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: **September 18, 2019**
TIME: **1:00 – 3:00 PM**
LOCATION: **Los Angeles County Emergency Medical Services Agency**
10100 Pioneer Boulevard, EMSC Hearing Room 128, 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 – John Hisserich, Dr.PH., Chairman

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS
Dawn Terashita, LA County Department of Public Health, Official Influenza Order

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
July 17, 2019

2. CORRESPONDENCE
2.1 (07-15-2019) Distribution: Trauma System Annual Reports for the Year 2018
2.2 (07-23-2019) Tom Lenahan: EMT Local Optional Scope Program Approval
2.3 (07-23-2019) Scott Bixby: Public Safety Naloxone Program Approval
2.4 (07-23-2019) Dr. Charles Drehsen: King LTS(D) Airway Program Approval for Specialty Care Transport
2.5 (08-08-2019) Mario Rueda: Autopulse™ Approval
2.6 (08-19-2019) Distribution: Required Notification of the Emergency Medical Services Agency for Personnel Related Potential Health and Safety Code Violations

3. COMMITTEE REPORTS
3.1 Base Hospital Advisory Committee
3.2 Data Advisory Committee
3.3 Provider Agency Advisory Committee

4. POLICIES
4.1 Policy No. 207: EMS Commission Advisory Committees
4.2 Policy No. 304: Paramedic Base Hospital Standards
4.3 Policy No. 412: AED Requirements
4.4 Policy No. 412.1: AED Application
4.5 Policy No. 412.2: AED Annual Report
4.6 Policy No. 451.1a: Private Ambulance Medical and Protective Equipment
4.7 Policy No. 608: Retention of Records
4.8 Policy No. 612: Release of EMS Records
4.9 Policy No. 622: Release of EMS Data
4.10 Policy No. 701: Supply and Resupply of EMS Units
4.11 Policy No. 703: ALS Unit Inventory
4.12 Policy No. 713: RCP Staffed SCT Inventory

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
5.4 Body Worn Cameras and Other HIPAA-Related Concerns
5.5 Glendora Community Hospital – Planned Closure of General Acute Care Services – Public Hearing

BUSINESS (NEW)

5.6 Approval of Bylaws and Specific Committees
5.7 Letter of Support for Suicidal Calls to 9-1-1 Diversion Project
5.8 Additional Criteria for 9-1-1 Receiving Center Designation

V. COMMISSIONERS' COMMENTS/REQUESTS

VI. LEGISLATION

VII. EMS DIRECTOR'S REPORT

VIII. ADJOURNMENT

To the meeting of November 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.

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MINUTES
JULY 17, 2019

COMMISSIONERS	ORGANIZATION	EMS AGENCY STAFF	POSITION
☒ Ellen Alkon, M.D.	So. CA Public Health Assn.	Cathy Chidester	Executive Director
☒ Lt. Brian S. Bixler	Peace Officers' Assn. of LAC	Denise Watson	Commission Liaison
☒ Erick H. Cheung, M.D.	So. CA Psychiatric Society	Richard Tadeo	Assistant Director
☒ Roxana Yoonessi-Martin	L.A. County Medical Assn.	Kay Fruhwirth	Assistant Director
☐ *Chief Eugene Harris	LAC Police Chiefs' Assn.	Christine Clare	EMS Staff
☒ John Hisserich, Dr.PH	Public Member, 3rd District	Michelle Williams	EMS Staff
☒ Lydia Lam, M.D.	So. CA Chapter American College of Surgeons	Vanessa Gonzalez	EMS Staff
☒ James Lott, MBA	Public Member, 2nd District	Olivia Castro	EMS Staff
☒ Robert Ower	LAC Ambulance Association	Christine Zaiser	EMS Staff
☒ Margaret Peterson, PhD	Hospital Assn. of So. CA	Jacqui Rifenburg	EMS Staff
☒ Paul S. Rodriguez	CA State Firefighters' Assn.	David Wells	EMS Staff
☒ Joseph Salas	Public Member, 1st District	John Telmos	EMS Staff
☒ Nerses Sanossian, M.D.	American Heart Association		
☒ Carole Snyder	Emergency Nurses Assn.		
☐ *Diana Tang	League of CA Cities/LAC		
☒ Atilla Uner, M.D.	American College of Emergency Physicians CAL-ACEP		
☒ Gary Washburn	Public Member, 5th District		
☐ *David White	L.A. Area Fire Chiefs' Assn.		
☐ Ab-Pajmon Zarrineghbal	Public Member, 4th District		

GUESTS

Ivan Orloff	Downey Fire Department	Alina Candal	PIH Health Whittier
Dustin Robertson	LACoFD	Jaime Garcia	HASC
Brian Chu	L.A. County Counsel		

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

I. CALL TO ORDER:

The Emergency Medical Services Commission (EMSC) meeting was held at La Fetra Senior Center at 333 East Foothill Boulevard, Glendora, California 91741. The meeting was called to order at 3:30 p.m. by Chairman John Hisserich. A quorum was present with 15 Commissioners in attendance.

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS:

Self-introductions were made starting with EMSC members followed by Emergency Medical Services (EMS) Agency staff and guests. Chairman Hisserich announced that immediately following the EMS Commission meeting, there would be a Public Hearing for the pending closure of Glendora Community Hospital's acute care services and emergency department.

III. CONSENT AGENDA:

Chairman John Hisserich, Dr.PH., called for approval of the Consent Agenda.
Motion/Second by Commissioners Ower/Snyder to approve the Consent Agenda was carried unanimously:

1. MINUTES

May 15, 2019 Minutes

2. CORRESPONDENCE

2.1 Expiring County Issued Duodotes™

There was discussion concerning expired Duodotes Countywide and the caches that the EMS Agency, County Fire and City Fire have on the ALS units. The EMS Agency Disaster section is waiting to hear back from the Food and Drug Administration (FDA) to see if the expiration dates of the Duodotes can be extended, and if the inventory on the ALS units can be decreased from 30 to 9 Duodotes.

2.2 EMS Authority Approved 2018 Trauma System Status Report

2.3 Hilary Aquino: 9-1-1 Alternate Transport Destination Clinic

Cathy Chidester, EMS Agency Director and EMS Commission Executive Director, provided background on the Alternate Transport Destination pilot project by Los Angeles City Fire (City Fire) to transport patients to psychiatric and sobering centers. The pilot project was reviewed and approved by the State EMS Authority in the Office of Statewide Health Planning and Development (OSHPD). As part of the pilot project, the EMS Agency approved the alternate destinations (psychiatric urgent care clinics and sobering center managed by Exodus and contracted with the County). The Agency ensured that clinic staff meet qualifications which are over and above what the State requires. Some of the qualifications are that staff have Basic Life Support (BLS) cards, staffed 24 hours, seven days a week (24/7) with a registered nurse, AED program in place, there are mechanisms to contact a physician, a mechanism to secondarily transport the patient to a hospital if there are any issues. The psychiatric urgent care has a psychiatrist on call 24/7. There is also a psychiatrist and a psychologist there during the day.

Data is being collected in compliance with the pilot program. Exodus Centers, City Fire and the EMS Agency has information on every patient that is transported. For patients who need a subsequent 9-1-1 transfer to acute care facilities, there is an email or text message that goes out immediately to key people. This data will be submitted to the State OSHPD quarterly.

There was discussion about the EMS Agency or EMS Commission getting involved to improve psychiatric care in the average emergency department (ED), possibly encouraging the ED to meet certain requirements, such as having a psychiatrist on-call, to become a 9-1-1 receiving center.

2.4 Rex Manuel: 9-1-1 Alternate Transport Destination Clinic

2.5 Courtney Vance: 9-1-1 Alternate Transport Destination Clinic

2.6 Marc Eckstein 9-1-1 Alternate Destination Response Unit
2.7 Jan Price: 9-1-1 Alternate Transport Destination Clinic
2.8 Diana Tang: Appointment to EMS Commission
2.9 Roxana Yoonessi-Martin: Appointment to EMS Commission
2.10 Nick Ippolito: Update on Mobile Stroke Unit Motion, March 12, 2019
2.11 Participating Physicians: Physician Services for Indigents Program Reimbursement Rates for Fiscal Year 2019-20
2.12 Eligible Physicians: Physician Services for Indigents Program – Emergency Services and Trauma Services

3. COMMITTEE REPORTS

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

4. POLICIES

4.1 Policy No. 406: Authorization for Paramedic Provider Status
4.2 Policy No. 451.1: Ambulance Licensing Administrative Fines
4.3 Policy No. 710: Basic Life Support Ambulance Equipment
4.4 Policy No. 712: Nurse Staffed Specialty Care Transport Unit Inventory

END OF CONSENT AGENDA

IV. BUSINESS:

BUSINESS (OLD)

5.1 **Prehospital Care of Mental Health and Substance Abuse Emergencies Report**
Commissioner Erick Cheung recommending continuing the topic of additional criteria for 9-1-1 receiving center designation during a future meeting.

UCLA has offered to review the current standards for field procedures of de-escalation and management of agitation in violent patients, and recommend any changes which may lead to opportunity for improving current practices.

Ms. Chidester reported having met with the Los Angeles Police Chief's Association, and offered to have further discussion about the use of midazolam in the field and sedating patients. She has met with Long Beach Police and Fire Chiefs specifically to discuss the topic of midazolam. Long Beach agreed to collecting some baseline data such as how often midazolam is given with law enforcement there, and how exactly it is being administered. Another meeting is scheduled with the City of Covina PD and LA County Fire Department (County Fire).

Commissioner Paul Rodriguez noted that administration of midazolam depends on the patient's condition at the time they are restrained. If they get restrained and are calm and complying with the instruction, more than likely they are not going to be given midazolam. If they are restrained because it is a safety issue for all personnel, more than likely midazolam will be administered.

The EMS Agency believes that once the police understand the EMS protocol and benefit, the use of midazolam will expand. We are encouraging police and fire to have discussions and educate the patrol units to get a better understanding of the safe use of midazolam. Further discussion, review and education of the paramedics, base hospitals and law enforcement is needed.

Commissioner Cheung brought up current interest in the dispatch center triage of 9-1-1 calls, where the patient is articulating thoughts about suicide, and possibly doing a pilot test of routing those calls through the suicide prevention center. Commissioner Brian Bixler noted that he received word from the Department of Mental Health (DMH) that they are willing to fund two crisis counselor positions by which LAPD 9-1-1 operators would be able to transfer certain calls away from police response directly to a 9-1-1 suicide prevention hotline. The first planning workgroup meeting is scheduled for August 12, 2019.

5.2 **Ad Hoc Committee (Wall Time/Diversion)**

Richard Tadeo, EMS Agency Assistant Director, noted the Ad Hoc Committee met on May 29, 2019. The Agency is working with our Exclusive Operator Area (EOA) ambulance providers Care Ambulance, McCormick and AMR to use their Ambulance Patient Offload Time (APOT) data, which reflects the patients assessed and treated by County Fire. Once we receive the data from the ambulance companies, we can identify hospitals having extended APOT. Though the consistency of the data is improving, we still are missing APOT data from City Fire.

5.3 **Updates from Physio-Control/Stryker on the ePCR**

Mr. Tadeo reported Los Angeles City data is current through June of 2018, and LA County Fire Department's data is current through October 2018.

BUSINESS (NEW)

5.4 **Body Worn Cameras and HIPAA-Related Concerns**

Kay Fruhwirth, EMS Agency Assistant Director, reported receiving a copy of the Los Angeles Police Department's policy, and noted that they do have an exception in their policy for filming in a patient care area in a hospital or health plan connected to it, and they do not film unless it is related to custody procedures. This was the only law enforcement policy she obtained prior to the EMS Commission meeting. The EMS Agency created a survey for the fire chiefs with questions related to body camera use and privacy issues. The survey will be sent to the fire chiefs later this month.

Commissioner Bixler reported that body cameras continue to run and if protected health information is heard, that information can be used and reported without getting a release of medical information because it was in the course and scope of law enforcement duties while performing law enforcement activities. The cameras are not used for disclosing medical information, but are generally there until there is no longer a public interaction and there is no longer a need for an officer to do any enforcement activity. At that time the camera will be shut off. If interviewing a person regarding a crime, the body camera would be on at that time even when in a hospital.

This item, for further discussion and survey results, will be on the September 18, 2019 agenda.

5.5 **Bylaws and Specific Committees**

At the May 15, 2019, EMS Commission meeting there was discussion about dissolving the Education Advisory Committee (EAC), and revision to the Bylaws.

Ms. Fruhwirth reported that Provider Agency Advisory Committee (PAAC), has recommended to dissolve the EAC and add one member from the paramedic program and one member from the EMT program to PAAC to represent the education component.

Motion/Second by Commissioners Lott/Sanossian was approved to dissolve the Education Advisory Committee and add two EAC members, one EMT program representative and one Paramedic program representative, to the Provider Agency Advisory Committee and to change the Bylaws to reflect these changes was carried unanimously.

The Commission suggested adding the word education to all standing committee definitions since we are adding an educational component within Provider Agency and Base.

The revised Bylaws will be brought to the September commission meeting, and if any changes are required a new motion could be made at that time to modify them.

5.6 **Glendora Community Hospital – Planned Closure of General Acute Care Services – Public Hearing**

Ms. Chidester reported that Glendora Community Hospital is closing their emergency department and downgrading services in September, 2019, and that a public hearing would be held immediately following this EMS Commission meeting at 5:30 p.m. An Impact Analysis Report was prepared by staff to inform the community what happens to their records, how the system works, and to inform the paramedics and police this hospital may be closing and where to refer the community if required. The Commission's role is to hear testimony from the public.

COMMISSIONERS' COMMENTS/REQUESTS:

Commissioner Robert Ower requested an update from the PAAC Agenda under 2.3 Influenza, noting that there is the discussion of contacting meeting representatives for influenza vaccine orders. Commissioner Atilla Uner requested that a representative from the Department of Public Heath be invited to the September commission meeting to provide information on the influenza vaccine orders.

VI. LEGISLATION:

The Emergency Medical Services Administrators Association (EMSAAC) Legislative report was reviewed for bills of interest to the Commission by Ms. Chidester.

AB 1544 – The Gibson Bill – Community Paramedicine and Alternate Destination. This also changes the makeup of the EMS Commission, and this is going through the legislative process.

SB 438 – Hertzberg Bill – Requires all dispatch of 9-1-1 medical emergencies be done through a public dispatch entity, and not allowing any private dispatch agencies.

AB 1 - Requires an EMT to be at all school football practices and football games at the high school level.

VII. DIRECTOR'S REPORT:

Ms. Chidester reported that the State EMS Authority Director, Dr. Howard Backer, retired this past June 2019, and an interim director has been appointed.

There was a motion at the Board of Supervisor's meeting this week requesting a report from the Chief Executive Office, Department of Mental Health, County Fire and the EMS Agency on the use of nurse practitioners or mental health personnel to be utilized in the Special Planning Areas to transport patients to alternate destinations such as sobering centers and psychiatric centers.

VIII. ADJOURNMENT:

Adjournment by Chairman Hisserich at 5:00 pm to the next meeting of September 18, 2019.

Next Meeting: **Wednesday, September 18, 2019**
EMS Agency
10100 Pioneer Boulevard
1st Floor Hearing Room 128
Santa Fe Springs, CA 90670

Recorded by:
Denise Watson
Secretary, Health Services Commission

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

July 15, 2019

TO: Chief Executive Officer, Each Trauma Center
Trauma Director, Each Trauma Center
Trauma Program Manager, Each Trauma Center

FROM: Michelle Williams, MSN, RN, MICN
Chief, Data Management

SUBJECT: **TRAUMA SYSTEM ANNUAL REPORTS FOR THE YEAR 2018**

Enclosed are the Trauma System Annual Reports for the Year 2018. These reports are identified in the Trauma Center Service Agreement and are generated from the trauma database in TEMIS (Trauma and Emergency Medicine Information System). The report numbers and names are listed below:

1. Trauma Center Volume by Injury Type
2. Mechanism of Injury by Trauma Center
3. Hospital and ICU Length of Stay (LOS) for Level I and Level II Trauma Centers
4. Hospital and ICU Length of Stay (LOS) for Level I and Level II Trauma Centers - Blunt Trauma
5. Hospital and ICU Length of Stay (LOS) for Level I and Level II Trauma Centers – Penetrating Trauma
6. Outcome by Injury Type and ISS Range Summary
7. Outcome by Injury Type and ISS Range: Blunt/Penetrating Breakdown
8. Outcome by Injury Type and ISS Range: Blunt Trauma - Adult/Pediatric Breakdown
9. Outcome by Injury Type and ISS Range: Penetrating Trauma - Adult/Pediatric Breakdown
10. ISS >15 by Injury Type for Level I and Level II Trauma Centers

If you have any questions or comments about the reports, please contact me at (562) 378-1658, or Sean Chen at (562) 378-1657.

c: Director, EMS Agency
Medical Director, EMS Agency
Assistant Director, EMS Agency
Emergency Medical Services Commission
Hospital Association of Southern California
Trauma System Program Manager, EMS Agency
Epidemiologist, EMS Agency

Los Angeles County EMS Agency

Trauma System

Annual Reports for the Year 2018

(January 1, 2018 to December 31, 2018)

Los Angeles County EMS Agency TEMIS Report
Trauma Hospital Volume by Injury Type
Annual Report for the Year 2018 (January 1 to December 31, 2018)

	TOTAL PATIENTS				BLUNT TRAUMA				PENETRATING TRAUMA				BLANK/ NOT APPLICABLE		
	Adult	Peds	Total	*% of Total Pts*	Adult	Peds	Total	*% of Total Pts*	Adult	Peds	Total	*% of Total Pts*	Adult	Peds	Total
AVH	1,081	36	1,117	*5%*	897	33	930	*83%*	184	3	187	*17%*	0	0	0
CAL	1,665	9	1,674	*7%*	1,216	8	1,224	*73%*	449	1	450	*27%*	0	0	0
CHH	53	341	394	*2%*	52	336	388	*98%*	1	5	6	*2%*	0	0	0
CSM	1,644	28	1,672	*7%*	1,458	25	1,483	*89%*	185	3	188	*11%*	1	0	1
HCH	1,233	4	1,237	*5%*	1,037	3	1,040	*84%*	196	1	197	*16%*	0	0	0
HGH	2,521	188	2,709	*12%*	1,956	158	2,114	*78%*	559	28	587	*22%*	6	2	8
HMH	1,227	7	1,234	*5%*	1,124	7	1,131	*92%*	103	0	103	*8%*	0	0	0
HMN	746	31	777	*3%*	696	30	726	*93%*	48	1	49	*6%*	2	0	2
LBM	1,333	156	1,489	*7%*	1,184	151	1,335	*90%*	148	3	151	*10%*	1	2	3
NRH	1,044	106	1,150	*5%*	917	100	1,017	*88%*	122	5	127	*11%*	5	1	6
PVC	1,576	48	1,624	*7%*	1,338	43	1,381	*85%*	235	5	240	*15%*	3	0	3
SFM	1,617	16	1,633	*7%*	1,139	15	1,154	*71%*	474	1	475	*29%*	4	0	4
SMM	580	1	581	*3%*	473	1	474	*82%*	106	0	106	*18%*	1	0	1
UCL	1,201	38	1,239	*5%*	1,065	36	1,101	*89%*	135	2	137	*11%*	1	0	1
USC	3,815	197	4,012	*18%*	2,959	172	3,131	*78%*	850	25	875	*22%*	6	0	6
TOTAL	**21,336**	**1,206**	**22,542**	**100%**	**17,511**	**1,118**	**18,629**	***83%***	**3,795**	**83**	**3,878**	***17%***	**30**	**5**	**35**

Los Angeles County EMS Agency TEMIS Report
Mechanism of Injury by Trauma Hospital
Annual Report for the Year 2018 (January 1 to December 31, 2018)

	Assault	Auto vs. Ped/Bicycle	Enclosed Vehicle Accident	Fall	GSW	Motorcycle/ Moped	Other	Self-Inflicted Accidental	Self-Inflicted Intentional	Sports	Stabbing	Thermal Burn/Electric Shock	Unenclosed Vehicle Accident	Unknown	Work Related	Grand Total
AVH	32	115	422	155	59	32	19	4	4	6	105	0	159	3	2	1,117
CAL	165	401	207	320	212	24	19	18	8	5	188	6	44	50	7	1,674
CHH	16	24	36	211	6	4	31	16	0	21	0	0	0	29	0	394
CSM	114	333	200	607	64	155	47	2	3	8	80	2	8	47	2	1,672
HCH	81	221	312	306	86	53	16	13	6	8	70	0	48	11	6	1,237
HGH	195	458	453	730	279	91	101	18	8	37	213	18	66	25	17	2,709
HMH	42	157	213	521	39	8	16	6	6	11	44	0	161	10	0	1,234
HMN	23	56	210	286	13	20	11	6	8	25	22	2	87	5	3	777
LBM	73	200	303	558	69	137	34	0	1	23	69	4	0	18	0	1,489
NRH	51	191	291	350	45	55	30	7	11	19	54	6	16	14	10	1,150
PVC	83	227	417	407	80	135	41	16	13	20	111	5	44	14	11	1,624
SFM	135	370	268	325	258	12	22	36	21	5	164	9	2	2	4	1,633
SMM	48	133	82	158	32	1	21	5	7	2	55	1	19	16	1	581
UCL	27	425	280	177	56	9	44	0	2	25	72	2	89	29	2	1,239
USC	338	755	622	1,013	311	91	169	11	5	10	400	11	169	97	10	4,012
TOTAL	1,423	4,066	4,316	6,124	1,609	827	621	158	103	225	1,647	66	912	370	75	22,542

Los Angeles County EMS Agency TEMIS Report
Hospital and ICU Length of Stay (LOS) for Level I and Level II Trauma Hospitals
Annual Report for the Year 2018 (January 1 to December 31, 2018)

	BLUNT TRAUMA			PENETRATING TRAUMA			ALL TRAUMA *		
Hospital LOS	**Level I**	**Level II**	**System**	**Level I**	**Level II**	**System**	**Level I**	**Level II**	**System**
Total Patients	**8,217**	**10,412**	**18,629**	**1,793**	**2,085**	**3,878**	**10,010**	**12,497**	**22,507**
Patients Admitted	**5,752**	**7,234**	**12,986**	**1,143**	**1,289**	**2,432**	**6,895**	**8,523**	**15,418**
Total Hospital Days for Admitted Patients	46,424	48,854	95,278	7,978	8,263	16,241	54,402	57,117	111,519
Mean Hospital LOS in Days	8.07	6.75	7.34	6.98	6.41	6.68	7.89	6.70	7.23
Median Hospital LOS in Days	4	4	4	4	4	4	4	4	4
Maximum Hospital LOS in Days	230	124	230	109	133	133	230	133	230
Patients Not Admitted	**2,465**	**3,178**	**5,643**	**650**	**796**	**1,446**	**3,115**	**3,974**	**7,089**
Discharged Home/Jail	2,235	2,837	5,072	556	669	1,225	2,791	3,506	6,297
Transferred	141	219	360	30	52	82	171	271	442
Expired	89	122	211	64	75	139	153	197	350
*** Number of DOAs Included*	*20*	*34*	*54*	*10*	*28*	*38*	*30*	*62*	*92*

ICU LOS	Level I	Level II	System	Level I	Level II	System	Level I	Level II	System
Total Patients with an ICU LOS	**2,437**	**3,020**	**5,457**	**435**	**457**	**892**	**2,872**	**3,477**	**6,349**
ICU Total Patient Days	15,172	14,537	29,709	2,418	2,024	4,442	17,590	16,561	34,151
Mean ICU LOS in Days	6.23	4.81	5.44	5.56	4.43	4.98	6.12	4.76	5.38
Median ICU LOS in Days	3	3	3	3	3	3	3	3	3
Maximum ICU LOS in Total Days	101	87	101	109	85	109	109	87	109

