Emergency Department Director, Santa Monica/UCLA Medical Center
Emergency Department Director, Sherman Oaks Hospital
Emergency Department Director, Southern California Hospital at Culver City
Emergency Department Director, Valley Presbyterian Hospital
Emergency Department Director, White Memorial Medical Center/Adventist Health

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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To ensure timely, compassionate and quality emergency and disaster medical services.

May 30, 2017

BJ Bartleson, RN, MS, NEA-BC
California Hospital Association
1215 K Street, Suite 800
Sacramento, CA 95814

Dear Ms. Bartleson:

The Los Angeles County Emergency Medical Services (EMS) Agency would like to express our support for the Emergency Care Systems Initiative (ECSI) sponsored by the California Hospital Association, Hospital Council of Northern and Central California, Hospital Association of Southern California (HASC) and the Hospital Association of San Diego and Imperial Counties. It is critical that we address California's emergency care system through a consensus-driven approach where all stakeholders' perspectives are considered and an effective roadmap for change is developed.

Californians are turning to hospital emergency departments in record numbers, often because they cannot get the care or assistance they need elsewhere. Caring for patients in the appropriate setting can lower costs and improve patients' well-being.

We urge you to fund this initiative so we can engage all stakeholders, identify root causes, align solutions and effect change in a coordinated, data-driven effort.

Sincerely,

Cathy Chidester
Director

c: Jaime Garcia, Regional Vice President, HASC

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
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To ensure timely, compassionate, and quality emergency and disaster medical services.

May 25, 2017

TO: Distribution

FROM: Marianne Gausche-Hill, MD
Medical Director

SUBJECT: INAPPROPRIATE UTILIZATION OF 9-1-1 FOR INTERFACILITY TRANSFER (IFT)

This memo is to address the recent increase in the inappropriate utilization of the 9-1-1 system by acute care hospitals for the transportation needs of interfacility transfer (IFT) of patients between hospitals. These inappropriate transfers have public safety implications as well as potential EMTALA and Licensing violations.

The role of 9-1-1 emergency medical services providers is to be readily available to respond and provide care for individual's experiencing a medical emergency in the community where medical care in unavailable. The 9-1-1 system in Los Angeles County is not designed to respond to hospitals for IFTs.

There are only two acceptable circumstances where by the 9-1-1 system may be utilized to expedite transportation needs of an IFT. These involves patients who are in the hospital's ***emergency department*** and have either:

- **S-T Elevation Myocardial Infarction (STEMI) requiring emergent percutaneous intervention (PCI)**, or

- **Injured patients who meet one or more of the following 9-1-1 Trauma Re-triage Criteria to a trauma center:**
  - Persistent signs of poor perfusion
  - Need for immediate blood replacement therapy
  - Intubation required
  - Glasgow Coma Scale (GCS) less than 9
  - GCS deteriorating by 2 or more points during observation
  - Penetrating injuries to head, neck and torso
  - Extremity injury with neurovascular compromise or loss of pulses
  - Patients, who in the judgement of the evaluating emergency physician, have a high likelihood or requiring emergent life- or limb-saving intervention within 2 hours

EMTALA obligations need to be met by transferring hospitals even when 9-1-1 is utilized to transport patients who meet the criteria listed above. 9-1-1 should not be activated until the patient is fully ready to be transported to a facility who has accepted the patient. 9-1-1 paramedic transport units may only transport to hospitals that are reachable within 30 minutes. Hospitals should also be aware that paramedic units may transport patients who only require care within the scope of practice of a paramedic. The paramedic scope of practice does not include paralyzing agents or blood products.

For all inpatients and ED patients who do not meet the criteria above, transportation arrangements are to be made with a private ambulance company. It is the transferring hospital's responsibility to ensure that the appropriate type of transportation is utilized based upon the anticipated needs of the patient during transport.

The EMS Agency strongly encourages all acute care hospitals to develop agreements with ambulance companies to ensure timely availability of transports resources for IFTs.

Please ensure all your personnel who may be involved in IFTs are provided this information. Please do not hesitate to contact me or Richard Tadeo, Assistant Director, EMS Agency, at (562) 347-1610.

MHG:rt/cc

Distribution:

Director, EMS Agency
CEO, Each Acute Care Hospitals
ED Administrators, Each Acute Care Hospitals
Fire Chief/CEO, Each EMS Providers
Regional Vice President, HASC
Prehospital Care Coordinators, Each Paramedic Base Hospital

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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To ensure timely, compassionate and quality emergency and disaster medical services.

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

July 6, 2017

Lou Meyer, Project Manager
Community Paramedicine-Mobile Integrated Health
EMS Authority
10901 Gold Center Dr., Suite 400
Rancho Cordova, CA 95670

Dear Mr. Meyer:

Los Angeles County is interested in participating and submitting of applications for new sites in the Community Paramedicine Pilot Project. This is in response to the June 22, 2017 letter from the Emergency Medical Services Authority (EMSA).

The EMS Agency plans to partner with Arcadia, Los Angeles City, and Los Angeles County Fire Departments on projects specific to Alternate Destination as follows:

Arcadia Fire Department, Chief Michael Lang
Alternate Destination-Mental Health
Partner Destination - Arcadia Mental Health Center
330 E. Live Oak Avenue
Arcadia, CA 91006

Los Angeles City Fire Department, Chief Ralph Terrazas
Alternate Destination-Sobering Center
Partner Destination – Dr. L. Murphy Sobering Center
640 S. Maple Avenue
Los Angeles, CA 90012

Los Angeles City Fire Department, Chief Ralph Terrazas
Alternate Destination-Mental Health
Partner Destination – Exodus Recovery Center
1920 Marengo Street
Los Angeles, CA 90033

Los Angeles County Fire District – Chief Daryl Osby
Alternate Destination – Mental Health
Partner Destination – Exodus Recovery Center
12021 Wilmington Avenue
Los Angeles, CA 90059

Unfortunately, we will not have the benefit of UCLA's Center for Prehospital Care management of these projects. However, we do have the experience of participating and coordinating the previous Community Paramedic pilot projects and will certainly seek guidance from UCLA's Center for Prehospital Care.

We have scheduled a first meeting to review the pilot project requirement with the participating agencies and begin the development of the applications. Dr. Marianne Gausche-Hill, Medical Director, will be leading the work on the protocol and policy development for these projects.

These Alternate Destination projects are important to our EMS system operations and the community that we serve. We look forward to working with you and will be happy to answer any questions as necessary.

Sincerely,

Cathy Chidester
Director

c: Director, Health Agency
EMS Commission
Medical Director, EMS Agency
Fire Chief, City of Arcadia
Medical Director, City of Arcadia
Fire Chief, City of Los Angeles
Medical Director, City of Los Angeles Fire Department
Fire Chief, Los Angeles County Fire District
EMS Chief, Los Angeles County Fire District
Medical Director, Los Angeles County Fire District

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

BASE HOSPITAL ADVISORY COMMITTEE MINUTES

June 14, 2017

MEMBERSHIP / ATTENDANCE

	REPRESENTATIVES		EMS AGENCY STAFF
☐	Mark Eckstein, M.D., Chair	EMS Commission	Dr. Nichole Bosson
☐	Margaret Peterson, Vice Chair	EMS Commission	Richard Tadeo
☐	Carol Snyder, RN.	EMS Commission	Christine Clare
☐	Erick Cheung, Ph.D.	EMS Commission	Susan Mori
☐	Jessica Strange	Northern Region	Lorrie Perez
☑	Karyn Robinson	Northern Region	Christy Preston
☑	Annette Cornell	Northern Region, Alternate	Lucy Hickey
☑	Kristina Crews	Southern Region	Paula Rashi
☐	Samantha Verga-Gates	Southern Region	Gary Watson
☑	Laurie Mejia	Southern Region	David Wells
☑	Natalie Burciago	Southern Region, Alternate	Michelle Williams
☐	Christine Farnham	Southern Region, Alternate	Rebecca Garnet
☑	Paula Rosenfield	Western Region	
☑	Ryan Burgess	Western Region	
☑	Alex Perez-Sandi	Western Region, Alternate	
☐	Laurie Sepke	Eastern Region	
☑	Alina Candal	Eastern Region	**GUESTS**
☐	Jenny Van Slyke	Eastern Region, Alternate	Jamie Kahn, Torrance LCM
☑	Lila Mier	County Hospital Region	Michael Natividad,
☑	Emerson Martell	County Hospital Region	Kevin Millikan, Torrance Fire
☐	Jose Garcia	County Hospital Region, Alternate	
☐	Mike Hansen	Provider Agency Advisory Committee	
☐	Michael Murrey	Provider Agency Advisory Committee, Alt.	
☐	Jazmin Gonzalez	MICN Representative	
☐	Jeff Warstler	MICN Representative, Alt.	
☑	Robin Goodman	Pediatric Advisory Committee	
☐	Kerry Gold-Tsakonas	Pediatric Advisory Committee, Alt.	

	PREHOSPITAL CARE COORDINATORS				
☑	Kevin Lennox (AMH)	☐	Adrienne Roel (AMH)	☑	Laura Leyman (SFM)
☑	Courtney Derryberry (AVH)	☐	Rosie Romero (CAL)	☑	Kelly Arroyo (SMM)
☑	Dee Josing (HMN)	☑	Rachel Caffey (NRH)		
☐	Heidi Ruff (NRH)	☐	Gloria Guerra (QVH)		

1. **CALL TO ORDER:** The meeting was called to order at 13:04 P.M. by Alina Candal, Chairperson pro tem.

2. **APPROVAL OF MINUTES -** The April 12, 2017, meeting minutes were approved as submitted.

   M/S/C (Burgess/Crews)

3. **INTRODUCTIONS/ANNOUNCEMENTS:**
   - Rebecca Garnet, previously from Saint Francis Medical Center, was introduced as the new EMS Data Systems Coordinator.
   - Revised EMS Personnel Certification Fees effective July 1, 2017.

4. **REPORTS & UPDATES:**
   4.1 EMS Update 2017 *(R. Tadeo)*

   EMS Update 2017 training is halfway through and the EMS Agency has received positive feedback. Protocol clarifications and typographical errors are being addressed as they

are received and corrections will be posted on the EMS website by July 15, 2017, in time for August 1st implementation.

4.2 Sidewalk CPR *(S. Mori)*

The EMS Agency is in the process of collecting data, once participation totals are collected they will be published.

4.3 Treatment Protocol Development *(R. Tadeo)*

In the final stages of protocol development. Once drafted protocols are ready, anticipated in mid-July, a work group will convene to review and provide feedback. As discussed, a 2-3 month pilot study is planned for the Fall and subsequently finalized for endorsement by the Medical Advisory Council by December 2017.

4.4 Reference No. 1400 *(R. Tadeo)*

EMS Agency, in collaboration with the various medical directors of emergency medical dispatch centers, has developed guidelines for "pre-arrival instructions". These guidelines were planned to be Reference No. 1400. As an alternative they will be an attachment to Reference No. 227.

4.5 Cannabis Regulations and Licensing *(C. Clare)*

With the legalization of marijuana the Office of Marijuana Management (OMM) was formed February 2017 by the LA County CEO's office. There are multiple subcommittees that are part of OMM; Chris Clare is participating in the Cannabis Data Subcommittee and Dr. Bosson is participating in the First Responder Cannabis Subcommittee. Historical data will be collected and provided to OMM, from the trauma data base for trauma and marijuana usage. Next year marijuana usage, along with other substances, will be added to the EMS forms to allow for greater ability to evaluate substance usage.

5. UNFINISHED BUSINESS:

5.1 Reference No. 302, 9-1-1 Receiving Hospital Requirements *(R. Tadeo)*

M/S/C (Burgess/Crews) Approved as presented.

6. NEW BUSINESS:

6.1 Reference No. 610, 9-1-1 Receiving Hospital Data Dictionary *(R. Tadeo)*

Provided for information only.

6.2 Reference No. 838, Application of Patient Restraints *(C. Jennings)*

M/S/C (Crews/Mejia) Approved as presented.

6.3 Reference No. 1013, EMS Continuing Education (CE) Provider Approval And Program Requirements *(D. Wells)*

Page 10, Policy Xll. A. 2., Add a parenthesis around "s" in objectives, change wording from "(minimum of 2 per topic)" to say (minimum of 1 per hour)

Page 10, Policy XII. B. After key add “(if applicable)”

Page 10, Policy XII. G. Remove all of item G.

M/S/C (Burgess/Mejia) Approve Reference No. 1013, EMS Continuing Education (CE) Provider Approval and Program Requirements with recommended changes.

7. OPEN DISCUSSION:

R. Tadeo presented a request by the EMS Commission for the EMS Agency to develop a subcommittee addressing paramedic wall times. A group will be convened with representation from hospitals and providers to include: PIH, CAL, Pomona area, San Fernando Valley, Culver City and LA Ambulance Association. More details to follow in the future.

Dr. Bosson has just completed two studies: 1. Implementation of Reference No. 1303, Cath. Activation Algorithm- preliminary data indicates a decrease in cath. lab activation, by 1 in 16, based on a false positive EKG reading. This is a benefit to the system and if implemented into internal protocols could be a benefit to hospital programs.
2. Evaluation of 900 patients and the administration of Nitroglycerin vs. no Nitroglycerin during a suspected inferior MI. Preliminary data indicates by not administering Nitroglycerin, there is no change in patient outcome, and and administering NTG can cause a significant drop in blood pressure.

8. NEXT MEETING: BHAC’s next meeting is scheduled for **August 9, 2017**, at the EMS Agency @ 1:00 P.M.

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

ACCOUNTABILITITY: Lorrie Perez

9. ADJOURNMENT: The meeting was adjourned at 14:27 P.M.

EMERGENCY MEDICAL SERVICES COMMISSION
DATA ADVISORY COMMITTEE
WEDNESDAY, June 14, 2017

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

MEMBERSHIP / ATTENDANCE		
MEMBERS	ORGANIZATION	EMS AGENCY
☒ Nerses Sanossian , Chair	EMS Commissioner (MD)	Nichole Bosson
☒ Paul Rodriguez, Vice Chair	EMS Commissioner (CA State Firefighters' Assoc.)	Richard Tadeo
☒ John Hisserich	EMS Commissioner (Community Member)	Christine Clare
□ Colin Tudor	EMS Commissioner (League of CA Cities)	Michelle Williams
□ Matt Armstrong	Ambulance Advisory Board (LACAA)	Sara Rasnake
□ Trevor Stonum	Ambulance Advisory Board (alternate)	Rebecca Garnet
☒ Gloria Guerra	Base Hospital Advisory Committee (BHAC) (RN)	Susan Mori
□ Alina Candal	BHAC (alternate)	
☒ Ryan Burgess	Hospital Association of Southern California (HASC)	
□ Nathan McNeil	HASC (alternate)	
☒ Joanne Dolan	Long Beach Fire Department (LBFD) (RN)	
□ Don Gerety	LBFD (alternate)	OTHERS
☒ Dan France	Los Angeles Area Fire Chiefs Association	Geron Sheppard, Compton Fire Department
☒ Sean Stokes	LA Area Fire Chiefs Association (alternate)	
☒ Nicole Steeneken	Los Angeles County Fire Department (LACoFD)	
* Victoria Hernandez	LACoFD (alternate)	
☒ Al Flores	Los Angeles Fire Department (LAFD)	
□ John Smith	LAFD (alternate)	
□ VACANT	Medical Council (MD)	
☒ Marc Cohen	Medical Council (alternate)	
□ Corey Rose	Provider Agency Advisory Committee (PAAC)	
□ VACANT	PAAC (alternate)	
* Tchaka Shepherd	Trauma Hospital Advisory Committee (THAC) (MD)	
□ David Hanpeter	THAC (MD) (alternate)	
* Marilyn Cohen	THAC (RN)	
☒ Gilda Cruz-Manglapus	THAC (RN) (alternate)	
☒ Present *Excused □ Absent		

1. **CALL TO ORDER:** The meeting was called to order at 10:03 am by Commissioner Sanossian.

2. **APPROVAL OF MINUTES:** The minutes of the February 8, 2017 meeting were approved as written.

3. **INTRODUCTIONS/ANNOUNCEMENTS**

- LA County stroke data was presented at the International Stroke Conference held in Houston in March; analysis of data for last known well time in the field versus last known well time in the hospital will be submitted for publication.
- The annual EMSAAC conference was held on May 9-10, 2017 at the Loews Coronado Bay Resort in Coronado. Highlights included discussion on code 3 response times, tiered dispatch systems, and de-emphasis on code 3 transports due to risk to public safety.

