



**LOS ANGELES COUNTY
BOARD OF SUPERVISORS**

Hilda L. Solis
First District

Mark Ridley-Thomas

Second District

Sheila Kuehl

Third District

Janice Hahn

Fourth District

Kathryn Barger

Fifth District

COMMISSIONERS

Ellen Alkon, M.D.

Southern California Public Health Assn.

Lt. Brian S. Bixler

Peace Officers Association of LA County

Erick H. Cheung, M.D., Chairman

Southern CA Psychiatric Society

Marc Eckstein, M.D.

LA County Medical Association

Chief Eugene Harris

Los Angeles County Police Chiefs' Assn.

John Hisserich, Dr. PH., Vice-Chair

Public Member (3rd District)

Lydia Lam, M.D.

American College of Surgeons

James Lott, PsyD., MBA

Public Member (2nd District)

Mr. Robert Ower

LA County Ambulance Association

Margaret Peterson, Ph.D.

Hospital Association of Southern CA

Mr. Paul S. Rodriguez

CA. State Firefighters' Association

Mr. Joseph Salas

Public Member (1st District)

Nerses Sanossian, MD, FAHA

American Heart Association

Western States Affiliate

Carole A. Snyder, RN

Emergency Nurses Association

Mr. Colin Tudor

League of Calif. Cities/LA County Division

Atilla Uner, MD, MPH

California Chapter-American College of

Emergency Physicians (CAL-ACEP)

Mr. Gary Washburn

Public Member (5th District)

Chief David White

Los Angeles Area Fire Chiefs Association

Mr. Pajmon Zarrineghbal

Public Member (4th District)

EXECUTIVE DIRECTOR

Cathy Chidester

(562) 378-1604

CChidester@dhs.lacounty.gov

COMMISSION LIAISON

Denise Watson

(562) 378-1606

DWatson@dhs.lacounty.gov

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

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

(562) 378-1604 FAX (562) 941-5835

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

DATE: January 16, 2019

TIME: 1:00 – 3:00 PM

LOCATION: Los Angeles County Emergency Medical Services Agency
10100 Pioneer Boulevard, 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

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

September 19, 2018

2. CORRESPONDENCE

- 2.1 (10-18-2018) Distribution: Public Safety Naloxone Program Approval
Attachment: Public Safety Agencies Naloxone Approved as of 1/8/19
- 2.2 (11-01-2018) Distribution: Sponsorship of Emergency Medical Services' 50th Anniversary
- 2.3 (11-05-2018) Distribution: Hospital Service Area Boundaries
- 2.4 (12-06-2018) Distribution: Comprehensive Stroke Center Annual Fee
- 2.5 (12-12-2018) Distribution: Basic Tactical Casualty Care
- 2.6 (12-12-2018) Distribution: Public Safety AED Service Provider Program Approval

3. COMMITTEE REPORTS

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

4. POLICIES

- 4.1 Policy No. 312: Pediatric Liaison Nurse
- 4.2 Policy No. 506: Trauma Triage
- 4.3 Policy No. 704: Assessment Unit Inventory
- 4.4 Policy No. 840: Medical Support During Tactical Operations
Attachments: A) Summary by Committee; B) Summary of Comments
- 4.5 Policy No.1010: Mobile Intensive Care Nurse (MICN) Certification
- 4.6 Policy No.1011: Mobile Intensive Care Nurse (MICN) Field Observation
Attachment: MICN Recertification Field Observation CE Documentation

END OF CONSENT AGENDA

IV. BUSINESS

BUSINESS (OLD)

- 5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies Report
- 5.2 Ad Hoc Committee (Wall Time/Diversion)
- 5.3 Updates from Physio-Control/Stryker on ePCR for Los Angeles County Fire Department
- 5.4 Measure B Funding
- 5.5 Nominating Committee (Chair/Vice-Chair – 2019)

BUSINESS (NEW)

- 5.6 Nominations (Standing Committees – 2019)
- 5.7 Education Advisory Committee – Revise Purpose and Membership
- 5.8 ECG Task Force Recommendations and Implementation Plan

V. COMMISSIONERS' COMMENTS/REQUESTS

VI. LEGISLATION

VII. EMS DIRECTOR'S REPORT

VIII. ADJOURNMENT

To the meeting of March 20, 2019

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.



**LOS ANGELES COUNTY
BOARD OF SUPERVISORS**

Hilda L. Solis

First District

Mark Ridley-Thomas

Second District

Sheila Kuehl

Third District

Janice Hahn

Fourth District

Kathryn Barger

Fifth District

COMMISSIONERS

Ellen Alkon, M.D.

Southern California Public Health Assn.

Lt. Brian S. Bixler

Peace Officers Association of LA County

Erick H. Cheung, M.D., Chairman

Southern CA Psychiatric Society

Marc Eckstein, M.D.

LA County Medical Association

Chief Eugene Harris

Los Angeles County Police Chiefs' Assn.

John Hisserich, Dr. PH., Vice-Chair

Public Member (3rd District)

Lydia Lam, M.D.

American College of Surgeons

James Lott, PsyD., MBA

Public Member (2nd District)

Mr. Robert Ower

LA County Ambulance Association

Margaret Peterson, Ph.D.

Hospital Association of Southern CA

Mr. Paul S. Rodriguez

CA State Firefighters' Association

Mr. Joseph Salas

Public Member (1st District)

Nerses Sanossian, MD, FAHA

American Heart Association

Western States Affiliate

Carole A. Snyder, RN

Emergency Nurses Association

Mr. Colin Tudor

League of Calif. Cities/LA County Division

Atila Uner, MD, MPH

California Chapter-American College of

Emergency Physicians (CAL-ACEP)

Mr. Gary Washburn

Public Member (5th District)

Chief David White

Los Angeles Area Fire Chiefs Association

Mr. Pajmon Zarrineghbal

Public Member (4th District)

EXECUTIVE DIRECTOR

Cathy Chidester

(562) 378-1604

CChidester@dhs.lacounty.gov

COMMISSION LIAISON

Denise Watson

(562) 378-1606

DWatson@dhs.lacounty.gov

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

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

(562) 378-1604 FAX (562) 941-5835

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

MINUTES

September 19, 2018

COMMISSIONERS	ORGANIZATION	EMS AGENCY STAFF	POSITION
<input checked="" type="checkbox"/> Ellen Alkon, M.D.	So. CA Public Health Assn.	Kay Fruhwirth	Assistant Director
<input checked="" type="checkbox"/> Lt. Brian S. Bixler	Peace Officers' Assn. of LAC	Denise Watson	Commission Liaison
<input type="checkbox"/> *Erick H. Cheung, M.D.	So. CA Psychiatric Society	Marianne Gausche-Hill	Medical Director
<input type="checkbox"/> *Marc Eckstein, M.D.	L.A. County Medical Assn.	Lily Choi	EMS Staff
<input type="checkbox"/> *Chief Eugene Harris	LAC Police Chiefs' Assn.	Sara Rasnake	EMS Staff
<input type="checkbox"/> *John Hisserich, Dr.PH	Public Member, 3 rd District	Jennifer Calderon	EMS Staff
<input type="checkbox"/> *Lydia Lam, M.D.	So. CA Chapter American College of Surgeons	Lorrie Perez	EMS Staff
<input type="checkbox"/> *James Lott, MBA	Public Member, 2 nd District	Gary Watson	EMS Staff
<input type="checkbox"/> *Robert Ower	LAC Ambulance Association	Christine Zaiser	EMS Staff
<input checked="" type="checkbox"/> Margaret Peterson, PhD	Hospital Assn. of So. CA	Michelle Williams	EMS Staff
<input checked="" type="checkbox"/> Paul S. Rodriguez	CA State Firefighters' Assn.	Puneet Gupta	EMS Staff
<input checked="" type="checkbox"/> Joseph Salas	Public Member, 1 st District	Jacqui Rifenburg	EMS Staff
<input checked="" type="checkbox"/> Nerses Sanossian, M.D.	American Heart Association	Denise Whitfield	EMS Staff
<input checked="" type="checkbox"/> Carole Snyder	Emergency Nurses Assn.	David Wells	EMS Staff
<input type="checkbox"/> *Colin Tudor	League of CA Cities/LAC	Susan Mori	EMS Staff
<input checked="" type="checkbox"/> Atila Uner, M.D.	American College of Emergency Physicians CAL-ACEP	Cathlyn Jennings John Telmos	EMS Staff EMS Staff
<input checked="" type="checkbox"/> Gary Washburn	Public Member, 5 th District	Terry Cramer	EMS Staff
<input type="checkbox"/> *David White	L.A. Area Fire Chiefs' Assn.	Adrian Romero	EMS Staff
<input checked="" type="checkbox"/> Pajmon Zarrineghbal	Public Member, 4 th District	Puneet Gupta	EMS Staff
GUESTS			
Victoria Hernandez	LACoFD	Jessica Strange	SJS
Susan Hayward	Burbank Fire Department	Clayton Kazan	LACoFD
Jaime Garcia	HASC	Mike Barilla	Pasadena Fire Dept.
Ilse Wogau	LACoFD	Nicole Steeneken	LACoFD
Brian Wong	LACoFD	Roger Yang	PFD/Hunting Hosp.
Unikka Wilson	MLK	Yun Son Kim	LACoFD
Jenny Van Slyke	PFD/Hunting Mem. Hospital		

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

I. CALL TO ORDER:

The Emergency Medical Services (EMS) Commission meeting was held in the EMS Commission (EMSC) Hearing Room at 10100 Pioneer Boulevard, Santa Fe Springs, CA 90670. Chairman Erick Cheung and Vice-Chair John Hisserich were on excused absences. In Cathy Chidester's absence (EMS Commission Executive Director), Kay Fruhwirth, EMS Agency Assistant Director, asked Commissioner Carole Snyder to act as Chair Pro Tempore. A quorum was present with 10 commissioners in attendance. ***Motion by Commissioners Washburn/Salas to approve Carole Snyder as the Chair Pro Tempore was carried unanimously.***

The meeting was called to order at 1:00 p.m. by Chair Pro Tempore Carole Snyder.

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS:

Chair Pro Tempore Snyder opened the meeting with self-introductions, starting with EMSC members followed by EMS Agency staff and guests.

Dr. Marianne Gausche-Hill, EMS Agency Medical Director, presented certificates of appreciation to members of the Pasadena Fire and Burbank Fire Departments, along with Los Angeles County "superstar" pins for some key individuals for their critical role in working with the EMS Agency on the provider impression based treatment protocol pilot project. She commended them on their outstanding commitment to promoting excellence and innovation in emergency medical services.

III. CONSENT AGENDA:

Chair Pro Tempore Snyder asked for a motion to approve the Consent Agenda.

Motion by Commissioners Rodriguez/Bixler to approve the Consent Agenda was carried unanimously.

1. MINUTES:

July 18, 2018 Minutes were approved.

2. CORRESPONDENCE:

- 2.1 California EMS for Children Assessment
- 2.2 Diversion Request Requirements for Emergency Department Saturation
- 2.3 Agreement – Data Use

3. COMMITTEE REPORTS:

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

4. POLICIES:

- 4.1 Policy No. 1006: Paramedic Accreditation

END OF CONSENT AGENDA

IV. BUSINESS:

BUSINESS (OLD)

- 5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies Report
Ms. Fruhwirth stated upon recommendation from the EMS Commission to reach out directly to the police departments that did not complete the survey previously sent to law enforcement, consequently additional surveys were returned from several police

departments, Los Angeles Police Dispatch and the Sheriff's Department. There is a 60% return rate for the surveys, and a report will be provided at the next meeting for recommendations and next steps going forward.

5.2 Ad Hoc Committee (Wall Time/Diversion)

Ms. Fruhwirth stated Reference No. 503.1 of the diversion policy allowing provider agencies to place hospitals on diversion if they meet the thresholds as established in the policy, a memo was sent out regarding the go-live date on September 1, 2018, and that the go-live was delayed due to finalization of the work with ReddiNet. It did go-live on September 15, 2018. Per the Medical Alert Center (MAC) prior to today's meeting, they have not had any requests during the first three days of implementation. No provider agencies have called the MAC asking to place a hospital on diversion for excessive wall time. The EMS Agency will monitor diversion instituted based on provider agency requests and report on the frequency and any other issues at future EMS Commission meetings.

Chair Pro Tempore Snyder questioned when Ambulance Patient Offload Time (APOT) numbers and times would be provided. EMS Agency staff, Michelle Williams, agreed to forward the report covering April 1, to June 30, 2017, looking at wall time for most of the providers. Twenty of the public providers are above 90% which means they have less than a 21-minute wall time. There are some outliers, but more of a data entry issue. She will provide this information to the EMS Commission Liaison to provide to commissioners. She stated the reports for the State EMS Commission are in the process of being finalized.

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

Ms. Williams reported that Version Seven (7) test files were received and reviewed, and that some mapping and other issues have arisen. The EMS Agency, L.A. County Fire (LACoFD), Stryker and L.A. City Fire are in on the discussion to get everything resolved, and are working toward getting their data. Version 7 applies to data collected from July 1, 2017, to present date. Ms. Williams reported being current with LACoFD data and L.A. City data through June 30, 2017.

BUSINESS (NEW)

Numbering error: No items were numbered 5.4, 5.5 or 5.6

5.7 EMS Commission Annual Report for Fiscal Year 2017-2018

Chair Pro Tempore Snyder asked for a motion to approve the EMS Commission Annual Report for Fiscal Year 2017-2018.

Motion by Commissioners Washburn/Sanossian to approve the EMS Commission Annual Report was carried unanimously.

5.8 EMS Commission Meeting for November 21, 2018 – Reschedule/Cancel Due to Holiday

Chair Pro Tempore Snyder asked for a motion to approve cancellation of the November 21, 2018 EMS Commission meeting.

Motion by Commissioners Salas/Washburn to cancel the November 21, 2018 EMSC meeting and reconvene January 16, 2019, was carried unanimously.

5.9 Measure B Funding

Ms. Fruhwirth reported that the Measure B Advisory Board (MBAB) funding proposal form was sent to EMS Commission members to work with their constituent groups to

determine if there were any funding needs that were consistent with the intent of Measure B; and, if so, to submit the proposal by August 15, 2018. The MBAB received \$27 million in requests for Measure B funding. The majority were \$23 million for ongoing annual funding. Funding can only be allocated on a year-to-year basis and cannot be allocated on a future basis because we do not know if funds will be available. Some unspent funding may be attributed to higher collections; or, people having an allocation but the actual reimbursement was less because their expenses were less than what was allocated by the Board of Supervisors (Board). The MBAB will make recommendations to the Board of Supervisors related to each funding proposal by ranking the requests as high, medium and low priority. The Board of Supervisors makes the ultimate decision about the allocation of the Measure B funds.

The MBAB falls under the Brown Act and meetings are open to the public. The next scheduled meeting is October 9, 2018, at 1:00 p.m.

5.10 Nominating Committee

Chair Pro Tempore Snyder asked for three commissioners to volunteer for the Nominating Committee to help select the Chair and Vice-Chair nominees for 2019. Commissioners Nerses Sanossian, Margaret Peterson and Carole Snyder volunteered, and will participate on a conference call prior to the January 2019 EMS Commission meeting to identify nominees.

Motion by Commissioners Washburn/Rodriguez to approve the Nominating Committee was carried unanimously.

V. COMMISSIONERS COMMENTS/REQUESTS:

Chair Pro Tempore Snyder requested that a review of the purpose of the Education Advisory Committee and its function be added to the next EMS Commission Agenda since the meetings have been cancelled quite often over the last year-and-a-half. She would like to discuss revamping or possibly cancelling it at the next EMS Commission meeting.

Dr. Gausche-Hill commented on the challenges in providing continuing education, the annual EMS Update, and would like to discuss future planning since Dr. Denise Whitfield has been added to the EMS Agency to facilitate education and innovation for the EMS Agency. She would like to keep it, and consider revamping on how to bring greater value to the stakeholders by providing actual educational content through our website and some other features. She stated rather than disbanding the committee, it might be worthwhile taking an internal look to see where we might go in the future and how to bring greater value to it.

Dr. Gausche-Hill addressed questions from the commissioners concerning the closure of the Pediatric Center at Huntington Hospital. She stated that as of October 1, 2019, they will not continue as a Pediatric Medical Center. They are not closing their doors, they are still an Emergency Department Approved for Pediatrics (EDAP), but their ability to get adequate numbers of pediatric patients in the Pediatric Intensive Care Unit (PICU) is not happening so they recognized this and made the decision to close their PICU. There are 10 other Pediatric Medical Centers in the County, so there is plenty of coverage.

We are asking all our Pediatric Medical Centers to have either a transport team in-house, or to contract for that service. We are tracking this through our Quality Improvement process. There is a system in place for the secondary transfers for children throughout the County.

Dr. Roger C. Yang of Huntington Hospital confirmed the closure of the PICU is the result of not having the volume to remain open, and stated they will remain open until the end of the year rather than close on October 1, 2019, which was the original close date.

VI. LEGISLATION:

Ms. Fruhwirth stated the legislative session is done for the year. We are awaiting the outcome of AB 3115 which is the Gibson with Herzberg Community Paramedicine Bill which did pass as a “gut and amend” bill, and stated it is at Governor Jerry Brown’s desk to determine if he signs or vetoes it.

Ms. Fruhwirth referenced the Canine Bill, and will provide more detail on this Bill after further research.

VII. DIRECTOR’S REPORT:

Ms. Fruhwirth played a video called “Exercise: Tranquil Terminus” that was part of a national exercise on testing the response and transport of patients diagnosed with Ebola Virus Disease or highly infectious disease responses. She stated that we were part of that exercise, and the federal government made a video which reflects the work we do at the EMS Agency and L.A. County in making sure we are prepared for disaster.

“Exercise: Tranquil Terminus”
<https://www.youtube.com/watch?v=LL1BEwy-2DQ>

VIII. ADJOURNMENT:

The meeting was adjourned by Chair Pro Tempore Snyder to the meeting of January 16, 2019.

**Next Meeting: Wednesday, January 16, 2019
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

**Los Angeles County
Board of Supervisors**

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

October 18, 2018

Cynthia Renaud, Chief of Police
Santa Monica Police Department
333 Olympic Dr
Santa Monica, CA 90401

Dear Chief Renaud,

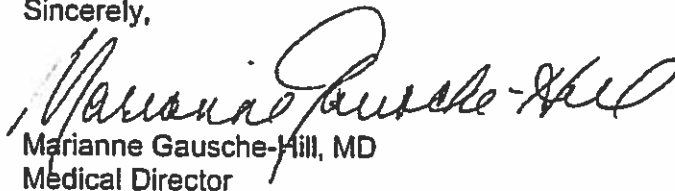
PUBLIC SAFETY NALOXONE PROGRAM APPROVAL

This letter is to confirm that the Santa Monica Police Department (SMPD) has been approved by the Emergency Medical Services (EMS) Agency for the utilization of intranasal naloxone for persons with suspected opiate overdose.

As part of the quality improvement process required for implementation, SMPD will be required to submit quarterly reports to the EMS Agency for purposes of system evaluation and aggregate reporting on the utilization of naloxone by public safety personnel.

Please contact me at (562) 378-1600 or Susan Mori at (562) 378-1681 for any question or concerns.

Sincerely,



Marianne Gausche-Hill, MD
Medical Director

MGH:JT:gk
10-21

c: ✓Director, EMS Agency
Kristina Cochran, Training Officer, Santa Monica Police Department



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

January 8, 2019

PUBLIC SAFETY AGENCIES NALOXONE PROGRAM APPROVED

1. Alhambra Police Department
2. Azusa Police Department
3. Bell Gardens Police Department
4. Claremont College Police Department
5. Claremont Police Department
6. Covina Police Department
7. Downey Police Department
8. El Segundo Police Department
9. Glendale Police Department
10. Glendora Police Department
11. Hawthorne Police Department
12. Hermosa Beach Police Department
13. Inglewood Police Department
14. Los Angeles Police Department
15. Los Angeles Port Authority
16. Los Angeles Airport Police
17. Los Angeles County Sheriff's Department
18. La Verne Police Department
19. Manhattan Beach Police Department
20. Montebello Police Department
21. Monrovia Police Department
22. Redondo Beach Police Department
23. Santa Monica Police Department
24. South Gate Police Department
25. Torrance Police Department
26. Vernon Police Department
27. West Covina Police Department



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

**Los Angeles County
Board of Supervisors**

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Shella Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
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.*



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

November 1, 2018

SPONSORSHIP OF EMERGENCY MEDICAL SERVICES 50TH ANNIVERSARY

In recognition of the 50th anniversary (1969-2019) of the Emergency Medical Services (EMS) system in Los Angeles County, the EMS Agency has partnered with the Los Angeles County Fire Museum to host a 50th Anniversary Celebration on March 21, 2019. Los Angeles County was the site of one of the first EMS systems in the United States and to date is one of the largest nationwide. This event will highlight the important men and women who worked tirelessly to develop the foundation of the innovative EMS system that we have today.

As an integral part of EMS, we would like to give your organization the opportunity to sponsor a portion of this important event in the history of EMS. We feel that it is important to mark the 50 years of this vital public service that has saved countless lives and which became the model for EMS service delivery in the nation.


Gold, Silver, Bronze and Friends of EMS donation opportunities are outlined on the attached. If you have any questions prior to selecting your sponsor level, please contact Joe Woyjeck at oldschoolfd@aol.com or 562-547-8919.

Be sure to check the event website at <https://www.ems50th.org/sponsor-opportunities> to set up your sponsorship and for additional information and updates between now and March 2019. If you prefer to mail your sponsorship check, please fill out the Mail in Sponsorship form and return it with your check made out to LA County Fire Museum (please write **EMS 50th** on the check).

In order for your sponsorship ad to be included in the event brochure and your logo to be included on the event website, please submit the artwork by January 10, 2019 to Richard Tadeo at rtadeo@dhs.lacounty.gov. Full size artwork at 300dpi is required.

We look forward to recognizing your organization's sponsorship of this celebration honoring the 50 years of service excellence in EMS.

Thank you for your support on behalf of the 50 Years of EMS organizing committee!

Sincerely,

Cathy Chidester
Director

Mail in Sponsorship Form

If you prefer to mail your sponsorship check, please fill out the attached form and return it with your check made out to **LA County Fire Museum** (please write **EMS 50th** on the check) to:

EMS 50th Celebration
In Care of: Los Angeles County Fire Museum
9834 Flora Vista Street
Bellflower, CA 90706

FIRST NAME:		LAST NAME:	
COMPANY:			
ADDRESS			
CITY:		STATE:	
ZIP:			
PHONE:		EMAIL:	
COMPANY WEBSITE		SPONSORSHIP LEVEL	\$ AMOUNT



**EMERGENCY MEDICAL SERVICES
50TH ANNIVERSARY CELEBRATION
MARCH 21, 2019
SPONSOR OPPORTUNITIES**

GOLD SPONSOR

\$5,000

- Full page color ad in event brochure
- Company web link and logo prominently displayed on event website
- Company recognition at event
- Company staff photo with SQUAD 51
- Four (4) passes for dinner
- Deadline for artwork submission is January 10, 2019

SILVER SPONSOR

\$3,000

- Half page color ad in event brochure
- Company web link and logo prevalently displayed on event website
- Company recognition at event
- Company staff photo with SQUAD 51
- Two (2) passes for dinner
- Deadline for artwork submission is January 10, 2019

BRONZE SPONSOR

\$1,000 - \$2,999

- Quarter page color ad in event brochure
- Company web link and logo on event website
- (Higher Bronze level - better logo location and size)
- Company recognition at event
- Company staff photo with SQUAD 51
- Two (2) passes for dinner
- Deadline for artwork submission is January 10, 2019

FRIENDS OF EMS

\$100 - \$999

- Sponsorship recognized in event brochure

EVENT BROCHURE ONLY

Full Page Color Ad	\$1,500
Half Page Color Ad	\$1,000
Quarter Page Color Ad	\$ 500
Business Card Color Ad	\$ 250
Deadline for artwork submission is January 10, 2019	

Contact: Joe Woyjeck at (562) 547-8919
Make checks payable to Los Angeles County Fire Museum
(please write **EMS 50th** on the check)

Mail to: 9834 Flora Vista Street, Bellflower, CA 90706

Credit Card accepted through PayPal on-website:
<https://ems50th.org/sponsor-opportunities>

The Los Angeles County Fire Museum is a private 501(c)(3) nonprofit corporation # 33-0294056
The Museum is not an agency of the County of Los Angeles or the County of Los Angeles Fire Department
Any funds not used/needed for the 50th Anniversary Celebration will be donated to the Fire Museum



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

2.3 CORRESPONDENCE

November 5, 2018

CERTIFIED

**Los Angeles County
Board of Supervisors**

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Shella Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

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



Marc Eckstein, MD
Commander – EMS Bureau
Los Angeles Fire Department
200 N. Main Street
Los Angeles, CA 90012

Dear Dr. Eckstein:

HOSPITAL SERVICE AREA BOUNDARIES

Background:

The Service Areas (SA) were put into place in the late 1980s to mitigate the potential closures of the inner city emergency departments (ED). These hospital EDs were severely impacted by patients transported from areas beyond the communities primarily served by these EDs. The high volume of patients negatively impacted the ability of the EDs to provide timely and adequate patient care. SA boundaries were created primarily to prevent the transport of patients to these EDs from distant communities that are outside the SA boundaries. In return the hospital EDs made a commitment to remain open as a full service hospital and provide emergency medical care to its immediate community by not diverting 9-1-1 patients to other hospitals.

Since the opening of MLK Community Hospital (MLK) in Willowbrook two years ago, the 29 bed ED has consistently seen dramatic increases in its ED visits. To date, the ED sees an average of 250 patients daily and frequently over 300. Despite the implementation of operational changes that improved patient thru-put, the continued increase in ED visits has become extremely challenging. The hospital has oftentimes cited dangerous conditions in the ED due to the overcrowding.

The County Board of Supervisors, Department of Health Services, MLK and the EMS Agency have been meeting regularly to develop mitigation plans to address short, mid-range and long term goals which include increasing the physical footprint of the ED to increase capacity, exploring opportunities to further improve efficiency and developing additional partnerships with other health agencies to increase patient disposition and discharge opportunities. One of the short term strategies being targeted is managing the volume of ambulance transports into the ED.

Los Angeles Fire Department (LAFD) EMS personnel have not been consistently compliant with Ref. No. 509, Service Area Hospital. This compounds the ED overcrowding problem at MLK. Patients located within the SAs for Centinela Hospital (CNT), White Memorial Medical Center (WMH) and California Medical Center (CAL) are inappropriately transported to MLK. Additionally, patients located between the SA boundaries of CAL and WMH, assigned to LAC+USC Medical Center (USC), are also being transported to MLK.

Attached for your reference is a map of the SA boundaries for CAL, CNT and WMH.

Dr. Eckstein
November 5, 2018
Page 2

We have explored your recommendation to develop a separate SA for MLK. This is not feasible at this time given the lack of hospital and ED services in areas located south of MLK. Enforcing the existing SA boundaries is the most viable immediate solution to reduce the volume of ambulance transports into MLK.

We are requesting that LAFD implement the following actions to assist with the decompression strategies for MLK:

- Re-educate LAFD EMS personnel on SA policies and boundaries for CNT, CAL and WMH (Ref. Nos. 509, 509.1, 509.1a, 509.2, 509.2a, 509.4 and 509.4a. Patients from the area between the eastern boundary of CAL (Broadway Boulevard to Temple Street) and the western boundary of WMH (Central Avenue and Alameda Street) are to be transported to USC. Please provide the EMS Agency, within 30 days of receipt of this correspondence, documentation verifying that re-education has been completed.
- Provide the EMS Agency monthly reports on the number of transports to CAL, CNT, MLK, USC and WMH.

