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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: May 16, 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 (Revised)

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

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

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

1 MINUTES
- March 21, 2018

2 CORRESPONDENCE
2.1 (05-10-2018) Distribution: SART Forensic Exams Rate Increase
2.2 (04-19-2018) Distribution: Paramedic Communication with UCLA Base Hospital
2.3 (04-12-2018) Distribution: Patient Outcome Data
2.4 (04-03-2018) Distribution: General Public Ambulance Rates July 1, 2018, through June 30, 2019

3 COMMITTEE REPORTS
3.1 Base Hospital Advisory Committee – Cancelled
3.2 Data Advisory Committee – Cancelled
3.3 Education Advisory Committee
3.4 Provider Agency Advisory Committee

4 POLICIES
4.1 Policy No. 414: Specialty Care Transport Provider
4.2 Policy No. 702: Controlled Drugs
4.3 Policy No. 702.1: Medical Director Controlled Drug
4.4 Policy No. 702.2: Controlled Drug Inventory
4.5 Policy No. 702.3: Controlled Drug Loss
4.6 Policy No. 702.4: Monthly Drug Storage Form
4.7 Policy No. 703.1: Private Provider ALS Unit Inventory

4 POLICIES (Continued)

4.8 Policy No. 712: Nurse Staffed Specialty Care Transport Inventory
4.9 Policy No. 713: Respiratory Care Staffed Specialty Care Transport Inventory
4.10 Policy No. 834: Refusal of Treatment Transport
4.11 Policy No. 836: Communicable Disease Exposure
4.12 Policy No. 836.1: Communicable Disease Flowchart
4.13 Policy No. 836.2: Communicable Disease Notification Form
4.14 Policy No. 836.3: Court Petition to Test Blood
4.15 Policy No. 1014: EMT Certification
4.16 Policy No. 1210: Non-Traumatic Cardiac Arrest Adult (Information Only)

END OF CONSENT AGENDA

IV. BUSINESS

Old Business

5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies Report
5.2 Ad Hoc Committee (Wall Time/Diversion) – Draft: Reference No. 503.1
5.3 Updates from Physio-Control/Stryker on the ePCR for the Los Angeles County Fire Department

New Business

5.4 Pending Closure Emergency Department – Impact Evaluation Report
5.5 Update 2018
5.6 Measure B Advisory Board Funding Proposal

V. COMMISSIONERS COMMENTS/REQUESTS

VI. LEGISLATION

VII. EMS DIRECTOR'S REPORT

VIII. ADJOURNMENT

(To the meeting of July 18, 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.

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COMMISSIONERS	ORGANIZATION	EMS AGENCY STAFF	POSITION
☑ Ellen Alkon, M.D.	So. CA Public Health Assn.	Marianne Gausche-Hill	Medical 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	Denise Watson	Secretary, Commission
☑ John Hisserich	Public Member, 3rd District	Cathlyn Jennings	EMS Staff
* Lydia Lam, M.D.	CAL/ACEP	Adrian Romero	EMS Staff
* James Lott	Public Member, 2nd District	Christy Preston	EMS Staff
☑ Robert Ower	LAC Ambulance Association	Nick Todd	EMS Staff
* Margaret Peterson, PhD	HASC	Gary Watson	EMS Staff
☑ Paul S. Rodriguez	CA State Firefighters' Assn.	Lorrie Perez	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	Dorothy Habret	EMS Staff
* Gary Washburn	Public Member, 5th District	Christine Clare	EMS Staff
☑ Chief David White	LA Chapter-Fire Chiefs Assn.	Sara Rasnake	EMS Staff
* Pajmon Zarrineghbal	Public Member, 4th District	Susan Mori	EMS Staff

GUESTS

Steven Hall	Alhambra Fire Department	Arnold DeAnnunti	Physio Control/Stryker
Mitch Bray	Alhambra Fire Department	Darris Clark	Physio Control/Stryker
Erik Sarafian	Alhambra Fire Department	Natalie Osborne	Physio Control/Stryker
Elizabeth Benjamin, MD	LAC+USC HERT Team	Shane Cook	LA County Fire Dept.
Wally Bugg, MD	LAC+USC HERT Team	Yun Son Kim	LA County Fire Dept.
Stephanie Kem, RN	LAC+USC HERT Team	Joanne Dolan	Long Beach Fire Dept.
Lynda Harkness	Visitor	Caroline Jack	Torrance Fire Dept.
Ed Newton, MD	LAC+USC	Samantha V. Gates	APCC LA County
Elaine Pappas	LA County Fire Dept.	Matthew Conroy	LA Fire Dept.
Richard Roman	Compton Fire Dept.		

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

CALL TO ORDER:
The Emergency Medical Services (EMS) Commission (EMSC) meeting was held in the EMSC Hearing Room at 10100 Pioneer Boulevard, Santa Fe Springs, CA 90670. The meeting was called to order at 1:29 p.m. by Chairman Erick Cheung. A quorum was present with nine (9) Commissioners in attendance.

INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS:
Prior to the 1:29 p.m. "Call to Order," Dr. Marianne Gausche-Hill, EMS Medical Director, presented Clinical Excellence Awards to members from the LAC+USC Hospital Emergency Response Team (HERT) and the Alhambra Fire Department in recognition of their heroic efforts that saved a man's life. The EMS Agency hosted a reception for the awardees.

Self-introductions were made. Guest names were noted from presentations, as well as the sign-in sheets.

Ms. Karolyn Fruhwirth, EMS Assistant Director, sitting in for Cathy Chidester, EMS Director and EMSC Executive Director, announced that this would be Lucy Hickey's last EMSC meeting, wishing her well in her retirement, and thanked her for 40 years of Los Angeles County service and her 20-year contribution to the EMS System.

CONSENT CALENDAR:
Chairman Cheung called for approval of the Consent Calendar.

Motion by Commissioners Eckstein/Hisserich to approve the Consent Calendar was carried unanimously.

1. **MINUTES:**
   January 17, 2018 Minutes were approved.

2. **CORRESPONDENCE:**
   2.1 Designation of Comprehensive Stroke Centers
   Ms. Fruhwirth announced that there are now 18 designated Comprehensive Stroke Centers (CSCs).

   Dr. Gausche-Hill announced that CSC implementation is going really well after working on this project for over two years. She stated that data suggests patients who receive clot removal do far better than those who get standard therapy. The EMS Agency is now asking our paramedics to evaluate patients using a triage tool that has been vetted here in L.A. County to identify those patients that are likely to benefit from this therapy. For the patients, the paramedics do a pre-hospital triage scoring and those patients that have the most severe strokes are directed to a CSC. There was already one big save within the first two hours of implementation of the complex stroke system on January 8th, and the EMS Agency has heard about a number of others.

   Chairman Cheung asked if there is a known ratio of the number of stroke centers per population for the availability to serve.

   Dr. Gausche-Hill replied that there is no magic number per se; it is about five primary centers to one comprehensive center more or less. She also commented that we did something very innovative by providing a bridge program to allow some of the centers who are able to do the thromectomy, which is the clot removal, to enter and become part of our system even before they become certified. They go through a process of applying

and meeting all the standards of the CMS approving body, which is the Joint Commission in this case. Our team went out and surveyed all these hospitals to make sure that they really met the standards.

2.2 Countywide Sidewalk Cardiac Resuscitation Day – Tuesday, June 5, 2018
Ms. Fruhwirth announced that the EMS Annual Cardiac Resuscitation Day is scheduled for Tuesday, June 5th, and encouraged entities to participate and teach hands-only CPR during the first week of June. She stated that last year as a County and the EMS system, we trained over 5,000 people and this years' press conference event is being planned to be held at L.A. Live.

Dr. Gausche-Hill informed every one of the EMS Agency's collaboration with the California Chapter of the American College of Emergency Physicians, the American Heart Association and Los Angeles Fire Department, to bring a hands-only CPR to the forefront all over California the first week of June. During that week, there will be simultaneous big events: one in Sacramento on the steps of the Capital building that is being planned by Cal ACEP, as well as the EMS Medical Director's Association California (EMDAC), and the EMS Administrators Association California (EMSAAC).

EMSAAC and EMDAC will be tracking all the events throughout the state. A tool kit was created for all the local EMS agencies (LEMSA's) within California that should go out within the next couple days, and hopefully each of those 33 LEMSA's, L.A. County being one, will plan their own event and we will try to pool our numbers and see how we did.

2.3 California EMSA's Application for Grant Funding to Initiate the Health Information Exchange Project for Emergency Medical Services Authority (EMSA)
No discussion.

2.4 Paramedic Vaccination Program Approved
No discussion.

3. COMMITTEE REPORTS
3.1 Base Hospital Advisory Committee
3.2 Data Advisory Committee
3.3 Education Advisory Committee
3.4 Provider Agency Advisory Committee
No discussion.

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
No discussion.

5. BUSINESS (Old)
5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies Report
Chairman Cheung discussed the follow-up regarding the nine (9) recommendations that were issued by that committee at the request of the Commission two years ago, and the current update on this item is that there are roughly three projects or items underway.

Chairman Cheung stated the first project is a survey of Los Angeles area police departments and dispatch centers with whom they work to better understand dispatch procedures related to mental health emergencies, areas of challenge, and get better detailed understanding on if there is an opportunity to improve upon that system. It is related to the committee and Commission's concerns that police officers and law enforcement agencies have been doing their best to try to evaluate and manage mental health emergencies, but that there may be opportunities for EMS to be more involved in the response to behavioral emergencies.

Ms. Fruhwirth provided an update on the survey stating that it was set up at the beginning of February, and law enforcement departments were asked to return it by the end of February. The survey was sent to roughly 46 law enforcement entities. There were two different surveys: one on the dispatch side and one on the field response side. We received 21 surveys back. Some departments returned both dispatch and field, and other departments returned only one or the other. The EMS Agency is reaching out to the president of the L.A. Area Police Chief's Association to see how we can get additional surveys submitted and extend the due date. At some point we will have to analyze the data we have. It is actually a good response rate for a survey (45% rate of return).

Chairman Cheung stated that the second item related to 5.1 would be the initial process going on at the UCLA School of Para Medicine to, including himself, look at their current curriculum and clinical training related to mental health emergencies and whether there might be any opportunities to either enhance or offer new clinical training in an efficient and high-yield way for their paramedic student. He stated discussions are on-going about doing a pilot program within the next six (6) months or year.

Chairman Cheung stated the third item, which will be reported on in the legislative report, is the Gipson Bill which relates to the EMSC Ad Hoc Committee's work on alternate destinations.

5.2 Ad Hoc Committee (Wall Time/Diversion)

Christine Clare, EMS Agency, gave an update for Ambulance Patient Offload Times (APOT), stating that their last meeting was on March 1st, and that the work group was continuing to meet.

Richard Tadeo, EMS Agency, noted that a draft policy is being negotiated by the Ad Hoc Committee. The policy has provisions that will allow the providers to put hospitals on diversion due to emergency department saturation. Discussions are continuing regarding the criteria and process for requesting diversion. The Ad Hoc Committee plans to meet again within the next couple of weeks, and hopefully the policy can be finalized at that time and we can report back at the next Commission meeting.

Commissioner Marc Eckstein commented that the focus needs to be on patients who should go to the waiting room or triage that are forced to remain on an ambulance gurney. The problem is even if the providers have the option to place hospitals on diversion, the domino effect is, and literature is very compelling about this, that diversion in and of itself has not been shown to be of any benefit in the first place, and if there is nowhere else to go and one hospital goes on diversion, the nearby hospitals are quickly impacted and they subsequently have to divert. He stated the low-hanging fruit would be for all patients to be triaged and sent to the lobby if they do not need to be monitored irrespective of the mode of arrival. If someone comes in a private vehicle who would have gone to the waiting room, they should go to the waiting room if they come in by ambulance.

Commissioner Eckstein commented that how effective the hospitals are in triaging Basic Life Support (BLS) patients to the waiting room or wheelchairs is highly variable.

Mr. Tadeo stated that the Ad Hoc Committee has discussed this issue at length, and said that we have worked closely with the Hospital Association to develop guidance on this and have a white paper that has been distributed to the hospitals. The challenge in terms of triage is that there are different scales and different capabilities and capacities of the emergency rooms. This Ad Hoc Committee is trying to address the patient offload times. As reported in previous meetings, there were a variety of recommendations including imposing fines on hospitals to allowing them to close permanently. What the Ad Hoc Committee has come up with at this point in time is a lot more flexibility for the providers, particularly in the cases where hospitals are so inundated and the paramedics and Emergency Medical Technicians (EMTs) are stuck on the wall because hospitals do not go on diversion. The first step the Ad Hoc Committee decided to tackle was what we could offer to the providers to give some relief when hospital administration does not allow them to go on diversion and give them an opportunity to transport to the next hospital. It is not a perfect solution at this time and the Ad Hoc Committee understands. It is a complex issue and the group is taking baby steps to find resolution. Part of the problem we have right now in addressing APOT is obtaining accurate data, determining how data is captured and determining whether the data is measured the same way by every single provider and successfully sent to the EMS Agency. There certainly are some questions about the quality of the data, who is capturing the data and how was the data validated.

Commissioner Eckstein commented that based on his experience having been in this as many years as he has, and published and researched on this, the majority of patients that are not on monitors are not Advanced Life Support (ALS) patients, and this is an important component that this is clearly not a magic solution. In terms of data, Commissioner Eckstein agreed with Mr. Tadeo from the hospital side. You cannot have just the provider agencies providing the data; and, from his own agency, the Los Angeles Fire Department (LAFD), data is extremely inaccurate because you have to rely on the paramedic when they become available and there is a tendency to not be available to get back to the primary area. Having met with a number of CEOs and CMOs of hospitals, and ED directors over the last several years to discuss this issue, some hospitals that actually track their wall time at their hospital is vastly different than the wall time by the provider agencies. He stated it is clearly a huge problem and pause should be taken before taking one side's data with a grain of salt.

5.3 Updates from Physio-Control/Stryker on the ePCR for the Los Angeles County Fire Department

Mr. Tadeo called attention to a one-page document detailing the chronology of the ePCR since the last Commission meeting in January. He explained the handout in detail, stating there was a meeting with Los Angeles County Fire Department (LACoFD) and Physio-Control representatives on February 7th to go over line by line, data element by data element to address the issues of data submission. He stated they are only working with Version 6, which can be seen on the first date on the handout which covers May 1, 2016, to June 30, 2017. Once that is completed we have to go back and relook at the document with Version 7. That would be a separate process that we have to go through. There were some test files submitted to the EMS Agency that we looked at and compared to the PDF format that is provided to the hospitals. On February 8th, we provided feedback on some of the discrepancies. On the document table, working data exists or does not exist on the ePCR PDF that is sent to the hospitals and the discrepancies that come to the EMS Agency when they submit their data. As of yesterday, we stayed in close contact

with LACoFD in terms of counting those issues. There were some updates and unresolved issues on the 8th of March. Resolved issues were removed from the table. So, what you see on the table are the issues that as of the 8th were not resolved. Today, the trauma maintenance and injury mapping were completed. They gave us their mapping and we will review them line by line to see what the discrepancy is and make some recommendations as to some of those where they should be mapped. For example, NEMSIS collects overdoses as a mechanism of injury and we do not include overdose in mechanism of injuries.

Arnold DeAnnunti, Director, Professional Services, Physio-Control, Inc. (Stryker), gave a PowerPoint presentation and discussed his responsibility for service delivery and technical support of Stryker's products. He introduced Natalie Osborne, On-Site Project Manager, who works with LACoFD and is a direct line between the Department of Health Services (DHS) and LACoFD's requirements for export; and Darris Clark, Product Manager, who is responsible for making sure those things get implemented.

Mr. DeAnnunti stated that LACoFD is Stryker's direct customer, and DHS is their indirect customer. He stated the following as things that are being tracked:

1. The governance mechanism used since their last meeting. LACoFD has volunteered to host meetings between DHS, Stryker and L.A. County representatives. That meeting occurred on February 7, 2018. Stryker flew in an engineer from Duluth, Minnesota who spent time reviewing the data dictionary line items. There are 186 line items in DHS's data dictionary. The purpose of that exercise was to map across from the data dictionary line items from DHS to the fields in data that is available in the application. Statistics will be provided on the progress that was made in that meeting.

2. The second item is the actual mapping itself for Version 6, and when finished will move on to Version 7. Aside from the actual data export itself, there is a PDF file if DHS is interested in making modifications to it. There was agreement that they would not deal with the PDF file until they have solidified the mapping for the export itself, then they will know exactly what needs to be done to export before moving on to Version 7.

3. The February 7th meeting activity and output was a complete review of the data dictionary and mapping. In attendance were Chief O'Brien, Chief Pappas and Nicole Stenken from L.A. County; Christine Clare, Richard Tadeo and Michelle Williams from EMS Agency; and Natalie Osborne and Kim Baris from Hoosier Software Engineer.

Four categories of items were agreed to as part of the mapping exercise:

1. Items are mapped correctly- everyone was in agreement
2. Items in pink still require review by DHS in terms of acceptability or not
3. Update to PDF – will not update until all agree data export and data elements are locked down.
4. Update to Mobile Touch once items are reviewed. It was determined the actual application needs some sort of update.

Mr. DeAnnunti reviewed timelines and deliverables noted in his PowerPoint presentation. He also noted that Chief O'Brien offered to continue meetings every two weeks and hold a group meeting where everyone gets together to move through outstanding items. LACoFD communicated to DHS that Stryker would be submitting a new set of test files to

them. He discussed the percentage of completion, items agreed on and those still pending further review. Majority of items are completed and some items remain.

Dr. Gausche-Hill asked for a timeline for completion as challenges exist for the EMS Agency in Quality Improvement from the system perspective, as well as requirements to the State that we have not been able to meet due to not having LACoFD's data, as well as LAFD's data.

Mr. DeAnnunti stated items that are required where the application requires changing will be available the week of April 2. The other items, which are the small percentage items noted on his presentation, are the items that require the groups to work together and agree upon the final mapping. He stated updates to Mobile Touch request – 8% represents software changes and April 2nd is the expected release date. Stryker committed to do the PDF once actual export elements are locked down. From Stryker's perspective when they release software April 2nd, if they start now on the remaining items, they should be able to lock those things down between now and April 2nd and all that would be left is PDF, which we would use the actual finalized export as the basis for the PDF and collaborate with DHS what needs to be done.

Dr. Gausche-Hill asked about collaboration with LAFD, as they also use the Stryker product and have not been able to transmit their data. Between LAFD and LACoFD two-thirds of our EMS system is really involved in this process.

Mr. DeAnnunti stated the data for the export has been provided; and, as far as Stryker is concerned, there have been some issues with the export, but those things have been resolved or are being resolved. The majority of those exports have been very successful. Stryker will look to DHS to comment further or Commissioner Eckstein for an opinion.

Commissioner Eckstein commented that Stryker and DHS and LAFD are in a much better place than in the recent past, stating there is a clear trajectory with issues in terms of the compatibility with today's dictionary and exporting data from the providers. He stated that this clearly is a solution that is working with tangible results and a reasonable timeline to have these problems resolved.

Mr. DeAnnunti stated in terms of Version 7, Stryker will work as quickly as possible once they finalize the data export for Version 6 and finalize the PDF. The majority of heavy lifting was in mapping and getting everyone to agree. There will probably be some differences between Version 6 and Version 7, but will have to go through the exercise of addressing those individual items which would be the same mapping exercise as we are engaged in now in making that happen.

Mr. Tadeo made the recommendation that the Commission adds it to their agenda to keep us on track. He stated that once Version 6 is completed and we have moved forward with Version 7, he is optimistic but also realistic in terms of the challenges we found going through the mapping exercise with Version 6.

Mr. DeAnnunti made a commitment to attend the EMS Commission meetings as often as requested, and a personal commitment to satisfy everyone's requirements getting through Version 7.