*** Does not include 35 patients with "blank" or "not applicable" injury type**
**** DOA: Death declared on arrival with minimal/no resuscitation attempt**

Los Angeles County EMS Agency TEMIS Report
Hospital and ICU Length of Stay (LOS) for Level I and Level II Trauma Hospitals
Blunt Trauma
Annual Report for the Year 2018 (January 1 to December 31, 2018)

	MVA			Auto vs. Pedestrian/Bicycle			Other Blunt Trauma Mechanisms			ALL BLUNT TRAUMA		
Hospital LOS	**Level I**	**Level II**	**System**	**Level I**	**Level II**	**System**	**Level I**	**Level II**	**System**	**Level I**	**Level II**	**System**
Total Patients	**2,267**	**3,780**	**6,047**	**1,995**	**2,068**	**4,063**	**3,955**	**4,564**	**8,519**	**8,217**	**10,412**	**18,629**
Patients Admitted	**1,625**	**2,588**	**4,213**	**1,278**	**1,315**	**2,593**	**2,849**	**3,331**	**6,180**	**5,752**	**7,234**	**12,986**
Total Hospital Days for Admitted Patients	11,722	16,568	28,290	12,767	11,764	24,531	21,935	20,522	42,457	46,424	48,854	95,278
Mean Hospital LOS in Days	7.21	6.40	6.71	9.99	8.95	9.46	7.70	6.16	6.87	8.07	6.75	7.34
Median Hospital LOS in Days	4	4	4	5	5	5	4	4	4	4	4	4
Maximum Hospital LOS in Days	230	116	230	163	102	163	132	124	132	230	124	230
Patients Not Admitted *	**642**	**1,192**	**1,834**	**717**	**753**	**1,470**	**1,106**	**1,233**	**2,339**	**2,465**	**3,178**	**5,643**
Discharged Home/Jail	594	1,083	1,677	666	676	1,342	975	1,078	2,053	2,235	2,837	5,072
Transferred	19	59	78	15	22	37	107	138	245	141	219	360
Expired	29	50	79	36	55	91	24	17	41	89	122	211
** Number of DOAs Included*	*9*	*12*	*21*	*9*	*20*	*29*	*2*	*2*	*4*	*20*	*34*	*54*

ICU LOS	**Level I**	**Level II**	**System**	**Level I**	**Level II**	**System**	**Level I**	**Level II**	**System**	**Level I**	**Level II**	**System**
Total Patients with an ICU LOS	**573**	**857**	**1,430**	**529**	**563**	**1,092**	**1,335**	**1,600**	**2,935**	**2,437**	**3,020**	**5,457**
ICU Total Patient Days	3,621	4,424	8,045	3,994	3,378	7,372	7,557	6,735	14,292	15,172	14,537	29,709
Mean ICU LOS in Days	6.32	5.16	5.63	7.55	6.00	6.75	5.66	4.21	4.87	6.23	4.81	5.44
Median ICU LOS in Days	3	3	3	4	3	4	3	3	3	3	3	3
Maximum ICU LOS in Total Days	101	52	101	85	87	87	100	77	100	101	87	101

*** DOA = Death declared on arrival with minimal/no resuscitation attempy**

Report #4: 07/15/19

Los Angeles County EMS Agency TEMIS Report
Hospital and ICU Length of Stay (LOS) for Level I and Level II Trauma Hospitals
Penetrating Trauma
Annual Report for the Year 2018 (January 1 to December 31, 2018)

	GSW			Stab Wounds			Other Penetrating Trauma Mechanisms			ALL PENETRATING TRAUMA		
Hospital LOS	**Level I**	**Level II**	**System**	**Level I**	**Level II**	**System**	**Level I**	**Level II**	**System**	**Level I**	**Level II**	**System**
Total Patients	**713**	**892**	**1,605**	**763**	**881**	**1,644**	**317**	**312**	**629**	**1,793**	**2,085**	**3,878**
Patients Admitted	**506**	**602**	**1,108**	**458**	**490**	**948**	**179**	**197**	**376**	**1,143**	**1,289**	**2,432**
Total Hospital Days for Admitted Patients	4,069	4,707	8,776	2,906	2,602	5,508	1,003	954	1,957	7,978	8,263	16,241
Mean Hospital LOS in Days	8.04	7.82	7.92	6.34	5.31	5.81	5.60	4.84	5.20	6.98	6.41	6.68
Median Hospital LOS in Days	5	5	5	4	3	4	4	3	3	4	4	4
Maximum Hospital LOS in Days	61	73	73	109	133	133	54	25	54	109	133	133
Patients Not Admitted *	**207**	**290**	**497**	**305**	**391**	**696**	**138**	**115**	**253**	**650**	**796**	**1,446**
Discharged Home/Jail	149	215	364	277	366	643	130	88	218	556	669	1,225
Transferred	5	12	17	18	16	34	7	24	31	30	52	82
Expired	53	63	116	10	9	19	1	3	4	64	75	139
** Number of DOAs Included*	*9*	*22*	*31*	*1*	*5*	*6*	*0*	*1*	*1*	*10*	*28*	*38*
ICU LOS	**Level I**	**Level II**	**System**	**Level I**	**Level II**	**System**	**Level I**	**Level II**	**System**	**Level I**	**Level II**	**System**
Total Patients with an ICU LOS	**236**	**256**	**492**	**157**	**151**	**308**	**42**	**50**	**92**	**435**	**457**	**892**
ICU Total Patient Days	1,421	1,348	2,769	816	503	1,319	181	173	354	2,418	2,024	4,442
Mean ICU LOS in Days	6.02	5.27	5.63	5.20	3.33	4.28	4.31	3.46	3.85	5.56	4.43	4.98
Median ICU LOS in Days	4	3	3	3	2	3	3	3	3	3	3	3
Maximum ICU LOS in Total Days	36	47	47	109	85	109	25	10	25	109	85	109

*** DOA = Death declared on arrival with minimal/no resuscitation attempt**

Los Angeles County EMS Agency TEMIS Report
Outcome by Injury Type and ISS Range Summary
Annual Report for teh Year 2018 (January 1 to December 31, 2018)

ADULTS	BLUNT TRAUMA*				PENETRATING TRAUMA*				ALL TRAUMA*			
	Lived	Died	Total #	% Died	Lived	Died	Total #	% Died	Lived	Died	Total #	% Died
0	34	0	34	0.0%	0	0	0	0.0%	34	0	34	0.0%
1 to 9	11,400	71	11,471	0.6%	2,669	15	2,684	0.6%	14,069	86	14,155	0.6%
10 to 15	2,946	51	2,997	1.7%	486	5	491	1.0%	3,432	56	3,488	1.6%
16 to 24	1,632	100	1,732	5.8%	220	26	246	10.6%	1,852	126	1,978	6.4%
>24	776	433	1,209	35.8%	159	177	336	52.7%	935	610	1,545	39.5%
Blank	15	1	16	6.3%	0	1	1	100.0%	15	2	17	11.8%
NA**	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
Total	16,803	656	17,459	3.8%	3,534	224	3,758	6.0%	20,337	880	21,217	4.1%
	# DOAs not included: 52				# DOAs not included: 37				# DOAs not included: 89			

PEDS	BLUNT TRAUMA*				PENETRATING TRAUMA*				ALL TRAUMA*			
	Lived	Died	Total #	% Died	Lived	Died	Total #	% Died	Lived	Died	Total #	% Died
0	9	0	9	0.0%	0	0	0	0.0%	9	0	9	0.0%
1 to 9	790	5	795	0.6%	71	0	71	0.0%	861	5	866	0.6%
10 to 15	163	2	165	1.2%	4	0	4	0.0%	167	2	169	1.2%
16 to 24	87	2	89	2.2%	2	1	3	33.3%	89	3	92	3.3%
>24	48	10	58	17.2%	1	3	4	75.0%	49	13	62	21.0%
Blank	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
NA**	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
Total	1,097	19	1,116	1.7%	78	4	82	4.9%	1,175	23	1,198	1.9%
	# DOAs not included: 2				# DOAs not included: 1				# DOAs not included: 3			

ALL PTS	BLUNT TRAUMA*				PENETRATING TRAUMA*				ALL TRAUMA*			
	Lived	Died	Total #	% Died	Lived	Died	Total #	% Died	Lived	Died	Total #	% Died
0	43	0	43	0.0%	0	0	0	0.0%	43	0	43	0.0%
1 to 9	12,190	76	12,266	0.6%	2,740	15	2,755	0.5%	14,930	91	15,021	0.6%
10 to 15	3,109	53	3,162	1.7%	490	5	495	1.0%	3,599	58	3,657	1.6%
16 to 24	1,719	102	1,821	5.6%	222	27	249	10.8%	1,941	129	2,070	6.2%
>24	824	443	1,267	35.0%	160	180	340	52.9%	984	623	1,607	38.8%
Blank	15	1	16	6.3%	0	1	1	100.0%	15	2	17	11.8%
NA**	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
Total	17,900	675	18,575	3.6%	3,612	228	3,840	5.9%	21,512	903	22,415	4.0%
	# DOAs not included: 54				# DOAs not included: 38				# DOAs not included: 92			

***Does not include DOAs and 35 patients with "blank" or "not applicable" injury type; "Not Applicable**
NOTE: DOA = Death declared on arrival with minimal/no resuscitation attempt

Los Angeles County EMS Agency TEMIS Report
Outcome by Injury Type and ISS Range
Blunt/Penetrating Breakdown
Annual Report for the Year 2018 (January 1 to December 31, 2018)

BLUNT

	MVA*			
	Lived	Died	Total #	% Died
0	22	0	22	0.0%
1 to 9	3,869	14	3,883	0.4%
10 to 15	1,072	17	1,089	1.6%
16 to 24	607	28	635	4.4%
>24	289	105	394	26.6%
Blank	3	0	3	0.0%
NA**	0	0	0	0.0%
Total	5,862	164	6,026	2.7%

DOAs not included: 21

	Auto vs. Pedestrian/Bicycle*			
	Lived	Died	Total #	% Died
0	1	0	1	0.0%
1 to 9	2,449	12	2,461	0.5%
10 to 15	708	9	717	1.3%
16 to 24	430	25	455	5.5%
>24	243	155	398	38.9%
Blank	1	1	2	50.0%
NA**	0	0	0	0.0%
Total	3,832	202	4,034	5.0%

DOAs not included: 29

	Other Blunt Trauma Mechanisms*			
	Lived	Died	Total #	% Died
0	20	0	20	0.0%
1 to 9	5,872	50	5,922	0.8%
10 to 15	1,329	27	1,356	2.0%
16 to 24	682	49	731	6.7%
>24	292	183	475	38.5%
Blank	11	0	11	0.0%
NA**	0	0	0	0.0%
Total	8,206	309	8,515	3.6%

DOAs not included: 4

	ALL BLUNT TRAUMA*			
	Lived	Died	Total #	% Died
0	43	0	43	0.0%
1 to 9	12,190	76	12,266	0.6%
10 to 15	3,109	53	3,162	1.7%
16 to 24	1,719	102	1,821	5.6%
>24	824	443	1,267	35.0%
Blank	15	1	16	6.3%
NA**	0	0	0	0.0%
Total	17,900	675	18,575	3.6%

DOAs not included: 54

PENETRATING

	GSW*			
	Lived	Died	Total #	% Died
0	0	0	0	0.0%
1 to 9	935	10	945	1.1%
10 to 15	235	3	238	1.3%
16 to 24	107	19	126	15.1%
>24	109	155	264	58.7%
Blank	0	1	1	100.0%
NA**	0	0	0	0.0%
Total	1,386	188	1,574	11.9%

DOAs not included: 31

	Stab Wounds*			
	Lived	Died	Total #	% Died
0	0	0	0	0.0%
1 to 9	1,259	5	1,264	0.4%
10 to 15	200	1	201	0.5%
16 to 24	100	6	106	5.7%
>24	46	21	67	31.3%
Blank	0	0	0	0.0%
NA**	0	0	0	0.0%
Total	1,605	33	1,638	2.0%

DOAs not included: 6

	Other Penetrating Trauma Mechanisms*			
	Lived	Died	Total #	% Died
0	0	0	0	0.0%
1 to 9	546	0	546	0.0%
10 to 15	55	1	56	1.8%
16 to 24	15	2	17	11.8%
>24	5	4	9	44.4%
Blank	0	0	0	0.0%
NA**	0	0	0	0.0%
Total	621	7	628	1.1%

DOAs not included: 1

	ALL PENETRATING TRAUMA*			
	Lived	Died	Total #	% Died
0	0	0	0	0.0%
1 to 9	2,740	15	2,755	0.5%
10 to 15	490	5	495	1.0%
16 to 24	222	27	249	10.8%
>24	160	180	340	52.9%
Blank	0	1	1	100.0%
NA**	0	0	0	0.0%
Total	3,612	228	3,840	5.9%

DOAs not included: 38

* Does not include DOAs; **Not Applicable;
NOTE: DOA = Death declared on arrival with minimal/no resuscitation attempt

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

July 23, 2019

Tom Lenahan, Fire Chief
Hollywood Burbank Airport Fire Department
2627 Hollywood way
Burbank, CA 91505

Dear Chief Lenahan,

EMT LOCAL OPTIONAL SCOPE PROGRAM APPROVAL

This letter is to confirm Hollywood Burbank Airport Fire Department (BAFD) has been approved by the Los Angeles County Emergency Medical Services (EMS) Agency for the implementation of the following EMT local optional scope of practice skills:

- Naloxone intranasal or auto-injector for suspected opiate overdose
- Epinephrine auto-injector for suspected anaphylaxis
- Perform finger stick glucose testing for suspected hypoglycemia

The quality improvement process required for implementation of the new EMT skills will be reviewed as deemed necessary by the EMS Agency.

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

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:JT:gk
07-18

c: Director, EMS Agency
Captain Mark Domingo, Hollywood Burbank Airport Fire Department
Medical Director, Hollywood Burbank Airport Fire Department

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

July 23, 2019

Scott Bixby, Chief of Police
Culver City Police Department
4040 Duquesne Avenue
Culver City, CA 90232-2882

Dear Chief Bixby,

PUBLIC SAFETY NALOXONE PROGRAM APPROVAL

This letter is to confirm that the Emergency Medical Services (EMS) Agency has approved Culver City Police Department (CPD) for the utilization of intranasal naloxone for persons with suspected opiate overdose.

The EMS Agency is in the process of developing a Naloxone Data Registry for purposes of system evaluation and aggregate reporting on the utilization of naloxone by public safety personnel. A letter will be distributed in the near future providing additional information and instructions for use when the registry becomes available. In the interim, CPD is required to collect and maintain the data for the registry as part of the quality improvement process.

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:RT:SM:gk
07-17

c: Director, EMS Agency

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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.

July 23, 2019

Dr. Charles Drehsen
Medical Director
American Medical Response
Los Angeles County
12638 Saticoy Street South
North Hollywood, CA. 91605

Dear Dr. Drehsen,

KING LTS(D) AIRWAY PROGRAM APPROVAL FOR SPECIALTY CARE TRANSPORT

This letter is to confirm that the Emergency Medical Services (EMS) Agency has reviewed and approved American Medical Response (AMR) for the utilization of the King LTS-D airway for Specialty Care Transport to include, Nurse Staffed Critical Care and Respiratory Care Practitioner transports.

The quality improvement process required for implementation and tracking the utilization of the King LTS-D may be reviewed during AMR Program Review or as deemed necessary by the EMS Agency for purposes of system evaluation and aggregate reporting on the utilization of the King LTS-D.

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:SM:gk
07-16

c: Director, EMS Agency
Gary Cevello. Nurse Manager, American Medical Response

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.

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

August 8, 2019

Mario Rueda, Fire Chief
San Marino Fire Department
2200 Huntington Drive
San Marino, CA 91108

Dear Chief Rueda,

AUTOPULSE™ APPROVAL

This letter is to confirm that San Marino Fire Department (SA) has been approved by the Los Angeles County Emergency Medical Services (EMS) Agency to implement the AutoPulse™ Resuscitation System for patients receiving cardiopulmonary resuscitation.

The quality improvement process approved for implementation of the AutoPulse program will be reviewed during your annual EMS Program Review or as deemed necessary by the EMS Agency. Additionally, SA will be required to present data on the AutoPulse program to the Medical Advisory Council for purposes of peer review and system evaluation.

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

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:JT:sm
08-08

c: Cathy Chidester, Director, EMS Agency
Medical Director, San Marino Fire Department
EMS Director, San Marino Fire Department
Quality Improvement Coordinator, San Marino Fire Department

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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.

August 19, 2019

TO: Fire Chief, Each Public Provider Agency
Chief Executive Officer, Each Licensed Ambulance Company

FROM: Cathy Chidester
Director

SUBJECT: **REQUIRED NOTIFICATION OF THE EMERGENCY MEDICAL SERVICES AGENCY FOR PERSONNEL RELATED POTENTIAL HEALTH AND SAFETY CODE VIOLATIONS**

This memo is to remind provider agencies of the requirement to report personnel related potential violations of the Health & Safety (H&S) Code, pursuant to Section 1798.200. The relevant employer with employees that possess an Emergency Medical Technician (EMT) certificate and/or a Paramedic (PM) license must report any arrest, or other known or suspected violation of H&S Code as per sections 1798.200 and 1799.112 to the certifying/licensing entity. Please refer to Prehospital Care Policy Reference No. 214*: Base Hospital and Provider Agency Reporting Responsibilities* (attached) for the list of reportable potential violations.

Concerns about arrests or other potential violations involving an EMT must be reported to the local Emergency Medical Services Agency (LEMSA) and those involving a PM must be reported to the LEMSA and the Emergency Medical Services Authority (EMSA).

Additionally, if the LEMSA and/or EMSA become aware of an arrest, or other potential violations of the H&S Code they are required to notify the relevant employer to ensure that all involved parties are informed and taking appropriate actions.

If you have any questions or concerns, please contact Jacqueline Rifenburg, Chief of Certification, 562-378-1640 or jrifenburg@dhs.lacounty.gov

CC:jr

Attachment

c: Paramedic Coordinator, Each Provider Agency

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **BASE HOSPITAL AND PROVIDER AGENCY REPORTING RESPONSIBILITIES** REFERENCE NO. 214

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

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

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

DEFINITIONS:

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

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

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

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

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

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

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

APPROVED: Cathy Chidester
Director, EMS Agency

Marianne Alvarado-Kellems
Medical Director, EMS Agency

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

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

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

POLICY:

I. Base hospital and provider agencies shall prepare and forward a written report within three working days to the EMS Agency medical director regarding any action of certificated or licensed prehospital personnel which may constitute a violation under Section 1798.200 (c) of the Health and Safety Code as listed in Section II. Any other items of concern resulting from an apparent deficiency of patient care should also be reported.

   A. The report shall be signed by an authorized representative of the prehospital provider agency or base hospital and must contain, at a minimum, the following:

      1. Names and certification/license numbers of all EMS personnel involved in the incident.

      2. Date, time, and location of the incident.

      3. A written summary of the alleged facts related to of the incident.

      4. The Health and Safety Code violation listed under 1798.200.

      5. A copy of the EMS Report Form, if applicable.

      6. A copy of the Base Hospital Report Form and base hospital tape audio recording, if applicable.

   B. Any report made to the local EMS Agency shall be copied to the employer of the affected individual.

II. Any of the following actions, listed under the Health and Safety Code, Division 2.5, Section 1798.200 (c), by EMS personnel shall be considered evidence of a threat to the public health and safety and, if found to be true, **may** result in probation, denial, suspension, or revocation of a certificate or license issued under Division 2.5:

   A. Fraud in the procurement of a certificate or licensure

   B. Gross negligence

   C. Repeated negligent acts

D. Incompetence

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

F. Conviction of any crime which is substantially related to the qualifications, functions, and duties of prehospital personnel. The record of conviction or certified copy of the record shall be conclusive evidence of the conviction.

G. Violation or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel.

H. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substance.

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

J. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification.

K. Demonstration of irrational behavior or occurrence of a physical disability to; the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired.

L. Unprofessional conduct exhibited by any of the following:

1. The mistreatment or physical abuse of any patient resulting from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties would use if confronted with a similar circumstance. Nothing in this section shall be deemed to prohibit an EMT, Advanced EMT, or Paramedic from assisting a peace officer, or a peace officer who is acting in the dual capacity of peace officer and EMT, Advanced EMT, or Paramedic, from using force that is reasonably necessary to effect a lawful arrest or detention.

2. The failure to maintain confidentiality of patient medical information, except as disclosure is otherwise permitted or required by law in Sections 56 to 56.6, inclusive, of the Civil Code.

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

PROCEDURE:

I. BASE HOSPITAL RESPONSIBILITIES

A. MICN Personnel

1. May conduct investigations to determine disciplinary cause, and may suspend privileges during the period of investigation.

2. May request that the LEMSA conduct the investigation to determine disciplinary cause.

3. Shall notify the LEMSA Medical Director in writing that the alleged action occurred **within three (3) working days after an allegation has been validated as potential for disciplinary cause**.

4. Upon determination of disciplinary cause, the respective Prehospital Care Coordinator (PCC), in collaboration with the Base Hospital Medical Director, may develop and implement a disciplinary plan. Disciplinary plans shall be signed and dated by the authorized representative of the base hospital.

   a. The disciplinary plan, along with the relevant findings of the investigation related to disciplinary cause, shall be submitted to the EMS Agency Medical Director **within three (3) working days** of adoption of the disciplinary plan.

   b. The disciplinary plan may include a recommendation that the EMS Agency Medical Director consider taking action against the holder's MICN certificate to include denial, suspension, revocation, or placement of a MICN certificate on probation.

5. The respective PCC shall notify the LEMSA Medical Director in writing of the alleged action within three (3) working days of the occurrence of any of the following:

   a. The MICN is terminated or suspended for a disciplinary cause;

   b. The MICN resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause; or

   c. The MICN is removed from their related duties for a disciplinary cause after the completion of the employer's investigation.

II. PROVIDER AGENCY RESPONSIBILITIES

A. EMT Personnel

1. May conduct investigations, to determine disciplinary cause, and may suspend privileges during the period of investigation.

2. May request that the LEMSA conduct the investigation to determine disciplinary cause.

3. Upon determination of disciplinary cause, the respective Paramedic Coordinator (PC), in collaboration with the Provider Agency Medical Director, may develop and implement a disciplinary plan in accordance with the MDOs.

    a. The relevant employer shall submit that disciplinary plan along with the relevant findings of the investigation related to disciplinary cause to the LEMSA that issued the certificate, **within three (3) working days** of adoption of the disciplinary plan. In the case where the certificate was issued by a non-LEMSA certifying entity, the disciplinary plan shall be submitted to the LEMSA that has jurisdiction in the county in which the headquarters of the certifying entity is located.

    b. The employer's disciplinary plan may include a recommendation that the LEMSA medical director consider taking action against the holder's certificate to include denial, suspension, revocation, or placement of a certificate on probation.

4. The respective Provider Agency shall notify the LEMSA medical director in writing that has jurisdiction in the county in which the alleged action occurred **within three (3) working days after an allegation has been validated as potential for disciplinary cause**.

5. The respective Provider Agency shall notify the LEMSA medical director that has jurisdiction in the county in which the alleged action occurred within three (3) working days or the occurrence of any of the following:

    a. The EMT is terminated or suspended for a disciplinary cause;

    b. The EMT resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause; or

    c. The EMT is removed from their related duties for a disciplinary cause after the completion of the employer's investigation.

