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: **July 15, 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 - Revised

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.
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II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS
Rangell Oruga, MPH, Public Health Meth Campaign

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
May 20, 2020

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
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)

BUSINESS (NEW)
5.5 EMS Personnel Administering Vaccinations
5.6 LA County COVID-19 Modeling – EMS Agency Data
5.7 Chapter 13 Issue for Firefighters and Fire Chiefs

V. COMMISSIONERS' COMMENTS / REQUESTS

VI. LEGISLATION

VII. EMS DIRECTOR'S REPORT

VIII. ADJOURNMENT

To the meeting of September 16, 2020

COUNTY OF LOS ANGELES
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MINUTES
MAY 20, 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.		
☒ John Hisserich, Dr.PH	Public Member, 3rd District	Nichole Bosson	Asst. Medical Director
☒ Lydia Lam, M.D.	So. CA Chapter American College of Surgeons	Richard Tadeo	Assistant Director
☒ James Lott, MBA	Public Member, 2nd District	Kay Fruhwirth	Assistant Director
☒ Robert Ower	LAC Ambulance Association	Roel Amara	Assistant Director
☒ Margaret Peterson, PhD	Hospital Assn. of So. CA	Sara Rasnake	EMS Staff
☒ Paul S. Rodriguez	CA State Firefighters' Assn.	Jacqui Rifenburg	EMS Staff
☒ Jeffrey Rollman	So. CA Public Health Assn.	Joel Mendoza	EMS Staff
☒ Joseph Salas	Public Member, 1st District	Adrian Romero	EMS Staff
☒ Nerses Sanossian, M.D.	American Heart Association	John Telmos	EMS Staff
☒ Carole Snyder	Emergency Nurses Assn.	David Wells	EMS Staff
☐ Vacant	League of CA Cities/LAC	Lorrie Perez	EMS Staff
☒ Atilla Uner, M.D.	American College of Emergency Physicians CAL-ACEP		
☒ Gary Washburn	Public Member, 5th District		
☒ David White	L.A. Area Fire Chiefs' Assn.		
☐ (*) Pajmon Zarrineghbal	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.
Members of Public		Gloria Molleda	League of CA Cities

(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 California statewide stay-at-home orders related to the Coronavirus (COVID-19) pandemic. The meeting was called to order at 1:02 p.m. by Chairman John Hisserich. A quorum was present with 15 Commissioners in attendance.

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

Executive Director, Cathy Chidester, took roll for commissioners and acknowledged members of the public and EMS Agency staff present on the call.

Dr. Marianne Gausche-Hill, EMS Medical Director, gave Zoom instructions to provide participants with meeting rules and general guidelines for asking questions and using Zoom.

III. CONSENT AGENDA

Chairman Hisserich called for approval of the Consent Agenda and opened the floor for discussion. Ms. Chidester asked if there were any Correspondence items the Commissioners wanted removed, or if they preferred to approve the Consent Agenda as is, noting that some Correspondence would be discussed later under New Business related to COVID-19.

Motion/Second by Commissioners Snyder/Uner to approve the Consent Agenda including all Correspondence was carried unanimously.

1. MINUTES

January 15, 2020 Minutes were approved.

2. CORRESPONDENCE

2.1 (01-02-2020) From EMS Authority: LA EMS Agency 2017-18 Children System Plan Approval
2.2 (01-07-2020) Distribution: Fire Chief, Each Fire Department: Electronic Patient Care Report
2.3 (01-07-2020) Emergency Department Closure of St. Vincent Medical Center
2.4 (01-08-2020) Mark Gillaspie, Downey Fire: Approval: AutoPulse™ and ResQPOD®
2.5 (01-08-2020) Chief Kurt Norwood, Sierra Madre Fire: Fentanyl Program Approval
2.6 (01-08-2020) Xavier Espino, Long Beach Fire Chief: Approval: Intraosseous Infusion – Humeral Placement
2.7 (01-08-2020) Andranik Bableyan, FirstMed Ambulance: TCP Program Approval
2.8 (01-09-2020) From St. Vincent Medical Center: Closure of St. Vincent Medical Center
2.9 (01-13-2020) Margaret Pfeiffer, Interim CEO, St. Vincent: Closure of St. Vincent Medical Center
2.10 (01-14-2020) Distribution: Prehospital Care Coordinator – Each Base Hospital: Prehospital Administration of Stroke Therapy-Trans Sodium Crocetinate (PHAST-TSC) Trial Study
2.11 (01-19-2020) Tom McGinnis, EMS Authority: 2017/2018 EMS Plan for Los Angeles County EMS Agency
2.12 (01-23-2020) Melissa Harris, AmbuServe Ambulance, Inc.: Kings LTS(D) Airway Program Approval for Specialty Care Transport
2.13 (01-23-2020) Rick Fields, PRN Ambulance, Inc.: Kings LTS(D) Airway Program Approval for Specialty Care Transport
2.14 (02-06-2020) Edward Mirzabegian, Antelope Valley Hospital: Delay of Patient Prehospital Transport
2.15 (02-06-2020) Richard Allen, Palmdale Regional Medical Center: Delay of Patient Prehospital Transport
2.16 (02-13-2020) Mildred Carlisle, Liberty Ambulance: King LTS(D) Airway Program Approval for Specialty Care Transport
2.17 (02-28-2020) Clayton Kazan, MD, Los Angeles County Fire: Telemedicine for Alternate Destination Pilot Project Approval
2.18 (03-03-2020) Distribution: Sidewalk CPR Training Coordinators: Sidewalk CPR Toolkit
2.19 (03-05-2020) Daryn Dryum, Manhattan Beach Fire Chief: Approval: AutoPulse™

2.20 (03-05-2020) Vincent Capelle, West Covina Fire Chief: Approval: Intraosseous Infusion – Humeral Placement
2.21 (03-10-2020) Boris Krutonog, AMWest Ambulance: CPAP Program Approval
2.22 (03-10-2020) Paul Scarborough, Premier Medical Transport: King LTS(D) Airway Program Approval for Specialty Care Transport
2.23 (03-12-2020) From LA County Counsel to Susan Fanelli, California Department of Public Health: Closure of St. Vincent Medical Center
2.24 (03-19-2020) Distribution: 9-1-1 Dispatch Centers and Paramedic Provider Agencies: Screening Calls and Not Dispatching a Resource
2.25 (03-19-2020) Distribution: Trauma Centers: Trauma Center Leadership COVID-Update
2.26 (03-23-2020) From Mark Eckstein, MD, Los Angeles City Fire: Letter of Support Re: Telehealth Pilot
2.27 (03-31-2020) Distribution: Hospital CEOs: USNS Mercy Patient Transfer Process
2.28 (04-01-2020) Distribution List: Change in SART Center Designation
2.29 (04-02-2020) Distribution: Fire Department Chiefs, Public and Private Provider Medical Directors, Private Ambulance Company CEOs, Public and Private Sector Nurse Educators: Process for Acquiring Positive COVID-19 Results of an EMS Transported Patient
2.30 (04-03-2020) Rick Fields, PRN Ambulance, Inc.: EMT Local Optional Scope Program Approval
2.31 (04-06-2020) Distribution: Receiving Hospitals, Base Hospitals, Fire Departments, Ambulance Operators, EMS Providers: COVID-19 Update #7: EMS Handoffs
2.32 (04-06-2020) Distribution: Receiving Hospital CEOs and Emergency Department Medical Directors: Hydroxychloroquine Sulfate Availability
2.33 (04-07-2020) Distribution: Receiving Hospitals, Base Hospitals, Fire Departments, Ambulance Operators, EMS Providers: COVID-19 Update #8: Los Angeles County EMS Agency Approvals for Alternate Destinations (ADs)
2.34 (04-07-2020) Distribution List: Temporary Closure of Perinatal Services – PIH Health Hospital – Downey
2.35 (04-08-2020) From EMS Authority: Response to LA County's Request for Extension to Submit Annual Maddy Fund Report

3. COMMITTEE REPORTS

3.1 Base Hospital Advisory Committee (February 12, 2020)
3.2 Data Advisory Committee (April 8, 2020 Meeting Cancelled)
3.3 Provider Agency Advisory Committee (February 19, 2020)

4. POLICIES

4.1 Reference No. 506: Trauma Triage
4.2 Reference No. 506.2: 9-1-1 Trauma Re-Triage

END OF CONSENT AGENDA

IV. BUSINESS

BUSINESS (OLD)

5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies
Commissioner Erick Cheung expressed no current or updated activity related to Mental Health and Substance Abuse Emergencies.

5.2 Ambulance Patient Offload Time (APOT)
Richard Tadeo, EMS Assistant Director, reported a decrease in the number of ambulance transports; and, anecdotally opined, COVID-19 may be the reason for no complaints about long offload times from any providers or hospitals.

5.3 Criteria for 9-1-1 Receiving Center Designation (Reference No. 302 Attached)
The Criteria for 9-1-1 Receiving Hospitals is on hold, and no work has been done on this.

BUSINESS (NEW)

5.4 Update to Commission on EMS Agency Activities related to Coronavirus (COVID-19)
Ms. Chidester reported that the EMS Commission meetings are usually in-person, public meetings governed by the Brown Act; however, due to COVID-19 and emergency declarations by the Los Angeles County Board of Supervisors to suspend this Brown Act requirement, the EMS Commission is utilizing the Zoom Video Conferencing technology to hold meetings until further notice.

There has been a lot of COVID response activity within the EMS Agency, and it is important for the Commission to know what the roles of the EMS Agency are and what we are doing in response to the COVID-19 pandemic. Policies, procedures, and letters have gone out, as well as changes to the EMS system.

One of the roles of the EMS Agency is system coordination with prehospital care providers and hospitals. The EMS Agency functions as an intermediary between hospitals and the pre-hospital arena. The EMS Agency has a role with the Hospital Preparedness Program (HPP), which is federally funded and involves coordination of the disaster response throughout Los Angeles County. We have developed 13 Disaster Resource Centers (DRC) with these funds, as well as caches of equipment (e.g., warehouse to store equipment, vehicles and tents). We also work with all other hospitals on their disaster planning and surge capabilities.

Each hospital in LA County has emergency managers that we work directly with for their emergency and disaster planning. As part of this, with the State and federal government, programs relationships have been developed. In place is the Medical Health Operational Area Coordinator (MHOAC) program along with regional coordinator. We have connections and communications from the County level to the State and federal government levels. We hold drills every year and work very closely with the hospitals. LA County, the Department of Health Services (DHS) works directly with Public Health (DPH). The director of the MHOAC program is listed under the name Cathy Chidester.

The MHOAC takes requests for any type of medical equipment and supplies and distributes them. If we do not have the equipment or supplies, we send the request to the State. The State sends the request to the federal government or sends the EMS Agency equipment and supplies if they have it.

The EMS Agency has the pre-hospital policies, hospital policies, and the MHOAC program. We also have a Department Operations Center (DOC) which communicates with the County's Emergency Operations Center (EOC).

As part of the HPP program and the ReddiNet system, we get data from the hospitals and do what is called HAvBED polling (hospital available bed data). The hospitals

provide the EMS Agency with their staff bed availability in our poll. As all of these things started happening with COVID-19 and the COVID-19 process, the planning, drilling, implementation of surge capacity and hospitals getting prepared by decreasing the number and then finally eliminating the number of elective surgeries; moving patients, developing their surge plans including creating more ICU beds; identifying where the ventilators are, all of those things were happening at the beginning of the COVID-19 emergency declaration and everything was revolving around hospitals' availability to surge, particularly ICU beds and ventilators.

We consistently felt like we were two weeks behind in everything at the outbreak of COVID-19, and there was a flurry of activity. Requests were coming in immediately for personal protective equipment (PPE), the tents we had, and the supplies that we had. There were requests coming in through the EOC for the Federal Medical System, for medical assets for the military, and so on. We were told we were approximately two weeks behind New York and needed to get our beds in place, the capacity and staffing in place, and no one had enough PPE. We had a warehouse full of PPE; the N95 masks, gloves, gowns, and goggles; so, our staff immediately began pushing out the PPE that we had to the pre-hospital care providers and the hospitals.

Kay Fruhwirth, EMS Nursing Director, provided details on the PPE distribution of supplies and equipment the EMS Agency distributed from February 1, 2020, through May 17, 2020. As there were many resource requests and for large-quantities, the EMS Agency's PPE stock was depleted in approximately one week and PPE were eventually restocked from requests sent to the State. Personal protective equipment distribution was focused on hospitals and EMS providers; and, for part of the response time, the focus shifted to skilled nursing facilities (SNF) and the Community Clinic Association.