4. **REPORTS AND UPDATES**

4.1. TEMIS Update *(Michelle Williams)*

Los Angeles County Fire (CF) Update: CF is still working with their vendor to resolve the data issues. Their goal is to be able to submit data from their electronic patient care records (ePCR) by July 31, 2017.

Los Angeles Fire (CI) Update: Data from January-June 2016 has been submitted. Vendor is working on submitting data for July 2016-current.

4.2. Service Changes *(Michelle Williams)*

Primary Stroke Centers (PSCs)
Kaiser Permanente South Bay Medical Center (KFH) and Memorial Hospital of Gardena (MHG) became PSCs on April 1, 2017.

Trauma Centers (TCs)
Pomona Valley Hospital Medical Center (PVC) became a Level II trauma center on March 1, 2017.

4.3 Data Verification *(Michelle Williams)*

Digital EMS continues to have mapping issues with 12-lead ECG fields and chief complaints=Other instead of Local Neuro, goal is to have resolution of issue in July. To prevent confusion by the providers, future data verification reports will not be sent to any provider until these issues are resolved.

5. UNFINISHED BUSINESS

5.1 Agenda Items *(Nerses Sanossian)*

Suggestions for future agenda items were requested from the committee, committee has no suggestions at this time.

6. NEW BUSINESS

6.1. Reference No. 610, 9-1-1 Receiving Hospital Data Dictionary *(Richard Tadeo)*

The 9-1-1 Receiving Hospital Database was created to receive outcome data on all patients transported to a 9-1-1 receiving facility, which will allow for a more comprehensive review of the 9-1-1 system within the County. Hospitals voiced concerns over increased workload required to manually enter data into the 9-1-1 Receiving Hospital Database. The goal is to have the ePCRs from the providers interface with the electronic medical records (EMRs) at the hospitals so that the data can be imported automatically. The idea of collecting data from the 9-1-1 receiving facilities was endorsed by the committee and a workgroup will be developed to discuss the details and processes needed to move this project forward.

6.2 Cannabis Data Collection *(Christine Clare)*

In November 2016, California voted to legalize the recreational use of marijuana, effective January 1, 2018. The Office of Marijuana Management (OMM) was created by the County to evaluate the impact the legalization of marijuana use will have within the County. Data from Colorado, where marijuana is already legal, demonstrated that overdose rates increased after the use of marijuana was legalized. Currently in LA County, only the trauma hospitals are collecting data on the specific drugs used by patients, County Fire is adding fields to their ePCR now to begin collecting data on any patients they treat who are under the influence of marijuana. Similar fields will be added to the EMS Report Form next year.

OPEN DISCUSSION: Richard Tadeo discussed that the EMS Commission recommended the development of a workgroup to evaluate ambulance patient off-load times (APOT), also known as wall time. The State has provided guidance on how to monitor wall time but confusion remains on how to define certain fields, such as arrival at hospital time, etc. The workgroup will consist of representatives from the hospitals and providers with the first meeting in early July 2017. Data on APOT will not be released to the public until the workgroup completes their evaluation.

7. NEXT MEETING: August 9, 2017 at 10:00 a.m. (EMS Agency Hearing Room – First Floor).

8. ADJOURNMENT: The meeting was adjourned at 10:44 a.m. by Commissioner Sanossian.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

Tel: (562) 347-1500
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To ensure timely, compassionate and quality emergency and disaster medical services.

EMERGENCY MEDICAL SERVICES COMMISSION

EDUCATION ADVISORY COMMITTEE

MEETING NOTICE

Date:	Wednesday, June 21, 2017
Time:	10:00 a.m.
Location:	EMS Agency Headquarters EMS Commission Hearing Room 10100 Pioneer Blvd Santa Fe Springs, CA 90670

No meeting due to a lack of a quorum.

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, June 21, 2017

MEMBERSHIP / ATTENDANCE

MEMBERS	ORGANIZATION	
☑ Dave White, Chair	EMSC, Commissioner	
☑ Robert Ower, Vice-Chair	EMSC, Commissioner	
☐ *LAC Ambulance Association*	EMSC, Commissioner	
☐ *LAC Police Chiefs' Association*	EMSC, Commissioner	
☐ Jodi Nevandro	Area A	
☐ Sean Stokes	Area A Alt	*(Rep to Med Council, Alt)*
☑ Nick Berkuta	Area B	
☑ Clayton Kazan, MD	Area B, Alt.	
☐ Victoria Hernandez	Area B Alt.	*(Rep to Med Council)*
☑ Ken Leasure	Area C	
☑ Susan Hayward	Area C, Alt	
☑ Jason Henderson	Area E	
☐ Mike Beeghly	Area E, Alt.	
☑ Josh Hogan	Area F	
☑ Joanne Dolan	Area F, Alt.	
☑ Mike Hansen	Area G	*(Rep to BHAC)*
☐ Michael Murrey	Area G, Alt.	*(Rep to BHAC, Alt.)*
☐ Corey Rose	Area H	*(Rep to DAC)*
☑ Ellsworth Fortman	Area H, Alt.	
☑ Luis Vazquez	Employed Paramedic Coordinator	
☑ Tisha Hamilton	Employed Paramedic Coordinator, Alt.	
☑ Jenny Van Slyke	Prehospital Care Coordinator	
☐ Alina Chandal	Prehospital Care Coordinator, Alt.	
☑ Andrew Respicio	Public Sector Paramedic	
☑ Andrew Gano	Public Sector Paramedic, Alt.	
☐ Maurice Guillen	Private Sector Paramedic	
☐ Scott Buck	Private Sector Paramedic, Alt.	
☐ Marc Eckstein, MD	Provider Agency Medical Director	
☐ Stephen Shea, MD	Provider Agency Medical Director, Alt.	
☑ Ian Wilson	Private Sector Nurse Staffed Ambulance Program	
☐ Vacant	Private Sector Nurse Staffed Ambulance Program, Alt	

EMS AGENCY STAFF PRESENT	
Marianne Gausche-Hill, MD	Richard Tadeo
Lucy Hickey	Christine Clare
Cathlyn Jennings	Susan Mori
Paula Rashi	Christy Preston
Rebecca Garnet	Ashley Sanello, MD
Michelle Williams	Gary Watson

OTHER ATTENDEES	
Geron Sheppard, MD	Compton FD
Caroline Jack	Torrance FD
Al Flores	LAFD
Marianne Newby	ULCA - CPC
Kirsten Survillas	Emergency Ambulance
Roger Braum	Culver City FD
Joshua Parker	PRN Ambulance
Nathan Cooke	El Segundo FD
Jack Feria	So California Ambulance
Doug Cain	Antelope Ambulance
Matt Ware	Antelope Ambulance
Chad Richardson	La Habra Heights FD
Ivan Orloff	Downey FD
Kevin Millikan	Torrance FD
Micah Bivens	LACo Lake Lifeguards
Mike Barilla	Pasadena FD

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

CALL TO ORDER

Chair, Commissioner David White called meeting to order at 1:05 p.m.

1. APPROVAL OF MINUTES (Leasure/Berkuta) April 19, 2017 minutes were approved as written.

2. INTRODUCTIONS / ANNOUNCEMENTS

2.1 New Members to Committee

- Ellsworth Fortman, Battalion Chief (LAFD), filing role as Area H, Alternate.
- Ian Wilson, RN (AMR Ambulance) replacing Diane Baker as the representing Private Sector Nurse Staffed Ambulance Programs.

2.2 EMS Personnel Certification Fees and EMT Regulation Changes *(Lucy Hickey)*

- Certification fee changes go into effect July 1, 2017. Details of the changes are posted on the EMS Agency's Certification/Accreditation webpage.
- State EMT Regulations have changed. The EMS Agency will be hosting a meeting for EMT training programs and CE providers sometime in August to review the new changes. Meeting announcement will be sent out at a later date.

3. REPORTS & UPDATES

3.1 Cannabis Regulations and Licensing *(Christine Clare)*

- Due to recent passage of Proposition 64 in November 2016, allowing cannabis usage by adults 21 years of age or older, the Los Angeles County Board of Supervisors has drafted a document describing the proposed County regulations.
- The County of Los Angeles has developed the Office of Marijuana Management and includes a sub-committee which addresses data, first responders and public health.
- Any concerns you wish to have brought up at these committees, may be directed to the EMS Agency.

3.2 Ambulance Patient Offload Time (APOT) *(Richard Tadeo)*

- State has defined "Offload Time" as being time at hospital and the time patient is transferred to hospital's equipment. However, the EMS Agency has received concerns that this definition needs to be more clearly defined and bench marks need to be established specific to Los Angeles County.
- With the recommendation from the EMS Commission, the EMS Agency is putting together a 15-member work group that will include representatives from fire departments, ambulance companies and hospitals. The first meeting is being planned for the 3rd week of July.

3.3 Treatment Protocols *(Richard Tadeo)*

- The EMS Agency is in its final stages of reviewing the new Treatment Protocols. Once complete, a work group will be reviewing the protocols. This will be the same work group as EMS Update development workgroup.
- After the work group has completed its review, Pasadena and Burbank Fire Departments will be utilizing the protocols in a pilot study.
- Plan is to include the new Treatment Protocols in EMS Update 2018.

4. UNFINISHED BUSINESS

4.1 Reference No. 302, 9-1-1 Receiving Hospital Requirements *(Richard Tadeo)*

Policy reviewed and approved as presented.

M/S/C (Leasure/Berkuta) Approve Reference No. 302, 9-1-1 Receiving Hospital Requirements.

5. NEW BUSINESS

5.1 Reference No. 416, Assessment Unit *(Richard Tadeo)*

Policy reviewed and Tabled with the following recommendation:

- Representatives from Los Angeles Area Fire Chief's Association will develop a single form that will incorporate Ref. No. 703, ALS Unit Inventory and Ref. No. 704, Assessment Unit Inventory.

TABLED: M/S/C (Leasure/Berkuta) Table Reference No. 416, Assessment Unit.

5.2 Reference No. 838, Application of Patient Restraints *(Cathlyn Jennings)*

Policy reviewed and approved as presented.

M/S/C (Leasure/Berkuta) Approve Reference No. 838, Application of Patient Restraints.

5.3 Reference No. 1013, EMS Continuing Education (CE) Provider Approval and Program Requirements *(Lucy Hickey)*

Policy reviewed and Tabled until recent recommendations from Base Hospital Advisory Committee are included in policy.

TABLED: M/S/C (Wilson/Respicio) Reference No. 1013, EMS Continuing Education (CE) Provider Approval and Program Requirements.

6. OPEN DISCUSSION:

6.1 National Drug Shortages *(Marianne Gausche-Hill, MD)*

- Of the drug shortages we are currently experiencing, Epinephrine 0.1mg/mL IV seems to be the most critical. Others include Sodium Bicarbonate 8.4% 50mL, Atropine 1mg/10mL and Calcium Chloride 1Gm/10mL.
- Various options to meet the medication needs were discussed. Those requesting assistance from the EMS Agency in meeting the challenges of the current medication shortage, may contact the EMS Agency's Medical Director or Gary Watson at gwatson@dhs.lacounty.gov.
- In the near future, the EMS Agency will be developing recommended strategies for providers to follow on handling future medication shortages. Input from provider agencies are encouraged.

7. NEXT MEETING: June 21, 2017

8. ADJOURNMENT: Meeting adjourned at 2:05 p.m.

SUBJECT: **DISPATCHING OF EMERGENCY MEDICAL SERVICES**

REFERENCE NO. 227

PURPOSE: To establish minimum requirements for the dispatching of emergency medical services.

AUTHORITY: California Health and Safety Code, Division 2.5, Section 1797.220

State of California Health and Human Services Agency, Emergency Medical Services Authority, Dispatch Program Guidelines, March 2003

DEFINITIONS:

Continuing Dispatch Education: Development and implementation of educational experiences designed to enhance knowledge and skill in the application of dispatch.

Emergency Medical Dispatch (EMD): A system of telecommunications established to enable the general public to request emergency assistance, which provides medically approved pre-arrival instructions, and dispatches a level of response according to pre-established provider guidelines through caller interrogation by a specially trained dispatcher.

Emergency Medical Dispatcher/ Call taker: An employee of an agency providing emergency medical dispatch services who has completed a nationally recognized dispatch program or Provider Agency specific program approved by the EMS Agency, and who is currently certified as an Emergency Medical Dispatcher (EMD), or Emergency Medical Technician (EMT) with current local scope of practice training. An Emergency Medical Dispatcher/Call taker is specially trained to provide post-dispatch/pre-arrival instructions.

Dispatch Center Medical Director: A physician licensed in California, board certified or eligible in emergency medicine, who possesses knowledge of emergency medical services (EMS) systems in California and the local jurisdiction and who is familiar with dispatching systems and methodologies; or a physician responsible for the dispatch medical direction of the nationally–recognized EMD program.

Post-dispatch/Pre-arrival instructions: Telephone rendered protocols reflecting current evidence based medical practice and standards, including instructions intended to encourage callers to provide simple lifesaving maneuvers to be used after EMS units have been dispatched and prior to their arrival.

Quality Improvement: A program designed to evaluate, monitor, and improve performance and compliance with policies and procedures to ensure safe, efficient, and effective delivery of emergency medical dispatching.

PRINCIPLE:

1. All callers requesting emergency medical care should have direct access to qualified dispatch personnel for the provision of EMS.

APPROVED: _____ _____

Director, EMS Agency | Medical Director, EMS Agency

2. EMS Provider Agencies that implement Emergency Medical Dispatch (EMD) should comply with the State of California Health and Human Services Agency, Emergency Services Authority, Dispatch Program Guidelines of March 2003 and Los Angeles County EMS policies.

3. EMS Provider Agencies that do not currently utilize EMD are required to incorporate post-dispatch/pre-arrival instructions in their practice of dispatching EMS. These providers should comply with the minimum requirements established in Ref. No. 227, Dispatching of Emergency Medical Services or send the highest level of care available.

4. The emergency medical dispatching protocols developed by the dispatch center shall be approved by the Dispatch Center Medical Director.

POLICY

I. Program Requirements

A. Each dispatch center shall have a Dispatch Center Medical Director to oversee protocol development, quality improvement and shall have a Dispatch Coordinator to oversee daily operations.

B. If the dispatch center utilizes a nationally-recognized EMD program, the following shall be submitted to the EMS Agency:

1. Name of EMD program

2. Name of Dispatch Center Medical Director

3. Post-dispatch/Pre-arrival instructions that are clearly defined in compliance with EMS Agency guidelines

4. Quality Improvement Program

B. If the dispatch center develops its own emergency medical dispatching protocols, the following shall be submitted to the EMS Agency:

1. Education standards and qualifications for call-takers and dispatchers

2. Pre-determined interrogation questions

3. Guidelines and procedures that assist with decision-making

4. Post-dispatch/Pre-arrival instructions that are clearly defined in compliance with EMS agency guidelines.

5. Quality Improvement Program

6. Name, contact information, and credentials of the Dispatch Center Medical Director

II. Dispatch Center Medical Director

A. Provides medical direction and oversight of the emergency medical dispatch program by review and approval of:

1. Policies and procedures related to Emergency Medical Dispatch and patient care

2. Standards for qualifying education and continuing education.

3. Dispatch guidelines including pre-arrival instructions.

4. Oversees quality improvement (QI) and compliance standards

5. Provides ongoing periodic review of dispatch records for identification of potential patient care issues

6. Provides oversight and participates in dispatch quality improvement, risk management and compliance activities

7. Attends, participates by phone conference call, or sends a representative to the Dispatch Center Advisory meetings scheduled by the Los Angeles County EMS Agency

II. Emergency Dispatch Coordinator

A. Oversees daily operations of the center and ensures staffing on a continuous 24 hour basis of qualified Emergency Medical Dispatchers/Call-Takers that meets the EMS provider agency's needs

B. Ensures that a dispatch supervisor or designee is readily accessible 24 hours daily

C. Ensures for availability of a 24 hour contact phone number to be utilized to coordinate or disseminate information in case of critical incident or disease outbreak

D. Coordinates QI activities with the Medical Director.

1. Provides ongoing periodic review of dispatch records for identification of potential patient care issues

2. Participates in dispatch quality improvement, risk management and compliance activities

3. Attends or participates by phone conference call in the Dispatch Center Advisory meetings scheduled by the Los Angeles County EMS Agency

III. Emergency Medical Dispatcher / Call-Taker Qualifications

A. Initial Qualifications

1. A Valid current BLS certification at the healthcare provider level. Must include hands on skills validation (e.g., American Heart Association, American Red Cross, National Safety Council, or American Safety Health Institute)

2. EMD Certification, or a minimum initial training of twenty-four (24) hours that meets the requirements of the California EMS Authority's Emergency Medical Services Dispatch Program Guidelines

B. Recertification

1. Recertification as an EMD, if applicable

2. A minimum of (twenty four) 24 hours of continuing dispatch education (CDE) every two years.

V. Quality Improvement:

The Emergency Medical Dispatch Center shall have a Quality Improvement Program that will evaluate indicators specific to the dispatch of emergency medical services in order to foster continuous improvement in performance and quality patient care.