BUSINESS (New)

5.4 Pending Closure Emergency Department

Ms. Fruhwirth discussed the letter from MemorialCare System, which Community Medical Center Long Beach (CMCLB) is a member hospital of, that was sent to the EMS Agency on March 7, 2018, informing the EMS Agency that they would be closing the emergency department (ED) and the hospital as a whole in July 2018. The letter triggered the EMS Agency to move forward and to hold a public hearing, as well as to do an Impact Evaluation Report to the Board of Supervisors based on our policy and on our role and responsibilities during the downgrade or closure of a 9-1-1 receiving facility.
Ms. Fruhwirth discussed the EMS Commission as the hearing body for public hearings, and advised the Commission that we do need to have a quorum. She discussed possible dates to hold the public hearing, and requested the Commissioners' responses to set the date for the hearing, advising the date will be confirmed soon. She reiterated that these hearings are under the Brown Act, and the EMS Commissioners cannot participate by phone. Ms. Fruhwirth explained that under the Brown Act, if you have a remote site they have to be open to the public, they have the same posting requirements, people have to be able to come and speak publicly, and it is just not feasible because it would have to be at any and all sites. Therefore, we need in-person participation.

Ms. Fruhwirth noted that the last public hearing for an ED closure was approximately eight (8) to ten (10) years ago, stating that hospitals have closed but they did not provide sufficient notice to hold a hearing. The hearing requirement is in the Health and Safety Code. We have 60 days from the time we are noticed to conduct a public hearing, then write up the Impact Evaluation Report (IER) and submit it to the Board for approval, and then submit the IER to the California Department of Public Health. She noted that we have a very short time period that we are working with. Ms. Fruhwirth stressed the importance of getting the date finalized and Commissioners' participation.

Commissioner John Hisserich noted that on April 11th a Base Hospital meeting was scheduled for the afternoon, and questioned if the hearing could be in the afternoon instead of evening.

Ms. Fruhwirth stated the purpose of the hearing is for the community to be able to come and express their concerns, and to meet that purpose it has to be in the evening and geographically located near the hospital. She stated we are working with MemorialCare, but until we have a date we do not know what sites are available.

Ms. Fruhwirth stated the driving factor of this closure has to do with the seismic safety requirements for hospitals, and that CMCLB is actually on a fault line and their ability to rebuild a facility would be very limited in size and the property is owned by the City so it is complicated all around.

5.5 EMS Update 2018

Mr. Tadeo stated that samples were provided of the Prehospital Treatment Protocols distributed in the packets, and on the 2nd page of that packet is a listing of the protocols which is based on provider impression. Patients are currently treated based on chief complaint. With the California EMS Authority's requirements for us to move toward provider impression, we found that it was necessary for us to do a whole revision of our treatment protocols.

The EMS Agency conducted a pilot program with Burbank Fire and Providence St. Joseph Medical Center in Burbank, and Pasadena Fire and Huntington Hospital in Pasadena.

Mr. Tadeo stated that we found opportunities to refine the protocols, and that we are in the process of finalizing them and targeting to move these two providers and these two hospitals off the pilot process. We did not see any reason to stop the pilot project or go back or change and revert back to our protocols. They will continue using the treatment protocols that are based on provider impression.

Mr. Tadeo stated we have convened a task force for the EMS Update. We have representatives from Base Hospitals, nurse educators and paramedics from provider agencies and EMS Agency staff. The update is going to be very extensive, not like in the past where it took only three (3) or four (4) hours. This is one of our biggest changes in our system for many years, and we would like to be able to roll this out in a very methodical manner. The Train-the-Trainer (TtT) roll out will be an entire day of training. We will train Base Hospitals first, and the TtT will be in May. The Base Hospitals will start training their Mobile Intensive Care Nurses (MICNs) in July and August, and the training for the MICNs will be a minimum of 4.5 hours. Hopefully by September 1st all MICN's are trained. At this point they can begin using the new protocols. We believe this will be transparent for the providers because they will just be ordering what is in the protocol.

Mr. Tadeo stated that based on the request of the provider agencies, we delayed the training for the providers to September, October or November, particularly for the bigger Fire Departments. We are targeting the provider TtT for July. Again, this will be an entire day of training. The training for the providers will be a minimum of 4.5 hours. The goal is for the entire system to be transitioned into the new treatment protocol by December 1st. Smaller providers can implement the protocols sooner if their Base Hospital(s)' MICNs are trained and all their provider agency personnel are trained.

Mr. Tadeo stated that outside of the EMS Update 2018, one of the concerns brought to the task force is training for our EMTs. The revised treatment protocol would eliminate Reference No. 808: *Base Hospital Contact and Transport Criteria*, and Reference No. 806: *Procedures Prior to Base Contact*. Those concepts have all been integrated into the treatment protocols. But, one of the unforeseen impacts that came to light during the pilot is the impact of removing these two policies for the EMTs. The EMTs, if they are responding first, use 808 to determine if they need to upgrade and call for a paramedic. We are investigating developing a different policy and different kind of education for our EMTs.

6. COMMISSIONERS COMMENTS/REQUESTS:

Commissioner Hisserich commented on recent research done by the University of Kansas which found that nationwide, when Uber services became available in a community the demand for emergency ambulances went down by an average of 7%. Many Uber drivers reported that they had encountered passengers wanting a ride to the hospital sometimes because of labor pains. Commissioner Hisserich expressed that it might warrant that they be given some sort of training about what to do in such situations.

7. LEGISLATION:

Ms. Fruhwirth gave the following highlights on Legislation:

The EMSAAC Legislative Report is the report we use, so the comments and positions taken are from their perspective.

AB 2623 Enriquez Bill, related to the lunch breaks for ambulances. This Bill is currently being held, and the EMS Agency is continuing to watch this.

7. LEGISLATION (Continued):

AB 1795 Gipson Bill, in relation to allowing paramedics to transport patients to other than emergency departments, but specifically Sobering Centers or Psychiatric Urgent Care Centers. It is set for hearing in April. Stakeholder meetings have been ongoing to make sure there is support and refining the language to get widespread support. There was a stakeholder meeting last week that Cathy Chidester, EMS Agency Director, attended. NAMI was there and asked for some changes in regards to the family being notified if patients are transported. Other than that, the Bill is still going through the process.

AB 2293 has to do with the California Conservation Camp Program where inmates are used to work the fire lines and, based on their convictions, a lot of them would not be eligible for EMT certification based on the EMT regulations. This bill is being introduced trying to change those requirements so ex-inmates could be hired by a Fire Department because most Fire Departments also require their employees have EMT certification. EMSAAC is not in favor, and has taken an opposed position. They feel like the standards should be the same for everyone for EMT certification, and the current requirements provide for patient safety in the community.

AB 2961 O'Donnell, refers to APOT data. It is still being developed, and not sure where this Bill is going. The details will be worked out and we will see what the verbiage is to see where EMSAAC takes a position on that Bill.

SB 944 Hertzberg Bill, relating to community para medicine programs. It is sitting there as a place holder and no activity.

SB 1305 addresses emergency pre-veterinary service and relates to the police dog transport. We are not sure where this bill is coming from, but please share if anybody has any knowledge.

8. EMS DIRECTOR'S REPORT:

Ms. Fruhwirth gave a brief report on influenza activity, noting while there is still widespread influenza in California, across the nation it is tapering back to regional and local activity. She noted that we are seeing a decline in flu activity that is consistent with the flu season which is typically October to March. The positive is that it is less of an impact to our emergency system on a daily basis. The County's Department of Public Health published an influenza watch report that is provided for your information.

9. ADJOURNMENT:

The Meeting was adjourned by Chairman Cheung at 2:29 p.m. until the Public Hearing (date to be announced). The next EMS Commission meeting will be held on May 16, 2018.

Next Meeting: **Wednesday, May 16, 2018**
EMS Agency
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670

Recorded by:
Denise Watson
Secretary, Health Services Commission

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

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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.

May 10, 2018

MaryAnn Lague, RN
SART Program
Providence Little Company of Mary – Torrance
4201 Torrance Boulevard, Suite 250
Torrance, CA 90502

Dear Ms. Lague:

This letter is to inform you that on May 1, 2018 the Los Angeles County Board of Supervisors approved a motion that directed the County Sheriff to increase the reimbursement rate for Sexual Assault forensic exams to $1,020 per exam. Additionally, the reimbursement rate for incomplete exams will be increased to $300 per exam. These rates are effective July 1, 2018.

The motion also provided that an adjustment to the reimbursement rate be made annually based on the change to the Consumer Price Index. Therefore, effective July 1, 2019 and each year thereafter the rates will be adjusted effective July 1 of that year.

Enclosed for your records are the report that was submitted to the Board and the Board motion.

If you have any questions, please contact Kay Fruhwirth, Assistant Director at kfruhwirth@dhs.lacounty.gov or (562) 378-1596.

Sincerely,

Cathy Chidester
Director

CC:kf

Enclosure

c: Karen Rodgers, EMS Agency SART Program Coordinator

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

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Fax: (562) 941-5835

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

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

April 19, 2018

TO: Distribution VIA EMAIL

FROM: Cathy Chidester
Director

SUBJECT: PARAMEDIC COMMUNICATION WITH UCLA BASE HOSPITAL

Effective April 24, 2018 Ronald Reagan UCLA Medical Center (UCL) will be reconfiguring their base station communications system as a pilot project approved by the EMS Agency. The EMS Agency, after consulting with County Internal Services Department, Los Angeles Fire Department, and Los Angeles County Fire District, is providing UCL Base Station a waiver for radio communications. As such, they will eliminating use of the Med Net radio system. Because data has demonstrated that 99% of the base contacts are completed by phone, we do not expect this to impact operations in any way.

UCL base station telephone number will remain the same:
(310) 208-5387
(This number will automatically roll over to additional lines if needed)

VMED 28 (HEAR) radio will remain operational.

The EMS Agency will monitor and evaluate this project over the next 12 months. Please contact John Telmos, at jtelmos@dhs.lacounty.gov with any questions or issues.

Distribution: Fire Chiefs
EMS Coordinators, Public Providers
Ambulance Company EMS Coordinators
Prehospital Coordinators
Nurse Educators, Provider Agencies

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

April 12, 2018

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

TO: CEO, Each Paramedic Base Hospital

FROM: Cathy Chidester
Director

SUBJECT: **PATIENT OUTCOME DATA**

This is to advise you that the Emergency Medical Services (EMS) Agency has been revising the Prehospital Treatment Protocols (TP) and Medical Control Guidelines (MCG) in the past two years. The revisions align the TPs and MCGs with EMS Provider Impressions as approved and mandated by the California EMS Authority.

The revised TPs and MCGs provide greater clarity of instruction, based on provider impression, and enhances the role of Base Hospital online medical direction to individualize care in complex patients. These changes increase the autonomy and responsibility of our Paramedics and Mobile Intensive Care Nurses (MICNs).

This is a substantive change for our EMS system, and a comprehensive quality improvement process is necessary to address any patient care issues and concerns that may arise. In order to verify appropriate provider impression and patient care, it is of utmost importance to obtain patient outcome on all patients transported to the hospital. Currently, your hospital only provides patient outcome on those patients that were called into your Base Hospital for online medical direction and subsequently transported to your facility.

The EMS Agency is requesting Base Hospitals to provide patient outcome on all patients transported to your facility via the 9-1-1 system (irrespective of whether online medical direction was provided). To ensure accuracy and reduce man-hours for data abstraction and data entry of patient outcomes, we are highly recommending Base Hospitals to explore technological solutions utilizing your Electronic Medical Record management system.

The revised TPs and MCGs are scheduled for implementation for the Base Hospitals in September 2018. We are providing you this advance notice to prepare for these changes.

Please do not hesitate to contact me or Richard Tadeo, Assistant Director, at (562) 378-1610 or rtadeo@dhs.lacounty.gov if you have any questions.

CC:rt

c: Medical Director, EMS Agency
Emergency Department Administrative Director, Each Base Hospital
Prehospital Care Coordinator, Each Base Hospital

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

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Second District

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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.

April 3, 2018

TO: Fire Chief, All 9-1-1 Paramedic Provider Agencies
CEO, Private Provider Agencies
City Manager, Each Los Angeles County City

FROM: Cathy Chidester
Director

SUBJECT: GENERAL PUBLIC AMBULANCE RATES JULY 1, 2018 THROUGH June 30, 2019

Attached are the maximum allowable rates chargeable to the general public for ambulance transportation as of July 1, 2018, as per Section 7.16.340, Modification of Rates, of the County Ordinance (Attachment I).

Transportation services provided on or after July 1, 2018 may not be billed above the allowable maximum rates according to the attached Rate Schedule.

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

CC:jt
03-24a

Attachment

c: Kathy Hanks, Director, Contracts and Grants Division, Health Services
Brian Chu, Deputy County Counsel, Health Services
Cristina Talamantes, Ordinance liaison, Board of Supervisors
Executive Office

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

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

EMERGENCY MEDICAL SERVICES
BASE HOSPITAL ADVISORY COMMITTEE

MEETING NOTICE

Date: April 11, 2018
Time: 1:00 P.M.
Location: EMS Headquarters
EMS Commission Hearing Room 1st Floor
10100 Pioneer Blvd.
Santa Fe Springs, CA 90670

BASE HOSPITAL ADVISORY COMMITTEE
DARK FOR April 11, 2018

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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.

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

EMERGENCY MEDICAL SERVICES COMMISSION
DATA ADVISORY COMMITTEE

MEETING NOTICE

Date & Time: Wednesday, April 11, 2018 10:00 A.M.
Location: EMS Agency, First Floor Hearing Room
10100 Pioneer Boulevard
Santa Fe Springs, 90670-3736

DATA ADVISORY COMMITTEE
DARK FOR APRIL 2018

County of Los Angeles
Department of Health Services

COMMITTEE REPORT 3.3

EMERGENCY MEDICAL SERVICES COMMISSION
EDUCATION ADVISORY COMMITTEE MINUTES

Wednesday, April 18, 2018

Attendance

Members	Organization	EMS Agency Staff Present	Position
☒ Carole Snyder, RN, Chair	EMSC/Cal ENA	Kay Fruhwirth, RN	Assistant Director
☐ Atilla Uner, MD, Vice-Chair	EMSC/Cal ACEP	David Wells, RN	Program Approvals
☐ Ellen Alkon, MD, Commissioner	EMSC/SC PH Association	Nichole Bosson, MD	Assistant Medical Director
☒ Alina Candal, RN	APCC		
☒ Tina Crews, RN	APCC		
☐ Alex Perez-Sandi, RN	APCC - alternate		
☐ Joanne Dolan, RN	LAAFCA		
☐ Susan Hayward, RN	LAAFCA		
☒ Sean Stokes, RN	LAAFCA - alternate		
☐ Luis Vazquez, PM	LACAA	**Others Present**	**Agency/Representing**
☒ Jim Karras, EMT	LACAA	Paula LaForge	LACoFD
☒ Tish Hamilton, RN	LACAA - alternate	Don Gerety	LBFD
☒ Mark Ferguson, RN	PTI Paramedic Education	Carl Voskamp	n/a
☐ Jacqueline Rifenburg, RN	PTI Paramedic Education- alternate		
☒ Ray Mosack, PM	Mt SAC Paramedic Education		
☒ Jamie Hirsch, PM	Mt SAC Paramedic Education - alternate		
☐ Heather Davis, PM	UCLA Paramedic Education		
☐ Stanley Bakey, PM	UCLA Paramedic Education - alternate		
☒ Aaron Aumann, PM	UAV Paramedic Education		
☒ William Barrett, PM	UAV Paramedic Education - alternate		
☒ Adrienne Roel, RN	MICN		
☐ Jazmine Gonzalez, RN	MICN - alternate		
☐ Charles Drehsen, MD	Med Council		
☒ Marc Cohen, MD	Med Council - alternate		
☒ Ken Leasure, PM	LAAFCA		
☐ James Altman, PM	LAAFCA - alternate		
☐ Scott Buck, PM	LACAA		
☐ William Gonzales, PM	LACAA - alternate		
☒ Anthony Mendoza, PM	EMS Educator – Non PD		
☐ VACANT	EMS Educator – Non PD - alternate		
☒ Michael Kaduce, PM	EMT Program Director		
☒ Scott Jaeggi, PM	EMT Program Director		
☐ Ryan Carey, EMT	EMT Program Director - alternate		★ - Excused

1. CALL TO ORDER - C. Snyder, Chair called the meeting to order at 10:04 a.m.

2. APPROVAL OF MINUTES - October 18, 2017 minutes approved by committee

3. INTRODUCTIONS AND ANNOUNCEMENTS

4.1 Sidewalk CPR (Fruhwirth)
A request was sent to all providers to participate on June 5th. The EMS Agency is coordinating with AHA to have a press conference followed by a large public event providing Hands-only CPR training and performing a flash mob at public location. The location is yet to be determined. Contact Susan Mori for further information or to register to conduct training.

4. REPORTS & UPDATES

4.1 California Prehospital Program Directors (CPPD) (Hirsch)
Coordinating a meet and greet at the CFED West Conference in May to facilitate regular meetings in the future.

4.2 California Council of EMS Educators (C^2E^2) (Karras)
Committee has voted to dissolve.

4.3 Association of Prehospital Care Coordinators (APCC)
No report

4.4 California Association of Nurses and EMS Professionals (CALNEP)
No report

4.5 Disaster Training Unit
No report

4.6 EMS Quality Improvement Report
No report

4.7 EMS Update (Dr. Bosson)
Provider Impression Treatment Protocols are the subject of EMS Update 2018. Train-the-Trainer (TTT) will occur in May for base hospitals and July for providers. The TTT sessions are approximately eight hours as it includes quality improvement and scenario based training. The anticipated length of EMS Update is four to five hours. A provider agency may implement the treatment protocols early once the training has been completed. The system-wide implementation date is December 1. Changes in the medical therapies of the treatment protocols are relatively minimal. The significant changes to the system involve the when and why to make Base Hospital contact. Ref. No. 806 and 808 will be eliminated. Policies have been updated or developed to reflect the changes in the protocols. Discussion by the group related to fallouts and the process. Dr. Bosson discussed fallout examples which include personnel identifying a provider impression and not following the treatment protocol or not supporting a provider impression with appropriate documentation. Discussion by the group related to the level of training and implementation of provider impression for EMTs.

4.8 EMT Regulatory 2017 Changes (Wells)
All EMT training programs are required to incorporate the added regulatory content and hours by July 1, 2018. In order to confirm the implementation EMT Training programs must submit a signed attestation form, obtained from the EMT Training Program thumb drive, to the EMS Agency.

The EMS Agency is authorizing EMS CE programs to provide the one-time mandatory training for currently certified EMTs in epinephrine auto-injector, glucometer and naloxone. Prior to providing the training, the program director must submit a signed attestation form obtained from the EMS Agency web page. The training is a requirement for all EMTs to renew their certification beginning with personnel who expire after June 30, 2019. Submit the signed attestation forms to David Wells. Training does not authorize the ability to carry and perform these therapies. Contact Susan Mori regarding the approval process for a specific provider to be authorized to perform this scope of practice.

5. UNFINISHED BUSINESS

6. NEW BUSINESS

7. OPEN DISCUSSION

8. ADJOURNMENT - The meeting adjourned at 11:07 a.m. Next meeting: Wednesday, June 20, 2018 at 10:00 a.m.

County of Los Angeles
Department of Health Services

EMERGENCY MEDICAL SERVICES COMMISSION

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, April 18, 2018

MEMBERSHIP / ATTENDANCE

MEMBERS	ORGANIZATION	
☐ Dave White, Chair	EMSC, Commissioner	
☑ Robert Ower, Vice-Chair	EMSC, Commissioner	
☑ Paul Rodriquez	EMSC, Commissioner	
☐ Brian Bixler	EMSC, Commissioner	
☐ Jodi Nevandro	Area A	
☑ Sean Stokes	Area A, Alt.	*(Rep to Med Council, Alt)*
☑ Nick Berkuta	Area B	
☑ Clayton Kazan, MD	Area B, Alt.	
☐ Victoria Hernandez	Area B, Alt.	*(Rep to Med Council)*
☑ Ken Leasure	Area C	
☐ Susan Hayward	Area C, Alt.	
☑ Richard Roman	Area E	
☐ Mike Beeghly	Area E, Alt.	
☑ James Flint	Area F	
☑ Joanne Dolan	Area F, Alt.	
☑ Alec Miller	Area G	*(Rep to BHAC)*
☐ Michael Murrey	Area G, Alt.	*(Rep to BHAC, Alt.)*
☐ Corey Rose	Area H	*(Rep to DAC)*
☐ Ellsworth Fortman	Area H, Alt.	
☑ Doug Zabilski	Area H, Alt.	
☑ Luis Vazquez	Employed Paramedic Coordinator	
☐ Tisha Hamilton	Employed Paramedic Coordinator, Alt.	
☐ Rachel Caffey	Prehospital Care Coordinator	
☐ Heidi Ruff	Prehospital Care Coordinator, Alt.	
☐ Jenny Van Slyke	Prehospital Care Coordinator, Alt.	
☑ Andrew Respicio	Public Sector Paramedic	
☑ Andrew Gano	Public Sector Paramedic, Alt.	
☑ Maurice Guillen	Private Sector Paramedic	
☑ Scott Buck	Private Sector Paramedic, Alt.	
☐ Marc Eckstein, MD	Provider Agency Medical Director	
☐ Stephen Shea, MD	Provider Agency Medical Director, Alt.	
☑ Ian Wilson	Private Sector Nurse Staffed Ambulance Program	
☐ Vacant	Private Sector Nurse Staffed Ambulance Program, Alt.	