The EMS Agency warehouse could not adequately staff and support all the resource requests and delivery of PPE we were doing; so, we partnered with DPH, LA County Fire Department (LACoFD) and an incident management team to open a warehouse in Long Beach where we operated for over a month.

Ventilators are a high priority for the Covid-19 response. We continue to assess hospital ventilator needs every day by looking at how many ventilators they have available, how many they are using and how we can support hospitals if they need more. We also mobilized our Mobile Medical System (MoMS). We have many tents and other support equipment that are still distributed throughout the County.

Most recently, the demand has been for testing for Coronavirus or COVID-19, and we have been filling orders to support the collection of the specimens, the swabs and the bio-transport media. We have been distributing allocations of remdesivir (antiviral medication) for the treatment of COVID-19 patients.

This is a high-level overview of our response in dealing with resource requests and helping meet the needs so that the front-line caregivers could provide care, be safe and have the supplies and equipment they needed while providing patient care.

Dr. Gausche-Hill provided an introduction to the EMS Agency website and the information surrounding COVID-19 PPE and equipment coming in. She acknowledged the Air Force Thunderbirds' flyover salute to the first responders. The U.S. Naval Ship Mercy was here for some time helping the EMS Agency, and she acknowledged

Dr. Denise Whitfield who coordinated arrival and set up with the U.S. Naval Ship Mercy commanders.

Richard Tadeo provided an overview of hospital polling data and Dr. Nichole Bosson reviewed the COVID-19 and non-COVID-19 paramedic provider impressions, as well as our ongoing efforts to collect data. We have been polling the hospitals every day to assist a special modeling expert team, and the lead of that is Dr. Roger Lewis who will talk today about what that means in terms of predicting future hospital bed, ICU bed and ventilator needs.

Commissioner Carole Snyder thanked Kay Fruhwirth and her team for all the PPE pushes, stating once they got that process down it went really well for the DRCs to push it out to other hospitals in their region. On the data side, there are a number of data polls being asked for by a lot of different entities. ReddiNet has 20-30 questions every day; the California Department of Public Health (CDPH) has another 20-30 questions; and the State of California does not talk to HHS. Since this is probably going to go on for a while, is there any chance that County will talk to State and State is going to talk to federal Health and Hyman Services (HHS) where the number of polls can be decreased? Hospitals are probably doing upwards of six polls a day for different entities. California Department of Public Health has a SNF poll. There are a lot of polls out there and it is a lot of work and very time consuming with running on skeletal crews while trying to build back up.

Dr. Gausche-Hill responded that all of our data gets forwarded to the California Department of Public Health. The difference between our polling from the ReddiNet and the polling that is done by CDPH is that our Disaster Operations Center staff actually vets all of the data. We give the data to Dr. Roger Lewis's team, who is leading our modeling team, who may identify an issue with the data. We call the hospitals directly to clarify responses. Dr. Gausche-Hill has had discussions with California Public Health, and they also have to answer to HHS, and the bottom line is there are slightly different purposes for each of these efforts, but we do send all of our data that is vetted to CDPH, and we are aligning more and more because of that so, it does not address your issue, and I do not know when they will stop collecting their data, but our plans are through December of 2020 to see what happens as we move forward with the reopening of the State.

Dr. Roger Lewis, MD, PhD, Chair of Emergency Medicine at Harbor-UCLA (H-UCLA) Medical Center, gave a slide presentation on Modeling for Surge. He discussed how they are working to understand what is going to happen in the near future with respect to COVID-19 activity across Los Angeles County, and stated that "so much of what you see in media and social media represents some real misconceptions regarding what the available data likely means".

This modeling team includes representatives from other DHS offices, the Department of Public Health, Claire Jarashow who leads the DPH team that posts the epidemiologic numbers, people from the Chief Information Officer's Office, colleagues who are expert statistical modelers from Berry Consultants, a private group in Austin, Texas, and folks from UCLA including those from epidemiology and from mathematics. The key findings are updated every week on Wednesday afternoon at the DHS website.

There are a large group of susceptible people, and it is important to understand that we are virtually all still susceptible. Once someone is exposed to enough of the virus so

that you will become positive, there is usually an incubation time that is a few days although it can be as long as 12 days before you become contagious. Once you are contagious, you represent a threat to other susceptible individuals, and one generally becomes contagious a couple of days before you have any symptoms whatsoever. So, the reason that universal precautions of some sort are being recommended, is because well-intentioned people who are trying to follow instructions will be able to expose other people to illness before they have any symptoms that warns them that they might pose a threat to others. It is a very small fraction who get the very severe illness. And, there is a period of time after that where you are no longer contagious, although there is evidence that some people may remain contagious for a period of time maybe up to a couple of weeks after their symptoms have resolved. In epidemiologic modeling, the group that are not contagious also includes people who have died from the infection because they are no longer moving around and exposing others. So, the "not contagious" is an odd label.

There is a lot of discussion about the R number. So, the number R is the average number of new cases that result from transmission from each current case, and R is the average number of new cases in the future from each case we have today. At the very beginning of March when no one knew what was going on and no steps had been taken to reduce transmission, on average each case was leading to over three (3) new cases. So, the R was "3". Then the physical distancing orders were put into place and that resulted in a rapid decrease in the average number of new cases. So, if there is any question in people's minds that the physical distancing orders worked, this should address that concern.

If the actual transmission number is below one (R<1), then the number of cases will fall over time. If it is above that, they will increase over time. You may notice that the model is able to make a pretty precise estimate of the value of R about through a couple of weeks ago, and that is because the model knows that the daily case numbers we see today represent the transmission two weeks ago. So, they are telling us about what R was two weeks ago. There are no data we have available today that tells us what R is today. So, we are always predicting based on data from at least a couple of weeks, and probably as much as four weeks behind.

So, as we open up the economy we will be looking at the daily cases and if there is an uptake, the model will show that the estimate for R has curved up, and once it goes above one (R>1), that means we expect that increase in cases to continue with greater increases over time unless we do something new to reduce transmission.

If we translate those daily counts to the need for hospital beds this is what it looks like. So, what we have done is we have taken the number of people who present to the hospital each day requiring hospitalization with COVID-19 and we have used the information we have gathered over time on how long people tend to stay in the hospital, which varies tremendously, to predict the cumulative number of hospital beds. And, you can see that the model fits very well. We are on a down turn and as long as transmission remains with an R number less than 1 we will continue to trend down. But, if it curves up we could even within the next four (4) weeks see a greater number of total people in the hospital above the peak that we saw in late April.

The data collection effort from the EMS Agency where we have taken the available hospital beds and added that to the current number of beds used to see how much

headroom we have to see if we have the system capability to provide hospital beds to people who become ill with COVID-19, even if the rate of transmission increases, it looks likely that we are in pretty good shape for the next four weeks. It is possible that if we continued with an R >1.5, we would run out of hospital beds sometime in June. Similarly, we can project for ICU beds, but their things look a little bit more tenuous.

The model was used to ask the question, "What fraction of everybody who lives within LA County will have been infected by COVID-19 by December 1, 2020, depending on our ability to control transmission of number R?" Right now, probably 5% or 6% of everybody within Los Angeles County including children have been exposed to the virus, either currently infected or have been infected, and recovered or succumbed. If we are able to keep R at 1 or slightly less than 1 by December, then we think that 5% will become 9% and the epidemic will die out. With lack of contact goes up by just 50%; however, in contrast, the average transmission is increased by just 50%, then by the beginning of December we expect 44% of persons in Los Angeles County to have experienced the illness. To illustrate, there are 10 million people in LA County, if 4 million infected, 1% = 40,000, ½ percent = 20,000, which would reflect 20,000 deaths in LA County cumulatively through December 1st. Going back to March, before any mitigation, then virtually everybody in LA County would be infected, and about ½ of 1% of persons infected would succumb to COVID. EMS Agency data allows these predictions.

Commissioner Atilla Uner questioned if the goal of public health is to decrease the number of those infected, perhaps we should decrease the risk of infection in high-risk populations and not so much in low-risk populations, noting that at some point we need to develop immunity, and this might be a way to accomplish this. He also asked, "If we mitigate the virus in LA County, how do you stop it globally?"

High risk populations receive care from low risk populations. It is infeasible to separate the high and low risk population. In skilled nursing facilities, both residents and staff epidemic doubled in 5 days. Let it run in low risk strategy is impossible to implement.

If we can find a set of changed behavior that in total reduces the transmission number below 1; then, when reintroduced, each little cluster dies out. The long-term strategy is the very blunt instrument of physical distancing which allows us to buy time and transition to a multi-factorial layering to reduce transmission and allow the economy to reopen with social distancing, mask in public, better hygiene, and attention to shared surfaces to slowly reopen the economy. People will die if the economy is not rescued as well. Reducing the average number of new cases that result from transmission from each current case we have today to below 1, until there is a vaccine (1 to 3 years out), also allows us to control reintroduction events. The vaccination reduces the effective R further. This will also require testing and contact tracing.

It was noted that there was a remarkable decrease in transmission associated with the orders of closing of schools, venues and the safer at home program. This does keep people from contacting each other.

Dr. Nichole Bosson presented pre-hospital care data, and data reports on the EMS Agency website, with special thanks to Chris Clare and Michelle Williams of the EMS Agency for putting this data together daily.

The effect on total EMS responses began tracking on March 1, 2020. From monthly data, we have about 5,000 less calls in March of 2020 than we had in March 2019, and that trend has continued on into April and you can see the trend starting to go down which is not a typical trend.

We have compiled 7 provider impressions that relate to respiratory and febrile illness, and we track them. Not all are COVID-19 patients, but COVID was increasing the burden of these types of patients in our EMS system. Increase from Mid-March of 2019 to 2020 divergence, and we have an increase in our respiratory and febrile illness presenting to our EMS system. This trend persisted through April 2020, and we are back down for the month of May.

Provider impressions predominantly in March and April, cold, flu, and fever really increased. Did not see as much of increase in respiratory failure, respiratory distress, hypoxia, etc. Focus was on identifying potential COVID patients. We are still seeing COVID-19 presenting to our EMS system.

Tracking the effect of COVID-19 on our specialty and critical care patients. Looking at the increase in number of cardiac arrests persisted through April, and still up in May.

Patients are delaying care and going to the hospitals due to COVID-19. We saw a slight decrease in STEMI. Stroke for March followed a similar trend as 2019, as these patients are usually walk-ins. Trauma took a nose dive with stay-at-home orders. Lower rates of trauma incidences, lower than 2019.

Dr. Bosson reported on protocol changes during COVID-19 crisis, remarking that we must provide the same quality of care to patients, and must do so while considering risk to providers to keep them safe at the same time.

In response to this pandemic, Reference No. 1245 – Treatment Protocol for COVIID-19, was developed to be used in conjunction with our standing treatment protocols on all calls with the idea that all patients would be screened for potential COVID-19 infection. For all calls, providers will wear appropriate PPE, which is a minimum of surgical mask, eye protection and gloves, perform initial assessment from 6 feet away if possible, or send in a single paramedic in full PPE to assess the patient and decide what level of PPE needs to be provided. The protocol highlights the deviations in care that are appropriate for managing care for patients with respiratory complaints, cardiac arrests and distress during the COVID-19 pandemic in order to make sure we balance the needs of the patients with the risks of the providers.

We implemented a shift from oxygenating patients who may not require that level of oxygenation. Only use oxygen for patients who only have below 90 oxygen level, and placing surgical masks on patients to reduce the flow of the virus from the patients' nose and mouth as they are in the ambulance or interacting with the paramedic. We established a goal of reducing the amount of virus in the environment and minimizing exposure, and one way is by utilizing the PPE.

For severe respiratory distress patients, balancing the need with the CPAP with nebulizer with the risks by deciding what we think is causing this patient to present and determining what a patient actually needs, utilizing alternate non-aero solation therapies. This helps reduce paramedic exposure while treating patients. We also do not want to expose people at the hospitals which could leave virus suspended in the

air. So, developing protocols for paramedics and hospitals and moving these patients to negative pressure rooms to reduce exposure was an alternative.

Reference No. 834 – Patient Refusal of Treatment or Transport was updated along with policy waivers, which was approved by the EMS Agency. It is important for the Commission to see the policy and understand the thought process. We are pushing alternate care sites; however, the best place to care for a patient is within the hospital.

Commissioner Uner would like to address Reference 834 and have it on the next agenda for discussion.

Dr. Bosson covered Reference No. 1142 – Pre-Hospital Policy Waivers and described that in the EMS Agency's intent to anticipate what might occur, the EMS Agency tried to respond quickly to the needs of system.

Treatment Protocol Reference No. 1245 – Potential Covid-19 Patient went into effect in late March. Dr. Bosson reviewed changes to the following policies:

Reference 1210 – Cardiac Arrest Resuscitation Protocol on Scene.
Reference 814 – Determination of Death.

