Cathy Chidester
Executive Director
(562) 378-1604
CChidester@dhs.lacounty.gov

Denise Watson
Commission Liaison
(562) 378-1606
DWatson@dhs.lacounty.gov

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
(562) 378-1604 FAX (562) 941-5835
http://ems.dhs.lacounty.gov/

DATE: **November 20, 2019**
TIME: **1:00 – 3:00 PM**
LOCATION: **Los Angeles County Emergency Medical Services Agency**
10100 Pioneer Boulevard, EMSC Hearing Room – 1st Floor
Santa Fe Springs, CA 90670

The Commission meetings are open to the public. You may address the Commission on any agenda item before or during consideration of that item, and on other items of interest which are not on the agenda, but which are within the subject matter jurisdiction of the Commission. Public comment is limited to three (3) minutes and may be extended by Commission Chair as time permits.

NOTE: Please SIGN IN if you would like to address the Commission.

AGENDA

I. CALL TO ORDER – John Hisserich, Dr.PH., Chairman

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS
Jonathan Sherin, MD, PhD, Director, Los Angeles County Department of Mental Health

Stephen Sanko,MD, Assistant Medical Director, Los Angeles Fire Department Sobering Center/Psychiatric Urgent Care Center Pilot Project

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

1. MINUTES
September 18, 2019

2. CORRESPONDENCE
2.1 (10-01-2019) Clayton Kazan, MD: Approval to Implement an Advance Provider Response Unit Pilot Project
2.2 (10-07-2019) Jonathan E. Sherin, MD, PhD: Letter of Support for Suicidal Calls to 9-1-1 Diversion Project

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

4. POLICIES
4.1 Reference No. 316: Emergency Department Approved for Pediatric (EDAP) Standards
4.2 Reference No. 318: Pediatric Medical Center (PMC) Standards
4.3 Reference No. 324: Sexual Assault Response Team (SART) Center Standards
4.4 Reference No. 510: Pediatric Patient Destination
4.5 Reference No. 832: Treatment/Transport of Minors
4.6 Reference No. 901: Paramedic Training Program Approval
4.7 Reference No. 1350: Medical Control Guideline: Pediatric Patients

END OF CONSENT AGENDA

IV. BUSINESS

BUSINESS (OLD)

5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies
5.2 Ambulance Patient Offload Time (APOT)
5.3 Body Worn Cameras and Other HIPAA-Related Concerns
5.4 Criteria for 9-1-1 Receiving Center Designation

BUSINESS (NEW)

5.5 EMS Commission Annual Report for Fiscal Year 2018-19
5.6 Nominating Committee
5.7 Standing Committee Selections

V. COMMISSIONERS COMMENTS/REQUESTS

VI. LEGISLATION

VII. EMS DIRECTOR'S REPORT

VIII. ADJOURNMENT

To the meeting of January 15, 2020

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.

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
(562) 378-1604 FAX (562) 941-5835
http://ems.dhs.lacounty.gov/

MINUTES
SEPTEMBER 18, 2019

COMMISSIONERS	ORGANIZATION	EMS AGENCY STAFF	POSITION
☒ Ellen Alkon, M.D.	So. CA Public Health Assn.	Kay Fruhwirth	Assistant 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.	Marianne Gausche-Hill	Medical Director
☐ *Chief Eugene Harris	LAC Police Chiefs' Assn.	Nichole Bosson	Asst. Medical Director
☒ John Hisserich, Dr.PH	Public Member, 3rd District	Roel Amara	Assistant Director
☒ Lydia Lam, M.D.	So. CA Chapter American College of Surgeons	Christy Preston	EMS Staff
☐ (Ab) James Lott, MBA	Public Member, 2nd District	Gary Watson	EMS Staff
☒ Robert Ower	LAC Ambulance Association	David Wells	EMS Staff
☒ Margaret Peterson, PhD	Hospital Assn. of So. CA	Jacqui Rifenburg	EMS Staff
☒ Paul S. Rodriguez	CA State Firefighters' Assn.	Natalie Greco	EMS Staff
☐ *Joseph Salas	Public Member, 1st District	Adrian Romero	EMS Staff
☒ Nerses Sanossian, M.D.	American Heart Association	Elaine Forsyth	EMS Staff
☐ *Carole Snyder	Emergency Nurses Assn.		
☐ *Diana Tang	League of CA Cities/LAC	Chris Clare	EMS Staff
☐ *Atilla Uner, M.D.	American College of Emergency Physicians	Michelle Williams	EMS Staff
	CAL-ACEP	Lorrie Perez	EMS Staff
☒ Gary Washburn	Public Member, 5th District	Lily Choi	EMS Staff
☒ David White	L.A. Area Fire Chiefs' Assn.	John Telmos	EMS Staff
☐ *Pajmon Zarrineghbal	Public Member, 4th District		

GUESTS

Dr. Dawn Terashita	LACo Public Health Dept	Brenda Bridwell	Long Beach Fire Dept
Samantha Verga-Gates	APCC	Richard Roman	Compton Fire Dept
Matthew Conroy	L.A. Fire Dept	Christina Eclarino	LACo Public Health / EMS Agency

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

I. CALL TO ORDER:

The Emergency Medical Services Commission (EMSC) meeting was held in the EMSC Hearing Room at 10100 Pioneer Boulevard, Santa Fe Springs, CA 90670. The meeting was called to order at 1:00 p.m. by Chairman John Hisserich. A quorum was present with 12 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.

Dawn Terashita, M.D., Los Angeles County Department of Public Health, gave a presentation providing an overview and background on the August 30, 2019, Official Influenza Vaccination Order. The Order mandates that healthcare providers, including EMS providers, with patient contact be vaccinated annually or wear a mask during flu season, November 1 through April 30. The goal is a 90% vaccination rate.

III. CONSENT AGENDA:

Chairman John Hisserich, Dr.PH., called for approval of the Consent Agenda.

Motion/Second by Commissioners White/Sanossian to approve the Consent Agenda was carried unanimously except for Policy item 4.1, which was deferred until Business item 5.6 was discussed pertaining to Bylaws and Committees. Motion/Second by Commissioners White/Bixler to hold the vote on Policy item 4.1 until after Business item 5.6 was discussed was carried unanimously. After discussion on Business item 5.6, Motion/Second by Commissioners Ower/Cheung to approve the entire Consent Agenda including item 4.1 was approved unanimously.

1. MINUTES

July 17, 2019 Minutes were approved.

2. CORRESPONDENCE

2.1 Trauma System Annual Reports for the Year 2018
2.2 EMT Local Optional Scope Program Approval
2.3 Public Safety Naloxone Program Approval
2.4 King LTS(D) Airway Program Approval for Specialty Care Transport
2.5 Autopulse™ Approval
2.6 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 Re-supply 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**
Kay Fruhwirth, EMS Assistant Director sitting in for Executive Director Cathy Chidester, reported that DMH convened a workgroup to look at the acute care and outpatient mental health resources needed and available throughout the County. They are working on a report on their findings and this report will be shared with the Commission as soon as it is officially released and available.

5.2 **Ad Hoc Committee (Wall Time/Diversion)**
Richard Tadeo, EMS Agency Assistant Director, discussed the Wall Time/Diversion report and a letter from EMS Agency Director Cathy Chidester to 27 hospital CEOs advising them of their ambulance patient offload time (APOT). A meeting was held in May 2019 to look at hospital compliance with good performers and poor performers, and to look at best practices. Subsequently, the EMS Agency started receiving data from Care Ambulance and AMR, which is close to about two-thirds of Los Angeles County Fire Department's (LACoFD) volume. Los Angeles City Fire's (LAFD) data was not included in the report.

5.3 **Updates from Physio-Control/Stryker on the ePCR**
Mr. Tadeo reported LAFD's electronic patient care reporting (ePCR) data is current through June 2018, and LACoFD's ePCR data is current through February 2019.

5.4 **Body Worn Cameras and HIPAA-Related Concerns**
Ms. Fruhwirth reported that Commissioner Dave White worked on a survey that was sent out to the fire chiefs regarding police body-worn cameras. There was previous discussion about police video recording during patient-care events, and what, if any, was the impact related to HIPAA. It was determined that law enforcement agencies are not covered entities, and therefore not governed by HIPAA.

The results of the survey sent out to the fire chiefs indicated that 66% felt it was a local issue between the local fire department and the local police department, and 33% thought it was a Countywide issue, although the County has no legal jurisdiction over HIPAA which is a federal regulation.

Mr. Rex Pritchard from the local union in Long Beach was not present, but reportedly sent a survey out to the unions for the different fire departments to gather input from the frontline providers related to this issue. Mr. Pritchard's survey results were not available.

5.5 **Glendora Community Hospital – Planned Closure of General Acute Care Services – Public Hearing**
Glendora Community Hospital emergency department is now closed, and all ambulances and patients will be handled by nearby hospital facilities.

BUSINESS (NEW)

5.6 **Approval of Bylaws and Specific Committees**
Ms. Fruhwirth reported on a July EMSC Motion to approve revising the Bylaws to eliminate the Education Advisory Committee, add two members to the Provider Agency Advisory Committee (PAAC), add education as one of the areas of

responsibility to the PAAC, and to bring those revisions to the Commission for review and approval or to make any recommendations or amendments.
Motion/Second by Commissioners Ower/Cheung to approve the modified Bylaws and Specific Committees was carried unanimously.

5.7 **Letter of Support for Suicidal Calls to 9-1-1 Diversion Project**
Commissioner Brian Bixler reported on a meeting between the Los Angeles Police Department (LAPD) and Didi Hirsch from the Department of Mental Health (DMH), that was held in August 2019 to establish a pilot program by which calls coming into LAPD's 9-1-1 Call Center that are suicidal in nature can be diverted to Didi Hirsch's suicide hotline instead of dispatching a police officer to the scene. Currently, 9-1-1 calls in the City of Los Angeles are handled by police dispatchers. If there is a medical complaint, LAPD refers the call to LAFD.

The Department of Mental Health is working with Didi Hirsch to determine a funding source for this program. Since Didi Hirsch is a direct service provider through the Department of Mental Health, this will require a renegotiation of their contract. Because there is some negotiation required, LAPD is asking for a letter of support for this program from the EMS Commission. This would reduce the amount of police response to persons who are suicidal without any public danger.

As part of this pilot project, LAPD will also develop policies and procedures together with their steering committee comprised of staff from LAPD, DMH, and Didi Hirsch. Included in the policy and procedures will be a direct line back to LAPD with no waiting if the counselor determines the need for police resource or other resource.

Commissioner Erick Cheung reiterated the request for the EMS Commission to write a letter in support of a pilot project to be funded by DMH, or any other reasonable entity for this project.

Motion/Second by Commissioners Bixler/Cheung to approve a Letter of Support for Suicidal Calls to 9-1-1 Diversion Project was carried unanimously.

5.8 **Additional Criteria for 9-1-1 Receiving Center Designation**
This item was tabled until the November EMS Commission meeting.

Motion/Second by Commissioners Ower/Yoonessi-Martin for item 5.8 to be tabled until the November EMS Commission meeting was carried unanimously.

COMMISSIONERS' COMMENTS/REQUESTS:
None.

VI. LEGISLATION:
Ms. Fruhwirth gave the legislative report:

Most of the bills the Emergency Medical Services Administrators Association (EMSAAC) and the EMS Commission have been watching have turned into two-year bills.

Two bills were passed and signed by Governor Gavin Newsom:

AB 1 - Requires an EMT, paramedic or physician be onsite during all youth football practices and football games.

The other bill that was signed by the governor requires the addition of dementia and Alzheimer education for paramedics. When regulations get published we can see the impact of whether it increases the hours for the EMT and paramedic programs, or if it is a continuing education training.

AB 1544 – The Gibson Bill – Community Paramedicine and Alternate Destination has been pulled by the author.

Chapter 4 of the paramedic regulations have been out several times for public comment. The EMS Authority had added language related to the ability to transport to alternate destinations such as psychiatric urgent care centers and sobering centers as part of the paramedic regulations. However, last week that addition to those regulations was removed and the regulations are back out for comment. The EMS Authority has a new medical director, Dr. Dave Duncan, as Howard Backer retired in June, and this will provide an opportunity for the new director to review.

VII. DIRECTOR'S REPORT:

Ms. Fruhwirth reported that DMH had a press conference to unveil their own transport vehicles used to dispatch their personnel when a mental health patient is in crisis. They will do the mental health evaluation and can now transport the person in a van-type vehicle. The sheriffs were also at the press conference and unveiled their transport vehicle for mental health patients, which is an unmarked SUV. The Sheriff's Department has approximately 33 vehicles in use to transport mental health patients in crisis.

Dr. Marianne Gausche-Hill reported on data collaboratives with specialty centers to address questions important to the Department of Health Services such as ST elevation MI (STEMI), Trauma, Stroke and Pediatric issues. Many publications that are the result of these collaboratives are listed on the EMS website. The EMS Agency has also submitted our work with the collaborative for presentations at scientific meetings, as well as go through the peer review process.

Dr. Nichole Bosson reported on data analysis done that demonstrates the change in our stroke system from a single-tier to two-tier system, and how access to thrombectomy care increased from approximately 40% coverage in the County to 93% after the implementation of the Comprehensive Stroke System. Additional analysis has been done on that data that was submitted for peer review. One of the concerns with two-tier routing was a potential delay in thrombolysis or decreased thrombolysis for patients because you are increasing their transport time potentially and bypassing a closer hospital that can provide I.V. thrombolytic. Our percent of thrombolysis went up slightly, did not decrease, and the time to thrombolysis went down a little bit.

This is in line with some single center studies that have shown that if you transport to a comprehensive stroke center you gain some time, or reduce your time to administration of the drug in the hospital, and that makes up for the very short change in the increase in transport time. We are looking more deeply at our routing policies. About two years ago, we changed our routing time from six (6) hours from acute stroke to 24 hours from acute stroke. This was based on additional data that came out with trials of Adan and Diffuse which show that in certain stroke patients you can affect a benefit in that 6-to-24-hour range for acute stroke patients to get thrombectomy and benefit from thrombectomy.

Further statistics on those patients receiving thrombectomy was provided, and it was reported that this data will be presented at the International Stroke Conference which is coming to Los Angeles in February 2020.

The EMS Agency is looking at submitting data on our entire system in the CARES registry, which is the Cardiac Arrest Registry for Enhanced Survival, so we will be able to benchmark ourselves against other EMS systems by having our pre-hospital data and in-hospital data part of this registry. Dr. Gausche-Hill stated if each of the communities tracked their data you could see if community efforts, e.g., hands only CPR, have an impact within a community. In most communities, Citizen CPR is done about 30% of the time and we know you are three (3) times more likely to survive if you have citizen CPR.

Dr. Bosson discussed working on the STEMI and Cardiac Arrest Research Consortium and looking at the variability in our system in terms of care at the hospitals stating the desire to reduce variability in care. They looked at targeted temperature management and if the patients went on to get coronary angiography. We are working to identify best practices and making things more uniform in the County.

The EMS Agency is also working toward a Countywide coronary angiography guideline, and developing performance metrics for our hospitals to set specific thresholds to measure quality in our specialty centers.

VIII. ADJOURNMENT:

Adjournment by Chairman Hisserich at 2:15 pm to the next meeting of November 20, 2019.

Next Meeting: **Wednesday, November 20, 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

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

October 1, 2019

Clayton Kazan, MD
Medical Director
Los Angeles County Fire Department
Emergency Medical Services Bureau
1255 Corporate Center, Suite 212
Monterey Park, California 91754

CERTIFIED

Dear Dr. Kazan:

APPROVAL TO IMPLEMENT AN ADVANCE PROVIDER RESPONSE PILOT PROJECT

The Emergency Medical Services (EMS) Agency has reviewed the protocols for the new assessment resource, Advanced Provider Response Unit (APRU), and are in support of the 12-month pilot project. Los Angeles County (CF) Fire Department (CF) is approved to implement the Pilot as of Monday, October 7, 2019.

The two APRU vehicles (AP - 11 and AP - 17) were inspected on September 26, 2019 and both units met the requirements as outlined in Ref. No. 704, Assessment Unit Inventory. Any additional supplies or medications out of the paramedic scope of practice and not included on Ref No. 704, are under the direct control/oversight of the advanced practice provider.

As part of the approval process, CF is required to submit quarterly Pilot project reports to the EMS Agency containing at minimum, the following items:

- Number of patient contacts including diagnosis
- Number of patients where an upgrade to an acute care facility was necessary
- Adverse reactions or complications
- Appropriate statistical evaluation
- Summary of the 48-hour patient follow-up, to include any patients requiring emergency department follow-up or hospital admission

In addition to the above requirements, please report all Sentinel event within 24 hours of occurrence.

Quarterly reports should be addressed to me and are due 30 days after the end of each quarter, with the first report being due January 31, 2020.

Sincerely,

Marianne Gausche-Hill, M.D.
Medical Director

MGH:jt
09-35

c. Fire Chief, Los Angeles County Fire Department
Director, EMS Agency
Deputy Chief, EMS Bureau, Los County Fire Department

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

October 07, 2019

Jonathan E. Sherin, MD, PhD
Director
L.A. County Department of Mental Health
550 South Vermont Avenue
Los Angeles, CA 90020

Dear Dr. Sherin:

This letter is to share the Emergency Medical Services Commission's (EMSC) support of the pilot project between the Los Angeles Police Department and Didi Hirsch Suicide Prevention Center, to develop appropriate 9-1-1 triage protocols and to evaluate the efficacy and safety of routing 9-1-1 calls for suicidal ideation to the Suicide Hotline for risk assessment and intervention.

Background

The EMSC acts in an advisory capacity to the Board of Supervisors and the Director of Health Services regarding County policies, programs and standards for emergency medical care services throughout the County. The EMSC endorsed The *Ad Hoc Committee on Prehospital Care of Mental Health and Substance Abuse Emergencies Final Report* (found at http://file.lacounty.gov/SDSInter/dhs/1006550_EMSCAdHocCommitteeReportNovember2016.pdf), which highlights nine (9) recommendations for change to the mental health/substance abuse field response and disposition by emergency medical services (EMS) and law enforcement.

An important area of focus to improve pre-hospital mental health services relates to 9-1-1 dispatch and triage of mental health and substance abuse (MH/SA) calls. The EMSC in coordination with the Los Angeles County Police Chiefs Association (LAAPCA), conducted a survey in early 2018 to develop a more thorough understanding of the challenges that LA County's law enforcement agencies encounter in dispatching 9-1-1 mental health calls, and responding to mental health emergencies. Additionally, the Commission sought input on potential future solutions that could improve the care of such individuals in crisis.

A key recommendation that emerged from this survey included:

Consider a pilot project to evaluate whether diversion or co-triage of calls related to suicidal ideation (without attempt or risk of imminent harm) to the Suicide Prevention Lifeline is feasible, and whether it would reduce field responses, mental health holds, and emergency department utilization, while increasing referral to appropriate mental health resources.

The Los Angeles County Department of Mental Health's support of this pilot project, both financial and programmatic, will support the important work of the EMSC. Furthermore, the pilot project is a critical first step in potentially reducing the costs and risks of over-utilization of law enforcement to address mental health emergencies, reducing emergency department utilization, and connecting individuals to trained professionals for crisis resolution, evaluation of suicide risk, and referral to appropriate mental health resources.

If you have any questions, please contact Erick Cheung, MD at EHCheung@mednet.ucla.edu or Lieutenant Brian Bixler at Brian.Bixler@lapd.online or 213-996-1349 who are both members of the EMSC and are personally involved in the development of this proposed pilot project.

Sincerely,

John Hisserich, DrPH
Chair EMSC

JH:CC:kf

c: EMS Commissioners

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

EMERGENCY MEDICAL SERVICES
BASE HOSPITAL ADVISORY COMMITTEE

MEETING NOTICE

Date: October 9, 2019
Time: 1:00 P.M.
Location: EMS Headquarters
EMS Commission Hearing Room 1st Floor
10100 Pioneer Blvd.
Santa Fe Springs, CA 90670

The Base Hospital Advisory Committee meetings are open to the public. You may address the Committee on any agenda item before or during consideration of that item, and on other items of interest that are not on the agenda, but are within the subject matter jurisdiction of the Committee.

BASE HOSPITAL ADVISORY COMMITTEE
DARK FOR OCTOBER 9, 2019

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

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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, October 9, 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 OCTOBER 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, October 16, 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.
☐ Michael Kaduce	EMT Training Program
☑ Scott Jaeggi	EMT Training Program, Alt.
☐ Danny Lopez	Paramedic Training Program
☐ Heather Davis	Paramedic Training Program, Alt.

