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Emergency Nurses Association

Mr. Colin Tudor

League of Calif. Cities/LA County Division

Atilla Uner, MD

California Chapter-American College of

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Mr. Gary Washburn

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Pajmon Zarrineghbal

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Los Angeles County Police Chiefs Assn.

Cathy Chidester

Executive Director

(562) 347-1604

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Amelia Chavez

Secretary, Health Services Commission

(562) 347-1606

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**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: March 21, 2018

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

Presentation of Awards to honor the HERT team from USC and Alhambra Fire Department – *All Commissioners are invited to join us at 12:30pm for cake and refreshments.*

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

1 MINUTES

- January 17, 2018

2 CORRESPONDENCE

- 2.1 (02-26-2018) Distribution: Designation of Comprehensive Stroke Centers.
- 2.2 (02-21-2018) Distribution, Countywide Sidewalk Cardiac Resuscitation Day – Tuesday, June 5, 2018.
- 2.3 (01-18-2018) Howard Backer, MD, MPH, FACEP, Director, Emergency Medical Services Authority (EMSA): In Support of the California EMSA's Application for Grant Funding to Initiate the Health Information Exchange Project for Emergency Medical Services.
- 2.4 (01-02-2018) Charles Drehsen, MD, Medical Director, American Medical Response: Paramedic Vaccination Program Approved.

3. COMMITTEE REPORTS

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

4. POLICIES

- 4.1 Policy No. 214: Base Hospital and Provider Agency Reporting Responsibilities
- 4.2 Policy No. 503: Guidelines for Hospitals Requesting Diversion of ALS Patients
- 4.3 Policy No. 521: Stroke Patient Destination
- 4.4 Policy No. 607: Electronic Submission of Prehospital Data
- 4.5 Policy No. 901: Paramedic Training Program Approval Requirements

5. BUSINESS (Old)

- 5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies Report
- 5.2 Ad Hoc Committee (Wall Time/Diversion)
- 5.3 Updates from Physio-Control/Stryker on the ePCR for the Los Angeles County Fire Department

New

- 5.4 Pending Closure Emergency Department
- 5.5 Update 2018

6. COMMISSIONERS COMMENTS/REQUESTS

7. LEGISLATION

8. EMS DIRECTOR'S REPORT

9. ADJOURNMENT

(To the meeting of May 16, 2018)

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

March 21, 2018

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- January 17, 2018

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January 17, 2018

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Secretary, Health Services Commission

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COMMISSIONERS	ORGANIZATION	EMS AGENCY STAFF	POSITION
☑ Ellen Alkon, M.D.	So. CA Public Health Assn.	Cathy Chidester	Director
* Lt. Brian S. Bixler	Peace Officers Assn. of LAC	Richard Tadeo	Assistant Director
☑ Erick H. Cheung, M.D.	So. CA Psychiatric Society	Karolyn Fruhwirth	Assistant Director
☑ Marc Eckstein, M.D.	L.A. County Medical Assn	Amelia Chavez	Secretary, Commission
☑ John Hisserich	Public Member, 3 rd District	Cathlyn Jennings	EMS Staff
☑ Lydia Lam, M.D.	CAL/ACEP	Christine Zaiser	EMS Staff
☑ James Lott	Public Member, 2 nd District	Christy Preston	EMS Staff
☑ Robert Ower	LAC Ambulance Association	David Wells	EMS Staff
☑ Margaret Peterson, PhD	HASC	Gary Watson	EMS Staff
☑ Paul S. Rodriguez	CA State Firefighters' Assn.	Joann Lockwood	EMS Staff
* Nerses Sanossian, M.D.	American Heart Association	Karen Rodgers	EMS Staff
☑ Carole Snyder	Emergency Nurses Assn.	Lucy Hickey	EMS Staff
* Colin Tudor	League of California Cities	Michelle Williams	EMS Staff
* Atilla Uner, M.D.	CAL/ACEP	Nnabuike Nwanonyi	EMS Staff
* Gary Washburn	Public Member, 5 th District	Phillip Santos	EMS Staff
☑ Chief David White	LA Chapter-Fire Chiefs Assn.	Sara Rasnake	EMS Staff
* Pajmon Zarrineghbal	Public Member, 4 th District	Susan Mori	EMS Staff
GUESTS			
Michael Natividad	APCC	Yunson Kim	LA County Fire Dept.
Richard Roman	Compton Fire Dept.	Chief John Incontro	LA County P.C. Assn.
Matt Conroy	LA City Fire Department	Joanne Dolan	Long Beach Fire Dept.
Nicholas Gonzalez	LA City Fire Department	David Kenieczny	McCormick Ambulance
Matt Armstrong	LA County Ambulance Assn.	Roy Arreola	MLKCH
Bob Sawyer	LA County Fire Department	Arnold DeAnnunti	Physio Control/Stryker
Carlos Santiago	LA County Fire Department	Darris Clark	Physio Control/Stryker
David Christian	LA County Fire Department	Kim Marone	Physio Control/Stryker
Eleni Pappas	LA County Fire Department	Mitchel Smith	Physio Control/Stryker
Nicole Steeneken	LA County Fire Department	Natalie Osborne	Physio Control/Stryker
Victoria Hernandez	LA County Fire Department	San Chao	Water
		Humberto Ramirez	West Coast Ambulance

(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 1:03 PM by Chairman Erick Cheung, M.D. A quorum was present with 11 Commissioners in attendance.

ANNOUNCEMENTS/PRESENTATIONS:

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

CONSENT CALENDAR:

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

Motion by Commissioner White/Hisserich to approve the Consent Calendar, excluding Policy 4.1 Reference No. 414: Specialty Care Transport (SCT) Provider, as it is being requested by Commissioner Ower to be held for clarification. Motion carried unanimously.

Ms. Cathy Chidester, Director, EMS Agency, reiterated information on the following items from Correspondence:

2.1 Implementation of Comprehensive Stroke System in Los Angeles County:

Happy to announce that we began the Comprehensive Stroke Center Program. It was a two to three year process since it was presented to the Board of Supervisors to develop the agreements. As hospitals are ready to participate and they meet the requirements of the contract, we will enter into the agreement with them and they will open up as a Comprehensive Stroke Center.

2.2, 2.3, 2.7, 2.8 and 2.9 Fentanyl Program Approval

Some of the Provide Agencies have been approved to use Fentanyl instead of Morphine.

2.4, 2.5 and 2.11 Public Safety Naloxone Program Approval

The use of Naloxone has been approved for some of the Public Safety Agencies.

Commissioner Ower referred to the following item held item from the Consent Calendar:

4.1 Reference No. 414: Specialty Care Transport (SCT) Provider:

After reviewing page 4, items B to F and considering the possibility or removing part of these items, and page 6, item E6 and not having clarification of the actual implementation of “*The sending Physician’s Statement of Responsibility for the patient during transfer in accordance with EMTALA*”, it was decided for this policy not to be part of the approval of the consent calendar, but to take it back to the Provider Agency Advisory Committee (PAAC) for further review and clarification.

5. BUSINESS (old)

5.1 Community Paramedicine (September 2017)

Ms. Chidester stated that there have been discussions for a few years on the Community Paramedicine concept and the initial projects looked at Community Paramedicine doing home follow-up for patients with CHF in an attempt to reduce readmission to the hospital, and the other projects that we have been interested in is Alternate Destination to a Psychiatric Facility or a Sobering Center.

In late 2017, the State opened up the ability to add more pilot projects with approval from the Office of Statewide Health Planning and Development (OSHPD). Los Angeles City Fire Department (LAFD) submitted their application and was approved by OSHPD to begin a pilot project for sobering center destination and for alternate destination to a psychiatric urgent care.

An Assembly Bill (AB 1795) was re-introduced that would address alternate destinations for paramedics. This Bill allows local EMS agencies to put into their EMS Plan to develop policies and procedures and a designation process for paramedics to transport to alternate sites such as sobering centers and psychiatric urgent cares. The Board of Supervisors made a motion to submit a five signature letter to the Governor in support of AB 1795.

The California Nurses Association (CNA) sent an opposition letter to the original Bill that was addressing alternate transport destinations (AB 820, Emergency Medical Services Authority: task force). It is anticipated that CNA will also be in opposition of AB 1795, as well as, the California Chapter of the American College of Emergency Physicians (ACEP), but there may be support from the California Professional Fire Fighters Association and it will be important to get support from entities like the Psychiatric Associations, Law Enforcement, Public Health, the District Attorney, the Sheriff's Department, etc.

There are six (6) sobering centers throughout of the State and sixteen (16) psychiatric urgent care centers; this limits the amount of Counties that will benefit and therefore participate but AB 1795 allows implementation to be County by County. Ms. Chidester added that because this Bill is specific to the paramedic scope of practice and the Health and Safety Code, a State Regulation, there is not a connection or alignment with Federal Regulations.

Commissioner Eckstein, Medical Director, LAFD, added that they are now transporting these type of patients by using their EMS Advance Providers for medical clearance and that one way to help with the opposition raised by political groups is to collect outcome data demonstrating patient's safety.

Chairman Cheung added that development of psychiatric urgent cares and sobering centers as appropriate care facilities is a big step in the right direction for the LA County to become widely integrated into the care channels that are used as an appropriate surrogate for crisis and emergency situations.

5.2 Prehospital Care of Mental Health and Substance Abuse Emergencies Report

Chairman Cheung reported that of the number of recommendations that were made, the current direction that the Ad Hoc Committee is moving it is to survey the dispatch processes related to 9-1-1 mental health emergency and determine what level of consistency there is in sending various providers, and get a better understanding of dispatch protocols, get a better understanding of the rate of which Law Enforcement vs Fire or both are sent to the scene, what type of questions are the lead-in to sending one or the other, and at the same time this dispatch survey is aiming to assess the level of readiness by Law Enforcement Departments and their mental health training. We will attempt to gather some more clear data about the availability on mental health trained sworn officers, mental health teams that exist embedded within Law Enforcement Departments and what the triggers are for when sending these different types of responders as well as the barriers to increasing trainings.

5.3 APOT Ad Hoc Committee for (Wall Time / Diversion)

Mr. Richard Tadeo, Assistant Director, reported that the next Ad Hoc Committee meeting will be on Monday, January 22, 2018. They will work on a draft of a policy as recommended by the workgroup to allow provider agencies to request diversion when they are at a hospital where ambulances are significantly backed up and waiting extended length of time to off-load their patients.

5.4 Nominating Committee Recommendations

Commissioner Ower announced that the Committee members recommend for Dr. Cheung to serve another year as the EMS Commission Chairman and for Commissioner Hisserich to serve as the EMS Commission Vice-Chair.

There being no additional nominations from the floor, Chairman Cheung requested a motion.

Motion by Commissioners White/Peterson for Commissioner Cheung to be the Chairman and Commissioner Hisserich to be the Vice-Chairman of the EMS Commission for 2018. Vote carried unanimously.

BUSINESS (New)

5.5 Standing Committee Recommendations

Mr. Tadeo announced the Commissioners to serve as Chair, Vice-Chair and Commissioners for the EMS Sub-Committees being as follows:

Base Hospital Advisory Committee (BHAC):

Dr. Marc Eckstein, Chair and Dr. Margaret Peterson, Vice-Chair
Dr. Lydia Lam, and John Hisserich, Dr. PH., Commissioners

Data Advisory Committee (DAC):

Dr. Nerses Sanossian, Chair and Mr. Pajmon Zarrineghbal, Vice-Chair
Mr. Collin Tudor and Mr. James Lott, PsyD., Commissioners

Education Advisory Committee (EAC):

Ms. Carole Snyder, RN, Chair and Dr. Atilla Uner, Vice-Chair
Dr. Ellen Alkon and Mr. Gary Washburn, Commissioners

Provider Agency Advisory Committee (PAAC):

Chief Dave White, Chair and Mr. Robert Ower, Vice-Chair
Lt. Brian Bixler and Mr. Paul Rodriguez, Commissioners

Motion by Commissioners Ower/Peterson to ratify appointments to the EMSC Sub-Committees. Vote carried unanimously.

5.6 Presentation from Physio-Control/Stryker on the ePCR for the Los Angeles County Fire Department (LACoFD)

Chairman Cheung opened up the opportunity for representatives from Physio-Control/Stryker to provide a presentation on the ePCR for the LACoFD and LAFD,

Mr. Tadeo started the presentation by briefing the EMS Commission on EMS Systems Data which began with sharing that the State Assembly Bill 1129 and Los Angeles County Prehospital Care Policy Reference No. 607 require EMS Provider Agencies to capture EMS data and submit electronic data to the EMS Agency, as a background.

Mr. Tadeo also added that data is critical for system management and performance measurement as well as the compliance with data reporting requirements for the National Trauma Data Bank, CEMSIS-Trauma, STEMI, Stroke, EMS Core Measures, etc. Additionally, he presented the following as being the current status of EMS Data:

EMS Provider	EMS Volume (FY 15-16)*	ePCR Go-Live date	% Submitted to EMS
LACoFD – ePCR - Stryker	286,746 (43%)	May - August 2016 (Mobile Touch)	2016: 30% 2017: 0%
LAFD – ePCR - Stryker	219,598 (33%)	June 2011 (Sansio Version) March 2017 (Mobile Touch)	2016: 100% 2017: 25%
25 Other FD – ePCR - Digital EMS or Source Code 3	108,102 (16%)	April 2012 – April 2017	2016: 100% 2017: 90%
4 Other FD – Paper EMS Report	54,613 (8%)	1 st Quarter 2018 (estimated)	2016: 100% 2017: 75%

*Countywide total volume

Mr. Tadeo also presented to the Commission members a list of the actions taken to resolve outstanding items, once reviewed, Mr. Mitchel Smith, Business Leader, proceeded with his presentation in which he provided a general briefing of Physio-Control/Stryker, a company dedicated to the success of EMS both as an industry and as individual entities.

Mr. Smith added that EMS has a different format for exporting the data, and that the data dictionary defines the fields and the words but not necessarily the full interactions between words or the other logical application of them; therefore, presenting issues, errors, failures and feedback. This is an area that does not have a technological but a communication and understanding problem and it is seen as very solvable and not something needing a new technology created. Mr. Smith also presented the precise steps taken at their end and identified the changes that can be made including the possibility of different functionality and/or different logic to be added, to be able to make this a priority and make as a change from the software. The goal is being able to

capture the requirements that are not in the data dictionary, the things that are the source of the company's errors, put it into a document, make it the source of agreement, meet that obligation, then we will have satisfied the needs of both, LA County and the other constituent users.

Michelle Williams, Chief of Data, EMS Agency, stated that the problem is the mapping between NEMSIS and our system – it is not the EMS Agency's data dictionary and that the other companies are successful because they built the export specific to our data dictionary, which was specified in our contract with LACoFD.

Upon mutual conversation between Commission members, EMS Agency staff and the five (5) representatives from Physio-Control/Stryker, it was concluded to have this item on the Commission agenda on an on-going basis to monitor progress in resolving this issue.