6. Disciplinary plans shall be signed and dated by an authorized representative of the provider agency.

B. Paramedic Personnel

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

    a. A paramedic is terminated or suspended for disciplinary cause or reason.

    b. A paramedic resigns following notice of an impending investigation based upon evidence indicating disciplinary cause or reason.

c. A paramedic is removed from paramedic duties for disciplinary cause or reason.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 201, **Medical Management of Prehospital Care**
Ref. No. 216, **EMT Certification Review Process**
Ref. No. 304, **Role of the Base Hospital**
Ref. No. 308, **Base Hospital Medical Director**
Ref. No. 310, **Role of the Prehospital Care Coordinator**
Los Angeles County **EMS Agency Situation Report**

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

BASE HOSPITAL ADVISORY COMMITTEE MINUTES

August 14, 2019

MEMBERSHIP / ATTENDANCE

	REPRESENTATIVES		EMS AGENCY STAFF
☒	Robert Ower, RN., Chair	EMS Commission	Dr. Marianne Gausche-Hill
☐	Erick Cheung, M.D., Vice Chair	EMS Commission	Dr. Nichole Bosson
☐	Atilla Uner, M.D.	EMS Commission	Richard Tadeo
☐	Margaret Peterson, Ph.D.	EMS Commission	Michelle Williams
☒	Rachel Caffey	Northern Region	Christy Preston
☒	Melissa Carter	Northern Region	Paula Rashi
☐	Charlene Tamparang	Northern Region, Alternate	Cathy Jennings
☒	Samantha Verga-Gates	Southern Region	Susan Mori
☐	Laurie Donegan	Southern Region	Dr. Denise Whitfield
☐	Shelly Trites	Southern Region	Christine Zaiser
☐	Christine Farnham	Southern Region, Alternate	Dr. Natalia Alvarez
☒	Paula Rosenfield	Western Region	Jennifer Calderon
☒	Ryan Burgess	Western Region	Natalie Greco
☐	Alex Perez-Sandi	Western Region, Alternate	
☒	Erin Munde	Western Region, Alternate	
☒	Laurie Sepke	Eastern Region	
☒	Alina Candal	Eastern Region	**GUESTS**
☒	Jenny Van Slyke	Eastern Region, Alternate	Dr. Clayton Kazan, LACOFD
☒	Lila Mier	County Hospital Region	Sheryl Gradney, LACOFD
☒	Emerson Martell	County Hospital Region	Nicole Steeneren, LACOFD
☐	Jose Garcia	County Hospital Region, Alternate	Yun Son Kim, LACOFD
☐	Yvonne Elizarraz	County Hospital Region, Alternate	
☒	Alec Miller	Provider Agency Advisory Committee	
☐	Chris Morrow	Provider Agency Advisory Committee, Alt.	
☒	Michael Wombald	MICN Representative	
☐	Adrienne Roel	MICN Representative, Alt.	
☐	Robin Goodman	Pediatric Advisory Committee	
☐	Kerry Gold-Tsakonas	Pediatric Advisory Committee, Alt.	

	PREHOSPITAL CARE COORDINATORS				
☒	Karyn Robinson (GWT) APCC Pres.	☒	Heidi Ruff (NRH)	☐	Laura Leyman (SFM)
☐	Gloria Guerra (QVH) APCC Pres. Elect	☒	Jessica Strange (SJS)	☐	Chad Sibbett (SMM)
☒	Coleen Harkins (AVH)	☒	Michael Natividad (AMH)		

1. **CALL TO ORDER:** The meeting was called to order at 1:01 P.M. by Robert Ower, Chairperson.

2. **APPROVAL OF MINUTES**: The meeting minutes for June 12, 2019, were approved as submitted.

   M/S/C (Burgess/Natividad)

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

4. REPORTS & UPDATES:

4.1 Glendora Community Hospital (HEV) Emergency Department (ED) Closure

The public hearing was held last month for the closure of Glendora Community Hospital's ED. The hospital will be on internal disaster September 13-15, 2019, followed by ED closure on September 16, 2019, this will also include the closure of all acute care services. Inpatient Psychiatric services will continue to be available with a twenty-one (21) bed capacity and plans to add an additional twenty-three (23) beds.

4.2 Draft Paramedic Regulations

The Paramedic Regulations are in the second round of public comment. Major changes include:

- Alternate destination, allowing for transport directly to psychiatric urgent care centers, and sobering centers.

- Data reporting requirements from Local Emergency Medical Services Agency (LEMSA) to the State.

The EMS Agency is in support of most of the changes. The Regulations will be submitted to the State EMS Commission for approval. We will keep you posted on the progress.

4.3 Treatment Protocols & Medical Control Guidelines

Changes made to the Treatment Protocols (TP) & Medical Control Guidelines (MCG) will go into effect September 1, 2019. Although a lot of TPs were revised, the actual changes in medical care are minimal. The main change is the addition of route administration of Morphine Sulfate via intramuscular (IM). The revised TPs & MCGs, including a summary of changes, have already been sent out to the educators and will be posted to the EMS Agency's website next week.

4.4 Research Updates (Stroke ISC Abstract, ECMO Pilot, PHAST-TSC)

Current EMS Collaborative studies and pilot projects include:

- SRC study: An initial data analysis of out of hospital care of cardiac arrest patients has shown variations of care throughout the system, the initial analysis has been submitted to the National Association of EMS Physicians Conference. The goal is to establish system-wide standardization of care to improved cardiac arrest outcome.
- Stroke study: Frequency of thrombectomy based on last known well time as determined by paramedics (≤6 hrs., >6 to ≤16 hrs., ≥16 to 24 hrs.) and appropriate routing of suspected stroke patients to the appropriate stroke center. An abstract has been submitted to the International Stroke Conference 2020 supporting the EMS stroke routing policies.
- ECMO pilot: Multiple providers in conjunction with LAC+USC, Cedars Sinai Medical Center, and Ronald Reagan UCLA will be participating in the ECMO Pilot with plans to expand provider participation. This pilot is currently in the planning phase, more information to follow.
- PHAST-TSC pilot: Pre-Hospital Administration of Stroke Therapy – Trans Sodium Crocetinate (PHAST-TSC). This study will be conducted at two geographic locations, Los Angeles County and Charlottesville, VA. Enrollment

will begin early next year for patients that meet study inclusion criteria as identified by a trained paramedic provider, in collaboration with the study doctor. Target enrollment is 120 patients with an estimated completion time of study is 18 months. This study is currently in the planning phase, more information to follow.

4.5 EMS Update 2020

The EMS Update work group will reconvene on October 21, 2019. The EMS Agency is seeking representation from the Base Hospital Advisory Committee.

Train the Trainer is scheduled for March 4, 2020, morning and afternoon session; and March 12, 2020, morning session only. Topics for next year's update include: Pain Management, QI-based scenarios, Capnography, and Cardiac Arrest Management.

5. UNFINISHED BUSINESS:

5.1 Base Hospital Advisory Committee (BHAC) Representative to the Innovation, Technology, and Advancement Committee (ITAC)

ITAC convened its first meeting on August 5, 2019, with future meetings to be held on a quarterly basis. Jenni Van Slyke was nominated to represent the BHAC and Ryan Burgess as the alternate.

5.2 Reference No. 1305, Medical Control Guideline – Capnography

A review of recommended changes was presented by Dr. Bosson, see Attachment 1.

Dr. Gausche-Hill and Dr. Bosson expressed their gratitude to the BHAC members for their contribution and recommended changes.

6. NEW BUSINESS:

6.1 Reference No. 304, Paramedic Base Hospital Standards

The revised version of Reference No. 304, Paramedic Base Hospital Standards, is an integration of Ref. No. 304, Role of the Base Hospital; Ref. No. 308, Base Hospital Medical Director; and Ref. No. 310, Prehospital Care Coordinator.

Clarification: Page 2, Policy II. A. 1.c. A "specific" form is not required by the EMS Agency as proof of completion of requirement. As an example, Appendix C – PTI Instructor Ride Along form will be provided, see Attachment 2.

Revisions for Reference No. 304, Paramedic Base Hospital Standards, with the following recommendations.

- Page 2, Policy II. A. 1.e. Change six (6) months to read as twelve (12) months.
- Page 2, Policy II. A. 2. Add: Attends annual EMS Update or Train the Trainer session.
- Page 5, Policy III. A. 1.b. Remove the word "Satisfactorily", to read as follows: Complete the hospital's Base Hospital Orientation Program within thirty (30) days of assuming base physician responsibilities
- Page 6, Policy V. Include in the header: Educational Requirements

- Page 6-7, Policy V. B. 5. To read as follows: Orientation to the prehospital program for paramedic base hospital staff.
- Page 7-8, Policy VII. C. Change the word “taped” to read as: audio recordings

M/S/C (Robinson/Sepke) Approved with recommended changes

6.2 Reference No. 510, Pediatric Patient Destination

M/S/C (Robinson/Burgess)

6.3 Reference No. 832, Treatment/Transport of Minors

M/S/C (Van Slyke/Burgess)

6.4 Reference No. 1350, Medical Control Guideline – Pediatric Patients

Changes were presented. A brief discussion ensued regarding the use of the Pediatric Assessment Triangle (PAT), found on pages 3-4.

7. **OPEN DISCUSSION:** A lengthy discussion ensued with concerns on the identification of hypotension vs. shock, by the prehospital providers. A request was made that the Provider Impression of hypotension (HOTN) be changed to a Base Hospital Contact Required.

8. **NEXT MEETING:** BHAC’s next meeting is scheduled for **October 9, 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 14:40 P.M.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC, MICN, EMT)
REFERENCE NO. 1305

Medical Control Guideline: CAPNOGRAPHY

DEFINITIONS:

Capnography: ~~Continuous a~~Analysis and recording of carbon dioxide (CO_2) concentrations in respiratory gases via continuous waveform. ~~Capnography provides both a specific value for the end-tidal CO_2 measurement and a continuous waveform representing the amount of CO_2 in the exhaled air.~~

Capnometry: Measurement of the amount of carbon dioxide in exhaled air. This gives a specific value for the end-tidal CO_2 measurement.

Colorimetric CO_2 device: Device that changes color due to a chemical reaction in the presence of CO_2, which can be used to detect CO_2 in exhaled air in order to confirm placement of an advanced airway.

End-Tidal CO_2 ($ETCO_2$): The amount of carbon dioxide measured at the end of exhalation.

PRINCIPLES:

1. Ventilation is an active process, which is assessed with end-tidal CO_2 measurement. End-tidal CO_2 measurement is an indication of air movement in and out of the lungs. The normal value of exhaled CO_2 is 35-45 mmHg.

2. Oxygenation is a passive process, which occurs by diffusion of oxygen across the alveolar membrane into the blood. The amount of oxygen available in the bloodstream is assessed with pulse oximetry.

3. Capnography provides both a specific value for the end-tidal CO_2 measurement and a continuous waveform representing the amount of CO_2 in the exhaled air. A normal capnography waveform is square, with a slight upslope to the plateau phase during exhalation. (See figures below) The height of the waveform at its peak corresponds to the $ETCO_2$.

4. Capnography is necessary to monitor ventilation. For patients requiring positive pressure ventilation, capnography is most accurate with proper mask seal (two-hand mask hold for adults during bag-mask ventilation) or with an advanced airway.

~~3.~~5. Capnography can also be applied via a nasal cannula device to measure end-tidal CO_2 in the spontaneously breathing patient. It is useful to monitor for hypoventilation, in patients who are sedated either due to ingestion of substances or treatment with medication with sedative properties such as midazolam or opioids. In a patient with suspected sepsis, an $ETCO_2$ <25 mmHg further supports this provider impression.

~~4.~~6. Capnography is standard of care for confirmation of advanced airway placement. Unlike simple colorimetric devices, capnography is also useful to monitor the airway position over time, for ventilation management, and for early detection of return of spontaneous circulation (ROSC) in patients in cardiac arrest.

~~5.~~7. Capnography is the most reliable way to confirm advanced airway placement. Capnography provides instantaneous measurement of the amount of CO_2 in the exhaled air and values < 10 mmHg in the intubated patient suggests dislodgement.

~~6.~~8. Capnography provides the most reliable way to continuously monitor advanced airway position. The waveform provides a continuous assessment of ventilation over time. A normal waveform which becomes suddenly absent suggests dislodgement and requires clinical confirmation.

~~7.~~9. The value of exhaled CO_2 is affected by ventilation (effectiveness of CO_2 elimination), perfusion (transportation of CO_2 in the body) and metabolism (production of CO_2 via cellular metabolism). In addition to the end-tidal CO_2 value, the ventilation rate as well as the size and shape of the capnograph must be used to interpret the results.

~~8.~~10. Decreased perfusion will reduce the blood flow to the tissues, decreasing offload of CO_2 from the lungs. Therefore, patients in shock and patients in cardiac arrest will generally have reduced end-tidal CO_2 values.

~~9.~~11. A sudden increase in perfusion will cause a sudden rise in end-tidal CO_2 values and is a reliable indicator of ROSC. It is common to have an elevated $ETCO_2$ reading after ROSC. Hyperventilation is harmful and should not be done to in attempt to normalize the $ETCO_2$.

~~10.~~12. Ventilation can have varied effect on CO_2 measurement. Hyperventilation will reduce end-tidal CO_2 by increasing offload from the lungs. Disorders of ventilation that reduce CO_2 elimination (e.g., COPD), will cause CO_2 to build up in the body, increasing the measured value once ventilation is restored. Generally, hypoventilation will increase measured end-tidal CO_2 values by decreasing offload from the lungs. However, in patients with decreased tidal volumes, hypoventilation can also reduce end-tidal CO_2, because of the relative increase in dead space.

~~11.~~13. End-tidal CO_2 can be detected using a colorimetric device ($ETCO_2$ detector). These devices provide limited information about $ETCO^2$ as compared to ~~are inferior to use of~~ capnography. Colorimetric devices do not provide continuous measurement of the value of CO_2 in the exhaled air and cannot be used in ongoing monitoring. Colorimetric devices should only be used for confirmation of endotracheal tube placement if capnography is unavailable due to equipment failure.

GUIDELINES:

1. Capnography shall be used for ALL patients receiving positive-pressure ventilation (BMV or advanced airway). Utilize the capnography waveform to assess the patient's ventilation and perfusion status. Refer to the figures below for examples of typical waveform tracings.

2. Always attach the capnography device to the monitor first and wait for the capnography display to appear prior to applying the device to the patient. This zeros the device to ensure an accurate reading.

3. Apply the capnography device immediately upon initiating any positive-pressure ventilation, or as soon as feasible.

4. During bag-mask-ventilation, maintain a continuous seal in order to obtain accurate capnography readings.

5. When an advanced airway is placed, ~~Reapply~~ the capnography device shall be applied/re-applied immediately ~~after placement of an advanced airway and use it as the primary method~~ to confirm airway placement, along with assessing bilateral breath sounds and absence of gastric sounds.

~~2.~~6. Visualization of ~~the~~ a normally shaped waveform with a normal or elevated value confirms placement. Extremely low values (<10 mmHg) without the typical waveform implies esophageal placement and the endotracheal tube should be removed. For patients in shock or cardiac arrest, the value (and height of the waveform) will likely be reduced but the shape of the waveform should be ~~similar~~normal.

~~3.~~7. Continuously monitor the waveform, report the capnography reading to the base hospital and document capnography reading on the patient care record as follows:
   a. Immediately after placement of an advanced airway
   b. With any change in patient condition
   c. After any patient movement
   d. Every five minutes during transport
   e. Upon transfer of care

8. For patients in cardiac arrest, continuously monitor capnography during resuscitation. A sudden rise in $ETCO_2$, along with an organized rhythm, is a reliable sign of ROSC and should prompt a pulse check. Do not hyperventilate regardless of the $ETCO_2$ value; elevated values will normalize with proper ventilation. A drop in $ETCO_2$ below normal can signify progressive hypotension or re-arrest.

9. Consider use of capnography via nasal cannula, if available, in spontaneously ventilating patients who are:

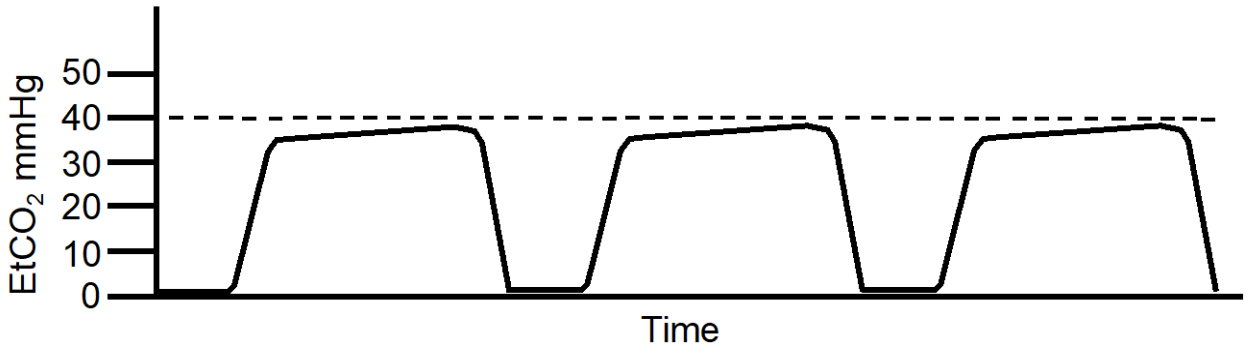
   a. Sedated due to illicit substance ingestion
   b. Treated with medications with sedative properties (e.g., midazolam or opioids)
   c. In severe respiratory distress

10. In spontaneously breathing patients, monitor for significant hypoventilation or apnea as an indication to begin assisted ventilation. A "shark-fin" waveform on $EtCO_2$ monitoring indicates bronchospasm; treatment with albuterol is indicated.

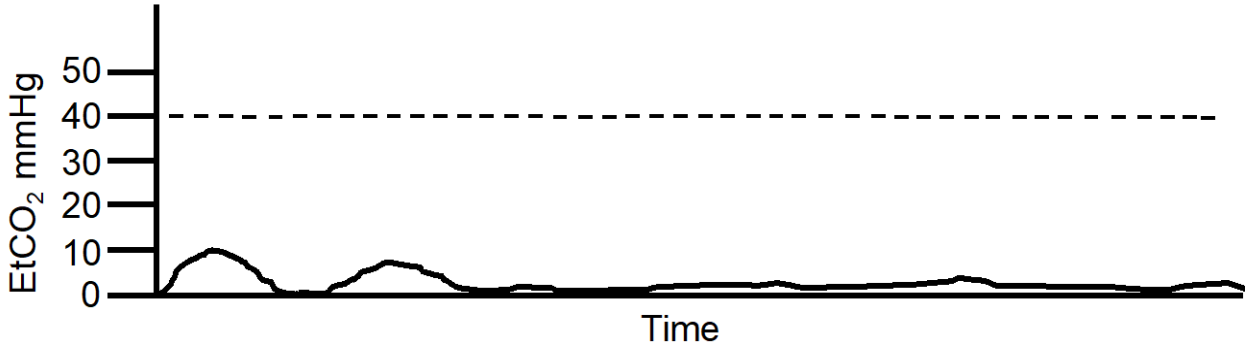
11. During positive-pressure ventilation, if a "shark-fin" pattern and/or an elevating $EtCO_2$ waveform ("breath stacking") is visualized, decrease ventilation rate to avoid increases in intrathoracic pressure which can ~~progres~~lead to decrease in venous blood return to the heart and~~sion to~~ cardiopulmonary arrest.

Capnography Waveforms

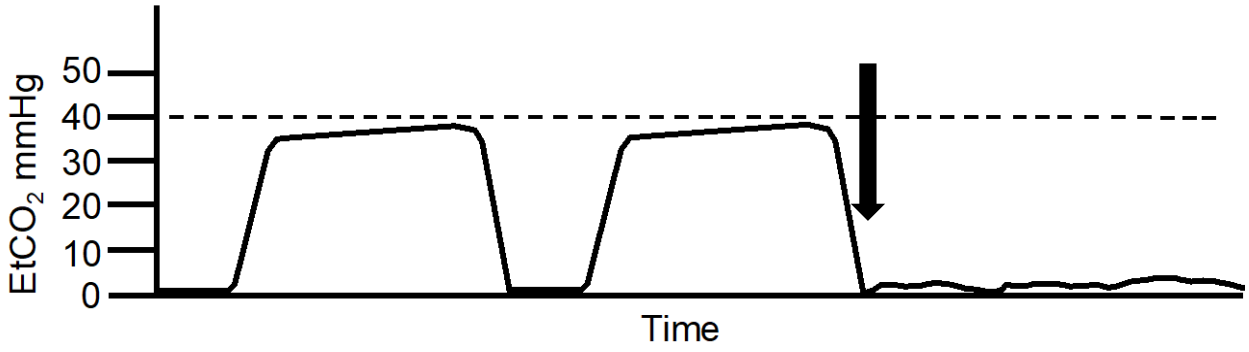
Normal shape of the capnograph (Normal waveform is depicted below)



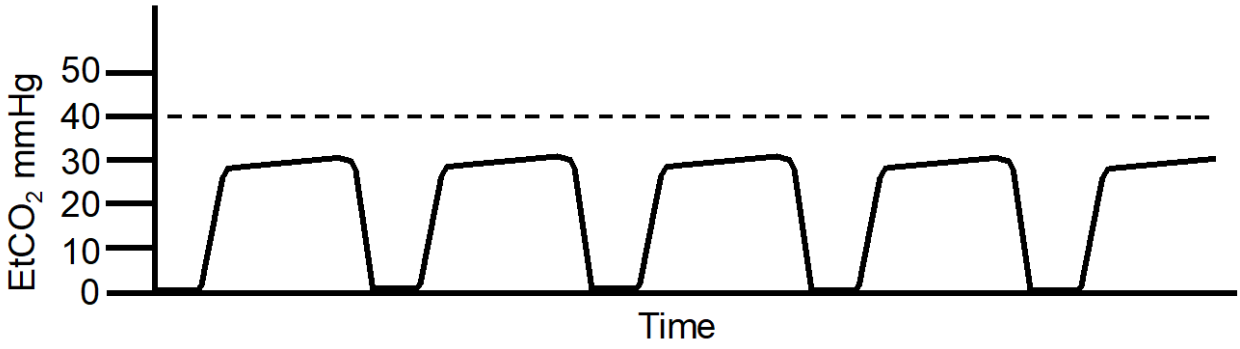
Esophageal Intubation (Low values <10 and ~~poor~~irregular wave~~-~~form or flat line)



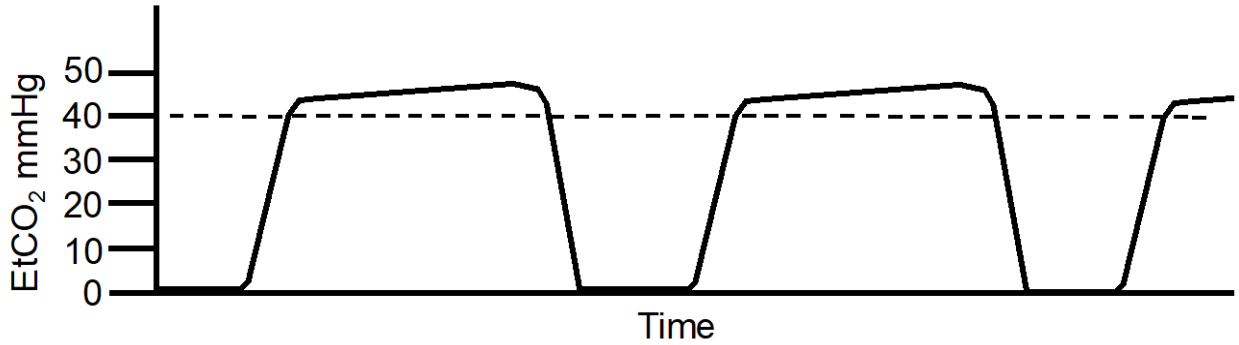
Obstructed or Dislodged Endotracheal Tube (~~Normal box~~Sudden loss of normal wave~~-~~form followed by low irregular waveform or flat line)