EMS AGENCY STAFF PRESENT	
Denise Whitfield, MD	Richard Tadeo
Natalia Alvarez, MD	Jennifer Calderon
Chris Clare	Elaine Forsyth
Christy Preston	Sara Rasnake
Jacqueline Rifenburg	David Wells
Fritz Bottger	Natalia Greco
Cathlyn Jennings	Susan Mori
Gary Watson	

OTHER ATTENDIES	
Jack Ewell	LA Sheriff's Department
Jennifer Nulty	Torrance FD
Terry Millsaps	LACoFD
Paula LaFarge	LACoFD
Caroline Jack	Beverly Hills FD
Brian Fong, MD	Guardian & MedReach Amb
Jeffrey Tsay	San Marino FD
Tina Crews	LACoFD
Aaron Aumann	University of Antelope Valley
Bill Barrett	University of Antelope Valley
Richard Roman	Compton FD
Brenda Bridwell	Long Beach FD
CJ Bartholomew	Care Ambulance

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 1:02 p.m.

2. INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS

2.1 New Committee Membership Structure *(Paul Rodriguez)*

Due to disbanding of the Educational Advisory Committee, two represented areas have been added to the PAAC structure and the following representatives were introduced:

A. Emergency Medical Technician (EMT) Training Programs
   a. Representative: Michael Kaduce, Center for Prehospital Care/UCLA
   b. Alternate: Scott Jaeggi, Rio Hondo College
B. Paramedic Training Program
   a. Representative: Danny Lopez, Mount San Antonio College
   b. Alternate: Heather Davis, EdD, Center for Prehospital Care/UCLA

3. APPROVAL OF MINUTES (Lara/Leasure) August 21, 2019 minutes were approved as written.

4. REPORTS & UPDATES

4.1 Disaster Services Update *(Elaine Forsyth)*

- The Statewide Medical and Health Exercise is scheduled for November 21, 2019. Scenario: Flood.
- Registration closes on October 31, 2019.
- Providers interested in participating may either contact Elaine Forsyth at eforsyth@dhs.lacounty.gov or Gary Watson at gwatson@dhs.lacounty.gov

4.2 EMS Update 2020 *(Denise Whitfield, MD)*

- Topics include:
  - Pain Management (Use of Ketoralac and future piloting of Ketamine)
  - Capnography
  - Quality Improvement Topics (Provider Impressions, Altered Level of Consciousness, Shock/Hypotension, Weakness and ST Elevation Myocardial Infarction)
- First EMS Update planning meeting scheduled for October 21, 2019.

4.3 Innovation, Technology and Advancement Committee (ITAC) *(Denise Whitfield, MD)*

- First quarterly meeting was held on August 5, 2019.
- Purpose of Committee is to review products and form a recommendation as to whether or not a product can be implemented within the Los Angeles County EMS System.
- A new Reference No., Reference No. 205.1, Innovation, Technology and Advancement Committee (ITAC) Recommendations, will be posted in the Prehospital Care Manual section of the EMS Agency's webpage to list this Committee's recommendation of specific products/innovations.

4.4 Epinephrine Dosage Changes *(Richard Tadeo)*

Reminder to all providers – As of July 2019, maximum dose of Epinephrine during cardiac arrests is 3mg. Further doses require base contact.

5. UNFINISHED BUSINESS

There was no unfinished business

6. NEW BUSINESS

6.1 APOT Report *(Richard Tadeo)*

- Ambulance Patient Offload Time (APOT) taskforce has met and formed the APOT definition: *Time when the transporting unit parks vehicle at the receiving hospital's unloading area and the time when patient is transferred to hospital equipment (wheelchair, chair or gurney)*
- APOT Report (April 1, 2019 through June 30, 2019), was reviewed and discussed.
- Future plan is to meet with area hospitals to address best practices.

6.2 Reference No. 901, Paramedic Training Program Approval *(Jacqueline Rifenburg)*

Policy reviewed and approved as written.

M/S/C (Conroy/Leasure) Approve Reference No. 901, Paramedic Training Program Approval

7. OPEN DISCUSSION:

7.1 2019 Mission: Lifeline EMS Recognition *(Richard Tadeo)*

At the recent desert retreat with Los Angeles Areas Fire Chief Association, the EMS Agency presented American Heart Association awards to all providers.

The Gold Plus, 2019 Lifeline EMS Recognition Award, recognizes Los Angeles County as a system and met the following specific metrics:

- 75% (or greater) of the patients with non-traumatic chest pain (age greater than 35 years), received a 12-lead electrocardiogram (ECG)
- 75% (or greater) hospitals received notification via the transmission of 12-lead ECG of patients with STEMI alert
- 75% (or greater) of the patients with STEMI, were transported directly to a STEMI-receiving facility.

Providers who were not at this Retreat may contact Gary Watson to obtain their plaques.

7.2 STEMI Feedback Forms *(Richard Tadeo)*

With the assistance from Los Angeles Fire Department (LAFD) and Los Angeles County Fire Department (LACoFD), forms were created that allow hospitals to provide direct feedback to the transporting providers on all STEMI patients.

The "STEMI Follow-Up Form" is now available on the EMS Agency's webpage for receiving hospitals to complete.

The "Cognito Forms" for both LAFD and LACoFD are also posted below the STEMI Follow-Up Form.

7.3 Safely Surrendered Baby Kit – Order Forms *(Gary Watson)*

Safe Surrender kits and training material can be ordered through the California Department of Social Services webpage: https://www.cdss.ca.gov/inforesources/Safely-Surrendered-Baby

8. NEXT MEETING: December 18, 2019

9. ADJOURNMENT: Meeting adjourned at 1:30 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EMERGENCY DEPARTMENT APPROVED FOR PEDIATRIC (EDAP) STANDARDS**

REFERENCE NO. 316

PURPOSE: To establish minimum standards for the designation of Emergency Departments Approved for Pediatrics (EDAP). These Emergency Departments (ED) 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.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 14

DEFINITIONS:

Board Certified (BC): Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialties (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.

Department of Children and Family Services (DCFS): A mandated component of Emergency Response Services, administered by the Los Angeles County Department of Children and Family Services. The Child Protection Hotline (CPH) intake evaluation staff is responsible for assessing any referral, whether verbal or written, which alleges child abuse, neglect or exploitation to determine whether an in-person investigation and consultation is required.

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.

EDAP Medical Director: A qualified specialist in Emergency Medicine (EM) or Pediatric Emergency Medicine (PEM), also referred to as the Physician Pediatric Emergency Care Coordinator.

Emergency Nursing Pediatric Course (ENPC): Two-day course developed by the Emergency Nurses Association (ENA) that provides core-level pediatric knowledge and psychomotor skills needed to care for pediatric patients in the emergency care setting.

Designated Pediatric Consultant: a qualified specialist in pediatrics and/or pediatric subspecialty

Pediatric Advanced Life Support (PALS): Pediatric resuscitation course that is recognized by the EMS Agency and valid for two years (e.g., American Heart Association, American Red Cross).

APPROVED: _____ _____

Director, EMS Agency | Medical Director, EMS Agency

Pediatric Advisory Committee (PedAC): Acts in an advisory capacity to the EMS Agency and is responsible for all matters regarding pediatric care and policy development pertinent to the practice, operation and administration of prehospital care, emergency departments, and pediatric intensive care units (PICU). Committee reviews, evaluates and makes recommendations on EMS issues impacting the pediatric population.

Pediatric Emergency Course (PEC): Two-day course, with topics pre-approved by the EMS Agency, that provides knowledge about the acutely ill and injured child, and a minimum of 14 hours of Board of Registered Nursing (BRN) approved continuing education.

Pediatric Intensivist: A qualified specialist in Pediatric Critical Care

Pediatric Liaison Nurse (PdLN): A Registered Nurse currently licensed to practice in the State of California and appointed by the Hospital to coordinate pediatric emergency care, also referred to as Nurse Pediatric Emergency Care Coordinator.

Pediatric Medical Center (PMC): A licensed acute care hospital that is designated by the EMS Agency to receive **critically ill** pediatric patients via the 9-1-1 system based on guidelines outlined in Reference No. 510, Pediatric Patient Destination.

Pediatric Patient: In the prehospital setting, is a child who is 14 years of age or younger.

Pediatric Trauma Center (**PTC)**: A licensed acute care hospital that is designated by the EMS Agency to receive **injured** pediatric patients via the 9-1-1 system based on guidelines outlined in Reference No. 506, Trauma Triage. These centers provide tertiary pediatric care and serve as referral centers for critically injured pediatric patients.

Promptly Available: Able to be physically present in the ED within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, should not have a measurable harmful effect on the course of patient management or outcome. Hospital guidelines shall be established that address response time for on-call physicians.

Qualified Specialist: A physician licensed in the State of California who has become BC or BE in the corresponding specialty by American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA).

Sexual Assault Response Team (SART) Centers: A center specializing in forensic examinations in the case of an acute sexual assault/abuse event (defined as occurring within 120 hours), which has the capabilities of providing comprehensive medical and psychological forensic examinations and consist of a knowledgeable staff whose training, expertise, and state-of-the-art equipment exceeds the community standards.

Telehealth: The remote delivery of health care services and clinical information using telecommunications technology. This includes a wide array of clinical services using internet, wireless, satellite, and telephone media.

POLICY:

I. EDAP Designation / Re-Designation

A. EDAP initial designation and EDAP re-designation is granted for a period of three years after a satisfactory review by the EMS Agency

B. The EMS Agency reserves the right to perform scheduled site visits or request

additional data of the EDAP at any time

C. The EDAP shall immediately provide written notice to the Director of the EMS Agency if unable to adhere to any of the provisions set forth in the EDAP Standards, including structural changes, relocation of ED and change in pediatric inpatient resources

D. The EDAP shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw from the EDAP program

E. The EDAP shall notify the EMS Agency within 15 days, in writing of any change in status of the EDAP Medical Director, ED Nurse Manager/Director, Designated Pediatric Consultant, or Pediatric Liaison Nurse (PdLN) by submitting the Notification of Personnel Change Form (Reference No. 621.2)

F. Execute and maintain a Specialty Care Center EDAP Designation Agreement with the EMS Agency

II. General Hospital Requirements

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

1. Maintain a special permit for Basic or Comprehensive Emergency Medical Service, and

2. Accredited by a Centers for Medicare & Medicaid Services (CMS) recognized Hospital Accreditation Organization

B. Appoint an EDAP Medical Director

C. Appoint a PdLN and provide non-clinical time to perform duties based upon the ED's annual pediatric volume:

1.	Low	<1,800
2.	Medium	1,800 – 4,999
3.	Medium-High	5,000 – 9,999
4.	High	>10,000 (highly recommend 1 full time equivalent)

D. Hospital shall have a mechanism to track and monitor pediatric continuing education, including PALS, of pertinent staff

E. Pediatric Interfacility Transfer

Establish and maintain a written Interfacility Consultation and Transfer Agreement for tertiary or specialty care, which shall include, at a minimum, the following:

1. A plan for subspecialty consultation (telehealth or on-site) 24 hours per day

2. Identification of transferring and receiving hospitals' responsibilities in accordance with Emergency Medical Treatment and Active Labor Act (EMTALA)

3. A process for selecting the appropriately staffed transport service to match the patient's acuity level

III. EDAP Leadership Requirements

A. EDAP Medical Director

1. Responsibilities:

a. Oversee EDAP quality improvement (QI) program and monitor to ensure adherence to the EDAP standards

b. Promote and verify adequate skills and current knowledge of ED staff physicians and mid-level practitioners in pediatric emergency care and resuscitation

c. Participate in a multidisciplinary ED and pediatric committees (if applicable) to ensure that pediatric care needs are addressed and communicated across disciplines

d. Liaison with PMCs, PTCs, other hospitals, prehospital care providers, and the EMS Agency to ensure pediatric care needs are addressed

e. Collaborates with the ED Nurse Manager/Director and the PdLN to ensure adherence to the EDAP standards for staffing, medication, equipment, supplies, and other resources for children in the ED

f. Participate in EMS Agency activities and meetings and attend a minimum of two (2) PedAC meetings per year

B. Designated Pediatric Consultant

1. Responsibilities:

a. Promptly available for consultation

b. Participate in the development and monitoring of pediatric QI program, and pediatric policies and procedures

c. Collaborate with the EDAP Medical Director and PdLN as needed

d. May also be the EDAP Medical Director

C. ED Nurse Manager/Director

1. Responsibility: provide organizational support to meet EDAP requirements and initiatives

D. Pediatric Liaison Nurse (PdLN)

1. Qualifications:

a. At least two years of experience working in pediatrics, or in an ED that provides care for pediatric patients, within the previous five years; and currently working for the ED

b. Current PALS provider or instructor certification

c. Completion of a two-day PEC or ENPC every four years

d. Completion of seven hours of BRN approved pediatric continuing education (CE) every two years.

2. Responsibilities:

a. Collaborate with the EDAP Medical Director, ED Nurse Manager/Director, and Designated Pediatric Consultant to ensure compliance with the EDAP Standards, Ref. No. 312, Pediatric Liaison Nurse, and policies and procedures established by the EMS Agency

b. Implement, maintain and monitor the EDAP QI program

c. Serve as a liaison and maintain effective lines of communication with:

1) ED management, physicians, and personnel
2) Hospital pediatric management, physicians, and personnel
3) Other EDAPs and PMCs
4) Prehospital care coordinators (PCCs), as needed, to follow up with pediatric treatment/transport concerns
5) EMS providers as needed, to follow up with pediatric treatment and/or transport concerns
6) EMS Agency

d. Serve as a contact person for the EMS Agency and be available upon request to respond to County business

e. Ensure pediatric ED continuing education and competency evaluation in pediatrics for ED staff

f. Participate in EMS Agency activities and meetings and attend a minimum of two (2) PedAC meetings per year

IV. Personnel Requirements

A. ED Physicians

1. At least 75% of the physicians attending in the ED shall be BC or BE in EM or PEM.

2. ED Physicians who are not EM or PEM BC or BE shall have current PALS provider or instructor certification.

B. Pediatricians (applies to EDAPs with associated pediatric admission unit)

There shall be a call panel for telephone consultation and a qualified specialist in pediatrics to be available to the ED twenty-four hours per day

C. Pediatric Subspecialty Services

Pediatric subspecialty physicians, to include pediatric intensivist, shall be available through in-house call panel, telehealth or transfer agreements

D. Advanced Practice Providers (Physician Assistants and Nurse Practitioners)

1. Advanced Practice Providers shall be licensed in the State of California

2. Advanced Practice Providers assigned to the ED caring for pediatric patients must have PALS provider or instructor certification

E. Registered Nurses

1. All RN staff in the ED caring for pediatric patients must have a current PALS provider or instructor certification

2. All nurses assigned to the ED shall attend at least 14 hours of BRN-approved pediatric emergency education (not including PALS) every four years (e.g., PEC or ENPC)

a. At least one RN per shift shall have completed a two-day Pediatric Emergency Course within the last 4 years and be available for patient care. It is highly recommended that all nurses regularly assigned to the ED complete this course as well.

V. Two-Day PEC – Continuing Education

A. May be completed in-house or off-site

B. The interval between Day/Part 1 and Day/Part 2 must be completed within a six-month period. If the interval between Day/Part 1 and Day/Part 2 is greater than six months, this will only fulfill the 14 hour requirement in Section IV.E.2 above.

C. Curriculum should be selected from this broad spectrum of pediatric topics which have been pre-approved by the EMS Agency:

1. Airway management
2. Brief Resolved Unexplained Event (BRUE)
3. Burns
4. Child maltreatment (suspected child abuse, neglect, and sexual assault) to include the mandated reporting process
5. Coordination of care with a SART Center for an acute suspected sexual assault victim requiring a forensic examination
6. Death
7. Disaster preparedness
8. Fever
9. Female presenting with signs & symptoms of recent delivery and no history of giving birth / newborn abandonment
10. Human trafficking
11. Injury prevention

12. Medical conditions (e.g., diabetic ketoacidosis, inborn errors of metabolism, etc.)
13. Medication safety
14. Neonatal resuscitation
15. Pain management
16. Disaster management
17. Poisonings / overdose
18. Procedural sedation
19. Respiratory emergencies
20. Resuscitation
21. Seizures
22. Sepsis
23. Shock / hypotension
24. SIDS/SUID
25. Special health care needs
26. Submersions
27. Surgical emergencies
28. Trauma
29. Triage

D. A copy of the course flyer, with agenda, shall be sent electronically to the EMS Agency Pediatric Program Coordinator no later than eight weeks before the scheduled course

VI. Ancillary Services

A. Respiratory Care Practitioners (RCP)

1. At least one RCP shall be in-house twenty-four hours per day to respond to the ED

2. All RCPs that work or respond to the ED and care for pediatric patients shall have a PALS provider or instructor certification

B. Radiology

1. The radiology department shall have pediatric-specific policies and procedures pertaining to imaging studies of children

2. Qualified specialist in radiology must be on-call and promptly available twenty-four hours per day

3. Radiology technician must be in-house twenty-four hours per day

4. Provide the following services 24 hours per day/seven days per week:

a. Computerized tomography (CT)

b. Ultrasonography

c. Magnetic resonance Imaging (MRI)

C. Laboratory

Laboratory service shall have pediatric-specific policies and procedures pertaining to laboratory studies of children, including, but not limited to, obtaining samples, and microtechnique for small or limited sample sizes

VII. Policies and Procedures

The hospital shall develop and maintain, at minimum, the following policies and procedures pertaining to the emergency care of children. Multiple required elements may be incorporated into one policy (e.g., Care of the Pediatric Patient in the ED).

A. Weight and Vital Sign Measurement:

1. Vital signs shall be obtained and recorded at triage for all children. The policy shall include age-appropriate methods to obtain temperature, heart rate, respiratory rate, and pain scale.

2. Blood pressure and pulse oximetry monitoring shall be available for children of all ages. Optimally, blood pressure and pulse oximetry should be assessed on all children and shall be measured on all children requiring admission or transfer. Exceptions must be addressed in policy and monitored.

3. All pediatric weights shall be recorded in kilograms upon arrival to the ED:

a. Children shall be weighed in kilograms. For children who require emergency stabilization or those who cannot be safely weighed, a length-based resuscitation tape may be used to estimate weight in kilograms. The weight shall be recorded in a prominent place on the medical record such as with the vital signs.

b. Scales used to weigh children must be configured to display weights only in kilograms.

c. Electronic medical records shall only allow for weight entries in kilograms

C. Pediatric patient safety in the ED (e.g., environment of care)

D. Immunization assessment and management of the under immunized patient

E. Mandated reporting of child maltreatment (suspected child abuse, neglect, and sexual assault)

The Child Protection Hotline (CPH) operates 24 hours per day, 7 days a week. The 24-hour number (1-800-540-4000) is staffed by employees of the DCFS and responsible for screening calls from the community related to issues of child abuse and neglect. In the event, the volume calls received by CPH exceed the number of social workers available, an overflow/call back provisional number (not an official reporting number) is given to the caller. The caller is responsible for re-contacting CPH to make a referral to ensure the mandated reporting process is initiated and completed.

1. An immediate, or as soon as practically possible, verbal telephone report shall be made to Child Protection Hotline (CPH) and/or law enforcement.

2. A Suspected Child Abuse Report (SCAR) #8572 report shall be submitted to the Department of Children and Family Services (DCFS), the report may be submitted online. https://mandreptla.org/results/Blank_SCAR_Report.pdf

3. The case number or referral number shall be documented in the patient's medical record. If SCAR filed electronically, the electronic tracking number must also be documented in the patient's medical record.

4. Review by the physician-on-duty to ensure that mandated reporting requirements are completed.

5. Quarterly QI review of all suspected child maltreatment cases shall be conducted by Social Services and the ED to assure the appropriate recognition of and reporting processes have been completed. A checklist may be utilized to ensure complete documentation and facilitate the review.

F. Coordination of care with a SART Center for an acute suspected sexual assault patient/victim who may require a forensic evidentiary examination or appropriate referral, the policy/procedure shall include the following (may be incorporated into the policy/procedure above):

1. Patient shall receive an interview to determine whether the assault was acute (defined as occurring with the last 120 hours) which may require immediate forensic evidentiary examination or the assault occurred over 120 hours which may be appropriate for referral to a SART Center (Ref. No. 503.1). The ED may consult with a forensic nurse.

2. ED nurse or physician shall notify the law enforcement agency in the appropriate jurisdiction where the crime occurred.

   a. Collaborate with law enforcement to determine plan of care and/or forensic evidentiary examination.

   b. Document the officer's identification, department and badge number. in the medical record.

   c. The ED may also contact the forensic nurse for consultation or clarification regarding patient care as it relates to evidence preservation.