EMS AGENCY STAFF PRESENT	
Cathy Chidester	Kay Fruhwirth
Nichole Bosson, MD	Mark Ferguson
Cathlyn Jennings	Elaine Forsyth
Christy Preston	Paula Rashi
John Telmos	David Wells
Michelle Williams	Christine Zaiser
Nnabuike Nwanonenyi	Christina Eclarino
Gary Watson	

OTHER ATTENDEES	
Adrienne Roel	UCLA Ctr Prehosp Care
Michael Barilla	Pasadena FD
Roger Braum	Culver City FD
Paula LaForge	LACoFD
William Gonzales	AmbuServ Ambulance
Stefan Viera	Torrance FD
Brian Hubbell	Ambulnz Ambulance
Nicole Steeneken	LACoFD
Caroline Jack	Torrance FD
Kristina Crews	Compton FD
Micah Bivens	LACo Lake Lifeguard
Jacob Wagoner	Lynch Ambulance
Greg Heinze	Lynch Ambulance
Ashley Sanello, MD	Compton FD
Marc Cohen, MD	El Segundo FD
	Manhattan Beach FD
	Torrance 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: Vice-Chair, Commissioner Robert Ower called meeting to order at 1:04 p.m.

1. **APPROVAL OF MINUTES (Berkuta/Leasure)** February 21, 2018 minutes were approved as written.

2. **INTRODUCTIONS / ANNOUNCEMENTS**

2.1 Optimizing ECG Transmission *(Nichole Bosson, MD)*

- Since July 2017, the EMS Agency has been holding monthly taskforce meetings with provider agencies and ECG vendors. The purpose of this taskforce is to explore options of improving ECG transmissions to hospitals.
- On April 23, 2018 at 1 pm, LACoFD and Verizon Wireless will be presenting one of the options that LACoFD is currently utilizing to improve their ECG transmission to hospitals. This meeting is held in the EMS Agency's Hearing Room; all providers interested are welcome.

3. REPORTS & UPDATES

3.1 Disaster Section Update *(Elaine Forsyth)*

- Annual MCI Training – June 28, 2018. Open to EMTs, Paramedics, EMS nurse educators.
- Statewide Medical and Health Exercise – November 15, 2018. This year will focus on radiological emergencies. Providers are encouraged to participate in the planning committee and/or in the event itself.
- For more information on any of the above, contact Elaine Forsyth at (562) 347-1647 or eforsyth@dhs.lacounty.gov.
- The EMS Agency acknowledged Care Ambulance and McCormick Ambulance for their active participation on April 11, 2018, during a nationwide exercise that tested the ability to move patients with highly infectious diseases safely and securely to regional treatment centers.

3.2 EMT Regulations Update *(David Wells)*

- Emergency Medical Technician (EMT) programs (primary and refresher) are to provide the EMS Agency with a completed attestation form by July 1, 2018, stating that the following training have been incorporated into their EMT curriculum: epinephrine auto-injector, glucometer, naloxone and basic tactical casualty care.
- EMS Continuing Education (CE) programs may provide the one-time training for epinephrine auto-injector, glucometer and naloxone after submitting a completed CE program attestation form (found on the EMS Agency's webpage).
- Approved EMS Providers (fire departments and licensed LA County ambulance providers) may apply to the EMS Agency for approval to train EMT personnel to administer and add to vehicle inventory the epinephrine auto-injector, glucometer or naloxone. (See Ref. 802, EMT Scope of Practice)

3.3 General Public Ambulance Rates *(John Telmos)*

Annual rate adjustments go into effect on July 1, 2018.

4. UNFINISHED BUSINESS

4.1 EMS Update 2018: Revised Treatment Protocols and Medical Control Guidelines *(Gary Watson / Nichole Bosson, MD)*

- Openings remain available for "Train-the-Trainer" classes scheduled in May and July 2018. To RSVP, please contact Vanessa Gonzalez at (562) 347-1607 or vgonzalez3@dhs.lacounty.gov.
- Each "Train-the-Trainer" training module is expected to last 4 - 4½ hours.

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

4.2 Reference No. 834, Patient Refusal of Treatment/Transport and Treat and Release at Scene *(Nichole Bosson, MD)*

After lengthy discussion, policy approved with the following recommendations:

- Page 2, Definitions: "Treat and Refer" – add wording from Page 5 (C) to include: "You should seek care with your regular healthcare provider or a doctor's office or clinic within 24 hours."
- Page 3, Principle 4 – add wording "patient retains the right to refuse medical care"
- Page 3, Principle 6 – place directly under Principle 4
- Page 3, Principle 8, last sentence – remove "shall" and replace with "should"
- Page 4, Policy I, B – remove wording after "AMA".
- Page 5, Policy III, B – add wording "should be transported or signed out AMA:"
- Page 6, Policy V – replace with: "Quality Improvement: Each provider shall have a QI program to review documentation related to patients who refuse medical care or transport or who were treated and released without base contact."

M/S/C (Berkuta/Zabilski) Approve Reference No. 834, Patient Refusal of Treatment/Transport and Treat and Release At Scene, with above recommendations.

5. NEW BUSINESS

5.1 Reference No. 836, Communicable Disease Exposure and Testing *(Info Only)* *(Christina Eclarino, Public Health)*

Policy reviewed as information only. Committee had the following recommendation:

- Page 7, VII, last sentence – replace "will" with "may".

5.2 Reference No. 703.1, Private Provider Non 9-1-1 ALS Unit Inventory *(Info Only)* *(John Telmos)*

Policy reviewed as information only.

5.3 Reference No. 414, Specialty Care Transport (SCT) Provider *(Info Only)* *(John Telmos)*

Policy reviewed as information only.

5.4 Reference No. 712, Nurse Staffed Specialty Care Transport (SCT) Unit Inventory *(Info Only)* *(John Telmos)*

Policy reviewed as information only.

5.5 Reference No. 1014, Emergency Medical Technician Certification (Info Only) *(Kay Fruhwirth)*

Policy reviewed as information only. Committee requested clarification on the following:

- Page 5, Policy II, 3. – Must the EMT and/or provider agency maintain a physical copy of the current CPR card or can verification be maintained electronically? (EMS Agency staff will inquired and bring back to Committee).

5.6 Reference No. 702, Controlled Substance Carried on ALS Units *(John Telmos)*

Policy reviewed and approved with the following recommendations:

- Throughout Policy and Attachments – Replace word "narcotic" with "controlled drugs"
- Page 6, III. D. – Replace "Fentanyl or morphine and midazolam" with "Controlled Drugs"
- Page 6, III. E. 1. – Add wording "by physical count"
- Page 6, III. E. 3. – Last sentence add wording to read "Entries shall be in blue or black ink only; or electronic equivalent."
- Page 8, IV. A. – Add language reflecting that the records can also be electronically secured.
- Page 8, IV. B. – Add language "or a container approved for destruction of controlled drugs."

M/S/C (Wilson/Berkuta) Approve Reference No. 702, Controlled Substances Carried on ALS Units, with above recommendations.

Reference No. 702.1

Policy reviewed and approved as written.

M/S/C (Wilson/Berkuta) Approve Reference No. 702.1, Provider Agency Medical Director Notification of Controlled Substance Program Implementation.

Reference No. 702.2

Policy reviewed and approved with the following recommendation:

- Subject line – Remove "And Key".

M/S/C (Wilson/Berkuta) Approve Reference No. 702.2, Daily Controlled Drug Inventory Form, with above recommendation.

Reference No. 702.3

Policy reviewed and approved with the following recommendations:

- Line 5 – add "or designee"
- Add new line entry to include names/titles of individuals who last performed an inventory prior to the discovery of lost/missing controlled drug.

M/S/C (Wilson/Berkuta) Approve Reference No. 702.3, Lost/Missing Controlled Drug Reporting Form, with above recommendations.

Reference No. 702.4

Policy reviewed and approved as written.

M/S/C (Wilson/Berkuta) Approve Reference No. 702.4, Monthly Drug Storage Inspection Form.

Controlled Substance Oversite Clarification:
According to the State Board of Pharmacy and Business & Professions Code 4119, the local EMS Agency does not provide oversite to the ADDS systems. However, non-ADDS controlled substance programs, must have departmental policies that are to be followed and submitted to the local EMS Agency. For providers who utilize ADDS, only the controlled substance logs from ALS units will be reviewed by the EMS Agency for proper documentation.

5.7 Reference No. 1200.1, Treatment Protocol: General Instructions *(Nichole Bosson, MD)*

Policies review and approved as written.

M/S/C (Zabilski/Wilson) Approve Reference No. 1200.1, Treatment Protocol: General Instructions.

5.8 Reference No. 1200.2, Treatment Protocol: Base Contact Requirements *(Nichole Bosson, MD)*

Policies review and approved as written.

M/S/C (Zabilski/Wilson) Approve Reference No. 1200.2, Treatment Protocol: Base Contact Requirements.

5.9 Reference No. 1200.3, Treatment Protocol: Provider Impressions *(Nichole Bosson, MD)*

Policies review and approved as written.

M/S/C (Zabilski/Wilson: Approve Reference No. 1200.3, Treatment Protocol: Provider Impressions.

5.10 Reference No. 1200.4, Treatment Protocol: BLS Upgrade to ALS Assessment *(Nichole Bosson, MD)*

Policy review and approved with the following recommendations:

- Guidelines: 4. C. i. – Remove "Abdominal pain"
- Change definition of "abnormal vital signs" to be more concerning/unacceptable values, as it pertains to when BLS unit calls for ALS assessment. Final decision of "abnormal vital signs" thresholds will be deferred to the EMS Agency.

M/S/C (Berkuta/Leasure) Approve Reference No. 1200.4, Treatment Protocol: BLS Upgrade to ALS Assessment, with above recommendations.

5.11 Reference No. 1210, Treatment Protocol: Non-Traumatic Cardiac Arrest (Adult) *(Info Only)*
(Nichole Bosson, MD)

Policy presented as information only.

6. **OPEN DISCUSSION:**

   No open discussions.

7. **NEXT MEETING:** June 20, 2018

8. **ADJOURNMENT:** Meeting adjourned at 3:00 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **SPECIALTY CARE TRANSPORT PROVIDER** REFERENCE NO. 414

PURPOSE: To define the criteria to be approved as a Registered Nurse/Respiratory Specialty Care Transport (SCT) Provider in Los Angeles County.

AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.52, 1797.178, 1798.170, and 1798.172.
Business and Professions Code, Section 3700-3706
Emergency Medical Treatment and Labor Act of 2006
Los Angeles County Code, Title 7. Chapter 7.16. Ambulances
Los Angeles County Code, Title 7 Chapter 7.08. Denial or Revocation Conditions

DEFINITIONS:

Advanced Life Support (ALS) Transport: A ground or air ambulance transport of a patient who requires or may require skills or treatment modalities that do not exceed the paramedic scope of practice. An ALS transport may be required for either a non-emergency or emergency transport.

Basic Life Support (BLS) Transport: A ground or air ambulance transport of a patient who requires skills or treatment modalities that do not exceed the Los Angeles County EMT scope of practice. A BLS transport may be sufficient to meet the needs of the patient requiring either non-emergency or emergency transport.

Registered Nurse-Staffed SCT (RN-SCT): A ground or air ambulance interfacility transport of a patient who may require skills or treatment modalities that exceed the paramedic scope of practice, but do not exceed the RN scope of practice. A nurse-staffed SCT may be required for either a non-emergency or emergency interfacility transport.

Respiratory Care Practitioner Staffed SCT (RCP-SCT): A ground or air ambulance interfacility transport of a patient who requires the skills or treatment modalities that exceed the Los Angeles County EMT scope of practice, but does not exceed the RCP scope of practice. A RCP-staffed SCT may be required for either a non-emergency or emergency interfacility transport.

Specialty Care Transport (SCT): An interfacility transport of a critically injured or ill patient by a ground vehicle, including the provision of the medically necessary supplies and services, at a level of service beyond the scope of practice of the paramedic.

PRINCIPLES:

1. A private ambulance provider must be licensed by the County of Los Angeles as a basic life support (BLS) provider in order to be eligible for approval as a SCT provider.

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

2. A BLS private ambulance provider must be approved by the EMS Agency to employ registered nurses (RNs) and/or respiratory care practitioners (RCPs) to staff and provide interfacility SCTs.

3. Staffing a SCT vehicle/unit consists of a minimum of one RN and/or RCP and two EMTs. Physicians, RNs, RCPs, perfusionists, or other personnel may be added to the SCT team as needed.

4. RCPs may be utilized to perform duties commensurate with their scope of practice; however, additional transport personnel (EMTs, RNs, physicians, or paramedics) must accompany the RCP based on the level of acuity and anticipated patient care requirements.

5. This policy does not apply when RNs and/or RCPs employed by a healthcare facility are utilized by an ALS or BLS provider agency to provide interfacility patient transport (i.e., emergent situations, specialized transport teams, etc.).

6. Any violation of this policy or ordinance could result in a program request denial or the cancellation of a provider's SCT program.

POLICY:

I. Eligibility Requirements

A BLS ambulance provider licensed by Los Angeles County may be approved to utilize RNs and/or RCPs to provide interfacility transports if the eligibility requirements outlined in this policy are met.

A. Transport Medical Director

1. Provider shall have a medical director who is currently licensed as a physician in the State of California, qualified by training and/or experience, current practice in acute critical care medicine and board certified or eligible by the American Board of Emergency Medicine or in their corresponding specialty.

2. The Medical Director or designee of the EMS Agency must approve all Transport Medical Director Candidates.

3. The Transport Medical Director shall:

a. Sign and approve, in advance, all medical protocols and SCT policies and procedures.

b. Oversee the ongoing training of all SCT medical personnel.

c. Be familiar with the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements.

d. Attend the EMS Orientation Program within six months of

employment as a Transport Medical Director.

e. Participate in the development, implementation, and ongoing evaluation of a quality improvement (QI) program.

f. Sign and submit Ref. No. 701.1, Provider Agency Drug Authorizing Physician Confirmation of Agreement to Purchase Drugs and Medical Supplies for the SCT provider.

g. Sign and submit Ref. No. 702.4, Provider Agency Medical Director Notification of Controlled Substance Program Implementation for the SCT provider (if applicable).

B. Transport Coordinator

1. RN Coordinator: Providers utilizing RNs to staff SCTs shall have a Coordinator who is currently licensed in the State of California as a RN, meets all minimum requirements of a transport RN, has a minimum of one year experience in ambulance transports, and current practice in emergency medicine, critical care nursing or specialty care transports (minimum of 96 working hours annually).

2. RCP Coordinator: Providers utilizing RCPs to staff SCTs shall have a RCP Coordinator who is currently licensed in the State of California as a RCP, meets all minimum requirements of a transport RCP, has a minimum of one year experience in ambulance transports, and current practice in acute respiratory care or specialty care transports (minimum of 96 working hours annually).

   The RN Coordinator may function as the RCP Coordinator; however, the RCP Coordinator may NOT function as the RN Coordinator.

3. The Transport Coordinator shall:

   a. Sign and approve, in advance, all policies and procedures to be followed for SCTs.

   b. Maintain documentation indicating that all SCT personnel have been oriented to the RN/RCP-staffed SCT program.

   c. Maintain documentation of all applicable licensure, certification and/or accreditation requirements for all SCT personnel.

   d. Be familiar with EMTALA and HIPAA.

   e. Ensure the development, implementation and ongoing evaluation of a QI program in collaboration with the Transport Medical Director.

   f. Attend the EMS Agency Orientation Program within six months of employment as Transport Coordinator.

g. Perform annual skills competency evaluation of all medical personnel.

h. Submit a written and signed affirmation of adherence to all federal, state, and local rules, regulations and laws, including Los Angeles County prehospital care policies and procedures as outlined in Title 7, Chapter 7.16, Ambulances.

C. Transport Personnel

1. Two EMTs comprise the BLS interfacility transport team; additional personnel (physicians, RNs, and/or RCPs) shall be added to the BLS team based on the acuity and anticipated needs of the patient during transport.

   Staffing exceptions must be approved by the EMS Agency prior to utilization by the ambulance provider.

2. RNs, RCPs and EMTs shall:

   a. Be currently licensed or certified for unrestricted practice in California.

   b. Be currently certified by AHA or equivalent in healthcare provider level cardiopulmonary resuscitation (CPR).

   c. Successfully complete a RN/RCP Staffed Interfacility SCT Program Orientation sponsored by the provider agency and approved by the EMS Agency.

   d. Successfully complete an annual skills competency evaluation conducted by the provider agency and approved by the EMS Agency.

   e. Be familiar with EMTALA and HIPAA.

   f. Submit a written and signed affirmation of adherence to all federal, state, and local rules, regulations and laws, including Los Angeles County prehospital care policies and procedures as outlined in Title 7, Chapter 7.16, Ambulances.

3. In addition to the requirements listed in Section I. C. 2. all transport RNs shall:

   a. Have a minimum of two years nursing experience in a critical care area relevant to the type of SCT transports the RN will provide (pediatric vs. adults), within the previous 18 months prior to employment as a transport nurse.

   b. Be currently certified in Advanced Cardiac Life Support (ACLS)

and, if participating in pediatric transports, currently certified in Pediatric Advanced Life Support (PALS).

c. For full-time transport nurses, complete a total of 30 continuing education (CE) contact hours approved by the California Board of Registered Nursing (BRN) annually, that are relevant to their clinical setting and types of transports performed.

d. For part-time (working less than 32 hours per week as a transport RN), complete 96 hours of documented critical care experience per year or complete a total of 30 CE contact hours approved by the California BRN annually, that are relevant to their clinical setting and type of transports performed.

e. Recommendation: Certified Emergency Nurse (CEN), Critical Care Registered Nurse (CCRN), and/or Mobile Intensive Care Nurse (MICN).

4. In addition to the requirements listed in Section I. C. 2., all transport RCPs shall:

a. Have a minimum of two years respiratory care experience in an acute care or respiratory care hospital, relevant to the type of SCT transports the RCP will provide (pediatric vs. adults), within 18 months prior to employment as a transport RCP or have successfully passed the Adult Critical Care Specialty (ACCS) Examination, and are in good standing with the National Board for Respiratory Care (NBRC).

b. Be current in ACLS and, if participating in pediatric transports, be current in PALS.

c. For full-time transport RCPs, complete 30 CE contact hours approved by the Respiratory Care Board of California annually, that are relevant to their clinical setting and type of transports performed.

d. For part time transport RCPs (working less than 32 hours per week as a transport RCP), complete 96 hours of documented critical care experience per year or complete a total of 30 CE contact hours approved by the Respiratory Care Board of California annually, that are relevant to their clinical setting and type of transports performed.

D. Subcontracting SCT Services

1. If the licensed BLS provider intends to subcontract SCT services, the EMS Agency must be notified in advance for approval.

2. The subcontracting company must submit program information through the licensed BLS provider to the EMS Agency for approval prior to

providing SCT services.

3. Subcontractors must meet the same standards/requirements as the ambulance provider, including insurance.

E. Insurance Requirements

1. It is the ambulance provider agency's responsibility to ensure insurance requirements are maintained as required by the Los Angeles County Code of Ordinance.