A. Each QI Program shall have a written plan that includes, at minimum, the following components:

1. Mission statement, objectives, and goals for process improvement

2. Organizational chart or narrative description of how the QI program is integrated within the dispatch center, process(s) for data collection and reporting. Include templates utilized in standardize reports

3. Key performance measures or indicators related to delivery of emergency medical dispatching. Methods or activities designed to address deficiencies and measure compliance to protocol standards as established by the EMD Medical Director through ongoing random case review for each emergency medical dispatcher

4. Activities designed to acknowledge excellence in the delivery of emergency medical dispatch performance

5. The QI process shall:

a. Monitor the quality of medical instruction given to callers, including ongoing random case review for each emergency medical dispatcher and observing telephone care rendered by emergency medical dispatchers for compliance with defined standards.

b. Conduct random or incident specific case reviews to identify calls/practices that demonstrate excellence in dispatch performance and/or identify practices that do not conform to defined policy or procedures so that appropriate training can be initiated.

c. Review EMD reports, and/or other records of patient care to compare performance against medical standards of practice.

d. Recommend training, policies and procedures for quality improvement.

CROSS REFERENCES:

Pre-hospital Care Manual:
Reference No. 226, **Private Ambulance Provider Non 9-1-1 Medical Dispatch**
Reference No: 620, **EMS Quality Improvement Program**

LOS ANGELES COUNTY - DEPARTMENT OF HEALTH SERVICES

DISPATCH PRE-ARRIVAL INSTRUCTIONS

REFERENCE NO. 227.1

TABLE OF CONTENTS

DISPATCH PRE-ARRIVAL INSTRUCTIONS

REFERENCE NO. 227.1

This document is a result of review of submitted dispatch protocols to the Los Angeles County EMS Agency. EMS Agency staff have updated these templates for pre-arrival instructions based on the latest available evidence and published guidelines. These templates may be used by Dispatch Centers' administrators in the development of pre-arrival instructions.

BASIC MEDICAL INSTRUCTIONS PROCEDURE

Initial Screening: Evaluate all calls for severity of complaint and possible cardiac arrest

1. **Determine whether the caller is calling for himself/herself or someone else. If the caller is calling for someone else, immediately after confirming location ask the following screening questions:**
    a. **Is the person alert?**
        i. **Check for response to verbal or other stimuli**
    b. **Is the person breathing normally?**

2. **If the answer to both is 'No' proceed to the age-appropriate cardiac arrest instructions and instruct the caller in CPR. (see below)**

GENERAL MEDICAL for such chief complaints such as:
Abdominal Pain
Back Pain
Chest Pain
Headache
Sick Person (including fainting)
Stroke

1. If alert, allow the patient to rest in a position of comfort.
2. If not alert, rest the patient with the left side down and assess breathing.
3. Do not give the patient anything to eat or drink.
4. Gather the patient's medications.
5. If the patient begins to vomit, turn onto their left side.
6. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

AED INSTRUCTIONS

1. Place the patient on their back.
2. Turn the AED on.
    a. The AED will verbally instruct you of all the steps. Follow prompts spoken by the machine
3. Remove clothing and undergarments to expose the patient's bare chest.
4. If wet, wipe the chest dry.
5. If excessively hairy, consider shaving the chest (some AEDs come with razors).
6. Place the pads adhesive-side down onto the patient's chest as illustrated (on the non-adhesive sides of the pads).
    - For adults, place one pad just below the patient's right collar bone (above the nipple) and the other pad below and outside to the left nipple (for women, place the left pad just below the intra-mammary fold).
    - For children, place one pad in the middle of the chest (between the nipples) and the other pad in the middle of the back (between the shoulder blades).
7. Assure that the two pads are plugged into the AED.
8. Once pads are placed, allow the machine to analyze the patient. Do not touch the patient during this time.
9. If shock is advised, yell "clear" and assure that no one is touching the patient. Once clear, press the shock button. If shock is not advised or the patient does not improve after 1st shock, resume 2 minutes of chest compressions before analyzing again.

ALLERGIC REACTION/ANAPHYLAXIS

1. If alert, allow the patient to rest a position of comfort.
2. If not alert, rest the patient on their left side and assess breathing.
3. Refer to BREATHING PROBLEMS instructions as needed.
4. If the patient has a history of severe allergic reaction to the same allergen and is prescribed an epinephrine auto-injector (e.g., Epi-Pen), assist with administration. Refer to the epinephrine auto-injector instructions as needed.
    a. Remove cap but do not press on the top of the cap; this will release the needle); place on outer thigh about 6 inches above the knee cap; press down firmly (the needle can puncture clothing); count to "three" before removal; do not throw away but place to the side.
    b. If another form of auto-injector is available, refer to those instructions for administration.
5. If the patient was stung by an insect such as a bee or wasp, remove the stinger by scraping the stinger away with a finger nail or with the edge of a credit card.
6. Once the stinger is removed, rinse the area with soap and water as able and apply a cold pack to affected part.
7. Do not give the patient anything to eat or drink.
8. Gather the patient's medications.
9. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

BEHAVIORAL PROBLEMS

1. Observe the patient from a safe distance. If safety is in doubt, leave the scene.
2. Be calm and reassuring and avoid sudden movements.
3. Do not attempt to restrain the patient.
4. If hanging, cut the patient down immediately.
5. Refer to BLEEDING, BREATHING PROBLEMS or INGESTION/OVERDOSE/POISONING instructions as needed.
6. Tell the patient to rest in the most comfortable position.
7. Do not give the patient anything to eat or drink.
8. Gather the patient's medications if safe to do so.
9. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

BITES/STINGS

1. If alert, allow the patient to rest in a position of comfort.
2. If not alert, rest the patient on their left side and assess breathing.
3. Refer to BREATHING PROBLEMS instructions as needed.
4. If the patient has a history of severe allergic reaction to the same allergen and is prescribed an epinephrine auto-injector (e.g., Epi-Pen), assist with administration. Refer to the EPI-PEN or other epinephrine auto-injector as needed; refer to ALLERGIC REACTION.
5. Provide local wound care:
    - **Hymenoptera (ants, bees, wasps):** remove the stinger by scraping with fingernail or edge of a credit card. Once the stinger is removed, apply a cold pack to the affected part.
    - **Mammalian bites (cats, dogs, humans):** immobilize affected part below heart level. If bleeding, apply direct pressure.
    - **Marine envenomation and toxins**: if the stingray spine is deeply embedded into the skin do not remove it. For other marine envenomations, remove the barb/stinger and immerse affected part in warm water (stingray); apply vinegar and immerse affected part in warm water (jellyfish).
    - **Snake and spider bites:** immobilize affected part below heart level. Do NOT apply ice, a tourniquet. Do NOT attempt to "suck" venom out of affected part.
6. Do not give the patient anything to eat or drink.
7. Gather the patient's medications.
8. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

BREATHING PROBLEMS

1. If alert, allow the patient to rest in a position of comfort.
2. If not alert, rest the patient on their left side and assess breathing.
3. If unresponsive and not breathing (or breathing abnormally), refer to CARDIAC ARREST instructions.
4. Refer to the ALLERGIC REACTION or CHOKING instructions as needed.
5. Calmly reassure the patient to take slow, deep breaths.
6. If the patient takes medication for a known breathing problems (asthma, COPD), assist with administration of inhaler.
7. Do NOT encourage the patient to breathe into a paper bag.
8. If a pediatric patient is conscious without signs of choking, allow the patient to sit on parent's lap and do not attempt to look into the child's mouth.
9. Do not give the patient anything to eat or drink.
10. Gather the patient's medications.
11. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

BURNS

1. Confirm scene safety and evacuate the area.
2. If the patient is on fire, STOP-DROP-ROLL (with or without a blanket) or douse with water.
3. Provide local wound care:
    - **Chemical burn:**
        - dry chemical- gently brush off with something other than bare hand
        - wet chemical- flush with large amounts of water.
    - **Electrical burn:** if the patient is still in contact with the electrical source, **do not touch the patient.** If appliance can be unplugged or electrical switch turned off safely then do so.
    - **Thermal burn:** cool with water, but stop cooling if patient begins shivering, and remove jewelry in affected area.
4. Do not give the patient anything to eat or drink.
5. Gather the patient's medications.
6. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

DISPATCH PRE-ARRIVAL INSTRUCTIONS

REFERENCE NO. 227.1

CARDIAC ARREST: ADULT AND CHILD

1. Verify that the patient is unresponsive and not breathing (or is breathing abnormally).
2. Place the patient on a flat, hard surface backside down.
3. Place the heel of one hand in the middle of patient's chest (on the breastbone) and place your other hand on top of the first hand.
4. Interlock your fingers.
5. Begin compressions at a rate of at least 100-120 compressions/minute at a depth of 2 inches and allow for complete recoil; rate can be estimated by singing the song "Stayin' Alive".
6. Continue compression-only CPR until AED or help arrives.
7. Once available, set-up the AED. Refer to the AED instructions as needed.
8. If shock is not advised or the patient does not improve after 1st shock, resume 2 minutes of CPR before analyzing again.

CARDIAC ARREST: PEDIATRIC (infant from birth to 1 year)

1. Verify that the patient is unresponsive and not breathing (or is breathing abnormally).
2. Place the patient on a flat, hard surface backside down.
    - Infants: Hands encircle the chest with thumbs between the nipples in the center of the chest; compress at a depth of 1.5 inches.
    - Children: heal of hand in the middle of the chest between the nipples and compress 1.5 inches.
3. Begin compressions at a rate of at least 100 to 120 compressions/minute and allow for complete recoil.
4. Optional to give rescue breaths if dispatch operator feels rescuer able to understand and follow instructions - 30 chest compressions followed by 2 breaths (30:2).
    - Begin with head-tilt, or chin-lift.
    - Cover the patient's mouth and nose while providing breaths.
    - Blow until rescuer observes chest rise, allow for exhalation and repeat the breath.
5. Continue 30:2 for 2 minutes (about 5 cycles) before switching rescuer roles (if available).
6. If unable or unwilling to provide breaths, continue compression-only CPR until AED or help arrives.

CARDIAC ARREST: NEWBORN

1. After drying and stimulating the newborn, verify that the baby is unresponsive and not breathing (or is breathing abnormally).
2. Place the patient on a flat, hard surface backside down.
3. Encircled hands around chest and supporting the back, and place 2 thumbs in the middle of the patient's chest (on the breastbone)
4. Optional to begin 3 compressions followed by 1 breath (3:1) and allow for complete recoil.
    - Head-tilt, chin-lift.
    - Cover both the patient's nose and mouth with your mouth while providing small breaths.
    - Observe chest rise.
5. Continue for 2 minutes before switching rescuer roles (if available)
6. If unable or unwilling to provide breaths, continue compression-only CPR until help arrives.

CHILDBIRTH

1. Is the baby already born?
    - Yes: Dry and stimulate the baby. Is the baby breathing?
        - Yes: Proceed to Step 6.
        - No: Refer to the CARDIAC ARREST: NEWBORN instructions.
    - No: Proceed to Step 2.
2. Have the mother remove all clothing from waist-down.
3. Assist the mother onto a clean, safe surface such as a bed or floor, backside down.
    - If the woman states she is ready to push, or if the head is visible in the vaginal opening birth is imminent (about to occur)
    - If possible, place a plastic sheet with a bed sheet or newspaper down to absorb the liquid and obtain towels to dry the baby once delivered.
    - Help the woman lie down with her legs apart and back supported by a rolled towel or pillow.
    - Use plastic disposable gloves if available. If gloves not available, wash your hands.
    - Often women grab their knees, squat or lie on the left side. Allow her to do as she prefers.
4. Look for a presenting part of the baby:
    - Nothing: encourage the mother not to push. Continue to monitor for a presenting part.
    - Head (normal): Proceed to Step 5.
    - Arm, foot (breech): Proceed to Step 7.
    - Cord (prolapsed cord): Proceed to Step 8.
5. Normal delivery (head first)
    - If the baby's head is visible in the vaginal opening, the birth is about to occur.

- Encourage the mother to exhale and push with each contraction. Several contractions may be required to deliver the baby.
- Gently place one hand on the top of the baby's head to prevent the baby from delivering too quickly.
- Do not try to hurry the birth by pulling on the baby's head. Let the woman push the baby out.
- When the head is outside of the vagina, put two fingers along the top side of the head and feel around the neck area for a loop of the umbilical cord. It will be about the thickness of your little finger. If you can feel it, hook the loop of cord with your two fingers and slide it gently over the baby's head.
- Assist the delivery by supporting the baby's head and shoulder. The baby may turn as it exits the vagina but do not pull or yank on the baby.
- Be careful during delivery as the baby is slippery; have a dry towel available to quickly dry the baby removing membranes from the birth sac around the nose and mouth.
- Dry and stimulate the baby. Is the baby breathing?
    - Yes: Proceed to Step 6.
    - No: Refer to the CARDIAC ARREST: NEONATE instructions.

6. Post-delivery
    - Dry the baby, wrap the baby (excluding the face) in a clean, dry blanket or towel, and place the baby on the mother's chest or abdomen for warmth. You do not need to remove the whitish sticky substance on the baby's skin. Discard wet towels.
    - Do not cut the umbilical cord keep the baby at the level of the mother's stomach and lower chest and await EMS providers to clamp and cut the cord.
    - The placenta may deliver if so do not pull on the cord but allow the placenta to deliver naturally. Save the placenta for the EMS personnel when they arrive. Place the placenta in a plastic trash bag and set on the bed next to the mother or place on a table at the level of the baby being held by mother until EMS arrives;
    - If the mother continues to bleed after the placenta (afterbirth) delivers, firmly massage the mother's lower abdomen.
    - Continue to re-assess the baby and mother until help arrives.
7. Breech delivery:
    - If the presenting part is not the head, assist the mother into 1 of 2 positions:
        - While still laying backside down, elevate/prop up the mother's hips up high.
        - Roll the mother onto her hands/elbows and knees.
    - Encourage the mother to breathe deeply and not to push with each contraction.
    - Continue to re-assess the mother until help arrives.
8. Cord Prolapse:
    - Elevate the presenting part of the cord; don't push the cord back inside the mother.
    - Continue elevating the presenting part until help arrives.

CHOKING: ADULT and CHILD (1-8 years old)

1. Patient is conscious:
    - **Partial obstruction (able to breath, cough, cry, speak)**: calmly reassure the patient and encourage continued coughing to expel the object. Continue to carefully monitor for decompensation to complete obstruction.
    - **Complete obstruction (unable to breath, cough, cry, speak)**:
        - o Perform abdominal thrusts only if the patient is able to stand and is conscious
            - From behind, wrap your arms around the patient's abdomen.
            - Make a fist just above the patient's belly button. Wrap one hand over the other.
            - Quickly and forcefully, jerk inward and upward on the patient's stomach.
            - Repeat until the object is expelled or the patient becomes unconscious (see below).
        - o Chest thrusts:
            - If the patient is pregnant or obese, chest thrusts can be done in lieu of abdominal thrusts.
            - From behind, wrap your arms around the patient's chest.
            - Make a fist in the middle of the patient's chest (breastbone).
            - Quickly and forcefully, jerk into the patient's chest.
            - Repeat until the object is expelled or the patient becomes unconscious (see below).
2. Patient is not conscious:
    - Adult:
        - o Refer to the CARDIAC ARREST: ADULT instructions.
        - o Caveat: prior to breaths, look in the patient's mouth for expelled object and, if visible in the mouth, carefully remove with your fingers – do not attend blind finger sweeps as the foreign body could be pushed deeper in the throat.
    - Child:
        - o Refer to the CARDIAC ARREST: PEDIATRIC instructions.
        - o Caveat: prior to breaths, look in the patient's mouth for expelled object and, if visible in the mouth, carefully remove with your fingers– do not attend blind finger sweeps as the foreign body could be pushed deeper in the throat.