3. Appropriate discharge and referral

G. Pediatric assessment and reassessment, include identification of abnormal vital signs according to the age of the patient, and physician notification when abnormal values are obtained

H. Pain assessment, treatment, and reassessment, utilize developmentally appropriate pain scales (include a description of the tools used for infant and child)

I. Consent and assent for emergency treatment, include situations in which a parent/legal guardian is not immediately available

J. Do Not Resuscitate (DNR) orders/Advanced Health Care Directives (AHCD)

K. Death of the child in the ED and care of the grieving family

L. Care and safety for the pediatric patient with mental and/or behavioral health emergencies

M. Physical and chemical restraint of patients

N. Procedural sedation

O. Reducing radiation exposure for pediatric patients

P. Safe surrender of newborns

Q. Daily verification of proper location and functioning of equipment and supplies for the pediatric crash cart, and a content listing of items in each drawer

R. Family Centered Care, include the following:

1. Supporting appropriate family presence during all aspects of care to include invasive procedures and resuscitation

2. Education of the patient, family, and regular caregivers

3. Discharge planning and instructions

4. Culturally and linguistically appropriate services

S. Communication with patient's medical home or primary provider based on illness and severity (e.g., aftercare instructions, x-ray results, laboratory studies, as appropriate)

T. Transfer from the ED to another facility

U. A surge plan for back-up personnel in the ED

V. Disaster preparedness addressing the following pediatric issues:

1. Minimizing parent-child separation, and methods for reuniting separated children with their families

2. Pediatric surge capacity for both injured and non-injured children

3. Medical and mental health therapies, and social services for children in the event of a disaster

4. Disaster drills that include a pediatric mass casualty incident at least once every two years

5. Decontamination

W. Medication safety addressing the following pediatric issues:

1. Medication orders should be written clearly in milligrams per kilogram and should specify the total dose.

2. Processes for prescribing, safe medication storage, and delivery should be established. Include the use of pre-calculated dosing guidelines for children of all ages.

3. Involve the patient and family in the medication safety process to ensure accurate patient identification. Include patient and family education as to the rationale for the medication.

VIII. Equipment, Supplies, and Medications

A. Pediatric equipment, supplies, and medications shall be easily accessible, labeled, and logically organized. A mobile pediatric crash cart shall be utilized.

B. A locator chart or grid identifying the locations of all required equipment and supplies shall be developed and maintained in order for staff to easily identify location of all items.

C. Required EDAP equipment, supplies, and medications

1. General Equipment

a. Weight scale measuring only in kilograms for both infants and children

b. Standardized length-base resuscitation tape (most recent edition) or other standardized method to estimate pediatric weights in kilograms

c. Pediatric drug dosage reference material with dosages calculated in milligrams, micrograms, milliequivalents, etc. per kilogram (either posted or readily available)

d. Developmentally appropriate pain scale assessment tools for infants and children

e. Blood and IV fluid warmer (Rapid infuser)

f. Warming and cooling system with appropriate disposable blankets

g. Restraints in various sizes

2. Monitoring Equipment

a. Blood pressure cuffs

1) Neonatal
2) Infant
3) Child
4) Adult arm

5) Adult thigh

b. Vascular Doppler device (handheld)

c. ECG monitor/defibrillator

1) ECG electrodes in pediatric and adult sizes
2) Defibrillator paddles in pediatric and adult sizes, and/or; Hands-free defibrillation device
3) External pacing capability
4) Multifunction pads in pediatric and adult sizes

d. Thermometer with hypothermia capability

3. Airway Management

a. Bag-Mask-Ventilation (BMV) device with self-inflating bag

1) Infant (minimum 450ml)
2) Child
3) Adult

b. BMV clear masks

1) Neonate
2) Infant
3) Child
4) Adult

c. Laryngoscope handle

1) Pediatric
2) Adult

d. Laryngoscope Blades

1) Macintosh/curved: 2, 3
2) Miller/straight: 00, 0, 1, 2, 3

e. Endotracheal Tubes

1) Uncuffed: size mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5
2) Cuffed: size mm 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0

f. Stylets for endotracheal tubes

1) Pediatric
2) Adult

g. Magill Forceps

1) Pediatric
2) Adult

h. Continuous end-tidal CO2 monitoring device for pediatric and adult patients (preferred). If not available, colorimetric CO2 detector may be utilized.

i. Pulse oximeter unit with sensors

1) Infant
2) Pediatric
3) Adult

j. Nasopharyngeal Airways

1) Infant (sizes 12-14)
2) Child (sizes 18-28)
3) Adult (sizes 30-36)

k. Oropharyngeal Airways

1) Infant (size 00)
2) Child (size 0-2)
3) Adult (sizes 3-5)

l. Clear oxygen masks

1) Infant
2) Child
3) Adult

m. Non-rebreather masks

1) Infant (partial non-rebreather)
2) Child
3) Adult

n. Nasal cannulas

1) Infant
2) Child
3) Adult

o. Suction catheters

6, 8, 10, 12 Fr

p. Yankauer suction tips

q. Feeding tubes

5, 8 Fr

r. Nasogastric Tubes

5, 8, 10, 12, 14, 16, 18 Fr

s. Supraglottic Airway Devices

1) Neonatal
2) Infant
3) Child
4) Adult

t. Difficult Airway Kit

u. Tracheostomy trays: optional for EDAP, required for PMC

1) Pediatric
2) Adult

v. Tracheostomy Tubes: optional for EDAP, required for PMC

1) Neonatal: size mm 2.0, 2.5, 3.0, 3.5, 4.0, 4.5
2) Pediatric: size mm 3.0, 3.5, 4.0, 5.0, 5.5, 6.0

4. Vascular Access Equipment

a. Arm boards

1) Infant
2) Child
3) Adult

b. IV administration sets with calibrated chambers

c. IV catheters

16, 18, 20, 22, 24 gauge

d. 3-way stopcocks

e. Device or needle to achieve intraosseous (IO) vascular access, to include needles in the appropriate sizes for pediatric and adult patients

f. IV solutions, 250ml and/or 500ml bags

1) 0.9 NS
2) D5.45NS
3) D5NS
4) D10W

5. Fracture Management Devices

a. Splinting supplies for long bone fractures

b. Cervical spine motion restriction equipment (e.g., cervical collar)

1) Pediatric
2) Adult

c. Spinal board with the appropriate straps

6. Specialized Trays or Kits

a. Newborn delivery kit to include:

1) Bulb syringe
2) Umbilical clamps
3) Towels
4) Scissors

b. Newborn initial resuscitation equipment should be readily available, include:

1) Radiant warmer or warming mattress
2) BMV device with self-inflating bag and clear mask for newborns
3) Umbilical vein catheters, or 5.0 Fr feeding tube

c. Thoracostomy tray

d. Chest drainage system

e. Chest tubes (at least one in each size range)

(10 – 12) (16 – 24) (28 – 40) Fr – required for EDAP
8, 12, 16, 20, 24, 28, 36 Fr – required for PMC

f. Lumbar Puncture trays and spinal needles

1) 22 g, 3 inch
2) 22-25 g, 1½ inch

g. Urinary catheterization sets and indwelling urinary catheters

5, 8, 10, 12, 14, 16 Fr

7. Pediatric-Specific Resuscitation

a. Immediately available drug calculation resources

b. The following medications must be immediately available:

1) Adenosine
2) Albuterol
3) Amiodarone
4) Atropine
5) Calcium chloride
6) Dobutamine
7) Dopamine
8) Epinephrine 0.1mg/mL **(IV administration**)
9) Epinephrine 1mg/mL (**IM administration**)
10) Epinephrine for inhalation
11) Fentanyl

12) Ipratropium bromide (Atrovent)
13) Ketamine
14) Lidocaine
15) Mannitol or hypertonic saline
16) Naloxone
17) Norepinephrine
18) Neuromuscular blocking agent
19) Procainamide
20) Sedative agent
21) Sodium Bicarbonate 4.2% (or a process to obtain the drug in an emergency situation)
22) Sodium Bicarbonate 8.4%

IX. Quality Improvement (QI) Program Requirements

A QI program shall be developed as per Reference No. 620, EMS Quality Improvement Program, and monitored by the EDAP Medical Director, ED Nurse Manager/Director, and PdLN, with input as needed from the Designated Pediatric Consultant.

A. Develop a mechanism to easily identify pediatric (14 years of age and under) visits to the ED. The mechanism should be able to delineate between a 9-1-1 versus self-transport.

B. Identification and trending of important aspects of pediatric care requiring improvement, to include:

1. 100% medical record review by physician and PdLN of:

a. Deaths in the ED
b. Child Maltreatment (suspected child abuse, neglect, and sexual assault) to include the mandated reporting process
c. Transfers to higher level of care
d. Unscheduled/unplanned return visits to the ED within 48 hours and are admitted or transferred for continued acute care

2. System-wide QI projects selected by the EMS Agency and endorsed by the PedAC

3. Track and trend two (2) QI Indicators (important aspects of patient care) identified by the Medical Director and PdLN

C. Maintain written QI plan, trending and analysis reports, agenda, minutes and attendance rosters, these records shall be readily available to the EMS Agency for review.

D. Complete the National Pediatric Readiness Project (NPRP) assessment annually https://www.pedsready.org/, and submit a copy of the NPRP Assessment Gap Analysis to the EMS Agency by February 1st of each year.

E. Submit data as requested by the EMS Agency for quality improvement purposes to include physician-specific reviews of EMS Agency identified important aspects of care.

X. Data Collection Requirements

A. Participate in the data collection process established the EMS Agency

B. Submit data to the EMS Agency, within 45 days of patient discharge, which shall include data elements listed in Ref. No. 652, EDAP and PMC Data Dictionary

CROSS REFERENCE:

Prehospital Care Policy Manual
Ref, No. 216, **Pediatric Advisory Committee (PedAC)**
Ref. No. 312, **Pediatric Liaison Nurse**
Ref. No. 318, **Pediatric Medical Center (PMC) Standards**
Ref. No. 324, **SART Center Standards**
Ref. No. 506, **Trauma Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 620, **EMS Quality Improvement Program**
Ref. No. 621.2, **Notification of Personnel Change Form**
Ref. No. 652, **EDAP and PMC Data Dictionary**

Emergency Nursing Pediatric Course (ENPC)
National Pediatric Readiness Project (NPRP)

ACKNOWLEDGEMENTS

The EMS Agency EDAP Standards were first developed by the Committee on Pediatric Emergency Medicine (COPEM), which is made up of representatives from the following organizations: Los Angeles Pediatric Society, Pediatric Liaison Nurses of Los Angeles County, California Chapter of the American College of Emergency Physicians (ACEP), National Emergency Medical Services for Children (EMSC) Resource Alliance, American Academy of Pediatrics (AAP)-California Chapter 2, Emergency Nurses Association (ENA), American College of Surgeons (ACS), and the EMS Agency.

The EDAP Standards have since been revised, endorsed by The Hospital Association of Southern California, and now meet or exceed the guidelines established by the Emergency Medical Services Authority (EMSA) #182: Administration, Personnel, and Policy for the Care of Pediatric Patients in the Emergency Department, and the 2009 Joint Policy Statement: Guidelines for Care of Children in the Emergency Department which was ratified by the AAP, ACEP, and the ENA.

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

REFERENCE NO. 316, Emergency Department Approved for Pediatrics (EDAP) Standards

	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			
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee	09/10/2019	09/10/2019	Yes
	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**

POLICY REVIEW - SUMMARY OF COMMENTS REFERENCE NO. 202.2

REFERENCE NO. 316, Emergency Department Approved for Pediatrics (EDAP) Standards

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
IV. Personnel Requirements A.1.	PedAC 09/10/2019	Remove addition that 100% of ED physicians must be Board Certified or Board Eligible and keep wording as currently written	Change made
VII. Policies and Procedures A.	PedAC 09/10/2019	Change from “Triage” to “Weight and Vital Sign Measurement”	Change made
A.2.		Add wording “and transfer”	Change made
A.3.		Add wording “upon arrival to ED”	Change made
E.1.		Add wording “or as soon as practically possible”	Change made
E.5.		Change the word “Monthly” to “Quarterly”	Change made
VIII. Equipment, Supplies and Medication C.3.s.1-4	PedAC 09/10/2019	Remove specific sizes	Change made
C.6.b		Keep wording “Radiant warmer” and add “or”	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **PEDIATRIC MEDICAL CENTER (PMC) STANDARDS** REFERENCE NO. 318

PURPOSE: To establish minimum standards for the designation of Pediatric Medical Centers (PMC). The PMC will provide an emergency department capable of managing complex pediatric emergencies, a Pediatric Intensive Care Unit (PICU), physicians with pediatric sub-specialties and/or experience in pediatric care, pediatric critical care consultation for community hospitals, and outreach education programs for the Emergency Medical Services (EMS) community.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 14

DEFINITIONS:

Board Certified (BC): Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialties (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.

Certified Registered Nurse Anesthetist (CRNA): An advanced practice registered nurse (APRN) who has acquired graduate-level education and board certification in anesthesia.

Children with Special Health Care Needs: Children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that is required by children generally.

Department of Children and Family Services (DCFS): A mandated component of Emergency Response Services, administered by the Los Angeles County Department of Children and Family Services. The Child Protection Hotline (CPH) intake evaluation staff is responsible for assessing any referral, whether verbal or written, which alleges child abuse, neglect or exploitation to determine whether an in-person investigation and consultation is required.

The CPH operates 24 hours a day, seven days a week. The 24 hour number (1-800-540-4000), staffed by employees of the DCFS, is responsible for screening calls from the community related to issues of child abuse and neglect.

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

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

established policies and procedures, as per the guidelines outlined in Ref. No. 316, Emergency Department Approved for Pediatrics (EDAP) Standards.

Immediately Available: Unencumbered by conflicting duties or responsibilities, responding without delay when notified, and being physically available to the specified area of the PMC.

On call: Agreeing to be available, according to a predetermined schedule, to respond to the Pediatric Medical Center (PMC) in order to provide a defined service.

Pediatric Advisory Committee (PedAC): Acts in an advisory capacity to the EMS Agency and is responsible for all matters regarding pediatric care and policy development pertinent to the practice, operation and administration of prehospital care, emergency departments, and pediatric intensive care units (PICU). Committee reviews, evaluates and makes recommendations on EMS issues impacting the pediatric population.

Pediatric Critical Care Education: Topics in pediatric critical care that addresses fundamental principles for the management of the critically ill pediatric patient, and a minimum of 14 hours of continuing education every four years.

Pediatric Advanced Life Support (PALS): Pediatric resuscitation course that is recognized by the EMS Agency and valid for two years (e.g. American Heart Association, American Red Cross)

Pediatric Experience: A physician specialty approved by the appropriate hospital body and the PMC Medical Director, based on education, training, and experience to provide care to the pediatric patient.

Pediatric Intensivist: A Qualified Specialist in Pediatric Critical Care Medicine

Pediatric Liaison Nurse (PdLN): A Registered Nurse currently licensed to practice in the State of California and appointed by the hospital to coordinate pediatric emergency care required by the EDAP Standards, also referred to as Nurse Pediatric Emergency Care Coordinator.

Pediatric Medical Center (PMC): A licensed acute care hospital that is designated by the EMS Agency to receive **critically ill** pediatric patients via the 9-1-1 system based on guidelines outlined in Ref. No. 510, Pediatric Patient Destination.

PMC Medical Director: A Qualified Specialist in Pediatric Critical Care Medicine who oversees and directs implementation of these standards within the designated PMC.

PMC Nurse Coordinator: A Registered Nurse currently licensed to practice in the State of California and appointed by the Hospital to coordinate pediatric critical care.

Pediatric Trauma Center (**PTC)**: A licensed acute care hospital that is designated by the EMS Agency to receive **injured** pediatric patients via the 9-1-1 system based on guidelines outlined in Ref. No. 506, Trauma Triage. These centers provide tertiary pediatric care and serve as referral centers for critically injured pediatric patients.

Promptly Available: Able to be physically present in the PMC within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, should not have a measurable harmful effect on the course of patient management or outcome. Hospital guidelines shall be established that address response time for on-call physicians not to exceed thirty (30) minutes by telephone and in person within one hour.

Qualified Specialist: A physician licensed in the State of California who has become BC or BE in the corresponding specialty by the ABMS or the AOA.

Senior Resident: A physician licensed in the State of California who is in training as a member of the residency program at the designated hospital, has completed at least two years of the residency, and is in good standing.

Sexual Assault Response Team (SART) Centers: A center specializing in forensic examinations in the case of an acute sexual assault/abuse event (defined as occurring within 120 hours), which has the capabilities of providing comprehensive medical and psychological forensic examinations and consist of a knowledgeable staff whose training, expertise, and state-of-the-art equipment exceeds the community standards.

Suspected Child Abuse and Neglect (SCAN) Team: A team of healthcare professionals who are specialists in diagnosing and treating suspected child abuse, neglect, and sexual assault.

Telehealth: The remote delivery of health care services and clinical information using telecommunications technology. This includes a wide array of clinical services using internet, wireless, satellite, and telephone media.

POLICY:

I. PMC Designation / Re-Designation

A. PMC initial designation and re-designation is granted for a period of three years after a satisfactory review by the EMS Agency.

B. The EMS Agency reserves the right to perform scheduled site visits or request additional data of the PMC at any time.

C. The PMC shall immediately (within 72 hours) provide written notice to the Director of the EMS Agency if unable to adhere to any of the provisions set forth in the PMC Standards including structural changes or relocation of the PICU.

D. The PMC shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw from the PMC program.

E. The PMC shall notify the EMS Agency within 15 days, in writing of any change in status of the PMC Medical Director, PMC Nurse Coordinator, or PICU Nurse Manager/Director by submitting Ref. No. 621.2, Notification of Personnel Change Form.

F. Have a fully executed Specialty Care Center PMC Designation Agreement with the EMS Agency

II. General Hospital 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 Medical Service, and

2. Accredited by a Centers for Medicare & Medicaid Services (CMS) recognized Hospital Accreditation Organization

B. Designated by the EMS Agency as an Emergency Department Approved for Pediatrics (EDAP)

C. Have a Suspected Child Abuse and Neglect (SCAN) Team

D. Have a licensed inpatient pediatric unit

E. Have a Pediatric Intensive Care Unit (PICU)

F. Appoint a PMC Medical Director and a PMC Nurse Coordinator

III. PMC Leadership Requirements

A. PMC Medical Director

1. Responsibilities:

a. Implement and ensure compliance with the PMC Standards

b. Serve as chairperson of the PMC Committee or assign a designee

c. Coordinate medical care across departmental and multidisciplinary committees

d. Maintain direct involvement in the development, implementation, and maintenance of a comprehensive multidisciplinary QI program

e. Identify, review, and correct deficiencies in the delivery of pediatric critical care

f. Review, approve, and assist in the development of transfer guidelines and all PMC policies and procedures

g. Collaborates with the PMC Nurse Coordinator, ED Medical Director and ED Nursing Director to ensure appropriate pediatric critical care education programs are provided to the staff related to the quality improvement findings

h. Coordinates with PMC Nurse Coordinator to liaison with other PMCs, pediatricians, ED Directors, PdLNs and community hospitals

i. Shall have direct involvement in defining the credentialing/privileging criteria/process utilized in determining pediatric experience for the non-boarded physicians

B. PMC Nurse Coordinator

1. Qualifications:

a. Current PALS provider or instructor certification

b. Shall have a minimum of three years' experience or specialty certification, in the care of critically ill children, and currently working in the PICU

c. Shall have education, training and demonstrated competency in pediatric critical care nursing and attend at least 14 hours of Board of Registered Nursing (BRN) approved pediatric critical care education every four years

d. May hold other positions in the hospital organization (e.g., PICU staff nurse, PICU Charge Nurse, PICU Nurse Manager/Director)

2. Responsibilities:

a. Ensure the implementation and compliance of the PMC Standards in collaboration with the PMC Medical Director and PICU Nurse Manager/Director

b. Serve as a member of the PMC Committee

c. Direct involvement in the development, implementation, and maintenance of comprehensive multidisciplinary QI program

d. Liaison with other hospital multidisciplinary committees.

e. Ensure appropriate pediatric critical care education programs are provided to the staff

f. Liaison with other PMCs, hospitals and PdLNs

g. Serve as the contact person for the EMS Agency and be available upon request to respond to County business

h. Participate in EMS Agency activities and meetings and attend a minimum of two (2) PedAC meetings per year

i. Maintain joint responsibility with the PICU Medical Director and PICU Nurse Manager/Director for the development and review of policies, procedures and QI activities in the PICU

C. PICU Nurse Manager/Director – Shall serve as a member of the PMC committee

IV. Personnel Requirements

A. Pediatric Intensivist

1. Responsibilities:

a. Shall be on-call and promptly available

b. Shall not be on-call for more than one facility at the same time

c. Participate in all major therapeutic decisions and interventions

B. Anesthesiologist with pediatric experience

1. Responsibilities:

a. Shall be on-call and promptly available

b. Provide oversight for all patients requiring interventions by the senior resident or Certified Registered Nurse Anesthetist (CRNA) and be present for all surgical procedures

C. Specialties who shall be on-call and promptly available:

1. Radiologist with pediatric experience (can be achieved by off-site capabilities)

2. Neonatologist

3. Pediatric Cardiologist

4. General Surgeon with pediatric experience

5. Otolaryngologist with pediatric experience

6. Obstetrics/Gynecologist with pediatric experience

7. Mental health professionals with pediatric experience

8. Orthopedist with pediatric experience

D. Qualified specialists who shall be available 24 hours per day, 7 days per week for consultation which may be met through a transfer and/or telehealth agreement:

1. Pediatric Gastroenterologist
2. Pediatric Hematologist/Oncologist
3. Pediatric Infectious Disease
4. Pediatric Nephrologist
5. Pediatric Neurologist
6. Pediatric Surgeon
7. Cardiac surgeon with pediatric experience
8. Neurosurgeon with pediatric experience
9. Pulmonologist with pediatric experience
10. Pediatric endocrinologist

E. Nursing Personnel on the Pediatric Unit

1. The Pediatric Unit shall be staffed with RNs and Licensed Vocational Nurses (LVNs) who are licensed to practice in the State of California

2. RNs and LVNs shall have current PALS provider or instructor certification

3. RNs and LVNs shall have attended at least 14 hours of BRN or Board of

Vocational Nursing and Psychiatric Technicians approved pediatric education every four years

4. Nursing staff shall have experience and demonstrated pediatric clinical competence. The hospital shall have methods for documenting clinical competency (i.e., course completion certificates, course attendance rosters, etc.)