Motion by Commissioners White/Snyder to add a report on Physio-Control/Stryker data submission to the EMS Commission Agendas for further review at future Commission meetings. Vote carried unanimously.

5.7 Treatment Protocols

Mr. Tadeo provided a briefing on the Treatment Protocols to the Commission members that included the following:

Background:

The current Treatment Protocols (TP) were developed to treat the presenting chief complaint and related signs/symptoms of the patient. Correspondingly, the TPs are titled and organized based on chief complaints such as Chest Pain, Altered Level of Consciousness, Abdominal Pain, etc. The TPs provide treatment guidelines of "classic" presentations and are utilized for patients with the same disease but may have differing complaints and presentation, and conversely, patients with similar signs/symptoms who may have very different diagnosis.

In recent years, the national training standards have shifted from a sign/symptom orientation in treating the prehospital care patient to the utilization of Provider Impressions (PI). In California, all EMS providers are mandated to report and document their PI when treating a patient. Unlike chief complaint, PI is the EMS personnel's initial impression based on a complete prehospital assessment of the patient. PI is not a diagnosis.

Rationale for Revising the Treatment Protocols:

- To better organize the TPs such that each PI will have an appropriate TP. This will streamline TP selection once the PI is established.
- To provide a clearer guidance to pediatric specific patient assessment, care and treatment.
- To enhance EMS data collection, which will support system management and quality improvement activities.

Implementation Plan:

- Revised TPs were released for public comment through the EMS Commission's Subcommittees, Medical Advisory Council, Pediatric Advisory Committee, Association of Prehospital Care Coordinators and LA Area Fire Chief's Association.
- A 2-3 month pilot project was implemented with Burbank Fire Department and Providence St. Joseph Medical Center on December 4, 2017. Pasadena Fire Department and Huntington Hospital started the pilot project on January 8, 2018. The pilot project involves extensive quality monitoring and 100% patient outcome data collection.
- The TPs will be the subject matter content for the EMS Update 2018 training, which is projected to commence summer 2018. Implementation countywide is projected to commence in fall/winter 2018.

6. COMMISSIONERS COMMENTS/REQUESTS

None.

7. LEGISLATION

See discussion under Business (Old), Item 5.1, *Community Paramedicine*, regarding AB 1795.

8. DIRECTOR'S REPORT

Ms. Karolyn Fruhwirth, Assistant Director, shared a copies of Weekly Influenza Surveillance Reports, which reflect the influenza activity levels, a copy of the News Release from the County of Los Angeles Public Health, in which it is announced that influenza activity is elevated and is increasing throughout LA County, and a copy of the Influenza Watch, Surveillance Week 52, ending December 30, 2017, presenting a table that reflects a percent positive flue tests, percent flue A/B, and the pediatric and adult flu deaths for Fiscal Years 2016/2017 and 2017/2018.

9. ADJOURNMENT

The Meeting was adjourned by Chairman, Erick Cheung, MD., at 2:42 PM. The next meeting will be held on March 21, 2018.

Next Meeting:

**Wednesday, March 21, 2018
EMS Agency
10100 Pioneer Blvd. Suite 200
Santa Fe Springs, CA 90670**

Recorded by:
Amelia Chavez
Secretary, Health Services Commission



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Michael D. Antonovich
Fifth District

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*

February 26, 2018

TO: Distribution

VIA E-MAIL

FROM: Marianne Gausche-Hill, MD
Medical Director

SUBJECT: DESIGNATION OF COMPREHENSIVE STROKE CENTERS

The Emergency Medical Services Agency is pleased to announce that effective Thursday, March 1, 2018 the following facilities are now designated as Comprehensive Stroke Centers (CSC):

NEWLY APPROVED:

- Providence Saint John's Health Center

PREVIOUSLY APPROVED:

- Cedars Sinai Medical Center
- Dignity Health – Northridge Hospital Medical Center
- Glendale Adventist Medical Center
- Good Samaritan Hospital
- Huntington Hospital
- Kaiser Foundation Hospital- Los Angeles (Sunset)
- Los Alamitos Medical Center (Orange County)
- Long Beach Memorial Medical Center
- Los Robles Hospital & Medical Center (Ventura County)
- Methodist Hospital of Southern California
- PIH Health Hospital – Whittier
- Pomona Valley Hospital Medical Center
- Providence Little Company of Mary – Torrance
- Providence Saint Joseph Medical Center
- Ronald Reagan UCLA Medical Center
- Saint Jude Medical Center (Orange County)
- Torrance Memorial Medical Center

Please visit the EMS Agency website at <http://ems.dhs.lacounty.gov> for the most current information about the new CSCs and a map showing the approved hospitals. If you have any questions, please feel free to contact me at (562) 347-1600, or Christine Clare, Chief of Hospital Programs at (562) 347-1661.

MGH:cac
02-07

- c: Director, EMS Agency
Fire Chief, Each Fire Department
Paramedic Coordinator, Each Provider Agency
Prehospital Care Coordinator, Each Base Hospital
Nurse Educator, Each Fire Department
Stroke Coordinator, Each Approved Stroke Center
Stroke Medical Director, Each Approved Stroke Center
Medical Alert Center



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



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*To ensure timely,
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February 21, 2018

TO: Distribution

FROM: Cathy Chidester 
Director

**SUBJECT: COUNTYWIDE SIDEWALK CARDIAC RESUSCITATION DAY –
TUESDAY, JUNE 5, 2018**

Los Angeles County Emergency Medical Services (EMS) Agency, in collaboration with the American Heart Association (AHA), and the California American College of Emergency Physicians is coordinating a countywide SideWalk “Hands-Only” Cardiopulmonary Resuscitation (CPR) public education event on **Tuesday, June 5, 2018**. The first week of June is designated as National CPR and AED Awareness Week and provides a perfect opportunity for public education on this life-saving skill.

We would like to invite your facility/agency to participate in this exciting campaign. The EMS Agency will coordinate the participation through pre-registration (attached). Registration provides contact information for the distribution of the basic curriculum, sample press release, program ideas, and rosters/sign-in sheets to track the number of persons trained during the event. **Early registration** allows us to list your training site(s) on the web page for press coverage and community information.

Additionally, this year’s main press conference and anchor event is planned to be held at LA Live with additional support from the National American Heart Association, Los Angeles City Fire Department and Anthem Blue Cross. More details on this event will be emailed as they become available.

Even though June 5 is the main event day, we encourage you to train any time between June 1-7. You should publicize the hours and location for training to your local community.

At the end of training, each participating organization will report the number of citizens trained between June 1-7 to the EMS Agency. We will provide a report on the total number trained in Los Angeles County to the AHA, EMS community, and interested parties. Last year the SideWalk CPR program trained over **5,000 people in LA County!**

We hope that you will choose to participate in the LA County SideWalk CPR. Please complete the attached registration form and return it to the EMS Agency by May 31, 2018.

Please call Susan Mori at 562.347.1681 for more information or questions.

CORRESPONDENCE 2.2



SideWalk-CPR
LA County EMS System



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

SIDEWALK CPR DAY

REGISTRATION FORM

DATE: Tuesday, June 5, 2018

TIME: To be determined by the organization providing the training

Please complete the following registration form and submit it to Vanessa Gonzalez, by
May 29, 2018 @ vgonzalez3@dhs.lacounty.gov

PLEASE PRINT

Facility/Provider Name

Name of Designated Coordinator

Mailing Address

Email Address

Phone Number

Location **Address** and **Time** of Sidewalk CPR Training for **Each Site**



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Marianne Gausche-Hill, MD
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January 18, 2018

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Director
Emergency Medical Services Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670

Dear Dr. Backer:

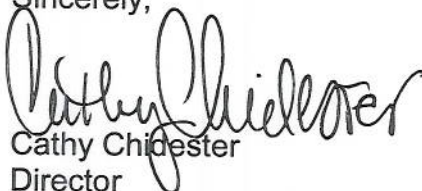
I am writing this letter to support the California Emergency Medical Services Authority's application for grant funding to initiate the Health Information Exchange (HIE) project for Emergency Medical Services. I believe that this project will improve transitions of care from the pre-hospital setting to the hospital emergency department. Uniquely, grant funding will also facilitate a 90/10 matching of Federal Medicaid dollars that will build the infrastructure for the secure, movement of patient information and allow for better measurement of quality patient care and outcomes.

The California Emergency Medical Services Authority has already demonstrated significant progress as part of the successful Patient Unified Look-up System for Emergencies and the +EMS pilot project. The opportunity to continue funding will allow more local EMS agencies to coordinate the design, development and implementation of health information systems to improve patient care by connecting emergency medical services (EMS) providers with hospitals for bi-directional patient information exchange.

Our local EMS agency is highly supportive and would like to participate in this project, which will build greater capability to treat patients. The statewide nature of this project is ambitious but achievable. The use of HIE for EMS providers, on a daily basis or by health care professionals during a disaster, will benefit patients and the EMS system as a whole.

I would like to offer my support to help achieve funding of this important statewide project.

Sincerely,


Cathy Chidester
Director



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



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

**Los Angeles County
Board of Supervisors**

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

10100 Pioneer 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.*

January 2, 2018

Charles Drehsen, MD, Medical Director
American Medical Response
5257 N. Vincent Avenue
Irwindale, CA 91706

Dear Dr. Drehsen,

PARAMEDIC VACCINATION PROGRAM APPROVED

This letter is to confirm that American Medical Response of Southern California (AR) has been approved by the Los Angeles County Emergency Medical Services Agency for a Paramedic Vaccine Program as an expanded local optional of scope of practice during the California state of emergency for the hepatitis A virus outbreak.

AR may utilize paramedics who have successfully completed the Los Angeles County Department of Public Health Vaccine Administration Training to administer the hepatitis A vaccine to AR personnel.

Vaccine storage/handling, record keeping, and Vaccine Adverse Event Reporting will be managed by AR.

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

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:sm
1-01

c: Director, EMS Agency
General Manager, AR
Nurse Educator, AR
Paramedic Coordinator, AR

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





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

**BASE HOSPITAL ADVISORY COMMITTEE
MINUTES**

February 14, 2018

MEMBERSHIP / ATTENDANCE



REPRESENTATIVES		EMS AGENCY STAFF
<input checked="" type="checkbox"/> Mark Eckstein, M.D., Chair	EMS Commission	Dr. Marianne Gausche-Hill
<input type="checkbox"/> Margaret Peterson, Vice Chair	EMS Commission	Dr. Nichole Bosson
<input type="checkbox"/> Lydia Lam, M.D.	EMS Commission	Richard Tadeo
<input checked="" type="checkbox"/> John Hisserich	EMS Commission	Christine Clare
<input type="checkbox"/> Rachel Caffey	Northern Region	Lucy Hickey
<input type="checkbox"/> Annette Cornell	Northern Region	Michelle Williams
<input checked="" type="checkbox"/> Heidi Ruff	Northern Region, Alternate	Christy Preston
<input type="checkbox"/> Samantha Verga-Gates	Southern Region	Cathy Jennings
<input type="checkbox"/> Laurie Mejia	Southern Region	Susan Mori
<input checked="" type="checkbox"/> Kristina Crews	Southern Region	Gary Watson
<input checked="" type="checkbox"/> Christine Farnham	Southern Region, Alternate	David Wells
<input checked="" type="checkbox"/> Paula Rosenfield	Western Region	Dr. Denise Whitfield
<input checked="" type="checkbox"/> Ryan Burgess	Western Region	Christine Zaiser
<input checked="" type="checkbox"/> Alex Perez-Sandi	Western Region, Alternate	Lorie Perez
<input checked="" type="checkbox"/> Susana Sanchez	Western Region, Alternate	
<input checked="" type="checkbox"/> Laurie Sepke	Eastern Region	
<input checked="" type="checkbox"/> Alina Candal	Eastern Region	
<input checked="" type="checkbox"/> Jenny Van Slyke	Eastern Region, Alternate	
<input type="checkbox"/> Lila Mier	County Hospital Region	
<input type="checkbox"/> Emerson Martell	County Hospital Region	
<input type="checkbox"/> Jose Garcia	County Hospital Region	
<input type="checkbox"/> Yvonne Elizarraz	County Hospital Region	
<input checked="" type="checkbox"/> Alec Miller	Provider Agency Advisory Committee	
<input type="checkbox"/> Michael Murrey	Provider Agency Advisory Committee, Alt.	
<input checked="" type="checkbox"/> Laarni Abdenoja	MICN Representative	
<input type="checkbox"/> Adrienne Roel	MICN Representative, Alt.	
<input checked="" type="checkbox"/> Robin Goodman	Pediatric Advisory Committee	
<input type="checkbox"/> Kerry Gold-Tsakonas	Pediatric Advisory Committee, Alt.	
PREHOSPITAL CARE COORDINATORS		
<input checked="" type="checkbox"/> Michael Natividad (AMH)	<input type="checkbox"/> Deanna Josing (HMN)	
<input checked="" type="checkbox"/> Kelly Arroyo (SMM)	<input checked="" type="checkbox"/> Gloria Guerra (QVH)	
<input checked="" type="checkbox"/> Coleen Harkins (AVH)	<input checked="" type="checkbox"/> Jessica Strange (SJS), APCC Pres.	
<input checked="" type="checkbox"/> Laura Leyman (SFM)	<input checked="" type="checkbox"/> Karyn Robinson (GWT), APCC Pres. Elect.	
		GUESTS
		Caroline Joel, Torrance FD
		Ashley Sarello, Torrance MC
		Stefan Vera, EMS Capt. Torrance FD

- 1. CALL TO ORDER:** The meeting was called to order at 1:05 P.M. by Chairperson Mark Eckstein, M.D.
- 2. APPROVAL OF MINUTES:** The meeting minutes for December 13, 2017 were approved as submitted.

M/S/C (Burgess/Arroyo)

3. INTRODUCTIONS/ANNOUNCEMENTS:

- Self-introductions were made by all.
- Base Hospital operations at LAC + USC Medical Center will be temporarily suspended. The base radio room is in need of emergency repairs and access to the radio consoles will not be possible during construction repair. The closure dates will be announced once available.

3.1 2018 Annual EMSAAC Conference is scheduled for May 30 & 31, 2018 and will be located in San Diego at Loews Coronado Resort on Coronado Island. Please visit www.EMSAAC.org for more information.

3.2 Side Walk CPR will take place the first week of June. The EMS Agency has partnered with AHA and will host this event on June 5, 2018. The location will be at LA Live, there will be a press conference and flash mob to highlight this important event.

4. REPORTS & UPDATES:

4.1 Comprehensive Stroke System

Rerouting of stroke patients with suspected large vessel occlusion to a Comprehensive Stroke Center (CSC) was initiated on January 8, 2017. Los Angeles County is the first EMS system in the United States to include Thrombectomy Capable Stroke Centers (TSC) in a regionalized stroke system of care. To date there are a total of 17 Los Angeles County designated Comprehensive Stroke Centers including 3 out of County, refer to the link below for the most current Stroke Centers map.

http://file.lacounty.gov/SDSInter/dhs/1020303_StrokeCenters0329172.pdf

5. UNFINISHED BUSINESS:

5.1 EMS Update 2018: Revised Treatment Protocols and Medical Control Guidelines

Tentative timeline for EMS Update 2018 is as follows:

- The EMS Update work group will reconvene in late March. Representatives from the provider agencies and base hospitals that participated in the Treatment Protocol Pilot Study will be invited to participate in the workgroup.
- Training will start by mid-Summer and will take 3-4 months and will be focused on the Treatment Protocols and Medical Control Guidelines.