If you have any questions, please contact me or Richard Tadeo at rtadeo@dhs.lacounty.gov or (562) 378-1610. Thank you for your prompt attention to this matter.

Sincerely,


Cathy Chidester
Director

CC:rt

Attachments

- c. Fire Chief, Los Angeles Fire Department
Director, Department of Health Services
CEO, LAC+USC Medical Center



**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

Don Knabe
Fourth District

Michael D. Antonovich
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*



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

2.4 CORRESPONDENCE

December 6, 2018

TO: Connie Yee, Division Chief
Auditor Controller – Accounting Division

Attention: Rachelle Anema, Principal Accountant

FROM: Cathy Chidester, Director
Department of Health Services, EMS Agency

SUBJECT: COMPREHENSIVE STROKE CENTER – ANNUAL FEE

This is to request your office to review and approve the EMS Comprehensive Stroke Center revised annual fee.

The Stroke Center Programs have been established by the EMS Agency and approved by the Board of Supervisors to regionalize the care of heart attack stroke patients. Regionalization involves the designation of hospitals that meet established standards in order to provide the specialized care needed by patients sustaining stroke. In order to maintain the level of care required by these patients, continuous evaluation and monitoring of the designated hospitals is critical to ensure that the hospitals meet licensure, medical and nursing staff, medical equipment and patient care standards. It is imperative that a data system is in place to collect necessary information to evaluate system performance and conduct quality assurance/improvement activities and ensure appropriate resource allocation.

If you have any questions or need additional information, please contact Maria Morales, Finance Manager, at (562) 378-1591 or by email at marmorales@dhs.lacounty.gov.

Thank you for your support.

CC:mm

Attachments

c: Kay Fruhwirth, Assistant Director, EMS



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

**Los Angeles County
Board of Supervisors**

Hilda L. Soils
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs CA 90670

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

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



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

2.5 CORRESPONDENCE

December 12, 2018

Eric Lane
Hawthorne Police Department
12501 Hawthorne Boulevard
Hawthorne, CA 90250

Dear Lt. Lane:

BASIC TACTICAL CASUALTY CARE

This letter is to inform you that Hawthorne Police Department's (HPD) Basic Tactical Casualty Care (BTCC) Training Program is approved. The BTCC training program requirements outlined in Reference No. 911, *Public Safety First Aid and Basic Tactical Casualty Care Training Program Requirements* have been met.

The approval for the HPD BTCC training program is granted for four (4) years, effective December 12, 2018 through December 31, 2022. The Los Angeles County BTCC provider number for HPD is BTCC-HPD1. This number must appear on all advertisements, rosters and course completion certificates.

The responsibilities for an approved BTCC training program provider are detailed in Reference No. 911. In addition, the following are required:

- Submit a training schedule to the EMS Agency prior to offering a course.
- If significant changes are made to the curriculum, these must be submitted to the EMS Agency for approval, prior to any further course offerings.

Prior to your program expiration in 2022, please submit a complete curriculum renewal application packet to the EMS Agency. This packet needs to be received a minimum of sixty calendar days prior to the expiration date of your program to prevent a lapse in your ability to provide curriculum to approved training programs.

If you have any questions, please contact David Wells at (562) 378-1689 or dwells@dhs.lacounty.gov.

Sincerely,


Cathy Chidester
Director

CC:dw



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Shella Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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



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

2.6 CORRESPONDENCE

December 12, 2018

Michael Ishii, Police Chief
Hawthorne Police Department
12501 Hawthorne Blvd.
Hawthorne, CA 90250

Dear Chief Ishii:

PUBLIC SAFETY AED SERVICE PROVIDER PROGRAM APPROVAL

The Emergency Medical Services (EMS) Agency has completed the review of documents submitted by Hawthorne Police Department (HPD) and is pleased to inform you that HPD has met the requirements outlined in Reference No. 413, Public Safety AED Service Provider Program Requirements.

HPD's program is approved effective December 12, 2018 through November 30, 2021. Uninterrupted program approval requires the following:

- Comply with Agency policies for public safety AED Service Provider Programs
- Submit an AED Service Provider Annual Report to the Agency by March 31st for the preceding year
- Complete a post-event medical review for each incident
- Maintain a roster of public safety personnel including a copy of the following:
 1. Basic Life Support for the Healthcare Provider card
 2. Documentation demonstrating competency in CPR and AED annually

The EMS Agency commends Hawthorne Police Department for electing to provide AED services. Please contact Greg Klein at (562) 378-1685 or gklein@dhs.lacounty.gov for any questions or concerns.

Sincerely,


Cathy Chidester
Director

08-32
CC:JT:SM:gk

c: Lieutenant Eric Lane, Hawthorne Police Department



3.1 COMMITTEE REPORTS
County of Los Angeles • Department of Health Services
Emergency Medical Services Agency



**BASE HOSPITAL ADVISORY COMMITTEE
MINUTES**

December 12, 2018

MEMBERSHIP / ATTENDANCE

REPRESENTATIVES		EMS AGENCY STAFF
<input checked="" type="checkbox"/> Mark Eckstein, M.D., Chair	EMS Commission	Dr. Marianne Gausche-Hill
<input type="checkbox"/> Margaret Peterson, Vice Chair	EMS Commission	Richard Tadeo
<input type="checkbox"/> Lydia Lam, M.D.	EMS Commission	Jaqueline Rifenburg
<input checked="" type="checkbox"/> John Hisserich	EMS Commission	John Telmos
<input type="checkbox"/> Rachel Caffey	Northern Region	Christy Preston
<input checked="" type="checkbox"/> Melissa Carter	Northern Region	Paula Rashi
<input checked="" type="checkbox"/> Charlene Tamparang	Northern Region, Alternate	Susan Mori
<input type="checkbox"/> Samantha Verga-Gates	Southern Region	Gary Watson
<input checked="" type="checkbox"/> Laurie Mejia	Southern Region	David Wells
<input type="checkbox"/> Shelly Trites	Southern Region	Christine Zaiser
<input checked="" type="checkbox"/> Christine Farnham	Southern Region, Alternate	Dr. Puneet Gupta
<input checked="" type="checkbox"/> Paula Rosenfield	Western Region	Jennifer Calderon
<input checked="" type="checkbox"/> Ryan Burgess	Western Region	Lily Choi
<input type="checkbox"/> Alex Perez-Sandi	Western Region, Alternate	Lorrie Perez
<input checked="" type="checkbox"/> Susana Sanchez	Western Region, Alternate	
<input checked="" type="checkbox"/> Laurie Sepke	Eastern Region	
<input checked="" type="checkbox"/> Alina Candal	Eastern Region	
<input checked="" type="checkbox"/> Jenny Van Slyke	Eastern Region, Alternate	
<input type="checkbox"/> Lila Mier	County Hospital Region	
<input checked="" type="checkbox"/> Emerson Martell	County Hospital Region	
<input checked="" type="checkbox"/> Jose Garcia	County Hospital Region	
<input checked="" type="checkbox"/> Yvonne Elizarraz	County Hospital Region	
<input type="checkbox"/> Alec Miller	Provider Agency Advisory Committee	
<input type="checkbox"/> Michael Murrey	Provider Agency Advisory Committee, Alt.	
<input checked="" type="checkbox"/> Laarni Abdenoja	MICN Representative	
<input type="checkbox"/> Adrienne Roel	MICN Representative, Alt.	
<input checked="" type="checkbox"/> Robin Goodman	Pediatric Advisory Committee	
<input type="checkbox"/> Kerry Gold-Tsakonas	Pediatric Advisory Committee, Alt.	
PREHOSPITAL CARE COORDINATORS		
<input checked="" type="checkbox"/> Michael Natividad (AMH)	<input checked="" type="checkbox"/> Heidi Ruff (NRH)	<input type="checkbox"/> Laura Leyman (SFM)
<input checked="" type="checkbox"/> Kelly Arroyo (SMM)	<input checked="" type="checkbox"/> Jessica Strange (SJS), APCC Pres.	<input type="checkbox"/> Gloria Guerra (QVH)
<input checked="" type="checkbox"/> Coleen Harkins (AVH)	<input checked="" type="checkbox"/> Karyn Robinson (GWT) APCC Pres. Elect.	

GUESTS

Shira Schlesinger, M.D. (HGH)

- 1. CALL TO ORDER:** The meeting was called to order at 1:05 P.M. by Jessica Strange, Chairperson pro tem.
- 2. APPROVAL OF MINUTES:** The meeting minutes for June 13, 2018, were approved as submitted.

M/S/C (Burgess/Goodman)

- 3. INTRODUCTIONS/ANNOUNCEMENTS:**
 - Self-introductions were made by all.

4. REPORTS & UPDATES:

4.1 MICN Development Course

Revised objectives for the MICN Development Course have been completed and forwarded to the President of the Association of Prehospital Care Coordinators for distribution.

4.2 EMS Update 2018

EMS Update 2018 has been completed for all base hospitals and MICNs. A notification was provided announcing the implementation of the new Treatment Protocols by all base hospitals to the providers. Paramedics seeking on-line medical direction are expected to carry out medical orders provided by the base hospital. (See attached notification, A1)

4.3 Base Hospital Agreement

A replacement Base Hospital Agreement is being negotiated. The next negotiation meeting will be scheduled for January 2019, more information to come.

4.4 EmergiPress

The EmergiPress has evolved into an online educational module developed by the EMS Agency Physicians. The educational module will consist of a clinical Case of the Month, ECG of the Month, and a video learning module. MICN's and paramedics will have an opportunity to complete a post-test and evaluation to received one (1) hour of non-instructor based EMS CE credit.

Please forward all suggestions and comments to Dr. Marianne Gausche-Hill at mgausche-hill@dhs.lacounty.gov, or Dr. Denise Whitfield at dwhitfield@dhs.lacounty.gov.

5. UNFINISHED BUSINESS:

None

6. NEW BUSINESS:

6.1 Reference. No. 416, Assessment Unit

Changes were approved with no additional recommend changes from the Base Hospital Advisory Committee.

M/S/C (Burgess/Hisserich)

6.2 Reference No. 506, Trauma Triage

Discussion ensued regarding the inclusion of patients with an AV fistula, non-trauma, hemorrhage control with tourniquet, to be transported to a trauma center.

Recommendation: Page 2, J. remove "injuries". To read as, "J. Extremity with:".

6.3 Reference No. 704, Assessment Unit Inventory

Changes were approved with no additional recommend changes from the Base Hospital Advisory Committee.

M/S/C (Burgess/Hisserich)

6.4 Reference No. 1309, Color Code Drug Doses

Changes were approved with no additional recommend changes from the Base Hospital Advisory Committee.

M/S/C (Arroyo/Sepke)

7. **OPEN DISCUSSION:** Dr. Gausche-Hill expressed her gratitude to the BHAC members for their valuable contributions to the Los Angeles County EMS System and their continued participation in the BHAC meetings.

8. **NEXT MEETING:** BHAC's next meeting is scheduled for **February 13, 2019**, location is the EMS Agency, Hearing Room @ 1:00 P.M.

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

ACCOUNTABILITY: Lorrie Perez

9. **ADJOURNMENT:** The meeting was adjourned at 1:40 P.M.

**EMERGENCY MEDICAL SERVICES COMMISSION
DATA ADVISORY COMMITTEE**

MEETING NOTICE

Date & Time: Wednesday, December 12, 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 DECEMBER 2018**



**Los Angeles County
Board of Supervisors**

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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



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



COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION
10100 Pioneer Blvd, Suite 200 Santa Fe Springs, CA 90670
(562) 378-1500 FAX (562) 941-5835



EDUCATION ADVISORY COMMITTEE
MEETING CANCELTION NOTICE

DATE: December 10, 2018

TO: Education Advisory Committee Members

SUBJECT: CANCELTION OF MEETING

Due to a lack of agenda items, the Education Advisory Committee meeting scheduled for December 19, 2018 has been canceled.

NEXT MEETING:

Date: Wednesday, February 20, 2019
Time: 10:00 am
Location: EMS Agency Headquarters
EMS Commission Hearing Room
10100 Pioneer Blvd, Room 128
Santa Fe Springs, CA 90670

EMERGENCY MEDICAL SERVICES COMMISSION
PROVIDER AGENCY ADVISORY COMMITTEE
MINUTES

Wednesday, October 17, 2018

MEMBERSHIP / ATTENDANCE

MEMBERS

- ☒ Dave White, Chair
- ☒ Robert Ower, Vice-Chair
- ☐ Paul Rodriguez
- ☐ Brian Bixler
- ☐ Jodi Nevandro
 - ☒ Sean Stokes
- ☒ Nick Berkuta
 - ☒ Clayton Kazan, MD
 - ☒ Victoria Hernandez
- ☐ Ken Leasure
 - ☐ Susan Hayward
- ☒ Ivan Orloff
 - ☒ Mike Beeghly
- ☐ James Flint
 - ☒ Joanne Dolan
- ☐ Alec Miller
 - ☐ Michael Murrey
- ☒ Doug Zabalski
 - ☐ Anthony Hardaway
 - ☐ Matthew Conroy
- ☒ Luis Vazquez
 - ☐ Tisha Hamilton
- ☐ Rachel Caffey
 - ☐ Jenny Van Slyke
- ☐ Andrew Respicio
 - ☒ Andrew Gano
- ☒ Maurice Guillen
 - ☐ Scott Buck
- ☐ Marc Eckstein, MD
 - ☐ Stephen Shea, MD
- ☒ Ian Wilson
 - ☐ Vacant

ORGANIZATION

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

EMS AGENCY STAFF PRESENT

Marianne Gausche-Hill, MD	Nichole Bosson, MD
Richard Tadeo	Denise Whitfield, MD
Jennifer Calderon	Chris Clare
Elaine Forsyth	Cathlyn Jennings
Susan Mori	Nnabuike Nwanonyi
Paula Rashi	Jacqui Rifenburg
Phillip Santos	John Telmos
Gary Watson	David Wells
Michelle Williams	Christine Zaiser
Lily Choi	

OTHER ATTENDIES

Joe Nakagawa, MD	McCormick Ambulance
Randy Howard	Ambulnz Ambulance
Emilio Gaona	Royalty Ambulance
Christina LaPiene	Viewpoint Ambulance
Brooke Sisneros	Viewpoint Ambulance
Richard Roman	Compton FD
Humberto Ramirez	West Coast Ambulance
Paula LaFarge	LACoFD
Jacob Wagoner	Lynch Ambulance
Jay Ibey	Downey FD
Dave Molyneux	AMWest Ambulance
Richard Morrison	Firstmed Ambulance
Charles Burgess	Firstmed Ambulance

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

CALL TO ORDER: Committee Chair, Commissioner David White called meeting to order at 1:06 p.m.

1. APPROVAL OF MINUTES (Orloff/Berkuta) August 15, 2018 minutes were approved as written.

2. INTRODUCTIONS / ANNOUNCEMENTS

2.1 Committee Membership Change (David White)

Area H Representative: Doug Zabalski (Los Angeles FD) replacing Corey Rose (Los Angeles FD)
 Area H Alternate: Anthony Hardaway (Los Angeles FD) replacing Ellsworth Fortman (Los Angeles FD)
 Area H Alternate: Matthew Conroy (Los Angeles FD) replacing Doug Zabalski (Los Angeles FD)

2.2 Change to EMS Agency Staff (Richard Tadeo)

Please welcome Jacqueline Rifenburg into the position as Chief of Prehospital Certification and Training Program Approvals; replacing Lucy Hickey, who retired in April 2018.

3. REPORTS & UPDATES

3.1 EMS Update 2018 / Provider Impressions (Richard Tadeo)

During November and December 2018, the EMS Agency will be hosting “Train-the-Trainer” classes. Contact Jacqui Rifenburg (jrifenburg@dhs.lacounty.gov) or Nick Todd (ntodd@dhs.lacounty.gov) to RSVP.

Provider Impressions (PI) Implementation – Six public providers have implemented the new PI. LACoFD and LAFD have been approved to start implementation during the 1st Quarter 2019. All base hospitals have implemented the new PI.

Suspension Letters - Providers and base hospitals are to provide the EMS Agency with training rosters once their paramedics and MICNs have completed EMS Update 2018. Deadline to complete EMS Update 2018 is December 1, 2018. Beginning December 17, 2018, suspension letters will be sent to those who have not completed the Update training. Suspensions will go into effect January 2, 2019.

Quality Improvement – Once the new PI have been implemented, providers are to conduct a 100% review; then, based on your department's results, you may reduce to 25% QI review.

The EMS Agency is looking into a Systemwide QI plan that would include providers reporting the number of PIs utilized, total number of PIs reviewed, how many of fallouts, and the reason for the fallout. Initially, there would be monthly reporting to the EMS Agency and eventually transition to a quarterly reporting.

Outcome Data – The EMS Agency has looked into the possibility of providers given access to the TEMIS system in order to retrieve outcome data. For access to occur, several steps would have to take place: TEMIS would have to create a “view” only program; each of the provider's computer would have to download a specific TEMIS icon; and providers would have to buy into a subscription program.

However, over the next couple of years, the EMS Agency is looking into converting TEMIS into a web-based system. This would allow more flexibility on who can access TEMIS with a subscription.

In the interim, the EMS Agency will develop specific TEMIS fallout reports. Once these reports are built, providers may request specific fallout reports through the EMS Agency.

The EMS Agency also is looking into piloting a program called “EDIE” in order to obtain outcome data from receiving hospitals who participate in EDIE. This software program is able to query specific data from hospital records and push that data the other participating hospitals. The goal is the pilot is to determine whether outcome data can be pushed to TEMIS.

3.2 Disaster Programs Update (Elaine Forsyth)

Infection Control Assessment: During 2016-2017, the Department of Public Health in conjunction with the EMS Agency, conducted an infection control assessment of selected private and public providers of Los Angeles County through ambulance ride-a-longs. Blinded results of these assessments were presented.

As a result of these assessments, infection control training sessions were conducted during the month of September 2018. Those interested in receiving this training material may contact either Christina Eclarino (ceclarino@ph.lacounty.gov) or Gary Watson (gwatson@dhs.lacounty.gov).

Hepatitis A Vaccine: Those who received the first dose of the vaccine, should be seeking the 2nd dose through their primary healthcare providers.

3.3 ECG Transmission Task Force (Nichole Bosson, MD)

The task force has concluded after meeting monthly for the past year. This task force came up with several recommendations in order to assist providers in reaching the goal of transmitting 100% of the acquired ECGs within one minute to the receiving hospitals.

Many recommendations have been incorporated into the new Medical Control Guidelines being rolled out with the revised Treatment Protocols. Other recommendations and additional training modules will be rolled out through the Emergi-Press over the next year.

Dr. Bosson and Dr. Gausche-Hill stressed the importance that, if a paramedic disagrees with the electronic interpretation of an ECG, they should communicate this to the base and/or SRC.

3.4 Emergi-Press Newsletter (Denise Whitfield, MD)

New website design for the EMS Agency's Emergi-Press was presented. Future plan is to have the monthly newsletter sent out through a subscription-based, email distribution list. Also, reviewing the possibility of making the education material available for providers who want to issue continuing education hours to their personnel.

3.5 Spinal Motion Restriction (SMR) (Nichole Bosson, MD)

In 2014, the EMS Agency transitioned from the terminology and practice of "spinal immobilization" to "spinal motion restriction". This presentation discussed risks and benefits of the use of backboards and cervical collars during SMR; how the EMS Agency incorporated SMR into the new Medical Control Guidelines; and looked at potential future innovations of SMR.

4. UNFINISHED BUSINESS

There was no unfinished business.

5. NEW BUSINESS

5.1 Reference No. 840, Medical Support During Tactical Operations (John Telmos)

Policy reviewed and approved with the following recommendations:

- Page 1 of 4, DEFINITIONS: Police Canine (K-9):
Remove word "Police" or add verbiage to be more inclusive of other first responders such as urban search and rescue teams
- Page 3 of 4, Policy IV. B.:
Last sentence, replace the word "provider" with the word "handler".

M/S/C (Gano/Orloff) Approve Reference No. 840, Medical Support During Tactical Operations, with above recommendations.

6. OPEN DISCUSSION:

6.1 Stop the Bleed Initiative (Susan Mori)

LA County Department of Public Health is hosting classes to become a certified bleed control trainer for the Stop the Bleed initiative in Los Angeles County. Training is free. Those interested in this train the trainer course can contact Phyllis Tan at ptan@ph.lacounty.gov

6.2 Controlled Drug Policy Revisions (Gary Watson)

For providers who are utilizing a standardized policy template (ex. Lexipol) as a guide to creating their department's controlled substance policy, please ensure it follows your own department's process and the required language found in the most recent Reference No. 702, Controlled Drugs Carried on ALS Units.

6.3 Transitioning to New Treatment Protocols (Doug Zabitski)

A question was asked as to whether a paramedic may implement a base hospital order from the new treatment protocols (and the order does not exist in the old protocols) when the paramedic has not completed the EMS Update training. The EMS Agency confirmed that a paramedic may implement these base orders provided it is within their scope of practice. A request was made for the EMS Agency to codify in writing that paramedics may accept online orders from the Base Hospitals regardless of whether the paramedic has completed the EMS Update training (e.g., fluid resuscitation for patients with sepsis). However, the paramedics may not implement procedures or treatment that they have not been trained on or do not have the equipment/pharmaceutical in their inventory (e.g., administration of lidocaine and IO on the alert conscious patient).

Reminder: Open communication between the paramedics and base hospitals of any concerns is paramount to providing optimum patient care.

- 7. NEXT MEETING:** December 19, 2018
- 8. ADJOURNMENT:** Meeting adjourned at 2:15 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELESSUBJECT: **PEDIATRIC LIAISON NURSE**REFERENCE NO. 312

PURPOSE: To establish accountability for the oversight of the Emergency Department Approved for Pediatrics (EDAP) Program according to the current EDAP Standards.

AUTHORITY: EDAP Standards

DEFINITION: **Pediatric Liaison Nurse (PdLN):** Nurse coordinator appointed by an EDAP hospital to coordinate the activities required by the EDAP Standards for pediatric emergency care.

POLICY:

I. Qualifications:

- A. Licensed as a Registered Nurse (RN) in the State of California.
- B. At least two years of experience working in pediatrics, or in an Emergency Department (ED) that provides care for pediatric patients, within the previous five (5) years.
- C. Current American Heart Association Pediatric Advanced Life Support (PALS) provider or instructor.
- D. Completion of a two-day pediatric emergency course within the last four (4) years.
- E. Completion of seven hours of pediatric continuing education (CE) approved by the Board of Registered Nursing every two years.

II. Responsibilities:

- A. Collaborates with the EDAP Medical Director, ED Nurse Manager/Director, and Designated Pediatric Consultant to ensure compliance with Reference No. 316, EDAP Standards, and policies and procedures established by the EMS Agency.
- B. Implement and monitor the EDAP quality improvement program to include data collection and reporting as per Reference 620, EMS Quality Improvement Program.
- C. Serves as a liaison and maintains effective lines of communication with:
 - 1. ED management, physicians, and personnel
 - 2. Hospital pediatric management, physicians, and personnel
 - 3. Paramedic base hospital personnel

EFFECTIVE: 01-01-16
REVISED: XX-XX-19
SUPERSEDES: 01-01-16

PAGE 1 OF 2

APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

4. System PdLNs
 5. Prehospital Care Coordinators as needed to follow up with pediatric treatment and/or transport concerns
 6. Prehospital care providers as needed to follow up with pediatric treatment and/or transport concerns
 7. Other EDAPs and Pediatric Medical Centers
 8. EMS Agency
- D. Serves as the contact person for the EMS Agency and be available upon request to respond to County business.
- E. Develop a mechanism to track and monitor pediatric continuing education, including PALS, for the ED staff.
- F. Participate in EMS activities and meetings, and attend a minimum of two (2) Pediatric Advisory Committee meetings per year.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 316, **Emergency Department Approved for Pediatrics (EDAP) Standards**
Ref. No. 620, **EMS Quality Improvement Program**
Ref. No. 621, **Notification of Personnel Change**
Ref. No. 621.1, **Notification of Personnel Change**



SUBJECT: TRAUMA TRIAGE

PURPOSE: To establish criteria and standards which ensure that patients requiring the care of a trauma center are appropriately triaged and transported.

AUTHORITY: California Code of Regulations, Title 13, Section 1105(c) California Code of Regulations, Title 22, Section 100236 et seq. Health and Safety Code, Div. 2.5, Section 1797 et seq., and 1317.

PRINCIPLES:

1. Trauma patients should be secured and transported from the scene as quickly as possible, consistent with optimal trauma care.
2. Paramedics shall make base hospital contact and/or notification to the receiving trauma center on all injured patients who meet trauma triage criteria and/or guidelines, or if in the paramedic's judgment it is in the patient's best interest to be transported to a trauma center. Contact shall be accomplished in such a way as not to delay transport.
3. Do not delay transport of hypotensive patients with penetrating torso trauma in order to apply spinal motion restriction.
4. EMT personnel may immediately transport hypotensive patients with life-threatening, penetrating injuries to the torso to the closest trauma center, not the Most Accessible Receiving (MAR), when the transport time is less than the estimated time of paramedic arrival. The transporting unit should make every effort to contact the receiving trauma center.
5. When pediatric and adult trauma patients are transported together in one aircraft, the receiving trauma center shall be both a trauma center and a pediatric trauma center.

POLICY:

- I. Trauma Criteria – Requires immediate transportation to a designated trauma center

Patients who fall into one or more of the following categories are to be transported directly to the designated trauma center, if transport time does not exceed 30 minutes.

