COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

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

DATE: **September 16, 2020**
TIME: **1:00 – 3:00 PM**
LOCATION: **Zoom Video Conference Meeting**
Join Zoom Meeting:

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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 – John Hisserich, Dr.PH, 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.
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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
July 15, 2020

2. CORRESPONDENCE
2.1 (07-13-20) Norman Bergman: Gifts and Donations Fourth Quarter of Fiscal Year 2019-2020
2.2 (07-16-20) Robert Metzger, Fire Chief: Approval AutoPulse™ Pilot Study

2.3 (07-16-20) Mr. Ronald Marks: King LTS(D) Airway Program Approval for Specialty Care Transport
2.4 (07-20-20) Selam Alem: Response to 07-15-20 Public Comment
2.5 (07-21-20) Distribution: Delays in Emergency Department Bed Availability for Patients Arriving via Ambulance
2.6 (07-22-20) Brent Bartlett, Fire Chief: Approval: LUCAS® Chest Compression System, Los Angeles County EMS Optional Scope of Practice
2.7 (08-11-20) Funding for the Mobile Stroke Unit (Item No.2d-4 Agenda June 26, 2017)
2.8 (08-18-20) Xavier Espino, Fire Chief: Newly Appointed Medical Director – Tiffany Abramson, MD

3. COMMITTEE REPORTS

3.1 Base Hospital Advisory Committee
3.2 Data Advisory Committee
3.3 Provider Agency Advisory Committee

4. POLICIES

4.1 Reference No. 316: Emergency Department Approved for Pediatric (EDAP) Standards
4.2 Reference No. 326: Psychiatric Urgent Care Center (PUCC) Standards
4.3 Reference No. 328: Sobering Center (SC) Standards
4.4 Reference No. 510: Pediatric Patient Destination
4.5 Reference No. 511: Perinatal Patient Destination
4.6 Reference No. 516: Cardiac Arrest (Non-Traumatic) Patient Destination
4.7 Reference No. 526: Behavioral / Psychiatric Crisis Patient Destination
4.8 Reference No. 526.1: Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care Center (PUCC)
4.9 Reference No. 528: Intoxicated (Alcohol) Patient Destination
4.10 Reference No. 528.1: Medical Clearance Criteria Screening Tool for Sobering Center (SC)
4.11 Reference No. 618: EMS Quality Improvement Committees
4.12 Reference No. 1102: Disaster Resource Center (DRC) Designation and Mobilization
4.13 Reference No. 1102.2: DRC Equipment Checklist List Items Deployed to Other Facilities
4.14 Reference No. 1104: Disaster Pharmaceutical Caches Carried by Authorized ALS Providers
4.15 Reference No. 1106: Mobilization of Local Pharmaceutical Caches (LPCs)
4.16 Reference No. 1106.1: LPC Inventory and Checklist for Items Deployed
4.17 Reference No. 1106.2: LPC Photograph
4.18 Reference No. 1107.1: M/SS Cache Inventory and Checklist for Items Deployed
4.19 Reference No. 1108.1: Chempack Inventory List
4.20 Reference No. 1108.2: Chempack Photograph
4.21 Reference No. 1122: Bed Availability Reporting
4.22 Reference No. 1122.1: Bed Availability Report
4.23 Reference No. 1128: Decontamination Trailer Deployment for Mass Casualty Event
4.24 Reference No. 1132: Amateur Radio Communications
4.25 Reference No. 1138.1: Burn Resource Center Required Equipment/Supplies/ Pharmaceuticals
4.26 Reference No. 1138.2: Local Burn Lead Specialist Call Panel
4.27 Reference No. 1138.3: Remote Burn Lead Specialists
4.28 Reference No. 1140: Mobile Medical System Deployment
4.29 Reference No. 1140.1: Mobile Medical System Deployment Summary

END OF CONSENT AGENDA

IV. BUSINESS

BUSINESS (OLD)

5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies

5.2 Ambulance Patient Offload Time (APOT)
5.3 Criteria for 9-1-1 Receiving Center Designation (Tabled)
5.4 Patient Refusal of Treatment/Transport (Reference No. 834 – Sub Committee Report)
5.5 EMS Personnel Administering Vaccinations
5.6 LA County COVID-19 Modeling – EMS Agency Data

BUSINESS (NEW)

5.7 Report: Jonathan Sherin, MD, PhD, Director, LA County Department of Mental Health

V. COMMISSIONERS' COMMENTS / REQUESTS

VI. LEGISLATION

VII. EMS DIRECTOR'S REPORT

VIII. ADJOURNMENT

To the meeting of November 18, 2020

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
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MINUTES
JULY 15, 2020
Zoom Meeting

☒ Lt. Brian S. Bixler	Peace Officers' Assn. of LAC	Cathy Chidester	Executive Director
☒ Erick H. Cheung, M.D.	So. CA Psychiatric Society	Denise Watson	Commission Liaison
☐ Vacant	L.A. County Medical Assn.	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	John Telmos	EMS Staff
☒ James Lott, MBA	Public Member, 2nd District	Christine Zaiser	EMS Staff
☒ Robert Ower	LAC Ambulance Association	Jacqui Rifenburg	EMS Staff
☒ Margaret Peterson, PhD	Hospital Assn. of So. CA	Michelle Williams	EMS Staff
☒ Paul S. Rodriguez	CA State Firefighters' Assn.	Sara Rasnake	EMS Staff
☒ Jeffrey Rollman	So. CA Public Health Assn.	Denise Whitfield	EMS Staff
☒ Joseph Salas	Public Member, 1st District	Christine Clare	EMS Staff
☒ Nerses Sanossian, M.D.	American Heart Association	Natalie Greco	EMS Staff
☒ Carole Snyder	Emergency Nurses Assn.	Susan Mori	EMS Staff
☐ Vacant	League of CA Cities/LAC	Cathy Jennings	EMS Staff
☒ Atilla Uner, M.D.	American College of Emergency Physicians CAL-ACEP	David Wells	EMS Staff
☒ Gary Washburn	Public Member, 5th District	Lorrie Perez	EMS Staff
☒ David White	L.A. Area Fire Chiefs' Assn.		
☐ Vacant	Public Member, 4th District		

GUESTS

Clayton Kazan	LA County Fire Department	Jennifer Nulty	Torrance Fire Dept.
Jaime Garcia	Hospital Assn. Southern Cal.	Diego Caivano	LA County Med.Assn.
Brian Chu	LACo County Counsel	Shelly Trites	Public
Rangell Oruga	LACo Dept. Public Health	Andy Reno	Public
Selam Alem	Public	Scott	Public
Laurie Donegan	Public	Stephanie	Public
		Unidentified (8)	Public

(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 1:04 p.m. by Chairman John Hisserich. A quorum was present with 15 Commissioners on the call.

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

Executive Director Cathy Chidester did roll-call for the Commissioners, and acknowledged members of the public and EMS Agency staff present on the call. General Instructions for asking questions and/or making comments using Zoom were provided to participants. The names of the new Commissioners to fill current vacancies, pending completion of the process, were given.

Mr. Rangell Oruga, Health Program Analyst with Los Angeles County (LA County) Department of Public Health (DPH) Substance Abuse Prevention and Control unit, gave a presentation on LA County DPH's Methamphetamine (meth) Media Campaign that ran for two months and ended in April 2020, shortened by the Coronavirus (COVID-19) pandemic. History and statistics were presented for the years 2000 to 2018 on meth use, decline and resurgence. Since 2008, the percentages of hospitalizations, emergency department visits and deaths related to methamphetamine have increased to extremely high rates compared to earlier years. Statistics from 2018 revealed that meth was involved in more deaths than any other drug in proportion to all drug-related deaths in LA County. Methamphetamine abuse, as a significant proportion of drug-related visits, continues as compared to the opioid crisis in other areas of the country.

The Meth Campaign looked at the reasons for use, consequences, demographics, geographic locations, and other areas of concern to address this epidemic. Outreach efforts through social media, billboards, websites, radio ads, telephone hotline and surveys were used to gather information that created useful findings and future campaign tools to help guide people affected by meth use and abuse to a path of prevention, treatment and recovery.

Commissioners thanked Mr. Oruga and the Department of Public Health for this campaign, and expressed appreciation for leading these efforts.

Public Comment - Ms. Selam Alem, public speaker, addressed the EMS Commission. She thanked the EMTs and paramedics for their tireless efforts during this time of COVID-19, but noted that they should not ignore other patients calling in with pre-existing conditions who are not COVID-19 calls. She spoke of her concerns with EMTs and paramedics mislabeling patients and boxing them in as behavioral and requested the EMS Commission look into a particular group's behavior.

Chairman Hisserich suggested that Ms. Alem write to those agencies to handle her concerns, and explained that this was outside of the EMS Commission's purview and the Commission is not the appropriate agency to resolve the matters she described.

III. CONSENT AGENDA

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

Commissioner Uner expressed concern that Correspondence Item 2.10, a request by the local Medical Health Operational Area Coordinator (MHOAC) to the EMS Authority to suspend transfer requests from Imperial County, was sent to the EMS Authority and to hospital leadership given the limited resources available to Imperial County, and felt the EMS Agency had no authority to make this request. It was noted that three days later LA County MHOAC retracted this request in Correspondence Item 2.11.

Dr. Marianne Gausche-Hill, EMS Agency Medical Director, explained the issue was to establish a more reasonable process and fair distribution of patients so as not to overwhelm any one hospital.

Ms. Chidester expressed the factors were that there was no clear process in place at the time, hospitals from Imperial County were calling hospitals directly, the Transfer Center that the State EMS Authority had put in place was also calling hospitals directly, and it was a challenging time for all hospitals as there was an increased number of COVID-19 positive cases being admitted into the LA County hospitals. The EMS Agency looked at our data on emergency department wait times, as well as admitted COVID patients, and asked the EMS Authority to suspend the process on that Friday, June 5, 2020. The reason the letter was sent to hospital leadership was to be transparent and let them know what the EMS Agency was doing. After further review and discussion with our stakeholders, the EMS Agency notified the State that LA County hospitals would participate in the transfers of these patients and would provide data to the Transfer Center on that Monday, June 8, 2020.

There was further discussion on a different concern which was losing two additional perinatal centers, and the question was raised on whether or not this may be a trend. Dr. Gausche-Hill responded it is not perceived to be an issue nor will it have a big impact on our system because there are other full-service perinatal centers around these two hospitals that are easily accessible. For the hospitals that closed perinatal services, they need to ensure they have a transfer process in place for those patients that might self-transport to them and thus would need to arrange secondary transfer to a more appropriate facility.

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

1. MINUTES

May 20, 2020 Minutes were approved.

2. CORRESPONDENCE

2.1 (04-30-20) Alhambra Fire Department: System-wide Quality Improvement During the COVID-19 Outbreak
2.2 (05-14-20) Distribution: Sidewalk CPR Day Postponed to 10-16-20
2.3 (05-15-20) Letter from PIH Health: Notification of permanent closure of the Family Birth Center/Labor and Delivery and Special Care Nursery at PIH Health Downey Hospital
2.4 (05-18-20) Distribution: COVID-19 Update #10: Rescind Ref. 834.1/834.2
2.5 (05-18-20) Distribution: Allocation of Remdesivir
2.6 (05-18-20) Distribution: Suspension of Measure B Funding Project Proposals Process for 2020
2.7 (05-21-20) Distribution: Temporary Closure of Perinatal Services
2.8 (05-26-20) Distribution: Additional Allowable Charges for Medi-Cal Patients Not Outlined in the General Public Ambulance Rates
2.9 (05-29-20) Joe Losorelli, Los Angeles City Park Rangers: Public Safety Naloxone Data Registry
2.10 (06-05-20) Brad Gates, EMS Authority: MHOAC Program Request for Suspension of COVID-19+ Patient Transfers from Imperial County into LA County
2.11 (06-08-20) Brad Gates, EMS Authority: State's Transfer Center May Resume Presenting Patients from Imperial County into LA County
2.12 (06-16-20) Distribution: Prehospital Patient Care Record and Transfer Patients
2.13 (06-18-20) Distribution: Addition of Ketorolac to Unit Inventories

3. COMMITTEE REPORTS

3.1 Base Hospital Advisory Committee (June 10th – Attached)
3.2 Data Advisory Committee (June 10th – Cancelled)
3.3 Provider Agency Advisory Committee (April 15th – Cancelled, June 17th – Attached)

4. POLICIES

4.1 Reference No. 222: Downgrade or Closure of 9-1-1 Receiving Hospital or Emergency Medical Services
4.2 Reference No. 322: Stroke Receiving Center Standards
4.3 Reference No. 322.1: Stroke Performance Measures
4.4 Reference No. 606: Documentation of Prehospital Care
4.5 Reference No. 644: Base Hospital Documentation Manual (Information Only)

END OF CONSENT AGENDA

IV. BUSINESS

BUSINESS (OLD)

5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies

Ms. Chidester provided information about an ad hoc committee report in which the EMS Commission presented their findings and recommendations to law enforcement, fire departments, and District Attorney Jackie Lacey's office. As some of the recommendations were not within the EMS Agency's purview, the report was sent out to the appropriate agencies for their responses; one of which was to create 9-1-1 dispatch and treatment protocols, and how to move forward with consistency on some of the other recommendations in the report.

The LA County Board of Supervisors (Board) made a motion approximately six months ago, requesting that the LA County Department of Mental Health (DMH) organize teams and create a system within the field setting to address the need for consistent protocols across the various agencies in managing the care of mental health emergencies.

Jonathan Sherin, M.D., Ph.D., Director of LA County Department of Mental Health, chaired a meeting by TEAMS this past Friday to address the issues and requests from the Board. Ms. Chidester was on this call, along with District Attorney Jackie Lacey, Michael Moore, EMS Commissioner-Captain Brian Bixler, John Gannon from the Sheriff's Department and others. The purpose was to find a systematic approach to address behavioral health and substance abuse calls from the field.

District Attorney Lacey brought up the EMS Commission ad hoc report, and told Dr. Sherin this is a good foundation and start for them to be looking at to address the recommendations that were made by the EMS Commission. Ms. Chidester sent the report to Dr. Sherin who, in turn, forwarded it to the group in preparation for the next meeting.

It was noted that there is funding for this project.

Commissioner Bixler reported on the three main needs and talking points Dr. Sherin wanted to emphasize:

1. The right triage – What practices do we need to have across the County to properly triage behavioral health/substance abuse calls? There was a lot of talk about using the 9-1-1 system as a primary point of entry and looking at a type of non-police 9-1-1 dispatch center where a non-police entity answers the call, triages the call and then sends it out to fire, EMS, or DMH. Once it is determined that this call does

not need to go to police or fire, but can go to a mental health or health agency, then we need to have the right response.

2. The right response – This consists of Psychiatric Mobile Response Teams (PMRT) and psychiatric therapeutic transport vans that Dr. Sherin and DMH have. Five of them are going to be deployed to Los Angeles Fire Department stations hopefully by September 1, 2020 as a part of getting this project going. Staffing is also an issue. Dr. Sherin and DMH do not have enough PMRTs to go 24/7 to all the calls coming in.
3. The right destination – Building more urgent care centers, and building more critical care beds and more facilities like that to be able to receive these individuals so they do not end up in a jail or end up getting turned out on the street.

The pieces we are starting to build in is the suicide diversion hotline that DMH is actually looking at the funding right now. Also, some private investors have stepped forward to say if DMH does not fund it they would like to.

The other piece is the therapeutic transport vans that Dr. Sherin is implementing with Los Angeles Fire Department to be able to respond through Fire dispatch, and it would be a 9-1-1 call routed to the fire departments, and the fire departments would triage it and realize that it is a call the therapeutic transport van can handle.

This workgroup's first meeting was about triage and looking at what criteria is needed. The second meeting is this Friday about transport and looking at if there are pieces in effect in the City and County that we can utilize for transport other than police or fire. The last piece is to develop the clinics and urgent care centers that need to be opened (at least 17 more in the County per the report) to be able to handle the volume they are seeing in the field.

Commissioner Erick Cheung expressed appreciation, as one of the participants in the original Ad Hoc Committee in 2016, and thanks to Dr. Kazan who helped co-chair that committee, and to Commissioner Bixler as well as several others who might still be on the Commission who participated in that very comprehensive report. Our Commission has been ahead of the curve on this, and we should be recognizing that the EMS Commission created this report several years ago, which exactly is a roadmap for how some of this can move forward. A lot of work went into very clearly delineating what the response systems look like whether law enforcement or medical response in the field, and expressed hope that the County can act upon this work. Commissioner Bixler's project with the Suicide Hotline is a really important part of it, and was also recommended by this Commission in our follow-up to the dispatch survey.

The report is very clear about some of the principles of how we believe these types of emergencies should be handled. The report specifically called out that mental health and substance abuse emergencies are by their very nature medical emergencies and would be best treated by people who are appropriately trained, equipped, and experienced to evaluate and manage those individuals. And, in Ms. Chidester's comments, though law enforcement has done tremendous work to build up the ability to respond, they are still not necessarily the best responders in a lot of these circumstances. Now is the time to move the dial back from law enforcement who has been the default responder for too many mental health emergencies.

With regards to the task list that was generated and the potential areas of opportunity, in follow up to our report, it is a good idea that we reconsider where we are with those

items. One of them which we have not yet taken on and addressed fully is whether EMS protocols for management of agitated patients is as up to date as it could be. That would be a worthwhile area for us to look into. We began that work a year or two ago, only to be somewhat delayed in completing that work, but that is an area of opportunity for this body.

Dr. Gausche-Hill commented about working together on refining our protocols for example, utilizing Olanzapine for psychiatric emergencies that are not agitated delirium where midazolam is utilized. We had talked about ketamine for agitated delirium, but there was some resistance from our stakeholders, as well as some potential harm from the published literature. We will continue to explore options for improving our protocols.

Commissioner Cheung commented that both pharmacologic and non-pharmacologic de-escalation protocols would be a good idea, but not sure whether non-pharmacologic de-escalation techniques and protocols are already written in as training requirements and spelled out in our protocols.

5.2 Ambulance Patient Offload Time (APOT)
Ms. Chidester reported that the data from the Patient Offload Time for the last quarter will look good because emergency departments have not been very busy or impacted because of the Safer at Home Order during COVID-19. With the relaxation of this order and the opening up of businesses over the last few weeks, we have had anecdotal reports of ambulances and paramedics having long offload times again. We are very concerned because it is not just the long offload times, but patients are being asked to wait in the ambulance for long periods of time. We will be addressing that with Hospital Association (HASC) first. This will be addressed with the hospital CEOs on a call she participates on.

It was reported that call volumes have gone down 20-40%, but in the last few weeks the calls have been going up and are almost back to their normal numbers. Transports are down too, but the transports are slowly increasing and going up, but only 20% less than what they were previously and not up to pre-COVID-19 numbers.

Ms. Chidester reported there were multiple issues and that some patients don't want to go to the hospital, not 100% sure what is going on now. At the beginning of COVID-19, there were a lot of comments from the press conferences that said folks should stay at home and should not go to the emergency department. Now, the dialogue has changed to, "You need to go to the emergency department if you are sick." Elective surgeries are back on and hospitals are seeing the impact on patients of delays in care.

5.3 Criteria for 9-1-1 Receiving Center Designation (Tabled)
Ms. Chidester reported the EMS Agency has criteria that is a policy for becoming a 9-1-1 receiving center for a hospital to take patients. To be able to take ambulance traffic they have to meet specific guidelines of this policy. This policy will be changed to an agreement format. The Commission is looking at if there are additional items that can be put into this policy to help ensure that 9-1-1 patients are appropriately cared for. We will table this because we are having more discussions within the EMS Agency, but will bring back to the Commission at the next meeting.

5.4 Patient Refusal of Treatment/Transport (Reference No. 834 – Sub Committee Report)
Dr. Gausche-Hill reported on Policy Reference 834 based on concerns brought up at the Commission, and stated, "In order to refine this, we developed an ad hoc task force

to evaluate and update and revise Reference 834 which is Patient Refusal of Treatment/Transport and Treat and Release at the Scene." We have had several meetings and will continue to meet, and as we have already made progress, once we get a revised draft, we will bring it back to the Commission.

Additionally, we are initiating a non-transport group of investigators and working collaboratively with LA County Fire. Thanks to Dr. Kazan and his staff who are helping the EMS Agency identify patients who will be called to find out the circumstances of the call and the instructions by the EMS providers. These data will be analyzed and a report can be made to the Commission.

BUSINESS (NEW)

5.5 EMS Personnel Administering Vaccinations.

Dr. Gausche-Hill reported that in the past when we had the Hepatitis A outbreak in LA County, the paramedics were approved to be able to provide a Hepatitis A vaccine during time of declared public health emergency. She reached out to State EMS Authority and Dr. Duncan, and discussed with him the idea that during this public health emergency, we should indeed again ask for expansion of local optional scope to include influenza vaccine as well as COVID-19 vaccine when it becomes available. Dr. Duncan was very supportive of the idea, and said there would be a memo – a directive coming out from the State or an application from the EMS Agency for expansion of the local optional scope of practice. This plan will increase the likelihood that all our work force get immunized against influenza and COVID-19 vaccine when it is available.

Commissioner Jeffrey Rollman thanked for Dr. Gausche-Hill for coverage on this topic he suggested discussion on in early March of 2020, and looks forward to hearing back from Dr. Duncan.

The question was raised if this could be extended to the public.

Dr. Gausche-Hill responded that it is a possibility. This has been done with Pasadena Public Health. They have nurse/paramedic teams that work together on vaccinations, and it is just a matter of developing that type of collaboration. During the time of influenza season over 4000 employees can be leveraged to do vaccines; and, given what we are seeing today, it is a good idea to move forward.

5.6 LA County COVID-19 Modeling – EMS Agency Data.

Dr. Gausche-Hill reported on COVID-19 modeling, and shared resources and updates on information from Public Health that shows a number of states and what their curves look like. There were comparisons between LA County with New York and their ability to flatten their curve, while LA County's is going up. We did have a period of where it was relatively flat, but it is going up and our healthcare system has overall been able to handle it, but we are monitoring it. There were comparisons of LA County to Georgia and Arizona with Arizona cases going up.

There was an example showing the cumulative cases of COVID-19 per 100,000 people, which demonstrates the steep curve and the difference in the curves between New York, Arizona, Georgia and LA County which is relatively flat, and pretty much the same as Nevada and Washington.

The mortality rate was discussed. In New York, their medical system became overwhelmed. California has had a relatively flat curve over this time-period, and she

thinks part of that is our ability to social distance.

California case rate has not gone up as steeply as others, but has a slight rise. The number of case rise is related to increase in 18- to 65-year-old population. With the people coming out and businesses opening up, they are representing a larger number of the cases.

Prehospital we see cold and flu and fever going up initially and then back to 2019 levels. With the public going back to work, we are beginning to see more cases.

We have seen a decrease in the number of cases of patients coming in with bronchospasm maybe because they are staying at home, and sepsis has been up and down throughout this pandemic.

Regarding non-COVID-19, we have seen an increase in non-traumatic cardiac arrest which has been reported by a number of other systems including New York. We really need to consider training in Citizens CPR, Hands-Only CPR, which was pushed back because of COVID-19, but we will be bringing that back in October. All of us in our communities should encourage Citizens CPR which increases the likelihood of survival by three times. And, finally, 70% of cardiac arrests occur in the home.

Chest pain – STEMI overall has gone down which could be fear of coming into hospitals because of COVID-19. Stroke has been up and down, but consistent with 2019. Traumatic injury – we saw initially a sharp decline down and as the economy gets open we are beginning to see that increase somewhat.

The July 15, 2020, modeling update from Dr. Roger Lewis was shared with Dr. Gausche-Hill to present. He did explain about the transmissibility and that transmission number is called “R” and initially in the outbreak it was 2 to 3, and we successfully brought it down to essentially 1 or <1. We are still seeing a slight increase in R above 1 which will increase the spread of COVID-19, but it is not as steep as we might have predicted, and therefore the estimates on hospital beds and ventilators are likely to be adequate over the next month or so.

Currently the ICU beds are limited. Although we have demonstrated overall capacity, Public Health is quite concerned. We do know from the numbers shown from Public Health that the increase seems to be in a younger population which is going to do better in terms of hospitalization.

More graphs were shown to demonstrate that we have about a 20-30% COVID-19 burden meaning 20-30% of the patients admitted to the hospital are for COVID-19.

In regards to the ICU beds or ventilators, we generally have about 600 or 800 patients in the hospitals at any one time that are in the ICU. We currently have 2500 available staffed beds. Again, as R increases, part of the scarce resources may be those ICU beds. At this point we are not seeing it. We do have some hospitals that are impacted more than others, and we are trying to address their needs with bringing them resources.

Finally, ventilators. It is clear that we have had enough ventilators, although that was a real concern in New York and Italy in terms of implementing crisis standards of care where not everyone can receive a ventilator. We have not come close to that and we

seem to have great capacity in terms of number of ventilators.

Current, weekly census. San Gabriel Valley seems to be a hot spot right now, as well as LA County USC is fairly impacted. We have great capacity still. With that said, all of our hospitals have implemented surge plans meaning they are ready to surge as needed based on our resource needs. This is our ICU capability as you can see. Here is the number of admitted patients, our COVID-19 burden is around 29%, and previously it has been as high as 40%. As you know, we had many federal assets brought to us and they were of help but of limited use based on the fact that hospitals do not have staffing. We should not be complacent, but we should be vigilant about collecting these data and working with our hospitals to ensure they have the resources that they need.

Admissions have gone up, which is a concern of Public Health and the Modeling Team, but at least at this point it has not overwhelmed our system. The ICUs really have not gone up at the same pace as hospital admissions, and this may reflect several things: 1) the patients are younger overall; 2) we now have things in our tool box to be able to treat these patients, including remdesivir and dexamethasone; and 3) we have learned a lot in terms of how to care for these patients to try to keep them off of ventilator and improve their outcome.

The discharges are going up which is a positive sign that the discharges might be able to match the admissions in a way that allows our hospitals to have continued capacity during this crisis.

Commissioner James Lott inquired if LA County is having any problems with renewed PPE supplies?

Dr. Gausche-Hill responded that we bring in PPE every week. We are in constant communication and have brought in tens of millions recently of N95s and gowns. She thinks it is a continued issue for sure that we have to stay on it. She would say, “Yes,” but we are trying to reach out to the State to meet the need.

Ms. Chidester noted that it seems like there is a shortage of different things, it just depends on the time. The State did purchase N95s and we have been pushing those out to the hospitals. We got almost 800,000 gowns that we pushed out to the hospitals. A lot of PPE is more available now than it was in March, April and May. It seems that you get caught up on one thing and then there is another focus. Now, they are using and asking for high flow oxygen, and some of the equipment that is needed to administer the high flow oxygen is now becoming a little bit of a shortage. We are constantly looking to see and keeping our ears open as to what the shortages are now and what hospitals are looking for. Hospitals seem ok with the gowns now because we have been pushing them out, and N95s seem to be better.