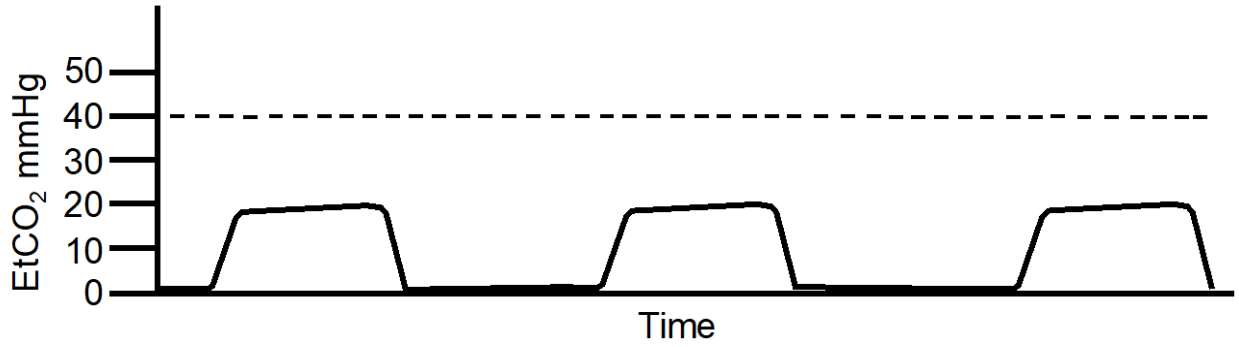
Hyperventilation (~~Short regular box~~ Normal waveform with reduced height, ~~values~~ < 35 ~~and >20~~ mmHg, and high ventilation rate)



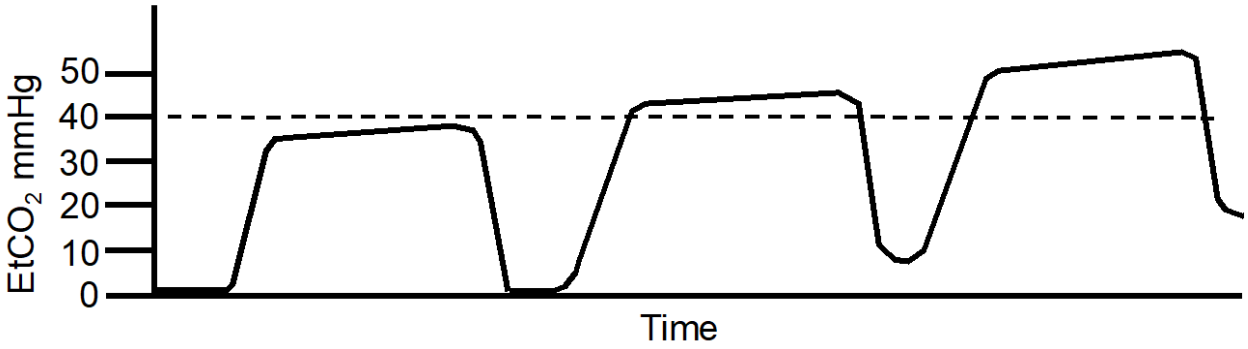
Hypoventilation/ ~~(b~~Bradypnea~~)~~ (~~Values greater~~Normal waveform with increased height, ~~> than~~ 45 mmHg ~~with normal waveform~~)



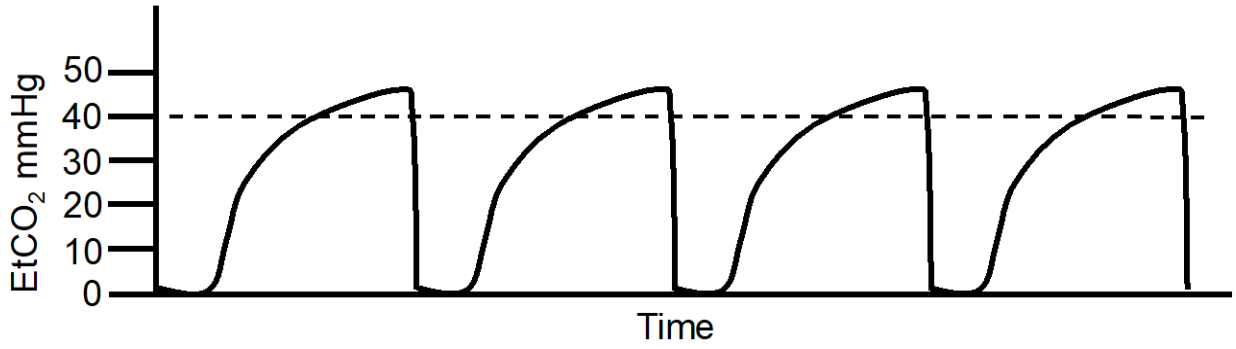
Hypoventilation/ Low tidal volumes (Normal waveform with reduced height, < 35 mmHg, and slow ventilation rate; A similar reduced height waveform can also be seen with shock - see progressive hypotension below).



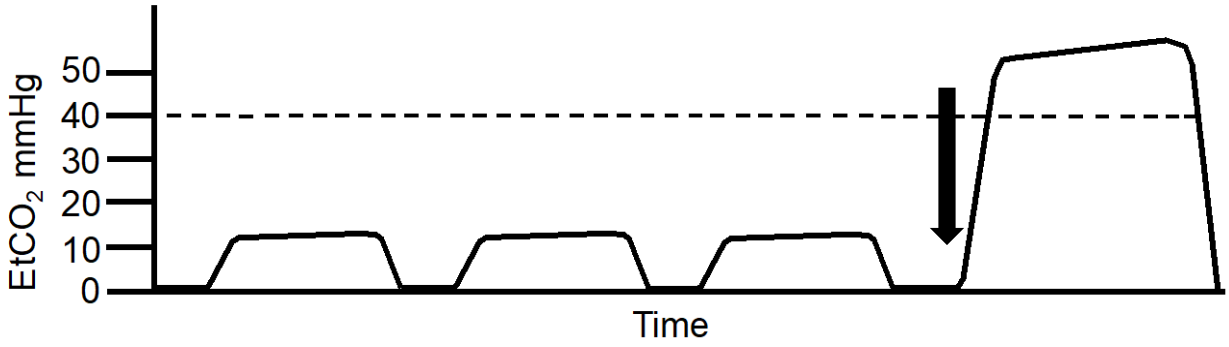
Air Trapping / Breath Stacking (Box wave forms that show increasing values with each successive breath)



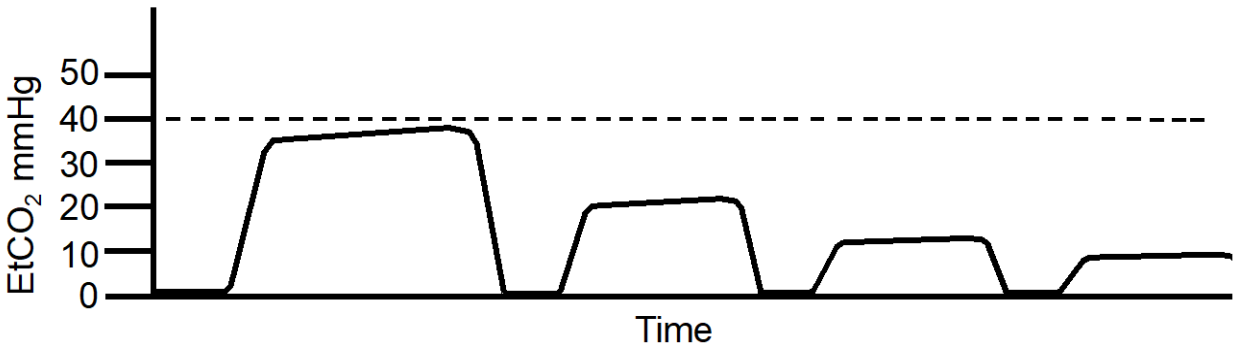
Bronchospasm ("Shark Fin Pattern")



Return of Spontaneous Circulation (Sudden increase in values in a patient in cardiac arrest)



Progressive Hypotension or Re-arrest (Progressive decrease in values with each successive breath)



APPENDIX C – PTI INSTRUCTOR RIDE ALONG

This experience is unlike that required for MICN Certification. While it might be interesting to watch paramedics at work, the goal for this ride-along is to learn about the fire house environment, the role of the student/intern, and various working situations. Following are key questions that will provide guidance in meeting the goal of the ride-along.

Firefighter hours:

- How long is a shift?
- What is a firefighter schedule like?
- How many days per month does a firefighter work?

Firefighter training and organization:

- How does the department differ from other departments?
- How long does it take to be hired on as a firefighter?
- How much formal education does a firefighter generally have?
- What are the meaning of “friction loss”, “pump pressure”, “cavitation”? This concepts are sometimes used to relate physiology of the heart and blood vessels.

Firefighter work:

- How many people are dispatched to a 9-1-1 call?
- What are the differences between a fire call and a medical call?
- What percentage of calls are EMS related?
- What equipment is generally brought to the scene?
- How does dispatch work for this particular department?
- What is tiered dispatch?
- What do the phrases “task force”, “light force” and “3 alarm” mean
- What is the difference between a fire truck, engine, quint, etc.?
- What is a Battalion, Company, or Platoon?

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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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

EMERGENCY MEDICAL SERVICES COMMISSION
DATA ADVISORY COMMITTEE

MEETING NOTICE

Date & Time: Wednesday, August 14, 2019 10:00 A.M.
Location: EMS Agency, First Floor Hearing Room
10100 Pioneer Boulevard
Santa Fe Springs, 90670-3736

DATA ADVISORY COMMITTEE
DARK FOR AUGUST 2019

County of Los Angeles
Department of Health Services

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

EMERGENCY MEDICAL SERVICES COMMISSION

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, August 21, 2019

MEMBERSHIP / ATTENDANCE

MEMBERS	ORGANIZATION	
☑ Paul Rodriquez, Chair	EMSC, Commissioner	
☑ David White, Vice-Chair	EMSC, Commissioner	
☐ Eugene Harris	EMSC, Commissioner	
☐ Brian Bixler	EMSC, Commissioner	
☐ Jodi Nevandro	Area A	
☑ Sean Stokes	Area A, Alt.	*(Rep to Med Council, Alt)*
☑ Dustin Robertson	Area B	
☑ Clayton Kazan, MD	Area B, Alt.	
☐ Victoria Hernandez	Area B, Alt.	*(Rep to Med Council)*
☐ Ken Leasure	Area C	
☐ Philip Ambrose	Area C, Alt.	
☑ Ivan Orloff	Area E	
☐ Mike Beeghly	Area E, Alt.	
☑ James Flint	Area F	
☐ Joanne Dolan	Area F, Alt.	
☑ Alec Miller	Area G	*(Rep to BHAC)*
☐ Christopher Morrow	Area G, Alt.	*(Rep to BHAC, Alt.)*
☑ Doug Zabilski	Area H	
☐ Anthony Hardaway	Area H, Alt.	
☑ Matthew Conroy	Area H, Alt.	*(Rep to DAC)*
☐ Luis Vazquez	Employed Paramedic Coordinator	
☑ Tisha Hamilton	Employed Paramedic Coordinator, Alt.	
☐ Rachel Caffey	Prehospital Care Coordinator	
☑ Jenny Van Slyke	Prehospital Care Coordinator, Alt.	
☑ Andrew Respicio	Public Sector Paramedic	
☑ Daniel Dobbs	Public Sector Paramedic, Alt.	
☐ Maurice Guillen	Private Sector Paramedic	
☐ Scott Buck	Private Sector Paramedic, Alt.	
☑ Ashley Sanello, MD	Provider Agency Medical Director	
☐ Vacant	Provider Agency Medical Director, Alt.	
☑ Andrew Lara	Private Sector Nurse Staffed Ambulance Program	
☐ Gary Cevello	Private Sector Nurse Staffed Ambulance Program, Alt.	

EMS AGENCY STAFF PRESENT	
Nichole Bosson, MD	Denise Whitfield, MD
Denise Whitfield, MD	Natalia Alvarez, MD
Richard Tadeo	Jennifer Calderon
Chris Clare	Elaine Forsyth
Cathlyn Jennings	Jacqueline Rifenburg
John Telmos	Michelle Williams
Christine Zaiser	Gary Watson

OTHER ATTENDIES	
Robert Ower	EMS Commissioner
Karen Bustillos	Sierra Madre FD
Nanci Medina	LACoFD
Robert Heaton	LACoFD
Todd McClung	REACH Air Medical
Paula LaFarge	LACoFD
Josh Parker	PRN Ambulance
Tina Crews	LACoFD
Sean Evans	Lynch EMS Ambulance
Dave Smith	Redondo Beach FD
Adrienne Roel	Culver City FD
Daniel Graham	Liberty Ambulance
Nichole Steeneken	LACoFD
Jennifer Nulty	Torrance FD
Yun Son Kim	LACoFD
Josh Ward	Pasadena FD
Jeffrey Tsay	San Marino FD
Chris Backley	San Gabriel FD
Jim Michael	Glendale FD
Rick Roman	Compton FD
Terry Millsaps	LACoFD
Brian Fong, MD	Guardian/CalMed Ambulance
Carissa Kinkor	Liberty Ambulance
Issac Yang	Redondo Beach FD

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

1. CALL TO ORDER: Committee Chair, Commissioner Paul Rodriquez, called meeting to order at 1:03 p.m.

2. INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS

2.1 New EMS Fellow – Natalia Alvarez, MD *(Nichole Bosson, MD)*

Natalia Alvarez, MD started the 1-year EMS Fellowship training on July 1, 2019. As part of the training, EMS Fellows participate in several ALS ride-a-longs per month and various EMS projects. Thank you to all the providers who assist in this training process.

2.2 PAAC Representative to Data Advisory Committee (DAC) *(Paul Rodriquez)*

The following PAAC members will represent the Committee during DAC meetings:

- Daniel Dobbs, Culver City FD – Primary Representative
- Ivan Orloff, Downey FD – Alternate Representative

2.3 Influenza Vaccination *(John Telmos)*

- On September 30, 2019 / 1:00 PM, at the EMS Agency's Hearing Room, a meeting is planned with the provider agency union representatives to review the upcoming influenza vaccine mandate. Provider agency members are welcome to attend.
- This is a follow-up to the PAAC meeting on April 17, 2019, regarding a Department of Public Health anticipated Mandate, requiring all patient care personnel to receive the influenza vaccination for the 2020 influenza seasons.

3. APPROVAL OF MINUTES (White/Lara) June 19, 2019 minutes were approved as written.

4. REPORTS & UPDATES

4.1 Disaster Service Update *(Elaine Forsyth)*

- The 2019 Statewide Medical and Health Exercise (Flood scenario) is scheduled for November 21, 2019. Those interested may register on the following webpage: https://www.eventbrite.com/e/2019-los-angeles-county-statewide-medical-and-health-exercise-tickets-68371562183
- Registration closes on October 31, 2019
- Training is open to all Los Angeles County fire departments and ambulance companies.
- Questions regarding this training exercise can be directed to Elaine Forsyth at eforsyth@dhs.lacounty.gov

4.2 Field Internship Changes *(Jacqueline Rifenburg)*

Reference No. 901, Paramedic Training Program Approval, will be revised to indicate changes in field internship hours and include:

- Field internship shall consist of no less than 480 hours and; internship must be completed within 6 months of the 1st shift, beginning of internship.
- Change will go into effect late September 2019 or early October 2019.

4.3 Reporting Health & Safety Code Violations *(Jacqueline Rifenburg)*

- All providers will be receiving a Memo from the EMS Agency, with a reminder of the requirements in reporting Health & Safety Code violations.
- In summary, any Emergency Medical Technician (EMT) with potential Code violations are to be reported to the EMS Agency, regardless of the certifying entity.
- And, any paramedic with potential violations are to be reported to the EMS Agency and the State EMS Authority.
- If unsure a violation has occurred, please contact the EMS Agency for clarification.

4.4 Draft Paramedic Regulations *(Richard Tadeo)*

- New proposed paramedic regulations have been posted for public comment.
- Public comment section is located on the California EMS Authority's webpage and will expire September 3, 2019. After which time, the State EMS Commission will vote to approve or reject the proposed regulations.

4.5 Base Hospital and Public Provider QI Meeting *(Richard Tadeo)*

- During a recent systemwide QI review of the provider impressions shock and hypotension, it was identified that providers were having challenges in identifying shock vs. hypotension.
- Currently, Treatment Protocol: Shock/Hypotension (Reference No. 1207), state that shock requires base contact and hypotension does not require base contact.
- To avoid further challenges and upon recommendation from Base Hospital Advisory Committee, both provider impressions will require base hospital contact.
- This change will go into effect October 1, 2019.

4.6 EMS Update 2020 *(Richard Tadeo and Denise Whitfield, MD)*

- Train-the-Trainer sessions are scheduled for March 4, 2020 (morning and afternoon session) and March 12, 2020 (morning session only).
- Educational topics include: Pain management and introduction of new analgesic; capnography; cardiac arrests; and various QI topics (fever vs. sepsis, altered level of consciousness and STEMI)
- The EMS Agency is exploring various learning management systems for presenting the Update.
- EMS Update workgroup will begin on October 21, 2019. The following Committee members volunteered to participate in the workgroup: Jenny Van Slyke, Doug Zabilski and Alec Miller.

4.7 Education Advisory Committee *(Richard Tadeo)*

- On April 17, 2019, Education Advisory Committee met and decided to disband.
- Once approved by the EMS Commission, representatives from the following two groups will be added to the Provider Agency Advisory Committee: Primary Paramedic Training Programs and EMT Training Programs

5. UNFINISHED BUSINESS

5.1 Reference No. 451.1a, Private Ambulance Vehicle Essential Medical and Personal Protective Equipment *(John Telmos)*

Policy reviewed and approved as written.

M/S/C (Lara/White) Approve Reference No. 451.1, Private Ambulance Vehicle Essential Medical and Personal Protective Equipment

5.2 Reference No. 713, Respiratory Care Practitioner Staffed Specialty Care Transport Unit Inventory *(John Telmos)*

Policy reviewed and approved as written.

M/S/C (Lara/Robertson) Approve Reference No. 713, Respiratory Care Practitioner Staffed Specialty Care Transport Unit Inventory

5.3 Reference No. 1305, Medical Control Guideline: Capnography *(Nichole Bosson, MD)*

Policy reviewed and approved with the following recommendations:

1. Add wording that addresses capnography monitoring during Interfacility Transfers (IFT)
2. Principal 7, last sentence: Add wording and similar phrase, stating “values that suddenly drop below 10 mmHg may suggest dislodgment. Other factors such as change in perfusion, may also affect capnography.”

M/S/C (Lara/Guillen) Approve Reference No. 1305, Medical Control Guideline: Capnography, with above recommendations.

6. NEW BUSINESS

6.1 Survey: Federal EMS for Children *(Chris Clare)*

- The Federal government sponsors EMS for children and provides funds to the State regarding this program.
- As part of this program, the government conducts a survey every 2 years of provider agencies, to verify National benchmarks are being reached.
- Within the next couple of months, the EMS Authority will be sending out another survey. Prior to this, Dr. Gausche-Hill will send out a pre-notification information memo.

6.2 Reference No. 412, AED Service Provider Program Requirements *(John Telmos)*

Policy reviewed and approved as written.

M/S/C (Miller/Flint) Approve Reference No. 412, AED Service Provider Program Requirements

6.3 Reference No. 510, Pediatric Patient Destination *(Richard Tadeo)*

Policy reviewed and approved as written.

M/S/C (Lara/Guillen) Approve Reference No. 510, Pediatric Patient Destination

6.4 Reference No. 832, Treatment/Transport of Minors *(Richard Tadeo)*

Policy reviewed and approved as written.

M/S/C (Robertson/Miller) Approve Reference No. 832, Treatment/Transport of Minors

6.5 Reference No. 1350, Medical Control Guideline: Pediatric Destination *(Richard Tadeo)*

Policy reviewed and approved as written.

M/S/C (Van Slyke/Miller) Approve Reference No. 1350, Medical Control Guidelines: Pediatric Destination

6.6 Reference No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles *(John Telmos)*

Policy reviewed and approved as written.

M/S/C (Orloff/Flint) Approve Reference No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles

6.7 Reference No. 703, ALS Unit Inventory *(John Telmos)*

Policy reviewed and approved as written.

M/S/C (Orloff/White) Approve Reference No. 703, ALS Unit Inventory

6.8 Reference No. 703.2, Cardiac Monitor Requirements *(Nichole Bosson, MD and Richard Tadeo)*

- Draft policy presented to Committee for feedback and review.

- Additional feedback can be directed to Nichole Bosson, MD at nbosson@dhs.lacounty.gov or Richard Tadeo at rtadeo@dhs.lacounty.gov.
- Policy removed from agenda until final draft is complete.

7. OPEN DISCUSSION:

7.1 Emergency Department Diversion *(Clayton Kazan, MD and Jenny Van Slyke)*

- Committee member requested a review of Reference No. 502, Patient Destination, and requested policy change allowing field personnel (along with the base hospital collaboration) the flexibility of deciding to transport a patient beyond the allowable 15 minutes, in cases when the most accessible receiving (MAR) is on ED diversion.
- After discussion and review, policy will remain unchanged.

7.2 Traumatic Arrest Destination *(Jenny Van Slyke)*

- Committee requested clarification on whether traumatic arrests require base contact or notification?
- The EMS Agency clarified that traumatic arrests do require base contact and Reference No. 1200.1, Treatment Protocol: General Instruction, will be updated to reflect this wording.

8. NEXT MEETING: October 16, 2019

9. ADJOURNMENT: Meeting adjourned at 2:57 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EMS COMMISSION ADVISORY COMMITTEES** REFERENCE NO. 207

PURPOSE: To establish a forum for exchange of ideas regarding prehospital care continuing education programs, training programs, certification and accreditation issues, policy development and operational issues involving prehospital care.

POLICY:

I. Provider Agency Advisory Committee

A. Mission: This committee is responsible for all matters regarding prehospital licensure, certification and accreditation, and policy development pertinent to the practice, primary and continuing EMS education, operation and administration of prehospital care.

B. Meeting Frequency: Third Wednesday, even months (additional meetings may be held as determined by the chair).

C. Committee Membership Structure:

1. Chaired by an EMS Commissioner.

2. Two or more EMS Commissioners.

3. One representative from each major department and public geographic region:

a. Area A – Western Region
b. Area B – Los Angeles County Fire Department
c. Area C – Northern Region
d. Area E – Southeast Region
e. Area F – Long Beach Fire Department
f. Area G – South Bay Region
g. Area H – Los Angeles Fire Department

4. One currently employed paramedic coordinator, selected by the Los Angeles County Ambulance Association (LACAA).

5. One prehospital care coordinator selected by the Base Hospital Advisory Committee (BHAC).

6. One public sector paramedic routinely assigned to an Advanced Life Support (ALS) Unit, selected by the Los Angeles Area Fire Chiefs Association (LAAFCA).

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

7. One private sector paramedic routinely assigned to an ALS Unit selected by the LACAA.

8. One provider agency medical director selected by Medical Council.

9. One critical care transport (CCT) coordinator from a private sector CCT provider selected by LACAA.

10. One representative from a Los Angeles County approved Paramedic Training Program selected by the EMS Agency.

11. One representative from a Los Angeles County approved EMT Training Program selected by the EMS Agency based on the highest volume of student enrollment.

12. Each standing committee member may have an alternate. The alternate member votes or brings motions only when the regular member is not present.