2. Minimum insurance levels must be maintained as outlined in Title 7, Chapter 7.16, Ambulances, with the exception of Professional Liability. Professional Liability limits must be maintained at $2,000,000 per claim and $3,000,000 per aggregate.

F. Policies and Procedures

Provider shall have a policy and procedure manual that includes, at a minimum, the following:

1. A description of the interfacility transport orientation program and process utilized to verify skill competency for registered nurses, EMTs, RCPs and, if applicable, other medical personnel.

2. Identify the Transport Medical Director, and RN and/or RCP Transport Coordinator. The EMS Agency shall be notified in writing of any changes in these key personnel utilizing Ref. No. 621.1, Notification of Personnel Changes.

3. Procedures for contacting the Transport Medical Director and SCT Coordinator if needed during a patient transport.

4. Interfacility transfer paperwork that complies with Title 22, Section 70749.

5. Record retention procedures which meets the requirements listed in Ref. No. 608, Retention and Disposition of Prehospital Patient Care Records.

6. The sending physician's Statement of Responsibility for the patient during transfer in accordance with EMTALA.

7. Procedures to be followed for changes in destination due to unforeseen changes in the patient's condition or other unexpected circumstances.

8. Current patient care protocols which have been approved by the Transport Medical Director.

9. A controlled drug policy which meets the requirements of Ref. No. 701, Supply and Resupply of Designated EMS Units/Vehicles and if applicable, Ref. No. 702, Controlled Drugs Carried on ALS Units.

G. Quality Improvement (QI) Program

1. The Provider Agency shall have a QI Program that meets the standards outlined in Ref. No. 618, EMS Quality Improvement Program Committees, and Ref. No. 620, EMS Quality Improvement Program.

2. Records of QI activities shall be maintained by the provider and available for review by the EMS Agency.

H. Required Equipment

1. Each transport vehicle shall include as minimum standard inventory all items required by Ref. No. 710, Basic Life Support Ambulance Equipment.

2. RN staffed SCT vehicles shall also be equipped with the standardized inventory specified in Ref. No. 712, Nurse Staffed Critical Care Inventory.

3. RCP staffed SCT vehicles shall also be equipped with the standardized inventory specified in Ref. No. 713, Respiratory Care Practitioner Staffed Critical Care Inventory.

4. In addition, each transport vehicle shall have equipment and supplies commensurate with the scope of practice of any additional transport medical personnel (e.g. balloon pump technicians, neonatal intensive care unit transport teams, etc.) staffing the SCT unit. This requirement may be fulfilled through the utilization of appropriate kits (cases/packs), which must be removed if the vehicle is being utilized for BLS transport purposes.

5. Biomedical equipment used for patient care must show evidence of ongoing maintenance and safety certification (e.g., service agreements, calibration logs, etc.).

II. Application Process and Program Review

Request for approval of a SCT program must be made in writing to the Director of the Los Angeles County EMS Agency and shall include the following:

A. Specify the type of SCT services the provider will supply (RN-SCT, RCP-SCT or both).

B. Proposed identification and location of the SCT units.

C. Procedures and protocols as outlined in Section I. F.

D. Documentation of qualifications of the proposed Transport Medical Director (resumé/curriculum vitae, copy of medical license and applicable board certification).

E. Documentation of qualifications of the proposed SCT Coordinator(s) (resumé(s)

or curriculum vitae, copy of current license(s) and certifications).

F. Copy of the current QI Plan (include specific indicators which will be utilized to monitor the SCT program) as outlined in Section I. G.

G. Statement acknowledging agreement to comply with all policies and procedures of the EMS Agency, including immediate notification in writing of a change in Transport Medical Director, or SCT Coordinator (Ref. No. 621.1).

H. The documents needed for approval of a SCT program are due to the EMS Agency as a **complete** packet within 30 (thirty) days of receipt of letter from the EMS Agency acknowledging the request for approval. If a complete packet (application) is not received within a 30 (thirty) day period, the request will be denied. A subsequent request for approval will not be accepted for 90 (ninety) days. This will result in the providers' inability to provide SCT services until approved by the EMS Agency.

III. Program Review

A. The EMS Agency shall perform periodic on-site audits of transport records, QI processes, equipment/vehicle inspections, and personnel qualifications to ensure compliance with this policy.

B. Non-compliance with this policy may lead to the EMS Agency suspending or revoking approval of the SCT program.

C. SCT programs that do not operate for a period of 6 consecutive months or greater, may result in program suspension or termination.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 414.4 **Verification of Employment Letter**
Ref. No. 421 **Private Ambulance Operator Medical Director**
Ref. No. 517, **Provider Agency Transport/Response Guidelines**
Ref. No. 608, **Retention and Disposition of Prehospital Patient Care Records**
Ref. No. 618, **EMS Quality Improvement Program Committees**
Ref. No. 620, **EMS Quality Improvement Program**
Ref. No. 701, **Supply and Resupply of Designated EMS Units/Vehicles**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**
Ref. No. 710, **Basic Life Support Ambulance Equipment**
Ref. No. 712, **Nurse Staffed Critical Care Unit Inventory**
Ref. No. 713, **Respiratory Care Practitioner (RCP) Critical Care Unit Inventory**
Ref. No. 802, **Emergency Medical Technician (EMT) Scope of Practice**
Ref. No. 803, **Los Angeles County Paramedic Scope of Practice**

Business and Professions Code:
California Nursing Practice Act, Section 2725
California Respiratory Care Practice Act, Sections 3700 et al
Centers for Medicare & Medicaid Services, Department of Health and Human Services
Title 22, California Code of Regulations Division 5, Section 70749

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC)

SUBJECT: **CONTROLLED DRUGS CARRIED ON ALS UNITS** REFERENCE NO. 702

PURPOSE: To ensure accountability for all controlled drugs issued to Advanced Life Support (ALS) units.

AUTHORITY: Health and Safety Code, Chapter 5, 1797.220 and 1798
California Business and Professions Code, Section 4005 and 4119 .01, 4034.5, 4205.5
Department of Justice, DEA Regulations, Title 21, Code of Federal Regulations, Section 1300-END
Controlled Substances Act, 21 USC 801-890

DEFINITIONS:

Provider Agency Medical Director: A physician who has been appointed by an approved EMS Provider Agency and meets the criteria outlined in Ref. No. 411, Provider Agency Medical Director, agrees to procure controlled drugs under their DEA Registrant, and provide medical oversight of the prehospital care program of the Provider Agency, advise and coordinate the medical aspects of field care

Automated Drug Delivery System (ADDS): A mechanical pharmaceutical storage and dispensing system that utilizes computer-controlled tracking of medications.

PRINCIPLES:

1. Effective controls and procedures are essential to guard against theft and diversion of controlled drugs due to the risks associated with mishandling of these drugs.

2. Controlled drugs will be restocked and stored only in full amounts. Unused, partial doses shall be discarded appropriately.

3. Providers shall carry only one narcotic analgesic on the ALS units. Provider Agency Medical Directors who intend to carry Fentanyl, in lieu of morphine sulfate, shall contact the EMS Agency's Medical Director for approval.

4. Provider agencies may utilize an ADDS for storage and dispensing of controlled drugs.

5. It is the responsibility of the Provider Agency Medical Director to be knowledgeable of the Federal, State, and local regulations that govern controlled drugs.

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

QUANTITIES OF CONTROLLED DRUGS TO BE CARRIED ON ALS UNITS:

Fentanyl:	100mcg unit dose, minimum amount 500mcg not to exceed 1500mcg unless otherwise approved by the EMS Agency Medical Director.
Morphine sulfate:	4mg unit dose, minimum amount 32mg not to exceed 60mg unless otherwise approved by the EMS Agency Medical Director.
Midazolam (Versed®):	5mg unit dose, minimum amount 20mg not to exceed 40mg unless otherwise approved by the EMS Agency Medical Director.

POLICY:

I. Provider Agencies shall obtain Controlled Drugs through its appointed Medical Director.

II. Controlled Drug Program:

A. Provider agencies shall maintain a controlled drug program in accordance with the policies and procedures set forth by the EMS Agency.

B. Provider agencies shall have a policy(s) in place, approved by the EMS Agency, which address, at minimum, the following:

1. Description of the methodology (safe, etc.) utilized to store controlled drugs in locations other than the ALS unit(s).

2. Description of the procedure used to track inventory control (restocking and dispensing) of controlled drugs.

3. Description of procedure for restocking controlled drugs on an ALS unit(s).

4. Identify the level of personnel who have access to the controlled drug storage area.

III. Controlled Drug Security:

A. Controlled drug security requirements apply to all provider agencies.

B. Paramedics assigned to an ALS unit shall be responsible for maintaining the correct controlled drug inventory and security of the drug keys (or confidentiality of the keypad/padlock combination) for their assigned unit at all times.

C. Controlled drugs shall not be stored in any location other than on ALS units or ADDS. Alternate storage areas shall be authorized by the EMS Agency. The initial authorization process requires EMS Agency inspection of the storage facility and approval of the provider agency internal policy specifying the location, security, access, and procedure for obtaining drugs from the alternate controlled drug locations.

D. Controlled drugs shall be secured on the ALS units under double lock. Provider agencies that have more than one approved ALS unit must have unique double locking mechanisms for each ALS unit.

E. Daily Inventory Procedures of controlled drugs on an ALS unit:

1. Controlled drugs shall be inventoried by physical count by two paramedics at least daily, and anytime there is a change in personnel.

2. The key to access controlled drugs shall be in the custody of the individual who performed the inventory.

3. The Daily Controlled Drug Inventory Form, Ref. No. 702.2 or its equivalent, shall be co-signed with the names of the relinquishing and the receiving paramedic. Entries shall be in blue or black ink only, or electronic equivalent.

4. Errors shall be corrected by drawing a single line through the incorrect wording; the writing underneath the single line must remain readable. The individual making the change should initial adjacent to their correction. Correction fluid or other erasure material is not permitted.

5. The Daily Controlled Drug Inventory Form, Ref. No. 702.2 or its equivalent, must be maintained by the provider agency for a minimum of three years. An entry shall be made on this form for each of the following situations:

    a. Change of shift.

    b. Any change to the controlled drug inventory.

    c. Any time there is a change of responsible personnel.

    d. Providers authorized to participate in the 1:1 Staffing Program for Interfacility Transports are required to inventory controlled drugs at the end of the specified shift, when two paramedics are available to count and co-sign for the drugs.

F. Lost or Missing Controlled Drug

1. Any lost, missing, or discrepancy of controlled drugs shall be reported by the following business day (telephone notification is acceptable) to the paramedic coordinator, the EMS Agency, and the authorizing Provider Agency Medical Director. Verbal notification must be followed by a written report within three business days including completion of Ref. No. 702.3, Lost/Missing Controlled Drug Reporting Form.

2. A police report must be completed for any missing, lost, or suspected diversion of a controlled drug.

3. Any significant loss, breakage, or discrepancy in the count requires notification to the DEA, utilizing DEA Form 106 or electronically via the DEA web site, within one business day of discovery.

4. Any loss shall initiate supervisory review at the involved provider agency. If a provider agency's internal investigation into a controlled drug loss exceeds 30 days, the provider shall submit a status update to the Provider Agency Medical Director and the EMS Agency at the 30th day.

G. Disposal of controlled drugs

The provider agency shall dispose of expired controlled drugs through a DEA licensed pharmaceutical reverse distributor and/or by implementing the guidelines outlined in the Code of Federal Regulations, 1317, Disposal of Controlled Substance by Registrants.

IV. Record Keeping:

A. All controlled drugs issued to a provider agency must be accounted for. The provider agency shall retain a copy (printed or electronic) of the Patient Care Record (PCR) for each patient to whom a controlled drug was administered and maintain it with any completed controlled drug inventory and report forms, drug orders, invoices, or other associated documentation in a separate file for a minimum of three years.

B. If the total amount of the drug is not administered, the remaining amount shall be wasted at the receiving facility, or in a container approved for destruction of controlled drugs.

1. Document the amount of wasted drugs (partial or whole) in the "Drug Waste/Witness" section of the PCR.

2. Obtain the signature of the witness who observed the disposal of the remaining solution and print the witness' name on the PCR. A witness shall include a registered nurse, physician, pharmacist, or if none of these options are available, a second paramedic with a current California paramedic license.

C. Controlled drug inventories and logs are subject to inspection by the EMS Agency, the issuing pharmacy, the California Board of Pharmacy, and agents of the Bureau of Narcotic Enforcement Administration of the Department of Justice, and the Federal Drug Enforcement Administration.

V. ADDS

Provider agencies that use ADDS for storage and dispensing of controlled drugs are responsible for ensuring compliance with State and Federal regulations as it relates to implementing and maintaining the system.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 214 **Base Hospital and Provider Agency Reporting Responsibilities**
Ref. No. 411, **Provider Agency Medical Director**
Ref. No. 606, **Documentation of Prehospital Care**

Ref. No. 607, **Electronic Submission of Prehospital Data**
Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
Ref. No. 702.1, **Provider Agency Medical Director Notification of Controlled Drug Program Implementation**
Ref. No. 702.2 **Daily Controlled Drug Inventory Form**
Ref. No. 702.3 **Lost / Missing Controlled Drug Reporting Form**
Ref. No. 702.4 **Monthly Drug Storage Inspection Form**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **PROVIDER AGENCY MEDICAL DIRECTOR NOTIFICATION OF CONTROLLED DRUG PROGRAM IMPLEMENTATION** REFERENCE NO. 702.1

I_____ am a physician licensed by the State of California to practice medicine, and authorized by the U.S. Department of Justice - Drug Enforcement Administration to purchase schedule II - IV controlled drugs. My DEA registration number is _____. I have current knowledge of all Federal, State and County Regulations governing controlled drug procurement and administration and will assume total responsibility for the controlled drug "program" at _____, Fire Department/Approved ALS Provider Agency, including but not limited to, procurement, storage, control, safeguards, recordkeeping, disposal, and inventory.

Physician	Fire Chief/CEO/President
_____	_____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
Date	Date

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DAILY CONTROLLED DRUG INVENTORY FORM** REFERENCE NO. 702.2

Provider Agency: _____ ALS Unit: _____

DATE	TIME	MIDAZOLAM 5 mg/1 ml Maximum 8 unit doses				MORPHINE SULFATE 4 mg/1 ml Maximum 15 unit doses				FENTANYL 100 mcg/2 ml Maximum 15 unit doses				SIGNATURE/LICENSE # RELINQUISHING PERSONNEL	SIGNATURE/LICENSE # RECEIVING PERSONNEL
		Start	Out (-)	In (+)	Total	Start	Out (-)	In (+)	Total	Start	Out (-)	In (+)	Total		

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **LOST / MISSING CONTROLLED DRUG REPORTING FORM** REFERENCE NO. 702.3

1. Provider Agency: _____ Unit number: _____

2. The following drug(s) and quantities are being reported as missing:

Drug	# of syringes or equivalent	Strength	Total
Fentanyl			mcg
Midazolam			mg
Morphine Sulfate			mg

3. Date and time narcotic loss was discovered: ____/____/____ @ ___:___

4. Date and time reported to the medical director: ____/____/____ @ ___:___

5. Date and time reported to the paramedic coordinator, or designee: ____/____/____ @ ___:___

6. Date and time reported to the EMS Agency: ____/____/____ @ ___:___

7. Print name and title of individual(s) who discovered the narcotic loss:

_____

_____

8. Print name and title of individual(s) who last completed the Daily Controlled Drug Inventory:

_____

_____

9. If missing, provide a detailed description of the incident (attach additional pages as needed):

_____

_____

10. Date and time missing controlled drug reported to the local police department:

____/____/____ @ ___:___ Police report number: _____

11. Print name/title of person completing this form: _____

Signature: _____ Date completed: ____/____/____

12. Paramedic Coordinator's Signature: _____

13. EMS Agency Representative Signature: _____

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **MONTHLY DRUG STORAGE INSPECTION FORM** REFERENCE NO. 702.4

Provider Agency: _____ ALS Unit: _____

Date/Time Monthly Drug Storage Inspection Form conducted: _____

VERIFY THE FOLLOWING ITEMS:	YES	NO
1. Controlled drugs are adequately locked and secured.		
2. Expiration dates were verified. Indicate any expired drugs: _____		
3. Controlled drug physical inventory count matches documentation.		
4. All forms are complete and legible including:		
a. RN printed name and signatures and clearly displayed.		
b. Paramedic signatures and license numbers clearly displayed.		
c. Name of drug and amount wasted clearly noted.		
5. Other Findings:		
6. Recommendations:		
7. Actions Taken:		
8. Comments:		
INSPECTOR'S NAME/TITLE:		
INSPECTOR'S SIGNATURE		

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC, MICN)

SUBJECT: **PRIVATE PROVIDER NON 9-1-1 ADVANCED LIFE SUPPORT UNIT INVENTORY**

REFERENCE NO. 703.1

PURPOSE: To provide a standardized minimum inventory for private provider agencies approved for Advanced Life Support (ALS) interfacility transfers.

PRINCIPLE: Any equipment or supplies carried for use in providing emergency medical care must be maintained in good working order.

POLICY:

I. Providers may only carry one narcotic analgesic on the ALS units. Provider Agency Medical Directors may request approval from the EMS Agency's Medical Director to carry Fentanyl.

II. ALS Units shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency. Transport vehicles shall also be equipped and supplied according to the Department of the California Highway Patrol, California Administrative Code, Title 13.