CHOKING: INFANT (<1 years old)

1. Patient is conscious:
    - **Partial obstruction (able to breath, cough, cry, speak)**: calmly reassure the patient and encourage continued coughing to expel the object. Continue to carefully monitor for decompensation to complete obstruction.
    - Complete obstruction **(unable to breath, cough, cry, speak)**:

- From a seated position, place the infant on your forearm facedown, keeping the head lower than the body.
- With the heel of your hand, deliver 5 back blows between the shoulder blades.
- Turn the infant over and place 2 fingers in the middle of the patient's chest (on the breastbone) and deliver 5 chest compressions at a depth of 1.5 inches each.
- Repeat until the object is expelled, is visible in the mouth and can be removed, or the patient becomes unconscious (see below).

2. Patient is not conscious:
   - Refer to the CARDIAC ARREST: PEDIATRIC instructions.
     - Caveat: prior to breaths, look in the patient's mouth for expelled object and, if visible in the mouth, carefully remove with your fingers– do not attend blind finger sweeps as the foreign body could be pushed deeper in the throat.

COLD EXPOSURE

1. If possible, move the patient to a warm, sheltered area out of cold air, wind, or water spray.
2. If hypothermia is suspected:
   - Remove wet clothing and wrap the patient in dry clothing and/or blankets.
   - Do not give the patient alcohol or caffeine (may worsen hypothermia).
3. If frostbite is suspected:
   - Wrap or cover affected part with something dry and warm.
   - Elevate affected part.
   - Do not rub or place affected part in hot water.
4. Do not give the patient anything to eat or drink.
5. Gather the patient's medications.
6. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

CONVULSIONS/SEIZURES

1. Still seizing:
   - Do not attempt to restrain or hold the patient down.
   - Do not place anything in the patient's mouth.
   - Move objects away from the patient.
   - Stay on the phone until the seizure stops and then verify that the patient is breathing.
   - Saliva from the mouth can be wiped away with a dry towel.
2. Stopped seizing:
   - Rest the patient on their left side with right knee forward in recovery position.
   - Do not give the patient anything to eat or drink.
   - Gather the patient's medications.

- Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

DIABETIC PROBLEMS

1. If alert, allow the patient to rest in the most comfortable position.
   - If low blood sugar is suspected (hypoglycemia), give the patient candy, juice, non-diet soda, or any other form of sugar.
2. If not alert, rest the patient on their left side and assess breathing.
   - Do not give the person anything to eat or drink.
3. If the patient begins to vomit, turn onto their left side.
4. Gather the patient's medications.
5. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

EMERGING INFECTIONS (e.g. Ebola)

1. Confirm that the patient has travelled to the affected area of the world and is presenting with concerning signs or symptoms, such as fever and bleeding.
2. Ask other individuals in the area to remove themselves from the immediate area, but not to leave the scene/ property.
3. Responding EMS units may contact the Public Health Officer for additional instruction 24/7 at 213-974-1234.

EYE INJURIES

1. If **chemical injury**, flush the affected eye with tap water continuously. Take care to flush from nose to ear, avoiding the unaffected eye.
2. If there is an **impaled or penetrating object** in the affected eye, do not remove the object. If possible, attempt to stabilize object in place.
3. If **blunt injury**, sit the patient upright and calmly reassure them.
4. Do not put pressure on the affected eye.
5. Do not put drops or ointment into the affected eye.
6. Do not give the patient anything to eat or drink.
7. Gather the patient's medications.
8. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

HEAT EXPOSURE

1. If possible, move the patient to a cool, well-vented area out of direct sunlight or away from other source(s) of heat.
2. If the patient is trapped in an automobile and is conscious, call police. If unconscious, attempt to safely break the window. Refer to the UNCONSCIOUS instructions as needed.
3. Remove outer clothing.

4. If very hot, apply room-temperature to cool (not cold nor iced) water to the patient's skin. Use fans if available.
5. If available, apply cold packs (indirectly) to the armpits or groin.
6. If alert, allow the patient to rest in a position of comfort.
7. If not alert, rest the patient on their L-side and assess breathing.

INGESTION/OVERDOSE/POISONING

1. Refer to the BREATHING PROBLEMS and CONVULSIONS/SEIZURES instructions as needed.
2. If alert, allow the patient to rest in a position of comfort.
3. If not alert, rest the patient on their left side and assess breathing.
4. Do not give the patient anything to eat or drink.
5. Gather the patient's medications, including empty pill bottles.
6. If the patient begins to vomit, turn onto their left side.
7. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

UNCONSCIOUS (including "MAN DOWN")

1. If the patient is not breathing, refer to the CARDIAC ARREST instructions.
2. If the patient is having difficulty breathing, refer to the BREATHING PROBLEMS instructions.
3. If alert, allow the patient to rest in the most comfortable position.
4. If not alert, rest the patient on their left side and assess breathing.
5. Look for a medical alert bracelet/necklace.
6. Do not give the patient anything to eat or drink.
7. Gather the patient's medications.
8. If the patient begins to vomit, turn onto their left side.
9. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

TRAUMA INSTRUCTIONS

GENERAL TRAUMA for chief complaints such as: Falls, Injury, Motor Vehicle Collisions

1. Do not move an injured patient unless they are in immediate risk of danger/injury.
2. If an injured patient must be moved, stabilize the neck and log-roll the body as a unit.
3. If an **amputation** or **severe bleeding** is present, apply continuous, firm, direct pressure and refer to the BLEEDING instructions as needed.
4. If a **fracture** is suspected, do not move the affected part; stabilize in the position found.
5. If an **impaled object** is present, do not pull or remove the object. If possible, attempt to stabilize object in place.
6. Do not give the patient anything to eat or drink.
7. Gather the patient's medications.

8. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.
9. If time and scene safety allow, ask potential witnesses to remain on scene until responders arrive.

ASSAULT

1. Confirm scene safety and advise putting a barrier between the patient and the assailant (door, wall).
2. Do not move an injured patient unless they are in immediate risk of danger/injury.
3. Reassure the patient that help is on the way.
4. Encourage the patient not to change, bathe, shower, or go to the bathroom.
5. Encourage the patient not to disturb the scene or move weapons.
6. Refer to BLEEDING instructions as needed.
7. Do not give the patient anything to eat or drink.
8. Gather the patient's medications.
9. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

BLEEDING

1. Control bleeding with continuous, firm, direct pressure. If more pressure is needed for bigger wounds, use the heel of your hand or knee.
2. Do not try to make and place a homemade tourniquet(s) as incorrect application may cause increased bleeding.
3. Place amputated part(s) into a clean, dry bag. Do not place in liquid or on ice.
4. Do not remove impaled objects, attempt to stabilize object in place.
5. For a nosebleed, have the patient sit up straight, lean forward slightly, and pinch just below the nasal bridge between their index finger and thumb.
6. Do not give the patient anything to eat or drink.
7. Gather the patient's medications.
8. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

DIVING/DROWNING

1. Patient in water:
    - **Deep water:** throw a flotation device or rope to the patient. Do not go into water unless safe to do so.
    - **Shallow water:** consider neck or spinal injury.
        - If neck injury is suspected and the patient is **breathing**, stabilize the neck and support the patient's body until the patient can safely be removed from water.
        - If neck injury is suspected and the patient **not breathing**, stabilize the neck, remove the patient from water, and begin CPR. Refer to the CARDIAC ARREST instructions.

2. Patient out of water:
    - **Not breathing:** begin CPR. Refer to the CARDIAC ARREST instructions.
    - **Breathing:** rest the patient on their left side.
    - Do not give the patient anything to eat or drink.
    - Gather the patient's medications.
    - Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

ELECTROCUTION

1. Confirm scene safety and advise caller of continued risks such as electrified water (standing water which may conduct electricity).
2. Check to see if the patient is free from current: if no or unsure, do not touch the patient or source of current.
3. If safe to do so, turn power off: disconnect from the wall (appliance) or turn off the main breaker (home). If near downed utility pole, obtain number of adjacent pole only if visible and safe to do so. *(Dispatcher: contact utility company with pole number).*
4. Only touch the patient if the power has been confirmed off.
5. If alert, allow the patient to rest in the most comfortable position.
6. If not alert, rest the patient on their left side and assess breathing.
7. If unresponsive and not breathing (or breathing abnormally), refer to the CARDIAC ARREST instructions.
8. Refer to the BURNS and GENERAL TRAUMA instructions as needed.
9. Do not give the patient anything to eat or drink.
10. Gather the patient's medications.
11. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

PENETRATING INJURY (including GUNSHOT and STAB injuries)

1. Confirm scene safety. If safety is in doubt, leave the scene.
2. Avoid disrupting the scene— do not touch or move weapons.
3. Do not pull or remove impaled object. If possible, attempt to stabilize object in place.
4. Control bleeding. Refer to the BLEEDING instructions as needed.
5. If internal organs are exposed, cover with a clean dry cloth.
6. Do not give the patient anything to eat or drink.
7. Gather the patient's medications.
8. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

ADDITIONAL INSTRUCTIONS

CARBON MONOXIDE INHALATION

1. Confirm scene safety and evacuate the area to the outside.

2. If the patient cannot be evacuated, ventilate the area by opening doors and windows (as long as patient is not trapped in a structure fire).
3. Refer to the BURNS instructions as needed.
4. If alert, allow the patient to rest in a position of comfort.
5. If not alert, rest the patient on their left side and assess breathing.
6. Do not give the patient anything to eat or drink.
7. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

TRAPPED IN CONFINED SPACE (including INDUSTRIAL ACCIDENT)

1. Confirm scene safety and advise caller of continued risks such as running machinery.
2. If safe to do so, shut off running machinery.
3. Do not remove a trapped patient.
4. Refer to the GENERAL TRAUMA instructions as needed.
5. Determine a location to meet rescuers and assign someone to meet them.
6. Assign someone to gather maintenance/mechanical staff to assist rescuers with machinery.
7. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

TRAPPED IN STRUCTURE FIRE

1. Re-confirm caller location (address, floor, room number/type, location within room).
2. Close the door (do not lock).
3. Cover nose and mouth with thin material such as a shirt.
4. Cover crack between door and floor with a towel, rug, or anything else that is readily available.
5. Do not open or break windows.
6. Hang an object such as a white sheet from the window to signal help.
7. Do not jump from great heights (> 2 stories or 20 feet).

TRAPPED IN SUBMERGED VEHICLE

1. Unbuckle your seat belt.*
2. Unlock but do not open the door.
3. Roll down the window— break it if necessary. (Reassure caller that this may feel counterintuitive but that this is their best chance of survival).
4. Exit through the window.
5. If unable to exit through the window, breathe within the vehicle's air pocket until the vehicle has filled with water.
6. Once the vehicle has completely filled with water the door will open easier.
7. Take a deep breath, exit through the door, and swim toward the surface.*

*****If children are present, unbuckle their seatbelt(s) after releasing your own. Help propel/push them out of the submerged vehicle prior to your exit.

DEPARTMENT OF HEALTH SERVICES REFERENCE NO 202.1
COUNTY OF LOS ANGELES

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 227- Dispatching of Emergency Medical Services

SECTION	COMMITTEE/ DATE	COMMENT	RESPONSE
Pre-Hospital	Dispatch Committee November 14, 2016	QI policy too extensive and impractical for dispatch centers. Strike reference to ref. 620. Change term CQI to QI.	Policy to be reviewed and simplified for QI with change of CQI to QI
Pre Hospital	Provider Agency Advisory Committee February 15, 2017	For information only. Noted and reviewed by committee	Approved to move on to BHAC and PAAC
	BHAC April 12, 2017	No recommendations for changes.	Approved as written.
	PAAC April 19, 2017	No recommendations for changes	Approved as written.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reviewed 11-28-2016

SUBJECT: **PROVIDER AGENCY MEDICAL DIRECTOR** REFERENCE NO. 411

PURPOSE: To describe the role and responsibilities of Medical Directors of approved Los Angeles County Emergency Medical Services (EMS) Provider Agencies.

DEFINITION:

Provider Agency Medical Director: A physician designated by an approved EMS Provider Agency to provide advice and coordinate the medical aspects of field care, to provide oversight of all medications utilized by EMTs and paramedics including controlled medications, and to oversee the provider's quality improvement process, as defined by the Los Angeles County EMS Agency

Requirements for the Provider Agency Medical Director include but are not limited to the following:

1. Board eligible or certified by the American Board of Emergency Medicine

2. Engaged in the practice, supervision, or teaching of emergency medicine and/or EMS.

3. Knowledgeable on the current policies, procedures, and protocols of the Los Angeles County EMS Agency

4. Attend an EMS system orientation provided by the EMS Agency and participate in a field care observation (ride-along) with the sponsoring agency.

PRINCIPLE: Medical Directors enhance the quality of prehospital care by providing medical expertise in EMS and serve as a liaison between the EMS Agency Medical Director, hospitals, and other Provider Agency Medical Directors to ensure the delivery of safe and effective medical care.

ROLE AND RESPONSIBILITIES OF THE PROVIDER AGENCY MEDICAL DIRECTOR

I. Medical Direction and Supervision of Patient Care

A. Advises the provider agency in planning and evaluating the delivery of prehospital medical care by EMTs and paramedics.

B. Reviews and approves the medical content of all EMS training performed by the provider agency and ensures compliance with continuing education requirements of the State and local EMS Agency.

C. Reviews and approves the medical components of the provider agency's dispatch system.

D. Assists in the development of procedures to optimize patient care.

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

E. Reviews and recommends to the EMS Agency Medical Director any new medical monitoring devices under consideration and ensures compliance with State and local regulation.

F. Evaluates compliance with the legal documentation requirements of patient care.

G. Participates in direct observation of field responses as needed. Medical direction during a direct field observation may be provided by the Provider Agency Medical Director in lieu of the base hospital under the following conditions:

1. The EMTs, paramedics, and Provider Agency Medical Director on scene must be currently employed by, or contracted with, the same provider agency.

2. If base contact has already been established, the Provider Agency Medical Director may assume medical direction of patient care. The base hospital shall be informed that the Provider Agency Medical Director is on scene. They are not required to accompany the patient to the hospital.

4. EMS personnel shall document the involvement of the Provider Agency Medical Director on the EMS Report Form when orders are given

5. The receiving hospital shall be notified of all patients whose field care is directed by a Provider Agency Medical Director.

H. Participates as needed with appropriate EMS committees and the local medical community. Attend at least 50% of the Medical Advisory Council meetings or delegate a designee.

I. Ensures provider agency compliance with Los Angeles County EMS Agency controlled substance policies and procedures.

II. Audit and Evaluation of Patient Care

A. Assist the provider agency in the development and implementation of a continuous quality improvement program to ensure the provision of quality medical care. Provides recommendations for training and operational changes based on quality improvement results.

B. Evaluates the adherence of provider agency medical personnel to medical policies, procedures and protocols of the Los Angeles County EMS Agency.

C. Coordinates delivery and evaluation of patient care with base and receiving hospitals.

III. Investigation of Medical Care Issues

A. Reviews incidents with unusual or adverse patient outcomes, inadequate performance of EMS personnel, and complaints related to the delivery of medical care.

B. Evaluates medical performance, gathers appropriate facts and, as needed, forwards those facts in writing to the Los Angeles County EMS Agency Medical Director.

C. Ensures that appropriate actions are taken on cases with patient care issues with adverse outcomes, e.g., training, counseling, etc.

CROSS REFERENCE:

Prehospital Care Manual:
Reference No. 214, **Base Hospital and Provider Agency Reporting Responsibilities**
Reference No. 414, **Registered Nurse/Respiratory Specialty Care Transport Provider**
Reference No. 816, **Physician at the Scene**
Reference No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
Reference No. 702, **Controlled Drugs Carried on ALS Units**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 411, Provider Agency Medical Director

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Definition	BHAC April 12, 2017	Added: Provider Medical Director, "to provide oversight of all medications utilized by EMTs and paramedics including controlled medications, and to oversee the provider's quality improvement process".	Approved as written.
		Medical Director is required to be Board "eligible".	Approved as written.
		Medical Director is engaged in, ~~clinical~~ practice, supervision, or teaching of emergency medicine and/or EMS.	Approved as written.
Section "1.H"		"Attend at least 50% of the Medical Advisory Council meetings or delegate a designee."	Approved as written.
As above	PAAC April 19, 2017	As written above, no other changes.	Approved as written.