She also reviewed Reference No. 834.1 – on non-transports. The purpose of this policy was specific to patients experiencing mild illness possibly related to COVID-19. We provided paramedics guidelines on who would be low risk in this policy. We subsequently removed this policy as we were not overwhelmed, and successfully flattened the curve. There was no longer a reason to continue this policy, and it is now removed. Patients in field will be transported to hospital if they want to be transported if they call 9-1-1.

Reference No. 834 – Patient Refusal of Treatment or Transport guides the paramedic when patients refuse transport to hospital. If patient refuses transport and is acting against medical advice (AMA), or if there was a treat and refer, this is defined as a low-risk patient. If they do not meet high risk conditions, they do not need to sign AMA if stable.

Reference No. 834 became effective in late 2018. Paramedics needed better guidance in terms of AMA versus releasing without signing them out AMA. Data reflects that with COVID-19 there has been an increase in the number of patients not wanting to be transported to the hospitals.

Commissioner Uner expressed concern that people dialing 9-1-1 are not being transported 10-20% of the time, we do not know what is happening to these patients, it seems high and there is no follow up on people who called 9-1-1. There is concern that the severity of the caller's need for transport to hospital (pre-COVID-19) may be unrecognized by paramedics.

Dr. Bosson stated that an Ad Hoc Committee is being formed to develop quality improvement tools to track these situations and to outline how we document this.

Commissioner Jim Lott asked if anyone is looking at infection rates for non-COVID-19 patients contracted with COVID-19 while in the hospitals. It was noted that the hospitals are now testing upon arrival and departure.

Commissioner Paul Rodriguez expressed that Long Beach Fire applied for the one-to-one staffing, and wanted to make sure some other models were in place with spike in COVID-19. They set up a separate response for COVID calls which seems to work good for them with a decline in fire fighters exposure to COVID-19.

5.5 LA County COVID-19 Modeling (Tabled to July 15, 2020)
5.6 EMS Personnel Administering Vaccinations (Tabled to July 15, 2020)

V. COMMISSIONERS' COMMENTS / REQUESTS

Chairman Hisserich inquired about firefighter unions' concern about State regulation changing 201 designation.

The Chapter 13 issue for firefighters and fire chiefs will be discussed at the next commission meeting.

VI. LEGISLATION

No report.

VII. EMS DIRECTOR'S REPORT

VIII. Happy EMS week and happy doctors' and nurses' recognition. Los Angeles County Ambulance Association thanks the EMS Agency for the nice video put out by Cathy Chidester and Dr. Gausche-Hill.

IX. ADJOURNMENT:

Adjournment by Chairman Hisserich at 3:08 pm to the meeting of July 15, 2020.

Next Meeting: Wednesday, July 15, 2020, 1:00-3:00pm
EMS Agency–Zoom Conference:

https://zoom.us/j/92513404736?pwd=a25CUjBGUUZzT1I2aUI2bG85akJpQT09
Meeting ID: 925 1340 4736
Password: 641376

One tap mobile
+16699009128,,92513404736# US (San Jose)
+12532158782,,92513404736# US (Tacoma)

Dial by your location
+1 669 900 9128 US (San Jose)
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
Find your local number: https://zoom.us/u/ag4w1FxZT

Recorded by:
Denise Watson
Secretary, Health Services Commission

Lobbyist Registration: Any person or entity who seeks support or endorsement from the EMS Commission on official action must certify that they are familiar with the requirements of Ordinance No. 93-0031. Persons not in compliance with the requirements of the Ordinance shall be denied the right to address the Commission for such period of time as the non-compliance exists.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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Board of Supervisors

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First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

April 30, 2020

Via Email

TO: Jennifer Breeher, Nurse Educator, Alhambra Fire Department
Edward Guerrero, EMS Director, Alhambra Fire Department
Joseph Lawrence, Paramedic Coord., Alhambra Fire Department

FROM: Marianne Gausche-Hill, MD
Medical Director

SUBJECT: **SYSTEMWIDE QUALITY IMPROVEMENT DURING THE COVID-19 OUTBREAK**

The Systemwide Quality Improvement (QI) Task Force, convened from the Base Hospital/Public Provider Agency QI Committee, has been suspended until further notice due to ongoing COVID-19 activities. The quarterly rotational systemwide QI will focus on evaluating the utilization of Treatment Protocol (TP) Ref. No.1245, Potential COVID-19 Patients and Ref. No. 834.1, Treat and Refer for Ill Patients During the COVID-19 Outbreak.

Attached are the Quarterly Data Reporting Tool, Patient Care Record Worksheets for Ref. No.1245 and 834.1. The worksheets are optional; however, they provide the required fields for data collection. The Quarterly Data Reporting Tool contains the required dataset for submission to the Emergency Medical Services (EMS) Agency. Ref. No. 1373, Treatment Protocol Quality Improvement Fallout Data Dictionary will continue to serve as reference for fallouts.

The EMS Agency is requesting 100% review and submission of Ref. No. 1245 and 834.1 data from all provider agencies for the next two quarters. In addition to the COVID-19 data, the STEMI, stroke, and non-traumatic cardiac arrest data will continue with the current reporting criteria outlined on the Quarterly Data Reporting Tool.

Please submit the data electronically to Gary Watson (gwatson@dhs.lacounty.gov) and copied to John Telmos (jtelmos@dhs.lacounty.gov) as follows:

- Second quarter 2020 (April – June) by July 15, 2020
- Third quarter 2020 (July – September) by October 15, 2020

If you have any questions or concerns, please contact John Telmos, Chief Prehospital Operations, at (562) 378-1677 or Gary Watson, Prehospital Programs Coordinator at (562) 378-1679.

MGH:JT:sm
04-22

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

SideWalk-CPR
LA County EMS System

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."

May 14, 2020

TO: Distribution

FROM: Cathy Chidester
Director

SUBJECT: SIDEWALK CARDIAC RESUSCITATION DAY – POSTPONED TO OCTOBER 16, 2020

The Los Angeles County Emergency Medical Services (EMS) Agency annual SideWalk Hands-Only CPR training event scheduled for the first week of June will be postponed to October due to the COVID-19 outbreak. This year's event will be held on *World Restart a Heart Day*, a global initiative observed on October 16th to promote bystander CPR.

Though we will be postponing SideWalk CPR, we are concerned that there may be confusion and fear of the public when faced with a person in cardiac arrest during this pandemic. The American Heart Association (AHA) published updated CPR guidelines that include recommendations for the lay rescuer during the COVID-19 pandemic.
https://www.ahajournals.org/doi/10.1161/CIRCULATIONAHA.120.047463

AHA recommends lay rescuers perform at least hands-only CPR after recognition of a cardiac arrest event. Although 70% of cardiac arrests occur at home, cardiac arrest can occur anytime, anywhere. A face mask or cloth covering the mouth and nose of the bystander/rescuer and/or victim may reduce the risk of transmission to a non-household bystander.

The SideWalk CPR training event in October will need to be presented in a different format that will support learning hands-only CPR in a safe environment. The EMS Agency is working on an alternate training method and will provide additional information on this year's event when available.

Thank you for your ongoing commitment to improving out-of-hospital cardiac arrest survival.

Please contact me at cchidester@dhs.lacounty.gov or Susan Mori at sumori@dhs.lacounty.gov if you have questions or would like more information.

PIH HEALTH
12401 Washington Blvd.
Whittier, CA 90602-1006
T: 562.698.0811
Hearing Impaired
TDD: 562.696.9267
PIHHealth.org

May 15, 2020

Ms. Cathy Chidester, Director
Emergency Medical Services
Los Angeles County
10100 Pioneer Blvd. Suite 200
Santa Fe Springs, CA 90670

Re: Notification of permanent closure of the Family Birth Center/Labor and Delivery and Special Care Nursery at PIH Health Downey Hospital

Dear Ms. Chidester:

Last month, we informed you that the PIH Health Downey Hospital Family Birth Center would be temporarily consolidated with PIH Health Whittier Hospital's Labor and Delivery and Neonatal Intensive Care Unit from April 11, 2020 through May 31, 2020. This move enabled us to reduce the risk of exposure to COVID-19 for mothers and babies, and prepare for an increase in patients at PIH Health Downey Hospital due to the COVID-19 pandemic.

In assessing the consolidation, PIH Health has decided to make the consolidation permanent. Therefore, the PIH Health Downey Hospital Family Birth Center will permanently close on June 1, 2020. Expectant mothers will continue to deliver at PIH Health Whittier Hospital and infants with special care needs will be admitted to the PIH Health Whittier Hospital Neonatal Intensive Care Unit.

The PHDH Emergency Department will continue to provide emergent pediatric care and is prepared to manage OB emergencies should the need arise.

Please feel free to contact me for any questions.

Sincerely,

Judy Pugach, MPH RN CPHQ CPHRM
Vice President, Regulatory Affairs
PIH Health
12401 Washington Blvd.
Whittier, CA 90602
536 698-0811, ext. 12408

cc: James R. West

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"

May 18, 2020

MEMORANDUM

TO: **See Distribution**

FROM: **Marianne Gausche-Hill, MD**
Medical Director, Los Angeles County EMS Agency

SUBJECT: **COVID-19 UPDATE # 10: Rescind Ref. 834.1/834.2**

This is to notify you of the intent to rescind **Ref 834.1 and 834.2** effective May 18, 2020.

As we have tracked the volume of EMS calls and also hospital capacity, it is now evident that the EMS systems has adequate capacity to care for patients. When the COVID-19 pandemic began it was not clear if our EMS system would be overwhelmed. In an attempt to fully align with public health order to stay at home, we had created 834.1/834.2 to provide COVID-specific guidance to allow for EMS providers to assess patients presenting with minor COVID-related complaints such as mild respiratory illness and/or fever without any high-risk features and treat and refer, per our policy.

Our standing policy on **Patient Refusal of Treatment/Transport and Treat and Release Ref. 834** will remain in effect. Going forward we will develop an Ad Hoc committee to review this policy and revise if indicated. This policy allows EMS providers to assess and treat and refer, versus signing out against medical advice, those patients without ANY evidence of an acute emergency condition, with normal vital signs and pulse oximetry, and who wish not to be transported. **Patients desiring transport, must be transported.**

Thank you to all for your hard work and dedication to outstanding patient care during this pandemic.

Distribution:

Base Medical Directors, Base Hospitals
Prehospital Care Coordinators, Base Hospitals
Fire Chief, Fire Departments
CEOs, Ambulance Operators
Paramedic Coordinators, EMS Providers
Nurse Educators, EMS Providers

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

May 18, 2020

Sent by Email

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

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

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

TO: Each Hospital Receiving Remdesivir Allocation

FROM: Marianne Gausche-Hill, MD
Medical Director

SUBJECT: **ALLOCATION OF REMDESIVIR**

This memo is to inform you of Los Angeles County's notification of an allocation of 8,393 vials (100 mg each) of Remdesivir from the State, the methodology used to distribute this limited supply of Remdesivir and the requirements to receive the quantity identified for your hospital.

Sixty hospitals received an initial allocation of Remdesivir on May 15, 2020. This new allocation of Remdesivir from the State will supplement the amount provided to these hospitals and provide Remdesivir to the hospitals that did not receive Remdesivir last week and report COVID-19 positive patients.

Distribution Methodology

As reported in the media, Gilead donated their supply of Remdesivir to the Federal government. In return, the Federal government is allocating this supply to States based on data reported by hospitals via https://teletracking.protect.hhs.gov.

The California Department of Public Health (CDPH) then used the most recent hospital census data related to COVID-19 patients that you report to them, to proportionately distribute the Remdesivir to the counties in the State. Los Angeles County then used the data reported by your hospital in our daily COVID-19 poll to determine the COVID burden of each hospital. The COVID burden is defined as the number of COVID-19 positive patients each hospital is treating. Using the hospital's COVID burden and a five-day treatment regimen of six vials per patient an equitable allocation was determined based on Los Angeles County's total allotment of medication.

While we realize, this allocation may not be adequate to meet the needs of all COVID-19 positive patients your hospital is treating, it will provide much needed treatment for hospitalized patients with COVID. Additionally, future allocations are anticipated in the weeks and months to come ensuring benefit to more patients on an on-going basis.

Hospital Determination of Patients that will Receive Remdesivir

In determining which patients will receive the Remdesivir, CDPH recommends that hospitals consider an ethical framework for the distribution of remdesivir to patients and refers you to the *California SARS-CoV-2 Crisis Care Guidelines and California Guidance for Hospitals Regarding Allocation of Scarce Medications for COVID-19* (attached).