5.7 Chapter 13 Issue for Firefighters and Fire Chiefs

Scott Clough, Chairperson for the EMS section for the California State Firefighters Association (CSFA) who sat on the original Chapter 13 task force, provided a brief overview and gave the fire service perspective and position on the Chapter 13 issue that started nearly 10 years ago. One issue is that the task force has not formally met in nearly six years. In the timeframe that Chapter 13 task force had stopped meeting, a number of things had taken place in California and on a national level that took place mainly in court decisions and those types of things. But, Chapter 13 has not really had

an opportunity to really formally address or discuss the impacts of some of those changes in the system.

In this particular issue, the fire service, Fire District Association of California (FDAC), California State Firefighter's Association (CSFA), Cal Chiefs, California Professional Fire Fighters, all had a stake in this. The California Fire Chiefs and California Professional Firefighters had challenged the State's use of the current regulations for use in competitive bidding, exclusive operating areas, the administrative capability of 201 cities and fire districts. And in that suit that was brought forward, the Administrative Law Judge went with EMS Authority, they took the briefs and basically went with the State EMS Authority who had admitted they were in fact running the statewide system, using underground regulations. In that process, Dr. Howard Backer, who was Medical Director at the time, had voluntarily signed a Form 280 Declaration which is that Dr. Backer had certified that all of the regulations as found in 141, 141-B, and 310 were in fact all underground regulations.

In addition to acknowledging that those regulations were never codified through the Administrative Procedural Acts process, they also certified that in no way shape or form would they use those regulations in the administration of the EMS systems statewide. And that was a good step forward. However, the State EMS Authority had reclassified these regulations as what they called guidelines, and then subsequently to signing the 280 Declaration with the State of California, EMS Authority continued to administer the same regulations but under the pretense that they were now guidelines and, therefore, they could utilize them and they, in some cases, utilized those guidelines for enforcement. In the State of California, a guideline if is used in the form of a regulation or in place of a statute, has the same force as if it was a codified regulation.

Southern California Fire Chiefs launched a second lawsuit that EMS Authority should not be able to use those regulations. The Fire Service prevailed in that. The judge did come back with a written finding, and the judge did in fact state that those regulations/guidelines were underground regulations and that EMS Authority did not follow the APA process in codifying those regulations. In turn, that decision opened up the door for lots of opportunities to go back and correct some items.

The last part that was very troublesome for the Fire Service is. In these regulations, even if they went through the public comment phase, once they go through the public comment they are brought forth back to the EMS Commission to vote on. If they were voted on and approved, it would trigger a lawsuit on several levels because the regulations as they are written are contrary to certain provisions under the California Constitution. They are also in conflict with California statute and several laws. The issue in trying to get these pulled by the Fire Service was to save the need of launching a lawsuit which saves everybody money, but also because the Fire Service perspective is that these regulations can go forward, but they need to go forward with a fresh set of eyes. They should not be moving forward for public comment on regulations that were drafted over six years ago and then contain 29 pages of new documents.

Ms. Chidester commented that in the interest of time, we will carry this to the next meeting to have a fuller description on some of the impacts.

Mr. Clough responded that he works at the behest of the President of the CSFA, and if Commissioner Paul Rodriguez would desire to be part of the organization and if you would like to schedule another meeting with more in-depth information, Mr. Clough

would be happy to attend at your request and would be happy to provide whatever resources to help with your questions.

V. COMMISSIONERS' COMMENTS / REQUESTS

None.

VI. LEGISLATION

No report.

VII. EMS DIRECTOR'S REPORT

EMS Commissioner and Fire Chief David White is retiring. On behalf of the EMS Commission, thanks for all the work, the number of years you have served on this Commission, and the support that you have provided to the EMS Agency and EMS system.

Commissioner White thanked the Commission, and noted that Chief Martin Serna would be in touch regarding his replacement.

VIII. ADJOURNMENT:

Adjournment by Chairman Hisserich at 3:04 pm to the meeting of September 16, 2020.

Next Meeting: Wednesday, September 16, 2020, 1:00-3:00pm
Join by Zoom Videoconferencing

Join Zoom Meeting
https://zoom.us/j/97038940033?pwd=U3NROGVnSGxsZUx1RG1NTTFQWXdNZz09

Meeting ID: 970 3894 0033
Password: 137625
One tap mobile
+16699009128,,97038940033# US (San Jose)
+13462487799,,97038940033# US (Houston)

Dial by your location
+1 669 900 9128 US (San Jose)
+1 346 248 7799 US (Houston)
+1 253 215 8782 US (Tacoma)

Recorded by:
Denise Watson
Secretary, Health Services Commission

EMERGENCY MEDICAL SERVICES AGENCY
OF LOS ANGELES COUNTY

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."

July 13, 2020

TO: Norman Bergman
Fiscal Services-Special Projects
Health Services Administration

FROM: Cathy Chidester, RN, MSN
Director, EMS Agency

SUBECT: **GIFTS AND DONATIONS FOURTH QUARTER OF FISCAL YEAR 2019-2020**

As required by Department of Health Services (DHS) financial practice, the attached scheduled summarizes the gifts and donations (cash and non-cash) received by the Emergency Medical Services (EMS) Agency during the period April 1 to June 30, 2020.

The total amount of donations received by the EMS Agency was $841,679.62 and twenty four (24) total number of donors. We did not receive cash donations or Non-COVID-19 donations.

If you have any questions or require additional information please contact John Telmos, Chief Prehospital Operations at (562) 378-1677.

CC:jt
07-14

Attachment

c. Manal Dudar
Oralia Alveno
Mindy Wang

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

10100 Pioneer Blvd, 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

July 16, 2020

Robert Metzger, Fire Chief
Redondo Beach Fire Department
401 S. Broadway Street
Redondo Beach, CA 90277

Dear Chief Metzger,

APPROVAL: AUTOPULSE™ PILOT STUDY

This letter is to confirm Redondo Beach Fire Department (RB) has been approved by the Los Angeles County Emergency Medical Services (EMS) Agency to pilot the AutoPulse™ Resuscitation System for non-traumatic patients receiving cardiopulmonary resuscitation.

The quality improvement process approved for implementation and evaluation of the pilot study requires quarterly reports to be submitted to the EMS Agency. Additionally, RB may be required to report and provide outcome data to the Medical Advisory Council for purposes of peer review and system evaluation.

Upon implementation of the AutoPulse™, the quarterly reports should be submitted to me at MGausche-Hill@dhs.lacounty.gov (please copy Susan Mori at sumori@dhs.lacounty.gov). The reports are due 30 days after the end of each quarter and should include the following:

- Number of AutoPulse™ applications
- Time to AutoPulse™ application
- Initial cardiac rhythm
- Number of endotracheal/King LTS-D intubations
- Capnography values at initial assessment and at return of spontaneous circulation (ROSC) or termination of resuscitation (TOR)
- Number ROSC achieved
- Number transported
- Number with ROSC at receiving hospital
- Number of TOR and not transported
- Adverse events

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

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:JT:sm
07-16

c: Cathy Chidester, Director, EMS Agency
Gary Watson, EMS Agency, Prehospital Operations
Medical Director, Redondo Beach Fire Department
EMS Division Chief, Redondo Beach Fire Department
Nurse Educator, Redondo Beach Fire Department

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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Fax: (562) 941-5835

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

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

July 16, 2020

Mr. Ronald Marks
President
California Medical Response Inc.
1557 Santa Anita Blvd
South El Monte, CA. 91733

Dear Mr. Marks,

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

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

The quality improvement process required for implementation of the King Airway will be reviewed during your annual program review or as deemed necessary by the EMS Agency. Validation of training to include, attendance rosters and graded written exams being available for review during annual site visits and upon request from the EMS Agency. CL may also be required to submit data to the EMS Agency on the use of the King Airway for purposes of system wide evaluation and aggregate reporting.

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

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:JT:SM:gk
07-20

c: Director, EMS Agency
Andrew Lara, CCT Coordinator, Cal-Med Ambulance
Brian Fong, MD Medical Director, Cal-Med Ambulance
Christine Zaiser, Nursing Instructor, Ambulance Programs
Nnabuike Nwanonenyi, Nursing Instructor, Ambulance Programs

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

July 20, 2020

Selam Alem
selamworld@gmail.com
selam10900@twc.com

Dear Ms. Selam Alem:

Thank you for your public participation during the July 15, 2020, Emergency Medical Services (EMS) Commission Zoom Conference Call. The EMS Commission found your comments very interesting.

Unfortunately, the EMS Commission does not have the authority to address your concerns and comments. You may find the City Manager for Culver City, the Fire Department and/or Police Department for Culver City to be more viable resources to assist you.

Sincerely,

John Hisserich
Chairman, EMS Commission

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

10100 Pioneer 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."

July 21, 2020

TO: CEO, 9-1-1 Receiving Facilities
Emergency Department Medical Director, 9-1-1 Receiving Facilities
Emergency Department Director, 9-1-1 Receiving Facilities

FROM: Cathy Chidester, MSN
Director, EMS Agency

SUBJECT: **DELAYS IN EMERGENCY DEPARTMENT BED AVAILABILITY FOR PATIENTS ARRIVING VIA AMBULANCE**

The following incidents have recently been brought to the attention of the Emergency Medical Services (EMS) Agency:

- Ambulances transporting patients to 9-1-1 receiving facilities are being instructed by emergency department (ED) staff to wait in the ambulance with the patient until an ED bed is available. Some wait times have been reported to be in excess of six (6) hours.
- Patients are being evaluated, treated, and discharged from the ambulance in lieu of being transferred into the ED.
- Patients are receiving diagnostic studies (e.g., x-rays, blood work, IV fluids etc.) in the ambulance while waiting for an ED bed.

The EMS Agency is aware that many EDs are experiencing a recent increase in patient visits. However, the practices listed above are not acceptable and pose a safety risk for patients and negatively impact the provision of emergency medical services to the community. We are also concerned that these practices may be potential violations of the Emergency Medical Treatment and Active Labor Act (EMTALA).

Facilities should review (and implement) plans to accommodate periods of high census. Publications are available that may assist your facility in developing strategies to address extended offload times. One such publication produced by the California Hospital Association titled "Toolkit to Reduce Ambulance Patient Offload Delays in the Emergency Department" is available at:
http://file.lacounty.gov/SDSInter/dhs/1020054_WallTime_Electronic.pdf

Additionally, Ambulance Patient Offload Time (APOT) has been an ongoing problem for many years without resolution. In the near future, the EMS Agency will be convening the EMS Commission's APOT Ad-Hoc Committee to develop a timely, fair and equitable APOT fee that may be billed to hospitals on a case by case basis by ambulance companies and fire departments that operate an emergency ambulance transportation service.

The EMS Agency is an advocate for our hospital system, prehospital providers, and patients. In this role, we need to ensure viability and fair practices that support our system and provide for quality patient care. We are confident that you understand that holding ambulance staff and equipment for extended periods of time awaiting patient transfer of care is an unfair and risky business practice. This practice is no longer sustainable for ambulance providers and fire departments in our EMS system.

Going forward, we will be working with our APOT Ad-Hoc Committee, which has representatives from hospitals, fire departments and ambulance companies, to explore a timely and reasonable billing policy. The final policy will go through our committee process and ultimately the EMS Commission for final recommendation to the EMS Agency. We will keep our stakeholders informed as we move forward.

Thank you for your attention to this matter and your support of the EMS system. If you have any questions or concerns, feel free to contact me at (562) 378-1604.

CC:jt
07-21

c: Director, DHS
President, LA Area Fire Chiefs Association
President, Los Angeles County Ambulance Association
Hospital Association of Southern California
Los Angeles County Emergency Medical Services Commission
APOT Ad-Hoc Committee

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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."

July 22, 2020

Brent Bartlett, Fire Chief
Sierra Madre Fire Department
232 W. Sierra Madre Boulevard
Sierra Madre, CA 91024

Dear Chief Bartlett,

APPROVAL: LUCAS® CHEST COMPRESSION SYSTEM, LOS ANGELES COUNTY EMS OPITIONAL SCOPE OF PRACTICE

This letter is to confirm that Sierra Madre Department (SI) has been approved by the Los Angeles County Emergency Medical Services (EMS) Agency to implement the LUCAS® Chest Compression System for non-traumatic patients receiving cardiopulmonary resuscitation.

The quality improvement process required to implement the LUCAS® will be reviewed during your annual program review or as deemed necessary by the EMS Agency. Additionally, SI may also be required to submit data on the LUCAS® for purposes of systemwide evaluation and aggregate reporting.

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

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:JT:sm
07-18

c: Director, EMS Agency
Gary Watson, Prehospital Program Coordinator, EMS Agency
Medical Director, Sierra Madre Fire Department
EMS Director, Sierra Madre Fire Department

Health Services
LOS ANGELES COUNTY

August 11, 2020

313 N. Figueroa Street, Room 912
Los Angeles, CA 90012

Tel: (213) 288-8050
Fax: (213) 481-0503

www.dhs.lacounty.gov

"To advance the health of our patients and our communities by providing extraordinary care"

TO: Supervisor Kathryn Barger, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Janice Hahn

FROM: Christina R. Ghaly, M.D.
Director

SUBJECT: **FUNDING FOR THE MOBILE STROKE UNIT (ITEM NO. 2d-4 AGENDA JUNE 26, 2017)**

On June 26, 2017, the Los Angeles County (LA County) Board of Supervisors (Board) directed the Director of the Department Health Services (DHS) to:

1. Allocate $1,460,000 in one-time Measure B funding to be used for the UCLA Medical Center Mobile Stroke Unit in a 30-month pilot and follow-up evaluation;

2. Instruct the Director of Health Services' Emergency Medical Services Agency to partner with the UCLA Medical Center Mobile Stroke Unit pilot to evaluate and submit a report back to the Board on program effectiveness, as described above; and

3. Authorize the Director of Health Services to execute an agreement with The Regents of the University of California on behalf of its UCLA Medical Center to include the funding required for the 30-month pilot and follow-up evaluation.

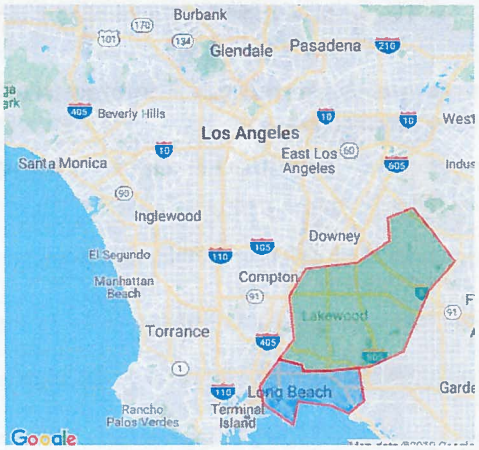
As directed, this report provides the 30-month follow-up evaluation of DHS' Emergency Medical Services (EMS) Agency and the UCLA Medical Center (UCLA MC) Mobile Stroke Unit (MSU) pilot program's effectiveness funded by the allocated $1.46 million in one-time Measure B funding.

Agreement Execution

On January 8, 2018, DHS executed an agreement with UCLA MC to provide funding in the amount of $1,465,000 for the MSU pilot to provide extension of the research study period beyond the 18-month period in addition to a weekly operating schedule and expanded services into Districts two and four. The agreement term is through January 7, 2023. In October 2019, the agreement was amended as the Board approved the allocation of an additional $1,745,000, in one-time Measure B funding to

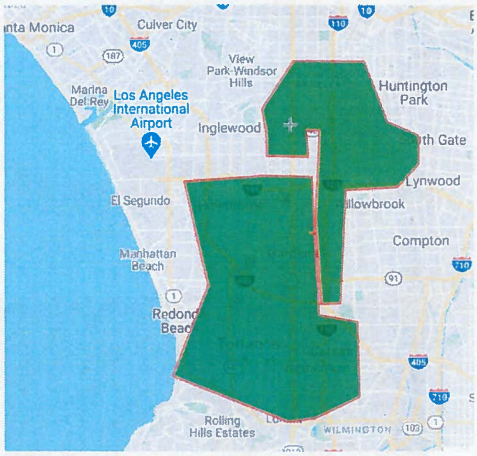
Southern Geographic Site

- Alternating weeks of Mon-Thurs clinical operations
- 6:30 am – 4:30 pm
- Operational Partners:
  - LACoFD (Battalion 9 & 21)
  - LBFD
- Receiving Hospitals:
  - Coast Plaza Hospital
  - Kaiser Downey Hospital
  - Lakewood Regional Hospital
  - Long Beach Memorial Medical Center
  - Los Alamitos Medical Center
  - PIH Whittier Hospital
  - Saint Jude's Medical Center
  - Saint Mary's Hospital



South Bay Geographic Site

- Weekly Fri – Sun clinical operations
- 6:30 am – 4:30 pm
- Operational Partners:
  - LACoFD (Battalion 7 & 18)
  - LAFD (Battalion 13)
  - Torrance FD
  - Future Potential Partners: El Segundo FD, Manhattan FD, Redondo FD, Compton FD
- Receiving Hospitals:
  - Centinela Hospital
  - Gardena Memorial Hospital
  - Good Samaritan Hospital
  - Kaiser South Bay Hospital
  - Little Company of Mary Medical Center
  - Long Beach Memorial Medical Center
  - Torrance Memorial Medical Center



Preliminary Data Based on Clinical Field Operations

Since September 2017, as access to care with the MSU has increased with the increasing number of fire department collaborations, this clinical unit has responded to 911 calls suspicious for stroke and has served to diagnose and treat ischemic stroke patients, hemorrhagic stroke patients, and to route them to the most appropriate level of stroke care based on clinical and radiographic findings. Data collection and analysis for quality improvement will continue throughout the duration of clinical operations.

Total Number of 911 Calls MSU Has Responded To:	632	100%
Number of Patients Assessed/Treated & Transported:	145	23%

LA County is one of seven participating metropolitan regions collaboratively performing a nationwide comparative effectiveness demonstration project to quantify clinical benefit and assess healthcare utilization and cost of operating MSUs in the United States. This PCORI project, BEST-MSU, is designed to compare up to 2,000 stroke patients treated during weeks when an MSU was operational in a catchment area and treated during weeks when only standard paramedic ambulances were operational in a catchment area. The Los Angeles MSU has been contributing data to the BEST-MSU collaboration since 2017. Enrollment nationally in the BEST-MSU study is anticipated to achieve targeted sample size in August/September of 2020. Allowing three more months for the last patient's 90-day follow-up visit and three further months for data query resolution and database lock, unblinding of trial data and performance and reporting of topline prespecified primary analyses is anticipated to occur in February of 2021.

If the BEST-MSU study shows a substantial benefit of MSU care in the US, similar to that reported in February 2020 by a European study, the data will be submitted to Medicare and additional third-party payors to support start of clinical reimbursement for clinical care, imaging, medications, and other clinical services on MSUs. If data are positive and regulatory responses are efficient, standard clinical reimbursement from third-party payors for MSU care could begin as early as mid 2022.

A full report of BEST-MSU study findings, including data regarding patients enrolled by the LA County MSU across multiple participating receiving hospitals in the county, will be shared with the Board by the MSU team when they become available. This report will contain information regarding clinical efficacy of MSU care for ischemic stroke as well as cost-effectiveness analysis of unit operations. This is anticipated in by mid-year 2021.

Geospatial Mapping Study

Supported by Measure B funds from the Board, a formal study is well underway to perform sophisticated geospatial mapping analysis of stroke occurrence across the entirety of LA County and determine the number and location of MSU units needed to provide cost-effective MSU care to the preponderance of Los Angelenos. The geospatial analysis is including geographic location of all incident strokes in LA County, circadian patterns of occurrence, proximity and access to advanced level stroke centers, socioeconomic access to care, and geographic variation in the frequency of stroke-predisposing premorbid conditions. The main goal of this study is to understand the number and geographic placement of mobile stroke units needed to provide access to all citizens of LA County to this specialized resource. Study results are anticipated in February of 2021.

The following are research publications or presentations from data collected in the Los Angeles Regional MSU:

1. Nour, M, Starkman, S, Sharma, L, Saver, J (2017). Magnitude of Benefit of Prehospital Mobile Stroke Unit vs Conventional ED Thrombolysis: Preliminary

If you have any questions, you may contact me or your staff may contact Cathy Chidester, EMS at (562) 378 1604 or by email at cchidester@dhs.lacounty.gov.

CRG:cc

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

August 18, 2020

Xavier Espino, Fire Chief
Long Beach Fire Department
3205 Lakewood Boulevard
Long Beach, California 90808

Dear Chief Espino:

NEWLY APPOINTED MEDICAL DIRECTOR – TIFFANY ABRAMSON, MD

This letter is to acknowledge that the Emergency Medical Services (EMS) Agency has received notification from Long Beach Fire Department (LB) that effective June 8, 2020, Tiffany Abramson, M.D., has been appointed as Medical Director and will be providing medical oversight to LB's paramedic program.

Based on the documents provided to the EMS Agency, Dr. Abramson meets the requirements as Medical Director set forth in the Los Angeles County Prehospital Care Manual, Reference No. 411, Provider Agency Medical Director.

The EMS Agency has also received the necessary documentation confirming that Dr. Abramson has agreed to purchase drugs and medical supplies for LB and will be providing complete oversight to LB's controlled substance program.

I would like to welcome Dr. Abramson to the Los Angeles County EMS system. If there are any questions during this transition or in the future, please don't hesitate to contact me directly.

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:gw
08-11

c. Medical Director, Long Beach Fire Department
EMS Director, Long Beach Fire Department
Paramedic Coordinator, Long Beach Fire Department
Nurse Educator, Long Beach Fire Department

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

BASE HOSPITAL ADVISORY COMMITTEE MINUTES

August 12, 2020

MEMBERSHIP / ATTENDANCE
VIA ZOOM

	REPRESENTATIVES		EMS AGENCY STAFF
☒	Robert Ower, RN., Chair	EMS Commission	Dr. Marianne Gausche-Hill
☒	Carole Snyder, RN., Vice Chair	EMS Commission	Dr. Nichole Bosson
☐	Joe Salas	EMS Commission	Richard Tadeo
☒	Rachel Caffey	Northern Region	Christine Clare
☒	Melissa Carter	Northern Region	Jackie Rifenburg
☒	Charlene Tamparong	Northern Region, Alternate	Michelle Williams
☐	Samantha Verga-Gates	Southern Region	Paula Rashi
☒	Laurie Donegan	Southern Region	Cathy Jennings
☐	Shelly Trites	Southern Region	Susan Mori
☒	Christine Farnham, APCC Pres. Elect.	Southern Region, Alternate	David Wells
☒	Paula Rosenfield	Western Region	Christie Preston
☒	Ryan Burgess	Western Region	Christine Zaiser
☒	Alex Perez-Sandi	Western Region, Alternate	Dr. Denise Whitfield
☐	Erin Munde	Western Region, Alternate	Dr. Allen Cheng
☒	Laurie Sepke	Eastern Region	Mark Ferguson
☒	Alina Candal	Eastern Region	Gary Watson
☒	Jenny Van Slyke	Eastern Region, Alternate	John Telmos
☒	Lila Mier	County Hospital Region	Sara Rasnake
☒	Emerson Martell	County Hospital Region	Natalie Greco
☒	Yvonne Elizarraz	County Hospital Region, Alternate	Fritz Bottger
☒	Antoinette Salas	County Hospital Region, Alternate	**GUESTS**
☒	Alec Miller	Provider Agency Advisory Committee	Dr. Clayton Kazan, LACOFD
☒	Jennifer Nulty	Provider Agency Advisory Committee, Alt.	Dr. Ashley Sanello, Compton Fire
☐	Laarni Abdenoja	MICN Representative	Dr. Shira Schlesinger, HGH
☐	Jennifer Grere	MICN Representative, Alt.	
☐	Heidi Ruff	Pediatric Advisory Committee	

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

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

2. **APPROVAL OF MINUTES**: The meeting minutes for June 10, 2020, were approved as submitted.

   M/S/C (Donegan/Sepke)

3. INTRODUCTIONS/ANNOUNCEMENTS:

- Delays in Emergency Department Bed Availability for Patients Arriving Via Ambulance (Notification), presented as information only.

4. REPORTS & UPDATES:

4.1 EMS Update 2020

EMS Update 2020 completion deadline is September 1, 2020. Jackie Rifenburg, Chief of Certification & Program Approvals, is tracking completions and has notified the Base Hospitals of MICNs that have not completed EMS Update. A second notification will be sent out next week. Decertification letters will be mailed out to MICNs that do not complete EMS Update by the deadline date. For participants that are on extended leave and unable to complete EMS Update, please notify Jackie Rifenburg at, jrifenburg@dhs.lacounty.gov.

Richard Tadeo: Reminder, the Color Code App. has been updated to reflect the addition of Ketorolac.

4.2 EmergiPress

July EmergiPress was offered on the Advanced Problem Solving (APS) Learning Management System, allowing MICN's access to the same material offered on the EMS Agency website. The material is presented in an online course format, including course material, course test, course evaluation, and completion/CE certificate. EmergiPress will continue to be offered via the EMS Agency website, and will also be available via the APS Learning Management System.

4.3 PHAST-TSC

Update: The Pre-Hospital Administration of Stroke Therapy – Trans Sodium Crocetinate (PHAST-TSC) study has been on ongoing since January 2020, with the participation of Culver City Fire and Santa Monica Fire. Training has begun with Los Angeles County Fire Battalion 12 & Battalion 13, they will be transporting to PIH Health Hospital-Whittier (PIH), MemorialCare Long Beach Medical Center (LBM), and LAC+USC Medical Center. This study will also impact the Mobile Stroke Unit which will also be transporting to PIH and LBM. In the coming weeks, the EMS Agency will provide notification as the new Provider Agencies and Stroke Centers begin enrollment.

4.4 ECMO Pilot

Update: The extracorporeal membrane oxygenation (ECMO) Pilot, treatment and transport of patients in refractory ventricular fibrillation (VF) out of hospital cardiac arrest, has resumed. Participating providers include Culver City Fire, Beverly Hills Fire, and specific Los Angeles County Fire Stations equipped with the LUCAS device, will transport to Cedars Sinai and UCLA Medical Center. We will keep you informed as additional providers/hospitals enroll in the ECMO Pilot.

During this initial phase, there will be no change in patient routing. The most accessible receiving (MAR) hospitals will not be bypassed to transport to participating hospitals.

4.5 Data Collaboratives

We have multiple data collaboratives focusing on areas of interest including trauma, stroke, pediatrics, and STEMI. They meet regularly to discuss areas of interest and to evaluate our system, including policy changes, system changes, and how the system is impacted. Most recently, the focus has been COVID and how the system has been impacted and the dissemination of information.

