COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

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

DATE: **January 15, 2020**
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

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
November 20, 2019

2. CORRESPONDENCE
2.1 (11-07-2019) Letter From Los Angeles County Ambulance Association, Inc.: Request to Update Ambulance Ordinance 7.16
2.2 (11-12-2019) Dave Duncan, MD, EMS Authority: Request for Proposal for Emergency Ambulance Transportation Services 9-1-1 Response for the City of Monrovia, Exclusive Operating Area Two
2.3 (12-15-2019) Lisa Galindo, EMS Agency Rancho Cordova: EMS Plan Addendum (Fiscal Year 2017-2018)
2.4 (12-24-2019) Matt Armstrong, LACAA: Response to Ambulance Ordinance Inquiry
2.5 (12-31-2019) Distribution: EMS Update 2020 Train-the-Trainer (Revised)
2.6 (01-03-2020) Letter From EMS Authority: LA EMSC Plan Approval

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

4. POLICIES
4.1 Reference No. 320: ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) Standards
4.2 Reference No. 320.3: SRC Performance Measures
4.3 Reference No. 418: Authorization and Classification of EMS Aircraft
4.4 Reference No. 702: Controlled Drugs Carried on ALS Units

END OF CONSENT AGENDA

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IV. BUSINESS

BUSINESS (OLD)

5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies
5.2 Ambulance Patient Offload Time (APOT)
5.3 Criteria for 9-1-1 Receiving Center Designation
5.4 Nominating Committee - Nominations

BUSINESS (NEW)

None

V. COMMISSIONERS' COMMENTS/REQUESTS

VI. LEGISLATION

VII. EMS DIRECTOR'S REPORT

VIII. ADJOURNMENT

To the meeting of March 18, 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.

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MINUTES
NOVEMBER 20, 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	John Quiroz III	EMS Staff
☐ (Ab) Lydia Lam, M.D.	So. CA Chapter American College of Surgeons	Christine Zaiser	EMS Staff
☐ (Ab) James Lott, MBA	Public Member, 2nd District	Sara Rasnake	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.	Lorrie Perez	EMS Staff
☒ Joseph Salas	Public Member, 1st District	Adrian Romero	EMS Staff
☐Ab.Nerses Sanossian, M.D. ☒ Carole Snyder	American Heart Association Emergency Nurses Assn.	Denise Whitfield	EMS Staff
☐ *Diana Tang	League of CA Cities/LAC	Chris Clare	EMS Staff
☒ Atilla Uner, M.D.	American College of Emergency Physicians CAL-ACEP	Lorrie Perez	EMS Staff
☒ Gary Washburn	Public Member, 5th District	John Telmos	EMS Staff
☒ David White	L.A. Area Fire Chiefs' Assn.		
☐ *Pajmon Zarrineghbal	Public Member, 4th District		

GUESTS

Dr. Jonathan Sherin	Department of Mental Health	Dr. Stephen Sanko	Los Angeles City Fire
Jaime Garcia	HASC	Laurie Donegan	APCC LBM
Miriam Brown	Department of Mental Health	James Flint	Long Beach Fire Dept
Richard Roman	Compton Fire Department	Nicole Steeneken	LACoFD
Bryan Wells	LACoFD		

(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, and 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. Karolyn Fruhwirth, Assistant EMS Director, sat in as the EMS Commission Executive Director in Cathy Chidester's absence.

Chairman Hisserich announced that Dr. Ellen Alkon will resign from the EMS Commission at the end of December, 2019 and thanked her for her diligence and representation of the Southern California Public Health Association. He presented her with an EMS Challenge Coin as a token of appreciation.

Chairman Hisserich introduced Jonathan Sherin, MD, PhD, Director of Los Angeles County Department of Mental Health (DMH), who attended at the request of the EMS Commission to answer questions about DMH's response to behavioral health needs in the County.

Dr. Sherin described the challenges of LA County and beyond, and how the work of crisis response fits in as it relates to people with mental health challenges. He spoke about the concept of community, and the difficulty of individuals with general disabilities or healthcare challenges to stay in community where people belong and have a purpose and have access to the resources they require. For the population with behavioral health challenges, community in terms of resources, investments and programs, means there is a need for very strong prevention-oriented programming initiatives to help connect people early with resources that are going to help them. There is a shortage of social determinants of health such as enough housing, jobs or employment, purposeful activities, and social networks to help people connect. With strong prevention, the social determinants are in place, and then you have quality treatment which goes with health care. By not having enough treatment available, we are not doing the social determinants adequately and do not have a prevention infrastructure.

The Psychiatric Mobile Response Team (PMRT), all law enforcement co-response teams, and School Threat Assessment Response Teams (START) are all real-time responses managed by Miriam Brown, Deputy Director for LA County DMH. PMRT is being expanded by adding therapeutic transport vans into their fleet that are unlike transport by sheriff or police car, or ambulance when it is unnecessary, and having to lie down onto a gurney. These vans are comfortable and they are equipped with space and with a peer on the workforce along with nursing personnel. DMH is looking to expand services to engage people more effectively with more skillsets in terms of staffing and expertise, as well as psychiatric telemedicine services in the future.

In addition to the mental health workforce, mental health facilities are also needed. There is the need for urgent cares and hospital beds or mental health treatment beds. It is not just about acute hospitals, it is about subacute beds, Medicaid Institutions for Mental Diseases (IMD), residential treatment, and crisis residential treatment programs. That whole array is a way to connect with people who are falling out of community.

In a recent report, Dr. Sherin suggested that LA County is about 3,000 beds short to treat the mental health population in our county, and that these are largely subacute beds and residential treatment beds, not acute hospital beds. The reason for not having enough acute hospital beds is because there is nowhere to move people to lower levels of care. This background and framework is necessary for the conversation.

The work of the EMS Commission and the crisis response system is the perimeter, the guard rails around community. So, rather than having people spill out of community into the open-air asylum of the streets or the closed asylum of jails, they finally get the care and treatment they need and

are brought back into the community. And, the Department of Mental Health is dedicated to creating a strong perimeter and reinforcing the guardrails around community.

Questions were raised and discussion ensued about how the therapeutic vans will be deployed; how the interface between EMS and the Department of Mental Health will be; and what staffing and budget looks like.

Dr. Sherin reported that initially 10 vans will be deployed within the next two weeks, two per supervisorial district, and noted that the City of Santa Monica wants their own and therefore working on having 11 vans. When someone calls 854-7771, or gets connected to DMH's emergency team, they deploy staff. The entire fleet of PMRT should be these vans and they should be properly staffed. To cover the geography and the different functions EMS, the therapeutic transport, fire and police, regardless of jurisdiction, must be communicating at one hundred percent. There also needs to be "air traffic control," and a way to avoid redundant coverage. Therapeutic transport is a great thing for an individual who can be managed through this process who may not have to go to an emergency department where the emergency department does not have enough resources for them. Quality urgent care is a place where someone can get help to de-escalate and be connected to resources to get them back into the community, mitigating the need for hospitalization or mitigating an outburst of potential violence in an emergency department. We need law enforcement and our co-response teams. People who have medical issues that are unpredictable or seem acute will require EMS to come in. That is where those resources will be needed which we currently do not have enough of.

Dr. Sherin stated that capacity is half of the problem. One area most dramatically under-resourced is the subacute mental health treatment bed and the open residential treatment bed. With appropriate resources to discharge patients to, people would not sit and languish in emergency departments and acute wards at great expense. They would not get discharged from a hospital and go back to the streets and/or the jail, or come right back to the emergency department. People of organizations experience a phenomenon in our field which is learned helplessness. When there are no beds available, over time you lose the energy to get people placed because there is nowhere for them to go.

The Department of Mental Health has certain authorities and responsibilities, along with access to certain types of funding, to provide good customer service to our network of clients/patients. This means to operate as a network we need information sharing, training, and other coordination type processes. Getting up to capacity in terms of bed numbers and creating the network where there is communication and standards for what to do when someone is sick and requires attention from the crisis response system will require taking ownership of and responsibility for operating proactively.

There is a need to integrate a proper triage function for 9-1-1, 2-1-1, 4-1-1, the mental health line, the Substance Abuse Prevention and Control (SAPC) line, and Substance Use Disorder (SUD) line. However, the funding for addiction services and mental health funding is siloed in that it is provided and administered separately. Each department's call line has their own kind of demands which is something that DHS, DPH and DMH are optimistic about figuring out a way to really bring the health and human services and public health and public safety into a system where the communications are properly triaged in this coordination.

Commissioner Atilla Uner inquired about the proposed hiring of nine Nurse Practitioners (NP) as a psychiatric and substance abuse response, and questioned what the functional roles are that NPs are being hired to do. He asked if billing will be involved, what the anticipated number of

patients seen per year will be, and how they arrived at the proposed budget of $1.8 million per year.

Miriam Brown, Department of Mental Health, responded that consideration was given for staffing with either nurse practitioners (NP) or psychiatric nurses. The goal was to staff adequately so that if fire is called and the mental evaluation team is there and the patient complains of chest pain or reports having high blood pressure or some medical condition that needs to be checked before they can be taken to a mental health facility or a hospital, they can be cleared on the scene to be rerouted to a psychiatric facility if appropriate.

Commissioner Uner stated that if medical clearance was the reason why NPs would be on the response of a patient who complains of chest pain, you probably won't find an NP that will clear that person on scene.

Ms. Brown reported having recently met with EMS, LA County Fire, LA City Fire, and three other fire departments from different cities to come up with the initial plan on how they would be billing for these services, but indicated they have not figured out all the details yet because of regulations. The Board of Supervisors tasked them to submit a report with a potential plan and this is what they came up with. A second report will refine the plan after a second meeting where the group will look at the actual impact of the services being provided to the individuals, what is billable and what is not billable, and since this is a pilot project that will begin with City Fire and County Fire Departments it is not known how many calls will be received on any given day.

Commissioner Uner asked what the actual cost of the entire program is, and stated if you do not know how many patients you are going to see, but somehow came up with hiring nine NPs and it is going to cost $1.8 million dollars, according to one of his colleagues who is either the current or past chair of the Cal ACEP Reimbursement Committee, in the emergency department an NP would have to see 26,000 patients a year to bring $1.8 million dollars in revenue. The average pay for a level 4 in the ER is about $70.00. Therefore, it would be helpful for the EMS Commission to know how many patients they are going to be seeing for the $1.8 million and where the funds are coming from. Are they coming from the County? Are they coming from federal? Are they coming from at least part reimbursement by insurers?

Dr. Sherin stated the goal with the therapeutic transport vans is not to only have therapeutic, but to also have nursing. They are not going to be replacing the emergency department nurse or urgent care nurse in terms of what they can do, what they can clear, and what they cannot clear. We need to be able to facilitate the triage with people who are sick and in the field, and that would be one of the ways we would trigger EMS if there was something detected that was challenging in terms of medical stability.

Dr. Sherin commented that the whole payment system is busted, but he will not put together a system that is driven entirely by allowable services because we are never going to solve the problems of our communities if we do that. The Department of Mental Health is in the process of trying to get payment reform through California Advancing and Innovating Medi-Cal (CalAIM), which is an advance that is about Medicaid through different uses of in a simpler system for monies that they get. For example, the Mental Health Services Act (MHSA) Proposition 63 dollars, the type of service to be delivered to engage someone in the street cannot be quantified and qualified by a fee-for-service, per-minute system.

Commissioner Uner, responded that since the EMS Commission is here as an oversight committee making sure that EMS does not just function in an echo chamber, it is important to come up with the actual cost of the program. That does not mean it is not money well-spent. You

may operate at a loss and the community decides this is money well-spent. But, we still need to spell out what it does cost. What is not here is medical malpractice costs, I didn't see that listed. Is there going to be physician oversight, and is that going to be factored into the cost per year?

Dr. Sherin stated that physician oversight is provided to all their NPs, and that all licensed NPs have physician oversight. There are several different options to funding, and they are trying to figure it out and looking for partners to help to support it. However, they do not know exactly how they are going to fund this.

The therapeutic transport is a significant advance and one where we need to invest. If we are going to be partnering with fire or law enforcement, we ought to be able to roll like EMS rolls. That project is funded through a State innovation fund, and State innovation funds allow us to use resources a bit more flexibly to demonstrate impact. We will then have a better idea of what kind of volume we are managing, and hopefully the outcomes of the people we are serving and the outcomes for the community which are much more important than the processes that we currently kind of tabulate to demonstrate that we are doing work.

Commissioner Uner responded with his agreement, and stated that in the end the community of Los Angeles might decide that the money saved on preventing incarcerations may offset the program. They might decide that, even if it costs us, it is worth the expense to be a better community. He requested Dr. Sherin to come before the EMS Commission again when they have more experience and data because this is incomplete as it is right now where the actual cost of the program is not being provided.

Commissioner Joe Salas asked how much of this is mirrored with what LA City has been doing for the last three or four years, and questioned if the cars that are provided to City Fire with the NP will be deployed in and around downtown, specifically near skid row and other high density areas where there is extreme need.

Dr. Sherin responded that the cars will function as the next generation of DMH's PMRT and this is how they are looking at how it will be triggered. He noted they are certainly underinvested in real-time health and human service response and that their real-time response, not just in L.A. but probably even as a country, focuses on public safety. Whether we are over- or under-invested in public safety, there are arguments you can make either way. We are under-invested, in terms of real-time response to health and human service issues. That is why we end up having to rely upon law enforcement way too much and this is a core problem. As we build up more health and human service capacity, which initially started a long time ago with LAPD and the co-response teams, there will be greater understanding of what the right balance is and what the right types of programs are to deal with the different functions. They are meeting different needs, and really core to all of this is the collaborative spirit and coordinating and communicating amongst the different service providers.

Commissioner Margaret Peterson expressed that it is exciting to see something happening, but there are a lot of questions in terms of integration and the infrastructure of the program. She suggested taking a city like Santa Monica or Los Angeles and working out the integration to see how it works to more successfully answer the questions that are being asked rather than to just roll it out.

Dr. Sherin noted this is a good point, but the question is who to partner with. Santa Monica is very invested, but there is also the County. Your point is well-taken, but I would say we should at least think about how 9-1-1 is being used and how we can have a little more sophisticated triage. It is the same thing in recognizing that a lot of what is coming in is going to need a different kind

of health and human service response. I would be thrilled to try to do something to model the way that the communication between the different service providers could be weaved and integrated at a smaller scale.

Commissioner Peterson stated that without that integration and seamlessness it could end up becoming like our crisis teams that are kind of in their own little world. Unless that integration is there, you could end up becoming your own world although that does not work well for those who take care of the patients.

Dr. Sherin stated that is kind of the situation now, we are in our own worlds. But, I came here from L.A. Fire talking about this and the therapeutic transport vehicles. I think we are moving in that direction. I think going back to the legacy of co-response teams, that there is more communication and integration. This is not about mental health. It is not about the Department of Mental Health. It is not about therapeutic transport vehicles. This is something where we all must really go after it as a collective and, if there is a compelling reason that can help navigate some of the politics to really go after a certain jurisdiction because it is more strategic, maybe it is the City.