CDPH also recommends the establishment of a clinical prioritization team to make allocation decisions that is distinct from the clinicians providing direct care to ensure those patients who would most likely benefit from the medication, receive the medication, and to ensure that decisions are fair and consistent. Other recommendations include the following:

- Withholding or reserving remdesivir for future use is not recommended, particularly if there are current patients with severe illness within 10 days of symptom onset.

- Children and pregnant mothers are currently eligible to receive remdesivir through compassionate use from Gilead directly and should not utilize the donated remdesivir allocation.

- Patients who have already received remdesivir should not be eligible to receive additional doses from this donated allocation.

The Food and Drug Administration (FDA) issued an emergency use authorization (EUA) on May 1, 2020. The fact sheet for health care providers (attached) reviews the full conditions of use and should be reviewed prior to administration of the medication.

The EUA allows treatment of COVID-19 in adults and children hospitalized with severe disease (defined as a low blood oxygen level (oxygen saturation < 94%)), needing oxygen therapy, or requiring mechanical ventilation or extracorporeal membrane oxygenation (ECMO). EUA conditions of use include the following:

- Empiric treatment of hospitalized patients with suspected COVID-19 can be considered pending laboratory confirmation of COVID-19 infection.

- A 5-day treatment course (6 doses) is recommended for adults and pediatric patients not requiring invasive mechanical ventilation or ECMO. Treatment may be extended up to 10 days if not showing clinical improvement.

- A 10-day treatment course (11 doses) is recommended for adult and pediatric patients requiring invasive mechanical ventilation or ECMO.

- All patients must have an estimated glomerular filtration rate (eGFR) determined and hepatic laboratory testing performed before dosing.

- Health care providers are responsible for mandatory FDA MedWatch reporting of all medication errors and serious adverse events or deaths considered to be potentially attributable to remdesivir.

- Health care providers must communicate information consistent with the "Fact Sheet for Patients and Parents/Caregivers (and provide a copy) prior to the patient receiving remdesivir.

- Hepatic laboratory testing should be performed daily while receiving remdesivir. Remdesivir should be discontinued in patients who develop an ALT ≥ 5 times the upper limit of normal or an ALT elevation accompanied by signs or symptoms of liver inflammation or increasing conjugated bilirubin, alkaline phosphatase, or INR. Grade 3 or 4 hepatic laboratory abnormalities were reported in approximately 5% of participants receiving remdesivir in Gilead's clinical trial.

Included with this memo are the FDA Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Remdesivir and the FDA Fact Sheet for Patients and Parents/Caregivers.

All adverse events must be reported at www.fda.gov/medwatch/report.htm.

Reporting of Remdesivir use in Los Angeles County

We are asking each of the hospitals to record the use of Remdesivir by completing the *Remdesivir Use Tracking Tool* (attached). These will be submitted to me at the email listed below for each allotment. These data will be used to develop a report of the impact of emergency use of this medication and will be shared with all participating hospitals on request.

Acceptance of Remdesivir Allocation

To ensure that your hospital understands the requirement of using Remdesivir under the Emergency Use Authorization and the willingness to use Remdesivir to treat COVID-19 patients, we are requesting that each hospital complete the attached *Acceptance of Remdesivir Form.*

For hospitals that already received an allocation of Remdesivir and completed this form on May 14, 2020 there is not a need to submit another form. For any hospital who will be receiving their first allocation of Remdesivir, we ask that the *Acceptance of Remdesivir Form* be completed and returned to the EMS Agency no later than 5:00 p.m. on May 19, 2020. Once the acceptance form is signed and returned, the EMS Agency will work with the hospital pharmacist to deliver your hospital's allocation of Remdesivir.

If you have any questions, please contact me at mgausche-hill@dhs.lacounty.gov.

MGH:kf

Attachments

May 18, 2020

TO: See Distribution

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

Mason Matthews
Chief Executive Office
Co-chair Measure B Advisory Board

SUBJECT: **SUSPENSION OF MEASURE B FUNDING PROJECT PROPOSALS PROCESS FOR 2020**

This memo is to inform you and your constiuents that the Measure B Advisory Board (MBAB) is suspending the acceptance of project proposals for Measure B funding consideration for 2020.

During these unprecedented times, the impact of COVID-19 has resulted in great uncertainties and significant County budget shortfalls. Included in these uncertainties is the amount of Measure B funds that would be unallocated and available to fund any projects through the MBAB process. Therefore, the prudent action is the suspension of the MBAB process for 2020.

The County will continue to evaluate its fiscal outlook and will notify all constiuents of the MBAB process for 2021, as soon as it is determined in 2021.

If you have any questions please contact Cathy Chidester, Director, EMS Agency at cchidester@dhs.lacounty.gov or (562) 378-1604.

CC:kf

Distribution:
Measure B Advisory Board Committee Members
Peace Officers Association of Los Angeles County
Southern California Psychiatric Society
Los Angeles County Medical Association
Los Angeles County Police Chiefs Association
Trauma Hospital Advisory Committee
Los Angeles County Ambulance Association
Hospital Association of Southern California
Los Angeles County 9-1-1 Receiving Hospitals
California State Firefighters' Association

Distribution (cont.):
American Heart Association, Western States Affiliate
Emergency Nurses Association California Chapter
California Chapter American College of Emergency Physicians
Los Angeles Area Fire Chiefs Association
Los Angeles County Division League of California Cities
Health Deputy, Each Board of Supervisor Office
Los Angeles County Fire Department
Los Angeles County Sheriff Department – Air Operations
Los Angeles City Fire Department – Air Operations
Los Angeles County Department of Public Health
Los Angeles County Department of Health Services
Los Angeles County Hospital and Healthcare Commission
Los Angeles County Public Health Commission
Los Angeles County Emergency Medical Services Agency
Los Angeles County Approved Emergency Medical Technician Training Programs
Los Angeles County Approved Paramedic Training Programs
California Nurses Association Emergency Department Nurses
SEIU Emergency Department Nurses

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

May 21, 2020

TO: Distribution **VIA E-MAIL**

FROM: Cathy Chidester
Director

SUBJECT: **TEMPORARY CLOSURE OF PERINATAL SERVICES**

This is to advise you that Greater El Monte Community Hospital (GEM) is temporarily withdrawing as a Perinatal Center effective May 22, 2020.

Effective Thursday, **May 21, 2020, at 2359**, patients who are at least 20 weeks pregnant and have a complaint related to their pregnancy shall no longer be transported via the 9-1-1 system to GEM. These patients shall be transported to surrounding perinatal centers in the area in accordance with Reference No. 511, Perinatal Patient Destination.

You will be notified when they resume perinatal services. If you or your staff have any questions or require further information, please contact Chris Clare, Chief Hospital Programs, at cclare@dhs.lacounty.gov or (562) 378-1661.

CC:cac
05-05

c. Medical Director, EMS Agency
Medical Alert Center, EMS Agency
CEO, Greater El Monte Community Hospital
Fire Chief, Los Angeles County Fire Department
Paramedic Coordinator, Los Angeles County Fire Department
Fire Chief, Arcadia Fire Department
Paramedic Coordinator, Arcadia Fire Department
Director of Operations, Care Ambulance Service
Prehospital Care Coordinator, Methodist Hospital of Southern California
Prehospital Care Coordinator, Emanate Health Queen of the Valley Hospital

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

10100 Pioneer Boulevard, Suite 200
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"To advance the health of our communities by ensuring quality emergency and disaster medical services."

May 26, 2020

TO: Each Licensed Ambulance Operator

FROM: Cathy Chidester, Director
Emergency Medical Services Agency

SUBJECT: ADDITIONAL ALLOWABLE CHARGES FOR MEDI-CAL PATIENTS NOT OUTLINED IN THE GENERAL PUBLIC AMBULANCE RATES

In 2014 a memorandum was sent to all licensed ambulance operators outlining/authorizing that provider agencies may bill Medi-Cal for cardiac monitoring and 12-lead electrocardiograms.

The Emergency Medical Services (EMS) Agency has been asked to clarify this practice since the charge is not addressed in the Los Angeles County General Public Ambulance Rates.

Because Medi-Cal does not allow billing for ALS level care but has separate billing codes for cardiac monitoring and 12- lead electrocardiograms, provider agencies may bill Medi-Cal for each therapy provided when indicated and performed by prehospital personnel. If both therapies are provided, the provider agency may only bill for one or the other.

Additionally, providers may bill Medi-Cal for the following; Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary wing), (per hour) to a maximum of 10 hours per day, when applicable. The applicable billing code A0424 may be used to bill for either emergency or non-emergency services.

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

CC:jt
05-21a

c. Daryl Osby, Fire Chief, Los Angeles County Fire Department
Jon O'Brien, Deputy Chief, EMS Section, Los Angeles County Fire Department
Helen Jo, Financial Management Division, Los Angeles County Fire Department

EMERGENCY MEDICAL SERVICES AGENCY
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Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

Tel: (562) 378-1500
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"To advance the health of our communities by ensuring quality emergency and disaster medical services."

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

May 29, 2020

Joe Losorelli, Chief of Police
Los Angeles City Park Rangers
4730 Crystal Springs Drive
Los Angeles, CA 90027

CERTIFIED

Dear Chief Losorelli,

PUBLIC SAFETY NALOXONE DATA REGISTRY

The Emergency Medical Services (EMS) Agency has implemented an online naloxone data registry for reporting the utilization of intranasal naloxone for persons with suspected opiate overdose.

The Public Safety Data Registry is a secure reporting system located on the EMS Agency website at http://dhs.lacounty.gov/wps/portal/dhs/ems/. The data registry will serve to facilitate system evaluation and aggregate reporting on the utilization of naloxone in Los Angeles County by public safety personnel.

Los Angeles City Park Rangers has been assigned a unique identification number (ID) and password to access the data registry. Upon the initial login, there is a link to a brief tutorial on how to enter data. The data fields provide general information regarding the circumstances of the naloxone administration. All approved public safety agencies may utilize the data registry to run reports on their data only and cannot view another agency/department's data.

All public safety agencies are required to collect, maintain, and report all naloxone administrations to the EMS Agency as part of the naloxone program approval process. Each agency can continue their current process of data collection; however, the written reports must be entered into the Public Safety Data Registry within 30 days of the naloxone administration.

Naloxone administrations from January 2019 up to present will need to be entered into the Public Safety Data Registry. Your agency can enter the past data directly or email/send to Susan Mori at sumori@dhs.lacounty.gov for data entry.

LA City Rangers Police Department ID: **LACP**; Password: **138580**

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

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:RT:SM:gk
05-50

c: Director, EMS Agency
Ranger Sean Kleckner, Los Angeles City Park Rangers

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

June 5, 2020

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."

Brad Gates, EMT-P
Senior Emergency Services Coordinator
Plans and Training Unit
Disaster Medical Services Division
Emergency Medical Services Authority
10901 Gold Center Drive, 4th Floor
Rancho Cordova, CA 95670

Dear Mr. Gates,

The Los Angeles County Medical and Health Operational Area Coordination Program (MHOAC) is requesting the Emergency Medical Services Authority (EMSA) to suspend request for patient transfers of Covid+ patients from Imperial County into Los Angeles County (LAC) effective immediately. LAC hospitals are currently experiencing a surge of Covid+ patients and Persons Under Investigation (PUI) presenting to our hospitals. This is a temporary request until the LAC MHOAC can obtain further data and analyze the situation.

LAC Hospital Data:

	May 1-31, 2020 Average	June 1-3, 2020 Average
Non-ICU Census (confirmed + PUI)	1400 patients	1234 patients
Non-ICU Bed Availability	900 beds	703 beds
ICU Census (confirmed + PUI)	550 patients	517 patients
ICU Bed Availability	200 beds	180 beds

Although the census numbers for non-ICU and ICU patients are lower, we are concerned about the number of available beds. Also, the June data includes only three days but the trend shows that the numbers are increasing significantly after the Memorial Day weekend. More concerning is that four of our largest hospitals are currently experiencing a surge of Covid+ patients and PUIs. One hospital is in the process of decompressing their facility due to a staffing shortage because of high-risk exposure.

Thank you for your consideration. LAC is committed to assisting EMSA and our partner counties during this pandemic but we feel that it is prudent to ensure that we are managing our resources appropriately so we do not add to the overall State-wide burden.

Sincerely,

Cathy Chidester
Director, MHOAC

EMERGENCY MEDICAL SERVICES AGENCY
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.

June 8, 2020

Sent via email

Brad Gates, EMT-P
Senior Emergency Services Coordinator
Plans and Training Unit
Disaster Medical Services Division
Emergency Medical Services Authority
10901 Gold Center Drive, 4th Floor
Rancho Cordova, CA 95670

Dear Mr. Gates:

This letter is to inform you that the State's transfer center may resume presenting patients from Imperial County to Los Angeles County (LAC) hospitals for their consideration to accept transfers.