V. Special Services and Resources

The following services may be met by contractual or written transfer agreements:

A. Acute burn care management

B. Urgent dialysis (i.e., hemodialysis, peritoneal)

C. Peritoneal dialysis

D. Pediatric rehabilitation

E. Organ transplantation

F. Home health

G. Reimplantation

H. Hospice

VI. Pediatric Intensive Care Unit

A. General Requirements for the PICU:

1. Shall be a distinct, separate unit within the hospital

2. Provide at minimum, eight licensed beds

3. Admit a minimum of 200 patients per year and a minimum or 40 ventilator day per year

B. PICU Medical Director

1. Serve as a member of the PMC Committee, and may hold PMC Medical Director position

2. Work with the PMC Medical Director to ensure PMC Standards are met

C. PICU Clinical Nurse Specialist (CNS) shall:

1. Be licensed to practice in the State of California as a CNS

2. Collaborate with the PMC Nurse Coordinator to ensure the PMC Standards are met

3. Develop and oversee pediatric critical care educational programs for the nursing staff in the PICU

D. PICU Staff Nurse shall:

1. Be licensed to practice in the State of California as RN or LVN

2. Have a current PALS provider or instructor certification

3. Have education, training, demonstrated competency in pediatric critical care nursing and have attended at least 14 hours of BRN or Board of Vocational Nursing and Psychiatric Technician approved pediatric education every four years

E. Social Worker shall:

1. Be licensed to practice in the State of California as a Medical Social Worker (MSW)

2. Have a Master's Degree in Social Work

3. Have pediatric experience in psychosocial issues affecting seriously ill children and their families, including management of child abuse and neglect cases

4. Have 4 hours of continuing education every two (2) years in topics related to health, housing and welfare of children (e.g., child abuse reporting)

F. Other professional services with minimum one year pediatric experience shall be available to the PICU:

1. Pharmacist shall be available 24 hours per day, 7 days a week

2. Clinical Registered Dietician

3. Occupational Therapist

4. Physical Therapist

5. Behavioral health specialist to include psychiatrists, psychologists, and nurses

VII. Policies and Procedures

The hospital shall develop and maintain policies and procedures required in Ref. No. 316, Emergency Department Approved for Pediatrics (EDAP) Standards, and those listed below. These policies and procedures, shall be reviewed periodically by the PICU Medical Director in collaboration with the PICU Nurse Manager/Director, and endorsed by hospital administration. All policies and procedures shall be easily accessible in the PICU.

Additional PMC policies and procedures shall address the following:

A. Policies

1. Age appropriate physical environment

2. Credentialing process for physicians who provide care for pediatric patients

3. Do-Not-Resuscitate Orders

4. Family centered care

   a. Care of grieving family and caregivers

   b. Contacting appropriate clergy per request of the parents or primary caregiver

   c. Death of a child in the PICU

5. Infection surveillance and prevention

6. Mechanism and guidelines for bioethical review to include an Ethics Committee

7. Mental health and substance abuse

8. PICU admission, transfer and discharge criteria and process

9. Referral for rehabilitation

B. Procedures

1. Appropriate use and monitoring of equipment

2. Pain management, includes utilization of developmentally appropriate pain tools

3. Patient care, which include nursing and respiratory management of infants, children and adolescents

4. Procedural sedation

VIII. PICU Equipment, Supplies, and Medications

A. Pediatric equipment, supplies, and medications shall be easily accessible to PICU staff and may be physically housed in other locations besides the PICU. A mobile pediatric crash cart shall be utilized and available on all units where pediatric patients are treated to include but not limited to, ED, radiology and in-patient services.

B. A locator chart or grid identifying the locations of all required equipment and supplies shall developed and be maintained in order for staff to easily identify location of all items.

C. Required equipment, supplies, and medications:

1. General Equipment

   a. Weight scale measuring only in kilograms for both infants and children, including bed scales

b. Standardized length-base resuscitation tape (most recent edition) or other standardized method to estimate pediatric weights in kilograms

c. Pediatric drug dosage reference material with dosages calculated in milligrams per kilogram (either posted or readily available)

d. Developmentally appropriate pain scale assessment tools for infants and children

e. Blood and IV fluid warmer (rapid infuser)

f. Warming and cooling system with appropriate disposable blankets

g. Restraints in various sizes

2. Monitoring Equipment

a. Blood pressure cuffs

1) Neonatal
2) Infant
3) Child
4) Adult arm
5) Adult thigh

b. Vascular Doppler device (handheld)

c. ECG monitor/Defibrillator/Pacing (Crash cart unit and Transport unit)

1) ECG electrodes in pediatric and adult sizes
2) Defibrillator paddles in pediatric and adult sized, and/or; hands-free defibrillation device
3) External pacing capability
4) Multifunction pads in pediatric and adult

d. Thermometer with hypothermic capabilities

e. Respiration and oxygen saturation monitoring

1) Pulse oximeter unit with sensors
   i. Infant
   ii. Pediatric
   iii. Adult

2) Continuous end-tidal CO_2 monitoring device for pediatric and adult

f. Arterial pressure

g. Central venous pressure

h. Intracranial pressure

i. Pulmonary arterial pressure

j. Automated/noninvasive blood pressure modules

3. Airway Management

a. Bag- Mask-Ventilation (BMV) device with self-inflating bag

1) Infant (minimum 450mL)
2) Child
3) Adult

b. BMV clear masks

1) Neonate
2) Infant
3) Child
4) Adult

c. Laryngoscope handle

1) Pediatric
2) Adult

d. Laryngoscope blades

1) Macintosh/curved: 2, 3
2) Miller/straight: 00, 0,1, 2, 3

e. Endotracheal tubes

1) Uncuffed: mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5
2) Cuffed: mm 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0

f. Stylets for endotracheal tubes

1) Pediatric
2) Adult

g. Magill Forceps

1) Pediatric
2) Adult

h. Nasopharyngeal Airways

1) Infant
2) Child
3) Adult

i. Oropharyngeal Airways

1) Infant

2) Child (size 0-2)
3) Adult (size 3-5)

j. Clear oxygen masks

1) Infant
2) Child
3) Adult

k. Non-rebreather masks

1) Infant
2) Child
3) Adult

l. Nasal cannula

1) Infant
2) Child
3) Adult

m. Oxygen capability

n. Suction capability

o. Suction catheters

6, 8, 10, 12 Fr

p. Yankauer suction tips

q. Feeding tubes

5, 8 Fr

r. Nasogastric tubes

5, 8, 10, 12, 14, 16, 18 Fr

s. Supraglottic Airways

1) Neonatal
2) Infant
3) Child
4) Adult

t. Cricothyrotomy Catheter set (pediatric)

u. Tracheostomy trays:

1) Pediatric
2) Adult

v. Tracheostomy Tubes

1) Neonatal: size mm 2.0, 2.5, 3.0, 3.5, 4.0, 4.5
2) Pediatric: size mm 3.0, 3.5, 4.0, 5.0, 5.5, 6.0

4. Vascular Access Equipment

a. Arm boards

1) Infant
2) Child
3) Adult

b. IV volume rate control administration sets with calibrated chambers

c. IV catheters

16, 18, 20, 22, 24 gauge

d. 3-way stopcocks

e. Device or needle to achieve intraosseous (IO) vascular access, to include needles in the appropriate sizes for pediatric and adult patients

f. IV solutions, in 250mL and/or 500mL bags

1) 0.9 NS
2) D5.45NS
3) D5NS
4) D10W
5) Lactated Ringers

g. Ultrasound for facilitating peripheral and central venous access

5. Fracture Management Devices

a. Splinting supplies for long bone fractures

b. Cervical spine motion restriction equipment (e.g. cervical collar)

c. Spinal board with the appropriate straps

6. Specialized Trays or Kits

a. Thoracostomy tray

b. Chest drainage system

c. Chest tubes, one in each size

8, 12, 16, 20, 24, 28, 36 Fr

d. Lumbar Puncture trays and spinal needles

1) 22 g, 3 inch

2) 22-25 g, 1½ inch

e. Urinary catheterization sets and indwelling urinary catheters

5, 8, 10, 12, 14, 16 Fr

f. Central line trays, with one of each catheter size

1) 4.0 Fr
2) 5.5 Fr
3) 7.0 Fr

g. Tray for insertion of ICP monitor

h. Arterial line trays with one of each catheter size

1) 2.5 Fr
2) 4.0 Fr

i. Paracentesis tray

7. Pediatric-Specific Resuscitation

a. Immediately available drug calculation resources

b. The following medications must be immediately available:

1) Adenosine
2) Albuterol
3) Amiodarone
4) Atropine
5) Atrovent
6) Calcium chloride
7) Dobutamine
8) Dopamine
9) Epinephrine 0.1mg/mL **(IV administration**)
10) Epinephrine 1mg/mL (**IM administration**)
11) Epinephrine for inhalation
12) Fentanyl
13) Ketamine
14) Lidocaine
15) Mannitol or hypertonic saline
16) Milrinone
17) Naloxone
18) Norepinephrine
19) Procainamide
20) Prostaglandin E1
21) Neuromuscular blocking agent
22) Sedative agent
23) Sodium Bicarbonate 4.2% (or a process to obtain the drug in an emergency situation)
24) Sodium Bicarbonate 8.4%
25) Vasopressin

8. Portable Equipment (promptly available)

a. Air-oxygen blenders (21-100%)

b. Air Compressor

c. Bilirubin lights

d. Cribs

e. Electrocardiogram (ECG 12 lead)

f. Electroencephalogram (EEG)

g. Echocardiogram (Echo)

h. Oxygen tank

i. Radiant warmer

j. Servo-controlled heating units (with or without open crib)

k. Suction unit

l. Transcutaneous pCO_2 monitor

m. Transcutaneous pO_2 monitor

n. ECG monitor/Defibrillator/Pacing transport unit

o. Ultrasound

p. Ventilator – pediatric capability

IX. Outreach and Education Program

A. Establish outreach with surrounding facilities to facilitate transfer of pediatric patients

B. Inform and provide educational programs to EMS providers regarding pediatric patients discharged with special health care needs in their jurisdiction

C. Provide outreach and pediatric education to EDAPs and EMS providers

X. Ancillary Services

Ancillary services shall have the capabilities and technologist appropriately trained to manage a critically ill pediatric patient. These services shall be in-house and available 24 hours per day.

A. Respiratory Care Practitioners working in the PICU shall:

1. Be license as a Respiratory Car Practitioner (RCP) in the State of California

2. Have current PALS provider or instructor certification

3. Successfully complete additional training in pediatric critical care and attend a minimum of 4 hours of pediatric critical care education annually

B. Radiology

1. Shall have pediatric-specific policies and procedures pertaining to imaging studies of children

2. Radiology technicians must be in-house 24 hours per day, 7 days per week

3. Provide the following services 24 hours per day:

a. Nuclear medicine on-call and promptly available

b. Computerized Tomography (CT)

c. Ultrasound

d. Magnetic Resonance Imaging (MRI) on-call and promptly available

e. Angiography (may be provided through a transfer agreement)

C. Clinical laboratory shall have pediatric-specific policies and procedures pertaining to laboratory studies of children, including, but not limited to, obtaining samples by trained phlebotomists, micro technique for small or limited sample sizes, and ability to provide autologous and designated donor transfusions.

XI. PMC Committee

A. The purpose of the Committee is to establish a forum for exchange of ideas regarding the provision of emergency, inpatient and critical care to the pediatric patient.

B. The membership shall include interdepartmental and multidisciplinary representatives from the emergency department, PICU, pediatric unit, nursing, social services, respiratory services, discharge planning, SCAN team, and other relevant services as applicable, such as: prehospital care, pediatric sub-specialties, and pediatric interfacility transport team.

C. The Committee is responsible for all matters regarding the medical care provided to the pediatric patient which include, but not limited to, the following:

1. Review and recommend revision to policies and procedures to verify compliance with the PMC Standards

2. Review the quality improvement process to identify system-related performance and operational issues, and recommend corrective action plans

D. Meeting Frequency: Quarterly, additional meetings may be held on an as needed basis

E. Meeting minutes and attendance rosters shall be maintained and made available to the EMS Agency when requested

XII. Suspected Child Abuse and Neglect

A. Suspected Child Abuse and Neglect (SCAN) Team shall:

1. Consist of a medical director, coordinator, social worker, physician, and/or nurse consultants as applicable

2. Assist nursing and medical staff in the evaluation of pediatric patients who have alleged to have been abused or neglected

3. Have a member on-call and available to all areas of the hospital 24 hours per day

4. Review cases of suspected child abuse/neglect to verify adequacy of care, reporting and follow-up

B. SCAN Team Medical Director

Shall be board certified in Pediatrics and/or Child Abuse Pediatrics:

Responsibilities:

1. Collaborate with the SCAN Team Coordinator:

a. To monitor the SCAN Team’s activities

b. Ensure the development of education for nursing and medical staff in the evaluation of children suspected of child abuse and neglect.

2. Serve as a member of the PMC Committee

3. Oversee the review of suspected child abuse, neglect and sexual assault cases for appropriateness of care, compliance with mandated reporting and appropriateness of follow-up

C. SCAN Team Coordinator

Shall have experience and training in the management of a child abuse, neglect and sexual assault victim, and obtain 14 hours of pediatric education every four years

Responsibilities:

1. Oversees scheduling to ensure a SCAN Team member is available 24 hours per day/seven day a week

2. Serve as a member of the PMC Committee

3. Review cases of suspected child abuse, neglect and sexual assault in consultation with the SCAN Team Medical Director for appropriateness of care, compliance with mandated reporting, appropriateness of follow-up and completeness of documentation

4. Assist nursing and medical staff in the evaluation of children who have alleged to have been abused, neglected or sexually assaulted

5. Develop educational training for medical and nursing staff in the recognition and management of children with suspected child abuse, neglect and sexual assault

D. Social Worker

1. Qualifications:

a. Licensed to practice as a Medical Social Worker (MSW) by the State of California

b. Must have experience and training in the management of child abuse, neglect and sexual assault

c. Have 4 hours of continuing education every two (2) years in topics related to health, housing and welfare of children (e.g., child abuse reporting)

2. Responsibilities:

a. Assist nursing and medical staff in the evaluation of children alleged to have been abused, neglected or sexually assaulted

b. Provide support and resources for the abused, neglected or sexually assaulted children and their family

E. SCAN Team Physician and/or Nurse Consultants

1. Qualifications:

a. Physicians shall be board certified in Pediatrics, Child Abuse Pediatrics, or Emergency Medicine with medical experience in diagnosing and managing suspected child abuse, neglect and sexual assault cases

b. Nurse consultant shall have training and experience in evaluating and managing suspected child abuse, neglect and sexual assault cases

2. Responsibilities:

a. Provide guidance or consultation, as needed, in suspected child abuse, neglect or sexual assault cases

F. Pediatric Forensic Examination

1. The PMC shall ensure a forensic examination and an interview are completed for acute (defined as occurring within 120 hours) sexual assault/abuse event, or appropriate referral was made for such examination, if the event occurred over 120 hours

2. If the PMC does not provide the necessary forensic examination, a written consultation and transfer agreement shall exist with an EMS Agency designated SART Center

XIII. Pediatric Interfacility Transport (PIFT) Program

PMCs shall have a PIFT program or have written agreements to provide PIFT services for the timely transport of patients *in or out* of the PMC. The PIFT program shall have the capability to transport neonatal and pediatric patients. The PIFT program shall also include back-up processes or agreements for the timely transport of patients with time sensitive conditions when the estimated time of arrival of the primary transport team is greater than 1 hour.

A. PMCs with a PIFT program shall have program policies and procedures and composition of PIFT as determined by the level of care needed

1. The hospital maintaining the PIFT program shall have written agreements with referring and receiving facilities that utilize the program

2. Agreements should specify the role and responsibilities of the transport program and the hospitals to include the following:

a. Agreement to transfer and receive appropriate pediatric patients when indicated

b. Responsibilities for patient care before, during and after transport

c. Documentation and transferring appropriate information/records

B. If the PMC does not have a PIFT program, written agreements shall exist with agencies or other programs that will provide timely transportation of critically ill pediatric patients to and from the PMC. Written agreements shall be with a PIFT program that meets the specifications outlined in XIII.A.

XIV. Quality Improvement (QI) Program

A. The PMC shall develop a multidisciplinary QI program for the purpose of improving patient outcomes of critically ill children. The QI program shall interface with the emergency department, PICU, NICU, pediatric unit, SCAN Team, PIFT Program and EMS providers. The QI program shall also interface with hospital wide and emergency department QI activities.

B. The PMC Medical Director and Nurse Coordinator shall be responsible for the development, implementation and review of the QI program as it pertains to the care of the pediatric patients transported to the PMC.

C. The PMC's QI program shall meet the requirements stipulated in Ref. No. 620, Section V, QI Program Requirements, which includes, at minimum, the following:

1. QI Plan
2. Identification of indicators
3. Methods to collect data
4. Written results and conclusions
5. Recognition of improvement
6. Action(s) taken (e.g., education of staff or feedback to referring facilities and EMS providers)
7. Assessment of effectiveness of action(s) taken
8. Dissemination of QI information to stakeholders

D. The QI review process shall include, at a minimum, a detailed 100% physician review, tracking and trending of the following cases:

1. Deaths in the ED
2. Cardiac arrests brought in by EMS
3. Unexpected transfers for higher level of care
4. Sentinel events
5. Suspected child abuse, neglect and sexual assault
6. Readmissions to the PICU within 72 hours
7. Unexpected admissions from the operating room
8. Unplanned admissions to the PICU

E. The QI process shall include providing feedback, via appropriate process or channels, to referral facilities and/or EMS providers on items that may require commendation, positive reinforcement, fact-finding, case/peer review, education/competency verification or remediation.

XV. Data Requirement

A. Participate in the data collection process established by the EMS Agency.

B. Submit data to the EMS Agency, within 45 days of patient's discharge, which shall include data elements listed in Ref. No. 652, EDAP and PMC Data Dictionary.

CROSS REFERENCE:

Prehospital Care Policy Manual:
Ref. No. 216, **Pediatric Advisory Committee (PedAC)**
Ref. No. 316, **Emergency Department Approved for Pediatrics (EDAP) Standards**
Ref. No. 324, **SART Center Standards**
Ref. No. 506, **Trauma Triage**
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 508.1, **SART Center Roster**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 620, **EMS Quality Improvement Program**
Ref. No. 621, **Notification of Personnel Change**
Ref. No. 621.2, **Notification of Personnel Change Form**
Ref. No. 652, **EDAP and PMC Data Dictionary**

California Clinical Forensic Medical Training Center, California Sexual Assault Response Team (SART) Manual

California Children's Services: Provider Standards, https://dhcs.ca.gov/services/ccs/Pages/ProviderStandards.aspx
ACEP: Emergency Information Form, https://.acep.org/content.aspx?id=26276
AAP: Emergency Information Form, https://pediatriccare.solutions.aap.org/data/Multimedica/Emergency Information Form-SpecialNeeds.pdf

ACKNOWLEDGEMENTS

The EMS Agency Pediatric Medical Center Standards were first developed by the Committee on Pediatric Emergency Medicine (COPEM), Los Angeles County Pediatric Society, Pediatric Liaison Nurses of Los Angeles County, California Chapter of American College of Emergency Physicians (ACEP) National Emergency Medical Services for Children (EMSC) Resource Alliance, American Academy of Pediatrics California Chapter 2, Emergency Nurses Association, and the EMS Agency.