SUBJECT: **PRIVATE AMBULANCE OPERATOR MEDICAL DIRECTOR**

REFERENCE NO. 420

PURPOSE: To describe the role and responsibilities of Medical Directors of licensed Los Angeles County Private Ambulance Operators.

DEFINITION:

Private Ambulance Operator Medical Director: A physician designated by an approved EMS Private Ambulance Operator and approved by the Los Angeles County EMS Agency Medical Director, to provide oversight of all medications utilized by EMTs and paramedics including controlled medications, and oversees the private provider agency's quality improvement process, as defined by the Los Angeles County EMS Agency.

The Private Ambulance Operator Medical Director shall:

1. Be board certified or eligible by the American Board of Emergency Medicine.

2. Engaged in the practice, supervision, or teaching of emergency medicine and/or EMS.

3. Be knowledgeable on the current policies, procedures, and protocols of the Los Angeles County EMS Agency.

4. Attend an EMS system orientation provided by the EMS Agency within six (6) months of hire.

PRINCIPLE: Medical Directors enhance the quality of prehospital care by providing medical expertise in EMS and serve as a liaison between the EMS Agency Medical Director, hospitals, and other Private and Public Ambulance Operator Medical Directors to ensure the delivery of safe and effective medical care.

POLICY

I. Role And Responsibilities Of The Private Operator Medical Director

A. Medical Direction and Supervision of Patient Care

1. Advises the private ambulance operator in planning and evaluating the delivery of prehospital medical care by EMTs and, if applicable, paramedics, nurses, and respiratory therapists.

2. Reviews and approves the medical content of all EMS training performed by the private ambulance operator. If approved as a continuing education provider in Los Angeles County, ensures compliance with State and local EMS Agency continuing education requirements.

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

3. Reviews and approves the medical components of the private ambulance operator's dispatch policies and procedures as demonstrated by a dated signature or other mechanism in place for approval, such as electronic signature.

4. Assists in the development of procedures to optimize patient care.

5. Evaluates compliance with the legal documentation requirements of patient care.

6. Provides oversight and participates in the private ambulance operator's Quality Improvement program.

7. Ensures private ambulance operator compliance with Los Angeles County EMS Agency controlled substance policies and procedures, if applicable.

B. Audit and Evaluation of Patient Care

1. Assists the private ambulance operator in the development and implementation of a continuous quality improvement program to ensure the provision of quality medical care. Provides recommendations for training and operational changes based on quality improvement results.

2. Evaluates private ambulance operator medical personnel for adherence to medical policies, procedures and protocols of the Los Angeles County EMS Agency. Provides ongoing periodic review of dispatch and patient care records for identification of potential patient care issues.

3. Reviews the delivery and evaluation of patient care with base and receiving hospitals, as applicable.

C. Investigation of Medical Care Issues

1. Reviews incidents with unusual or adverse patient outcomes, inadequate performance of EMS personnel, and complaints related to the delivery of medical care.

2. Evaluates medical performance and appropriate facts and, as needed, forwards those facts in writing to the Los Angeles County EMS Agency Medical Director.

Ensures that appropriate actions (e.g., training, counseling, etc.) are taken related to patient care issues with adverse outcomes, near misses, etc.

II. Role And Responsibilities Of The Private Ambulance Operator

A. Designates and maintains a Medical Director at all times.

B. Ensures Medical Director is involved in the development of all medically related policies, procedures, quality improvement and medical dispatch programs, as applicable.

C. Provides the EMS Agency with notification of any changes in the designated Medical Director as specified in Reference No. 621, Notification of Personnel Change.

D. Immediately notify the EMS Agency in the event the Medical Director abruptly resigns or is otherwise unable to fulfill his/her duties and no immediate replacement is available.

CROSS REFERENCE:

Prehospital Care Manual:
Reference No. 226, **Private Ambulance Provider Non 9-1-1 Medical Dispatch**
Reference No. 414, **Registered Nurse/Respiratory Specialty Care Transport Provider**
Reference No. 517, **Private Provider Agency Transport/Response Guidelines**
Reference No. 620, **EMS Quality Improvement Program**
Reference No. 621, **Notification of Personnel Change**
Reference No. 621.1, **Notification of Personnel Change Form**
Reference No. 816, **Physician at the Scene**
Reference No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
Reference No. 702, **Controlled Drugs Carried on ALS Units**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 420, Private Provider Ambulance Operator Medical Director

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Definition	BHAC April 12, 2017	Added: Private prover medical director oversees, “private ambulance operator’s” quality improvement process.	Approved as written.
As Above	PAAC April 19, 2017	As above.	Approved as written.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **PRIVATE PROVIDER AGENCY TRANSPORT/RESPONSE GUIDELINES** (EMT, PARAMEDIC, MICN) REFERENCE NO. 517

PURPOSE: To provide guidelines for private ambulance providers handling requests for emergency and non-emergency transports.

AUTHORITY: Los Angeles County Code, Title 7, Business License, Division 2, Chapter 7.16
Health & Safety Code, Division 2, Section 1250,
Health & Safety Code, Division 2.5, Sections 1797.52 - 1797.84,
California Code of Regulations Section 100169
Emergency Medical Treatment and Labor Act of 2006 (EMTALA)

DEFINITIONS:

Health Facility: A health facility may include any of the following:

General Acute Care Hospital
Skilled Nursing Facility
Clinic/Urgent Care Center
Physician Office
Dialysis Center
Intermediate Care Facility
Acute Psychiatric Facility

Interfacility Transport (IFT): The transport of a patient from one health facility to another health facility as defined above.

Life-Threatening Medical Condition: An acute medical condition that, without immediate medical attention, could reasonably be expected to result in serious jeopardy to the health of an individual (in the case of a pregnant woman, the health of the woman or her unborn child) or serious impairment or dysfunction of any bodily organ or part.

Response Time: The time from initial dispatch to arrival at the physical location/address of incident

9-1-1 Response: An emergency response by the primary emergency transportation provider or its designee for that geographic area in which the response is requested. Requests for a 9-1-1 response are generally made by the public but may include requests from health facilities.

PRINCIPLES:

1. A private ambulance company must be licensed by the County of Los Angeles as a Basic Life Support provider. Each of the company's ambulance vehicles that operate within the County of Los Angeles shall also be licensed by the County.

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

2. Private ambulance providers are prohibited from dispatching an ambulance to any call that would normally be considered an emergency 9-1-1 call for the authorized emergency transportation provider for that geographical area. A private ambulance provider may only dispatch an ambulance to such a call if the request is from either the 9-1-1 jurisdictional provider or the authorized emergency transportation provider requesting backup services.

3. Any ambulance personnel observing the scene of a traffic collision or other emergency should:

    a. Contact their respective dispatch center and request that the jurisdictional 9-1-1 provider agency be notified.

    b. Follow the internal policy developed by their employer in regard to stopping at the scene of an observed emergency.

4. It is the responsibility of the requested transport provider, in consultation with the facility requesting the transport, to provide the appropriate level of transport (Basic Life Support, Advanced Life Support or Critical Care Transport) based on the transferring physician's determination of the medical needs of the patient (Refer to Reference No. 517.1, Guidelines for Determining Level of Interfacility Transport).

5. Health facilities shall provide the transport personnel with appropriate transfer documents in compliance with Title 22 and EMTALA transfer requirements.

6. A health facility may not have the staffing and equipment available to assess, treat and/or monitor a patient for extended time frames. Therefore, 9-1-1 emergency responses may be necessary for those patients whose condition may deteriorate while waiting for a private provider response.

7. If it is known that transfer arrangements were not made, the transporting unit shall make every possible effort to contact the receiving facility and advise them of the patient's imminent arrival. This may be done through the provider's dispatch center.

8. Patients with a valid Do-Not-Resuscitate (DNR) form or order shall be transported as outlined in Reference No. 815, Honoring Prehospital Do-Not-Resuscitate Orders.

9. The transferring physician, in consultation with the receiving physician, assumes responsibility for determining the appropriateness of the transfer. It is not the responsibility of the base hospital or the transport personnel to determine whether the transfer is appropriate.

10. Private provider agencies shall ensure that a patient care record (PCR) is completed for each patient transport performed including, but not limited to, critical care transports. The PCR shall include documentation regarding patient monitoring and care during transport, from the time of the patient contact at the sending facility until transfer of care at the receiving health facility or other patient destination. For patients transported to a health facility, each private provider agency shall ensure there is a mechanism in place to provide the receiving facility with a copy of the transport PCR at the time of transfer of care.

POLICY:

I. Transport Modalities

A. Basic Life Support (BLS) Transport

1. Unit is staffed with two EMTs.

2. Requests may be for emergency or non-emergency response.

3. Patient requires care which does not exceed the Los Angeles County EMT scope of practice.

4. Patient does not meet base hospital contact criteria as outlined in Section I of Reference No. 808, Base Hospital Contact and Transport Criteria, at the time of transport.

5. Patients who develop a life threatening medical condition enroute shall be diverted to the most accessible facility appropriate to the needs of the patient.

B. Advanced Life Support (ALS) Transport

1. Unit is staffed with two paramedics unless the ambulance provider has been given approval by the EMS Agency to staff ALS IFT units with one paramedic and one EMT.

2. Requests may be for emergency or non-emergency response.

3. Patient requires skills or treatment modalities which do not exceed the Los Angeles County paramedic scope of practice.

4. Base hospital contact is not required to monitor therapies established by the sending facility prior to transport if such therapies fall within the Los Angeles County paramedic scope of practice.

5. If the patient's condition deteriorates or warrants additional therapies enroute, Procedures Prior to Base Contact Field Reference (Ref. No. 806.1) may be initiated and base hospital contact is required. The base hospital will determine if the patient may be transported to the original destination requested by the sending facility, which should occur whenever possible, or if the patient requires diversion to the most accessible receiving facility appropriate to the needs of the patient.

6. Paramedics may not accept standing orders or medical orders from the transferring physician or provider medical director.

C. Nurse and/or Respiratory Care Practitioner (RCP) Specialty Care Transport (SCT)

1. Unit is staffed by a qualified registered nurse and/or RCP and two EMTs or paramedics. Other medical personnel (e.g., physician, perfusionist, etc.) may be added to meet the needs of the patient.

2. Requests may be for emergency or non-emergency response.

3. Patient requires, or may require, skills or treatment modalities that are within the nurse's and/or RCP's scope of practice.

4. Registered nurses and RCPs are not required to make base hospital contact. Nurses and RCPs may follow medical orders of the transferring physician and/or orders approved by their SCT Medical Director within their applicable scope of practice for patient care enroute. However, if paramedic(s) are part of the SCT transport team, they can only perform medical orders received from a base hospital.

5. Patient destination requested by the sending facility will be honored; however, if the patient's condition deteriorates enroute, the registered nurse or RCP may determine it is in the patient's best interest to divert the patient to the most accessible facility appropriate to the needs of the patient.

II. Transport Requests and Response Levels

A. If a transport request is received and it is determined that the patient's condition would normally be considered an emergency 9-1-1 call for the authorized emergency transportation provider as identified in policy Section (I.) of Reference No. 808, Base Hospital Contact and Transport Criteria, the dispatcher shall immediately refer the request to the jurisdictional 9-1-1 provider under the following circumstances:

1. A private citizen requesting ambulance transportation.

2. If the patient is at a health facility but has not been evaluated and stabilized to the extent possible by a physician prior to the facility requesting transport.

B. If upon arrival at a health facility or private residence and EMTs or paramedics find that the patient has a life-threatening emergency medical condition as identified in policy Section (I.) of Reference No. 808, Base Hospital Contact and Transport Criteria, the EMS personnel shall determine whether it is in the best interest of the patient to request the jurisdictional 9-1-1 provider to respond or to provide rapid transport to the most accessible receiving facility. If on-scene personnel determine that immediate transport is indicated, the jurisdictional 9-1-1 provider shall be notified and justification shall be documented on the patient care record.

C. Emergency Response Requests

1. Request by a 9-1-1 Provider Agency

Ambulance providers shall dispatch an ambulance within the maximum response times for emergency calls specified in the County Code in response to an emergency call from a public safety agency or authorized emergency transportation provider for that geographical area, unless the caller is immediately advised of a delay in responding to the call. Response times for emergency and non-emergent request are as follows:

A. For an emergent response (code 3) maximum response times are:
Urban area – 8 min and 59 seconds
Rural area – 20 min and 59 seconds
Wilderness area – as soon as possible

B. For a non-emergent (code 2) the maximum response times are:
Urban area – 15 minutes
Rural area – 25 minutes
Wilderness area – as soon as possible

2. Request by a Health Facility

a. If a physician in the emergency department at the health facility has evaluated and stabilized the patient to the extent possible and arranged an interfacility transfer, a private ground (or air) ambulance transport may be arranged and the jurisdictional 9-1-1 provider is not ordinarily contacted.

b. **The jurisdictional 9-1-1 provider may only be contacted if the ETA of the private provider is delayed and the condition of the patient warrants a rapid response and transport suggests that there is an acute threat to life or limb that warrants immediate response and transport. Patient destination will then be determined as outlined in the applicable patient destination policy.**

D. Non-Emergency Response Requests - Request by a Health Facility or Private Citizen

1. A request for transport of a patient who has, or is perceived to have a stabilized medical condition that requires transport, and the patient does not have a life threatening emergency medical condition as identified in policy Section (I.) of Reference No. 808, Base Hospital Contact and Transport Criteria

2. Transports are handled by a private ambulance provider with BLS, ALS, or SCT staffed units, depending upon the medical requirements of the patient and the EMS personnel's scope of practice.

III. Role of the Base Hospital in ALS Interfacility Transports

A. Provide immediate medical direction to paramedics if the patient's condition deteriorates or warrants additional therapies during transport.

B. Determine if the patient may be transported to the original destination requested by the sending facility, which should occur whenever possible, or if the patient requires diversion to the most accessible receiving facility appropriate to the needs of the patient if the patient's condition changes while enroute to the pre-designated facility. If diverted, the base hospital shall:

1. Contact the new receiving hospital and communicate all appropriate patient information.

2. Advise the original receiving hospital that a diversion has occurred.

C. Clarify the scope of practice of EMS personnel when requested to do so by a sending facility.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 304, **Role of the Base Hospital**
Ref. No. 414, **Specialty Care Transport (SCT) Provider**
Ref. No. 502, **Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 511, **Perinatal Patient Destination**
Ref. No. 513, **ST Elevation Myocardial Infarction Patient Destination**
Ref. No. 513.1 **Interfacility Transport of Patients with St-Elevation Myocardial Infarction**
Ref. No. 514, **Prehospital EMS Aircraft Operations**
Ref. No. 516, **Return of Spontaneous Circulation (ROSC) Patient Destination**
Ref. No. 517.1 **Guidelines for Determining Level of Interfacility Transport**
Ref. No. 802, **EMT Scope of Practice**
Ref. No. 802.1 **EMT Scope of Practice, Table Format**
Ref. No. 803, **Paramedic Scope of Practice**
Ref. No. 803.1 **Paramedic Scope of Practice, Table Format**
Ref. No. 806, **Procedures Prior to Base Contact**
Ref. No. 806.1 **Procedures Prior to Base Contact, Field Reference**
Ref. No. 808, **Base Hospital Contact and Transport**
Ref. No. 815, **Honoring Prehospital Do-Not-Resuscitate (DNR) Orders**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. **517-PRIVATE PROVIDER AGENCY TRANSPORT/RESPONSE GUIDELINES**

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Definitions	PAAC/4-19-17	Added the following definition of response time. "The time from initial dispatch to arrival at the physical location/address of incident"	Change made
IIC2a	PAAC/4-19-17	Addition of "in the emergency department." The sentence will read "If a physician **in the emergency department** at the health facility has evaluated and stabilized the patient to the extent possible and arranged an interfacility transfer, a private ground (or air) ambulance transport may be arranged and the jurisdictional 9-1-1 provider is not ordinarily contacted.	Change made
IIC2b	PAAC/4-19-17	The following language was updated new sentence will read "**The jurisdictional 9-1-1 provider may only be contacted if the ETA of the private provider is delayed and the condition of the patient ~~warrants a rapid response and transport~~ suggests that there is an acute threat to life or limb that warrants immediate response and transport. Patient destination will then be determined as outlined in the applicable patient destination policy.**	Change made
Throughout policy	PAAC/4-19-17	Update all references to critical care transport (CCT) to specialty care transport (SCT).	Change made

SUBJECT: **MULTIPLE CASUALTY INCIDENT TRANSPORTATION MANAGEMENT** (EMT, PARAMEDIC, DISPATCH) REFERENCE NO. 519.3

PURPOSE: To provide guidelines for the rapid and efficient dispatch of ambulances in response to multiple casualty incidents (MCI).