The LAC Medical and Health Operational Area Coordination (MHOAC) Program analyzed the COVID+ and Person Under Investigation (PUI) admission data of hospitals in our Operational Area (OA) over the past week and determined that there was a temporary surge of patients in LAC. However, over the past few days, our hospitals were able to make the necessary adjustments to ensure that the OA has adequate capacity for both COVID-19 related patients, as well as, non-COVID-19 patients.

Thank you for granting our request to temporarily suspend the presentation of potential patient transfers into our hospitals. This action provided the necessary time needed to analyze the situation in our OA. We want to reiterate that LAC is committed to assisting the Emergency Medical Services Authority and our partner counties during this pandemic. If you have any questions about this matter, please contact Roel Amara, EMS Assistant Director, at (562) 378-1598 or ramara@dhs.lacounty.gov.

Sincerely,

Kay Fruhwirth for

Cathy Chidester
Director

CC:ra

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

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

June 16, 2020

TO: Distribution **VIA E-MAIL**

FROM: Marianne Gausche-Hill, MD, FACEP, FAAP, FAEMS
Medical Director

SUBJECT: **PREHOSPITAL PATIENT CARE RECORD (PCR) AND TRANSFER PATIENTS**

The EMS Agency has been made aware that the Prehospital PCR (patient care record) is frequently not provided with other medical record documents, when transferring a patient who arrived at the initial hospital via EMS and subsequently requires transfer for a higher level of care. EMTALA regulations require disclosure of medical care and the "transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented..."

In order to provide continuity of care for patients from the time of initial treatment to their final care destination, hospitals receiving transfers from other facilities for higher level of care are required to capture and record specific information regarding the care provided in all phases, including the prehospital phase.

In order to collect the necessary information related to the continuity of care, the sending facility must include the Prehospital PCR with the transfer documents. This may require accessing the appropriate provider database and printing the prehospital PCR. The receiving hospital does not have access to these records therefore they must be provided by the transferring hospital.

Please ensure your staff is informed of these requirements and develop procedures/processes/checklists to ensure the complete medical record is provided upon transfer, which includes the Prehospital PCR.

If you have any questions or need additional information, please contact the hospital the patient is being transferred to or the EMS Agency during normal business hours at (562) 378-1661.

MGH cac
06-01

Distribution: Director, EMS Agency
ED Medical Director, Each 9-1-1 Receiving Hospital
ED Clinical Administrator(s), Each 9-1-1 Receiving Hospital
Trauma Program Managers, Each Trauma Center
Prehospital Care Coordinators, Each Base Hospital
SRC Program Manager, Each SRC
Stroke Program Manager, Each Approved Stroke Center

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

June 18, 2020

VIA ELECTRONIC MAIL & USPS

TO: Fire Chief, Each Fire Department
CEO/President, Each Private Ambulance Company

FROM: Marianne Gausche-Hill, MD FACEP, FAAP, FAEMS
Medical Director, EMS Agency

SUBJECT: ADDITION OF KETOROLAC TO UNIT INVENTORIES

Effective September 1, 2020, ketorolac will be added to the EMS inventory for the treatment of pain in the prehospital setting. To be consistent with Ref. No. 1309, Color Code Drug Doses, the two approved formulations and minimum quantities are:

Four (4) 15 mgs/mL-unit dose ketorolac
or
Two (2) 30 mgs/2mL-unit dose ketorolac

All Advanced Life Support (ALS), Assessment Units (AU), EMS Aircraft, Nurse Staffed Specialty Care Transport (SCT), and Fireline Paramedic units will be required to carry one of the two formulations of ketorolac listed above. Updated unit inventories listing Ketorolac are available on the EMS Agency Website.

As outlined above, these are "minimum" quantities and each provider, based on utilization, may increase their par levels as deemed necessary. Please be aware, for those agencies stocking the 30 mg/2 mL, this unit dose is intended for a single patient use. If the entire 30 mgs are not indicated/administered, the remainder needs to be discarded.

Presently, ketorolac is listed on the FDA Drug Shortage List indicating limited availability from numerous pharmaceutical manufacturers. Therefore, your agency is encouraged to place their ketorolac order as soon as feasible to meet the September 1, 2020 deadline.

For review of ketorolac indications, contraindications and administration, you may refer to the following resources; Pain Management Module included in EMS Update 2020, Ref. No 1317.22, Drug Reference-Ketorolac, Ref. No.1309 or, download the Mobile Drug Dose Application onto your smart phone available for both iOS, "LA County EMS" or Android, PlaySmart "LA County EMS Drug Doses."

If you have any questions or concerns, feel free to contact me directly at (562) 378-1600 or, John Telmos, Chief Prehospital Operations at (562) 378-1677.

MGH:jt
06-13

c Medical Director, Each ALS Provider Agency
Paramedic Coordinator, Each ALS Provider Agency
Nurse Educator, Each ALS/SCT Provider Agency
Prehospital Care Coordinator, Each Base Hospital
Emergency Department Manager, Each 9-1-1 Receiving Hospital

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

BASE HOSPITAL ADVISORY COMMITTEE MINUTES

June 10, 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	Natalie Greco
☒	Ryan Burgess	Western Region	Christine Zaiser
☒	Alex Perez-Sandi	Western Region, Alternate	Dr. Denise Whitfield
☐	Erin Munde	Western Region, Alternate	
☒	Laurie Sepke	Eastern Region	
☒	Alina Candal	Eastern Region	
☒	Jenny Van Slyke	Eastern Region, Alternate	
☐	Lila Mier	County Hospital Region	**GUESTS**
☐	Emerson Martell	County Hospital Region	Dr. Clayton Kazan, LACOFD
☒	Yvonne Elizarraz	County Hospital Region, Alternate	
☒	Antoinette Salas	County Hospital Region, Alternate	
☒	Alec Miller	Provider Agency Advisory Committee	
☒	Jennifer Nulty	Provider Agency Advisory Committee, Alt.	
☐	Laarni Abdenoja	MICN Representative	
☒	Jennifer Grere	MICN Representative, Alt.	
☐		Pediatric Advisory Committee	

	PREHOSPITAL CARE COORDINATORS				
☐	Gloria Guerra (QVH), APCC Pres.	☒	Heidi Ruff (HMN)	☒	Laura Leyman (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 1:05 P.M. by Robert Ower, Chairperson.

2. **APPROVAL OF MINUTES**: The meeting minutes for February 12, 2020, were approved with the addition of K. Robinson, and J. Strange to the attendance roster.

   M/S/C (Donegan/Van Slyke)

3. INTRODUCTIONS/ANNOUNCEMENTS:

- SideWalk CPR 2020 has been postponed until "Restart a Heart Day", October 16, 2020, more information to come.
- Los Angeles County EMS orientation is scheduled for July 28, 2020, via Zoom. Please contact Cathy Jennings at cajennings@dhs.lacounty.gov to schedule attendance.

4. REPORTS & UPDATES:

4.1 EMS Update 2020

EMS Update completion deadline has been extended to September 1, 2020. Reminders will be sent out, at the beginning of the month, for June and July, and on a weekly basis starting in August. Also included will be a list of MICNs that have completed the update. Contact Dr. Denise Whitfield at DWhifield@dhs.lacounty.gov with your concerns.

Dr. Marianne Gausche-Hill: Reminder, the use of Ketorolac in the prehospital care setting will be implemented on September 1, 2020.

4.2 PHAST-TSC

Update: The Pre-Hospital Administration of Stroke Therapy – Trans Sodium Crocetinate (PHAST-TSC) study is ongoing with the participation of Culver City Fire and Santa Monica Fire, training has begun with additional Providers who will join the study in the future. The EMS Agency will provide notification as additional Provider Agencies and Stroke Centers enroll in the study.

4.3 ECMO Trial

As a result of COVID, the ECMO Trial is on hold. For the treatment of patients in cardiac arrest refer to Ref. No. 1210, Cardiac Arrest. The team has been meeting on a monthly basis to discuss the study and the optimal time for resumption of the study, we will keep you posted.

5. OLD BUSINESS:

None

6. NEW BUSINESS:

6.1 STEMI Cognito Feedback Form

Reminder: With the help of Los Angeles County Fire, the STEMI Cognito Feedback Form was designed to provide feedback to Provider Agencies for STEMI patients transported to STEMI Receiving Centers. The goal is to provide consistent feedback on all cases that are transported as a STEMI (treatment, outcome, etc.). Link provided below.

https://www.cognitoforms.com/LosAngelesCountyFireDepartment/STEMIPatientEMSFollowupForm

The STEMI Transmission Task Force determined the Feedback Form to be a best practice. We appreciate any input on the implementation of this system, you can contact Dr. Nichole Bosson at Nbosson@dhs.lacounty.gov.

6.2 Ref. No. 606. Documentation of Prehospital Care

Approved as presented.

M/S/C (Van Slyke & Caffey)

Clarification provided. The Base Hospital Form should only reflect the information provided by the prehospital care provider and medical control provided by the Base.

Lengthy discussion ensued related to concerns that receiving hospitals are not receiving patient care reports from the private EMT non 9-1-1 transports. Request for volunteers to collaborate with the Ambulance Association in developing a resolution. Volunteer contact information will be forwarded to R. Ower.

6.3 Ref. No. 644, Base Hospital Documentation Manual

Approved as presented.

M/S/C (Burgess & Caffey)

6.4 Base Hospital Form Revisions

Presented as information only. Once finalized, a copy of the revised Base Hospital Form will be distributed. Estimated delivery date of new forms will be late August or September.

6.5 Receiving Hospital Patient Data

The EMS Agency is working with TEMIS to obtain Base Hospital outcome data on all transported patients, including BLS and ALS patients. We will reconvene the Data Work Group, to include PCC and IT representation from the Base Hospitals, to discuss EMS data requirements. More information to come.

Base Hospitals that have a data submission process in place, should continue providing outcome data on BLS patients, to the providers only. Once an electronic solution has been developed, BLS outcome data can then be provided to the Agency.

7. OPEN DISCUSSION:

- The Los Angeles County Drug Doses mobile app. is available to download for both iPhone and Android. App. utilization data was presented by Dr. Gausche-Hill and Richard Tadeo.
- The National Pediatric Readiness Project has been postponed until further notice. Please visit the website for additional information, https://pedsready.org/ .
- Question posed regarding provider exposure to COVID, and the responsibility of the Base Hospital to report to Public Health. Dr. Gausche-Hill to follow up with State Public Health for clarification.

8. **NEXT MEETING:** BHAC's next meeting is scheduled for **August 12, 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 2:43 P.M.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County Board of Supervisors

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Second District

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Janice Hahn
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Fifth District

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Health Services
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EMERGENCY MEDICAL SERVICES COMMISSION
DATA ADVISORY COMMITTEE

MEETING NOTICE

Date & Time: Wednesday, June 10, 2020 10:00 A.M.
Location: EMS Agency, First Floor Hearing Room
10100 Pioneer Boulevard
Santa Fe Springs, 90670-3736

DATA ADVISORY COMMITTEE
DARK FOR JUNE 2020

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES

PROVIDER AGENCY ADVISORY COMMITTEE

CANCELLATION NOTICE

DATE: **April 15, 2020**

TIME: **1:00 pm**

LOCATION: **Los Angeles County EMS Agency**
EMS Commission Hearing Room – 1st Floor
10100 Pioneer Boulevard
Santa Fe Springs, California 90670

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

NEXT MEETING

June 17, 2020

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, June 17, 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. Roll-call was taken by Chair to verify those in attendance. 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
☐ Heather Davis	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

1. **CALL TO ORDER:** Committee Chair, Commissioner Paul Rodriquez, called meeting to order at 1:00 p.m.

2. INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS

2.1 2020 Side Walk CPR Event *(Marianne Gausche-Hill, MD)*

- 2020 Side Walk CPR has been cancelled due to the COVID-19 pandemic.
- However, the Worldwide "Restart A Heart" Day, scheduled for October 16, 2020, is still proceeding. More information to come.

2.2 EMS Orientation *(Cathy Jennings)*

The next EMS Orientation is scheduled for July 21, 2020 and will be conducted via ZOOM conference call. Those requesting to attend should RSVP with Cathlyn Jennings at cajennings@dhs.lacounty.gov.

3. APPROVAL OF MINUTES (Kazan/Kaduce) February 19, 2020 minutes were approved as written.

4. REPORTS & UPDATES

4.1 Disaster Services Update

Deferred.

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

- Power Point slides were presented to the Committee on COVID-19 update in Los Angeles County.
- The EMS Agency's Medical Director reminded providers to wear their complete personal protective equipment (PPE) during aerosolized treatments and if unable to maintain social distancing, a protective mask must be worn.