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

REFERENCE NO. 318, Pediatric Medical Center (PMC) Standards

	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			
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee	09/10/2019	09/10/2019	Yes
	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**

POLICY REVIEW - SUMMARY OF COMMENTS REFERENCE NO. 202.2

REFERENCE NO. 318, Pediatric Medical Center (PMC) Standards

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
III. PMC Leadership Requirements B.1.c.	PedAC 09-10-2019	Delete the wording "pediatric critical care" after 'Shall have'. Change the wording to "…approved pediatric critical care education…"	Change made Change made
IV. Personnel Requirements A.1.c.	PedAC 09-10-2019	Delete the wording "during on call periods"	Change made
VIII. PICU Equipment, Supplies and Medication C.2.d	PedAC 09-10-2019	Change the wording to "Thermometer with hypothermic capabilities"	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **SEXUAL ASSAULT RESPONSE TEAM (SART) CENTER STANDARDS** REFERENCE NO. 324

PURPOSE: To establish minimum standards for the designation of Sexual Assault Response Team (SART) Centers. The SART Centers provide care to victims of sexual assault by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures.

The goal of the Los Angeles County Emergency Medical Services (EMS) Agency is to transport these patients to a SART Center, where healthcare practitioners have special training in treating victims of sexual assault/abuse and in the collection of forensic evidence.

DEFINITIONS:

Board Certified (BC): Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialties (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 program with progression to board certification based on the time frame specified by the ABMS or AOA.

California Governor's Office of Emergency Service (Cal OES): Cal OES Public Safety Division provides funding to programs that train law enforcement, court education, victim notification, victim/witness assistance, reducing crime lab backlogs, and post-conviction DNA testing. Cal OES has developed the standardized forensic-medical forms which must be used to document the sexual assault examination.

Department of Children and Family Services (DCFS): A mandated component of Emergency Response Services, administered by the Los Angeles County Department of Children and Family Services. The Child Protection Hotline (CPH) intake evaluation staff is responsible for assessing any referral, whether verbal or written, which alleges child abuse, neglect or exploitation to determine whether an in-person investigation and consultation is required.

Patient: A person who has been sexually assaulted. The patient can also be identified as the victim and/or survivor. In the criminal justice system, the patient is identified as a crime victim. For rape crisis centers providing counseling and advocacy, the patient is identified as a survivor.

Qualified Medical Specialist: A physician licensed in the State of California who is BC or BE in the corresponding specialty by the ABMS or AOA.

Qualified Health Care Professional: Any physician or surgeon, or a nurse or a professional registered nurse working in consultation with a physician and surgeon who conducts examinations or provides treatment in a general acute care hospital or in a physicians or surgeon's office pursuant to the California Penal Code 13823.5 (e).

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

Rape Crisis Advocate: An individual who is affiliated with a Rape Crisis Center and functions as a support person for the patient throughout the entire medical/legal process and who meets the requirements of Penal Code 679.04.

Sexual Assault Forensic Examiner (SAFE) / Sexual Assault Nurse Examiner (SANE): A specially trained healthcare provider (i.e., physician, nurse practitioner, physician assistant, registered nurse) who independently and competently performs sexual assault forensic medical exams. Examiners are trained healthcare professionals who perform adult and adolescent sexual assault forensic medical examinations and/or child sexual abuse forensic medical examinations.

Sexual Assault Response Team (SART)**:** A coordinated interdisciplinary intervention model between law enforcement, crime laboratory, District Attorney's (DA) Office, medical and advocacy experts to meet the forensic needs of the criminal justice system and the medical and emotional needs of the sexual assault/abuse victim.

Sexual Assault Response Team (SART) Centers: A hospital sponsored program that is designated by the EMS Agency to receive patients who are victims of sexual assault/abuse. A SART Center specializes in forensic examinations in the case of an acute sexual assault/abuse event (defined as occurring within 120 hours), which has the capabilities of providing comprehensive medical forensic examinations and psychological support. The center consists of knowledgeable staff whose training, expertise, and state-of-the-art equipment exceeds the community standards.

Quality Improvement (QI): The analysis of performance and systematic effort to improve it.

POLICY:

I. SART Center Designation / Re-Designation Agreement:

A. SART Center initial designation and SART Center re-designation is granted for a period of three years after satisfactory review by the EMS Agency

B. The EMS Agency reserves the right to perform scheduled site visits or request additional data of the SART Center at any time

C. The SART Center shall immediately provide written notice to the Director of the EMS Agency if unable to adhere to any of the provisions set forth in the SART Center Standards

D. The SART Center shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw from the SART program.

E. The SART Center shall notify the EMS Agency within 15 days, in writing of any change in status of the SART Medical Advisor or SART Program Director/Coordinator by submitting the Notification of Personnel Change Form (Reference No. 621.2)

F. Execute and maintain a Specialty Care Center SART Center Designation Agreement with the EMS Agency

II. General SART Center Requirements

A. All designated SART Centers shall be sponsored by a hospital and the hospital shall be:

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

a. Be approved for Basic or Comprehensive Emergency Medical Services

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

c. Have a SART team available 24 hours a day, 7 days a week.

d. Have a dedicated private space away from the emergency department that provides a secure area for the examination and interview process

B. SART Center Leadership Requirements:

1. SART Center Medical Advisor

a. Qualifications:

i. BC in Emergency Medicine, Obstetrics/Gynecology, Family Practice or Pediatrics with education and interest in the care of patients/victims of sexual assault

ii. Completion of the initial SAFE Course for adult/adolescent and pediatrics, minimum of 40-hour curriculum, in compliance with the medical forensic examination standards set forth in the Penal Code 13823.11

iii. Complete eight hours of approved continuing medical education (CME) related to sexual assault forensic examination every three years

b. Responsibilities:

i. Be available for consultation with forensic examiners as needed

ii. Ensure up-to-date knowledge and skills regarding sexual assault forensic medical examination performance and interpretation of findings

iii. Coordinate medical care across departmental and multidisciplinary services as needed

iv. Provide medical oversight in the development, implementation, and maintenance of a comprehensive QI

program as it pertains to the care of the sexual assault victim

v. Collaborate with the SART Center Program Director on educational programs: review and ensure content is medically sound and appropriate

vi. Be available for consultation with other SART Centers, EMS providers, EMS Agency, community hospitals (non-SART), local health clinics, law enforcement, local crime laboratory, rape crisis advocacy response groups, DA's Office and forensic examiners.

c. A written job description defining the authority and responsibilities of the SART Center Medical Advisor shall exist

2. SART Program Director

a. Qualifications

i. A Registered Nurse currently licensed to practice in the State of California

ii. Completion of the initial SAFE Course for adult/adolescent and pediatrics, minimum of 40 hours curriculum, in compliance with the medical forensic examination standards set forth in the Penal Code 13823.11

iii. Completion of eight hours of Board of Registered Nursing (BRN) approved continuing education (CE) related to sexual assault forensic examinations every three years

b. Responsibilities

i. Implement and ensure compliance with the SART Center Standards

ii. Ensure that a chairperson is designated for the Multidisciplinary SART Center Committee

iii. Ensure that a QI process is in place to identify, review, and correct deficiencies in the delivery of care to the sexual assault victim

iv. Ensure that appropriate sexual assault education programs are provided to the SART Center personnel in collaboration with the SART Center Medical Advisor

v. Maintain records of completed continuing education by SART Center personnel

vi. Liaison with other SART Centers, EMS providers, EMS Agency, community hospitals, local health clinics, law

enforcement, local crime laboratory, rape crisis advocacy response groups, DA's Office and forensic examiners as needed

vii. Serve as a contact person for the EMS Agency and be available upon request to respond to County business regarding SART Center issues.

viii. Ensures the EMS Agency is notified, in writing, when there is a personnel change of the SART Center Medical Advisor or SART Center Program Director

ix. Ensure compliance with SART Center Standards and EMS Agency policies and procedures related to the care of sexual assault/abuse victims

x. Ensure that the QI reports are presented at applicable SART or hospital committees (e.g.: ED, hospital-wide QI, and/or pediatric committees)

xi. Ensures that all SART Center policies and procedures are reviewed at least annually with multidisciplinary committee approval at least triennial

c. A written document defining the authority and responsibilities of the SART Center Program Director shall exist

C. Personnel

1. Sexual Assault Forensic Examiner (SAFE) / Sexual Assault Nurse Examiner (SANE)

a. Qualifications:

i. Licensed as a Physician, RN, or Physician Assistant in the State of California

ii. Completion of the initial SAFE Course for adult/adolescent and pediatrics, minimum of 40-hour curriculum, in compliance with the medical forensic examination standards set forth in the Penal Code 13823.11

iii. Completion of eight hours of BRN or CME approved CE related to sexual assault forensic examinations every three years

b. A written job description defining the authority and responsibilities of the SAFE/SANE Examiner shall exist

2. Rape Crisis Center Personnel

a. Rape Crisis Center Director provides leadership advocating for the needs and rights of the survivors, provides Cal OES training for

rape crisis advocates, and maintains on-call schedules indicating 24-hour, 7 days a week availability

b. Rape Crisis Center Advocate shall have successful completion of a 40-hour training consistent with Cal OES training and in-service requirements set forth in the Penal Code 679.04

c. A written document defining the authority and responsibilities of the Rape Crisis Center Director and Advocate shall exist

III. Competency

Competency of all SART Center examiners shall be evaluated during orientation and at least annually to ensure up-to-date knowledge and skills regarding sexual assault forensic medical exam performance and interpretation of findings to include the following:

A. Consents

1. Explains exam

2. Obtains consents per the Cal OES forms and protocols

3. Assesses patients understanding of explanation

B. Interview – Uses therapeutic approach to information gathering (Assault History)

C. Obtains complete history per Cal OES forms and protocols and clarifies events as needed

D. Examination

1. Physical exam per Cal OES protocol

2. Exam relevant to history or per Cal OES protocol

3. Identifies physical findings

E. Evidence Collection

1. Identifies appropriate areas for collection

2. Collects evidence accurately per Cal OES protocols

3. Handles, labels, and packages evidence properly

4. Demonstrates and maintains chain of custody

F. Equipment – Demonstrates proficiency in use of site specific equipment (alternate light source, camera, digital imaging system, colposcope, etc.)

G. Documentation – Accurately and properly completes the most current Cal OES 2-923 Form to include accurate documentation of injuries

H. Medical Care

1. Assesses and explains risks of sexually transmitted infections and HIV post exposure prophylaxis (PEP), and/or pregnancy

2. Offers appropriate screening and/or diagnostic tests as applicable

3. Appropriately offers and administers medications and/or treatments as indicated

4. Provides and reviews with patient, recommended aftercare instructions

5. Provides appropriate referrals

IV. Multidisciplinary SART Center Committee

A. The multidisciplinary SART Center Committee should meet, at a minimum, on a quarterly basis and more frequently as needed, to review system-related performance issues. The committee members or a designee shall attend at least 50% of the meetings.

B. The multidisciplinary SART Center committee shall include representatives from the following:

1. EMS Provider(s), as applicable

2. Emergency Department

3. Law Enforcement

4. SAFE/SANE

5. Rape crisis advocacy groups

6. Local crime laboratory

7. District Attorney's (DA) Office

C. Responsibilities:

1. Review and ensure compliance with the SART Center Standards

2. Review and ensure the coordination of SART services across departmental and multidisciplinary lines

3. Review and ensure a comprehensive and multidisciplinary quality improvement (QI) program as per Section V

4. Review and discuss the development and implementation of policies and procedures listed in Section VI

5. Maintain attendance rosters and meeting minutes. The minutes shall

reflect the review including, when appropriate, the analysis and proposed corrective actions.

V. Quality Improvement (QI) Program Requirements

QI program shall be developed as per Reference No. 620, EMS Quality Improvement Program, and monitored by the SART Center Director and SART Center Medical Advisor.

A. Program shall be an organized multidisciplinary program for the purpose of improving care of the sexual assault victim and ensuring the integrity of evidence collection

B. A written SART QI Program plan shall be developed, monitored, and reviewed by the SART Center Program Director and Medical Advisor at a minimum of every two years

C. SART personnel shall interface with EMS, emergency department, law enforcement, SAFE/SANE, local crime laboratory, rape crisis advocate, DA's Office and other relevant services regarding identified QI issues as needed

D. A written QI plan, tracking and trending reports, agenda, minutes and attendance rosters shall be maintained

E. Timely QI review should occur following each exam. This review should include:

1. Review of Cal OES examination form documentation

2. Review of forensic digital images which must also be retrievable for summons at the DA's request

3. Evidence collection procedures and management

4. Incorporation of feedback information from the crime laboratory when available

F. Submit data as requested by the EMS Agency for quality improvement purposes to include number of medical examinations, based on the following categories: Adult, Pediatric, Suspects, and DCFS referrals to the Medical Hub as applicable.

VI. Policies

A. There shall be a current SART Center policy manual reviewed and signed by the Program Director and Medical Advisor and readily accessible in the SART Center.

B. SART Centers shall follow the Cal OES protocols and utilize the current Cal OES forms and shall establish specific written policies that address, but are not limited to, the following:

1. Hours of operation, patients served (adults and/or pediatric), provisions for after-hours and mobile examinations

2. Role and responsibilities of the SART members

3. Patient care management to include:

    a. Providing examination within 120 hours from time of sexual assault

    b. Physician availability and/or consultation of the sexually abused patient

    c. Patient request for a physician examination

4. Consent for forensic evaluation

5. Unconscious sexual assault patient

6. Strangulation sexual assault patient

7. Alcohol and Drug Facilitated Sexual Assault (DFSA) patient

8. Management of Injuries

9. Family presence during examination

10. SART Activation or “CALL-OUT” procedures

11. Emergency Department Medical Screening Examination

12. Referral of pediatric patients who are victims of sexual assault to hospitals with a pediatric SART, if applicable.

13. Patient referral from non-SART hospitals

14. Treatment recommendations and aftercare instructions for the following:

    a. Sexually transmitted infection prophylaxis

    b. Pregnancy prophylaxis

    c. Healthcare referral and follow up

    d. HIV information and referral for immediate HIV PEP

    e. First Aid Instructions

    f. Referrals for counseling and mental health follow up

15. Medical record storage and release, including digital images

16. Evidence collection and storage, including locked refrigerator storage

17. Routine maintenance and monitoring of equipment

18. Specific populations and their needs, which include but are not limited to

the following:

a. Persons with disabilities

b. Hearing impaired

c. Elderly

d. Pregnant

e. Provision for foreign language translation

f. Suspect exams:

i. Process ensuring that the victims do not come in contact with the suspect

ii. Back-up-procedure to ensure the same examiner does not perform both the victim and suspect exam whenever possible, and a policy in preventing cross contamination if the same examiner does both exams

g. Lesbian, gay, bisexual, transgender/transsexual, queer/questioning, intersex, and asexual (LGBTQIA)

19. Interface with the other agencies/departments, including:

a. Law enforcement

b. Local crime laboratory

c. County/City DA's Office

d. Local rape crisis center

e. Other SART centers

f. Adult Protective Services

g. DCFS

h. Shelters for battered women

i. Child abuse and neglect treatment centers

j. County/City Public Health Departments

k. County/City Victim Witness Assistance Programs

l. Local Health Clinics

m. County Mental Health Services

VIII. Space, Equipment, Supplies and Medications

A. Safety for patients and the SART members, privacy and confidentiality for patients, and comfortable peaceful surroundings are important considerations

B. SART equipment, supplies, and medications shall be easily accessible, labeled, and logically organized

C. The following are minimum requirements for space, equipment, supplies, and medications:

1. The SART Center shall be a designated space located away from the emergency department and include:

a. Designated examination room

b. Designated patient bathroom

c. Waiting room for the patients, family members, and friends which ensures privacy

d. Separate waiting area for law enforcement which supports their report writing

e. Evidentiary examination supplies and sexual assault evidence collection kit storage

f. Storage for administrative and forensic medical records

2. The following is the minimum required equipment, supplies and medications:

a. Locked specimen refrigerator for storage of evidence with chain of custody

b. Sexual assault evidence collection kits from the local crime laboratory

c. Small copier near the exam room

d. Accessible fax machine

e. Videocamera, Camera, or Colposcope with photographic capabilities

f. Alternate light source

g. Swab dryer

h. Digital imaging system

i. Examination table with stirrups

j. Secure area to preserve the chain of custody

k. Locked file cabinets to store forensic records

l. Medications for:

i. Pregnancy prophylaxis

ii. Treatment of sexually transmitted diseases after sexual assault as recommended by current Center for Disease Control and Prevention (CDC) guidelines

CROSS REFERENCE:

Prehospital Care Policy Manual
Reference No. 508, **Sexual Assault Patient Destination**
Reference No. 508.1, **SART Center Roster**
Reference No. 620, **EMS Quality Improvement Program**
Reference No. 621, **Notification of Personnel Change**
Reference No. 621.2, **Notification of Personnel Change Form**
Reference No. 822, **Suspected Child Abuse/Neglect Reporting Guidelines**

REFERENCES:

California Clinical Forensic Medical Training Center California Sexual Assault Response Team (SART) Manual, https://www.ccfmtc.org/
Cal OES 2-923 Adult/Adolescent Sexual Assault Forensic Medical Report
Cal OES 2-924 Abbreviated Adult/Adolescent Sexual Assault Examination Forensic Medical Report
"Sexual Assault and Abuse and STDs -2015 STD Treatment Guidelines." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 4 June 2015, www.cdc.gov/std/tg2015/sexual-assault.htm
Federal Violence Against Women Act (VAWA)

ACKNOWLEDGEMENTS

The Los Angeles County Sexual Assault Committee (LACSAC), and the California Coalition Against Sexual Assaults (CALCASA) made significant contributions in the development of these SART Center Standards.

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

REFERENCE NO. 324, Sexual Assault Response Team (SART) Center Standards

	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			
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: SART Program Coordinators	08/26/2019	08/26/2019	Yes

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

POLICY REVIEW - SUMMARY OF COMMENTS REFERENCE NO. 202.2

REFERENCE NO. 324, Sexual Assault Response Team (SART) Center Standards

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
IV. Policies B.18.f.ii	SART Center Program Managers 8/26/2019	Add wording “whenever possible, and a policy to prevent cross contamination”	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT-I, PARAMEDIC, MICN)

SUBJECT: **PEDIATRIC PATIENT DESTINATION** REFERENCE NO. 510

PURPOSE: To ensure that 9-1-1 pediatric patients are transported to the most appropriate facility that is staffed, equipped and prepared to administer emergency and/or definitive care appropriate to the needs of the pediatric patient.

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

DEFINITIONS:

Pediatric Patient: Children 14 years of age or younger.

Emergency Department Approved for Pediatrics (EDAP): A licensed basic or comprehensive emergency department that is designated by the Emergency Medical Services (EMS) Agency to receive pediatric patients via the 9-1-1 system.

Pediatric Medical Center (PMC): A licensed acute care hospital that is approved by the County of Los Angeles EMS Agency to receive critically **ill** pediatric patients via the 9-1-1 system based on guidelines outlined in this policy. These centers also provide referral services for critically ill pediatric patients.

Pediatric Trauma Center (PTC): A licensed acute care hospital that is designated by the EMS Agency to receive critically **injured** pediatric patients via the 9-1-1 system based on guidelines outlined in this policy. These centers provide tertiary-level pediatric care and serve as referral centers for critically injured pediatric patients.

Brief Resolved Unexplained Event (BRUE): A brief episode characterized by any one of the following (for children 12 months of age or younger): absent, decreased, or irregular breathing; color change (usually cyanosis or pallor); marked change in muscle tone (usually limpness or hypotonia, may also include hypertonia); and/or altered level of responsiveness.

PRINCIPLE:

In all cases, the health and well-being of the patient is the overriding consideration in determining patient destination. Factors to be considered include severity and stability of the patient's illness or injury; current status of the pediatric receiving facility; anticipated transport time; request by the patient, family, guardian or physician; and EMS personnel and base hospital judgment.

POLICY:

I. Guidelines for transporting pediatric patients to a specialty care center (i.e., EDAP, PMC, PTC, Perinatal, Sexual Assault Response Team Center, or Trauma Center):

   A. Patients who require transport, and do not meet guidelines for transport to a

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

PMC or PTC shall be transported to the most accessible EDAP.

B. BLS units shall call for an ALS unit on pediatric patients who meet criteria for Base Hospital Contact and ALS Transport as listed in Ref. No. 1200.1, Treatment Protocols General Instructions.

C. BLS units shall transport pediatric patients not requiring ALS unit response to the most accessible EDAP unless criteria are met for Treat and Refer as outlined in Ref. No. 834, Patient Refusal of Treatment/Transportation and Treat and Release at Scene.