- A. Systolic blood pressure less than 90 mmHg, or less than 70 mmHg in infants age less than one year
- B. Respiratory rate greater than 29 breaths/minute (sustained), less than 10 breaths/minute, less than 20 breaths/minute in infants age less than one year, or requiring ventilatory support

EFFECTIVE DATE: 06-15-87
REVISED: XX-XX-19
SUPERSEDES: 06-01-18

PAGE 1 OF 5

APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

- C. Cardiopulmonary arrest with penetrating torso trauma unless based upon the paramedic's thorough assessment is found apneic, pulseless, asystolic, and without pupillary reflexes upon arrival of EMS personnel at the scene
- D. All penetrating injuries to head, neck, torso, and extremities proximal to the elbow or knee
- E. Blunt head injury associated with a suspected skull fracture, altered level of consciousness (Glasgow Coma Score less than or equal to 14), seizures, unequal pupils, or focal neurological deficit
- F. Injury to the spinal column associated with acute sensory or motor deficit
- G. Blunt injury to chest with unstable chest wall (flail chest)
- H. Diffuse abdominal tenderness
- I. Suspected pelvic fracture (excluding isolated hip fracture from a ground level fall)
- J. Extremity with:
 - 1. Neurological/vascular compromise and/or crushed, degloved, or mangled extremity
 - 2. Amputation proximal to the wrist or ankle
 - 3. Fractures of two or more proximal (humerus/femur) long-bones
 - 4. Bleeding not controlled by direct pressure requiring the usage of a hemorrhage control tourniquet or hemostatic agent (approved provider agencies only)
- K. Falls:
 - 1. Adult patients from heights greater than 15 feet
 - 2. Pediatric patients from heights greater than 10 feet, or greater than 3 times the height of the child
- L. Passenger space intrusion of greater than 12 inches into an occupied passenger space
- M. Ejected from vehicles (partial or complete)
- N. Auto versus pedestrian/bicyclist/motorcyclist thrown, run over, or with significant (greater than 20 mph) impact
- O. Unenclosed transport crash with significant (greater than 20 mph) impact

- P. Major / Critical Burn (excluding those in which the MAR is a recognized Burn Center, e.g., LAC+USC Medical Center, Torrance Memorial Medical Center, West Hills Hospital):
 - 1. Patients 15 years of age or older with 2nd (partial thickness) and 3rd (full thickness) degree burns involving equal to or greater than 20% Total Body Surface Area (TBSA)
 - 2. Patients ≤ 14 years of age with 2nd (partial thickness) and 3rd (full thickness) degree burns involving equal to or greater than 10% TBSA
- II. Trauma Guidelines – Mechanism of injury and patient history are the most effective methods of selecting critically injured patients before unstable vital signs develop. Paramedics and base hospital personnel should consider mechanism of injury and patient history when determining patient destination. At the discretion of the base hospital or approved SFTP provider agency, transportation to a trauma center is advisable for:
 - A. Passenger space intrusion of greater than 18 inches into any unoccupied passenger space
 - B. Automobile versus pedestrian/bicyclist/motorcyclist (impact equal to or less than 20 mph)
 - C. Injured victims of vehicular crashes in which a fatality occurred in the same vehicle
 - D. Patients requiring extrication
 - E. Vehicle telemetry data consistent with high risk of injury
 - F. Injured patients (excluding isolated minor extremity injuries):
 - 1. on anticoagulation therapy, other than aspirin-only
 - 2. with bleeding disorders
- III. Special Considerations – Consider transporting injured patients with the following to a trauma center:
 - A. Patients in blunt traumatic full arrest who, based on a paramedic's thorough patient assessment, was not found apneic, pulseless, and without organized ECG activity (narrow complex supraventricular rhythm) upon the arrival of EMS personnel at the scene
 - B. Adults age greater than 55 years
 - C. Systolic blood pressure less than 110 mmHg may represent shock after age 65 years
 - D. Pregnancy greater than 20 weeks gestation

E. Prehospital judgment

IV. Extremis Patients - Requires immediate transportation to the MAR:

- A. Patients with an obstructed airway or those with concern for imminent airway obstruction due to inhalation injury
- B. Patients, as determined by the base hospital personnel, whose lives would be jeopardized by transportation to any destination but the MAR

V. When, for whatever reason, base hospital contact cannot be made, the destination decision for injured patients will be made by paramedics using the principles set forth above.

VI. 9-1-1 Trauma Re-Triage – This section applies to injured patients in emergency departments of non-trauma centers whose injuries were initially estimated by EMS to be less serious (under triaged) or patients who self-transported (walk-in) to a non-trauma center, and subsequently assessed by the non-trauma center physician to require immediate trauma center care. The referring facility shall utilize the procedure outlined below to expedite transfer arrangements and rapid transport to the trauma center. This process should be reserved for patients with life-threatening traumatic injuries requiring emergent surgical intervention.

A. Determine if the injured patient meets any of the following 9-1-1 Trauma Re-Triage criteria:

- 1. Persistent signs of poor perfusion
- 2. Need for immediate blood replacement therapy
- 3. Intubation required
- 4. Glasgow Coma Score less than 9
- 5. Glasgow Coma Score deteriorating by 2 or more points during observation
- 6. Penetrating injuries to head, neck and torso
- 7. Extremity injury with neurovascular compromise or loss of pulses
- 8. Patients, who in the judgement of the evaluating emergency physician, have high likelihood of requiring emergent life- or limb-saving intervention within two (2) hours.

B. Contact the designated receiving trauma center or pediatric trauma center if the patient is less than or equal to 14 years of age and transport does not exceed 30 min. Do not delay transfer by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.

- C. Contact 9-1-1 for transportation. The paramedic scope of practice (Ref. No. 803) does not include paralyzing agents and blood products.
- D. Prepare patient and available medical records for immediate transport. Do not delay transport for medical records which could be sent at a later time.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 501, **Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No. 504, **Trauma Patient Destination**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 803, **Paramedic Scope of Practice**
Ref. No. 814, **Determination/Pronouncement of Death in the Field**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **ASSESSMENT UNIT INVENTORY**

(PARAMEDIC, MICN)
REFERENCE NO. 704

PURPOSE: To provide a standardized minimum inventory on all Assessment Units.

PRINCIPLE:

1. Any equipment or supplies carried for use in providing emergency medical care must be maintained in good working order.
2. The minimum required amounts may be augmented according to anticipated needs in consultation with the Provider Agency Medical Director or the Medical Director of the Emergency Medical Services Agency

POLICY:

- I. Assessment Units shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency.
- II. All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens.

MEDICATIONS* (minimum required amounts)			
Adenosine	6mgs	Glucagon	1mg
Albuterol (pre-mixed with NS)	5mgs	Naloxone	2mgs
Aspirin (chewable 81 mg)	648mgs	Normal saline (for injection)	2 vials
Atropine sulfate (1 mg/10 ml)	1mg	Nitroglycerin (SL) spray, tablets, or single dose powder packets	1 pump/ bottle/ or 36 packets
Dextrose 10% / Water 250 mL	1	Ondansetron 4mg ODT	16mgs
Dextrose solution (glucose paste may be substituted)	100gms	Ondansetron 4mg IV	16mgs
Epinephrine (1mg/mL)	1mg	Sodium bicarbonate	50mls
Epinephrine (0.1mg/mL)	2mgs		
INTRAVENOUS FLUIDS (minimum required amounts)			
250 or 500 ml normal saline	2 bags		
SUPPLIES* (minimum required amounts)			
Airways – Oropharyngeal		Bag-valve mask	
Large	1	Large	1
Medium	1	Medium	1
Small Adult/Child	1	Small Adult/Child	1
Infant	1	Infant	1
Neonate	1	Neonate	1

EFFECTIVE: 01-01-78
REVISED: XX-XX-19
SUPERSEDES: 08-01-17

PAGE 1 OF 3

APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

SUPPLIES* (minimum required amounts)			
Adhesive dressing (Band-Aids®)	5	Laryngoscope Handle Adult (compatible w/ pediatric blades)	1
Alcohol prep pads	5	Laryngoscope Blades	
Bag-valve device with O ₂ inlet and reservoir Adult & Pediatric	1 each	Adult, curved and straight	1 each
Burn pack or burn sheets	1	Pediatric, Miller #1 & #2	1 each
Cardiac Monitor-Defibrillator with oscilloscope	1	Magill Forceps Adult & Pediatric	1 each
Cervical collars (rigid)		Mucosal Atomization Device (MAD)	2
Adult (adjustable)	1	Needle, filtered-5micron ¹	1
Pediatric	1	Normal saline for irrigation	1 bottle
Reference No. 1309, Color Code Drug Doses	1	OB pack and bulb syringe	1
Contaminated needle container	1	Oxygen cannula	1
Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5" 14G	2	Oxygen Masks (non-rebreather) Adult & Pediatric	1 each
Defibrillator pads or paste (including pediatric)	2	Pediatric Length-Based Resuscitation Tape (Broselow 2011A or newer)	1
ECG Electrodes Adult & Pediatric	6	Personal Protective Equipment – mask, gown, eye protection	1 each per provider
Endotracheal tubes with stylets Sizes 6.5-7.5	1 each	Radio transmitter receiver (Hand-Held) ⁴	1
End Tidal CO ₂ Detector or Aspirator (Adult)	1	Saline locks	2
Flashlight or Penlight	1	Scissors	1
Gauze sponges 4x4 (sterile)	4	Sphygmomanometer Adult, Pediatric, & Thigh	1 each
Gauze bandages	2	Stethoscope	1
Gloves Unsterile	6 pairs	Suction Unit (portable) w/adaptor	1
Glucometer with strips	1	Suction Instruments Sizes 8Fr.-12Fr. Catheters	1 each
Hand-held nebulizer pack	1	Tonsillar Tip	1
Intravenous catheters Sizes 16G-22G	2 each	Syringes 1ml – 60ml w/luer adapter	assorted
Intravenous Tubing	2	Tape (various types, must include cloth)	1
King LTS-D (Disposable Supraglottic Airway w/ 60mL Syringe)		Tourniquets	2
Small Adult (Size 3)	1	Tourniquets (commercial for bleeding control)	2
Adult (Size 4)	1	Tube Introducer	2
Large Adult (Size 5)	1	Vaseline gauze	2
Lancets (automatic retractable)	2		
SUPPLIES* (approved optional equipment)			
Continuous Positive Airway Pressure (CPAP) Device ²	1	Lidocaine 2% ³	
Hemostatic Dressings ²		Splints – (long and short)	2 each
Intraosseous Device ² Adult & Pediatric	1 each	Splints – traction Adult & Pediatric	1 each

¹ Optional, if not utilizing glass ampules² Requires EMS Agency approval, which includes an approved training program and QI method prior to implementation³ Utilized with infusions through IO access⁴ Los Angeles County Department of Communications, Spec. No. 2029/2031/2033

This policy is intended as an Assessment 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. 416, **Assessment Units**

Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **MEDICAL SUPPORT DURING TACTICAL OPERATIONS** EMT, PARAMEDIC, MICN, PHYSICIAN
REFERENCE NO. 840

PURPOSE: To provide direction for tactical emergency medical services (TEMS) personnel assigned to a tactical team by an agency that is conducting a preplanned law enforcement incident.

To provide guidance for emergency transportation of police and EMS responder canine's injured in the line of duty.

AUTHORITY: Health and Safety Code 1797.10, 1797.220, 1797.221, 1798
California Code of Regulations, Title 22, Division 9, Chapter 3

DEFINITIONS:

Peace Officer Standards and Training (POST): The California Commission on Peace Officer Standards and Training develops training standards and evaluates/approves curriculum for basic police officer training programs in California.

Tactical Medicine Training Program: A POST-certified and EMSA-approved, specific operational training program for tactical medicine providers and operators that trains EMS personnel to safely deliver medical care during a law enforcement response.

Tactical Emergency Medical Services (TEMS) Personnel: Physicians, Emergency Medical Technicians (EMTs), paramedics or Mobile Intensive Care Nurses (MICNs) that have successfully completed a tactical medicine training program, that provide medical care during a tactical response utilizing their authorized scope of practice.

Weapons of Mass Destruction (WMD): Weapons or devices intended to cause death or serious bodily injury to a significant number of people through the release of toxic chemicals. A disease organism, or radiation.

Hot Zone: The area in which there is a direct and immediate threat.

Warm Zone: The area deemed by law enforcement to no longer have direct or immediate threats which can be utilized to perform tactical field care and triage to victims.

Cold Zone: The area where no significant danger or threat is reasonably anticipated for the provider or patient.

Police/EMS Responder Canine (K-9): A dog that is part of a team of law enforcement officers or EMS providers, with specific training in and duties that may include, but not limited to, search and rescue, passive alert dog, and service dog.

EFFECTIVE: 03-30-11

PAGE 1 OF 4

REVISED:

SUPERSEDES:

APPROVED:

Director, EMS Agency

Medical Director, EMS Agency

PRINCIPLES:

1. Training is a critical role in the ability of TEMS personnel to effectively support law enforcement and contribute to the safe and successful resolution of critical incident responses.
2. These guidelines are not intended to replace existing EMS policies or circumvent the established response of EMS in the local county.
3. While medical support is important at any tactical operation, agencies should carefully consider the risk versus benefit of adding armed personnel with limited firearms and tactical experience.
4. A primary objective of TEMS is to provide the medical treatment of victims outside of the hot zone. Ideally, patient care should be provided in the cold zone.
5. The TEMS provider agency should participate in the pre-planning of incident management.
6. EMS personnel who operate in the cold zone should receive an orientation to TEMS operations.
7. K-9 units are an integral part of the team, working collaboratively with EMS responders and police officers as first responders to incidents and crime scenes. K-9s injured in the line of duty may require immediate transport to a facility capable of caring for their injuries.

POLICY:

I. Certification

- A. Paramedics and MICNs that are a member of a TEMS team shall be employed on duty and sponsored by an approved Advanced Life Support (ALS) provider.
 1. Paramedics shall be licensed by the State and accredited in Los Angeles County.
 2. MICNs shall have a current California license as a Registered Nurse and a current Los Angeles County MICN certification.
- B. EMTs shall be certified by the State and have successfully completed the Los Angeles County local scope of practice.

II. Training

- A. TEMS personnel who operate within a hot zone shall be trained, at minimum, through a POST-certified and EMSA-approved or equivalent tactical medicine training program. The training hour requirements as outlined in POST/EMSA Recommendations are:
 1. Non-law enforcement TEMS personnel

- a. An 80-hour minimum course which includes didactic and skills training, tactical weapons operations, medical scenarios and includes final written, skills and tactical medical scenario examinations.

2. Law Enforcement TEMS personnel

- a. Must be pre-qualified by successful completion of a POST-approved Basic Special Weapons and Tactics (SWAT) course and an approved WMD training including medical care for WMD.
- b. A 40-hour minimum course which includes didactic and skills training, medical scenarios and includes final written, skills and tactical medical scenario examinations.

III. Deployment

- A. TEMS personnel should be familiar with the location of the nearest medical centers, paramedic base hospitals and specialty centers such as trauma, pediatric trauma centers, etc.
- B. When responding to jurisdictions outside of Los Angeles County, TEMS personnel shall operate within their accredited scope of practice.

IV. Emergency Treatment and Transportation of an Injured Police/EMS Responder K-9

- A. A licensed Los Angeles County Ambulance Operator is authorized to transport a police/EMS responder K-9 injured in the line of duty, to a veterinary medical facility capable of treating the K-9 if the unit is unencumbered and no person is requiring medical services of the ambulance at the time the decision is made to transport the K-9.
- B. It is the responsibility of the handler to maintain control of the K-9 while providing medical treatment en-route. If comfortable, the ambulance crew may assist in the moving and transportation of the K-9 while allowing the necessary space in the back of the ambulance for the handler to render care.
- C. An injured K-9 may be aggressive towards its handler, therefore, the ambulance crew should only assist with the K-9's care when it is determined to be safe and at the direction of the handler.
- D. The handler is responsible to have all necessary equipment and supplies to care for the injured K-9. The ambulance crew may provide additional supplies (dressings, etc.) if requested.
- E. It is the handler's responsibility to be familiar with, and provide directions to, the most appropriate receiving veterinary facility. The ambulance crew, or their dispatch, at the request of the handler, may contact the veterinary facility (contact information will be provided by the handler) while en-route, in order to provide an estimated time of arrival to the facility.

CROSS REFERENCES:

Prehospital Care Policy Manual:

Ref. No. 502, **Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 802, **Emergency Medical Technician (EMT) Scope of Practice**
Ref. No. 802.1, **EMT Scope of Practice, Table Forma**)
Ref. No. 803, **Los Angeles County Paramedic Scope of Practice**
Ref. No. 803.1, **Los Angeles County Paramedic Scope of Practice, Table Format**
Ref. No. 1006, **Paramedic Accreditation**
Ref. No. 1010, **Mobile Intensive Care Nurse (MICN) Certification/Recertification**

California Peace Officer Standards and Training (POST) in collaboration with the Emergency Medical Services Authority, *Tactical Medicine, Operational Programs and Standardized Training Recommendations*, July 2009.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

POLICY REVIEW - SUMMARY BY COMMITTEE

ATTACHMENT A

Reference No. 840, Medical Support During Tactical Operations

		Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES		Provider Agency Advisory Committee	11/17/2018	11/17/2018	Y
		Base Hospital Advisory Committee			
		Data Advisory Committee			
		Education Advisory Committee			
OTHER COMMITTEES/RESOURCES		Medical Council			
		Trauma Hospital Advisory Committee			
		Ambulance Advisory Board			
		EMS QI Committee			
		Hospital Association of So California			
		County Counsel			
		Disaster Healthcare Coalition Advisory Committee			
		Other:			

*See **Summary of Comments** (Attachment B)

Reference No. 840 - Medical Support During Tactical Operations

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Definitions	PAAC 10/17/18	Change wording in definition for police canine (k-9)), to include EMS responders. Will read "police/EMS Responder"	Change made
IV-B	PAAC 10/17/18	Change provider in the last sentence to "handler"	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELESSUBJECT: **MOBILE INTENSIVE CARE NURSE
(MICN) CERTIFICATION**REFERENCE NO. 1010

PURPOSE: To outline the requirements for Los Angeles County Mobile Intensive Care Nurse (MICN) certification and recertification.

AUTHORITY: Health and Safety Code, Division 2.5, Chapter 2, Sections 1797.56, 1797.58, 1797.63 and Chapter 3, Article 5, Section 1797.175; California Code of Regulations, Title 22, Division 9, Sections 100168 – 100170

DEFINITIONS:

Mobile Intensive Care Nurse (MICN): A registered nurse authorized by the Medical Director of the local Emergency Medical Services (EMS) agency to provide prehospital advanced life support (ALS) or issue instructions to prehospital emergency personnel within an EMS system according to standardized procedures developed by the local EMS agency consistent with statewide guidelines.

Base Hospital: Hospital responsible for directing the advanced life support system and prehospital care system assigned to it by the local EMS agency.

PRINCIPLES:

1. An MICN is only certified to practice within Los Angeles County if authorized by the Medical Director of the Los Angeles County EMS Agency.
2. Recertification application with approval from sponsoring agency and all applicable documentation must be received 30 days prior to certification expiration to ensure continuous certification. Continuing education (CE) must be completed during the current certification cycle to satisfy the requirements for recertification. CE completed during the month which the current certificate expires may be applied to the next recertification application if not used to meet the CE requirements for the current renewal.
3. CE hours for nationally recognized classes, including but not limited to, Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), Emergency Nursing Pediatric Course (ENPC), Trauma Nursing Core Course (TNCC), and Advanced Trauma Care for Nurses (ATCN) will be accepted as part of the required renewal CEs based on the hours on the Board of Registered Nursing issued certificate of completion.
4. In the case of lapsed certification, only CE completed within the twenty-four (24) months prior to application for recertification shall apply to meet the requirements for recertification.
5. Certification/recertification as an MICN shall be for two (2) years from the last day of the month in which all requirements are completed and the certification was issued. When

EFFECTIVE: 03-01-86
REVISED: XX-XX-19
SUPERSEDES: 03-01-14

PAGE 1 OF 8

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

recertification requirements are met prior to the expiration date, the certification date will be the first day after the expiration of the current certification cycle.

6. Upon successful completion of all certification requirements, the Los Angeles County EMS Agency shall issue an MICN certification card with the bearer's name, certification number, effective date, expiration date, and signature of the EMS Agency Medical Director.
7. In the event that an MICN is employed by more than one approved agency, a primary sponsor must be designated. All other agencies must be designated as secondary sponsors. The EMS Agency must be notified in writing of all sponsorship changes by submitting required data on the change of status/data update form to the Office of Certification.

POLICY:

I. Eligibility for MICN Certification

- A. Licensed as a registered nurse (RN) in the United States for a period of not less than one (1) year and currently licensed in California.
- B. Employment equivalent to one (1) year full-time (36-40 hours/week) within the last three (3) years as a RN in a critical care area; six (6) months of which must be in the emergency department of an acute care hospital.
- C. Current American Heart Association (AHA) certification as an ACLS provider or instructor.

II. Initial MICN Certification

- A. Meet the professional licensure and experience requirements as specified in Section I.
- B. Be sponsored by one of the following agencies approved to utilize MICNs in Los Angeles County:
 1. Base hospital
 2. EMS Agency
 3. Paramedic training program
 4. Paramedic provider agency
- C. Complete an approved Los Angeles County MICN Development Course.
- D. Complete a minimum of eight (8) hours field observation with a Los Angeles County ALS unit, and observe and document at least one (1) ALS patient assessment that results in an ALS transportation to a 9-1-1 receiving hospital and/or a base hospital contact.
- E. Application Process:

1. Completed Los Angeles County EMS Agency MICN Application and the established fee.
2. Letter of Recommendation signed by the sponsoring facility/agency medical director, department supervisor, and prehospital care coordinator or equivalent.
3. Documentation of a valid California RN license.
4. Documentation of current AHA certification as an ACLS provider or instructor.
5. Documentation of MICN Candidate Field Observation.
6. Copy of MICN Development Course completion certificate.

F. Certifying Examination Process

1. All professional licensure and experience requirements must be met prior to the candidate taking the MICN certification examination. Certification application and documentation must be received at least ten (10) working days before the scheduled examination. Upon receipt of all required documents, the MICN candidate must pass the certifying examination within one (1) year of completing the MICN Development Course.
2. A candidate who fails the MICN certification examination may retake the examination one time only. Retake exams may be taken after seven (7) days but within thirty (30) days of the initial exam. Failure to appear for the examination will be considered as an examination failure for purposes of retesting.
3. A candidate who fails the retake examination must repeat the entire certification process which includes repeating the MICN Development Course.

G. Radio Internship

Upon successful completion of the MICN certification examination, the MICN candidate must complete a radio internship within six (6) months. A radio internship consists of a minimum of ten (10) base hospital ALS runs under the direct supervision of a certified MICN or base hospital physician.

1. Radio internship requires a minimum of one (1) ALS run in each of the following categories:
 - a. Neurology to include provider impressions of Altered Level of Consciousness, Seizure, or Stroke.
 - b. Respiratory to include provider impressions of Respiratory Distress or Respiratory Arrest.

- c. Trauma to include provider impressions of Crush Injury/Syndrome or Traumatic Injury that meets Trauma Center criteria or guidelines.
 - d. Cardiovascular to include provider impression of Cardiac Arrest.
 - e. Cardiovascular to include provider impressions of Cardiac Chest Pain or Cardiac Dysrhythmia.
 - f. General Medical to include provider impression of Shock or Hypotension.
 - g. Pediatric patient with any provider impression.
- 2. If after fifteen (15) satisfactory ALS runs, the candidate has not met all category requirements, run categories may be simulated.
 - 3. A performance evaluation will be completed for each ALS run or simulation and a final written Radio Internship Evaluation based on the Los Angeles County Performance Evaluation Standards must be completed and submitted to the Office of Certification.
 - 4. The prehospital care coordinator shall submit a letter of explanation when the MICN candidate fails to complete the radio internship within six (6) months of the certification examination. If an extension is requested, the projected date of completion must be stated. Extensions may only be granted after review by the Office of Prehospital Certification. In no case may the radio internship exceed one (1) year from the date of the certification examination.
 - 5. An MICN candidate failing to meet the radio internship requirements will be eligible for certification only after successfully repeating the entire certification process, which includes repeating the MICN Development Course.

III. MICN Certification by Challenge

A. Eligibility Requirements:

- 1. Licensed as a RN in California.
- 2. Employed and sponsored by one of the agencies approved to utilize MICNs in Los Angeles County as specified in Section II.B.
- 3. Current AHA certification as an ACLS provider or instructor.
- 4. Complete a minimum of eight (8) hours field observation with a Los Angeles County ALS unit and observe and document at least one (1) ALS patient assessment with a base hospital contact.

B. Application Process:

1. Completed Los Angeles County EMS Agency MICN Application and the established fee.
2. Letter of Recommendation signed by the sponsoring facility/agency medical director, department supervisor, and prehospital care coordinator or equivalent.
3. Documentation of a valid California RN license.
4. Documentation of current or previous MICN certification.
5. Documentation of current AHA certification as an ACLS provider or instructor.
6. Documentation of MICN Candidate Field Observation.

C. Additional Requirement

Pass the Los Angeles County Paramedic Accreditation written examination prior to taking the MICN Certification Exam.

D. Examination Process

Pass the written certification examination as specified in Section II.F.1-3.

E. Radio Internship

Complete a radio internship as specified in Section II.G.1-5.

IV. Recertification

A. Eligibility Requirements for Continuous Certification

1. Certified as a Los Angeles County MICN.
2. Maintain continuous licensure as a RN in California.
3. Maintain continuous AHA certification as an ACLS provider or instructor.
4. Maintain sponsorship as specified in Section II.B.1-4.
5. Complete a minimum of forty-eight (48) hours of EMS continuing education (CE) every two (2) years (certification cycle).

It is the responsibility of each recertification candidate to maintain documentation of his/her own continuing education hours, not the CE provider. Credit may be received **no more than twice** for attending the same educational session during the same certification cycle.

EMS CE topics related to emergency and prehospital care include:

- a. Field Care Audits - Review of base hospital audio tapes and/or written patient care records totaling a minimum of twelve (12) hours.
- b. Structured Field Experience - Field observation totaling a minimum of four (4) hours to a maximum of eight (hours), which must be documented on a MICN Recertification Field Observation CE Documentation form (Los Angeles County EMS Continuing Education Program Manual).
- c. Restricted CE - A maximum of fifty percent (50%) of required CE hours can be issued to an individual per certification cycle as follows:
 - i. Teaching an approved CE course, EMT, AEMT, Paramedic training program, or MICN Development course.
 - ii. Clinical precepting of EMS personnel.
 - iii. Courses related to indirect patient care or medical operations.
 - iv. Media-based/serial productions that are not instructor based.
 - v. Employers sponsoring an MICN may further restrict continuing education hours in specific categories to meet their requirements for a recertification candidate.
- 6. Complete all mandatory Los Angeles County EMS programs.
- 7. Submit the following at least 30 days prior to certification expiration date:
 - a. Completed Los Angeles County EMS Agency MICN Application with the established fee.
 - b. Completed MICN Statement of Continuing Education.
- B. Eligibility Requirements for Certification Lapse of Less Than Six (6) Months
 - 1. Meet all recertification requirements as specified in Section IV.A.1-7.
 - 2. Complete an additional four (4) hours of Field Care Audits.
- C. Eligibility Requirements for Certification Lapse of Six (6) Months or More, But Less Than Twelve (12) Months
 - 1. Meet all recertification requirements as specified in Section IV.A.1-7.
 - 2. Complete an additional twelve (12) hours of CE, four (4) hours must be additional Field Care Audits.

3. Pass the Los Angeles County Paramedic Accreditation written examination.
 4. Complete a radio internship as specified in Section II.G.1-5.
- D. Eligibility Requirements for Certification Lapse of Twelve (12) Months or More, But Less Than Twenty-four (24) Months
1. Meet all recertification requirements as specified in Section IV.A.1-7.
 2. Complete an additional twelve (12) hours of CE, four (4) hours must be additional Field Care Audits.
 3. Pass the Los Angeles County Paramedic Accreditation written examination.
 4. Pass the MICN certification examination as specified in Section II.F.1-3.
 5. Complete a radio internship as specified in Section II.G.1-5.
- E. Eligibility Requirements for Certification Lapse of Twenty-four (24) Months or More
- Candidate is no longer eligible for recertification. Individual shall meet all initial certification requirements as specified in Section II.A-G.
- F. Eligibility Requirements for Recertification of Reservists Deployed for Active Duty
- An individual who is a member of the reserves and is deployed for active duty with a branch of the Armed Forces of the United States, whose Los Angeles County MICN certificate expires during the time the individual is on active duty or less than six (6) months from the date the individual is deactivated/released from active duty, may be given an extension of the renewal of the individual's MICN certificate for up to six (6) months from the date of the individual's deactivation/release from active duty in order to meet the renewal requirements for the individual's MICN certificate upon compliance with the following provisions:
1. Provide documentation from the respective branch of the Armed Forces of the United States verifying the individual's dates of activation and deactivation/release from duty.
 2. Complete a Los Angeles County EMS Agency MICN Application and pay the established fee.
 3. Demonstrate current holder and submit copies of:
 - a. Licensure as a RN in California
 - b. AHA certification as an ACLS provider or instructor

4. Complete all mandatory Los Angeles County EMS programs.
5. Be employed and sponsored as specified in Section II.B.1-4.
6. Upon receipt and verification of the above items by the EMS Agency, the individual shall complete and submit the following requirements for renewal of their MICN certificate by the date specified; otherwise the individual shall complete requirements in accordance with Section III.
 - a. Complete a minimum of forty-eight (48) hours of EMS CE as specified in Section IV.A.5.
 - b. Completed MICN Statement of Continuing Education.
 - c. CE completed by the individual thirty (30) days prior to the current renewal certificate issued through the six (6) month extension of fulfilling requirements for renewal shall be valid.
 - d. Complete a radio internship as specified in Section II.G.1-5.