AUTHORITY: Health & Safety Code, Division 2.5, Chapter 3, Article 4
Health & Safety Code, Division 2.5, Chapter 4, Article 1, Section 1797.220
9-1-1 Emergency Ambulance Transportation Services Agreement

DEFINITIONS (see Reference 519.1 for additional definitions):

Level I Response – An MCI in which the number of ambulances required for the incident are 10 or less. The first ambulance must arrive within 8 minutes and 59 seconds.

NOTE: 9-1-1 providers with transport capabilities will follow their established operational response policy.

Level II Response – An MCI in which the number of ambulances required for the incident exceeds the number of ambulances available through the 9-1-1 provider or is greater than 10.

Ambulance Strike Team (AST) – Pre-established set of 5 ambulances and 1 supervisor which meets the guidelines established by the State EMS Authority.

Central Dispatch Office (CDO) – Dispatch for the Los Angeles County EMS Agency Department of Health Services ambulances.

Exclusive Operating Area (EOA) Contractor – Private Ambulance Company that is contracted with the Department of Health Services to provide emergency patient transportation within the established areas of the County where emergency transportation is not provided by the jurisdictional 9-1-1 provider.

Operational Area (OA) – Consists of all political subdivisions within a county's geographical area that provides coordination and communication between local jurisdictions and OES Regions.

Regional Disaster Medical and Health Coordinator (RDMHC) – Responsible for coordinating disaster medical and health operations for Mutual Aid Region I. The EMS Agency administrator is the designated RDMHC and is contacted through the MAC.

PRINCIPLES:

1. Upon notification by a jurisdictional dispatch center, the Fire Operational Area Coordinator (FOAC) is responsible for coordinating the dispatch of ten or more ambulances to an MCI within Los Angeles County. Los Angeles County Fire Department Dispatch performs the FOAC function for the County.

2. Exclusive Operating Area (EOA) contractors shall establish mutual aid agreements with licensed ambulance companies to provide backup emergency ambulance transportation.

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

3. Jurisdictional 9-1-1 providers with transport capabilities will follow their established operational response policies related to mutual aid agreements with other 9-1-1 providers with transport capabilities.

4. Response Time frames:

    a. Level I – Immediate, with first ambulance arriving within 8 minutes and 59 seconds
    b. Level II – Tiered response with arrival to scene within 30 to 60 minutes

5. All ambulance requests require the following information:

    a. Requesting agency, contact name, position, phone/e-mail
    b. Field Command Agency Representative, name or identifier
    c. Type of incident- mission/tasks
    d. Reporting location/person to report to
    e. Expected duration of operations
    f. Number/type of ambulances requested (ALS/BLS/CCT)
    g. Potential hazards encountered at scene
    h. Radio channel/frequency/phone # for ambulance coordinator
    i. Other special instructions (may include an order number)

6. Private ambulance providers shall not respond to an MCI unless specifically requested by the jurisdictional provider or incident commander.

7. Although the jurisdictional 9-1-1 provider may be able to provide the required number of ambulances as specifically defined in the levels of response, jurisdictional 9-1-1 providers may utilize the FOAC to request additional ambulance resources as needed.

8. Educational sessions and/or drills regarding the communication and coordination involving the FOAC, CDO, and EOA contractors should be conducted on a routine basis.

POLICY:

I. **Level I Response** –Up to 10 ambulances required

The Jurisdictional 9-1-1 Dispatch Center (JDC) shall request ambulances from the EOA contractor in which the incident is located or 9-1-1 providers with transport capabilities will follow their established operational response policy. Contracted backup providers may be utilized as needed.

When responding to the incident, the EOA Contractor shall identify an Ambulance Supervisor who will liaison with the scene Ambulance Coordinator.

II. **Level II Response** – greater than 10 ambulances required.

A. Jurisdictional 9-1-1 Dispatch Center shall notify the FOAC (LA County Fire Dispatch) of:
    1. the MCI,
    2. the number of ambulances already responding,
    3. additional number of ambulances requested by the Incident Commander and

4. Other known incident information.

B. The FOAC shall coordinate a conference call with:
1. The EOA contracted providers,
2. CDO (who will notify the Los Angeles County EMS Agency Administrator on Duty), and
3. Other agencies as determined.

C. Conference call participants shall:

1. Provide the FOAC with the number/type of ambulances that will be available within 30 to 60 minutes.

2. Provide the FOAC with the number of units responding, unit identifier and the estimated time of arrival (ETA).

3. If necessary, contact the licensed backup ambulance companies pre-assigned to the contractor if additional ambulances are needed to respond to the MCI.

4. The EMS Agency Administrator on Duty (AOD) will determine which, if any, EMS Agency resources will be dispatched to the incident.

5. If sufficient EMS resources are not available within Los Angeles County, the EMS AOD will activate the regional resource request process, using MHOAC and RDMHC procedures.

D. The MAC shall contact the EMS Agency AOD, and the RDMHC.

E. The RDMHC shall:

1. Assess the incident and anticipate possible ambulance resource requirements from outside of the OA.

2. Notify the MHOACs of incident progression and de-escalation as appropriate.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 519, **Management of Multiple Casualty Incidents**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. Multiple Casualty Incident Transportation Management

SECTION	COMMITTEE/ DATE	COMMENT	RESPONSE
Multiple Sections	In-house Policy Review Committee	Multiple changes.	Forwarded to BHAC and PAAC for review.
N/A	BHAC 4/12/2017	No recommended changes.	Approved as written.
N/A	PAAC 4/19/2017	No recommended changes.	Approved as written.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reviewed 11-28-2016

SUBJECT: **PHYSICIAN AT THE SCENE** REFERENCE NO. 816

PURPOSE: To establish guidelines for interaction between paramedics and a patient's personal physician, or physicians at the scene of a medical emergency who may not be the patient's personal physician.

NOTE: The guidelines set forth in this policy are intended for physicians at the scene who are <u>not</u> responding as a Provider Agency Medical Director.

AUTHORITY: California Health and Safety Code, Section 1798.6(a) provides that "authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional at the scene of an emergency who is most medically qualified specific to the provision of rendering emergency medical care".

DEFINITIONS:

Base Hospital Medical Director: A physician who is providing oversight for prehospital operations at a Base Hospital who meets the criteria outlined in Reference No. 308.

EMS Fellow: A physician who is participating in an accredited postgraduate sub-specialty training program (i.e., EMS/Disaster/Research) following successful completion of a residency program in emergency medicine.

Provider Agency Medical Director: A physician designated by an approved EMS Provider Agency to advise and coordinate the medical aspects of field care who meets the criteria outlined in Reference No. 411.

PRINCIPLES:

1. Although the law does not preclude a physician at the scene of a medical emergency from <u>rendering</u> patient care, it does prohibit them from <u>directing</u> paramedic personnel in advanced life support procedures. Such direction must come from the base hospital unless direct voice communication with the base hospital cannot be established or maintained. The following physicians may direct paramedics in advanced life support procedures at the scene of a medical emergency: the Medical Director and Assistant Medical Director of the EMS Agency, Provider Agency Medical Director, Medical Director of an approved Los Angeles based Paramedic Training School, Base Hospital Medical Director or EMS Fellow in a Los Angeles based fellowship program.

2. Instructions by a private physician who is not on scene are subject to approval by the base hospital physician or Mobile Intensive Care Nurse (MICN) who is in direct voice contact with the paramedic.

3. A Provider Agency Medical Director may direct EMS personnel in lieu of base hospital contact.

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

POLICY:

I. Physician Identification

A. Paramedics shall obtain proper identification, consisting of a California Physicians and Surgeons License, and note the physician's name, license number, and license expiration date on the EMS Report Form.

B. When a physician on scene does not have identification or is in phone contact only, base hospital contact should be made to determine the extent of permissible interaction between the paramedics and the physician.

II. Patient Care

A. Paramedics shall contact the base hospital and notify them of the presence of the physician on scene. If base hospital contact cannot be established immediately, it shall be made as soon as possible and a full report rendered.

B. When communication cannot be established or maintained, paramedics may assist the physician and may provide advanced life support under the direction of the physician provided that their instructions are consistent with local EMS Agency policies and procedures.

C. If either the paramedics or the base hospital physician perceive any problem(s) with the instructions of the patient's personal physician or physician on scene, the base hospital physician or MICN should speak directly with this physician to clarify or resolve the issue. If this direct contact is not possible, paramedics should follow the direction of the base hospital so that patient care is not delayed or compromised.

D. When the physician on scene chooses to assume or retain responsibility for medical care, paramedics shall instruct the physician that they must take total responsibility for the care given. They must also accompany the patient until the patient arrives at a hospital and responsibility is assumed by the receiving physician <u>unless</u> relieved of the responsibility by the base hospital.

III. Patient Destination

A. Except when the physician on scene has accepted responsibility for patient care, patient destination shall be determined by the base hospital in accordance with EMS Agency policies.

B. When the physician at the scene has accepted full responsibility for patient care, the patient may be transported to a general acute care hospital with a licensed basic emergency department chosen by the physician.

C. If the paramedic provider agency determines that such transport would unreasonably remove the transport unit from the area, an alternate destination shall be agreed upon between the physician at the scene and the base hospital physician.

D. If the patient's condition permits, alternate transportation may be arranged.

E. If the patient's condition requires immediate transport, the decision of the base hospital physician or MICN shall be followed.

CROSS REFERENCE:

Prehospital Care Manual
Reference No. 308, **Base Hospital Medical Director**
Reference No. 411, **Provider Agency Medical Director**
Reference No. 502, **Patient Destination**
Reference No. 514, **Prehospital EMS Aircraft Operations**
Reference No. 803, **Los Angeles County Paramedic Scope of Practice**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 816-**PHYSICIAN AT SCENE**

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Definitions	Medical Council 3/1/17	Add definition for **Base Hospital Medical Director. "**A physician who is providing oversight for prehospital operations, at a Base Hospital who meets the criteria outlined in Reference No. 308."	Change made
Principle I	Medical Council/ 3-7-17	Add base hospital medical director to the sentence. Sentence will now read "the following physicians may direct paramedics in advance life support procedures at the scene of a medical emergency: the medical director and assistant medical director of the EMS agency, provider agency medical director, medical director of an approved Los Angeles-based paramedic training school, base hospital medical director or EMS fellow in a Los Angeles-based fellowship program."	Change made

SUBJECT: **PUBLIC SAFETY FIRST AID (PSFA) AND BASIC TACTICAL CASUALTY CARE (BTCC) TRAINING PROGRAM REQUIREMENTS** REFERENCE NO. 911

PURPOSE: To establish procedures for a training program in Los Angeles County to obtain approval for a Public Safety First Aid (PSFA) and/or Basic Tactical Casualty Care (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 Curriculum: Curriculum approved by the EMS Agency without receiving PSFA and/or BTCC training program approval.

Approved PSFA and/or BTCC Training Program: A training program that has been approved by the EMS Agency or the California EMS Authority to train public safety 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. Training programs providing training or headquartered in Los Angeles County are eligible to apply for approval of a PSFA and/or BTCC training program.

2. An individual or organization may request PSFA and/or BTCC curriculum approval. Curriculum approval is not authorization for an individual or organization to conduct PSFA and/or BTCC training.

3. 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.

4. 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.

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

POLICY:

I. TRAINING PROGRAM APPROVAL

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

A. Approval Process:

1. The EMS Agency shall be the approving agency for PSFA and/or BTCC training programs whose headquarters or training is 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 training programs shall obtain a PSFA and BTCC training program application packet from the EMS Agency website.

2. Any individual or organization, public or private, interested in providing PSFA and/or BTCC training for public safety personnel shall submit a complete application packet. Courses shall not be advertised or offered until program 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, as identified in the EMS Agency training program application, 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:

a. Course schedule
b. Instructional objectives
c. Lessons/training
d. 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:

a. All personnel will be trained in CPR equivalent to BLS for the Healthcare Provider (American Heart Association) or Professional Rescuer (American Red Cross)

b. Training will be competency based and consist of no less than eight hours for retraining and twenty-one hours if applying for an initial training program.

c. 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, stating 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.

h. Pay the established fee with application for approval or re-approval

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 EMS Agency 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 training program application

b. Revoke training program approval

c. Place training program 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 training program 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.

4. If 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 training program 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 request for change in training program 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) "Instructor I and II," 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 Education Attendance Record shall be maintained by the program. A legible copy (unless the original is requested) of the 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

Programs shall issue a tamper resistant document (method determined by the training program) that contains 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. Education 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

XIII. CURRICULUM APPROVAL

An individual or organization may request PSFA and/or BTCC curriculum approval. Curriculum approval does not authorize an individual or organization to conduct PSFA and/or BTCC training.

A. Any individual or organization, public or private, interested in requesting approval for PSFA and/or BTCC curriculum only shall submit:

1. A letter or memo, signed by the individual or Chief of an organization which:

a. requests approval of PSFA and/or BTCC curriculum

b. acknowledges the approval is for the curriculum only and not authorization to conduct training as a training program

c. identifies that an individual or organization which desires to utilize this curriculum, if it is approved, will be notified of the EMS Agency requirement to apply for PSFA and/or BTCC training program approval.

2. A complete curriculum, as identified in the EMS Agency checklist, 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:

a. Course schedule:
   i. PSFA - Initial: 21 hours and Retraining: 8 hours and/or
   ii. BTCC - 4 hours

b. Instructional objectives

c. Lessons/training

d. Written and skills performance evaluations with:
   i. Answer key
   ii. Passing criteria

e. CPR training is equivalent to BLS for the Healthcare Provider (American Heart Association) or Professional Rescuer (American Red Cross)

B. Curriculum approval may be granted up to four (4) years from the last day of the month in which the request is approved. This approval is not transferable from person to person or organization to organization.

C. EMS Agency shall be notified of curriculum changes and a request for re-approval shall be required for changes in medical practice or regulation.

D. The EMS Agency shall notify the applicant in writing within sixty (60) days from the receipt of a complete curriculum request of the decision to approve or deny. The curriculum request is only considered for approval if it is complete and all requirements are met.

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)

Los Angeles County EMS Agency

POLICY REVIEW SUMMARY BY COMMITTEE

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

	Committee/Group	Assigned (Y if yes)	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	✓	4/19/17	
	Base Hospital Advisory Committee			
	Data Advisory Committee			
	Education Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

***** See attached **Summary of Comments Received**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HOSPITAL)

SUBJECT: **9-1-1 RECEIVING HOSPITAL REQUIREMENTS** REFERENCE NO. 302

PURPOSE: To outline the guidelines to be approved as a 9-1-1 receiving hospital.

AUTHORITY: Health & Safety Code 1797.88, 1798.175(a)(1)(2)

DEFINITIONS:

9-1-1 Receiving Hospital: A licensed, general acute care hospital with a permit for basic or comprehensive emergency medicine service and approved by the Los Angeles County EMS Agency to receive patients with emergency medical conditions from the 9-1-1 system.

PRINCIPLES:

1. Patients who call 9-1-1 receive optimal care when transported to a facility that is staffed, equipped and prepared to administer emergency medical care appropriate to their needs.

2. Emergency departments equipped with the communications required of 9-1-1 receiving facilities drill regularly with other system participants and can communicate effectively during multi-casualty incidents and disasters.

3. Data collection and evaluation is critical to assess system performance and evaluate for educational and improvement needs.

POLICY:

I. Procedure for Approval to be a 9-1-1 Receiving Hospital

   A. Submit a written request to the Director of the Emergency Medical Services (EMS) Agency to include:

      1. The rationale for the request to be a 9-1-1 receiving hospital.

      2. A document verifying the hospital has a permit for basic or comprehensive emergency medical service.

      3. The proposed date the emergency department (ED) would open to 9-1-1 traffic.

   B. Communications

      1. All 9-1-1 Receiving Hospitals in Los Angeles County are required to:

         a. Have an operational ReddiNet terminal with redundant connectivity via satellite and internet.

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

b. Collaboration with provider agencies, to provide and maintain a printer capable of printing electronic records received from prehospital care providers, when applicable.

2. Install VMED28 for communication with paramedic providers and the Medical Alert Center during multiple casualty incidents.

3. Install a dedicated telephone line to facilitate direct communication with the paramedic base hospitals, 9-1-1 personnel, and the Medical Alert Center.

C. Site Visit

1. Once all required communication systems are installed and hospital staff training on the equipment is complete, the EMS Agency will coordinate a site visit.