D. Patients meeting medical guidelines for transport to a PMC:

1. Shall be transported to the most accessible PMC if ground transport is ≤30 minutes.

2. If ground transport time to a PMC is >30 minutes, the patient may be transported to the most accessible EDAP.

E. Patients meeting trauma criteria/guidelines for transport to a PTC:

1. Shall be transported to the most accessible PTC if the transport time is ≤30 minutes.

2. If a PTC cannot be accessed but a trauma center can be accessed under the parameter in (E.1), the patient may be transported to the trauma center.

3. If a PTC or trauma center cannot be accessed as specified above, the patient may be transported to the most accessible PMC, or if >30 minutes to the closet EDAP.

F. Pediatric patients who have an uncontrollable, life-threatening situation (e.g., unmanageable airway or uncontrollable hemorrhage) shall be transported to the most accessible EDAP.

G. Pediatric patients may be transported to a non-EDAP provided all of the following are met:

1. The patient, family, or private physician requests transport to a non-EDAP facility.

2. The patient, family, or private physician is made aware that the receiving facility is not an EDAP and may not meet current EDAP standards.

3. The base hospital concurs and contacts the requested facility and ensures that the facility has agreed to accept the patient.

4. All of the above shall be documented on the Patient Care Record.

II. Guidelines for identifying critically **ill** pediatric patients who require transport to a PMC:

A. Cardiac dysrhythmia

B. Severe respiratory distress

C. Cyanosis

D. Persistent altered mental status

E. Status epilepticus

F. Brief Resolved Unexplained Event (BRUE) ≤12 months of age

G. Focal neurologic signs not associated with trauma (e.g.; pediatric stroke, atypical migraine, petit mal seizures)

H. Choking associated with cyanosis, loss of tone or apnea

III. Guidelines for identifying critically **injured** pediatric patients who require transport to a PTC:

Trauma triage criteria and/or guidelines identified in Ref. No. 506, Trauma Triage.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 316, **EDAP Standards**
Ref. No. 318, **Pediatric Medical Care (PMC) Standards**
Ref. No. 324, **Sexual Assault Response Team (SART) Standards**
Ref. No. 502, **Patient Destination**
Ref. No. 504, **Trauma Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 508.1, **SART Center Roster**
Ref. No. 511, **Perinatal Patient Destination**
Ref. No. 512, **Burn Patient Destination**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 816, **Physician at Scene**
Ref. No. 832, **Treatment/Transport of Minors**
Ref. No. 834, **Patient Refusal of Treatment/Transport and Treat and Release at Scene**
Ref. No. 1200.1, **Treatment Protocols General Instructions**

California Emergency Medical Services Authority (EMSA) # 182: Administration, Personnel and Policy for the Care of Pediatric Patients in the Emergency Department

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

REFERENCE NO. 510, Pediatric Patient Destination

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	08/14/2019	08/14/2019	No
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee	08/21/2019	08/21/2019	No
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee	09/10/2019	09/10/2019	No
	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

(EMT-I/EMT-P/MICN)

SUBJECT: **TREATMENT/TRANSPORT OF MINORS** REFERENCE NO. 832

PURPOSE: To describe the guidelines for treatment and/or transport of a patient under the age of eighteen.

AUTHORITY: Health and Safety Code Section 124260
California Family Code 6922, 6925, 6926, 6927, 6929(, 7002, 7050, 7122, 7140
Business and Professions Code 2397

DEFINITIONS:

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

Implied Consent: In the absence of a parent or legal representative, emergency treatment and/or transport of a minor may be initiated without consent.

Legal Representative: A person who is granted custody or conservatorship of another person by a court of law.

Minor: A person less than eighteen years of age.

Minor not requiring parental consent is a person who is:

1. Married or was previously married.
2. Not married and has an emergency medical condition and parent is not available.
3. On active duty with the Armed Forces.
4. Self-sufficient 14 years of age or older, living separate and apart from his/her parents, and managing his/her own financial affairs.
5. An emancipated minor with a declaration by the court or an identification card from the Department of Motor Vehicles.
6. Seeking care related to the treatment or prevention of pregnancy.
7. In need of care for sexual assault or rape.
8. Seeking care related to an abortion.

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

9. 12 years of age or older and in need of care for communicable reportable disease, prevention of a sexually transmitted infection (STI), alcohol or substance abuse, or outpatient mental health.

Voluntary Consent: Treatment or transport of a minor child shall be with the verbal or written consent of the parents or legal representative.

PROCEDURES:

I. Treatment/Transport of Minors

A. In the absence of a parent or legal representative, minors with an emergency medical condition shall be treated and transported to the appropriate receiving facility or a specialty care center (e.g. EDAP, PMC, PTC, SART Center, Trauma Center, etc.).

B. Hospital or provider agency personnel shall make every effort to inform a parent or legal representative where their child has been transported.

C. If prehospital care personnel believe a parent or other legal representative of a minor is making a decision which appears to be endangering the health and welfare of the minor by refusing indicated immediate care or transport, law enforcement authorities should be involved.

D. Infants ≤ 12 months of age shall be transported, regardless of chief complaint and /or mechanism of injury, in accordance with Ref. No. 1200.2, Treatment Protocol: Base Contact Criteria.

II. Minors **Not** Requiring Transport

A. A minor child (excluding children ≤ twelve (12) months of age) who is evaluated by EMS personnel and determined not to be injured, to have sustained only minor injuries, or to have illnesses or injuries not requiring immediate treatment or transportation, may be released to:

1. Self (consideration should be given to age, maturity, environment and other factors that may be pertinent to the situation)

2. Parent or legal representative

3. A responsible adult at the scene

4. Designated care giver

5. Law enforcement

B. Children 13 - 36 months of age require base hospital contact and/or transport, except those with no medical complaint or with isolated minor extremity injury.

C Prehospital care personnel shall document on the EMS Report Form to whom the patient was released.

CROSS REFERENCE:

Prehospital Care Manual
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 508.1, **SART Center Roster**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 822, **Suspected Child Abuse Reporting Guidelines**
Ref. No. 834, **Patient Refusal of Treatment / Transport & Treat & Release at Scene**
Ref. No. 1200.2 **Treatment Protocol: Base Contact Requirements**

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

REFERENCE NO. 832, Treatment / Transport of Minors

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	08/14/2019	08/14/2019	No
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee	08/21/2019	08/21/2019	No
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee	09/10/2019	09/10/2019	No
	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: **PARAMEDIC TRAINING PROGRAM APPROVAL** REFERENCE NO. 901

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

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

DEFINITIONS:

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

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

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

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

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

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

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

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

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

PRINCIPLES:

1. The purpose of a paramedic training program is to prepare individuals for licensure in order to render prehospital ALS at the scene of an emergency, during transport of the sick and injured, or during interfacility transfer within an organized EMS system.

2. Los Angeles County approved paramedic training programs shall meet State regulations and established EMS Agency policies.

3. Eligible training institutions requesting approval shall meet the standards for CAAHEP accreditation.

4. New programs shall submit their application, fee, and self-study for accreditation to CoAEMSP within twelve (12) months following the start-up of classes.

5. New programs shall receive and maintain CAAHEP accreditation no later than two years from the date of application to CoAEMSP for accreditation.

6. Only paramedic training programs and locations approved by the EMS Agency may provide training in Los Angeles County. This applies to all phases of training.

7. Approved training program shall provide clinical and internship assignments for 100% of their students within the required time frames.

8. Approved training programs, shall notify the EMS Agency in writing, within thirty (30) days, of changes in curriculum, hours of instruction, program staff, and clinical and field internship sites.

9. Approved training programs shall participate in the EMS System Quality Improvement Program (EMSQIP).

10. Training programs may be approved as a Continuing Education (CE) provider.

11. Paramedic interns shall be measured against the standard of entry level paramedics.

POLICY:

I. Approving Authority

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

II. Program Eligibility

Eligibility shall be limited to the following institutions:

A. Accredited universities and colleges, including junior and community colleges, and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau of Private Postsecondary Education.

B. Medical training units of a branch of the Armed Forces or Coast Guard of the United States.

C. Licensed general acute care hospitals which meet all of the following criteria:

1. Hold a special permit to operate a basic or comprehensive emergency medical service pursuant to the provisions of Division 5.

2. Provide continuing education (CE) to other health care professionals.

3. Accredited by a Center for Medicare and Medicaid Services approved deeming authority.

D. Agencies of government.

III. Application

A. Eligible training institutions shall submit a written request for program approval to the EMS Agency Director.

B. Obtain an application packet from the EMS Agency. The required content that should be submitted to the EMS Agency is listed in the application instructions.

C. Current CAAHEP accredited programs shall submit the following:

1. All documents submitted to and received from CoAEMSP and CAAHEP to include, but not limited to:

a. Initial approval documentation

b. Self-study documents

c. Documents required to maintain accreditation

d. Annual report

e. Copy of current accreditation certificate

f. Copy of academic affiliation

IV. Program Requirements

A. Student Eligibility: All candidates shall:

1. Possess a high school diploma or general education equivalent (GED).

2. Possess a current basic cardiac life support (CPR) card for BLS Provider, Healthcare Provider or Professional Rescuer which meet the current American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care.

3. Be certified as one of the following:

a. California emergency medical technician (EMT)

b. California Advanced EMT

4. Have current CPR and EMT certifications at time of entry into a paramedic training program and remain current throughout all phases of training.

5. Have a minimum of six (6) months full-time or one (1) year part-time EMT experience.

B. Course Content

1. Paramedic Training Program course hours shall consist of no less than one thousand and ninety (1090) hours and are divided as follows:

a. Minimum of four-hundred and fifty (450) hours didactic instruction and skills laboratories.

b. Minimum of one hundred and sixty (160) hours clinical experience.

c. Minimum of four hundred and eighty (480) hours field internship with at least fifty (50) ALS contacts. An ALS patient contact shall be defined as the performance of one or more ALS skills, except cardiac monitoring and CPR.

2. Excluded from program hours are:

a. Course material designed to teach or test exclusively EMT knowledge or skills, including CPR.

b. Examination for student eligibility.

c. The teaching of any material not prescribed in the National EMS Education Standards – Paramedic.

d. Written and practical student testing.

e. Examination for paramedic licensure.

3. Didactic Instruction and Skills Practice

a. Didactic/skills practice shall consist of no less than four hundred and fifty (450) hours.

b. The content of a paramedic course shall meet the current National EMS Education Standard, Paramedic Curriculum.

c. Course shall include EMS Agency mandatory training programs, which reflect current practice and policies, Ref. No. 1200, *Treatment Protocols* and Ref. No. 1300, *Medical Control Guidelines*.

d. Conduct periodic competency-based examinations and a final comprehensive written and practical examination using program passing criteria.

e. No more than six students shall be assigned to one instructor during skills practice/laboratory.

4. Clinical Education

a. The clinical education and training shall consist of no less than one hundred and sixty (160) hours.

i. A minimum of one hundred and twenty (120) hours must be assigned in a general acute care hospital.

ii. An additional forty (40) hours may be assigned out of the hospital setting as approved by the EMS Agency.

b. Program shall provide clinical assignments for 100% of their students within thirty (30) days of completion of didactic instruction. The course director and student may mutually agree to a later date in the event of a special circumstance such as student illness, death or birth in the family, student's military duty, etc.

c. Program shall have signed written agreements (to include end date) with each clinical facility.

d. Clinical assignments shall include, but not limited to emergency, cardiac, surgical, obstetrical, and pediatric patients.

e. No more than two (2) students shall be assigned to one preceptor or health care professional during the supervised clinical education, which includes direct patient care responsibilities.

f. Medication administration and procedures shall include those in Ref. No. 803, Paramedic Scope of Practice and any paramedic skill that the precepting health care professional feels comfortable having the student perform with supervision.

5. Field Internship

a. The student must meet the EMS Agency requirements to intern in Los Angeles County and pass the written Accreditation Examination.

b. Programs shall provide internship assignments for 100% of their students within ninety (90) days after completion of the clinical education. The course director and student may mutually agree to a later date in the event of a special circumstance such as student illness, death or birth in the family, student's military duty, etc.

c. Field internship shall consist of no less than four hundred and eighty (480) hours and shall not go beyond six (6) months from the date of beginning field internship.

d. The field provider must be a primary 9-1-1 ALS provider with a minimum run volume of one thousand two hundred (1200) EMS responses in the previous calendar year.

e. Programs shall have signed written agreements (to include end date) with ALS providers.

f. Field preceptor assignments shall be coordinated with the training program and the ALS provider to ensure the preceptor has the required experience and training.

g. No more than one intern shall be assigned to a response vehicle during the intern's internship.

h. The intern shall perform a minimum of fifty (50) ALS patient contacts. At least 50% of contacts shall be in the team lead role providing the full continuum of care, beginning with the initial contact through release of the patient to a receiving hospital or medical care facility.

i. Documentation of the intern's progress, including identified weaknesses or problems, shall be provided to the intern daily with a comprehensive evaluation at the 7th, 14th, and 20th shift, and following extension shifts.

j. Internship must be completed within 6 months after the end of the clinical phase. The course director and student may mutually agree to a later date in the event of a special circumstance such as student illness, death or birth in the family, student's military duty, etc.

k. Successful performance in the clinical and field setting shall be required prior to course completion.

V. Teaching Staff Qualifications and Responsibilities

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

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

1. Four (4) semester units of upper division credit in educational materials, methods, and curriculum development, or equivalent.

2. California State Fire Marshall (CSFM) "Instructor I and II.

3. National Fire Academy's (NFA) "Fire Service Instructional Methodology Course", or equivalent.

4. National Association of EMS Educators "EMS Instructor Course".

5. Courses which meet the U.S. Department of Transportation/National Highway Traffic Safety 2002 Guidelines for Educating EMS Instructors.

A. Medical Director

1. Qualifications:

a. Currently licensed and in good standing in the State of California as a physician.

b. Two (2) years experience in prehospital care in the last five (5) years.

c. Qualified by education or experience in methods, materials, and evaluation of instruction.

d. Attend the Los Angeles County EMS Orientation (new Medical Directors, only).

2. Responsibilities shall include, but are not limited to:

a. Review and approve educational content of the program curriculum, training objectives for clinical and field instruction, and to certify the ongoing appropriateness and medical accuracy of the program.

b. Review and approve the quality of medical instruction, supervision, and evaluation of students in all areas of the program.

c. Approve provisions for hospital and/or medical facilities for clinical and field internship experiences.

d. Approve principal instructors in conjunction with the course director.

B. Course Director

1. Qualifications:

a. Currently licensed in California as a physician, registered nurse, or paramedic who has a baccalaureate degree, or an individual who holds a baccalaureate degree in a related health field or education.

b. Minimum of one (1) year experience in an administrative or management level position.

c. Minimum of three (3) years academic or clinical experience in prehospital care education within the last five (5) years.

d. Qualified by education and experience in methods, materials, and evaluation of instruction.

e. Attend the Los Angeles County EMS Orientation (new Course Directors only).

2. Responsibilities shall include, but are not limited to:

a. Provide administrative oversight, organize, and supervise the educational program.

b. Approve principal instructor(s), teaching assistant(s), clinical and field preceptors, in conjunction with the Medical Director.

c. Approve clinical and field internship assignments.

d. Coordinate the development of curriculum, including instructional objectives, and approve all methods of evaluation.

e. Ensure training program compliance with State regulations, current EMS policies, and other related laws.

f. Sign all course completion records.

g. Maintain all course records for a period of four (4) years.

C. Principal Instructor(s)

1. Qualifications:

a. Currently licensed in California as a physician, registered nurse, physician assistant, or paramedic.

b. Two (2) years experience in advanced life support prehospital care.

c. Knowledgeable in the course content of the most recent National EMS Education Standards, Paramedic course curriculum.

d. Work Experience and Education:

i. Six (6) years experience in an allied health field and an associate degree; OR

ii. Two (2) years experience in an allied health field and a baccalaureate degree.

e. Qualified by education and experience in methods, materials, and evaluation of instruction.

2. Responsibilities shall include, but are not limited to:

    a. Curriculum development

    b. Course coordination

    c. Course instruction

D. Teaching Assistant(s)

1. Qualifications:

    Teaching Assistant (s) are qualified by training and experience in prehospital care. A teaching assistant shall be supervised by a principal instructor, the course director, and/or the medical director.

2. Responsibilities shall include, but are not limited to:

    a. Assist with teaching the course.

    b. Teach and test the required skills.

E. Hospital/Medical Facility Clinical Preceptor(s)

1. Qualifications:

    a. Currently licensed in California as a physician, registered nurse, or physician assistant.

    b. Worked in emergency medical care for the last two (2) years.

    e. Received instruction in evaluating paramedic students in the clinical setting which may include educational brochures, orientation, clinical training programs, or training videos.

2. Responsibilities include, but are not limited to:

    a. Create a positive and supportive learning environment.

    b. Evaluate student ability to safely administer medications and perform assessments.

    c. Assess student behaviors using cognitive, psychomotor, and affective domains.

    d. Document student performance using established criteria.

    e. Identify appropriate student progress.

    f. Counsel the student who is not progressing.

g. Utilize training program support services available to the student and the preceptor.

h. Contact appropriate training program personnel regarding a student who is ill, injured, or has had an exposure to a communicable disease or hazardous material.

3. A clinical preceptor shall be supervised by a principal instructor, the course director, and/or the medical director.

F. Field Preceptor(s)

1. Qualifications:

a. Currently licensed in California as a paramedic and accredited by Los Angeles County EMS Agency.

b. Working in the field as a licensed paramedic providing direct patient care for the last two (2) years.

c. Completed field preceptor training approved by the EMS Agency.

2. Responsibilities include, but are not limited to:

a. Create a positive and supportive learning environment.

b. Measure students against the standard of entry level paramedics.

c. Assess student behaviors using cognitive, psychomotor, and affective domains.

d. Perform and document daily, cumulative, and final evaluation of students using written field criteria.

e. Identify appropriate student progress.

f. Counsel the student who is not progressing.

g. Utilize training program support services available to the student and the preceptor.

h. Contact appropriate training program personnel regarding a student who is ill, injured, or has had an exposure to a communicable disease or hazardous material.

i. Ensure the required minimum number of fifty (50) ALS contacts are met.

3. A field preceptor shall be supervised by a principal instructor, the course director, and/or the medical director.

VI. Course Completion Records

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

A. Name of the individual.

B. Date of course completion.

C. Name of the paramedic training program approving authority.

D. Signature of the program medical director, optional.

E. Signature of the course director.

F. Name and location of the training program issuing the course completion record.

G. Statement: *The individual named on this record has successfully completed an approved paramedic training program*.

H. Statement in bold print: ***THIS IS NOT A PARAMEDIC LICENSE***.

I. Course hours of instruction divided into didactic/skills instruction, clinical training and field internship with a minimum of fifty (50) ALS patient contacts. In lieu of placing on the completion record, these may be addressed in a letter on official program letterhead.

J. List of optional scope of practice procedures and/or medications taught in the course approved pursuant to subsection §100146 (c) (2) (A-D) of the California Code of Regulations, Title 22. In lieu of placing on the completion record, these may be addressed in a letter on official program letterhead.

K. List of additional National ALS courses completed (ACLS, PALS, PHTLS, PEPP, etc.). In lieu of placing on the completion record, these may be addressed in a letter on official program letterhead.

VI. Record Keeping

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

A. All required documentation as specified in the application packet for program approval.

B. Paramedic Program Class Roster.

C. Documentation of course completion certificates issued.

D. Original documentation or summaries of student performance and course evaluations.

E. Curriculum vitae for instructors with a copy of current licenses and certifications in their field of expertise, or evidence of specialized training.

VII. Program Reporting

A. During the approved program period, the EMS Agency shall be notified in writing, a minimum of thirty (30) days in advance, of any changes in the following:

1. Summary of changes to curriculum

2. Hours of instruction

3. Program staff

4. Clinical or field internship sites

B. The training program shall submit a complete course schedule thirty (30) days prior to the start of each course.

C. The training program shall submit a course roster and student application a minimum of thirty (30) days prior to the Accreditation Examination. Programs shall coordinate with the EMS Agency's Office of Certification for scheduling the Accreditation Examination.

IX. Program Re-approval

A. The training program must receive and maintain CAAHEP accreditation to be considered eligible to be re-approved. The training program shall continue to meet all requirements to be considered for renewal.

B. Application for re-approval process:

1. Submit a written request for re-approval to the EMS Agency.

2. Obtain a re-approval application packet.

C. Submit the following to the EMS Agency:

All documentation submitted to and received from CoAEMSP and CAAHEP during the approved program period to include, but not limited to the current list of teaching staff and a copy of the current accreditation certificate.

