# 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:** **March 17, 2021**
**TIME:** **1:00 – 3:00 PM**
**LOCATION:** **Zoom Video Conference Meeting**
Join Zoom Meeting:
https://zoom.us/j/97565380793?pwd=L1dhaUVybnMyK2tiZE95Q29jK3RDdz09
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***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 INPUT YOUR NAME if you would like to address the Commission.**

## AGENDA

**I. CALL TO ORDER – Mr. Paul Rodriguez, Chairman**

**Instructions for Zoom**:
1) Please use your computer to join the Zoom meeting to see documents.
2) Join Zoom meeting by computer (preferable) or phone.
3) Input your name when you first join so we know who you are.
4) You can join Zoom by one tap mobile dialing.
5) Join meeting by landline using any of the "dial by location" numbers and manually entering the Meeting ID and following # prompts.
6) Mute and unmute yourself by clicking on the microphone icon at the bottom of computer screen, or *6 by phone.
7) Volume is adjusted by using the little arrow next to the microphone icon.

**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**
January 20, 2021

**2. CORRESPONDENCE**
2.1 (01-12-21) Distribution: Shoring Up for the Surge of COVID-19 Patients
2.2 (01-21-21) Martin Serna: Paramedic Vaccination Program Approval
2.3 (02-22-21) Stephen Albrecht: Psychiatric Urgent Care Center Designation (Star Behavioral Health - City of Industry)
2.4 (02-22-21) Stephen Albrecht: Psychiatric Urgent Care Center Designation (Star Behavioral Health - Long Beach)

2.5 (03-15-21) Distribution: Submission of Measure B Funding Proposal for 2021

**3. COMMITTEE REPORTS**

3.1 Base Hospital Advisory Committee
3.2 Data Advisory Committee – Cancelled for February 2021
3.3 Provider Agency Advisory Committee

**4. POLICIES**

4.1 Reference No. 218: Trauma Hospital Advisory Committee (THAC)
4.2 Reference No. 222: Downgrade or Closure of 9-1-1 Receiving Hospital or Emergency Medical Services
(Attachments: AB 2037 and All Facilities Letter from CDPH)
4.3 Reference No. 508: Sexual Assault Patient Destination
4.4 Reference No. 606: Documentation of Prehospital Care
4.5 Reference No. 814: Determination / Pronouncement of Death in the Field
4.6 Reference No. 834: Patient Refusal of Treatment/Transport and Treat and Release at Scene

**END OF CONSENT AGENDA**

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## IV. BUSINESS

**BUSINESS (OLD)**

5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies
5.1.1 Ad Hoc Workgroup on the Pre-Hospital Care of Mental Health and Substance Abuse Emergencies – Recommendation Eight
5.1.2 John Franklin Sierra – LA County Department of Mental Health Process Overview
5.2 Ambulance Patient Offload Time (APOT)
5.3 LA County COVID-19 Modeling – EMS Agency Data
5.4 Olympia Medical Center ED Closure – Impact Evaluation Report – February 24, 2021
(Control + Click link below to view report)
http://file.lacounty.gov/SDSInter/dhs/1103517_CDPHNotification2021-02-24.pdf

**BUSINESS (NEW)**

5.5 EMS Commission Representative to the Measure B Advisory Board (MBAB)
5.6 Measure B Advisory Board Proposal Submission 2021

## V. COMMISSIONERS' COMMENTS / REQUESTS

## VI. LEGISLATION

## VII. EMS DIRECTOR'S REPORT

## VIII. ADJOURNMENT

To the meeting of May 19, 2021

# COUNTY OF LOS ANGELES
# EMERGENCY MEDICAL SERVICES COMMISSION

**10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670**
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## MINUTES
## JANUARY 20, 2021
## Zoom Meeting

| | | | |
|---|---|---|---|
| ☒ Lt. Brian S. Bixler | Peace Officers' Assn. of LAC | Cathy Chidester | Executive Director |
| ☐ *Diego Caivano, M.D. | L.A. County Medical Assn. | Denise Watson | Commission Liaison |
| ☒ Erick H. Cheung, M.D. | So. CA Psychiatric Society | Marianne Gausche-Hill | EMS Medical Director |
| ☒ Chief Eugene Harris | LAC Police Chiefs' Assn. | Nichole Bosson | Asst. Medical Director |
| ☒ John Hisserich, Dr.PH | Public Member, 3rd District | Roel Amara | Assistant Director |
| ☒ Lydia Lam, M.D. | So. CA Chapter American College of Surgeons | Richard Tadeo | Assistant Director |
| ☒ James Lott, PsyD, MBA | Public Member, 2nd District | Kay Fruhwirth | Nursing Director |
| ☒ Carol Meyer, RN | Public Member, 4th District | John Telmos | EMS Staff |
| ☒ Gloria Molleda | League of CA Cities/LA County | Michelle Williams | EMS Staff |
| | | Christy Preston | EMS Staff |
| ☒ Robert Ower, RN | LAC Ambulance Association | Sara Rasnake | EMS Staff |
| | | Karen Rodgers | EMS Staff |
| ☒ Garry Olney, DNP | Hospital Assn. of So. CA | Denise Whitfield | EMS Staff |
| | | Adrian Romero | EMS Staff |
| ☒ Kenneth Powell | LA Area Fire Chiefs' Assn. | Christine Clare | EMS Staff |
| | | Jacqueline Rifenburg | EMS Staff |
| ☒ Paul S. Rodriguez | CA State Firefighters' Assn. | Natalie Greco | EMS Staff |
| | | David Wells | EMS Staff |
| ☒ Jeffrey Rollman | So. CA Public Health Assn. | Millicent Wilson | EMS Staff |
| | | Cathlyn Jennings | EMS Staff |
| ☒ Joseph Salas | Public Member, 1st District | Terry Crammer | EMS Staff |
| | | Jennifer Calderon | EMS Staff |
| ☒ Nerses Sanossian, M.D. | American Heart Association | Christine Zaiser | EMS Staff |
| | | Lorrie Perez | EMS Staff |
| ☒ Carole A, Snyder, RN | Emergency Nurses Assn. | Gary Watson | EMS Staff |
| ☒ Atilla Uner, M.D., MPH | American College of Emergency Physicians CAL-ACEP | | |
| ☒ Gary Washburn | Public Member, 5th District | | |

### GUESTS

| | | | |
|---|---|---|---|
| Clayton Kazan, MD | LA County Fire Department | Jennifer Nulty | Torrance Fire Dept. |
| Jaime Garcia | Hospital Assn. Southern Cal. | Laurie Donegan | APCC |
| Shelly Trites | Torrance Memorial | Tianci Liu | |
| Brit Alton | Burbank Fire | Blayne Baker | |
| Joel L. | | Saman Kashani | |

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

## I. CALL TO ORDER

The Emergency Medical Services Commission (EMSC) meeting was held via Zoom Video Communications Conference Call due to the California Statewide Safer at Home Order related to the Coronavirus (COVID-19) pandemic. The meeting was called to order at 1:00 p.m. by Chairman John Hisserich. A quorum was present with 18 Commissioners on the call.

## II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

Executive Director Cathy Chidester did roll-call of the Commissioners, acknowledged members of the public and EMS Agency staff. General Instructions to mute/unmute and to make public comments using Zoom were provided to participants. Commissioners were asked to state their names when making a motion/second.

## III. NOMINATION COMMITTEE

The Nomination Committee meeting participants were Commissioners Carole Snyder, Carol Meyer, Robert Ower and Commission Liaison Denise Watson. Commissioner Snyder reported nomination for the 2021 EMS Commission Chairman was Commissioner Paul Rodriguez, and for Vice-Chair was Commissioner Joe Salas. The floor was opened for additional nominations and discussion.

***Motion/Second by Commissioners Snyder/Uner to approve Commissioner Paul Rodriguez as Chairman, and Commissioner Joe Salas as Vice-Chair for 2021 was approved and carried unanimously.***

Commissioner Hisserich passed the Chairmanship to newly elected Chairman Paul Rodriguez who thanked everyone and proceeded with the meeting.

Richard Tadeo, EMS Assistant Director, provided information about Commissioner roles on the Standing Committees listed below under Committee Reports. A description of how each committee functions will be provided to Commissioners. The Agenda, Minutes and attachments will be provided to individual Commissioners for the specific committee they serve. Commissioners can email Mr. Tadeo to request agendas and attachments for meetings they were not assigned to. The EMS Agency meeting schedule for 2021 was provided to the Commission.

## IV. CONSENT AGENDA

Chairman Rodriguez called for approval of the Consent Agenda and opened the floor for discussion.

***Motion/Second by Commissioners Lott/Hisserich to approve the Consent Agenda, was approved and carried unanimously.***

### 1. MINUTES

November 18, 2020 Minutes were approved.

### 2. CORRESPONDENCE

2.1 (11-17-20) Marc Eckstein: Field-Initiated Telemedicine for Alternate Destination Pilot Program Approval
2.2 (11-18-20) From EMS Authority: STEMI Critical Care System Plan Update Approved
2.3 (11-18-20) From EMS Authority: Stroke Critical Care System Plan Update Approved
2.4 (12-15-20) COVID-19 Surge and Delays in Emergency Department Ambulance Patient Offload Times (APOT)
2.5 (12-18-20) Distribution: EMS Transport of Pediatric Patients (17 Yrs. And Younger) to Pediatric Medical Centers (Directive #1)
2.6 (12-22-20) Distribution: Suspension of Service Area Boundaries (Ref. Nos. 509, 509.1 & .1a, 509.2 & .2a, 509.3 & .3a, 509.4 & .4a) (COVID-19 Surge Directive #3)
2.7 (12-23-20) Distribution: EMS Offload of ALS and BLS Patients to the Emergency Department Waiting Room (Directive #4)

2.8 (12-23-20) Distribution: Diversion of ALS Patients Due to E.D. Saturation (Directive #5)
2.9 (01-04-21) Distribution: Revised: EMS Transport of Patients in Traumatic and Non-Traumatic Cardiac Arrest (Directive #6)
2.10 (01-04-21) Distribution: EMS Use of Oxygen (Directive #7)
2.11 (01-04-21) Distribution: Revision #3 – 9-1-1 Transportation of Patients with a Poist and Comfort-Focused Care Directive (COVID-19 Surge Directive #2)
2.12 (01-12-21) Distribution: Shoring up for the Surge of COVID-19 Patients

**3. COMMITTEE REPORTS**

3.1 Base Hospital Advisory Committee
3.2 Data Advisory Committee – Cancelled for December 7, 2020
3.3 Provider Agency Advisory Committee

Mr. Tadeo reported that the Base Hospital Advisory Committee and Provider Agency Advisory Committee met in December and reviewed the policies included in the Consent Agenda.

**4. POLICIES**

4.1 Reference No. 228: ReddiNet® Utilization
4.2 Reference No. 518: Decompression Emergencies/Patient Destination
4.3 Reference No. 804: Fireline Emergency Medical Technician – Paramedic (FEMP)
4.4 Reference No. 815: Honoring Pre-Hospital Do Not Resuscitate Orders, Physician Orders for Life Sustaining Treatment and End of Life Option (Aid-in-Dying Drug)
4.5 Reference No. 830: EMS Pilot and Scientific Studies

**END OF CONSENT AGENDA**

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## V. BUSINESS

**BUSINESS (OLD)**

5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies
5.1.1 Ad Hoc Workgroup on the Pre-Hospital Care of Mental Health and Substance Abuse Emergencies – Recommendation Eight

Commissioner Erick Cheung reported that the Ad Hoc Workgroup on Recommendation Eight has had a series of meetings, two with the larger group and more with subgroups, and divided the work into three areas to address the following:

1. Review of policies, practices, Medical Control Guidelines; written materials that would be more specific in detail in addressing behavioral and substance abuse emergencies in the field, namely agitation and things related to agitation. This group is working on revising and creating new documents but has been stalled due to the pandemic in December 2020.
2. Focus on medication for pharmacologic treatment of agitation, including a review of current medication midazolam, and make recommendations on other agents.
3. Focus on dispatch algorithms and review Long Beach Police and Fire Department's current 9-1-1 dispatch with the goal of developing a co-dispatch of EMS and law enforcement for behavioral health and substance abuse field emergencies. A planned meeting and tour were cancelled due to the pandemic but will be rescheduled.

Dr. Marianne Gausche-Hill, EMS Agency Medical Director, reported on two treatment protocols under review: 1) the care of behavioral and psychiatric crisis, and 2) agitated delirium. The goal is to revise both protocols to markedly improve the behavioral and psychiatric crisis care in the field for adults and children. Along with these protocols, the committee is developing a Medical Control Guideline on care of the agitated patient, which includes de-escalation techniques and integrating those techniques in the recognition of suicidality to assist pre-hospital providers and provide additional resources.

Dr. Denise Whitfield, EMS Agency Director of Education and Innovation, reported on the medication workgroup which consisted of five physicians who reviewed literature on various medications utilized for behavioral crisis or agitated delirium.

Commissioner Cheung reported that LA County Department of Mental Health, at the request of the Board of Supervisors, is undergoing a parallel process of reviewing their models for intervention in the field in what they are calling an alternative crisis response model.

5.2 Ambulance Patient Offload Time (APOT)
Mr. Tadeo reported that the APOT workgroup met on December 7, 2020 despite requests to cancel the meeting. The workgroup met to discuss actions that could be implemented to address the prolonged APOT times due to the current pandemic surge. Three items came out of that meeting:

1. Implementing Basic Life Support (BLS) Diversion that could be requested by the hospital or provider agency when three or more ambulances are waiting to offload a patient for greater than one hour.

2. The process for implementing this was streamlined. Rather than having multiple phone calls verifying the status of the hospitals, the Medical Alert Center (MAC) would immediately put the hospital on BLS Diversion and notify the hospitals after putting them on diversion.

3. The EMS Agency administrator on duty may consider putting hospitals that are severely inundated or impacted by the surge on specialty care center diversion, specifically for STEMI, Stroke, Comprehensive Stroke and Trauma Diversion.

Copies of the APOT Minutes were provided to Commissioners.

Commissioners Jim Lott and Carol Meyer raised questions about the frequency that hospitals are put on diversion, and how the APOT Workgroup took on this responsibility.

Commissioner Lott requested to participate in the APOT Workgroup meetings and asked that meeting notices and agenda be sent to him. He expressed interest in participating not as a voting member but as an engaged Commission member.

Mr. Tadeo expressed that the EMS Commission's initial directive was to have equal representation from hospitals and the provider agencies. The EMS Agency requested HASC to identify representatives who were subject matter experts and that same request was made to the fire departments. The EMS Agency also reached out to the

LA County Ambulance Association for representation. The Commission will need to decide on altering the membership that was originally agreed upon by the Commission.

The discussion concluded with agreement that Commissioner Lott would receive the Minutes and invitation to attend and observe the meetings.

Dr. Gausche-Hill reported that through the Disaster Operations Center (DOC), hospital diversions are being monitored on a regional level every day. In late December 2020, and early January 2021, a large number of facilities were severely impacted by the pandemic and were on diversion, including specialty care centers. Several mitigation strategies were implemented including:

1. BLS Diversion.

2. Reference 855, which allows for a regional EMS provider to come and assess the situation and begin assisting hospitals and triaging ambulances so ambulances can go back into service.

These mitigation strategies were monitored very closely; and, if a hospital was placed on BLS diversion, it was also placed on ALS diversion. Then, the facility was contacted to determine whether specialty care center diversion was necessary. In addition, the Disaster Resource Centers were requested to meet to discuss load level strategies from a pre-hospital standpoint and ensure that the specialty service, i.e., STEMI, Stroke, Trauma and Peds, were indeed available within each of the regions.

5.3 EMS Personnel Administering Vaccinations

Dr. Gausche-Hill reported that the EMS Agency applied to the State for Local Optional Scope of Practice to allow EMTs to administer vaccines. Paramedics have already been approved to administer the vaccines during this public health crisis. Approximately 16,000 first doses of the vaccines have been administered to EMS providers, both public and private. The EMTs who would participate in the vaccination program will require some training. A PowerPoint training module has been developed and a supervised skill verification checklist will be completed. EMTs will not draw up the medication, they only are there as a team member and a vaccinator. EMTS who will be approved for this Local Optional Scope may also vaccinate the public. There needs to be either a nurse or paramedic or physician present during the time the EMTs are engaging in vaccinations.

Dr. Gausche-Hill reported that EMTs have been approved to work in static locations, so if it is within the body of a vaccination clinic and they are trained, we would need to understand who would be supervising and training these EMTs. They are limited in what they can do in those locations.

Commissioner Jeffrey Rollman asked if this applies to unaffiliated EMTs and paramedics, and/or affiliated with provider agencies but not working under paid time, but working on their days off, if that is something paramedics or EMTs can volunteer for on their days off.

Dr. Gausche-Hill responded that the original intent was to have provisions for oversight through affiliated, already approved programs. For someone unaffiliated, they would need training and oversite and I am not aware that other fire departments will oversee and take responsibility for EMTs or paramedics that are unaffiliated. Retired EMTs or paramedics have been utilized for clerical functions but not patient care. Probably in the range of 12,000 or more EMTs currently in LA County. Also, for the private providers they can train their people as well.

Commissioner Hisserich asked if a firefighter who is an EMT on his day off, could they be employed by a hospital to administer the vaccine or do they have to do it under the egis of the department that they belong to. Any EMT or paramedic must have oversite by their department or hired by the hospital who trains them and provides oversight as well as liability coverage for them.