4.6 Patient Care Report Workgroup

The Patient Care Report Workgroup was formed to improve communication between private prehospital care providers and receiving hospitals. The group met to discuss access to the private provider prehospital patient care record. In follow-up, a Hospital Information Spreadsheet has been distributed to collect contact information, please submit to Robert Ower at, rower@guardianambulance.net.

5. OLD BUSINESS:

None

6. NEW BUSINESS:

6.1 Ref. No. 510, Pediatric Patient Destination

Approved with the following recommended changes:

- I.A. - Add verbiage: 1. Newborn patient requiring assisted ventilation and/or chest compressions should be transported to the closest EDAP that is also a Perinatal Center with a NICU.
- I.A. – Add verbiage: 2. Newborn patient without distress should be transported to the nearest EDAP that is also a Perinatal Center.
- I.F. - Change verbiage to: Pediatric patients who have an uncontrollable, life-threatening situation (e.g., unmanageable airway or uncontrollable hemorrhage) should be transported to the most accessible EDAP.
- II. - Change verbiage to: Critically **ill** pediatric patients exhibiting conditions listed below should be transported to a PMC:

M/S/C (Van Slyke & Burgess)

6.2 Ref. No. 511, Perinatal Patient Destination

Approved as presented.

M/S/C (Burgess & Caffey)

6.3 Ref. No. 516, Cardiac Arrest (Non-Traumatic) Patient Destination

Approved as presented.

M/S/C (Perez-Sandi & Caffey)

6.4 Ref. No. 618, EMS Quality Improvement Program Committees

Approved as presented.

M/S/C (Van Slyke & Burgess)

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

Extensive discussion ensued regarding recommended changes. The policy was ultimately tabled for review by the EMS Agency. Following further revision, the policy will be returned to BHAC for review and approval.

The following were present as information only

6.6 Ref. No. 326, Psychiatric Urgent Care Center (PUCC) Standards
6.7 Ref. No. 328, Sobering Center (SC) Standards
6.8 Ref. No. 526, Behavioral/Psychiatric Crisis Patient Destination
Ref. No. 526.1, Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care Center
6.9 Ref. No. 528, Intoxicated (Alcohol) Patient Destination
Ref. No. 528.1, Medical Clearance Criteria Screening Tool for Sobering Center

7. OPEN DISCUSSION:

None

8. NEXT MEETING: BHAC's next meeting is scheduled for **October 14, 2020**, 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 3:07 P.M.

EMERGENCY MEDICAL SERVICES COMMISSION
DATA ADVISORY COMMITTEE
WEDNESDAY, AUGUST 12, 2020

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

MEMBERSHIP / ATTENDANCE		
MEMBERS	ORGANIZATION	EMS AGENCY
☒ Nerses Sanossian, Chair	EMS Commissioner (MD)	Denise Whitfield
□ Pajmon Zarrineghbal, Vice Chair	EMS Commissioner (Public Member, 4th District)	Richard Tadeo Christine Clare
□ Jim Lott	EMS Commissioner (Public Member, 2nd District)	Michelle Williams
☒ Lydia Lam	EMS Commissioner (American College of Surgeons)	Sara Rasnake
☒ Matt Armstrong	Ambulance Advisory Board (LACAA)	Joel Mendoza
□ Kris L. Thomas	Ambulance Advisory Board (alternate)	Susan Mori
☒ Christine Farnham	Base Hospital Advisory Committee (BHAC) (RN)	Lorrie Perez
☒ Gloria Guerra	BHAC (alternate)	OTHERS
☒ Ryan Burgess	Hospital Association of Southern California (HASC)	Eddie Light, Lancet by ESO
□ Nathan McNeil	HASC (alternate)	John Bennett, Lancet by ESO
☒ Don Gerety	Long Beach Fire Department (LBFD)	Brad Cottrell, ESO
☒ Brenda Bridwell	LBFD (alternate)	Brent Myers, ESO
☒ Sean Stokes	Los Angeles Area Fire Chiefs Association	Michael Natividad, AMH
□ VACANT	LA Area Fire Chiefs Association (alternate)	Colleen Harkins, AVH
☒ Nicole Steeneken	Los Angeles County Fire Department (LACoFD)	Alex Perez-Sandi, CAL
□ Victoria Hernandez	LACoFD (alternate)	Melissa Carter, HCH
☒ Matt Conroy	Los Angeles Fire Department (LAFD)	Yvonne Elizarraraz, HGH
□ John Smith	LAFD (alternate)	Antoinette Salas, HGH
☒ Marc Cohen	Medical Council (MD)	Jenny Van Slyke, HMH
□ VACANT	Medical Council (alternate)	Heidi Ruff, HMN
☒ Daniel Dobbs	Provider Agency Advisory Committee (PAAC)	Laurie Sepke, PVC
□ Ivan Orloff	PAAC (alternate)	Rachel Caffey, NRH
□ Tchaka Shepherd	Trauma Hospital Advisory Committee (THAC) (MD)	Chad Sibbett, SMM
☒ David Hanpeter	THAC (MD) (alternate)	Gina Sulmeyer, TOR
☒ Marilyn Cohen	THAC (RN)	Ashwin Rohra, TOR
☒ Gilda Cruz-Manglapus	THAC (RN) (alternate)	Leonila Mier, USC
		Emerson Martell, USC
		Andrew Reno, LBFD
		Sergio Nardi, Image Trend
		Kashi Khan, Image Trend
		Tori Koistinen, Image Trend
☒ Present *Excused □ Absent		

1. CALL TO ORDER: The meeting was called to order at 10:01 am by Commissioner Sanossian.

2. NEW BUSINESS

2.1 Lancet/ESO Health Data Exchange Demonstration *(Richard Tadeo, Brad Cottrell and Brent Myers)*

Lancet Technology was purchased by ESO Solutions in late 2019. One of ESO's products, Health Data Exchange (HDE), was recently introduced to the EMS Agency and could potentially benefit the EMS community. The HDE demonstration was also presented to the Innovation, Technology and Advancement Committee (ITAC) on August 3, 2020, where a workgroup will be formed to further explore the product.

Brad Cottrell and Brent Myers from ESO presented HDE to the committee. HDE is a platform designed to exchange data between the hospitals and EMS providers. The process for HDE begins upon patient arrival to the hospital, at which point the EMS provider scans a barcode specifically assigned to the patient. This allows the patient's medical record number and hospital visit number to be recorded into the EMS electronic patient care record (ePCR) and then the ePCR can be received into the patient's hospital electronic medical record (EMR). Once the patient is discharged, the patient's outcome will be sent to the applicable EMS provider. HDE also has analytic reporting, the most popular of which is comparing the EMS provider impression with the primary hospital diagnosis.

Extensive discussion ensued regarding what data can be shared amongst the entities and additional benefits for hospital registrars, prehospital care coordinators, and specialty centers, besides providing feedback to the EMS providers.

Concerns were voiced by the committee that because the ePCR is not available to be incorporated in the EMR until it is completed by the EMS provider, it may not beneficial from the hospital perspective to utilize HDE to assist in real-time care of a patient. The committee would like to know more about the value of the product for each stakeholder and how feasible it will be to integrate HDE into the hospitals' IT infrastructure.

A HDE information packet will be sent to the attendees and once the ITAC workgroup has explored the product, their recommendations will be brought to this committee.

3. **NEXT MEETING:** October 14, 2020 at 10:00 a.m. via Zoom

4. **ADJOURNMENT:** The meeting was adjourned at 10:57 am by Commissioner Sanossian.

County of Los Angeles
Department of Health Services

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

EMERGENCY MEDICAL SERVICES COMMISSION

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, August 19, 2020

Due to the ongoing COVID-19 pandemic and to comply with regulations on Social Distancing, this meeting was conducted via ZOOM conference call-in. Member's attendance was verified by presence on participant list. Quorum was reached and meeting continued.

MEMBERSHIP / ATTENDANCE

MEMBERS	ORGANIZATION
☑ Paul Rodriquez, Chair	EMSC, Commissioner
☐ David White, Vice-Chair	EMSC, Commissioner
☐ Eugene Harris	EMSC, Commissioner
☐ Brian Bixler	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)*
☑ Ken Leasure	Area C
☑ Lyn Riley	Area C, Alt.
☐ Ivan Orloff	Area E
☐ Mike Beeghly	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 Conroy	Area H, Alt. *(Rep to DAC)*
☐ Julian Hernandez	Employed Paramedic Coordinator
☐ Tisha Hamilton	Employed Paramedic Coordinator, Alt.
☑ Rachel Caffey	Prehospital Care Coordinator
☐ Jenny Van Slyke	Prehospital Care Coordinator, Alt.
☑ Andrew Respicio	Public Sector Paramedic
☑ Daniel Dobbs	Public Sector Paramedic, Alt.
☐ Maurice Guillen	Private Sector Paramedic
☐ Scott Buck	Private Sector Paramedic, Alt.
☐ Ashley Sanello, MD	Provider Agency Medical Director
☐ Vacant	Provider Agency Medical Director, Alt.
☑ Andrew Lara	Private Sector Nurse Staffed Ambulance Program
☐ Gary Cevello	Private Sector Nurse Staffed Ambulance Program, Alt.
☑ Michael Kaduce	EMT Training Program
☑ Scott Jaeggi	EMT Training Program, Alt.
☐ Danny Lopez	Paramedic Training Program
☐ Vacant	Paramedic Training Program, Alt.

EMS AGENCY STAFF (Virtual Attendance)

Marianne Gausche-Hill, MD	Nichole Bosson, MD
Denise Whitfield, MD	Richard Tadeo
Cathlyn Jennings	Jacqueline Rifenburg
John Telmos	Gary Watson

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

Due to technical difficulties, Chair Rodriquez was dropped off the call prior to calling the meeting to order. Chair Rodriguez was able to join the Committee's ZOOM conference call at a later time. Committee Member Andrew Lara self-nominated to filled in as Chair ProTem for this meeting until Commissioner Rodriquez rejoined; Member Scott Jaeggi second the motion, with no objections from the Committee.

1. **CALL TO ORDER:** Interim Committee Chair, Andrew Laura, called meeting to order at 1:13 p.m.

2. **INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS**

2.1 Commissioner David White - Retirement *(Cathy Chidester)*

- Commissioner David White has retired effective July 31, 2020. Chief White served as Commissioner representing the LA Area Fire Chiefs Association (LAAFCA) on EMS Commission and on this Committee since January 2016.
- Well wishes were shared throughout this Committee and other participants.

3. **APPROVAL OF MINUTES (Jaeggi/Caffey)** June 17, 2020 minutes were approved as written.

4. **REPORTS & UPDATES**

4.1 Disaster Services Update *(Elaine Forsyth)*

Nothing new to report.

4.2 2019 Novel Coronavirus *(Marianne Gausche-Hill, MD)*

- EMS Agency Medical Director thanked providers and hospitals who have been participating in the weekly calls on COVID-19 Updates.
- Los Angeles County is currently seeing mortality rates decreasing and hospitals continue to have adequate bed capacity to accommodate the current COVID-19 admissions.
- More information is available on the EMS Agency's and LAAFCA's webpages.

4.3 EMS Update 2020 *(Denise Whitfield, MD and Jacqueline Rifenburg)*

- Completion deadline for this year's EMS Update is September 1, 2020.
- This was the first year that this educational material was presented completely on-line. Based on course evaluations, objectives were achieved. Providers are encouraged to submit their attendance rosters as quickly as possible for those who have completed EMS Update.
- EMS Agency is beginning to plan for EMS Update 2021. Possible topics include: out of hospital cardiac arrests; Ref. 834, Treat and Refer; pediatric medication dosing; trauma and traumatic full arrests; teamwork and patient safety; de-escalation techniques; and MCI management.
- Those interested in participating in the development of EMS Update 2021 or those with comments/suggestions may contact Dr. Whitfield at dwhitfield@dhs.lacounty.gov.

4.4 EmergiPress Update *(Denise Whitfield, MD)*

- These continuing education (CE) modules continue to be available on the EMS Agency's webpage. Format will be changing to the same web-based platform as EMS Update.
- Questions regarding this change can be directed to Dr. Whitfield at dwhitfield@dhs.lacounty.gov.

4.5 PHAST-TSC Trial *(Marianne Gausche-Hill, MD and Nichole Bosson, MD)*

- Trial continues with more providers and hospitals joining.
- Planned participants include Los Angeles County Fire Department, PIH-Whittier Hospital and Long Beach Memorial.

4.6 ECMO Pilot *(Nichole Bosson, MD)*

- After pilot was initially placed on hold due to the COVID-19 pandemic, on July 27, 2020, the pilot resumed; and data collection has begun. (No enrollments thus far)
- As a reminder to all providers and hospitals participating in this pilot, patient destination for enrolled patients does not change. Providers are not to bypass the most accessible receiving hospital.

4.7 Documenting the Correct Receiving Hospital on ePCRs *(Cathlyn Jennings)*

Providers are reminded to document the correct 3-letter receiving hospital code on each patient care record. Receiving hospitals are unable to retrieve the ePCR unless this 3-letter code is documented correctly.

5. UNFINISHED BUSINESS

5.1 Reference No. 528, Intoxicated (Alcohol) Patient Destination *(Richard Tadeo)*

Policy approved with the following recommendation:

- Page 3, III, A. 1a.: Change wording to be more clear.

M/S/C (Haller/Leasure) Approved Reference No. 528, Intoxicated (Alcohol) Patient Destination, with above recommendation.

5.2 Reference No. 528.1, Medical Clearance Criteria Screening Tool for Sobering Center *(Richard Tadeo)*

Policy approved with the following recommendation:

- Page 1, 4. Glasgow Coma Score $\geq$ 14: Change to define best GCS.

M/S/C (Kazan/Respicio) Approved Reference No. 528.1, Medical Clearance Criteria Screening Tool for Sobering Center, with above recommendation.

6. NEW BUSINESS

6.1 Reference No. 328, Sobering Center (SC) Standards *(Richard Tadeo)*

Policy reviewed and approved as written.

M/S/C (Kazan/Leasure) Approved Reference No. 328, Sobering Center (SC) Standards.

6.2 Reference No. 326, Psychiatric Urgent Care Center (PUCC) Standards (*Richard Tadeo)*

Policy reviewed and approved as written.

M/S/C (Leasure/Dobbs) Approved Reference No. 326, Psychiatric Urgent Care Center (PUCC) Standards.

6.3 Reference No. 526, Behavioral / Psychiatric Crisis Patient Destination *(Richard Tadeo)*

Policy reviewed and approved as written.

M/S/C (Leasure/Kazan) Approved Reference No. 526, Behavioral / Psychiatric Crisis Patient Destination.

6.4 Reference No. 526.1, Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care *(Richard Tadeo)*

Policy reviewed and approved as written.

M/S/C (Dobbs/Jaeggi) Approved Reference No. 526.1, Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care.

6.5 Reference No. 510, Pediatric Patient Destination *(Christine Clare)*

Policy reviewed and approved with the following recommendation:

- Page 2, A.1 and A.2: Change word "Neonatal" to read "Newborn"

M/S/C (Dobbs/Haller) Approved Reference No. 510, Pediatric Patient Destination, with above recommendation.

6.6 Reference No. 511, Perinatal Patient Destination *(Christine Clare)*

Policy reviewed and approved with the following recommendation:

- Page 2, Policy V: Add wording similar to "when possible" or "when feasible".

M/S/C (Leasure/Dobbs) Approved Reference No. 511, Perinatal Patient Destination, with above recommendation.

6.7 Reference No. 516, Cardiac Arrest (Non-Traumatic) Patient Destination *(Christine Clare)*

Policy reviewed and approved as written.

Committee recommended Treatment Protocol, Reference No. 1210, Cardiac Arrest, be updated to align with Reference No. 516.

M/S/C (Kazan/Leasure) Approved Reference No. 516, Cardiac Arrest (Non-Traumatic) Patient Destination.

6.8 Reference No. 618, EMS Quality Improvement Program Committee *(Christine Clare)*

Policy reviewed and approved as written.

M/S/C (Dobbs/Haller) Approved Reference No. 618, EMS Quality Improvement Program Committee.

6.9 Reference No. 1013, EMS Continuing Education (CE) Provider Approval and Program Approval *(David Wells)*

Policy reviewed and approved with the following recommendations:

- Page 9, IX. A.: Add wording to include instructor-based education
- Page 9, IX. A. 1.: Add wording to state this applies to those courses that are open

to the public.
- Page 10, XI. 1.: Add wording “not to exceed 4 years”

M/S/C (Respicio/Leasure) Approved Reference No. 1013, EMS Continuing Education (CE) Provider Approval and Program Approval, with above recommendations.

7. OPEN DISCUSSION:

7.1 Influenza Immunization – Health Office Order *(Marianne Gausche-Hill, MD)*

In September 2020, the Los Angeles County Public Health Department will be coming out with another Health Officer Order for the influenza vaccine, which will be similar to the previous year, requiring EMS personnel who decline the immunization to wear masks while engaging in patient care. Additionally, this year provider agencies will be required to track and report their employee’s immunization compliance rates.
Those who are unable to receive the influenza vaccine, because of medical reasons, or decline the vaccination for other reasons, would be required to wear a mask while at work.

7.2 Ketorolac Reminder *(John Telmos)*

Providers are reminded, beginning September 1, 2020, Ketorolac is being added to the required inventory lists including, ALS Unit Inventory, Assessment Unit Inventory, ALS EMS Aircraft Inventory, Nurse Staffed SCT Inventory and Fireline EMT-P Inventory.

7.2 Personal Protective Equipment (PPE) *(John Telmos)*

The EMS Agency has distributed over 1.5 million surgical masks that were donated. Masks packaged in boxes that are marked “Not For Medical Use” are only to be used while inside stations or vehicles. These are not to be used during patient contacts.

8. NEXT MEETING: October 21, 2020

9. ADJOURNMENT: Meeting adjourned at 3:02 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

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

REFERENCE NO. 316

PURPOSE: To establish minimum standards for the designation of Emergency Departments Approved for Pediatrics (EDAP). These Emergency Departments (ED) provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures.

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

DEFINITIONS:

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

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

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

Emergency Department Approved for Pediatrics (EDAP): A licensed basic or comprehensive emergency department (ED) that is designated by the Emergency Medical Services (EMS) Agency to receive pediatric patients via the 9-1-1 system. These EDs provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures.

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

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

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

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

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

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

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

Pediatric Intensivist: A qualified specialist in Pediatric Critical Care.

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

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

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

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

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

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

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

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

POLICY:

I. EDAP Designation / Re-Designation

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

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

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

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

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

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

II. General Hospital Requirements

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

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

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

B. Appoint an EDAP Medical Director.

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

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

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

E. Pediatric Interfacility Transfer

Establish and maintain a written Interfacility Consultation and Transfer

Agreement for tertiary or specialty care, which shall include, at a minimum, the following:

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

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

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

III. EDAP Leadership Requirements

A. EDAP Medical Director

1. Responsibilities:

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

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

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

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

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

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

B. Designated Pediatric Consultant

1. Responsibilities:

a. Promptly available for consultation

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

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

d. May also be the EDAP Medical Director

C. ED Nurse Manager/Director

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

D. Pediatric Liaison Nurse (PdLN)

1. Qualifications:

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

b. Current PALS provider or instructor certification.

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

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

2. Responsibilities:

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

b. Implement, maintain, and monitor the EDAP QI program.

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

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

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

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

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

IV. Personnel Requirements

A. ED Physicians

1. 75% of the physicians attending in the ED shall be BC or BE in EM or PEM. 100% of the physicians attending in the ED shall be BC or BE in EM or PEM is recommended

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

3. ED Physicians who are not EM or PEM BC or BE shall have an affidavit signed by the EDAP Medical Director and Chief Medical Officer verifying competency in caring for pediatric patients, within the past two years.

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

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

C. Pediatric Subspecialty Services

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

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

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

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

E. Registered Nurses

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

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

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

V. Two-Day PEC – Continuing Education

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

B. The interval between Day/Part 1 and Day/Part 2 must be completed within a six-month period. If the interval between Day/Part 1 and Day/Part 2 is greater than

six months, this will only fulfill the 14-hour requirement in Section IV.E.2 above.

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

1. Airway management
2. Brief Resolved Unexplained Event (BRUE)
3. Burns
4. Child maltreatment (suspected child abuse, neglect, and sexual assault) to include the mandated reporting process
5. Coordination of care with a SART Center for an acute suspected sexual assault victim requiring a forensic examination
6. Death
7. Disaster preparedness
8. Fever
9. Female presenting with signs & symptoms of recent delivery and no history of giving birth / newborn abandonment
10. Human trafficking
11. Injury prevention
12. Medical conditions (e.g., diabetic ketoacidosis, inborn errors of metabolism, etc.)
13. Medication safety
14. Neonatal resuscitation
15. Pain management
16. Disaster management
17. Poisonings / overdose
18. Procedural sedation
19. Respiratory emergencies
20. Resuscitation
21. Seizures
22. Sepsis
23. Shock / hypotension
24. SIDS/SUID
25. Special health care needs
26. Submersions
27. Surgical emergencies
28. Trauma
29. Triage

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

VI. Ancillary Services

A. Respiratory Care Practitioners (RCP)

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

2. All RCPs that work or respond to the ED shall have a PALS provider or instructor certification.

B. Radiology

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

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

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

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

a. Computerized tomography (CT)

b. Ultrasonography

c. Magnetic resonance Imaging (MRI)

C. Laboratory

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

VII. Policies and Procedures

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

A. Weight and Vital Sign Measurement:

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

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

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

a. Children shall be weighed in kilograms. For children who require emergency stabilization or those who cannot be safely weighed, a length-based resuscitation tape, approved by the EMS Agency (e.g., Broselow 2011A or newer), may be used to estimate weight in kilograms. The weight shall be recorded in a prominent place on the medical record such as with the vital signs.

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

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

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

C. Immunization assessment and management of the under immunized patient

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

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

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

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

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

4. Collaborative discussion shall occur with Social Worker, ED Physician, and RN prior to patient being discharged, to ensure patient is discharged to the appropriate location or with the appropriate services.

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

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

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

2. ED nurse or physician shall notify the law enforcement agency in the

appropriate jurisdiction where the crime occurred.

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

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

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

3. Appropriate discharge and referral.

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

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

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

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

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

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

L. Physical and chemical restraint of patients

M. Procedural sedation

N. Reducing radiation exposure for pediatric patients

O. Safe surrender of newborns

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

Q. Family Centered Care, include the following:

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

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

3. Discharge planning and instructions

4. Culturally and linguistically appropriate services

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

S. Transfer from the ED to another facility

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

U. Disaster preparedness addressing the following pediatric issues:

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

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

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

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

5. Decontamination

V. Medication safety addressing the following pediatric issues:

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

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

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

VIII. Equipment, Supplies, and Medications

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

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

C. Required EDAP equipment, supplies, and medications

1. General Equipment

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

b. Standardized length-base resuscitation tape, approved by the EMS Agency (e.g., Broselow 2011A or newer), or other standardized method to estimate pediatric weights in kilograms

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

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

e. Blood and IV fluid warmer (Rapid infuser)

f. Warming and cooling system with appropriate disposable blankets

g. Restraints in various sizes

2. Monitoring Equipment

a. Blood pressure cuffs

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

b. Vascular Doppler device (handheld)

c. ECG monitor/defibrillator

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

d. Thermometer with hypothermia capability

3. Airway Management

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

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

b. BMV clear masks

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

c. Laryngoscope handle

1) Pediatric
2) Adult

d. Laryngoscope Blades

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

e. Endotracheal Tubes

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

f. Stylets for endotracheal tubes

1) Pediatric
2) Adult

g. Magill Forceps

1) Pediatric
2) Adult

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

i. Pulse oximeter unit with sensors

1) Infant
2) Pediatric
3) Adult

j. Nasopharyngeal Airways

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

k. Oropharyngeal Airways

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

l. Clear oxygen masks

1) Infant
2) Child
3) Adult

m. Non-rebreather masks

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

n. Nasal cannulas

1) Infant
2) Child
3) Adult

o. Suction catheters

6, 8, 10, 12 Fr

p. Yankauer suction tips

q. Feeding tubes

5, 8 Fr

r. Nasogastric Tubes

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

s. Supraglottic Airway Devices

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

t. Difficult Airway Kit

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

1) Pediatric
2) Adult

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

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

4. Vascular Access Equipment

a. Arm boards

1) Infant
2) Child
3) Adult

b. IV administration sets with calibrated chambers

c. IV catheters

16, 18, 20, 22, 24 gauge

d. 3-way stopcocks

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

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

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

5. Fracture Management Devices

a. Splinting supplies for long bone fractures

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

1) Pediatric
2) Adult

c. Spinal board with the appropriate straps

6. Specialized Trays or Kits

a. Newborn delivery kit to include:

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

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

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

c. Thoracostomy tray

d. Chest drainage system

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

1) Required for EDAP: (10 – 12) (16 – 24) (28 – 40) Fr
2) Required for PMC: 8, 12, 16, 20, 24, 28, 36 Fr

f. Lumbar Puncture trays and spinal needles

1) 22 g, 3 inch
2) 22-25 g, 1½ inch

g. Urinary catheterization sets and indwelling urinary catheters

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

7. Pediatric-Specific Resuscitation

a. Immediately available drug calculation resources

b. The following medications must be immediately available:

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

IX. Quality Improvement (QI) Program Requirements

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

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

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

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

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

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

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

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

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

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

X. Data Collection Requirements

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

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

CROSS REFERENCE:

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

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

ACKNOWLEDGEMENTS

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

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

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

REFERENCE NO. #316, Emergency Department Approved for Pediatric (EDAP

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee			
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee			
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee	9/8/2020	9/8/2020	N
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **PSYCHIATRIC URGENT CARE CENTER (PUCC) STANDARDS** REFERENCE NO. 326

PURPOSE: To establish minimum standards for the designation of Psychiatric Urgent Care Centers (PUCC).

AUTHORITY: Health & Safety Code, Division 5, Sections 1797.220, 1798
Title 22, California Code of Regulations, Section 100170 (a)(5)

DEFINITIONS:

Behavioral/Psychiatric Crisis: A provider impression for patients who are having a mental health crisis or a mental health emergency. This is not for anxiety or agitation secondary to medical etiology.

Emergency Medical Condition: A condition or situation in which an individual has an immediate need for medical attention. The presence of abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure – except isolated asymptomatic hypertension, oxygen saturation) are also indications of an emergency medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital Notification (Ref. No. 1200.2) are also considered to have an emergency medical condition.

Psychiatric Urgent Care Center (PUCC): A mental health facility authorized by the Department of Mental Health and approved by the EMS Agency by meeting the requirements in this Standards.

PUCC EMS Liaison Officer: A qualified administrative personnel appointed by the PUCC to coordinate all activities related to receiving patients triaged by paramedics whose primary provider impression is Behavioral/Psychiatric Crisis.