III. All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens.

MEDICATIONS* (minimum required amounts)			
Adenosine	**24mgs**	Epinephrine (0.1mg/mL)	**5mgs**
Albuterol (pre-mixed with NS)	**10mgs**	Fentanyl [1, 2]	**500mcgs**
Amiodarone	**450mgs**	Midazolam [3]	**20mgs**
Aspirin (chewable 81 mg)	**648mgs**	Morphine sulfate [4]	**20mgs**
Atropine sulfate (1 mg/10 ml)	**3mgs**	Naloxone	**4mgs**
Calcium Chloride	**1gm**	Normal saline (for injection)	**2 vials**
Dextrose solution (glucose paste may be substituted)	**45gms**	Nitroglycerin (SL) spray, tablets, or single dose powder packets	**1 pump/ bottle/ or 10 DOSE packets**
Dextrose 10% / Water 250 mL	**2**	Ondansetron 4mg ODT	**16mgs**
Diphenhydramine	**50mgs**	Ondansetron 4mg IV	**16mgs**
Epinephrine (1mg/mL)	**5mgs**		
INTRAVENOUS FLUIDS (minimum required amounts)			
1000 ml normal saline	**4 bags**	250 or 500 ml normal saline	**2 bags**

APPROVED: _____ Director, EMS Agency

_____ Medical Director, EMS Agency

SUPPLIES* (minimum required amounts)			
Adhesive dressing (Band-Aids®)	**1 box**	Hemostats, padded	**1**
Airways – Nasopharyngeal		Intravenous catheters Sizes 16G-22G	**5 each**
Large (34-36)	**1**	Intravenous Tubing	**6**
Medium (26-28)	**1**	King LTS-D (Disposable Supraglottic Airway w/ 60mL Syringe)	
Small (20-22)	**1**	Small Adult (Size 3)	**1**
Airways – Oropharyngeal		Adult (Size 4)	**1**
Large	**1**	Large Adult (Size 5)	**1**
Medium	**1**	Lancets (automatic retractable)	**5**
Small Adult/Child	**1**	Laryngoscope Handle Adult (compatible w/ pediatric blades)	**1**
Infant	**1**	Laryngoscope Blades	
Neonate	**1**	Adult, curved and straight	**1 each**
Alcohol prep pads	**1 box**	Pediatric, Miller #1 & #2	**1 each**
Backboards	**2**	Magill Forceps Adult & Pediatric	**1 each**
Bag-valve device with O_2 inlet and reservoir Adult & Pediatric	**1 each**	Mucosal Atomization Device (MAD)	**2**
Bag-valve mask		Needle, filtered-5micron [6]	**2**
Large	**1**	Normal saline for irrigation	**1 bottle**
Medium	**1**	OB pack and bulb syringe [7]	**1**
Small Adult/Child	**1**	Oxygen cannulas	**3**
Infant	**1**	Oxygen Masks (non-rebreather) Adult & Pediatric	**3 each**
Neonate	**1**	Pediatric Length-Based Resuscitation Tape (Broselow 2011A or newer)	**1**
Burn pack or burn sheets	**1**	Personal Protective Equipment - mask, gown, eye protection	**1 each per provider**
Cervical collars (rigid)		Pulse Oximeter	**1**
Adult (adjustable)	**4**	Radio transmitter receiver (Hand-Held) [8]	**1**
Pediatric	**2**	Saline locks	**4**
Cardiac Monitor-Defibrillator with oscilloscope	**1**	Scissors	**1**
Color Code Drug Doses LA County Kids Reference No. 1309	**1**	Sphygmomanometer Adult, Pediatric, & Thigh	**1 each**
Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5" 14G	**1**	Splints – (long and short)	**2 each**
Contaminated needle container	**1**	Splints – traction Adult & Pediatric	**1 each**
Defibrillator pads or paste (including pediatric)	**2 each**	Stethoscope	**1**
ECG Electrodes Adult & Pediatric	**6 each**	Suction Unit (portable) w/adapter	**1**
Endotracheal tubes with stylets Sizes 6.0-8.0	**1 each**	Suction Instruments Sizes 8Fr.-12Fr. Catheters	**1 each**
End Tidal CO_2 Detector or Aspirator (Adult)	**1**	Tonsillar Tip	**1**
Extrication device or short board	**1**	Syringes 1ml – 60ml w/luer adapter	**assorted**

SUPPLIES* (minimum required amounts)			
Flashlight or Penlight	1	Hand-held nebulizer pack	2
Gauze bandages	5	Tape (various types, must include cloth)	1
Gauze sponges 4x4 (sterile)	12	Tourniquets	2
Gloves Sterile	2 pair	Tourniquets (commercial for bleeding control)	2
Gloves Unsterile	1 box	Tube Introducer	2
Glucometer with strips	1	Vaseline gauze	2

SUPPLIES* (approved optional equipment)	
Continuous Positive Airway Pressure (CPAP) Device [2]	Mechanical CPR device [2]
Glucagon	Pediatric Laryngoscope Handle FDA-Approved
Hemostatic Dressings [2]	Resuscitator with positive pressure demand valve (flow rate not to exceed 40L/min)
Impedance Threshold Device [2]	Sodium Bicarbonate
Lidocaine 2% [2, 9]	Transcutaneous Pacing [2]
Intraosseous Device [2]	Waveform Capnography

[1] Fentanyl carried on ALS Unit is not to exceed 1500mcgs.
[2] Requires EMS Agency approval, which includes an approved training program and QI method prior to implementation
[3] Midazolam carried on ALS Unit is not to exceed 40mgs.
[4] Morphine sulfate carried on ALS Unit is not to exceed 60mgs.
[6] Optional, if not utilizing glass ampules
[7] OB Kits with clamps / scissors (no scalpels)
[8] Los Angeles County Department of Communications, Spec. No. 2029/2031/2033
[9] Utilized with infusions through IO access

This policy is intended as a Private Provider ALS Unit inventory only. Supply and resupply shall be in accordance with Ref. No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**
Ref. No. 710, **Basic Life Support Ambulance Equipment**
Ref. No. 712, **Nurse Staffed Critical Care Transport (CCT) Unit Inventory**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **NURSE STAFFED SPECIALTY CARE TRANSPORT UNIT INVENTORY** REFERENCE NO. 712

PURPOSE: To provide a standardized minimum inventory on all Nurse Staffed Specialty Care Transport (SCT) Units.

PRINCIPLE: Any equipment or supplies carried for use in providing emergency medical care must be maintained in good working order.

POLICY:

I. Nurse staffed SCT vehicles shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency. Transport vehicles shall also be equipped and supplied according to Ref. No. 710, Basic Life Support Ambulance Equipment.

II. Nurse staffed vehicles performing advanced life support (ALS) level transports do not require the addition of the ALS inventory; however, if nurses are utilized in lieu of respiratory care practitioners (RCPs) for the transport of ventilator patients, all medications and equipment on Reference No. 713, Respiratory Care Practitioner (RCP) SCT Unit Inventory and not included herein, must be added to the SCT unit.

III. All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens.

MEDICATIONS* (minimum required amounts)			
Adenosine	**24mgs**	Dopamine (premix or vials)	**800mgs**
Albuterol (pre-mixed with NS)	**20mgs**	Epinephrine (1mg/mL)	**1mgs**
Amiodarone	**450mgs**	Epinephrine (0.1mg/mL)	**5mgs**
Aspirin (chewable 81 mg)	**648mgs**	Fentanyl [1]	**500mcgs**
Atropine sulfate (1 mg/10 ml)	**4mgs**	Lidocaine	**200mgs**
Calcium chloride	**1gm**	Midazolam [2]	**20mgs**
Dextrose 10% / Water 250 mL	**3**	Morphine sulfate [3]	**20mgs**
Dextrose solution (glucose paste may be substituted)	**100gms**	Naloxone	**2mgs**
Diphenhydramine	**100mgs**	Nitroglycerin (SL) spray, tablets, or single dose powder packets	**1 pump/ bottle/ or 36 packets**
INTRAVENOUS FLUIDS (minimum required amounts)			
1000 ml normal saline	**2 bags**	250 ml normal saline	**2 bags**

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_____ Medical Director, EMS Agency

SUPPLIES* (minimum required amounts)			
Adhesive dressing (Band-Aids®)	**1 box**	Gauze bandages	**2**
Airways – Nasopharyngeal		Gauze sponges 4x4 (sterile)	**6**
Large (34-36)	1	Gloves Sterile	**2 pair**
Medium (26-28)	1	Gloves Unsterile	**1 box**
Small (20-22)	1	Glucometer with strips	**1**
Airways – Oropharyngeal		Hand-held nebulizer pack	**2**
Large	1	Hemostats, padded	**1**
Medium	1	Infusion pump with 3 chamber drip capability	**1**
Small Adult/Child	1	Infusion pump tubing	**2 full sets 4 half sets**
Infant	1	Intravenous catheters Sizes 14G-22G	**5 each**
Neonate	1	Intravenous Tubing Macrodrip	**2**
Alcohol prep pads	**1 box**	Microdrip	**2**
Backboards	1	Lancets (automatic retractable)	**5**
Back-up Power source/Adjunct power source (invertor batteries, etc.) Second required if transporting IABP patients	1	Normal saline for irrigation	**1 bottle**
Bag-valve device with O_2 inlet and reservoir Adult & Pediatric	**1 each**	OB pack and bulb syringe [4]	**1**
Bag-valve mask		Oxygen cannulas Adult & Pediatric	**3 each**
Large	1	Oxygen Masks (non-rebreather) Adult & Pediatric	**3 each**
Medium	1	Pediatric Length-Based Resuscitation Tape (Broselow 2011A or newer)	**1**
Small Adult/Child	1	Pulse Oximeter	**1**
Infant	1	Saline locks	**4**
Neonate	1	Scissors	**1**
Cardiac Monitor-Defibrillator	1	Sphygmomanometer Adult, Pediatric, & Thigh	**1 each**
ECG, 12-lead capable	1	Stethoscope	**1**
End tidal CO_2 monitor/Waveform capnography	1	Suction Unit (portable) w/adapter	**1**
Cellular Phone (personal or company supplied)	1	Suction catheters Sizes 8Fr.-12Fr.	**1 each**
Color Code Drug Doses LA County Kids Ref. No. 1309	1	Tonsillar Tip	**1**
Contaminated sharps container	1	Syringes 1ml – 10ml w/luer adapter	**assorted**
Defibrillator pads or paste (including pediatric)	**2 each**	Tape (various types, must include cloth)	**1**
ECG Electrodes Adult & Pediatric	**6 each**	Transcutaneous (external) Pacing	**1**

SUPPLIES* (approved optional equipment)			
Filter needles [5]	**2**	Ondansetron (orally disintegrating tablets)	**12mgs**
Flumazenil	**1mg**	Ondansetron (intravenous) 4mgs/2mls	**12mgs**
Furosemide	**100mgs**	Sodium Bicarbonate	**50mls**
Levalbuterol HCL	**7.5mgs**	Mucosal Atomization Device (MAD)	**2**
Lidocaine (1gm/250ml)	**1bag**	Respiratory Ventilator	**1**
Lopressor	**20mgs**	Impedance Threshold Device	**1**
Lorazepam	**4mgs**	Vasostrict®	**20 units**

[1] Fentanyl carried on ALS Unit is not to exceed 1500mcgs
[2] Midazolam carried on ALS Unit is not to exceed 40mgs
[3] Morphine sulfate carried on ALS Unit is not to exceed 60mgs
[4] OB Kits with clamps / scissors (no scalpels)
[5] Optional, if not utilizing glass ampules

This policy is intended as an SCT Unit inventory only.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 414, **Specialty Care Transport (SCT) Provider**
Ref. No. 710, **Basic Life Support Ambulance Equipment**
Ref. No. 713, **Respiratory Care Practitioner (RCP) Specialty Care Transport (SCT) Unit Inventory**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **RESPIRATORY CARE PRACTITIONER STAFFED SPECIALITY CARE TRANSPORT UNIT INVENTORY** REFERENCE NO. 713

PURPOSE: To provide a standardized minimum inventory on all Respiratory Care Practitioner (RCP) Specialty Care Transport (SCT) Units.

PRINCIPLE: Any equipment or supplies carried for use in providing emergency medical care must be maintained in good working order.

POLICY:

I. RCP staffed SCT vehicles shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency. Transport vehicles shall also be equipped and supplied according to Reference No. 710, Basic Life Support Ambulance Equipment.

II. All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens.

MEDICATIONS* (minimum required amounts)			
Albuterol (pre-mixed with NS)	**30mgs**	Atrovent	**2mgs**
SUPPLIES (minimum required amounts)			
Airways – Nasopharyngeal		Pulse Oximeter probes Adult & Pediatric	**1 each**
Large (34-36)	**1**	Cell Phone (personal or company)	**1**
Medium (26-28)	**1**	Color Code Drug Doses LA County Kids Reference No. 1309	**1**
Small (20-22)	**1**	Coupler/Quick Connect (oxygen connection)	**2**
Airways – Oropharyngeal		End tidal CO_2 detector (portable)	**2**
Large	**1**	$ETCO_2$ Filter line	**6**
Medium	**1**	Endotracheal tubes with stylets Sizes 2.0-8.0	**2 each**
Small Adult/Child	**1**	Gloves (Sterile)	**2**
Infant	**1**	Heat/Moisture Exchange (HME) Ventilator Filters	
Neonate	**1**	Adult	**4**
Airway Guard (bite blocker)	**2**	Pediatrics	**2**
Bag-valve device with O_2 inlet and reservoir Adult & Pediatric	**1 each**	King LTS-D (Disposable Supraglottic Airway Device)	
Bag-valve mask		Small Adult (Size 3)	**1**
Large	**1**	Adult (Size 4)	**1**

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Director, EMS Agency Medical Director, EMS Agency

Medium	1	Large Adult (Size 5)	1
Small Adult/Child	1	Laryngoscope Handle Adult (compatible w/ pediatric blades)	1
Infant	1	Laryngoscope Blades	
Neonate	1	Adult, curved and straight	1 each
Normal Saline Pillows (ampoules/inhalant)	10	Magill Forceps Adult & Pediatric	1 each
Oxygen Masks Adult & Pediatric	3 each	Non-sterile gloves	1 box
Oxygen Hose	1	Sphygmomanometer Adult, Pediatric, & Thigh	1 each
Oxygen Regulator	2	Suction Catheters Sizes 8Fr.-14Fr.	1 each
Oxygen Tree	2	Stethoscope	1
Oxygen Key	2	Syringes 10ml	2
Pediatric Length-Based Resuscitation Tape (Broselow 2011A or newer)	1	Tape (various types, must include cloth)	1
Pediatric Blades		Tracheostomy Mask Adult & Pediatric	2 each
Miller 0	1	Ventilator filters	6
Miller 1	1	Ventilator Circuits (disposable)	
Miller 2	1	Adult	4
PEEP Valve Adult & Pediatric	1 each	Pediatrics	2
Penlight	1	Ventilator (non-pneumatic)	1
Portable Suction	1	Venturi Mask	3
Personal Protective Equipment – mask, gown, eye protection	1 each per provider	Waveform Capnography	
SUPPLIES (approved optional equipment)			
Levalbuterol	7.5mgs		

This policy is intended as a RCP Inventory only.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 414, **Specialty Care Transport (SCT) Provider**
Ref. No. 710, **Basic Life Support Ambulance Equipment**
Ref. No. 712, **Nurse Staffed Specialty Care Transport Unit Inventory**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT/PARAMEDIC/MICN)

SUBJECT: **PATIENT REFUSAL OF TREATMENT/TRANSPORT AND TREAT AND RELEASE AT SCENE** REFERENCE NO. 834

PURPOSE: To provide guidelines for EMS personnel to determine which patients who do not wish to be transported to the hospital have decision-making capacity to refuse EMS treatment and/or transport, and to identify those who may be safely released at scene.

AUTHORITY: California Health and Safety Code, Division 2.5, Sections 1797.220, 1798, (a). California Welfare and Institution Code, Sections 305, 625, 5150, and 5170. Title 22, California Code of Regulations, Section 100169.

DEFINITIONS:

Adult: A person at least eighteen years of age.

Minor: A person less than eighteen years of age.

Minor Not Requiring Parental Consent is a person who:

- Is 12 years or older and in need of care for a reportable medical condition or substance abuse
- Is pregnant and requires care related to the pregnancy
- Is in immediate danger of suspected physical or sexual abuse
- Is an emancipated minor

Emancipated Minor: A person under the age of 18 years is an emancipated minor if any of the following conditions are met:

- Married or previously married
- On active military duty
- The person has received a declaration of emancipation pursuant to Section 7122 of the California Family Code, which includes all of the following: at least fourteen (14) years of age, living separate and apart from their parents and managing their own financial affairs (may be verified by DMV Identification Card)

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

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

The lack of decision-making capacity may be:

- Temporarily lost (e.g., due to unconsciousness, influence of mind altering

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Director, EMS Agency Medical Director, EMS Agency

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

Emergency Medical Condition: A condition or situation in which an individual has an immediate need for medical attention. The presence of abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure – except isolated asymptomatic hypertension, oxygen saturation) are also indications of an emergency medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital Notification are also considered to have an emergency medical condition.

Implied Consent: This is a type of consent involving the presumption that an unconscious or a person lacking decision-making capacity would consent to lifesaving care. This shall include minors with an emergency medical condition and a parent or legal representative is not available.

Medical Home: A team-based health care delivery model, which is led by a health care provider (i.e., primary care physician) to provide continuous, coordinated, and comprehensive medical care.

Refusing Care Against Medical Advice (AMA): A patient or a legal representative of a patient who has decision-making capacity to refuses treatment and/or transport for an emergency medical condition.

"Release at Scene" (Patients not requiring transport): A patient who, after an assessment by EMS personnel, does not have an emergency medical condition and does not appear to require immediate treatment and/or transportation. These patients meet one or more of the following conditions:
- Deny a medical condition and decline need for treatment
- Called EMS personnel for assistance for non-medical related issues (i.e., public assists)
- Meet criteria for "Treat and Refer"

"Treat and Refer": A patient who, after an assessment and treatment by EMS personnel, does not have an ongoing emergency medical condition, does not desire transport to the emergency department for evaluation, and is stable for referral to the patient's regular healthcare provider or a doctor's office or clinic.

Psychiatric Hold: A patient who is held against their will for evaluation under the authority of Welfare and Institutions Code (e.g., Section 5150) because the patient is a danger to themselves, a danger to others, and/or gravely disabled (i.e., unable to care for self). This is a written order by law enforcement officer, County mental health worker, or a health worker certified by the County to place an individual on a psychiatric hold.

PRINCIPLES:

1. An adult or emancipated minor who has decision-making capacity has the right to determine the course of their medical care including the refusal of care. These patients must be advised of the risks and consequences resulting from refusal of medical care.

2. A patient less than eighteen (18) years of age, with the exception of minors not requiring parental consent, must have a parent or legal representative to refuse evaluation, treatment, and/or transport for an emergency medical condition.

3. A patient determined by EMS personnel or the base hospital to lack decision-making capacity may not refuse care AMA or be released at scene. Mental illness, drugs, alcohol, or physical/mental impairment may impair a patient's decision-making capacity but are not sufficient to eliminate decision-making capacity. Patients who have attempted suicide, verbalized suicidal intent, or if other factors lead EMS personnel to suspect suicidal intent, should be regarded as lacking the decision-making capacity. Capacity determinations are specific only to the particular decision that needs to be made.

4. A patient on a psychiatric hold may not be released at scene and cannot sign-out AMA. The patient can refuse any medical treatment.

5. At no time are EMS personnel to put themselves in danger by attempting to treat and/or transport a patient who refuses care.

6. A patient or a legal representative of a patient may contact EMS for minor complaints in order to have an assessment performed and determination made of the seriousness of the complaint and need for treatment. In such cases, the EMS personnel may perform an assessment and for those who meet the definition of "Treat and Refer" may be treated at the scene and referred to the patient's medical home or primary care physician. If the patient or legal representative requests that the patient be transported despite assurance that transportation is not needed, EMS personnel should honor the request and transport the patient to the most appropriate receiving facility in accordance with applicable patient destination policies.

7. Patients who refuse treatment and/or transportation, and all those released at the scene are high risk patients and require additional quality review.

8. Certain patients are at increased risk of having a bad outcome if released on scene. These include patients with a medical complaint at extremes of age (≤ 12 months or ≥ 70 years old), patients with abnormal vital signs, and patients with high-risk chief complaints including chest pain, shortness of breath, abdominal pain, gastrointestinal or vaginal bleeding, and syncope. These patients are more challenging to fully evaluate in the field and should be transported to the emergency department.

POLICY:

I. Adult With Decision-Making Capacity or Minor (Not Requiring Parental Consent) Refusing Transport Against Medical Advice

   A. EMS personnel shall advise the patient of the risks and consequences which may result from refusal of treatment and/or transport. The patient should be advised to seek immediate medical care.

   B. If the patient has an emergency medical condition as defined above and a BLS unit is alone on scene, an ALS unit should be requested for evaluation prior to AMA.

C. When base hospital contact is made, contact should be made prior to the patient leaving the scene. Paramedics shall advise the base hospital of all the circumstances including care, transportation, reasons for refusal, and the patient's plans for follow-up care.

D. EMS personnel shall have the patient or their legal representative, as appropriate, sign the release (AMA) section of the Patient Care Record (EMS Report Form/Electronic Patient Care Record/ePCR). The signature shall be witnessed, preferably by a family member.

E. A patient's refusal to sign the AMA section should be documented on the Patient Care Record.

II. Individual Lacking Decision-Making Capacity or a Minor (Requiring Parental Consent)

A. The patient should be transported to an appropriate receiving facility under implied consent. A psychiatric hold is not required.

B. If EMS personnel or the base hospital determines it is necessary to transport the patient against their will and the patient resists, or the EMS personnel believe the patient will resist, assistance from law enforcement should be requested in transporting the patient. Law enforcement may consider the placement of a psychiatric hold on the patient but this is not required for transport.

C. Law enforcement should be involved whenever EMS personnel believe a parent or other legal representative of the patient is acting unreasonably in refusing immediate care and/or transport.

III. Patients Released at Scene

A. EMS personnel shall ensure that the patient does not have an ongoing emergency medical condition and that they or their legal representative as appropriate have the capacity to decline transport.

B. Patients with a medical complaint, and with the following high-risk features, are not appropriate for Release at the Scene and should be transported or sign a refusal of transport against medical advice:

1. Extremes of age (≤ 12 months or ≥ 70 years old)

2. Abnormal vital signs – except isolated asymptomatic hypertension

3. High risk chief complaints including chest pain, shortness of breath, abdominal pain, gastrointestinal or vaginal bleeding, and syncope

C. EMS personnel shall advise the patient or their legal representative as appropriate to seek follow-up treatment or immediate medical care, including re-contacting 9-1-1 if they develop symptoms at a later time. The advice given should be documented on the Patient Care Record. The following statement is recommended: "It appears that you do not require immediate care in the

emergency department. You should seek care with your regular healthcare provider or a doctor's office or clinic within 24 hours. If you have worsening symptoms recontact 9-1-1."