Chairman Rodriguez responded that if the firefighter folks are trained to administer the vaccine and it is their day off, they will try to grab them to assist with whatever vaccination program we have within our City. Long Beach just set up their mega-pod down at the Long Beach Convention Center.

5.4 LA County COVID-19 Modeling – EMS Agency Data

Dr. Gausche-Hill reported on the latest COVID-19 modeling and reviewed a data graph that covered week-by-week starting back until April 2020, which shows COVID-19 patients admitted to hospital, and currently available beds.

One thing I think the Commission should know which was pretty striking was that the modeling team predicted last week that one in three persons in LA County have either been infected or currently infected with the virus since the beginning of the pandemic. So, it is a significant impact on the health of our community. I will say that the healthcare sector has really stepped up in a major way to meet this head on, and I want to thank also our Public Health colleagues for their continued efforts

Commissioner Lott commented that one of the issues of concern is the policy of having to go to triage or rationing, and he asked for an explanation on the Directive that says that pre-hospital personnel are being asked not to bring COVID-19 patients who do not have a possible prognosis of improvement, don't bring them. I understand how the news twists things, so for us I want to hear it correctly, not what the news says, but I want to hear it correctly from the Agency.

Dr. Gausche-Hill responded, there is no rationing of services. In regard to Directive number 6, this is EMS Transport of Traumatic and Non-Traumatic Cardiac Arrest. We have for a long time asked our pre-hospital providers to do high quality cardiopulmonary resuscitation (CPR) on all patients with either a traumatic or non-traumatic cardiac arrest. Specifically, for non-traumatic cardiac arrest we are very clear the best chance for them to survive is to get return of spontaneous circulation (ROSC) or pulse back in the field. They always have had the opportunity to contact the Base hospital and transport the patient in continued cardiac arrest if indeed it is felt that it is reasonable to do so. There is no additional therapy that is going to be offered at the hospital for these patients besides what is being done in the field. The EMS providers have everything they need to resuscitate a patient in the field, and it is considered best practice to initiate a full and high-quality resuscitation in the field setting, and so we wanted to emphasize that. One of the things that we stated in this Directive which is a restatement of what we have already stated as part of our treatment protocols, is that we felt that transport

of these patients does not provide any additional therapy at the hospital, and it actually can be harmful, meaning in a moving ambulance doing CPR does not necessarily work well, and that's why staying on scene is really important. The other thing is that as hospitals are impacted, a transport of a patient who otherwise should not be transported. Many of these hospitals are too inundated to actually provide any additional resuscitation, not that resuscitation would result in improved outcome.

Commissioner Lott said, I get that, if I may interrupt you, and I apologize for shutting you down right now, but I know we have a time constraint here too. I represent the second district which is medically under-served, and that's why I am pursuing this discussion. I am concerned about the messaging here because what everyone in the Second District is hearing is that you may not be able to go to a hospital because someone is going to make the decision that you are too sick and you just need to die because we have no room in our hospitals and that is going to disproportionately impact underserved communities. We are talking about health equities and the anxieties of communities and populations when they hear things like a decision is being made in the field pre-hospital, not to bring a patient to a County hospital if that patient has no chance of surviving.

Dr. Gausche-Hill expressed that this is specifically about cardiac arrest, and there is no rationing that is being done. Everybody receives resuscitation efforts by EMS. We have had this protocol in place for some time, and we found that there are situations where paramedics would bring patients to the hospital, and even though that is not our standing protocol.

Chairman Rodriguez asked what Commissioner Lott's recommendation would be.

Commissioner Lott's recommendation is to request a little bit more aggressive or positive response coming from the County to these news media releases which are not true.

Dr. Gausche-Hill reported that she, Dr. Bosson the County Public Information Officer and Dr. Denise Whitfield have participated in multiple communications with the media, explaining exactly what we are doing. I cannot be responsible for irresponsible media. All I can say is we have addressed it in every possible way, verbal, written communications, Zoom Communications, and if the media chooses to promote inequity that is very unfortunate. We feel very strongly that every patient has the same chance of survival in the field, and our policies reflect that.

Commissioner Lott requested a recommendation from this Commission to the Board of Supervisors that they do follow up on the negative media that is going on. In the County somewhere, somebody needs to counter this stuff very actively and proactively. Our EMS Agency staff are doing all that they can do, but it is not enough because all the people in the second district are hearing is if you call 9-1-1 you may not get taken to a hospital if you have COVID-19.

Dr. Gausche-Hill replied that the supervisors are well-aware and have messaged this as well. The National Association of EMS Physicians came out supporting what we have done as best practice. Also, on social media, EM Docs, everybody has been 100% supportive of our previous and current practice. I think there has been a lot of poor messaging to the public on what is actually happening. I appreciate your concern and the fact that messaging has not been good, but I think everyone in our organization and above me have been messaging on this particular issue including DHS Director,

Dr. Christina Ghaly and DPH Director Dr. Barbara Ferrer.

Commissioner Ower responded that Commissioner Lott is representative of the Second District and he has been appointed by his Supervisor of that District, and this is a media problem and not an EMS problem, then I think Commissioner Lott should go back to them and help get that message out to your District. I am not sure what the Commission as a whole can do to promote that equity, but the messaging is what needs to be promoted. As you understand healthcare and our policies, you would be a good person to go out there and represent and talk to the people in the District and help them know what is going on.

Dr. Gausche-Hill asked Commissioner Lott if there is a specific organization you think we should reach out to, that would be helpful. She is more than happy to work together on that messaging and identify who to reach out to within those communities. I want to thank you for bringing it up. I don't feel anything but pride in what we have done. So, I would like to work with you if I can reach out to you individually and we can have a conversation about how to get that message out.

Chairman Rodriguez thanked all for their comments, and Commissioner Lott for bringing up the issue because many people in the County need the services. It is incumbent upon everyone on the Commission and involved in this hard fight to continue to message correctly, to continue to explain to folks whoever we meet whether its neighbors, or different organizations about the real work that is going on out there and help dispel some of the myths. So, again if there is any additional organizations or groups in your specific District that you think would be a powerful resource for us to use as a conduit to get that message out, please reach out to the EMS Agency so we can get to those folks and share with them what is going on from a fact-based perspective.

**BUSINESS (NEW)**

5.5 EMS Agency Directives

Dr. Gausche-Hill provided a brief explanation on each of the Directives. Directive number one has to do with EMS transport of pediatric patients to pediatric medical centers these are usually larger centers that also have pediatric ICUs. If they cannot reach that within the 30-minute timeframe, they go to the closest emergency department approved for pediatrics (EDAP). This was to try to offload some of our smaller community hospitals that were EDAPs that were inundated by adult COVID-19 patients. From a medical standpoint, children are less impacted, at least directly, by the pandemic, certainly indirectly they are significantly impacted. So, we directed patients 17 and younger to go to these pediatric medical centers that had greater capacity to care for children of all ages.

We also had some concern that patients who really were at the end of life on comfort care only were also being transported to hospitals where no additional therapy would be provided. These are patients that have physician's orders for life sustaining care, and that we communicated with Public Health and our skilled nursing facilities as well as long term care and hospice.

Next is suspension of service area boundaries to allow specifically for hospitals that had these service areas those were lifted. That allows any hospital that is greatly impacted to be able to go on diversion, and that would create an opportunity for us to have a more regional approach and those hospitals would not be impacted as much by looking to service area and have their ability to go on ALS or BLS diversion.

Directive #4 allows paramedics for very stable patients our EMTs that come into hospitals to be able to bring them directly to the waiting area. Instead of waiting in a line to be triaged, they would go directly to the waiting area communicate with the emergency department staff and be able to then offload those patients to the waiting area.

Directive #7 – EMS Use of Oxygen, there was significant limitations in terms of the numbers of cannisters. Also, our hospitals were impacted by large numbers of patients on oxygen within hospitals which created pressure issues. This is a different issue and not directly impacted by Directive #7. Directive #7 says that any patient who requires oxygen will receive it. We generally titrate to 94%. We opted to titrate to 90% and above in order to conserve oxygen while ensuring safety. This is based on recommendations by the Assistant Secretary for Preparedness and Response a Guidance of Use of Oxygen during disaster scenarios. Any patient who requires 100% oxygen will get 100% oxygen. Oxygen is actually a drug, and certain patients with conditions are actually harmed by oxygen. For example, too much oxygen with neonates can have blindness, as well as for patients with cardiac and stroke can have adverse outcomes with the empiric use of oxygen. Patients with low-pulse oximetry we recommend they all receive oxygen. This was a way to better align our policy with what we know is safe and to allow for appropriate resource utilization during the pandemic.

5.6 Letter from Jonathan E. Sherin, MD, PhD: Transportation and Destination of Individuals on Behavioral Health Holds
Mr. Tadeo reported that this letter included in the EMS Commission packet, is basically directing law enforcement, making a request to transport patients out not to the emergency department if they are on 5150 without any medical complaint.

5.7 Downgrade of Services Notification – Olympia Medical Center
Mr. Tadeo reported that Olympia Medical Center notified the EMS Agency a couple of weeks ago about their intent to temporarily suspend services at the hospital. The hospital is currently owned by the UCLA Regents, and is being leased by the current operator. The hospital has 192 general acute care beds, with 17 emergency department treatment stations, and six coronary care units, and six intensive care units.

In the packet is a letter signed by Ms. Chidester requesting a postponement of the closure and given the difficult time of the pandemic it is not a good time to close a hospital. We are required by Title 22 to hold a Public Hearing, and it appears that January 27th is the date with most Commissioner responses to availability, and a notice will be forthcoming once the date is confirmed for the Public Hearing. It will be a virtual hearing to comply with the pandemic restrictions.

Commissioner Lott stated that the County of Los Angeles must have a public hearing pursuant to the Gallegos Law, and the EMS Commission is delegated by the County to conduct the public hearing.

Ms. Chidester reported that Olympia Medical Center responded to the letter she signed, but they did not feel any points brought up in the letter were pertinent to the circumstances and they felt that a hearing could be done by Zoom without any problem and they are still going forward.

Commissioner Lott asked what access we have to information developed by the owners

at the new hospital.

Ms. Chidester reported that UCLA has leased back to the operator of the hospital and UCLA is not in a hurry to make the changes to the hospitals and what they are planning to do is to make an overall behavioral health center for different levels of behavioral health and rehabilitation and they wanted to make it a center of excellence. So, it is a good thing what they are doing but the timing is not very good. UCLA would be willing to lease the hospital for another six months.

Olympia Medical Center has plans posted on their website. Information will be gathered and provided to the EMS Commission prior to our meeting with the community.

Commissioner Cheung recused himself from participation in the Public Hearing by virtue of his employment with UCLA.

Commissioner Rollman also recused himself from participation in the Public Hearing as he is also a UCLA employee.

## VI. COMMISSIONERS' COMMENTS / REQUESTS

Commissioner Meyer complimented all of the EMS personnel in the field.

Commissioner Lott expressed that our pre-hospital people have been doing a fantastic job, and how everyone has been behaving during this public health crisis has been extra stellar. The EMS Agency has been very responsive and Public Health has been extremely responsive to both the pre-hospital people and hospitals on how to engage and make this happen.

## VII. LEGISLATION

No legislative report.

## VIII. EMS DIRECTOR'S REPORT

APOD Handout

Mr. Tadeo reported this is from the State EMS Authority. The APOD handout is a compilation of the reports being sent by the local EMS agencies to the State. More detailed reports are being requested from the counties to provide a more granular report.

Criminal History Impact on EMT Certification

Mr. Tadeo reported this report is also from the State EMS Authority regarding the criminal records of EMTs. The conclusion was that a criminal history is not necessarily an impediment for getting an EMT certification. However, of note, in LA County, EMT Training Programs are advised to pre-screen their students so they do not go through EMT training and later on find out that they do not qualify for certification due to specific criminal history.

Mr. Tadeo provided information on a Diversion report with the percentages of the hospitals that requested ALS diversion, and the percentage of time on ALS diversion. This tracking detail began from the first of the year. In early January, almost all hospitals were on ALS diversion between 70% to 80% of the time. To date, that has decreased to 50% and 25% of the time. BLS diversion has almost gone down to zero. Many heavily impacted hospitals were placed on Internal Disaster. In the last five days or week, no hospital required internal disaster due to the COVID-19 surge. Specialty Care Center diversion has also significantly decreased. Overall, this is showing that hospitals are beginning to cope with the current surge.

The mitigation strategies in collaboration with CDPH and State EMSA by providing the hospitals with equipment, staffing and assisting with discharges to the skilled nursing facilities has enabled hospitals to cope with the surge and thereby reflected is less diversion time.

**IX. ADJOURNMENT:**

Adjournment by Chairman Rodriguez at 3:02 pm to the meeting of March 17, 2021.

***Motion/Second by Commissioners Hisserich/Lam to adjourn to the meeting of Wednesday, March 17, 2021, was approved and carried unanimously.***

**Next Meeting:** Wednesday, March 17, 2021, 1:00-3:00pm
Join by Zoom Videoconferencing

Join Zoom Meeting
https://zoom.us/j/97565380793?pwd=L1dhaUVybnMyK2tiZE95Q29jK3RDdz09
Meeting ID: 975 6538 0793
Passcode: 991629

One tap mobile
+16699009128,,97565380793# US (San Jose)
+13462487799,,97565380793# US (Houston)

Dial by your location
+1 669 900 9128 US (San Jose)
+1 346 248 7799 US (Houston)

Recorded by:
Denise Watson
Secretary, Health Services Commission

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

January 12, 2021



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

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

*To advance the health of our communities by ensuring quality emergency and disaster medical services.*

TO: Chief Executive Officer
Each General Acute Care Hospital

FROM: Cathy Chidester
Director

SUBJECT: **SHORING UP FOR THE SURGE OF COVID-19 PATIENTS**

Over the past weeks, hospitals have experienced an unprecedented surge in COVID-19 cases straining hospital staffing, space and other resources. Most recently, the number of hospitalized COVID-19 cases have plateaued; however, there is a concern of another surge from the holiday gatherings. In preparation for this potential surge, this memo is to remind hospitals to continue their focus on surge planning addressing the following issues:

**Staffing**

- Reach out to your contracted registries including travelers to obtain additional staffing resources specifically, ICU RNs and Respiratory Therapists.
- Continue to use the CDPH Waiver process to expand nursing ratios to extend your available staffing to care for additional patients.
- Consider supplementing your staffing with the use of emergency medical technicians and paramedics.
- If the above actions do not result in meeting your staffing needs, submit a resource request via the ReddiNet system for needed staff.

**Space**

- Ensure all areas within the walls of the hospital that can be used to care for patients are explored and plans developed on what type of patients could be cared for in each area and the resources needed to convert these spaces.
- Fully utilize the tent facilities located on your hospital campus and ensure plans are developed on what type of patients can be cared for in the tent facilities.
- Give special attention to use of tents outside of your emergency department for the offloading of ambulance crews to release the EMS providers back to field. See Reference No. 855: *Hospital EMS Surge Assistance Plan* for details (attached).
- If tent facilities are needed, submit a resource request via the ReddiNet system.

**Stuff**

- Ensure adequate PPE is available to protect the workforce caring for the COVID-19 patients. Procure needed supplies from your normal vendors. If unable to procure in a timely manner or quantity needed, submit a resource request via the ReddiNet system.

- Evaluate the equipment that would be needed to care for additional patients to include patient monitoring equipment, IV pumps, feeding tube pumps, ventilators, high flow O2 delivery systems and supplies. Work with your medical vendors to procure these items now. If unable to procure in a timely manner or quantity needed, submit a resource request via the ReddiNet system.
- Evaluate the capacity of your liquid oxygen delivery system and, working with your oxygen vendor, develop plans to mitigate any issues that increased demand could place on the system.
- Ensure that all portable oxygen tanks are routinely refilled by your oxygen gas provider and determine if additional large H tanks are needed and work to procure these. If emergent needs for oxygen tank refills are needed, the State and the EMS Agency are setting up tank refilling stations (Oxygen Depots) to supplement your vendor's capabilities.

The EMS Agency appreciates all the work each hospital is doing to deal with the surge. Your continued vigilance with a focus on shoring up your facility's capabilities will help mitigate the impact.

CC:kf

Attachment

c: Each General Acute Care Hospital Emergency Management Officer

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY



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

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Fax: (562) 941-5835

*"To advance the health of our communities by ensuring quality emergency and disaster medical services."*

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

January 21, 2021

Martin Serna, Fire Chief
Torrance Fire Department
1701 Crenshaw Boulevard
Torrance, CA 90501

Dear Chief Serna,

**PARAMEDIC VACCINATION PROGRAM APPROVAL**

This letter is to confirm that Torrance Fire Department (TF) has been approved by the Emergency Medical Services (EMS) Agency for implementation of a Paramedic Vaccination Program for the administration of seasonal influenza and COVID-19 (SARS-CoV2) vaccines as a local optional scope of practice in Los Angeles County.

TF's Paramedic Vaccination Program includes approval to provide training and add Emergency Medical Technician (EMT) personnel to the Paramedic Vaccination Program.