POLICY:

I. General Requirements

A designated PUCC shall:

A. Be authorized by the Department of Mental Health to provide mental health services

B. Operate 24 hours a day, 7 days a week, 365 days a year

C. Provide up to 23 hours of immediate care focusing on intensive crisis services

D. Provide and maintain adequate parking for ambulance vehicles to ensure access of PUCC

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

E. Appoint a PUCC EMS Liaison Officer to act as a liaison between the EMS Agency and the authorized EMS provider agency

F. Accept all patients who have been triaged by paramedics regardless of the patient's ability to pay (see Inclusion Criteria in Ref. No. 526, Behavioral/Psychiatric Crisis Patient Destination)

G. Maintain General Liability Insurance as follows:

1.	General aggregate	$2 million
2.	Products/completed operations aggregate	$1 million
3.	Personal and advertising injury	$1 million
4.	Each occurrence	$1 million
5.	Sexual Misconduct	$2 million per claim and $2 million aggregate
6.	Worker's Compensation and Employers Liability	$1 million per accident

II. PUCC Leadership and Staffing Requirements

A. PUCC EMS Liaison Officer

1. Responsibilities:

a. Implement and ensure compliance with the PUCC Standards

b. Maintain direct involvement in the development, implementation and review of PUCC policies and procedures related to receiving patients triaged by paramedics to the PUCC

c. Serve as the key personnel responsible for addressing variances in the care and sentinel events as it relates to patients triaged by paramedics to the PUCC

d. Liaison with EMS Provider Agencies and law enforcement agencies

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

B. A physician licensed in the State of California shall be on-call at all times.

C. A registered nurse licensed in the State of California shall be on-site at all times.

D. Staffing may be augmented by licensed psychiatric nurse practitioners, licensed vocational nurses, social workers, and other mental health professionals.

E. All medical and nursing staff shall have current certification on Cardiopulmonary Resuscitation (CPR) through the American Heart Association or Red Cross.

III. Policies and Procedures

Develop, maintain and implement policies and procedures that address the following:

A. Receipt, immediate evaluation, short term management and monitoring of patients who meet PUCC triage inclusion criteria

B. Timely transfer of patients who require a higher level of care to an acute care hospital utilizing non-911 ambulance provider(s)

C. Immediate transfer of patients with emergency medical condition to the most accessible 9-1-1 receiving facility/emergency department

D. Record keeping of EMS Report Forms

E. Data reporting requirements established by the EMS Agency

F. Procedure for notifying the EMS Agency of patient transfers from PUCC requiring 9-1-1 transport for an emergency medical condition within six hours of admission to the PUCC; notification shall be provided as soon as possible, but not to exceed 72 hours after such transport (s)

IV. Equipment and Supplies

A. Dedicated telephone line to facilitate direct communication with EMS personnel

B. ReddiNet® capability to communicate PUCC's real-time capacity status

C. Public Access Device/Layperson Automated External Defibrillator on site with staff trained on its proper use

D. An up-to-date community referral list of services and facilities available to patients

V. Procedure for Approval to be a designated PUCC

A. Submit a written request to the Director of the EMS Agency to include:

1. The rationale for the request to be a designated PUCC

2. A document verifying that the facility has been approved by the Department of Mental Health to provide mental health services (i.e., written service agreement)

3. The proposed date the PUCC will open to accept patients triaged by paramedics to the PUCC

4. Copies of the policies and procedures required in Section III

5. Proposed Staffing

6. Hours of operation

B. Site Visit

1. Once all General Requirements are met, the EMS Agency will coordinate a site visit to verify compliance with all the requirements.

2. Administrative and field personnel from local EMS provider agencies will be invited to exchange contact information, and become familiar with the physical layout of the facility.

C. PUCC Designation/Re-Designation

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

VI. Other Requirements

A. The EMS Agency reserves the right to perform scheduled site visits or request additional data from the PUCC at any time.

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

C. The PUCC shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw as a designated PUCC.

D. The PUCC shall notify the EMS Agency within 15 days, in writing of any change in status of the PUCC Program Coordinator by submitting Ref. No. 621.2, Notification of Personnel Change Form.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 326.1, **Designated Psychiatric Urgent Care Center (PUCC) Roster**
Ref. No. 526, **Behavioral/Psychiatric Crisis Patient Destination**
Ref. No. 621.2, **Notification of Personnel Change Form**

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

Ref. No. 326, PSYCHIATRIC URGENT CARE CENTER (PUCC) STANDARDS

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	12/11/19	12/11/19	
	Data Advisory Committee			
	Provider Agency Advisory Committee	12/18/19	8/19/20	
	Medical Council	03/03/20	03/03/20	
OTHER COMMITTEES / RESOURCES	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California – EHS Committee	02/06/20	02/06/20	
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **SOBERING CENTER (SC) STANDARDS** REFERENCE NO. 328

PURPOSE: To establish minimum standards for the designation of Sobering Centers (SC).

AUTHORITY: Health & Safety Code, Division 5, Sections 1797.220, 1798
Title 22, California Code of Regulations, Section 100170 (a)(5)

DEFINITIONS:

Alcohol Intoxication: A patient who appears to be impaired from alcohol, demonstrated by diminished physical and mental control **with** evidence of recent alcohol consumption (e.g., alcohol on breath, presence of alcoholic beverage container(s)) and **without** other acute medical or traumatic cause. Alcohol intoxication is typically associated with one of more of the following:

- Speech disturbance – incoherent, rambling, slurring
- Decline in cognitive function – confusion, inappropriate behavior, impaired decision-making capacity
- Imbalance – unsteady on feet, staggering, swaying
- Poor coordination – impaired motor function, inability to walk a straight line, fumbling for objects

Emergency Medical Condition: A condition or situation in which an individual has an immediate need for medical attention. The presence of abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure – except isolated asymptomatic hypertension, oxygen saturation) are also indications of an emergency medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital Notification (Ref. No. 1200.2) are also considered to have an emergency medical condition.

Sobering Center (SC): A non-correctional facility designated by a city or county to provide a safe, supportive environment for intoxicated individuals to become sober. A SC shall be approved by the EMS Agency by meeting the requirements in this Standards.

SC EMS Liaison Officer: A qualified administrative personnel appointed by the SC to coordinate all activities related to receiving patients triaged by paramedics whose primary provider impression is Alcohol Intoxication.

POLICY:

I. General Requirements

A designated SC shall:

A. Be designated by a city or county to provide a safe, supportive environment for intoxicated individuals to become sober

B. Operate 24 hours a day, 7 days a week, 365 days a year

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

C. Provide and maintain adequate parking for ambulance vehicles to ensure access of SC

D. Appoint a SC EMS Liaison Officer to act as a liaison between the EMS Agency and the authorized EMS provider agency

E. Accept all patients who have been triaged by paramedics regardless of the patient's ability to pay (see Inclusion Criteria in Ref. No. 528, Intoxicated (Alcohol) Patient Destination)

F. Maintain General Liability Insurance as follows:

1.	General aggregate	$2 million
2.	Products/completed operations aggregate	$1 million
3.	Personal and advertising injury	$1 million
4.	Each occurrence	$1 million
5.	Sexual Misconduct	$2 million per claim and $2 million aggregate
6.	Worker's Compensation and Employers Liability	$1 million per accident

II. SC Leadership and Staffing Requirements

A. SC EMS Liaison Officer

1. Responsibilities:

a. Implement and ensure compliance with the SC Standards

b. Maintain direct involvement in the development, implementation and review of SC policies and procedures related to receiving patients triaged by paramedics to the SC

c. Serve as the key personnel responsible for addressing variances in the care and sentinel events as it relates to patients triaged by paramedics to the SC

d. Liaison with EMS Provider Agencies and law enforcement agencies

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

B. A physician licensed in the State of California shall be on-call at all times.

C. A registered nurse licensed in the State of California shall be on-site at all times.

D. Staffing may be augmented by licensed nurse practitioners, licensed vocational nurses, social workers, and other mental health professionals.

E. All medical and nursing staff shall have current certification on Cardiopulmonary Resuscitation (CPR) through the American Heart Association or Red Cross.

III. Policies and Procedures

Develop, maintain and implement policies and procedures that address the following:

A. Receipt, immediate evaluation, short term management and monitoring of patients who meet SC triage inclusion criteria

B. Timely transfer of patients who require a higher level of care to an acute care hospital utilizing non-911 ambulance provider(s)

C. Immediate transfer of patients with emergency medical condition to the most accessible 9-1-1 receiving facility/emergency department

D. Record keeping of EMS Report Forms

E. Data reporting requirements established by the EMS Agency

F. Procedure for notifying the EMS Agency of patient transfers from SC requiring 9-1-1 transport for an emergency medical condition within six hours of admission to the SC; notification shall be provided as soon as possible, but not to exceed 72 hours after such transport(s)

IV. Equipment and Supplies

A. Dedicated telephone line to facilitate direct communication with EMS personnel

B. ReddiNet® capability to communicate SC's real-time capacity status

C. Public Access Device/Layperson Automated External Defibrillator on site with staff trained on its proper use.

D. An up-to-date community referral list of services and facilities available to patients

V. Procedure for Approval to be a designated SC

A. Submit a written request to the Director of the EMS Agency to include:

1. The rationale for the request to be a designated SC

2. A document verifying that the facility has been designated by a city or county to provide a safe, supportive environment for intoxicated individuals to become sober

3. The proposed date the SC will open to accept patients triaged by paramedics to the SC

4. Copies of the policies and procedures required in Section III

5. Proposed Staffing

6. Hours of operation

B. Site Visit

1. Once all General Requirements are met, the EMS Agency will coordinate a site visit to verify compliance with all the requirements.

2. Administrative and field personnel from local EMS provider agencies will be invited to exchange contact information, and become familiar with the physical layout of the facility.

C. SC Designation/Re-Designation

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

VI. Other Requirements

A. The EMS Agency reserves the right to perform scheduled site visits or request additional data from the SC at any time.

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

C. The SC shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw as a designated SC.

D. The SC shall notify the EMS Agency within 15 days, in writing of any change in status of the SC Program Coordinator by submitting Ref. No. 621.2, Notification of Personnel Change Form.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 328.1, **Designated Sobering Center (SC) Roster**
Ref. No. 528, **Intoxicated (Alcohol) Patient Destination**
Ref. No. 621.2, **Notification of Personnel Change Form**

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

Ref. No. 328, SOBERING CENTER (SC) STANDARDS

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	12/11/19	12/11/19	
	Data Advisory Committee			
	Provider Agency Advisory Committee	12/18/19	8/19/20	
	Medical Council	03/03/20	03/03/20	
OTHER COMMITTEES / RESOURCES	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California – EHS Committee	02/06/20	02/06/20	
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT-I, PARAMEDIC, MICN)

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

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

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

DEFINITIONS:

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

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

Newly Born: Refers to patients from birth to two hours after birth.

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

Pediatric Patient: Children 14 years of age or younger.

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

PRINCIPLE:

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

POLICY:

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

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

A. Patients who require transport, and do not meet guidelines for transport to a PMC or PTC should be transported to the most accessible EDAP.

1. Newly born patient requiring assisted ventilation and/or chest compression should be transported to the most accessible EDAP that is also a Perinatal Center with a NICU
2. Newly born patient without distress should be transported to the nearest EDAP that is also a Perinatal Center.

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

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

D. Patients meeting conditions listed in Section II:

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

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

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

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

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

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

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

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

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

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

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

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

II. Critically **ill** pediatric patients exhibiting conditions listed below should be transported to a PMC:

A. Cardiac dysrhythmia

B. Severe respiratory distress

C. Cyanosis

D. Persistent altered mental status

E. Status epilepticus

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

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

H. Post cardiopulmonary arrest in whom return of spontaneous circulation (ROSC) is achieved

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

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

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 316, **EDAP Standards**
Ref. No. 318, **Pediatric Medical Care (PMC) Standards**
Ref. No. 324, **Sexual Assault Response Team (SART) Standards**
Ref. No. 501, **9-1-1 Receiving Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 504, **Trauma Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 508.1, **SART Center Roster**
Ref. No. 511, **Perinatal Patient Destination**
Ref. No. 512, **Burn Patient Destination**
Ref. No. 516, **Cardiac Arrest Patient Destination**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 816, **Physician at Scene**
Ref. No. 832, **Treatment/Transport of Minors**
Ref. No. 834, **Patient Refusal of Treatment/Transport and Treat and Release at Scene**
Ref. No. 1200.1, **Treatment Protocols General Instructions**

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

REFERENCE NO. #510, Pediatric Patient Destination

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	8/12/2020	8/12/2020	Y
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee	8/19/2020	8/19/2020	Y
OTHER COMMITTEES / RESOURCES	Medical Council	9/8/2020	9/8/2020	Y
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee	9/8/2020	9/8/2020	N
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

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

REFERENCE NO. #510, Pediatric Patient Destination

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy I. D.	BHAC 8-12-2020	Change"…medical guidelines for transport to a PMC" to "…conditions listed in Section II"	Change Made
Policy I. D.1	BHAC 8-12-2020	Change "Shall" to "Should"	Change Made
Policy I. E.1	BHAC 8-12-2020	Change "Shall" to "Should"	Change Made
Policy I. F.	BHAC 8-12-2020	Change "Shall" to "Should"	Change Made
Policy II.	BHAC 8-12-2020	Change "Guidelines for identifying critically ill pediatric patients who require transport to a PMC" to "Critically ill pediatric patients exhibiting conditions listed below should be transported to a PMC"	Change Made
Policy I.A.1	PAAC 8-12-2020	Change "Neonatal" to "Newborn"	Change made
Policy I.A.2	PAAC 8-12-2020	Change "Neonatal" to "Newborn"	Change made
Definitions	MAC 9-8-2020	Add definition for 'Newly Born'	Added
Policy I.A.	MAC 9-8-2020	Change 'shall' to 'should'	Change made
Policy I.A.1	MAC 9-8-2020	Change 'Newborn' to 'Newly born'	Change made
Policy I.A.2	MAC 9-8-2020	Change 'Newborn' to 'Newly born'	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES **DRAFT**

(EMT, PARAMEDIC, MICN)

SUBJECT: **PERINATAL PATIENT DESTINATION** REFERENCE NO. 511

PURPOSE: To provide guidelines for transporting perinatal patients to the most accessible facility appropriate to their needs.

DEFINITIONS:

Newly born: Refers to patients from birth to two hours after birth.

Perinatal: Refers to patients who are at least 20 weeks pregnant.

Perinatal Center: Refers to a general acute care hospital with a basic emergency department permit and obstetrical service. This terminology is not intended to indicate the absence or presence of a neonatal intensive care unit (NICU).

EDAP: Emergency Department Approved for Pediatrics

PMC: Pediatric Medical Center

PTC: Pediatric Trauma Center

PRINCIPLES:

1. Perinatal patients should be transported to the most accessible facility appropriate to their needs. This determination will be made by the base hospital physician or Mobile Intensive Care Nurse (MICN) after consideration of the guidelines established in this policy. Final authority for patient destination rests with the base hospital handling the call.

2. If delivery occurs prior to arrival at a hospital, the mother and the newborn should be transported to the same facility.

3. BLS units shall call for an ALS unit on perinatal patients who meet criteria outlined in Ref. No. 1200.4, BLS Upgrade to ALS Assessment; or transport perinatal patients to the most accessible perinatal center.

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

5. For destination specific for the newly born, refer to Ref. No. 510, Pediatric Patient Destination.

POLICY:

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

I. The following perinatal patients should be transported to the most accessible perinatal center:

   A. Patients who appear to be in active labor, whether or not delivery appears imminent

   B. Patients whose chief complaint appears to be related to the pregnancy. Patients who appear to be having perinatal complications

   C. Injured patients who do not meet trauma criteria or guidelines

   D. Patients with hypertension (blood pressure 140/90 mmHg or greater)

II. Post-partum patients (up to 6 weeks) with hypertension (blood pressure 140/90 mmHg or greater) shall be transported to a perinatal center.

III. Perinatal patients who have delivered prior to arriving at a health facility should be transported to the most accessible perinatal center which is also an EDAP (consider a perinatal center with a NICU).

IV. Perinatal patients meeting trauma criteria and/or guidelines should be transported to a trauma center.

V. Perinatal patients in cardiac arrest should be transported to a ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) that is also a Perinatal Center when feasible.

VI. Perinatal patients for whom transportation to a perinatal center would exceed 30 minutes should be transported to a receiving facility which is also an EDAP.

VII. The following perinatal patients should be transported to the most accessible receiving facility:

   A. Patients in acute respiratory distress

   B. Patients whose chief complaint is clearly not related to the pregnancy

VIII. Consideration may be given by the base hospital to:

   A. Direct patients who are equal to or less than 34 weeks pregnant, whose chief complaint appears to be related to the pregnancy, to a perinatal receiving facility with a NICU, regardless of service area considerations/rules.

   B. Honor patient destination requests for those patients who have made previous arrangements for obstetrical care at a given hospital. This consideration should be based on the following:

      1. If the condition of the patient permits such transport

      2. Transportation to the requested obstetrical facility would not exceed 30 minutes and would not unreasonably remove the ALS unit from its area of primary response

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 502, **Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 516, **Cardiac Arrest (Non-Traumatic) Patient Destination**
Ref. No. 834, **Patient Refusal of Treatment/Transport and Treat and Release at Scene**

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

REFERENCE NO. #511, Perinatal Patient Destination

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	8/12/2020	8/12/2020	N
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee	8/19/2020	8/19/2020	Y
OTHER COMMITTEES / RESOURCES	Medical Council	9/8/2020	9/8/2020	Y
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee	9/8/2020	9/8/2020	N
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

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

REFERENCE NO. 511, Perinatal Patient Destination

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Principles, 5	PAAC 8/19/2020	Change 'neonate' to 'newborn'	Change made
Policy, V.	PAAC 08/19/2020	Add 'when feasible' to end of statement	Added
Definitions	MAC 09/08/2020	Add definition for 'Newly born'	Added
Principle 5	MAC 09/08/2020	Change 'newborn' to 'newly born'	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC, MICN)

SUBJECT: **CARDIAC ARREST (NON-TRAUMATIC) PATIENT DESTINATION**

REFERENCE NO. 516

PURPOSE: To ensure that 9-1-1 patients in cardiopulmonary arrest (non-traumatic) are transported to the most appropriate facility that is staffed, equipped and prepared to perform resuscitative measures.

This policy does not apply to traumatic arrest or to decompression emergencies. For decompression emergencies, refer to Ref. No. 518, Decompression Emergencies/Patient Destination.

AUTHORITY: Health & Safety Code, Division 2.5, Sections, 1798

DEFINITIONS:

Cardiac Etiology: Sudden cardiac death from ischemic heart disease, congenital heart disease, channelopathy or dysrhythmia. One presumes cardiac etiology when it is a sudden event without evidence of alternate causes (e.g. trauma, terminal illness, overdose, sepsis, drowning, or respiratory arrest).

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

ST-Elevation Myocardial Infarction (STEMI): An acute myocardial infarction that generates ST-segment elevation on the prehospital 12-lead electrocardiogram (ECG).

STEMI Receiving Center (SRC): An acute care facility licensed for a cardiac catheterization laboratory and cardiovascular surgery by the California Department of Public Health and designated by the Los Angeles County EMS Agency as a SRC.

PRINCIPLE:

1. In all cases, the health and well-being of the patient is the overriding consideration in determining patient destination. Factors to be considered include: clinical presentation, severity and stability of the patient's condition; current status of the SRC; anticipation of transport time; and request by the patient, family, guardian or physician.

2. Optimal post cardiac arrest treatment may include an interventional cardiac procedure in a significant percentage of patients.

3. Resuscitation efforts for patients greater than 14 years of age who are in non-traumatic cardiopulmonary arrest should take place in the field until ROSC is achieved or the patient is pronounced. Transport of patients without ROSC is discouraged with the exception of patients who qualify for ECMO transported on a mechanical compression device by an approved provider agency.

APPROVED: _____ _____

Director, EMS Agency | Medical Director, EMS Agency

4. For cardiac arrest in patients age 14 and younger, refer to Reference No. 510, Pediatric Patient Destination.

5. Patients with refractory ventricular fibrillation (3 or more shocks) or EMS witnessed arrests of presumed cardiac etiology may benefit from transport to the SRC for consideration of percutaneous coronary intervention despite prolonged resuscitation.

POLICY:

I. Establish base hospital contact for medical direction for all cardiac arrest patients who do not meet criteria for determination of death per Ref. No. 814.

II. For patients with STEMI and ROSC, direct contact with the receiving SRC shall be established for patient notification and/or to discuss cath lab activation criteria.

III. Patients with non-traumatic cardiac arrest shall be transported to the most accessible open SRC if ground transport is 30 minutes or less regardless of service area boundaries including:

   A. Patients with sustained ROSC

   B. Patients with ROSC who re-arrest en route

   C. Patients with persistent cardiac arrest for whom the Base Physician determines transport is required, because futility is not met despite lack of ROSC with on scene resuscitation

   D. Patients who have progressed into cardiopulmonary arrest while en route and had a pre-arrest STEMI 12-lead ECG.

IV. Cardiac arrest patients who meet SRC transportation criteria should be transported to the most accessible SRC regardless of **ED Diversion** status.

V. If ground transport time to a SRC is greater than 30 minutes, the patient shall be transported to the most accessible receiving facility.

VI. If the closest SRC has requested **SRC Diversion** (as per Ref. No. 503), cardiac arrest patients who meet SRC transportation criteria should be transported to the **next** most accessible **open** SRC if ground transport time is less than 30 minutes.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 501, **Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref No. 506, **Trauma Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 517, **Private Provider Agency Transport/Response Guidelines**
Ref. No. 518, **Decompression Emergencies/Patient Destination**
Ref. No. 1210, **Cardiac Arrest**

Ref. No. 1303, **Algorithm for Cath Lab Activation**
Ref. No. 1308, **Cardiac Monitoring/12-Lead ECG**

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

REFERENCE NO. #516, Cardiac Arrest (Non-Traumatic) Patient Destination

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	8/12/2020	8/12/2020	N
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee			
OTHER COMMITTEES / RESOURCES	Medical Council	9/7/2020	9/7/2020	N
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee	9/7/2020	9/7/2020	N
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC)

SUBJECT: **BEHAVIORAL / PSYCHIATRIC CRISIS PATIENT DESTINATION** REFERENCE NO. 526

PURPOSE: To provide guidelines for the transport of patients with a primary provider impression of Behavioral/Psychiatric Crisis to the most appropriate facility that is staffed, equipped and prepared to administer medical care appropriate to the needs of the patient.

AUTHORITY: Health & Safety Code, Division 5, Sections 1797.220, 1798
Title 22, California Code of Regulations, Section 100170 (a)(5)

DEFINITIONS:

Behavioral/Psychiatric Crisis: A provider impression for patients who are having a mental health crisis or a mental health emergency. This is not for anxiety or agitation secondary to medical etiology.

Emergency Medical Condition: A condition or situation in which an individual has an immediate need for medical attention. The presence of abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure, and oxygen saturation – except isolated asymptomatic hypertension) are also indications of an emergency medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital Notification (Ref. No. 1200.2) are also considered to have an emergency medical condition.

Mental Health Crisis: Is a non-life threatening situation in which an individual is exhibiting extreme emotional disturbance or behavioral distress, considering harm to self or others, disoriented or out of touch with reality, has a compromised ability to function, or is otherwise agitated and unable to be calmed. Examples of mental health crisis includes:

- Talking about suicide threats
- Talking about threatening behavior
- Self-injury, but not needing immediate medical attention
- Alcohol or substance abuse
- Highly erratic or unusual behavior
- Eating disorders
- Not taking their prescribed psychiatric medications
- Emotionally distraught, very depressed, angry or anxious

Mental Health Emergency: Is a life-threatening situation in which an individual is imminently threatening harm to self or others, severely disoriented or out of touch with reality, has a severe inability to function, or is otherwise distraught and out of control. Examples of a mental health emergency includes:

- Acting on a suicide threat
- Homicidal or threatening behavior
- Self-injury needing immediate medical attention

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

- Severely impaired by drugs or alcohol
- Highly erratic or unusual behavior that indicates very unpredictable behavior and/or inability to care for themselves

Most Accessible Receiving Facility (MAR): Is the geographically closest (by distance) 9-1-1 Receiving Hospital approved by the EMS Agency to receive patients with emergency medical conditions from the 9-1-1 system.

Psychiatric Urgent Care Center (PUCC): A mental health facility authorized by the Department of Mental Health and approved by the EMS Agency by meeting the requirements in Ref. No. 326, Psychiatric Urgent Care Center Standards.

PRINCIPLES:

1. EMS provider agencies must be approved by the Emergency Medical Services (EMS) Agency to triage patients with behavioral/psychiatric crisis to a designated PUCC.

2. Paramedics who have completed an 8-hour educational session regarding the triage of patients to a PUCC are the only EMS personnel authorized to utilize this policy.

3. Patients exhibiting mental health crisis who meet PUCC inclusion criteria may also be released at the scene to the local law enforcement agency. Law enforcement officers are highly encouraged to transport these patients to a designated PUCC. Paramedics shall document on the EMS Report Form to whom the patient was released.

4. In instances where there is a potential for the patient to harm self or others, EMS personnel shall consider seeking assistance from law enforcement.