CROSS REFERENCES:

Prehospital Care Policy Manual:

Ref. No. 1011, **Mobile Intensive Care Nurse (MICN) Field Observation**
Ref. No. 1013, **EMS CE Provider Approval and Program Requirements**

Sample Letter of Recommendation
MICN Certification Application
MICN Candidate Field Observation Documentation
MICN Radio Internship Evaluation
MICN Radio Internship Performance Evaluation Standards
MICN Statement of Continuing Education
Los Angeles County EMS Continuing Education Program Manual

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELESSUBJECT: **MOBILE INTENSIVE CARE NURSE (MICN)
FIELD OBSERVATION**

REFERENCE NO. 1011

PURPOSE: To establish the functions and responsibilities of the MICN/MICN candidate while participating in field observation for EMS continuing education (CE) credit or completion of certification requirements.

AUTHORITY: California Health and Safety Code, Division 2.5, Chapter 2, Sections 1797.56, 1797.175; California Code of Regulations, Title 22, Chapters 4 and 11

DEFINITIONS:

Mobile Intensive Care Nurse (MICN): A registered nurse authorized by the Medical Director of the local EMS agency to provide prehospital advanced life support or issue instructions to prehospital emergency personnel within an EMS system according to standardized procedures developed by the local EMS agency consistent with statewide guidelines.

POLICY:

- I. Field observation is an extension of the MICN's responsibilities, providing first-hand knowledge of how Los Angeles County treatment and legal protocols are applied in the prehospital setting.
- II. The EMS CE program director or clinical director will work with the individual MICN/MICN candidate to determine the field observation schedule, which includes a pre-discussion and agreeing on the objectives to be addressed during the field observation.
- III. The MICN/MICN candidate will be covered by the sponsoring agency's Workman's Compensation and malpractice insurance or other similar coverage.
- IV. The MICN/MICN candidate will dress in a professional and sensible manner, including wearing their employee identification badge.
- V. The primary function of the MICN/MICN candidate is to observe Paramedic operations. The MICN/MICN candidate is not to become involved in patient care activities. The MICN/MICN candidate may only participate in patient care activities in the following circumstances:
 - A. At the request of the Paramedic(s), within the California Registered Nurse scope of practice.
 - B. When the MICN/MICN candidate observes a life-threatening situation not recognized by the Paramedic(s), e.g., when an unsafe drug or dosage is going to be administered or when a serious or life threatening problem is overlooked in the patient's assessment.

EFFECTIVE: 03-10-77
REVISED: XX-XX-19
SUPERSEDES: 07-01-13

PAGE 1 OF 2

APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

- C. When a MICN participates or intervenes in the care of a patient the MICN's name and certification number shall be recorded on the EMS Report Form. If the individual performing the field observation is an MICN candidate, their name and RN license number shall be recorded.

VI. Field Observation Documentation and Credit

- A. To assure credit for performing the field observation:
 - 1. The MICN Recertification Field Observation CE Documentation form shall be signed and dated by the Paramedic with their Accreditation number.
 - 2. Results of experience for each objective shall be documented in detail in the results of experience box or on a separate sheet of paper.
 - 3. Complete the Field Observation Preceptor Evaluation form.
 - 4. Submit completed forms to the sponsoring agency's EMS CE program director or clinical director for review.
- B. MICN Candidate
 - 1. Candidate shall observe a minimum of one (1) ALS patient assessment that results in an ALS transportation to a 9-1-1 receiving hospital and/or a base hospital contact to observe the full continuum of care.
 - 2. MICN Candidate Field Observation Documentation form shall be used from the forms section of the Agency web page.
- C. MICN
 - 1. The following signatures and documentation are required on the MICN Recertification Field Observation CE Documentation form and shall serve as proof of completion used for certification/recertification purposes.
 - a. MICN signature
 - b. Paramedic name, signature, and Accreditation number
 - c. EMS CE Program Director or Clinical Director signature
 - d. Documentation of "time in" and "time out"
 - 2. MICN Recertification Field Observation Documentation form shall be used from the forms section of the Agency web page.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 1010, **Mobile Intensive Care Nurse (MICN) Certification/Recertification**

Ref. No. 1013, **EMS Continuing Education (CE) Provider Approval and Program Requirements**

Los Angeles County EMS Continuing Education Program Manual

Los Angeles County EMS Agency



MICN RECERTIFICATION FIELD OBSERVATION CE DOCUMENTATION

NAME:		CERTIFICATION #: N		SPONSORING AGENCY:	
Pre-discussion Date:		Discussed with EMS CE Program Director or Clinical Director Signature:			
Date of Experience:	Time In:	Time Out:	Total Hours:	Location of Experience: Provider Agency and ALS Unit #:	

This experience has been approved for _____ hours of continuing education credit by California EMS CE Provider # 19 - _____.*

*maximum of eight (8) hours credit per certification cycle.

Learning Objectives – check (✓) three or more	Plan to Meet Objectives	Results of Experience (Completed by MICN)
() 1. Enhance communication between prehospital care team members	1. Communication <ul style="list-style-type: none"> ■ Establish rapport and networking relationships with prehospital personnel 	
() 2. Identify organizational and procedural differences/similarities among EMS provider agencies	2. Organizational/Procedural differences/similarities <ul style="list-style-type: none"> ■ Discuss the differences/similarities among EMS provider agencies 	
() 3. Identify the importance of and the techniques for ensuring a safe prehospital environment	3. Safe Environment <ul style="list-style-type: none"> ■ Discuss what is required to ensure a safe environment such as crowd control, traffic control ■ Observe techniques employed 	
() 4. Identify the differences/similarities in the performance of patient assessment and treatment in the prehospital and emergency department setting	4. Differences/similarities of patient assessment and treatment <ul style="list-style-type: none"> ■ Observe how the prehospital setting affects assessment and the delivery of patient care 	
() 5. Identify the communication patterns and roles/responsibilities of prehospital care personnel	5. Communication Patterns and Roles/Responsibilities <ul style="list-style-type: none"> ■ Observe communication patterns between EMTs, firefighters, paramedics, captains, field supervisors, etc. ■ Observe roles/responsibilities of prehospital personnel 	

Learning Objectives	Plan to Meet Objectives	Results of Experience (Completed by MICN)
() 6. Identify the ways in which paramedic and base hospital communication or standing field treatment protocols (SFTP) impact patient care	6. Base Communication and SFTPs <ul style="list-style-type: none"> ■ Observe communication between paramedics and base hospital personnel ■ Observe the utilization of SFTPs 	
() 7. Other (specify)	7. Specify	
() 8. Other (specify)	8. Specify	

General Instructions
<ol style="list-style-type: none"> 1. Pre-discussion is mandatory to define objectives and ensure a structured field observation. 2. Pre-discussion must be conducted by the EMS CE program director or clinical director from the sponsoring agency. 3. Minimum of three objectives must be completed. New or additional objectives can be written specific to the needs of the MICN. 4. Field Observation time less than one (1) hour will not be approved. 5. Field Observation time greater than one (1) hour will be granted in no less than half-hour increments. 6. The MICN must complete the "Results of Experience" section to demonstrate successful achievement of the objectives. This section must be filled out in order to receive CE credit. 7. Signature of field paramedic must be obtained at the time of the experience. 8. Field Observation Preceptor Evaluation form, all signatures and "time in" and "time out" must be completed to receive credit.

MICN Signature: 	Date: 	Paramedic Print Name: _____ LA County Accreditation #: P _____ Signature: _____	Date:
Field Observation results reviewed and approved by EMS CE Program Director or Clinical Director: Print Name: _____ Signature: _____	Date: 	<ul style="list-style-type: none"> ■ This document must be retained for a period of four (4) years ■ Credit will be denied if signatures or "Results of Experience" omitted 	

LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES COMMISSION

Los Angeles County's 9-1-1 Dispatch and Field Response to Mental Health and Substance Abuse Emergencies

Rev. 1/7/19

BACKGROUND

The Emergency Medical Services Commission (EMSC) is an advisory body to the Board of Supervisors and the Director of Health Services regarding County policies, programs and standards for emergency medical care services throughout the County. In September 2015, the EMSC established an Ad Hoc Committee to address the significant issues identified by representatives of Fire Departments, EMS, and Law Enforcement personnel in the prehospital care of behavioral emergencies. Key members of the committee included representatives from the Los Angeles Area Police Chiefs Association (LAAPCA).

The committee's final report, titled "*The Ad Hoc Committee on Prehospital Care of Mental Health and Substance Abuse Emergencies Final Report*" highlighted nine recommendations for change to the mental health / substance abuse field response, processes of care, and disposition by emergency medical services (EMS) and law enforcement. The report can be found at:

http://file.lacounty.gov/SDSInter/dhs/1006550_EMSCAdHocCommitteeReportNovember2016.pdf

An important area of focus relates to 9-1-1 dispatch and triage of mental health and substance abuse (MH/SA) calls. The EMSC in coordination with the LAAPCA, conducted a survey in early 2018 to develop a more thorough understanding of the challenges that LA County's law enforcement agencies encounter in

- 1) Dispatching 9-1-1 mental health calls, and
- 2) Responding to mental health emergencies.

Additionally, The Commission sought input on potential future solutions that could improve the care of such individuals in crisis.

This document summarizes the findings of the survey conducted by the EMS commission on the Los Angeles County 9-1-1 Dispatch and Field Response to Mental Health and Substance Abuse Emergencies.

SUMMARY OF FINDINGS

Details of the survey results are described in this report. 66% (28 of 42) of dispatch agencies and 61% (28 of 46) of law enforcement (LE) agencies responded to questions regarding mental health 9-1-1 calls that they received in 2017.

The overall key findings are as follows:

- 8% of 9-1-1 calls were coded as MH/SA emergencies by dispatchers.
- Only 1 in 5 agencies (18%) report having a standardized dispatch protocol for MH/SA emergencies. Many agencies agreed that a standardized dispatch protocol to determine whether the call is related to mental health related would be beneficial.
- Over 90% of the emergency MH/SA calls are initially dispatched to LE. Approximately 27% of calls will result in an EMS co-dispatch. It is extremely rare for EMS to be dispatched without LE to MH/SA calls (4%).
- 76% of law enforcement agencies have at least some embedded mental health clinicians, but their availability varies widely and is overall quite limited (often not 24 hours or 7 days a week).
- MH/SA training has increased significantly for LE officers. The current data suggests that MH/SA trained officers are able to respond to MH/SA emergencies 58% of the time.
- 96% of LE agencies agree that individuals who are experiencing a MH/SA emergency would benefit from continued and increased training of officers in managing such situations.
- 54% of MH/SA field encounters resulted in the placement of an involuntary psychiatric hold (range 2% to 99% depending on the LE agency)
- Main challenges in responding to MH emergencies included lack of resources (including for people who need services but do not meet hold criteria), time spent transporting/waiting in hospitals, stigma/lack of MH education, and lack of access to specialized mental health teams.
- 54% of LE provider respondents felt that the patient would benefit from EMS response
- LE agencies believe the response system could be improved by including more specialized MH/SA teams available 24/7, improved training for dispatchers to screen MH/SA calls, increasing training for LE responders.
- 28% of MH 9-1-1 calls were related to suicidal ideation without an attempt.
- Limitations: Data were obtained by survey only (no independent verification of data response), and results were not weighted resulting in average estimates. There may be substantial variation between agencies, based on size of department, volume of calls or encounters, geographic location, and proximity to nearby resources (such as psychiatric emergency department or mental health urgent care).

RECOMMENDATIONS

1. Consider a pilot project to evaluate whether diversion or co-triage of calls related to suicidal ideation without attempt to the Suicide Prevention Lifeline is feasible, and whether it would reduce field responses, mental health holds, and emergency department utilization, while increasing referral to appropriate mental health resources.
2. Recommend identification of the appropriate agencies to develop follow-up referrals or instructions for individuals who are not transported (left at scene).
3. Explore the feasibility / utility of developing standardized dispatch protocols that aid in identifying when 9-1-1 calls are MH/SA related.
4. Explore protocols for dispatching EMS along with, or after, LE response.
5. Explore avenues of funding for increased number and availability of 24/7 emergency mental health response teams, as well as resources for LE officers' MH/SA training.
6. Investigate the large variance in law enforcement agency's rate of utilization of 5150 psychiatric holds for 9-1-1 mental health emergencies (which was reported as between 2 and 99%).

DETAILED SURVEY RESULTS

GENERAL NOTES

- Two simultaneous surveys were conducted for Law Enforcement Dispatch and Field Response.
- Law Enforcement Dispatch Survey Response Rate: 28 of 42 (66%) LA County Law Enforcement Dispatch agencies responded to the dispatch survey. The majority of police departments and the Sheriff do their own dispatch and only dispatch for their department. There is one regional law enforcement dispatch center that dispatches for six (6) police departments.
- Law Enforcement (LE) Field Response Survey Response Rate: 28 of 46 (61%) Law Enforcement Agencies completed the survey with reliable data (31 total responded, 3 were either duplicate or unusable data).
- All data reported are for calendar year 2017.

DISPATCH AGENCIES SURVEY RESULTS

1. How often do dispatch agencies receive MH/SA emergency calls?

- On average, 8% of 9-1-1 calls received by dispatch agencies were coded as MH/SA emergencies by dispatch. Note: many agencies report the unreliability of their estimates, given no standard classification system, and reliance on public reported incidents.
- Dispatch providers estimated the proportion of mental health calls in the following categories:

Suicidal Thoughts (no attempt)	28%
Suicide Attempt	13%
Homicidal thoughts, behaviors; agitation; erratic or dangerous behaviors	30%
Other non-suicidal, non-homicidal, non-dangerous mental health issues	29%

- The estimated number of total 9-1-1 calls received by survey respondents was 5,881,851 for calendar year 2017.

2. How often are the calls dispatched to law enforcement (LE), EMS, or both?

- While >90% of the emergency calls are initially dispatched to LE, in a little more than 1/4 of the cases (27%) EMS will also be co-dispatched. 4% of the time EMS is dispatched independently.
- Triggers to dispatch EMS include: known injury or medical issue (such as accidental overdose of prescription medication, panic attack, unconscious subjects, self harm requiring medical attention), if the situation was clearly recognized as non-dangerous / non-violent, expectations that the patient will require an ambulance transport, drug/alcohol use, delirium tremens or excited delirium.
- It appears that the identification of "mental illness" is sufficiently risky or variable in terms of dangerousness that LE are typically dispatched.

3. Do dispatchers have triage protocols, or standardized lines of determining if a call is mental health related?

- A large majority, 82% (23 of 28) of dispatch agencies do not have a procedure that includes defined questions to determine if this call is related to a MH/SA emergency.
- Roughly 1 in 5 agencies (18%) report having a standardized dispatch protocol. Many agencies commented that a standardized dispatch protocol that aids in determining whether the call is mental health related would be beneficial.

4. Do dispatchers have a protocol to determine if/when mental health trained personnel should respond? (MET/SMART, mental health trained officers, or mental health clinicians)

- Roughly half of the dispatch agencies have a protocol that determines when to deploy the specialized response (57% with protocol, 43% without)
- Often, the responding police unit determines whether a special mental health team response is needed (e.g. SMART, MET) response.
- Due to limited availability, the MH/SA clinician is often not the first responder.

5. Open Response: How would you improve the dispatch protocols for 9-1-1 mental health emergencies?

- Increased training for dispatchers on specific mental illnesses, verbal queues, and trigger words
- Standardized protocol/defined questions and training for dispatch to triage MH/SA conditions
- Requesting to have a full time clinician with an officer instead of just have one periodically
- If "drop off" procedure could be streamlined that so that LE wouldn't have to wait in EDs for hours while person is being evaluated
- Having the officer who handled a call which turns out to be mental health related (though not originally recognized as such) advise the dispatchers that it was a MH/SA emergency, in order to improve data accuracy
- "Have mental health experts attend more patrol line training to touch base with officers and dispatchers and advise them of available resources to use as referrals."

LAW ENFORCEMENT FIELD RESPONSE SURVEY RESULTS

1. What types of MH/SA emergencies do LE encounter?

- LE providers estimated the proportion of mental health calls in the following categories:

Suicidal Thoughts (no attempt)	36%
Suicide Attempt	11%
Homicidal thoughts or behaviors; agitation; erratic or dangerous behaviors	27%
Other non-suicidal, non-homicidal, non-dangerous mental health issues	26%

2. What is the availability of embedded mental health clinicians?

- 76% of departments (n=22) have embedded mental health clinicians (social workers, psychologists, or physicians) responding to mental health emergencies.
- 14% (n=4) do not have embedded mental health clinicians.
- The real-time availability of mental health clinicians is varied:
 - 7 days / week (5 departments)
 - 3-6 days / week (Mon-Thu) (10 departments)
 - 0.5-2 days / week (7 departments).
 - (Vast majority 8-10hrs/day, 4 agencies have 20-24hr/day coverage)

3. How often do mental health trained personnel respond to MH/SA emergencies?

- 58% of the time a mental health trained officer, clinician and/or a "special response" team (including MET, SMART) is able to respond to 9-1-1 mental health emergencies. Eight (8) agencies reported a MH/SA trained response in 90-100% of cases.

4. What kind of training do sworn officers receive?

- Sources of mental health training for sworn officers in the past 5 years included the following:

Mental Health Awareness: Crisis Intervention for Law Enforcement	50%
Mental Health Intervention Training	29%
Crisis Intervention Training (CIT)	16%
Mental Health First Aid	24%

(Total percentages >100% due to training in more than one course)

Other courses that officers attended: Mental Health Decision Making, L.A.P.D/SMART Team training, Policing the Mentally Ill, Mental Health Domestic Violence, Interacting with the Mentally Ill, Investigations within Mental Health, Field Encounters with the Mentally Ill, Emergency Personnel Response to Individuals with Mental Illness.

5. How adequate is the training for LE?

- 96% of respondents agree or strongly agree that individuals who are experiencing a mental health emergency would benefit from increased training of officers in managing such situations

6. Who is the most appropriate first responder?

- 54% agree or strongly agree that individuals who are experiencing a 9-1-1 mental health emergency would benefit from a response by EMS personnel as opposed to law enforcement if there is no acute violence or safety issues.
- 32% disagree or strongly disagree (9 departments), 14% undecided (4 departments)

7. What are the barriers to increased mental health training?

- The barriers to increased mental health training for officers were reported as follows:

Barrier	Agree or strongly agree
Lack of funding	75%
Lack of time	75%
Individual officers' resistance	29%

8. Where do Law Enforcement transport patients to for mental health emergencies?

- Average of law enforcement agency responses (not weighted for actual # of encounters)

Destination	Percentage
Psychiatric Urgent Care Centers (such as Exodus, Olive View UCC)	26%
Free standing Psychiatric Hospital	14%
Psychiatric Emergency Service (Harbor-UCLA, LAC+USC or Olive View)	21%
LPS designated hospital emergency department	18%
Non-LPS designated hospital emergency department	5%
Jail	3%
Sobering Center	2%
Leave at Scene	12%
Other (describe)	1%

9. What is the frequency of involuntary detainment in the field?

- 54% of mental health field encounters result in the placement of a 5150 involuntary psychiatric hold (range 2% to 99%)

10. Open ended question: What are the most significant challenges for your agency/department in responding to mental health emergencies?

- More mental health cases than resources available
- Challenge to locate available beds at facilities other than LAC+USC in order to not overutilize their hospital
- Not enough LPS hospital beds and placement options
- Time spent transporting/waiting in hospitals
- Not enough resources to deal with juveniles
- Lack of resources for people who need MH services but do not meet LPS hold criteria
- Repeated calls regarding pts after just being treated
- Responding to mental health calls takes an extended amount of time
- Stigma, cultural barriers/lack of education
- No access to SMART/MET team, not enough staffing, time

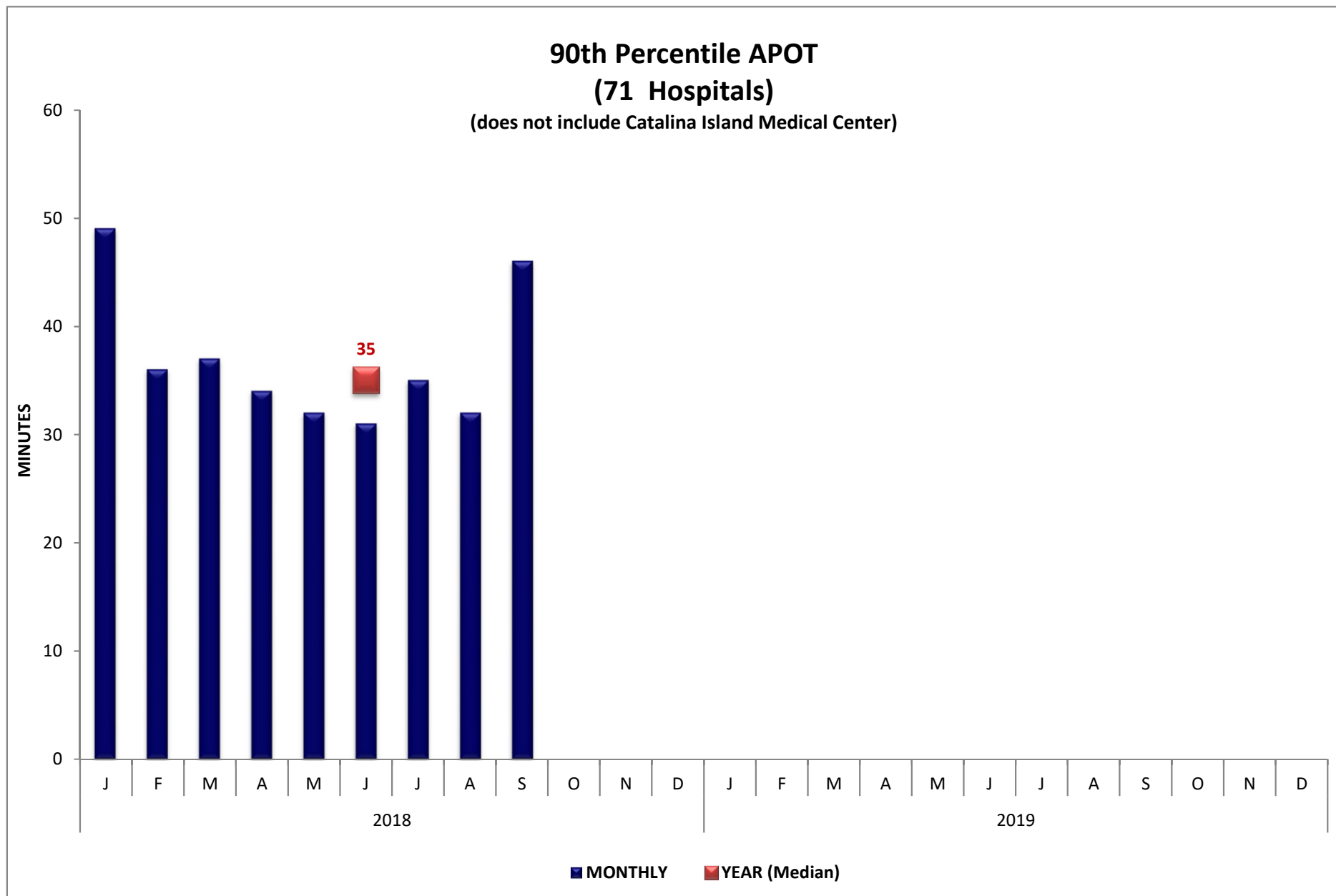
11. Open ended question: Describe ways that you believe that the 9-1-1 mental health emergency response system could be improved

- More MET staff/teams available 24/7 to respond to calls
- More hospital beds and placement options
- More housing facilities
- Dispatchers better trained to screen mental health related calls for service
- Increased training for both dispatches and first responders
- Continued efforts for multi-agency and multi-disciplinary training and education
- Diverting more calls away from police response to medical, mental health, or crisis line
- More psychiatric urgent care facilities, long term placements and housing

- Access to MH services for those who do not meet 5150 criteria
- Allow paramedics to transport to LPS facilities outside their area
- Better solutions to drug abuse

DRAFT

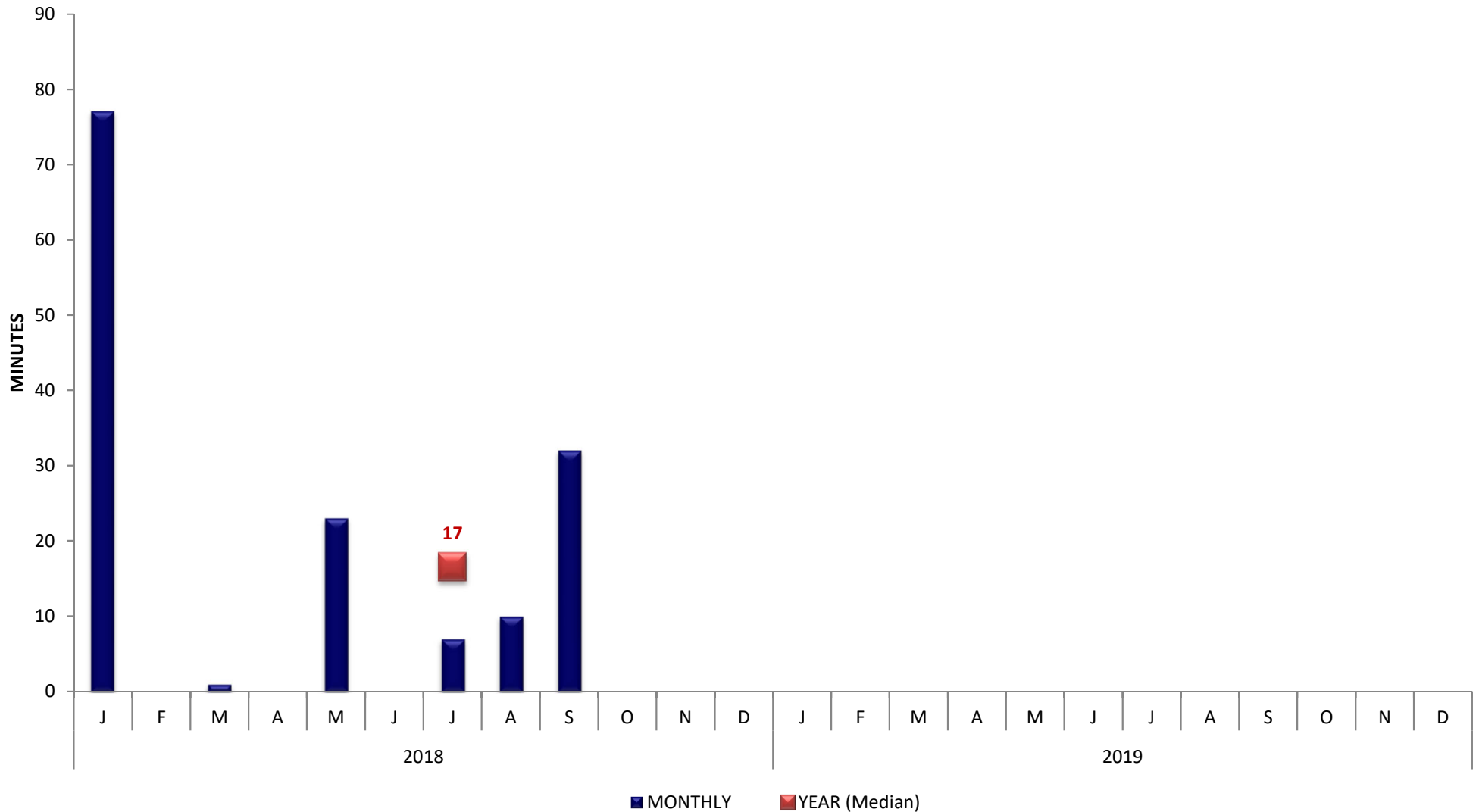
Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT)