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

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:JT:sm
01-08

c: Director, EMS Agency
Medical Director, Torrance Fire Department
Nurse Educator, Torrance Fire Department

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY



10100 Pioneer Blvd, Suite 200
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Tel: (562) 378-1500
Fax: (562) 941-5835

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

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

February 22, 2021

Stephen Albrecht **CERTIFIED**
Regional Administrator
Star Behavioral Health Urgent Care Center
3210 Long Beach Blvd.
Long Beach, CA 90807

Dear Mr. Albrecht:

**PSYCHIATRIC URGENT CARE CENTER DESIGNATION (CITY OF INDUSTRY)**

This is to report that Star Behavior Health Urgent Care Center (SBH-COI), City of Industry, has successfully completed its site visit conducted by the Emergency Medical Services (EMS) Agency on February 4, 2021 for designation as a Psychiatric Urgent Care Center (PUCC). The EMS Agency received SBH-COI's response to the EMS Agency's review of its Policies and Procedures manual and has determined that SBH-COI has satisfactorily addressed the missing documentation; therefore, meets the requirements of Reference No. 326, Psychiatric Urgent Care Center (PUCC).

Effective February 22, 2021, SBH-COI is a designated PUCC. This approval is valid indefinitely, unless terminated by the EMS Agency or voluntarily withdrawn by SBH-COI.

SBH-COI may start receiving patients transported via 9-1-1 who meet the patient inclusion criteria as outlined in Ref.No.526, Behavioral/Psychiatric Crisis Patient Destination.

As a reminder, participation in this program requires SBH-COI submit/report data to the EMS Agency in accordance to Reference No. 326. This report is due to the EMS Agency 30 days after the end of each quarter; therefore, SBH-COI's first data submission must be received by April 30, 2021.

Thank you for any commitment to the Los Angeles County EMS System and your voluntary participation in this new

If you have any questions, please contact John Telmos, Chief of Prehospital Care Operations or Cathlyn Jennings, Prehospital Program Coordinator, at (562) 378-1680.

Sincerely,

Cathy Chidester
Director

CC:JT:cj
02-06

c. Medical Director, EMS Agency
Medical Director, Los Angeles County Fire Department
Chief Clinical Officer, Austina Bongnai Cho, M.D.
Program Director, Yvonne Lozano
Chief, Data Systems, EMS Agency

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY



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

February 22, 2021

Stephen Albrecht
Regional Administrator
Star Behavioral Health Urgent Care Center
3210 Long Beach Blvd.
Long Beach, CA 90807

**CERTIFIED**

Dear Mr. Albrecht:

**PSYCHIATRIC URGENT CARE CENTER DESIGNATION (LONG BEACH)**

This is to report that Star Behavior Health Urgent Care Center (SBH-LB), Long Beach, has successfully completed its site visit conducted by the Emergency Medical Services (EMS) Agency on February 4, 2021 for designation as a Psychiatric Urgent Care Center (PUCC). The EMS Agency received SBH-LB's response to the EMS Agency's review of its Policies and Procedures manual and has determined that SBH-LB has satisfactorily addressed the missing documentation; therefore, meets the requirements of Reference No. 326, Psychiatric Urgent Care Center (PUCC).

Effective February 22, 2021, SBH-LB is a designated PUCC. This approval is valid indefinitely, unless terminated by the EMS Agency or voluntarily withdrawn by SBH-LB.

SBH-LB may start receiving patients transported via 9-1-1 who meet the patient inclusion criteria as outlined in Ref.No.526, Behavioral/Psychiatric Crisis Patient Destination.

As a reminder, participation in this program requires SBH-LB submit/report data to the EMS Agency in accordance to Reference No. 326. This report is due to the EMS Agency 30 days after the end of each quarter; therefore, SBH-LB's first data submission must be received by April 30, 2021.

Thank you for any commitment to the Los Angeles County EMS System and your voluntary participation in this new

If you have any questions, please contact John Telmos, Chief of Prehospital Care Operations or Cathlyn Jennings, Prehospital Program Coordinator, at (562) 378-1680.

Sincerely,

Cathy Chidester
Director

CC:JT:cj
02-05

c. Medical Director, EMS Agency
Medical Director, Los Angeles County Fire Department
Chief Clinical Officer, Austina Bongnai Cho, M.D.
Program Director, Yvonne Lozano
Chief, Data Systems, EMS Agency

March 15, 2021

**TO:** See Distribution

**FROM:** Cathy Chidester
Emergency Medical Services Agency Director
Co-chair Measure B Advisory Board

**SUBJECT: SUBMISSION OF MEASURE B FUNDING PROPOSALS FOR 2021**

This memo is to inform you and your constiuents that the Measure B Advisory Board (MBAB) is accepting funding proposals for consideration beginning April 15 through July 15, 2021. Los Angeles County Department of Health Services determined that there is $13.0 million in unallocated Measure B funds available to fund the projects submitted for consideration.

The MBAB Funding Proposal Process (Attachment I) provides the detailed information on what expenditures are allowable under Measure B and the process for submitting a proposal as well as the process the MBAB uses to evaluate and rank the proposals and make recommendations to the Board of Supervisors.

A virtual submitters conference will be held via Zoom on Tuesday, April 13, 2021 from 10:00 am until 11:30 am. This meeting will address the MBAB Funding Proposal Process. The link to join the submitters conference is:

https://zoom.us/j/91205762730?pwd=RXVwRDZlUjNpU1I3QzFVQjlKMm1nZz09
Meeting ID: 912 0576 2730
Passcode: 244688

If you are interested in having a project considered, please complete the Measure B Funding Proposal Form (Attachment II) and submit it to the Emergency Medical Services Agency no later than 5:00 pm on July 15, 2021. Any proposals submitted after July 15, 2021 will not be considered and will be returned to the submitter.

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

CC:kf

Attachments

Distribution:
Measure B Advisory Board Members
Peace Officers Association of Los Angeles County.
Southern California Psychiatric Society
Los Angeles County Medical Association
Los Angeles County Police Chiefs Association
Trauma Hospital Advisory Committee
Los Angeles County Ambulance Association
Hospital Association of Southern California
Los Angeles County 9-1-1 Receiving Hospitals
California State Firefighters' Association
American Heart Association, Western States Affiliate
Emergency Nurses Association California Chapter
California Chapter American College of Emergency Physicians
Los Angeles Area Fire Chiefs Association
Los Angeles County Division League of California Cities
Health Deputy, Each Board of Supervisor Office
Los Angeles County Fire Department
Los Angeles County Sheriff Department – Air Operations
Los Angeles City Fire Department – Air Operations
Los Angeles County Department of Public Health
Los Angeles County Department of Health Services
Los Angeles County Hospital and Healthcare Commission
Los Angeles County Public Health Commission
Los Angeles County Emergency Medical Services Agency
Los Angeles County Approved Emergency Medical Technician Training Programs
Los Angeles County Approved Paramedic Training Programs
California Nurses Association Emergency Department Nurses

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

# Measure B Funding
# Process for Submitting Funding Proposals
# 2021

## Background

Measure B is a special property assessment that was passed by the voters of Los Angeles County on November 5, 2002. This assessment is imposed upon all improvements (buildings) located in Los Angeles County and is added to Los Angeles County property taxes to provide funding for the Countywide System of Trauma Centers, Emergency Medical Services, and Bioterrorism Response.

The use of Measure B funds is restricted to four areas and authorized expenditures must fall within one of these areas:

| | |
|---|---|
| Trauma Centers | • Maintain all aspects of countywide system of trauma centers.<br>• Expand system of trauma centers to cover all areas of the county.<br>• Provide financial incentives to keep existing trauma centers within the system<br>• Pay for the costs of trauma centers, including physician and other personnel costs |
| Emergency Medical Services | • Coordinate and maintain a countywide system of emergency medical services<br>• Pay for the costs of emergency medical services, including physician and other personnel costs. |
| Bioterrorism Response | • Enable stockpiling of safe and appropriate medicines to treat persons affected by a bioterrorism or chemical attack.<br>• Train health care workers and other emergency personnel to deal with the medical needs of those exposed to a bioterrorism or chemical attack.<br>• Provide medical screenings and treatment for exposure to biological or chemical agents in the event of a bioterrorism or chemical attack.<br>• Ensure the availability of mental health services in the event of a terrorist attack. |
| Administration | • Defray administrative expenses, including payment of salaries and benefits for personnel in the Los Angeles County Department of Health Services and other incidental expenses<br>• Recover the costs of the special election in 2002<br>• Recover the reasonable costs incurred by the county in spreading, billing and collecting the special tax. |

## Submitting a Proposal

Proposals for Measure B funding can be submitted each year from April 15 through July 15 of that year. The proposals will be reviewed prior to the Measure B Advisory Board (MBAB) proposal review meeting, to insure the proposed expenditures are authorized for Measure B funding. Any proposals

for expenditures not authorized for under Measure B will be removed and the submitting entity will be notified of this action.

The MBAB will review and rank all submitted requests for Measure B funding with proposed expenditures that are authorized for Measure B at the MBAB proposal review meeting, typically scheduled in September of each year. If additional time is needed to review and evaluate the requests, another meeting will be scheduled typically later in September or in October of that year.

Below are the steps for submitting a proposal:

1. Complete the Measure B Proposal form and submit it, along with any supporting documents, via mail or email to the Los Angeles County EMS Agency no later than 5:00 pm on July 15 of the year to allow adequate time for the proposals to be reviewed and distributed prior to the first MBAB proposal review meeting. Supporting documents include price quotations for equipment purchases, budget, and pertinent financial statements. Financial statements will be required for funding request to offset the operational loss for providing a specific service (e.g. Trauma Services). The financial statements must clearly show direct expenses incurred and revenue received and expected to be received from all sources (including subsidy and donations) for providing the service. For proposed new services or activities, a detailed budget must accompany the funding request, that includes a list of personnel, equipment, supplies and services costs, and an explanation of how these costs are determined. Additionally, when a request requires the hiring of personnel or incurring other long-term financial obligations (e.g. lease) for future years, the requesting entity must provide supporting documentation demonstrating how they will cover the personnel cost and these obligations if Measure B funding is not available in future years. Every requesting entities must provide a letter from the organization's Department Head/Executive Office approving the proposal submission.

2. Proposers are encouraged to attend the MBAB proposal review meeting(s) to provide a brief overview of their project, limited to two minutes and be available to answer any questions that the members of the MBAB may have related to their proposal. If a second meeting is also scheduled for review of proposals, the proposers are encouraged to also attend this meeting. The first meeting is typically scheduled in September of the year and if another meeting is needed, it will be scheduled typically later in September or in October of that year.

3. After reviewing all eligible proposals, the MBAB members will rank score the projects while the proposers are in attendance. However, the ranking score given by the MBAB does not guarantee approval by the Board of Supervisors.

**Evaluating and Rank Ordering of the Proposals**

After reviewing all eligible proposals submitted for a given year, the MBAB will rank the proposals using a three-level ranking system. Each qualified proposal will be given a high priority (Score of 3), medium priority (Score of 2), or low priority (Score of 1) score. All MBAB members may vote on any proposals being considered, even if they are affiliated with the requesting entity, or has an interest in or will benefit from a proposal(s), unless it is deemed inappropriate by the MBAB Co-Chairs. The ranking will be done by each MBAB voting member providing a number ranking and an average score will be determined using all voting member rankings for each proposal.

When evaluating/ranking each proposal, the committee may take into consideration the following:

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

**Board Consideration**

A memo to the Board of Supervisors providing information on all the eligible proposals that were submitted and reviewed will be written by the Co-Chairs. The Board memo will highlight the amount of unallocated Measure B funding that is available and the rank order score of each proposal. It shall be the Board's sole discretion and decision on what proposals are to be funded, as well as the amount awarded.

Once a proposal is approved by the Board, additional processes may need to be implemented prior to disbursement of the funds. This includes entering into a written agreement with the County outlining the use of the funding and the timeframe for incurring expenses. Typically, any Measure B funds that are awarded should be expended within 12 months of award. All Measure B funding is awarded on a reimbursement basis, with the receiving entity incurring the expense and then submitting the claim or invoice to Los Angeles County - Department of Health Services / Health Services Administration Finance for reimbursement.

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

## Los Angeles County Measure B Funding Proposal 2021

Measure B funding will be allocated on a one-time basis with all expenditures to be completed within 12 months of award. If the proposal requires year to year funding the proposer must provide supporting documents on how they will cover the on-going costs in future years.

| | |
|---|---|
| Requesting Entity Name: | |
| Point of Contact Name: | |
| Point of Contact Phone: | |
| Point of Contact email address: | |
| Amount of Funding Requested: | |
| Brief Project Description: | |
| Describe the gap in Emergency Medical Services, Trauma Services or Bioterrorism Preparedness that the requested funds addresses: ***Discuss the current situation, strategy to solve the identified gap and how the allocation of Measure B funds benefits the citizens of Los Angeles Count)*** | |

| | |
|---|---|
| Justification:<br>***Place a checkmark next to each of the applicable statements and incorporate comments into your brief 2-3 paragraph narrative justification.*** | ☐ Achieves compliance with legal requirements, mandate, citation or audit.<br>☐ Increases capacity to meet patient care demand.<br>☐ Provides for improvements in emergency preparedness activities.<br>☐ Improves timely access to healthcare.<br>☐ Provides a new service for patients.<br>☐ Improves efficiency.<br>☐ Increases patient safety/reduces risk.<br>☐ Other<br><br>Narrative Justification: |
| Timeline<br>**When *funds will be needed, how long will it take to implement. Explain/list the major milestones to achieve implementation and the approximate timeline for each.*** | |

Provide as separate attachments the following supporting documents:

- List of equipment and price quotations for equipment purchases.
- Financial statements will be required for funding request to offset the operational loss for providing a specific service (e.g. Trauma Services). The financial statements must clearly show direct expenses incurred and revenue received and expected to be received from all sources (including subsidy and donations) for providing the service, with the request for Measure B funding no more than the gap between the revenue and expenses.

- For proposed new services or activities, a detailed budget must accompany the funding request, that includes a list of personnel, equipment, supplies and services costs, and an explanation of how these costs are determined.

- When a request requires the hiring of personnel or incurring other long-term financial obligations (e.g. lease) for future years, the requesting entity must provide supporting documentation demonstrating how they will cover the personnel cost and these obligations if Measure B funding is not available in future years.

- If the requesting entity is a Los Angeles County department, provide a letter from the Chief Executive Office approving the addition of the requested item to the department's budget.

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

Submit all documents via mail or email no later than July 15 of the year to:

Los Angeles County

Emergency Medical Services Agency

Measure B Advisory Board

10100 Pioneer Boulevard, Suite 200

Santa Fe Springs, CA 90670

Attention: Kay Fruhwirth

kfruhwirth@dhs.lacounty.gov

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

# BASE HOSPITAL ADVISORY COMMITTEE MINUTES

**February 10, 2021**

## MEMBERSHIP / ATTENDANCE
## VIA ZOOM

| | REPRESENTATIVES | | EMS AGENCY STAFF |
|---|---|---|---|
| ☒ | Carol Meyer., Chair | EMS Commission | Dr. Marianne Gausche-Hill |
| ☒ | Carole Snyder, RN., Vice Chair | EMS Commission | Dr. Nichole Bosson |
| ☐ | Atilla Uner, MD, MPH | EMS Commission | Richard Tadeo |
| ☒ | Lydia, Lam, MD | EMS Commission | Christine Clare |
| ☒ | Diego Caivano, MD | EMS Commission | Dr. Dipesh Patel |
| ☐ | Erick Cheung, MD | EMS Commission | Jackie Rifenburg |
| ☐ | Garry Olney | EMS Commission | John Telmos |
| ☐ | Rachel Caffey | Northern Region | Michelle Williams |
| ☒ | Melissa Carter | Northern Region | Christy Preston |
| ☒ | Charlene Tamparong | Northern Region, Alternate | Paula Rashi |
| ☒ | Samantha Verga-Gates | Southern Region | Cathy Jennings |
| ☒ | Laurie Donegan | Southern Region | Susan Mori |
| ☒ | Shelly Trites | Southern Region | Sara Rasnake |
| ☒ | Christine Farnham, APCC President | Southern Region, Alternate | Fritz Bottger |
| ☒ | Paula Rosenfield | Western Region | Gary Watson |
| ☒ | Ryan Burgess | Western Region | David Wells |
| ☐ | Susana Sanchez | Western Region, Alternate | Dr. Denise Whitfield |
| ☐ | Erin Munde | Western Region, Alternate | Christine Zaiser |
| ☒ | Laurie Sepke | Eastern Region | Natalie Greco |
| ☒ | Alina Candal | Eastern Region | Dr. Allen Chang |
| ☒ | Jenny Van Slyke | Eastern Region, Alternate | |
| ☒ | Lila Mier | County Hospital Region | |
| ☒ | Emerson Martell | County Hospital Region | |
| ☒ | Yvonne Elizarraz | County Hospital Region, Alternate | |
| ☒ | Antoinette Salas | County Hospital Region, Alternate | **GUESTS** |
| ☒ | Alec Miller | Provider Agency Advisory Committee | Dr. Shira Schlesinger, Harbor UCLA |
| ☒ | Jennifer Nulty | Provider Agency Advisory Committee, Alt. | Dr. Mark Eckstine, LAC+USC |
| ☒ | Laarni Abdenoja | MICN Representative | Dr. Sean Denny, Harbor UCLA |
| ☒ | Jennifer Breeher | MICN Representative, Alt. | |
| ☒ | Heidi Ruff | Pediatric Advisory Committee | |

| | PREHOSPITAL CARE COORDINATORS | | | | |
|---|---|---|---|---|---|
| ☒ | Michael Natividad (AMH) | ☒ | Lorna Mendoza (SFM) | ☒ | Jessica Strange (SJS) |
| ☐ | Chad Sibbett (SMM) | ☒ | Karyn Robinson (GWT) | ☒ | Heidi Ruff (HMN) |
| ☒ | Coleen Harkins (AVH) | ☒ | Erica Candelaria (QVH) | | |

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

2. **APPROVAL OF MINUTES**: The meeting minutes for December 9, 2020, were approved as submitted.