II. Base Hospital Advisory Committee

A. Mission: This committee is responsible for all matters regarding MICN certification and policy development pertinent to the practice, primary and continuing EMS education, operation and administration of prehospital care.

B. Meeting Frequency: Second Wednesday, even months (additional meetings may be held as determined by chair).

C. Committee Membership Structure:

1. Chaired by an EMS Commissioner.

2. Two or more EMS Commissioners.

3. Two currently employed base hospital prehospital care coordinators (PCC) from each of the major geographic regions:

a. Northern Region
b. Southern Region
c. Western Region
d. Eastern Region
e. County Region

4. One provider agency representative selected by the Provider Agency Advisory Committee (PAAC).

5. One base hospital medical director, selected by Medical Council.

6. One currently employed MICN selected by the Association of Prehospital Care Coordinators (APCC).

7. One pediatric specialty care center (EDAP/PMC/PTC) representative selected by the Pediatric Advisory Committee.

8. Each standing committee member may have an alternate except for the regional representation, which has one alternate member per region. The alternate member votes or brings motions only when the regular member is not present.

III. Data Advisory Committee

A. Mission: This committee is responsible for all matters regarding quality of prehospital data, report generation, prehospital research and policy development impacting TEMIS.

B. Meeting Frequency: Second Wednesday, even months (additional meetings may be held as determined by chair).

C. Committee Membership Structure:

1. Chaired by an EMS Commissioner.

2. Two or more EMS Commissioners.

3. One base hospital administrator or assistant administrator, or a non-administrator duly authorized to represent a base hospital administrator/assistant administrator, selected by the Hospital Association of Southern California (HASC).

4. One public sector paramedic provider representative selected by PAAC.

5. One public sector paramedic provider representative selected by the Los Angeles County Fire Department.

6. One public sector paramedic provider representative from the Los Angeles Fire Department.

7. One public sector paramedic provider representative from the Long Beach Fire Department.

8. One private sector paramedic provider representative, selected by LACAA.

9. One prehospital care coordinator selected by BHAC.

10. A trauma program manager and one physician selected by the Trauma Hospital Advisory Committee (THAC).

11. One base hospital medical director selected by the Medical Council.

12. One fire chief, selected by the LAAFCA.

13. Each standing committee member may have an alternate. The alternate member votes or brings motions only when the regular member is not present.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 202, **Prehospital Care Policy Development and Revision**
Ref. No. 206, **Emergency Medical Services Commission Ordinance No. 12,332 – Chapter 3.20 of the Los Angeles County Code**

SUBJECT: **PARAMEDIC BASE HOSPITAL STANDARDS** REFERENCE NO. 304

PURPOSE: To establish minimum standards for the designation of a paramedic base hospital in the Los Angeles County Emergency Medical Services (EMS) system.

AUTHORITY: Health & Safety Code, Division 2.5, 1797.56, 1797.58, 1797.59
California Code of Regulations, Title 22, Section 100169 and 100170
Specialty Care Center Paramedic Base Hospital Designation Agreement

DEFINITIONS:

Base Hospital Medical Director (BHMD): A physician currently licensed to practice in the State of California, Board Certified in Emergency Medicine and appointed by the hospital to provide medical oversight of the Base Hospital Program.

Board Certified (BC): Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialists (ABMS) or American Osteopathic Association (AOA) including an examination designed to assess the knowledge, skills, and experience necessary to provide quality patient care in a particular specialty.

Board Eligible (BE): Successful completion of a residency training program with progression to board certification based on the timeframe as specified by the ABMS or AOA for a specific specialty.

Emergency Department Approved for Pediatrics (EDAP): A licensed basic or comprehensive emergency department (ED) that is designated by the Emergency Medical Services (EMS) Agency to receive pediatric patients via the 9-1-1 system. These EDs provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures, as per the guidelines outlined in Ref. No. 316, Emergency Department Approved for Pediatric (EDAP) Standards.

Mobile Intensive Care Nurse (MICN): A registered nurse who has been authorized by the medical director of the EMS Agency as qualified to provide prehospital advanced life support or to issue instructions to EMS personnel within the Los Angeles County EMS system in accordance with standardized procedures that are consistent with statewide guidelines.

Paramedic Base Hospital (PBH): A paramedic base hospital, herein referred to as base hospital, is one of a limited number of hospitals which, upon designation by and completion of a written contractual agreement with the EMS Agency, is responsible for providing online medical direction and prehospital education to prehospital care personnel in accordance with standardized procedures, and conducting quality improvement activities within the Los Angeles County EMS system that is consistent with state guidelines.

Prehospital Care Coordinator (PCC): A Registered Nurse currently licensed to practice in the State of California, currently certified as a MICN in Los Angeles County, and appointed by the hospital to coordinate all prehospital activities sponsored by that base hospital, assist the BHMD in the medical direction and supervision of prehospital emergency medical care personnel, and to maintain the daily operations of the Base Hospital.

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

POLICY:

I. General Requirements

A. Licensed by the State of California Department of Public Health (CDPH) as a General Acute Care Hospital, and

1. Have a special permit for Basic or Comprehensive Emergency Medicine Service; and

2. Be accredited by a Centers for Medicare and Medicaid Services (CMS) recognized Hospital Accreditation Organization.

B. Be designated by the EMS Agency as an EDAP.

C. Have a fully executed Specialty Care Center PBH Designation Agreement with the EMS Agency.

D. Appoint a Base Hospital Medical Director and a Prehospital Care Coordinator.

E. Subscribe and have access to ReddiNet® and VMED28 communications system.

II. PBH Leadership Requirements

A. Base Hospital Medical Director (BHMD)

1. Qualifications:

a. Has experience in, and knowledge of, base hospital operations, and local EMS Agency policies and procedures.

b. Engaged at the base hospital in the field of emergency medicine as a full-time emergency physician as defined by spending a monthly average of at least ninety-six (96) hours in the practice of emergency medicine at the base hospital. These hours may include administrative hours spent in meeting BHMD responsibilities.

c. Familiar with the prehospital care environment by performing ride-alongs with assigned ALS units, a minimum of 16 hours during the first 12 months as a BHMD.

d. Complete an orientation to the PBH's prehospital care program.

e. Attend the EMS Agency's Orientation Program within twelve (12) months of assuming the position as BHMD.

f. Attend the EMS Agency's Updates or the Train the Trainer sessions.

2. Responsibilities:

a. Directs and coordinates the medical aspects of prehospital care and related medical activities of all base hospital and EMS personnel assigned to base hospital.

b. Ensures a physician, licensed in the State of California and BC or BE in Emergency Medicine, is assigned to the emergency department and available at all times to provide immediate medical direction to MICNs or paramedic personnel.

c. Ensures the provisions of appropriate medical direction given by base hospital personnel is within the Paramedic Scope of Practice and adheres to the current policies, procedure, and protocols of the EMS Agency.

d. Ensures the development and provision of formal prehospital education programs for base hospital physicians, MICNs, and EMS provider personnel and trainees.

e. Ensures the development and implementation of a quality improvement (QI) program approved by the EMS Agency to include a written plan describing the program objectives, authority, organization, scope, and mechanisms for overseeing the following:

   1) Compliance with all current policies, procedures, treatment protocols, and medical control guidelines of the EMS Agency; and

   2) Standards of care and quality improvement indicators that measure quality of prehospital care issues.

f. Ensures the participation of the base hospital in the EMS Agency's system wide QI program.

g. When notified of the possible deviation from medical guidelines, the BHMD shall:

   1) Ensure efforts are made to gather accurate facts, and that a determination is made as to whether a deviation in medical care has occurred.

   2) Provide, in writing, the referral of these facts to the EMS Agency for its review when the seriousness of the medical care warrants such a referral or constitutes a violation under Section 1798.200 of the Health & Safety Code.

   3) Notify, in writing, the appropriate EMS provider agency of the referral of facts to the EMS Agency regarding substandard medical care rendered by its employee.

   4) Make efforts to preserve the confidential nature of the referral.

h. Attends the Medical Council and other appropriate EMS Agency advisory committees.

i. Ongoing liaison with EMS provider agencies, local medical community, and the EMS Agency.

j. Collaborates with the PCC to ensure adherence to these Standards and the Specialty Care Center PBH Designation Agreement.

k. In the event the BHMD questions the medical impact of a policy of the EMS Agency, the BHMD shall submit a written statement to the Medical Director of the EMS Agency requesting a review of the policy.

B. Prehospital Care Coordinator (PCC)

1. Qualifications:

a. Have experience in, and knowledge of, base hospital operations and EMS Agency policies and procedures.

b. Be familiar with the paramedic scope of practice.

c. Be familiar with the requirements of the Specialty Care Center PBH Designation Agreement.

d. Attend the EMS Agency's Orientation Program within six (6) months of assuming the position as PCC.

2. Responsibilities:

a. Serves as a liaison by maintaining effective lines of communication with base hospital personnel, EMS Agency, EMS provider agencies, and local 9-1-1 receiving facilities.

b. Be sufficiently available during normal County business hours to meet the responsibilities of the PCC.

c. Evaluates the performance of MICN candidates and submits recommendations for certification to the EMS Agency.

d. Collaborates with the BHMD and the EMS provider agencies to provide ongoing evaluation of assessment, reporting, communication, and technical skills of assigned ALS units. Such evaluation shall include, but not limited to:

1) Audit of audio recorded communication;

2) Review of patient care records;

3) Coordination of structured field observation experience including transfer of patient care upon arrival at the receiving facility; and

4) Coordination of direct observation of performance during scheduled clinical hours in the emergency department.

e. Coordinates, in conjunction with the BHMD, a base hospital meeting or other process, which should include representation from hospital administration, MICNs, base hospital physicians, and EMS providers for:

1) Providing updates on policies, procedures, and protocols.

2) Providing orientation to field and base hospital operations.

3) Providing a forum for problem-solving.

f. Reports to the EMS Agency, in conjunction with the BHMD, any action of certified or licensed personnel, which results in apparent deficiencies in medical care or potentially constitutes a violation under Section 1798.200 of the Health & Safety Code.

g. Maintain records of communication with base hospital personnel which may be inclusive of, but not limited to, base hospital meetings, e-mail communications, newsletters, or other communication related materials.

h. Collaborates with the BHMD to ensure compliance to these Standards and the Specialty Care Center PBH Designation Agreement.

i. Represents the base hospital at system-wide and/or regional meetings sponsored by the EMS Agency that address prehospital care issues and participates in committees and other task forces that may be developed.

III. Base Hospital Personnel Requirements

A. Base Hospital Physicians – Hospital shall ensure that at least one (1) full-time emergency department physician is on duty at all times who shall be responsible for prehospital management of patient care and patient destination.

1. Qualifications:

a. BC or BE in Emergency Medicine.

b. Complete the hospital's Base Hospital Orientation Program within thirty (30) days of assuming base physician responsibilities.

2. Responsibilities:

a. Provide online medical direction and supervision of prehospital triage, treatment, advance life support, and patient destination.

b. Shall be immediately available for consultation by an MICN providing online medical direction to paramedics.

B. Mobile Intensive Care Nurses (MICN) – Hospital shall ensure that at least one (1) MICN is on duty at all times.

1. Qualifications:

a. Currently certified as a MICN in Los Angeles County.

b. Current Advanced Cardiac Life Support (ACLS) Provider or Instructor by the American Heart Association.

c. Employed by one of the following: Base Hospital, EMS Agency, Paramedic Training Program, or Paramedic Provider Agency.

2. Responsibility: provide online medical direction and supervision of prehospital triage, treatment, advance life support, and patient destination under the direction of the base hospital physician on duty.

C. Data Entry Personnel – Hospital shall assign a primary and qualified back-up personnel (excluding PCC) to enter data into the County's base hospital data collection system – Trauma and Emergency Medicine Information System (TEMIS).

IV. Paramedic Communication System (PCS)

A. Hospital shall ensure that base hospital paramedic communication equipment is staffed and operational at all times by personnel who are properly trained and certified in its use according to the policies, procedures, and protocols of the EMS Agency.

B. Hospital shall comply with the specifications for hospital-owned PCS equipment as outlined in the Specialty Care Center PBH Designation Agreement.

C. Hospital shall provide a mechanism to record, retain, and retrieve audio recordings of all voice field communications between the base hospital and receiving facilities and the paramedics.

V. Educational Requirements

A. Hospital shall have an EMS Agency approved Continuing Education (CE) program as outlined in Ref. No. 1013, EMS Continuing Education (CE) Provider Approval and Program Requirements.

B. Develop and institute prehospital care education programs for MICNs, paramedics, paramedic trainees, and base hospital physicians (in collaboration with the BHMD). Programs shall include, but are not limited to, specific issues identified by quality improvement activities. Education requirements include the provision of:

1. An accumulative average of twelve (12) hours of education per year, of which an average of six (6) hours per year are field care audits. A base hospital may require additional hours of field care audits for MICN sponsorship.

2. A mechanism for providing and evaluating structured clinical experience.

3. A mechanism to facilitate the scheduling of field observation experience for MICNs.

4. Special and mandatory training programs deemed necessary by the EMS Agency. Mandatory classes shall be given and scheduled, at a minimum, three (3) sessions so as to provide continuing education to the majority of the ALS Units assigned to the base hospital.

5. Orientation to the prehospital program for new PBH staff.

C. The following documents shall be submitted to the EMS Agency:

1. Monthly – a continuing education schedule for the upcoming month.

2. Annually (by January 31 of each year) – a summary of the CE classes provided during the previous year to include: date, course title, category, and number of CE hours.

3. Within 30 days – rosters of courses mandated by the EMS Agency.

VI. Quality Improvement (QI)

A. Base hospital shall have a current prehospital QI plan approved by the EMS Agency and ensure participation in the EMS Agency's system wide QI program by designating a representative for the meetings.

B. Base hospital shall have a process developed, with input from the BHMD, base hospital physicians, PCC, MICNs, paramedics, and hospital administration to:

1. Identify important aspects of prehospital care and develop related QI indicators;

2. Evaluate prehospital care and service, including trends, to identify opportunities for improvement;

3. Implement corrective action to improve prehospital care and service delivery, or to solve problems; and evaluate the effectiveness of those actions;

4. Identify relevant topics for the CE program; and

5. Document audio communications and records reviewed, actions recommended and/or taken, and problem resolution.

VII. Data Collection

A. Participate in the data collection process outlined in Ref. No. 644, Base Hospital Documentation Manual and the Specialty Care Center PBH Designation Agreement.

B. Ensure that appropriate accountability and confidentiality are maintained for:

1. Patient care records (i.e., Base Hospital Forms, EMS Report Forms, logs and audio communications);

2. QI records;

3. CE records; and

4. Records pertaining to investigations or review of possible provision of substandard medical care.

C. Ensure compliance with requirements for retention and release of audio recordings, Base Hospital Forms, logs and information sheets, and maintain retrieval system in collaboration with hospital's medical record department.

CROSS REFERENCE

Prehospital Care Manual
Ref. No. 201, **Medical Management of Prehospital Care**
Ref. No. 204, **Medical Council**
Ref. No. 214, **Base Hospital and Provider Agency Reporting Responsibilities**
Ref. No. 316, **Emergency Department Approved for Pediatrics (EDAP) Standards**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 610, **Retention of Prehospital Care Records**
Ref. No. 612, **Release of Emergency Medical Services (EMS) Records**
Ref. No. 620, **EMS Quality Improvement Program**
Ref. No. 621.2 **Notification of Personnel Change Form Hospital Program**
Ref. No. 644, **Base Hospital Documentation Manual**
Ref. No. 716, **Paramedic Communications System**
Ref. No. 803, **Los Angeles County Paramedic Scope of Practice**
Ref. No. 1010, **Mobile Intensive Care Nurse (MICN) Certification**
Ref. No. 1013, **EMS Continuing Education (CE) Provider Approval and Program Requirements**
Ref. Nos. 1200, **Treatment Protocols**
Ref. Nos. 1300, **Medical Control Guidelines**

Specialty Care Center Paramedic Base Hospital (PBH) Designation Agreement

POLICY REVIEW – COMMITTEE ASSIGNMENT REFERENCE NO. 202.1
(ATTACHMENT A)

REFERENCE NO. 304, Paramedic Base Hospital Standards

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	08/14/2019	08/14/2019	Y
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee			
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

*****See Ref. No. 202.2, **Policy Review - Summary of Comments**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **AED SERVICE PROVIDER PROGRAM REQUIREMENTS** (EMT/PUBLIC SAFETY) REFERENCE NO. 412

PURPOSE: To establish policies and procedures for AED service providers, EMT and Public Safety, in Los Angeles County.

AUTHORITY: Health and Safety Code Sections; 1797.170, 1797.190, 1797.196
California Code of Regulations, Title 22, Division 9, Chapter 1.5. First Aid and CPR Standards and Training for Public Safety Personnel 100017 100021 100022, Chapter 2 Sections 100056,100056.1, 100063, 100063.1.

DEFINITIONS:

Automated External Defibrillator (AED): An external defibrillator capable of cardiac rhythm analysis that will charge and deliver a shock, either automatically or by user interaction, after electronically detecting and assessing ventricular fibrillation or ventricular tachycardia.

Authorized Individual: EMT personnel employed by an EMT AED service provider who has met the training requirements and is authorized to use an AED.

EMT (Emergency Medical Technician): An individual who is currently certified in California as an EMT.

EMT AED Service Provider: An agency or organization approved by the EMS agency and is responsible for and authorizes EMTs to operate an AED for the purpose of providing services to the general public.

Public Safety AED Service Provider: An agency or organization approved by the EMS agency and is responsible for and authorizes public safety personnel to operate an AED for the purpose of providing services to the general public.

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

PRINCIPLES:

1. All AED service provider agencies shall meet State regulations and established EMS Agency policies.

2. Only agencies or organizations that employ EMTs and/or public safety personnel are eligible for approval as an AED service provider.

3. An approved AED service provider and their authorized personnel shall be recognized statewide.

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

POLICY

I. Approving Authority

The EMS Agency shall be the approving authority for all AED service provider programs whose headquarters/local operations are located within Los Angeles County.

II. Program Approval

The EMS Agency:

A. Shall notify the applicant within fourteen (14) business days that the application was received and specify what information, if any, is missing or deficient.

B. Shall review and approve all first aid and/or Cardiopulmonary Resuscitation (CPR)/AED training programs which are not approved by American Heart Association (AHA), American Red Cross (ARC), American Safety Health Institute (ASHI), Peace Officer's Standards and Training (POST), or the EMS Authority.

C. May conduct a site survey prior to approval.

D. Shall provide written approval authorizing AED services within thirty (30) calendar days, when all requirements have been met.

E. May revoke or suspend an AED program, prohibiting the use of AEDs, if the AED service provider:

1. Is found to be out of compliance with applicable state regulations and/or EMS Agency policies, procedures, or reporting requirements.

2. Fails to correct identified deficiencies within the specified length of time after receiving written notice from the EMS Agency.

III. Program Staff Requirements

Each program shall designate a program coordinator.

A. Requirements

An individual designated by the fire chief, supervisor, or general manager of the AED service provider organization or agency.

B. The duties shall include but are not limited to:

1. Program management.

2. Submission of required data annually via AED Annual Report.

3. Ensure that a California licensed physician, physician assistant, registered nurse, or paramedic, who has the ability to interpret electrocardiogram (ECG) rhythms, will timely and competently:

a. Review all cases where an AED was applied.

b. Maintain required data set for annual report.

c. Review and summarize system performance.

d. Make recommendations, as indicated, for modification of system design, performance protocols, or training standards designated to improve patient outcome.

4. Comply with department and EMS Agency policies and procedures.

IV. Program Requirements

A. Initial Application

An organization or agency employing certified EMTs and/or employing public safety personnel may seek approval by submitting the following:

1. A complete application, Los Angeles County EMS Agency Ref. No. 412.1, AED Service Provider Program Application.

2. A written request or letter of intent which includes the following:

a. A statement that the organization or agency is willing to abide by Los Angeles County EMS Agency Ref. No. 412, AED Service Provider Program Requirements.

b. An assurance that all AED devices in use meet current AHA Emergency Cardiovascular Care (ECC) guidelines.

c. Report changes in key personnel or equipment to the Los Angeles County EMS Agency within thirty (30) days.

d. Notification of discontinuance of an approved EMS AED program will be sent to the Los Angeles County EMS Agency within thirty (30) days of closure.

B. Public Safety Programs Initial Training Requirements:

1. CPR and First aid training not less than 21 hours. POST-approved basic academy training covers this training requirement.

2. AED training and orientation of authorized personnel shall include the following topics and skills:

a. Proper use, maintenance, and periodic inspection of the AED.

b. The necessity of CPR, defibrillation, advanced life support (ALS), and adequate airway care.

c. Overview of the EMS system, 9-1-1 access, interaction with EMS personnel, and organization's internal response and operational plan.

d. Assessment of an unconscious patient, to include evaluation of airway, breathing, and circulation to determine cardiac arrest.

e. Appropriate care if rhythm analysis reports "no shock advised".

f. AED safety precautions to enable the individual to administer a shock without jeopardizing the safety of the patient, rescuers, or bystanders.

g. Recognition that an electrical shock has been delivered to the patient and that the defibrillator is no longer charged.

h. Rapid, accurate assessment of the patient post defibrillation.

i. Appropriate care following defibrillation.

j. Documentation and reporting requirements

C. Public Safety Programs Skills Competency:

1. Complete a retraining course in first aid, CPR, and AED use once every two (2) years at a minimum which consists of not less than eight (8) hours.

OR

2. Pass a competency based written and skills pretest on first aid, CPR, and AED use every two (2) years at a minimum with the following restrictions:

a. Appropriate retraining is provided on those topics indicated necessary by the pretest in addition to any new developments in first aid, CPR, and AED use.

b. Successful completion of a written test covering the topics on which retraining occurred.

c. The hours for the retraining may be reduced to those hours needed to cover the topics indicated necessary by the pretest.

D. EMT Programs Training and Competency Requirements:

1. CPR with AED training to the level of health care provider or professional rescuer in accordance with current AHA ECC guidelines.

2. Orientation to the use and maintenance of the EMT service provider's specific AED device(s).

3. Instruction in documentation, internal response and operational plan, reporting requirements, and EMS Agency policies and procedures related to AED use.

4. Continued competency training and documented demonstration of skills proficiency which shall occur, at a minimum, every two (2) years.

E. Provide the following to the EMS Agency or EMS Authority upon request for each AED authorized user:

1. If an EMT AED provider, EMT certification number with expiration date and issuing agency.

2. Date of most recent CPR/AED training.

3. Most recent AED skills competency date.

F. Maintenance of Equipment/Supplies

1. Have a written policy with the procedure to be used to ensure AED equipment is properly maintained.

2. All AEDs and supplies shall be maintained and inspected after each use and, at a minimum, every thirty (30) days.

G. Response and Operational Plan shall include the following:

1. How emergency response will be activated, e.g. 9-1-1 call, internal number, radio, etc.

2. Geographical response area, location of each AED and number of AEDs in service.

3. Response personnel.

4. Scene safety.

5. Documentation post AED application.

V. Program Review and Reporting

A. Approved programs shall be subject to periodic on-site surveys by the EMS Agency.

B. The EMS Agency shall be notified in writing within thirty (30) days of any change to program coordinator, and/or changing, adding, or upgrading AEDs.