Commissioner Roxanna Yoonessi-Martin stated she agrees with both, and thinks these are great ideas. However, she believes a lot of it is not flushed out and does not understand how we get from point A to point B. If there is going to be tele-psychiatry available on the vans, does that mean the NPs are going to be in one centralized location and just providing care electronically? Or, does it mean that they go out? Each time the van is deployed it is going to be a one-to-two-hour visit with transport time, evaluation determination time, and the time it takes to talk to multiple mental health facilities trying to find a bed. So, that goes back to the question Dr. Uner asked, which is what is your turnover going to be, and how many are you really going to be able to see in a day? Maybe the staff need to be at a static location who can give orders electronically, and that way you can increase the number of patients you're seeing at a time because they don't need to physically be moving from one point to another. It would be great if we could just screen and figure out who the safe people are for them to go pick up. In thinking about workplace safety, one incident of a nurse being caught unprotected with a dangerous patient in a confined space will be enough to kind of dismantle the whole entire thing. Choosing a small area to do a pilot in sounds like the right place to start. Maybe you just pick a 20-block radius or something like that and start there.

This ended the discussion with Dr. Sherin who was thanked for his time and willingness to share his vision for DMH, and answer questions from the Commissioners.

Chairman Hisserich introduced Stephen Sanko, MD, Assistant Medical Director, Los Angeles City Fire Department, who attended at the request of the EMS Commission to answer questions about their Sobering Center/ Psychiatric Urgent Care pilot program, and to provide an overview and background on the LA City Fire Advanced Practice Response Unit (APRU), which utilizes both NPs and Physician Assistants and has been operating for the past three or four years.

Dr. Sanko discussed that their different approaches to providing field response were motivated by the increase in volume of how people were using 9-1-1 over the last few years. Mobile Integrated Health at LA City Fire, and specifically their Alternate Destination Pilot Projects use paramedics with advance training to medically screen select patient types. They found select pockets and patient demographic types that were using 9-1-1 more frequently in ways that were historically not seen before. They were seeing issues in looking at demographics, ages of patients, mental health exacerbations, substance use disorders, elderly patients, and minor trauma patients who also had mental health exacerbations. To meet those needs and increased

volumes, they looked at their different partners in emergency care and began dialogue to understand how this was impacting the emergency departments whose volumes had also gone up. Wait times were up, as well as ambulance patient offload times being increased. The result was that several prehospital resources at the busiest hospitals were also in areas of the city with established health disparities who did not have access to begin with, and where there was a paucity of healthcare providers in general.

The concept of Mobile Integrated Healthcare (MIH) has been around for over the last 15 years which sometimes overlaps and gets confused with community paramedicine. However, MIH is a more inclusive term and refers to the idea that we can leverage prehospital experience and space and presence. Being embedded in 106 different neighborhoods in the city of Los Angeles, being focal points of the community, and being members of the community oftentimes are members within the local area where they serve in the station. We want to leverage that position of being in patient's homes every day to improve patient navigation and improve patient experience of care, decrease cost of care by visits to relatively more-costly acute care hospitals, especially with low-acuity emergencies, and then improve efficiency of EMS and we stay available.

So, we came up with this idea of the Advanced Practice Response Unit (APRU), originally called a Nurse Practitioner Response Unit modeled in part after efforts going on in South Metro Denver, as well as Mesa, Arizona. The mission of the APRU is to offer treatment in place. Every patient who is engaged by the Nurse Practitioner (NP) or the APRU is offered a trip to the emergency department. So, they call 9-1-1 on their behalf which we take very seriously. However, they are offered the chance to be evaluated and treated in place by providers who have additional training in health promotion, health teaching, and in differential diagnosis. All the practitioners have experience in emergency departments. They can clear patients to go to alternate destinations including mental health urgent cares or sobering centers. We have even taken patients to their primary care doctor's office to promote continuity of care.

We also developed a new type of unit in collaboration with DHS through Housing for Health specifically, as well as Exodus Recovery, a unit called the Sobriety Emergency Response Unit, which is a converted ambulance that has an Exodus nurse practitioner, a case manager from DHS, as well as a firefighter/paramedic with street smarts. This went into service in November of 2017, and over the first 18 months they attended to some 902 patients that they medically cleared and transported to sobering centers. We kept close tabs on each of these patients, and cross-referenced them with both historic as well as prospective evaluation to see if they bounced back to EMS or if they were noted by a coroner's office. There were 26 total patients that required secondary transport including four by 9-1-1. For the secondary transport, we only have 2.6% which is the same as the bounce back rate for emergency departments in a 2013 study of all California emergency departments. Through this new mechanism, we allow patients to sober in sobering centers as opposed to busy LA County emergency departments which allows them to attend to other time-critical patients in much more timely fashion which is in everybody's interest.

Another type of care pathway we have established is using paramedics with advance training through a pilot project process supported by our local EMS Agency (LEMSA) to examine select public inebriated patients, as well as patients with acute exacerbations of their mental illness. These patients were then able to be transported to either the sobering center or the mental health urgent care if they screened these patients and they were successfully passed.

These pilot projects were approved by the State EMS Authority and OSHPD, and are closely monitored both by them and by us. We have trained a team to operate Monday through Thursday, 4/10 schedule, operating 10 hours a day. They were selected from a large pool of highly qualified candidates and we provided additional training to them in the form of 20 hour curriculums

designed by LAFD medical directors in alliance with what is being done elsewhere in the State where they provide these types of clearance through pilot projects. It also incorporates lessons learned from other programs nationally. It has been approved by both the local and state EMS agencies and OSHPD. The content included things like epidemiology of substance use disorders, specifically alcohol. Discussion of systems issues, case studies, discussions, quizzes, exams. We had a very large focus in this on case studies and looking at mimics of the patients who were intoxicated because as an emergency physician, what worries me the most is that my paramedic is going to go out to somebody who may have a subtle inter-cranial hemorrhage or serious bacterial infection, or some other type of dangerous pathology and I need them to start to understand the ramifications of what they are doing and have a higher level of suspicion for these things.

We were also fortunate enough to have medical directors help train our medics and go through every single case with very close review. We have on our staff four medical directors who are Board Certified in emergency medicine, as well as emergency medical services a recognized sub-specialty of emergency medicine. There are very specific criteria for a patient to be considered for transport to an alternate destination must pass. In addition to that, if the medics feel some other concern about the patient's appropriateness for these alternate destinations, they can either contact myself directly who is on call for them, 40 hours per week. We also have very close follow up mechanisms with our alternate destinations. We can discuss these cases, or they can simply say they do not feel the patient is appropriate.

Our community partner in this has been Exodus Recovery. This is a private organization that works closely with Los Angeles County Department of Health Services, as well as the Department of Mental Health. They have contracted with them for several years, and have helped to serve as an escape valve for our overburdened emergency department.

Exodus Recovery has bricks and mortar office buildings where they can provide crisis stabilization. They are open 24/7. They provide a warm and welcoming environment. They meet them where they are. If they need to have a cigarette, they may offer them that. They have an excellent manner of establishing patient rapport, and for this reason and others, I think they are successfully able to clear patients from their mental health holds, perhaps more effectively than not only our emergency departments, as well as our psychiatric emergency departments.

We also have been working very closely with the sobering center. The sobering center has now been open for two-to-three years. They have 50 beds in total divided by gender. They can provide respite, showers, and hydration. There is an on-scene nurse; and, for a select number of hours per day, they have a Nurse Practitioner. They have a physician on call 24/7 through whom they can do tele-health examinations.

Our pilot programs have a 100% review of all transports to Exodus. We review all the time metrics; elapsed time-to-patient contact; accuracy of dispatch codes, vital signs, narratives, their attachment of check lists; and we are accountable as medical directors to ensure everybody's safety. We want to ensure that our members, as well as the patients that we take care of, are safe. We want to make sure the care we are providing and the check list use is consistent, and any inconsistencies in the narrative are clearly addressed. And, if they are not addressed, then we know it about it immediately and discuss it with the end users or members to rectify it.

We also have a very thorough process for detection of any rekindles, which is fire speak for if a patient needs a secondary transport or they have some unanswered need that needs to be addressed through 9-1-1. But, we use this not only to detect secondary transports, but also any changes in destination, any potential injuries, or even more exchanges because we think

collegiality and patient experience of care and perceived quality care are paramount. So, this is an example of how we receive all those notifications.

Take home points are that we believe this is a safe, patient-centered approach that has significant effects not just for the patient but also for other units that are freed up and other patients who are part of the through-put of our local emergency departments and benefit from this. We feel confident that through our multi-faceted training, case review and monitoring process, we can keep patients secure and problem-solve together with our partners. We feel this approach has the potential, if proven safe over this pilot project period, to come to scale throughout the 480 square miles and catchment population of over four million patients that we serve.

Questions were raised about simple labs on patients being performed before determining suitability to go to mental health or sobering centers; patient consents; options to go to alternate destinations; billing of insurance; and NPs billing for transport or medical services.

Dr. Sanko stated that under their Alternate Destination pilot project they do not use portable lab test machines. For their APRU, LA City is in the process of implementing use of iStat for low-complexity or waived-CLIA complexity point of care tests. All patients are voluntary, and every patient is offered transport to the emergency department. They do have a Glasgow Coma Scale (GCS) cutoff for any patient evaluated by a paramedic and taken to an alternate destination. CMS and private payers in turn have historically only provided payment for prehospital care when it results in transport to an acute care hospital emergency department. None of these alternate destinations are based on an acute care hospital property, and they have not collected a single cent from any patients to date. There are pilot projects, for example CMMI, which is the innovation center within the Center for Medicare and Medicaid services has proposed a project called ET3, which for limited sets of patients, they may offer some degree of reimbursement. They have considered participating in that and have developed an application. That said, he does not know which direction this is ultimately going to go.

The cost benefit of mobile integrated health care is a very difficult thing to quantify. And, while reimbursement is part of it, what we see as our primary benefit is that our units spend less time on scene, they are put back into service sooner, and have a decreased cycle time and increased number of runs that they can do per shift. It also frees up hospital beds so when they do take a patient to an emergency department they are not holding the wall for hours at a time for exorbitant amounts of time.

Commissioner Paul Rodriguez asked how they handle the dispatch component for these units to respond in the field? Do they do triaging on the phone to know who goes, or is that all done in the field.

Dr. Sanko replied, given the call volumes in their communication center, they try not to have the call takers making those judgment calls in real time. However, they program their mobile integrated healthcare resources into the computer assisted dispatch system so they are automatically linked with certain call types, and they cover the City of Los Angeles proper which does range down from the harbor up through the valley. They have specific battalions that we are focused on engaging with our APRU. For the alternate destination response units, those are paramedic run units. They rove around five different battalions.

The APRUs are dispatched from the communications center. However, members on scene can also request both the APRU with our paramedics, as well as our advanced practice providers or the APRU can listen to radio traffic and try and pinpoint high likelihood calls and buy in.

Commissioner Peterson commented the bigger societal issue is that many of these patients do have insurance, i.e., Medi-Cal or VA system, and it seems we are taking the burden off the payers of looking at how these folks can receive ongoing care and really taking responsibility for their health is just another way of relieving them of their burden also of what they should be doing or what we should be doing. It is kind of a stop-gap band aide. How long do you think you can continue to run this program with the funding sources that you have or do not have?

Dr. Sanko replied, a lot of discussion has been had about this, and there is still a lot to learn about each other's business. But, we are going to grow together, and I think where we start in the discussion is trying to understand what works and what does not work. For our APRU model, it is still going to take several years to understand if we are truly accomplishing the goals that we want: to improve access, maintain patient quality of care and experience of care, and relieve our EMS system.

Dr. Gausche-Hill requested an update about the integration of Los Angeles Care or Blue Shield of California and Care First in supporting/funding APRU services.

Dr. Sanko noted they have made several contacts because of the EMS Agency Integrated Health Summit that have been helpful in generating conversation. They have had numerous meetings, both with Blue Shield as well as Los Angeles Care, and reached out to others to try to understand what the potential is with these new care pathways. However, they have not arrived at any type of agreements to date, but those conversations are ongoing.

Commissioner Uner questioned how they were able to get the cooperation of the psychiatric facilities, Exodus, to accept their patients because they try to transfer patients and can't get rid of their patients for days.

Dr. Sanko stated that they started to have the discussion about three years ago, and around the State a police officer can take a patient directly to a mental health urgent care and place an application for a hold, but a paramedic with 30 years of experience cannot do that. A lot of that has to do with the perception of whether or not a patient has acute medical issues. Most community hospitals depend on advance practice providers to see certain levels of patients and to maintain flow and ensure that patient beds are open for time-critical patients. As we all depend on these, what if we were to start using them and see if there is a way we can work together and transport patients over there? That was the genesis of it, and ultimately, I think what they have found is that because we have gone to great lengths to cultivate that relationship including close case review, data sharing, and close follow-up with patients, they value that relationship as well.

There will be a publication coming out of LA City Fire's first 18-months experience with their APRUs, and there may be some difference in how patients are processed, the acuity perhaps. And, there may be significant benefit to timely mental health evaluation for many 9-1-1 patients with mental health exacerbations. When we implemented our APRU approach, and met patients where they were and did not insist on taking them to a local emergency department where they may sit in a bed for days on end with different types of care from different providers over time, we decreased that time from first medical contact to being seen by a mental health provider to 26 minutes. With timely care, meeting patients where they are, timely access to medications and expertise has been a big factor in decreasing inpatient admission rate down to 2%.

There were additional questions about funding sources for the program; if Exodus bills for patients or have their own practitioners who provide care when they get there that they can bill for;

Dr. Sanko answered that their initial Nurse Practitioner Response Unit was funded through an innovation grant from Mayor Eric Garcetti, and subsequent to that APRUs hired to start and to be folded into permanent city funding. That said, we have also entered public/private partnerships to get certain APRUs up and off the ground. And, if they demonstrate an impact, and maintain safety and quality of care that is examined by close follow up of our patients as well as surveying of our patients, then the fire chief and the mayor and our city councilmen have the option of considering folding the funding together for our new budget. Exodus did not receive any of the dollars from this grant.

With respect to whether Exodus bills for these patients or have their own practitioners who provide care when they get there that they can bill for, that would be a question for Exodus as we are not entirely sure what their billing capacities are.

Commissioner Yoonessi-Martin stated this goes to Commissioner Uner's point of how are they incentivized to get these patients and it may be because they are billing for some of the services that were previously provided in emergency departments that they are now providing in Exodus for these patients. There may be some financial offset there that is involved which is great. Everybody wants to have a little money. But, I guess my other question was if you had pulled data on utilization and looking at the same patient population and seeing how many repeat users you have and seeing if year over year you are seeing an increase in utilization by the same patients or a decrease in utilization by the same patients of the services you're providing.

Dr. Sanko stated they present data in their most recent manuscript about 18 high-utilizers of which a 67% decreased their 90-day utilization after APRU encounter versus before. That said, there are a few complexities in terms of evaluating effectiveness of high-utilizer engagement strategies. No one in EMS across the country has really found a magic bullet or magic recipe to handle high utilizers because it takes a village, it takes returning them to communities Dr. Sherin elegantly put it, and it is going to take a lot more types of novel collaboration to see that through.