More information to follow as it becomes available.

6. NEW BUSINESS:

6.1 Reference No. 214, Base Hospital and Provider Agency Reporting Responsibilities

Revisions for Reference No. 214, Base Hospital and Provider Agency Reporting Responsibilities, with the following recommendations.

- Page 3-4, Procedure A., include verbiage where appropriate: temporarily suspend sponsorship pending investigation.
Also, page 4, 4 – to read as follows: Upon determination of the disciplinary cause, the respective Prehospital Care Coordinator (PCC) or Paramedic Coordinator (PC), in consultation with the Base Hospital Medical Director, may develop and

implement a disciplinary plan. Disciplinary plans shall be signed and dated by the authorized representative of the base hospital or provider agency.

6.2 Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients

Revisions for Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients, with the following recommendations.

- Page 3-4, 7. Internal Disaster, a. iv. to read as follows: Law enforcement operations (ex. Active shooter, hostage situation, bomb threat/explosion)

M/S/C (Goodman/Crews) Approved with recommended changes

6.3 Reference No. 506, Trauma Triage

Reference No. 506, Trauma Triage, lengthy discussion ensued regarding transportation of a trauma patient and Page 3, Q. Major/Critical Burn Injury. Language for this reference will be revised and presented at next BHAC meeting.

6.4 Reference No. 521, Stroke Patient Destination

Revisions for Reference No. 521, Stroke Patient Destination, with the following recommendations.

- Page 3, IV changed to, III. Destinations of Stroke Patients. Under A. Transportation to the PSC, item 2. will be moved to Principles and read as follows: Patients with a history of previous stroke with new or worsening deficits should be routed to a stroke center according to this policy. These patients shall be transported to the most accessible PSC. Diversion may occur when the most accessible PSC has requested diversion due to internal disaster, a non-functioning CT-scan or patient request and ground transport time to the more distant PSC is 30 minutes or less.

M/S/C (Leyman/Candal) Approved with recommended changes

6.5 Reference No. 834, Patient Refusal of Treatment or Transport

Revisions for Reference No. 834, Patient Refusal of Treatment or Transport, with the following recommendations.

- Page 3, Principles: 3., strike through “but are not sufficient to eliminate decision making capacity” as well as “Capacity determinations are specific only to the particular decision that needs to be made.”
- Page 3, Principles: 4., change 5150 to read: psychiatric hold.
- Page 4, Principles: 7., to read as follows: Patients who refuse treatment and/or transport, and leaving patients at the scene is potentially high risk and will require additional quality review.
- Page 5, IV Documentation: D. 2., to read as follows: 2. For patients with no medical complaint who do not request for treatment, document situation and assistance provided.

M/S/C (Burgess/Candal) Approved with recommended changes

7. OPEN DISCUSSION: None

8. NEXT MEETING: BHAC's next meeting is scheduled for **April 11, 2018**, location is the EMS Agency, Hearing Room @ 1:00 P.M.

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

ACCOUNTABILITY: Lorrie Perez

9. ADJOURNMENT: The meeting was adjourned at 2:55 P.M.



**EMERGENCY MEDICAL SERVICES COMMISSION
DATA ADVISORY COMMITTEE
WEDNESDAY, FEBRUARY 14, 2018**



MEMBERSHIP / ATTENDANCE		
MEMBERS	ORGANIZATION	EMS AGENCY
<input checked="" type="checkbox"/> Nerses Sanossian , Chair <input type="checkbox"/> Pajmon Zarrineghbal, Vice Chair <input type="checkbox"/> Jim Lott <input type="checkbox"/> Colin Tudor <input type="checkbox"/> Matt Armstrong <input type="checkbox"/> Trevor Stonum <input checked="" type="checkbox"/> Christine Farnham <input type="checkbox"/> Gloria Guerra <input checked="" type="checkbox"/> Ryan Burgess <input type="checkbox"/> Nathan McNeil * Joanne Dolan <input type="checkbox"/> Don Gerety <input type="checkbox"/> Dan France * Sean Stokes <input type="checkbox"/> Nicole Steeneken <input type="checkbox"/> Victoria Hernandez <input checked="" type="checkbox"/> Matt Conroy <input type="checkbox"/> John Smith <input checked="" type="checkbox"/> Marc Cohen <input type="checkbox"/> VACANT <input type="checkbox"/> Corey Rose <input type="checkbox"/> VACANT <input type="checkbox"/> Tchaka Shepherd <input type="checkbox"/> David Hanpeter * Marilyn Cohen * Gilda Cruz-Manglapus	EMS Commissioner (MD) EMS Commissioner (Public Member, 4 th District) EMS Commissioner (Public Member, 2 nd District) EMS Commissioner (League of CA Cities) Ambulance Advisory Board (LACAA) Ambulance Advisory Board (alternate) Base Hospital Advisory Committee (BHAC) (RN) BHAC (alternate) Hospital Association of Southern California (HASC) HASC (alternate) Long Beach Fire Department (LBFD) (RN) LBFD (alternate) Los Angeles Area Fire Chiefs Association LA Area Fire Chiefs Association (alternate) Los Angeles County Fire Department (LACoFD) LACoFD (alternate) Los Angeles Fire Department (LAFD) LAFD (alternate) Medical Council (MD) Medical Council (alternate) Provider Agency Advisory Committee (PAAC) PAAC (alternate) Trauma Hospital Advisory Committee (THAC) (MD) THAC (MD) (alternate) THAC (RN) THAC (RN) (alternate)	Nichole Bosson Richard Tadeo Christine Clare Michelle Williams Sara Rasnake Susan Mori Denise Whitfield OTHERS
<input checked="" type="checkbox"/> Present *Excused <input type="checkbox"/> Absent		

1. CALL TO ORDER: The meeting was called to order at 10:08 am by Commissioner Sanossian.

2. APPROVAL OF MINUTES: The minutes of the December 13, 2017 meeting were approved as written.

3. INTRODUCTIONS/ANNOUNCEMENTS

- The EMSAAC Conference will be held in San Diego on May 30 and May 31, 2018
- Sidewalk CPR event will be held on Tuesday June 5th. This year the EMS Agency is working with the American College of Emergency Physicians (ACEP) and the American Heart Association (AHA) to increase involvement with the event.
- Sara Rasnake will replace Michelle Williams as the EMS Agency staff representative for the Data Advisory Committee (DAC) meetings.

4. REPORTS AND UPDATES

4.1. TEMIS Update (Michelle Williams)

The EMS Agency is up-to-date with data entry. Only three providers (Torrance, Sierra Madre, and Long Beach) are still on paper. Torrance and Long Beach plan to go live with their ePCRs by the end of March 2018.

4.2. Service Changes (Michelle Williams)

Public Providers

Effective December 30, 2017, Hermosa Beach Fire Department (HB) is no longer a fire department. The area previously covered by HB has been absorbed by Los Angeles County Fire (CF).

Primary Stroke Centers (PSCs)

Beverly Hospital became a PSC on January 31, 2018.

Comprehensive Stroke Centers (CSCs)

Transportation of stroke patients with suspected large vessel occlusions to a CSC began system-wide on January 8, 2018. The following twelve hospitals were designated as CSCs on January 8, 2018:

- Cedars-Sinai Medical Center
- Adventist Health Glendale
- Huntington Memorial Hospital
- Los Alamitos Medical Center (Orange County)
- Long Beach Memorial Medical Center
- Los Robles Hospital and Medical Center (Ventura County)
- Methodist Hospital of Southern California
- PIH Health Hospital – Whittier
- Providence Little Company of Mary Torrance
- Providence St. Joseph Medical Center
- Ronald Reagan UCLA Medical Center
- Saint Jude Medical Center (Orange County)

Kaiser Permanente Los Angeles Medical Center and Northridge Hospital Medical Center became CSCs on February 5, 2018.

Pomona Valley Hospital Medical Center and Torrance Memorial Medical Center became CSCs on February 15, 2018.

Extensive discussion was held regarding concerns from the Prehospital Care Coordinators (PCCs) on how the LAMS could be performed on an altered patient and how the inability to perform the LAMS could impact the destination of a CSC versus a PSC. A suggestion was made to possibly add language to Ref. No. 521, *Stroke Patient Destination*, that would allow for the use of judgment when deciding to send a patient to a CSC. However, since the destination of CSCs is new, the decision was made to delay making any changes to Ref. No. 521 at this time.

Discussion was also held regarding the confusion of Last Known Well Time (LKWT) in relation to 'wake-up' strokes. The Stroke Advisory Committee recommended to increase the treatment window from six hours to twenty-four hours to capture this sub-set of patients. At this time, final decision on this recommendation has not been made.

Exclusive Operating Area (EOA)

One out of the four EOA providers, CARE Ambulance, has successfully begun submitting electronic data to the EMS Agency.

4.3 Data Verification (Michelle Williams)

Digital EMS is continuing to work on a resolution to the mapping issues with the 12-lead ECG fields and chief complaint=Other instead of Local Neuro. The goal is to have the issues resolved so that distribution of the data verification reports can be resume by the beginning of summer.

4.4 International Stroke Conference (*Nerses Sanossian*)

The International Stroke Conference was held in Los Angeles on January 24-26, 2018. Research was presented at the conference that utilized Los Angeles County data.

5. UNFINISHED BUSINESS

5.1 CF/CI Data Submission (*Richard Tadeo*)

Per the recommendation from the Data Advisory Committee, representatives from Stryker gave a presentation to the EMS Commission on January 17, 2018, which addressed how Stryker plans to resolve the data submission issues with Los Angeles County (CF) and Los Angeles City (CI) Fire Departments. The EMS Agency met with staff from CF and Stryker to review the content and mapping of each data field, mapping of the trauma complaints and mechanism of injury are still being reviewed. This topic will be a standing agenda item on the EMS Commission's agenda and an update will be provided at the March meeting.

6. NEW BUSINESS

6.1. EMS Report Form Draft (*Michelle Williams*)

A draft of the proposed revisions to the EMS Report Form was presented. Due to the legalization of marijuana, the 'Suspected Drug Use' field will be moved up towards the top of the form and picklist choices will be added so that the type of drug used can be tracked and monitored. Based on feedback from the treatment protocol pilot project, the provider impression list will be alphabetized by long text instead of being grouped by body system. No further recommendations were made by the committee.

7. NEXT MEETING: April 11, 2018 at 10:00 a.m. (EMS Agency Hearing Room – First Floor).

8. ADJOURNMENT: The meeting was adjourned at 10:47 a.m. by Commissioner Sanossian.



**COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION**
10100 Pioneer Blvd, Suite 200 Santa Fe Springs, CA 90670
(562) 347-1500 FAX (562) 941-5835



**EDUCATION ADVISORY COMMITTEE
MEETING CANCELATION NOTICE**

DATE: February 8, 2018

TO: Education Advisory Committee Members

SUBJECT: CANCELATION OF MEETING

Due to a lack of agenda items, the Education Advisory Committee meeting scheduled for February 21, 2018 has been canceled.

INFORMATION IN LIEU OF MEETING:

1. A pilot program is continuing with provider impression treatment protocols and medical control guideline with Pasadena and Burbank Fire Departments in conjunction with Huntington Hospital and Providence St. Joseph Medical Center Base Hospitals.
2. EMS Update 2018 will focus on training EMS personnel for the system-wide implementation of the provider impression treatment protocols and medical control guidelines. Further information to follow at a later date.
3. Sidewalk CPR is scheduled for Tuesday, June 5, 2018. Further information to follow at a later date.
4. The 2018 EMSAAC conference is scheduled for May 30 & 31, 2018 in San Diego. Conference information is available at emsaac.org.
5. The 2018 CFED West conference is scheduled for May 20-24, 2018 in Indian Wells. Conference information is available at cfedwest.com.
6. EMS Week is May 20-26, 2018.
7. Lucy Hickey is retiring! Please come and join us to celebrate her contributions to EMS on March 27, 2018. Please review attached.

NEXT MEETING:

Date: Wednesday, April 18, 2018
Time: 10:00 am
Location: EMS Agency Headquarters
EMS Commission Hearing Room
10100 Pioneer Blvd, Room 128
Santa Fe Springs, CA 90670



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, February 21, 2018

MEMBERSHIP / ATTENDANCE

MEMBERS

- ☒ Dave White, Chair
- ☒ Robert Ower, Vice-Chair
- ☒ Paul Rodriguez
- ☐ Brian Bixler
- ☒ Jodi Nevandro
 - ☒ Sean Stokes
- ☒ Nick Berkuta
 - ☒ Clayton Kazan, MD
 - ☐ Victoria Hernandez
- ☒ Ken Leasure
 - ☐ Susan Hayward
- ☒ Richard Roman
 - ☐ Mike Beeghly
- ☒ Josh Hogan
 - ☒ Joanne Dolan
- ☐ Alec Miller
 - ☐ Michael Murrey
- ☐ Corey Rose
 - ☐ Ellsworth Fortman
 - ☒ Doug Zabitski
- ☒ Luis Vazquez
 - ☐ Tisha Hamilton
- ☐ Rachel Caffey
 - ☐ Heidi Ruff
 - ☒ Jenny Van Slyke
- ☐ Andrew Respicio
 - ☐ Andrew Gano
- ☐ Maurice Guillen
 - ☐ Scott Buck
- ☐ Marc Eckstein, MD
 - ☐ Stephen Shea, MD
- ☒ Ian Wilson
- ☐ Vacant

ORGANIZATION

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

EMS AGENCY STAFF PRESENT

Marianne Gausche-Hill, MD Richard Tadeo
 Denise Whitfield, MD Lucy Hickey
 Susan Mori Elaine Forsyth
 Christy Preston Paula Rashi
 John Telmos David Wells
 Michelle Williams Christine Zaiser
 Gary Watson

OTHER ATTENDEES

Adrienne Roel UCLA Ctr Prehosp Care
 Michael Barilla Pasadena FD
 Roger Braum Culver City FD
 Sam Chao W.A.T.E.R.
 Monica Bradley Culver City FD
 Stefan Viera Torrance FD
 Kris Thomas Ambulnz Ambulance
 Nicole Steeneken LACoFD
 Caroline Jack Torrance FD
 Brittany Anderson Burbank FD
 Alex Castro SoCal Ambulance
 Jerry Melendez Care Ambulance
 Julian Zermeno Santa Monica FD
 Lorie Lopez Care Ambulance
 Richard Morrison FirstMed Ambulance
 Evan Hendrix Royalty Ambulance
 Ivan Orloff Downey FD
 Dina Carr El Segundo FD

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

CALL TO ORDER: Chair, Commissioner David White called meeting to order at 1:00 p.m.