   **M/S/C (Burgess/Carter)**

## 3. INTRODUCTIONS/ANNOUNCEMENTS:

- Richard Tadeo: Update on the closure of Olympia Medical Center (MID); a public hearing took place on January 27, 2021- there were 180 attendees and testimony given by 15 individuals. The EMS Commission made a motion to postpone the closure until September 30, 2021. However, in speaking with the CEO and General Counsel for MID, the intended closure date was unchanged and remains March 31, 2021.
- We would like to welcome the new Base Hospital Advisory Committee members:
  - Carol Meyer, Chair EMSC Commissioner (Public Member)
  - Carole Snyder, RN, Vice Chair EMSC Commissioner (Emergency Nurses Assoc.)
  - Dr. Diego Caivano, EMSC Commissioner (LA Medical Assoc.)
  - Dr. Lydia Lam, EMSC Commissioner (LA Surgical Society)
  - Dr. Erick Cheung, EMSC Commissioner (So. Cal. Psychiatric Society)
  - Garry Olney, EMSC Commissioner (HASC)

## 4. REPORTS & UPDATES:

### 4.1 EMS Update 2021

EMS Update 2021 is currently being developed. Train the Trainer is scheduled for Thursday, April 29th, (AM & PM session), and Thursday, May 6th, (AM session). As in previous years, Advanced Problem Solving (APS) will be providing the online platform, as well as the instructional design.

EMS Update completion deadline is September 1, 2021.

### 4.2 EmergiPress

The January/February edition is being developed and will be available in the coming weeks. EmergiPress can be accessed via the Los Angeles County Emergency Medical Services website or the APS portal of which MICN's have an established account, provided by Los Angeles County EMS Agency.

Please continue to submit feedback and suggestions for future topics to Dr. Denise Whitfield at, dwhitfield@dhs.lacounty.gov.

### 4.3 ECMO Pilot

Because of the COVID Pandemic, the ECMO Pilot has been postponed until further notice.

### 4.4 Data Collaboratives

The Data Collaboratives continue to meet regularly. There are projects being worked on for both the SRC Collaborative and Stroke Collaborative, more to come.

Recent publications:

Utility of Glucose Testing and Treatment of Hypoglycemia in Patients with Out-of-Hospital Cardiac Arrest, by Dr. Tiffany M. Abramson.
https://doi.org/10.1080/10903127.2020.1869873

## 5. OLD BUSINESS:

5.1 Ref. No. 508, Sexual Assault Patients Destination

Approved with recommended change:
- PRINCIPLE: 2., after "local law enforcement agency", add "where the sexual assault occurred".

**M/S/C (Burgess/Farnham)**

5.2 Health Data Exchange (HDE)

Update provided by Richard Tadeo: HDE project was initially presented at the BHAC meeting in October 2020. This system allows for real-time bi-directional data exchange between EMS Provider ePCR and receiving hospital EMR, for all 911 transports. An additional benefit is the automatic upload of EMS data into TEMIS.

The HDE project will be funded by the CARES Act Provider Relief Fund through the Department of Health and Human Services. The grant will fund the one-time installation fee and the first-year annual subscription. Those interested, contact Richard Tadeo at, rtadeo@dhs.lacounty.gov or (562) 378-1610.

Attached is a fact sheet and additional information regarding the HDE project. (ATTACHMENT 1)

## 6. NEW BUSINESS:

6.1 Ref. No. 606, Documentation of Prehospital Care

Concern was expressed regarding Page 4, II.C.3., and the information that should be documented for an MCI involving 3 or more patients versus the information that is provided by the paramedics.

This matter will be reviewed and if needed the Data Work Group will reconvene to discuss.

Approved as presented.

**M/S/C (Burgess/Van Slyke)**

6.2 Ref. No. 814, Determination / Pronouncement of Death in the Field

Approved with recommended change:
- Page 5, III. A., add "(for approximately 5 minutes)".

**M/S/C (Burgess/Carter)**

6.3 Ref. No. 834, Patient Refusal of Treatment or Transport

Approved with recommended changes:
- Page 1, Decision-Making Capacity, add verbiage "if available" after "in the patient's primary language."

- Page 5, I. D., add verbiage “if base personnel determines it is warranted.”

**M/S/C (Carter/ Donegan)**

6.4 Ref. No. 1210, Cardiac Arrest

Lengthy discussion ensued regarding the use of the King LT as the preferred advanced airway versus endotracheal intubation (ETI) as an option.

Approved with recommended change:
- Page 5, Special Considerations, 14, add verbiage “unless there are contraindications for the use of the King LT, in which ETI can be utilized as the advanced airway.

**M/S/C (Burgess/Carter)**

6.5 Ref. No. 1210-P, Cardiac Arrest

Approved as presented.

**M/S/C (Burgess/Sepke)**

6.6 Ref. No. 1216-P, Newborn / Neonatal Resuscitation

Approved with the addition of verbiage, “stay on scene until the initiation of resuscitation.”

**M/S/C (Burgess/Sepke)**

6.7 Ref. No. 1243, Airway Obstruction

Approved as presented.

**M/S/C (Burgess/Donegan)**

6.8 Ref. No. 1243-P, Airway Obstruction

Approved as presented.

**M/S/C (Burgess/Donegan)**

**7. OPEN DISCUSSION:**

None

**8. NEXT MEETING:** BHAC’s next meeting is scheduled for **April 14, 2021**, location is to be determined.

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

**ACCOUNTABILITY:** Lorrie Perez

**9. ADJOURNMENT:** The meeting was adjourned at 3:22 P.M.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

**Los Angeles County Board of Supervisors**

**Hilda L. Solis**
First District

**Holly J. Mitchell**
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 Boulevard, Suite 200
Santa Fe Springs, CA 90670

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

*"To advance the health of our communities by ensuring 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, February 10, 2021 10:00 A.M.
Location: Zoom Meeting

# DATA ADVISORY COMMITTEE
# DARK FOR FEBRUARY 2021

County of Los Angeles
Department of Health Services
**EMERGENCY MEDICAL SERVICES COMMISSION**

# PROVIDER AGENCY ADVISORY COMMITTEE

## MINUTES

Wednesday, January 17, 2021

Due to the ongoing COVID-19 pandemic and to comply with the Health Officer's Order on Social Distancing, this meeting was conducted via ZOOM conference call-in. General public and Committee Members' attendance was verified by presence of name on the participant list. Quorum was reached and the meeting continued.

## MEMBERSHIP / ATTENDANCE

| MEMBERS | ORGANIZATION |
|---|---|
| ☑ Robert Ower, Chair | EMSC, Commissioner |
| ☑ Kenneth Powell, Vice-Chair | EMSC, Commissioner |
| ☑ Gene Harris | EMSC, Commissioner |
| ☐ Paul Rodriguez | EMSC, Commissioner |
| ☐ Brian Bixler | EMSC, Commissioner |
| ☑ John Hisserich | EMSC, Commissioner |
| ☑ Sean Stokes | Area A |
| ☐ Justin Crosson | 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)* |
| ☑ Todd Tucker | Area C |
| ☑ Ken Leasure | Area C, Alt. |
| ☑ Ivan Orloff | Area E |
| ☑ Kurt Buckwalter | Area E, Alt. |
| ☑ Wade Haller | Area F |
| ☐ Brenda Bridwell | Area F, Alt. |
| ☑ Alec Miller | Area G *(Rep to BHAC)* |
| ☑ Jennifer Nulty | Area G, Alt. *(Rep to BHAC, Alt.)* |
| ☑ Doug Zabilski | Area H |
| ☐ Anthony Hardaway | Area H, Alt. |
| ☑ Matthew Potter | 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. |
| ☑ David Mah | Paramedic Training Program |
| ☐ David Fillip | Paramedic Training Program, Alt. |

| EMS AGENCY STAFF (Virtual) | |
|---|---|
| Marianne Gausche-Hill, MD | Cathy Chidester |
| Nichole Bosson, MD | Richard Tadeo |
| Denise Whitfield, MD | Dipesh Patel, MD |
| Jennifer Calderon | Chris Clare |
| Elaine Forsyth | Natalie Greco |
| Cathlyn Jennings | Susan Mori |
| Lorrie Perez | Christy Preston |
| John Quiroz | Paula Rashi |
| Jacqueline Riffenburg | Phillip Santos |
| John Telmos | Gary Watson |
| David Wells | Michelle Williams |
| Christine Zaiser | |

| PUBLIC ATTENDEES (Virtual) | |
|---|---|
| Christina Eclarino | LA County Public Health |
| Allen Chang, MD | EMS Fellow |
| Angela Loza-Gomez, MD | Glendale/Montebello FD |
| Brian Fong, MD | |
| Puneet Gupta, MD | |
| Marc Cohen, MD | Three area FDs |
| Andrew Reno | Long Beach FD |
| Jon O'Brien | LACoFD |
| Dave Smith | Redondo Beach FD |
| Britney Alton | Burbank FD |
| Catherine Borman | Santa Monica FD |
| Blayne Baker | Torrance FD |
| Craig Hammond | Glendale FD |
| Jennifer Breeher | Alhambra FD |
| Anathea Gordon | Los Angeles FD |
| Adrienne Roel | Culver City FD |
| Jack Ewell | Los Angeles Co. Sheriff |
| Caroline Jack | Beverly Hills FD |
| Aspen Di-ilolo | Monterey Park FD |
| Jeff Tsay | San Marino FD |
| Phillip Apparis | San Gabriel FD |
| Roger Braum | Culver City FD |
| Ryan Cortina | Burbank FD |
| Kristina Hong | Downey FD |
| Paula LaFarge | LACoFD |
| Chad Van Meeteren | Santa Fe Springs |
| Lyn Riley | UCLA - Prehospital |
| Robert Aragon | MedReach Amb |
| Doug Cain | Antelope Amb |
| Tina Ziolkowski | Los Angeles FD |
| CJ Bartholomew | Care Ambulance |
| Drew Bernard | Emergency Amb |

1. **CALL TO ORDER:** 1:03 p.m.: Chair, Robert Ower, called meeting to order.

2. **INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS**

   There were no Introductions, Announcements or Presentations

3. **APPROVAL OF MINUTES (Leasure/Kazan)** December 16, 2020 minutes were approved as written.

4. **REPORTS & UPDATES**

**4.1** COVID-19 Update *(Marianne Gausche-Hill, MD)*

- COVID-19 hospital admissions have decreased dramatically in Los Angeles County; from >8000 admissions to approximately 2000 admissions per day. These numbers continue to decrease in both the hospital and prehospital areas.
- We are waiting to hear how Blue Shield will be involved in the management of the COVID vaccination clinics. More information will be available once this is known.
- Most of the public and private providers have received their 2nd dose of the COVID vaccine. Many law enforcement personnel have been able to receive their doses from various vaccination sites or hospitals contacts. However, there remains several law enforcement personnel still needing the vaccine and will be more readily available when the Vaccination Allocation expands to Phase 1B.
- Several of the EMS Agency's Directives have been rescinded and a summary was sent via email and hard copy to providers and hospital contacts. Additionally, directives are available for review on the EMS Agency webpage.

**4.2** Disaster Services Update *(Jennifer Calderon)*

- COVID-19 vaccination series is complete for personnel from ambulance companies, fire departments and members of the LA County Sheriff's Department - Special Enforcement Bureau. Total vaccinations distributed was 4,350; however, this number does not include members from Los Angeles Fire Department (LAFD) and Los Angeles County Fire Department (LACoFD) who also received the vaccine.
- The EMS Agency would like to thank all those who were involved in this project, including the Los Angeles Area Fire Chiefs Association (LAAFCA) and the Los Angeles County Ambulance Association (LACAA).
- The EMS Agency is working with LAAFCA and LACoFD to assist with the vaccinations for local law enforcement agencies. However, allocation of the vaccine is still pending.

**4.3** EMS Update 2021 *(Denise Whitfield, MD)*

- Final stages of development are near completion. And will be using an on-line module, like the previous year.
- Train-the-Trainer dates are scheduled for April 29 (AM and PM sessions) and May 6 (AM session only). Announcements will be sent out later whether this training will be in-person or virtual. Sign-ups have not started yet.
- This year's educational focus will be on out-of-hospital cardiac arrests (pediatric and adult), traumatic cardiac arrests, revisions of Reference 834 (Patient Refusal of Transport / Treat and Release policy); and quality improvement modules on sepsis and anaphylaxis.

**4.4** EmergiPress Update *(Denise Whitfield, MD)*

- February edition will be posted on the EMS Agency's webpage at the end of this month and will be available for upload to provider's learning management system. Those interested in receiving updates/announcements regarding EmergiPress may contact Dr. Whitfield at dwhitfield@dhs.lacounty.gov

**4.5** ECMO Pilot *(Nichole Bosson, MD)*

- This pilot is currently on hold due to COVID-19 surge. Because of the decreasing number of COVID-19 cases, it is anticipated that this pilot will resume soon.

**4.6** Bag Mask Sizes *(Nichole Bosson, MD)*

- Dr. Bosson presented for discussion four publications favoring the use of pediatric or small adult sized bag valve devices rather than the traditionally used adult bag. Siting that research studies have shown that the small bag size targets the correct tidal volume at a much better frequency than the larger adult bag.
- The EMS Agency asked for provider feedback in their willingness to support this concept and if any operational costs would prevent this transition? Providers posted in the ZOOM chat, favoring the change with little financial impact.
- To assist with a decision of removing adult sized bag valve devices from inventory, the EMS Agency will send out a Survey Monkey to all providers, asking information on the current bag manufacturers, size of the bag device and the tidal volume each bag delivers.
- More information will be presented later.

## 5. UNFINISHED BUSINESS

There was no unfinished business.

## 6. NEW BUSINESS

**6.1** Reference No. 606, Documentation of Prehospital Care *(Michelle Williams)*

Policy reviewed and approved with the following recommendations:

- DEFINITIONS: Add new definition: "Public Assist", to include same description as stated in Reference No.834, Patient Refusal of Treatment/Transport and Treat and Release at Scene
- PRINCIPLES 1.e.: change wording "public assist" to read "public assist involving a person"
- PRINCIPLES 4.c.: change wording "Public assist" to read "Public assist involving a person"
- POLICY III: change wording to read "Modification of the Patient Care Record"
- POLICY III, A.: change wording to read "Modifying the patient care record (additions, deletions or changes) after the patient care record has been completed or disseminated"

**M/S/C (Kazan/Hernandez) Approved Reference No. 606, Documentation of Prehospital Care, with the above recommendations.**

**6.2** Reference No. 814, Determination/Pronouncement of Death in the Field *(Nichole Bosson, MD)*

Policy reviewed and approved with the following recommendations:

- POLICY III. A.1.: add back wording "for 5 minutes"
- POLICY III. B.1.: remove capitalization of "NOT"

**M/S/C (Van Slyke/Kazan) Approved Reference No. 814, Determination/Pronouncement of Death in the Field, with the above recommendations.**

**6.3** Reference No. 834, Patient Refusal of Treatment/Transport and Treat and Release at Scene *(Marianne Gausche-Hill, MD)*

Policy reviewed and approved with the following recommendations:

- DEFINITIONS, High Risk Presentations: include wording "patients with complicated co-morbidities"
- DEFINITIONS, Treatment in Place: Add "Advanced" to "Authorized Health Care Provider" to read "Authorized Advanced Health Care Provider"; and add "(e.g., physician, nurse practitioner, physician assistant)
- DEFINITIONS: add the definition of "Patient" as stated in Reference No. 606, Prehospital Care Documentation
- PRINCIPLES, 4.: add wording at end of sentence "These patients may decline treatment but cannot decline transport"
- POLICY I.D.: move wording into POLICY I.B.
- POLICY IV.B.1.h.: add wording "if applicable"
- POLICY V.A.3.: remove sentence

Committee recommends that after policy is revised by the EMS Agency, a clean version of the policy be provided to the Committee for further review.

**M/S/C (Orloff/Zabilski) Approved Reference No. 834, Patient Refusal of Treatment/Transport and Treat and Release at Scene, with the above recommendations.**

**6.4** Reference No. 1210, Treatment Protocol: Cardiac Arrest (Non-Traumatic) *(Nichole Bosson, MD)*

Policy reviewed and approved with the following recommendation:

- SPECIAL CONSIDERATIONS: add wording for the use of mechanical CPR devices

**M/S/C (Van Slyke/Kazan) Approved Reference No. 1210, Treatment Protocol: Cardiac Arrest (Non-Traumatic), with the above recommendation.**

**6.5** Reference No. 1210-P, Treatment Protocol: Cardiac Arrest (Pediatric) *(Marianne Gausche-Hill, MD)*

Policy reviewed and approved as written.