This ended the presentation and discussion with Dr. Sanko, and he was thanked for his time and willingness to share Los Angeles City Fire Department's experience with APRU and Alternate Destination Pilot Project and answer the questions from the Commissioners.

III. CONSENT AGENDA:

Chairman John Hisserich, Dr.PH., called for approval of the Consent Agenda, and noted replacement pages for policies items 4.1 through 4.3.

Motion/Second by Commissioners White/Salas to approve the Consent Agenda was carried unanimously.

1. MINUTES

September 18, 2019 Minutes were approved.

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 Policy No. 316: Emergency Department Approved for Pediatric (EDAP) Standards
4.2 Policy No. 318: Pediatric Medical Center (PMC) Standards
4.3 Policy No. 324: Sexual Assault Response Team (SART)
4.4 Policy No. 510: Pediatric Patient Destination
4.5 Policy No. 832: Treatment/Transport of Minors
4.6 Policy No. 901: Paramedic Patient Destination
4.7 Policy 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 Report**
No further discussion.

5.2 **Ambulance Patient Offload Time (APOT)**
Richard Tadeo, EMS Agency Assistant Director, noted that eight hospitals in the eastern/southern region with prolonged patient offload times met on November 14, 2019, and most of them were surprised in terms of how long their APOT was, i.e., patients waiting for two hours. They requested timely reporting, and EMS will focus on this region to provide more timely reporting in terms of APOT. We will also focus on those instances over 60 minutes and over 120 minutes. We will tease out those calls and provide that information to the hospitals so they can consider those individual cases to see the types of those cases, and if they may be behavioral cases that take a lot of time waiting for restraints to be put on or waiting for security to show up. We are currently looking at the third quarter APOT which will be published in December 2019.

Los Angeles City data is missing because they do not have the facility equipment time on their EMR. In the past, we have used assorted data element but this skews the data so we chose to not use their data. When APOT data is sent to the State, we inform them the data is incomplete.

5.3 **Body Worn Cameras and Other HIPAA-Related Concerns**
Ms. Fruhwirth reported that at the previous EMS Commission meeting on September 18, 2019, the results were reported from the fire chiefs' survey that indicated that the Fire Chief felt this was an issue between the local law enforcement agency and local fire department to work out. A request was made to remove this item from the agenda. ***Motion/Second by Commissioners Ower/Snyder to remove item 5.3 Body Worn Cameras and Other HIPAA-Related Concerns from the agenda was approved unanimously.***

5.4 **Criteria for 9-1-1 Receiving Center Designation**
Mr. Tadeo reported as part of the consolidation of our different designation agreements for trauma centers, comprehensive stroke centers, paramedic base hospitals, the department has moved toward using a Master Specialty Care Center Designation Agreement. This contract will be one contract with a 10-year performance period, which will include sub-exhibits pertaining to the statement of work specific to the

specialty such as trauma, stroke centers, STEMI, pediatric centers, EDAPs, and Hospital Preparedness Program participation.

Item 5.4 is placed here for consideration to create requirements for a 9-1-1 Receiving Center. It is currently in policy format. We currently require 9-1-1 Receiving Centers to be licensed as a basic or comprehensive emergency medicine service. The EMS Agency wants to look at other requirements that should be included. For example, providing the EMS Agency with outcome data of the 9-1-1 transports. We do have outcome from our specialty care centers, but this represents less than 10% of the total population of EMS transports. We are looking at funding sources for them to incentivize the hospitals to move towards providing us with outcome data. We are going to move forward with developing draft standards similar to EDAP standards that the commission recently approved.

BUSINESS (NEW)

5.5 **EMS Commission Annual Report for Fiscal Year (FY2018-19)**

The EMS Commission Annual Report was prepared by Denise Watson and approved. ***Motion/Second by Commissioners White/Rodriguez to approve the Annual Report for FY2018-19 was approved unanimously.***

5.6 **Nominating Committee**

Commissioners Carole Snyder, Margaret Peterson, and Nerses Sanossian will represent as the Nominating Committee to nominate a EMSC Chair and Vice-Chair for 2020. A meeting will be scheduled to discuss potential nominees, and committee recommendations will be presented at the January 15, 2020 meeting.

5.7 **Standing Committee Selections**

Ms. Fruhwirth reviewed the Standing Committee recommendations, and there was no opposition to the selections.

COMMISSIONERS' COMMENTS/REQUESTS:

Commissioner Paul Rodriguez inquired about Correspondence Item 2.1, Approval to Implement an Advance Provider Response Unit Pilot Project, for Los Angeles County, and asked if this is similar to LA City Fire's pilot program? It was confirmed that LA County is implementing a mobile integrated health unit.

Dr. Gausche-Hill reported that they are not really doing the mental health screening at this point, but they are doing other health related screening, as well as minor procedures, wound care, and that type of thing. The staffing for this is a nurse practitioner and may be a physician as well. Our EMS Fellow will staff that along with the paramedic, and then at times, Dr. Clayton Kazan has also staffed it. It will either be an NP with a paramedic, or a physician with a paramedic at this point.

VI. LEGISLATION:

No legislative report at this time.

VII. DIRECTOR'S REPORT:

Ms. Fruhwirth reported that the Molina, Wu group is scheduled to open what was previously the Community Hospital Long Beach in January 2020. They are working with the City of Long Beach and licensing with the California Department of Public Health. The EMS Agency will work with them to make sure they meet all the requirements to be a 9-1-1 Receiving Hospital based on current policy. They will open in the footprint of the prior hospital. They still have the seismic safety issue to deal with, but the timeline has been

extended to 2025 to come into compliance with that. The SART program is slated to be returning once the Molina, Wu opening happens.

The EMS Authority holds an awards ceremony annually to recognize excellence in EMS. This year they have selected EMS Agency Director Cathy Chidester as Administrator of the Year, and Dr. Marianne Gausche-Hill was selected as the Medical Director of the Year. Both John Michael Criley and Carol Bebout were selected to receive Distinguished Service Medals for pioneering the paramedic program in Los Angeles County.

The Los Angeles County Quality and Productivity Commission presented Cathy Chidester, on behalf of the EMS Agency, with a Special Merit Award recognizing the Comprehensive Stroke System, and the EMS Agency received a plaque.

The EMS Agency has submitted a revised EMS Plan and has made a revision in relationship to our destination policies. We have had preliminary discussions with the State in terms of developing standards for psychiatric urgent care centers, and tied in with that would be our patient destination policy for behavioral and psychiatric crisis to identify and allow EMS to triage patients to psychiatric urgent care centers. Similarly, the EMS Agency developed policy for sobering centers which will include patients with provider impression of alcohol intoxication. That destination policy will also define the parameters for triaging and transporting patients to approved sobering centers. These policies are scheduled to go to the Base Hospital Advisory Committee, as well as Provider Agency Advisory Committee, in December 2019.

It is flu season with flu being widespread in California and there was a handout for this with some discussion.

VIII. <u>ADJOURNMENT</u>:

Adjournment by Chairman Hisserich at 3:00 pm to the next meeting of January 15, 2020.

Next Meeting: **Wednesday, January 15, 2020**
EMS Agency
10100 Pioneer Boulevard
1st Floor Hearing Room 128
Santa Fe Springs, CA 90670

Recorded by:
Denise Watson
Secretary, Health Services Commission

LACAA
LOS ANGELES COUNTY
AMBULANCE ASSOCIATION, INC.
LOS ANGELES COUNTY AMBULANCE ASSOCIATION
P.O BOX 2305 SANTA FE SPRINGS, CA. 90670

November 7, 2019

Los Angeles County EMS Agency
10100 Pioneer Blvd, Ste. 200
Santa Fe Springs, Ca. 90670

Dear Cathy:

On behalf of the Los Angeles County Ambulance Association (LACAA), I would like to first thank you for your efforts in the huge task of pursuing to update the Los Angeles County Ambulance Ordinance 7.16.

Your staff spent quality time listening to our issues, and ensured we had the opportunity to help recommend changes during the draft version process.

We have been waiting on the Treasurer Tax Collector Department since October of 2017. Is there anything the LACAA can do to help facilitate a completion? We know this is out of your control, but 2 years seems like an awfully long time.

If the LACAA can be of any use to you or your staff in helping this project come to completion, please feel free to inform me of your thoughts.

The LACAA as an organization, is committed to high quality medical transportation and your efforts and collaboration is always appreciated. We stand ready to support the EMS Agency on future endeavors to improve patient care.

Regards,

Matt Armstrong
President
Los Angeles County Ambulance Association

Serving the residents and visitors of Los Angeles County for 60 years

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

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

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

November 12, 2019

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

Dear Dr. Duncan:

REQUEST FOR PROPOSAL (RFP) FOR EMERGENCY AMBULANCE TRANSPORTATION SERVICES 9-1-1 RESPONSE FOR THE CITY OF MONROVIA, EXCLUSIVE OPERATING AREA TWO (2)

Pursuant to the Health & Safety Code section 1797.224, the Los Angeles County Emergency Medical Services (EMS) Agency is submitting the enclosed draft RFP for Emergency Ambulance Transportation Services for the City of Monrovia, Exclusive Operating (EOA) 2. The EMS Agency is seeking the State's approval of the RFP in order to begin the competitive process for selecting a provider for this EOA.

Schaefer Ambulance Service (SC) was awarded exclusive transportation rights for EOA 2 in December 2016 and notified the EMS Agency in February 2018 of financial difficulties affecting their ability to continue providing the service. SC Filed for bankruptcy protection soon after this notification.

The Emergency Medical Services Authority (EMSA) was notified of such and subsequently approved the temporary assignment of EOA 2 to Care Ambulance Service (CA), while the EMS Agency worked on developing an RFP.

The EMS Agency is requesting that the term on the agreement coincide with the expiration of the existing eight (8) Los Angeles County EOA's, November 2026.

We will work closely with your staff to address any issues. Please let us know if you have any questions or concerns.

Sincerely,

Cathy Chidester
Director

CC:jt
11-10

c. Contract and Grants, Los Angeles County

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

December 15, 2019

Lisa Galindo
Emergency Medical Services Agency
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670

Dear Ms. Galindo:

EMS PLAN ADDENDUM (FISCAL YEAR 2017-2018)

As required by California Code of Regulations, Title 22, Division 9, Chapters 7.1, 7.2, and 14, the Los Angeles (LA) County Emergency Medical Services (EMS) Agency is submitting the required addendums to LA County EMS Agency's Annual EMS Plan for fiscal year 2017-2018:

- STEMI Critical Care System – Exhibit 1
- Stroke Critical Care System – Exhibit 2
- Emergency Medical Services for Children – Exhibit 3

The LA County EMS Agency has maintained similar programs:

- 1989 – Emergency Medical Services for Children System
- 2005 – STEMI Critical Care System
- 2009 – Stroke Critical Care System

Please contact me at (562) 378-1604 or Christine Clare, Chief Hospital Programs at (562) 378-1661 for any questions.

Sincerely,

Cathy Chidester
Director

CC:cac
12-19

c: Medical Director, EMS Agency

Los Angeles County EMS Agency STEMI Critical Care System Plan

In 2005, through grants and "seed" money from Los Angeles (LA) County, all primary 9-1-1 EMS providers in LA County were required to purchase 12-lead electrocardiogram (ECG) monitors and provide education on the presentation and management of patients with myocardial infarction.

On December 1, 2006, LA County EMS Agency designated the first three (3) hospitals as ST-Elevation Myocardial Infarction (STEMI) Receiving Centers (SRC). 9-1-1 patients with suspected STEMI were routed to these SRCs when the 12-lead electrocardiogram (ECG) interpretation was "Acute Myocardial Infarction". The maximum transport time to reach an SRC was 30-minute otherwise the patient was transported to the closest most accessible 9-1-1 receiving hospital. The primary goals of the program were to regionalize care of patients with suspected STEMI to hospitals that can provide rapid percutaneous coronary intervention (PCI) 24 hours a day, 7 days a week, 236 days a year.

In October 2010, patients who had a non-traumatic out-of-hospital cardiac arrest (OHCA) and had a return of spontaneous circulation (ROSC) in the prehospital setting were also transported to the SRC.

In January 2011, studies have demonstrated the improved neurological outcomes of OHCA patients with ROSC when managed with Therapeutic Hypothermia/Target Temperature Management (TTM). SRCs were required to have equipment, policies, and procedures for identifying patient eligible for TTM and for administering TTM.

As of June 30, 2018, there were 36 SRCs designated by LA Couth EMS Agency (including one in Orange County and one in Ventura County.

§100270.121(c)

(1) Names and Titles of EMS Agency personnel with a role in the STEMI critical care system

Cathy Chidester, EMS Agency Director

Dr. Marianne Gausche-Hill, EMS Agency Medical Director

Dr. Nichole Bosson, EMS Agency Assistant Medical Director

Richard Tadeo, EMS Agency Assistant Director

Christine Clare, Chief-Hospital Programs

Paula Rashi, STEMI Receiving Center (SRC) Program Manager

Michelle Williams, Chief Data Systems Management

(2) List of STEMI designated facilities with the agreement expiration dates

Attachment A

See map of designated SRCs as of June 30, 2018 (Attachment B)

(3) A description or copy of the local EMS agency's STEMI patient identification and destination policies

Reference No. 513, ST-Elevation Myocardial Infarction Patient Destination (Attachment C)

Reference No. 1211, Treatment Protocol: Cardiac Chest Pain (Attachment D)

(4) A description or a copy of the method of field communication to the receiving hospital-specific to STEMI patients, designed to expedite time-sensitive treatment on arrival

Reference No. 513, ST-Elevation Myocardial Infarction Patient Destination (Attachment C)

Reference No. 716, Paramedic Communications System (Attachment E)

Reference No. 1211, Treatment Protocol Cardiac Chest Pain (Attachment D)

(5) A description or a copy of the policy that facilitates the inter-facility transfer of a STEMI patient

Reference No. 513.1, Interfacility Transport of Patients with ST-Elevation Myocardial Infarction (Attachment F)

(6) A description of the method of data collection from the EMS providers and designated STEMI hospitals to the local EMS agency and EMS Authority

Reference No. 320, ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) Standards (Attachment G)

Reference No. 607, Electronic Submission of Prehospital Data (Attachment H)

Our database system vendor is NEMSIS compliant and is currently working with the CEMSIS vendor to submit EMS data to the EMS Authority.

(7) A policy or description of how the Local EMS agency integrates a receiving center in a neighboring jurisdiction

Los Angeles County EMS, with concurrence from neighboring EMS Agencies, reached out to hospitals in neighboring jurisdictions that receive patients from LA County to solicit interest in participating in the in the SRC program. The ST-Elevation Myocardial Infarction (STEMI) Receiving Center Standards, Reference No. 320 was provided to hospitals that expressed interest, and upon meeting all requirements, the hospital was then designated as a SRC. Currently, there are two designated SRCs bordering counties (one in Orange County and one in Ventura County).