1. **APPROVAL OF MINUTES (Hogan/Berkuta)** December 21, 2017 minutes were approved as written.
2. **INTRODUCTIONS / ANNOUNCEMENTS**

2.1 2018 New Committee Membership

Chair David White welcomed Doug Zabitski (Los Angeles Fire Department) – Area H, Alternate

2.2 Side Walk CPR – June 5, 2018 (Marianne Gausche-Hill, MD)

- All providers are encouraged to participate in this annual, nation-wide event to promote the training of CPR to the public.
- Registration forms will be sent out this week.
- For more information, contact Susan Mori at sumori@dhs.lacounty.gov

2.3 EMSAAC Conference – May 30 & 31, 2018 *(Marianne Gausche-Hill, MD)*

- This year's theme "EMS Aim High: Tribute to Those Who Serve". Topics will include current issues in EMS administration, management and field operations.
- Location of Conference: Coronado Bay Resort, San Diego.
- Register before May 12, 2018 and receive a reduced price.
- For more information can be found on the following webpage: <https://www.emsaac.org/conference>

2.4 EMS For Children – Performance Measures *(Marianne Gausche-Hill, MD)*

- Nationally organized Program that raises awareness among healthcare professionals, EMS and trauma system planners, and the general public that children respond differently—physically, emotionally, and psychologically—to illness and injury compared to adults.
- Nine performance measures were presented that would facilitate consistency in the EMS and trauma systems for the care of children across the nation.
- More information on this program may be found on the following webpage: <http://www.nedarc.org/performanceMeasures>

3. REPORTS & UPDATES

3.1 Hepatitis A Outbreak *(Marianne Gausche-Hill, MD)*

- At the end of 2017, because of the sudden increase in reported Hepatitis A cases, EMS providers were encouraged to receive the preventive vaccine and two provider agencies were approved to assist Public Health with providing the vaccine to the general public. Because of these efforts, the number of reported cases have drastically declined and it is felt that this outbreak is essentially over.
- The EMS Agency continues to work with Public Health on the immunization program.

3.2 Pediatric Color Code Survey *(Marianne Gausche-Hill, MD)*

- Survey was sent out to all ALS providers, with approximately 500 responses.
- Results will be provided by the EMS Agency once the qualitative evaluation is complete.

3.3 Comprehensive Stroke Center (CSC) *(Richard Tadeo)*

- CSC system was implemented on January 8, 2018, with great success.
- Currently, there are 17 CSC in our system (3 of the 17 are outside LA County); with the plan to have three more by the end of 1st Quarter 2018.

3.3 Disaster Section Update *(Elaine Forsyth)*

- Fire Department Dispatch Survey: Sent out 2 weeks ago. Dispatch centers are encouraged to complete survey and return to the EMS Agency.
- Upcoming Training: Anticipate, Plan, and Deter: Maximizing Resilience of Healthcare Workers during Disasters. Two classes will be offered (April and May). 1.5 CEUs provided.
- Statewide Disaster Exercise is scheduled for November 15, 2018. This year will focus on radiological emergencies.
- Senate Bill 432 was presented entitled, Changes to notification requirements to emergency prehospital medical care personnel of exposure to a reportable communicable disease. There are new reporting requirements for acute care facilities and provider agencies - Reference No. 836, Communicable Disease Exposure and Testing, will be updated to reflect these changes.
- emPOWER: Computer-based program that identifies MediCare beneficiaries who have electricity-dependent equipment (ie, ventilators, oxygen concentrators, IV pumps, etc) and are affected during severe weather and disasters that cause power outages. (<https://empowermap.hhs.gov/>)

Questions presented in the Disaster Section Update can be directed to Elaine Forsyth at eforsyth@dhs.lacounty.gov

4. UNFINISHED BUSINESS

4.1 EMS Update 2018: Revised Treatment Protocols and Medical Control Guidelines (Richard Tadeo)

- Workgroup is being formed.
- The following training timeline was presented:
 - May 2018 – Train-the-trainer for Base Hospitals
 - June/July 2018 – Training of MICNs
 - August, September, October 2018 – Training of all providers
 - November 2018 – Providers transition to new Treatment Protocols and Medical Control Guidelines
- Quality Improvement of this new system is being developed and will include 100% review of provider impressions during the initial implementation.
- When new system is implemented providers will be encouraged to obtain Base Hospital feedback (outcome data).

(This topic remains on PAAC Agenda until project is complete)

5. NEW BUSINESS

5.1 Reference No. 214, Base Hospital And Provider Agency Reporting Responsibilities (Lucy Hickey)

Policy reviewed and approved as presented.

M/S/C (Leasure/Van Slyke) Approve Reference No. 214, Base Hospital And Provider Agency Reporting Responsibilities.

5.2 Reference No. 503, Guidelines For Hospitals Requesting Diversion of ALS Patients (Christy Preston)

Policy reviewed and approved as presented.

M/S/C (Leasure/Van Slyke) Approve Reference No. 503, Guidelines For Hospitals Requesting Diversion of ALS Patients.

5.3 Reference No. 506, Trauma Triage (Christy Preston)

Policy reviewed and approved with the following recommendation:

- Policy I, D: Blunt traumatic full arrest language to match language listed in Reference No. 814, Determination/Pronouncement of Death in the Field.
- Policy I, Q.1: Change age of burns to: "> 15 years of age", instead of "10 years of age or older".
- Policy I, Q. 2: Change age of burns to: "<= 14 years", instead of "under 10 years of age".

M/S/C (Nevandro/Zabilski) Approve Reference No. 506, Trauma Triage, with above recommendations.

5.4 Reference No. 521, Stroke Patient Destination (Christy Preston)

Policy review and approved as presented.

M/S/C (Van Slyke/Wilson) Approve Reference No. 521, Stroke Patient Destination.

5.5 Reference No. 607, Electronic Submission of Prehospital Data (Michelle Williams)

Policy reviewed and approved as presented.

M/S/C (Berkuta/Nevandro) Approve Reference No. 607, Electronic Submission of Prehospital Data.

5.6 Reference No. 834, Patient Refusal of Treatment/Transport and Treat and Release at Scene
(Richard Tadeo)

Policy reviewed and after lengthy discussion regarding “Treat and Refer”, policy was tabled until further revisions are made by the EMS Agency.

Committee recommended a clearer definition of “Reportable Medical Condition”.

TABLED: Reference No. 834, Patient Refusal of Treatment/Transport and Treat and Release at Scene.

6. OPEN DISCUSSION:

6.1 Drug Shortages and Unit Inventory Changes (Marianne Gausche-Hill, MD)

- Reduction of minimum inventory amounts in ALS unit was discussed and supported by the EMS Agency.
- The EMS Agency is also looking into developing two ALS Unit Inventory lists: one for private providers and one for public providers.
- This will be a topic for future discussion.

6.2 Documentation of Patient Care Given by Law Enforcement (Susan Mori)

- Providers are reminded, when documenting any field treatment that is provided by police on scene, to include the name of the police department and police unit number on the patient care record.
- This has been added to the annual patient care record review during annual paramedic program audits.

7. NEXT MEETING: April 18, 2018

8. ADJOURNMENT: Meeting adjourned at 3:15 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **BASE HOSPITAL AND PROVIDER AGENCY
REPORTING RESPONSIBILITIES**

REFERENCE NO. 214

PURPOSE: To provide guidelines for reporting actual or possible violation(s) of California Health and Safety Code Section 1798.200, Sub-sections (a) through (c) and comply with relevant employer reporting responsibilities.

AUTHORITY: California Health and Safety Code, Division 2.5, Sections 1797.200, 1798.200. California Code of Regulations, Title 22, Chapter 4, Sections 100168, 100172 100173; Chapter 6, Section 100208.1; Base Hospital Agreement.

PRINCIPLE: Prior to initiating disciplinary proceedings, all information available to the Emergency Medical Services (EMS) Agency or received from a credible source shall be evaluated for evidence of a threat to public health and safety pursuant to Section 1798.200 of the Health and Safety Code.

DEFINITIONS:

Authorized Representative: The base hospital medical director, emergency department manager/director, or prehospital care coordinator; or, provider agency medical director, Chief/CEO, emergency medical services director or paramedic coordinator.

California EMT Certifying Entity: A public safety agency, if the agency has a training program for EMT personnel that is approved pursuant to the standards developed pursuant to Section 1797.109 of the Health and Safety code, or the medical director of the local EMS agency (LEMSA).

Disciplinary Cause: An act that is substantially related to the qualification, functions, and duties of prehospital personnel and is evidence of a threat to public health and safety, per Health and Safety Code Section 1798.200.

Discipline: A disciplinary action taken by a relevant employer pursuant to California Code of Regulations, Title 22 Division 9, Chapter 6, Section 100206.2 or certification action taken by a medical director, or both a disciplinary plan and certification action.

Disciplinary Plan: A written plan of action that can be taken by a relevant employer as a consequence of any action listed in the California Health and Safety Code Section 1798.200(c). The disciplinary plan may include recommendation for certification actions pursuant to the Model Disciplinary Orders.

Local EMS Agency (LEMSA): The agency, department or office having primary responsibility for administration of emergency medical services in a county.

Medical Director: The medical director of the local emergency medical services agency.

EFFECTIVE DATE: 3-5-87

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REVISED: XX-XX-XX

SUPERSEDES: 8-1-11

APPROVED: _____

Director, EMS Agency

Medical Director, EMS Agency

Model Disciplinary Orders: The Recommended Guidelines for Disciplinary Orders and Conditions of Probation for EMT's and Paramedics developed by the State EMS Authority to provide consistent and equitable discipline in cases dealing with disciplinary cause.

Relevant Employer: Ambulance providers permitted by the Department of the California Highway Patrol or a public safety agency, that the certificate holder works for or was working for at the time of the incident under review, as a paid employee or a volunteer.

Valid, Validate or Validation: Verification, within reasonable certainty, that a violation of Health and Safety Code Section 1798.200 may have occurred and that said violation may be reason for disciplinary cause.

POLICY:

- I. Base hospital and ~~Prehospital~~ provider agencies shall prepare and forward a written report within three working days to the LEMSA medical director regarding any action of certified or licensed prehospital personnel which may constitute a violation under Section 1798.200 (c) of the Health and Safety Code as listed in Section II. Any other items of concern resulting from an apparent deficiency of patient care should also be reported.
 - A. The report shall be signed by an authorized representative of the base hospital or provider agency and must contain, at a minimum, the following:
 1. Names and certification/license numbers of all EMS personnel involved in the incident.
 2. Date, time, and location of the incident.
 3. A written summary of the alleged facts related to of the incident.
 4. The Health and Safety Code violation listed under 1798.200.
 5. A copy of the EMS Report Form or patient care report, if applicable.
 6. A copy of the Base Hospital Report Form and audio recording, if applicable.
 - B. Any report made to the LEMSA shall be copied to the employer of the affected individual.
- II. Any of the following actions, listed under the Health and Safety Code, Division 2.5, Section 1798.200 (c), by EMS personnel shall be considered evidence of a threat to the public health and safety and, if found to be true, **may** result in probation, denial, suspension, or revocation of a certificate or license under Division 2.5:
 - A. Fraud in the procurement of a certificate or license
 - B. Gross negligence
 - C. Repeated negligent acts
 - D. Incompetence

- E. The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of prehospital personnel.
- F. Conviction of any crime which is substantially related to the qualifications, functions, and duties of prehospital personnel. The record of conviction or certified copy of the record shall be conclusive evidence of the conviction.
- G. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel.
- H. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.
- I. Addiction to, the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.
- J. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification.
- K. Demonstration of irrational behavior or occurrence of a physical disability to; the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired.
- L. Unprofessional conduct exhibited by any of the following:
 - 1. The mistreatment or physical abuse of any patient resulting from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties would use if confronted with a similar circumstance. Nothing in this section shall be deemed to prohibit an EMT, Advanced EMT or Paramedic from assisting a peace officer, or a peace officer who is acting in the dual capacity of peace officer and EMT, Advanced EMT or Paramedic, from using force that is reasonably necessary to effect a lawful arrest or detention.
 - 2. The failure to maintain confidentiality of patient medical information, except as disclosure is otherwise permitted or required by law in Sections 56 to 56.6, inclusive, of the Civil Code.
 - 3. The commission of any sexually related offense specified under Section 290 of the Penal Code.

PROCEDURE:

I: **BASE HOSPITAL AND PROVIDER AGENCY RESPONSIBILITIES**

A. **MICN Personnel**

- 1. May conduct investigations to determine disciplinary cause.

2. May request that the LEMSA conduct the investigation to determine disciplinary cause.
3. Shall notify the LEMSA Medical Director in writing that the alleged action occurred **within three (3) working days after an allegation has been validated as potential for disciplinary cause.**
4. Upon determination of disciplinary cause, the respective medical director and Prehospital Care Coordinator (PCC) or Paramedic Coordinator (PC) may develop and implement a disciplinary plan. Disciplinary plans shall be signed and dated by the authorized representative(s) of the base hospital or provider agency.
 - a. The disciplinary plan, along with the relevant findings of the investigation related to disciplinary cause, shall be submitted in writing to the LEMSA Medical Director **within three (3) working days** of adoption of the disciplinary plan.
 - b. The disciplinary plan may include a recommendation that the EMS Agency Medical Director consider taking action against the holder's MICN certificate to include denial, suspension, revocation, or placement of a MICN certificate on probation.
5. The respective PCC or PC shall notify the LEMSA Medical Director in writing of the alleged action within three (3) working days of the occurrence of any of the following:
 - a. The MICN is terminated or suspended for a disciplinary cause
 - b. The MICN resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause or
 - c. The MICN is removed from their related duties for a disciplinary cause after the completion of the employer's investigation.

III. PROVIDER AGENCY RESPONSIBILITIES

A. EMT Personnel

1. May conduct investigations, to determine disciplinary cause
2. May request that LEMSA conduct the investigation to determine disciplinary cause.
3. Upon determination of disciplinary cause, the relevant employer may develop and implement a disciplinary plan in accordance with the MDOs
 - a. The relevant employer shall submit that disciplinary plan along with the relevant findings of the investigation related to disciplinary cause to the LEMSA that issued the certificate, **within three (3)**

working days of adoption of the disciplinary plan. In the case where the certificate was issued by a non-LEMSA certifying entity, the disciplinary plan shall be submitted to the LEMSAs that has jurisdiction in the county in which the headquarters of the certifying entity is located

- b. The employer's disciplinary plan may include a recommendation that the LEMSAs medical director consider taking action against the holder's certificate to include denial, suspension, revocation, or placement of a certificate on probation.
4. The respective Provider Agency shall notify the LEMSAs medical director in writing that has jurisdiction in the county in which the alleged action occurred **within three (3) working days after an allegation has been validated as potential for disciplinary cause.**
5. Shall notify the LEMSAs medical director in writing that has jurisdiction in the county in which the alleged action occurred within three (3) working days or the occurrence of any of the following:
 - a. The EMT is terminated or suspended for a disciplinary cause
 - b. The EMT resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause or
 - c. The EMT is removed from their related duties for a disciplinary cause after the completion of the employer's investigation.
6. Disciplinary plans shall be signed and dated by authorized representatives of the provider agency.