2. Administrative and field personnel from local EMS provider agencies will be invited to exchange contact information, participate in the VMED28 and the ReddiNet system tests, and become familiar with the physical layout of the facility.

3. Representatives from the nearest base hospital (Administrative, Medical Director and/or Prehospital Care Coordinator) will provide contact information, explain the role and function of the paramedic base, and discuss how patient information is communicated to the surrounding 9-1-1 receiving hospitals.

D. Transfer Policies

1. All 9-1-1 Receiving Hospitals in Los Angeles County are required to develop and submit to the EMS Agency for approval an interfacility transfer policy that addresses the following:

a. Compliance with Title XXII transfer requirements and EMTALA

b. Utilization of appropriate transport modality, specifically when to contact private ambulance companies and what situations warrant appropriate use of the 9-1-1 system [e.g., 9- 1-1 Trauma Re-Triage (Ref. No. 506) and confirmed STEMI patient (Ref. No. 513.1)]. The jurisdictional 9-1-1 provider may only be contacted if the estimated time of arrival of a private ambulance is delayed and the condition of the patient suggests that there is an acute threat to life or limb that warrants an immediate response and transport. Patient destination will then be determined as outlined in the applicable patient destination policy.

c. A mechanism shall be implemented to ensure that each transfer on which 9-1-1 was used is reviewed for appropriateness, and correction measures are taken when problems and issues arise to prevent future similar problems from occurring

d. A tracking mechanism to capture all transfers utilizing the 9-1-1 system and document the results of the review

5. EMS Agency role at the site visit:

a. Conduct ReddiNet drills and VMED28 tests

b. Explain the role of the Medical Alert Center and provide contact information

c. Discuss disaster preparedness activities

d. Review the Prehospital Care Policy Manual, Medical Control Guidelines, Treatment Protocols and other relevant materials:
   i. Ref. No. 502, Patient Destination
   ii. Ref. No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients
   iii. Ref. No. 620.1, Notification of Personnel Change
   iv. EMS Agency staff contacts
   v. Base hospital/receiving hospital contacts
   vi. EMS Agency meeting calendar
   vii. Situation Report/Problem resolution
   viii. EmergiPress

II. Responsibilities: the 9-1-1 Receiving Hospital shall:

A. Maintain communication requirements listed in Section I.B. of this policy

B. Attend EMS Agency sponsored meetings for 9-1-1 Receiving Hospitals to stay current with EMS practice, policy and equipment.

C. Provide updated contact information to the base hospital and the EMS Agency whenever there is a change in key personnel.

D. Maintain an accurate list of hospital services and contact information in the ReddiNet for disaster and MCI purposes

E. Collect and submit data to the EMS Agency on patients transported via the 9-1-1 system by 2018. Data submission requirements will be defined in Ref. No. 610, 9-1-1 Receiving Hospital Data Dictionary.

F. Implement measures to ensure compliance with Section I.D of this policy.

CROSS REFERENCES:

Prehospital Care Manual:
Reference No. 304, **Role of the Base Hospital**
Reference No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Patients**

Reference No. 503.1, **Hospital Diversion Request Requirements for Emergency Department Saturation**
Reference No. 506, **Trauma Triage**
Reference No. 610, **9-1-1 Receiving Hospital Data Dictionary**
Reference No. 621, **Notification of Personnel Change**
Reference No. 621.1, **Notification of Personnel Change Form**
Reference No. 513.1, **Emergency Department Interfacility Transport of Patients with ST-Elevation Myocardial Infarction**

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 302, **9-1-1 RECEIVING HOSPITAL REQUIREMENTS**

SECTION	COMMITTEE/ DATE	COMMENT	RESPONSE
N/A	HASC EHS 6/1/2017	No recommended changes.	Approved as written.
N/A	BHAC 4/12/2017	No recommended changes.	Approved as written.
N/A	PAAC 4/19/2017	No recommended changes.	Approved as written.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT/ PARAMEDIC/MICN)

SUBJECT: **APPLICATION OF PATIENT RESTRAINTS** REFERENCE NO. 838

PURPOSE: To provide guidelines for emergency procedures and use of restraints in the field or during transport of patients who are violent or potentially violent, or who may harm self or others.

AUTHORITY: California Code of Regulations, Title 22, Sections 100063, 100145, 100169(a)(1,2) and (c)(1)
Welfare and Institutions Code, 5150
California Code of Regulations, Title 13, Section 1103.2
Health and Safety Code, Section 1798(a)

PRINCIPLES:

1. The safety of the patient, community, and responding personnel is of paramount concern when considering the use of restraints.

2. Staff should be properly trained in the appropriate use and application of restraints and in the monitoring of patients in restraints.

3. The application of restraints is a high risk procedure due to the possibility of injury; therefore, the least restrictive method that protects the patient and emergency medical services (EMS) personnel from harm should be utilized. Restraints should be used only when necessary in situations where the patient is potentially violent or is exhibiting behavior that is dangerous to self or others.

4. EMS personnel must consider that aggressive or violent behavior may be a symptom of medical conditions such as head trauma, alcohol, drug related problems, metabolic disorders, stress and psychiatric disorders. Base contact criteria shall be strictly adhered to for those conditions that require it.

4. The responsibility for patient health care management rests with the highest medical authority on scene. Therefore, medical intervention and patient destination shall be determined by EMS personnel according to applicable policies. Authority for scene management shall be vested in law enforcement, where applicable.

5. The method of restraint used shall allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway or compromise neurological or vascular status.

6. This policy is not intended to negate the need for law enforcement personnel to use appropriate restraint equipment approved by their respective agency to establish scene management control.

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

POLICY

I. Forms of Restraining Devices

A. Restraint devices applied by EMS personnel (including interfacility transport of psychiatric patients) must be either padded hard restraints or soft restraints (i.e., vest with ties, velcro or seatbelt type). Both methods must be keyless and allow for quick release. Restraints shall be applied as a two point padded wrist and belt restraint or four point padded wrist and ankle restraints.

B. The following methods of restraint shall NOT be utilized by EMS personnel:

1. Hard plastic ties or any restraint device requiring a key to remove.

2. Restraining a patient's hands and feet behind their back.

3. "Sandwich" method (e.g., backboard, scoop stretcher or flats).

4. Materials applied in a manner that could cause vascular, neurological or respiratory compromise (e.g., gauze bandage or tape).

II. Application and Monitoring of Restraints

A. Restraints shall be applied in such a manner that they do not cause vascular, neurological or respiratory compromise.

B. Restrained extremities should be evaluated for pulse quality, capillary refill, color, temperature, nerve and motor function immediately following application and every 15 minutes thereafter. Any abnormal findings require adjustment, removal and reapplication of restraints if necessary. It is recognized that the evaluation of nerve and motor status requires patient cooperation and thus may be difficult to monitor.

C. Under no circumstances are patients to be transported in the prone position regardless of who applies the restraint. EMS personnel must ensure that the patient's position allows for adequate monitoring of vital signs, does not compromise respiratory, circulatory, or neurological status, and does not preclude any necessary medical intervention to protect or manage the airway should vomiting occur.

D. Restraints shall not be attached to movable side rails of a gurney.

E. Restraint methods must allow the patient to straighten the abdomen and chest to take full breaths.

F. Restraint devices applied by law enforcement require the officer's continued presence to ensure patient and scene management safety. The officer shall accompany the patient in the ambulance. In the unusual event that this is not possible, the officer should follow by driving in tandem with the ambulance on a pre-determined route. A method to alert the officer of any problems that may develop during transport should be discussed prior to leaving the scene.

III. Required Documentation on the Patient Care/EMS Report Form

A. Reason restraints were applied.

B. Type of restraints applied.

C. Identity of agency/medical facility applying restraints.

D. Assessment of the overall cardiac and respiratory status of the patient; and the circulatory, motor and neurological status of the restrained extremities every 15 minutes.

E. Reason for removing or reapplying the restraints or any abnormal findings.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 502, **Patient Destination**
Ref. No. 703, **ALS Unit Inventory**
Ref. No. 808, **Base Hospital Contact and Transport Criteria**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 838, Application of Restraints

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
N/A	BHAC	No recommended changes.	N/A
N/A	PAAC	No recommended changes.	N/A

Los Angeles County EMS Agency

POLICY REVIEW SUMMARY BY COMMITTEE

Reference No. 838, Application of Restraints

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	6/21/17	6/21/17	Y
	Base Hospital Advisory Committee	6/14/17	6/14/17	Y
	Data Advisory Committee			
	Education Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

***** See attached **Summary of Comments Received**

Emergency Medical Services Commission
Ad Hoc Committee on
The Prehospital Care of Mental Health / Substance Abuse Emergencies
Recommendations Action Plan

Recommendation	Short Term ≤ 1 year	Medium Term 1-2 years	Long Term > 2 years	Action	Responsible entity
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".			**X**	Watch and wait This item is dependent on upstream items including regulatory changes which are cited in the recommendations below.	None presently
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.	**X**			Set up meeting (or attend existing meeting?) to discuss with Law Enforcement oversight groups to further investigate current process in deployment of units. Monitor further development/growth of MHSA specialty teams.	EMS Agency, LAPCA, DMH
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.	**X**			Engage DMH in the identification of appropriate MH/SA services and resource materials for non-transported persons. Identify or Create appropriate web-based information that can be printed/provided to non-transported persons. Develop education plan for EMS/LE	DMH, EMS Agency

Recommendation	Short Term ≤ 1 year	Medium Term 1-2 years	Long Term > 2 years	Action	Responsible entity
4. Standardize training/protocol across the County for all LE agencies regarding what constitutes a need for a medical evaluation by EMS providers.		**X**		Review any existing protocols / criteria (such as Exodus criteria) Engage ED physicians / EMS medical director in drafting basic triage criteria Develop training / education materials	EMS Agency, LAPC and DMH
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.		**X**		Set up meeting with HASC and/or stakeholders to discuss	EMS Agency and Hospital Association of Southern California
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.			**X**	Watch and Wait Pending – requires legislative changes. Work with State representatives to sponsor a Bill that supports the transport of 9-1-1 emergency patients to alternate destinations in specific circumstances	Health Services Government Relations and the CEO Legislative Group work with local State Senator or Assemblyperson
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			**X**	Pending changes in Medi-Cal program to cover addiction treatment Discuss with DMH / State Medi-Cal	Health Agency Government Relations and the CEO Legislative Group work with local State Senator or Assemblyperson.

Recommendation	Short Term ≤ 1 year	Medium Term 1-2 years	Long Term > 2 years	Action	Responsible entity
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.					Department of Public Health Substance Abuse Division
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 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.	**X**			Research and determine how other EMS systems address the care of combative, agitated and potentially violent patients	EMS Agency Medical Director
	X			Conduct literature review on subject	EMS Agency Medical Director
		X		Draft Treatment Protocol as it relates to Provider Impressions to include Agitated Delirium and Psychiatric/Behavioral Crisis and review at Medical Council for input and adoption	EMS Agency Medical Director
		X		Develop training program on new Treatment Protocol and roll out the training for entire County	EMS Agency Medical Director
9. Explore the option of Sobering Centers as a patient destination for inebriates as these resources become more available in the community.			**X**	Watch and wait Pending legislative/regulatory changes	Health Agency Government Relations and the CEO Legislative Group work with local State Senator or Assemblyperson. Department of Mental Health Substance Abuse Division
			X	Sobering Centers need to be available across the County for access to all patients who would meet criteria for transport to a Sobering Center.	

AGN. NO.

MOTION BY SUPERVISORS SHEILA KUEHL AND JANICE HAHN February 7, 2017

Cannabis Regulation and Licensing

The recent passage of Proposition 64 by the voters of the State of California approved the use of cannabis by adults 21 years of age or older. To effectuate the terms of the Proposition, the State will begin issuing various licenses beginning in January 2018. The initiative also allows local jurisdictions to enact appropriate regulations to govern the licensing and siting of cannabis cultivation, distribution, manufacturing, testing and retail sales. Given the strong voter support for legalization of cannabis and the difficulty in enforcing bans, it is important that the county establish a comprehensive regulatory framework to coordinate with existing state laws.

The county's regulations should prioritize the protection of public safety and health as well as the quality of life in our communities. It also must include a robust public education and prevention campaign. Should the county fail to regulate, it could open the door to a number of negative impacts: illegal sales or use of hazardous materials in the manufacturing process, to name a few. The county has an interest in ensuring that cannabis businesses sell products that have been lab tested and provide

MOTION

Solis	_____
Kuehl	_____
Hahn	_____
Barger	_____
Ridley-Thomas	_____

protection to consumers. It is critical that our zoning regulations promote equity in availability and siting while not placing an undue burden on any one unincorporated community in the County. Effective and rational regulations, developed in coordination with community stakeholders and the cannabis industry, can protect the environment and foster a sustainable cannabis industry in Los Angeles County.

WE, THEREFORE, MOVE that the Board of Supervisors:

1. Direct the Chief Executive Officer ("CEO") to conduct stakeholder engagement with community members from each supervisorial district to assist the county in reviewing appropriate medical and commercial cannabis regulations and best practices, and to identify additional opportunities for community outreach and engagement throughout the county.
2. Direct the CEO to coordinate with all affected County departments, including, but not limited to, County Counsel, Sheriff, District Attorney, Public Defender, Alternate Public Defender, Regional Planning, Public Health, Agricultural Commissioner/Weights and Measures, Public Works, Fire, Treasurer and Tax Collector, Consumer and Business Affairs, as well as the Assessor, to:
    A. Prepare any necessary amendments to current ordinances as well as environmental reviews required by the California Environmental Quality Act (CEQA), including, but not limited to, amendments to Title 22 of the County Code (Zoning Code), Title 8 (Consumer Protection, Business and Wage Regulations), and Title 7 of the County Code (Business Licenses), to allow, license, and appropriately regulate and enforce the

cultivation, transportation, distribution, processing, manufacturing, testing, retail sale, and delivery of medical and commercial (recreational) cannabis in unincorporated County areas.

B. Incorporate into any current or amended ordinances, requirements and best practices for regulating medical and commercial cannabis, including, but not limited to the following:

   i. Best practices for land use which limit and/or address any impacts to blight and the health and safety of County neighborhoods and that also adhere to previous County recommendations regarding equitable development including but not limited to the following:

      a. Consideration of buffers from sensitive uses such as schools, daycare facilities, off-site alcohol sales, parks and recreational centers, residential neighborhoods, etc.;

      b. Minimum spacing requirements or numerical limitations to prevent over-concentration, excessive exposure and access to both cannabis businesses and advertising;

      c. Consideration of environmental impacts as described in the CEO's report dated November 15, 2016;

      d. Frontage requirements to maintain community character and maximize safety;

      e. Recommendations that minimize impacts on public health, safety, and quality of life, and maximize transition from an illicit and unregulated cannabis market to a regulated market. Any such

regulations shall prohibit outdoor commercial cultivation in all zones, permit cultivation, distribution, and manufacturing in industrial and commercial manufacturing zones, and permit all other associated medical and commercial cannabis related enterprises in zones C-3 or higher. Such regulations shall reflect a careful evaluation of potential impacts to existing community standards districts (CSD) and community plans. The Director of Planning may also consider and recommend other zoning options that more effectively achieve the board's desired outcomes.

ii. Regulations and best practices that promote positive benefits to local communities, especially those disproportionately impacted by historical enforcement policies that concentrated criminal justice consequences in poor communities of color despite similar rates of drug use and sales in other communities. Regulations should include opportunities for local worker hire requirements where feasible and other programs that give back to local communities;

iii. Regulations and best practices that minimize the illicit and unregulated cannabis market, including, but not limited to, development standards and licensing requirements designed to reduce opportunities for crime, such as minimum security requirements, proscribed hours of operation, usage of security cameras, and other appropriate regulations to prevent crime,

diversion of cannabis to illicit and unregulated markets and use by underage minors;

iv. Regulations and best practices to promote sustainable businesses with limited impact on the environment, including mandates to achieve the lowest feasible energy and water consumption by utilizing methods such as renewable energy, energy efficient lighting, techniques to reduce overall lighting requirements, and water recycling;

v. Regulations and best practices with respect to licensing, permitting, and/or registering of cannabis businesses to promote compliance and compatibility with surrounding uses and limit the over-commercialization and monopolization of cannabis businesses, including, but not limited to, a possible cap on the number of business licenses issued within any one community, supervisorial district and/or countywide. Recommendations regarding the number of business licenses should take into account the lowest and highest licensee revenue and cost estimates derived by the Marijuana Policy Group, as reported by the CEO on November 15, 2016, and should also consider alcohol regulatory systems as a potential model;

vi. Regulations which put into place an appropriate County governance model to implement, oversee, and enforce the regulatory program or otherwise appropriately control the impacts of legal cannabis business activity; and

vii. Regulations and best practices for consumer protection including, but not limited to, product labeling and testing.