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

- New deadline for completing EMS Update 2020 is September 1, 2020.
- Ketorolac will be required on all ALS/AU units beginning September 1, 2020.
- Since Ketorolac is on the FDA's short supply list, providers are encouraged to place their orders as soon as possible.
- Ketorolac will be added to the Color Code Drug Doses LA County Kids mobile application and to all of the appropriate inventory policies.

4.4 PHAST-TSC Trial *(Nichole Bosson, MD)*

Pre-Hospital Administration of Stroke Therapy – Trans Sodium Crocetinate

- Trial continues through the COVID-19 pandemic.
- Culver City and Santa Monica Fire Departments began the Trial study in February 2020.
- The following fire departments will begin Trial once orientation is complete: LA County FD, Torrance FD, Burbank FD and Pasadena FD.

4.5 ECMO Trial *(Nichole Bosson, MD)*

Extracorporeal Membrane Oxygenation

Due to the COVID-19 pandemic, ECMO and Arrive-Alive Trials have been placed on hold.

4.6 Basic Life Support (BLS) Unit – Records Distribution *(John Telmos)*

Small workgroup is being formed comprised of representative from Base Hospital Advisory Committee, Los Angeles County Ambulance Association, and EMS Agency staff to address the concern of patient care records from private ambulance providers not being left with the receiving hospitals.

5. UNFINISHED BUSINESS

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

Policy tabled to allow continued review by the EMS Agency.

TABLED: Reference No. 528, Intoxicated (Alcohol) Patient Destination

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

Policy tabled to allow continued review by the EMS Agency.

TABLED: Reference No. 528.1, Medical Clearance Criteria Screening Tool for Sobering Center.

6. NEW BUSINESS

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

Policy reviewed and approved with the following recommendation:

- Page 5. Policy II, 3.: Add wording to state: "The following should be documented for MCIs involving three or more patients (for online medical control):"
- Page 5. Policy II, 3. i: Add wording to state: "Brief patient assessment, when possible"
- Page 5. Policy II, 3. j: Add wording to state: "Brief description of treatment provided, when possible"

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

7. OPEN DISCUSSION:

7.1 Personal Protective Equipment (PPE) Update *(JohnTelmos)*

- N95 masks [and other PPE] are continuing to be distributed to the Disaster Resource Centers (DRC). Hospitals and providers may pick up their allotted supplies from their assigned DRC, when notified.
- For those provider agencies utilizing the Battelle vapor phase hydrogen peroxide system for decontamination of filtering facepiece respirators (FFR), please note that the KN95s (manufactured in China) and other non-NIOSH-approved FFRs manufactured in China are not authorized by the FDA for decontamination.

8. NEXT MEETING: April 15, 2020

9. ADJOURNMENT: Meeting adjourned at 2:47 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

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

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

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

PRINCIPLES:

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

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

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

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

PROCEDURE:

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

   A. As soon as possible but not later than 90 days prior to a planned reduction of EMS services or closing of a health facility, the facility shall provide a written notice of the proposed downgrade or elimination of emergency services to the following entities:

      1. The Emergency Medical Services Agency

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

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

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

4. All health care service plans

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

B. Not less than 30 days prior to closing a health facility or reducing EMS services, the facility shall provide public notice, including a notice posted at the entrance to all affected facilities:

The required notice shall include:

1. A description of the proposed reduction or elimination.

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

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

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

   a. The health facility.

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

   c. The chief executive officer.

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

6. It shall be provided within the 30-day time frame specified in Section I.

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

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

   b. Soliciting media coverage regarding the change.

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

   d. Notifying contracting health care service plans.

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

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

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

2. Cites the ED for unsafe staffing practices.

II. Responsibilities of the Local EMS Agency

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

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

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

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

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

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

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

7. The average emergency department diversion of surrounding facilities.

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

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

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

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

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

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

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

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

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

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

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

CROSS REFERENCES:

Prehospital Care Manual:

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **STROKE RECEIVING CENTER STANDARDS** REFERENCE NO. 322

PURPOSE: To establish minimum standards for the designation of Primary Stroke Centers (PSC) and Comprehensive Stroke Centers (CSC) to ensure that patients transported by the 9-1-1 system in Los Angeles County who exhibit signs and symptoms of stroke are transported to a hospital appropriate for their needs.

AUTHORITY: California Health and Safety Code, Sections 1255, 1256, 1797.220, 1798, 1798.170, 1798.172;
California Code of Regulations, Title 22, Sections 100170 and Division 9, Chapter 7.2

DEFINITIONS:

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

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

Qualified Specialist: A physician licensed in the State of California who has become BC or BE in the corresponding specialty by ABMS or AOA. For endovascular neurointerventionalist, this is a physician who has obtained Committee on Advanced Subspecialty Training (CAST) certification in NeuroEndovascular Surgery (NES) **or** Accreditation Council of Graduate Medical Education specialty training for Endovascular Surgical Neuroradiology **or** experience in ischemic stroke treatments including thrombectomy and carotid stenting with on-going experience in neurovascular interventions including five (5) per year of any of the following:

- Aneurysm management, including those presenting with rupture
- Intracranial embolization
- Intracranial stent placements
- Intracranial infusions
- Extracranial embolization

Stroke Center: A licensed general acute care hospital that has met all the PSC or CSC requirements listed in this policy and has been designated by the LA County EMS Agency as a PSC or CSC.

Stroke Medical Director: A Qualified Specialist in Neurology, Neurosurgery, Neuroradiology, or Emergency Medicine, privileged by the hospital and active in performing stroke care.

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

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

Program.

Telemedicine: 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. Stroke Center Designation/Re-Designation

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

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

C. The Stroke Center shall provide, within 72 hours, written notice to the Medical Director of the EMS Agency if unable to adhere to any of the provisions set forth in these Stroke Receiving Center Standards.

D. The Stroke Center shall provide a 90-day, written notice to the Medical Director of the EMS Agency if Stroke Center intends to withdraw from the Stroke Program.

E. The Stroke Center shall notify the EMS Agency, in writing, of any changes in status of the Stroke Medical Director or Stroke Program Manager by submitting Ref. No. 621.2, Notification of Personnel Change Form.

F. Prior to designation, the Stroke Center shall provide six months of performance and tracking measure data listed in Ref. No. 322.1 and ensure quality improvement process of measures are in place. Performance measures shall be consistently achieved to maintain PSC/CSC designation.

G. The Stroke Center shall have a fully executed Specialty Care Center PSC/CSC Designation Agreement with the EMS Agency.

H. The Stroke Center shall establish a fully executed written transfer agreement with a CSC that is certified by an EMS Agency approved accrediting body and designated by the EMS Agency as a Comprehensive Stroke Center.

II. General Hospital Requirements

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

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

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

3. Certified as a Stroke Center (e.g., Primary Stroke, Primary Plus,

Thrombectomy Capable, Comprehensive) by an EMS Agency approved certifying body – representatives from the EMS Agency may attend the certification site review. In the event of action items, deficiencies or similar findings are identified, the hospital shall submit a copy of the findings and any action plans for improvement to the EMS Agency

4. All physicians attending in the Emergency Department (ED) shall be qualified specialists in Emergency Medicine (EM) or Pediatric EM

B. Appoint a Stroke Medical Director and Stroke Program Manager who shall be responsible for meeting the Stroke Program requirements and allocate adequate time such that they can meet the requirements of the Stroke Receiving Center Standards.

C. Develop and maintain a Clinical Stroke Team that is immediately available to evaluate a potential stroke patient and provide appropriate care.

D. Have the ability to perform the following diagnostic studies when clinically necessary:

1. Transesophageal echocardiography (TEE) and transthoracic echocardiography (TTE)

2. Computed tomography angiography (CTA) and/or magnetic resonance angiography (MRA)

III. Stroke Leadership Requirements

A. Stroke Medical Director

1. Medical oversight and ongoing performance of the Stroke quality improvement (QI) programs

2. Participates in the hospital Stroke Committee or equivalent and other committees associated with stroke care

3. Collaborates with the Stroke Program Manager to ensure adherence to these Standards

4. Liaison with hospital administration, Stroke Program Manager, medical and clinical staff across the stroke patient's continuums of care

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

a. Alternate neurologist, neuroradiologist or neurosurgeon from the same Stroke Center. For PSCs, may also be an alternate EM physician

b. Call-in option when available

B. Stroke Program Manager

1. Qualifications:

    a. Knowledgeable in neurocritical care and interventional stroke procedures

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

2. Responsibilities:

    a. Collaborates with the ED Medical and Clinical Directors regarding stroke care

    b. Collaborates with the Stroke Medical Director to ensure adherence to these Standards

    c. Maintain and monitor Stroke QI Program

    d. Participates in the hospital Stroke Committee or equivalent and other committees associated with stroke care

    e. Assure hospital policies are consistent with these Standards

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

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

        a. Alternate stroke RN from the same Stroke Center

        b. Call-in option when available

    h. Assures processes are in place to capture data from patients transported to the Stroke Center by EMS providers, including patients transferred from other acute care hospitals

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

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

IV. Clinical Stroke Team

The Stroke Center shall have a clinical stroke team available to evaluate the potential acute stroke patient within 15 minutes following patient's arrival to the ED or following a suspected diagnosis of potential acute stroke. The clinical stroke team shall include, at a minimum:

A. A Qualified Specialist in EM and neurology, neurosurgery, or interventional

neuro-radiology in person or via telemedicine.

B. A registered nurse (RN), physician assistant or nurse practitioner with education and training in the care of the acute stroke patient

V. Data Collection and Submission Requirements

A. Ensure adequate data entry personnel, who work collaboratively with ED personnel, to assure capture and entry of patients meeting inclusion criteria into the Stroke Database on an ongoing basis.

1. Back-up data entry personnel should be identified and trained in the event primary data personnel are unable to meet the data entry requirements.

2. Data Inclusion Criteria – all patients who are initially transported via the 9-1-1 system and meet **one or more** of the following:

a. EMS Provider Impression is Stroke/CVA/TIA

b. EMS Provider utilized Treatment Protocol 1232

c. Final hospital (if admitted) or ED (if not admitted) diagnosis is ischemic stroke, transient ischemia attack, intracerebral hemorrhage, intraventricular hemorrhage, or subarachnoid hemorrhage

d. Transfer from a non-stroke center to a PSC or CSC for stroke care and the initial transport to the non-stroke center was via the 9-1-1 system within 24 hours prior to transfer

e. Transfer from a PSC to the CSC for stroke care and the initial transport to the PSC was via the 9-1-1 system within 24 hours prior to transfer

B. Stroke data shall be entered within 45 days of patient's discharge into the Stroke Database and shall include all patients who meet data inclusion criteria and all applicable data elements listed in Ref. No. 650, Stroke Data Dictionary.

C. Submit a monthly tally of patients meeting inclusion criteria to the EMS Agency Stroke Program Coordinator by end of the month for the previous month (e.g., January tally is due February 28th).

D. The Stroke Center must maintain a minimum 90% compliance for:

1. Capture of patients meeting the data inclusion criteria

2. Data field completion

3. Data field accuracy

4. Timely data entry

5. Timely tally submission

VI. Quality Improvement

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

1. Meeting participation should include the Stroke Medical Director, Stroke Program Manager, EMS providers, stroke care coordinators, stroke/provider educators, neurologists, ED physicians and ED personnel, as well as other healthcare specialties including neurointerventionalists, or endovascular neurosurgery when applicable.

2. Meetings to be held quarterly, at a minimum.

3. Meeting minutes and roster must be maintained for each meeting and available for review.

4. Stroke Centers that are also a Base Hospital are encouraged to provide periodic Stroke Base Hospital education with the collaboration of the Stroke Clinical Director.

B. The stroke QI program shall:

1. Track and trend performance measures as per Ref. No. 322.1, Stroke Performance Measures

2. Collaborate with referral/receiving facilities in regard to inter-facility transfers to evaluate care of transfer patients to include:

a. Door-in to door-out time at sending facility (goal <120 minutes)

b. Quality of care issues and delays

C. Address other issues, processes or personal trends identified from hospital specific data.

VII. A Comprehensive Stroke Center (CSC) shall:

1. Meet all the requirements specified in Sections I through VI of this policy

2. Appoint a Stroke Medical Director who is BC in Neurology or Neurosurgery by ABMS or AOA with extensive experience and expertise in one or more of the cerebrovascular disease subspecialties of:
   a. Stroke or vascular neurologist
   b. Neurocritical Care
   c. Endovascular Neurosurgery

3. Appoint a Stroke Program Manager who shall be dedicated solely to the CSC program.

4. Have the capacity to perform mechanical thrombectomy for the treatment of ischemic stroke 24 hours per day/7 days per week.