**M/S/C (Van Slyke/Kazan) Approved Reference No. 1210-P, Treatment Protocol: Cardiac Arrest (Pediatric).**

**6.6** Reference No. 1216-P, Treatment Protocol: Newborn/Neonatal Resuscitation *(Marianne Gausche-Hill, MD)*

Policy reviewed and approved as written.

**M/S/C (Van Slyke/Kazan) Approved Reference No. 1216-P, Treatment Protocol: Newborn/Neonatal Resuscitation.**

**6.7** Reference No. 1243, Traumatic Arrest *(Nichole Bosson, MD)*

Policy reviewed and approved as written.

**M/S/C (Van Slyke/Kazan) Approved Reference No. 1243, Traumatic Arrest.**

**6.8** Reference No. 1243-P, Traumatic Arrest (Pediatric) (*Nichole Bosson, MD)*

Policy reviewed and approved as written.

**M/S/C (Van Slyke/Kazan) Approved Reference No. 1243-P, Treatment Protocol: Traumatic Arrest (Pediatric).**

Dr. Gausche-Hill announced that final versions of the above policies will be returned to this Committee on April 21, 2021, for review.

## 7. OPEN DISCUSSION

**7.1** Health Data Exchange *(Richard Tadeo)*

This is a follow up announcement from initial presentation several months ago.
The EMS Agency is in the final steps of amending the Health Data Exchange agreement and most likely will begin implementation within a couple of weeks.
Once ready, the EMS Agency will reach out to those providers and hospitals who expressed interest in participation.

**8. NEXT MEETING:** April 21, 2021

**9. ADJOURNMENT:** Meeting adjourned at 3:58 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **TRAUMA HOSPITAL ADVISORY COMMITTEE (THAC)** REFERENCE NO. 218

PURPOSE: To describe the composition and function of the Trauma Hospital Advisory Committee (THAC).

AUTHORITY: Health and Safety Code Division 2.5
California Code of Regulations, Title22, Chapter 7, Section 100256
California Evidence Code, Section 1157.7
California Civil Code, Part 2.6, Section 56

POLICY:

I. General Committee Description

A. The Trauma Hospital Advisory Committee (THAC) acts in an advisory capacity to the Board of Supervisors, the Director of the Department of Health Services, and the Emergency Medical Services (EMS) Agency regarding County policies, programs, and standards for trauma services throughout the County. The THAC provides a forum for the exchange of ideas regarding trauma system policy development and operational issues involving the care of trauma patients.

B. THAC's mission is to ensure access to timely, compassionate, and comprehensive quality trauma services in a coordinated trauma system that reduces overall morbidity and mortality across the continuum of care through prevention and continuous quality improvement.

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

II. Chair

The Chair shall be a Trauma Medical Director from a designated Level I or Level II Trauma Center elected by the THAC. Officers (Chair and Vice Chair) terms shall be two (2) years, eligible for up to two (2) consecutive terms or until their successors are elected. No THAC member may serve more than two full terms (four years) in succession in the same office.

III. Election and Replacement of Officers

A. Election of Officers:

1. The Chair shall appoint a minimum of three members to be a Nominating Committee, subject to the approval of the THAC.



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

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

3. An election shall be conducted. If there is only one nominee for an office, the Chair can declare that the nominee is elected; otherwise, election shall be by majority vote (50% + 1) of the THAC voting members.

B. Replacement of Officers

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

1. The Chair shall appoint three committee members to be a Nominating Committee, subject to the approval of the THAC.

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

3. Additional nominations may be made and the election shall be conducted in compliance with this policy.

IV. Duties of Officers

A. The Chair shall:

1. Supervise all matters pertaining to the THAC.

2. Preside at all THAC meetings.

3. Rule on all points of order.

4. Sign all official THAC documents.

5. Ensure that minutes are maintained.

B. The Vice Chair shall:

1. Perform the duties of the Chair in their absence.

2. Perform other duties as assigned to them by the Chair or the THAC.

V. Committee Membership Structure

A. Voting Members include:

1. Trauma Medical Director (each designated Trauma Center), or designee

2. Trauma Program Manager (each designated Trauma Center), or designee

3. General Members

B. General Members:

1. Emergency Medical Services Commissioner (American College of Surgeons, Southern California Chapter) (1)

2. Healthcare Association of Southern California Representative (1)

3. Neurosurgical Society Representative (1) (*)

4. Committee on Trauma Representative (1) (*)

(*) Representative must be from a designated Trauma Center

C. Staff Members:

The committee will be attended and staffed at a minimum by the following Emergency Medical Services (EMS) Agency personnel:

1. Director, EMS Agency or designee

2. Medical Director, EMS Agency

3. Trauma System Program Manager, EMS Agency

4. Additional EMS Agency personnel may attend on an as needed basis

D. Ad Hoc Members

Representatives may be requested on an as needed basis for relevant agenda items and selected from the following organizations/facilities:

1. Trauma Center Administrators (County Facility representative (1) and Private Sector representative (1))

2. Los Angeles County Fire Chiefs Association

3. Los Angeles County Ambulance Association

4. Los Angeles County Medical Association

5. Los Angeles County Society of Anesthesiology

6. Department of Coroner

7. Emergency Medicine Physician (designated Trauma Center)

8. Base Hospital Medical Director (non-trauma center)

9. Critical Care Specialist (designated Trauma Center)

10. Rehabilitation Center

VI. Meetings

A. Regular meetings of the THAC shall be held at 1:00 P.M. on the fourth Wednesday of each odd month. If any regular meeting falls on a holiday, the regular meeting shall be held one week later.

B. All THAC meetings shall be open to the public. This policy shall be stated on all agendas.

C. Minutes of THAC meetings shall be maintained and distributed to all members before scheduled meetings.

D. A quorum is required for any official business, including regular and special meetings. A quorum shall consist of a majority, greater than 50% of the voting members.

E. Special THAC meetings may be held on call of the Chair or any five members of the THAC. The call shall be by telephone notice to all THAC members not less than three days prior to the date set for the meeting. The telephone notice must specifically set forth the subject matter of the meeting, and no other subject matter may be considered at the meeting.

F. Unless otherwise prescribed by this policy, all THAC meetings and all committee meetings shall be governed by Robert's Rules of Order, Revised.

VII. Policy Amendment

This policy maybe amended by a three-fourths (3/4) vote of the voting THAC members if notice of intention to amend the policy, setting forth the proposed amendments, has been sent to each member of the THAC no less than ten days before the date set for consideration of the amendments.

VIII. Committees

A. Scope and Responsibilities of Standing Committees

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

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

B. Activity Requirements

Committees will be responsible for their own activities, including the location and frequency of meetings, designation of chairs and vice chairs, and formation and composition of subcommittees, if desired.

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

1. THAC - Trauma System Quality Improvement Committee (Ad Hoc)

a. This committee shall be convened as needed to evaluate unresolved system and institutional issues affecting the trauma system identified by the THAC-QI Subcommittee and/or the Los Angeles County EMS Agency.

b. Trauma System Quality Improvement Committee membership shall consist of the following:

1) Director, Department of Health Services

2) Director, EMS Agency

3) Medical Director, EMS Agency

4) Chief, Hospital Programs, EMS Agency

5) Trauma System Program Manager, EMS Agency

6) At least one administrator and one medical representative from affected facility/agency

7) Two unbiased representatives (one Trauma Medical Director and one Trauma Program Manager) from the THAC

8) Others, as necessary, to provide applicable expertise

c. The EMS Agency shall be responsible for the agenda, minutes, and any other supporting documentation.

d. Records of proceedings shall be maintained by the EMS Agency in a confidential manner.

2. THAC – Quality Improvement Subcommittee (THAC-QI)

a. This committee shall meet to assess, monitor, and facilitate the quality improvement (QI) process for Los Angeles County's Trauma Centers.

b. The proceedings of the THAC-QI shall be free from disclosure and discovery (Section 1157.7, California Evidence Code).

c. THAC-QI shall be responsible for:

1) The ongoing review of Los Angeles Trauma Center System Regional Quality Improvement Program.

2) Exploring variability in outcome to identify and share Best Practices.

3) Reducing the variability in care through the development of Evidence Based Guidelines.

4) Developing new and validating current system QI filters.

5) Identifying system issues, developing a plan for improvement, and monitoring results.

6) Coordinating and compiling focused studies/research on selected issues.

7) Developing quality management recommendations for the trauma system.

8) Providing feedback to participating centers on their performance relative to their peers.

d. THAC-QI membership will represent both private and County-operated Trauma Centers and a geographical cross section of Los Angeles County. THAC-QI membership shall consist of the following:

1) One physician representative from a Level I and II Trauma Center from each Regional Quality Improvement Committee (R-QIC), and alternate

2) One Trauma Program Manager from a Level I and II Trauma Center from each R-QIC, and alternate

3) Trauma System Program Manager, EMS Agency

4) Two Trauma Quality Improvement Nurse Specialists

5) Other individuals whose presence is germane to the quality assurance/improvement process may be invited as ad hoc members

e. THAC-QI Procedures

1) Meet on a quarterly basis.

2) Meeting location and agenda shall be the responsibility of the EMS Agency Trauma System Program Manager.

3) A representative from each Trauma Hospital Regional Quality Improvement Committees (R-QIC) shall provide a report of the region’s activities and a summary of the quarterly system indicators.

4) Unresolved system issues shall be forwarded, with written recommendations, to the Trauma System Quality Improvement Committee for action.

5) The EMS Agency Trauma System Program Manager shall maintain official attendance rosters in a confidential manner and shall include Section 1157.7 of the California Evidence Code.

6) The EMS Agency shall maintain all records in a confidential manner.

3. Trauma Hospital Regional Quality Improvement Committees (R-QICs)

a. These committees shall assist the EMS Agency in providing regional evaluation of the Los Angeles County Trauma System.

b. R-QICs shall be structured to ensure that each region includes a minimum of a Level I Trauma Center so as to derive maximum benefit from these institutions as teaching hospitals and research centers, and a Pediatric Trauma Center to ensure regular inclusion of pediatric trauma in the quality improvement process.

c. The proceedings of the R-QICs shall be free from disclosure and discovery (Section 1157.7, California Evidence Code).

d. R-QICs shall be responsible for:

1) Reviewing system-wide indicators approved by THAC.

2) Reviewing issues affecting the internal quality improvement activities of each member Trauma Center.

3) Identifying regional issues for trending and/or improvement.

4) Reporting summary of regional meetings to THAC-QI by a designated representative.

e. R-QICs membership shall include, at a minimum:

1) Trauma Medical Director or designated trauma surgeon from each designated Trauma Center in the region

2) Trauma Program Manager from each designated Trauma Center in the region

3) Trauma System Program Manager, EMS Agency

f. R-QIC shall consist of the following regions:

1) Region I – North/East

i. Antelope Valley Hospital

ii. Children's Hospital Los Angeles
iii. Huntington Hospital
iv. Pomona Valley Hospital Medical Center
v. LAC+USC Medical Center

2) Region II – North/West

i. Cedars Sinai Medical Center
ii. Henry Mayo Newhall Hospital
iii. Dignity Health - Northridge Hospital Medical Center
iv. Providence Holy Cross Medical Center
v. Ronald Reagan UCLA Medical Center

3) Region III – South

i. Dignity Health - California Hospital Medical Center
ii. Harbor-UCLA Medical Center
iii. MemorialCare Long Beach Medical Center
iv. St. Francis Medical Center
v. Dignity Health - St. Mary Medical Center

g. EMS Agency responsibilities:

1) Develop policies addressing QI and system evaluation.

2) Annual and periodic performance evaluation of the trauma system.

3) Provide system-wide data reports and analysis of trauma issues to committees as requested.

h. Trauma Center Responsibilities:

1) Implement and maintain a QI program approved by the EMS agency that reflects the organization's current QI process.

2) Recommend measurable and well-defined standards of care for trauma patients to the THAC-QI. Monitor compliance with or adherence to these standards.

3) Conduct multidisciplinary trauma peer review meetings.

4) Participate in the trauma system-wide data registry.

5) Participate in R-QIC and monitor selected QI filters on a quarterly basis.

i. R-QIC Procedures:

1) The R-QICs shall meet quarterly with additional meetings called as determined by the committee members.

2) Meeting locations shall be determined by the members.

3) Meeting notification to all members shall be the responsibility of the host Trauma Center.

4) Each Trauma Center shall bring to the meeting a written report (using the THAC-QI approved audit filter form), provide a verbal report on the system-wide indicators approved by THAC, and any internal QA/QI activities.

5) An official attendance roster form which refers to the Evidence Code 1157.7 section regarding confidentiality, meeting minutes, tallies of all actions taken on each indicator, a description of any regional issues to be brought to THAC-QI, audit filter forms for each meeting shall be maintained by the EMS Agency.

6) Elect physicians and nurses from both a Level I and II Trauma Center to represent the region at the THAC-QI. The term of office will be for a minimum of one year.

4. Trauma System Data Committee

This committee shall advise, provide guidance, direction, and support for all aspects of the trauma data collection process including the selection of data elements, abstraction, coding, and data entry that comprise the Los Angeles County Trauma Registry.

a. Trauma System Data Committee shall be responsible for:

1) Reviewing, revising, and standardizing the trauma data elements utilized by the Los Angeles County Trauma Registry to include but not limited to the Trauma Data Dictionary.

2) Reviewing, revising, and standardizing system reports to include those utilized in the trauma data validation process (Clean-up Reports).

3) Ensuring that the Los Angeles County Trauma Registry is a valuable resource for education and research.

4) Reviewing issues affecting the internal quality improvement activities of each member Trauma Center.

5) Identifying regional issues for trending and/or improvement.

6) Reporting summary of regional meetings to THAC-QI by a designated representative.

b. Trauma System Data Committee membership shall include the following:

1) Trauma Program Manager, each Trauma Center

2) Trauma Registrar, each Trauma Center

3) Trauma System Program Manager, EMS Agency

4) Trauma Data Manager, EMS Agency

5) Trauma and Emergency Medicine Information System (TEMIS) Vendor Representative(s)

5. Special Committees

a. A special committee may be appointed at the discretion of the THAC Chair only if the following conditions are met:

1) The task will be short term; and

2) The assignment falls outside the scope of the standing committees.

b. The special committee chair will be appointed by the THAC Chair with the approval of the THAC.

c. The THAC Chair will determine the composition of the Special Committee in consultation with the Special Committee Chair.

d. Special committees will be responsible for their own activities including location and frequency of meetings, designation of an alternate chair, and formation and composition of the subcommittees, if desired.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DOWNGRADE OR CLOSURE OF 9-1-1 RECEIVING HOSPITAL OR EMERGENCY MEDICAL SERVICES** REFERENCE NO. 222

PURPOSE: To establish a procedure to be followed if a general acute care facility plans to downgrade or eliminate emergency medical services or close the hospital completely.

AUTHORITY: California Code of Regulations 70105(a), 70351(a), 70351(b)(1), 70351(b)(5), 70367(a)
Health and Safety Code, Sections 1255.1, 1255.2, 1255.25, 1300

PRINCIPLES:

1. Hospitals with a basic or comprehensive emergency department permit provide a unique service and an important link to the community in which they are located. In certain instances, the reduction or withdrawal of these services may have a profound impact on the emergency medical services (EMS) available in their area and to the community at large.

2. Every effort should be made to ensure that essential emergency medical services are continued until emergency care can be provided by other facilities or until EMS providers can adjust resources to accommodate anticipated needs.

3. Before any changes are finalized, the EMS Agency should have sufficient time and opportunity to develop an EMS Impact Evaluation Report (IER) that examines the closure's effect on the community.

4. Before approving a downgrade or closure of emergency services, the California State Department of Public Health (Department) shall receive a copy of the IER to determine the expected impact of the changes, including access to emergency care and the effect of the closure on emergency services provided by other entities.

PROCEDURE:

I. Responsibilities of the Health Facility Proposing the Downgrade or Closure

   A. As soon as possible but not later than 180 days prior to a planned reduction of EMS services or closing of a health facility, the facility shall provide a written notice of the proposed downgrade or elimination of emergency services to the following entities:

      1. The Emergency Medical Services Agency

      2. The local government entity in charge of the provision of health services and the Board of Supervisors of the county in which the health facility is located



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

3. The city council of the city in which the health facility is located

4. The California State Department of Public Health, Licensing and Certification Division

5. All health care service plans

6. Other entities under contract with the hospital that provide services to enrollees

B. Not less than 180 days prior to closing a health facility or reducing EMS services, the facility shall provide public notice, including a notice posted at the entrance to all affected facilities:

The required notice shall include:

1. A description of the proposed reduction or elimination.

2. The description shall be limited to publicly available data, including the number of beds eliminated, if any, the probable decrease in the number of personnel, and a summary of any service that is being eliminated, if applicable.

3. A description of the three nearest available comparable services in the community. If the health facility closing these services serves Medi-Cal or Medicare patients, the health facility shall specify if the providers of the nearest available comparable services serve these patients.

4. A telephone number and address for each of the following where interested parties may offer comments:

   a. The health facility.

   b. The parent entity, if any, or contracted company, if any, that acts as the corporate administrator of the health facility.

   c. The chief executive officer.