(8) A description of the integration of STEMI into an existing quality improvement committee or a description of any STEMI-specific quality improvement committee

A biannual SRC Advisory/QI Meeting is held by the EMS Agency. SRC Medical Directors and Program Managers from all SRCs are expected to attend 100% of the meetings.

Agenda items include: policy and practice issues; best practices; and system-wide quality improvement and performance metrics.

Los Angeles County EMS Agency Stroke Critical Care System Plan

In November 2009, the Los Angeles (LA) County EMS Agency began designating LA County 9-1-1 receiving hospitals as Stroke Centers. This allowed the rerouting of 9-1-1 patients with suspected stroke to a designated stroke center for earlier definitive diagnosis and treatment. Paramedics utilized the modified LA Prehospital Stroke Scale (mLAPSS) as the stroke screening tool.

On September 11, 2017, Ronald Reagan UCLA Medical Center and Santa Monica Fire Department began operation of a Mobile Stroke Unit (MSU) through a written agreement. The MSU program was approved by the Los Angeles (LA) County EMS Agency and fully supported by the LA County Board of Supervisors. The MSU program is part of a nationwide study, Benefits of Stroke Treatment Delivered Using a Mobile Stroke Unit (BEST-MSU), to evaluate patient outcomes and the cost-effectiveness of accelerated field treatment. The MSU was only in operation in the City of Santa Monica and for no more than 40 hours every other week.

On January 8, 2018, the MSU operations were expanded to the study's off week covering the areas in and around the cities of Lakewood and Cerritos. This was made possible through additional funding provided by the LA County Board of Supervisors. This expansion also involved the collaboration of LA County Fire Department.

Also on January 8, 2018, the EMS Agency expanded its Stroke Program by designating Comprehensive Stroke Centers (CSC) through a solicitation process and written agreements with hospitals that met the solicitation requirements. This expansion allowed for a two-tier routing of 9-1-1 patients with suspected stroke to either a designated Primary Stroke Center (PSC) or CSC. This allowed the rerouting of patients with large vessel occlusion to centers that have the capability to perform thrombectomy (CSC). The Los Angeles Motor Score (LAMS) is the paramedic triage tool utilized to determine large vessel occlusions (LAMS score 4 or 5). At the time of implementation, there were 13 hospitals that were designated CSC (3 of which are in bordering counties that receive 9-1-1 transports from LA County). As of June 30, 2018, there are 19 CSCs designated by the EMS Agency.

§100270.220(c)

(1) Names and Titles of EMS Agency personnel with a role in the stroke critical care system

Cathy Chidester, EMS Agency Director

Dr. Marianne Gausche-Hill, EMS Agency Medical Director

Dr. Nichole Bosson, EMS Agency Assistant Medical Director

Richard Tadeo, EMS Agency Assistant Director

Christine Clare, Chief-Hospital Programs

Lorrie Perez, Stroke Program Coordinator

Michelle Williams, Chief Data Systems Management

(2) List of stroke designated facilities with the agreement expiration dates

Attachment A

See map of designated stroke centers as of June 30, 2018 (Attachment B)

(3) A description or copy of the local EMS agency's stroke patient identification and destination policies

Reference No. 521, Stroke Patient Destination (Attachment C)

Reference No. 1232, Treatment Protocol: Stroke/CVA/TIA (Attachment D)

(4) A description or a copy of the method of field communication to the receiving hospital-specific to stroke patients, designed to expedite time-sensitive treatment on arrival

Reference No. 521, Stroke Patient Destination (Attachment C)

Reference No. 716, Paramedic Communications System (Attachment E)

Reference No. 1232, Treatment Protocol: Stroke/CVA/TIA- which requires Base Hospital Contact (Attachment D)

(5) A description or a copy of the policy that facilitates the inter-facility transfer of stroke patients

Reference No. 322, Stroke Receiving Center Standards (Attachment F)

(6) A description of the method of data collection from the EMS providers and designated stroke hospitals to the local EMS agency and EMS Authority

Reference No. 322, Stroke Receiving Center Standards (Attachment F)

LA County EMS Agency has a written agreement with IQVIA, for access to Get With The Guidelines Stroke (GWTG-S) Patient Management Tool for all participating stroke centers that enter their patient data into GWTG-S. (Attachment G)

For stroke centers that do not participate in GWTG-S, LA County EMS has a designated database in which they must enter the required data elements for all patients meeting inclusion criteria. (Attachment H)

Reference No. 607, Electronic Submission of Prehospital Data (Attachment I)

(7) A policy or description of how the Local EMS agency integrates a receiving center in a neighboring jurisdiction

Los Angeles County EMS, with concurrence from neighboring EMS Agencies, reached out to hospitals in neighboring jurisdictions that receive patients from LA County to solicit interest in participating in the stroke receiving center program. The Stroke Receiving Center Standards, Reference No. 322 was provided to hospitals that expressed interest, and upon meeting all requirements in the standards, the hospital was

designated as a Stroke Receiving Center for LA County. Currently, there are three designated CSCs in bordering counties (two in Orange County and one in Ventura County).

(8) A description of the integration of stroke into an existing quality improvement committee or a description of any stroke-specific quality improvement committee

A biannual Stroke Advisory/QI Meeting is held by the EMS Agency. Stroke Medical Directors and Program Managers from all designated stroke centers (PSC and CSC) are expected to attend 100% of the meetings. Agenda items include: policy and practice issues; best practices; and system-wide quality improvement and performance metrics.

A Stroke Data Collaborative Group is also convened by the EMS Agency on a biannual basis to discuss data collection, data utilization and publication projects. This group is comprised of subject matter experts in stroke care who provides the EMS Agency with recommendations on current and upcoming best practices.

Los Angeles County EMS Agency Emergency Medical Services for Children System Plan

The entry level of Pediatric Receiving Center designation for Los Angeles (LA) County is Emergency Department Approved for Pediatrics (EDAP) which is equivalent to a General Pediatric Receiving Center (PedRC) as per the regulations. LA County also designates qualified hospitals as Pediatric Medical Center (PMC) for providing higher level of care for the critically ill pediatric patient. Pediatric Trauma Centers (PTC) are designated hospitals that meet the minimum regulatory requirements to provide pediatric trauma care. All PMCs and PTCs are required to be EDAPs. PMCs meet the standards for Advanced PedRC and PTCs meet the regulatory requirements of Comprehensive PedRCs per the regulations.

In 1985, the LA County EMS Agency designated 63 EDAPs. Three additional EDAPs were designated in the subsequent years. However, by the end of 2005, 21 hospitals have relinquished their EDAP designation. As of June 30, 2018, there were 38 designated EDAPs (this includes one in Orange County and one in Ventura County).

In the mid-1980's, the LA County EMS Agency began designating Pediatric Critical Care Centers (PCCC) to care for critically ill and injured pediatric patients. The revised trauma regulations were released in 1999 which allowed LA County EMS to designated PTCs and develop a separate list of requirements for hospitals that can provide higher level of care (non-traumatic) to critically ill pediatric patients. In 2005, the EMS Agency changed the name designation from PCCC to PMC for critically ill children to more clearly differentiate from PTC.

§100450.216(c)

(1) <u>EMSC program goals and objectives</u>

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 to the pediatric patient. This is done by establishing minimum standards for the designation of EDAP, PMC and PTC. These facilities 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.

(2) <u>The names and titles of local EMS Agency personnel with a role in the planning, implementation, and management of an EMSC program</u>

Cathy Chidester, EMS Agency Director

Dr. Marianne Gausche-Hill, EMS Agency Medical Director

Dr. Nichole Bosson, EMS Agency Assistant Medical Director

Richard Tadeo, EMS Agency Assistant Director

Christine Clare, Chief-Hospital Programs

Paula Rashi, STEMI Receiving Center (SRC) Program Manager

Karen Rodgers, EDAP and PMC Programs Coordinator

Michelle Williams, Chief Data Systems Management

(3) Injury and illness prevention planning that includes coordination, education, and data collection

All EDAPs must have policies and procedures in place that address immunization assessment and management of the under-immunized patient and pediatric safety in the emergency department. Data submission is also required.

Reference No. 316, Emergency Department Approved for Pediatrics (EDAP) Standards (Attachment A)

In addition to the above, all PMC's have policies related to mental health and substance abuse. They must also provide outreach and pediatric education to EDAPs and EMS providers and they must have a Suspected Child Abuse and Neglect (SCAN) Team.

Reference No. 318, Pediatric Medical Center (PMC) Standards (Attachment B)

All PTCs are required to have an outreach program which includes trauma prevention for the general public and public education and illness/injury prevention education, as per Title 22, Chapter 7, Subsection 100261 (e) (4) (B) and (C)

(4) (A) Policies for care and services rendered to pre-hospital EMS pediatric patients:

1. First response non-transport

   Reference No. 832, Treatment/Transport of Minors (Attachment C)

2. Transport

   Reference No. 510, Pediatric Patient Destination (Attachment D)

   Reference No. 832, Treatment/Transport of Minors (Attachment E)

3. Interfacility transfer

   9-1-1 EMS is not utilized in the interfacility facility transfer of critically ill pediatric patients. All PMCs are required to either have a pediatric interfacility transport program or have a written agreement with agencies or other programs to provide timely transportation of critically ill pediatric patients to and from the PMC.

   Reference No. 318, Pediatric Medical Center (PMC) Standards (Attachment B)

   For critically injured pediatric patients that are not at a designated trauma center and meet designated criteria, 9-1-1 EMS may be utilized for trauma re-triage.

   Reference No. 506, Trauma Triage (Attachment F)

4. Critical care

This is for initial care and transport of critical children only, for secondary transfer of critical children see (4)(A)3. above.

Reference No. 510, Pediatric Patient Destination (Attachment D)

Reference No. 832, Treatment/Transport of Minors (Attachment E)

(B) <u>This shall include, but not be limited to:</u>

1. Pediatric-specific personnel training

The EMS Agency annually mandates an EMS Update for all EMS paramedic providers and Mobile Intensive Care Nurses (MICN). This education always has pediatric components and is a minimum of 4 hours. The following pediatric topics were included in the most recent EMS Updates:

2016: Pediatric Resuscitation

2017: Case studies for the following Provider Impressions (PI) which included pediatric patients:

Brief Unresolved Unexplained events (BRUE)

Hypoglycemic emergencies

Respiratory distress

Seizure activity

2018: New Treatment Protocols- which resulted in 40 distinct pediatric specific treatment protocols. Previously for all but 6, the pediatric protocols were incorporated in the adult protocols. In addition, there were pediatric-specific scenario based teaching modules.

2. Pediatric ambulance equipment

Reference No. 703, ALS Unit Inventory (Attachment G)

Reference No. 703.1, Private Provider Non–9-1-1 ALS Unit Inventory (Attachment H)

Reference No. 704, Assessment Unit Inventory (Attachment I)

Reference No. 706, ALS EMS Aircraft Inventory (Attachment J)

Reference No. 710, Basic Life Support Ambulance Equipment (Attachment K)

Reference No. 712, Nurse Staffed Critical Care Transport Unit Inventory (Attachment L)

Reference No. 713, Respiratory Care Practitioner Staffed Critical Care Transport Unit Inventory (Attachment M)

(5) A quality improvement plan contacting process-outcome measures as referenced in section 100450.224 of this Chapter

All EDAPs are required to have a quality improvement (QI) process in place which includes all elements included in section 100450.224. These processes are reviewed at each re-designation survey to ensure compliance.

Reference No. 316, Emergency Department Approved for Pediatrics (EDAP) Standards (Attachment A)

Reference No. 618, EMS Quality Improvement Program Committees (Attachment N)

Reference No. 620, EMS Quality Improvement Program (Attachment O)

(6) A list of facilities providing pediatric critical care and pediatric trauma services

See attached map.

Facilities with a green box are designated Pediatric Medical Centers that provide pediatric critical care services. Facilities with a yellow dot are designated Pediatric Trauma Centers

(7) List of designated hospitals with agreements to participate in the EMSC system of care

See attached map

(8) A list of facilities providing pediatric physical rehabilitation resources

Children's Hospital Los Angeles

Miller's Children Hospital

Rancho Los Amigo

(9) Copies of the local EMS agency's EMSC pediatric patient destination policies

Reference No. 510, Pediatric Patient Destination (Attachment D)

(10) A description of the method of field communication to the receiving hospital specific to the EMSC patient

Reference No. 510, Pediatric Patient Destination (Attachment D)

Reference No. 716, Paramedic Communications System (Attachment P)

(11) A description of the method of data collection from the EMS providers and designated EMSC hospital to the local EMS agency and the EMS Authority

Reference No. 316, Emergency Department Approved for Pediatric (EDAP) Standards (Attachment A)

Reference No. 318. Pediatric Medical Center (PMC) Standards (Attachment B)

Reference No. 607, Electronic Submission of Prehospital Data (Attachment Q)

(12) A policy or description of how the local EMS agency integrates a PedRC in a neighboring Jurisdiction

Los Angeles County EMS, in collaboration with neighboring EMS Agencies, reached out to hospitals in neighboring jurisdictions that receive patients from LA County. LA County EMS asked these neighboring hospitals if they would like to participate in the pediatric receiving center program within LA County and receive 9-1-1 pediatric patients from LA County. Upon meeting all of the requirements, the hospital was then approved as an EDAP for LA County. Currently there are two designated EDAPs in bordering counties (one in Orange County and one in Ventura County).

(13) Pediatric surge planning

All EDAPs are required to have a policy addressing pediatric surge planning. Review of said policy is completed at each designation/re-designation survey.

Reference No. 316, Emergency Department Approved for Pediatrics (EDAP) Standards (Attachment A)

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

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

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

December 24, 2019

Mr. Matt Armstrong, President
Los Angeles County Ambulance Association Inc.
PO Box 2305,
Santa Fe Springs, CA 90670

Dear Mr. Armstrong:

RESPONSE TO AMBULANCE ORDINANCE INQUIRY

Thank you for the Association's inquiry on the status of revisions to the Los Angeles County Ambulance Ordinance, Chapter 7.16-Ambulances (7.16).

The Emergency Medical Services (EMS) Agency staff began working on revisions to 7.16 in 2016 with the goal of updating numerous obsolete sections and to establish a "freestanding" 7.16 to decrease the necessity to refer to other sections of the County Code when dealing with ambulance licensing or regulatory issues.

The EMS Agency's efforts required working closely with the Department of Health Services (DHS) County Counsel, the Los Angeles County Treasurer and Tax Collector (TTC) and their Counsel. The revisions were also complicated by the revisions made by TTC to other sections of the Los Angeles County Code. This will require both departments to present revisions to the Board of Supervisors (BOS) concurrently.

There have been many challenges staying on course with revisions to 7.16, due in part to staff reassignments and retirements. We have been in contact with DHS Counsel and have been informed that County Counsel has reached out to TTC County Counsel and we will be back on course shortly.

If you have any additional questions or concerns, please feel free to contact m at (562) 378-1677, or John Telmos, Chief Prehospital Operations at (562) 378-1677.

Sincerely,

Cathy Chidester
Director
CC:jt
12-22

c. Edward Morrissey, Principal Deputy County Counsel, Los Angeles County
Brian Chu, Principal Deputy County Counsel, Los Angeles County

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.