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

ANTELOPE VALLEY - NEWHALL REGION (n=3 Hospitals)

90th Percentile APOT

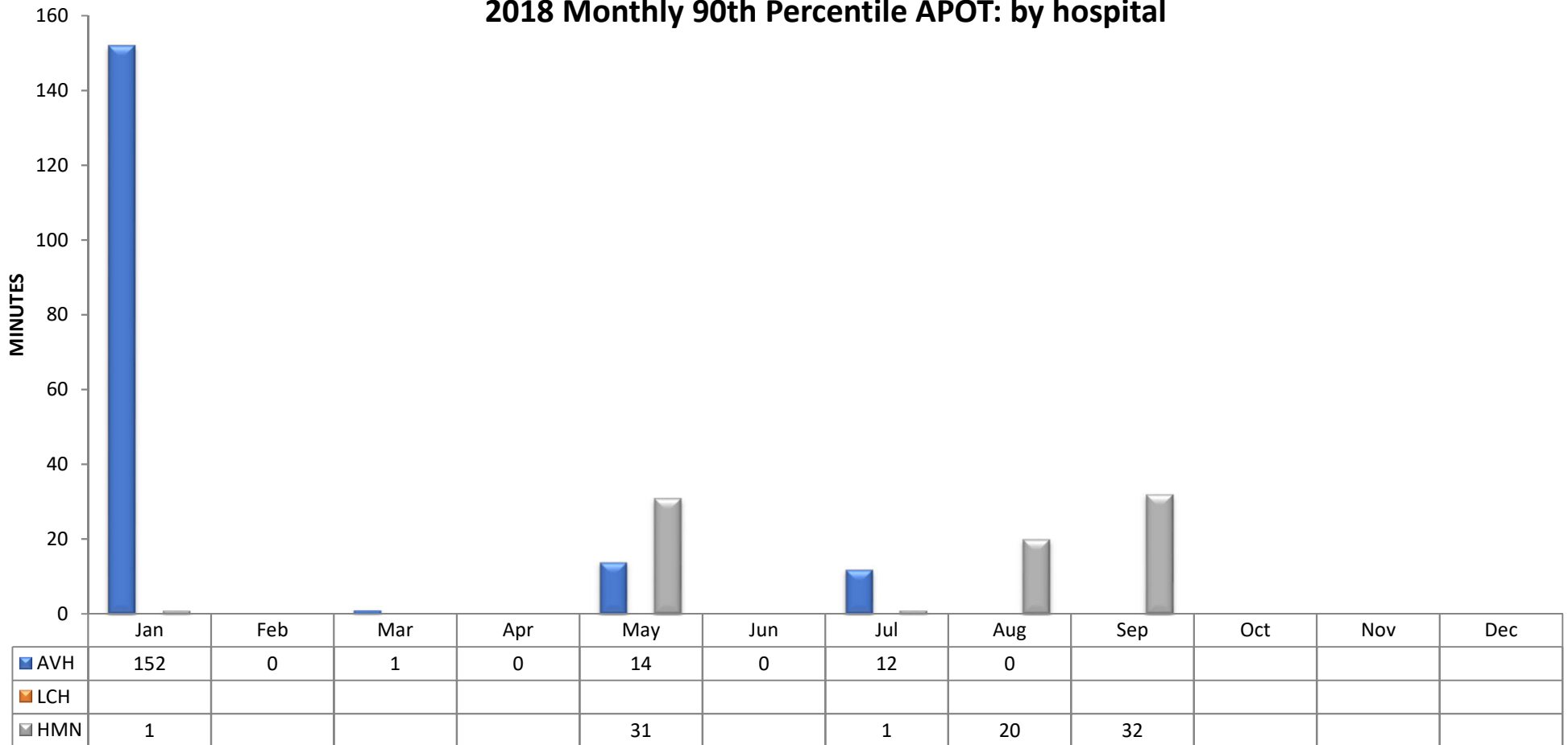


Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

ANTELOPE VALLEY - NEWHALL REGION (n=3 Hospitals)

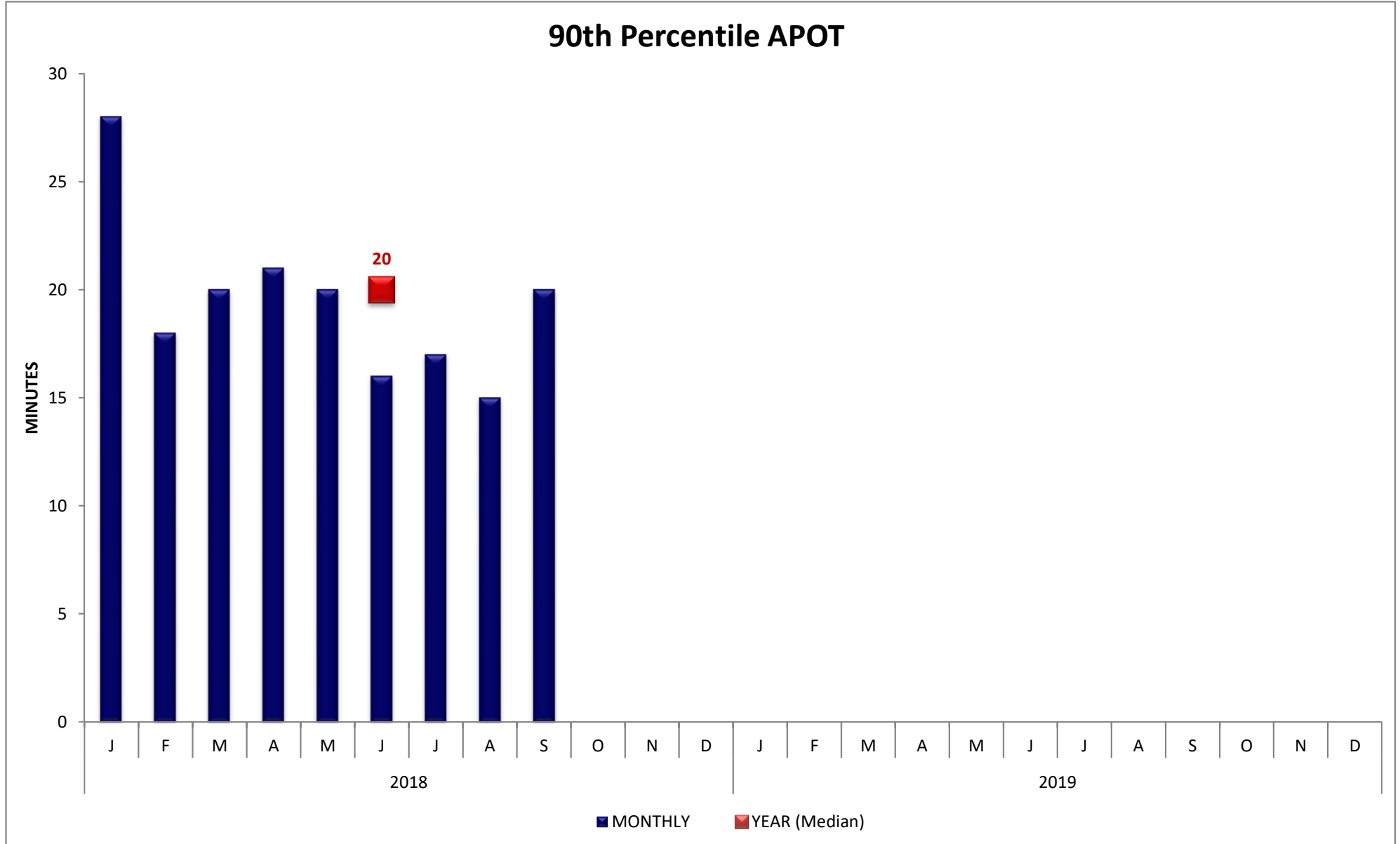
2018 Monthly 90th Percentile APOT: by hospital



CODE	HOSPITAL NAME	CODE	HOSPITAL NAME	CODE	HOSPITAL NAME
AVH	Antelope Valley Hospital	LCH	Palmdale Regional Medical Center	HMN	Henry Mayo Newhall Memorial Hospital

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

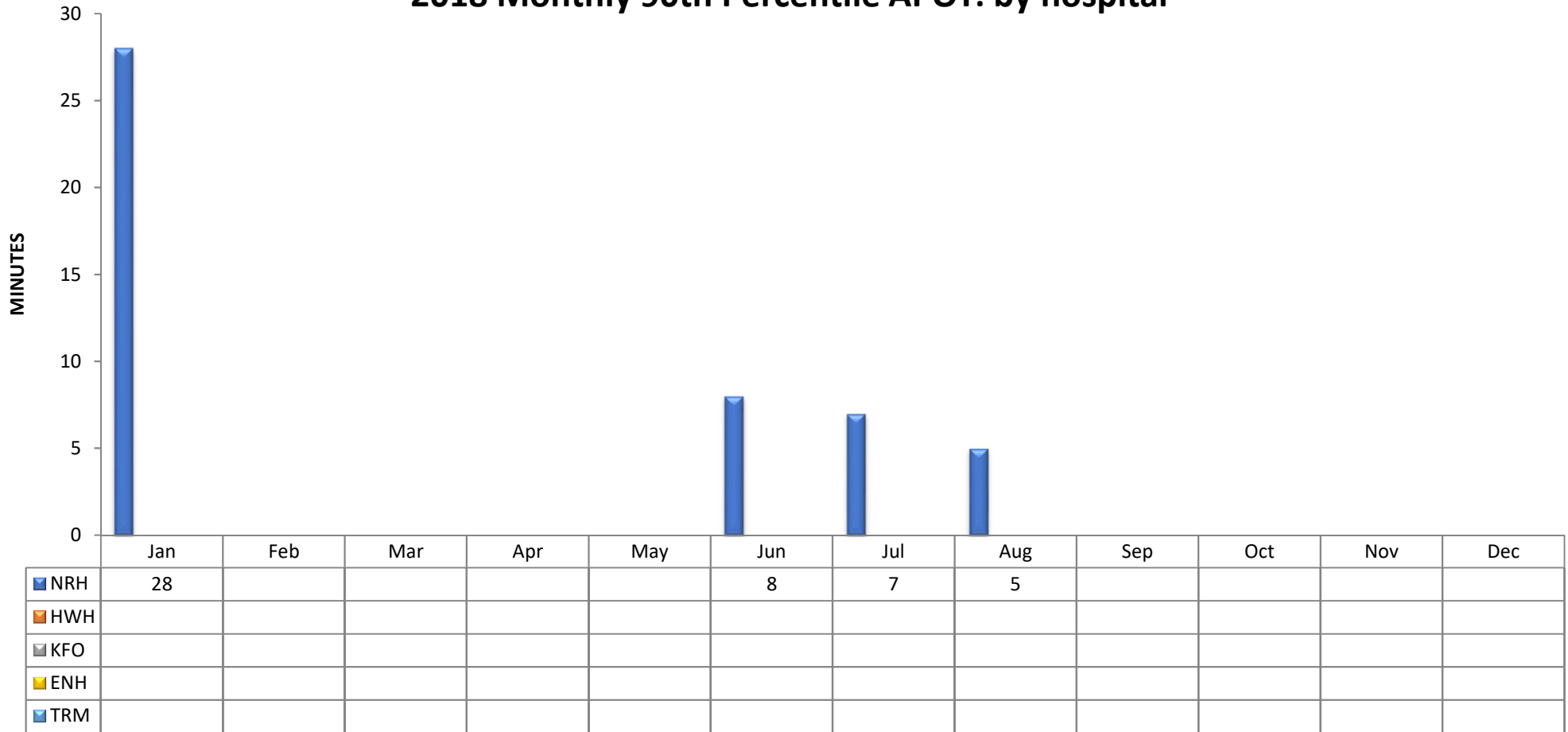
SAN FERNANDO VALLEY REGION (n=16 Hospitals)



AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

SAN FERNANDO VALLEY REGION (n=16 Hospitals)

2018 Monthly 90th Percentile APOT: by hospital



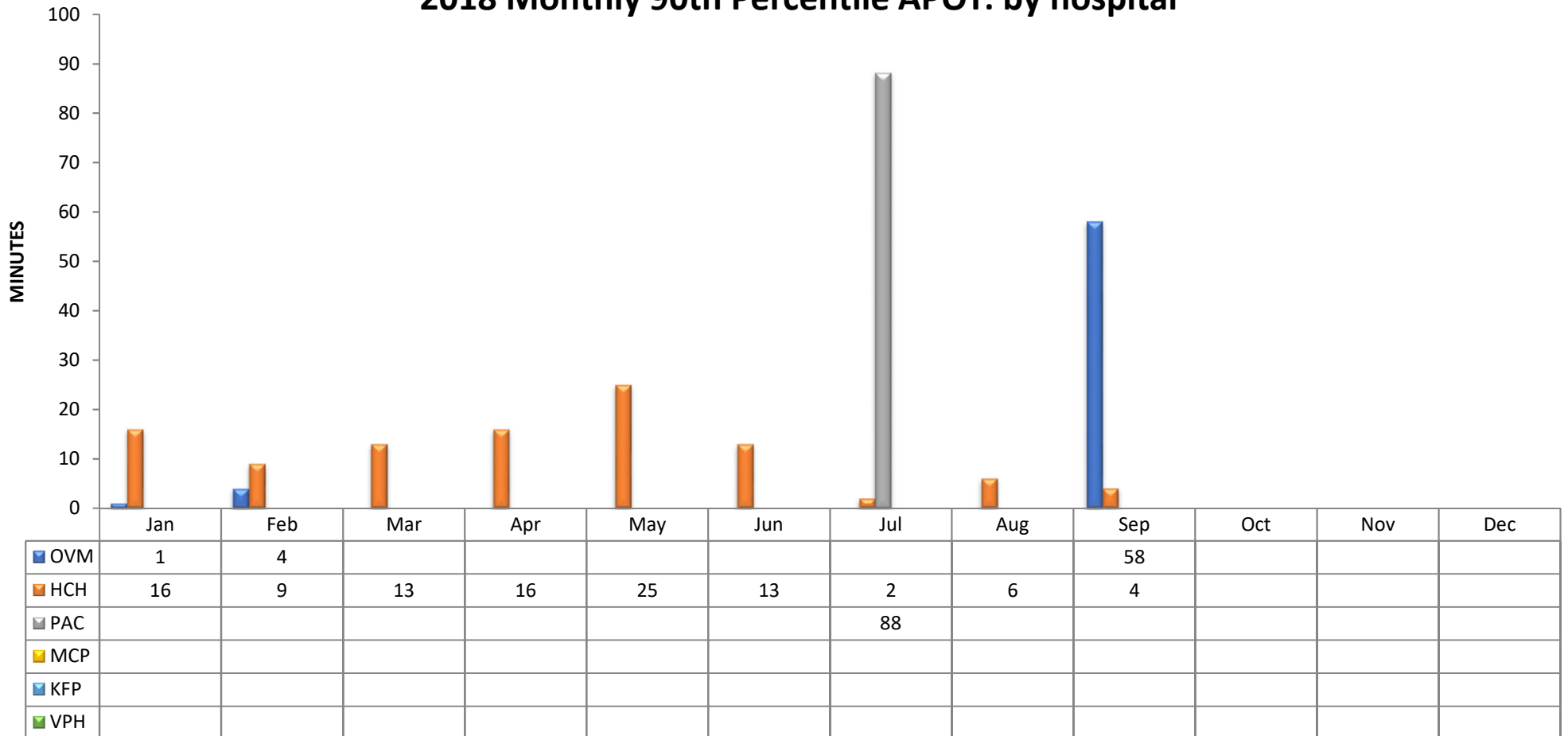
CODE	HOSPITAL NAME	CODE	HOSPITAL NAME	CODE	HOSPITAL NAME
NRH	Northridge Hospital Medical Center	KFO	Kaiser, Woodland Hills	TRM	Providence Tarzana Medical Center
HWH	West Hills Medical Center	ENH	Encino Hospital Medical Center		

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

SAN FERNANDO VALLEY REGION (n=16 Hospitals)

2018 Monthly 90th Percentile APOT: by hospital



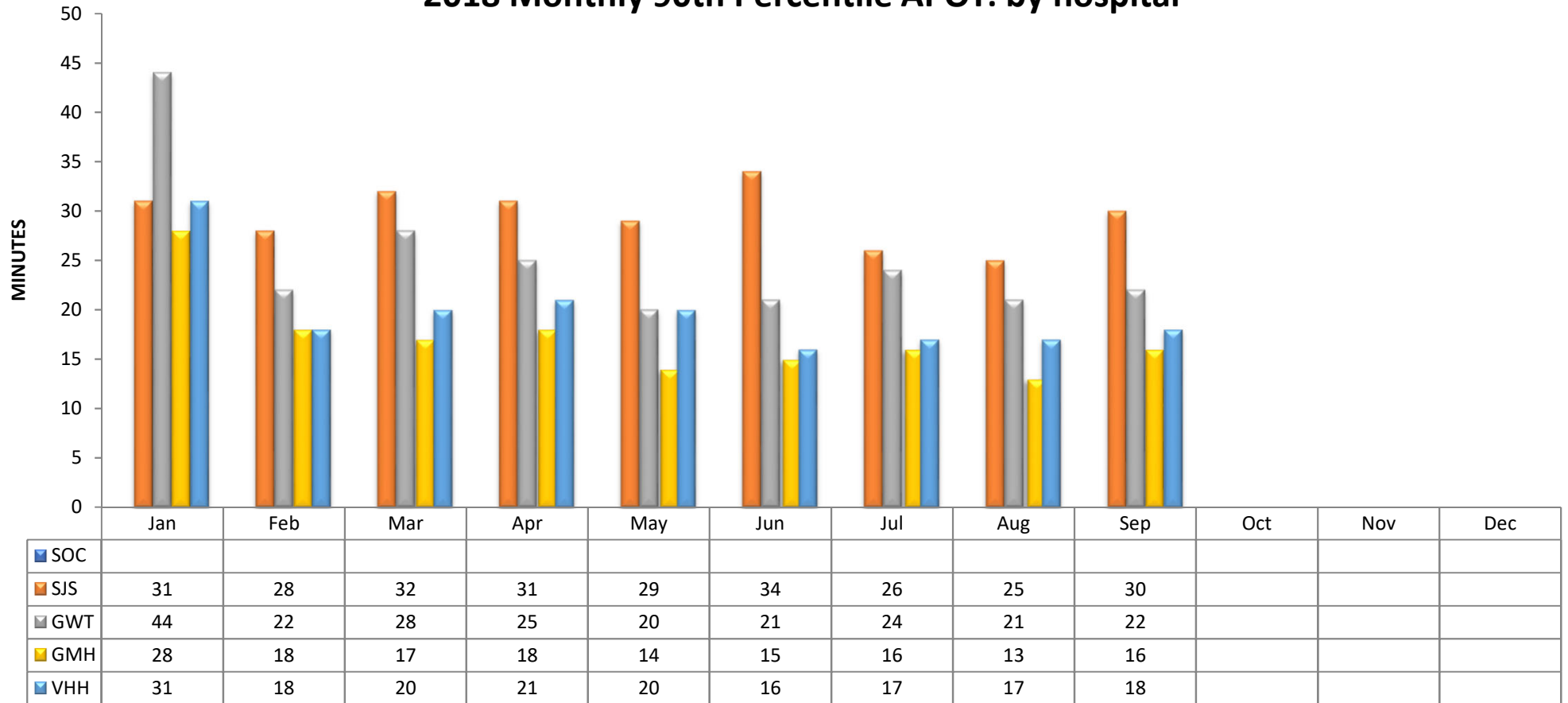
CODE	HOSPITAL NAME	CODE	HOSPITAL NAME	CODE	HOSPITAL NAME
OVM	Olive View-UCLA Medical Center	PAC	Pacifica Hospital of the Valley	KFP	Kaiser, Panorama City
HCH	Providence Holy Cross Med. Center	MCP	Mission Community Hospital	VPH	Valley Presbyterian Hospital

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

SAN FERNANDO VALLEY REGION (n=16 Hospitals)

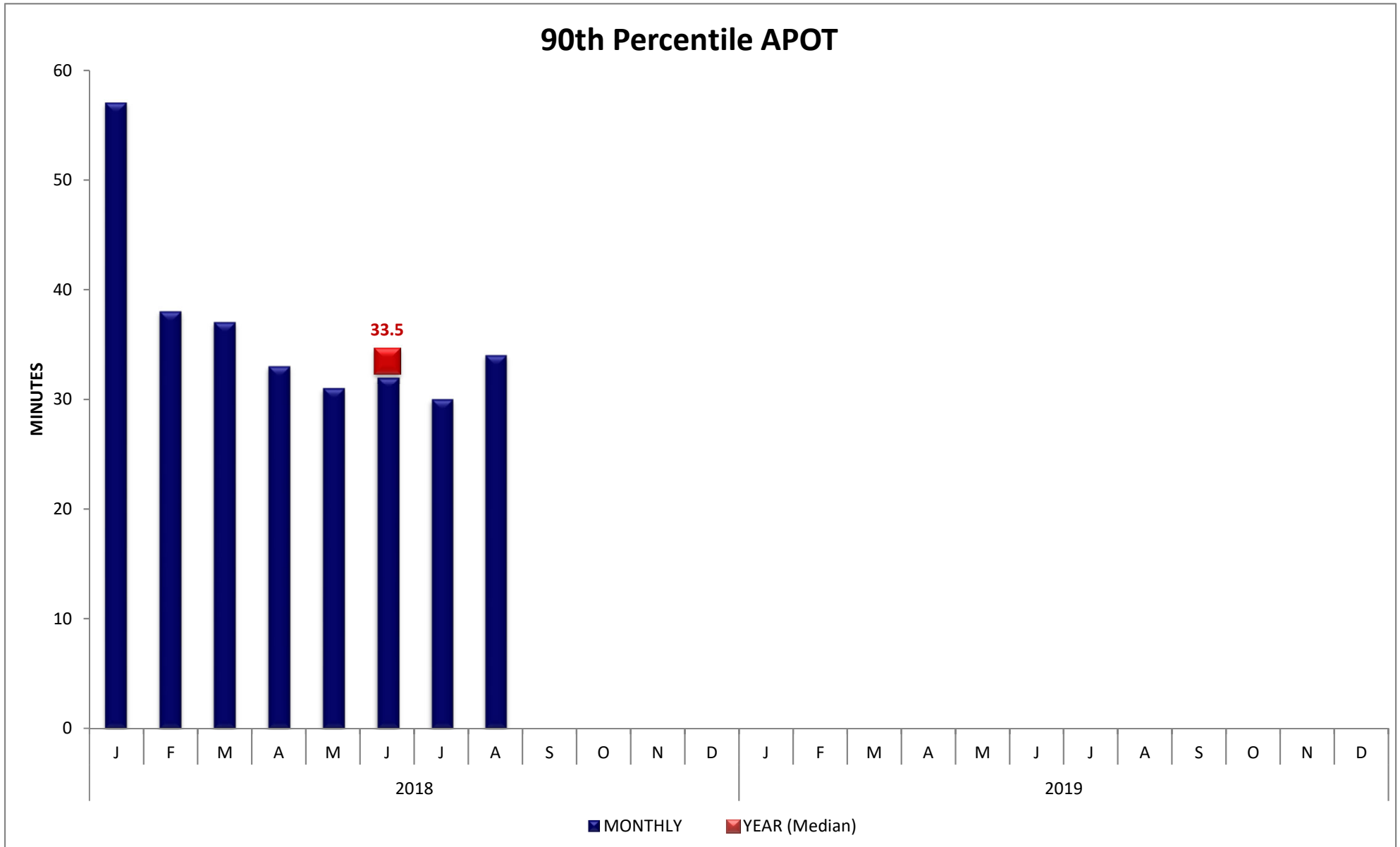
2018 Monthly 90th Percentile APOT: by hospital



CODE	HOSPITAL NAME	CODE	HOSPITAL NAME	CODE	HOSPITAL NAME
SOC	Sherman Oaks Hospital	GWT	Glendale Adventist Medical Center	VHH	Verdugo Hills Hospital
SJS	Providence St. Joseph Med. Center	GMH	Glendale Memorial Medical Center		

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

SAN GABRIEL VALLEY REGION (n=14 Hospitals)

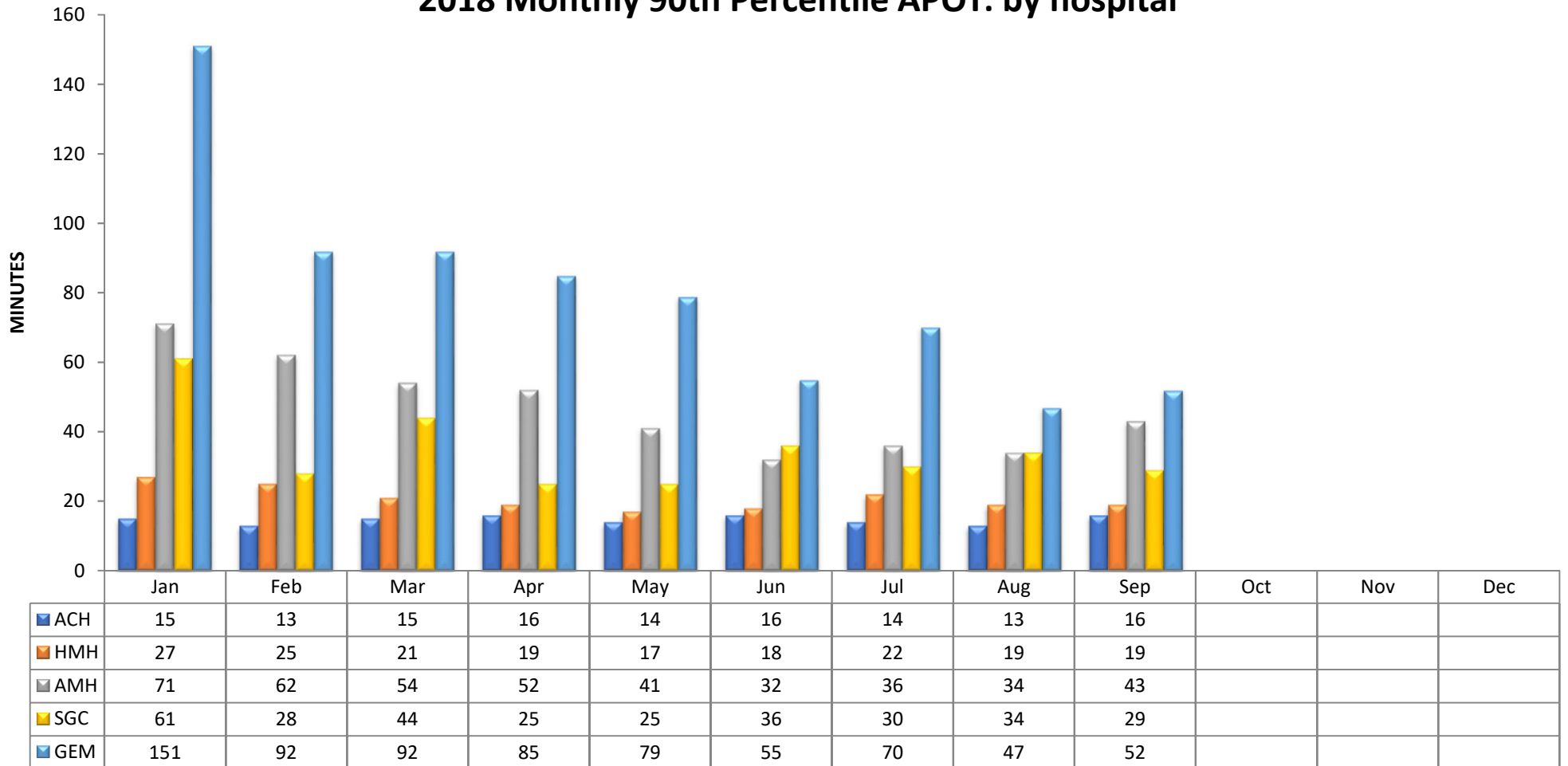


Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

SAN GABRIEL VALLEY REGION (n=14 Hospitals)