D. EMS personnel should not require patients released at scene, including those treated and referred, to sign the release (AMA) section of the Patient Care Record, as this implies that the patient is at significant risk by not utilizing the EMS system for treatment and/or transportation.

E. If the patient or the patient's legal representative requests that the patient be transported after assurance that transport in not needed; EMS personnel should honor the requests and transport to the Most Accessible Receiving Facility (MAR) for adults and to the closest Emergency Department Approved for Pediatrics (EDAP) for children.

IV. Documentation

A Patient Care Record must be completed for each patient encounter, including those refusing emergency medical evaluation, care and/or transportation against medical advice and those released at scene. EMS personnel shall ensure that documentation includes, at a minimum, the following:

A. Patient history and assessment, including absence of findings of an emergency medical condition or requirement to make Base Contact.

B. Description of the patient which clearly indicates their decision-making capacity.

C. For Refusal of Care Against Medical Advice (AMA):

1. What the patient is refusing (i.e., medical care, transport)

2. Why the patient is refusing care

3. Risk and consequences of refusing care as explained to the patient or legal representative

4. Statement that the patient understands the risks and consequences of refusing care

5. Signature of patient or legal representative refusing care

6. Patient's plan for follow-up care

7. If Treatment Protocol requires Base contact, Base contact should be made prior to leaving the patient on scene

D. For Release at Scene:

1. For Treat and Refer:

a. Assessment for all patients

b. Field treatments

c. Plan for follow-up care

2. For patients with no medical complaint who do not request treatment, document the situation and the assistance that was provided.

E. For Minors, document the relationship of the person(s) to whom the patient is being released.

V. Quality Improvement

Each Provider Agency shall have a quality improvement program to review patient care records for patient who refuse medical care or transport, or who were treated and released without Base Contact.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 832, **Treatment/Transport of Minors**
Ref. No. 1200, **Treatment Protocols**, et al.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **COMMUNICABLE DISEASE EXPOSURE AND TESTING** (EMT, PARAMEDIC, HOSPITALS) REFERENCE NO. 836

PURPOSE: To provide guidelines for EMS personnel exposed to blood, airborne biological agents, or other potentially infectious material.

AUTHORITY: California Health and Safety Code, Division 105, Chapter 3.5, Sections 120260-120263
California Health and Safety Code, Sections 1797.188 -189, 120980, 121050-121070
U.S. Department of Labor-Occupational Safety and Health Administration Bloodborne Pathogens Standard 1910.1030 6-8-2011
California Occupational Safety and Health Standards Exposure Control Plan for Bloodborne Pathogens (2001)
Ryan White HIV/AIDS Treatment Modernization Act of 2006
Code of Federal Regulations, Title 45, Section 164.512.b.4 (October 2007)
California Code of Regulations, Title 8, Section 5193 and 5199

DEFINITIONS:

Aerosol transmissible disease (ATD) or aerosol transmissible pathogen (ATP): A disease or pathogen for which droplet or airborne precautions are required such as tuberculosis (TB), Severe Acute Respiratory Syndrome (SARS), and pertussis.

Airborne infectious disease (AirID): 1) An ATD transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles; 2) a novel (unknown ATP) disease process suspected of being transmitted as above.

Attending physician of the source patient: Any physician or surgeon who provides health care services to the source patient.

Available blood or patient sample: Blood, other tissue, or material legally obtained in the course of providing health care services and in the possession of the physician or other health care provider of the source patient **prior to the release of the source patient from the physician's or health care provider's facility.**

Body Substance Isolation (BSI): A method of infection control designed to approach all body fluids as being potentially infectious. It is the preferred infection control concept for EMS personnel.

Certifying physician: Any physician consulted by the exposed individual for the exposure incident.

Communicable disease: Any disease that is transferable through an exposure incident, as determined by the certifying physician.

APPROVED:

Director, EMS Agency

Medical Director, EMS Agency

Designated officer: An official or officer designated by the prehospital emergency medical services provider or private ambulance company. This person is responsible for coordinating communicable disease exposure and testing procedures for the EMS personnel.

Exposed individual: Any individual health care provider, first responder, or any other person, including, but not limited to, any employee, volunteer, or contracted agent of any health care provider, who is exposed, within the scope of their employment, to the blood or other potentially infectious materials of a source patient.

Exposure certification: A determination by the certifying physician on the exposure's significance.

Health facility infection control officer: The official or officer who has been designated by the health facility to communicate with a designated officer, or his or her designee.

Legal representative: For purposes of giving consent to communicable disease testing, whenever the word "source patient" is used herein, it shall also be deemed to mean the source patient's legal representative.

Personal Protective Equipment (PPE): Specialized clothing or equipment worn by personnel for protection from exposure to blood or other potentially infectious material. See "universal infection control precautions".

Significant exposure: Direct contact with blood or other potentially infectious materials of a patient in a manner that is capable of transmitting a communicable disease.

Source patient: Any person receiving health care services whose blood or other potentially infectious material is the source of a significant exposure to prehospital care personnel.

Standard Precautions: A combination of the major features of Universal Precautions and Body Substance Isolation based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents.

Universal Infection Control Precautions: A method of infection control in which human blood and certain human body fluids are treated as if known to be infectious for blood borne pathogens.

Urgency reporting requirement: A disease required to be reported immediately by telephone or reported by telephone within one working day pursuant to subdivisions (h) and (i) of Section 2500 of Title 17 of the California Code of Regulations.

PRINCIPLES:

1. EMS personnel must observe "body substance isolation" in situations where there is a potential for contact with blood, body fluids, or other potentially infectious material.

2. EMS personnel are frequently exposed to blood and other potentially infectious materials of patients whose communicable disease infection status is unknown. EMS personnel who experience a significant exposure to these substances are permitted, under certain conditions, to learn the communicable disease infection status of the source patient.

3. Early knowledge of infection with a communicable disease is important to allow exposed persons to make informed health care decisions and take measures to reduce the transmission of the infection to others.

4. A health care provider shall not draw blood, or a patient sample for the sole purpose of communicable disease testing, if the source patient refuses communicable disease testing. If the source patient's communicable disease status is unknown and the patient refuses communicable disease testing, only available blood or patient sample may be tested for any communicable disease.

5. California law prohibits an exposed individual from attempting to directly obtain informed consent to communicable disease testing from a source patient.

POLICY:

I. Designated Officer

A. EMS provider agencies must appoint a designated officer. The designated officer, or his or her designee, shall be available either onsite or on call 24 hours per day as determined by the EMS Provider.

B. An employer of a prehospital emergency medical care personnel that maintains an internet web site shall post the title and telephone number of the designated officer or the facility's infection control officer in a conspicuous location on its internet web site accessible from the home page.

II. Infection Control Officer

A. The health facility infection control officer, or his or her designee, shall be available either onsite or on call 24 hours per day as determined by the health facility.

B. A health facility that maintains an internet web site shall post the title and telephone number of the health facility infection control officer in a conspicuous location on its internet web site accessible from the home page.

III. Evaluation and Certification of an Exposure

A. In the event of an exposure to blood or other potentially infectious material of a patient, exposed EMS personnel are to follow their provider agency's post-exposure protocol, including the completion of the Ref. No. 836.2, Communicable Disease Exposure and Notification Form, or the equivalent.

1. The exposed individual shall make a written request for exposure certification within 72 hours of the exposure and a physician should promptly evaluate the exposure.

2. No physician or other exposed individual shall certify their own exposure; however, an employing physician may certify the exposure of one of their employees.

3. **EMS personnel with a significant exposure should seek medical**

evaluation and treatment immediately.

B. The physician shall provide written certification of the exposure's significance within 72 hours of the request. The certification shall include the nature and extent of the exposure.

C. The health facility infection control officer shall notify:

1. The exposed individual's designated officer; and,

2. The Los Angeles County Health Officer or designee at (213) 240-7941 from 8 a.m. to 5 p.m. Monday through Friday, or (213) 974-1234 during non-business hours and ask for the on-call physician.

D. The designated officer shall immediately notify the prehospital emergency medical care person if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition.

E. The exposed individual shall be counseled regarding the likelihood of transmission, limitations of the tests performed, need for follow up testing, and the procedures that the exposed individual must follow regardless of the source patient's test results.

F. Within 72 hours of certifying the exposure as significant, the certifying physician shall provide written certification to the source patient's attending physician. The certification shall: a) indicate that a significant exposure has occurred, b) request information regarding the communicable disease status of the source patient and the availability of blood or other patient samples. The source patient's attending physician shall respond to the request for information within three working days.

G. **Many source patients are discharged from the emergency department; therefore, the exposure certification should be made immediately available to the emergency department where the source patient is being treated. This may allow the source patient to consent to communicable disease testing while still in the emergency department.**

IV. Communicable Disease Status of Source Patient

A. Known Communicable Disease Status

1. If the source patient's communicable disease status is known, the source patient's attending physician shall obtain consent to disclose the communicable disease status to the exposed individual.

2. If the source patient cannot be contacted, or refuses to consent to the disclosure, then the exposed individual may be informed of the communicable disease status by the attending physician as soon as possible after the exposure has been certified as significant.

B. Unknown Communicable Disease Status

1. If the communicable disease status of the source patient is unknown, and blood or other patient samples are available, and the exposed individual has tested negative on a baseline test for communicable diseases, the source patient shall be given an opportunity to give a voluntary, written, informed consent to test for communicable diseases.

2. The source patient shall be provided with medically appropriate pretest counseling and referred to appropriate posttest counseling and follow-up if necessary. The source patient shall be offered medically appropriate counseling whether or not he or she consents to testing.

3. Within 72 hours after receiving a written certification of significant exposure, the source patient's attending physician shall make a good faith effort to notify the source patient about the significant exposure. A good faith effort to notify includes, but is not limited to, a documented attempt to locate the source patient by telephone or by first-class mail with certificate of mailing. An attempt to locate the source patient and the results of that attempt shall be documented in the source patient's medical record.

4. An inability to contact the source patient after a good faith effort, or the inability of the source patient to provide informed consent **shall constitute a refusal of consent** provided all the following conditions are met:

   a. The source patient has no authorized legal representative,

   b. The source patient is incapable of giving consent, and

   c. In the opinion of the attending physician, the source patient will be unable to grant informed consent within the 72-hour period required to respond.

5. **If the source patient refuses consent to test for communicable diseases, any available blood or patient sample of the source patient may be tested. The source patient shall be informed that the available blood or patient sample will be tested despite their refusal, and the exposed individual shall be informed of the results regarding communicable diseases.**

6. If the source patient is deceased, consent to perform a test for any communicable disease on any blood or patient sample of the source patient legally obtained in the course of providing health care services at the time of the exposure shall be deemed granted.

7. The source patient shall have the option not to be informed of the test result. If a patient refuses to provide informed consent to communicable disease testing and refuses to learn the results of testing, documentation of the refusal shall be signed. The source patient's refusal to sign shall be

construed as a refusal to be informed of the test results. Test results shall only be placed in the source patient's medical record when the patient has agreed in writing to be informed of the results. If the source patient refuses to be informed of the test results, the test results shall only be provided to the exposed individual in accordance with applicable Federal and State occupational health and safety standards.

V. Confidentiality and Liability

A. The exposed individual shall be informed that any identifying information about the communicable disease test results and medical information regarding the communicable disease status of the source patient shall be kept confidential and may not be further disclosed, except as authorized by law. The exposed individual shall be informed of the civil and criminal penalties for which they would be **personally** liable for violating Health and Safety Code Section 120980.

B. The costs for communicable disease testing and counseling of the exposed individual, and/or the source patient, shall be borne by the employer of the exposed individual.

C. The source patient's identity shall be encoded on the communicable disease test result record.

D. If the health care provider has acted in good faith in complying with Health and Safety Code Chapter 3.5, the health care provider shall not be subject to civil or criminal liability or professional disciplinary action for:

1. Performing communicable disease tests on the available blood or patient sample of the source patient.

2. Disclosing the communicable disease status of a source patient to the source patient, the source patient's attending physician, the certifying physician, the exposed individual, or any attending physician of the exposed individual.

E. Any health care provider or first responder or any exposed individual who willfully performs or permits the performance of a test for communicable disease on a source patient that results in economic, bodily, or psychological harm to the source patient, without adhering to the procedure set forth in Health and Safety Code Chapter 3.5 is guilty of a misdemeanor, punishable by imprisonment in the county jail for a period not to exceed one year, or a fine not to exceed ten thousand dollars ($10,000), or both.

VI. Coroner's Cases

If the source patient is pronounced dead in the field, the County Medical Examiner/Coroner may test for any communicable disease when an autopsy is performed. The certifying physician or the exposed EMS personnel's employer shall notify the County Medical Examiner/Coroner of the exposure. If the County Medical Examiner/Coroner confirms a diagnosis of any communicable disease in the source patient, they shall notify the County Health Officer, who in turn shall apprise the exposed individual of the source patient's communicable disease status. The County Medical

Examiner/Coroner shall adhere to the procedure defined in Health and Safety Code 1797.189 in carrying out this process.

VII. Source Patient in Custody or Charged with a Crime

If the source patient is in custody or charged with a crime and refuses to voluntarily consent to communicable disease testing, Health and Safety Code 121060, 121060.1, and 121065 allows for the exposed health care provider to petition the court. The court may require the source patient to provide three specimens of blood to be tested for HIV, hepatitis B, and hepatitis C by court order (Ref. No. 836.3).

VIII. Aerosol Transmissible Disease

Provider agencies shall have written procedures to be followed in the event of an exposure incident in accordance with the California Code of Regulations, Title 8, Section 5199.

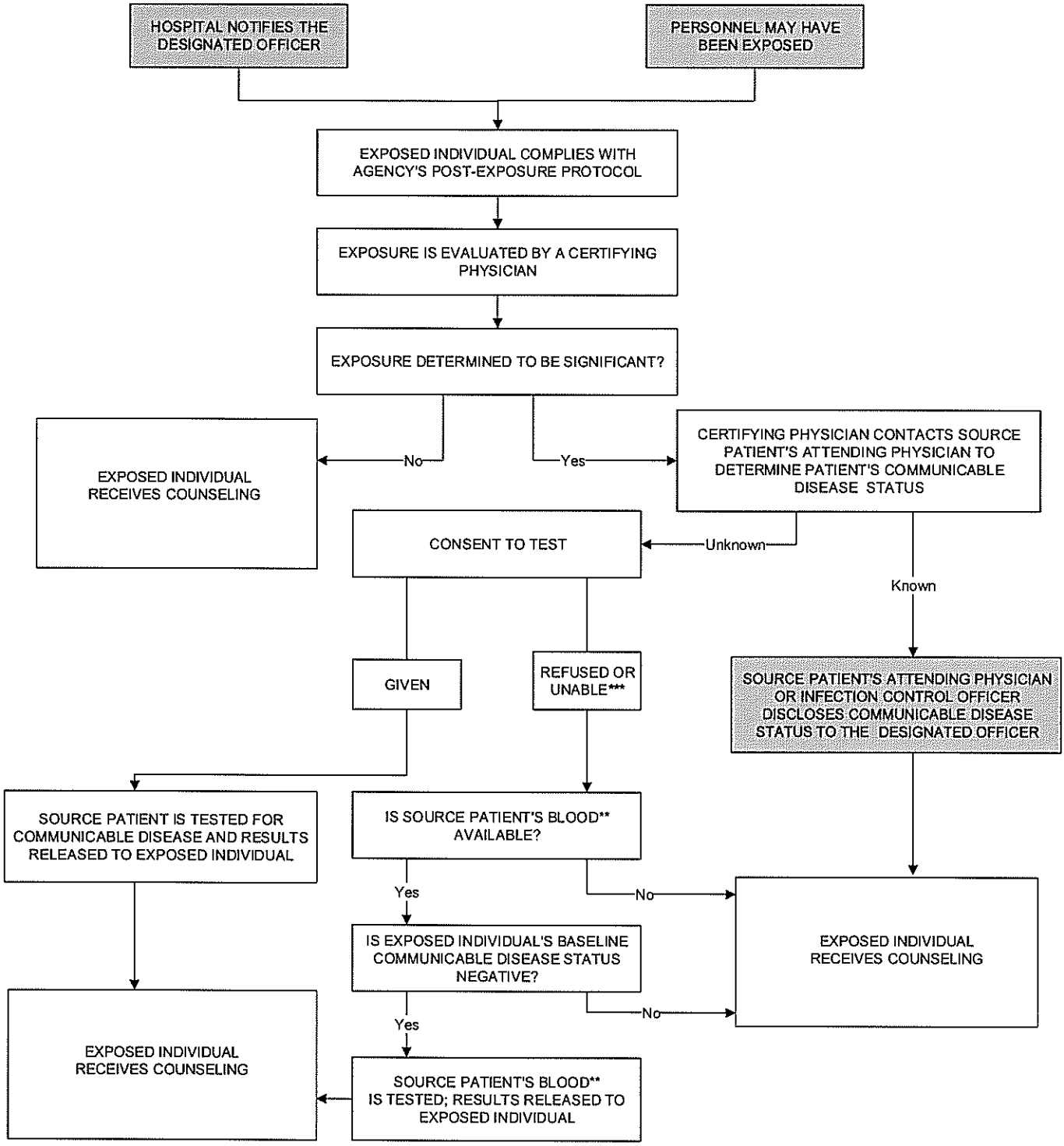
CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 836.1, **Communicable Disease Exposure and Testing Flow Chart**
Ref. No. 836.2, **Communicable Disease Exposure and Notification Report Form**
Ref. No. 836.3, **Court Petition for Order to Test Accused Blood**

Reportable Diseases and Conditions:
http://www.publichealth.lacounty.gov/acd/docs/DiseaseListOct2016.pdf

SUBJECT: **COMMUNICABLE DISEASE EXPOSURE AND TESTING FLOWCHART**

(EMT, PARAMAMEDIC, MICN)
REFERENCE NO. 836.1



* California law prohibits an exposed individual from attempting to directly obtain informed consent for communicable disease testing from a source patient
** Or other patient sample available for testing
*** If source patient is deceased, any available blood or patient sample may be tested without consent

EFFECTIVE: 04-01-04
REVISED: XX-XX-18
SUPERSEDES: 06-01-08

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **COMMUNICABLE DISEASE EXPOSURE AND NOTIFICATION REPORT FORM** REFERENCE NO. 836.2

COMMUNICABLE DISEASE EXPOSURE AND NOTIFICATION REPORT FORM

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Section 1797.188 (b)(1) of the Health and Safety Code requires the health facility infection control officer, upon determining that the person to whom the prehospital emergency medical care person provided the emergency medical or rescue services as being afflicted with a reportable disease or condition, and that the reportable communicable disease or condition may have been transmitted during the provision of care, shall immediately notify the designated officer of the prehospital emergency medical care person.

INSTRUCTIONS: COMPLETE THE FORM AND KEEP IT IN THE EMPLOYEES FILE

NAME OF EXPOSED PERSONNEL	EMPLOYEE NO.	EMT CERTIFICATION NUMBER
CALIFORNIA STATE LICENSE NO. (if paramedic)	LOCAL ACCREDITATION NUMBER (if paramedic)	EMS REPORT FORM SEQUENCE NUMBER
EMS PROVIDER NAME	STATION TELEPHONE NUMBER	DESIGNATED OFFICER NAME & EMAIL
BATTALION	STATION	SHIFT
PATIENT'S NAME	HEALTH FACILITY	INCIDENT DATE / TIME

CHECK PERSONNEL PROTECTIVE EQUIPMENT USED:

☐ GLOVES ☐ EYE PROTECTION ☐ GOWN ☐ MASK ☐ NONE

☐ OTHER:_____

CHECK TYPE OF EXPOSURE:

☐ Blood/Body fluid splash to eyes ☐ Blood/Body fluid splash to mouth ☐ Blood/Body fluid to open skin, i.e., cuts, scrapes, etc. ☐ Needle stick ☐ Bite ☐ Coughing or sneezing of unmasked patient (excluding common cold/flu)

☐ OTHER:_____

RECEIVED BY	
EMPLOYEE SIGNATURE	DATE

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **COMMUNICABLE DISEASE EXPOSURE COURT PETITION TO TEST ACCUSED BLOOD** REFERENCE NO. 836.3

COURT PETITION FOR ORDER TO TEST ACCUSED BLOOD

EMERGENCY MEDICAL SERVICES PERSONNEL PETITION

_____ _____

_____ _____
NAME AND NUMBER OF CASE

_____
NAME AND ADDRESS OF COURT

TO THE CLERK OF THE COURT:

I declare under penalty of perjury that the following is accurate and true to the best of my knowledge and belief:

1. My name is (type or print) _____.

   I am a (list occupation) _____.