B. Paramedic Personnel

Paramedic employers shall report in writing to the LEMSAs medical director and the EMS Authority and provide all supporting documentation within 30 days of whenever the following actions are taken:

1. A paramedic is terminated or suspended for disciplinary cause or reason.
2. A paramedic resigns following notice of an impending investigation based upon evidence indicating disciplinary cause or reason.
3. A paramedic is removed from paramedic duties for disciplinary cause or reason.

CROSS REFERENCES:

Prehospital Care Manual:

Reference No. 201, **Medical Management of Prehospital Care**

Reference No. 304, **Role of the Base Hospital**

Reference No. 308, **Base Hospital Medical Director**

Reference No. 310, **Role of the Prehospital Care Coordinator**
Reference No. 411, **Provider Agency Medical Director**
Los Angeles County **EMS Agency Situation Report**

Los Angeles County EMS Agency

POLICY REVIEW SUMMARY BY COMMITTEE

Reference No. 214, Base Hospital and Provider Agency Reporting Requirements

	Committee/Group	Assigned (Y if yes)	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	Y	Feb. 21, 2018	
	Base Hospital Advisory Committee	Y	Feb 14, 2018	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**

**Summary of Comments Received on Reference No. 214, Base Hospital and Provider Agency
Reporting Requirements**

ISSUE/ SECTION #	COMMITTEE	COMMENT	RESPONSE
Overall comment	Base Hospital Advisory	Following discussion, committee members requested additional support be identified and added to the policy as part of the review and reporting responsibilities.	Added Base Hospital and Provider Agency medical directors, Directors and Coordinators as personnel authorized to report and participate in the review and evaluation of issues related to the performance of prehospital personnel.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **GUIDELINES FOR HOSPITALS
REQUESTING DIVERSION OF ALS PATIENTS**

(HOSPITAL)
REFERENCE NO. 503

PURPOSE: To outline the procedure for receiving hospitals to request diversion of advanced life support (ALS) patients.

AUTHORITY: Health and Safety Code, Division 2.5, Section 1797.220
California Code of Regulations, Title 13, Section 1105 (c)

DEFINITIONS:

Advanced Life Support Patient (ALS): For the purpose of this policy, an ALS patient is any patient who requires paramedic assessment and/or intervention, including but not limited to patients meeting the criteria outlined in Ref. No. 808, Section I. In situations not described in Ref. No. 808, paramedics and EMTs shall exercise their best clinical judgment.

PRINCIPLES:

1. A receiving hospital may request diversion of 9-1-1 ALS patients away from its emergency department (ED) when unable to care for additional ALS patients due to inadequate staffing, equipment, and/or critical systems or infrastructure.
2. A receiving hospital may not request diversion of 9-1-1 BLS patients, except in the case of internal disaster. Base hospitals will honor diversion requests based on patient condition and available system resources.
3. Hospital diversion data are used in EMS system analysis, and to formulate critical early indicators of syndrome-specific illness outbreaks within the County.

POLICY:

- I. In general, diversion requests shall be communicated through the ReddiNet® system.
- II. Each hospital shall maintain a current diversion policy which requires the decision to request diversion be made jointly by representatives of the hospital's administration, emergency department, specialty services, and nursing. The name and title of the authorizing hospital administrator or designee are required to complete the diversion request process.
- III. EMS Agency staff may perform unannounced site visits to hospitals requesting diversion to ensure compliance with these guidelines.

PROCEDURE:

- A. Receiving hospitals are responsible for maintaining and updating ReddiNet diversion status to ensure that accurate information is available for patient destination decisions.

EFFECTIVE: 02-01-88
REVISED: XX-XX-XX
SUPERSEDES: 07-01-14

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APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

Telephone communication is necessary when the ReddiNet system is not operational or when a hospital is requesting diversion due to internal disaster. The Medical Alert Center (MAC) shall be notified via telephone at (866) 940-4401.

B. Diversion Request Categories

1. ED Saturation: ED resources (beds, equipment and/or staff are fully committed or are not sufficient to care for additional incoming ALS patients. Hospitals may request ED diversion via the ReddiNet for up to one hour at a time. At the end of one hour of diversion, ReddiNet will automatically re-open the hospital to all 9-1-1 traffic. The hospital may request additional ED diversion time in one-hour increments.
2. Computerized Tomography (CT) Scanner: Hospital is unable to provide essential diagnostic procedures due to lack of a functioning CT scanner.
3. Trauma (trauma centers and pediatric trauma centers only): Hospital is unable to care for additional trauma patients because the trauma team is fully committed caring for trauma patients. The rationale for a temporary diversion request shall be communicated via the ReddiNet system using the applicable reason code: Reason codes include the following:
 - a. Critical Equipment Unavailable: Diversion may be requested when critical equipment essential to definitive diagnosis or treatment of trauma patients is unavailable.
 - b. Operating Room Unavailable: Diversion may be requested when both the primary and the back-up ORs and staff are fully encumbered caring for trauma patients to the extent that the care of additional trauma patients may be jeopardized.
 - c. Trauma Team Encumbered: Diversion may be requested when trauma resources, including the trauma surgeon, are fully encumbered to the extent that the care of additional trauma patients may be jeopardized.
 - d. Other: For any other circumstances in which the trauma center may become temporarily unable to meet contractual requirements, to the extent that the care of certain trauma patients may be jeopardized, the trauma center shall contact the EMS Agency to request a waiver in advance of the diversion. If a waiver is granted, the hospital and the MAC will jointly ensure that affected base hospitals and EMS provider agencies are properly advised of the nature and extent of the waiver.
4. Pediatric Medical Center (PMC): Diversion may be requested only when critical equipment essential to definitive diagnosis or treatment of critical medical pediatric patients is unavailable. Lack of available Pediatric Intensive Care Unit beds alone is not sufficient cause to request PMC diversion.
5. ST Elevation Myocardial Infarction (STEMI) Receiving Center (SRC): Diversion may be requested only when all cardiac catheterization laboratories (cath labs) are fully encumbered caring for STEMI patients, to the extent that the care of

additional STEMI patients may be jeopardized. ED saturation is not sufficient cause to request SRC diversion.

6. Stroke:

- a. Primary Stroke Center (PSC): Diversion may be requested only when there is no means to perform diagnostic brain imaging – CT scan or MRI. The reason for diversion must be documented in ReddiNet. ED saturation is not sufficient cause to request PSC diversion.
- b. Comprehensive Stroke Center (CSC): Hospital is unable to care for additional stroke patients because the stroke team is fully committed caring for stroke patients. The rationale for a temporary diversion request shall be communicated via the ReddiNet system using the applicable reason code: Reason codes include the following:
 - i. Critical Equipment Unavailable: Diversion may be requested when critical equipment essential to definitive diagnosis or treatment of stroke patients is unavailable.
 - ii. Interventional Radiology (IR) Room Unavailable: Diversion may be requested when both the primary and the back-up IRs and staff are fully encumbered caring for stroke patients to the extent that the care of additional stroke patients may be jeopardized.
 - iii. Stroke Team Encumbered: Diversion may be requested when stroke resources, are fully encumbered to the extent that the care of additional stroke patients may be jeopardized.

7. Internal Disaster: Diversion of both ALS and BLS patients may be requested when a facility disruption threatens the ED or significant patient care services, to the extent that care of additional patients may be jeopardized.

- a. A hospital requesting diversion due to internal disaster must notify the MAC by telephone and provide the name of the administrator authorizing the diversion and the rationale for internal disaster. Appropriate rationale include:
 - i. Power outage impacting patient care, which cannot be sufficiently mitigated by emergency generators
 - ii. Critical infrastructure or systems failure impacting patient care, which cannot be sufficiently mitigated by emergency back-up procedures
 - iii. Fire
 - iv. Law enforcement operation e.g. active shooter, bomb threat, hostage situation.
 - v. Flooding
 - vi. Water disruption/contamination

- vii. Hazardous materials contamination of patient care areas
- viii. Other – Must be approved by the EMS Agency through the MAC or the Health Facilities Inspection Division of the Department of Public Health. **Internal Disaster does not apply to work actions.**
- b. For situations in which a hospital knows in advance that it will need to divert to internal disaster, hospital shall notify the EMS Agency in writing, well in advance of the scheduled diversion. It is the responsibility of the hospital to notify area base hospital(s) and all affected EMS provider agencies.
- c. Upon request by the EMS Agency, a hospital shall submit an after-action report within 60 days of the incident when a hospital's diversion due to internal disaster is greater than four (4) hours.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 502, **Patient Destination**
Ref. No. 503.1 **Diversion Request Requirements**
Ref. No. 504, **Trauma Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 511, **Perinatal Patient Destination**
Ref. No. 512, **Burn Patient Destination**
Ref. No. 513, **ST Elevation MI Patient Destination**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 521, **Stroke Patient Destination**

Paramedic Base Hospital Agreement
Trauma Services Hospital Agreement
Comprehensive Stroke System Agreement

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: POLICY REVIEW SUMMARY BY COMMITTEE

Reference No. 503, Guidelines for Diversion of ALS Units

		Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES		Provider Agency Advisory Committee	Y	02/21/18	Y
		Base Hospital Advisory Committee	Y	02/14/18	N
		Data Advisory Committee			
		Education Advisory Committee			
OTHER COMMITTEES/RESOURCES		Medical Council			
		Trauma Hospital Advisory Committee			
		Ambulance Advisory Board			
		Pediatric Advisory Committee			
		EMS QI Committee			
		Hospital Association of So California			
		County Counsel			
		Working Group			

* See attached **Summary of Comments Received**

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Procedure B. 7. iv	BHAC 2-14-18	Change the wording to "Law enforcement operation e.g. active shooter, bomb threat, hostage situation"	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)
REFERENCE NO. 521

SUBJECT: **STROKE PATIENT DESTINATION**

PURPOSE: To provide guidelines for transporting suspected stroke patients to the most accessible facility appropriate to their needs.

AUTHORITY: Health & Safety Code, Division 2.5, Section 1798

DEFINITIONS:

Primary Stroke Center (PSC): A 9-1-1 receiving hospital that has met the standards of a Center for Medicaid & Medicare Services (CMS) approved accreditation body as a Primary Stroke Center and has been approved as a Stroke Center by the Los Angeles (LA) County Emergency Medical Services (EMS) Agency.

Comprehensive Stroke Center (CSC): A 9-1-1 receiving hospital that has met the standards of a CMS approved accreditation body as a Comprehensive or Thrombectomy Capable Stroke Center and has been approved as a Comprehensive Stroke Center by the LA County EMS Agency. CSCs have subspecialty neurology and neurointerventional physicians available 24 hours a day and 7 days a week who can perform clot-removing procedures.

Local Neurological Signs: Signs and symptoms that may indicate a dysfunction in the nervous system such as a stroke or mass lesion. These signs include: speech and language disturbances, altered level of consciousness, unilateral weakness, unilateral numbness, new onset seizures, dizziness, and visual disturbances.

Modified Los Angeles Prehospital Stroke Screen (mLAPSS): A screening tool utilized by prehospital care providers to assist in identifying patients who may be having a stroke.

Los Angeles Motor Score (LAMS): A scoring tool utilized by prehospital care providers to determine the severity of stroke on patients who meet mLAPSS criteria. A large vessel involvement is suspected if the total LAMS score from the three categories is 4 or greater.

PRINCIPLES:

1. Patients experiencing a stroke should be transported to the most accessible facility appropriate to their needs. This determination will be made by the base hospital physician or Mobile Intensive Care Nurse after consideration of the guidelines established in this policy. Final authority for patient destination rests with the base hospital.
2. Basic Life Support units shall call an Advanced Life Support unit for suspected stroke patients.
3. In all cases, the health and well-being of the patient is the overriding consideration in determining patient destination. Factors to be considered include: severity and stability of the patient's condition; anticipation of transport

EFFECTIVE: 04-01-09
REVISED: XX-XX-2018
SUPERSEDES: 07-01-16

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APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

time; available transport resources; and request by the patient, family, guardian, or physician.

4. Service area rules and/or considerations do not apply to suspected stroke patients.
5. Patients with a history of previous stroke with new or worsening deficits should be routed to the Stroke Center according to this policy.

POLICY:

I. Responsibility of the Provider Agency

- A. Perform mLAPSS on all patients exhibiting local neurological signs. The mLAPSS is positive if all of the following criteria are met:

1. Symptom duration less than 6 hours
2. No history of seizures or epilepsy
3. Age 40 years or older
4. At baseline, patient is not wheelchair bound or bedridden
5. Blood glucose between 60 and 400 mg/dL
6. Obvious asymmetry-unilateral weakness with any of the following motor exams:
 - a. Facial Smile/Grimace
 - b. Grip
 - c. Arm Strength

- B. If mLAPSS is positive, calculate LAMS from the mLAPSS motor items:

- | | |
|----------------------|--------------------------|
| 1. Facial droop | Total Possible Score = 1 |
| a. Absent = 0 | |
| b. Present = 1 | |
| 2. Arm drift | Total Possible Score = 2 |
| a. Absent = 0 | |
| b. Drifts down = 1 | |
| c. Falls rapidly = 2 | |
| 3. Grip strength | Total Possible Score = 2 |
| a. Normal = 0 | |
| b. Weak grip = 1 | |
| c. No grip = 2 | |

- C. Transport the patient to the most appropriate stroke center in accordance with base hospital direction or section III of this policy.
- D. Document the results of mLAPSS, LAMS, and last known well date and time in the designated areas on the Patient Care Record.

- E. In order to ensure that proper consent for treatment can be obtained by hospital personnel, if possible, document the name and contact information of the family member, caregiver, or witness who can help verify the patient's last known well time in the Comments area of the Patient Care Record. When practical, transport the witness with the patient.

II. Responsibility of the Base Hospital

- A. Provide medical direction and destination for all patients who meet mLAPSS criteria or have symptoms strongly suggestive of a stroke.
- B. Determine patient destination based on stroke center status via the ReddiNet® system and section IV of this policy.
- C. Notify the receiving stroke center if the base hospital is not the patient's destination.
- D. Document the results of mLAPSS, LAMS, and last known well date and time in the designated areas on the Base Hospital Form.
- E. Prompt prehospital care personnel to obtain and document witness contact information on the Patient Care Record.

III. Destination of Stroke Patients

All patients who have a positive mLAPSS shall be transported to a LA County EMS Agency designated stroke center as follows:

- A. Transport to the PSC:

Patients with a LAMS of less than 4

- B. Transport to the CSC:

Patients with suspected acute onset stroke symptoms and a LAMS of 4 or greater, if ground transport time is less than 30 minutes. If ground transport time to the CSC is greater than 30 minutes, the patient shall be transported to the most accessible PSC.