2018 Monthly 90th Percentile APOT: by hospital



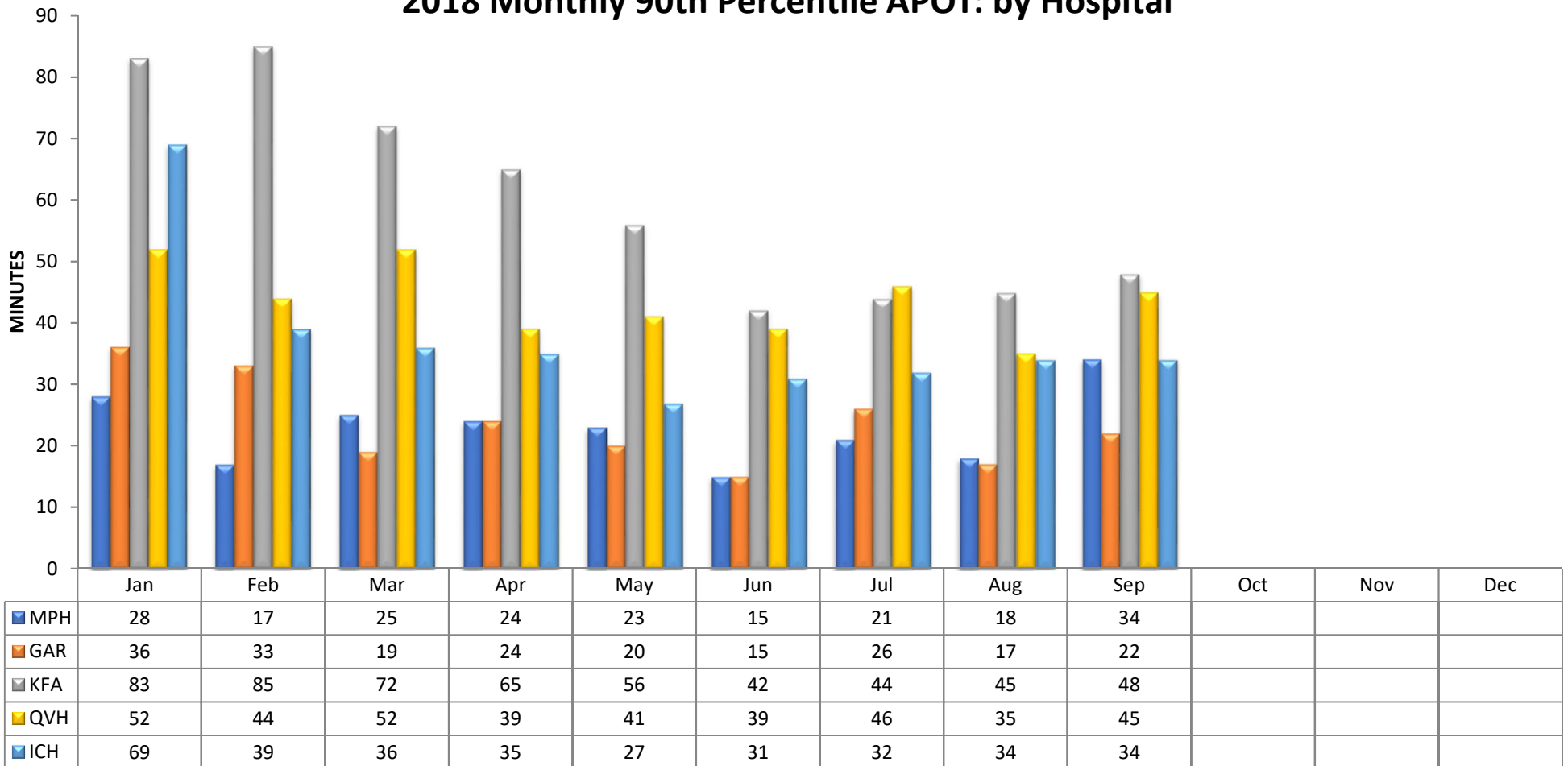
CODE	HOSPITAL NAME	CODE	HOSPITAL NAME	CODE	HOSPITAL NAME
ACH	Alhambra Community Hospital	AMH	Methodist Hospital of S. California	GEM	Greater El Monte Community Hosp.
HMH	Huntington Hospital	SGC	San Gabriel Valley Medical Center		

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

SAN GABRIEL VALLEY REGION (n=14 Hospitals)

2018 Monthly 90th Percentile APOT: by Hospital

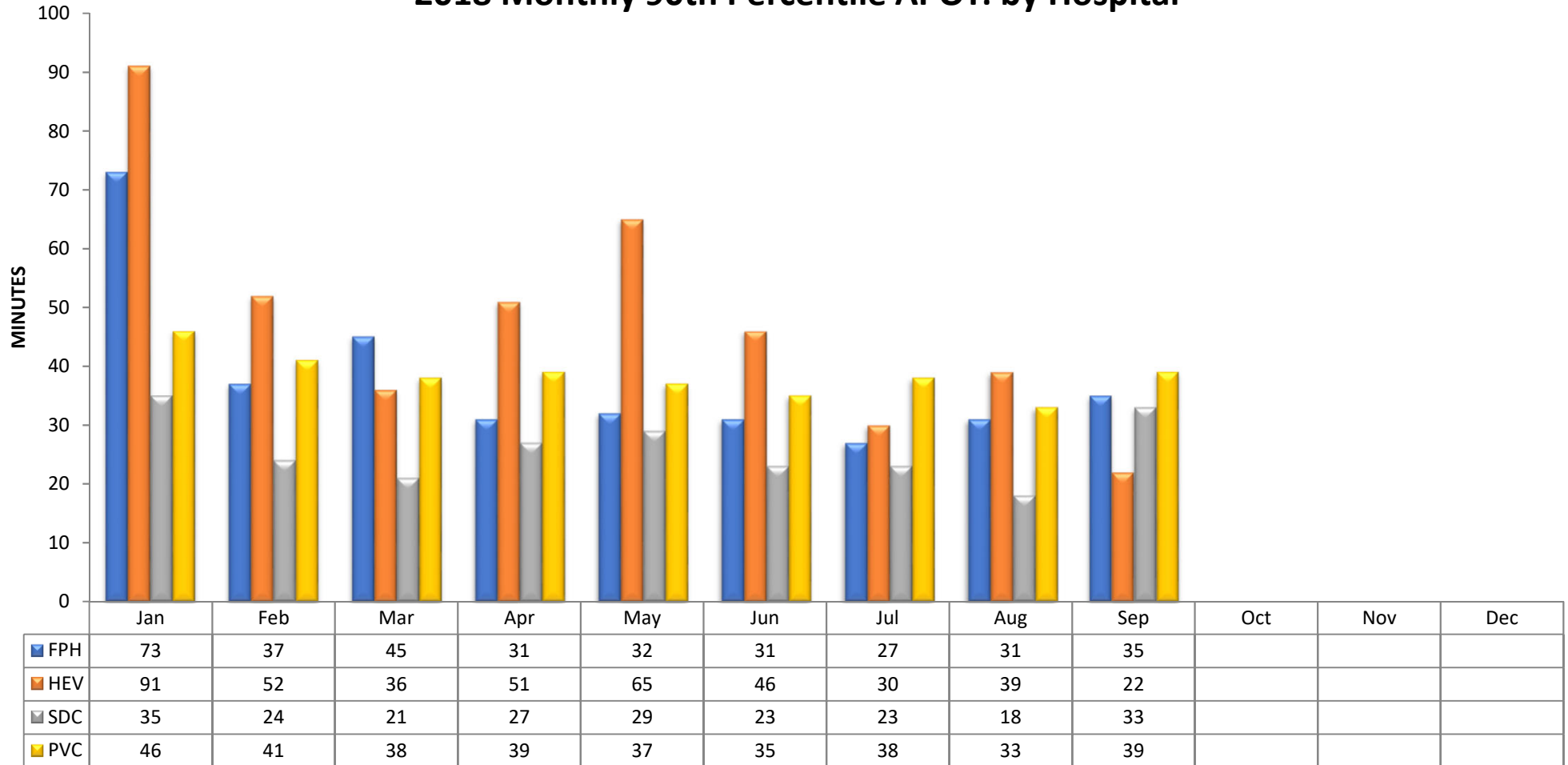


CODE	HOSPITAL NAME	CODE	HOSPITAL NAME	CODE	HOSPITAL NAME
MPH	Monterey Park Hospital	KFA	Kaiser, Baldwin Park	ICH	Emanate Health, Intercommunity
GAR	Garfield Medical Center	QVH	Emanate Health Queen of the Valley		

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

SAN GABRIEL VALLEY REGION (n=14 Hospitals)

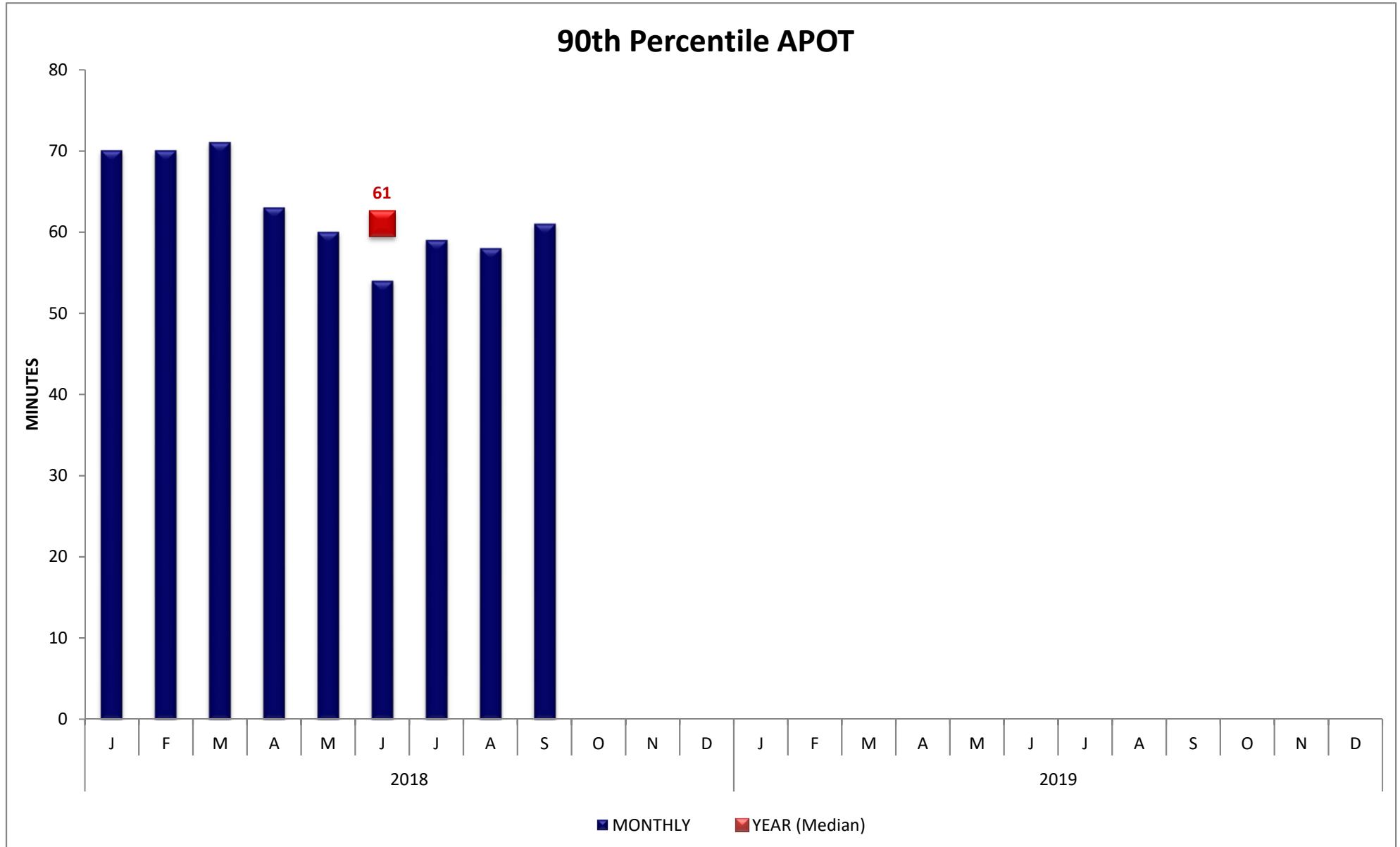
2018 Monthly 90th Percentile APOT: by Hospital



CODE	HOSPITAL NAME	CODE	HOSPITAL NAME
FPH	Emanate Health Foothill Presbyterian	SDC	San Dimas Community Hospital
HEV	East Valley Hospital	PVC	Pomona Valley Hospital Medical Center

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

EAST REGION (n=8 Hospitals)

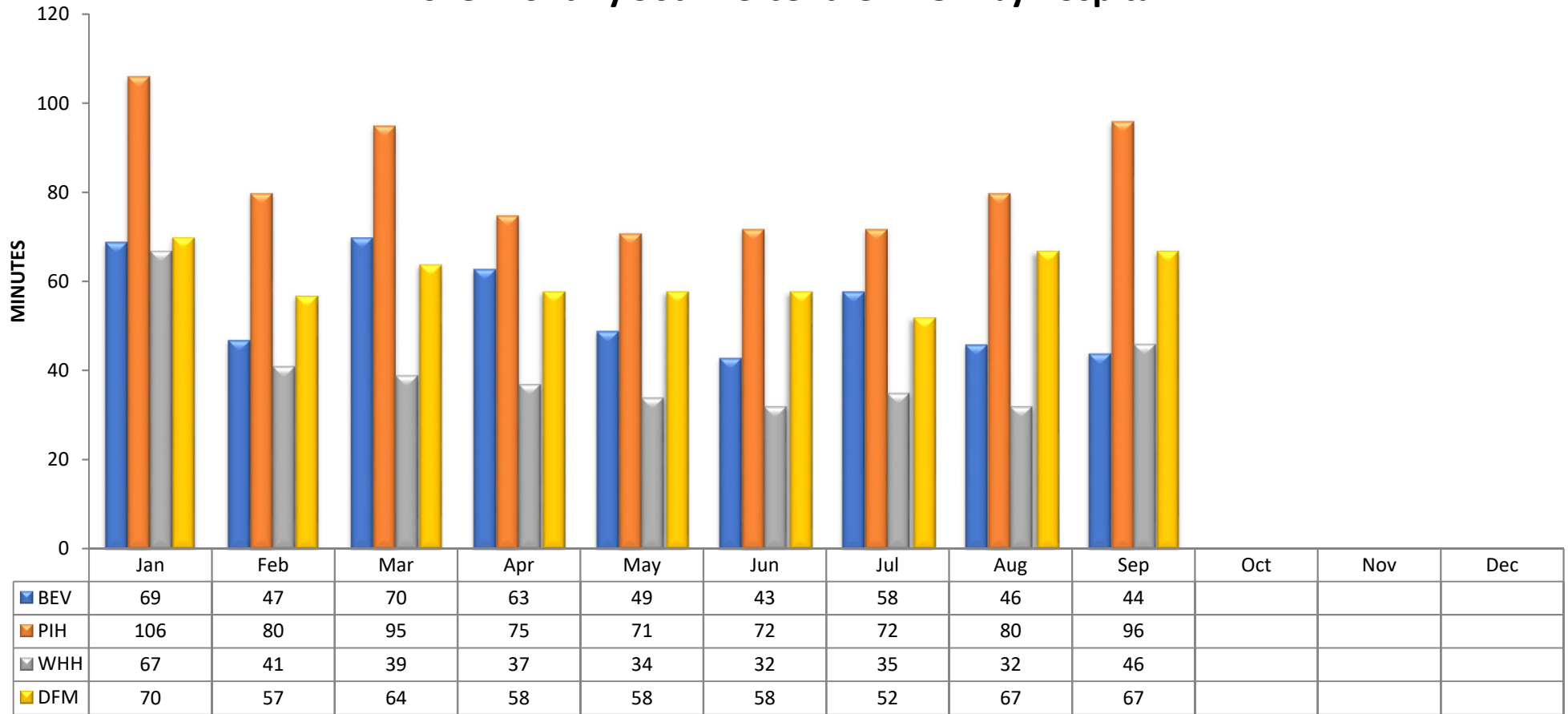


Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

EAST REGION (n=8 Hospitals)

2018 Monthly 90th Percentile APOT: by hospital



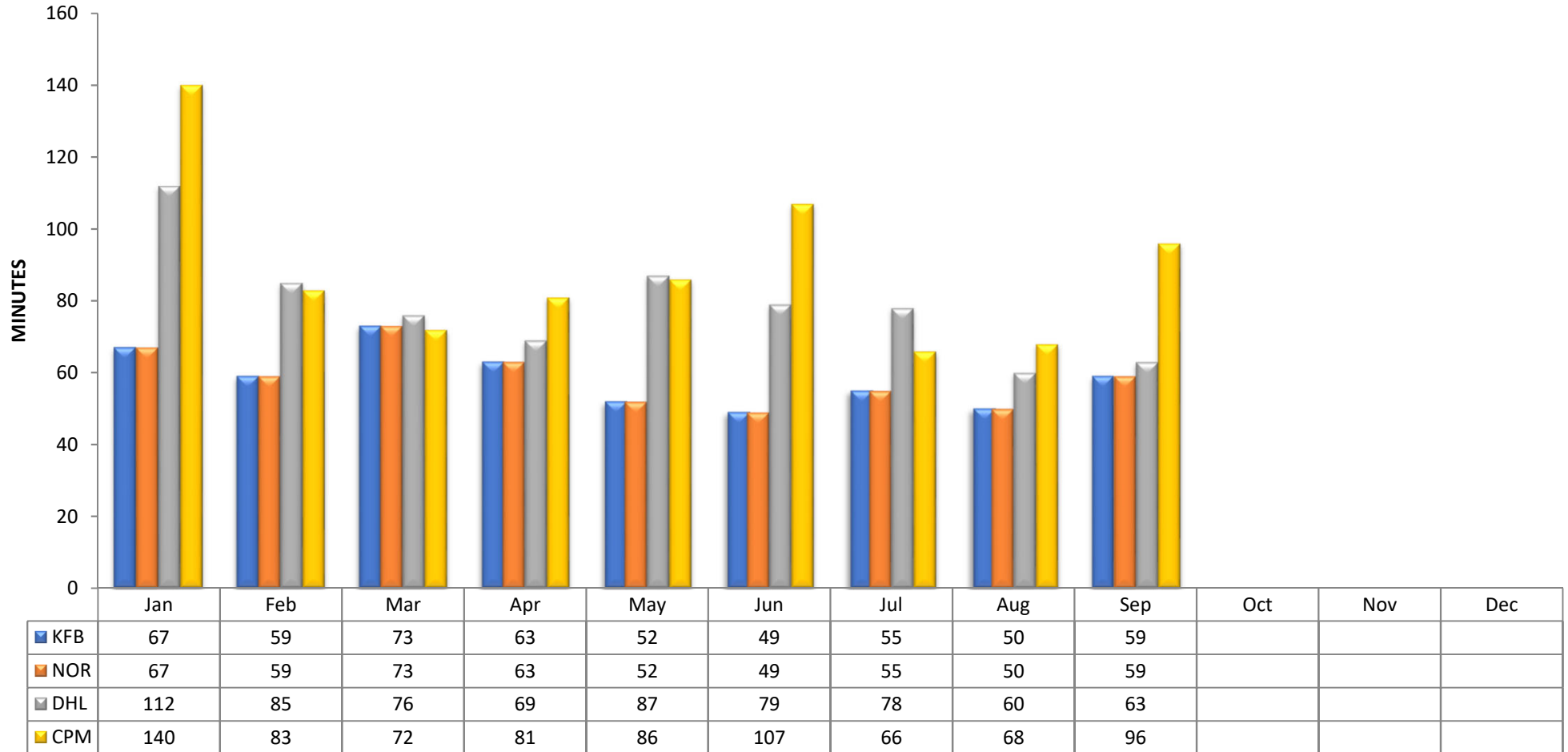
CODE	HOSPITAL NAME	CODE	HOSPITAL NAME
BEV	Beverly Hospital	WHH	Whittier Hospital Medical Center
PIH	PIH Health Whittier	DCH	PIH Health Downey

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

EAST REGION (n=8 Hospitals)

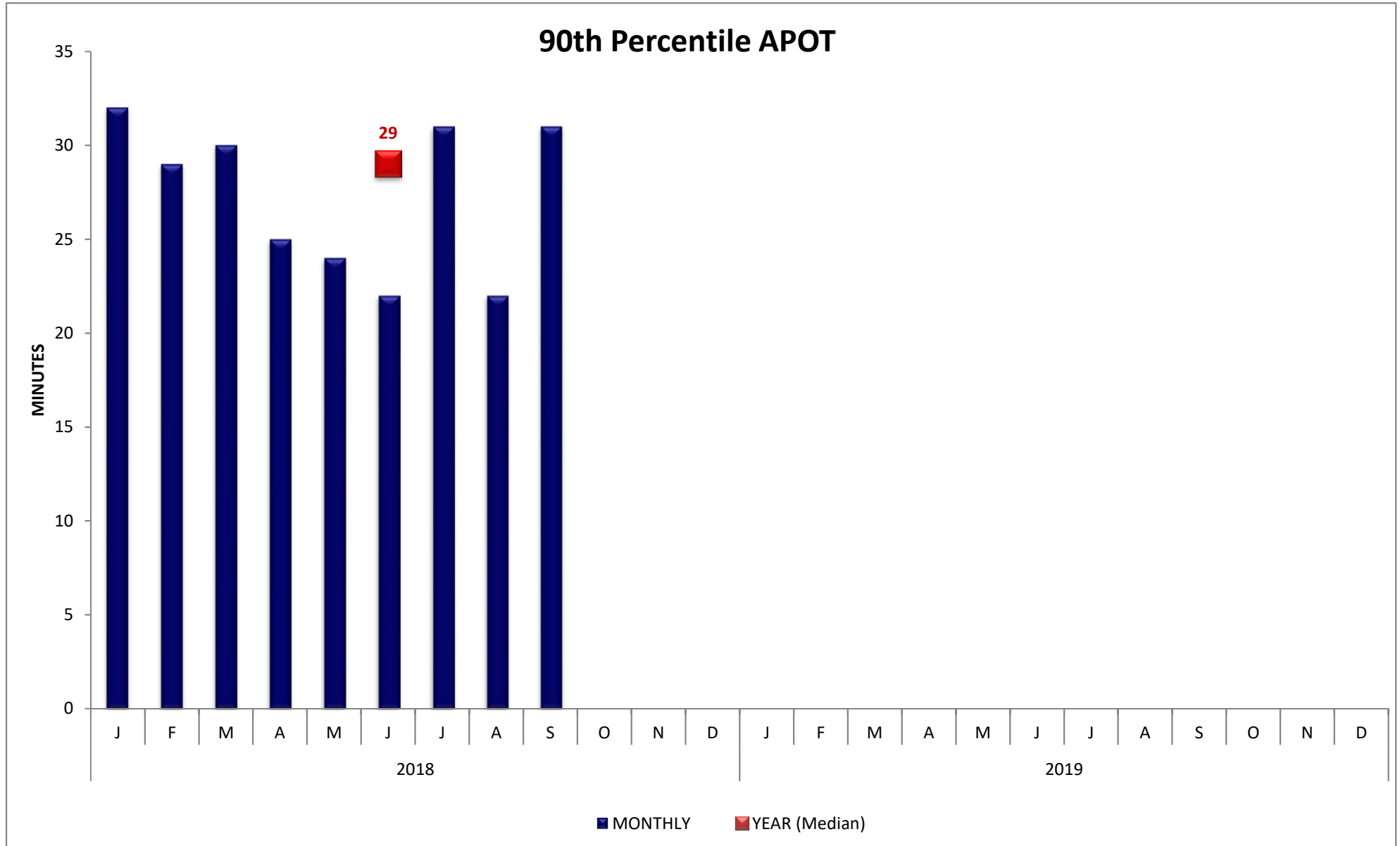
2018 Monthly 90th Percentile APOT: by hospital



CODE	HOSPITAL NAME	CODE	HOSPITAL NAME
KFB	Kaiser Foundation, Downey	DHL	Lakewood Regional Medical Center
NOR	LA Community of Norwalk	CPM	Coast Plaza Doctors Hospital

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

METRO REGION (n=12 Hospitals)

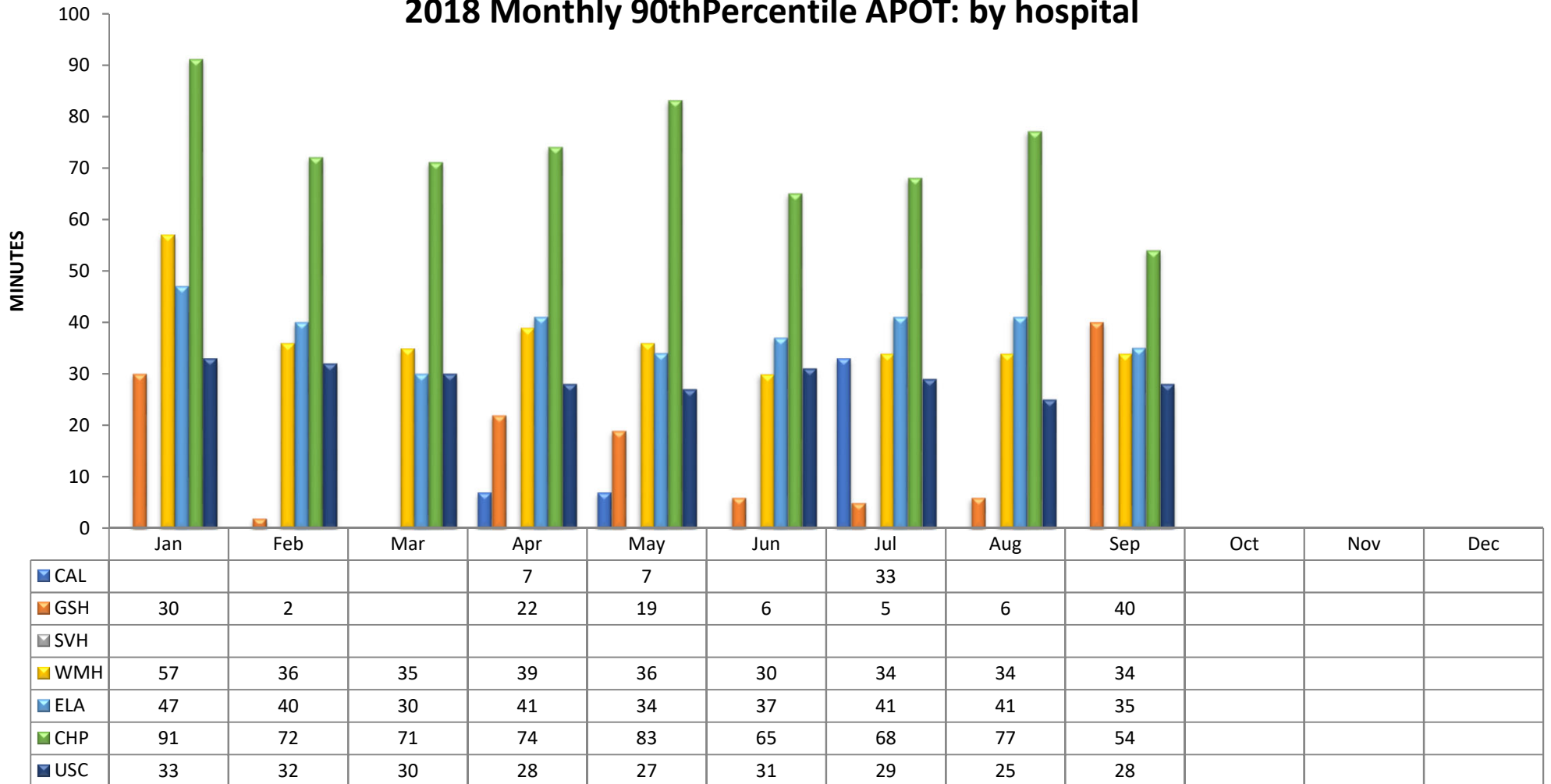


Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

METRO REGION (n=12 Hospitals)