C. Complete Ref. No. 412.2, AED Service Provider Annual Report and submit by March 31st for the previous calendar year.

VI. Record Keeping

A. Each program shall maintain the following records for four (4) years which shall be available for review:

1. All documentation required for program approval.

2. Training and competency rosters.

3. Instructional and testing material.

4. Maintenance/inspection log sheets.

5. Curriculum vitae and qualifications for the program coordinator.

B. Patient care records shall be maintained in accordance with EMS Agency policies.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 412.1, **EMT AED Service Provider Program Application**
Ref. No. 412.2 **AED Service Provider Annual Report**
Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 610, **Retention of Prehospital Care Records**
Ref. No. 814, **Determination/Pronouncement of Death in the Field**
Ref. No.911, **Public Safety First Aid (PSFA) and Basic Tactical Casualty Care (BTCC)Training Program Requirements**

POLICY REVIEW – COMMITTEE ASSIGNMENT REFERENCE NO. 202.1
(ATTACHMENT A)

REFERENCE NO. 412, Automated External Defibrillation (AED) Service Provider Requirements

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee			
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee	08/21/2019	08/21/2019	N
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

*See Ref. No. 202.2, **Policy Review - Summary of Comments**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **AED SERVICE PROVIDER PROGRAM APPLICATION** (EMT/PUBLIC SAFETY) REFERENCE NO. 412.1

AED Service Provider Program Application

To apply for approval as an AED service provider, the following documents/information needs to be submitted to the LA County EMS Agency:

- ☐ Curriculum Vitae (resume) of Program Coordinator
- ☐ Training materials including:
  - Curriculum to be used (if other than American Heart Association (AHA), American Red Cross (ARC), American Safety Health Institute (ASHI), or Peace Officer's Standards and Training (POST)
  - Documentation to be used for orientation and training for specific AED device(s)
  - Skill/training/testing sheet if other than AHA, ARC, ASHI, or POST
- ☐ Documentation of current EMT Certifications for all EMTs including issuing agency and expiration date.
- ☐ Departmental policy and procedures pertaining to AED Program shall include:
  - Internal response and operational plan
  - AED event procedures
  - CPR/AED initial training and retraining requirements
  - Frequency of checking authorized user's competency skills
  - Maintenance of equipment/devices
  - Data collection for quality assurance and annual report
- ☐ AED skill competency check list.
- ☐ AED response form (if other than an approved PCR or LA County EMS Agency form).
- ☐ AED maintenance check list.
- ☐ Letter of intent to include items listed in LA County Ref. No. 412, Automated External Defibrillator (AED) Service Provider Program Requirements.

Return completed application and required documentation to:

Los Angeles County EMS Agency
Attn: AED Program Coordinator
10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670
Phone: (562) 378-1633

AED Service Provider Program Application

Name of Provider		
Address	**City**	**Zip Code**
Program Coordinator	**Title**	
Phone	**Email**	

AED Manufacturer

□ Cardiac Science
□ Defibtech or Cintas
□ Heartsine
□ Medtronic
□ Philips
□ Welch Allyn
□ Zoll
□ Other _____

Model

□ Powerheart
□ G3 pro
□ G3 Plus
□ G3 Automatic
□ Lifeline
□ Reviver (DDU-100)
□ Samaritan
□ Samaritan PAD
□ Lifepak 1000
□ Lifepak CR Plus
□ FRx
□ FR2+
□ On-Site
□ AED 10
□ AED 20
□ AED plus
□ AED pro
□ M Series
□ E Series
□ Other _____

Total Number of AEDs	**Location of AEDs (patrol vehicles, ambulances, etc.)**
Provider Response Area (if not an existing 9-1-1 provider)	**Pediatric Equipment?** □ Yes □ No
Frequency of AED Checks (* Per Manufacturer's Recommendation) □ Daily □ Weekly □ Monthly	**AED Response Form** □ Approved PCR □ County EMS □ Self Designed

Curriculum

□ American Heart Association
□ American Safety Health Institute
□ Other _____
□ American Red Cross
□ Peace Officer's Standards and Training (must submit training material for approval)

Frequency of checking individual AED skill proficiency

□ Every 2 years □ Annually □ Every 6 months
□ Other _____

Completed by: _____/_____
(Signature) (Print name)

Title: _____

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

SUBJECT: **AED SERVICE PROVIDER ANNUAL REPORT** REFERENCE NO. 412.2

AED SERVICE PROVIDER ANNUAL REPORT

As required by State law and local polices, the following statistical information is required on an annual basis, due by March 31st for the previous calendar year.

AED Service Provider Name: _____

Reporting period: _____

1. Population served (estimate): _____

2. Number of responses to patients where an AED was used initially: _____

(To include **initial AED use only**, including use before ALS arrival. **DO NOT** include responses where only paramedic/ALS manual defibrillation was used. This information will be captured in the patient care records for ALS responses.)

3. Number of resuscitations attempted: _____

4. Number of resuscitations not attempted: _____

Ref. No. 814, Determination/Pronouncement of Death in the Field, valid Do-Not-Resuscitate (DNR), Advanced Health Care Directive (AHCD), Physicians Orders for Life Sustaining Treatment (POLST), personal physician, or family at scene requesting to withholding resuscitation efforts.

5. Number of patients on whom an AED was applied: _____

6. Total number **WITNESSED** arrest (seen or heard by AED provider personnel): _____

a) Number who received bystander CPR prior to arrival of emergency medical care _____

b) Number with initial rhythm of V-Fib or V-Tach (AED indicated shock advised with initial application) _____

c) Number who received a shock from an AED operated by the AED service provider _____

7. Total number **UNWITNESSED** arrest (prior to arrival of AED provider personnel): _____

a) Number who received bystander CPR prior to arrival of emergency medical care _____

b) Number with initial rhythm of V-Fib or V-Tach (AED indicated shock advised with initial application) _____

c) Number who received a shock from an AED operated by the AED service provider _____

8. Problems associated with AED operation or application: □ **Yes** □ **No**

If you answered yes, check appropriate box below and provide additional information.

a) **Equipment failure**

Machine shocks rhythm other than V-Fib or V-Tach	□
No discharge	□
Tape/Battery Malfunction	□
Other	□

_____

_____

_____

b) Lack of skill proficiency □ **Yes** □ **No**

_____

_____

_____

9. Name of MD, RN, PA, or Paramedic primary reviewer of AED application (s):

_____

Contact number: _____ Email address: _____

10. Manufacturer/Model of the AEDs: _____

Number of AEDs in Service: _____ Pediatric Pads □ **Yes** □ **No**

11. Number of personnel by level authorized to use AEDs within your agency:

a) EMT: _____

b) Public Safety personnel (**Non-EMT)**: _____
(Peace Officers, Lifeguards and Firefighters)

c) Non-licensed/non-certified personnel: _____
(Lay public/employees)

12. Frequency of individual AED/CPR skills competency verification:

☐ Every 2 years (EMT only) ☐ Annually ☐ Every 6 months Other: _____

AED Program Coordinator: _____ Title: _____

Email: _____ Contact Number: _____

AED Program Coordinator's Signature: _____ Date: _____

Submit report via mail, e-mail or fax to:

Los Angeles County EMS Agency
Attn: AED Coordinator
10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670
e-mail: aedprograms@dhs.lacounty.gov

Fax: (562) 941-5835

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

SUBJECT: **PRIVATE AMBULANCE VEHICLE ESSENTIAL MEDICAL AND PERSONAL PROTECTIVE EQUIPMENT** REFERENCE NO. 451.1a

PURPOSE: To establish the minimum essential medical and personal protective equipment that must be maintained on an in-service ambulance vehicle in order for the vehicle to remain in-service for the provision of patient care.

AUTHORITY: Los Angeles County Code, Title 7, Chapter 7.16

PRINCIPLES:

1. The essential medical equipment identified herein is the minimal amount of medical equipment, medical supplies and personal protective equipment (PPE) that an ambulance vehicle must have in order to remain in-service and continue to provide patient care. This policy does not supersede Reference No. 710, Basic Life Support Ambulance Equipment, which establishes the minimum equipment required for a basic life support (BLS) ambulance to be approved for licensing.

2. Failure to maintain the following quantity of essential medical equipment, medical supplies, and personal protective equipment on an ambulance vehicle that is in service shall result in a notice of violation and an administrative fine may be issued to the ambulance operator.

3. If an ambulance operator can demonstrate that an ambulance vehicle which does not meet these requirements is enroute to restock equipment and/or supplies the notice of violation and administrative fine will not be issued.

4. Expired medications, contaminated and/or compromised medications or medical supplies and/or equipment is considered not stocked for the purposes of this policy.

BASIC LIFE SUPPORT (BLS) UNIT

MEDICAL EQUIPMENT & SUPPLIES	QUANTITY
Ankle and wrist restraints • If soft ties are used, they should be at least three (3) inches wide (before tying) to maintain a two (2) inch width while in use	1 set
Bag-valve device with O_2 inlet and reservoir: • Adult • Pediatric	1 each
Bag-valve mask: • Large • Medium • Small adult/child • Toddler • Infant • Neonate	1 each

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

MEDICAL EQUIPMENT & SUPPLIES	QUANTITY
Blood pressure manometer, cuff and stethoscope: • Thigh • Adult • Child • Infant	1 each
*Cervical collars, rigid: • Adult • Pediatric • Infant *(1 adjustable pediatric meets infant requirement)	1 each
Immobilizer, Head: • Disposable or Reusable	1
Linen Supplies	1 set
Oropharyngeal airways: • adult • children • infant • newborn	1 each
Oxygen cannulas: • Adult • Child	1 each
Oxygen masks, transparent: • Adult • Child • Infant	1 each
Oxygen, portable • "D" or "E" cylinder with a minimum of 1000 psi	1
Oxygen, vehicle (house) • "M" or "H" cylinder with a minimum of 500 psi	1
Body Substance Isolation Equipment: • Mask • Gown • Eye protection	2 each
Spine boards, rigid, approximately 14 inches in width: • One approximately 72 inches in length with straps for immobilization of suspected spinal or back injuries	1
Stretchers: • Stretcher with wheels and the following: o mattress covered with impervious plastic material or the equivalent o have capability to elevate both the head and foot o straps to secure the patient to the stretcher, including shoulders, waist and legs o a means of securing the stretcher in the vehicle o be adjustable to at least four different levels	1
Suction equipment, portable device	1
Suction equipment, vehicle (house), capable of at least: • a negative pressure equivalent to 300 mm of mercury • 30 liter per minute air flow rate for 30 minutes of operation	1

MEDICAL EQUIPMENT & SUPPLIES	QUANTITY
Suction tubing: • Non-collapsible, plastic, semi-rigid, whistle tipped, finger controlled type is preferred • Flexible catheters for tracheostomy suctioning (8Fr.,10Fr., and 12Fr.)	1 each
Tourniquets (commercial, for control of bleeding)	2
PERSONAL PROTECTION EQUIPMENT (PPE)	**QUANTITY**
Gloves, work (multiple use, leather)	2 pairs
Hearing Protection (includes foam ear plugs)	2 sets
Jacket, EMS, with reflective stripes*	2
Rescue Helmet	2
Respiratory protection mask (N95) and general purpose mask	2 each
Safety vest meeting ANSI standards or equivalent* *Jackets meeting ANSI standards may be used in lieu of the Safety vest	2

ADVANCED LIFE SUPPORT (ALS) UNIT

An ALS unit must maintain all of the medical equipment and medical supplies listed for a BLS unit, plus the following additional items:

MEDICATIONS	QUANTITY
Albuterol (pre-mixed with NS)	10 mgs
Adenosine	18 mgs
Amiodarone	450 mgs
Aspirin (chewable 81 mg)	162 mgs
Atropine sulfate (1mg/10ml)	2 mgs
Calcium chloride	1 gm
Dextrose 10%/Water 250mL	1
Dextrose solution 45 gm (glucose paste may be substituted)	1
Diphenhydramine	50 mgs
Epinephrine (1:1,000) (1mg/mL)	4 mgs
Epinephrine (1:10,000) (0.1mg/mL)	5 mgs
Fentanyl* *Either Fentanyl or Morphine must be carried, may not stock both	400 mcgs
Glucagon	1 mg
Midazolam	10 mgs
Morphine sulfate **Either Fentanyl or Morphine must be carried, may not stock both	20 mgs
Naloxone	2 mgs
Normal saline (for injection)	2 vials
Nitroglycerin spray, tablets, or single dose powder packets	1 bottle/pump or 36 packets
Ondansetron 4mg ODT	8 mgs
Ondansetron 4mg IV	8 mgs
Sodium bicarbonate	50 mls

INTRAVENOUS FLUIDS	QUANTITY
1000 ml normal saline	2 bags
250 or 500 ml normal saline	2 bags
SUPPLIES	**QUANTITY**
Airways – Nasopharyngeal • Large (34-36) • Medium (26-28) • Small (20-22)	1 each
Airways – Oropharyngeal • Large • Medium • Small Adult/Child • Infant • Neonate	1 each
Burn pack or burn sheets	1
Color Code Drug Doses Reference No. 1309	1
Commercial Catheter-Over-Needle Chest Decompression Needle 3.0-3.5” 14G	1
Contaminated needle container	1
Defibrillator with oscilloscope	1
Defibrillator electrodes (including pediatric) or paste	2
ECG electrodes (adult and pediatric)	3 each
Endotracheal tubes with stylettes • Sizes 6.0-8.0	1 each
End Tidal CO_2 detector and aspirator (adult)	1 each
Gloves (sterile)	1 pair
Gloves (unsterile)	1 box
Glucometer with strips	1
Hand-held nebulizer pack	1
Hemostats, padded	1
Intravenous catheters (14G-22G)	1 each
Intravenous tubing • Microdrip • Macrodrip	2 each
King LTS-D (Disposable Supraglottic Airway device) • Small adult (size 3) • Adult (size 4) • Large Adult (size 5)	1 each
Lancets, automatic retractable	2
Laryngoscope Handle (adult)	1
Laryngoscope blades • Adult (curved and straight) • Pediatric (Miller #1 and #2)	1 each
Magill Forceps (adult and pediatric)	1 each
Mucosal Atomization Device (MAD)	1
Normal saline for irrigation	1 bottle
Pediatric Length-Based Resuscitation Tape (Broselow 2011A or newer)	1
Pulse Oximeter	1
Saline locks	2

Syringes (1 ml – 60 ml)	Assorted
Tube introducer	1
Vaseline gauze	2

NURSE STAFFED CRITICAL CARE TRANSPORT (CCT) UNIT

A nurse staffed CCT unit must maintain all of the medical equipment and medical supplies listed for a BLS unit, plus the following additional items:

MEDICATIONS	QUANTITY
Albuterol (pre-mixed with NS)	10 mgs
Adenosine	12 mgs
Amiodarone	450 mgs
Aspirin (chewable 80 mg)	162 mgs
Atropine sulfate (1mg/10ml)	2 mgs
Calcium chloride	1 gm
Dextrose 10%/Water 250mL	1 bag
Dextrose solution 45 gm (glucose paste may be substituted)	1
Diphenhydramine	50 mgs
Epinephrine (1:1,000) (1mg/mL)	1 mgs
Epinephrine (1:10,000) (0.1mg/mL)	5 mgs
Fentanyl	200 mcgs
Levophed 4mgs	1 Vial
Midazolam	10 mgs
Morphine	8 mgs
Naloxone	2 mgs
Nitroglycerin spray, tablets or single dose powder packets	1 bottle/pump or 36 packets
INTRAVENOUS FLUIDS	**QUANTITY**
1000 ml normal saline	1
250 normal saline	1
SUPPLIES	**QUANTITY**
Airways – Nasopharyngeal • Large (34-36) • Medium (26-28) • Small (20-22)	1 each
Back-up power source/adjunct power source (inverter, batteries, etc.). Second source required if transporting IABP patients.	1
Cardiac monitor/defibrillator oscilloscope including end tidal CO_2 detector, external pacemaker, pulse oximeter and optional 12 lead EKG capabilities	1
Cellular phone	1
Color Code Drug Doses Reference No. 1309	1
Glucometer, strips and lancets, automatic retractable	1
Hand-held nebulizer pack	1
Hemostats, padded	1
3 Infusion pump(s) or 1 w/ 3 chamber drip capability	1/3
Intravenous Tubing • Microdrip • Macrodrip	2 each
Normal Saline for irrigation	1 bottle

MEDICATIONS	QUANTITY
Pediatric Length-Based Resuscitation Tape (Broselow 2011A or newer)	1
Pulse Oximeter	1
Saline Locks	2
Suction, battery operated portable	1

RESPIRATORY CARE PRACTITIONER (RCP) STAFFED CCT UNIT

An RCP staffed CCT unit must maintain all the medical equipment and medical supplies listed for a BLS unit, plus the following additional items:

MEDICATIONS	QUANTITY
Albuterol (pre-mixed with NS)	10 mgs
Atrovent	20 mgs
SUPPLIES	**QUANTITY**
Airways – Nasopharyngeal • Large (34-36) • Medium (26-28) • Small (20-22)	1 each
Airway Guard (bite blocker)	1
Cellular Phone	1
Color Code Drug Doses Reference No. 1309	1
Continuous Positive Airway Pressure (CPAP) device or ventilator capable of providing non-invasive CPAP	1
Coupler/Quick Connect (oxygen connection)	1
End tidal CO_2 Detector (portable) adult/pediatric	1 each
$ETCO_2$ Filterline	2
Gloves (sterile)	1 pair
Heat/Moisture Exchange Ventilator Filters • Adult • Peds • 2 universals may be carried in lieu of one adult and one pediatric	1 each
King LTS-D (Disposable Supraglottic Airway device) • Neonate (size 0) • Pediatric (size 1) • Pediatric (size 2) • Small adult (size 3) • Adult (size 4) • Large Adult (size 5)	1 each
Laryngoscope Handle • Adult • Pediatric (or adult compatible with pediatric blades)	1 each
Laryngoscope Blades • Adult Curved • Adult Straight • Pediatric Miller 0 • Pediatric Miller 1 • Pediatric Miller 2	1 each

Magill Forceps • Adult • Pediatric	1 each
Pediatric Length-Based Resuscitation Tape (Broselow 2011A or newer)	1
PEEP Valve • Adult • Pediatric	1 each
SUPPLIES	**QUANTITY**
Pulse Oximeter • Adult Probe • Pediatric Probe	1 each
Suction – portable, battery operated	1
Ventilator Filters	2
Ventilator Circuits (disposable) • Adult • Pediatric	1 each
Ventilator (non-pneumatic or pneumatic) If utilizing ventilator to fulfill non-invasive CPAP requirement, must have 1 set of the necessary equipment (mask, circuit) to provide non-invasive CPAP	1

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **RETENTION AND DISPOSTION OF PREHOSPITAL PATIENT CARE RECORDS** (EMT, PARAMEDIC, MICN) REFERENCE NO. 608

PURPOSE: To outline the appropriate procedure for retention and disposition of Prehospital Patient Care Records which includes but is not limited to the following formats: electronic patient care record (ePCR), EMS Report form, Base Hospital Form, Multiple Casualty Incident (MCI) Base Hospital Form, Base Hospital Form Page 2, Advanced Life Support (ALS) Continuation Form, Triage Tags, base hospital radio contact logs, base hospital medical control audio recordings, and private provider agency patient care records.

AUTHORITY: California Code of Regulations, Title 22, Sections 100128, 100170
California Welfare and Institutions Code Section 14124.1
California Health and Safety Code section 1797.98(e)
Health Insurance Portability and Accountability Act of 1996

PRINCIPLES:

1. Prehospital patient care records contain patient information which is protected under the Health Insurance Portability and Accountability Act (HIPAA) and shall be maintained in accordance with HIPAA regulations.

2. Prehospital care providers and base hospitals have an obligation to ensure the security of confidential patient information.

3. Personnel responsible for all aspects of prehospital patient care record maintenance (including data entry personnel) shall receive appropriate training related to patient care record confidentiality.

4. Prehospital patient care records shall be maintained in a secure location with access limited to authorized personnel.

5. Provider agencies and base hospitals are responsible for maintaining the original copy of prehospital patient care records.

6. Original patient care records of all patients shall be retained for a minimum of seven years. Original patient care records of minors shall be kept for at least one year after such minors have reached the age of 18, but in no event less than seven years following the provision of service.

7. Records shall be accessible for audit review by EMS Agency personnel.

8. All records related to either suspected or pending litigation shall be retained indefinitely.

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

POLICY:

I. Provider Agency Prehospital Patient Care Records:

A. ePCR, EMS Report Form, and ALS Continuation Forms are utilized as applicable for all 9-1-1 patients (ALS and BLS) and for private provider transports where base contact is made for medical control and are distributed as follows:

1. White (Original) - Retained by the EMS Provider Agency that initiates the form.

2. Red (Receiving Hospital) - Left with the receiving facility for transported patients. This copy becomes part of the patient's medical record at the receiving facility. If the patient is not transported, disposition is at the discretion of the EMS Provider Agency that initiates the form.

3. Yellow (EMS Agency) - Sent to the EMS Agency within 45 days of the last day of the preceding month. The EMS Agency shall retain until the data has been entered into the Trauma Emergency Medical Information System (TEMIS) database.

B. Private provider agency-specific, non-9-1-1 prehospital patient care records are completed for all patients and are distributed as follows:

1. Original copy - Retained by the private provider agency that initiates the form.

2. Duplicate copy – Left with the receiving facility for patients transported to a healthcare facility. This copy becomes part of the patient's medical record at the receiving facility. If patient is not transported to a healthcare facility, disposition is at the discretion of the private provider agency that initiates the form.

C. Triage Tags - In the event of a multiple casualty incident where triage tags are utilized, the original triage tag will remain with the patient, if transported, the triage tag should become part of the patient's medical record at the receiving facility. If the patient is not transported, the triage tag is to be retained as the original patient care record.

II. Base Hospital Records: Base Hospital Form, MCI Base Hospital Form, and Base Hospital Form Page 2 are utilized, as applicable, for all patients requiring base hospital contact and are distributed as follows:

A. White (Original) - Retained by the Base Hospital that initiates the form.

B. Yellow (EMS Agency) - Sent to the EMS Agency within 60 days of the incident unless approved by EMS Agency not to submit.

C. Red (Complimentary) - Used at the discretion of the Base Hospital.

D. Black (Complimentary) - Used at the discretion of the Base Hospital.

III. Maintenance of Prehospital Care Patient Records

A. Prehospital patient care records shall be delivered to the EMS Agency in a manner that ensures form security and patient confidentiality.

B. Prehospital patient care records in paper format, may be stored electronically upon written approval by the EMS Agency.

IV. Destruction of Prehospital Care Patient Records

A. Prehospital patient care records that are eligible for destruction shall be disposed of in accordance with all applicable laws.

B. Complimentary and supplemental copies of prehospital patient care records shall be disposed of in accordance with all applicable laws.

CROSS REFERENCES:

Prehospital Care Policy Manual:
Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 607, **Electronic Submission of Prehospital Data**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **RELEASE OF EMERGENCY MEDICAL SERVICES (EMS) RECORDS** REFERENCE NO. 612

PURPOSE: To establish a procedure for release of EMS patient care records which contain protected health information.

AUTHORITY: Health & Safety Code, Sections 123100 – 123149.5
American Hospital Association, A Patient's Bill of Rights
Healthcare Information Portability and Accountability Act of 1996 (HIPAA)
Health Information Technology for Economic and Clinical Health (HITECH) Act

DEFINITIONS:

Protected Health Information (PHI): Individually identifiable health information that is held or transmitted in any form or media, whether electronic, written, spoken, printed, digital, recorded, or photographic, which can be linked to an individual, or there is reasonable basis to believe it can be used to identify an individual.

Emergency Medical Services (EMS) Records: EMS records exist in different formats and include those on which written, printed, spoken or digital information is recorded or preserved. For purposes of this policy, EMS records consist of the Base Hospital Forms and EMS Report Forms which include but are not limited to: Base Hospital Page 2s, Base Hospital Multiple Casualty Incident (MCI) Forms, Advanced Life Support (ALS) Continuation Forms, and Triage Tags.