- C. If there are no stroke centers (PSC or CSC) that are accessible by ground transport within the maximum allowable time of 30 minutes, the patient shall be transported to the most accessible receiving facility.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 322, **Stroke Receiving Center Standards**

Ref. No. 501, **Hospital Directory**

Ref. No. 502, **Patient Destination**

Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**

Ref. No. 1200, **Treatment Protocols**

Ref. No. 1251, **Stroke/Acute Neurological Deficits**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: POLICY REVIEW SUMMARY BY COMMITTEE

Reference No. 521, Stroke Patient Destination

		Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES		Provider Agency Advisory Committee	Y	02/21/18	Y
		Base Hospital Advisory Committee	Y	02/14/18	N
		Data Advisory Committee			
		Education Advisory Committee			
OTHER COMMITTEES/RESOURCES		Medical Council			
		Trauma Hospital Advisory Committee			
		Ambulance Advisory Board			
		Pediatric Advisory Committee			
		EMS QI Committee			
		Hospital Association of So California			
		County Counsel			
		Working Group			

* See attached **Summary of Comments Received**

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 521, Stroke Patient Destination

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy IV, A. 2.	BHAC 2-14-18	Make a Principle and change the wording to: "Patients with a history of previous stroke with new or worsening deficits should be routed to the Stroke Center according to this policy"	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELESSUBJECT: **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 Assembly Bill No. 1129
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)

DEFINITION:

Electronic Data: Patient Care Records submitted in electronic format (as per LA-EMS Data Dictionary) or field electronic Patient Care Records (ePCRs).

PRINCIPLES:

1. All submission of electronic personal health information (PHI) shall be in compliance with HIPAA regulations.
2. PCRs 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 requirement.
4. All public and private advanced life support (ALS), specialty care transport (SCT), and exclusive operating area (EOA) provider agencies shall submit data electronically, which meets the LA-EMS or LA-EOA Data Dictionary requirements, to the EMS Agency.
5. Provider agencies cannot utilize an ePCR until their selected vendor has been approved to submit data electronically to the EMS Agency.

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 or private provider agency's Chief Executive Officer, to the EMS Agency for approval which includes:

EFFECTIVE DATE: 12-01-09

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REVISED: XX-XX-18

SUPERSEDES: 12-01-13

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

- a. Ability to transmit data to the EMS Agency which meets the LA-EMS or LA-EOA Data Dictionary requirements.
 - b. A successful mechanism to provide immediate transfer of patient information to additional providers, including transporting agency (if necessary).
 - 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. Processing for confirming that an ePCR has been successfully generated for each patient.
 - e. 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 the receiving facility.
 - f. Back-up system available in case of system failure.
 - g. Staff members assigned to act as a liaison between the vendor and the EMS Agency to identify and correct data issues.
2. Notify the EMS Agency's Data Management Division Chief once a vendor has been selected and provide an estimated filed implementation date.
 3. Notify all hospitals that provider transports to, of the intent to convert to an ePCR system and the tentative start date.

B. Implementation

1. Ensure the selected vendor contacts the EMS Agency's Data System Management Division Chief 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. Submit validated test files, meeting the LA-EMS Data Dictionary and Extensible Markup Language (XML) Schema Definition (XSD) standard, and the corresponding copies of the ePCRs in PDF format, 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 Trauma Emergency Medicine Information System (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, and the corresponding copies of the ePCR in PDF format, 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 Provider Agency Advisory Committee.

CROSS REFERENCE:

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: POLICY REVIEW SUMMARY BY COMMITTEE

Reference No. 607, Electronic Submission of Prehospital Data

		Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES		Provider Agency Advisory Committee	Y	02/21/18	N
		Base Hospital Advisory Committee			
		Data Advisory Committee			
		Education Advisory Committee			
OTHER COMMITTEES/RESOURCES		Medical Council			
		Trauma Hospital Advisory Committee			
		Ambulance Advisory Board			
		Pediatric Advisory Committee			
		EMS QI Committee			
		Hospital Association of So California			
		County Counsel			
		Working Group			

* See attached **Summary of Comments Received**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

DRAFT NO 5

SUBJECT: **PARAMEDIC TRAINING PROGRAM APPROVAL**

REFERENCE NO. 901

PURPOSE: To define criteria for the approval of a paramedic training program in Los Angeles County.

AUTHORITY: Health and Safety Code, Division 2.5, Section 1797.173, 1797.185, 1797.192, 1797.194, 1798.200, 1797.208, and 1797.213.
California Code of Regulations (CCR), Title 22, Division 9, Chapter 4 et seq., and Section 11500 of the Government Code.

DEFINITIONS:

ALS Patient Contact: Student interaction with a patient and performance of one or more advanced life support (ALS) skills, except cardiac monitoring and basic cardiopulmonary resuscitation (CPR).

EMS System Quality Improvement Program (EMSQIP): Methods of evaluation that are composed of structure, process and outcome evaluations, which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process and recognize excellence in performance and delivery of care.

Commission on Accreditation of Allied Health Education Programs (CAAHEP):
Programmatic postsecondary accrediting agency.

Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions: The recognized accreditation body for EMS education in the State is CAAHEP's Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP).

Paramedic: A healthcare provider who has a valid California license and is educated and trained in all elements of prehospital ALS; whose scope of practice to provide ALS is in accordance with the standards prescribed in Chapter 4 of Division 9 of Title 22 of the California Code of Regulations.

EMS Response: The physical response of an emergency medical services (EMS) provider due to activation of the EMS system with a request for medical evaluation.

National Paramedic Curriculum: U.S. Department of Transportation (DOT) / National Highway Traffic Safety Administration (NHTSA) National EMS Education Standards, January 2009.

National Registry of Emergency Medical Technicians (NREMT): Organization that provides the written and skills licensure examination for paramedics in California.

EFFECTIVE: 10-18-88
REVISED: 40-1-07 XX-XX-18
SUPERSEDES: 40-18-94 10-01-07

PAGE 1 OF 15

APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

PRINCIPLES:

1. The purpose of a paramedic training program is to prepare individuals for licensure in order to render prehospital ALS at the scene of an emergency, during transport of the sick and injured, or during interfacility transfer within an organized EMS system.
2. Los Angeles County approved paramedic training programs shall meet State regulations and established EMS Agency policies.
3. Eligible training institutions requesting approval shall meet the standards for CAAHEP accreditation.
4. New programs shall submit their application, fee, and self-study for accreditation to CoAEMSP within twelve (12) months following the start-up of classes.
5. New programs shall receive and maintain CAAHEP accreditation no later than two years from the date of application to CoAEMSP for accreditation.
6. Only paramedic training programs and locations approved by the EMS Agency may provide training in Los Angeles County. This applies to all phases of training.
7. Approved training program shall provide clinical and internship assignments for 100% of their students within the required time frames.
8. Approved training programs, shall notify the EMS Agency in writing, within thirty (30) days, of changes in curriculum, hours of instruction, program staff, clinical and field internship sites.
9. Approved training programs shall participate in the EMS System Quality Improvement Program (EMSQIP).
10. Training programs may be approved as a Continuing Education (CE) provider.
11. Paramedic interns shall be measured against the standard of entry level paramedics.

POLICY:**I. Approving Authority**

The Los Angeles County EMS Agency is the approving authority for paramedic training programs whose headquarters or training locations are located within Los Angeles County including clinical and field internship experience.

II. Program Eligibility

Eligibility shall be limited to the following institutions:

- A. Accredited universities and colleges, including junior and community colleges, and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau of Private Postsecondary Education.
- B. Medical training units of a branch of the Armed Forces or Coast Guard of the United States.
- C. Licensed general acute care hospitals which meet all of the following criteria:
 - 1. Hold a special permit to operate a basic or comprehensive emergency medical service pursuant to the provisions of Division 5.
 - 2. Provide continuing education (CE) to other health care professionals.
 - 3. Accredited by a Center for Medicare and Medicaid Services approved deeming authority.
- D. Agencies of government.

III. Application

- A. Eligible training institutions shall submit a written request for program approval to the EMS Agency Director.
- B. Obtain an application packet from the EMS Agency. The required content that should be submitted to the EMS Agency is listed in the application instructions.
- C. Current CAAHEP accredited programs shall submit the following:
 - 1. All documents submitted to and received from CoAEMSP and CAAHEP to include, but not limited to:
 - a. Initial approval documentation
 - b. Self-study documents
 - c. Documents required to maintain accreditation
 - d. Annual report
 - e. Copy of current accreditation certificate
 - f. Copy of academic affiliation

IV. Program Requirements

- A. Student Eligibility: All candidates shall:
 - 1. Possess a high school diploma or general education equivalent (GED).
 - 2. Possess a current basic cardiac life support (CPR) card for BLS Provider, Healthcare Provider or Professional Rescuer which meet the current

American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care.

3. Be certified as one of the following:
 - a. California emergency medical technician (EMT).
 - b. California Advanced EMT
4. Have current CPR and EMT certifications at time of entry into a paramedic training program and remain current throughout all phases of training.
5. Have a minimum of six (6) months full time or one (1) year part time EMT experience.

B. Course Content

1. Paramedic Training Program course hours shall consist of no less than one thousand and ninety (1090) hours and are divided as follows:
 - a. Minimum of four-hundred and fifty (450) hours didactic instruction and skills laboratories
 - b. Minimum of one hundred and sixty (160) hours clinical experience
 - c. Minimum of four hundred and eighty (480) hours field internship with at least fifty (50) ALS contacts. An ALS patient contact shall be defined as the performance of one or more ALS skills, except cardiac monitoring and CPR.
2. Excluded from program hours are:
 - a. Course material designed to teach or test exclusively EMT knowledge or skills, including CPR.
 - b. Examination for student eligibility.
 - c. The teaching of any material not prescribed in the National EMS Education Standards – Paramedic.
 - d. Written and practical student testing.
 - e. Examination for paramedic licensure.
3. Didactic Instruction and Skills Practice
 - a. Didactic/skills practice shall consist of no less than four hundred and fifty (450) hours.
 - b. The content of a paramedic course shall meet the current National EMS Education Standard, Paramedic Curriculum

- c. Course shall include EMS Agency mandatory training programs, which reflect current practice and policies, Reference No. 1200 *Treatment Protocols* and Reference No. 1300 *Medical Control Guidelines*.
 - d. Conduct periodic competency-based examinations and a final comprehensive written and practical examination using program passing criteria.
 - e. No more than six students shall be assigned to one instructor during skills practice/laboratory.
4. Clinical Education
- a. The clinical education and training shall consist of no less than one hundred and sixty (160) hours.
 - i. A minimum of one hundred and twenty (120) hours must be assigned in a general acute care hospital.
 - ii. An additional forty (40) hours may be assigned out of the hospital setting as approved by the EMS Agency.
 - b. Program shall provide clinical assignments for 100% of their students within thirty (30) days of completion of didactic instruction. The course director and student may mutually agree to a later date in the event of a special circumstance such as student illness, death or birth in the family, student's military duty, etc.
 - c. Program shall have signed written agreements (to include end date) with each clinical facility.
 - d. Clinical assignments shall include, but not limited to emergency, cardiac, surgical, obstetrical, and pediatric patients.
 - e. No more than two (2) students shall be assigned to one preceptor or health care professional during the supervised clinical education, which includes direct patient care responsibilities.
 - f. Medication administration and procedures shall include those in Reference No. 803, Paramedic Scope of Practice and any paramedic skill that the precepting health care professional feels comfortable having the student perform with supervision.
5. Field Internship
- a. The student must meet the EMS Agency requirements to intern in Los Angeles County and pass the written Accreditation Examination.
 - b. Programs shall provide internship assignments for 100% of their students within ninety (90) days after completion of the clinical

education. The course director and student may mutually agree to a later date in the event of a special circumstance such as student illness, death or birth in the family, student's military duty, etc.

- c. Field internship shall consist of no less than four hundred and eighty (480) hours with a maximum of seven hundred and twenty (720) hours unless extension approved by EMS Agency Medical Director.
- d. The field provider must be a primary 9-1-1 ALS provider with a minimum run volume of one thousand two hundred (1200) EMS responses in the previous calendar year.
- e. Programs shall have signed written agreements (to include end date) with ALS providers.
- f. Field preceptor assignments shall be coordinated with the training program and the ALS provider to ensure the preceptor has the required experience and training.
- g. No more than one intern shall be assigned to a response vehicle during the intern's internship.
- h. The intern shall perform a minimum of fifty (50) ALS patient contacts. At least 50% of contacts shall be in the team lead role providing the full continuum of care, beginning with the initial contact through release of the patient to a receiving hospital or medical care facility.
- i. Documentation of the intern's progress, including identified weaknesses or problems, shall be provided to the intern daily with a comprehensive evaluation at the 7th, 14th, and 20th shift.
- j. Internship must be completed within 6 months after the end of the clinical phase. The course director and student may mutually agree to a later date in the event of a special circumstance such as student illness, death or birth in the family, student's military duty, etc.
- k. Successful performance in the clinical and field setting shall be required prior to course completion.

V. Teaching Staff Qualifications and Responsibilities

Each program shall consist of a medical director, course director, principal instructor(s), clinical and field preceptor(s) and teaching assistants who meet all requirements. Nothing in this section precludes the same individual from being responsible for more than one (1) position.

Any one of the following shall fulfill the requirement of being qualified by education and experience in methods, materials, and evaluation of instruction documented by at least forty (40) hours in teaching methodology.

1. Four (4) semester units of upper division credit in educational materials, methods and curriculum development or equivalent.
2. California State Fire Marshall (CSFM) "Instructor I and II.
3. National Fire Academy's (NFA) "Fire Service Instructional Methodology Course" or equivalent.
4. National Association of EMS Educators "EMS Instructor Course".
5. Courses which meet the U.S. Department of Transportation/National Highway Traffic Safety 2002 Guidelines for Educating EMS Instructors.

A. Medical Director

1. Qualifications:
 - a. Currently licensed and in good standing in the State of California as a physician.
 - b. Two (2) years experience in prehospital care in the last five (5) years.
 - c. Qualified by education or experience in methods, materials and evaluation of instruction.
 - d. Attend the Los Angeles County EMS Orientation (new Medical Directors, only).
2. Responsibilities shall include, but are not limited to:
 - a. Review and approve educational content of the program curriculum, training objectives for clinical and field instruction, and to certify the ongoing appropriateness and medical accuracy of the program.
 - b. Review and approve the quality of medical instruction, supervision, and evaluation of students in all areas of the program.
 - c. Approve provisions for hospital and/or medical facilities for clinical and field internship experiences.
 - d. Approve principal instructors in conjunction with the course director.