2018 Monthly 90thPercentile APOT: by hospital



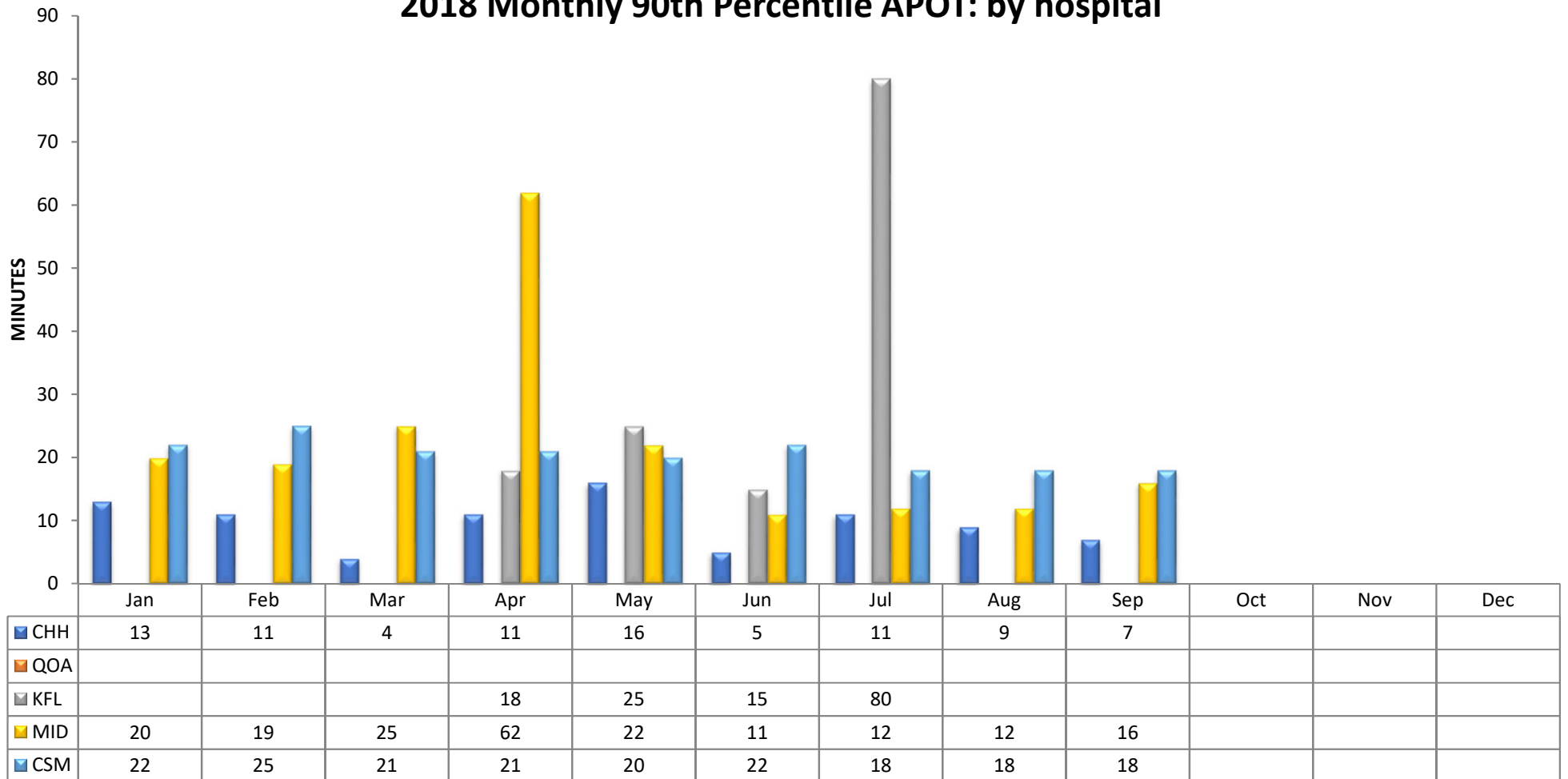
CODE	HOSPITAL NAME	CODE	HOSPITAL NAME	CODE	HOSPITAL Name
CAL	California Hospital Medical Center	WMH	White Memorial Medical Center	USC	LAC+USC Medical Center
GSH	Good Samaritan Hospital	ELA	East Los Angeles Doctors Hospital		
SVH	St. Vincent Medical Center	CHP	Community Hospital of Huntington Park		

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

METRO REGION (n=12 Hospitals)

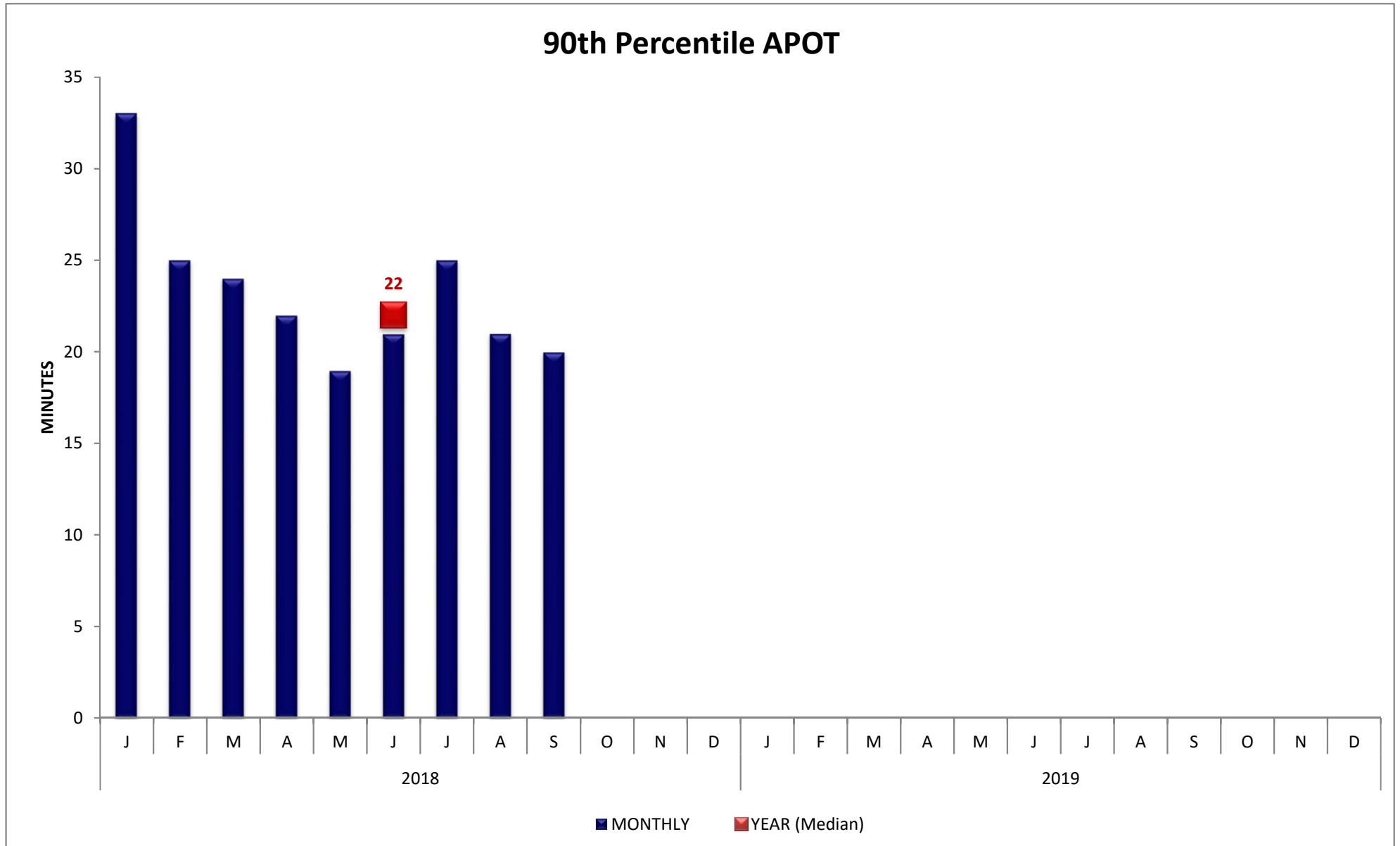
2018 Monthly 90th Percentile APOT: by hospital



CODE	HOSPITAL NAME	CODE	HOSPITAL NAME	CODE	HOSPITAL NAME
CHH	Childrens Hospital of Los Angeles	KFL	Kaiser, Los Angeles	CSM	Cedars Sinai Medical Center
QOA	Hollywood Presbyterian Medical Center	MID	Olympia Medical Center		

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

WEST REGION (n=6 Hospitals)

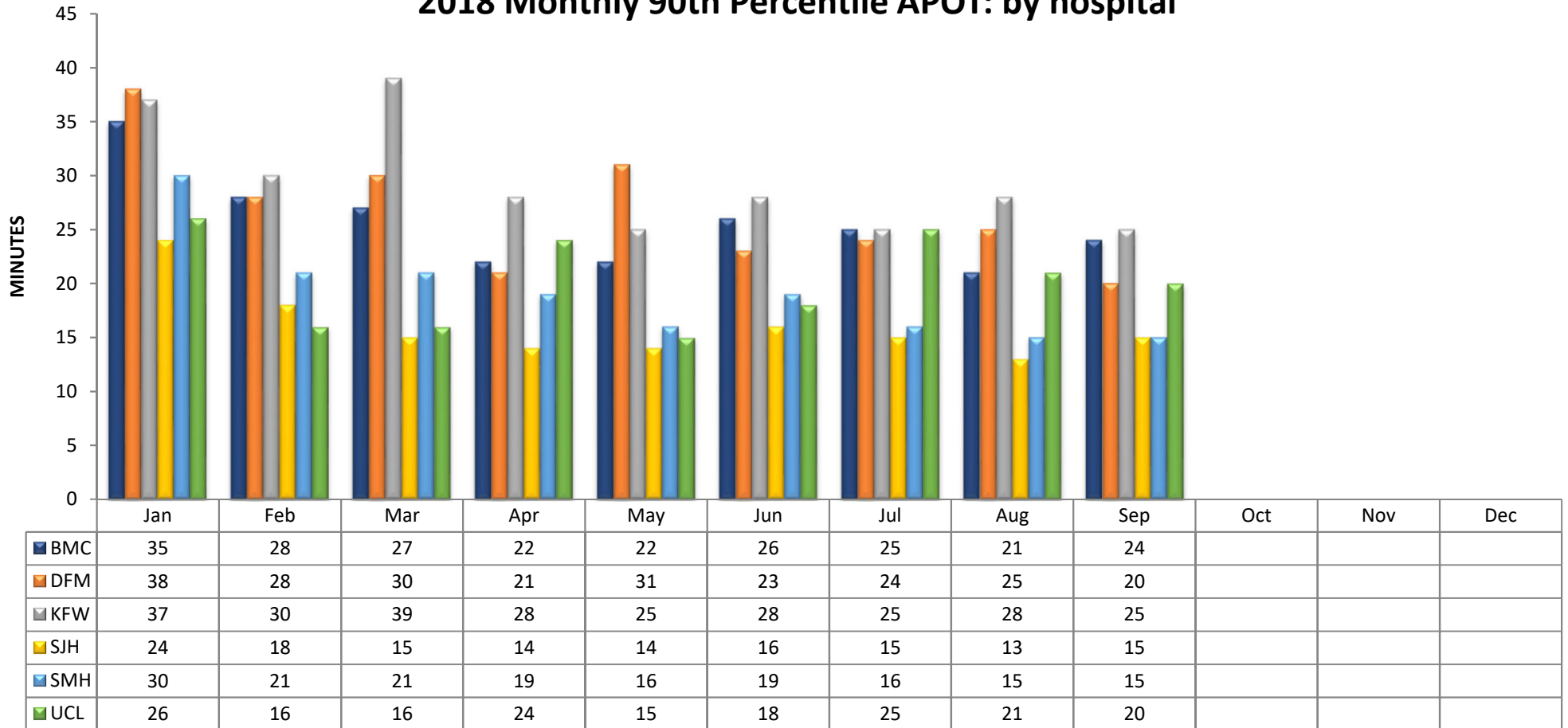


Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

WEST REGION (n=6 Hospitals)

2018 Monthly 90th Percentile APOT: by hospital



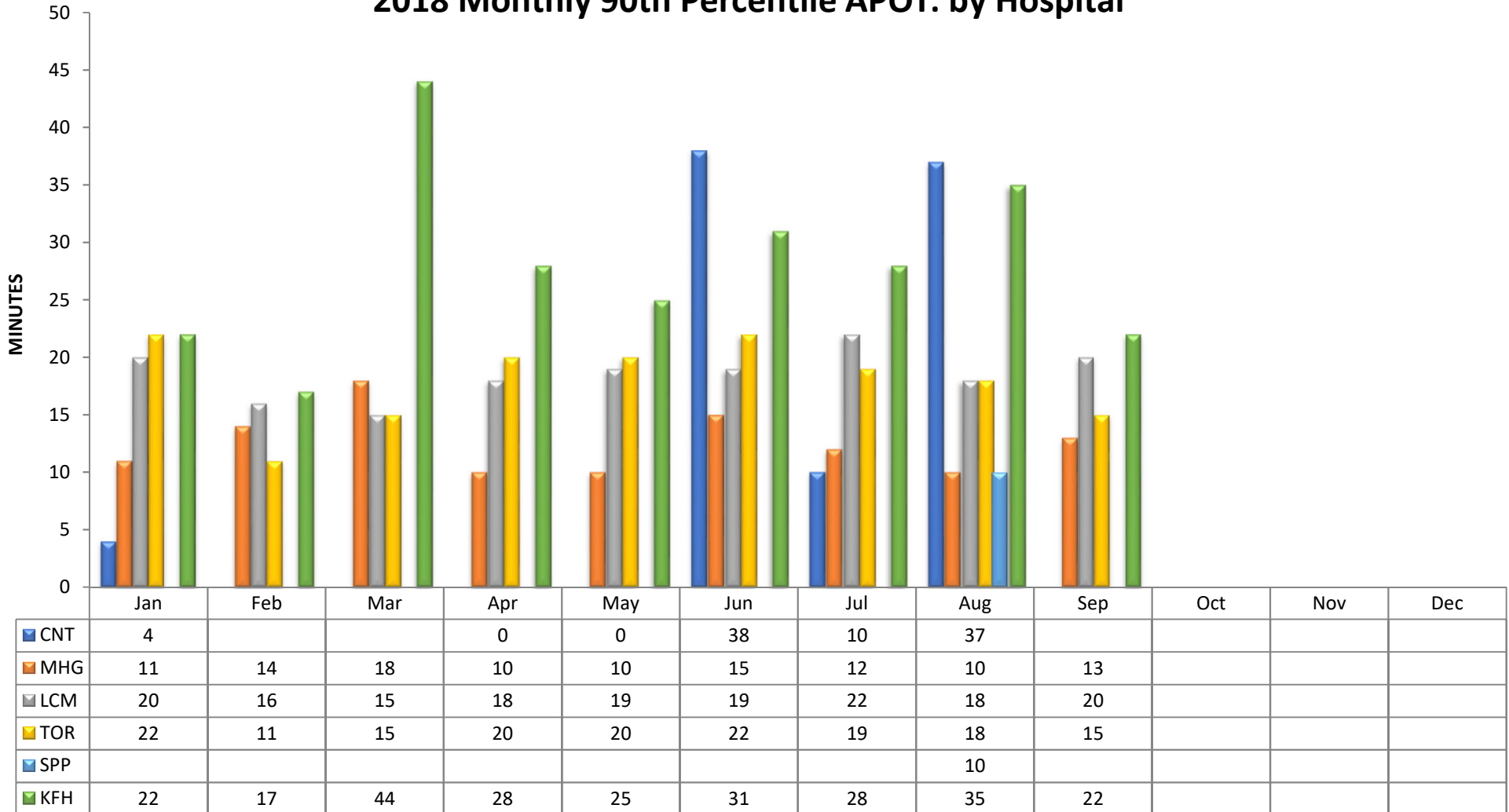
CODE	HOSPITAL NAME	CODE	HOSPITAL NAME	CODE	HOSPITAL NAME
BMC	S. California Hospital at Culver City	KFW	Kaiser, West Los Angeles	SMH	Santa Monica/UCLA Medical Center
DFM	Marina Del Rey Hospital	SJH	St. John's Hospital & Health Center	UCL	UCLA Medical Center

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

SOUTH REGION (n=12 Hospitals)

2018 Monthly 90th Percentile APOT: by Hospital



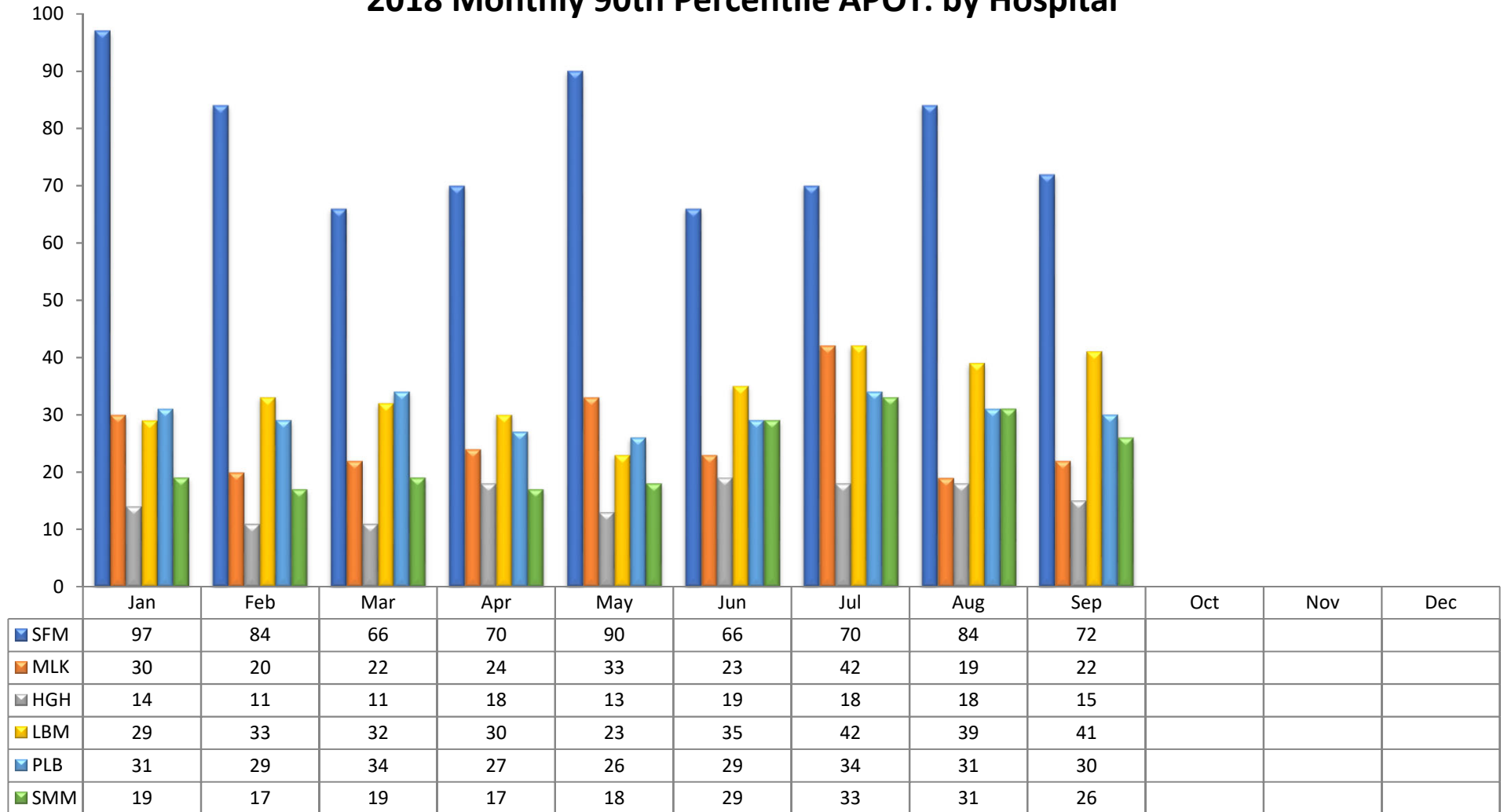
CODE	HOSPITAL NAME	CODE	HOSPITAL NAME	CODE	HOSPITAL NAME
CNT	Centinela Hospital Medical Center	LCM	Providence Little Company of Mary-Torrance	SPP	Providence Little Company of Mary-San Pedro
MHG	Memorial Hospital of Gardena	TOR	Torrance Memorial Medical Center	KFH	Kaiser Foundation - South Bay

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT

SOUTH REGION (n=12 Hospitals)

2018 Monthly 90th Percentile APOT: by Hospital



CODE	HOSPITAL NAME	CODE	HOSPITAL NAME	CODE	HOSPITAL NAME
SFM	St. Francis Medical Center	HGH	Harbor-UCLA Medical Center	PLB	College Medical Center
MLK	MLK Community Hospital	LBM	Long Beach Memorial Medical Center	SMM	St. Mary Medical Center



**LOS ANGELES COUNTY
BOARD OF SUPERVISORS**

Hilda L. Solis

First District

Mark Ridley-Thomas

Second District

Sheila Kuehl

Third District

Janice Hahn

Fourth District

Kathryn Barger

Fifth District

COMMISSIONERS

Ellen Alkon, M.D.

Southern California Public Health Assn.

Lt. Brian S. Bixler

Peace Officers Association of LA County

Erick H. Cheung, M.D., Chairman

Southern CA Psychiatric Society

Marc Eckstein, M.D.

LA County Medical Association

Chief Eugene Harris

Los Angeles County Police Chiefs' Assn.

John Hisserich, Dr.PH., Vice-Chair

Public Member (3rd District)

Lydia Lam, M.D.

American College of Surgeons

James Lott, PsyD., MBA

Public Member (2nd District)

Mr. Robert Ower

LA County Ambulance Association

Margaret Peterson, Ph.D.

Hospital Association of Southern CA

Mr. Paul S. Rodriguez

CA State Firefighters' Association

Mr. Joseph Salas

Public Member (1st District)

Nerses Sanossian, MD, FAHA

American Heart Association

Western States Affiliate

Carole A. Snyder, RN

Emergency Nurses Association

Mr. Colin Tudor

League of Calif. Cities/LA County Division

Atila Uner, MD, MPH

California Chapter-American College of

Emergency Physicians (CAL-ACEP)

Mr. Gary Washburn

Public Member (5th District)

Chief David White

Los Angeles Area Fire Chiefs Association

Mr. Pajmon Zarrineghbal

Public Member (4th District)

Executive Director

Cathy Chidester

(562) 378-1604

CChidester@dhs.lacounty.gov

Commission Liaison

Denise Watson

(562) 378-1606

DWatson@dhs.lacounty.gov

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

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

(562) 378-1604 FAX (562) 941-5835

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

Nominating Committee Meeting

December 12, 2018

EMS Commission Members Present:

Margaret Peterson, Ph.D.

Nerses Sanossian, M.D.

Carole Snyder, RN

Commission Secretary:

Denise Watson

Positions to be Filled:

Chair

Vice Chair

Nominating Committee Recommendations:

Chair – John Hisserich, Dr.PH

Vice Chair – Joseph Salas

September 19, 2018

Nominations from the floor for either position:

Chair – None

Vice Chair – None



EMERGENCY MEDICAL SERVICES COMMISSION STANDING COMMITTEE NOMINATIONS 2019

COMMITTEE	2017	2018	2019
Provider Agency Advisory Committee PAAC	Chair: Dave White Vice Chair: Robert Ower Commissioners: Brian Bixler Robert Barnes Staff: Gary Watson	Chair: Dave White Vice Chair: Robert Ower Commissioners: Brian Bixler Paul Rodriguez Staff: Gary Watson	Chair: Paul Rodriguez Vice Chair: Dave White Commissioners: Brian Bixler Eugene Harris Staff: Gary Watson
Base Hospital Advisory Committee BHAC	Chair: Marc Eckstein, MD Vice Chair: Margaret Peterson, PhD Commissioners: Eric Cheung, MD Staff: Lorrie Perez	Chair: Marc Eckstein, MD Vice Chair: Margaret Peterson, PhD Commissioners: John Hisserich Lydia Lam Staff: Lorrie Perez	Chair: Atilla Uner, MD, MPH Vice Chair: Robert Ower Commissioners: Erick Cheung, MD Margaret Peterson, PhD Staff: Lorrie Perez
Data Advisory Committee DAC	Chair: Nerses Sanossian, MD Vice Chair: Paul Rodriguez Commissioners: John Hisserich Colin Tudor Staff: Michelle Williams	Chair: Nerses Sanossian, MD Vice Chair: Pajmon Zarrineghbal Commissioners: James Lott Colin Tudor Staff: Michelle Williams	Chair: Nerses Sanossian, MD Vice Chair: Pajmon Zarrineghbal Commissioners: Lydia Lam James Lott Colin Tudor Staff: Sara Rasnake
Education Advisory Committee EAC	Chair: Carole Snyder, RN Vice Chair: Gary Washburn Commissioners: Ellen Alkon, MD Staff: David Wells	Chair: Carole Snyder, RN Vice Chair: Atilla Uner, MD, MPH Commissioners: Ellen Alkon, MD Gary Washburn Staff: David Wells	Chair: Carole Snyder, RN Vice Chair: Marc Eckstein, MD Commissioners: Gary Washburn Ellen Alkon Staff: David Wells

Electrocardiogram (ECG) Task Force Recommendations

Our mission: 100% successful ECG transmission within 1 minute of acquisition

Step 1 – Dispatch

- Rec: Chest pain ≥ 35 y/o should receive Advanced Life Support (ALS) dispatch [Provider Agencies]
- Rec: Basic Life Support (BLS) should receive education regarding when to up triage for those patients who are dispatched BLS [Provider Agencies/Emergency Medical Services (EMS) Educators]

Step 2 – Decision to obtain ECG

- Rec: Criteria for obtaining ECG should include the following: [EMS Agency]
 - Chest pain/discomfort
 - Dysrhythmia, with education that this is not to detect STEMI but to define rhythm
 - Syncope ≥ 35 y/o [all patients with syncope need to receive cardiorespiratory monitoring; if a dysrhythmia is suspected a 12-lead ECG should be performed]
 - Return of Spontaneous Circulation (ROSC)
 - Other symptoms with paramedic suspicion of cardiac etiology (e.g. non-traumatic shoulder, jaw, upper arm pain, dyspnea, epigastric pain, radiating pain)
 - Vague or unexplained symptoms (generalized weakness, abdominal pain, lightheaded, nausea, malaise, vomiting, diaphoresis) in patients at high risk of acute cardiac ischemia (Elderly patients or those with a history of: coronary artery disease (CAD), myocardial infarction (MI), diabetes mellitus (DM), stroke, or peripheral vascular disease (PVD))
- Rec: Pediatric protocols should include obtaining an ECG for dysrhythmias, or syncope of suspected cardiac cause. [EMS Agency]

Step 3 – Acquiring ECG

- Rec: Emergency Medical Technician (EMT) schools should teach proper lead placement and avoidance of artifact (patient motion and lead contact with skin (ie, skin preparation, shaving, gel application and fresh lead). [EMS Agency/EMS educators]
- Rec: Paramedics should be reminded of the importance of lead placement and avoidance of artifact (tips to optimize), and their responsibility to oversee EMTs [Provider Agencies/EMS Educators]
 - Rec: Vendors should produce and distribute educational materials to support optimal use of the ECG equipment. [Vendors]
 - Rec: When indicated, an ECG should be acquired with first set of vital signs.
 - Rec: A single-use washcloth should be kept in the monitor bag, and all patients should have their skin vigorously wiped before attaching electrodes.
 - Rec: Steps should be taken to minimize electrode exposure to air prior to use. If electrodes are left out of their sealed package for too long, this can affect ECG quality.
 - Rec: Bony landmarks for electrodes should be palpated on every patient and used to guide precordial electrode placement according to international consensus guidelines.
 - Rec: For female patients or obese patients of either gender, electrodes should be attached in the same anatomic location. This may require placement on the breast. The breast tissue should not be lifted to place the electrodes below directly on the chest wall underneath the breast.