PRINCIPLES:

1. Patients have the right to communicate with healthcare providers in confidence and to have the confidentiality of their PHI maintained.

2. Patients have the right to review and receive a copy their own medical records upon presenting to the healthcare provider a written request specifying the records to be copied.

3. Attorneys may request EMS records in accordance with the law.

POLICY:

Individual's requesting the release of an EMS record shall be directed in the following order:

I. Hospital

   A. The requesting individual will be referred to the Medical Records Department of the healthcare facility where the patient was transported.

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

B. If available, the facility's procedure for releasing medical records shall be followed.

II. Provider Agency

A. If the receiving hospital does not have a copy of the EMS record or if the patient was not transported, the individual may request the provider agency to release the document.

B. The provider agency's policy or procedure for releasing medical records shall be followed and the report shall be released only upon receipt of a:

1. Subpoena Duces Tecum, or

2. An authorization form signed by the patient or patient's representative such as a Release of Medical Records, Request for Patient Access to Health Information, or the provider agency's own form to ensure proper release of medical information.

III. EMS Agency

A. If neither the hospital nor the provider agency is able to provide the requested EMS record, the EMS Agency may be asked to release the document. Because forms are only retained at the EMS Agency for approximately 6 months after the incident date, the requested records may not be available.

B. If the records are available, they shall be released only upon receipt of a:

1. Subpoena Duces Tecum, or

2. An authorization form for Release of Medical Records, Request for Patient Access to Health Information or similar form signed by the patient or patient's representative.

AND

3. The EMS Agency shall require reasonable verification of identity, such as photo identification, prior to permitting inspection or copying of the EMS records.

CROSS REFERENCE

Prehospital Care Manual:
Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 622, **Release of EMS Data**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **RELEASE OF EMS DATA** REFERENCE NO. 622

PURPOSE: To outline the appropriate process for obtaining Emergency Medical Services (EMS) Agency data.

AUTHORITY: Health Information Technology for Economic and Clinical Health (HITECH) Act
Healthcare Information Portability and Accountability Act of 1996 (HIPAA)
Title 45, Code of Federal Regulations, Section 164.154

DEFINITIONS:

Covered Entities: Healthcare providers, health plans, and healthcare clearing houses that electronically transmit health information.

Limited Data Set Information: Information that does not include standard identifiers so as to ensure that remaining health information is not identifiable to an individual or incident. Some of the specific links include but are not limited to the following:

- Names
- Postal Address, information other than town or city, state, and zip code
- Dates including birth date, admission date, discharge date, date of death, and all ages over 89
- Telephone and fax numbers
- Electronic mail addresses
- Social Security numbers
- Medical records numbers
- Hospital visit numbers
- Health plan beneficiary numbers
- Account numbers
- Certification/license numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Web Universal Resource Locators (URLs)
- Internet Protocol (IP) address numbers
- Biometric identifiers, including finger or voice prints
- Full face photographic images and any comparable images
- Any other unique identifying number, characteristic or code

Health Insurance Portability and Accountability Act (HIPAA): A federal law passed in 1996, which established a set of national standards for the electronic transmission of health information, including research subjects. Covered entities are required to comply with HIPAA regulations.

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

Institutional Review Board (IRB): An Institutional Review Board, also known as an independent ethics committee, ethical review board, or research ethics board, is a type of committee used in medical research that has been formally designated to approve, monitor, and review biomedical and behavioral research involving humans. IRBs often conduct some form of risk-benefit analysis in an attempt to determine whether or not research should be done. The purpose of the IRB is to assure that the appropriate steps are taken to protect the rights and welfare of humans participating as subjects in a research study.

Protected Health Information (PHI): Individually identifiable health information that is held or transmitted in any form or media, whether electronic, written, spoken, printed, digital, recorded, or photographic, which can be linked to an individual, or there is reasonable basis to believe it can be used to identify an individual.

PRINCIPLES:

1. EMS data contains patient information which is protected under HIPAA. Without specific authorization, the EMS Agency will only release Limited Data Set Information.

2. Local EMS stakeholders and healthcare researchers are encouraged to utilize EMS data to evaluate patient care and outcomes and to answer other healthcare related questions that may lead to system improvements. Research studies will require approval from the appropriate IRBs.

3. All release of data will be approved by the Director of the EMS Agency (or designee). When applicable, the EMS Agency will seek the recommendation of the appropriate EMS Agency Advisory Committee.

4. Neither provider (i.e., hospital or prehospital care provider) nor the EMS Agency shall release another entity's identifiable information to any entity for public use without first receiving written permission from the entity's Executive Officer, except as permitted by required statute, regulation, or court order.

POLICY:

I. Requests for EMS Data:

A. Information that does not disclose the identity of the provider

1. Requesting party shall submit a written request utilizing Ref. No. 622.1, Data Request and Levels of Support, to the EMS Agency's Data System Management Division Chief (or designee). Augmentation to an original request may be considered a new data request.

2. The EMS Agency will:

a. Review the request and inform the requesting party of the approval/disapproval decision within 4 weeks of receiving the request.

b. Advise the requesting party of the anticipated timeframe for completion of the data request.

c. Prepare the data in the agreed upon format. If the data format has not been specified by the requesting party, an appropriate format will be utilized (i.e., graph, tables, etc.).

d. Release the data following receipt of IRB approval, if applicable, and approval by the Director of the EMS Agency (or designee).

B. Information that discloses the identity of the provider

1. Requesting party shall:

a. Submit a written request, along with Ref. No. 622.1, Data Request and Levels of Support, to the EMS Agency's Data System Management Division Chief (or designee). Augmentation to an original request may be considered a new data request.

b. Obtain written permission from the involved agency's Executive Officer authorizing the EMS Agency to release agency-identifiable data and provide that written permission to the EMS Agency.

2. The EMS Agency will:

a. Only release data for agencies that have provided written authorization permitting release of their data.

b. Provide a copy of the request to the appropriate committee(s) for comment and recommendation.

c. Notify the requesting party of the anticipated timeframe in determining the approval/disapproval of their request (depending on committee meeting schedules, recommendations, etc.).

d. Notify the requesting party of the approval/disapproval of their request as soon as responses are received from the involved agencies and committees.

e. Advise the requesting party of the anticipated timeframe for completion of the request for data.

f. Prepare the data in the agreed upon format. If no data format has been specified by the requesting party, an appropriate format will be utilized (i.e., graph, tables, etc.).

g. Release the data following receipt of IRB approval, if applicable, and approval by the Director of the EMS Agency (or designee).

II. Appeals:

A. Disapproval of data that does not disclose the identity of the provider:

Requesting party shall submit a written request for a review of the decision to the

Director of the Los Angeles County Department of Health Services.

B. Disapproval of data that discloses the identity of the provider:

There is no appeal for data release decisions regarding data that discloses the identity of the provider.

III. Fees:

A. The EMS Agency and/or its information technology vendor may charge the requesting party a data retrieval fee.

B. Fees will be determined following review of the application form, taking into account the complexity of the request, the anticipated time necessary to complete the request, and the level (s) of support requested.

C. Fees will be discussed with the requesting party prior to generating the requested data.

D. Fees will be collected prior to release of the requested data.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 622.1, **Data Request and Levels of Support**
Ref. No. 622.2, **Limited Data Set Information**
Ref. No. 622.3, **Intended Use of Limited Data Set Information**
Ref. No. 622.4, **Data Use Agreement**
Ref. No. 622.5, **Confidentiality Agreement**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **SUPPLY AND RESUPPLY OF DESIGNATED EMS PROVIDER UNITS/VEHICLES** (PARAMEDIC) REFERENCE NO. 701

PURPOSE: To provide a policy for 9-1-1 provider agencies to procure, store, and distribute medical supplies and pharmaceuticals identified in the ALS Unit Inventory that require specific physician authorization.

AUTHORITY: California Health and Safety Code, Division 10, Uniform Controlled Substances Act; and Division 2.5, Chapter 5, Section 1798.
California Code of Regulations, Title 22, Chapter 4, Article 6, Section 100168.
Code of Federal Regulations, Title 21, Section 801.109.

DEFINITION:

Restricted Drugs and Devices: Drugs and devices bearing the symbol statement "Rx Only"; legend statements, "Caution, federal law prohibits dispensing without prescription," or "Federal law restricts this device to sale by or on the order of a physician," or words of similar import.

POLICY:

I. Responsibilities of the Provider Agency

A. Each provider agency shall have a mechanism to procure, store, and distribute its own restricted drugs and devices under the license and supervision of a physician who meets the requirements specified in Ref. No. 411, Provider Agency Medical Director.

B. Provider agency shall furnish the EMS Agency with a completed Ref. No. 701.1, Physician Confirmation of Agreement to Purchase Drugs and Medical Supplies indicating that the respective physician will assume responsibility for providing medical authorization for procuring restricted drugs and devices.

C. Mechanisms of procurement may include the following:

1. Procurement of restricted drugs and devices from a hospital that determines it has the legal authority to resell pharmaceuticals and supplies to a provider agency.

2. Procurement of restricted drugs and devices through another legally authorized source, including but not limited to, a pharmaceutical distributor or wholesaler.

D. Each provider agency shall have policies and procedures in place for the procurement, transport, storage, distribution, and disposal of restricted drugs and devices. These policies shall be reviewed by the local Emergency Medical Services (EMS) Agency and shall include, but are not limited to, the following:

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

1. Identification (by title) of individuals responsible for procurement and distribution.

2. A determination of reasonable quantities of supplies and pharmaceuticals that must be maintained to resupply ALS units between deliveries by distributor.

3. Maintenance of copies of all drug orders, invoices, and logs associated with restricted drugs and devices for a minimum of three years.

4. Procedures for completing a monthly inventory, includes:

    a. Ensuring medications are stored in original packaging;

    b. Checking medications for expiration dates, rotating stock for use prior to expiration, and exchanging for current medications;

    c. Properly disposing of expired medications that cannot be exchanged;

    d. Accounting for restricted drugs and devices in stock and/or distributed to ALS units and other transport units; and

    e. Returning medications to the pharmaceutical distributor if notified of a recall.

5. Storage of drugs (other than those carried on the ALS unit itself) that complies with the following:

    a. Drugs must be stored in a locked cabinet or storage area.

    b. Drugs may not be stored on the floor (Storage of drugs on pallets is acceptable).

    c. Antiseptics and disinfectants must be stored separately from internal and injectable medications.

    d. Flammable substances, e.g., alcohol, must be stored in accordance with local fire codes.

    e. Storage area is maintained within a temperature range that will maintain the integrity, stability, and effectiveness of drugs.

6. A mechanism for procuring, storing, distributing, and accounting for controlled drugs that is consistent with the requirements outlined in Ref. No. 702, Controlled Drugs Carried on ALS Units

II. Pharmaceutical Shortages

A. Notification

1. Pharmaceutical recalls, shortages and other pharmaceutical-related concerns are identified through notifications from:

    a. The Food and Drug Administration (FDA)

    b. Public and private provider agencies

2. Once notification is received, FDA is contacted to verify report and retrieve an expected recovery date.

3. If notification content from the FDA is expected to impact the Los Angeles County (LAC) EMS System, all ALS providers will be formally notified by the EMS Agency's Medical Director.

B. Mitigation Strategies

Mitigation strategies are identified in two categories as follows: 1. Those that can be implemented by the EMS provider agency simultaneous with written notification to the LAC EMS Agency Medical Director, and 2. those that require prior approval of the LAC EMS Agency Medical Director prior to implementation.

1. Mitigation strategies which can be implemented by the EMS provider Agency with notification of the LAC EMS Agency Medical Director.

    a. Inventory Reduction:

        i. Provider agency may redistribute its current inventory amongst its own ALS units, from low volume to high volume utilizers.

        ii. The Medical Director of the EMS Provider Agency may temporarily reduce the minimum inventory par levels.

        iii. Provider agencies (public and private) that are low volume utilizers may redistribute a portion of its current inventory to other provider agencies that are high volume utilizers, with the exception of controlled substances.

    b. Provider agencies should attempt procurement from other pharmaceutical vendor resources.

    c. The EMS Provider Agency may contact the LAC EMS Agency to obtain approval to receive pharmaceuticals from the disaster preparedness pharmaceutical cache to provider agencies in most need.

    d. Use of expired medications as per published FDA extensions.

2. Mitigation strategies that require LA EMS Agency Medical Director approval prior to implementation:

a. Change in opioid medication from what has previously been approved (i.e., change from morphine to fentanyl).

b. Use of blanket extension for expiration dates on medications in shortage.

c. Dilution of any medication to achieve the desired formulation (e.g., epinephrine 1mg/mL to achieve epinephrine 0.1mg/mL).

d. Change in formulation of a medication that is not on the LAC EMS Agency approved list of formulations (Re. MCG 1309).

e. Approval for extension of expiration dates for medications not on the FDA extension list.

C. Recovery Phase

Once it has been identified that the current pharmaceutical shortage has resolved and provider agencies have received back-ordered medications, the following shall take place:

1. All ALS units shall return to the minimum inventory amounts, as outlined in appropriate unit inventory lists.

2. Pharmaceuticals acquired from the EMS Agency or other provider agencies (private and public) are to be equally replenished by the acquiring agency.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 411, **Provider Agency Medical Advisor**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**
Ref. No. 703, **ALS Unit Inventory**
Ref. No. 704, **Assessment Unit Inventory**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **ALS UNIT INVENTORY** REFERENCE NO. 703

PURPOSE: To provide a standardized minimum inventory on all Advanced Life Support (ALS) Units.

PRINCIPLE:

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

POLICY:

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

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

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

MEDICATIONS (minimum required amounts)			
Adenosine	**24mgs**	Fentanyl [2, 3]	**500mcgs**
Albuterol (pre-mixed w/ NS)	**20mgs**	Glucagon	**1mg**
Amiodarone	**900mgs**	Lidocaine 2% [4]	**200mg**
Aspirin (chewable 81mg)	**648mgs**	Midazolam [5]	**20mgs**
Atropine sulfate (1mg/10mL)	**2mgs**	Morphine sulfate [6]	**20mgs**
Calcium chloride	**1gm**	Naloxone	**4mgs**
Dextrose 10% / Water 250mL	**3 bags**	Normal saline (for injection)	**2 vials**
Dextrose solution (glucose paste may be substituted)	**45gms**	Nitroglycerin (SL) spray, tablets, or single dose powder packets	**1 pump/ bottle/ or 36 packets**
Diphenhydramine	**100mgs**	Ondansetron 4mg ODT	**16mgs**
Disaster Cache (mandatory for 9-1-1 responders) [1]	**1**	Ondansetron 4mg IV	**16mgs**
Epinephrine (1mg/mL)	**5mgs**	Sodium bicarbonate	**50mLs**
Epinephrine (0.1mg/mL)	**7mgs**		

INTRAVENOUS FLUIDS (minimum required amounts)			
Normal saline 1000 mL	**6 bags**	Normal saline 250 or 500 mL	**2 bags**

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

SUPPLIES (minimum required amounts)			
Adhesive dressing (Band-Aids®)	**1 box**	Endotracheal tubes w/ stylets Sizes 6.0-8.0	**2 each**
Airways – Nasopharyngeal		End Tidal CO_2 Detector or Aspirator (Adult)	**1**
Large (34-36)	**1**	Extrication device or short board	**1**
Medium (26-28)	**1**	Flashlight or Penlight	**1**
Small (20-22)	**1**	Gauze bandages	**5**
Airways – Oropharyngeal		Gauze sponges 4x4 (sterile)	**12**
Large	**1**	Gloves, sterile	**2 pair**
Medium	**1**	Gloves, unsterile	**1 box**
Small Adult/Child	**1**	Glucometer w/ strips	**1**
Infant	**1**	Hand-held nebulizer pack	**2**
Neonate	**1**	Hemostats, padded	**1**
Alcohol prep pads	**1 box**	Intraosseous device [3, 7] Adult & Pediatric **9-1-1 paramedic provider agencies only**	**1 each**
Backboards	**2**	Intravenous catheters Sizes 16G-22G	**5 each**
Bag-valve device w/ O_2 inlet and reservoir Adult* & Infant	**1 each**	Intravenous tubing - Macrodrip	**12**
Bag-valve mask		King LTS-D (Disposable Supraglottic Airway w/ 60mL syringe)	
Large	**1**	Small Adult (Size 3)	**1**
Medium	**1**	Adult (Size 4)	**1**
Small Adult/Child	**1**	Large Adult (Size 5)	**1**
Toddler	**1**	Lancets (automatic retractable)	**5**
Infant	**1**	Laryngoscope handle Adult (compatible w/ pediatric blades)	**1**
Neonate	**1**	Laryngoscope blades	
Burn pack or burn sheets	**1**	Adult: curved & straight	**1 each**
Cervical collars (rigid)		Pediatric: Miller #1 & #2	**1 each**
Adult (adjustable)	**4**	Magill forceps Adult & Pediatric	**1 each**
Pediatric	**2**	Mucosal Atomization Device (MAD)	**2**
Cardiac Monitor-Defibrillator w/ oscilloscope	**1**	Needle, filtered-5micron [8]	**2**
Color Code Drug Doses LA County Kids Ref. No. 1309	**1**	Normal saline for irrigation	**1 bottle**
Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5” 14G	**2**	OB pack & bulb syringe [9]	**1**
Contaminated needle container	**1**	Oxygen cannulas Adult & Pediatric	**3 each**
Continuous Positive Airway Pressure (CPAP) device [3, 7] **9-1-1 paramedic provider agencies only**	**1**	Oxygen masks (non-rebreather) Adult & Pediatric	**3 each**
Defibrillator pads or paste (including pediatric)	**2 each**	Pediatric Length-Based Resuscitation Tape (Broselow 2011A or newer)	**1**
ECG electrodes Adult & Pediatric	**6 each**	Personal Protective Equipment - mask, gown, & eye protection	**1 each per provider**
ECG, 12-lead & transmission capable **9-1-1 paramedic provider agencies only**	**1**	Pulse oximeter	**1**

SUPPLIES (minimum required amounts)			
Radio transmitter receiver (Hand-Held) [10]	**1**	Syringes 1mL – 60mL w/ luer adapter	**assorted**
Saline locks	**4**	Tape (various types, must include cloth)	**1**
Scissors	**1**	Tourniquets	**2**
Sphygmomanometer Adult, Pediatric, & Thigh	**1 each**	Tourniquets (commercial for bleeding control)	**2**
Splints – (long and short)	**2 each**	Transcutaneous pacing	**1**
Splints – traction Adult & Pediatric	**1 each**	Tube introducer	**2**
Stethoscope	**1**	Vaseline gauze	**2**
Suction unit (portable) w/adapter	**1**	Waveform capnography [7]	**1**
Suction instruments: Catheters sizes 8Fr.-12Fr.	**1 each**		
Tonsillar tip	**1**		

SUPPLIES (approved optional equipment)	
Hemostatic dressings [3]	Pediatric laryngoscope handle FDA-Approved
Intravenous tubing, blood	Resuscitator w/ positive pressure demand valve (flow rate not to exceed 40L/min)
Mechanical CPR device [3]	

[1] Disaster Cache minimum contents include: (9) DuoDote kits or equivalent;
And when available: (6) AtroPen Auto Injector 1.0mg
(6 AtroPen Auto Injector 0.5mg – Pediatric Use
[2] Fentanyl carried on ALS Unit is not to exceed 1500mcgs.
[3] Requires EMS Agency approval, which includes an approved training program & QI method prior to implementation
[4] Utilized w/ infusions through IO access
[5] Midazolam carried on ALS Unit is not to exceed 40mgs.
[6] Morphine sulfate carried on ALS Unit is not to exceed 60mgs.
[7] Mandatory for providers that respond to medical emergencies via the 9-1-1 system
[8] Optional, if not utilizing glass ampules
[9] OB kits w/ clamps / scissors (no scalpels)
[10] Los Angeles County Department of Communications, Spec. No. 2029/2031/2033

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

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**
Ref. No. 710, **Basic Life Support Ambulance Equipment**
Ref. No. 712, **Nurse Staffed Critical Care Transport (CCT) Unit Inventory**
Ref. No. 1104 **Disaster Pharmaceutical Caches Carried by First Responders**

POLICY REVIEW – COMMITTEE ASSIGNMENT REFERENCE NO. 202.1
(ATTACHMENT A)

REFERENCE NO. 703, ALS Unit Inventory

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee			
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee	08/21/2019	08/21/2019	N
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

*****See Ref. No. 202.2, **Policy Review - Summary of Comments**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

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

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

PRINCIPLE:

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

POLICY:

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

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

MEDICATIONS (minimum required amounts)			
Albuterol (pre-mixed w/ NS)	**30mgs**	Atrovent	**2mgs**

SUPPLIES (minimum required amounts)			
Airways – Nasopharyngeal		Bag-valve mask	
Large (34-36)	**1**	Large	**1**
Medium (26-28)	**1**	Medium	**1**
Small (20-22)	**1**	Small Adult/Child	**1**
Airways – Oropharyngeal		Toddler	**1**
Large	**1**	Infant	**1**
Medium	**1**	Neonate	**1**
Small Adult/Child	**1**	Cell phone (personal or company)	**1**
Infant	**1**	Color Code Drug Doses LA County Kids Reference No. 1309	**1**
Neonate	**1**	Coupler/Quick Connect (oxygen connection)	**2**
Airway guard (bite blocker)	**2**	End tidal CO_2 detector Adult & Pediatric	**2 each**
Bag-valve device w/ O_2 inlet and reservoir Adult & Pediatric	**1 each**	$ETCO_2$ filter line	**6**
Gloves, sterile	**2**	Oxygen tree	**2**

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

SUPPLIES (minimum required amounts)			
Gloves, non-sterile	**1 box**	Pediatric Length-Based Resuscitation Tape (Broselow 2011A or newer)	**1**
Nebulizer kit (including hand held and mask)	2 each	PEEP valve Adult & Pediatric	**1 each**
Heat / Moisture Exchange (HME) Ventilator Filters		Penlight	**1**
Adult	**4**	Personal Protective Equipment – mask, gown, & eye protection	**1 each/ provider**
Pediatrics	**2**	Portable suction (battery operated)	**1**
*King LTS-D (Disposable Supraglottic Airway Device)		Pulse oximeter	**1**
Neonate (size 0)	**1**	Pulse oximeter probes Adult & Pediatric	**2 each**
Pediatric (size 1)	**1**	Scissors	**1**
Pediatric (size 2)	**1**	Sphygmomanometer Adult, Pediatric, & Thigh	**1 each**
Small Adult (Size 3)	**1**	Suction catheters Sizes 8Fr.-14Fr.	**1 each**
Adult (Size 4)	**1**	Stethoscope	**1**
Large Adult (Size 5)	**1**	Syringes 10mL	**2**
Laryngoscope handle Adult (compatible w/ pediatric blades)	**1**	Tape (various types, must include cloth)	**1**
Laryngoscope blades – Adult Curved & Straight	**1 each**	Ventilator filters	**4**
Laryngoscope blades – Pediatric Miller 1, & Miller 2	**1 each**	Ventilator circuits (disposable)	
Magill forceps Adult & Pediatric	**1 each**	Adult	**4**
Normal saline pillows (ampoules/inhalant)	**10**	Pediatrics	**2**
Oxygen Cannulas Adult & Pediatric	**3 each**	Ventilator (non-pneumatic or pneumatic) – if utilizing ventilator to fulfill non-invasive CPAP requirement, must have 1 set of the necessary equipment (mask, circuit) to provide non-invasive CPAP)	**1**
Oxygen masks Adult & Pediatric	**3 each**		
Oxygen hose	**1**		
Oxygen key	**2**	Waveform capnography	**1**
Oxygen regulator	**2**		

SUPPLIES (approved optional equipment)			
Endotracheal tubes w/ stylets Sizes 2.0-8.0	**2 each**	Levalbuterol	**7.5mgs**
High velocity oxygen delivery system	**1**	Tracheostomy mask Adult & Pediatric	**2 each**
High velocity oxygen delivery nasal cannulas Adult & Pediatric	**2 each**	Venturi mask	**1**

This policy is intended as a RCP Inventory only.