X. Fees

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

XI. Responsibilities of the EMS Agency

A. Process Applications

1. Notify the program applicant in writing within ninety (90) days from the receipt of a complete application of the decision to approve or deny. The application is only considered for approval if it is complete and all requirements have been met.

a. Notify the program applicant within sixty (60) days of receipt of the application that the application was received and/or what information is deficient, or is missing, and the date the information is due.

b. Failure to submit requested information within specified time frame after receiving written notification shall render the application null and void.

2. Upon receipt of a complete application, the EMS Agency shall establish the effective date of program approval.

3. Initial approval and re-approval shall be for a period of four (4) years. Program approval or disapproval shall be made in writing by the EMS Agency to the program applicant.

B. Audit Programs

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

XII. Program Disciplinary Actions

A. Failure to comply with the provisions of CCR Div. 9, Ch. 4, et seq., such as violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any of the terms of the California Code of Regulations, Title 22, Chapter 4; the California Health and Safety Code, Division 2.5; or Los Angeles County Emergency Medical Services Prehospital Care Policies shall result in disciplinary action.

B. The requirements for training program noncompliance notification and actions are as follows:

1. The EMS Agency shall provide notification of noncompliance to the paramedic training program. This notification shall be in writing and sent by certified mail to the training program director.

2. Within fifteen (15) days from receipt of the noncompliance notification, the training program shall submit in writing, by certified mail, to the EMS Agency one (1) of the following:

a. Evidence of compliance with the provisions of Chapter 4, or

b. A plan to comply with the provisions of Chapter 4 within sixty (60) days from receipt of the notification of noncompliance.

3. Within fifteen (15) days from receipt of the training program's response, or if no response is received from the training program then within thirty (30) calendar days from the mailing date of the noncompliance notification, the EMS Agency shall issue a decision letter by certified mail to the State of California EMS Authority and the training program. The letter shall identify the EMS Agency's decision to take one or more of the following actions:

a. Accept the evidence of compliance provided.

b. Accept the plan for meeting compliance.

c. Place the training program on probation.

d. Suspend the training program.

e. Revoke the training program.

4. The decision letter shall include, but not be limited to, the following:

a. The date of the EMS Agency's decision.

b. The specific provisions found to be noncompliant.

c. The probation or suspension effective and ending date, if applicable.

d. The terms and conditions of the probation or suspension, if applicable.

e. The revocation effective date, if applicable.

C. If the training program does not comply with subsection VII., B., 2, of this reference, the EMS Agency may uphold the noncompliance finding and initiate a probation, suspension, or revocation action as described in subsection VII., B., 3., of this reference.

D. The EMS Agency shall establish the probation, suspension, or revocation effective dates no sooner than sixty (60) days after the date of the decision letter as described in subsection VII., B., 3., of this reference.

E. Causes for actions include, but are not limited to, the following:

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

b. Misrepresentation of any fact by a training program of any required information.

F. A paramedic training program is ineligible to reapply for approval following a denial or revocation for a minimum of twelve (12) months.

G. If a training program is placed on probation, the terms of probation shall be determined by the EMS Agency. During the probationary period, the EMS Agency must give prior approval for all programs offered. Course documents must be submitted to the EMS Agency at least thirty (30) days prior to each course being offered. The EMS Agency shall provide written notification of program approval to the program director within fifteen (15) days of the receipt of

the request. Renewal of the training program is contingent upon completion of the probationary period.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 802, **Los Angeles County EMT Scope of Practice**
Ref. No. 802.1, **Los Angeles County EMT Scope of Practice (Field Reference)**
Ref. No. 803, **Los Angeles County Paramedic Scope of Practice**
Ref. No. 803.1, **Los Angeles County Paramedic Scope of Practice (Field Reference)**
Ref. No. 1006, **Paramedic Accreditation**

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

REFERENCE NO. 901 – Paramedic Training Program Approval

	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	10/16/2019	10/16/2019	No
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**

Medical Control Guideline: PEDIATRIC PATIENTS

DEFINITION: Pediatric patients in the prehospital setting are defined as children 14 years of age and younger or, in the case that the is age unknown, the patient can be measured on the length-based resuscitation tape (e.g., Broselow™).

PRINCIPLES:

1. Pediatric patients require special consideration in assessment, treatment and medication administration.

2. Pediatric assessment includes: pre-arrival preparation, scene size-up for hazards to patient or providers, assessment of scene for signs of child maltreatment, the Pediatric Assessment Triangle (PAT), vital signs, focused history using SAMPLE (signs and Symptoms, Allergies, Medications, Past Medical History, Last food or liquid intake, and Events leading to illness or injury), and a detailed physical exam as dictated by the patient's presenting signs and symptoms and condition.

3. PAT is composed of three components Appearance, Work of Breathing and Circulation to the Skin (Figure 1).

    a. The PAT is a "rapid Assessment Tool" that uses only visual and auditory clues and requires no equipment.

    b. The PAT is intended to allow the EMS provider to:
        i. Establish the child's severity of illness
        ii. Determine sick or not sick
        iii. Recognize the general category of pathophysiology called the "general impression"
        iv. Determine the urgency of interventions

    c. Appearance: Recalled by the mnemonic TICLS, an abnormality in any component:
        i. **T**one
        ii. **I**nteractiveness
        iii. **C**onsolability
        iv. **L**ook/Gaze
        v. **S**peech/Cry

    d. Work of Breathing: Presence of any of the following implies abnormal work of breathing.
        i. Stridor
        ii. Wheezing
        iii. Grunting
        iv. Tripod positioning
        v. Retractions
        vi. Nasal flaring
        vii. Apnea/Gasping

e. Circulation to the Skin: Presence of any of the following indicates abnormal circulation to the skin or signs of poor perfusion.
   i. Pale
   ii. Mottled
   iii. Cyanotic

f. Combining the PAT assessment based on these components can be used to determine the general impression (i.e., what, if anything, is critically wrong with the patient in terms of pathophysiology) which will dictate immediate management priorities (Figure 2):
   i. Stable
   ii. Respiratory distress
   iii. Respiratory failure
   iv. Shock
   v. CNS/Metabolic disorder
   vi. Cardiopulmonary failure/Cardiopulmonary Arrest

4. Treatments, medication concentrations and drug dosages are weight-specific for the pediatric patient.

5. Accurate pediatric drug doses are obtained by:

   a. Measuring the patient against a pediatric length-based resuscitation tape (e.g., Broselow Tape™) to obtain the weight/color zone, and then
   b. Referring to the *MCG 1309* EMS Agency Color Code Drug Doses L.A. County Kids for the medication doses appropriate to that weight/color zone.

6. Brief Resolved Unexplained Events (BRUE) is defined as a brief episode characterized by any of the following (for children 12 months of age or younger):

   a. Absent, decreased or irregular breathing
   b. Color change (usually cyanosis or pallor)
   c. Marked change in muscle tone (usually limpness or hypotonia, may also include hypertonia)
   d. Altered level of consciousness

GUIDELINES:

1. Assess using the PAT and initiate immediate treatment based on your general impression (Stable, Respiratory Distress, Respiratory Failure/Arrest, Shock, Center Nervous System Disorder/Metabolic Disorder, or Cardiopulmonary Failure/Arrest).

2. Determine your Provider Impression and continue treatment per the corresponding Treatment Protocol.

3. Document findings of the PAT, your assessment, and your Provider Impression.

4. Obtain the patient's estimated weight utilizing a pediatric length-based resuscitation tape and document the corresponding weight and color zone on the EMS Report Form.

5. Pediatric Airway Management:

    a. Bag Mask Ventilation (BMV), nasopharyngeal (NP) airway, or oropharyngeal (OP) airway are approved airway adjuncts for pediatric patients.
    b. King airway is approved as a rescue airway for patients who are 12 years of age or older AND at least 4 feet tall.
    c. Endotracheal Intubation (ETI) is approved for patients 12 years of age or older **or** height greater than the length of the length-based resuscitation tape.

6. Pediatric Cardiopulmonary Resuscitation (CPR):

    a. Use Neonatal CPR for newborns up to 1 month of age
    b. Use Infant CPR for patients greater than one month of age to less than 13 months of age
    c. Use Child CPR for patients greater than or equal to 13 months of age to the onset of puberty

7. Automatic External Defibrillators (AED):
   Pediatric self-adhering pads or a pediatric attenuator system are recommended for infants and children younger than 8 years of age. When pediatric pads and/or a pediatric attenuator is not available, use adult AED and place front to back for infants and children

Figure 1: Pediatric Assessment Triangle

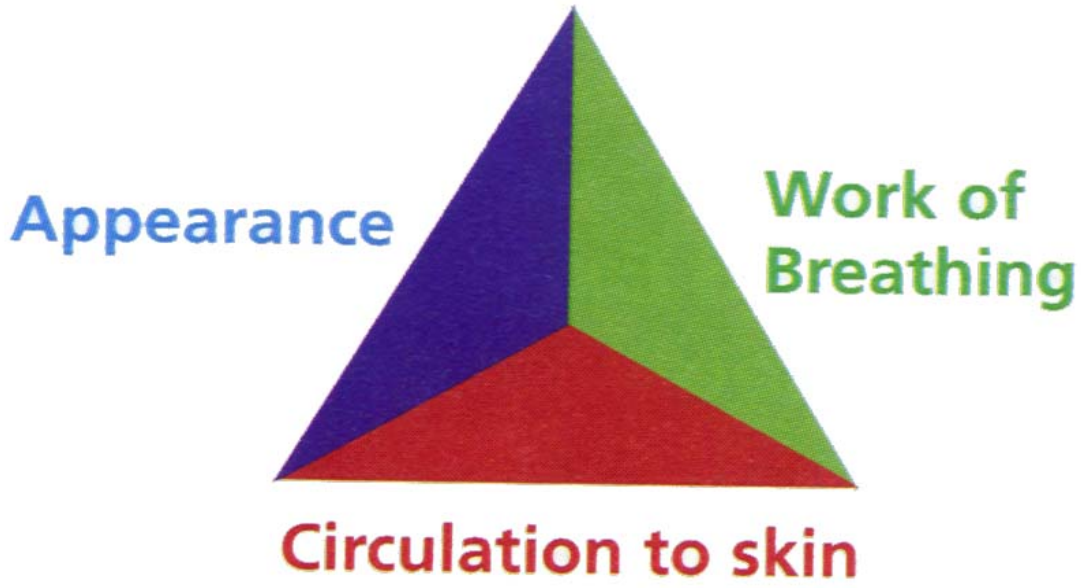
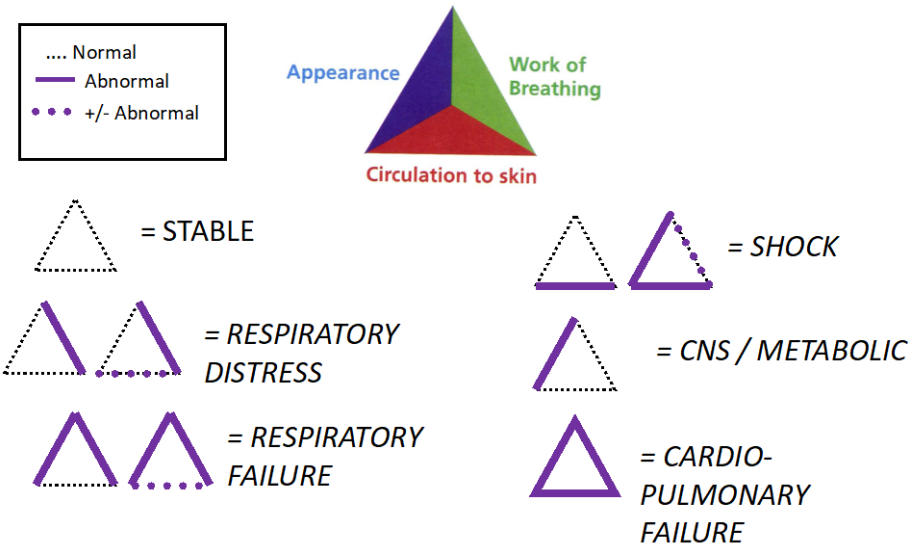


Figure 2: Using the components of the PAT to for a General Impression



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

REFERENCE NO. 1350, Pediatric Patients

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	08/14/2019	08/14/2019	No
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee	08/21/2019	08/21/2019	No
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee	09/10/2019	09/10/2019	No
	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 MENTAL HEALTH

hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
Director

Curley L. Bonds, M.D.
Chief Deputy Director
Clinical Operations

Gregory C. Polk, M.P.A.
Chief Deputy Director
Administrative Operations

October 17, 2019

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

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

SUBJECT: **REPORT RESPONSE FOR A PILOT PROGRAM FOR EMERGENCY TRANSPORT (ITEM 8, AGENDA OF JULY 9, 2019)**

On July 9, 2019, the Board of Supervisors issued a motion requesting a report on the feasibility of developing alternative means of transportation for emergency medical responders answering service calls for clients in need of resources at mental health urgent care facilities or sobering centers, including but not limited to the addition of a Full Time Equivalent (FTE) such as an Emergency Medical Technician, Nurse Practitioner, Psychiatric Nurse Practitioner or Physician's Assistant; recommendations for funding an additional FTE in each Service Planning Area (SPA); and the development of metrics for analyzing the one year pilot program, including the impact that the additional FTE has on clients served and Emergency Room utilization Countywide.

Background

Currently, paramedics are not allowed by State law to take individuals in need of mental health or substance abuse services directly to mental health urgent care centers or sobering centers. Instead, they are required to take individuals to Emergency Rooms for triage, which leads to longer wait times, limited bed availability, and a delay in individuals receiving the mental health or substance abuse services needed. Allowing paramedics to take these individuals directly to an appropriate setting would contribute to decompressing the Emergency Rooms and providing efficient access to care for individuals in crisis due to mental health or substance abuse.

Plan

In response to the motion, the Department of Mental Health (DMH), Department of Health Services (DHS), Los Angeles County Fire Department (LACFD), City of Los Angeles Fire Department, City of Torrance Fire Department, City of Arcadia Fire Department, Los Angeles Homeless Service Authority (LAHSA), Department of Public Health (DPH), and Chief Executive Office (CEO) developed a design and implementation workgroup to explore the feasibility of a pilot program for emergency transport. The workgroup agreed to the plan below:

1. DMH will identify funding to hire eight Nurse Practitioners or Psychiatric Nurses to work directly with City of Los Angeles Fire Department at an estimated cost of $1,876,722 per year, including services and supplies costs (see chart below).

Proposed Staffing, Services and Supplies Budget

Item # / Obj Code	Item Name	ORD	FTE	Amount
5121A	Nurse Practitioner	9	9	$1,779,534
2214A	Intermediate Typist Clerk	1	1	54,188
	Total Salaries and Variable Employee Benefits (S&EB)	**10**	**10**	**$1,833,722**
Services and Supplies (S&S)			**Unit Cost**	**Total Unit Cost**
2083	Telecommunication (Cell Phone/Pagers)		$700	$7,000
3240	Office Supplies		600	6,000
3969	Personal Computer Software		500	5,000
3971	Computers		1,000	10,000
3972	Printer/Peripherals (Scanner)		400	4,000
4612	Training		800	8,000
5092	Mileage		200	2,000
5110	Travel		100	1,000
	Total Services & Supplies		$4,300	**$43,000**
	Total S&EB and S&S			**$1,876,722**
	Grand Total			**$1,876,722**

2. DMH and City of Los Angeles Fire Department will develop a Memorandum of Understanding (MOU) that outlines expectations from each entity.

3. Consider the use of DMH Therapeutic Transportation vans as an option for this project.

Next Steps

The design and implementation workgroup will convene a meeting to occur within the next 30 days to identify funding to hire the additional FTEs listed above and make decisions on the metrics for analyzing the one-year pilot program with a written progress update to the Board in 45 days.

If you have any questions or require additional information, please contact me, or staff can contact Miriam A. Brown, Emergency Outreach and Triage Division, Deputy Director, at (213) 738-3412 or mbrown@dmh.lacounty.gov.

JES:mb

c: Executive Office, Board of Supervisors
James Sokalski, CEO
Cathy Chidester, DHS
Yanavia Lima, DPH
Colleen Murphy, LAHSA
Steve Sanko, City of LAFD
Clayton Kazan, LACFD

DEPARTMENT OF MENTAL HEALTH

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JONATHAN E. SHERIN, M.D., Ph.D.
Director

Curley L. Bonds, M.D.
Chief Medical Officer
Clinical Operations

Gregory C. Polk, M.P.A.
Chief Deputy Director
Administrative Operations

October 29, 2019

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

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

SUBJECT: **REPORT RESPONSE TO ADDRESSING THE SHORTAGE OF MENTAL HEALTH HOSPITAL BEDS (ITEM 8, AGENDA OF JANUARY 22, 2019)**

On January 22, 2019, the Board of Supervisors (Board) directed the Department of Mental Health (DMH), in coordination with Chief Executive Office (CEO), the Sheriff's Department, and the Health Departments, to assess how to address the shortage of mental health hospital beds in Los Angeles County. DMH was directed to provide the Board with a report to include the following information:

a. A plan for the creation of mental health hospital beds to include potential sites, funding options, patient population, and all other pertinent details;
b. The current and future need for mental health hospital beds that support the jail population;
c. An assessment of all contracted mental health hospital beds and make recommendations that allow the County to maintain and/or increase the number of beds available; and
d. An assessment of the current and future need for stepdown mental health beds and services, and draft a plan for the creation of both directly operated and contracted stepdown beds and services.

The attached report "Addressing the Shortage of Mental Health Hospital Beds" serves to fulfill the directives of the Board. In addition, we have attached a separate relevant report developed by an outside consultant, Mercer Health & Benefits LLC. This Mercer report assesses needs in Los Angeles County's mental health and substance use disorder

system of care, with a particular focus on inpatient and residential treatment, and offers recommendations on filling these needs.

If you have any question or need additional information, please contact me, or staff may contact Gregory Polk, Chief Deputy Director, Administrative Operations, at (213) 738-4601 or gpolk@dmh.lacounty.gov.

JES:GP:jfs

Attachments

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel
Department of Public Health
Department of Health Services
Los Angeles County Superior Court

County of Los Angeles
Department of Mental Health

Addressing the Shortage of Mental Health Hospital Beds: Board of Supervisors Motion Response

Jonathan E. Sherin. M.D., Ph.D.
Director
Department of Mental Health

Table of Contents

Executive Summary

We need to improve the mental health beds and related services in our public mental health care system in LA County. Beyond just acute hospital beds, we also especially need to improve the availability and quality of subacute and residential treatment services for clients with longer-term intensive needs, as well as our services to treat clients in crisis and provide alternatives to hospitalization and/or incarceration. To accomplish this, we must develop bed capacity and improve services throughout the continuum of care. Doing so will minimize client flow into hospitals, improve client flow out, and provide higher quality client care overall.

Recommended System Changes

Improving Mental Health Pre-Hospital Services (Client Flow In)

1. Develop more behavioral health urgent care centers
2. Continue to develop crisis residential treatment and similar programs
3. Continue to develop a more robust network of mobile crisis response services
4. Continue to improve the quality and coordination of pre-hospital services for clients in crisis
5. Develop options for intensive outpatient and partial hospitalization programs for clients in crisis
6. Continue to develop supportive and holistic pre-hospital services for clients who are on or may need a mental health (LPS) conservatorship
7. Continue to improve diversion services and programs that serve as alternatives to incarceration for justice-involved clients in crisis

Improving Mental Health Post-Hospital Services (Client Flow Out)

1. Develop more subacute beds and services
2. Develop more residential treatment beds and services which provide longer-term care
3. Continue to improve quality of care and client transitions across subacute and residential treatment beds and services
4. Support efforts to relax or eliminate the federal Medicaid SMI/SED IMD exclusion
5. Continue investing in supportive housing units and services, including board and cares
6. Develop intensive outpatient and/or partial hospitalization programs as a treatment option for individuals transitioning out of mental health beds
7. Continue to improve Full Service Partnerships as a post-hospital service
8. Develop better post-hospital services for clients on a mental health (LPS) conservatorship
9. Conduct further analyses of the system of care to refine estimates of additional needed post-hospital beds and services

Improving Mental Health Hospital Services

1. Develop more acute hospital beds for children
2. Develop more acute hospital beds which can serve clients diverted out of the jail
3. Increase the proportion of acute hospital beds available exclusively to DMH clients
4. Continue to improve quality of care and client transitions across hospital settings
5. Address the shortage of psychiatrists in the system

Recommended Actions for the Board of Supervisors

To help us move quickly to begin implementing the recommended system changes detailed throughout this report, the Department of Mental Health (DMH) is recommending that the Board of Supervisors take the following actions:

1. Authorize the Director of the Department of Mental Health (DMH), or his designee, to conduct a pilot to expand mental health bed capacity and improve existing capacity in the DMH network, within the following parameters:
    a. The pilot will last for two years from the date of Board approval; and
    b. DMH will seek to procure up to 500 State-licensed, approved, or exempt mental health beds of whichever type and mix will help meet the needs of the DMH network, derived through contracting for additional beds using DMH available ongoing funding.