5. Have fully executed written transfer agreements with LA County surrounding

stroke referral facilities, including PSCs.

6. Provide guidance and continuing stroke-specific medical education to hospitals designated as a PSC with which they have transfer agreements.

7. Have fully executed written transportation agreements with LA County licensed ambulance operators, written agreements shall include provisions to ensure transportation is available 24 hours a day/7 days a week and transport vehicle is available at the stroke referral facility within 60 minutes, including critical care transportation.

8. Provide neurosurgical services or have a written transfer agreement with another CSC that provides neurosurgical services 24 hours per day/7 days a week/365 days a year. For hospitals that provide neurosurgical services, a written plan for neurosurgical coverage and a neurosurgical call schedule is readily available to staff. The neurosurgeon must be BC and dedicated to the CSC and cannot be concurrently on-call at any other hospital. If concurrently on-call for another specialty service within the same hospital (e.g., trauma) must have back-up identified on the on-call schedule.

9. Have dedicated on-call endovascular neurointerventionalist, and BC/BE neurologist;,on-call physician cannot be concurrently on-call at any other hospital. If on-call for another specialty service (e.g., trauma) within the same hospital, must have back-up identified on the on-call schedule.

10. Have tele-medicine capabilities with surrounding PSCs that have an established transfer agreement with the CSC.

CROSS REFERENCE:

Prehospital Care Policy Manual:

Reference No. 322.1 Stroke Performance Measures
Reference No. 502, Patient Destination
Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients
Reference No. 521, Stroke Patient Destination
Reference No. 620, EMS Quality Improvement Program
Reference No. 622.2 Notification of Personnel Change Form
Reference No. 650 Stroke Data Dictionary
Reference No. 1232, Treatment Protocol: Stroke/CVA/TIA

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

REFERENCE NO. 322, Stroke Receiving Center Standards

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee			
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee			
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other: Stroke Advisory Committee	05/05/2020	06/30/2020	Y

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

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

SUBJECT: **STROKE PERFORMANCE MEASURES** REFERENCE NO. 322.1

PURPOSE: To provide standardized quantifiable indicators to assess and evaluate the performance, quality of care and program management of Emergency Medical Services (EMS) Agency designated Stroke Centers.

DEFINITIONS:

Door to Device Time (D2D): A time measurement that starts with the patient's arrival in the Emergency Department (ED) at the Comprehensive Stroke Center (CSC) and ends with the first pass of thrombectomy device.

Door to Needle Time (D2N): A time measurement that starts with the patient's arrival in the ED, and ends when IV thrombolytics are started.

First Medical Contact to Device Time (FMC2D): A time measurement that starts with the arrival of EMS at the patient and ends with the first pass of thrombectomy device.

First Medical Contact to Needle Time (FMC2N): A time measurement that starts with the arrival of EMS at the patient and ends when IV thrombolytics are started.

Stroke Center: A licensed general acute care hospital that has met all Primary Stroke Center (PSC) or CSC requirements in Ref. No. 322, Stroke Receiving Center Standards and has been designated by the LA County EMS Agency as a PSC or CSC.

POLICY:

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

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

III. Performance Measures:

A. 9-1-1 EMS patients meeting EMS Agency inclusion criteria are captured in the Stroke Database 90% of the time.

B. D2N for EMS patients is within 60 minutes 75% of the time and within 45 minutes 50% of the time.

C. FMC2N for EMS patients is within 90 minutes 75% of the time and within 75 minutes 50% of the time.

D. D2D for EMS patients is within 120 minutes 50% of the time.

E. FMC2D for EMS patients is within 150 minutes 50% of the time.

F. For inter-facility transfers for large vessel occlusion treatment, ambulance is at stroke referral hospital within sixty (60) minutes from time of CSC acceptance of transfer patient 90% of the time.

G. D2D for transfer patients is within 90 minutes 75% of the time and within 60 minutes 50% of the time.

IV. Tracking Measures

A. Percentage of ischemic stroke patients with a large vessel cerebral occlusion (i.e., internal carotid artery (ICA) or ICA terminus (T-lesion; T-occlusion), middle cerebral artery (MCA) M1 or M2, basilar artery) who receive mechanical endovascular reperfusion (MER) therapy and who achieve TICI 2B or higher for the primary vessel occlusion $\leq$ 60 minutes from the time of skin puncture.

B. Percentage of ischemic stroke patients who develop a symptomatic intracranial hemorrhage (i.e., clinical deterioration $\geq$ 4 point increase on National Institutes of Health Stroke Scale (NIHSS) and brain image findings of parenchymal hematoma, or subarachnoid hemorrhage, or intraventricular hemorrhage) $\leq$ 36 hours after the onset of treatment with intravenous (IV) thrombolytic therapy only.

C. Percentage of ischemic stroke patients who develop a symptomatic intracranial hemorrhage (i.e., clinical deterioration $\geq$ 4 point increase on National Institutes of Health Stroke Scale (NIHSS) and brain image findings of parenchymal hematoma, or subarachnoid hemorrhage, or intraventricular hemorrhage) $\leq$ 36 hours after the onset of treatment with intra-arterial (IA) thrombolytic therapy or MER therapy.

D. Percentage of ischemic stroke patients treated with intra-venous (IV) or intra-arterial (IA) thrombolytic therapy or who undergo MER therapy and have a discharge modified Rankin Scale $\leq$of 2 or back to baseline.

E. Percentage of confirmed stroke patients transported to your hospital by EMS and for whom $\leq$90 minutes was spent in the ED prior to transfer to a higher-level stroke center for time-critical therapy (e.g., MER)

V. Procedure for Non-Compliance with Performance Measures

Failure to meet any of these Performance Measures for two consecutive quarters (six months) will result in the corrective action as listed below.

Month	Action 1	Compliance Result	Action 2
7th	Stroke Center continues data collection for patients who meet inclusion criteria		
8th	EMS Agency reviews Stroke Center's 7th month compliance with all performance measures	Stroke Center does not meet 90% compliance in any one of the performance measures Significant Improvement	EMS Agency notifies Stroke Medical Director and Program Manger via e-mail or telephone, of non-compliance and assist in determining solutions. Monitor

Month	Action 1	Compliance Result	Action 2
9th	EMS Agency reviews Stroke Center's 8th month compliance with all performance measures	No significant improvement Significant improvement	EMS Agency sends a written notice to Stroke Medical Director and Program Manager notifying of compliance results and continued non-compliance. Monitor
10th	EMS Agency reviews Stroke Center's 9th month compliance with all performance measures	No significant improvement Significant improvement	EMS Agency notifies Stroke Medical Director and Program Manager in writing of compliance results and request to submit a corrective action plan within 15 calendar days a plan to correct deficiency. Monitor
11th	EMS Agency reviews Stroke Center's 10th month compliance with all performance measures	No significant improvement Significant improvement	Within 15 days of EMS Agency's receipt of Stroke Center's corrective action plan, the EMS Agency will provide Stroke Center a written approval or request additional modification to Stroke Center's corrective action plan. Monitor
12th	EMS Agency reviews Stroke Center's 11th month compliance with all performance measures	No significant improvement Improvement based on approved corrective action plan	EMS Agency notifies Stroke Medical Director and Program Manager in writing of compliance results and request modification to Stroke Center's corrective action plan. Monitor
13th	EMS Agency reviews Stroke Center's 12th month compliance with all performance measures	No significant improvement Improvement based on approved corrective action plan	EMS Agency notifies Stroke Center's Chief Executive Officer or President in writing of compliance results and continued failure to meet performance measures. Stroke Center is placed on a 3-month provisional status. Monitor
14th	EMS Agency reviews Stroke Center's 13th month compliance with all performance measures	No significant improvement	EMS Agency will notify Stroke Center of continued non-compliance

Month	Action 1	Compliance Result	Action 2
		Improvement based on approved corrective action plan	Monitor
15th	EMS Agency reviews Stroke Center's 14th month compliance with all performance measures	No significant improvement Improvement based on approved corrective action plan	EMS Agency will notify Stroke Center of continued non-compliance Monitor
16th	EMS Agency reviews Stroke Center's 15th month compliance with all performance measures	No significant improvement Improvement based on approved corrective action plan	EMS Agency notifies Stroke Center's Chief Executive Officer or President in writing that continued noncompliance may result in removal of Stroke Center designation. Monitor
17th	EMS Agency reviews Stroke Center's 16th month compliance with all performance measures	No significant improvement	EMS Agency will notify Stroke Center's Chief Executive Officer or President in writing of removal of hospital's Stroke Center designation.

POLICY REVIEW - SUMMARY OF COMMENTS REFERENCE NO. 202.2

REFERENCE NO. 322.1, Stroke Performance Measures

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
III. Performance Measures, D.	Stroke Advisory Committee 05-05-2020	Change wording to "D2D for EMS patients is within 120 minutes ~~75% of the time and within 90 minutes~~ 50% of the time"	Change made
III. Performance Measures, E.	Stroke Advisory Committee 05-05-2020	Change wording to "FMC2D for EMS patients is within ~~150 minutes 75% of the time and~~ within 120 minutes 50% of the time"	Change made
V. Procedure for Non-Compliance	Stroke Advisory Committee 05-05-2020	Add "Failure to meet any of these Performance Measures for two consecutive quarters (six months) will result in the corrective action as listed below."	Change made
V. Procedure for Non-Compliance (table)	Stroke Advisory Committee 05-05-2020	Start with month 7	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

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

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

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

DEFINITIONS:

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

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

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

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

PRINCIPLES:

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

    a. Patient care records
    b. Legal documents
    c. Quality improvement instruments
    d. Billing resources (EMS Record only)
    e. Records of canceled calls, false alarms, and no patient found (EMS Record only)

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

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

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

    a. Canceled calls
    b. No patient(s) found
    c. False alarms

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

POLICY:

I. EMS Record Completion – Paramedic/EMT Personnel

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

B. Paper-Based EMS Report Form Completion

1. Paramedic/EMT personnel from the first responding agency shall complete one Los Angeles County EMS Agency approved EMS Report Form (one for each patient) for every 9-1-1 patient contact which includes the following:
   a. Regular runs
   b. DOA (dead on arrival; patients determined or pronounced dead per Reference No. 814, Determination/Pronouncement of Death in the Field)
   c. ALS interfacility transfer patients

C. Electronic EMS Patient Care Record (ePCR) Completion

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

2. Paramedic/EMT personnel shall complete one EMS Agency approved ePCR(one for each patient) for every 9-1-1 patient contact which includes the following:
   a. Regular runs
   b. DOA (dead on arrival; patients determined or pronounced dead per Reference No. 814, Determination/Pronouncement of Death in the Field)
   c. ALS interfacility transfer patients

D. Multiple Providers

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

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

E. Multiple Casualty Incidents (MCI)

1. One standard EMS Record must be initiated for each patient transported in an MCI. Provider agencies may use alternate means of documenting MCIs

if the EMS Agency is notified prior to implementation and agrees with the proposed process.

2. Documentation should include the following, at minimum:

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

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

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

F. Completion of the EMS Record Prior to Distribution

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

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

G. Field Transfer of Care

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

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

3. If utilizing a paper-based EMS Report Form, the receiving hospital (red) copy of the EMS Report Form, as well as the PCR from the BLS transport provider (red copy), must accompany the patient to the receiving facility where it becomes part of the patient's medical record.

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

H. Completion of Advanced Life Support Continuation Form

1. If utilizing a paper-based EMS Report Form, required for each patient on whom advanced airway management is necessary or cardiopulmonary resuscitation is attempted or resuscitative measures are terminated in the field.

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

II. Base Hospital Form - MICN and/or Physicians

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

B. Base Hospital Form Completion

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

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

C. Base Hospital Directed Multiple Casualty Incidents (MCI)

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

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

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

a. Date
b. Time
c. Sequence number/Triage tag number
d. Provider and unit

e. Chief complaint
f. Mechanism of injury, if applicable
g. Age and units of age
h. Gender
i. Brief patient assessment
j. Brief description of treatment provided
k. Transporting provider, method of transport (ALS, BLS or Helicopter)
m. Destination
n. Receiving Facility

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

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

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

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

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

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

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

III. Modification of the Paper-Based EMS Report Form

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

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

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

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

B. Making substantive changes (documentation of additional medications, defibrillation attempts, pertinent comments, complaints, etc.) to the EMS Record:

1. Photocopy the paper-based EMS Report Form with the changes and send the copy, along with a cover letter, to all entities that received the original form (EMS Agency, receiving facility). The cover letter should explain the modifications and request that the modified copy be attached to the original copy.