December 31, 2019

VIA E-MAIL

TO: All Prehospital Care Coordinators
All Paramedic Coordinators
All Paramedic Nurse Educators
All Paramedic Training Program Directors
All Continuing Education Program Directors-ALS Providers

FROM: Denise Whitfield, MD, MBA
Medical Director, Education and Innovation

SUBJECT: EMS UPDATE 2020 TRAIN-THE-TRAINER (REVISED)

Train-the-Trainer classes will be held at the EMS Agency on the following dates:

Wednesday	March 4, 2020	8:00 am – 11:00 am
Wednesday	March 4, 2020	1:00 pm – 4:00 pm
Thursday	March 12, 2020	8:00 am – 11:00 am

This year's EMS Update is planned to be presented using a learning management system and will address the following topics:

- Clinical approach to managing pain, introduction of Ketorolac
- Capnography
- Quality Improvement Case Studies with focus on:
  - Provider Impression Weakness
  - Provider Impression Altered Level of Consciousness
  - ECG Interpretation

Please RSVP by January 30, 2020 by contacting Vanessa Gonzales at (562) 378-1607 or VGonzalez3@dhs.lacounty.gov to attend any of these training sessions.

Please do not hesitate to contact me at (562) 378-1663 or DWhitfield@dhs.lacounty.gov if you have any questions.

DW:rt

c. Director, EMS Agency
Medical Director, EMS Agency
Assistant Director, EMS Programs, EMS Agency
All Fire Chiefs
All CEOs, ALS Private Provider Agencies
EMS Commission
Office of Certification and Training Program Approvals, EMS Agency

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY GAVIN NEWSOM, *Governor*

EMERGENCY MEDICAL SERVICES AUTHORITY
10901 GOLD CENTER DR., SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

January 2, 2020

Cathy Chidester, EMS Director
Los Angeles County EMS Agency
10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Dear Cathy,

The EMS Authority (EMSA) has reviewed the 2017-2018 Los Angeles EMS Agency's EMS for Children system plan submitted on December 17, 2019, in accordance with the California Code of Regulations, Title 22, Chapter 14 EMS for Children. The 2018 Los Angeles EMS Agency's EMS for Children system plan is in compliance with the EMS for Children regulations and is approved.

In accordance with the Section 100450.217 of the EMS for Children regulations, your EMS for Children System Status Report will be due by January 2, 2021.

Please contact Heidi Wilkening at (916) 384-0556 or heidi.wilkening@emsa.ca.gov for any questions and technical assistant.

Sincerely,

Tom McGinnis, EMT-P
Chief, EMS Systems Division

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

BASE HOSPITAL ADVISORY COMMITTEE MINUTES

December 11, 2019

MEMBERSHIP / ATTENDANCE

	REPRESENTATIVES		EMS AGENCY STAFF
☒	Robert Ower, RN., Chair	EMS Commission	Dr. Nichole Bosson
☐	Erick Cheung, M.D., Vice Chair	EMS Commission	Richard Tadeo
☐	Atilla Uner, M.D.	EMS Commission	Christine Clare
☐	Margaret Peterson, Ph.D.	EMS Commission	Dr. Saranya Srinivasan
☐	Rachel Caffey	Northern Region	John Telmos
☒	Melissa Carter	Northern Region	Christy Preston
☒	Charlene Tamparang	Northern Region, Alternate	Paula Rashi
☒	Samantha Verga-Gates	Southern Region	Gary Watson
☒	Laurie Donegan	Southern Region	Dr. Denise Whitfield
☒	Shelly Trites	Southern Region	Christine Zaiser
☒	Christine Farnham	Southern Region, Alternate	Dr. Natalia Alvarez
☒	Paula Rosenfield	Western Region	Frederick Bottger
☒	Ryan Burgess	Western Region	
☒	Alex Perez-Sandi	Western Region, Alternate	
☒	Erin Munde	Western Region, Alternate	
☒	Laurie Sepke	Eastern Region	
☒	Alina Candal	Eastern Region	**GUESTS**
☒	Jenny Van Slyke	Eastern Region, Alternate	Dr. Clayton Kazan, LACOFD
☒	Lila Mier	County Hospital Region	Nicole Steeneken, LACOFD
☐	Emerson Martell	County Hospital Region	Jennifer Boccher, NRH
☒	Yvonne Elizarraz	County Hospital Region, Alternate	
☒	Antoinette Salas	County Hospital Region, Alternate	
☐	Alec Miller	Provider Agency Advisory Committee	
☐	Chris Morrow	Provider Agency Advisory Committee, Alt.	
☐	Michael Wombald	MICN Representative	
☒	Jennifer Grere	MICN Representative, Alt.	
☐	Robin Goodman	Pediatric Advisory Committee	
☐	Kerry Gold-Tsakonas	Pediatric Advisory Committee, Alt.	

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

1. **CALL TO ORDER:** The meeting was called to order at 1:00 P.M. by Robert Ower, Chairperson.

2. **APPROVAL OF MINUTES**: The meeting minutes for August 14, 2019, were approved as submitted.

   M/S/C (Robinson/Sepke)

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

4. REPORTS & UPDATES:

4.1 Epinephrine Dosing in Cardiac Arrest

A lengthy explanation was provided on limiting the use of Epinephrine in cardiac arrest (CA) patients. There is no evidence to support the administration of multiple doses of epinephrine to be beneficial in patients in CA. The likelihood of survival declines after the administration of three doses of epinephrine, and when not needed can be neurologically harmful to the patient. In patients with non-shockable rhythms, early administration of epinephrine may improve outcomes, but can worsen outcomes of patients in a shockable rhythm.

4.2 ITAC Committee

The ITAC Committee held the quarterly meeting in November, innovations and devices that were evaluated include, Certadose Anaphylaxis Convenient Kit and PALS Syringe Holder, electronic tracking systems, prehospital data integration software, S.T.A.T. Tourniquet, and WoundClot Hemostatic Dressing. Current recommendations can be found on the Los Angeles County EMS website, under Reference No. 205.1, and recommendations will be updated on a quarterly. Next update will be early 2020 and will offer recommendations for mechanical compression devices to assist with out of hospital CPR (e.g. LUCAS, EleGARD).

Link: http://dhs.lacounty.gov/wps/portal/dhs/ems/prehospitalcaremanual/???#tabs-3

4.3 Extracorporeal Membrane Oxygenation (ECMO) Trial

Multiple providers including Los Angeles County Fire, Los Angeles City Fire, Culver City Fire, and Beverly Hills Fire in conjunction with LAC+USC, Cedars Sinai Medical Center, and Ronald Reagan UCLA will be participating in the ECMO Trial. The projected start date is the 2nd quarter of 2020, and the study will run for two years. Due to the specificity of the study's inclusion criteria, a limited number of patients will bypass a closer SRC to be transported to an ECMO center. The Committee will be provided additional information as it becomes available.

5. UNFINISHED BUSINESS:

5.1 EMS Update

The EMS Agency is exploring offering EMS Update 2020 via a learning management system (LMS). If the LMS plan is implemented, Train the Trainer may be restructured. The EMS Agency will explore this as we move forward.

Topics for next year's update will be offered as modules that will be include, Clinical Approach to Managing Pain, Introduction of Ketorolac Administration, Capnography, Quality Improvement with a focus on Provider Impression, ALOC and Weakness, and ECG Interpretation.

5.2 Ref. No. 1200.1, TP General Instructions

M/S/C (Approved by all)

5.3 Ref. No. 1200.2, Base Contact Requirements

M/S/C (Approved by all)

5.4 Ref. No. 1210, Cardiac Arrest

M/S/C (Approved by all)

5.5 Ref. No. 1213 & 1213-P, Cardiac Dysrhythmia-Tachycardia

M/S/C (Approved by all)

5.6 Ref. No. 1220 & 1220-P, Burns

M/S/C (Approved by all)

5.7 Ref. No. 1241 & 1241-P, Overdose/Poisoning/ingestion

M/S/C (Approved by all)

5.8 Ref. No. 1317.1, Adenosine

M/S/C (Approved by all)

5.9 Ref. No. 1317.5, Amiodarone

M/S/C (Approved by all)

5.10 Ref. No. 1317.29, Naloxone

M/S/C (Approved by all)

5.11 Ref. No. 1317.33, Ondansetron

M/S/C (Approved by all)

5.12 Ref. No. 1373, TP QI Fallout Data Dictionary

M/S/C (Approved by all)

5.13 Ref. No. 326, Psychiatric Urgent Care Center Standards

Tabled for further review

5.14 Ref. No. 328, Sobering Center Standards

Tabled for further review

5.15 Ref. No. 526, Behavioral/Psychiatric Crisis Patient Destination

Tabled for further review

5.16 Ref. No. 526.1, Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care Center

Tabled for further review

5.17 Ref. No. 528, Intoxicated (Alcohol) Patient Destination

Tabled for further review

5.18 Ref. No. 528.1, Medical Clearance Screening Tool for Sobering Center

Tabled for further review

6. NEW BUSINESS:

No new business

7. OPEN DISCUSSION:

None

8. NEXT MEETING: BHAC's next meeting is scheduled for **February 12, 2020**, location is the EMS Agency, Hearing Room @ 1:00 P.M.

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

ACCOUNTABILITY: Lorrie Perez

9. ADJOURNMENT: The meeting was adjourned at 14:40 P.M.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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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, December 11, 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 DECEMBER 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, December 18, 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
☐ Vacant	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)*
☑ Julian Hernandez	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	
Cathy Chidester	Marianne Gausche-Hill, MD
Richard Tadeo	Natalia Alvarez, MD
Chris Clare	Elaine Forsyth
Susan Mori	Christy Preston
Paula Rashi	John Telmos
David Wells	Michelle Williams
Christine Zaiser	Gary Watson

OTHER ATTENDEES	
Marc Eckstein, MD	LAFD
Jennifer Nulty	Torrance FD
Luis Manjarrez	Glendale FD
Marianne Newby	Glendale FD
Karen Bustilles	Sierra Madre FD
Brian Fong, MD	Guardian & MedReach Amb
Chris Backley	San Gabriel FD
Kristina Crews	LACoFD
Aaron Aumann	University of Antelope Valley
Ilse Wogau	LACoFD
Adrienne Roel	Culver City FD
Nicole Steeneken	LACoFD
CJ Bartholomew	Care Ambulance
Craig Hammond	Glendale FD

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

1. CALL TO ORDER: Committee Chair, Commissioner Paul Rodriquez, called meeting to order at 1:02 p.m.

2. INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS

2.1 Retirement Announcement

Jodi Nevandro, Santa Monica Fire Department's Nurse Educator and Committee member since 2003, will be retiring at the end of this year; today being her last Committee meeting.

Committee Chair, Representing the EMS Commission; and EMS Agency Administration gave personal thanks to Ms. Nevandro for her dedication and exemplary service to the Los Angeles County EMS system. Certificate of Appreciation and EMS Challenge Coin was presented.

2.2 Changes to Committee Membership *(Paul Rodriguez)*

Chair announced the following changes to Committee membership:

- Employed Paramedic Coordinator, Representative:
  Julian Hernandez, AMR Ambulance, primary Representative; replacing Luis Vasquez.
- Area A, Representatives:
  Sean Stokes, Beverly Hills Fire Department, primary Representative; replacing Jodi Nevandro;
  Justin Crosson, Santa Monica Fire Department, Alternate Representative; replacing Sean Stokes.

3. APPROVAL OF MINUTES (White/Kazan) October 16, 2019 minutes were approved as written.

4. REPORTS & UPDATES

4.1 Disaster Services Update *(Elaine Forsyth)*

Public Access Bleeding Control Kits

- During the 2017 Las Vegas mass shooting, fire department personnel rapidly distributed bleeding control kits to the bystanders. These kits provided bystanders with necessary equipment to control the bleeding of the victims who received gunshot wounds.
- The EMS Agency has received government funding allowing for the purchase of Public Access Bleeding Control Kits. The plan is to purchase enough of these kits to supply all Los Angeles County fire department's EMS supervisor's vehicles with these potentially life-saving kits.
- To purchase an adequate amount of the kits, the EMS Agency is requesting each fire department provide the number of supervisor vehicles they utilize. To provide the amount requested and for more information, contact Elaine Forsyth at eforsyth@dhs.lacounty.gov prior to January 17, 2020.

4.2 Innovation, Technology and Advancement Committee (ITAC) Update *(Richard Tadeo)*

- ITAC continues to meet quarterly. All recommendations from this Committee are listed in Reference No. 205.1, ITAC Recommendations; and is updated regularly.
- After reviewing a product and/or technology, ITAC will make one of the four recommendations:
  - Implementation, Optional Use, Pilot, or Insufficient Favorable Data.
- The most recent products/technology reviewed include:
  - Mechanical CPR Devices
  - Impedance Threshold Device and Active Compression Decompression (ACD) CPR Devices
  - "Heads Up" CPR with Device-Assisted Controlled Sequential Elevation

4.3 EMS Update 2020 *(Richard Tadeo)*

- Workgroup meetings continue with representatives from base hospitals and provider agencies.
- Topics for EMS Update 2020 include: QI issues/case studies (to address provider impressions of WEAK, ALOC and STEMI); pain management/Ketorolac; and capnography.
- Train-the-Trainer notification letter will be distributed within the next couple of weeks. Training dates are scheduled for March 4, 2020 (AM and PM sessions) and March 12, 2020 (AM session only). RSVP is required.
- The EMS Agency is planning to utilize a Learning Management Solution (LMS) to deliver the EMS Update. If successful, a weblink will be provided to educators to review the educational material prior to the Train-the-Trainer sessions. This will provide more opportunity for the educators to formulate their questions and review the EMS Update materials.

4.4 Epinephrine Dosage Changes *(Marianne Gausche-Hill, MD)*

- To assist with the correct interpretation of recent changes to Epinephrine administration in cardiac arrests, as described in Reference No. 1210, Cardiac Arrest, discussion was provided.
- Summary of changes to Epinephrine (0.01mg/mL) include: Maximum dose of 3mg and repeat dosing every 5 minutes (instead of every 3-5 minutes).
- In order to improve the overall awareness and encourage uniformity amongst base hospitals, Committee recommends EMS Agency reach out to base hospital physicians and provide research-based rationale for the change in practice.

4.5 Ketamine Update *(Marianne Gausche-Hill, MD)*

Due to a manufacturer's formulary change, Ketamine will no longer be included in EMS Update 2020. However, Ketorolac will remain.

5. UNFINISHED BUSINESS

There was no unfinished business

6. NEW BUSINESS

Policies listed in 6.1 through 6.14 were reviewed and Approved; with one recommendation: *(Richard Tadeo)*

6.1 Reference No. 1200.1, General Instruction
6.2 Reference No. 1200.2, Base Contact Requirements
- Recommendation: EMS Agency to contact Children's Hospital Los Angeles and provide paramedics with a direct phone to the ED, which would allow paramedics to make direct contact with nursing staff during transport of pediatric trauma patient.