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

POLICY:

I. Responsibilities of the Paramedic

   A. Complete an 8-hour educational session regarding the triage of patients to a designated PUCC

   B. Comply with all patient destination policies established by the EMS Agency

II. EMS Provider Agency Requirements and Responsibilities

   A. Submit a written request to the Director of the EMS Agency for approval to triage patients who meet PUCC Inclusion Criteria. The written request shall include the following:

      1. Date of proposed implementation date

      2. Scope of deployment (identify response units)

3. Course/Training Curriculum addressing all items in Section IV

4. Identify a representative to act as the liaison between the EMS Agency, designated PUCC(s), and the EMS Provider Agency

5. Policies and procedures listed in Section B

B. Develop, maintain and implement policies and procedures that address the following:

1. Completion of one Medical Clearance Criteria Screening Tool for each patient (see sample Ref. No. 526.1)

2. Pre-arrival notification of the PUCC

3. Patient report to a licensed health care provider or physician at the PUCC

4. Confirmation that PUCC has the capacity to accept the patient prior to transport

C. Develop a Quality Improvement Plan or Process to review variances and adverse events

D. Comply with data reporting requirements established by the EMS Agency

III. Psychiatric Urgent Care Clinic (PUCC) Patient Triage Criteria

A. Inclusion Criteria – patients who meet the following criteria may be triaged for transport to a designated PUCC provided the PUCC can be accessed within a fifteen (15) minute transport time:

1. Provider impression of behavior/psychiatric crisis; and

a. Voluntarily consented or 5150 hold; and

b. Ambulatory, does not require the use of a wheelchair; and

c. NO emergent medical condition or trauma (with exception of ground level fall with injuries limited to minor abrasions below the clavicle); and

d. No focal neurological deficit

2. Age: ≥ 18 years and ≤65 years old

3. Vital Signs

a. Heart rate ≥60 bpm and ≤120 bpm

b. Respiratory rate ≥12 rpm and ≤24 rpm

c. Pulse oximetry ≥94% on room air

d. SBP ≥100 and <180 mmHg

Note: Isolated mild to moderate hypertension (i.e., SBP ≤180mmHg with no associated symptoms such as headache, neurological changes, chest pain or shortness of breath) in a patient with a history of hypertension is not a reason to exclude referral to a PUCC

4. Glasgow Coma Scale (GCS) Score of ≥14

5. If history of Diabetes Mellitus, no evidence of ketoacidosis and a blood glucose ≥60 mg/dL and <250 mg/dL

B. Exclusion Criteria – patients who meet the following conditions shall not be triaged to a PUCC, patient destination shall be in accordance with Ref. No. 502, Patient Destination or appropriate Specialty Care Center Patient Destination policy (i.e., Trauma Center, STEMI, Stroke):

1. Any emergent medical condition

2. Focal neurological deficit

3. Any injury that meet trauma center criteria or guideline

4. Complaint of chest pain, shortness of breath, abdominal/pelvic pain, or syncope

5. Open wounds or bleeding

6. Suspected pregnancy

7. Requires special medical equipment

8. Intellectual or developmental disability

9. Exhibits dangerous behavior

10. Signs and symptoms of agitated delirium (Reference No. 1208, Agitated Delirium)

11. EMS personnel feels the patient is not stable enough for PUCC

IV. Paramedic Training Curriculum – the 8-hour paramedic educational session regarding the triage of patients to a PUCC shall include, at minimum, the following:

A. An overview of the curriculum, educational objectives, resources and operational structure

B. Impact of mental health crisis/emergency on local public health and emergency medical system resources

C. Overview of PUCC capabilities and resources

D. Review of mental health disorders

E. In-depth review of the Inclusion and Exclusion Criteria, and the Medical Clearance Criteria Screening Tool for PUCC

F. Legal and Ethics, include considerations for release at scene, refusal of treatment or transport (Against Medical Advice)

G. Interactions with other agencies (i.e., law enforcement, mental health professional)

H. Patient care documentation

I. Quality improvement process and sentinel event reporting

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 326, **Psychiatric Urgent Care Center (PUCC) Standards**
Ref. No. 326.1, **Designated Psychiatric Urgent Care Center Roster**
Ref. No. 502, **Patient Destination**
Ref. No. 526.1, **Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care Center**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC)

SUBJECT: **MEDICAL CLEARANCE CRITERIA SCREENING TOOL FOR PSYCHIATRIC URGENT CARE CENTER (PUCC)** REFERENCE NO. 526.1

PROCEDURE:

1. Paramedic shall assess and evaluate the patient using all the criteria listed below.
2. If ALL criteria are **Yes (Green)** – triage patient to designated Psychiatric Urgent Care Center (PUCC), only if transport time is within 15 minutes.
3. If ANY criterion is **No (Red)** – triage patient to the most accessible 9-1-1 receiving hospital.
4. MEDICAL CLEARANCE CRITERIA FOR **PUCC**

Provider Impression of Behavioral/Psychiatric Crisis	Yes ☐	No ☐
Voluntarily consented or 5150 hold	Yes ☐	No ☐
Ambulatory, does not require wheelchair and no focal neurological deficit	Yes ☐	No ☐
No emergent medical condition	Yes ☐	No ☐
Age ≥ 18 years old and ≤ 65 years	Yes ☐	No ☐
Heart Rate ≥60 and ≤120 beats per minute	Yes ☐	No ☐
Respiratory Rate ≥12 and ≤24 respirations per minute	Yes ☐	No ☐
Pulse Oximetry ≥94% on room air	Yes ☐	No ☐
SBP ≥100 and <180 mmHg	Yes ☐	No ☐
Glasgow Coma Score ≥14	Yes ☐	No ☐
If diabetes, glucose ≥60 and <250mg/dL	Yes ☐	No ☐
No injury meeting TC criteria or guidelines	Yes ☐	No ☐
No complaint of: chest pain, SOB, Abdominal or pelvic pain, or syncope	Yes ☐	No ☐
No open wounds or bleeding	Yes ☐	No ☐
Not pregnant (known or suspected)	Yes ☐	No ☐
Not requiring special medical equipment	Yes ☐	No ☐
No intellectual or developmental disability	Yes ☐	No ☐
No dangerous behavior	Yes ☐	No ☐
No signs and symptoms of Agitated Delirium	Yes ☐	No ☐
EMS Personnel feel patient is stable for PUCC	Yes ☐	No ☐

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

Ref. No. 526, BEHAVIORAL/PSYCHIATRIC CRISIS PATIENT DESTINATION
Ref. No. 526.1, MEDCIAL CLEARANCE CRITERIA SCREENING TOOL FOR PSYCHIATRIC URGENT CARE CENTER

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	12/11/19	12/11/19	
	Data Advisory Committee			
	Provider Agency Advisory Committee	12/18/19	8/19/20	
	Medical Council	03/03/20	03/03/20	
OTHER COMMITTEES / RESOURCES	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California – EHS Committee			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC)

SUBJECT: **INTOXICATED (ALCOHOL) PATIENT DESTINATION** REFERENCE NO. 528

PURPOSE: To provide guidelines for the transport of patients with a primary provider impression of Alcohol Intoxication to the most appropriate facility that is staffed, equipped and prepare to administer medical care appropriate to the needs of the patient.

AUTHORITY: Health & Safety Code, Division 5, Sections 1797.220, 1798
Title 22, California Code of Regulations, Section 100170 (a)(5)

DEFINITIONS:

Alcohol Intoxication: A patient who appears to be impaired from alcohol, demonstrated by diminished physical and mental control **with** evidence of recent alcohol consumption (e.g., alcohol on breath, presence of alcoholic beverage container(s)) and **without** other acute medical or traumatic cause. Alcohol intoxication is typically associated with one of more of the following:

- Speech disturbance – incoherent, rambling, slurring
- Decline in cognitive function – confusion, inappropriate behavior, impaired decision-making capacity
- Imbalance – unsteady on feet, staggering, swaying
- Poor coordination – impaired motor function, inability to walk a straight line, fumbling for objects

Emergency Medical Condition: A condition or situation in which an individual has an immediate need for medical attention. The presence of abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure, and oxygen saturation – except isolated asymptomatic hypertension) are also indications of an emergency medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital Notification (Ref. No. 1200.2) are also considered to have an emergency medical condition.

Sobering Center (SC): A non-correctional facility designated by a city or county to provide a safe, supportive environment for intoxicated individuals to become sober. A SC shall be approved by the EMS Agency by meeting the requirements in this Standards.

PRINCIPLES:

1. EMS provider agencies must be approved by the Emergency Medical Services (EMS) Agency to triage patients with alcohol intoxication to a designated SC.

2. Paramedics who have completed an 8-hour education session regarding the triage of patients to a SC are the only EMS personnel authorize to utilize this policy.

3. Patients exhibit alcohol intoxication who meet SC inclusion criteria may also be released at scene to local law enforcement agency. Law enforcement officers are highly

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

encouraged to transport these patients to a designated SC. Paramedics shall document on the EMS Report Form to whom the patient was released.

4. In instances where there is potential for the patient to harm self or others, EMS personnel shall consider seeking assistance from law enforcement.

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

POLICY:

I. Responsibilities of the Paramedic

A. Complete an 8-hour educational session regarding the triage of patients to a designated SC.

B. Comply with all patient destination policies established by the EMS Agency.

II. EMS Provider Agency Requirements and Responsibilities

A. Submit a written request to the Director of the EMS Agency for approval to triage patients who meet SC Inclusion Criteria. The written request shall include the following:

1. Date of proposed implementation date

2. Scope of deployment (identify response units)

3. Course/Training Curriculum addressing all items in Section IV

4. Identify a representative to act as the liaison between the EMS Agency, designated SC(s), and the EMS Provider Agency

5. Policies and procedures listed in Section B

B. Develop, maintain and implement policies and procedures that address the following:

1. Completion of one Medical Clearance Criteria Screening Tool for each patient (see sample Ref. No. 528.1)

2. Pre-arrival notification of the SC

3. Patient report to a licensed health care provider or physician at the SC

4. Confirmation that SC has the capacity to accept the patient prior to transport

C. Develop a Quality Improvement Plan or Process to review variances and adverse events.

D. Comply with data reporting requirements established by the EMS Agency.

III. Sobering Center (SC) Patient Triage Criteria

A. Inclusion Criteria – patients who meet the following criteria may be triaged for transport to a designated SC provided the SC can be accessed within a fifteen (15) minute transport time:

1. Provider impression of alcohol intoxication (found on the street, a shelter or in police custody); and

a. Voluntarily consented or have implied consent to go to the SC; and

b. Cooperative and do not require restraints; and

c. Ambulatory, does not require the use of a wheelchair; and

d. NO emergent medical condition or trauma (with exception of ground level fall with injuries limited to minor abrasions below the clavicle); and

e. No focal neurological deficit

2. Age: ≥ 18 years old and ≤65 years old

3. Vital Signs

a. Heart rate ≥60 bpm and ≤120 bpm

b. Respiratory rate ≥12 rpm and ≤24 rpm

c. Pulse oximetry ≥94% on room air

d. SBP ≥100 and <180 mmHg

Note: Isolated mild to moderate hypertension (i.e., SBP ≤180mmHg with no associated symptoms such as headache, neurological changes, chest pain or shortness of breath) in a patient with a history of hypertension is not a reason to exclude referral to a SC

4. Best Glasgow Coma Scale (GCS) Score of ≥14.

Best GCS – upon initial assessment, an inebriated person may not have spontaneous eye opening without stimulation and may not be fully oriented which = GCS of 13. Upon secondary assessment, if eyes remain open with minimal confusion, GCS is 14 and meets criteria.

5. If history of Diabetes Mellitus, no evidence of ketoacidosis and a blood glucose ≥60 mg/dL and <250 mg/dL

B. Exclusion Criteria – patients who meet the following conditions shall not be triaged to a SC, patient destination shall be in accordance with Ref. No. 502, Patient Destination or appropriate Specialty Care Center Patient Destination policy (i.e., Trauma Center, STEMI, Stroke):

1. Any emergent medical condition
2. Focal neurological deficit or change from baseline
3. Any injury that meet trauma center criteria or guideline
4. Complaint of chest pain, shortness of breath, abdominal/pelvic pain, or syncope
5. Bleeding including any hemoptysis or GI bleed
6. On anticoagulants
7. Suspected pregnancy
8. Bruising or hematoma above the clavicles
9. Intellectual or developmental disability
10. EMS personnel feels the patient is not stable enough for SC

IV. Paramedic Training Curriculum – the 8-hour paramedic educational session regarding the triage of patients to a SC shall include, at minimum, the following:

A. An overview of the curriculum, educational objectives, resources and operational structure

B. Impact of alcohol intoxication on local public health and emergency medical system resources

C. Overview of SC capabilities and resources

D. Review of mental health disorders

E. In-depth review of the Inclusion and Exclusion Criteria, and the Medical Clearance Criteria Screening Tool for SC

F. Legal and Ethics, include considerations for release at scene, refusal of treatment or transport (Against Medical Advice)

G. Interactions with other agencies (i.e., law enforcement, mental health professional)

H. Patient care documentation

I. Quality improvement process and sentinel event reporting

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 328, **Sobering Center (SC) Standards**
Ref. No. 328.1, **Designated Sobering Center Roster**
Ref. No. 502, **Patient Destination**
Ref. No. 528.1, **Medical Clearance Criteria Screening Tool for Sobering Center**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC)

SUBJECT: **MEDICAL CLEARANCE CRITERIA SCREENING TOOL FOR SOBERING CENTER (SC)**

REFERENCE NO. 528.1

PROCEDURE:

1. Paramedic shall assess and evaluate the patient using all the criteria listed below.
2. If ALL criteria are **Yes (Green)** – triage patient to designated Sobering Center (SC), only if transport time is within 15 minutes.
3. If ANY criterion is **No (Red)** – triage patient to the most accessible 9-1-1 receiving hospital.
4. MEDICAL CLEARANCE CRITERIA FOR **SC**

Provider Impression of Alcohol Intoxication	Yes ☐	No ☐
Verbalizes consent	Yes ☐	No ☐
Cooperative and does not require restraints	Yes ☐	No ☐
Ambulatory, does not require wheelchair and no focal neurological deficit	Yes ☐	No ☐
No emergent medical condition	Yes ☐	No ☐
Age ≥ 18 years old and ≤ 65 years	Yes ☐	No ☐
Heart Rate ≥60 and ≤120 beats per minute	Yes ☐	No ☐
Respiratory Rate ≥12 and ≤24 respirations per minute	Yes ☐	No ☐
Pulse Oximetry ≥94% on room air	Yes ☐	No ☐
SBP ≥100 and <180 mmHg	Yes ☐	No ☐
Best Glasgow Coma Score ≥14*	Yes ☐	No ☐
If diabetes, glucose ≥60 and <250mg/dL	Yes ☐	No ☐
No injury meeting TC criteria or guidelines	Yes ☐	No ☐
No complaint of: chest pain, SOB, Abdominal or pelvic pain, or syncope	Yes ☐	No ☐
No bleeding including any hemoptysis or GI bleed	Yes ☐	No ☐
Not on anticoagulants**	Yes ☐	No ☐
Not pregnant (known or suspected)	Yes ☐	No ☐
No bruising or hematoma above the clavicles	Yes ☐	No ☐
No intellectual or developmental disability	Yes ☐	No ☐
No loss of consciousness within 24 hours (syncopal or seizure}	Yes ☐	No ☐
EMS Personnel feel patient is stable for SC	Yes ☐	No ☐

* Best GCS – upon initial assessment, an inebriated person may not have spontaneous eye opening without stimulation and may not be fully oriented which = GCS of 13. Upon secondary assessment, if eyes remain open with minimal confusion, GCS is 14 and meets criteria.

** Common Anticoagulants: Warfarin/Coumadin, Clopidogrel/Plavix. Enoxaprin/Lovenox, Rivaroxaban/Xarelto, Dagigatran/Pradaxa, Apixaban/Eliquis, Edoxaban/Savaysa, and Fondaparinux/Arixta.

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

Ref. No. 528, INTOXICATED (ALCOHOL) PATIENT DESTINATION
Ref. No. 528.1, MEDCIAL CLEARANCE CRITERIA SCREENING TOOL FOR SOBERING CENTER

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	12/11/19	12/11/19	
	Data Advisory Committee			
	Provider Agency Advisory Committee	12/18/19	8/19/20	
	Medical Council	03/03/20	03/03/20	
OTHER COMMITTEES / RESOURCES	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California – EHS Committee			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EMS QUALITY IMPROVEMENT PROGRAM COMMITTEES** REFERENCE NO. 618

PURPOSE: To monitor and evaluate the quality of prehospital care within Los Angeles County. The EMS Quality Improvement Program (EQIP) Committee(s) will review and make recommendations to the Medical Director concerning system prehospital emergency medical care.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 12
Health and Safety Code Division 2.5
California Evidence Code, Section 1157
California Civil Code Part 2.6, Section 56

PRINCIPLE:

The proceedings of the EQIP Committees are confidential; any information received during these proceedings shall be considered confidential and/or privileged by the committees. Anyone providing any evidence or information to these committees shall be assured that the information is being received in confidence.

POLICY:

I. The EQIP Committees include the following:

A. Base Hospital/911 Provider Agency QI Committee

B. Private Non-911 Provider Agency QI Committee

C. Specialty Center QI Committees:

1. Trauma System QI Committee (Ad Hoc)

2. Trauma Hospital Advisory Committee-QI Subcommittee (THAC-QI)

3. Trauma Hospital Regional QI Program

4. STEMI Receiving Center Advisory Committee

5. Pediatric Advisory Committee (PedAC)

6. Stroke Advisory Committee

II. Committee member or designee responsibilities include:

A. Participate in scheduled QI committee meetings.

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Director, EMS Agency Medical Director, EMS Agency

B. In collaboration with the Los Angeles EMS Agency, identify prehospital care issues, provide recommendations, develop a plan for improvement, and monitor results.

C. Develop and validate system QI indicators and/or studies.

D. Participate in systemwide data collection and reporting. Each QI Committee member shall submit data to the EMS Agency on systemwide indicators, when applicable.

E. Coordinate focused studies and compile data on selected issues.

III. QI Committee membership shall include, but is not limited to, the following representative(s) or designee(s):

A. Base Hospital/9-1-1 Provider Agency QI:

1. EMS Agency Medical Director
2. EMS Agency System QI Coordinator
3. Designated EMS Agency staff
4. Prehospital Care Coordinators from each Base Hospital
5. Paramedic Coordinator and/or Fire Department Nurse Educator from each 9-1-1 Provider Agency
6. Air Operations Provider Agency, ad hoc
7. Emergency Medical Dispatch, ad hoc
8. Ad hoc members, as needed

B. Private/Non-9-1-1 Provider Agency QI:

1. EMS Agency Medical Director
2. EMS Agency System QI Coordinator
3. Designated EMS Agency staff
4. QI Coordinator from Non 9-1-1 BLS/ALS/CCT provider agencies
5. Representative(s) from approved Paramedic Training Programs
6. Representative(s) from approved EMT Training Programs
7. 9-1-1 Provider Agency member, ad hoc
8. Emergency Medical Dispatch representative, ad hoc

9. Ad hoc members, as needed

C. Specialty Center QI – see applicable policies and bylaws:

1. Trauma Program

2. STEMI Advisory Committee

3. PedAC

4. Stroke Advisory Committee

IV. EQIP Committee Responsibilities:

A. The EQIP Committees shall meet quarterly unless otherwise specified by the EMS Agency Medical Director, policy, or committee bylaws.

B. The EMS Agency is responsible for arranging the meeting location, maintaining a membership attendance roster, meeting agenda, and recording/distributing meeting minutes.

C. Significant unresolved systems issues shall be forwarded, with written recommendations, to the EMS Agency Director and/or Medical Director for further review.

CROSS REFERENCES:

Prehospital Care Policy Manual:

Ref. No. 216, Pediatric Advisory Committee (PedAC)
Ref. No. 218, Trauma Hospital Advisory Committee (THAC)
Ref. No. 320, ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) Standards
Ref. No. 322, Stroke Receiving Center Standards
Ref. No. 620, **EMS Quality Improvement Program**
Ref. No. 620.1 **EMS Quality Improvement Program Plan**

LA County EMS Agency, **Quality Improvement Plan**

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

REFERENCE NO. #618, EMS Quality Improvement Program Committees

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	8/12/2020	8/12/2020	N
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee	8/19/2020	08/19/2020	N
OTHER COMMITTEES / RESOURCES	Medical Council	9/08/2020	9/8/2020	Y
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

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

REFERENCE NO. 618, EMS Quality Improvement Program Committees

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy I.C.5	MAC 9-8-2020	Delete abbreviation “SAC”	Change made
Policy III.C.4	MAC 9-8-2020	Change “SAC” to “Stroke Advisory Committee”	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DISASTER RESOURCE CENTER (DRC) DESIGNATION AND MOBILIZATION** (HOSPITAL) REFERENCE NO. 1102

PURPOSE: To define the role of the Disaster Resource Center (DRC) in Los Angeles County emergency medical services system and to provide guidelines for the activation and mobilization of DRC resources during disasters.

AUTHORITY: Public Health Services Act, 42 U.S.C.247d, Section 319, Public Health and Social Security Emergency Funds
Emergency Supplemental Appropriations for Recovery Form and Response to Terrorist Attacks on the United States Act, 2002, Public Law 107-117
Hospital Preparedness Program (HPP) Specialty Care Center Designation (SCCD) Master Agreement (HPP Exhibit)
California Code of Regulations Title 22 (22 CCR), §70805

DEFINITION:

Disaster Resource Center (DRC): Is one of a limited number of volunteer hospitals that are responsible for developing plans, relationships, and procedures to enhance hospital surge capacity for responding to a terrorist/disaster event in a geographical area. A DRC shall:

- Be licensed by the State Department of Health Services as a general acute care hospital.
- Have a special permit for basic or comprehensive emergency medicine service.
- Be designated by the Emergency Medical Services (EMS) Agency upon execution of the HPP Exhibit.

PRINCIPLES:

1. As a recipient of the (HPP) Grant, the County of Los Angeles must work with healthcare entities to ready hospitals and supporting healthcare systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies. The DRC program was developed to enhance surge capacity through:

    a. The provision of ventilators, pharmaceuticals, medical/surgical supplies, and large tent shelters to provide treatment to victims of a terrorist event, natural disaster, or other public health emergency.

    b. Hospital planning and coordination in a geographical area regarding the use of non-hospital space to shelter and treat mass casualties, and incorporate the role of local community health centers, clinics, and other healthcare partners.

2. DRC resources or portions of its contents shall be deployed to care for disaster victims when the local healthcare system is overwhelmed. The use and deployment of DRC

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

resources to the field and/or local hospitals shall be under the direction of the EMS Agency as the Medical and Health Operational Area Coordinator (MHOAC) for the County of Los Angeles.

3. If any or all of the DRC equipment and supplies are needed outside of the DRC's geographical area, the EMS Agency will coordinate the necessary transportation ensuring delivery to the impacted area.

4. Each DRC is responsible for having and maintaining the pharmaceutical cache and medical/surgical cache in a constant state of readiness. Replacement of the outdated items is the responsibility of each DRC.

5. The County of Los Angeles has designated the following thirteen (13) hospitals as DRCs:

   A. Cedars Sinai Medical Center

   B. Children's Hospital Los Angeles

   C. Dignity Health- California Hospital Medical Center

   D. Dignity Health- Saint Mary Medical Center

   E. Henry Mayo Newhall Hospital

   F. Kaiser Foundation Hospital- Los Angeles

   G. LAC Harbor/UCLA Medical Center

   H. LAC+USC Medical Center

   I. MemorialCare Long Beach Medical Center

   J. PIH Health Hospital- Whittier

   K. Pomona Valley Hospital Medical Center

   L. Providence Saint Joseph Medical Center

   M. Ronald Reagan UCLA Medical Center

POLICY:

I. DRC Responsibilities:

   A. Identify a hospital DRC Coordinator who shall be responsible for the functions of the DRC and serve as a liaison by maintaining effective lines of communication with DRC personnel, the local EMS Agency, assigned umbrella hospitals, local clinics, EMS provider agencies, and other healthcare entities.

B. Establish policies and procedures for the use of tent shelters and related equipment and ensure staff training in the set-up of the tents and equipment.

C. Maintain ongoing participation with community wide planning activities, to include collaboration with other hospitals, clinics, and EMS provider agencies within geographical area. Planning will have an emphasis on responding to mass casualty events.

D. Other provisions set forth in the HPP Exhibit.

II. DRC Supplies and Equipment

A. Tent structure and other support equipment as indicated in Ref. No. 1102. 2, Disaster Resource Centers in Los Angeles County.

B. Local Pharmaceutical cache as indicated in Ref. No.1106, Mobilization of Local Pharmaceutical Caches (LPCs).

C. Medical/Surgical Supply cache as indicated in Ref. No. 1107, Mobilization of Medical/Surgical Supply (M/SS) Caches.

D. At least one EMS and one hospital Chempack as indicated in Ref. No. 1108, Chempack Deployment for Nerve Agent Release.

E. Other provisions set forth in the HPP Exhibit.

III. Activation and Mobilization of DRC resources

A. Requests for the activation and mobilization of DRC resources shall be made to the County by contacting the EMS Agency's Medical Alert Center or Disaster Operation Center (DOC) via the ReddiNet or by telephone at (562) 378-1789. Hospital administration of the DRC and the EMS Agency will work collaboratively to accomplish this and make the site operational.

B. DRC activation to expand bed capacity in the DRC's geographic area

1. The DRC shall:

a. Identify location of the area on or adjacent to hospital site for the mobilization of tent structures.

b. Ensure tent is approved for set-up by local fire authority and Licensing and Certification district office.

c. Identify hospital staff to set-up the tent structure and support equipment.

d. Identify services being provided (level and type) of the tent site (triage, patient treatment, expanded isolation capacity, patient holding).

e. Identify and designate available hospital staff to perform the following duties:

i. Clinical care
ii. Management
iii. Security

f. Identify additional medical resources needed from the County to support medical operations using the Resource Request Medical and Health Form.

2. The EMS Agency shall:

a. Assist in providing medical and paramedical staff, as needed, to support medical operation.

b. Coordinate acquisition of additional medical equipment and supplies needed by the DRC that is not available through the medical facility.

c. Assist with the placement and transport of patients from the DRC site to other healthcare locations.

C. DRC activation to mobilize DRC resources to another geographic area

1. The DRC shall:

a. Receive a list of requested supplies and equipment to be transported to the designated site.

b. Prepare the requested supplies and equipment for deployment.

c. Provide access to the equipment trailer/storage area.

2. The EMS Agency shall:

a. Coordinate transportation of requested supplies and equipment to designated site.

b. Coordinate recovery of requested supplies and equipment from designated site to the DRC.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 1102.1, **Disaster Resource Centers in Los Angeles County**
Ref. No. 1102.2, **DRC Equipment Checklist for Items Deployed to Other Facilities**
Ref. No. 1106, **Mobilization of Local Pharmaceutical Caches (LPCs)**
Ref. No. 1107, **Mobilization of Medical/Surgical Supply (M/SS) Caches**
Ref. No. 1108, **Chempack Deployment for Nerve Agent Release**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HOSPITAL)

SUBJECT: **DRC EQUIPMENT CHECKLIST LIST ITEMS DEPLOYED TO OTHER FACILITIES**

REFERENCE NO. 1102.2

PURPOSE: To provide a mechanism for Disaster Resource Centers (DRC) to track DRC resources deployed to other facilities.

POLICY: The DRC shall utilize this checklist to document items deployed to other facilities.

Items	Quantity On Hand	Number Checked Out
Blankets/Sleeping Bags	75	
Radiation Detection Equipment	2	
Chairs	40	
Stretcher with-wheels	10	
Surge bed/cots	30	
Disposable Linen	50 Sets	
Electrical Cords	4	
Non-ambulatory Evacuation Equip	28	
Pop Up Canopy	4	
Gas Cans (5 gallon)	2	
Isolation HEPA Filters	2 Units	
Medical/Surgical Supplies	Per Policy 1107	
Outdoor Lighting	2	
Pharmaceutical Cache	Per Policy 1106	
Portable Fans	4	
Portable Sinks/Hand Washing Stations	2	
Portable Toilets	2	
Post - Decontamination Clothes (Adult)	40 Sets	
Post - Decontamination Clothes (Pediatric)	10 Sets	
Tables (6-8 feet long)	4	
Tents	4	
Decontamination Inserts	2	
HVAC Units	4	

Items	Quantity On Hand	Number Checked Out
Towable Generator (20 KW minimum)	1	
Towing Vehicle (Prime mover)	1	
Trailers	2	
Vortran® Portable Vents	50 adult, and 5 Event Cases	
Vortran® Portable Vents	20 pediatric, and 2 Event Cases	

Released by: _____ Date released: _____

Received by: _____ Facility: _____

Returned by: _____ Date returned: _____

Returned Items received by: _____

Statement of Verification

I hereby verify that an inventory of all Grant funded equipment listed above has been completed and all items are up to PAR and available for deployment.