5. The notice shall be provided in a manner that is likely to reach a significant number of community residents serviced by the facility to include:

   a. A continuous notice posted in a conspicuous location on the home page of the health facility's internet website.

   b. A notice published in a conspicuous location within a newspaper of general circulation serving the geographical area in which the facility is located. The notice shall continue for a minimum of 15 publications dates.

c. A continuous notice posted in a conspicuous location within the internet website of a newspaper of general circulation serving the local geographical area in which the facility is located.

d. A notice posted at the entrance of every community clinic within Los Angeles County that grants voluntary permission for posting.

6. It shall be provided within the 180-day time frame specified in Section I.

7. The facility should make reasonable efforts at public notice including, but not limited to:

a. Advertising the change in terms easily understood by a layperson.

b. Soliciting media coverage regarding the change.

c. Informing patients of the facility of the impending change.

d. Notifying contracting health care service plans.

8. This does not apply to county facilities subject to Health & Safety Code Section 1442.5.

C. Notify planning or zoning authorities of the proposed downgrade or closure so that street signage can be removed.

D. A hospital is not subject to the above if the Department:

1. Determines that the use of resources to keep the emergency department (ED) open substantially threatens the stability of the hospital as a whole.

2. Cites the ED for unsafe staffing practices.

II. Responsibilities of the Local EMS Agency

A. Develop an IER in consultation with impacted hospitals and 9-1-1 providers. Include, at minimum, the following evaluation criteria:

1. The hospital's geographic proximity to other facilities within a five and ten mile radius.

2. The annual number of 9-1-1 basic life support (BLS) and advanced life support (ALS) transports.

3. The number of ED treatment stations and total emergency department volume.

4. The number of paramedic contacts per month if the hospital is a paramedic base hospital.

5. The number of trauma patients received per month if the hospital is a designated trauma center.

6. The number of ST-Elevation Myocardial Infarction (STEMI) patients received per month if the hospital is a designated STEMI receiving center.

7. The number of stroke patients received per month if the hospital is a designated stroke center.

8. A list of the services provided by the hospital and the surrounding facilities (Emergency Department Approved for Pediatrics (EDAP), ST-Elevation Myocardial Infarction (STEMI) Receiving Center, Pediatric Medical Center (PMC), Disaster Resource Center (DRC), Approved Stroke Center, Sexual Assault Response Team (SART) Center, burn, perinatal).

9. The average emergency department diversion of surrounding facilities.

B. Conduct at least one public hearing if the service being downgraded or closed is the facility's emergency department. The public hearing shall be conducted by the Emergency Medical Services Commission (EMSC).

1. The EMSC may hold the public hearing at their normally scheduled meeting or convene a special meeting at the request of the Director of the EMS Agency.

2. The hearing shall be held within 30 days following notification of the intent to downgrade or close services.

C. Reconfigure the EMS system as needed. If the EMS Agency determines that the downgrade or closure of a hospital ED will significantly impact the EMS system, the Agency shall:

1. Determine the reason(s) a hospital has applied to do so; and

2. Determine whether any system changes may be implemented to maintain the hospital services within the system; or

3. Develop strategies to accommodate the loss of the ED or other identified specialized service to the system.

D. Forward the IER to the Board of Supervisors for adoption.

E. Forward the IER to the Department within three days of its adoption by the Board of Supervisors and within 60 calendar days after the initial notification from hospital of the proposed downgrade or closure.

III. Following receipt of the IER, Department shall notify the hospital, in writing, of its decision regarding the application to downgrade or close emergency services or the facility.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 206, **Emergency Medical Services Commission Ordinance No. 12332 - Chapter 3.20 of the Los Angeles County Code**

# Assembly Bill No. 2037

## CHAPTER 95

An act to amend Sections 1255.1 and 1255.25 of the Health and Safety Code, relating to health facilities.

[Approved by Governor September 18, 2020. Filed with Secretary of State September 18, 2020.]

### LEGISLATIVE COUNSEL'S DIGEST

AB 2037, Wicks. Health facilities: notices.

(1) Existing law requires the State Department of Public Health to license, regulate, and inspect health facilities, as specified. Existing law requires a hospital that provides emergency medical services to, as soon as possible, but not later than 90 days prior to a planned reduction or elimination of the level of emergency medical services, provide notice of the intended change to the department, other specified entities, and the public. Existing law also requires a health facility to provide public notice, as specified, not less than 30 days prior to closing the health facility, eliminating a supplemental service, as defined, or relocating the provision of supplemental services to a different campus.

This bill would require a hospital that provides emergency medical services to provide notice, as specified, at least 180 days before a planned reduction or elimination of the level of emergency medical services. The bill would require a health facility to provide at least 120 days' notice, as specified, prior to closing the health facility and at least 90 days prior to eliminating or relocating a supplemental service, except as specified. The bill would require the mandatory public notice to include specific notifications, including, among others, a continuous notice posted in a conspicuous location within the internet website of a newspaper of general circulation serving the local geographical area in which the hospital or health facility is located.

(2) Under existing law, violation of the provisions relating to health facility licensure is a misdemeanor.

By expanding the scope of a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

*The people of the State of California do enact as follows:*

SECTION 1. Section 1255.1 of the Health and Safety Code is amended to read:

1255.1. (a) Any hospital that provides emergency medical services under Section 1255 shall, as soon as possible, but not later than 180 days prior to a planned reduction or elimination of the level of emergency medical services, provide notice of the intended change to the department, the local government entity in charge of the provision of health services, and all health care service plans or other entities under contract with the hospital to provide services to enrollees of the plan or other entity.

(b) In addition to the notice required by subdivision (a), the hospital shall provide, at the same time as the notice specified in subdivision (a), public notice of the intended change in a manner that is likely to reach a significant number of residents of the community serviced by that facility.

(c) A hospital shall not be subject to this section or Section 1255.2 if the department does either of the following:

(1) Determines that the use of resources to keep the emergency center open substantially threatens the stability of the hospital as a whole.

(2) Cites the emergency center for unsafe staffing practices.

(d) For purposes of this section, the public notice required in subdivision (b) shall include, but not be limited to, all of the following:

(1) Written notice to the city council of the city in which the hospital is located.

(2) A continuous notice posted in a conspicuous location on the home page of the hospital's internet website.

(3) A notice published in a conspicuous location within a newspaper of general circulation serving the local geographical area in which the hospital is located. The notice shall continue for a minimum of 15 publication dates.

(4) A continuous notice posted in a conspicuous location within the internet website of a newspaper of general circulation serving the local geographical area in which the hospital is located.

(5) A notice posted at the entrance of every community clinic within the affected county in which the hospital is located that grants voluntary permission for posting.

SEC. 2. Section 1255.25 of the Health and Safety Code is amended to read:

1255.25. (a) (1) Not less than 120 days prior to closing a health facility, as defined in subdivision (a) or (b) of Section 1250, or 90 days prior to eliminating a supplemental service, as defined in Section 70067 of Chapter 1 of Division 5 of Title 22 of the California Code of Regulations, the facility shall provide public notice of the proposed closure or elimination of the supplemental service, including a notice posted at the entrance to all affected facilities and a notice to the department and the board of supervisors of the county in which the health facility is located.

(2) Not less than 90 days prior to relocating the provision of supplemental services to a different campus, a health facility, as defined in subdivision

(a) or (b) of Section 1250, shall provide public notice of the proposed relocation of supplemental services, including a notice posted at the entrance to all affected facilities and notice to the department and the board of supervisors of the county in which the health facility is located.

(b) The public notice required by paragraph (1) or (2) of subdivision (a) shall include all of the following:

(1) A description of the proposed closure, elimination, or relocation. The description shall be limited to publicly available data, including the number of beds eliminated, if any, the probable decrease in the number of personnel, and a summary of any service that is being eliminated, if applicable.

(2) A description of the three nearest available comparable services in the community. If the health facility closing these services serves Medi-Cal or Medicare patients, this health facility shall specify if the providers of the nearest available comparable services serve these patients.

(3) A telephone number and address for each of the following, where interested parties may offer comments:

(A) The health facility.

(B) The parent entity, if any, or contracted company, if any, that acts as the corporate administrator of the health facility.

(C) The chief executive officer.

(c) Notwithstanding subdivisions (a) and (b), this section shall not apply to county facilities subject to Section 1442.5.

(d) For purposes of this section, the public notice required in subdivision (a) shall include, but not be limited to, all of the following:

(1) Written notice to the city council of the city in which the health facility is located.

(2) A continuous notice posted in a conspicuous location on the homepage of the health facility's internet website.

(3) A notice published in a conspicuous location within a newspaper of general circulation serving the local geographical area in which the health facility is located. The notice shall continue for a minimum of 15 publication dates.

(4) A continuous notice posted in a conspicuous location within the internet website of a newspaper of general circulation serving the local geographical area in which the health facility is located.

(5) A notice posted at the entrance of every community clinic within the affected county in which the health facility is located that grants voluntary permission for posting.

(e) This section shall not apply to a health facility that is forced to close or eliminate a service as a result of a natural disaster or state of emergency that prevents the health facility from being able to operate at its current level.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of

Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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TOMÁS J. ARAGÓN, M.D., Dr.P.H.
*State Public Health Officer & Director*

State of California—Health and Human Services Agency

# California Department of Public Health

GAVIN NEWSOM
*Governor*

January 13, 2021

AFL 21-04

**TO:** General Acute Care Hospitals
Acute Psychiatric Hospitals

**SUBJECT:** AB 2037 - Updated Notice Timelines for Hospital Closure, Reduction or Elimination of Emergency Medical Service, and Relocation or Elimination of Supplemental Services

**AUTHORITY:** Health and Safety Code sections 1255.1 and 1255.25

**All Facilities Letter (AFL) Summary**

- This AFL notifies all general acute care hospitals and acute psychiatric hospitals (hospitals) of the requirements of Assembly Bill (AB) 2037 (Chapter 95, Statutes of 2020), which increases existing timeframes for hospitals to provide advance notice of impending hospital closure, closure or reduction of emergency medical services, or relocation or elimination of supplemental services.
- AB 2037 also specifies required public notice methods.

Effective January 1, 2021, AB 2037 (Chapter 95, Statutes of 2020) increases the timelines for the notices a hospital must provide to the California Department of Public Health (CDPH), the local government entity in charge of the provision of health services, all health care service plans or other entities under contract with the hospital to provide services to enrollees of the plan or other entity, and the public of planned reductions or eliminations of emergency medical services, hospital closures, or the relocation or elimination of supplemental services.

Hospitals must provide notice at least 180 days prior to a planned reduction or elimination of emergency medical services. A hospital is not subject to this requirement if CDPH determines that the use of resources to keep the emergency center open substantially threatens the stability of the hospital as a whole or cites the emergency center for unsafe staffing practices.

Hospitals must also provide notice at least 120 days prior to hospital closure and at least 90 days prior to relocation or elimination of a supplemental service of the hospital. The hospital must also post notice of the closure, elimination, or relocation at the entrance of all affected facilities. These reporting conditions do not apply to a facility forced to close or eliminate service as a result of a natural disaster or state of emergency that prevents the facility from operating at its full pre-emergency capacity.

All public notices must include all of the following information:

- A description of the proposed change, limited to publicly available data including the number of beds eliminated (if applicable), the probable decrease in the number of personnel, and a summary of any service that is being eliminated (if applicable)

- A description of the three nearest available comparable services in the community, with information regarding the providers' Medicare or Medi-Cal services if the hospital serves these patients
- A telephone number and address for the facility, the parent entity or contracted company that acts as the corporate administrator of the facility (if applicable), and the chief executive officer

Hospitals must provide the public notice of hospital closure, closure or reduction or emergency medical services, or relocation or elimination of supplemental services as indicated below:

- Written notice to the city council of the city in which the hospital is located
- A continuous notice posted in a conspicuous location on the home page of the hospital's internet website
- A notice published in a conspicuous location within a newspaper of general circulation serving the local geographical area in which the hospital is located, with the notice continuing for a minimum of 15 publication dates
- A continuous notice posted in a conspicuous location within the internet website of a newspaper of general circulation serving the local geographical area in which the hospital is located
- A notice posted at the entrance of every community clinic within the affected county in which the hospital is located that grants voluntary permission for posting

The information in this AFL is a brief summary of the provisions of AB 2037. Facilities are responsible for following all applicable laws. CDPH's failure to expressly notify facilities of statutory or regulatory requirements does not relieve facilities of their responsibility for following all laws and regulations. Facilities should refer to the full text of all applicable sections of the Health and Safety Code.

If you have any questions or concerns regarding this AFL, please contact your local district office.

Sincerely,

**Original signed by Heidi W. Steinecker**

Heidi W. Steinecker
Deputy Director

Center for Health Care Quality, MS 0512 . P.O. Box 997377 . Sacramento, CA 95899-7377
(916) 324-6630 . (916) 324-4820 FAX
Department Website (cdph.ca.gov)

Page Last Updated : January 13, 2021

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **SEXUAL ASSAULT PATIENT DESTINATION** REFERENCE NO. 508

PURPOSE: To provide guidelines for transporting patients who are alleged victims of sexual assault to the most accessible medical facility appropriate to their needs.

DEFINITIONS:

**Sexual Assault Patient:** A person who states they were sexually assaulted or a person suspected by the 9-1-1 personnel to have been the victim of a sexual assault.

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

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

PRINCIPLE:

1. When considering which facility is most appropriate to the needs of the sexual assault patient, the importance of evidence collection for legal proceedings should be one of the factors considered. However, in all cases, the health and well-being of the patient is the overriding consideration in determining hospital destination.

2. 9-1-1 Receiving Hospitals should have an internal policy for contacting and reporting to the law enforcement agency where the sexual assault occurred, any patient who is a victim of sexual assault for evidence collection. The law enforcement agency will determine the appropriate SART Center that will conduct the forensic examination.

POLICY:

I. Sexual assault patients who deny physical injuries and who do not meet base hospital contact and transport criteria may be released at the scene to the local law enforcement agency for appropriate follow-up. Law enforcement personnel are highly encouraged to transport these patients to a designated SART Center. EMS personnel shall document on the EMS Report Form to whom the patient was released.



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

II. Every effort should be made to transport sexual assault patients who meet base hospital contact and transport criteria to a specialty care center that has an affiliated designated SART Center. If EMS personnel determine that such a transport would unreasonably remove the transport unit from its primary response area, the patient should be transported to the most accessible receiving (MAR) facility.

III. EMS personnel shall notify the local law enforcement agency of sexual assault patients regardless of whether the patient complains of physical injuries. EMS personnel shall document on the EMS Report Form to whom the incident was reported.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 501, **Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 508.1 **SART Center Roster**

Ref. No. 1200.2, **Base Contact Requirements**

**Reference No. 508, Sexual Assault Patient Destination**

| | Committee/Group | Date Assigned | Approval Date | Comments* (Y if yes) |
|---|---|---|---|---|
| EMS ADVISORY COMMITTEES | Provider Agency Advisory Committee | 12/16/2020 | 12/16/2020 | N |
| | Base Hospital Advisory Committee | 12/09/2020 | 02/10/2021 | Y |
| | Data Advisory Committee | | | |
| | Education Advisory Committee | | | |
| OTHER COMMITTEES/RESOURCES | Medical Council | | | |
| | Trauma Hospital Advisory Committee | | | |
| | Ambulance Advisory Board | | | |
| | EMS QI Committee | | | |
| | Hospital Association of So California | | | |
| | County Counsel | | | |
| | Other: | | | |
| | | | | |

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

**POLICY REVIEW - SUMMARY OF COMMENTS** REFERENCE NO. 202.2
(ATTACHMENT B)

**REFERENCE NO.** 508, Sexual Assault Patient Destination

| SECTION | COMMITTEE/DATE | COMMENT | RESPONSE |
|---|---|---|---|
| Principle | BHAC 12/09/2020 | Add statement for hospital to ensure law enforcement is contacted to assist in coordination of forensic examination | Added |
| Principle 2 | BHAC 02/10/2021 | Change the wording from "…the local law enforcement agency…" to "…the law enforcement agency where the sexual assault occurred…" | Changed |
| | | | |
| | | | |
| | | | |

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **DOCUMENTATION OF PREHOSPITAL CARE** REFERENCE NO. 606

PURPOSE: To identify the base hospital and Emergency Medical Services (EMS) provider procedures for documentation of prehospital care.

AUTHORITY: California Code of Regulations, Title 22, Sections 100128, 100129, 100170, 100171

DEFINITIONS

**Patient:** A person who seeks or appears to require medical assessment and/or medical treatment.

**Patient Contact:** An EMS response that results in an actual patient or patients.

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

**Public Assist:** EMS is dispatched to a scene for assistance for nonmedical issues.

**Multiple Casualty Incident (MCI):** The combination of numbers of ill/injured patients and the type of injuries going beyond the capability of an entity's normal first response.

PRINCIPLES:

1. The EMS Record and the Base Hospital Form are:

    a. Patient care records
    b. Legal documents
    c. Quality improvement instruments
    d. Billing resources (EMS Record only)
    e. Records of canceled calls, no patient found, public assist involving a person, and person contact/no patient (EMS Record only)

2. Any assessment or treatment provided to, and medical history obtained from, the patient shall be accurately and thoroughly documented on the EMS Record.

3. Any person who alters or modifies the medical record of any person, with fraudulent intent, or who, with fraudulent intent, creates any false medical record, is guilty of a misdemeanor (section 471.5 of the California Penal Code).