2. For purposes of the pilot implementation and subject to all state and federal laws, prior review and approval as to form by County Counsel, and ten-day written notification to the Board and Chief Executive Officer (CEO), delegate authority to the DMH Director to negotiate, execute, and/or amend contracts with State-licensed, approved, or exempt facilities as needed, with up to a five year initial term and up to two one-year optional extensions, to increase the existing mental health bed capacity, including to:
    a. Revise, modify, or replace existing statement(s) of work;
    b. Reflect federal, State, or County regulatory and/or policy changes;
    c. Add or revise any negotiated supplemental rate(s) or any applicable State established rates; and
    d. Terminate any such contracts in accordance with the County's standard contract termination provisions, including termination for convenience.

3. Delegate authority to the DMH Director, or his designee, to retain a consultant on a temporary and/or intermittent basis to help design and execute an integrated plan for the pilot, develop statements of work for contracts, and assist with other activities as part of the pilot build out, as needed, with a maximum contract amount of $500,000 using DMH available one-time funds.

4. Direct the DMH Director to provide an annual status report to the Board of Supervisors with the first report due in January 2021 to include the following information and analysis:
    a. The number, type, and cost of beds contracted through the pilot;
    b. A projection of the amount of remaining DMH funding available to procure additional beds up to the pilot's 500 bed target;
    c. The impact of the additional contracted beds on the DMH network, including any departmental savings or other cost reduction offsets; improvements in client flow through the network; improvements in care quality and outcomes; and any other pertinent metrics; and
    d. Opportunities for further bed expansion, and the associated costs, needed to reach the pilot's 500 bed target, of whichever type and mix will help meet DMH's network needs that considers the work of all County efforts to expand the availability of mental health beds and services.

5. Direct the DMH Director to work with the CEO to develop a proposed funding plan for the costs associated with the remaining beds needed to get to the pilot's 500 bed target, in consultation with affected departments as necessary, which if adopted would to be phased in over future budget cycles, as needed, that will allow the recommendations to be considered within the context of DMH remaining available funding, the overall budget and numerous competing funding priorities and requests. If complete, include this proposed funding plan with the January 2021 report to the Board of Supervisors.
    a. Include in the plan options to convert an entity's existing licensed or approved beds to other types of licensed or approved beds which will meet the needs of the DMH network that consider one-time cost-sharing provisions whereby the County may fund a portion of the cost of bed conversions.
    b. Include in the plan consideration of additional funding that may be available through the State and federal government, private insurers and philanthropy.

6. Direct the DMH Director, in coordination with the CEO, to conduct a needs assessment for staffing and/or contract providers to further develop and improve outpatient and administrative programs and services that support the DMH network of facility-based treatment, including but not limited to: (1) mobile crisis response services; (2) utilization management services; (3) Full Service Partnership services; and (4) other alternatives to hospitalization, such as intensive outpatient and partial hospitalization; funded by DMH available ongoing funds and report back to the Board.
    a. Include in the assessment needs for additional management staff, technology, facility space, or other administrative infrastructure to support the work of these staff and programs.

7. Direct the CEO, in coordination with the Departments of Health Services, Mental Health, Public Health, Children and Family Services, the Homeless Initiative, the LA County Development Authority, and other departments serving populations who use the beds/services, to perform an analysis of the array of County programs and funding streams related to supportive housing (including board and cares, permanent supportive housing, and interim/bridge supportive housing and living environments otherwise) for those with physical, mental, or substance use disorder needs.
    a. Direct the CEO to include in this analysis options for managing these programs and funding streams to improve efficiencies and ensure needed supportive housing capacity as delineated above is developed using available funds.

JACKIE LACEY
LOS ANGELES COUNTY DISTRICT ATTORNEY

HALL OF JUSTICE
211 WEST TEMPLE STREET, SUITE 1200 LOS ANGELES, CA 90012-3205 (213) 974-3500

October 31, 2019

Jonathan E. Sherin, MD, PhD
Director
Los Angeles County Department of Mental Health
550 South Vermont Avenue
Los Angeles, CA 90020

Dear Dr. Sherin:

I urge you to support the pilot project between the Los Angeles Police Department (LAPD) and the Didi Hirsch Suicide Prevention Center (Didi Hirsch) to develop appropriate 9-1-1 triage protocols and to evaluate the efficacy and safety of routing 9-1-1 calls for suicidal ideation to the Suicide Hotline for risk assessment and intervention.

As you know, the Los Angeles County District Attorney's Office has taken a leadership role in mental health diversion. I strongly believe that mental health diversion can be an effective tool to safeguard the community when persons who live with mental illnesses can benefit from treatment instead of incarceration.

A 9-1-1 call is often the first contact with the justice system when people experiencing a mental illness seek help; but there is currently no countywide protocol for how these calls are handled. This creates variance between whether fire or law enforcement personnel will roll out to the scene in response to the call. Many of these calls could be more appropriately handled by our healthcare partners rather than our justice partners.

Diverting suicide calls to Didi Hirsch provides the right type of immediate help for someone in distress who has suicidal ideations. This screening protocol furthers our larger mental health diversion goal to prevent people from becoming a part of the criminal justice system.

I am informed that in 2018, only 5% of suicide related 9-1-1 calls resulted in an arrest by LAPD and 95% were referred to mental health services.

In light of this information, it makes sense that the first response should be a mental health intervention. Pursuant to LAPD's suggested protocol, these 9-1-1 suicide call diversions would *not* include the following situations: the person is threatening to jump from a bridge or structure; the person needs medical attention which would require an in person response; the person has a weapon and is in a public environment; the person has a weapon, is not in a public environment, but is in an area where other people are present.

Subject to these appropriate safeguards, I join the Emergency Medical Services Commission (EMSC) in full support of this program to divert non-imminent risk suicide calls directly to Didi Hirsch for mental health services.

Very truly yours,

Jackie Lacey
District Attorney

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HOSPITAL)

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

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

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

DEFINITIONS:

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

PRINCIPLES:

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

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

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

POLICY:

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

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

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

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

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

   B. Communications

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

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

APPROVED: Director, EMS Agency

Medical Director, EMS Agency

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

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

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

C. Site Visit

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

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

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

D. Transfer Policies

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

a. Compliance with Title XXII transfer requirements and EMTALA

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

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

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

5. EMS Agency role at the site visit:

a. Conduct ReddiNet drills and VMED28 tests

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

c. Discuss disaster preparedness activities

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

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

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

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

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

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

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

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

CROSS REFERENCES:

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

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

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/

Cathy Chidester
Executive Director
(562) 378-1604
CChidester@dhs.lacounty.gov

Denise Watson
Commission Liaison
(562) 378-1606
DWatson@dhs.lacounty.gov

November 20, 2019

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

FROM: Cathy Chidester
Executive Director

SUBJECT: **EMERGENCY MEDICAL SERVICES COMMISSION ANNUAL REPORT – FISCAL YEAR 2018/2019**

Attached is the Annual Report of the Emergency Medical Services Commission (EMSC) to the Board of Supervisors, which is submitted each Fiscal Year in compliance with Los Angeles County Code Title 3, Chapter 3.20, Section 3.20.070.5.

The Ordinance provides for 19 EMSC members. During this reporting period, all 19 positions were filled intermittently with brief periods of transitional gaps. At the time of this report, the EMS Commission has 19 sitting members.

The attached report describes the structure, membership and major activities of the Commission, policy approvals, and changes to the standing subcommittees during the period of July 1, 2018 through June 30, 2019.

If you have any questions, please feel free to contact me at (562) 378-1604.

CC:dw

Attachment

c: Christina R. Ghaly, M.D., Director of Health Services
Brian Chu, County Counsel
Celia Zavala, Executive Officer, Board of Supervisors
EMS Commission
Health Deputies, Board of Supervisors

LOS ANGELES COUNTY

EMERGENCY MEDICAL SERVICES COMMISSION

ANNUAL REPORT

TO THE

BOARD OF SUPERVISORS

JULY 1, 2018 – JUNE 30, 2019

Emergency Medical Services Agency
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670
Phone: (562) 378-1500 / Fax: (562) 941-5835
Website: http://ems.dhs.lacounty.gov

EMERGENCY MEDICAL SERVICES COMMISSION

Ellen Alkon, MD
Southern California Public Health Association

Lt. Brian S. Bixler
Peace Officers Association of Los Angeles County

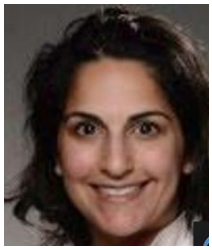
Erick H. Cheung, MD
Chairman 2017-2019
Southern California Psychiatric Society

Chief Eugene Harris
Los Angeles County Police Chiefs' Association

John C. Hisserich, DrPH
Vice-Chair 2018
Chairman a/o 1/2019
Public Member
Third Supervisorial District

Lydia Lam, MD
American College of Surgeons

James Lott, PsyD
Public Member
Second
Supervisorial District



Dr. Roxana Yoonessi-Martin
Los Angeles County Medical Association

Mr. Robert Ower
Los Angeles County Ambulance Association

Margaret Peterson, PhD
Hospital Association of Southern California

Paul Rodriguez, FF/Paramedic
California State Firefighters' Association

Mr. Joseph Salas
Vice-Chair a/o 1/2019
Public Member
First Supervisorial District

Nerses Sanossian, MD
American Heart Association
Western States Affiliate

Carole A. Snyder, RN
Emergency Nurses Association

Ms. Diana Tang
League of California Cities/L.A. County Division

Atilla Uner, MD, MPH
California Chapter American College of Emergency Physicians

Mr. Gary Washburn
Public Member
Fifth
Supervisorial District

Fire Chief David White
Los Angeles Area Fire Chiefs' Association

Mr. Pajmon Zarrineghbal
Public Member
Fourth Supervisorial District

Ms. Cathy Chidester
Executive Director
Director, EMS Agency

Ms. Denise Watson
Commission Liaison
EMS Agency Secretary

MISSION STATEMENT

To support and guide the Emergency Medical Services (EMS) Agency activities to ensure timely, compassionate and quality emergency and disaster medical services. The Emergency Medical Services Commission's (EMSC) mission complements the County's mission through improving the quality of life for the people and community of Los Angeles County (LA County).

HISTORICAL BACKGROUND / REGULATORY FOUNDATION

The EMSC was established by the Board of Supervisors (Board) in October 1979, and on April 7, 1981, the Board approved and adopted Ordinance No. 12332 of Title 3 – Advisory Commissions and Committees, Los Angeles County Code Chapter 3.20, Emergency Medical Services Commission, to establish the Commission in accordance with California Health and Safety Code Division 2.5, Sections:

1797.270 – Emergency Medical Care Committee Formation
1797.272 – Emergency Medical Care Committee Membership
1797.274 – Emergency Medical Care Committee Duties
1797.276 – Emergency Medical Care Committee Annual Report

On January 29, 2008, the Board approved amending the subject Ordinance to revise the selection of the licensed paramedic representative previously nominated by the California Rescue and Paramedic Association be made by the California State Firefighters Association Emergency Medical Services Committee as the previous entity had ceased to operate.

On November 1, 2011, the EMSC, in consultation with the Department of Health Services, amended the ordinance to add two Commission seats for the members nominated by the Los Angeles County Police Chiefs' Association (LACPCA) and Southern California Public Health Association (SCPHA) that would be beneficial to the EMSC and the County, and would allow for law enforcement and public health expert input. With this amendment, the addition of two Commission seats increased the number of commissioners from 17 to 19.

MEMBERSHIP

The EMSC is currently comprised of 19 commissioners who are non-County employees, and who act in an advisory capacity to the Board and the Director of Health Services. They advise on matters relative to emergency medical care and practices, and EMS policies, programs, and standards including paramedic services throughout the County of Los Angeles. There is an Executive Director and a Commission Liaison who are County employees, and who serve as staff to the Commission.

FUNCTIONS AND DUTIES

The EMS Commission performs the functions of the Emergency Medical Care Committee as defined in Sections 1750 et seq. of the Health and Safety Code, and includes the following duties:

- Act in an advisory capacity to the Board of Supervisors and the Director of Health Services regarding County policies, programs, and standards for emergency medical care services throughout the County, including paramedic services.
- Establish appropriate criteria for evaluation, and conduct continuous evaluations on the basis of these criteria of the impact and quality of emergency medical care services throughout LA County.
- Conduct studies of particular elements of the emergency medical care system as requested by the Board, the Director of DHS or on its own initiative; delineate problems and deficiencies and recommend appropriate solutions.

- Acquire and analyze the information necessary for measuring the impact and the quality of emergency medical care services.
- Report its findings, conclusions and recommendations to the Board at least every twelve months.
- Review and comment on plans and proposals for emergency medical care services prepared by LA County departments.
- Recommend, when the need arises, that LA County engages independent contractors for the performance of specialized, temporary, or occasional services to the EMSC, which cannot be performed by members of the classified service, and for which the LA County otherwise has the authority to contract.
- Advise the Director and the DHS on the policies, procedures, and standards to control the certification of mobile intensive care nurses and paramedics. Proposals of any public or private organization to initiate or modify a program of paramedic services or training.
- To arbitrate differences in the field of paramedic services and training between all sectors of the community, including, but not limited to, county agencies, municipalities, public safety agencies, community colleges, hospitals, private companies, and physicians.

FOCUS IN PAST YEARS

- Community Paramedicine Pilot Project in the County
- Pre-hospital care of behavioral emergencies: The EMSC recommended that an Ad Hoc committee be identified to develop a blueprint for addressing behavioral emergencies in the pre-hospital setting
- Monitor legislation of interest to emergency medical services
- Implementation of electronic data using electronic Patient Care Record (ePCR) systems by all fire department 9-1-1 providers
- Bystander CPR training (Sidewalk CPR)
- Recognized the members of the Hospital Emergency Response Team (HERT) and Alhambra Fire Department who responded to a patient with a horrific industrial injury requiring the bilateral leg amputation on scene
- Developed and administered a survey on law enforcement dispatch and field response to mental health emergencies and issued report of findings
- Ambulance Patient Offload Time (APOT) Ad Hoc Workgroup recommended changes to the current Ref. 503.1 Request for Diversion
- Reviewed and recommended policies for adoption by the EMS Agency

ACCOMPLISHMENTS AND SIGNIFICANT OUTCOMES FISCAL YEAR (FY) 2018-19

- Approved the FY 2017-18 EMSC Annual Report at the September 19, 2018 meeting
- Presented results of the law enforcement dispatch and field response survey at the Los Angeles Police Chiefs' Association's Annual meeting
- Education Advisory Committee dissolved with two positions added to the Provider Agency Advisory Committee to represent an EMT and Paramedic
- Impact Report to the Board of Supervisors for the July 3, 2018 closure of Community Medical Center Long Beach
- Approved Prehospital Care Policies to include Policy Reference Numbers:
  - 312: Pediatric Liaison Nurse
  - 416: Assessment Unit
  - 503.1: Diversion Request Requirements for Emergency Department Saturation
  - 506: Trauma Triage
  - 516: Cardiac Arrest Patient Destination
  - 704: Assessment Unit Inventory

- 814: Determination/Pronouncement of Death in the Field
- 840: Medical Support During Tactical Operations
- 1006: Paramedic Accreditation
- 1010: Mobile Intensive Care Nurse (MICN) Certification
- 1011: Mobile Intensive Care Nurse (MICN) Field Observation

ANNUAL WORK PLAN

UPCOMING GOALS/OBJECTIVES

- Monitor legislation affecting the EMS system
- Educate stakeholders on EMS Update training and issues
- Advise the EMS Agency on minimal requests for 9-1-1 receiving hospital designation
- Review, provide feedback and support the ***"Ad Hoc Committee on Prehospital Care of Mental Health and Substance Abuse Emergencies' Final Report"*** **r**ecommendations
- Continue to monitor implementation of the amended Ref. 503, Requests for Diversion, and the effect on the EMS System
- Continue to monitor progress of APOT data and recommend the best practice related to the data for optimum results
- Continue engagement with County committees that have similar missions and interests
- Continue engagement with Department of Mental Health on issues related to assessment, treatment and transport of patients in mental health crisis
- Continue to engage with law enforcement to support similar or overlapping response protocols, i.e., Tactical EMS, use of Narcan, transport of injured canine teams
- Ensure timely and complete data submission from all EMS providers

ONGOING LONG-TERM PROJECTS

- Review and recommend approval of EMS Agency policies
- Implementation of the recommendations found in ***"Ad Hoc Committee on Prehospital Care of Mental Health and Substance Abuse Emergencies' Final Report"***
- Share the results of the law enforcement dispatch and field response survey with stakeholders and encourage implementation of recommendations
- Ensure that individuals seen and assessed within the 9-1-1 system are transported to the appropriate destination that is best suited to meet their needs, i.e., sobering centers, emergency departments and psychiatric urgent care centers
- Decrease ambulance patient offload times by monitoring Ref. 503 Diversion Requests and APOT data
- Support education efforts for bystander Hands-Only CPR (Sidewalk CPR)
- Support Los Angeles Police Department's pilot project to triage 9-1-1 calls related to suicidal ideation to the Suicide Hotline
- Arrive Alive ePCR Pilot Program as utilization of the Lucas device to treat patients in cardiac arrest
- Monitor Public Safety Naloxone Program Participation
- Paramedic Provider Program Approval
- Participate on Measure B Advisory Board Committee
- Medical Support During Tactical Operations Policy No. 840 – emergency medical transport of police dogs by ambulance during tactical operations when injured in the line of duty
- ECG Task Force
- Trauma Triage
- EMS Commission Bylaws Revised
- Data Agreement Use

- Master Agreements
- System-Wide Provider Impression Quality Improvement Fallout Tracking
- Revised Prehospital Treatment Protocols and Medical Control Guidelines
- Trauma System Status Report
- Paramedic Pioneers Look Back on 50 Years

EMERGENCY MEDICAL SERVICES COMMISSION
STANDING COMMITTEE NOMINEES
2020

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

COMMITTEE	2018	2019	2020
Provider Agency Advisory Committee ***PAAC***	*Chair:* ***Dave White*** *Vice Chair:* ***Robert Ower, RN*** *Commissioners:* *Brian Bixler* *Paul Rodriguez* *Staff:* ***Gary Watson***	*Chair:* ***Paul Rodriguez*** *Vice Chair:* ***Dave White*** *Commissioners:* *Brian Bixler* *Eugene Harris* *Staff:* ***Gary Watson***	*Chair:* ***Paul Rodriguez*** *Vice Chair:* ***Dave White*** *Commissioners:* *Brian Bixler* *Eugene Harris* *Staff:* ***Gary Watson***
Base Hospital Advisory Committee ***BHAC***	*Chair:* ***Marc Eckstein, MD*** *Vice Chair:* ***Margaret Peterson, PhD*** *Commissioners:* *John Hisserich* *Lydia Lam, MD* *Staff:* ***Lorrie Perez***	*Chair:* ***Robert Ower, RN*** *Vice Chair:* ***Erick Cheung, MD*** *Commissioners:* *Atilla Uner, MD, MPH* *Margaret Peterson, PhD* *Staff:* ***Lorrie Perez***	*Chair:* ***Robert Ower, RN*** *Vice Chair:* ***Carole Snyder, RN*** *Commissioners:* *Joe Salas* *Staff:* ***Lorrie Perez***
Data Advisory Committee ***DAC***	*Chair:* ***Nerses Sanossian, MD*** *Vice Chair:* ***Pajmon Zarrineghbal*** *Commissioners:* *James Lott* *Colin Tudor* *Staff:* ***Michelle Williams***	*Chair:* ***Nerses Sanossian, MD*** *Vice Chair:* ***Pajmon Zarrineghbal*** *Commissioners:* *Lydia Lam, MD* *James Lott* *Colin Tudor* *Staff:* ***Sara Rasnake***	*Chair:* ***Nerses Sanossian, MD*** *Vice Chair:* ***Pajmon Zarrineghbal*** *Commissioners:* *Lydia Lam, MD* *James Lott* *Staff:* ***Sara Rasnake***
Education Advisory Committee ***EAC***	*Chair:* ***Carole Snyder, RN*** *Vice Chair:* ***Atilla Uner, MD, MPH*** *Commissioners:* *Ellen Alkon, MD* *Gary Washburn* *Staff:* ***David Wells***	*Chair:* ***Carole Snyder, RN*** *Vice Chair:* ***Marc Eckstein, MD*** *Commissioners:* *Ellen Alkon, MD* *Gary Washburn* *Staff:* ***David Wells***	***Education Advisory Committee (EAC)*** ***Dissolved*** ***September 18, 2019***