6.3 Reference No. 1210, Cardiac Arrest
6.4 Reference No. 1213, Cardiac Dysrhythmia – Tachycardia
6.5 Reference No. 1213-P, Cardiac Dysrhythmia – Tachycardia (Pediatric)
6.6 Reference No. 1220, Burns
6.7 Reference No. 1220-P, Burns (Pediatric)
6.8 Reference No. 1241, Overdose Poisoning Ingestion
6.9 Reference No. 1241-P, Overdose, Poisoning, Ingestion (Pediatric)
6.10 Reference No. 1317.1, Adenosine
6.11 Reference No. 1317.5, Amiodarone
6.12 Reference No. 1317.29, Naloxone
6.13 Reference No. 1317.33, Ondansetron
6.14 Reference No. 1373, Treatment Protocol: Quality Improvement Fallout Data Dictionary

M/S/C (White/Dobbs) policies (6.1 through 6.14) Approved, with one recommendation, as stated above.

After lengthy discussion, policies listed in 6.15 thru 6.19 were reviewed and Tabled; with the following recommendations: *(Richard Tadeo)*

6.15 Reference No. 326, Psychiatric Urgent Care Center (PUCC) Standards
6.16 Reference No. 328, Sobering Center (SC) Standards
6.17 Reference No. 526, Behavioral / Psychiatric Crisis Patient Destination Recommendation:
- Page 3, III. Align Definitions with Definitions described in Ref. 326

6.18 Reference No. 526.1, Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care Center
6.19 Reference No. 528, Intoxicated (Alcohol) Patient Destination
- Page 1, Definitions: Alcohol Intoxication – change wording to state something similar to: "Indication of alcohol consumption – odor of alcoholic beverage on breath, alcoholic beverage container. Plus, any of the following:"
- Page 2, II. E.: Move this responsibility to the Sobering Center.
- Page 3, III. A. g.: Recommend clear definition (ie, no seizure within the last 24 hours)

TABLED: Policies list in 6.15 through 6.19, with recommendations stated above.

6.20 Reference No. 418, Authorization and Classification of EMS Aircraft *(John Telmos)*

Policy reviewed and approved as presented.

M/S/C (Orloff/Dobbs) Approve Reference No. 418, Authorization and Classification of EMS Aircraft

6.21 Reference No. 702, Controlled Drugs Carried on ALS Units *(John Telmos)*

Policy reviewed and approved as presented.

M/S/C (Kazan/White) Approve Reference No. 702, Controlled Drugs Carried on ALS Units

7. OPEN DISCUSSION:

7.1 ALS Unit Inventory: Removal of Bulb/Syringe Aspirator *(Richard Tadeo)*

ALS unit inventories will reflect this change. The two methods for checking advanced airway tube placement include waveform capnography and a color metric device.

7.2 EMS Authority Awards *(Doug Zabilski)*

Committee announced the following 2019 [California] EMS Authority Awards, presented to:

Marianne Gausche-Hill, MD - EMS Medical Director of the Year
"For being instrumental in advancing the practice of EMS and working tirelessly to improve the care of all patients. As a pediatric emergency physician, Dr. Marianne Gausche-Hill has not only published extensively on pediatrics but has also led the implementation of EMS practices based upon current evidence. She serves in many leadership positions, including having been the president of the EMS Medical Directors Association of California and serving on countless national committees. Dr. Gausche-Hill is a mentor and role model for all levels of EMS professionals."

Cathy Chidester - EMS Administrator of the Year
"For her consistent dedication to emergency care and emergency medical services in the state of California. Cathy Chidester is relied upon as an expert in both EMS administration and EMS education. As the Director of the Los Angeles County EMS Agency, Chidester leads the largest multi-jurisdictional EMS system in the country. During her time in this position, she has helped expand the LA County Trauma System by adding new centers and services in 2010. She also helped oversee the implementation of STEMI, Cardiac Arrest, and Stroke Systems of Care. As a leader of many efforts to improve EMS delivery throughout the state, Cathy serves as the Regional

Disaster Medical Health Coordinator of Region 1. Chidester has served as the local EMS agency (LEMSA) representative and a Board Member and Executive Committee Member with the Emergency Medical Services Administrators' Association of California (EMSAAC)."

(Quoted transcripts taken directly from the EMS Authority's webpage, describing each of the recipient's accomplishments)

Congratulations!!

7.3 End of Year "Thank You" *(Marianne Gausche-Hill, MD)*

On behalf of the EMS Agency, Dr. Gausche-Hill thanked the Committee for their commitment and dedication in reviewing policies and providing valuable feedback throughout 2019.

8. NEXT MEETING: February 19, 2020

9. ADJOURNMENT: Meeting adjourned at 2:52 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **ST-ELEVATION MYOCARDIAL INFARCTION (STEMI) RECEIVING CENTER (SRC) STANDARDS** REFERENCE NO. 320

PURPOSE: To establish minimum standards for the designation of a ST-Elevation Myocardial Infarction Receiving Center (SRC) to ensure that patients transported by the 9-1-1 system in Los Angeles County who exhibit ST-elevation myocardial infarction (STEMI) and/or non-traumatic out-of-hospital cardiac arrest (OHCA), are transported to a hospital appropriate to their needs.

AUTHORITY: California Code of Regulations (CCR), Title 22, Division 9, Chapter 7.1

DEFINITIONS:

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

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

Interventional Cardiologist: Physician who has completed a residency in internal medicine, or fellowship in cardiology and/or interventional cardiology, and is BC or BE, and has privileges to perform percutaneous interventions.

Out-of-Hospital Non-traumatic Cardiac Arrest (OHCA): Sudden, sometimes temporary cessation of function of the heart not due to a traumatic cause.

Percutaneous Coronary Intervention (PCI): A procedure used to open or widen a narrowed or blocked coronary artery to restore blood flow supplying the heart.

Promptly Available: Able to be physically present in the emergency department (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 the patient management or outcome. Hospital guidelines shall be established that address response time for on-call physicians, usually 30 minutes or less

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).

Return of Spontaneous Circulation (ROSC): Following cardiopulmonary arrest, ROSC is the restoration of a spontaneous perfusing rhythm. Signs include: palpable pulse, breathing (more than an occasional gasp), a measurable blood pressure and/or a sudden rise in capnography to a normal/high reading.

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

SRC Medical Director: A Qualified Specialist in Interventional Cardiology, privileged by the hospital and active in performing PCI.

SRC Program Manager: A Registered Nurse currently licensed to practice in the State of California and appointed by the hospital to monitor, coordinate and evaluate the SRC Program

ST- Elevation Myocardial Infarction (STEMI): A myocardial infarction that generates ST-segment elevation on a 12-lead ECG.

STEMI Receiving Center (SRC): A licensed general acute care facility that meets the minimum hospital STEMI care requirements pursuant to CCR Section 100270.124 and is able to perform PCI, manage cardiac arrest and post-resuscitation care, and designated as a SRC by the Los Angeles County EMS Agency.

STEMI Referral Facility (SRF): A non-PCI capable hospitals that transfer a STEMI patient requiring emergency cardiac intervention to a designated SRC.

Targeted Temperature Management (TTM): Maintaining body temperature at a target between 32 and 36 degrees Celsius in a person for a specific duration of time for the purpose of preserving neurological function post cardiac arrest.

POLICY:

I. SRC Designation / Re-Designation

A. SRC initial designation and re-designation is granted for up to three years based on maintenance of these standards and after a satisfactory review and approval by the EMS Agency.

B. The EMS Agency reserves the right to perform a scheduled on-site survey or request additional data at any time.

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

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

E. The SRC shall notify the EMS Agency, in writing, of any change in status of the SRC Medical Director, SRC Program Manager, or data entry personnel by submitting Reference No. 621.2, Notification of Personnel Change Form.

F. Prior to designation, the SRC shall meet the performance measures listed in Ref. No. 320.3. Performance measures shall be consistently achieved to maintain SRC designation.

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,

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

3. Have a special permit to provide cardiac catheterization laboratory (cath lab) and cardiovascular surgery services pursuant to the provisions of Title 22, Division 5, California Code of Regulations.

B. Appoint a SRC Medical Director and SRC Program Manager who shall be responsible for meeting the SRC Program requirements and allocate non-clinical time such that they can meet the requirements of the SRC standards.

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

D. Have the capability to receive transmitted 12-Lead ECG from EMS providers through a process that is agnostic to monitor type and optimizes efficiency, and includes the following:

1. An alert when hospital receives ECG transmission

2. A process to ensure that firewalls do not block the transmission and distribution of the transmitted ECGs

E. Establish a Memorandum of Understanding (Ref. No. 320.2 MOU IFT for Acute STEMI) for the timely transfer of STEMI patients for emergent PCI from the regional SRFs to the SRC.

III. SRC Leadership Requirements

A. SRC Medical Director

1. Responsibilities:

a. Medical oversight and ongoing performance of the STEMI and OHCA quality improvement (QI) programs

b. Participate in the hospital Cardiology Committee or equivalent and other committees associated with STEMI, cardiac arrest, and post-resuscitation care

c. Collaborate with the SRC Program Manager to ensure adherence to these Standards

d. Liaison with hospital administration, SRC Program Manager, medical and clinical staff across the STEMI and OHCA patient's continuums of care

e. Attend 100% of the EMS Agency's SRC QI Meetings. Fifty percent (50%) of meetings may be attended by one of the following:

1) Alternate interventional cardiologist from the same SRC, or

2) Call-in option when available

B. SRC Program Manager

1. Qualifications:

a. Currently assigned in the cath lab (if duties are shared with other RN(s), one RN must be assigned to the cath lab)

b. Knowledgeable in critical care and interventional cardiac procedures

c. Able to facilitate internal hospital policy and procedure development and implementation

2. Responsibilities:

a. Collaborate with the ED Medical and Clinical Directors regarding STEMI, cardiac arrest, and post-resuscitation care

b. Collaborate with the SRC Medical Director to ensure adherence to these Standards

c. Maintain and monitor STEMI and OHCA QI programs

d. Participate in the hospital Cardiology Committee or equivalent and other committees associated with STEMI, cardiac arrest, and post-resuscitation care

e. Assure hospital policies are consistent with these Standards

f. Liaison with hospital administration, SRC Medical Director, medical and clinical staff across the STEMI and OHCA patient's continuums of care

g. Liaison with prehospital cardiac monitor vendors and EMS Provider Agencies to ensure successful ECG transmission

h. Attend 100% of the EMS Agency's SRC QI Meetings. Fifty percent (50%) of meetings may be attended by one of the following:

1) Alternate cath lab RN from the same SRC, or
2) Call-in option when available

i. Assure processes are in place to identify and track patients transported to the SRC by EMS providers, including patients transferred from other acute care hospitals

j. Provide oversight of accurate and timely data collection and submission

k. Develop relationships and collaborate with the surrounding SRFs to meet specified time metrics

I. Assures SRC diversion is consistent with EMS policies and processes are in place to minimize the need for diversion

IV. SRC Program Physician Participants

A. Hospital shall maintain a cardiac catheterization team and cardiothoracic surgery on-call panel 24 hours per day/7 days per week/365 days per year

B. ED Physicians

All physicians attending in the ED shall be BC or BE in Emergency Medicine

C. Interventional Cardiologists performing emergent percutaneous interventions must:

1. Maintain current board certification or, board eligibility, in interventional cardiology with privileges in PCI procedures, and credentialed by the hospital,

OR

2. Maintain current board certification in internal medicine or cardiovascular disease with privileges in PCI procedures, and credentialed by the hospital.

D. On-call interventionalists may only be on-call for **one** facility at a time.

E. Surgeons performing coronary artery bypass grafting (CABG) must maintain current board certification or, is board eligible, in Cardiovascular/Cardiothoracic surgery with specific privileges in CABG and credentialed by the hospital

F. On-call physicians should be promptly available, not to exceed 30 minutes, for a cath lab activation.

V. SRC Program Plan

The hospital shall develop and maintain a SRC Program Plan pertaining to the care of patients with STEMI and/or those who had an OHCA. The plan shall be reviewed annually and include, at minimum, the following:

A. Job descriptions and organization structure clarifying the relationship between the SRC Medical Director, SRC Program Manager and the cardiac catheterization team

B. Cath lab activation guidelines with the ability to track the activation and/or cancelation

C. Procedures for triage, diagnosis and cardiac catheterization team activation following EMS notification of impending arrival of a STEMI/OHCA patient, which shall include, at minimum, the following:

1. A process for immediate notification of the emergency physician and/or interventional cardiologist upon EMS notification of a STEMI patient transport

2. A protocol for physician review of patient data, including ECG if available, to determine if activation from the field is appropriate

3. A single call activation system to directly activate the cardiac catheterization team

4. A process for the triage and treatment of simultaneously arriving STEMI/OHCA patients

5. A process for direct feedback to the transporting paramedics on the patient's presumed diagnosis and ED disposition

D. A process to administer fibrinolytics, move other cath lab patients or transfer a STEMI patient to another SRC when there is a mechanical issue in the cath lab, or the hospital is on internal disaster

E. Mechanisms to assure SRC diversion is consistent with EMS policies and processes are in place to minimize the need for diversion

F. A process to collaborate with EMS providers and 12-Lead ECG vendors to integrate electronic prehospital patient care (ePCR) records into the hospital electronic medical record

G. SRC Program Manager shall ensure review and recommend revisions to the SRC Program Plan, policies and procedures to maintain compliance with SRC Standards.

VI. Data Collection and Submission Requirements

A. Ensure adequate data entry personnel, collaborate with ED personnel to assure capture and entry of patients meeting inclusion criteria, into the Los Angeles County EMS Agency database on an ongoing basis. Back-up data entry personnel should be identified and trained in the event primary data personnel is unable to meet the data entry requirements.

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

C. Maintain an Emergency Department (ED) Log to capture patients who are transported to the ED due to SRC designation.

D. Submit data to the EMS Agency, within 45 days of patient's discharge, which shall include all patients who meet data inclusion criteria and all applicable data elements listed in Ref. No. 648, STEMI Receiving Center Data Dictionary.

E. Submit a monthly tally of patients who meet the inclusion criteria to the EMS Agency by the 15th of the month for the previous month (For example: January tally is due February 15th).

F. Submit SRC quarterly data within four weeks from the end of the quarter (For example: 1st quarter's data is due April 30th).

G. Maintain a minimum 90% compliance for:

1. Capture of patients meeting the data inclusion criteria
2. Data field completion
3. Data field accuracy
4. Timely data entry
5. Timely tally submission
6. Timely quarterly submission

VII. Quality Improvement

A. SRC Program must include a comprehensive-multidisciplinary SRC QI Meeting.

1. Meeting participation should include the SRC Medical Director, SRC Program Manager, EMS providers and educators, interventional cardiologists, ED physicians, ED and cath lab personnel, other associated healthcare providers, as well as other healthcare specialties including neurology, thoracic surgery or TTM specialists when applicable.
2. Meeting to be held quarterly, at a minimum.
3. Meeting minutes and roster must be maintained for each meeting and available for review.
4. SRCs that are also a Base Hospital are encouraged to provide periodic SRC Base Hospital education with the collaboration of the SRC Program Manager.