4. An EMS Record must be completed for every EMS response if a provider agency is unable to submit a quarterly volume report to the EMS Agency for the following types of calls:

    a. Canceled calls
    b. No patient(s) found
    c. Public assist involving a person
    d. Person contact/no patient



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

POLICY:

I. EMS Record Completion – Paramedic/EMT Personnel

A. EMS providers shall document prehospital care according to procedures identified in the EMS Documentation Manual.

B. Paper-Based EMS Report Form Completion

1. Paramedic/EMT personnel from the first responding agency shall complete one Los Angeles County EMS Agency approved EMS Report Form (one for each patient) for every 9-1-1 patient contact which includes the following:

a. Regular runs
b. DOA (dead on arrival; patients determined or pronounced dead per Ref. No. 814, Determination/Pronouncement of Death in the Field)
c. ALS interfacility transfer patients

C. Electronic EMS Patient Care Record (ePCR) Completion

1. Paramedic/EMT personnel may document and submit prehospital care data electronically in lieu of the standard EMS Report Form if their department has received prior authorization from the EMS Agency.

2. Paramedic/EMT personnel shall complete one EMS Agency approved ePCR (one for each patient) for every 9-1-1 patient contact which includes the following:

a. Regular runs
b. DOA (dead on arrival; patients determined or pronounced dead per Ref. No. 814, Determination/Pronouncement of Death in the Field)
c. ALS interfacility transfer patients

D. Multiple Providers

1. In the event of an automatic or mutual aid incident when two first responding providers have each completed an EMS Record, or patient care is transferred from one ALS provider agency to another, each provider agency shall document the Original Sequence Number from the other provider's patient care record in the space designated for Second Sequence Number. DO NOT cross out or line through the imprinted Sequence Number if utilizing a paper EMS Report Form.

2. The provider agency transferring patient care must have a mechanism in place to provide immediate transfer of patient information to the transporting agency.

E. Multiple Casualty Incidents (MCI)

1. One standard EMS Record must be initiated for each patient transported in an MCI. Provider agencies may use alternate means of documenting MCIs if the EMS Agency is notified prior to implementation and agrees with the proposed process.

2. Documentation should include the following, at minimum:

    a. Name
    b. Provider Impression
    c. Chief Complaint
    d. Mechanism of Injury, if applicable
    e. Age and units of age
    f. Gender
    g. Brief patient assessment
    h. Brief description of treatment provided
    i. Transporting provider (provider code and unit number) and level of service (ALS, BLS or Helicopter)
    j. Destination
    k. Receiving facility

3. Non-transported patients should be documented on a standard EMS Record or a patient log.

4. Each provider agency should submit copies of all records and logs pertaining to an MCI of greater than 5 victims to the EMS Agency within 10 business days of the incident. MCI documents should be hand carried or delivered to the EMS Agency in an envelope clearly marked with the incident date and location.

F. Completion of the EMS Record Prior to Distribution

1. EMTs and paramedics responsible for documenting prehospital care shall ensure that EMS Records are completed in their entirety prior to dissemination to the receiving facility. In most instances, this means that the record is completed at the scene or upon arrival at the receiving facility.

2. An exception to this is when a first responding agency utilizing paper-based EMS Report Forms is giving the receiving hospital (red) copy to a transporting agency. In the interest of expediting the transfer of care, it is recognized that information such as the unit times may not be documented on the receiving hospital (red) copy of the EMS Report Form.

G. Field Transfer of Care

1. When patient care has been transferred from the first responding ALS or BLS provider agency to a BLS provider agency for transport to a receiving facility, the provider agency receiving the patient should **NOT** generate an ePCR with a new Sequence Number (this will result in the same patient being entered into TEMIS with two different sequence numbers).

2. The provider agency that receives the BLS patient for transport to a receiving facility shall complete their agency's ePCR and document the Sequence Number generated by the first responding ALS or BLS provider agency's ePCR on their ePCR or paper-based EMS Report Form.

3. If utilizing a paper-based EMS Report Form, the receiving hospital (red) copy of the EMS Report Form, as well as the PCR from the BLS transport

provider (red copy), must accompany the patient to the receiving facility where it becomes part of the patient's medical record.

4. It is the responsibility of the EMS Provider to ensure that a completed copy of the EMS Record is provided to the receiving facility upon transfer of care.

H. Completion of Advanced Life Support Continuation Form

1. If utilizing a paper-based EMS Report Form, required for each patient on whom advanced airway management is necessary .

2. Paramedics completing this form must ensure that the demographic information (patient name, date, provider code/unit, incident #) and Sequence Number are legibly and accurately transcribed from the EMS Report Form.

II. Base Hospital Form - MICN and/or Physicians

A. Base hospital personnel (MICNs and physicians) shall document prehospital care according to procedures identified in the Base Hospital Documentation Manual.

B. Base Hospital Form Completion

1. MICNs and/or physicians shall complete one EMS Agency approved Base Hospital Form (one for each patient in which medical direction is given) for every base hospital paramedic radio/telephone contact.

2. MICNs and/or physicians may document base hospital data electronically in lieu of the standard Base Hospital Form if the base hospital has received prior authorization from the EMS Agency.

C. Base Hospital Directed Multiple Casualty Incidents (MCI)

1. EMS Agency-approved MCI Base Hospital Forms may be utilized for incidents involving three or more patients.

2. Physicians and MICNs should limit requested information to **only** that which is essential to determine destination or medical management. Additional information and Sequence Numbers should be obtained after the MCI has cleared.

3. The following should be documented for MCIs involving three or more patients, when base contact is made for online medical control:

a. Date
b. Time
c. Sequence number/Triage tag number
d. Provider and unit
e. Chief complaint
f. Mechanism of injury, if applicable
g. Age and units of age
h. Gender
i. Brief patient assessment, when possible

j. Brief description of treatment provided, when possible
k. Transporting provider, method of transport (ALS, BLS or Helicopter)
l. Destination
m. Receiving Facility

4. Upon request of the EMS Agency the base hospital should submit all records pertaining to an MCI of greater than 5 victims to the EMS Agency within 10 business days.

5. Provider agencies may use alternate means of reporting MCIs. Base Hospitals will be notified by the EMS Agency when alternate reporting methods will be implemented by various provider agencies.

6. MCIs involving **ONLY** BLS patients: BLS patients who are transported to a receiving facility should be documented on one Base Hospital Form in the Comments Section (provided no medical direction is given).

7. MCIs involving ALS **and** BLS Patients:

   a. One standard Base Hospital Form or one EMS Agency-approved MCI Base Hospital Form must be completed for each ALS patient.

   b. BLS patients on whom no medical direction has been given do not require a Base Hospital Form. The number and disposition of the BLS patients may be documented on the Base Hospital Form of an ALS patient in the Comments Section.

8. Alternate methods of documenting MCIs may be initiated by base hospitals with the approval of the EMS Agency.

III. Modification of Patient Care Records

A. Modifying the Patient Care Record (additions, deletions or changes) after the Patient Care Record has been completed or disseminated:

1. For paper-based EMS Report Forms, make corrections by drawing a single line through the incorrect item or narrative (the writing underneath the single line must remain readable).

   Make the changes on the original, noting the date and time the changes were made, with the signature of the individual making the changes adjacent to the correction. Ideally, changes should be made by the individual who initially completed the form. Under no circumstances should changes to either patient assessment or patient treatment documentation be made by an individual who did not participate in the response.

2. An audit trail of changes made to an electronic record will be included on the ePCR.

B. Making substantive changes (documentation of additional medications, defibrillation attempts, pertinent comments, complaints, etc.) to the EMS Record:
1. Photocopy the paper-based EMS Report Form with the changes and send the copy, along with a cover letter, to all entities that received the original

form (EMS Agency, receiving facility). The cover letter should explain the modifications and request that the modified copy be attached to the original copy.

2. Do not re-write the incident on a new paper-based EMS Report Form because this would result in a mismatch in Sequence Number. If the form requiring corrections has been mutilated or soiled and cannot be photocopied, then a new form may be used to re-write the incident provided the Sequence Number of the new form has been replaced with the Sequence Number from the original form.

3. For electronic documentation systems, patient care related corrections are to be made as per provider agency policy. The provider agency shall notify its receiving hospital(s) of the mechanism by which ePCRs are updated and when an ePCR is updated. If the receiving hospital receives a printed copy of the record, a printed copy of the revised record will be provided directly to them.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 607, **Electronic Submission of Prehospital Data**
Ref. No. 608, **Retention and Disposition of Prehospital Patient Care Records**
Ref. No. 640, **EMS Documentation Manual**
Ref. No. 644, **Base Hospital Documentation Manual**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT/ PARAMEDIC/MICN)

SUBJECT: **DETERMINATION / PRONOUNCEMENT OF DEATH IN THE FIELD**

REFERENCE NO. 814

PURPOSE: This policy is intended to provide EMS personnel with parameters to determine whether or not to withhold resuscitative efforts in accordance with the patient's wishes, and to provide guidelines for base hospital physicians to discontinue resuscitative efforts and pronounce death.

AUTHORITY: California Health and Safety Code, Division 2.5
California Probate Code, Division 4.7
California Family Code, Section 297-297.5
California Health and Safety Code, Division 1, Part 1.8, Section 443 et seq.

DEFINITIONS:

**Advance Health Care Directive (AHCD):** A written document that allows patients who are unable to speak for themselves to provide health care instructions and/or appoint a Power-of-Attorney for Health Care. There is no one standard format for an AHCD. Examples of AHCDs include:

- Durable power of attorney for Healthcare (DPAHC)
- Healthcare proxies
- Living wills (valid in California if dated prior to 7-1-2000; advisory but not legally binding after that date)

**Agent:** An individual, eighteen years of age or older, designated in a durable power of attorney for health care to make health care decisions for the patient, also known as "attorney-in-fact".

**Aid-in-Dying Drug:** A drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to terminal illness. The prescribed drug may take effect within minutes to several days after self-administration.

**Conservator:** Court-appointed authority to make health care decisions for a patient.

**Determination of Death**: To conclude that a patient has died by conducting an assessment to confirm the absence of respiratory, cardiac, and neurologic function.

**End of Life Option Act:** This California state law authorizes an adult, eighteen years or older, who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease to make a request for an "aid-in-dying drug" prescribed for the purpose of ending his or her life in a humane and dignified manner.

**Immediate Family:** The spouse, domestic partner, parent, adult children, adult sibling(s), or family member intimately involved in the care of the patient.



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

**Organized ECG Activity**: A narrow complex supraventricular rhythm.

**Pronouncement of Death:** A formal declaration by a base hospital physician that life has ceased.

**Standardized Patient-Designated Directives**: Forms or medallions that recognize and accommodate a patient's wish to limit prehospital treatment at home, in long term care facilities, or during transport between facilities. Examples include:

- Statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form (Ref. No. 815.1)
- Physician Orders for Life-Sustaining Treatment (POLST, Ref. No. 815.2)
- State EMS Authority-approved DNR Medallion

PRINCIPLES:

1. Resuscitative efforts are of no benefit to patients whose physical condition precludes any possibility of successful resuscitation.

2. EMTs and paramedics may **determine** death based on specific criteria set forth in this policy.

3. Base hospital physicians may **pronounce** death based on information provided by the paramedics in the field and guidelines set forth in this policy.

4. If there is any objection or disagreement by family members or EMS personnel regarding terminating or withholding resuscitation, basic life support (BLS) resuscitation, including defibrillation, may continue or begin immediately and paramedics should contact the base hospital for further directions.

5. Aggressive resuscitation in the field to obtain the return of spontaneous circulation (ROSC) is encouraged. Transporting patients without ROSC is discouraged.

6. EMS personnel should honor valid do-not-resuscitate (DNR) orders and other patient designated end-of-life directives in the field and act in accordance with the patient's wishes when death appears imminent.

POLICY:

I. EMS personnel may determine death in the following circumstances:

   A. In addition to the absence of respiration, cardiac activity, and neurologic reflexes, one or more of the following physical or circumstantial conditions exist:

      1. Decapitation

      2. Massive crush injury

      3. Penetrating or blunt injury with evisceration of the heart, lung or brain

4. Decomposition

5. Incineration

6. Pulseless, non-breathing victims with extrication time greater than fifteen minutes, where no resuscitative measures can be performed prior to extrication.

7. Penetrating trauma patients who, based on the paramedic's thorough assessment, are found apneic, pulseless, asystolic, and without pupillary reflexes upon the arrival of EMS personnel at the scene.

8. Blunt trauma patients who, based on a paramedic's thorough patient assessment, are found apneic, pulseless, and without organized ECG activity (narrow complex supraventricular rhythm) due to traumatic mechanism upon the arrival of EMS personnel at the scene.

9. Pulseless, non-breathing victims of a multiple victim incident where insufficient medical resources preclude initiating resuscitative measures.

10. Drowning victims, when it is reasonably determined that submersion has been greater than one hour.

11. Rigor mortis (requires assessment as described in Section I, B.)

12. Post-mortem lividity (requires assessment as described in Section I, B.)

B. If the initial assessment reveals rigor mortis and/or post-mortem lividity only, EMTs and/or paramedics shall perform the following assessments (may be performed concurrently) to confirm the absence of respiratory, cardiac, and neurologic function for determination of death in the field:

1. Assessment of respiratory status:

   a. Assure that the patient has an open airway.

   b. Look, listen and feel for respirations. Auscultate the lungs for a minimum of 30 seconds to confirm apnea.

2. Assessment of cardiac status:

   a. Auscultate the apical pulse for a minimum of 60 seconds to confirm the absence of heart sounds.

   b. Adults and children: Palpate the carotid pulse for a minimum of 60 seconds to confirm the absence of a pulse.

   c. Infants: Palpate the brachial pulse for a minimum of 60 seconds to confirm the absence of a pulse.

3. Assessment of neurological reflexes:

a. Check for pupillary response with a penlight or flashlight to determine if pupils are fixed and dilated.

b. Check and confirm unresponsive to pain stimuli.

C. Patients in atraumatic cardiopulmonary arrest who do not meet the conditions described in Section I. A. require immediate BLS measures to be initiated. If one or more of the following conditions is met, resuscitation may be discontinued and the patient is determined to be dead:

1. A valid standardized patient-designated directive indicating DNR.

2. A valid AHCD with written DNR instructions or the agent identified in the AHCD requesting no resuscitation.

3. Immediate family member present at scene:

a. With a patient-designated directive on scene requesting no resuscitation

b. Without said documents at scene, with full agreement of immediate family requesting no resuscitation, and EMS providers concur

4. Parent or legal guardian is required and must be present at scene to withhold or terminate resuscitation for patients less than 18 years of age.

II. Patients in atraumatic cardiopulmonary arrest who do not meet the conditions described in Section I require immediate cardiopulmonary resuscitation in accordance with Ref. No. 1210, Treatment Protocol: Cardiac Arrest. Base contact for medical direction shall be established when indicated by Ref. No. 1210.

A. EMS Personnel may determine death if a patient is in **asystole** after 20 minutes of quality cardiopulmonary resuscitation on scene and meets ALL of the following criteria:

1. Patient 18 years or greater

2. Arrest not witnessed by EMS personnel

3. No shockable rhythm identified at any time during the resuscitation

4. No ROSC at any time during the resuscitation

5. No hypothermia

B. Base Physician consultation for pronouncement is not required if Section A is met.

C. Base Physician contact shall be established to guide resuscitation and to make decisions regarding timing of transport, if transport is indicated, for all patients

in cardiopulmonary arrest who do not meet the conditions described in Section I or IIA of this policy.

D. In the event that immediate family members on scene request termination of resuscitation after resuscitation is in progress, and the patient does not meet criteria in section IIA, base physician consultation shall be made for termination and pronouncement. This does not apply to brief initiation of CPR while establishing patient/family wishes as per I.C.3.

III. Physician guidelines for transport versus termination

A. Resuscitation should be continued on-scene until one of the following:

1. ROSC is confirmed with a palpable pulse and corresponding rise in $EtCO_2$ Paramedics should stabilize the patient on scene after ROSC (for approximately 5 minutes) per TP 1210 and initiate transport once ROSC is maintained.

2. Base physician determines further resuscitative efforts are futile

B. Patients who have NOT maintained ROSC after on-scene resuscitation and stabilization should NOT be transported unless the Base physician determines transport is indicated.

1. Early transport for patients with ongoing resuscitation is NOT advised.

2. The decision to transport a patient with refractory OHCA should be based on the availability of therapies at the receiving center that are not available on scene.

IV. Crime Scene Responsibility, Including Presumed Accidental Deaths and Suspected Suicides

A. Responsibility for medical management rests with the most medically qualified person on scene.

B. Authority for crime scene management shall be vested in law enforcement. To access the patient, it may be necessary to ask law enforcement officers for assistance to create a “safe path” that minimizes scene contamination.

C. If law enforcement is not on scene, EMS personnel should attempt to create a "safe path" and secure the scene until law enforcement arrives.

V. Procedures Following Pronouncement of Death

A. The deceased should not be moved without the coroner’s authorization. Any invasive equipment (i.e., intravenous line, endotracheal tube) used on the patient should be left in place.

**NOTE: If it is necessary to move the deceased because the scene is**

**unsafe, the body is creating a hazard, or the body is at risk of loss through fire or flood, the EMS personnel may relocate the deceased to a safer location, or transport to the most accessible receiving facility.**

B. If law enforcement or the coroner confirms that the deceased will not be a coroner's case and the personal physician is going to sign the death certificate, any invasive equipment used during the resuscitation may be removed.