* Requires EMS Agency approved training and quality improvement program.

CROSS REFERENCES:

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

POLICY REVIEW – COMMITTEE ASSIGNMENT REFERENCE NO. 202.1
(ATTACHMENT A)

REFERENCE NO. 713, Respiratory Care Practitioner Staffed Specialty Care Transport Unit Inventory

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee			
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee	06/19/2019 08/21/2019	Tabled Approved	N
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

*See Ref. No. 202.2, **Policy Review - Summary of Comments**

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

August 28, 2019

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.

Name
Chief Executive Officer
Hospital Name
Address
City

RE: AMBULANCE PATIENT OFFLOAD TIME REPORT

Dear Mr. XXX,

This letter is regarding your hospital's performance related to Ambulance Patient Offload Time (APOT). The Emergency Medical Services (EMS) Agency has developed a mechanism to track system-wide APOT as required by State Assembly Bill (AB) 1223 that passed in 2015. Based on our review of the data, your facility is not meeting the consensus APOT standard for Los Angeles County, which is 90% of all 9-1-1 emergency ambulance transports have an APOT of 30 minutes or less. This means that patients should be moved to hospital equipment and the care of the patient should be assumed by the emergency department personnel within 30 minutes or less of their arrival 90% of the time.

APOT has been a long-standing issue for the EMS providers throughout the State. The fact that an assembly bill was introduced and passed signifies the desire to correct the problem through legislative efforts. I am concerned that if the problem is not addressed locally through the efforts of hospital leadership, further legislation with significant consequences will be introduced.

The EMS Agency has been working with hospitals and EMS ambulance providers over the past three years to implement an APOT tracking system. An initial letter introducing APOT monitoring and performance was sent on February 5, 2019, to your emergency department leadership to introduce them to APOT. This letter acknowledged that there were gaps in the data collection and concerns about the data accuracy. The EMS Agency now feels confident with the accuracy of the data to share the APOT results with you, the hospital Chief Executive Officer.

<u>Background</u>

AB 1223 defined APOT and directed the California EMS Authority to develop a standard methodology to measure and report APOT statewide.

- APOT is the time interval between the time the patient arrives at the receiving hospital at the location outside the hospital ED where the patient will be unloaded from the ambulance to the time the patient is transferred to the ED gurney, bed, chair or other acceptable location and the emergency department assumes the responsibility for care of the patient.
- APOT time interval is measured in minutes and seconds then aggregated and reported at the 90th percentile.

In response to this Bill, the EMS Agency, at the direction of the EMS Commission, created an APOT workgroup with representatives from hospital leadership, EMS providers, EMS Commissioners, and the Hospital Association of Southern

California. This workgroup determined the APOT standard for Los Angeles County.

Attached is the APOT Report for the second quarter of 2019. The report is organized by geographic region. Certain regions of the County have collectively longer APOT, as well as, individual hospitals having prolonged APOT. The EMS Agency will be coordinating regional meetings of the hospitals in these geographic areas to address prolonged APOT and will start meeting with individual hospitals with prolonged APOT.

The EMS Agency is striving to work collaboratively with our hospital partners to improve and decrease APOT, in order to release the ambulance personnel so that they are available for the next 9-1-1 call. Please contact Richard Tadeo, Assistant Director at rtadeo@dhs.lacounty.gov or (562) 378-1610 for any questions.

Sincerely,

Cathy Chidester
Director

Attachment

c: Director, DHS
EMS Commission
Hospital Association of Southern California
Emergency Department Director, XXX Hospital

List of Hospitals that received the above letter (those with <90% APOT within 30 minutes):

Adventist Health White Memorial
Antelope Valley Hospital
Beverly Hospital
Coast Plaza Doctors Hospital
College Medical Center
Community Hospital of Huntington Park
Dignity Health – St. Mary Medical Center
East Los Angeles Doctors Hospital
Emanate Health Inter-Community Campus
Emanate Health Queen of the Valley Hospital
Emanate Health Foothill Presbyterian Hospital
Greater El Monte Community Hospital
Kaiser Foundation Baldwin Park
Kaiser Foundation Downey
Kaiser Foundation South Bay
Lakewood Regional Medical Center
Long Beach Memorial Medical Center
Los Angeles Community Hospital at Norwalk
Methodist Hospital of Southern California
Palmdale Regional Medical Center
PIH Health – Whittier
PIH Health – Downey
Pomona Valley Hospital Medical Center
Providence St. Joseph Medical Center
San Dimas Community Hospital
St. Francis Medical Center
Whittier Hospital Medical Center

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY 9-1-1 RECEIVING HOSPITAL

Time Period April 1, 2019 through June 30, 2019

APOT Standard: within 30 minutes, 90% of the time

HOSPITAL	Q2 2019													
	<21 mins		21-30 mins		31-40 mins		41-50 mins		51-60 mins		61-120 mins		>120 mins	
ANTELOPE VALLEY - NEWHALL REGION														
Antelope Valley Hospital	2,167	***46%***	1,052	***22%***	558	12%	258	6%	158	3%	376	***8%***	162	***3%***
Palmdale Regional Medical Center	742	***33%***	433	***20%***	260	12%	166	8%	101	5%	338	***15%***	180	***8%***
Henry Mayo Newhall Hospital	1,468	82%	208	12%	75	4%	30	2%	12	7%	9	5%		
SAN FERNANDO VALLEY REGION														
Dignity Health-Northridge Hospital Medical Center*	20	87%	1	4%	1	4%	1	4%						
West Hills Hospital and Medical Center*	2	50%	1	25%			1	25%						
Kaiser Foundation - Woodland Hills*														
Encino Hospital Medical Center*														
Providence Tarzana Medical Center*														
LAC Olive Medical Center*	5	83%	1	17%										
Pacifica Hospital of the Valley*	1	100%												
Kaiser Foundation - Panorama City*											1	100%		
Providence Holy Cross Medical Center*	19	86%	2	9%	1	5%								
Mission Community Hospital*														
Valley Presbyterian Hospital*														
Sherman Oaks Hospital*														
Providence Saint Joseph Medical Center	933	***76%***	152	***12%***	75	6%	35	3%	18	2%	10	2%		
Adventist Health Glendale	1,432	91%	86	6%	29	2%	15	1%	8	0.5%	7	0.4%		
Dignity Health-Glendale Memorial Hospital and Health Center	768	95%	20	3%	14	2%	4	0.5%	1	0.1%	1	0.1%		
USC Verdugo Hills Medical Center	491	91%	30	6%	6	1%	4	0.7%	2	0.4%	4	0.7%		
SAN GABRIEL VALLEY REGION														
Huntington Hospital	2,570	90%	137	5%	64	2%	23	0.8%	22	0.8%	31	1%	4	0.1%
Alhambra Hospital	332	98%	6	2%	1	0.3%								
San Gabriel Valley Medical Center	613	85%	49	7%	20	3%	13	2%	8	1%	12	2%	6	0.8%
Methodist Hospital of Southern California	1,642	***75%***	214	***10%***	115	5%	67	3%	47	2%	99	5%	14	0.6%
Greater El Monte Community Hospital	654	***67%***	127	***13%***	58	6%	32	3%	37	4%	50	5%	12	1%
Garfield Medical Center	592	94%	13	2%	12	2%	7	1%	2	0.3%	4	0.6%		
Monterey Park Hospital	294	89%	16	5%	6	2%	5	2%	5	2%	3	0.9%		
Kaiser Foundation - Baldwin Park	527	***59%***	165	***18%***	69	8%	43	5%	23	3%	53	6%	16	2%

*** No data from Los Angeles Fire Department**

**** No data from McCormick Ambulance**

% total may not equal 100% due to rounding.

Data source: LA TEMIS EMS Fire-Rescue 8-26-2019

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY 9-1-1 RECEIVING HOSPITAL

Time Period April 1, 2019 through June 30, 2019

APOT Standard: within 30 minutes, 90% of the time

HOSPITAL	Q2 2019													
	<21 mins		21-30 mins		31-40 mins		41-50 mins		51-60 mins		61-120 mins		>120 mins	
Emanate Health Inter-Community Campus	1,013	*73%*	191	*14%*	80	6%	37	3%	19	1%	48	3%	8	0.6%
Emanate Health Queen of the Valley Hospital	1,215	*63%*	239	*12%*	140	7%	93	5%	53	3%	142	7%	44	2%
Emanate Health Foothill Prebyterian Hospital	682	*68%*	134	*13%*	59	6%	33	3%	20	2%	72	7%	10	1%
San Dimas Community Hospital	356	83%	43	10%	11	3%	8	2%	3	0.7%	5	1%	1	0.2%
Pomona Valley Hospital Medical Center	2,167	*62%*	587	*17%*	324	9%	168	5%	83	2%	129	4%	20	0.6%
EAST REGION														
Beverly Hospital	527	*55%*	148	*16%*	89	9%	61	6%	35	4%	71	*7%*	24	*3%*
Whittier Hospital Medical Center	518	*67%*	92	*12%*	58	8%	39	5%	24	3%	34	*4%*	10	*1%*
PIH Health - Whittier	834	*42%*	319	*16%*	234	12%	168	8%	89	5%	243	*12%*	407	*5%*
PIH Health- Downey	797	*62%*	166	*13%*	82	6%	61	5%	39	3%	119	*9%*	25	*2%*
Kaiser Foundation - Downey	803	*59%*	229	*17%*	87	6%	58	4%	46	3%	101	*7%*	33	*2%*
Los Angeles Community Hospital at Norwalk	167	*65%*	28	*11%*	18	7%	17	7%	9	4%	12	*5%*	7	*3%*
Coast Plaza Doctors Hospital	418	*69%*	64	*11%*	33	6%	20	3%	14	2%	39	*7%*	14	*2%*
Lakewood Regional Medical Center	629	*49%*	187	*15%*	99	8%	70	5%	76	6%	172	*13%*	26	*4%*
METRO REGION														
Dignity Health-California Hospital Medical Center*														
Good Samaritan Hospital*	5	83%	1	17%										
St. Vincent Medical Center*														
Adventist Health White Memorial*	281	*73%*	50	*13%*	22	6%	16	4%	5	1%	10	3%		
Community Hospital of Huntington Park	691	*51%*	234	*17%*	155	12%	96	7%	62	5%	93	*7%*	17	*1%*
East Los Angeles Doctors Hospital	512	*75%*	84	*12%*	35	5%	29	4%	12	2%	9	1%	1	0.2%
LAC+USC Medical Center*	495	84%	49	8%	13	2%	17	3%	7	1%	11	2%	1	0.2%
Children's Hospital Los Angeles*	40	98%	1	2%										
Hollywood Presbyterian Medical Center*	1	100%												
Kaiser Foundation - Los Angeles*	1	100%												
Olympia Medical Center*	13	100%												
Cedars Sinai Medical Center*	506	87%	52	9%	13	2%	8	1%	1	0.2%	2	0.3%		
WEST REGION														
Southern California Hospital at Culver City	237	88%	29	11%			4	2%			1	0.4%		
Kaiser Foundation - West Los Angeles*	113	81%	18	13%	4	3%	1	0.7%	1	0.7%	2	1%		

*** No data from Los Angeles Fire Department**

**** No data from McCormick Ambulance**

% total may not equal 100% due to rounding.

Data source: LA TEMIS EMS Fire-Rescue 8-26-2019

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY 9-1-1 RECEIVING HOSPITAL

Time Period April 1, 2019 through June 30, 2019

APOT Standard: within 30 minutes, 90% of the time

HOSPITAL	Q2 2019													
	<21 mins		21-30 mins		31-40 mins		41-50 mins		51-60 mins		61-120 mins		>120 mins	
Cedars Sinai Marina Del Rey Hospital	290	81%	33	9%	10	3%	9	3%	6	2%	9	3%		
Providence Saint John's Health Center	226	95%	5	2%	1	0.4%	1	0.4%	2	0.8%	3	1%		
Santa Monica - UCLA Medical Center	389	96%	7	2%	4	1%	1	0.3%	3	0.7%	3	0.7%		
Ronald Reagan UCLA Medical Center*	158	90%	12	7%	2	1%	1	0.6%			1	0.6%	1	0.6%
SOUTH REGION														
Centinela Hospital Medical Center**	14	67%	6	29%										
Memorial Hospital of Gardena**	181	99%	2	1%										
Martin Luther King, Jr. Community Hospital	535	90%	28	5%	12	2%	7	1%	2	0.3%	11	2%	1	0.2%
St. Francis Medical Center	843	***62%***	139	***10%***	98	7%	56	4%	46	3%	127	***9%***	53	***4%***
LAC Harbor-UCLA Medical Center**	139	95%	5	3%	2	1%					1	0.7%		
Kaiser Foundation - South Bay**	71	***76%***	8	***9%***	4	4%	4	4%	2	2%	3	3%	1	1%
Torrance Memorial Medical Center	282	94%	9	3%	6	2%	1	0.3%	1	0.3%	1	0.3%		
Providence Little Company of Mary Medical Center - Torrance	493	89%	32	6%	14	3%	7	1%	2	0.4%	7	1%		
Providence Little Company of Mary Medical Center - San Pedro*														
College Medical Center	707	***72%***	129	***13%***	62	6%	33	3%	15	2%	34	3%	7	0.7%
Dignity Health-St. Mary Medical Center	1,872	***75%***	266	***11%***	122	5%	76	3%	58	2%	86	4%	15	0.6%
Long Beach Memorial Medical Center	1,478	***74%***	155	***8%***	79	4%	73	4%	31	2%	129	***6%***	57	***3%***
Catalina Island Medical Center	1	***50%***	1	***50%***										
ALL HOSPITALS	**37,301**	***68%***	**6,725**	***12%***	**3,463**	**6%**	**2,050**	**4%**	**1,260**	**2%**	**2,827**	**5%**	**922**	**2%**

*** No data from Los Angeles Fire Department**

**** No data from McCormick Ambulance**

% total may not equal 100% due to rounding.

Data source: LA TEMIS EMS Fire-Rescue 8-26-2019

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION
10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
(562) 378-1606 FAX (562) 941-5835
http://ems.dhs.lacounty.gov/

BYLAWS

Article I. General Commission Description

A. The Emergency Medical Services Commission (EMSC) acts in an advisory capacity to the Board of Supervisors and the Department of Health Services under County Ordinance Chapter 3.20.

B. The Chairperson shall have general supervision of all matters pertaining to the EMSC.

C. A Commissioner shall not take any action on behalf of, or in the name of, the EMSC unless specifically authorized to do so by the EMSC.

D. All EMSC meetings shall be open to the public. This policy shall be stated on all agendas.

E. EMSC agendas shall be posted ten calendar days in advance of the meeting.

Article II. Officers

The Officers shall consist of a Chair and a Vice Chair to be elected by the EMSC at its January meeting. Officers shall serve a term of one year or until their successors are elected. No EMSC member may serve more than two full terms in succession in the same office.

Article III. Election and Replacement of Officers

A. Election of Officers:

1. At the November meeting, the Chair shall appoint three Commissioners to be a Nominating Committee, subject to the approval of the EMSC.

2. At the January meeting, the Nominating Committee shall present a slate of candidates for the offices of Chair and Vice Char. Additional nominations may be made from the floor if the nominee agrees to serve.

3. An election shall be conducted at the January meeting. If there is only one nominee for an office, the Chair can declare that the nominee is elected; otherwise, election shall be by majority vote of the Commission.

B. Replacement of Officers

1. If, for any reason, the Chair is unable to complete their term of office, the Vice Chair becomes Chair for the remainder of the term.

2. If, for any reason, the Vice Chair is unable to complete their term of office, a new Vice Chair shall be chosen immediately as follows:

   a. The Chair shall appoint three commissioners to be a Nominating Committee, subject to the approval of the EMSC.

   b. The Nominating Committee shall present a slate of candidates for the office of Vice Chair at the first regular meeting following their appointment.

   c. Additional nominations may be made and the election shall be conducted in compliance with Article III, A, Sections 3 and 4 of these Bylaws.

   d. If neither the Chair nor Vice Chair is able to preside at any EMSC meeting, the following committee chairs shall serve as Chair Pro Tempore in the order listed:

      i. Chair, Provider Agency Advisory Committee
      ii. Chair, Base Hospital Advisory Committee
      iii. Chair, Data Advisory Committee
      iv. Chair, Education Advisory Committee

Article IV. Duties of Officers

A. The Chair shall:

1. Preside at all meetings of the EMSC.
2. Rule on all points of order.
3. Appoint the chair of each committee.
4. Be an ex-officio member of all committees.
5. Represent the EMSC at public functions or appoint an EMSC member to do so on their behalf.
6. Approve of all ministerial EMSC matters.
7. Sign all official documents.
8. Ensure that minutes are maintained.

B. The Vice Chair shall:

1. Perform the duties of the Chair in their absence.
2. Perform other duties as assigned to them by the Chair or the EMSC.

Article V. Committees

To facilitate operations and assure thorough coverage of EMSC duties and responsibilities, the EMSC structure shall include the following standing committees:

A. Standing Committees

1. Provider Agency Advisory Committee

This committee is responsible for all matters regarding prehospital licensure, certification and accreditation, policy development pertinent to the practice, operation and administration of prehospital care and the educational components associated with the delivery of prehospital care.

a. Chaired by an EMS Commissioner.
b. Two or more EMS Commissioners.
c. One representative from each major department and public geographic region:
   i. Area A - Western Region
   ii. Area B - Los Angeles County Fire Department
   iii. Area C - Northern Region
   iv. Area E - Southeast Region
   v. Area F - Long Beach Fire Department
   vi. Area G - South Bay Region
   vii. Area H - Los Angeles Fire Department
d. One currently employed paramedic coordinator, selected by the Los Angeles County Ambulance Association (LACAA).
e. One prehospital care coordinator selected by the Base Hospital Advisory Committee.
f. One public sector paramedic routinely assigned to an Advanced Life Support (ALS) Unit, selected by the Los Angeles Area Fire Chiefs Association (LAAFCA).
g. One private sector paramedic routinely assigned to an ALS Unit selected by the LACAA.
h. One provider agency medical director selected by the Medical Council.
i. One program director from an approved Paramedic Training program selected by the EMS Agency.
j. One program director from an approved EMT Training program selected by the EMS Agency.

2. Base Hospital Advisory Committee

This committee is responsible for all matters regarding MICN certification and policy development pertinent to the practice, operation and administration of prehospital care.

a. Chaired by an EMS Commissioner.

b. Two or more EMS Commissioners.

c. Two currently employed base hospital prehospital care coordinators from each of the major geographic regions.

   i. Northern Region
   ii. Southern Region
   iii. Western Region
   iv. Eastern Region
   v. County Region

d. One provider agency representative selected by the Provider Agency Advisory Committee.

e. One base hospital medical director selected by the Medical Council.

f. One currently employed MICN selected by the Association of Prehospital Care Coordinators (APCC).

3. Data Advisory Committee

This committee is responsible for all matters regarding quality of prehospital data, report generation, prehospital research and policy development impacting TEMIS.

a. Chaired by an EMS Commissioner

b. Two or more EMS Commissioners.

c. One base hospital administrator or assistant administrator, or a non-administrator duly authorized to represent a base hospital administrator/assistant administrator selected by the Hospital Association of Southern California (HASC).

d. One public sector paramedic provider representative selected by the Provider Agency Advisory Committee.

e. One public sector paramedic provider representative selected by the Los Angeles County Fire Department.

f. One public sector paramedic provider representative from the Los Angeles Fire Department.

g. One public sector paramedic provider representative from the Long Beach Fire Department.

h. One private sector paramedic provider representative selected by the LACAA.

i. One prehospital care coordinator selected by the Base Hospital Advisory Committee.

j. A trauma program manager and one physician selected by the Trauma Hospital Advisory Committee.

k. One base hospital medical director selected by the Medical Council.

l. One fire chief selected by the LAAFCA.

B. Scope and Responsibilities of Standing Committees

1. Standing committees shall review, evaluate and make recommendations on issues relating to emergency medical services as referred to them by the Commission or on their own initiative. No action undertaken by any committee shall be deemed official unless and until it has been approved by the Commission.

2. The Chair, with the consent of the EMSC, may assign any matter to more than one committee, and those committees may function jointly with respect to that specific matter.

C. Officers and Composition of Standing Committees

1. The chair of each standing committee shall be a commissioner appointed by the EMSC Chair.

2. The term of each standing committee chair shall be one year. No chair shall serve more than two consecutive terms.

3. At least two commissioners shall serve on each standing committee.

4. No individual shall serve on more than two standing committees.

5. Each standing committee member may have an alternate except for the Base Hospital Advisory Committee, which has one alternate member per region. The alternate member votes or brings motions only when the regular member is not present.

D. Activity Requirements

1. Committees will be responsible for their own activities, including the location and frequency of meetings, designation of alternate chairs, and formation and composition of subcommittees, if desired. Generally, the committees meet during alternate months from the EMSC.

   a. Minutes of committee meetings shall be maintained and distributed to all commissioners ten calendar days before the regular EMSC meeting.

   b. At the EMSC's May meeting, each standing committee will submit its plans, priorities and activities for the year.

   c. At the EMSC's July meeting, each standing committee will submit a report of the activities, findings and recommendations related to its goals.

E. Special Committees

1. A special committee may be appointed at the discretion of the EMSC Chair only if the following conditions are met:

   a. The task will be short term.

   b. The assignment falls outside the scope of the standing committees.

2. The special committee chair will be appointed by the EMSC Chair with the approval of the EMSC.

3. The EMSC Chair will determine the composition of the Special Committee in consultation with the Special Committee Chair. The Special Committee may include non-Commission members.

4. Special committees will be responsible for their own activities including location and frequency of meetings, designation of an alternate chair, and formation and composition of the subcommittees, if desired. Minutes of committee meetings will be written promptly and distributed to all EMSC members in a time frame determined by the EMSC.

Article VI. Meetings

A. Regular meetings of the EMSC shall be held at 1:00 P.M. on the third Wednesday of each odd month. If any regular meeting falls on a holiday, the regular meeting shall be held one week later.

B. A quorum is required for any official business, including regular and special meetings. A quorum shall consist of a majority of the sworn commissioners. Five commissioners constitute a quorum when the EMSC is hearing a matter under its arbitration function, as described in County Code Chapter 3.20, Section 3.20.070, Subsection 9.

C. Special EMSC meetings may be held on call of the Chair or any five members of the EMSC. The call shall be by telephone notice to all EMSC members not less than three days prior to the date set for the meeting. The telephone notice must specifically set forth the subject matter of the meeting, and no other subject matter may be considered at the meeting.

D Executive sessions will be in accordance with provisions found in the State and local laws that govern such sessions.

E. Unless the voting on a motion is unanimous, the Secretary shall conduct a roll call vote.

F. Unless otherwise prescribed by these Bylaws, all EMSC meetings and all committee meetings shall be governed by Robert's Rules of Order, Revised.

Article VII. Amendments

These Bylaws may be amended by a three-fourths (3/4) vote of the sworn members of the EMSC if notice of intention to amend the Bylaws, setting forth the proposed amendments, has been sent to each member of the EMSC not less than ten days before the date set for consideration of the amendments.

Adopted by the Commission 7/15/81

Amended: 3/17/82; 2/16/83; 2/15/84; 1/16/85; 3/19/86; 10/15/86; 4/18/90; 3/17/93; 7/17/96; 11/17/99; 5/19/04; 7/20/05; 11/17/10, 9/18/19