B. Course Director

1. Qualifications:
 - a. Currently licensed in California as a physician, registered nurse or paramedic who has a baccalaureate degree, or an individual who

- holds a baccalaureate degree in a related health field or education.
 - b. Minimum of one (1) year experience in an administrative or management level position.
 - c. Minimum of three (3) years academic or clinical experience in prehospital care education within the last five (5) years.
 - d. Qualified by education and experience in methods, materials and evaluation of instruction.
 - e. Attend the Los Angeles County EMS Orientation (new Course Directors only).
2. Responsibilities shall include, but are not limited to:
- a. Provide administrative oversight, organize, and supervise the educational program.
 - b. Approve principal instructor(s), teaching assistant(s), clinical and field preceptors, in conjunction with the Medical Director.
 - c. Approve clinical and field internship assignments.
 - d. Coordinate the development of curriculum, including instructional objectives, and approve all methods of evaluation.
 - e. Ensure training program compliance with State regulations, current EMS policies and other related laws.
 - f. Sign all course completion records.
 - g. Maintain all course records for a period of four (4) years.
- C. Principal Instructor(s)
1. Qualifications:
- a. Currently licensed in California as a physician, registered nurse, physician assistant, or paramedic.
 - b. Two (2) years experience in advanced life support prehospital care.
 - c. Knowledgeable in the course content of the most recent National EMS Education Standards, Paramedic course curriculum
 - d. Work Experience and Education
 - i. Six (6) years experience in an allied health field and an associate degree, OR,

- ii. Two (2) years experience in an allied health field and a baccalaureate degree.
 - e. Qualified by education and experience in methods, materials, and evaluation of instruction
 - 2. Responsibilities shall include, but are not limited to:
 - a. Curriculum development
 - b. Course coordination
 - c. Course instruction
- D. Teaching Assistant(s)
- 1. Qualifications:

Teaching Assistant (s) are qualified by training and experience in prehospital care. A teaching assistant shall be supervised by a principal instructor, the course director, and/or the medical director.
 - 2. Responsibilities shall include, but are not limited to:
 - a. Assist with teaching the course
 - b. Teach and test the required skills.
- E. Hospital/Medical Facility Clinical Preceptor(s)
- 1. Qualifications:
 - a. Currently licensed in California as a physician, registered nurse, or physician assistant.
 - b. Worked in emergency medical care for the last two (2) years.
 - c. Received instruction in evaluating paramedic students in the clinical setting which may include educational brochures, orientation, clinical training programs, or training videos.
 - 2. Responsibilities include, but are not limited to:
 - a. Create a positive and supportive learning environment.
 - b. Evaluate student ability to safely administer medications and perform assessments.
 - c. Assess student behaviors using cognitive, psychomotor, and affective domains.

- d. Document student performance using established criteria.
 - e. Identify appropriate student progress.
 - f. Counsel the student who is not progressing.
 - g. Utilize training program support services available to the student and the preceptor.
 - h. Contact appropriate training program personnel regarding a student who is ill, injured, or has had an exposure to a communicable disease or hazardous material.
3. A clinical preceptor shall be supervised by a principal instructor, the course director, and/or the medical director.

F. Field Preceptor(s)

1. Qualifications:
- a. Currently licensed in California as a paramedic and accredited by Los Angeles County EMS Agency.
 - b. Working in the field as a licensed paramedic providing direct patient care for the last two (2) years.
 - c. Completed field preceptor training approved by the EMS Agency.
2. Responsibilities include, but are not limited to:
- a. Create a positive and supportive learning environment.
 - b. Measure students against the standard of entry level paramedics.
 - c. Assess student behaviors using cognitive, psychomotor, and affective domains.
 - d. Perform and document daily, cumulative, and final evaluation of students using written field criteria.
 - e. Identify appropriate student progress.
 - f. Counsel the student who is not progressing.
 - g. Utilize training program support services available to the student and the preceptor.
 - h. Contact appropriate training program personnel regarding a student who is ill, injured, or has had an exposure to a communicable disease or hazardous material.

- i. Ensure the required minimum number of fifty (50) ALS contacts are met.
3. A field preceptor shall be supervised by a principal instructor, the course director, and/or the medical director.

VI. Course Completion Records

The training program shall issue a tamper resistant Course Completion Record no later than ten (10) working days from the date of successful completion of the program. The document must include the following information and statements:

- A. Name of the individual.
- B. Date of course completion.
- C. Name of the paramedic training program approving authority.
- D. Signature of the program medical director, optional.
- E. Signature of the course director.
- F. Name and location of the training program issuing the course completion record.
- G. Statement: *The individual named on this record has successfully completed an approved paramedic training program.*
- H. Statement in bold print: **THIS IS NOT A PARAMEDIC LICENSE.**
- I. Course hours of instruction divided into didactic/skills instruction, clinical training and field internship with a minimum of fifty (50) ALS patient contacts. In lieu of placing on the completion record, these may be addressed in a letter on official program letterhead.
- J. List of optional scope of practice procedures and/or medications taught in the course approved pursuant to subsection §100146 (c) (2) (A-D) of the California Code of Regulations, Title 22. In lieu of placing on the completion record, these may be addressed in a letter on official program letterhead.
- K. List of additional National ALS courses completed (ACLS, PALS, PHTLS, PEPP, etc.). In lieu of placing on the completion record, these may be addressed in a letter on official program letterhead.

VII. Record Keeping

Each program shall maintain the following records for four (4) years:

- A. All required documentation as specified in the application packet for program approval.
- B. Paramedic Program Class Roster.

- C. Documentation of course completion certificates issued.
- D. Original documentation or summaries of student performance and course evaluations.
- E. Curriculum vitae for instructors with a copy of current licenses and certifications in their field of expertise, or evidence of specialized training.

VIII. Program Reporting

- A. During the approved program period, the EMS Agency shall be notified in writing, a minimum of thirty (30) days in advance, of any changes in the following:
 - 1. Summary of changes to curriculum.
 - 2. Hours of instruction.
 - 3. Program staff.
 - 4. Clinical or field internship sites.
- B. The training program shall submit a complete course schedule thirty (30) days prior to the start of each course.
- C. The training program shall submit a course roster and student application a minimum of thirty (30) days prior to the Accreditation Examination. Programs shall coordinate with the EMS Agency's Office of Certification for scheduling the Accreditation Examination.

IX. Program Re-approval

- A. The training program must receive and maintain CAAHEP accreditation to be considered eligible to be re-approved. The training program shall continue to meet all requirements to be considered for renewal.
- B. Application for re-approval process:
 - 1. Submit a written request for re-approval to the EMS Agency.
 - 2. Obtain a re-approval application packet.
- C. Submit the following to the EMS Agency:
 - 1. All documentation submitted to and received from CoAEMSP and CAAHEP during the approved program period to include, but not limited to the following:
 - a. Initial approval documentation, if not previously submitted.
 - b. Self-study for accreditation.
 - c. Documents required for maintaining accreditation.

- d. Annual reports.
- e. Copy of current accreditation certificate.
- 2. Required documentation for re-approval as outlined in the re-approval packet.
- 3. A site survey may be conducted prior to re-approval.

X. Fees

Payment of the established fee, if applicable, is due at the time of initial program approval or for program re-approval must be submitted with the re-approval application.

XI. Responsibilities of the EMS Agency**A. Process Applications**

- 1. Notify the program applicant in writing within ninety (90) 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 have been met.
 - a. Notify the program applicant within sixty (60) days of receipt of the application that the application was received and/or what information is deficient, or is missing, and the date the information is due.
 - b. Failure to submit requested information within specified time frame after receiving written notification shall render the application null and void.
- 2. Upon receipt of a complete application, the EMS Agency shall establish the effective date of program approval.
- 3. Initial approval and re-approval shall be for a period of four (4) years. Program approval or disapproval shall be made in writing by the EMS Agency to the program applicant.

B. Audit Programs

Approved paramedic training programs shall be subject to a site survey prior to initial program period and periodic on-site evaluations during the approved period by the EMS Agency.

XII. Program Disciplinary Actions

- A. Failure to comply with the provisions of CCR Div. 9, Ch. 4, et seq. such as 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 4; the California Health and Safety Code, Division 2.5; or Los Angeles County Emergency Medical Services Prehospital Care Policies shall result in disciplinary action.

- B. The requirements for training program noncompliance notification and actions are as follows:
1. The EMS Agency shall provide notification of noncompliance to the paramedic training program. This notification shall be in writing and sent by certified mail to the training program director.
 2. Within fifteen (15) days from receipt of the noncompliance notification, the training program shall submit in writing, by certified mail, to the EMS Agency one (1) of the following:
 - a. Evidence of compliance with the provisions of Chapter 4, or
 - b. A plan to comply with the provisions of Chapter 4 within sixty (60) days from receipt of the notification of noncompliance.
 3. Within fifteen (15) days from receipt of the training program's response, or if no response is received from the training program then within thirty (30) calendar days from the mailing date of the noncompliance notification, the EMS Agency shall issue a decision letter by certified mail to the State of California EMS Authority and the training program. The letter shall identify the EMS Agency's decision to take one or more of the following actions:
 - a. Accept the evidence of compliance provided.
 - b. Accept the plan for meeting compliance.
 - c. Place the training program on probation.
 - d. Suspend the training program.
 - e. Revoke the training program
 4. The decision letter shall include, but not be limited to, the following:
 - a. The date of the EMS Agency's decision.
 - b. The specific provisions found to be noncompliant.
 - c. The probation or suspension effective and ending date, if applicable.
 - d. The terms and conditions of the probation or suspension, if applicable.
 - e. The revocation effective date, if applicable.

- C. If the training program does not comply with subsection VII., B., 2, of this reference, the EMS Agency may uphold the noncompliance finding and initiate a probation, suspension, or revocation action as described in subsection VII., B., 3., of this section.
- D. The EMS Agency shall establish the probation, suspension, or revocation effective dates no sooner than sixty (60) days after the date of the decision letter as described in subsection VII., B., 3., of this section.
- E. Causes for actions include, but are not limited to, the following:
 - a. Failure to correct identified deficiencies within the specified length of time after receiving written notice from the EMS Agency.
 - b. Misrepresentation of any fact by a training program of any required information.
- F. A paramedic training program is ineligible to reapply for approval following a denial or revocation for a minimum of twelve (12) months.
- G. If a training program is placed on probation, the terms of probation, shall be determined by the EMS Agency. During the probationary period, the EMS Agency must give prior approval for all programs offered. Course documents must be submitted to the EMS Agency at least thirty (30) days prior to each course being offered. The EMS Agency shall provide written notification of program approval to the program director within fifteen (15) days of the receipt of the request. Renewal of the training program is contingent upon completion of the probationary period.

CROSS REFERENCES:Prehospital Care Manual:

Ref. No. 802,	Los Angeles County EMT Scope of Practice
Ref. No. 802.1,	Los Angeles County EMT Scope of Practice (Field Reference)
Ref. No. 803,	Los Angeles County Paramedic Scope of Practice
Ref. No. 803.1,	Los Angeles County Paramedic Scope of Practice (Field Reference)
Ref. No. 903,	Paramedic Intern Clinical Experience and Field Internship Requirements
Ref. No. 1006,	Paramedic Accreditation

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO. 202.1

Summary of Comments Received on Reference No. 901, Paramedic Training Program Approval

ISSUE SECTION #	COMMITTEE	COMMENT	RESPONSE
Policy	The four Approved Paramedic Training Programs	The policy was updated with clarifying language and re-formatted, ensuring it complies with State Regulations. The revised policy was sent to all four approved Paramedic Training Programs for their review and comments.	



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VIA EMAIL AND FIRST CLASS MAIL

March 7, 2018

Adewole Adegoke, Ph.D., REHS, CFI.
District Supervisor, Acute & Ancillary Unit
Los Angeles County Department of Public Health
Health Facilities Inspection Division
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Marianne Gausche-Hill, M.D., FACEP, FAAP, Medical Director
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Los Angeles County Department of Health Services
10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670

The Honorable Janice Hahn
Supervisor, 4th District
Los Angeles County Board of Supervisors
500 W. Temple Street, Room 822
Los Angeles, CA 90012

**Re: MemorialCare Community Medical Center Long Beach (License No. 930000090)
– Elimination of Basic Emergency Medical Services and Closure of General Acute Care
Hospital**

Dear Dr. Adegoke, Ms. Childester, Dr. Gausche-Hill and Supervisor Hahn:

Pursuant to Health and Safety Code (HSC) §1255.1, this letter serves as ninety (90) day notice that MemorialCare Community Medical Center Long Beach (CMCLB), which operates under the license referenced above, will be eliminating basic emergency medical services no later than **July 3, 2018**. In addition, this letter will also serve as the required notice under HSC §1255.25 that CMCLB intends to cease operation as a general acute care hospital by no later than **July 3, 2018**.

Letter of Commitment
December 15, 2017
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The following is the specific information required under HSC §1255.25(b):

1. Description of proposed closure and service elimination:

By no later than the dates referenced above, CMCLB will close its department and will cease operation of all of its licensed acute care hospital services. CMCLB currently maintains 158 licensed beds¹, including 28 acute psychiatric beds and 20 intensive care beds, and provides the following supplemental outpatient services: imaging services, physical and occupational therapy services, and GI services. The hospital closure will affect approximately 270 personnel, some of whom will be transferred to positions at other MemorialCare facilities.

2. Nearest available comparable services in the community:

a. MemorialCare Long Beach Medical Center: 2801 Atlantic Avenue, Long Beach, CA 90806. Telephone No.: (562) 933-2000

b. St. Mary Medical Center: 1050 Linden Avenue, Long Beach, CA 90813. Telephone No.: (562) 491-9000

c. Los Alamitos Medical Center: 3751 Katella Ave, Los Alamitos, CA 90720. Telephone No.: (562) 598-1311

d. For Behavioral Health: College Medical Center: 2776 Pacific Avenue, Long Beach, CA 90806. Telephone No.: (562) 997-2000.

Each of these providers participates in the Medicare and Medi-Cal program and serves beneficiaries of the Medicare and Medi-Cal programs.

3. The addresses and telephone numbers where interested parties may offer comments:

a. **Health Facility:** MemorialCare Community Medical Center Long Beach, 1720 Termino Avenue, Long Beach, California 90804, Telephone No. (562) 933-9000.

¹ This number includes 24 licensed beds (10 coronary care and 14 general medical/surgical beds) that are currently in suspense.



Long Beach Medical Center
Community Medical Center Long Beach
Miller Children's & Women's
Hospital Long Beach

Letter of Commitment
December 15, 2017
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b. Parent Entity: Memorial Health Services, 17360 Brookhurst Street, Fountain Valley, CA, 92704: Telephone No. (714) 378-2900

c. Chief Executive Officer: John Bishop, 2801 Atlantic Avenue, Long Beach, CA. 90806. Telephone No. (562) 933-2000.

I am available to answer any questions you may have about the closure and can be reached at (562) 933-1111.

Sincerely,

A handwritten signature in blue ink that reads "John Bishop". The signature is fluid and cursive, with the first name "John" and last name "Bishop" clearly legible.