2. On _____ (date and time) the accused interfered with my official duties as a _____ (occupation) by biting, scratching, spitting, or transferring blood or other bodily fluids to me. During the performance of my duties _____ (identify the body fluid involved) was transferred to me.

3. The possible transfer of bodily fluid took place as the result of one or more of the following acts: (Please check one or more)

   ( ) Resisting Care
   ( ) Other

   _____

   _____

   _____

4. On the basis of these facts, and pursuant to Health and Safety Code Section 121050-121570, I request that this Court grant my petition for an order to test the accused blood for the Human Immunodeficiency Virus (HIV), Hepatitis B, Hepatitis C, and such other communicable diseases as the Court deems appropriate.

_____ _____
Date Signature of Emergency Medical Services Personnel

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EMERGENCY MEDICAL TECHNICIAN CERTIFICATION** REFERENCE NO. 1014

PURPOSE: To define the requirements for Emergency Medical Technician (EMT) initial certification, renewal certification, or reinstatement of certification, and disciplinary action.

AUTHORITY: California Health and Safety Code, Division 2.5
California Code of Regulations, Title 22. Division 9. Chapters 2, 6, 10, 11

DEFINITIONS:

Certification Action: Actions that may be taken by a Local Emergency Medical Services Agency (LEMSA) medical director that include denial, suspension, revocation of an EMT certificate, or placing an EMT certificate holder on probation.

Commission on Accreditation for Pre-hospital Continuing Education (CAPCE): An accrediting body charged with the review and accreditation of EMS continuing education (CE).

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

Discipline: Either a disciplinary plan taken by a relevant employer or certification action taken by a LEMSA Medical Director.

Emergency Medical Technician (EMT): An individual who has successfully completed an approved EMT course which meets California training requirements, has passed all required examinations, and is certified by a California EMT certifying entity.

EMT Certifying Entity: A public safety agency with an approved EMT training program for the purpose of certifying their personnel or the medical director of the LEMSA.

EMT Certifying Psychomotor Examination: The National Registry of Emergency Medical Technicians (NREMT) EMT psychomotor examination. Examination results shall be valid for application and certification purposes for two (2) years from the date of the examination.

EMT Certifying Cognitive Examination: The National Registry of Emergency Medical Technicians (NREMT) EMT cognitive examination. Examination results shall be valid for application and certification purposes for two (2) years from the date of the examination.

EMT Skills Competency Verification (EMT SCV): The direct observation of the required EMT skills by an approved skills verifier. Verification indicates the skill was competently performed by the EMT.

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

Local Emergency Medical Services Agency (LEMSA): The agency, department, or office having primary responsibility for administration of the EMS system in a county.

Model Disciplinary Orders: Recommended guidelines which were develop by the State EMS Authority to provide consistent and equitable certification action in cases dealing with disciplinary cause.

National Registry of Emergency Medical Technician (NREMT): The nations EMS certification agency.

PRINCIPLES:

1. An application for EMT certification or renewal shall be denied when an applicant does not meet the requirements for certification or renewal as outlined in the policy. Additionally, the LEMSA medical director may deny, place on probation, suspend or revoke a certification for the commission of a crime or act that is considered substantially related to the qualifications, functions, or duties of the certificate holder and is evidence of a threat to the public health and safety.

2. All certified EMTs and applicants shall obtain a criminal history background report with results that do not prohibit them from certification pursuant to Title 22, California Code of Regulations, Section 100214.3, and California Health and Safety Code, Section 1798.200.

3. Incomplete applications will delay processing. The applicant will be notified, in writing, of deficiencies and completion deadline. Failure to provide missing elements by established due date will result in closure of application and forfeiture of the application fee.

4. Renewal application with required documentation shall be submitted no later than thirty (30) days prior to certification expiration.

5. EMTs certified by the EMS Agency shall notify the Agency, in writing, of changes to legal name, address, phone, email, or employer within thirty (30) days of the event.

6. EMTs shall adhere to the current EMS Agency prehospital care policies, procedures, and protocols while functioning in Los Angeles County.

7. A California licensed paramedic may function and perform any activity in the EMT scope of practice without applying for EMT certification and needs no further training and/or testing.

POLICY:

I. Initial EMT Certification – No prior California EMT certification

   A. Eligibility by completing initial EMT training

      1. Be eighteen (18) years of age or older.

      2. Complete an EMT basic course and obtain an EMT course completion record from an EMT training program approved by either:

a. A California LEMSA, or

b. the EMS Authority, or

c. An out-of-state EMT program which meets current California training requirements

3. Pass the NREMT EMT cognitive and psychomotor (skills) examination within the preceding two (2) years.

4. Apply for certification within two (2) years of the date of EMT course completion.

5. Possess a current CPR card equivalent to American Heart or Red Cross Basic Life Support, which is valid at least three months beyond the date a complete application is submitted. Online CPR courses are not accepted.

6. Complete a live scan for a criminal history background report using the California Department of Justice Request for Live Scan Service form obtained from the EMS Agency web site. No other form shall be used.

7. Complete and sign the current EMS Agency EMT Initial Certification Application.

8. Disclose in a written statement, signed and dated, and include a minute order, docket report, statement of issues, or accusation for any and all:

a. Certification, accreditation or licensure action(s) against a healthcare or healing arts certificate.

b. Criminal history to include arrests, pending charges, and/or convictions.

9. Pay the established fee.

10. Submit all documentation listed above (original application and copies of all other documents) along with:

a. Copy of government-issued identification with photograph (Driver License, California I.D. card, or Passport).

b. Other health certifications or licenses.

B. Eligibility with current EMT certification from another State

1. All requirements listed in Section I. A. of this reference.

2. Two (2) year requirement for course completion and application are waived.

C. Eligibility with current EMT certification from the NREMT

1. All requirements listed in Section I. A. of this reference.

2. Two (2) year requirement for course completion and application are waived.

3. Two (2) year requirement for passing the NREMT EMT written and skills examinations are waived.

D. Eligibility with a current and valid Advanced EMT (AEMT) or Paramedic certification from California, another State, or NREMT in good standing

1. All requirements outlined in Section I.A.4-11 of this reference.

2. Submit a copy of current certification(s) and/or license(s).

E. Certification Issuance

1. EMT shall be issued a wallet-sized certificate card with an effective date when all requirements have been met and reviewed by the EMS Agency.

2. Expiration date shall be two (2) years to the end of the month from the date applicant completes all certification requirements.

II. Renewal of California EMT Certification

A. EMT certification is current and issued by the Los Angeles County EMS Agency, the following are required:

1. During the current certification cycle, obtain twenty-four (24) hours of EMS education by one of the following:

a. EMT Refresher course from an approved program, or

b. EMS approved continuing education from a California approved EMS CE Provider or Commission on Accreditation for Pre-Hospital Continuing Education (CAPCE) approval.

i. A maximum of eight (8) hours of EMS CE completed per day can be used towards the total CE hours required. Any hours over eight (8) completed on one day will be disallowed.

ii. A maximum of 12 hours of teaching or media-based education can be used towards the total CE hours required.

iii. All CE hours must be relevant to EMS in the assessment and management of prehospital patient care.

iv. Verification from a California approved paramedic training program which meets EMS education certificate

requirements documenting completion of didactic with the dates and hours signed by the program director.

2. EMT SCV (EMSA-SCV 01/17) from an approved California provider within the past two (2) years.

3. Current CPR card equivalent to American Heart or Red Cross Basic Life Support which is valid at least three months beyond the date an application is submitted. Online CPR courses are not accepted.

4. Disclose in a written statement, signed and dated, and include the court minute order or docket report, statement of issues or accusation for any and all:

   a. Certification, accreditation or licensure action(s) against a healthcare or healing arts license.

   b. Criminal background history including arrests, convictions or pending charges.

5. Complete and sign the current EMS Agency EMT Certification Renewal Application to include current EMS employer, if applicable.

6. Pay the established fee.

7. Submit all documentation listed above (original application and copies of all other documents) along with:

   a. Copy of government-issued identification with photograph (Driver License, California I.D. card, or Passport)

   b. Other health certification or licenses.

B. EMT certification is current but not issued by the Los Angeles County EMS Agency, the following are required:

1. Complete all requirements outlined in Section II. A. 1-4 of this reference.

2. Submit a copy of current certification(s) and/or license(s).

3. Complete a live scan for a criminal history background report using the California Department of Justice Request for Live Scan Service form obtained from the EMS Agency web site. No other form shall be used. Submit a copy of the Request for Live Scan Service form after performing live scan fingerprinting.

C. Renewal Certification Issuance

1. If renewal requirements are met less than six (6) months prior to expiration, EMT shall be issued a wallet-sized certificate card with an effective date immediately following the expiration date of the current

certificate. The expiration date shall be two (2) years from the date of the current certificate. OR

2. If renewal ~~recertification~~ requirements are met more than six (6) months prior to expiration, EMT shall be issued a wallet-sized certificate card EMT with an effective date when all requirements have been met and reviewed by the EMS Agency. The expiration date shall be two (2) years from the final day of the final month which recertification is issued.

III. Reinstatement of an Expired California EMT Certification

A. EMT certification issued by Los Angeles County EMS Agency with a lapse of less than six (6) months.

1. Complete all requirements in Section II. A. of this reference.

2. EMS education and EMT SCV submitted must be completed within the twenty-four (24) months prior to applying for reinstatement.

B. EMT certification issued by another California EMT Certifying Entity with a lapse of less than six (6) months.

Complete all requirements outlined in Section II. B. and III. A. of this reference.

C. EMT certification issued by Los Angeles County EMS Agency with a lapse of six (6) months or more and less than twelve (12) months.

1. Complete all requirements outlined in Section II. A. of this reference.

2. Complete an additional 12 hours of EMS education for a total of thirty-six (36) hours.

3. EMS education and EMT SCV submitted must be completed within the twenty-four (24) months prior to applying for reinstatement.

D. EMT certification issued by another California EMT Certifying Entity with a lapse of six (6) months or more and less than twelve (12) months.

Complete all requirements outlined in Section II. B. and III. C. of this reference.

E. EMT certification with a lapse of twelve (12) months or more.

1. Complete all requirements outlined in Section II. B. of this reference.

2. Complete an additional 24 hours of EMS education for a total of forty-eight (48) hours.

3. EMS education and EMT SCV submitted must be completed within the twenty-four (24) months prior to applying for reinstatement.

4. Pass the NREMT EMT cognitive and psychomotor examination within the preceding two (2) years or possess a current NREMT EMT certificate.

F. Renewal Certification Issuance

1. EMT shall be issued a wallet-sized certificate card with an effective date when all requirements have been met and reviewed by the EMS Agency.

2. The expiration date shall be two (2) years on the final day of the month which certification is issued.

IV. California EMT certification renewal for members of the Armed Forces of the United States while deployed on active duty

EMTs who are a member of the Armed Forces of the United States whose California EMT certificate expires during the time the individual is deployed on active duty or less than six (6) months from the date the individual is deactivated/released from active duty, shall receive six (6) months from the date of the individual's release from active duty to complete the reinstatement requirements outlined in Section III. A. or III. B. of this reference, with the following provisions:

A. Individual's EMT certification expiration date applies.

1. Certification expiration which occurs prior to deployment for active duty must meet reinstatement requirements according to the date of expiration.

2. If certification expiration occurs while on active duty or within 6 months of release, the certificate shall be deemed expired.

3. EMT with an expired certification shall not function as an EMT.

4. Live Scan is required if certification expiration is twelve (12) months or greater.

5. If the individual does not complete reinstatement requirements within six (6) months from active duty release, certification renewal requirements shall apply from the time of certification expiration.

B. Provision to complete reinstatement requirements begins at the time of release from active duty.

C. EMT shall submit documentation from their respective branch of the Armed Forces of the United States verifying membership and the individual's dates of activation and release from active duty.

D. Reinstatement of certification shall be issued as outlined in Section III. F. of this reference upon completing reinstatement requirements.

V. EMT Disciplinary Action

A. The EMS Agency medical director may deny, place on probation, suspend or revoke an EMT certification for the commission of a crime or act that is

considered substantially related to the qualifications, functions or duties of the certificate holder and is evidence of a threat to the public health and safety.

B. The following actions shall be considered evidence of a threat to the public health and safety:

1. Fraud in the procurement of an EMT certificate or paramedic license.

2. Gross negligence.

3. Repeated negligent acts.

4. Incompetence.

5. The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of prehospital personnel.

6. Conviction of any crime, which is substantially related to the qualifications, functions, and duties of prehospital personnel.

7. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of or conspiring to violate, any provision of Health and Safety Code Division 2.5 or regulations adopted by the EMS Authority pertaining to prehospital personnel.

8. Violating or attempting to violate any federal or state statute or regulation that regulates narcotics, dangerous drugs or controlled substances.

9. Addiction to, the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

10. Functioning outside the supervision of medical control in the field care system operating at the local level.

11. 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.

12. Unprofessional conduct exhibited by any of the following:

    a. The mistreatment or physical abuse of any patient.

    b. The failure to maintain confidentiality or patient medical information.

    c. The commission of any sexually related offense specified under Section 290 of the Penal Code.

C. For any of the above actions the EMS Agency will evaluate and investigate the incidence and make a determination of certification action based on the

provisions of Title 22, Division 9: Prehospital Emergency Services, Chapter 6. Process for EMT Disciplinary Action.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 214, **Base Hospital and Provider Agency Reporting Responsibilities**
Ref. No. 802, **Emergency Medical Technician (EMT) Scope of Practice**
Ref. No. 802.1, **EMT Scope of Practice (Table Format)**

TREATMENT PROTOCOL: NON-TRAUMATIC CARDIAC ARREST (ADULT) *

1. Basic airway
2. If arrest not witnessed by EMS:
   CPR for 2min at a compression rate of at least 100/min, minimize interruptions to chest compressions
3. Cardiac monitor: document rhythm and attach ECG strip
4. If asystole, confirm in more than one lead
5. If fine V-Fib is suspected, treat with V-Fib/Pulseless V-Tach

A 12-lead ECG shall be acquired on patients who complain of chest pain/discomfort of suspected cardiac etiology, non-traumatic post cardiac arrest patients with a return of spontaneous circulation (ROSC) and/or patients who the paramedics suspect are experiencing an acute cardiac event.

ASYSTOLE / PEA

6. If confirmed PEA, consider causes ❶
7. Venous access, if unable:
   place IO (if available)
8. **Epinephrine** (0.1mg/mL) ❹
   1mg IV or IO
9. Consider advanced airway ❷,
   capnography
10. If narrow complex and heart rate greater than 60bpm:
    Normal saline fluid challenge
    10ml/kg IV or IO at 250ml increments
11. CPR for 2min
12. **CONTINUE SFTP or BASE CONTACT**
13. **Epinephrine** (0.1mg/mL)
    1mg IVP or IO
    May repeat every 3-5min
14. If down time greater than 20min:
    Sodium bicarbonate
    1mEq/kg IV push
    May repeat 0.5mEq/kg every 10-15min
15. If resuscitative efforts are successful:
    Perform 12-lead ECG ❽
16. If resuscitative efforts are unsuccessful and the patient does not meet ALL criteria for Termination of Resuscitation in Ref. No. 814, Section II.A., consult with the Base Physician ❼

V-FIB / PULSELESS V-TACH

6. Defibrillate ❺❻
   Biphasic at 200J (typically)
   Monophasic at 360J
7. CPR for 2min
8. Venous access, if unable:
   place IO (if available)
9. Check rhythm ❸, and if indicated:
   Defibrillate
   Biphasic at 200J, monophasic at 360J
10. CPR for 2min
11. **Epinephrine** (0.1mg/mL) ❹
    1mg IVP or IO
12. Consider advanced airway ❷,
    capnography
13. Check rhythm, and if indicated:
    Defibrillate
    Biphasic at 200J, monophasic at 360J
14. **CONTINUE SFTP or BASE CONTACT**
15. **Amiodarone**
    300mg IV or IO
16. CPR for 2min
17. Check rhythm, and if indicated:
    Defibrillate
    Biphasic at 200J, monophasic at 360J
18. **Epinephrine** (0.1mg/mL)
    1mg IVP or IO
    May repeat every 3-5min
19. CPR for 2min
20. Check rhythm, and if indicated:
    Defibrillate
    Biphasic at 200J, monophasic at 360J
21. **Amiodarone**
    150mg IV or IO
    Maximum total dose 450mg
22. CPR for 2min
23. Check rhythm, and if indicated:
    Defibrillate
    Biphasic at 200J, monophasic at 360J

TREATMENT PROTOCOL: NON-TRAUMATIC CARDIAC ARREST (ADULT) *

25. If resuscitative efforts are successful: Perform 12-lead ECG ❽
26. If resuscitative efforts are unsuccessful consult with the Base Physician ❼

SPECIAL CONSIDERATIONS

❶ Consider causes of PEA: acidosis; cardiac tamponade; drug overdose; hyperkalemia; hypothermia; hypovolemia; hypoxia; massive MI; pulmonary embolus; or tension pneumothorax
Drugs to consider for specific suspected causes:

If hypoglycemia is suspected:
Dextrose 10% 250mL IV
250ml IV or IO

If narcotic overdose is suspected:
NARCAN (naloxone)
0.8-2mg IV or IO
2mg IN or IM

If dialysis patient:
CALCIUM CHLORIDE - BASE CONTACT REQUIRED
1gm IV or IO

SODIUM BICARBONATE – BASE CONTACT REQUIRED
1mEq/kg IV or IO

If tricyclic overdose suspected:
SODIUM BICARBONATE – BASE CONTACT REQUIRED
1mEq/kg IV or IO

If calcium channel blocker overdose suspected:
CALCIUM CHLORIDE – BASE CONTACT REQUIRED
1gm IV or IO

❷ Attempt to limit interruptions in CPR to no more than 10sec with advanced airway. Should utilize end tidal CO_2 monitoring for advanced airway and monitoring ROSC.

❸ Pulse check if a change in ECG rhythm, take no longer than 10sec to check for a pulse. If no pulse is detected within 10sec, resume chest compressions.

❹ If hypothermia is suspected, administer only one dose of epinephrine and **no other medications** until the patient is re-warmed

❺ Biphasic defibrillator settings may vary; refer to manufacturer's guidelines. If unknown, use 200J for biphasic, 360J for monophasic

❻ If hypothermia is suspected, defibrillate only once until the patient is re-warmed

❼ If hypothermia is suspected, resuscitation efforts should not be abandoned until the patient is re-warmed, or the base hospital orders termination of resuscitative efforts

❽ Post cardiac arrest patients with ROSC, with or without a 12 lead ECG analysis equivalent to "Acute MI", shall be transported to the most accessible open SRC if ground transport is 30 minutes or less regardless of service agreement rules and/or considerations.

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

SUBJECT: **DIVERSION REQUEST REQUIREMENTS FOR EMERGENCY DEPARTMENT SATURATION** REFERENCE NO. 503.1

PURPOSE: To outline the minimum requirements for hospitals to be placed on diversion of advanced life support (ALS) patients due to emergency department (ED) saturation.

DEFINITIONS:

Ambulance patient offload time (APOT): Time interval between the arrival of an ambulance at the location outside the hospital ED where the patient will be unloaded from the ambulance and the time the patient is transferred to the ED gurney, bed, chair or other acceptable location and the emergency department assumes responsibility for care of the patient.