C. EMS personnel should remain on scene until law enforcement arrives. During this time, when appropriate, the provider should provide grief support to family members.

VI. Required Documentation for Patients Determined Dead/Pronounced in the Field

A. The time and criteria utilized to determine death; the condition, location and position of the body, and any care provided.

B. The location and the rationale if the deceased was moved. If the coroner authorized movement of the deceased, document the coroner's case number (if available) and the coroner's representative who authorized the movement.

C. Time of pronouncement and name of the pronouncing physician if base hospital contact was initiated

D. The name of the agent identified in the AHCD or patient-designated directive or the name of the immediate family member who made the decision to withhold or withdraw resuscitative measures. Obtain their signature on the EMS Report Form.

E. If the deceased is **not** a coroner's case and their personal physician is going to sign the death certificate:

1. Document the name of the coroner's representative who authorized release of the patient, and

2. The name of the patient's personal physician signing the death certificate, and

3. Any invasive equipment removed

VII. End of Life Option Act

A. Resuscitation shall be withheld on patients in cardiopulmonary arrest who have self-administered an aid-in-dying drug (see Ref. No. 815.4, End of Life Option Field Quick Reference Guide).

B. Document the presence of a Final Attestation and attach a copy if available.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 516, **Cardiac Arrest (Non-Traumatic) Patient Destination**
Ref. No. 518, **Decompression Emergencies/Patient Destination**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 815, **Honoring Prehospital Do Not Resuscitate Orders**
Ref. No. 815.1, **EMSA/CMA Prehospital Do Not Resuscitate (DNR) Form**
Ref. No. 815.2, **Physician Orders for Life-Sustaining Treatment (POLST) Form**
Ref. No. 815.3, **Sample - Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner**
Ref. No. 815.4, **End of Life Option Field Quick Reference Guide**
Ref. No. 819, **Organ Donor Identification**

**Reference No. 814, Determination / Pronouncement of Death in the Field**

| | Committee/Group | Date Assigned | Approval Date | Comments* (Y if yes) |
|---|---|---|---|---|
| EMS ADVISORY COMMITTEES | Provider Agency Advisory Committee | 2/17/2021 | 2/17/2021 | Y |
| | Base Hospital Advisory Committee | 2/10/2021 | 2/21/2021 | Y |
| | Data Advisory Committee | | | |
| | Education Advisory Committee | | | |
| OTHER COMMITTEES/RESOURCES | Medical Council | 3/2/2021 | 3/21/2021 | N |
| | Trauma Hospital Advisory Committee | | | |
| | Ambulance Advisory Board | | | |
| | EMS QI Committee | | | |
| | Pediatric Advisory Committee | 3/2/2021 | 3/21/2021 | N |
| | County Counsel | | | |
| | Other: | | | |
| | | | | |

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

**POLICY REVIEW - SUMMARY OF COMMENTS** REFERENCE NO. 202.2
(ATTACHMENT B)

**Reference No. 814, Determination / Pronouncement of Death in the Field**

| SECTION | COMMITTEE/DATE | COMMENT | RESPONSE |
|---|---|---|---|
| Policy III.A.1 | BHAC<br>2/10/2021<br><br>PAAC<br>2/10/2021 | Reinstate “15 minute” language for stabilization prior to transport | Adopted |
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DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT/PARAMEDIC/MICN)

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

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

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

DEFINITIONS:

**Adult:** A person at least eighteen years of age.

**Against Medical Advice (AMA):** A patient or a legal representative of a patient who has decision-making capacity and who refuses treatment and/or transport for **an emergency medical condition** as advised by EMS providers, physician on scene, and/or Base personnel.

**Assess, Treat, and Release:** A patient who does not desire transport to the emergency department for evaluation and after an assessment and/or treatment by EMS personnel, **does not** have an ongoing emergent medical condition, a high-risk presentation, or social risk factors and is released at scene to follow-up with the patient's regular healthcare provider or a doctor's office or clinic.

**Authorized Advanced Health Care Provider:** An EMS physician authorized to direct EMS care on the scene or via telemedicine as per Ref. 816 – Physician at the Scene, or an advanced practiced provider who is identified by the EMS Provider Agency Medical Director to provide medical direction via telemedicine as approved by the EMS Agency Medical Director.

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

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

The lack of decision-making capacity may be:

- Temporarily lost (e.g., due to unconsciousness, influence of mind altering substances, mental illness, or cognitive impairment)
- Permanently lost (e.g., due to irreversible coma, persistent vegetative state,



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

untreatable brain injury, or dementia)
- Never existed (i.e., due to profound neurodevelopmental disorder, those who are deemed by the Court as incompetent or a person under conservatorship)

**Emancipated Minor:** A person under the age of 18 years is an emancipated minor if any of the following conditions are met:
- Married or previously married
- On active military duty
- The person has received a declaration of emancipation pursuant to Section 7122 of the California Family Code, which includes all of the following: at least fourteen (14) years of age, living separate and apart from their parents and managing their own financial affairs (may be verified by DMV Identification Card)

**Emergency Medical Condition:** A condition or situation in which a medical illness is suspected in a patient and there is an immediate need for medical attention. Patients with any abnormal vital signs: heart rate and rhythm, respiratory rate, blood pressure (except for isolated asymptomatic hypertension), oxygen saturation, and temperature (Ref. 1380 – Medical Control Guideline Vital Signs); and/or those who meet any criteria for Base Contact (Ref. 1200.2 – Base Contact Requirements) are considered to have an emergency medical condition.

**High Risk Presentation:** Features by history or presentation that are likely to be high risk for complications, progression of disease, underlying serious illness or injury, or require Base Contact. High risk chief complaints include chest pain, abdominal pain, pregnancy, gastrointestinal bleeding, syncope, neurologic symptoms (e.g., dizziness/vertigo, weakness, visual changes), and altered mental status. High risk features include:

- Patients less than 12 months of age
- Patients older than 70 years of age
- Patients with complicating comorbidities (i.e., active underlying cardiac, respiratory, kidney, liver, oncologic (cancer) or neurologic disease, or who are immunocompromised (e.g., history of HIV, chemotherapy, transplantation))

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

**Lift Assist:** EMS is dispatched to a scene to assist with transfer of a patient to a bed or wheelchair.

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

**Minor:** A person less than eighteen years of age.

**Minor Not Requiring Parental Consent is a person who:**
- Is 12 years or older and in need of care for a reportable medical condition or substance abuse
- Is pregnant and requires care related to the pregnancy
- Is in immediate danger of suspected physical or sexual abuse

- Is an emancipated minor

**No Contact / No Patient:** EMS is dispatched to a scene and is either cancelled prior to arriving at scene or no patient is found.

**Patient:** A person who seeks or appears to require medical assessment and/or medical treatment (Ref. 606, Documentation of Prehospital Care)

**Person Contact / No Patient:** EMS is dispatched to a scene and a person is identified as a potential patient, is alert and appropriate for situation and declines assessment by EMS.

**Psychiatric Hold:** A patient who is held against their will for evaluation under the authority of Welfare and Institutions Code (e.g., Section 5150, 5585 [minors]) because the patient is a danger to themselves, a danger to others, and/or gravely disabled (i.e., unable to care for self). This is a written order by law enforcement officer, County mental health worker, or a health worker certified by the County to place an individual on a psychiatric hold.

**Public Assist:** EMS is dispatched to a scene for assistance for nonmedical issues involving a person.

**Social Risk Factors:** Persons experiencing homelessness, patients in congregate living, and those who are a resident of skilled nursing facilities.

**Treatment in Place:** A patient who, after an assessment and treatment by EMS personnel and medical clearance by an authorized advanced healthcare provider ( e.g., physician, nurse practioner, physician assistant) on scene (Ref. 816 Physician at the Scene) or via Telemedicine, does not require ambulance transport to an emergency department. Appropriate follow-up should be arranged by the authorized advanced healthcare provider on scene or via Telemedicine.

PRINCIPLES:

1. An adult or emancipated minor who has decision-making capacity has the right to determine the course of their medical care including the refusal of care. These patients must be advised of the risks and consequences resulting from refusal of medical care. A patient less than eighteen (18) years of age, with the exception of minors not requiring parental consent, mush have a parent or legal representative to refuse evaluation, treatment, and/or transport for an emergency medical condition.

2. A patient determined by EMS personnel or the base hospital to lack decision-making capacity may not refuse care AMA or be released at scene. Mental illness, drugs, alcohol, or physical/mental impairment may impair a patient’s decision-making capacity but are not sufficient to eliminate decision-making capacity.

3. In situations where patients who have attempted suicide or expressed suicidal intent, or where other factors lead EMS personnel to suspect suicidal intent, such patients should be regarded as lacking decision-making capacity. These patients may decline treatment but cannot decline transport.

4. A patient on a psychiatric hold may not be released at scene and cannot sign-out AMA. The patient can refuse any medical treatment as long as it is not an imminent threat to life or limb.

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

6. If the patient or legal representative requests that the patient be transported, EMS personnel should honor the request and transport the patient to the most appropriate receiving facility in accordance with applicable patient destination policies.

7. Patients for whom 9-1-1 is called but are not transported represent a potentially high risk group and provider agencies should/shall have quality review programs specific to this patient population.

POLICY:

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

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

   B. Base contact should be made prior to the patient leaving the scene for patients who would otherwise meet Base Contact criteria (Ref. 1200.2 – Base Contact Requirements) in order for Base personnel to have the opportunity to interview the patient and to evaluate the appropriateness of the AMA prior to patient leaving AMA.

   C. EMS personnel shall relay all the circumstances to the Base including assessment and care rendered, reasons for refusal, and the patient's plan for transportation and follow-up care.

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

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

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

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

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

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

immediate care and/or transport.

III. Patients Assessed, Treated, and Released

A. EMS personnel shall assess the patient for an ongoing emergency medical condition, high risk presentations, social risk factors, and assess that the patient or their legal representative has the capacity to decline transport.

B. Patients with an ongoing emergency medical condition, high risk presentation or social risk factors who do not desire transport to the emergency department shall be handled as refusing transport against medical advice (refer to Policy Section I).

C. Patients or the legal representatives of patients who contact EMS for minor complaints in order to have an assessment performed and determination made of the seriousness of the complaint and need for treatment, but later *decline transport* qualify to be assessed, treated, and released.

1. In such cases, the EMS personnel should perform an assessment including vital signs, and after the patient or patient's legal representative's states they do not wish transport, the patient may be assessed, treated, and released at the scene.

2. Patients should be instructed by EMS to follow-up with the patient's medical home or primary care physician. The advice given should be documented on the Patient Care Record. The following statement is recommended: "After our assessment, you feel that you do not wish to be transported and you do not require immediate care in the emergency department. You should seek care with your regular healthcare provider or a doctor's office or clinic within 24 hours. If you have worsening or persistent symptoms or change your mind and desire transport, recontact 9-1-1."

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

IV. Documentation

A. Public Assist and Person Contact/No Patient does not require completion of a Patient Care Record. Documentation should follow the EMS provider agency's operational policy.

B. A Patient Care Record must be completed for each patient or contact encounter (i.e., Lift Assist, AMA, Assess, Treat and Release, and Treatment in Place), including those refusing emergency medical evaluation, care and/or transportation against medical advice and those released at scene. EMS personnel shall ensure that documentation is in compliance with Ref. 606 – Documentation of Prehospital Care. Patient Care Record documentation should include:

1. AMA:
   Patient history and assessment, including findings of an emergency medical condition or requirement to make Base Contact.

   a. Assessment by EMS that the patient or legal representative is alert and has the decision-making capacity to refuse EMS assessment

   b. What the patient is refusing (i.e., medical care, transport) and reason for refusal

   c. Risk and consequences of refusing care and/or transport, benefits of transport, and alternatives as explained to the patient or legal representative

   d. Statement that the patient understands and verbalizes the risks and consequences of refusing care and/or transport

   e. Signature of patient or legal representative

   f. Patient's plan for follow-up care

   g. Contact with Base Hospital, as applicable

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

2. Assess, Treat and Release:

   a. Patient history and assessment, including absence of findings of an emergency medical condition

   b. Assessment by EMS that the patient or legal representative is alert and has the capacity to make collaborative decision making with EMS to accept on-scene treatment, understand the need to have capacity for appropriate follow-up, but decline transport

   c. Discussion with patient including risks of non-transport, benefits of transport, and alternatives

   d. Plan for follow-up care including when to recall 9-1-1, seek emergency department care or follow-up with their medical home

   e. If Base contact was made (when applicable)

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

3. Treatment in Place:

   a. Document as per Assess, Treat, and Release and also include the name of the authorized advanced health care provider

V. Quality Improvement

A. Each Provider Agency shall have a quality improvement program for patients who are not transported to the ED. The quality improvement program should include but may not be limited to the following:

1. Monitor data on the frequency, percent, and type of nontransports.

2. Establish a process for review of patient care records on a percentage of nontransports to include assessment of impact on the patient's outcome, and education/training provided as indicated by this review.

3. Develop a process for evaluating rate of repeat call to 9-1-1 or "rekindles".

B. Base Hospital shall incorporate patients released at the scene into their Quality Improvement Program (Ref. 304 – Paramedic Base Hospital Standards). The quality improvement program may include but not limited to the following:

1. Review of select number of Base Hospital contacts for AMA, and provide education to base personnel as appropriate from that review.

2. Inclusion of cases of patients released at the scene in Base Hospital Audio Recording Reviews.

3. Notification of EMS provider agency quality improvement staff when the base has knowledge of patients who are released at the scene and return for evaluation in the emergency department.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 304, **Paramedic Base Hospital Standards**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 832, **Treatment/Transport of Minors**
Ref. No. 816, **Physician At The Scene**
Ref. No. 1200, **Treatment Protocols**, et al.
Ref. No. 1200.2, **Base Contact Requirements**
Ref. No. 1309, **Color Code Drug Doses**
Ref. No. 1380, **Medical Control Guidelines: Vital Signs**

**Reference No. 814, Patient Refusal of Treatment/Transport and Treat and Release at Scene**

| | Committee/Group | Date Assigned | Approval Date | Comments* (Y if yes) |
|---|---|---|---|---|
| EMS ADVISORY COMMITTEES | Provider Agency Advisory Committee | 2/17/2021 | 2/17/2021 | Y |
| | Base Hospital Advisory Committee | 2/10/2021 | 2/21/2021 | Y |
| | Data Advisory Committee | | | |
| | Education Advisory Committee | | | |
| OTHER COMMITTEES/RESOURCES | Medical Council | 3/2/2021 | 3/2/2021 | Y |
| | Trauma Hospital Advisory Committee | | | |
| | Ambulance Advisory Board | | | |
| | EMS QI Committee | | | |
| | Pediatric Advisory Committee | 3/2/2021 | 3/2/2021 | N |
| | County Counsel | | | |
| | Other: | | | |
| | 834 Ad Hoc Committee | 5/27/2020 | 12/21/2020 | Y |

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

**POLICY REVIEW - SUMMARY OF COMMENTS** REFERENCE NO. 202.2
(ATTACHMENT B)

**Reference No. 834, Patient Refusal of Treatment/Transport and Treat and Release at Scene**

| SECTION | COMMITTEE/DATE | COMMENT | RESPONSE |
|---|---|---|---|
| Definitions: Decision-Making Capacity | BHAC 2/10/2021 | Add "if feasible" after "…in the patient's primary language…" | Adopted |
| Definition: High Risk Presentation | PAAC 2/17/2021 | Add "gastrointestinal bleeding" after "…abdominal pain, pregnancy…" | Adopted |
| Definitions: High Risk Presentation | PAAC 2/17/2021 | Replace language in bullet #3 from "Patients with underlying cardiac, respiratory, kidney, liver, oncologic (cancer) or neurologic disease" with "Patients with complicating comorbidities (i.e., active underlying cardiac, respiratory, kidney, liver, oncologic (cancer) or neurologic disease, 0r who are immunocompromised (i.e., history of HIV, chemotherapy transplantation)) | Adopted |
| Definitions: | PAAC 2/17/2021 | Add definition for patient from Ref. No. 606 | Adopted |
| Definitions: Public Assist | PAAC 2/17/2021 | Add "involving a patient" after "…nonmedical issues" | Adopted |
| Definitions: Treatment in Place: | PAAC 2/17/2021 | Add "advanced" to "authorized health care provider" to as to read "authorized advanced healthcare provider"<br>Add "(e.g., physician, nurse practitioner, physician assistant) | Adopted |
| Policy I.B. | BHAC 2/10/2021 | Add "prior to patient leaving AMA (if base personnel feel it is warranted.). | Adopted |
| Policy I.D. | BHAC 2/10/2021 | Delete entire section D which reads "Base personnel should speak with the patient and/or family prior to AMA." Incorporate concept to I.B. | Adopted |
| Policy IV.B.1.b. Documentation | PAAC 2/17/2021 | Add "and reason for refusal" after "(i.e., medical care transport)" | Adopted |

**POLICY REVIEW - SUMMARY OF COMMENTS** REFERENCE NO. 202.2
(ATTACHMENT B)

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|---|---|---|---|
| Policy V.A.3. Quality Improvement | PAAC 2/17/2021 | Replace “Develop a process for follow-up of patients not transported to the ED.” with “Develop a process for evaluating rate of repeat call to 9-1-1 or “rekindles.” | Adopted |