- Rec: Limb leads should be attached on the extremities not on the torso. They should be positioned as proximal as is practical on the limbs. They may be attached anywhere on the upper extremities distal to the deltoid, and on the lower extremities anywhere distal to the inguinal line.
- Rec: The ECG wire fan-out (i.e., cable management or main junction point) should be attached directly to the patient's clothing, especially during transport to minimize movement.
- Rec: Electrodes and leads should be left attached to patient for continual monitoring and possible repeat ECGs.
- Rec: Paramedics should enter the correct age and gender of the patient prior to acquiring the ECG. This has implications for linking the patient to the ECG and affects the software interpretation. [EMS educators]
- Rec: Paramedics should repeat the ECG whenever there is a high clinical suspicion for STEMI with an initial non-diagnostic ECG and/or whenever the patient's clinical condition changes. [EMS educators]

Step 4 – Interpreting the ECG

- Rec: Software algorithms should continue to be refined to enhance sensitivity and specificity for STEMI. [Vendors]
- Rec: The interpretation statement should clearly distinguish STEMI from other findings. [Vendors]
- Rec: The software should continue to trend the ST-segment and should alert providers of changes to the baseline 12-lead ECG. [Vendors]
- Rec: Software interpretations should have an over-read (paramedic and/or MD) [EMS System]
- Rec: Paramedics should be independently interpreting the ECG and sharing that interpretation with hospital personnel. [EMS System]
 - The interpretation should include a standardized approach to J point identification and measurement of the J point position relative to the ST segment.
 - The interpretation should take into account the context of the patient – there are many reasons for ST elevation, not all of which are ischemic.
- Rec: Paramedics should receive continuing education on ECG interpretation at least annually. [EMS Agency/Provider Agencies/EMS Educators]
- Rec: For STEMI interpretations where at least two of the following: paramedic, software, and patient presentation are positive, paramedics should transmit the ECG and transport to the closest SRC. [EMS System]
- Rec: For software interpretations of STEMI for which the paramedic disagrees due to the patient's clinical presentation and paramedic ECG interpretation, paramedics should contact the Base Hospital for online medical control, to discuss destination decision. [EMS System]
- Rec: If either of the following conditions below are true, paramedics should repeat the ECG immediately after loading the patient prior to transport, and at any point the patient's clinical status changes:
 - High clinical index of suspicion AND initial ECG does NOT meet STEMI criteria.
 - Low clinical index of suspicion AND initial ECG meets STEMI criteria.

Step 5 – Transmitting the ECG

- Rec: The monitor should make multiple attempts to transmit the ECG at regular intervals and/or if J-point elevation thresholds are met. [Vendors]

- Rec: The monitor should have two-way communication with the hospital and provide an alert when transmission is complete or, if the transmission fails despite multiple attempts, give clear indication of failure. [Vendors]
- Rec: The default should be transmission of the ECG (Opt-out strategy rather than Opt-in). [Vendors]
 - The monitor should prompt the paramedic, “where do you want to transmit?”
 - The paramedic should immediately be presented with the list of hospitals to choose the location for transmission.
 - There should be an opt out function, which if chosen, will prompt an additional message “Are you sure you do not want to transmit?”. The location of the ‘No Transmission’ may be device specific, but should be integrated into the typical workflow for ECG transmission such that it cannot be used as a rapid bypass to the transmission process.
- Rec: All ECG with a software and/or paramedic interpretation of STEMI all ECGs acquired after ROSC should be transmitted. [EMS System]
- Rec: The pick-list for hospitals should be organized in alphabetical order and the top 3 most recent picks should default to the top of the list. [Vendors]
- Rec: There should ultimately be a global positioning system (GPS) solution to automatically present the hospital pick list with closest hospitals at top of list (future rec). [Vendors]
- Rec: There should be development of a ‘no button’ solution with automatic transmission (future rec). [Vendors]
 - Transmission would occur to a regional Countywide cloud automatically for all ECGs for which the software interpretation is STEMI. Paramedics could send any additional ECGs they choose via a manual method to this cloud. Transferring facilities could also send ECGs to the same cloud for inter-facility transfers.
 - Mobile Intensive Care Nurses ((MICNs), ED physicians, and cardiologists) would have immediate access to the ECG in the cloud via a smartphone application. Unidentified ECGs would be available for anyone with the application to view. Additional basic information (date/time/provider unit) would be available to subscribers that are identified as verified users in the system.
 - ECGs would be listed chronologically and be available in the cloud for a fixed period of time prior to automatic deletion (e.g. two hours).
 - ECG review must be for the sole purpose of determining appropriate Catheterization laboratory team activation and not for administration of fibrinolytics in the field.
 - An additional feature of the application should allow hospital personnel to provide follow-up information back to the field providers, by entering whether a coronary angiogram and percutaneous coronary intervention were performed on the patient. Providers would have access to this follow-up information through the application.
- Rec: The EMS system should consider the feasibility of moving ultimately to transmission of all ECGs. [EMS System]
- Rec: All provider agencies should apply for Wireless Priority Service (WPS) through the Department of Homeland Security. [Provider Agencies]
- Rec: All provider agencies should determine their data usage and work with Verizon to decide on the plan that ensures no throttling of ECG data will occur. For larger departments, this means a machine-to-machine plan, which prevents throttling at 22gb. Smaller departments, whose data usage is lower than this threshold, might continue a

regular plan. Departments should also consider a NPLS private network through Verizon. [Provider Agencies]

Step 6 – Receiving the ECG

- Rec: Hospitals should have the capability to receive 12 Lead ECGs through a process that is agnostic to monitor type and optimizes efficiency. [Hospitals/Vendors]
- Rec: Hospitals should receive an alert when the ECG transmission arrives. [Hospitals]
- Rec: Hospital IT administrators should be part of the 12 Lead ECG receiving selection solution. [Hospitals]
 - Hospital IT should work with vendors to ensure firewalls do not block transmission and distribution of the transmitted ECGs.
- Rec: Ultimately all hospitals should have mechanism to receive all ECGs and route them to the appropriate specialist for interpretation, specialist to implement systems of care for treatment of STEMI when present, and integrated into medical record (future rec). [Hospitals]
- Rec: In cases where hospitals are unable to receive the ECG, a validated clinical decision tool should be utilized to determine whether advanced activation of the catheterization team is warranted, even in absence of interpretation of the ECG by physician specialists. [Hospitals, EMS Agency]

Step 7 – Provider feedback

- Rec: Paramedics should receive direct feedback on their patient outcomes to reinforce and improve their clinical judgment.
 - SRC should provide feedback within 2 weeks via secure transmission to the provider agency's designated contact person (e.g., EMS educator). This may be achieved via a software solution or encrypted/secure email. [Hospitals]
 - Feedback will be simple and include the date of service, sequence number, provider unit, patient age and gender, whether the patient received an angiogram and percutaneous coronary intervention (PCI), and optional 'kudos' for positive feedback when a job is well done.
 - If no angiogram is performed, additional feedback as to why will be provided in 3 simple categories: patient factor (e.g., refusal, contraindication to angiography), ECG quality issue (i.e., poor quality field ECG led to misinterpretation), or non-ischemic ST elevation (e.g., early repolarization, bundle branch blocks, hyperkalemia, which led to ST elevation that was ultimately determined to be non-ischemic)
 - Provider agencies should have a mechanism to provide the timely feedback directly to the treatment providers. [Provider Agencies]
- Rec: Provider agencies should receive direct feedback on their performance as an agency in regards to false positive/ negative STEMI transports.
 - The EMS Agency should provide data on the number of coronary angiographies performed for the number of STEMI field alerts by provider agency at least semi-annually, to be included with the SRC data reports. [EMS Agency]

Step 1 – Dispatch

Recommendation	Implementation Steps
Chest pain ≥35 y/o should receive Advanced Life Support (ALS) dispatch [Provider Agencies]	<ul style="list-style-type: none">• NA - complete
Basic Life Support (BLS) should receive education regarding when to up triage for those patients who are dispatched BLS [Provider Agencies/Emergency Medical Services (EMS) Educators]	<ul style="list-style-type: none">• Update 1200.4 - complete• Finish BLS Module and record video• Disseminate and strongly recommend all EMTs to review BLS Module for EMS Update: Post on website, blast email link to all providers, ask all ambulance companies to distribute (take to LA area ambulance association), send to all 911 providers for EMT training

Step 2 – Decision to obtain ECG

Recommendation	Implementation Steps
<p>Criteria for obtaining an ECG should include the following: Chest pain/discomfort; Dysrhythmia, with education that this is not to detect STEMI but to define rhythm; Syncope ≥35 y/o [all patients with syncope need to receive cardiorespiratory monitoring; if a dysrhythmia is suspected a 12-lead ECG should be performed]; Return of Spontaneous Circulation (ROSC); Other symptoms with paramedic suspicion of cardiac etiology (e.g. non-traumatic shoulder, jaw, upper arm pain, dyspnea, epigastric pain, radiating pain); Vague or unexplained symptoms (generalized weakness, abdominal pain, lightheaded, nausea, malaise, vomiting, diaphoresis) in patients at high risk of acute cardiac ischemia (Elderly patients or those with a history of: coronary artery disease (CAD), myocardial infarction (MI), diabetes mellitus (DM), stroke, or peripheral vascular disease (PVD))</p> <p>[EMS Agency]</p>	<ul style="list-style-type: none"> • Include exact language in next revision of MCG 1308
<p>Pediatric protocols should include obtaining an ECG for dysrhythmias, or syncope of suspected cardiac cause.</p> <p>[EMS Agency]</p>	<ul style="list-style-type: none"> • NA – already complete

Step 3 – Acquiring the ECG

Recommendation	Implementation Steps
<p>Emergency Medical Technician (EMT) schools should teach proper lead placement and avoidance of artifact (patient motion and lead contact with skin (ie, skin preparation, shaving, gel application and fresh lead). [EMS Agency/EMS educators]</p> <p>Modification: EMTs should learn proper placement and avoidance of artifact.</p>	<ul style="list-style-type: none"> EMS Agency will make a recommendation: EMTs assisting with ECG acquisition be properly trained <ul style="list-style-type: none"> 911 providers shall develop training for EMTs EOA providers shall train their EMTs Post a module to the EMS Agency website that includes training on acquisition of a high-quality ECG - COMPLETED <ul style="list-style-type: none"> Module should include objectives so that providers can give CE Include this in the module update for the ALS providers that do 1:1 staffing - this will include all 4 EOA providers EMT forum – encourage teaching skills to assist the paramedic to obtain good quality ECG (limiting motion)
<p>Paramedics should be reminded of the importance of lead placement and avoidance of artifact (tips to optimize), and their responsibility to oversee EMTs [Provider Agencies/EMS Educators]</p>	<ul style="list-style-type: none"> Create training module to post to Emergipress website and distribute via email - COMPLETED Restart 'ECG of the month' for ECG training, emphasize good technique for acquisition - ONGOING
<p>Vendors should produce and distribute educational materials to support optimal use of the ECG equipment. [Vendors]</p>	<ul style="list-style-type: none"> Merge PTI training with Vendor training and create 1 unifying module Once created, distribute training materials all paramedic schools
<p>When indicated, an ECG should be acquired with first set of vital signs.</p>	<ul style="list-style-type: none"> Evaluate skills sheets for primary training – timing of ECG, reworking the thought process EMS Update scenario for STEMI – evaluate process, timing of ECG Look at protocol and MCG – emphasize timing in next update
<p>A single-use washcloth should be kept in the monitor bag, and all patients should have their skin vigorously wiped before attaching electrodes.</p>	<ul style="list-style-type: none"> Include wiping down chest in training module (on website and in BLS training) - COMPLETED Include washcloth specifically in inventory and educate provider agencies Include in MCG Include in primary training
<p>Steps should be taken to minimize electrode exposure to air prior to use. If electrodes are left out of their sealed package for too long, this can affect ECG quality.</p>	<ul style="list-style-type: none"> Include in training module (on website and in BLS training) Include in MCG Include in primary training
<p>Bony landmarks for electrodes should be palpated on every patient and used to guide precordial electrode placement according to international consensus guidelines.</p>	<ul style="list-style-type: none"> Include in training module (on website and in BLS training) Include in MCG Include in primary training
<p>For female patients or obese patients of either gender, electrodes should be attached in the same anatomic location. This may requirement placement on the breast. The breast tissue should not be lifted to place the electrodes</p>	<ul style="list-style-type: none"> Include in training module (on website and in BLS training) Include in MCG Include in primary training

below directly on the chest wall underneath the breast.	
Limb leads should be attached on the extremities not on the torso. They should be positioned as proximal as is practical on the limbs. They may be attached anywhere on the upper extremities distal to the deltoid, and on the lower extremities anywhere distal to the inguinal line.	<ul style="list-style-type: none"> • Include in training module (on website and in BLS training) • Include in MCG • Include in primary training
The ECG wire fan-out (i.e., cable management or main junction point) should be attached directly to the patient's clothing, especially during transport to minimize movement.	<ul style="list-style-type: none"> • Include in training module (on website and in BLS training) • Include in MCG • Include in primary training
Electrodes and leads should be left attached to patient for continual monitoring and possible repeat ECGs.	<ul style="list-style-type: none"> • Include in training module (on website and in BLS training) • Create STEMI case in 'Cases from the field' where repeat ECG required to make diagnosis • Include in MCG • Include in primary training
Paramedics should enter the correct age and gender of the patient prior to acquiring the ECG. This has implications for linking the patient to the ECG and affects the software interpretation. [EMS educators]	<ul style="list-style-type: none"> • Include in training module (on website and in BLS training) • Include in MCG • Include in primary training
Paramedics should repeat the ECG whenever there is a high clinical suspicion for STEMI with an initial non-diagnostic ECG and/or whenever the patient's clinical condition changes. [EMS educators]	<ul style="list-style-type: none"> • Include in training module (on website and in BLS training) • Include in MCG • Include in primary training

Step 4 – Interpreting the ECG

Recommendation	Implementation Steps
Software algorithms should continue to be refined to enhance sensitivity and specificity for STEMI. [Vendors]	<i>Vendors to implement</i>
The interpretation statement should clearly distinguish STEMI from other findings. [Vendors]	<ul style="list-style-type: none"> • Meet with Zoll to discuss current designation of ***Acute MI*** • Discuss with vendors re: universal nomenclature for STEMI interpretation
Software interpretations should have an over-read (paramedic and/or MD) [EMS System]	<ul style="list-style-type: none"> • Reinforce in TP/ MCG paramedic read of ECG • Hospital Notification requirements for STEMI to include paramedic interpretation of ECG • System-wide QI project • Include in STEMI standards: SRCs to have protocols for MD involvement in STEMI alerts pre-arrival (mechanism to emergently consult the MD to determine pre-activation of the cath lab) • Increase continuing education on ECG interpretation – Emergipress ECG of the month
Paramedics should be independently interpreting the ECG and sharing that interpretation with hospital personnel. [EMS System] <ul style="list-style-type: none"> • The interpretation should include a standardized approach to J point identification and measurement of the J point position relative to the ST segment. • The interpretation should take into account the context of the patient – there are many reasons for ST elevation, not all of which are ischemic. 	<ul style="list-style-type: none"> • Reinforce in TP/ MCG paramedic read of ECG • Hospital Notification requirements for STEMI to include paramedic interpretation of ECG • Increase continuing education on ECG interpretation – Emergipress ECG of the month
Paramedics should receive continuing education on ECG interpretation at least annually. [EMS Agency/Provider Agencies/EMS Educators]	<ul style="list-style-type: none"> • Include an ECG module annually in EMS Update • Increase continuing education on ECG interpretation – Emergipress ECG of the month • Require regular CE on ECGs at provider agencies, for provider agencies that have high % FP – divide CF and CI by sections
For STEMI interpretations where at least two of the following: paramedic, software, and patient presentation are positive, paramedics should transmit the ECG and transport to the closest SRC. [EMS System]	<ul style="list-style-type: none"> • Included in MCG 1303
For software interpretations of STEMI for which the paramedic disagrees due to the patient's clinical presentation and paramedic ECG interpretation, paramedics should contact the Base Hospital for online medical control, to discuss destination decision. [EMS System]	<ul style="list-style-type: none"> • Reinforce in MCG 1303 on next revision
If either of the following conditions below are true, paramedics should repeat the ECG	<ul style="list-style-type: none"> • Include in TP 1211 on next revision

immediately after loading the patient prior to transport, and at any point the patient's clinical status changes:

- High clinical index of suspicion AND initial ECG does NOT meet STEMI criteria.
- Low clinical index of suspicion AND initial ECG meets STEMI criteria.

Step 5 – Transmitting the ECG	
Recommendation	Implementation Steps
The monitor should make multiple attempts to transmit the ECG at regular intervals and/or if J-point elevation thresholds are met. [Vendors]	<i>Vendors to implement</i>
The monitor should have two-way communication with the hospital and provide an alert when transmission is complete or, if the transmission fails despite multiple attempts, give clear indication of failure. [Vendors]	<i>Vendors to implement</i>
<p>The default should be transmission of the ECG (Opt-out strategy rather than Opt-in). [Vendors]</p> <ul style="list-style-type: none"> • The monitor should prompt the paramedic, “where do you want to transmit?” • The paramedic should immediately be presented with the list of hospitals to choose the location for transmission. • There should be an opt out function, which if chosen, will prompt an additional message “Are you sure you do not want to transmit?”. The location of the ‘No Transmission’ may be device specific, but should be integrated into the typical workflow for ECG transmission such that it cannot be used as a rapid bypass to the transmission process. 	<i>Vendors to implement</i>
All ECG with a software and/or paramedic interpretation of STEMI and all ECGs acquired after ROSC should be transmitted. [EMS System]	<ul style="list-style-type: none"> • Included in TP 1210 and TP 1211 and MCG 1303 - COMPLETED • Ensure all providers receiving training on ECG transmission procedure <ul style="list-style-type: none"> ○ Create module for Emergipress ○ Include in primary training
The pick-list for hospitals should be organized in alphabetical order and the top 3 most recent picks should default to the top of the list. [Vendors]	<i>Vendors to implement</i>
There should ultimately be a global positioning system (GPS) solution to automatically present the hospital pick list with closest hospitals at top of list (future rec). [Vendors]	<i>Vendors to implement</i>
<p>There should be development of a ‘no button’ solution with automatic transmission (future rec). [Vendors]</p> <ul style="list-style-type: none"> • Transmission would occur to a regional Countywide cloud automatically for all ECGs for which the software interpretation is STEMI. Paramedics could send any additional ECGs they choose via a manual method to this cloud. Transferring facilities could also send ECGs to the same cloud for inter-facility transfers. • Mobile Intensive Care Nurses ((MICNs), ED physicians, and cardiologists) would have 	TBD – Pulsara?

<p>immediate access to the ECG in the cloud via a smartphone application. Unidentified ECGs would be available for anyone with the application to view. Additional basic information (date/time/provider unit) would be available to subscribers that are identified as verified users in the system.</p> <ul style="list-style-type: none"> • ECGs would be listed chronologically and be available in the cloud for a fixed period of time prior to automatic deletion (e.g. two hours). • ECG review must be for the sole purpose of determining appropriate Catheterization laboratory team activation and not for administration of fibrinolytics in the field. • An additional feature of the application should allow hospital personnel to provide follow-up information back to the field providers, by entering whether a coronary angiogram and percutaneous coronary intervention were performed on the patient. Providers would have access to this follow-up information through the application. 	
<p>Rec: The EMS system should consider the feasibility of moving ultimately to transmission of all ECGs. [EMS System]</p>	<p>TBD</p>
<p>All provider agencies should apply for Wireless Priority Service (WPS) through the Department of Homeland Security. [Provider Agencies]</p>	<ul style="list-style-type: none"> • Provide information to provider agencies regarding WPS and how to apply
<p>All provider agencies should determine their data usage and work with Verizon to decide on the plan that ensures no throttling of ECG data will occur. For larger departments, this means a machine-to-machine plan, which prevents throttling at 22gb. Smaller departments, whose data usage is lower than this threshold, might continue a regular plan. Departments should also consider a NPLS private network through Verizon. [Provider Agencies]</p>	<ul style="list-style-type: none"> • Set standard of 100% ECGs transmitted within 1 minute • Determine if data can be acquired on time to transmission and success frequencies by provider agency: Ask Zoll and Physio. • Provide information to provider agencies regarding throttling and the need to work with Verizon (or whomever their provider is) to optimize data transmission. Providers should determine if they are being throttled. • Initiate Base/Provider QI project evaluating these metrics.

Step 6 – Receiving the ECG

Recommendation	Implementation Steps
<p>Hospitals should have the capability to receive 12 Lead ECGs through a process that is agnostic to monitor type and optimizes efficiency. [Hospitals/Vendors]</p>	<ul style="list-style-type: none"> • Require in SRC standards, require policy on ECG retrieval, evaluate process on audits • Share best practices at SRC Advisory meetings • Host annual ‘Vendor Information Sessions’ to provide hospitals with info on latest technologies to include ED personnel, IT, cardiology • Track ECG transmission success in new SRC database, add metric to standards • Define metric on time from receipt to review by MD (? 3 minutes) – check with Zoll/Physio on data availability; develop QI process for hospitals to track this metric and add metrics to standards
<p>Hospitals should receive an alert when the ECG transmission arrives. [Hospitals]</p>	<ul style="list-style-type: none"> • Require in SRC standards, require in policy on ECG retrieval, evaluate process on audits • Share best practices at SRC Advisory meetings • Host annual ‘Vendor Information Sessions’ to provide hospitals with info on latest technologies to include ED personnel, IT, cardiology
<p>Hospital IT administrators should be part of the 12 Lead ECG receiving selection solution. [Hospitals]</p> <ul style="list-style-type: none"> • Hospital IT should work with vendors to ensure firewalls do not block transmission and distribution of the transmitted ECGs. 	<ul style="list-style-type: none"> • Require in SRC standards (ensure processes in place to receive ECG), require IT plan in policy on ECG retrieval, evaluate process on audits • Share best practices at SRC Advisory meetings • Host annual ‘Vendor Information Sessions’ to provide hospitals with info on latest technologies to include ED personnel, IT, cardiology
<p>Ultimately all hospitals should have mechanism to receive all ECGs and route them to the appropriate specialist for interpretation, specialist to implement systems of care for treatment of STEMI when present, and integrated into medical record (future rec). [Hospitals]</p>	<p>TBD</p>
<p>In cases where hospitals are unable to receive the ECG, a validated clinical decision tool should be utilized to determine whether advanced activation of the catheterization team is warranted, even in absence of interpretation of the ECG by physician specialists. [Hospitals, EMS Agency]</p>	<ul style="list-style-type: none"> • Reinforce use of MCG 1303 • Require review of internal protocol for field activation – including when ECG transmission fails • Evaluate process on field audits

Step 7 – Provider Feedback

Recommendation	Implementation Steps
<p>Paramedics should receive direct feedback on their patient outcomes to reinforce and improve their clinical judgment.</p> <ul style="list-style-type: none"> • SRC should provide feedback within 2 weeks via secure transmission to the provider agency's designated contact person (e.g., EMS educator). This may be achieved via a software solution or encrypted/secure email. [Hospitals] <ul style="list-style-type: none"> ○ Feedback will be simple and include the date of service, sequence number, provider unit, patient age and gender, whether the patient received an angiogram and percutaneous coronary intervention (PCI), and optional 'kudos' for positive feedback when a job is well done. ○ If no angiogram is performed, additional feedback as to why will be provided in 3 simple categories: patient factor (e.g., refusal, contraindication to angiography), ECG quality issue (i.e., poor quality field ECG led to misinterpretation), or non-ischemic ST elevation (e.g., early repolarization, bundle branch blocks, hyperkalemia, which led to ST elevation that was ultimately determined to be non-ischemic) • Provider agencies should have a mechanism to provide the timely feedback directly to the treatment providers. [Provider Agencies] 	<ul style="list-style-type: none"> • Require in SRC standards that feedback must be shared with providers, evaluate process on audits • Discuss at SRC Advisory – how can this be implemented? What should be the format of the form? Share best practices • Develop feedback tool template for SRCs to use <ul style="list-style-type: none"> ○ Ultimately create an instantaneous feedback; ask LA County Fire to share their EMS Feedback Form at PAAC • Develop list of points of contact for each Provider Agency and disseminate to hospitals, with mechanism to receive – minimum secure email to start <ul style="list-style-type: none"> • Discuss at Base/Provider QI and at PAAC how to implement • Require protocol for dispersal of feedback, review on audits <ul style="list-style-type: none"> ○ Providers with Digital EMS – could utilize Digital EMS System to attach feedback to the ePCR
<p>Provider agencies should receive direct feedback on their performance as an agency in regards to false positive/ negative STEMI transports.</p> <ul style="list-style-type: none"> • The EMS Agency should provide data on the number of coronary angiographies performed for the number of STEMI field alerts by provider agency at least semi-annually, to be included with the SRC data reports. [EMS Agency] 	<ul style="list-style-type: none"> • Develop systematic reports for Provider Agencies on semi-annual basis (by PI Chest Pain_STEMI) TP/FP to be distributed to Provider Agencies and include in SRC Advisory data reports by Provider • Present plan and data at Base/Provider QI