Verified By: _____ Date: _____
(Printed Name and Signature)

Should any item on the above list fall below PAR levels, notify the EMS Agency immediately.

Notification to EMS Agency by: _____ Date: _____

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DISASTER PHARMACEUTICAL CACHES CARRIED BY AUTHORIZED ALS PROVIDERS** (PARAMEDIC/EMT-1) REFERENCE NO. 1104

PURPOSE: To ensure accessibility to and accountability for disaster pharmaceutical caches carried by authorized Advanced Life Support (ALS) providers.

AUTHORITY: Health and Safety Code, Chapter 5, Section 1798
Title 22, California Code of Regulations, Section 72369

PRINCIPLE:

To ensure terrorism preparedness in Los Angeles County, the Emergency Medical Services Authority approved an expanded scope of practice for paramedics to stock and use certain disaster pharmaceuticals.

POLICY:

I. Disaster Pharmaceutical Cache (DPC) for Patient Use:

A. Pharmaceuticals

DuoDote Kits or their equivalent: a minimum of 9 auto injectors

B. Procurement

1. DPC stocking and re-supply of two-paramedic units will be through the provider agency's purchasing entity and medical director.

2. DPC re-supply and initial stocking of additional two-paramedic units will be through the provider agency purchasing entity and its medical director.

3. If additional nerve agent antidotes are required during an incident, request the deployment of an EMS CHEMPACK (Ref. No. 1108) via the Medical Alert Center at (562) 378-1789. Provide the MAC with the following information:

   a. Incident location;

   b. Chemical agent (if known);

   c. Number and severity of victims; and

   d. Chief complaints of patients.

C. Disaster Pharmaceutical Cache Security

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

1. Paramedics assigned to an ALS unit shall be responsible for maintaining the correct DPC inventory for their assigned unit at all times.

2. DuoDotes (or their equivalent) shall be stored in the DPC case.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
Ref. No. 703, **ALS Unit Inventory**
Ref. No. 807, **Medical Control During Hazardous Material Exposure**
Ref. No. 1106, **Mobilization of Local Pharmaceutical Caches (LPCs)**
Ref. No. 1108, **CHEMPACK Deployment for Nerve Agent Release**
Ref. No. 1225, **Nerve Agent Exposure**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **MOBILIZATION OF LOCAL PHARMACEUTICAL CACHES (LPCs)** REFERENCE NO. 1106

PURPOSE: To provide guidelines for the release of Local Pharmaceutical Cache (LPC) to designated personnel during times of medical need.

PRINCIPLES:

1. The County of Los Angeles has established six (6) County owned and maintained pharmaceutical caches and has funded private hospitals to maintain eleven (11) additional pharmaceutical caches that are stored at various locations throughout the County.

2. The authority to deploy LPCs or portions of its contents to the field, local hospitals, and/or dispensing sites rests with the Emergency Medical Services (EMS) Agency.

POLICY:

I. In the event of a major event, emergency or disaster which results in a need for additional pharmaceuticals, or the need to begin mass prophylaxis due to exposure to a biological agent, EMS/hospital/healthcare facility personnel shall request for the deployment of the LPC by contacting the EMS Agency via the Medical Alert Center (MAC), ReddiNet, VMED28 Radio:155.34mhz or telephone at (562) 378-1789.

   If EMS personnel are unable to contact the MAC, contact the Fire Operational Area Coordinator (FOAC) – Los Angeles County Fire District (which is contacted through its Dispatch Center).

   See Ref. No. 1108, CHEMPACK Deployment for Nerve Agent Release.

II. Once approved for deployment, the EMS Agency will contact the LPC storage facility to inform them of the need to release the cache and provide the following information:

   A. Identify they are from the EMS Agency and provide their name, employee number, and a phone number where they can be contacted;

   B. Provide the name of the person(s) who will be picking up the LPC; and

   C. Provide an estimated time of arrival.

III. Upon arrival at the storage facility, the authorized personnel picking up the LPC will:

   A. Contact the designated facility personnel;

   B. Be provided access to the LPC;

   C. Provide their name and employee number to the storage facility personnel; and

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

D. Sign the required form(s), Ref. No. 1106.1, LPC Inventory and Checklist for Items Deployed acknowledging the receipt of the LPC.

IV. The LPC may be delivered directly to the field, to a hospital, or to a staging site.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 1106.1, **LPC Inventory and Checklist for Items Deployed**
Ref. No. 1106.2, **LPC Photograph**
Ref. No. 1108, **CHEMPACK Deployment for Nerve Agent Release**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **LPC INVENTORY AND CHECKLIST FOR ITEMS DEPLOYED** REFERENCE NO. 1106.1

Item	Quantity On Hand (or equivalent)	Number Checked Out
Adenosine Injection (6mg/vial)	100 vials	
Albuterol Inhaler (20mg/inhaler)	100 inhalers	
Albuterol Oral Inhalation Solution (2.5mg/3ml/dose)	100 doses	
Amiodarone Injection (50mg/ampule)	30 ampules	
Atropine Injection (0.4mg/ml) 20ml multi-dose vial	250 vials	
Calcium Chloride 10% Injection (1gm/10ml) Pre-Filled Syringe	72 syringes	
Cefazolin Injection (1gm/vial)	50 vials	
Cephalexin Tablet (500mg/tablet)	500 tablets	
Ciprofloxacin Capsule (500mg/capsule)	5000 capsules	
Diphtheria-Tetanus (Td) Adsorbed Dose Injection (0.5ml/dose) - Adult	320 doses	
Diphtheria-Tetanus Toxoid (DT) Injection (0.5ml/dose) - Peds	50 doses	
Dextrose 50% Injection (50ml syringe)	25 syringes	
Diphenhydramine Injection (50mg/ml vial)	200 vials	
Dopamine Injection (200mg/vial)	100 vials	
Doxycycline Capsules (100mg/tablet)	1,000 tablets	
Epinephrine Injection 1:1,000 (1mg/ml/ampule)	50 ampules	
Epinephrine Injection 1:1,000 30ml vial	2 vials	
Epinephrine Injection 1:10,000 (1mg/10ml) Pre-Filled Syringe	240 syringes	
Glucagon Injection (1mg/vial)	10 vials	
Haloperidol Injection (5mg/vial)	40 vials	
Haloperidol Tablet (5mg/tablet)	100 tablets	
Insulin Regular Injection (100units/ml - 10ml vial)	25 vials	
Lactated Ringers Solution Injection (1000ml/bag)	192 bags	
Lidocaine Injection 2% (10mg/ml) Pre-Filled Syringe	120 syringes	
Lidocaine Injection 1% (20ml/vial)	25 vials	

Item	Quantity On Hand (or equivalent)	Number Checked Out
Magnesium Sulfate Injection (1gm/2ml)	72 vials	
Naloxone Injection (2mg/vial)	10 vials	
Nitroglycerin Tablets or Spray (0.4mg/tablet or spray - 100 doses)	200 doses	
Ondansetron Injection (2mg/vial)	40 vials	
Polymyxin Bacitracin Ointment (0.9gm/packet)	1,440 packets	
Potassium Chloride Injection (40mEQ/20ml)	120 each	
Sodium Bicarbonate Injection (44.6mEQ/50 ml) Pre-Filled Syringe	180 syringes	
Sodium Chloride 0.9% Injection (100ml/bag)	192 bags	
Sodium Chloride 0.9% Injection (1000ml/bag)	96 bags	
Sodium Polystyrene- Oral Powder (454gm/container)	6 containers	
Tetracaine Hydrochloride Ophthalmic Solution 0.5% (2ml/bottle) **or** Proparacaine Hydrochloride Ophthalmic Solution 0.5% (15ml/bottle)	36 bottles	

Released by: _____ Date released: _____

Received by: _____ Facility: _____

Returned by: _____ Date returned: _____

Returned Items received by: _____

Statement of Verification

I hereby verify that an inventory of all Grant funded pharmaceuticals listed above has been completed and all items are up to PAR and available for deployment.

Verified By: _____ Date: _____
(Printed Name and Signature)

Should any item on the above list fall below PAR levels, notify the EMS Agency immediately.

Notification to EMS Agency by: _____ Date: _____

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **LPC PHOTOGRAPH** REFERENCE NO. 1106.2

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **M/SS CACHE INVENTORY AND CHECKLIST FOR ITEMS DEPLOYED** REFERENCE NO. 1107.1

Bandages and Dressings	**Quantity On Hand**		**Number Checked Out**
Adhesive strip, 1” X 3”	100/box	5 boxes	
Alcohol pads	200/box	5 boxes	
Bandage elastic 2”	10/box	2 boxes	
Bandage elastic 4”	10/box	2 boxes	
Bandage elastic 6”	10/box	2 boxes	
Bandage, gauze non sterile 4” X 10’	96/case	1 case	
Bandage, gauze non sterile 4X4	200/pkg, 10 pkgs/case	1 case	
Bandage 4X4 sterile	2/pkg, 1200 pkgs/case	2 case	
Bandage 2X2 sterile	2/pkg, 3000 pkgs/case	1 case	
Eye pad, oval sterile	50/box	2 boxes	
Eye shields	Each	50	
Morgan Lens	12/box	4 boxes	
Petroleum gauze 5” X 9”	50/box	2 boxes	
Vaseline gauze	50/box	1 box	
Gauze Pad 5” X 9” sterile	400/case	1 case	
Tape 1” transparent	12/box 10 boxes/case	1 case	
Transparent dressing 4 X 4	50/box	2 boxes	
Non-adhesive Gauze (Various Sizes)	100/box	10 boxes	
Wound packing gauze	10 bottles/case	1 case	
Triangular bandages	12/box	8 boxes	
Disposable ice packs	24/case	10 cases	

Surgical Supplies	**Quantity On Hand**		**Number Checked Out**
Scalpel with blade, disposable #10	Each	48	
Scalpel with blade, disposable #15	Each	48	
Sterile gloves, sizes 6.5, 7.0, 7.5, and 8.0	50 pairs/box	4 boxes each size	
Surgical scrub brushes with betadine	144/case	1 case	
Suture set (disposable)	20/case	3 cases	

Surgical Supplies	Quantity On Hand		Number Checked Out
Suture removal kit	50/case	1 case	
Suture (nylon sutures various sizes)	12/box	6 boxes	
Steri-strips (assorted sizes)	50/box	3 boxes	
Disposable skin stapler and remover	72/case	3 cases	

Orthopedic Supplies	Quantity On Hand		Number Checked Out
Splint, cardboard 12”	25/case	1 case	
Splint, cardboard 18”	25/case	1 case	
Splint, cardboard 24”	25/case	1 case	
Splint, cardboard 34”	25/case	1 case	
Splint, fiberglass 3”	5/case	1 case	
Splint, fiberglass 4”	5/case	1 case	
Splint, fiberglass 5”	5/case	1 case	

IV Sets, Needles and Syringes	Quantity On Hand		Number Checked Out
IV start kits	Each	200	
IV catheter, 18 gauge	50/box	2 boxes	
IV catheter, 20 gauge	50/box	2 boxes	
IV catheter, 22 gauge	50/box	2 boxes	
IV catheter, 24 gauge	50/box	1 box	
IV administration set, adult	48/box	2 boxes	
IV administration set, pediatric	48/box	2 boxes	
IV piggyback tubing	50/box	1 box	
Needle disposable, 18 gauge	100/box	3 boxes	
Needle disposable, 22 gauge	100/box	3 boxes	
Needle disposable, 25 gauge	100/box	3 boxes	
Butterfly needles, 25 gauge	50/box	1 box	
Syringe, 1ml	100/box	3 boxes	
Syringe, 3 ml	100/box	5 boxes	
Syringe, 5 ml	100/box	2 boxes	
Syringe, 10 ml	100/box	2 boxes	

IV Sets, Needles and Syringes	Quantity On Hand		Number Checked Out
Syringe, 20 ml	25/box	1 box	
Syringe, 35cc, for wound irrigation	Each	25	
Syringe/needle, U100 insulin syringe 28 gauge, 1cc, ½" needle	100/box	1 box	
Syringe/needle, 3 ml, 22gauge X 1 ½"	100/box	2 boxes	
Syringe/needle, 1 ml, 25 gauge X 5/8"	100/box	1 box	
Syringe/needle 1 ml, 29 gauge X ½" (May substitute U100 insulin syringe, 28G X ½" or tuberculin syringe 26G X 3/8")	200/box	1 box	
Sharps container	8/case	1 case	

Airway Management Supplies	Quantity On Hand		Number Checked Out
Bag-valve-mask, adult	12/case	1 case	
Bag-valve-mask, pediatric	6/case	2 cases	
Airway adjunct, OP Airway	-	50 assorted sizes	
Airway adjunct, NP Airway	-	50 assorted sizes	
Cricothyrotomy / Shiley #4	Each	5	
Endotracheal tube, cuffed 8mm	10/box	2 boxes	
Endotracheal tube, cuffed, 7.5mm	10/box	4 boxes	
Endotracheal tube, cuffed 7mm	10/box	2 boxes	
Endotracheal tube, cuffed, 6mm	10/box	2 boxes	
Endotracheal tube, cuffed 2.5mm	10/box	1 box	
Endotracheal tube, cuffed 3mm	10/box	1 box	
Endotracheal tube, cuffed, 4mm	10/box	2 boxes	
Endotracheal tube, cuffed, 4.5mm	10/box	2 boxes	
Endotracheal tube, cuffed, 5mm	10/box	2 boxes	
Endotracheal tube, cuffed, 5.5mm	10/box	2 boxes	
Endotracheal tube, non-cuffed, 2.5mm	10/box	1 box	
Endotracheal tube, non-cuffed, 3mm	10/box	1 box	
Endotracheal tube, non-cuffed, 4mm	10/box	1 box	
Endotracheal tube, non-cuffed, 5mm	10/box	1 box	
Endotracheal tube holders	Each	50	

Airway Management Supplies	Quantity On Hand		Number Checked Out
Intubation kit, incl. Blades, medium handle, stylet and case – including magill forceps	Each	1 kit	
Intubation kit (Pediatrics), incl. Blades, medium handle, stylet and case – including magill forceps	Each	1 kit	
Nasal cannula, adult	50/case	2 cases	
Nasal cannula, pediatric	50/case	2 cases	
02 mask with tubing, pediatric	Each	25	
02 mask with tubing, adult	Each	50	
02 mask - non-rebreather, adult	Each	25	
Nebulizers – hand held	50/case	2 cases	
Nebulizers – masks	50/case	2 cases	
Ventilator circuits	10/case	2 cases	
Suction machine, portable	Each	3 each	
Suction catheters 10 French	50/case	1 case	
Suction catheters 12 French	50/case	1 case	
Suction catheters 14 French	50/case	1 case	
Yankauer suction	20/case	2 cases	
Suction tubing	Each	100	
Suction Canisters	Each	100	
NG Tubes	Each	50	
Thoracostomy Tubes, assorted sizes	-	10 various sizes	
Pleurivac & Heimlich valves	1/each	10	

Infection Control Supplies	Quantity On Hand		Number Checked Out
Cover/Isolation gowns	100/case	3 cases	
Splash guard for wound irrigation	Each	100	
Masks surgical	50/box 6 boxes/case	24 cases	
Face shield with eye shield	25/box 4 boxes/case	1 case	
Masks N-95	35/box 6 boxes/case	18 cases	
Patient exam gloves, small	100/box	2 boxes	
Patient exam gloves, medium	100/box	4 boxes	

Infection Control Supplies	Quantity On Hand		Number Checked Out
Patient exam gloves, large	100/box	4 boxes	
Shoe covers	150 pairs/case	2 cases	
Surgical caps	100/box 6 boxes/case	1 case	
Wipes, disposable	40/box	4 boxes	
Hand sanitizer gel	8 oz	12 bottles	
Child face masks (various sizes)	75/box	8 boxes	

Miscellaneous Supplies	Quantity On Hand		Number Checked Out
Bags, plastic 30 gallon, 8 mil	100/pkg	1 pkg	
Batteries, C for laryngoscope handle	Each	6	
Batteries, D for flashlights	Each	24	
Blankets lightweight	Each	48	
Clipboards	Each	48	
Diapers, disposable large	120/case	1 case	
Diapers, disposable medium	168/case	1 case	
Diapers, disposable small	216/case	1 case	
Diapers, disposable, large, peds	120/case	3 cases	
Diapers, disposable, medium, peds	168/case	3 cases	
Diapers, disposable, small, peds	216/case	3 cases	
Emesis basins, plastic	250/case	1 case	
Facial tissues	30boxes/case	4 cases	
Flashlights	Each	12	
Gloves work type leather/canvas	Each	12	
OB kits, disposable	Each	5	
Paper towel rolls	Each	12	
Patient ID bands	250/box	1 box	
Styrofoam cups	25/bag 40 bags/case	1 case	
Tongue depressors, non-sterile	500/box	1 box	
Disposable temperature strips	100/ Box	5 boxes	
Crutches (assorted sizes)	1 pair	50 pairs	

Miscellaneous Supplies	Quantity On Hand		Number Checked Out
Body bags	5/case	20 cases	

Non-Disposable Medical Supplies	Quantity On Hand		Number Checked Out
Blood pressure multi-cuff kit with adult, pediatric, infant and thigh cuff	Each	2	
Glucometer kit with lancets, test strips and battery	Each	2	
Portable otoscope/ophthalmoscope set with batteries	Each	2	
Pulse oximetry, portable	Each	2	
Stethoscope	Each	12	
Tourniquets 1”	100/pkg	1 pkg	
Trauma/paramedic scissors	Each	6	

Released by: _____ Date released: _____

Received by: _____ Facility: _____

Returned by: _____ Date returned: _____

Returned Items received by: _____

Statement of Verification

I hereby verify that an inventory of all Grant funded supplies listed above has been completed and all items are up to PAR and available for deployment.

Verified By: _____ Date: _____
(Printed Name and Signature)

Should any item on the above list fall below PAR levels, notify the EMS Agency immediately.

Notification to EMS Agency by: _____ Date: _____

Revised: 7-1-2020

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

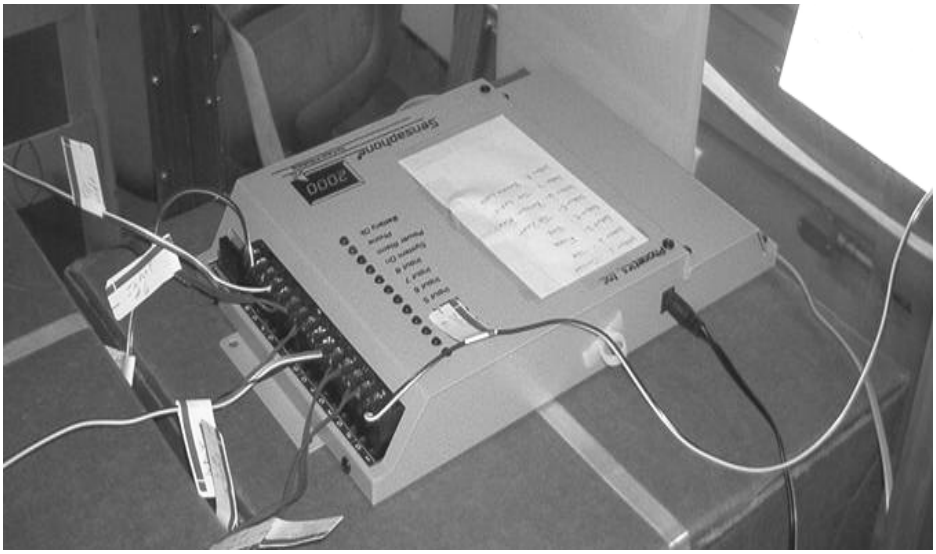
SUBJECT: **CHEMPACK INVENTORY LIST** REFERENCE NO. 1108.1

EMS CHEMPACK Container for 454 Casualties				
Contents	**Unit Pack**	**Cases per Container**	**Units in Container**	**Number Checked Out**
Atropine 0.5 mg auto injectors	144	1	144	
Atropine 1.0 mg auto injectors	144	1	144	
Atropine Sulfate 0.4mg/ml 20ml	100	1	100	
Diazepam 10mg/ml auto-injector	150	2	300	
Midazolam 5 mg/ml vial, 10 ml	25	2	50	
ATNAA – Antidote Treatment Nerve Agent Auto-Injector	240	6	1440	
Pralidoxime 1gm multi-dose vials	276	1	276	
Sterile water for injection 20cc Vials	100	1	100	
Sensaphone 2050®	1	1	1	
SATCO B DEA Approved Container	1	1	1	

HOSPITAL CHEMPACK Container for 1,000 Casualties				
Contents	**Unit Pack**	**Cases per Container**	**Units in Container**	**Number Checked Out**
Atropine 0.5 mg auto injectors	144	1	144	
Atropine 1.0 mg auto injectors	144	1	144	
Atropine Sulfate 0.4mg/ml, multi-dose vials	100	11	1100	
Diazepam 10mg/ml auto-injector	150	1	150	
Diazepam 5 mg/ml vial, 10 ml	25	3	75	
Midazolam 5mg/ml, 10ml vials	25	10	250	
Pralidoxime 1gm, 20ml vials	276	12	3312	
Sterile water for injection 20cc Vials	100	1	100	
Sensaphone 2050®	1	1	1	
SATCO B DEA Approved Container	1	1	1	

Revised: 07-01-20

SUBJECT: **CHEMPACK PHOTOGRAPH** REFERENCE NO. 1108.2



DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HOSPITALS)

SUBJECT: **BED AVAILABILITY REPORTING** REFERENCE NO. 1122

PURPOSE: To provide guidelines for determining and reporting of hospital bed availability.

AUTHORITY: Public Health Service Act, Section 2802(b)
Pandemic and All-Hazards Preparedness Act (Public Law 109-417)
Hospital Preparedness Program Basic and Expanded Agreements

DEFINITIONS:

Bed Types:

- **Adult Intensive Care Unit (ICU):** Beds that can support critically ill/injured patients, including ventilatory support.
- **Burn or Burn ICU:** Applies to designated burn centers only. These beds are either approved by the American Burn Association or self-designated. Note: These beds should be excluded from other ICU bed counts.
- **Medical/Surgical:** Otherwise referred to as "Ward" beds.
- **Negative Pressure/Isolation:** Beds provided with negative airflow to provide respiratory isolation. Note: This value may represent available beds included in the counts of other types.
- **Neonatal ICU:** Beds that can support critically ill/injured neonates. A neonate is a newborn infant up to one month of age.
- **OB/Gyn:** Applies to all perinatal beds, including labor and delivery beds, antepartum and post-partum beds.
- **Operating Rooms:** An operating room that is equipped, staffed, and could be made available for patient care in a short period.
- **Other:** Other types of beds that are available in the facility, i.e., acute rehabilitation, transitional care, skilled nursing. Facility will define type of bed upon data entry.
- **Pediatric:** Medical-surgical beds for patients 17 years or younger.
- **Pediatric ICU:** The same as adult ICU but for patients 17 years or younger.
- **Psychiatric:** Beds in a closed/locked psychiatric unit or medical-surgical beds where a patient will be attended by a sitter.
- **Telemetry:** Includes all monitored beds excluding ICU beds. These beds are capable of continuous cardiac monitoring.

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

- **Trauma:** Applies to designated Trauma Centers only. Beds that can support critically injured patients. Note: This value may represent available beds included in the counts of ICU beds.

Emergency Department (ED) Status: Applies to 9-1-1 receiving hospitals only. Diversion status of the ED.

HAvBED (Hospital Available Beds for Emergencies and Disasters): A national system for capturing bed availability data from divergent systems to create bed availability information based on standardized definitions.

Mass Decontamination Facility Availability: Available chemical/biological/radiological multiple patient decontamination capability.

Surge Capacity: The ability to quickly expand capacity and capability beyond normal operations to meet an increased demand for medical care in the event of a multiple casualty incident (MCI), bioterrorism or other large-scale public health emergencies.

Vacant/Available Beds: Beds that are vacant and to which patients can be transported immediately. These must include supporting space, equipment, medical material, ancillary and support services, and staff to operate under normal circumstances. These beds are licensed, physically available and have staff on duty to attend to the patient who will occupy the bed.

Ventilators: The number of ventilators that are present in the institution that are not currently in use and could be supported by currently available staff.

24 hour Beds Available: This value represents an informed estimate as to how many vacant (staffed and unoccupied) beds for each bed type above the current available beds could be made available within 24 hours. This would include created unlicensed surge beds as well as beds made available by discharging/transferring patients.

72 hour Beds Available: This value represents an informed estimate as to how many vacant (staffed and unoccupied) beds for each bed type above the current available beds could be made available within 72 hours. This includes created unlicensed surge beds as well as beds made available by discharging/transferring patients.

PRINCIPLES:

I. Accurate and rapid determination of bed availability is essential for effective coordination of patient transport and movement during an incident.

II. Hospitals using standardized definition of bed status will provide greater consistency in reporting bed availability information.

III. Bed availability assessment must be conducted by house supervision or bed control staff to provide accurate bed availability count for the entire facility.

POLICY:

I. Bed Availability Reporting

A. During an exercise or an actual event, the Medical Alert Center (MAC) will send a message to hospitals to complete or update their bed availability data in the ReddiNet system.

B. ED/hospital personnel responsible for monitoring the ReddiNet shall notify their house supervision or bed control staff to conduct a facility-wide bed availability assessment for each of the following type of beds and resources:

1. Adult ICU
2. Medical/Surgical
3. Burn
4. Pediatric ICU
5. Pediatric bed
6. Psychiatric
7. Negative pressure/Isolation
8. Obstetrics/Gynecology
9. Trauma
10. Telemetry
11. Neonatal ICU
12. Operating rooms
13. Other
14. Number of available ventilators
15. Mass decontamination availability

C. Based on the type of incident, additional assessment polls may be conducted to gather the following information:

1. Number of beds available within 24 hours
2. Number of beds available within 72 hours

D. Hospitals must complete, update, or submit their bed availability data **within 60 minutes of the request.**

II. Bed Availability Reporting Exercise

To familiarize hospital staff with bed availability reporting procedures, the Emergency Medical Services (EMS) Agency will conduct regularly scheduled exercises.