B. Pertinent aspects of care should be tracked and trended with the identification of areas requiring improvement and the action(s) necessary to improve care.

C. The SRC QI program shall:

1. Track and trend performance measures as per Ref. No. 320.3, SRC Performance Measures
2. Review the care and outcome on, but not limited to, the following patients:
   a. In-hospital STEMI deaths
   b. Coronary angiography complicated by intra-procedure or post-procedure bleeding requiring transfusion

c. Coronary angiography complicated by intra-procedural or post-procedural stroke

d. Any delays in care

e. All patients with OHCA with sustained ROSC – to include whether TTM and PCI were performed when indicated

3. Collaborate with SRF(s) to evaluate care of transfer patients, to include:

a. Door-in to door-out time (DIDO) at SRF (Goal <30 minutes)

b. Proportion of 9-1-1 IFTs for STEMI who went for emergency coronary angiogram (goal ≥90%)

c. Use of 9-1-1 for non-STEMI transfers

d. Quality of care issues and delays

4. Address other issues, processes or personnel trends identified from hospital specific data (i.e., less than 90% TIMI documentation, increase in fallouts over time and proportion of patients transported to the cath lab found not to have a STEMI).

5. SRC shall have a mechanism to provide feedback to EMS Providers and SRFs (i.e., encrypted/secure e-mail). The feedback shall be provided within two (2) working days of patient arrival at the SRC. Feedback shall include, but be not limited to, the following:

a. Date of service, sequence number, provider unit, patient age and gender, whether the patient received coronary angiogram and/or PCI, and positive feedback when a job was well done.

b. Rationale for not performing angiogram, which may be in the following three categories:

i. Patient factor (e.g., patient refusal, contraindication to angiogram)

ii. ECG quality (e.g., poor quality field ECG which led to misinterpretation)

iii. Non-ischemic ST elevation (e.g., early repolarization, bundle branch blocks, hyperkalemia)

3. Any quality of care concerns

XI. Public Education

SRC shall participate in the annual Los Angeles County EMS Agency sponsored Side-Walk CPR public education programs or annually provide a minimum of one public education class on CPR. Sign-in rosters need to be maintained. Classes may be in collaboration with other health care providers/organizations.

CROSS REFERENCE

Prehospital Care Manual
Ref. No. 320.1, **Target Temperature Management Guidelines**
Ref. No. 320.2, **Interfacility Transfer Memorandum of Understanding**
Ref. No. 320,3, **SRC Performance Measures**
Ref. No. 321.2, **Notification of Personnel Change Form**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Patients**
Ref. No. 513, **ST Elevation MI Patient Destination**
Ref. No. 513.1, **Interfacility Transfer of Patients with STEMI**
Ref. No. 516, **Cardiac Arrest Patient Destination**
Ref. No. 624, **STEMI Receiving Center QI Committee**
Ref. No. 1302, **Medical Control Guideline: 12-Lead Electrocardiogram**
Ref. No. 1303, **Medical Control Guideline: Cath Lab Activation Algorithm**
Ref. No. 1308, **Medical Control Guideline: Cardiac Monitoring / ECG**

2015 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care

ACKNOWLEDGEMENTS:

The input of the Hospital Association of Southern California's (HASC) Emergency Health Services Committee and the Cardiac Technical Advisory Group (TAG) was essential in the initial development of these standards. The TAG was composed of a cardiologist from the American Heart Association; Emergency Department physicians from teaching and community hospitals; an EMS Commissioner; nurse managers from emergency departments and catheterization labs; members of the Association of Prehospital Care Coordinators; a Paramedic Nurse Educator; and the Emergency Medical Services (EMS) Agency. Additional contributions were made by the Medical Council of the EMS Agency, the Commission, the American Heart Association and the Los Angeles County Medical Association.

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

REFERENCE NO. 320, SRC 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: SRC Advisory	10/1/2019	11/19/2019	Yes

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

POLICY REVIEW - SUMMARY OF COMMENTS REFERENCE NO. 202.2

REFERENCE NO. 320, SRC Standards

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Definitions: Promptly available	SRC Program Directors/Managers 11/26/19	Add wording 'usually 30 minutes or less'	Change made

SUBJECT: **SRC PERFORMANCE MEASURES** REFERENCE NO. 320.3

PURPOSE: To provide standardized quantifiable indicators to assess and evaluate the performance, quality of care and program management of designated STEMI Receiving Centers (SRC).

DEFINITIONS:

Cerebral Performance Category (CPC) Score: A tool used to assess neurologic outcome following cardiac arrest.

Door to Balloon Time (D2B): A time measurement that starts with the patient's arrival in the emergency department and ends when the first device (excluding guidewire) intervened at the culprit lesion during the first percutaneous coronary intervention.

Electrocardiogram (ECG) Time: Time 12-Lead ECG was obtained.

Emergency Department (ED) Door Time: Time of patient arrival at the ED.

Percutaneous Coronary Intervention (PCI): A procedure used to open or widen a narrowed or blocked coronary artery to restore blood flow supplying the heart.

Return of Spontaneous Circulation (ROSC): Following cardiopulmonary arrest, ROSC is the restoration of a spontaneous perfusing rhythm. Signs of ROSC include: palpable pulse, breathing (more than an occasional gasp), a measurable blood pressure and/or a sudden rise in capnography to a normal/high reading.

STEMI Referral Facility (SRF) Time: Time of patient arrival at the ED of the STEMI Referral Facility

Targeted Temperature Management (TTM): Maintaining body temperature at a target between 32 and 36 degrees Celsius in a person for a specific duration of time for the purpose of preserving neurological function post cardiac arrest.

POLICY:

I. The SRC shall meet compliance threshold on all performance measures to maintain SRC Designation.

II. The EMS Agency may terminate SRC designation at any time if SRC's non-compliance with the Performance Measures are deemed significant to result in poor patient outcomes.

III. Performance Measures:

A. Receipt of notification of transmission of prehospital ECG to MD ECG review is within 5 minutes 90% of the time

B. ED Door Time to ED ECG interpretation, when a confirmation ECG is required, is within 10 minutes 90% of the time

C. Prehospital ECG Time to PCI is within 120 minutes 90% of the time and 90 minutes 75% of the time

D. D2B for EMS (9-1-1) Transports: within 90 minutes 90% of the time and 60 minutes 75% of the time

E. SRF Door to PCI is within 150 minutes 90% of the time and 120 minutes 75% of the time

F. Prehospital/ED cardiac arrest patients who achieve ROSC with STEMI to cath lab is within 6 hours 90% of the time

G. TTM for patients who meet inclusion criteria is applied 90% of the time

H. Cerebral Performance Category (CPC) Score is documented upon discharge on cardiac arrest patients 90% of the time

IV. Procedure for Non-Compliance with Performance Measures

Month	Action 1	Compliance Result	Action 2
1st	SRC provides care to STEMI and OHCA Patients		
2nd	SRC starts data collection and electronic data collection for patients who meet inclusion criteria		
3rd	EMS Agency reviews SRC's 1st month compliance with all performance measures	SRC does not meet 90% compliance in any one of the performance measures Significant Improvement	EMS Agency notifies SRC's Medical Director and Program Manger via e-mail or telephone, of non-compliance and request corrective action plan and assist in determining solutions. Monitor
4th	EMS Agency reviews SRC's 2nd month compliance with all performance measures	No significant improvement Significant improvement	EMS Agency sends a written notice to SRC's Medical Director and Program Manager notifying of compliance results and continued non-compliance. Monitor
5th	EMS Agency reviews SRC's 3rd month compliance with all performance measures	No significant improvement	EMS Agency notifies SRC's Medical Director and Program Manager in writing of compliance results and request to submit within 15 calendar days a plan to correct deficiency.

Month	Action 1	Compliance Result	Action 2
		Significant improvement	Monitor
6th	EMS Agency reviews SRC's 4th month compliance with all performance measures	No significant improvement	Within 15 days of EMS Agency's receipt of SRC's corrective action plan, the EMS Agency will provide SRC a written approval or request additional modification to SRC's corrective action plan.
		Significant improvement	Monitor
7th	EMS Agency reviews SRC's 5th month compliance with all performance measures	No significant improvement	EMS Agency notifies SRC's Medical Director and Program Manager in writing of compliance results and request modification to SRC's corrective action plan.
		Improvement based on approved corrective action plan	Monitor
8th	EMS Agency reviews SRC's 6th month compliance with all performance measures	No significant improvement	EMS Agency notifies SRC's Chief Executive Officer or President in writing of compliance results and continued failure to meet performance measures. SRC is place on a 3-month provisional status.
		Improvement based on approved corrective action plan	Monitor
9th	EMS Agency reviews SRC's 7th month compliance with all performance measures	No significant improvement	EMS Agency will notify SRC of continued non-compliance
		Improvement based on approved corrective action plan	Monitor
10th	EMS Agency reviews SRC's 8th month compliance with all performance measures	No significant improvement	EMS Agency will notify SRC of continued non-compliance
		Improvement based on approved corrective action plan	Monitor
11th	EMS Agency reviews SRC's 9th month compliance with all performance measures	No significant improvement	EMS Agency notifies SRC's Chief Executive Officer or President in writing that continued noncompliance may result in revocation of SRC designation.
		Improvement based on approved corrective action plan	Monitor
12th	EMS Agency reviews SRC's 10th month compliance with all	No significant improvement	EMS Agency will notify SRC's Chief Executive Officer or President in writing of revocation

Month	Action 1	Compliance Result	Action 2
	performance measures		of hospital's SRC designation.

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

REFERENCE NO. 320.3 SRC Performance Measures

	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: SRC Advisory	10/1/2019	11/19/2019	Yes

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

POLICY REVIEW - SUMMARY OF COMMENTS REFERENCE NO. 202.2

REFERENCE NO. 320.3, Performance Measures

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Definitions: Return of Spontaneous Circulation	SRC Program Directors/Managers 11/26/19	Add specific description to definition	Change made
III. Performance Measures A.	SRC Program Directors/Managers 11/26/19	Add word ‘ “notification” of transmission of prehospital…’	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

DRAFT 9/2019

SUBJECT: **AUTHORIZATION AND CLASSIFICATION OF EMS AIRCRAFT**

REFERENCE NO. 418

PURPOSE: To define the criteria that must be met in order to be approved and classified as an EMS aircraft provider in the County of Los Angeles.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 8, Section 100276-100306.
Los Angeles County, Code of Ordinances, Title 7, Business Licenses, Division 2, Chapter 7.16, Ambulances

DEFINITIONS:

Advanced Life Support (ALS): Definitive prehospital emergency medical care approved by the local EMS Agency including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital or utilization of Los Angeles County Treatment Protocols,, as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the staff of that hospital.

Basic Life Support (BLS): Those procedures and skills contained in the EMT-I scope of practice, including emergency first aid and cardiopulmonary resuscitation.

Air Ambulance: Any aircraft which has been designated, constructed, modified or equipped, and is used for the purpose of responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has a minimum two (2) attendants whose scope of practice authorizes them to function at the ALS level.

Air Ambulance Service: Air transportation service, public or private, which utilizes aircraft specially constructed, modified or equipped to transport critically ill or injured patients. This includes the provision of qualified flight crew~~s~~ and aircraft maintenance.

Air Rescue Service: Air Service used for the purpose of responding to emergency calls, requiring special equipment and/or expertise due to the terrain and or circumstances of the incident, i.e., mountain rescue, water rescue, etc.

Air Ambulance or Air Rescue Service Provider: The individual or group that owns and/or operates an air ambulance or air rescue service and which is authorized by the EMS Agency as a provider.

Back-Up Air Ambulance Provider: An agency which has been designated by the local EMS Agency to provide back-up or second call emergency air ambulance service when requested to do so by the designated primary provider agency or the designated primary air ambulance provider.

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

Emergency Medical Services (EMS) Aircraft: Any aircraft utilized for the purpose of prehospital emergency patient response and transport. EMS aircraft includes air ambulances and all categories of rescue aircraft.

Rescue Aircraft: An aircraft whose usual function is not prehospital emergency patient transport but which may be utilized, in compliance with local EMS policy, for prehospital emergency patient transfer when use of an air or ground ambulance is inappropriate or unavailable. Rescue aircraft includes ALS, BLS, and auxiliary rescue aircraft.

Auxiliary Rescue Aircraft: A rescue aircraft which does not have a medical flight crew or whose medical flight crew does not meet the minimum requirements of an EMT-I.

Classifying and Authorizing EMS Agency: The Los Angeles County EMS Agency, which classifies EMS aircraft into categories and approves utilization of such aircraft within its jurisdiction.

Designated Dispatch Center: An agency which has been designated by the local EMS agency for the purpose of coordinating air ambulance or rescue aircraft response to the scene of a medical or traumatic emergency within the jurisdiction of the local EMS agency.

Medical Flight Crew: The individual(s), excluding the pilot, specifically assigned to care for the patient during the aircraft transport.

Primary Provider Agency: The provider agency authorized to provide 9-1-1 emergency medical services within a city or unincorporated area of Los Angeles County by the governmental authority responsible for that geographic area.

Immediately Available: Medical flight crew within the specified area of the EMS aircraft and responding without delay when dispatched to a patient response.

PRINCIPLES:

1. The Los Angeles County EMS Agency is responsible for the integration of EMS aircraft into the Los Angeles County EMS patient transport system and for the development of policies and procedures related to the integration of this specialized resource. EMS aircraft operating in Los Angeles County must be classified and authorized by the EMS Agency in order to provide prehospital patient transport.

2. EMS aircraft providers (excluding agencies of the federal government) who provide or make available prehospital air transport or medical personnel, either directly or indirectly, or any hospital where an EMS aircraft is based, housed, or stationed permanently or temporarily, shall adhere to all applicable federal, state, and local statutes, ordinances, policies, and procedures related to EMS aircraft operations, including qualifications of flight crews and aircraft maintenance.

3. No EMS aircraft shall respond to an incident without formal dispatch from a designated dispatch center or request for the primary provider agency responsible for the area in which the incident is located.

4. A planned and structured initial and recurrent training program specific to the air ambulance/air rescue service mission and scope of care of the medical flight crew must be ensured and documented for all regularly scheduled medical flight crew members.

5. Any privately owned/operated air ambulance service providing EMS services in Los Angeles County shall be licensed in accordance with Los Angeles County Code, Chapter 7.16, Ambulances.

POLICY:

I. General Provisions

A. No person or organization shall provide or hold themselves out as providing prehospital EMS aircraft or EMS air rescue services unless that person or organization has aircraft which have been designated by the EMS agency.

B. EMS aircraft shall be classified by the EMS Agency into one of the following categories:

1. Air Ambulance
2. ALS Rescue Aircraft
3. BLS Rescue Aircraft
4. Auxiliary Rescue Aircraft

C. EMS aircraft classification will be reviewed in accordance with this policy and reclassification may occur anytime there is a transfer of ownership or a change in the aircraft's capability.

D. The EMS Agency shall maintain an inventory of authorized EMS aircraft providers. This inventory shall include, but not be limited to, the number and type of authorized EMS aircraft, the patient capacity of each EMS aircraft, and the level of patient care provided by EMS aircraft personnel for each authorized EMS aircraft provider.