John Bishop
Chief Executive Officer
MemorialCare Community Medical Center Long Beach

cc: Jessica J. Ho, Senior Health Deputy, Supervisor Janice Hahn
Nick Ippolito, Chief of Staff, Supervisor Janice Hahn
Lisa Parker-Willis, RN, BSN, Los Angeles County Department of Public Health
Phyllis Nelson, Associate Administrator, CMCLB
Karen Weinstein, Esq., Assistant General Counsel, MemorialCare

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

**SUBJECT: DOWNGRADE OR CLOSURE OF 9-1-1
RECEIVING HOSPITALS OR EMERGENCY
MEDICAL SERVICES**

REFERENCE NO. 222

PURPOSE: To establish a procedure to be followed if a general acute care or psychiatric facility plans to downgrade or eliminate emergency medical services or close the hospital completely.

AUTHORITY: California Code of Regulations 70105(a), 70107(a), 70107(a)(12), 70351(a), 70351(b)(1), 70351(b)(5), 70367(a)
Health and Safety Code, Sections 1255.1, 1255.2, 1255.25, 1300

PRINCIPLES:

1. Hospitals with a basic or comprehensive emergency department permit provide a unique service and an important link to the community in which they are located. In certain instances, the reduction or withdrawal of these services may have a profound impact on the emergency medical services (EMS) available in their area and to the community at large.
2. Every effort should be made to ensure that essential emergency medical services are continued until emergency care can be provided by other facilities or until EMS providers can adjust resources to accommodate anticipated needs.
3. Before any changes are finalized, the Emergency Medical Services Agency should have sufficient time and opportunity to develop an EMS Impact Evaluation Report (IER) that examines the closure's affect on the community.
4. Before approving a downgrade or closure of emergency services, the California State Department of Public Health (Department) shall receive a copy of the IER to determine the expected impact of the changes, including access to emergency care and the affect of the closure on emergency services provided by other entities.

PROCEDURE:

I. Responsibilities of the Health Facility Proposing the Downgrade or Closure

- A. Not less than 30 days prior to closing a health facility, the facility shall provide public notice of the proposed downgrade or elimination of emergency services. Public notice shall include:
 1. A notice posted at the entrance to all affected facilities.
 2. A notice to the local government entity in charge of the provision of health services and the Board of Supervisors of the county in which the health facility is located.

EFFECTIVE: 06-30-99
REVISED: 01-01-17
SUPERSEDES: 07-01-13

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APPROVED:


Director, EMS Agency


Medical Director, EMS Agency

3. The California State Department of Public Health, Licensing and Certification Division.
 4. All health care service plans.
 5. Other entities under contract with the hospital that provide services to enrollees.
- B. The required notice shall include:**
1. A description of the proposed downgrade or elimination.
 2. The description shall be limited to publicly available data, including the number of beds eliminated, if any, the probable decrease in the number of personnel, and a summary of any service that is being eliminated, if applicable.
 3. A description of the three nearest available comparable services in the community. If the health facility closing these services serves Medi-Cal or Medicare patients, the health facility shall specify if the providers of the nearest available comparable services serve these patients.
 4. A telephone number and address for each of the following where interested parties may offer comments:
 - a. The health facility.
 - b. The parent entity, if any, or contracted company, if any, that acts as the corporate administrator of the health facility.
 - c. The chief executive officer.
 5. The notice shall be provided in a manner that is likely to reach a significant number of community residents serviced by the facility.
 6. It shall be provided within the 30-day time frame specified in Section I.
 7. The facility should make reasonable efforts at public notice including, but not limited to:
 - a. Advertising the change in terms easily understood by a layperson.
 - b. Soliciting media coverage regarding the change.
 - c. Informing patients of the facility of the impending change.
 - d. Notifying contracting health care service plans.
 8. This does not apply to county facilities subject to Health & Safety Code Section 1442.5.

- C. A hospital is not subject to the above if the Department:
 - 1. Determines that the use of resources to keep the emergency department (ED) open substantially threatens the stability of the hospital as a whole.
 - 2. Cites the ED for unsafe staffing practices.
- II. Responsibilities of the Local EMS Agency
 - A. Develop an IER in consultation with impacted hospitals and 9-1-1 providers.
 - 1. Include, at minimum, the following evaluation criteria:
 - a. The hospital's geographic proximity to other facilities within a five- and ten-mile radius.
 - b. The annual number of 9-1-1 basic life support (BLS) and advanced life support (ALS) transports.
 - c. The number of ED treatment stations and total emergency department volume.
 - d. The number of paramedic contacts per month if the hospital is a paramedic base.
 - e. The number of trauma patients received per month if the hospital is a trauma center.
 - f. A list of the services provided by the hospital and the surrounding facilities (Emergency Department Approved for Pediatrics, burn, perinatal, STEMI Receiving Center, PMC/PTC, Disaster Resource Center, Approved Stroke Center).
 - g. The average emergency department diversion of surrounding facilities.
 - B. Conduct at least one public hearing if the service being downgraded or closed is the facility's emergency department. The public hearing shall be conducted by the Emergency Medical Services Commission (EMSC).
 - 1. The EMSC may hold the public hearing at their normally scheduled meeting or convene a special meeting at the request of the Director of the EMS Agency.
 - 2. The hearing shall be held within 30 days following notification of the intent to downgrade or close services.
 - C. Notify planning or zoning authorities of the proposed downgrade or closure so that street signage can be removed.
 - D. Reconfigure the EMS system as needed.
 - 1. If the EMS Agency determines that the downgrade or closure of a hospital ED will significantly impact the EMS system, the Agency shall:
 - a. Determine the reason(s) a hospital has applied to do so, and

- b. Determine whether any system changes may be implemented to maintain the hospital service within the system, or
 - c. Develop strategies to accommodate the loss of the ED or other identified specialized service to the system.
 - E. Forward the IER to the Board of Supervisors for adoption.
 - F. Forward the IER to the Department within three days of its adoption by the Board of Supervisors and within 60 calendar days after the initial notification from hospital of the proposed downgrade or closure.
- III. Following receipt of the IER, Department shall notify the hospital, in writing, of its decision regarding the application to downgrade or close emergency services or the facility.

CROSS REFERENCES:

Prehospital Care Manual:

Reference No. 206, **Emergency Medical Services Commission Ordinance No. 12332-
Chapter 3.20 of the Los Angeles County Code**

INFLUENZA WATCH

Influenza and Related Disease Updates for Los Angeles County

Small increase in influenza activity seen in weeks 7 and 8, likely due to flu B

Although emergency room visits for influenza like illness have continued to decrease, other indicators suggest that influenza (flu) activity has increased in the last two weeks following a period of decline. During surveillance week 8, ending on February 24th, 16% of respiratory specimens tested at our sentinel laboratories were positive for flu compared with 10.2% in surveillance week 6. The increase in respiratory specimen testing positive for flu has been driven by an increase in flu B. Of the positive specimens, 71% were flu B in week 8 compared with 55% in week 6. This year's vaccine is more effective against flu B viruses (vaccine effectiveness: 42%) than against the H3N2 viruses (vaccine effectiveness: 25%) that predominated earlier in this flu season. We continue to urge everyone 6 months of age or older get their flu vaccine if they have not already done so because they can still benefit from flu vaccine protection.

An LA County [Health Officer Order](#) mandates that healthcare personnel working in acute and subacute care facilities either obtain an influenza vaccine or wear a face mask while in patient care areas from November 1 to March 31. Because it is not possible to predict when the flu season will end, LACDPH might extend the Order through April 15 if it seems likely that flu activity will remain elevated beyond March 31. [More information for health care workers is available at the LACDPH website.](#)

Table 1. Los Angeles County Influenza Surveillance Summary

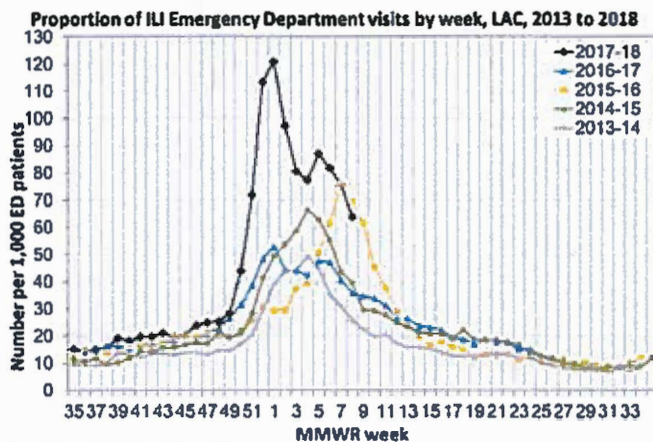
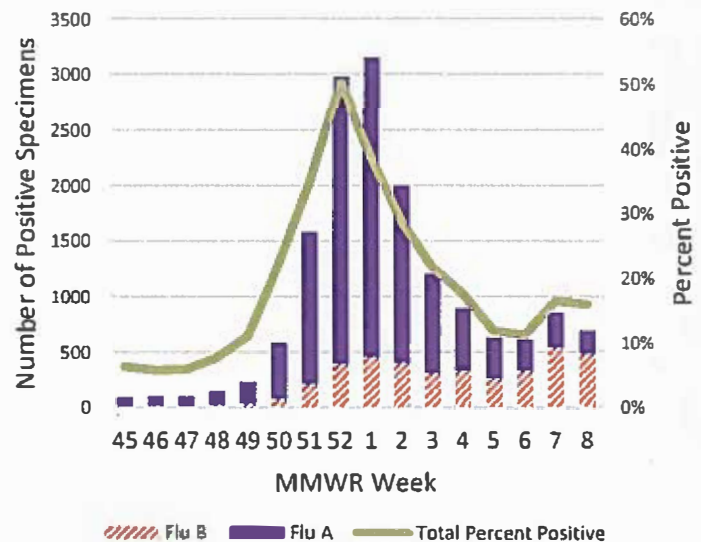
	2017-2018		2016-2017	
	Week 6*	YTD†	Week 6	YTD
Percent Positive Flu Tests	15.9	20.7	11.2	26.4
Percent Flu A/B	29/71	75/25	93/7	97/3
Pediatric Deaths‡		1		1
Adult Flu Deaths		205		65

*For the 2017-2018 season, week 8 starts 2/18/2018 and ends 2/24/2018.

†The influenza surveillance year started August 27, 2017.

‡Confirmed influenza death is defined by a positive lab test, ILI symptoms, and clear progression from illness to death.

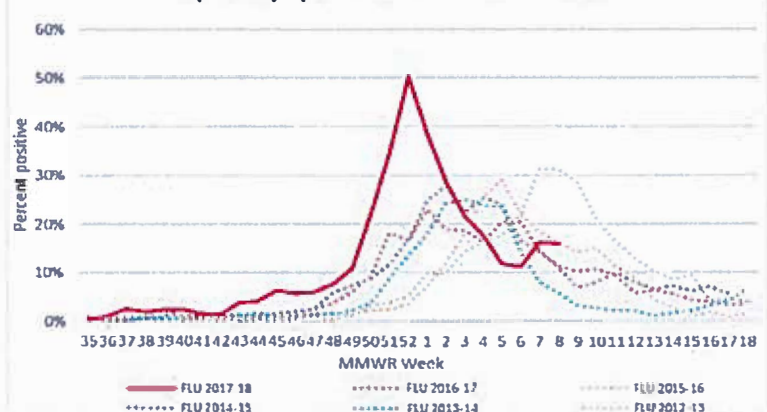
**Influenza Positive Tests from Sentinel Laboratories
Los Angeles County, 2017-18 Season**



Acute Communicable Disease Control Program

3/1/2018

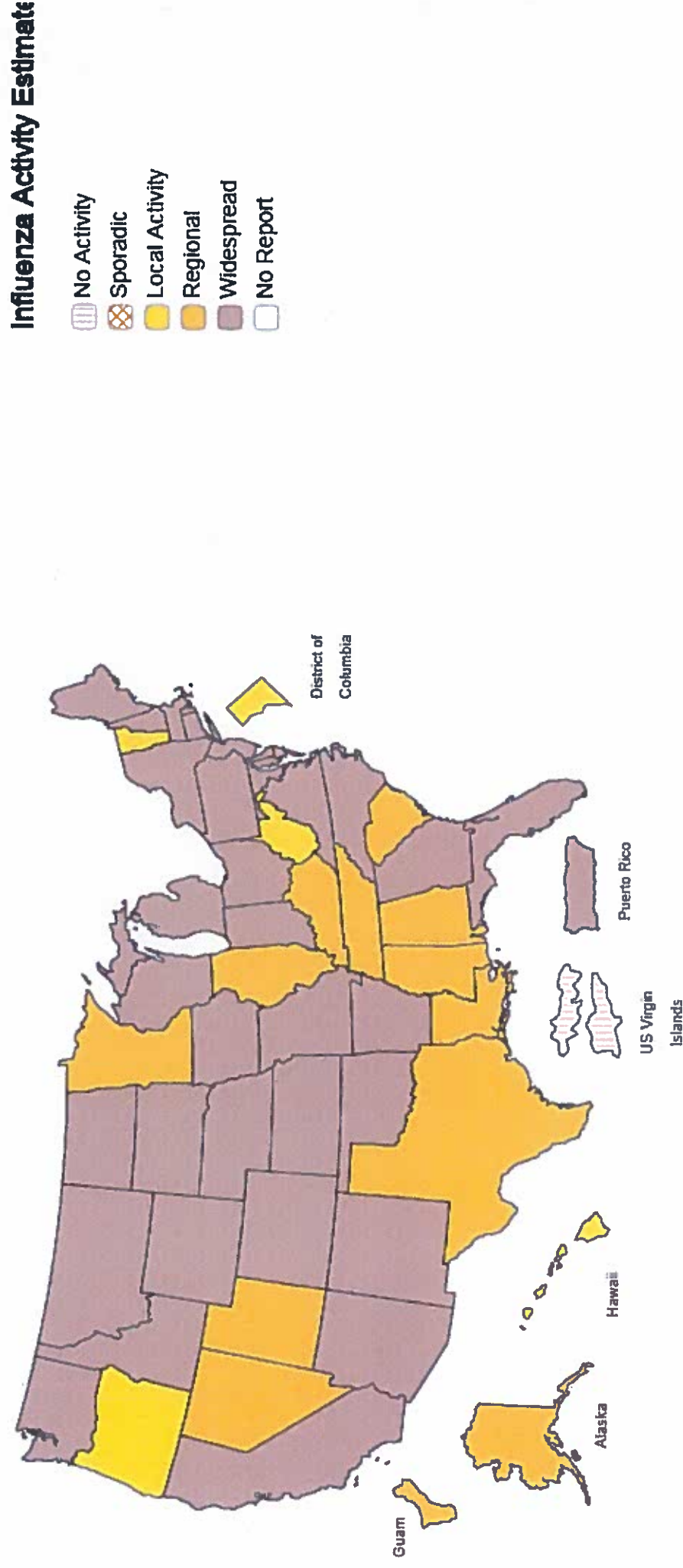
Respiratory Specimen Surveillance 2012- 2017



A Weekly Influenza Surveillance Report Prepared by the Influenza Division

Weekly Influenza Activity Estimates Reported by State and Territorial Epidemiologists*

Week Ending Mar 03, 2018 - Week 9



*This map indicates geographic spread and does not measure the severity of influenza activity.