III. Bed Availability Data Validation

A. The EMS Agency will monitor bed reporting activities and may contact any hospital to validate submitted information.

B. A quarterly report will be sent to each hospital's Emergency Management Coordinator.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 1122.1, **Bed Availability Report Form**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HOSPITALS)

SUBJECT: **BED AVAILABILITY REPORT** REFERENCE NO. 1122.1

Hospital Name: _____

	BED AVAILABILITY	# Available Immediately	# Available within 24 Hours Complete only when checked □	# Available within 72 Hours Complete only when checked □
1	Medical/Surgical			
2	Telemetry			
3	Adult ICU			
4	Pediatric ICU			
5	Neonatal ICU			
6	Pediatric Bed			
7	Obstetrics/Gynecology			
8	Trauma			
9	Burn			
10	Negative Pressure/Isolation			
11	Psychiatric			
12	Operating Room			
13	Other (please define)			
14	Ventilator			
15	Mass Decontamination Available	Yes or No		

Report completed by: _____
NAME

_____
PHONE NUMBER

_____
DATE

FAX COMPLETED FORM TO THE MEDICAL ALERT CENTER
AT (562) 906-4300
WITHIN 60 MINUTES OF REQUEST

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DECONTAMINATION TRAILER DEPLOYMENT FOR MASS CASUALTY EVENT** (EMT, PARAMEDIC, HOSPITALS) REFERENCE NO. 1128

PURPOSE: To provide guidelines for the release and deployment of Emergency Medical Services (EMS) Agency mobile decontamination trailers to sites where mass casualty decontamination is needed.

DEFINITION:

EMS AGENCY MOBILE DECONTAMINATION TRAILER: The EMS Agency owns and maintains two 32 ft. mobile decontamination trailers that are towed independently by two trucks. These can be deployed as a field resource or to a healthcare facility where decontamination capability is limited or non-existent. Each trailer has the following specifications:

- Decontamination must occur within 250 feet of a fire hydrant (uses approximately 40 gallons of water per minute).
- Water is instantly heated to 90 degrees Fahrenheit; trailers are air conditioned.
- Two ambulatory lanes separated for privacy. Each lane has one wash station and one rinse station. Each station has three wall mounted and one ceiling mounted shower heads. The wash station dispenses detergent soap mixed with water. Two additional ambulatory lanes (each lane capable of handling three (3) victims at a time) can be established externally below two booms on each side of the trailer.
- Non-ambulatory decontamination can be performed on a 15-ft. roller section on the street side of the trailer below two booms (wash and rinse) with three shower heads on each boom.
- Internal waste water can be collected in one 1,200-gallon bladder. External waste water flows into a collection basin and can be pumped into another bladder or toward a contaminated area of the operation.
- An onboard 200-gallon fresh water tank enables the decontamination process to begin prior to accessing a fire hydrant.
- Able to handle 96 ambulatory victims per hour (this is based on two (2) victims inside and six (6) victims outside showering for five (5) minutes each).

PRINCIPLES:

1. The County of Los Angeles EMS Agency has two mobile decontamination trucks and trailers that are stored and maintained at the County Disaster Staging Facility.

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

2. The overall authority to deploy the decontamination trailers to the field or to a healthcare facility rests with the EMS Agency who will coordinate the overall response and deployment.

3. In any event involving a terrorist attack with a release of a hazardous substance, the EMS Agency, healthcare facilities, and provider agencies shall implement their terrorism notification procedures and monitor the situation.

4. EMS Agency mobile decontamination trailer deployment shall be for incidents in which a hazardous substance is responsible for the casualties. The incident must be a true mass casualty incident which exceeds the provider agencies' decontamination capability or healthcare facilities' resources to deal with the patient load. As a general guideline, the incident should involve at least fifty (50) patients.

5. EMS Agency mobile decontamination trailer(s) may be pre-deployed for special events.

POLICY:

I. Types of Deployment

A. Field Deployment – This scenario involves the deployment of a decontamination trailer to an incident site in a public area. This would occur in the case of an overt chemical or radiological substance release in a populated area such as a stadium or inside a building.

B. Healthcare Facility Deployment – This scenario may involve an overt or covert chemical or radiological substance release in which the first sign might be the unexplained surge of patients seeking treatment at local hospital, clinic, or field treatment site for symptoms indicating exposure to or contamination with a hazardous substance.

C. Training Deployment – A scenario involving simulated or actual decontamination of volunteer victims in the field or at a healthcare facility during an exercise or drill.

II. Role of the EMS Agency

A. Deliver the trailer(s) to the decontamination site and deploy to a state of readiness.

B. Facilitate the integration of provider agency staff/trained healthcare facility decontamination team members into the operation and utilization of the decontamination trailer(s).

C. Coordinate and facilitate training on decontamination trailers for provider agency and healthcare facility staff.

D. Maintain and store the decontamination trailers.

III. Role of the Provider Agency

A. Notify the EMS Agency via the Medical Alert Center (MAC) by either telephone at (562) 378-1789, ReddiNet, or VMED28 of the incident.

B. Determine whether first responder decontamination resources are sufficient to handle the incident. If provider agency's decontamination resources are adequate to deal with the patient load, generally no other assistance would be requested.

C. If additional decontamination resources are required, request the deployment of decontamination trailer(s). Provide the MAC with the following information:

1. incident location;

2. contaminant (if known);

3. number and severity of victims; and

4. chief complaint of patients.

E. Provide personnel in appropriate level of personal protective equipment (PPE) to staff the trailer(s) in order to perform decontamination and/or assist victims with self-decontamination.

F. Coordinate with the local law enforcement agency for force protection and scene control.

IV. Role of the Affected Healthcare Facility

A. Notify the EMS Agency via the MAC by either telephone at (562) 378- 1789, ReddiNet, or VMED28 of a possible mass casualty event requiring decontamination. The healthcare facility shall provide the MAC with the following information:

1. contact person (Incident Commander or Liaison Officer);

2. decontamination site location;

3. contaminant (if known);

4. number and severity of victims; and

5. chief complaint of patients.

B. The healthcare facility shall determine whether its resources are adequate to deal with the patient load. If the healthcare facility's resources are adequate to deal with the patient load, generally no other assistance would be requested.

C. If the healthcare facility requires additional resources to deal with the patient load, the staff would request deployment of the mobile decontamination trailer(s) from the EMS Agency and/or request fire department/HazMat assistance.

D. Provide personnel in appropriate level of personal protective equipment (PPE) to staff the trailer(s) in order to perform decontamination and/or assist victims with self-decontamination.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 807, **Medical Control During Hazardous Material Exposure**
Ref. No. 1104, **Disaster Pharmaceutical Caches Carried by First Responders**
Ref. No. 1106, **Mobilization of Local Pharmaceutical Caches (LPCs)**
Ref. No. 1225, **Nerve Agent Exposure**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HOSPITALS, CLINICS)

SUBJECT: **AMATEUR RADIO COMMUNICATIONS** REFERENCE NO. 1132

PURPOSE: To provide guidelines on the use of Amateur Radio Operators (ARO) and equipment

AUTHORITY: Code of Federal Regulations, Title 47, Part 97 Amateur Radio Service

DEFINITIONS:

Departmental Operations Center (DOC): Los Angeles County Department of Health Services Emergency Medical Services Agency's DOC.

In-Net: Radio communication within the Net.

Net: A group of radio operators that communicate with each other on a designated radio frequency to achieve a specific goal.

Net Control: Directs all radio communications of a "Net" and manages the sequence of radio traffic to achieve an efficient and orderly "Net" to accomplish the goal.

Out-of-Net: Radio communication outside of the Net.

PRINCIPLES:

1. AROs provide back-up communications for the EMS Agency and healthcare facilities when other communication equipment becomes inoperable.

2. AROs are unpaid volunteers and will function under the direction of the requesting facility's command structure. FCC regulations Part 97 prohibit AROs from charging fees for their services as communicators on amateur radio frequencies.

3. AROs can be hospital personnel with an amateur radio license, a member of Amateur Radio Emergency Service (ARES) organization or other amateur radio organizations.

4. AROs may deploy to the requesting facility with their own radio equipment.

5. AROs communicate using common terminology and clear text with all transmissions.

6. Medical and health related communication will be directed to the DOC whenever possible.

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

7. Non-medical and health related communication will be directed to the city Emergency Operations Center (EOC) where the facility is geographically located.

POLICY:

I. Personnel

A. AROs will complete the following recommended training:

1. IS-100, Introduction to incident Command System or equivalent.
2. Standardized Emergency Management System (SEMS) course or equivalent.
3. Assigned healthcare facility specific training.

B. Amateur Radio Emergency Service (ARES) Organization will:

1. Provide a pool of specialized AROs dedicated to support the EMS Agency and healthcare facilities in LA County.
2. Pre-assign AROs to the EMS Agency and participating healthcare facilities.
3. Collaborate with authorized representatives of participating healthcare facilities to ensure the specialized AROs being pre-assigned meet the standards of the healthcare organization and have the healthcare organization’s approval for assignment.
4. Coordinate the deployment of AROs to the EMS Agency and requesting healthcare facilities.
5. Encourage AROs to participate in drills and exercises at their assigned healthcare facilities.
6. AROs must display ARES and/or healthcare facility issued photo ID care per healthcare facility’s policy.
7. Provide contact information to the EMS Agency and healthcare facility of AROs assigned to provide radio support to the agency and specific healthcare facility. These will include but not limited to:
   a. Home phone number
   b. Cell phone number
   c. E-mail address
   d. Amateur radio license number

II. Equipment

A. AROs will deploy with their own radio equipment but may also use the requesting facility’s radio equipment.

B. Recommended healthcare facility equipment include:

1. Multi-band transceiver (2 meter and 70 centimeter)
2. Antenna (for 2 meter and 70 centimeter bands)
3. Radios with High Frequency capability for Disaster Resource Centers
4. Appropriate 110 volts ac to 12 volts dc power supply, preferably with power pole connectors to allow connection to ARO provided radio equipment.

III. Activation

A. EMS Agency DOC

1. EMS Agency will request ARO through ARES using established notification protocol.
2. ARES will dispatch an ARO(s) Net Control operator to the DOC
3. ARO will report to the DOC and function under the direction of the Medical Alert Center (MAC) Group Supervisor or designee.

B. Healthcare Facility

1. Facility will contact their assigned ARO.
2. Facilities that have an internal amateur radio group, e.g., Kaiser Permanente Amateur Radio Network (KPARN), should follow their internal activation process.

NOTE: If these facilities do not have available AROs, they will submit a request to the DOC for ARO support

3. During a large scale incident, e.g. major earthquake, the ARO will contact their assigned healthcare facility. If the ARO is unable to contact their assigned facility, they will self-deploy to the facility after notifying the ARES Net Control operator.
4. ARO will report to the facility command center and function under the directions of the communications unit leader or designee.

IV. Amateur Radio Traffic Flow

A. Radio frequency designation will be determined by ARES and will primarily occur on the 2 meter or 70 centimeter bands.

B. Net Control will be determined by the DOC according to location and nature of the incident. There will be a minimum of one Net Control operator per district

impacted by the incident.

C. AROs operating in healthcare facilities will communicate with their respective Net Control District.

D. City of Long Beach (LBC):

1. An ARO will be assigned to the City of Long Beach's Emergency Operations Center (EOC). All infrastructure related communication for healthcare facilities within the city will be directed to the LBC's EOC. Medical and Health related communications (hospital status, service level, bed availability, medical and health resource requests) will be directed to the DOC.
2. The Southeast District Net Control ARO will provide status reports of all healthcare facilities within the city to LBC's EOC every six hours or as requested.
3. The ARO assigned to LBC's EOC will have the ability, independent of the Southeast District Net Control ARO, to contact healthcare facilities within the city as determined by LBC's EOC.
4. An ARO will be assigned to Long Beach Department of Health and Human Services as a direct link to LBC's EOC ARO.

NOTE: The LBC Traffic Flow process may be replicated by any city EOC as determined by their EOC manager.

E. KPARN (or other Amateur Radio Groups)

1. Hospital ARO groups shall follow their established internal process for activation and utilization AROs.
2. If a healthcare facility within this group needs to communicate with the DOC, they should communicate directly to their District Net Control ARO assigned to the DOC.

F. ARO "in-Net" communications shall be strictly related to the mission as set forth by the DOC or their assigned healthcare facility. AROs can engage in communications authorized by ARES or their hospital ARO group as needed. ARES or the hospital ARO group will establish guidelines for "out-of-Net" communications.

CROSS REFERENCES:
Amateur Radio MCI Assessment Form
Amateur Radio Hospital Status Assessment Form

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HOSPITAL)

SUBJECT: **BURN RESOURCE CENTER REQUIRED EQUIPMENT/SUPPLIES/PHARMACEUTICALS**

REFERENCE NO. 1138.1

PURPOSE: To provide a mechanism for Burn Resource Centers (BRC) to inventory BRC resources.

POLICY: The BRC shall utilize this checklist to inventory and report PAR levels.

EQUIPMENT SPECIFIC TO BURN PATIENT CARE		
EQUIPMENT	**REQUIRED MINIMUM QUANTITY***	**ACTUAL QUANTITY**
Video equipment for bronchoscope	1 each	
Fluid Infusion Warmer	3 each	
IV Pumps (dual channel)	12 each	
Thermal Mylar Blanket	24	
Thermal Blanket/Forced Air Warming Blanket	2 each	
Video laryngoscope with Pediatric & Adult blades	2 each	
Cauterizer	1	
Cautery Disposable Tips	12	
Cautery Grounding Pads	24	

PHARMACEUTICALS		
PHARMACEUTICALS	**REQUIRED MINIMUM QUANTITY***	**ACTUAL QUANTITY**
Silver Sulfadiazine 1%- Any Size	14,400grams	

Bacitracin (28.4 gm tube)	36 each	
Cyanide Antidote Kit **or** CyanoKit	5 kits	
Midazolam 5mg/ml	360 vials/ampules	
Naloxone 0.4mg/ml	360 vials/ampules	
Morphine Sulfate 10mg/ml	720 vials/ampules	
Lactated Ringers Solution 1 liter bags	250 bags	
D5 Lactated Ringers Solution 500 cc bags	100 bags	

BURN WOUND CARE SUPPLIES		
SUPPLIES	**REQUIRED MINIMUM QUANTITY***	**ACTUAL QUANTITY**
Burn Debridement/ Escharotomy Tray	24 trays	
Dry Burn Dressing (32X36)	600 each	
Gauze Bandage 4” Rolls	400 each	
Tubular Elastic Net Bandage (Size #1, 5, 6, 7, 10, 22)	36 each size	

Statement of Verification

I hereby verify that an inventory of all Grant funded items listed above has been completed and all items are up to PAR.

Verified By: _____ Date: _____
(Printed Name and Signature)

Should any item on the above list fall below PAR levels, notify the EMS Agency immediately.

Notification to EMS Agency by: _____ Date: _____

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **LOCAL BURN LEAD SPECIALIST CALL PANEL** REFERENCE NO. 1138.2

Burn Center Address	**Burn Beds**	**Priority Call***
Grossman Burn Center – West Hills West Hills Medical Center **Dr. Peter Grossman** 7300 Medical Center Drive West Hills, CA 91307 **(818) 676-4177**	30	Jan, Apr, Jul, Oct
LAC+USC Medical Center Southern California Regional Burn Center **Dr. Warren Garner** 2015 Morengo Street Inpatient Tower-5th Floor Los Angeles, CA 90033 **(323) 409-7991**	20	Feb, May, Aug, Nov
Torrance Memorial Medical Center **Dr. Vimal Murthy** 3330 Lomita Blvd. Torrance, CA 90505 **(310) 517-4622**	12	Mar, Jun, Sep, Dec
Total Burn Beds in Los Angeles County	**62**	

*If physician is not available move to next in line. If no Local Burn Lead Specialist is available contact Remote Burn Lead Specialist (Reference No. 1138.3)

Burn Center Address	**Burn Beds**	**Burn Center Address**	**Burn Beds**
Bothin Burn Center at St. Francis Medical Center **Dr. Richard Grossman** 900 Hyde St. San Francisco, CA 94109 (415) 353-6255	16	Shriners Hospital for Children **Dr. David Greenhalgh** 2425 Stockton Blvd. Sacramento, CA 91587 **(916) 453-2184**	30
Bakersfield Memorial **Dr. Rachael Williams** 420 34th Street Bakersfield, CA 93301 (661) 327-1792	7	University California Davis Medical Center **Dr. David Greenhalgh** 2315 Stockton Blvd. Sacramento, CA 91587 **(916) 734-3636**	12
Community Regional Medical Center **Dr. William Dominick** Leon S. Peters Burn Center 2823 Fresno Street Fresno, CA 93271 **(559) 459-4220**	10	University California Irvine Medical Center **Dr. Nicole Bernal** 101 The City Drive Orange, CA 92868 **(714) 456-5304**	8
Inland Counties Regional Burn Center Arrowhead Regional Medical Center **Dr. John Culhan** 400 N. Pepper Ave. Colton, CA 92324 **(909) 580-2100**	14	University California San Diego Medical Center **Dr. Jeanne Lee** 200 West Arbor Drive San Diego, CA 92103 **(619) 543-6502**	18
Orange County Global Medical Center Orange County Burn Center **Dr. Andrea Dunkelman** 1001 N. Tustin Ave. Santa Ana, CA 92705 **(714) 953-2377**	7	Zuckerberg San Francisco General Hospital & Trauma Center 1001 Potrero Avenue San Francisco, CA 94110 **(628) 206-8000**	8
Santa Clara Valley Medical Center **Dr. Yvonne Karanas*** 751 S. Bascom Ave. San Jose, CA 95128 (408) 885-6666	8		
Total Burn Beds in California (not including Los Angeles County)			**136**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, HOSPITAL)

SUBJECT: **MOBILE MEDICAL SYSTEM DEPLOYMENT** REFERENCE NO. 1140

PURPOSE: To provide guidelines for the release and deployment of Emergency Medical Services (EMS) Agency Mobile Medical System (MoMS) during a disaster or mass casualty event.

DEFINITIONS:

EMS AGENCY MOBILE MEDICAL SYSTEM (MoMS): The MoMS consists of a tractor-trailer facility and a tent facility. Each facility is self-contained and can be deployed independently of each other, either as a stand-alone treatment facility or at an existing treatment site such as a hospital.

- **TRAILER FACILITY:** The trailer (hard sided) facility consists of two 53 ft. trailers (one treatment trailer and one support trailer) towed by heavy duty commercial tractors. Each vehicle weighs approximately 86,000 lbs., with an overall length of 80 ft. and a turning radius of 90 ft. A minimum of 5,000 square feet of space is required to set up the trailer facility.

  The treatment trailer has three slide-outs that triple the trailer's width resulting in approximately 1,000 square feet of climate controlled treatment space. There are eleven treatment bays, four of which have cardiac monitors. There are two additional monitored beds in a procedure room. Available medical equipment and supplies include:

  - Portable digital x-ray
  - Cardiac monitor/defibrillators
  - Ventilators
  - Ultrasound
  - Bedside Laboratory Capability (CBC, blood chemistry, etc.)
  - Pharmaceutical cache
  - Medical oxygen piped to wall outlets
  - Wall suction

  The treatment trailer can also be configured with an overarching tent structure that provides approximately 6,500 square feet of weather protected (but not climate controlled) treatment or storage area. This space expands capacity for an additional 200 cots. However, it is not deployed with the additional 200 cots.

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

- **TENT FACILITY:** The tent (soft sided) facility has a potential capacity of 100 patients on cots. There are four (4) 25-patient capacity tents that can be set up in 25-, 50-, 75-, or 100-bed configurations. Each tent is approximately 70 ft. x 20 ft. There is a generator for each tent that supplies electrical power and a climate control unit for heating and air conditioning. The 100-bed configuration requires approximately 70,000 square feet of space to set up. Available equipment includes:

    - Portable cardiac monitor/defibrillators
    - Bedside laboratory analysis
    - Pharmaceutical cache
    - Medical oxygen delivered to bedside regulators
    - Portable suction

PRINCIPLES:

1. The EMS Agency maintains and stores the MoMS at the County Disaster Staging Facility.

2. The overall authority to deploy the MoMS rests with the EMS Agency, who will coordinate the response and deployment.

3. The MoMS is intended as a disaster recovery asset and should not be considered a rapid response unit. This is due to the time necessary to survey routing and set-up locations, assemble credentialed medical/support staff, and integrate the MoMS into the existing healthcare infrastructure. The response and set up may be as long as 2-3 days.

4. In situations where the EMS Agency receives several requests, the EMS Agency shall deploy the MoMS (or parts thereof) to the area(s) of greatest need or benefit.

POLICY:

I. The MoMS may be deployed in the following capacities:

    A. Replacement infrastructure – at an existing healthcare site that is physically damaged but retains in-house staffing capabilities.

    B. Surge capacity supplement – at an existing healthcare facility that may have far exceeded its normal patient capacity where healthcare demands continue to rise.

    C. Stand-alone facility – in a parking lot or open space independent from any existing or supporting healthcare site.

    D. Pre-deployment asset – for a significant event or large gathering where there is a possibility of localized patient surge (i.e., Tournament of Roses, incident of national significance, etc.). Medical treatment staff and supplies may either be included in original deployment plan or may not be provided to the facility until after the patient surge has been realized and the EMS Agency has authorized a full deployment.

E. Training and demonstration events – the trailer and/or tent facilities may be set up to maintain staff proficiency and to exhibit at health fair or public relations events.

II. Role of the EMS Agency

A. Prioritize requests for deployment.

B. Send an advance team to assess the potential deployment site including routing, ingress and site plan. Work with deployment site managers regarding issues such as staffing, re-supply, security, communication, patient movement, etc.

C. Deliver the MoMS to the requested site and deploy to a state of readiness.

D. Coordinate with healthcare facilities and volunteer agencies to obtain the healthcare workers necessary to staff the MoMS appropriate to its mission.

E. Provide logistical support for the duration of deployment. This involves all mechanical/maintenance issues. Responsibility for re-supply of fuel and other consumables will be negotiated as part of the deployment plan.

F. Provide just-in-time training to medical/support staff regarding MoMS equipment and safety considerations.

G. If deployment of the MoMS alters traditional ambulance destinations and transport times during a surge event, the EMS Agency will notify base hospitals and EMS providers of any alterations to traditional patient destinations and receiving facilities.

III. Role of LA County Departments

If available, the EMS Agency may request additional Commercial Driver's License Class "A" drivers to deliver the MoMS, or to provide personnel for assistance with set up.

IV. Role of Base Hospitals

Note EMS Agency-authorized modifications to patient destinations as a result of the MoMS deployment and direct ambulance patients accordingly.

V. Role of LA County Provider Agencies

Note modifications that may occur to traditional patient destinations within the EMS system resulting from the MoMS deployment and transport patients based on temporary EMS Agency directives.

VI. Role of the Requesting Organization

A. Notify the EMS Agency via the MAC by telephone at (866) 940-4401 (select option #1 for an emergency call), ReddiNet, or VMED28 of a possible patient surge event to request additional medical treatment resources. The healthcare facility shall provide the MAC with the following information:

a. Contact person (Incident Commander or Liaison Officer)

b. Hospital or healthcare site functionality
   i. Fully functional
      1) Surge capacity exceeded
   ii. Partially functional
      1) Damage (which department/s)
      2) Evacuation necessary
         a) Numbers and types of patients
   iii. Non-functional
      1) Damage
      2) Evacuation necessary
         a) Numbers and types of patients

c. Support requested
   i. Additional patient capacity
   ii. Supplies

B. Meet with EMS Agency advance team prior to deployment of MoMS.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 502, **Patient Destination**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 1102, **Disaster Resource Center (DRC) Designation and Mobilization**
Ref. No. 1104, **Disaster Pharmaceutical Caches Carried by Authorized ALS Providers**
Ref. No. 1106, **Mobilization of Local Pharmaceutical Caches (LPCs)**
Ref. No. 1122, **Bed Availability Reporting**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **MOBILE MEDICAL SYSTEM DEPLOYMENT SUMMARY** (HOSPITALS) REFERENCE NO. 1140.1

PURPOSE: To provide surge capacity when existing hospital resources are overwhelmed or incapacitated.

I. DESCRIPTION:

The Mobile Medical System (MoMS) consists of the following equipment:

1. Tractor/trailer facility; (2) 53 ft. tractor/trailers:

   (1) Treatment trailer: 11 exam beds (4 monitored); 2 monitored procedure room surgical beds. All beds have suction, oxygen, blood pressure cuff and otoscope/ophthalmoscope.

   (1) Support trailer: contains equipment used in treatment trailer (e.g., exam beds, portable digital x-ray, ramps, IV supplies, bandages, splints, PPE, O_2 masks, etc.).

2. Tent facility; (4) 32 ft. trailers each containing:

   (1) 25 person tent facility: heating, AC, lighting,

   (2) O_2 concentrators: 120 liters/min. each, empty medical supply carts, 30 bed central monitoring station, bedside commode.

Note: Each facility is self-contained and can be deployed independently of each other, either as a stand-alone facility or at an existing treatment site such as a hospital.

II. FOOTPRINT

Equipment	Travel Mode	Operational Mode
Tractor/support trailer	79 ft. long, 102” wide	95 ft. long (ramp open) Weight = 65,000 lbs.
Tractor/treatment trailer	79 ft. long, 102” wide	110 ft. long, 20 ft. wide (slide outs and patient ramp) Weight = 86,000 lbs.
Tent facility with F350 truck	50 ft. long	
(1) 25-person tent		125 ft. x 75 ft. (with 20 ft. buffer zone for acces
(2) 100-person tent		60,000 sq. ft. (approx. size of a football field) May require stakes into asphalt.
Full set-up (100 person tent wi treatment and support trailer)		70,000 sq. ft.

III. ACCESSIBILITY

Deployment site requirements:

1. Must be accessible to large commercial vehicles.
2. Overhang or bridge height must be greater than 14 ft. 6 in
3. Parking surface must be hard asphalt or concrete (no grass or bare earth foundations).
4. Parked vehicles must be removed from area.

IV. REQUESTING RESOURCES

The EMS Agency only provides logistical support for a MoMS deployment. This includes a team for initial set-up with one specialist provided to monitor mechanical systems 24 hours/day during the operational period. The requesting facility is responsible for providing the following:

1. A Resource Request Medical and Health that identifies a list of required equipment (specify which components of MoMS are being requested).
2. Medical and ancillary staff. Required staff that cannot be provided by the requesting facility may be obtained through a Resource Request Medical and Health.

Emergency Request: A resource request must be submitted to the DHS DOC to obtain the MoMS or any component thereof.

Planned Event Request: A planned event deployment request must be submitted at least two months in advance of the event scheduled date. Within three (3) days of the MoMS site assessment, the requesting facility must sign an MOU with the County regarding deliverables, indemnification, and insurance

V. PROCEDURE

1. **Deployment within Los Angeles County:** contact EMS Agency through Medical Alert Center or ReddiNet.

    a. Indicate current facility status and capability.
    b. Specify resource needs using an approved Resource Request form.
    c. Provide name, call back number, and location for advance team meeting.
    d. Any additional requests for resources during the operational period shall be made through the facility's hospital command center (HCC).