Diversion: Hospital Diversion is a request by a hospital or an EMS provider agency to have ALS patients bypass a facility for a limited period of time and should be requested only when necessary. This is **not** an absolute **closure** (see Principle 7). Basic life support (BLS) units may not be diverted with the exception of diversion due to internal disaster.

Diversion hour: Hospitals and EMS provider agencies may request diversion to ED Saturation for any amount of time up to 60 minutes. If the hospital is not re-opened by the end of the 60 minute period, it will be automatically re-opened by the ReddiNet system.

EMS provider agency diversion threshold: Three 9-1-1 transport ambulances are all waiting to offload patients for over 30 minutes.

Hospital diversion threshold categories: All ED treatment bays are full and 30% or greater of the ED has patients who fall into one or both categories below, including ED beds occupied by admitted patients but excluding fast track beds and waiting room patients.

(1) Resuscitative (unstable condition): the patient is hemodynamically unstable, requires an immediate airway or emergency medications. Other criteria: already intubated, apneic, pulseless, severe respiratory distress, pulse oximetry <90, acute mental status changes or unresponsive

(2) Immediate/Emergent (requires timely treatment): the patient has symptoms indicative of a potential threat to life and their condition is likely to change to "resuscitative" without aggressive intervention. Examples include but are not limited to the following: stable but active chest pain; stroke symptoms; abdominal pain in pregnancy or suspected pregnancy; suicidal or homicidal ideation; new onset confusion; lethargy or disorientation; severe pain

Special considerations: Unusual circumstances that overwhelm ED resources and are documented by hospital administration.

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

PRINCIPLES:

1. High quality emergency medical services (EMS) is the result of prehospital care providers, emergency departments and hospitals working together as a team to care for ill and injured patients.

2. Prolonged diversion and APOT ~~is~~ are not an emergency department problem alone; it is a hospital and EMS systemwide issue, both have negative impacts to the EMS providers' ability to respond to subsequent 9-1-1 medical calls which results in prolonged response times and may affect public safety and patient outcomes.

3. Each hospital shall have a diversion policy and a multidisciplinary team approach to ensure the ability of the facility to remain open and to flex to Surge Capacity, thereby preventing or minimizing time of hospital diversion and APOT.

4. As per EMTALA, the responsibility for patient care lies with the receiving facility once the patient being transported via ambulance arrives at the hospital property. Hospital staff shall make every effort to offload patients from ambulance gurneys as soon as possible.

5. Hospitals that have a consistently prolonged APOT should assign appropriate personnel to remain with patients while awaiting for an ER treatment bay in order to release EMS personnel back to the community.

6. Hospital personnel shall acknowledge and provide a visual assessment of patients arriving via ambulance within 10 minutes of arrival in the ED to determine whether the patient needs an ED treatment bay or can be sent to other areas of the emergency department.

7. In accordance with Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients, final authority for patient destination rests with the base hospital handling the call. Whether the diversion request will be honored depends on available system resources.

8. The State of California Emergency Medical Services Authority has adopted Standardized Methods for Data Collection and Reporting of APOT. The APOT Standard for Los Angeles County is 90% of all ambulance transports have an APOT of 30 minutes or less.

POLICY:

I. Responsibilities Prior to reaching Hospital Diversion Threshold

   A. ED Charge Nurse

      1. Identifies that all ED treatment bays are occupied and patients are waiting for an open treatment bay.

      2. Consults with all ED team members to determine if patient discharges or admissions can be expedited.

      3. Ensures that all ED treatment bays are appropriately utilized.

      4. Notifies the Laboratory and Radiology departments to expedite orders.

5. Notifies the Nursing Supervisor that the ED is near threshold.

B. Hospital Administration (CEO or administrative designee)

1. Consults with the ED physician and ED charge nurse.

2. Performs a walk-through of the ED and reviews options that can be utilized to prevent hospital diversion (CEO or administrative designee).

3. Assesses the ED for special considerations.

4. Activates the hospital's internal multidisciplinary surge plan.

5. Assesses the Medical/Surgical, Intensive Care and Telemetry units for available beds and possible discharges.

6. Expedites environmental services, ancillary services and patient admissions as necessary.

7. Approves diversion to ED saturation via the ReddiNet when ED capacity reaches the defined diversion threshold.

8. Reassesses ED capacity during diversion with the goal of remaining open.

9. Monitors hospital diversion hours.

10. Includes diversion in the ED performance improvement process.

C. 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.

II. Request for diversion of a hospital by an EMS Provider Agency

An EMS provider agency may request to put a hospital on diversion due to ED saturation when the EMS provider agency diversion threshold is met. Each EMS provider agency shall have a diversion request policy that is consistent with the following guidelines:

A. EMS provider agency personnel who are waiting to offload and transfer care to hospital staff shall contact the EMS provider agency's on-duty supervisor and provide the following information:

1. Units waiting to offload

2. Time of arrival at hospital of the unit waiting the longest to offload

3. Time of arrival at hospital of the unit waiting the shortest to offload

4. Estimated time to offload, obtain from ED Charge Nurse

B. The EMS provider agency's on-duty supervisor shall

1. Physically visit the emergency department and verify the report provided by the transport crew(s).

2. Collaborate with the charge nurse, on-duty physician, or house supervisor to identify alternatives to facilitate the transfer of the patients from EMS personnel to emergency department staff.

3. If determined that the offload and transfer of the patient will exceed 30 minutes (in addition to the EMS provider agency diversion threshold), contact the Medical Alert Center and request the facility to be placed on Diversion due to ED Saturation.

C. The Medical Alert Center shall:

1. Obtain all the necessary information to verify diversion threshold is met.

2. Place the hospital on diversion due to ED Saturation.

3. Notify hospital administration or designee that the hospital has been placed on diversion.

D. Hospital Administration (CEO or administrative designee)

1. Reassess ED capacity during diversion with the goal of lifting the diversion status.

2. Monitors diversion hours

3. Includes diversion in the ED performance improvement process.

E. Diversion requests will be up to one hour at a time. Additional diversion time may be requested in one hour increments if the EMS provider agency diversion threshold is met. Diversion request shall be made through the Medical Alert Center.

III. Diversion Audits

The EMS Agency reserves the right to conduct unannounced diversion audits as indicated.

CROSS REFERENCE:

Prehospital Care Manual:
Reference No. 502, **Patient Destination**
Reference No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Patients**

California EMSA: Ambulance Patient Offload Time (APOT) Standardized Methods for Data Collection and Reporting

Attachment A

IMPACT EVALUATION REPORT
on the Proposed Closure of
COMMUNITY MEDICAL CENTER LONG BEACH

I. PURPOSE OF IMPACT EVALUATION

On March 7, 2018, the Los Angeles County Emergency Medical Survives (EMS) Agency, the Board of Supervisors, and Department of Public Health - Health Facilities Inspection Division were notified by John Bishop, Chief Executive Officer MemorialCare, that they will be eliminating basic emergency medical services and intends to cease operation as a general acute care hospital by no later than July 3, 2018 at Community Medical Center Long Beach (CMCLB) (Exhibit I).

In response to this notification, Supervisor Janice Hahn introduced a motion on March 27, 2018 related to the pending closure of CMCLB. The motion was approved and included ensuring that the EMS Commission conducts the required public hearing before April 13, 2108 and that it be held in the City of Long Beach and instructed the EMS Agency to accomplish its Impact Evaluation Study by May 15 (Exhibit II).

The purpose of this report is to assess the impact of the proposed closure of CMCLB upon the community, including the impact on access to emergency care, the impact on services provided by surrounding hospitals, the impact on services provided by public and private EMS provider agencies, and the impact on local law enforcement agencies.

Following adoption by the Los Angeles County Board of Supervisors, the Impact Evaluation Report (IER) will be submitted to the State of California Department of Public Health (CDPH), in accordance with provisions of the Health and Safety Code (H&SC) Section 1300.

II. SCOPE OF IMPACT EVALUATION

The required scope of the IER is set forth in H&SC 1300. This IER will consider additional areas of concern that we recommend be addressed by MemorialCare and others potentially impacted by the closure of CMCLB. The impact evaluation will consider:

1. Impact of the CMCLB ED closure on surrounding hospitals, including specialty and disaster services;

2. Impact of the CMCLB ED closure on prehospital EMS provider agencies, including public and private providers;

3. The impact of CMCLB's closure on the surrounding community;

4. Public Hearing Testimony, including received written correspondence

Compliance with public notification requirements as outlined in H&SC are monitored by the California Department of Public Health.

III. IMPACT EVALUATION PROCESS

California State Law (H&SC 1255 and1300) places requirements upon general acute care hospitals related to downgrades and closures of emergency departments. Section 1255 outlines the hospital's obligations to proper notification, and section 1300 imposes the completion of the IER upon counties. Hospital notification must be made to the California Department of Public Health, to the local government agency in charge of health services, to health plans under contract with the hospital, and to the public. This notification must be made as soon as possible but **not later than 90 days prior to the proposed reduction or elimination of emergency services**. Public notice must be provided in a manner likely to reach a significant number of residents of the community served by the hospital whose services are being reduced or downgraded.

Section 1300 requires that the counties conduct an IER to determine impacts, including but not limited to, an impact evaluation of the downgrade or closure upon the community, including community access to emergency care, and how that downgrade or closure will affect emergency services provided by other entities. The IER must include at least one public hearing and **must be completed within 60 days of notification** by the hospital. The IER must be submitted to the California Department of Public Health within three days of completion. In Los Angeles County, the Board of Supervisors has designated the Emergency Medical Services Commission as the body to conduct the required public hearing.

The IER closure of CMCLB was prepared by the Los Angeles County Emergency Medical Services (EMS) Agency. The required public hearing was conducted by the Emergency Medical Services Commission on April 11, 2018, from 6:00 pm to 8:30 pm at The Grand Event Center in the City of Long Beach. Notification of the pending closure and an invitation to attend the public hearing was widely disseminated throughout the community (Exhibit III). Individuals and organizations were invited to participate in the public hearing and/or submit written testimony relevant to the proposed closure of CMCLB. Over 150 people attended the public hearing. Oral testimony was accepted from 27 individuals, including elected officials. Transcripts from the hearing are available for review.

Data used in the IER were obtained from the Rapid Emergency Department Digital Information Network (ReddiNet®) system, the Los Angeles County Trauma and Emergency Medicine Information System (TEMIS), CMCLB, and interviews with surrounding hospitals; health care organizations, affected EMS provider agencies, law enforcement and the Los Angeles County Department of Public Health.

Preliminary statistical data were prepared by Los Angeles County EMS Agency for the EMS Commission to assist in its conduction of the public hearing. This final report, which includes the proceedings and findings of the public hearing, is submitted by the Los Angeles County Department of Health Services to the Los Angeles County Board of Supervisors for adoption.

III. SUMMARY OF FINDINGS

1. MemorialCare operates two general acute care facilities permitted for basic emergency services within the City of Long Beach. Long Beach Memorial Medical Center is a full service acute care facility located 3.8 miles from CMCLB.

2. MemorialCare filed the required notifications to close CMCLB as an acute care facility on or before July 3, 2018.

3. MemorialCare leases the property at 1720 Termino Avenue from the City of Long Beach, which is the address of CMCLB.

4. CMCLB primarily serves the eastern section of the City of Long Beach, Signal Hill, and the northwest section of Seal Beach (Orange County). There are a total of eleven acute care facilities within ten miles of Long Beach Community Medical Center. Of these eleven facilities, four are within five miles (Exhibit IV).

5. CMCLB ED treated 27,740 patients in 2017, or approximately 76 patients per day.

6. CMCLB ED received 4,076 patients transported by the LA County 9-1-1 system in 2017, or approximately 11 patients per day.

7. From an EMS perspective, the closure of CMCLB will impact the residents of east Long Beach, Signal Hill, and northwest Seal Beach. EMS provider agencies that will be impacted include the Long Beach Fire Department, Los Angeles County Fire Department and Care Ambulance Service. All report longer transport times to alternate facilities and increased delay of prehospital personnel as they wait for transfer of patient care to hospital staff. These impacts will include:

    a. Longer travel times to reach emergency services. CMCLB currently receives 19.6% of the total number of patients transported by Long Beach Fire Department.

    b. Possible delays in obtaining prehospital emergency services as a result of longer out-of-service times for EMS personnel engaged in patient transports to more distant hospitals.

    c. Loss of geographic availability of basic emergency department services for residents of east Long Beach, Signal Hill, and northwest Seal Beach.

    d. Loss of a community resource for disaster response purposes.

    e. Loss of 30 critical care beds.

    f. Loss of 28 psychiatric beds.

    g. Increased requests from remaining hospitals to divert 9-1-1 ambulances due to an inability to move greater numbers of patients through their emergency departments (Exhibit V).

    h. Possible increased utilization of 9-1-1 by citizens who currently walk or drive to CMCLB.

    i. The only Sexual Assault Response Team (SART) in Long Beach is operated via a contract with CMCLB and SART. This very important program can be operated from any location with a change in contracts. For 2017, 232 victim examinations were conducted. Of those, 31 exams were for patients 12 years

of age or younger. An additional twenty-seven (27) suspect exams were performed. It should be noted that during the April 11 public hearing, Mr. Bishop committed to moving the SART to the Memorial campus.

8. The combined total number of emergency treatment stations in the 10 mile radius is 374 beds (does not include urgent care beds). The closure of CMCLB would reduce the number by 6% to 353 treatment stations.

9. Hospital emergency visits to the LA County facilities within the 10 mile radius were 543,333 patients for 2016. This equals 1,579 patients per treatment station. The closure of CMCLB would result in a ratio of 1,632 patients per treatment station (assuming patients currently seen at CMCLB would seek emergency care at one of the hospitals within the 10 mile radius) (Exhibit VI).

10. Patients with non-life-threatening illness or injury will most likely experience longer wait times in the emergency departments of surrounding hospitals due to the closure of CMCLB.

11. There are 144 licensed psychiatric beds within the 10 mile radius. CMCLB's licensed psychiatric beds account for 19% within the 10 mile radius and 43% within the 5 mile radius. The reduction in available licensed psychiatric beds will have a negative impact to the community's access to inpatient psychiatric services.

12. CMCLB is not an Emergency Department Approved for Pediatrics (EDAP). There will be no impact to children age 14 or younger in terms of 9-1-1 transports. The only children evaluated and cared for in the CMCLB ED would have been walk-ins or those requiring sexual assault examination who were brought in by law enforcement.

13. CMCLB is not a designated trauma center. There will be no impact on patients that meet trauma center criteria or guidelines.

14. CMCLB is not a ST Elevation Myocardial Infarction (STEMI) Receiving Center. There will be no impact to 9-1-1 patients experiencing a STEMI.

15. CMCLB is not an Approved Stroke Center. There will be no impact to 9-1-1 patients experiencing a stroke.

V. RECOMMENDATIONS

It is recommended that your Board take the following actions:

1. Advice the State Department of Public Health that closure of CMCLB and the loss of its emergency department services will have a negative impact upon the community and the closure does not serve the best interest of the community.

2. Support AB 295 (O'Donnell) that would delay the 2020 seismic requirements for CMCLB.

3. Support the addition of psychiatric beds within the County, particularly in this geographic area of East Long Beach.

4. Continue to monitor and support AB 1795 (Gipson), to allow paramedics to transport patients to psychiatric urgent care centers and sobering centers.

5. Ensure that the contracted SART program is relocated to the Long Beach Memorial Medical Center campus.

6. Instruct the EMS Agency to continue monitoring the Ambulance Patient Offload Times (APOT) times and work with the impacted hospitals to ensure that ambulances are released in a timely manner.

7. Ensure that MemorialCare provides a public information campaign and outreach program to direct the public on the appropriate use of Urgent Cares in the impacted area.

VI. CONCLUSION

Based on the above findings, the Los Angeles County EMS Agency concludes that:

1. MemorialCare has met the regulatory requirements of notifications to date.

2. Closure of the emergency department and acute care beds at CMCLB will have a negative impact on access to, and delivery of, emergency medical and psychiatric services in east Long Beach, Signal Hill and northwest Seal Beach.

MEASURE B ADVISORY BOARD
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670

Measure B Funding
Process for Submitting Funding Proposal

Background

Measure B is a special property assessment that was passed by the voters of Los Angeles on November 5, 2002. This assessment is imposed upon all improved parcels located in Los Angeles County and is added to Los Angeles County property taxes and generates revenue for use by the County as specified in the original resolution. The use of Measure B funds is restricted to four areas as follows:

1. Used in part to maintain all aspects of the Countywide System of Trauma Centers, to expand the system to cover all areas of the County, to provide financial incentives to keep existing Trauma Centers within the system, to pay for the costs of Trauma Centers, including physician and other personnel costs, to defray administrative expenses related to the foregoing, including payment of salaries and benefits of Department of Health Services (DHS) personnel and other incidental expenses.

2. Used in part to coordinate and maintain a countywide system of emergency medical services (EMS), to pay for the costs of EMS, including physician and other personnel costs; to defray administrative expenses related to the foregoing, including the payment of salaries and benefits of DHS personnel and incidental expenses.

3. Used in part to enable the stockpiling of safe and appropriate medicines to treat persons affected by a bioterrorist or chemical attack, to train healthcare workers and other emergency personnel in dealing with the medical needs of those exposed to a bioterrorist or chemical attack; to provide medical screenings and treatment for exposure to biological or chemical agents in the event of bioterrorist attacks, to ensure the availability of mental health services in the event of terrorist attacks, to defray administrative expenses related to the foregoing including the payment of salaries and benefits of DHS personnel and other incidental expenses.

4. Reasonable costs incurred by the County in spreading, billing and collecting the special tax.

Submitting a Proposal

The Measure B Advisory Board (MBAB) will review all submitted requests for Measure B funding at the October meeting of each year. If the request for use of the funding does not meet 1, 2 or 3 above the proposal will be rejected. Below are the steps for submitting a proposal:

1. Complete the attached Measure B Proposal form and submit it, along with any supporting documents, to the EMS Agency by August 15 of the year to allow adequate time for the proposals to be distributed and reviewed prior to the October MBAB meeting.
2. Proposers should attend the October MBAB meeting to be available to answer any questions the members of the MBAB may have related to the proposal.
3. Following the October MBAB meeting, the proposer will be notified whether the proposal was determined to meet proposed usage of Measure B funds and whether it will be recommended to the Board of Supervisors for consideration.

Evaluating and Rank Ordering of the Proposals

After reviewing all proposals submitted for a given year, the MBAB will rank the proposals using a three level ranking system, each qualified proposal will be given a high, medium or low priority. The ranking will be done by MBAB voting members through a consensus process. If a consensus cannot be reached, a simple majority vote of the members will determine the ranking.

The committee may take into consideration the following when evaluating each proposal:

- Consistency with the original intent of Measure B
- Regional or system-wide application and impact
- Improve overall services of trauma, EMS or bioterrorism
- Address any major gap in the system to ensure access and health equity
- Feasibility of proposed project, given the available time and resources

If you have any questions regarding submitting a proposal please contact Kay Fruhwirth, EMS Agency Assistant Director at kfruhwirth@dhs.lacounty.gov or 562-378-1596.

Measure B Funding Proposal

Requesting Agency Name: _____

Point of Contact Name: _____

Point of Contact Phone: _____

Point of Contact email: _____

Brief Project Description:

Describe the gap in Emergency Medical Services, Trauma Services or Bioterrorism Preparedness that the requested funds address:

Is this request for one time or on-going funding? ❑ One time funding ❑ On-going funding

Amount of Funding Requested: $_____

Is project scalable, if unable to fund entire cost? ❑ Yes ❑ No

If scalable, what is the minimal amount of funding needed to support the project?

$_____

Provide as a separate attachment the following documents:

- Budget detail for the requested project identifying the following cost categories: Personnel, Employee Benefits, Supplies, Equipment (unit cost of $5,000 or more) and/or Services.

- Project Timeline: include how soon project would begin once funded, for one-time funding indicate the total time needed to complete project and major milestones along the timeline.

Submit all documents no later than August 15 of the year to:

Los Angeles County

Emergency Medical Services Agency

Measure B Advisory Board

10100 Pioneer Boulevard, Suite 200

Santa Fe Springs, CA 90670