E. The EMS Agency shall have written agreements with air ambulance providers routinely serving Los Angeles County which may be incorporated and considered a part of the medical control agreements. These agreements shall specify the conditions under which air ambulance designation is maintained and assurance of compliance with all local, state and federal rules and regulations.

F. When prehospital aircraft are routinely requested from outside Los Angeles County, interagency agreements shall be executed between the County of Los Angeles and County in which the air ambulance provider is operationally based. The air ambulance provider shall attend a Los Angeles County EMS Agency orientation to include review of policies, procedures and interface with the Medical Alert Center (MAC). Pilot flight orientation to helipads shall be arranged by the EMS Agency with a currently approved Los Angeles County Air Operations Provider.

G. When aeromedical prehospital response is occasionally requested from outside Los Angeles County, the medical flight crew may perform their basic scope of practice provided that medical control is maintained by the jurisdiction of origin, and an intercounty agreement exists between the County of Los Angeles and the County in

which the air ambulance provider is operationally based. The air ambulance provider shall attend a Los Angeles County EMS Agency orientation to include review of policies, procedures and interface with the Medical Alert Center. Pilot flight orientation to helipads shall be arranged by the EMS Agency with a currently approved Los Angeles County Air Operations Provider.

H. Auxiliary rescue aircraft shall not transport patients unless all other resources have been exhausted and there are no other acceptable means for patient transport to an appropriate receiving facility. The EMS Agency shall be notified in writing of all such occurrences. Such notifications shall include the date, time, sequence number, and events surrounding the incident.

I. Each provider agency shall submit quarterly data on all EMS responses utilizing the EMS Agency approved data reporting template. Data is due no later than 30 calendar days after the end of each quarter.

J. In situations where the medical flight crew is less medically qualified than the ground personnel from whom they receive patients, they may assume patient care responsibilities only in accordance with local policies and procedures within their local scope of practice.

II. Personnel/Training

A. The medical flight crew of an EMS aircraft shall be immediately available and have as its primary responsibility the treatment and transport of EMS patients when the aircraft is available for EMS response for a given shift. The EMS aircraft provider shall ensure that the medical flight crew has met all initial and recurrent training requirements.

B. The medical flight crew of an air ambulance shall, at minimum, consist of two attendants in any combination of the following, whose scope of practice authorizes them to function at the ALS level:

1. A physician currently licensed in the State of California who is board certified in emergency medicine or has satisfied the requirements to take the emergency medicine board examination; unless otherwise authorized by the EMS Agency Medical Director.

2. A physician currently licensed in the state of California and who is current in the following:

    a. ACLS and PALS, or equivalent curriculum; and
    b. BTLS, or PHTLS, or ATLS, or equivalent curriculum

3. A registered nurse currently licensed in the State of California who meets the qualifications of an authorized registered nurse as defined in the Health and Safety Code, Chapter 2, Section 1797.56 and who is current in the following:

    a. ACLS and PALS, or equivalent curriculum; and
    b. BTLS, or PHTLS, or ATLS, or equivalent curriculum

4. A paramedic currently licensed in the State of California and accredited in Los Angeles County who meets the qualification of an Emergency Medical Technician-Paramedic as defined in the Health and Safety Code, Chapter 2, Section 1797.84 and who is current in the following:

    a. ACLS and PALS, or equivalent curriculum; and
    b. BTLS, or PHTLS, or ATLS, or equivalent curriculum

C. Medical flight crew members of an EMS Aircraft shall complete the provider agency's approved Aeromedical Program which includes, but is not limited to, the following topics:

1. General patient care in-flight assessment/treatment/preparation/handling/equipment);
2. Changes in barometric pressure, decompression sickness, and air embolism;
3. Changes in partial pressure of oxygen;
4. Other environmental factors affecting patient care;
5. Aircraft operational systems relating to patient care;
6. Day and night flight protocols;
7. Aircraft emergencies and safety;
8. Care of patients who require special consideration in the airborne environment;
9. Extrication devices and rescue operations (rescue aircraft only);
10. EMS system and communication procedures;
11. The Los Angeles County prehospital care system, including all applicable policies, procedures and protocols;
12. Use of onboard medical equipment; and
13. Additional topics specific to the mission statement and scope of practice of the air ambulance provider.

Course content may be reduced with the approval of the EMS Agency, and documentation of prior training in specific areas is available.

D. All medical flight crew members shall receive a minimum of eight (8) hours annually of continuing education/staff development specific to aeromedical transportation

based on the agency's identified QI needs (approved topics include, but are not limited to, those listed in C. 1-13).

E. Medical flight crew members (nurse, paramedic) shall have no less than one successful live, cadaver, human patient simulator or static manikin airway management experience per quarter.

III. Policies and Procedures

A. Policies shall be established by each prehospital EMS aircraft program which addresses, at a minimum, the following topics:

1. Patient loading and unloading procedures;

2. Refueling procedures with medical transport personnel or patient(s) on board which includes a requirement that at least one medical transport person shall remain with the patient at all times during refueling or stopover;

3. Combative patients;

4. Patient care and transport alternatives in the event that the aircraft must use alternative landing facilities due to deteriorating weather;

5. Response to hazardous materials request or unanticipated contact with hazardous materials;

6. Visual flight rules (VFR) "response" weather minimums; and

7. Emergency Procedures.

B. Each provider agency shall have a Post Incident Accident Plan (PAIP), also known as an Emergency Response Plan (ERP) in place and exercised at minimum, twice/year; one daylight and one night time drill.

IV. Aircraft Specifications/Required Equipment

A. Air ambulances shall have sufficient space in the patient compartment to accommodate a minimum of one (1) patient and two (2) ALS patient attendants. If more than one patient can be accommodated, there must be written guidelines describing types of patients that can be transported in a two-patient litter configuration if the aircraft does not allow for full access to the second patient.

B. Sufficient space in the patient compartment for the medical flight crewmembers to access the patient in order to carry out necessary procedures, including childbirth and CPR.

C. EMS aircraft shall have on board the required medical supplies and equipment as specified in Ref. No. 706, ALS EMS Aircraft Inventory.

D. Sufficient space for all required medical supplies and equipment.

E. Additional aircraft equipment as specified in the minimum equipment list for the applicable Federal Aviation Regulations (FARs).

F. EMS aircraft configuration shall ensure that the following requirements are met:

1. For ALS patients, the upper surface of the stretcher is not less than 30 inches from the ceiling of the aircraft or the under surface of another stretcher.

2. Stretchers, equipment and attendant's seats are arranged so as not to block a rapid exit by personnel or patient from the aircraft.

3. Adequate seat belts and tie-downs, which meet FAA standards or equivalent, for all personnel, patient(s), stretchers and equipment to prevent inadvertent movement.

4. A cargo door or entry that allows a stretcher to be loaded without excessive manipulation or rolling patient from side to side.

5. Adequate interior lighting for patient care arranged so that it does not interfere with the pilot's vision.

6. Each crewmember shall be provided with hearing protection and radio headsets for intra-aircraft communication.

7. Hearing protection shall be available for each patient transported and used whenever applicable.

8. Survival gear appropriate to the coverage area and the number of occupants.

9. If appropriately sized helmets are not worn (by all personnel on the aircraft except the patient), the interior modification of the aircraft must be clear of objects/projections or the interior of the aircraft must be padded to protect the head strike envelope of the air medical personnel and patients.

V. Record Keeping

A. Existing EMS policies and procedures for record keeping including, but not limited to, documentation of patient care, shall be adhered to.

B. Each designated dispatch center shall maintain an assignment record which contains all EMS aircraft dispatches. The record shall be retained for seven (7) years and shall include at a minimum the following:

1. Time and date of request and requesting agency;

2. Incident number and/or EMS sequence number;

3. EMS incident location;

4. Time of dispatch and EMS aircraft scene arrival time;

5. Person receiving the request;

6. Patient destination.

VI. Quality Improvement (QI)

A. At minimum, the QI program shall include: (Refer to Ref. No. 620)

1. A statement of QI program goals and objectives.

2. A description of how the QI program is integrated into the organization.

3. A description of those processes used in conducting QI activities, action plans and results.

4. Methods to document those processes used in QI activities.

5. Methods used to retrieve data regarding patient care and outcomes.

6. Description of how the QI program is integrated into the Los Angeles County EMS system.

B. Provider Agency Responsibilities:

1. Implement and maintain a Quality Improvement (QI) Program in conjunction with the assigned base hospitals and receiving hospitals.

2. Evaluate prehospital care performance standards.

3. Designate a representative to participate in the LA County EMS QI program.

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

VII. Designated Dispatch Center

A. A designated dispatch center is an agency which has been designated by the local EMS agency to coordinate air ambulance or rescue aircraft response to the scene of a medical emergency within the jurisdiction of the Los Angeles County EMS Agency.

B. Agencies dispatching EMS aircraft or auxiliary aircraft to the scene of a medical emergency for the purpose of transporting a patient(s) to medical facilities shall be designated by the Los Angeles County EMS Agency. Dispatch agencies shall be classified as follows:

1. Primary dispatch center – a dispatch center designated as first responder in a jurisdiction area.

2. Back-up dispatch center – a dispatch center designated to serve as back-up provider or second-call response when the primary dispatch center requests response.

C. No EMS or auxiliary EMS aircraft shall respond to an incident without formal dispatch from the designated dispatch center or request from the primary EMS provider agency dispatch center. An EMS aircraft provider receiving a request for service from an agency other than the designated dispatch center or jurisdictional EMS primary dispatch center shall notify the appropriate primary EMS provider agency of the call and shall only respond upon instructions from that agency.

D. Each designated primary dispatch center shall establish a back-up list or enter into a mutual aid agreement with another designated responder for the purpose of providing back-up EMS aircraft service when the primary provider agency is unable to respond. The list shall contain approved prehospital EMS aircraft providers.

E. If the designated dispatch center has no EMS aircraft available when requested, they shall determine the availability of other EMS aircraft identified in their back-up provider list. Based on availability, the dispatch center shall consider dispatch of a back-up EMS aircraft in an effort to ensure timely delivery of the patient to the most appropriate receiving facility. The dispatcher shall inform the agency requesting service of unavailability or any delay in dispatch of an EMS aircraft and the reason(s) for the delay. If a request for services is refused by a given provider (e.g. weather), the reason for the flight refusal will be conveyed to any subsequent recipient of the request for service.

VIII. Designation Process

A. The designation process shall include the following:

1. Completion and submission of the approved EMS Aircraft/Dispatch Center Application (Reference No. 418.1).

2. Current accreditation by the Commission on Accreditation of Medical Transport Systems (CAMTS) (or a similar professional organization approved by the EMS Agency) or successful completion of a site review by CAMTS in conjunction with the local EMS Agency and based on the criteria contained herein.

3. Program evaluation and site visit/inventory inspection.

4. Written agreement between the EMS aircraft provider and the County of Los Angeles.

5. For private, non-governmental EMS aircraft provider agencies, must be licensed by the EMS Agency as an air ambulance provider.

B. Designation is valid for a minimum of three (3) years.

CROSS REFERENCES:

Prehospital Care Manual:

Reference No. 406, **Authorization for Paramedic Provider Status**
Reference No. 408, **Advanced Life Support (ALS) Unit Staffing**
Reference No. 418.1, **EMS Aircraft/Dispatch Center Application**
Reference No. 514, **Prehospital EMS Aircraft Operations**
Reference No. 602, **Confidentiality of Patient Information**
Reference No. 606, **Documentation of Prehospital Care**
Reference No. 608, **Disposition of Copies of the EMS Report Form**
Reference No. 610, **Retention of Prehospital Care Records**
Reference No. 612, **Release of EMS Reports**
Reference No. 620, **EMS Quality Improvement Program Guidelines**
Reference No. 706, **ALS EMS Aircraft Inventory**
Reference No. 1200 **Treatment Protocols**
Reference No. 1300 **Medical Control Guidelines**

Emergency Medical Services Authority Guideline 144, Pre-hospital EMS Aircraft Guidelines

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

DRAFT 9/2019

(PARAMEDIC)

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

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

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

DEFINITIONS:

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

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

PRINCIPLES:

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

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

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

4. Implementation of a paperless (electronic tracking) Daily Controlled Inventory Form requires the prior approval of the EMS Agency.

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

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

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

QUANTITIES OF CONTROLLED DRUGS TO BE CARRIED ON ALS UNITS:

Fentanyl: 100mcg unit dose, minimum amount 500mcg not to exceed 1500mcg unless otherwise approved by the EMS Agency Medical Director.

Morphine sulfate: 4mg unit dose, minimum amount 20mg not to exceed 60mg unless otherwise approved by the EMS Agency Medical Director.

Midazolam (Versed®): 5mg unit dose, minimum amount 20mg not to exceed 40mg unless otherwise approved by the EMS Agency Medical Director.

POLICY:

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

II. Controlled Drug Program:

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

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

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

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

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

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

III. Controlled Drug Security:

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

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

C. Controlled drugs shall not be stored in any location other than on ALS units or ADDS. Alternate storage areas shall be authorized by the EMS Agency. The initial authorization process requires EMS Agency inspection of the storage facility and approval of the provider agency internal policy specifying the location, security, access, and procedure for obtaining drugs from the alternate controlled drug locations. If utilizing an electronic system to track controlled substances, there must be an electronic entry by two authorized personnel anytime the secured storage container is accessed, in addition to a physical count of the inventory conducted.

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

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

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

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

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

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

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

a. Change of shift.

b. Any change to the controlled drug inventory.

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

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

F. Electronic (paperless) Daily Inventory Procedures of Controlled drugs on an ALS unit

1. To implement an electronic tracking system for daily inventory, the provider agency shall choose a system that meets the following requirements

a. The system must fulfill all requirements listed in section III-C and E-5 above and possess the ability to produce a printed or electronic daily drug inventory report by, at minimum, calendar month.

b. Electronic documentation must verify the identity of the receiving and relinquishing party at change of shift or change of responsible

personnel, when medications are used, and at the time of restocking.

c. Access to the system shall require at minimum, an employee identification number and a personal identification number. Biometric (fingerprint, retinal scan, etc.) may be used in addition to or in lieu of the above requirements and is strongly encouraged.

d. The system must comply with all federal, state, and local regulations/policies.

e. The provider agency must have the ability to revert to a paper system in the event of temporary or long term downtime of the electronic system.

F. Lost or Missing Controlled Drug

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

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

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

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

G. Disposal of controlled drugs

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

IV. Record Keeping:

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

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

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

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

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

V. ADDS

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

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 214 **Base Hospital and Provider Agency Reporting Responsibilities**
Ref. No. 411, **Provider Agency Medical Director**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 607, **Electronic Submission of Prehospital Data**
Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
Ref. No. 702.1, **Provider Agency Medical Director Notification of Controlled Drug Program Implementation**
Ref. No. 702.2 **Daily Controlled Drug Inventory Form**
Ref. No. 702.3 **Lost / Missing Controlled Drug Reporting Form**
Ref. No. 702.4 **Monthly Drug Storage Inspection Form**