2. **Deployment outside of Los Angeles County:** use resource request process specified in CDPH/EMSA EOM.

    a. Indicate current facility status and capability.
    b. Specify resource needs using an approved Resource Request form.
    c. Provide name, call back number, and location for advance team meeting.
    d. Any additional requests for resources during the operational period shall be made through the through the MHOAC/RDMHC programs.

VI. RESPONSE TIME FROM INITIAL RESOURCE REQUEST

The MoMS is not an immediate response asset (e.g., an ambulance).

Within 6 hours: Upon receipt of a resource request to the DHS DOC, an "Advance Team" will be dispatched to assess the needs of the requesting facility and inspect the deployment location. This team may consist of an administrator, physician, and a class "A" driver. This assessment should take no longer than 2 hours, after which the team may identify issues that need to be addressed or requirements that must be in order for the MoMS to be deployed.

Within 8 hours: The MoMS will be activated and deployed to identified location if it has been determined to meet deployment site requirements (driving time to facility is additional).

VII. WRAP-AROUND SERVICES

The requesting facility must provide or contract for the following resources and services:

1. Fuel (diesel) – Treatment/support trailers have a capacity of 300 gallons diesel with a burn rate of six (6) gallons/hour; Tent generators (one per each 25-person tent) have a burn rate of 1.5 gallons/hour.

2. Water – Treatment trailer has 400 gallons of fresh water in the holding tank for hand washing; Support trailer has 100 gallons of fresh water in the holding tank for kitchen sink, restroom, and shower. Fresh water tanks can be refilled using garden hose.

3. Food service for patients and staff.

4. Linen/housekeeping – MoMS provides 1,000 disposable blankets, sheets, pillows for the tent cots. Linen is not provided for the exam beds in the treatment trailer.

5. Waste management – Grey water: Treatment trailer has a 200 gallon tank; Support trailer has a 40 gallon tank; Black water: Treatment trailer has a 200 gallon tank; Support trailer has a 60 gallon tank. Sharps and biohazards will be managed by requesting facility.

6. Site security -24/7.

VIII. SET-UP TIME

Treatment and Support trailers: Two (2) hours with five (5) people.

Tent Facility (25-person tent): 12 hours with five to six (5-6) people.

IX. MOMS EQUIPMENT/SUPPLIES

The MoMS will deploy with a limited amount of supplies and medical equipment. The following are carried with the intent to support an initial start-up for an alternate care site:

1. **Monitors:** (30) Welch Allyn central monitor station, (3) Philips Heartstart MRX monitor/defibrillators.

2. **IV pumps:** (6) Hospira Plum A+ pumps with approximately 100 IV cartridges.
3. **Pharmaceuticals:** Local pharmaceutical cache (see Ref. 1106.1 of the Prehospital Care Policy Manual).
4. **Laboratory:** (3) i-STAT handheld bedside testing devices.
5. **Oxygen:** Treatment trailer: (7) H tanks, liquid oxygen capable; Tent facility: (2) O_2 concentrators
   (120 L/min. each).
6. **X-ray:** (1) MinXray portable digital x-ray machine with developer.
7. **Ultrasound machine**.
8. **Patient beds:** Treatment trailer (11 exam beds, 2 OR beds); tent facility (100) cots, (4) cribs, (4) gurneys.
9. **Suction:** Treatment trailer: (1) at each bedside; Tent facility: (20) Laerdal suction units.
10. **Miscellaneous:** Bandages, splints, IV start equip. with NS, O_2 masks, suction, gloves, etc.
11. **Generators** for heat and air conditioning.

X. ELECTRICAL/POWER

1. Treatment trailer – Self-contained, 100 kW diesel generator located on each Volvo tractor.
2. Support trailer – Self-contained, 50 kW diesel generator on board.
3. Tent facility – 25 kW portable diesel generator with each 25-person tent.

XI. TERMS OF USE

The requesting facility will operate and maintain the MoMS as if it is part of their existing system. This includes organizational and functional areas such as scheduling workers, ordering supplies/equipment, running tests, and maintaining a clean and hazard free patient care environment.

The EMS Agency and requesting facility will coordinate for the demobilization and recovery aspects early in the deployment planning process.

If there are multiple requests for the MoMS unit, DHS DOC will determine the location of deployment.

XII. COST AND REIMBURSEMENT

1. DHS DOC, in coordination with the County Office of Emergency Management, will seek reimbursement through State and Federal disaster reimbursement programs after all costs and disaster related expenses have been calculated and documented.

2. Costs may be incurred for a disaster deployment or planned event and these costs may be passed on to the entity requesting the use of the MoMS on a case by case basis. The cost will be based on the approved County fees for MoMS deployment.

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
Director

Gregory C. Polk, M.P.A.
Chief Deputy Director

Curley L. Bonds, M.D.
Chief Medical Officer

August 17, 2020

TO: Supervisor Kathryn Barger, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Janice Hahn

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

SUBJECT: **CONSOLIDATED REPORT RESPONSE TO THE MOTIONS "CRISIS RESPONSE COORDINATION (ITEM 3, AGENDA OF MARCH 4, 2020)" AND "ALTERNATIVES TO LAW ENFORCEMENT CRISIS RESPONSE (ITEM 40-H, AGENDA OF JUNE 23, 2020)"**

On March 4, 2020, the Los Angeles County Board of Supervisors (Board) approved a motion directing the Department of Mental Health (DMH) and Chief Executive Officer (CEO) to report back with an assessment of Los Angeles (LA) County's current crisis response system and make recommendations for addressing gaps and improving coordination.

On June 23, 2020, the Board approved another motion authorizing DMH to collaborate with the Health and Human Services Crisis Response Coordination Steering Committee (renamed Alternative Crisis Response Steering Committee) to explore ways for LA County residents to call a number that is supported by and provides access to a consolidated health and human services response, consistent with and building off of the recommendations in the Alternatives to Incarceration Workgoup's "Care First, Jail Last" March 2020 report.

The attached report "LA County's Alternative Crisis Response: Preliminary Report and Recommendations" serve as the first phase (Phase 1) to fulfill the directives of the Board.

If you have any question or need additional information, please contact me, or staff may contact Dr. Amanda Ruiz, Mental Health Psychiatrist, at (213) 738-4651 or amaruiz@dmh.lacounty.gov.

JES:tld

Attachment

c: Chief Executive Office
Executive Office, Board of Supervisors
Department of Health Services
Alternative Crisis Response Steering Committee

Los Angeles County Alternative Crisis Response

Preliminary Report and Recommendations

Jonathan E. Sherin, M.D., Ph.D.
Director, Los Angeles County Department of Mental Health

Robert Ross, M.D.
President and CEO, The California Endowment

Table of Contents

Summary of Recommended Investments 3
Introduction: A Time for Change in LA County's Crisis System 4
A Vision for LA County's Crisis System 5
Values and Principles 5
Crisis System Models and Best Practices 5
A Redesigned Crisis System for LA County 5
LA County's Crisis System: Proposed Design 7
Preliminary Gap Analysis of LA County's Crisis System 7
Regional Crisis Call Centers 7
Crisis Mobile Response Teams 7
Crisis Receiving and Stabilization Facilities 8
Infrastructure: Technology, Funding, Policy 8
Next Steps 10
References 12

Preliminary Outline of Recommended One-Time and Ongoing Investments

Crisis System Core Component	Investment Description	Potential Offsets
Component 1: **"**Regional Crisis Call Center Network"	Design, construct, and implement a state-of-the-art Regional Crisis Call Center Network: • Acquire technology platforms equipped to ensure equitable omnichannel access (phone, text, chat) and support coordination (i.e., "air traffic control") of crisis calls, response team activities, and access to care; • Consolidate 911 and other crisis call center functions (requires reconfigurations); • Acquire adequate crisis call center staffing to include peers and clinicians 24/7; • Formalize countywide protocols for crisis and suicide risk evaluation, triage, and dispatch; • Engage ongoing, iterative community member and front-line staff focus groups; • Develop state-of-the-art data collection and analysis infrastructure to assess performance metrics and client as well as community/County outcomes; and • Deliver ongoing training for the system as needed based on indicators.	One-Time: • ATI Fund, Cities • Philanthropy • Private payers • Medi-Cal managed care plans • State/federal grants • DMH/DPH/DHS Ongoing: • ATI Fund, Cities • Private payers • Medi-Cal managed care plans • State/Federal match • DMH/DPH/DHS
Component 2: **"**Crisis Mobile Team Response"	Increase crisis mobile response team and (therapeutic) transport capacity and right-size co-response teams across jurisdictions (including unincorporated County).	
Component 3: **"**Crisis Receiving and Stabilization Facilities"	Increase behavioral health bed capacity including but not limited to urgent care center (UCC), crisis residential treatment program (CRTP), inpatient psychiatry, and peer respite resources.	

NB: As a part of next steps, subcommittees of the Alternative Crisis Response Steering Committee will be created for each of the three core Crisis System components. The subcommittees will be made up of subject matter experts (SMEs) tasked to detail rationale, design, cost, planning, and implementation strategies for these components. Subcommittees will include racial and geographic equity in all planning; throughout each component there is a need to weave in racial equity and measurements to ensure that any gaps identified lead towards improvements that are rooted in racial and geographic equity throughout implementation. Investments will produce a Return on Investment (ROI) via increased access to treatment and a reduction in significant costs of law enforcement responses, emergency room (ER) visits, repeat and extended stay hospitalizations, incarceration and episodes of homelessness across the County. Estimates of ROI will require further research and exploration by subcommittees of the ACR Steering Committee.

A Time for Change in Los Angeles (LA) County's Crisis Response System

Introduction

On March 4, 2020, the Los Angeles County Board of Supervisors (Board) unanimously approved a motion directing the Department of Mental Health (DMH) and Chief Executive Officer (CEO) to report back with an assessment of LA County's current crisis response system and make recommendations for addressing gaps and improving coordination [1].

The following week, the LA County Alternatives to Incarceration (ATI) Work Group released its final report and recommendations [4]. As context, for over a year, the ATI Work Group met and engaged with community members and leaders from throughout the County on how to develop a truly "care first, jails last" system. In response, the Board voted unanimously to establish an office to advance the ATI initiatives, and it was organized into five key strategies including initiative 2., **bolded** below, which has led to the work of the Alternative Crisis Response Steering Committee (ACR):

1. Expand and scale community-based, holistic care and services through sustainable and equitable community capacity building and service coordination.
2. **Utilize behavioral health responses for individuals experiencing mental health and/or substance use disorders, homelessness, unemployment, and other situations caused by unmet needs; avoid and minimize law enforcement responses.**
3. Support and deliver meaningful pre-trial release and diversion services.
4. Provide effective treatment services in alternative placements, instead of jail time.
5. Effectively coordinate the implementation of ATI recommendations, ensuring that strategies eliminate racial disparities and to authentically engage and compensate system-impacted individuals.

Since these prescient Board actions, the tragic murders of Breonna Taylor and George Floyd ignited a mass uprising for Black life that has reshaped the local, state, national, and global conversation on U.S. police practice. Included in this conversation is the urgent need to build new systems for receiving, assessing, triaging, and mounting our non-law enforcement response to crises across our communities. A June 23, 2020, motion from Board [2], and a similar motion from the LA City Council [3] affirmed this demand in Los Angeles and created processes to generate the change we need.

The ACR now charged to review the current state of affairs and develop recommendations for a future state in accordance with Board action, met on July 10, 17, and 24 to discuss a path forward for LA County's crisis system. The ACR is being chaired by Dr. Jonathan Sherin, Director of LA County DMH, and Dr. Bob Ross, President and CEO of The California Endowment and Chair of the ATI Work Group. Among numerous principal committee members is leadership from: County Health and Human Service Departments as well as County Fire and Sheriff's; LA City Fire and Police as well as leaders from other key municipalities; and community leaders from various other organizations across the County. This very preliminary and cursory report represents a consensus framework for how the ACR plans to move forward in developing detailed recommendations.

A Vision for LA County's Crisis System

Values and Principles

In developing a vision and plan for a better crisis system in LA County, it is critical that we adhere to a key set of values and principles that remain intact in deliberation, planning, and implementation efforts:

1. In furtherance of the ATI Work Group's commitment to the robust engagement of community stakeholders and front-line workers, the ongoing reform and transformation of our crisis system must explicitly engage those most impacted to help inform design through firsthand experience.
2. The culture of the rebuilt crisis system must not only meet real-time needs of community but also eliminate racial disparities perpetuated, directly or indirectly, by the current system.
3. A reengineered crisis system must incorporate, at its core, design features and implementation strategies that dramatically reduce and mitigate law enforcement responses wherever and whenever possible.

Crisis System Models and Best Practices

LA County has been an innovator in crisis response for decades. The Didi Hirsch Suicide Prevention Center, founded in 1958 as the first of its kind in the United States, still stands as a beacon of hope and universal access to mental health crisis services on Olympic Boulevard [12, 13]. In addition, the County Sheriff's and Los Angeles Police Department's co-response efforts, in operation for decades, make up one of the first and also largest law enforcement and mental health programs in the nation [14]. By learning from our crisis system experiences to date and best practices from around the country, LA County is once again poised to play a leading role through the further redesign and reengineering of an alternative crisis response system.

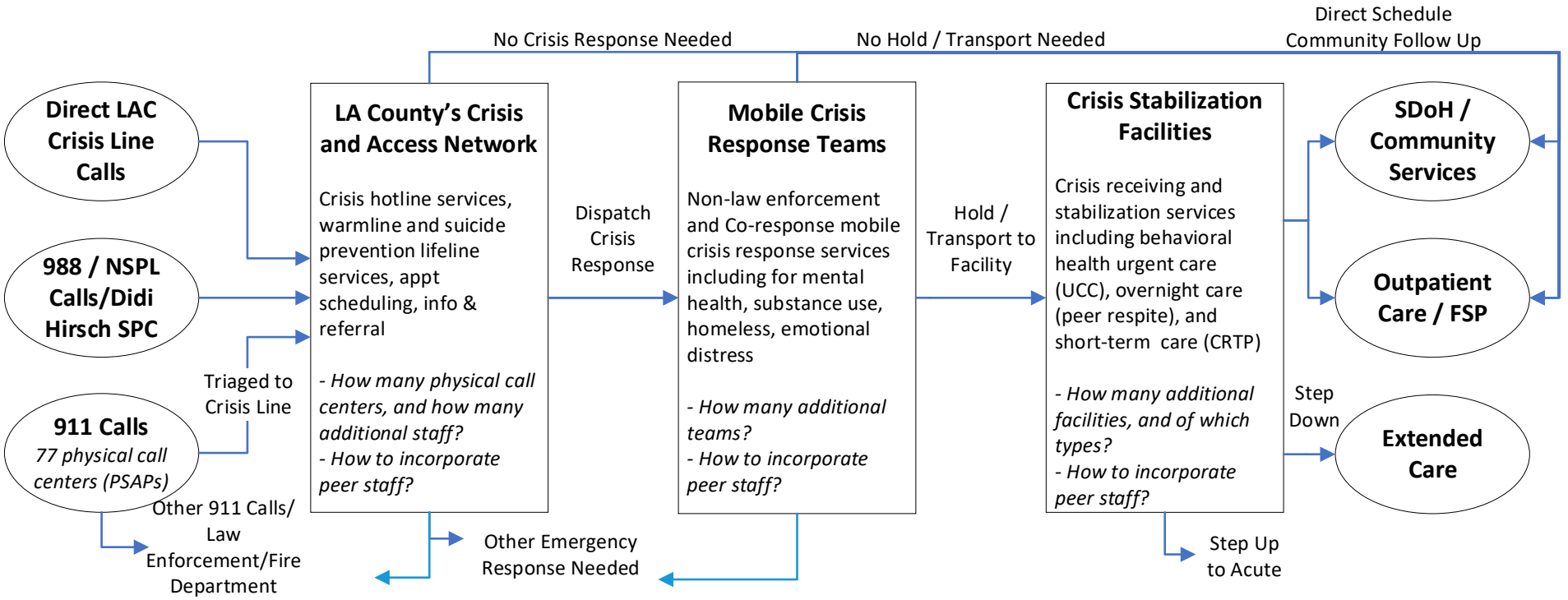
A recent report from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) offers guidance and best practices for developing and improving the three core components of a high-functioning crisis system [7]:

1. Regional Crisis Call Hub Services (Someone to Talk To)
2. Mobile Crisis Team Services (Someone to Respond)
3. Crisis Receiving and Stabilization Services (Somewhere to Go)

A Redesigned Crisis System for LA County

It is important to note that there are jurisdictions in the country that, though smaller, have been able to pull together a variety of the components described in the SAMHSA report including CAHOOTS and Crisis Now, as well as the Georgia Crisis, Sacramento Mental Health First, and Access Line. With lessons and guidance from these models as well as the body of knowledge and experience obtained locally for over 60 years, we as a County have the unique opportunity during this redesign phase to establish a high-level framework, overlaid and built upon LA County's current assets, to determine what we want our crisis system to look like, and how it ought to operate. Although purposefully cursory, like this report, we developed a Proposed Design diagram:

LA County's Crisis System: Proposed Design (Updated 8/5/20)



Technology Platform: Several applications required, must be stitched together into a cohesive system

(1) call/text routing and handling (incl. caller ID); (2) crisis call/case management (incl. disposition status tracking); (3) mobile team dispatch, routing and tracking (incl. GPS); (4) crisis health info exchange (e.g. EDIE, LANES + system interconnections); (5) crisis facility bed registry (e.g. ReddiNet, MHRLN); (6) outpatient care appt scheduling; (7) SDoH / community services referral management; (8) performance dashboards and reporting

Funding Structure: One time and ongoing funds to implement design

(1) one time grant funding for design and implementation projects, including tech platform build out (fed/state/philanthropy); (2) one time capital development funding for new call centers, mobile team offices, and crisis facility builds; (3) ongoing mental health plan / federal, and other health plan reimbursement for crisis services; (4) ongoing funding from local governments

Policy/Legislative Structure: Policy changes needed to realize ideal design

(1) allow EMS providers more flexibility in transport destination; (2) enable proper utilization and funding of peer staff throughout crisis system; (3) all payer case rates for crisis episodes (including for calls, team response, and crisis stabilization care)

Preliminary Gap Analysis of LA County's Crisis System

Regional Crisis Call Centers

Currently, crisis call centers in LA County include 911, DMH ACCESS and the Didi Hirsch Suicide Prevention Center (SPC), wherein DMH ACCESS and the Didi Hirsch SPC serve as behavioral health crisis call centers. The Didi Hirsch SPC currently powers the federal National Suicide Prevention Line (NSPL) for our region as well as the nationally reaching Disaster Distress Helpline, combined serving 130,000 individuals in crisis a year with numbers that have grown significantly during the pandemic. The 911 call center network, which includes 77 public safety answering points (PSAPs), is currently led by law enforcement and manages crisis calls. However, there are variations in screening, triage, handoffs (peers to clinicians) and dispatch processes among the PSAPs as well as the behavioral health call centers.

LA County is in need of a true regional crisis call center network, with shared standards for triage, the ability to dispatch non-law enforcement crisis response teams, and a shared view into available crisis stabilization resources, including treatment beds with an overall goal of minimizing law enforcement response to the maximum extent possible. The ACR considers a reconfigured and appropriately resourced 911 call center network integrated with the behavioral health crisis call center network as one means for all calls to be taken directly and functioning as a regional network to screen, triage, and dispatch crisis calls to a non-law enforcement response at every possible opportunity and law enforcement co-response teams where indicated. A reconfigured 911 call center network would include a re-branding media campaign through a lens of racial equity and in consideration of the communities' current perception of 911.

In terms of this network and its inclusion of 911, it should be noted that other jurisdictions, such as Houston, have 911 networks that are not led by law enforcement and have standard protocols for when to triage a call to law enforcement. This so called "opt-in" framework, whereby the default response is non-law enforcement unless explicitly determined to require law enforcement response during triage, stands in stark contrast to the current "opt-out" framework, where law enforcement response is the default unless otherwise indicated. Preliminary data from Houston shows 51% reduced overall dispatches, 50% reduced time for dispatched professionals in the field, and ~$6:1 ROI. The "opt-in" framework is a model that LA County needs to explore to allow for health and lived experience professionals to facilitate crisis triage options.

Crisis Mobile Response Teams

Reconfiguring the 911 and behavioral health call centers into a regional network is important but will not provide the desired outcomes without also increasing the ability to respond. There is a consensus amongst the ACR that the majority of additional capacity needed for such response ought to focus on interdisciplinary non-law enforcement crisis response with shared response protocols, and there is a strong consensus among the ACR that additional capacity is needed across the County. These teams also need to be better coordinated, more easily dispatched, equipped to manage transportation of clients and staffed with peers. There are also Crisis Mobile Co-Response Teams, including MET, LET, START, and SMART. While there is some consensus that there are an appropriate number of these teams in LA City, there is concern that additional teams are needed elsewhere and in the LA County MET

program in particular. Although these teams include an armed law enforcement officer, they are considered important much more broadly in the crisis response system.

Crisis Receiving and Stabilization Facilities

As indicated in the October 2019 report on addressing the shortage of mental health bed capacity, while LA County has behavioral health urgent care centers (UCCs) and crisis residential treatment programs (CRTPs) as well as inpatient psychiatric treatment and peer respite facilities, there is a significant need to increase these resources as well as facilities for substance use disorders. These facilities are absolutely critical to have a place to take individuals in crisis, other than emergency rooms, hospitals, and jail. There is also a need to evaluate the efficiency, including length of stay, for each of the community based mental health and substance use resources that would support a reimagined alternative crisis response system. There is a strong consensus in the ACR that many more of these facilities are needed and should be geographically distributed around LA County, especially in the outlying areas. Locating these facilities on hospital campuses (key components of our "Restorative Care Village" model) is also important to deal with siting difficulties as well as being conveniently located near public transportation and enriched clinical services. Additionally, the improved alternative crisis response system needs to ensure a better utilization of extant community and non-governmental mental health bed capacity.

Infrastructure: Technology, Funding, Policy

A robust crisis system will need to be supported by an infrastructure that helps to coordinate the various elements, supports the sustainability of the system, and is within a legal/regulatory framework.

Technology

- The current crisis system does not have a holistic technology platform to support it, similar to the proposed LA County's Crisis System proposed design diagram.
- The current crisis system components do not communicate efficiently to coordinate crises and share information in real-time as needed.
- Achieving true "air traffic control" of crisis cases will require a big technological overhaul, but given the ROI and likely human harms we could avoid, this would be worthwhile investment.
- Increase mobility by exploring the use of mobile device applications to directly connect health and human services workers to the appropriate crisis response teams

Funding

- Initial investments will require significant one-time funding, including leveraging grants, local health plans, and philanthropy in addition to various public funds.
- Sustaining investments will require significant ongoing funding and a structure that leverages those funds efficiently and effectively.
- DMH as the mental health plan, DPH SAPC, and the managed care plans (LA Care and HealthNet) can be used to draw down federal Medicaid funds for services provided in the Crisis Mobile Team Response and Crisis Receiving and Stabilization Facility components of the crisis response system provided all applicable federal and state requirements are met. Claiming to Medicaid for the Regional Crisis Call Center component is also possible limited.
- Proper reimbursement will be required from private/commercial health plans.

- States like Arizona and Washington have models for crisis call centers identifying and billing callers' public and private insurance plans.
- Explore partnerships with major telecom partners like Verizon or IBM which are funding communication systems in other parts of the country.

Policy

- Peers are a key element in a high-functioning crisis response system, at every step from the initial call all the way through to the crisis receiving and stabilization facilities. It is important to ensure they can receive compensation, and we await legislative action on Senate Bill (SB) 803, which would allow Medi-Cal billing for Peer Support Specialist Services to start in three or more years.
- We need more flexibility for EMS providers to transport clients to destinations by expanding the current waiver for paramedics (LAFD has a current waiver per discussion).
- An increase from 24 hours to 72 hours for reimbursable services in behavioral health urgent care centers will improve both the urgent care program and client outcomes but also assist with bringing in federal dollars.

Next Steps

1. **Continue the work.**
   Identify and implement changes that can begin immediately to improve the current system while addressing current barriers that exist and developing remedies to resolve those issues, including but not limited to, creating a direct line to DMH ACCESS for law enforcement.

   Develop the three alternative crisis system core components referenced in this report with input from the following principals and stakeholders to focus on the following areas:
   a. Representation across key public health, public safety, technology, capital, finance, labor and marketing fields with both public and private sector involvement;
   b. Clients previously exposed to the current system and community advocates as well as front-line workers to develop racial, ethnic and geographic equity measurements, and facilitate planning to ensure that any identified gaps guide efforts towards system improvement rooted in equity from design to implementation;
   c. Operations, finance structures, and relevant policy advocacy to ensure the sustainability of each component; and
   d. Granular, feasible and actionable recommendations for design, development, funding and implementation.

   Map the current, in development and potential assets within each supervisorial jurisdiction in Los Angeles, prioritizing those to whom response is most impacted by behavioral health crisis and issues relating to social determinants as well as incarceration

2. **Design a system for LA County.**
   Secure a consultant who, in coordination with the three subcommittees, a full range of community stakeholders, and front-line workers, will help:
   a. Analyze LA County's existing crisis system and gaps in more detail.
   b. Develop focused recommendations and an implementation plan to optimize the existing system and identify "early wins." These "early wins" need to address the current barriers that exist and develop remedies to resolve those issues to create an existing system that is fully functional.
   c. Design a new, scalable system structure in which the County can allocate additional needed resources in a way that will maximize a return on investment, both in terms of fiscal savings from reduced ER visits, hospitalizations, and law enforcement response and incarcerations, but even more importantly the elimination of racial disparities and preventable harms done to individuals and communities by the current system.
   d. Develop a long-term implementation plan for the new system design and work with County leaders to develop a funding plan for it.
   e. Establish performance metrics by which the system can measure and hold itself accountable for high quality outcomes.

3. **Don't reinvent the wheel.**
   Continue to leverage research and best practices of over 60 years in LA County as well as from around the country (e.g., Crisis Now, CAHOOTS, and the Mental Health First team) to inform the

vision for and implementation of a 21st century crisis system in LA County. Dr. Sherin kicked off the effort with a visit to Arizona to tour its crisis system and see firsthand implementation of the Crisis Now model.

4. **Be a model for the rest of the nation.**
   Work with local experts and research institutions to ensure this change process is documented and key outcomes are monitored according to high quality research principles. Leave no doubt about the impact of this new crisis system on LA County and show other jurisdictions throughout the country how they, too, can build a better crisis system.

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    b. Georgia Crisis and Access Line (GCAL)
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    d. Colorado Crisis Services
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