C. Schedule a series of multilingual and culturally competent town halls in each supervisorial district that include community members, business owners, community groups, public health experts, cannabis advocates, and industry associations, to obtain feedback on regulations and best practices, and to identify additional opportunities for community outreach and engagement.

D. Develop for the Board's consideration an appropriate ordinance and ballot measure to tax commercial cannabis with the goal of protecting public health and safety and minimizing the illicit and unregulated cannabis market while fostering a regulated legal marketplace which, at a minimum, generates net-new revenues to cover costs incurred by the county needed to regulate the industry.

E. Deploy a robust data collection program to monitor cannabis usage rates, especially among youth, crime rates associated with cannabis; traffic incidents and other injuries involving cannabis; cannabis cultivation and sales; cannabis abuse treatment; cannabis-related criminal reclassification, retroactive resentencing and diversion implementation; employment and job statistics; energy and water usage and other environmental effects of cannabis businesses; and all other data indicators necessary or desirable to measure any effects of legal

cannabis on County residents and the effectiveness of the County's regulatory program.

F. Develop appropriate safety and educational protocols for County employees who will be directly involved in cannabis businesses. Such safety protocols should include, at a minimum, training modules that provide appropriate safety information to County employees as well as those involved in cannabis businesses, to ensure that all County and industry personnel are aware of, can identify, can appropriately respond to, and can avoid any risks and hazards unique to the cannabis industry.

3. Direct the CEO, in coordination with affected County departments, to:

A. Work with local cities to promote uniformity of regulations and best practices within the entire County, with the goal of preventing impacts to any one city or unincorporated community from cannabis businesses in nearby cities or communities, and/or disparate impact and overconcentration of cannabis businesses in economically disadvantaged communities. This can include hosting a symposium with experts in the field, including representatives from the states of Colorado and Washington.

B. Advocate that the State of California and the federal government develop effective statutes and regulations at the State and federal levels concerning the legal use of cannabis, including, but not limited to, statutes and regulations that address problems associated with the disproportionately high use of cash in cannabis businesses.

4. Direct the Department of Public Health, in coordination with the CEO, and in partnership with community groups, schools, and other stakeholders, to develop education and prevention campaigns to deter young people from consuming cannabis and to educate all people about documented and validated potential effects stemming from the use of cannabis.
5. Direct the Department of Human Resources, in coordination with the CEO and County Counsel, to evaluate current drug use policies for County employees, and report back to the Board in writing on recommended policy changes, if any.
6. Request that the Sheriff and the District Attorney, in consultation with the Public Defender, Alternate Public Defender and the Civilian Oversight Commission, report in writing on best practices used across the country for methods of identifying and evaluating when drivers are held to be legally under the influence of cannabis with particular attention paid to methods that go beyond simply measuring the level of THC in the bloodstream.
7. Direct County Counsel, in coordination with the CEO, the Department of Regional Planning, the Treasurer and Tax Collector, the Sheriff and the District Attorney to report in writing on the current number and operations of cannabis dispensaries, the current enforcement policies for detecting and eliminating illicit dispensaries, and strategies for bringing them into compliance with upcoming regulations.
8. Authorize the CEO to enter into contracts with consultants, as necessary, provided funds are budgeted and contracts are approved as to form by

County Counsel, for the purposes of carrying out the above-mentioned directives.

9. Authorize the Department of Regional Planning to enter into contracts with consultants to conduct any necessary environmental review and zoning or land use studies related to this motion, provided funds are budgeted and contracts are approved as to form by County Counsel.
10. Direct the CEO to coordinate with all affected County departments to provide a written status update to the Board on a quarterly basis, or on a more frequent basis as determined by the CEO.
11. Direct the CEO to work with departments to determine budget impacts of the directives contained in this motion.
12. Direct the CEO to formally establish the Office of Marijuana Management (OMM) within the CEO, with reporting responsibilities to the CEO, allocate necessary resources and positions required for the unit through existing budgeted resources to allow the OMM to carry out the duties set forth in this motion, and submit a written report to the Board within 60 days with a recommendation for ongoing new or transferred County positions and budgetary resources required for the unit.

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CHIEF EXECUTIVE OFFICE
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SACHI A. HAMAI
Chief Executive Officer

July 3, 2017

To: Supervisor Mark Ridley-Thomas, Chairman
Supervisor Hilda L. Solis
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

From: Sachi A. Hamai
Chief Executive Officer

REPORT BACK ON A MEASURE B COUNTY ADVISORY BODY (ITEM NO. 12, AGENDA OF MAY 2, 2017)

As directed by the Board of Supervisors (Board) on May 2, 2017, the Chief Executive Office (CEO), working in conjunction with the Department of Health Services (DHS), is providing this report on: a) a countywide strategy for ensuring an objective, needs-based allocation of future unallocated Measure B funds that will ensure the maximum impact on Los Angeles (LA) County residents; and b) the feasibility of establishing a County advisory body for future unallocated Measure B funds, which shall consist of, but not limited to, the CEO, DHS, Emergency Medical Services (EMS) Agency, Department of Public Health (DPH), and other external stakeholders at the discretion of the CEO.

BACKGROUND

In May 2002, the State Auditor released a report that acknowledged that DHS faced significant budget constraints, and that DHS would incur a $688 million shortfall by fiscal year 2005-06 absent additional, ongoing revenues. The report further indicated the deficit would threaten DHS' ability to continue providing services to low income and medically indigent residents.

In November 2002, voters in the County approved Measure B, which authorized the County to levy a special tax on the structural improvements located within the County to provide funding for the countywide system of trauma centers, particularly those trauma hospitals operated by the County, emergency medical services, and for bioterrorism response throughout the County. Measure B was intended to stabilize DHS' fiscal condition, to provide an ongoing, dedicated revenue source to support its comprehensive safety net health care system, as well as to provide support for the countywide system of trauma centers, including those operated by non-County hospitals.

RECOMMENDATIONS

To address both of the Board's directives, it is recommended that the County create a Measure B Advisory Body (MBAB) and charge it with the following membership and scope.

Membership

Membership of the MBAB is proposed to have one member from each of the following entities:

- Co-chair: Chief Executive Office, Health and Mental Health Services
- Co-chair: LA County Emergency Medical Services Agency
- Member: LA County Auditor-Controller
- Member: LA County Department of Health Services
- Member: LA County Department of Public Health
- Member: LA County Fire Department
- Member: Representative of non-County trauma hospitals, as appointed by the Hospital Association of Southern California
- Member: Chair (or delegate) of the LA County Emergency Medical Services Commission
- Member: Surgeon practicing at a trauma hospital in the County as appointed by the Southern California chapter of the American College of Surgeons

Scope

As directed in the Board motion, the MBAB will provide advice to the Board on options and/or recommendations for spending future unallocated funds. Related to this scope, this may include a summary of options available to the Board for increasing the annual property tax assessment, which would make available additional Measure B funds.

Meeting frequency

The MBAB will meet quarterly, or more frequently as the need arises.

Approach

The Board motion included a directive to ensure that the allocation of future unallocated Measure B funds is "objective," "needs-based" and "ensure(s) the maximum impact on County residents." In an effort to achieve this important goal, the EMS Agency and DPH will be

required to develop and present for deliberations a summary of the state of trauma and emergency services and bioterrorism preparedness in the County. This presentation should include concrete trends in data on important indicators of the health of the system where available and should highlight areas of unmet need within the County's systems of care. The MBAB meetings will be open to the public, including a public posting of an agenda, and time for public comment.

Advisory Role Function

The MBAB will develop options and/or recommendations for spending available future unallocated Measure B funds for the Board to consider. A draft set of options will be shared publicly at least two weeks prior to a final document being sent to the Board. Actual allocation of funding will be solely at the discretion of the Board and contingent upon Board approval.

CONCLUSION

The CEO recommends the Board implement the MBAB as outlined above. The creation and implementation of the MBAB is a matter for Board determination.

If you have any questions, please contact Mason Matthews, Health and Mental Health Services, at (213) 974-2395 or mmatthews@ceo.lacounty.gov.

SAH:JJ:MM
MM:cg

c: Executive Office, Board of Supervisors
County Counsel
Auditor-Controller
Emergency Medical Services Commission
Fire
Health Services
Hospital Association of Southern California
Public Health
Southern California Chapter, American College of Surgeons

H:\cms_budget\chron 2017\Measure B County Advisory Body

Health Services
LOS ANGELES COUNTY

July 3, 2017

Mitchell H. Katz, M.D.
Director

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www.dhs.lacounty.gov

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

www.dhs.lacounty.gov

TO: Supervisor Mark Ridley-Thomas, Chairman
Supervisor Hilda L. Solis
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

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

SUBJECT: **STATUS AND MONITORING OF EMERGENCY AMBULANCE TRANSPORTATION AGREEMENTS (ITEM #S-1 FROM THE JUNE 20, 2017 BOARD MEETING)**

On June 20, 2017, the Board instructed the Director of the Department of Health Services (DHS) to report back prior to July 1, 2017 on evaluating the status of contractor readiness to implement the newly signed emergency ambulance transportation agreements for the Exclusive Operating Areas (EOAs) 2, 3, 4, and 5. In addition, the Board instructed the Director of DHS to begin reporting on a quarterly basis for a period of two years, on the status of the provisions of emergency ambulance services for all nine EOAs, including the monitoring of response times and other critical performance requirements under the County's agreements (Attachment I).

Purpose and Scope

With the implementation EOAs 2, 3, 4, and 5 of these agreements, there is no change in contractor for EOA 2 and 5; therefore, the emphasis of this report is on the transition of service providers in EOA 3 and 4 and their readiness to provide Emergency Ambulance Transportation Services (Attachment II).

The Emergency Medical Services (EMS) Agency is monitoring the following critical aspects of the contractor transition and agreement requirements:

1) Notification of Affected Parties, Fire Departments and Cities

a) Los Angeles County Fire Department (LACoFD): The EMS Agency has been in ongoing communication with LACoFD regarding the EOA agreements. On June 21, 2017, LACoFD was notified in writing of the Board's approval of the EOA agreements and transition date of July 1, 2017.

b) Santa Fe Springs Fire Department & Rescue (FD&R) and city manager: The EMS Agency notified Santa Fe Springs FD&R on June 21, 2017 of the continued service of Care Ambulance to the City of Santa Fe Springs, which is located in EOA 5.

c) Monrovia Fire Department (FD): The EMS Agency notified Monrovia FD on June 21, 2017 of the continued service of Schaefer Ambulance (Schaefer) to the City of Monrovia in EOA 2.

d) Montebello Fire Department (MB): The EMS Agency notified Montebello FD on June 21, 2017 of the continued service of Care Ambulance (Care) to the City of Montebello, which is located in EOA 5.

e) Contract Cities: Thirty-one (31) remaining cities located in EOA 3, 4, and 5 were notified by the EMS Agency in writing that on July 1, 2017, Care Ambulance will begin or continue service in their respective cities (Attachment II).

f) Integration of the new contractors into the LACoFD Command & Control, The Joint Power Communication Center (JPCC), and the Verdugo Fire Communications emergency dispatch systems.

2) Integration of Emergency Ambulance Transportation Services EOA Awardee into the emergency dispatch system of LACoFD, La Habra Heights FD, Montebello FD, Monrovia FD, and Santa Fe Springs FD&R.

a) EOA 2: The EMS Agency notified Verdugo Fire Communications on June 21, 2017 that Schaefer Ambulance will continue service in the City of Monrovia.

b) EOA 3, 4, 5: The EMS Agency notified LACoFD Command & Control on June 21, 2017, that Care Ambulance will begin service in EOA 3 and 4 and continue service in EOA 5 on July 1, 2017. This communication covers LACoFD dispatch service for La Habra Heights (EOA 5).

c) EOA 5: The EMS Agency notified the dispatch agencies for Santa Fe Springs and Montebello on June 21, 2017 that Care Ambulance will continue to provide services in those cities.

3) Approval of All Required Ambulances Equipment for each EOA

EOA	EOA 2 Schaefer	EOA 3 Care	EOA 4 Care	EOA 5 Care
Required number	2	25	21	54
# approved (licensed and inspected)	2	25	21	54
# in process of approval	N/A	N/A	N/A	N/A

4) Hiring and Training of Emergency Medical Technicians (EMTs)

a) Hiring of EMTs

EOA	EOA 2 Schaefer	EOA 3 Care	EOA 4 Care	EOA 5 Care
Required number	12	134	112	248
# of EMTs hired	12	81	79	250+*
# of EMTs in the process of hiring	N/A	54**	53**	N/A
Additional positions needed	0	0	0	0

** Currently serving EOA 5*
*** Ambulance company will hire more staff than required to backfill for employee turnover*

b) Training of EMTs

EOA	EOA 2 Schaefer	EOA 3 Care	EOA 4 Care	EOA 5 Care
Percentage of EMTs trained and ready to work in EOA	100%	60%	75%	100%

5) Operational status of designated ambulance stations

EOA	EOA 2 Schaefer	EOA 3 Care	EOA 4 Care	EOA 5 Care
Required number	2	10	10	16
# of stations with fully executed lease agreements	2	6	3	16*
# of stations that are in the process of being leased	N/A	2	5	2
# of stations that need to be identified	0	2	2	0

** Currently serving EOA 5*

Care Ambulance Dispatch Center

Care Ambulance expanded its dispatch center in Santa Fe Springs and was inspected by EMS Agency staff on June 19, 2017. The added staff and equipment used to dispatch went live on June 22, 2017, dispatching calls in EOA 5 and will include EOA 3 and 4 calls beginning July 1, 2017.

Conclusion

Care Ambulance continues to move forward with the personnel hiring and training. The number of EMTs that require training is an area of concern. However, Care Ambulance administration has confirmed the addition of sessions and increased class size to ensure that all EMTs who begin working on July 1, 2017 and beyond have completed the appropriate training. The EMS Agency is confident that there will be a smooth transition to the new service provider on July 1, 2017. We have confirmed that critical communication between Care Ambulance Service and current service providers are on-going. The EMS Agency will continue to monitor the transition and be available to answer questions from the community, providers and employees.

If you have any questions or need additional information, please contact Dr. Christina Ghaly, Chief Operations Officer, at (213) 240-7787 or at cghaly@dhs.lacounty.gov.

MHK:MH:ch:lb

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel

MOTION BY SUPERVISORS HILDA L. SOLIS AND JANICE HAHN **JUNE 20, 2017**

Report on the status and monitoring of emergency ambulance transportation agreements

Emergency ambulance transport services are a critical part of our daily lives. Residents and visitors countywide rely on these services to safely and quickly respond in cases of a medical emergency. To better manage the provision of these services, the Department of Health Services (DHS) has organized the county services areas into nine exclusive operating areas or EOAs. One important factor is that these ambulance services, when dispatched, arrive as soon as safely possible to the scene of a medical emergency in accordance with the County's strict response time requirements.

With approval from the State EMS Authority, the County's ten year contracts for emergency ambulance transport agreements have been re-solicited with the new contracts beginning in 2017. Five of the nine contracts for EOAs 1, 6, 7, 8 and 9 were executed with services beginning January 1, 2017. On approval by the Board, the remaining contracts for EOAs 2, 3, 4 and 5 will begin with an effective date of July 1, 2017.

To facilitate and ensure a smooth transition of these critical services, it is important that DHS update and inform the Board of Supervisors of the progress and operations of these new agreements.

– MORE–

	MOTION
Solis	_____
Ridley-Thomas	_____
Kuehl	_____
Hahn	_____
Barger	_____

WE, THEREFORE, MOVE THAT THE BOARD OF SUPERVISORS:

Instruct the Director of DHS provide to the Board a report prior to the July 1 effective date evaluating the status of contractor readiness to implement the newly signed emergency ambulance transportation agreements. In addition, the Director of DHS shall report to the Board beginning on July 1, 2017, and then on a quarterly basis for a period of two years, on the status of the provision of emergency ambulance services for all nine EOAs, including the of monitoring response times and other critical performance requirements under the County's agreements.

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LOS ANGELES COUNTY
9-1-1 AMBULANCE EXCLUSIVE OPERATING AREAS 2016