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

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

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 608, **Retention and Disposition of Prehospital Patient Care Records**
Ref. No. 607, **Electronic Submission of Prehospital Data**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 640, **EMS Documentation Manual**
Ref. No. 633, **Base Hospital Documentation Manual**

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

REFERENCE NO. 606, Documentation of Prehospital Care

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	6/10/2020	6/10/2020	N
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee	6/17/2020	6/17/2020	Y
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

POLICY REVIEW - SUMMARY OF COMMENTS REFERENCE NO. 202.2

REFERENCE NO. 606, Documentation of Prehospital Care

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy II.C.3	PAAC 06/17/2020	In a large scale MCI, paramedics are not always able to report multiple data points, add language to clarify	
C.3.		Add wording “when base contact is made for online medical control”	Change made
C.3.i.		Add wording “when possible”	Change made
C.3.j.		Add wording “when possible”	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **BASE HOSPITAL DOCUMENTATION MANUAL**

MICN/BASE PHYSICIAN
REFERENCE NO. 644

Base Hospital Documentation Manual

Los Angeles County

Emergency Medical Services Agency

LANCET TECHNOLOGY
Innovative Data Solutions
by eso

IMPLEMENTATION: August 2020

TABLE OF CONTENTS

COMMON NULL VALUES

Definition

These values are to be used with each of the data elements described in this document which have been defined to accept the Null Values

Field Values

- **F6**: Not Documented
- **F7**: Not Applicable

Additional Information

- For any collection of data to be of value and reliably represent intended information, a strong commitment must be made to ensure that data collected are complete and accurate
- Not Documented: This null value code applies if the documentation being referenced has nothing recorded in a specific field
- Not Applicable: This null value code applies if the data field referenced does not apply to the patient (e.g., “Reason for No Transport” if patient was transported)

NOTIFICATIONS

LOG

Definition

Number assigned by the hospital to each notification call that coincides with its numbered entry on a notification call log

Additional Information

- **Required** field for all notification calls
- Format is unique to each individual hospital
- Enter information into 'Log #' field on Base 1 tab in TEMIS. Information entered will auto-fill 'Log #' field on Notification tab

Uses

- Assists in locating the coinciding audio file

Data Source Hierarchy

- Notification Form
- Notification Log

NOTIFICATION ONLY?

Definition

Field indicating whether record being entered into TEMIS was a notification call

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Field is auto-filled with “N” and should be changed by user to “Y” when entering a notification call
- If changed to “Y”, go directly to the Notification tab to do data entry, do not enter any data into any other fields on the Base 1, Base 2, or Dispo/QI tabs
- Notifications, regardless if received from another base hospital or a public provider and regardless of the method, the base line or land line, utilized to make the notification, need to be entered into TEMIS
- If a base hospital erroneously receives a notification for a patient that is not transported to their facility, those notifications should not be entered
- Notifications from public providers for 9-1-1 IFTs need to be entered
- Notifications from private providers for IFTs and non-9-1-1 calls should not be entered

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Notification Form
- Notification Log
- Audio Records

SEQUENCE NUMBER

Definition

Unique, alphanumeric EMS record number provided by the paramedic, and found pre-printed at the top right corner of EMS report form hard copies. Electronically assigned to electronic patient care records (ePCRs) from approved providers

Additional Information

- **Required** field for all notification calls: data entry cannot begin without this number
- Consists of two letters and six digits on pre-printed EMS Report Forms; or two letters, ten digits if obtained from an approved ePCR provider. Neither format should contain spaces.
- If sequence number is missing or incorrectly documented, every effort must be taken by the base hospital to obtain it – either by reviewing the audio recording, or by contacting the appropriate provider agency directly. Only after all efforts to obtain the actual sequence number have been exhausted may a request be made of the EMS Agency for assistance, or as a last resort, a 'dummy' sequence number, in a **timely** fashion.
- A fictitious sequence number **should not** be generated for any reason.

Uses

- Unique patient identifier
- Essential link between other EMS Agency databases

Data Source Hierarchy

- Notification Form
- Notification Log
- Audio Records
- EMS Record
- Fire Station Logs
- EMS Agency

DATE

Definition

Date of notification call

Field Values

- Collected as MMDDYYYY

Additional Information

- **Required** field for all notification calls
- Excluding midnight crossover from New Year's Eve to New Year's Day, the last two digits of the date must match the first two numeric digits in a 12-digit sequence number

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- Notification Form
- Notification Log

TIME

Definition

Time of day that notification was initiated

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all notification calls

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- Notification Form
- Notification Log

PROVIDER CODE

Definition

Two-letter code for the EMS provider primarily responsible for the patient's prehospital care

Field Values

PUBLIC PROVIDERS			
AF	Arcadia Fire	**LV**	La Verne Fire
AH	Alhambra Fire	**MB**	Manhattan Beach Fire
AV	Avalon Fire	**MF**	Monrovia Fire
BA	Burbank Airport Fire	**MO**	Montebello Fire
BF	Burbank Fire	**MP**	Monterey Park Fire
BH	Beverly Hills Fire	**OT**	Other Provider
CC	Culver City Fire	**PF**	Pasadena Fire
CF	LA County Fire	**RB**	Redondo Beach Fire
CG	US Coast Guard	**SA**	San Marino Fire
CI	LA City Fire	**SG**	San Gabriel Fire
CM	Compton Fire	**SI**	Sierra Madre Fire
CS	LA County Sheriff	**SM**	Santa Monica Fire
DF	Downey Fire	**SP**	South Pasadena Fire
ES	El Segundo Fire	**SS**	Santa Fe Springs Fire
FS	U.S. Forest Service	**TF**	Torrance Fire
GL	Glendale Fire	**VE**	Ventura County Fire
LB	Long Beach Fire	**VF**	Vernon Fire
LH	La Habra Heights Fire	**WC**	West Covina Fire
PRIVATE PROVIDERS			
AR	American Medical Response	**WM**	West Med/McCormick Ambulance Service
CA	CARE Ambulance		

Additional Information

- **Required** field for all notification calls
- Refers to the public EMS provider agency providing notification for arrival of 9-1-1 patients, including 9-1-1 IFTs, or the transporting provider for calls downgraded from ALS to BLS
- Notification of arrival of IFTs or non-9-1-1 calls from private providers should not be entered

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Notification Form
- Notification Log
- Audio Records

PROVIDER UNIT

Definition

Alphanumeric apparatus code consisting of type of vehicle + numeric vehicle identifier for the paramedic unit establishing base contact or providing notification

Field Values

- AB: Private Ambulance
- AT: Assessment Truck
- AE: Assessment Engine
- BK: Bike
- BT: Boat
- CT: Cart
- HE: Helicopter
- PE: Paramedic Engine
- PT: Paramedic Truck
- SQ: Squad
- RA: Rescue

Additional Information

- **Required** field for all notification calls
- This is a free-text field – the values above reflect those commonly used by EMS providers

Uses

- System evaluation and monitoring

Data Hierarchy

- Notification Form
- Notification Log
- Audio Records

AGE

Definition

Numeric value for the age (actual or best approximation) of the patient

Field Values

- Enter the numeric age value

Additional Information

- **Required** field for all notification calls
- Must also indicate unit of age

Uses

- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics

Data Source Hierarchy

- Notification Form
- Notification Log
- Audio Records

AGE UNITS

Definition

Checkboxes indicating units of measurement used to report the age of the patient

Field Values

- **Y**rs: Years – used for patients 2 years old or older
- **YE:** Years Estimated
- **M**os: Months – used for patients 1 month to 23 months old
- **ME:** Months Estimated
- **W**ks: Weeks – used for patients whose age is reported in weeks instead of months
- **WE:** Weeks Estimated
- **D**ays: Days – used for patients 1 to 29 days old
- **DE:** Days Estimated
- **H**rs: Hours – used for patients who are newborn and up to 23 hours old
- **HE:** Hours Estimated

Additional Information

- **Required** field for all notification calls

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Notification Form
- Notification Log
- Audio Records

GENDER

Definition

Checkbox indicating the gender of the patient

Field Values

- **M**: Male
- **F**: Female
- **N**: Nonbinary

Additional Information

- **Required** field for all notification calls
- Patients who are undergoing or have undergone a hormonal and/or surgical sex reassignment should be coded using their stated preference
- Patients unable to state their preference should be coded per paramedic observation/judgment
- Nonbinary is a gender option within the State of California for individuals whose gender identity is not exclusively male or female

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Notification Form
- Notification Log
- Audio Records

PROVIDER IMPRESSION

Definition

Four-letter code(s) representing the provider's impression of the patient's presentation

Field Values

ABOP	Abdominal Pain/Problems	**ELCT**	Electrocution	**PREG**	Pregnancy Complications
AGDE	Agitated Delirium	**ENTP**	ENT/Dental Emergencies	**LABR**	Pregnancy/Labor
CHOK	Airway Obstruction/Choking	**NOBL**	Epistaxis	**RARF**	Respiratory Arrest/Failure
ETOH	Alcohol Intoxication	**EXNT**	Extremity Pain/Swelling – Non-Traumatic	**SOBB**	Resp. Distress/Bronchospasm
ALRX	Allergic Reaction	**EYEP**	Eye Problem – Unspecified	**RDOT**	Resp. Distress/Other
ALOC	ALOC – Not Hypoglycemia or Seizure	**FEVR**	Fever	**CHFF**	Resp. Distress/Pulmonary Edema/CHF
ANPH	Anaphylaxis	**GUDO**	Genitourinary Disorder – Unspecified	**SEAC**	Seizure – Active
PSYC	Behavioral/Psychiatric Crisis	**DCON**	HazMat Exposure	**SEPI**	Seizure – Postictal
BPNT	Body Pain – Non-Traumatic	**HPNT**	Headache – Non-Traumatic	**SEPS**	Sepsis
BRUE	BRUE	**HYPR**	Hyperglycemia	**SHOK**	Shock
BURN	Burns	**HYTN**	Hypertension	**SMOK**	Smoke Inhalation
COMO	Carbon Monoxide	**HEAT**	Hyperthermia	**STNG**	Stings/Venomous Bites
CANT	Cardiac Arrest– Non-Traumatic	**HYPO**	Hypoglycemia	**STRK**	Stroke/CVA/TIA
DYSR	Cardiac Dysrhythmia	**HOTN**	Hypotension	**DRWN**	Submersion/Drowning
CPNC	Chest Pain – Not Cardiac	**COLD**	Hypothermia/Cold Injury	**SYNC**	Syncope/Near Syncope
CPMI	Chest Pain – STEMI	**INHL**	Inhalation Injury	**CABT**	Traumatic Arrest – Blunt
CPSC	Chest Pain – Suspected Cardiac	**LOGI**	Lower GI Bleeding	**CAPT**	Traumatic Arrest – Penetrating
BRTH	Childbirth (Mother)	**FAIL**	Medical Device Malfunction – Fail	**TRMA**	Traumatic Injury
COFL	Cold/Flu Symptoms	**NAVM**	Nausea/Vomiting	**UPGI**	Upper GI Bleeding
DRHA	Diarrhea	**BABY**	Newborn	**VABL**	Vaginal Bleeding
DIZZ	Dizziness/Vertigo	**NOMC**	No Medical Complaint	**WEAK**	Weakness – General
DEAD	DOA – Obvious Death	**ODPO**	Overdose/Poisoning/Ingestion		
DYRX	Dystonic Reaction	**PALP**	Palpitations		

Additional Information

- **Required** field for all notification calls
- First copy of Provider Impression cannot be a null value
- Do not enter more than one copy of the same Provider Impression code

Uses

- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- Notification Form
- Notification Log
- Audio Records

HOSP DISPO

Definition

Checkbox indicating the emergency department disposition of patients transported to the base hospital as the receiving facility

Field Values

- **D**ischarged: Patient was discharged home from the emergency department
- **W**ard: Patient was admitted to a medical/surgical ward
- **S**tepdown: Patient was admitted to a Direct Observation Unit (DOU), Stepdown Unit, or Telemetry Unit
- **I**CU: Patient was admitted to an Intensive Care Unit or Cardiac Care Unit
- Obser**V**ation: Observation unit (provides < 24 hour stays)
- O**R**: Patient was transferred directly from the emergency department to the operating room
- **C**ath Lab: Patient was transferred directly from the emergency department to the Cardiac Catheterization Lab
- I**N**terventional Radiology: Patient was transferred directly from the emergency department to Interventional Radiology for embolization, angiography, etc.
- **E**xpired in ED: Patient died in the emergency department
- O**B**: Patient was admitted to an obstetrics department
- **T**ransferred to: Patient was transferred directly from the emergency department to another healthcare facility – document the name of the facility or the three-letter hospital code in the space provided
- **O**ther: Patient disposition other than those listed above – document disposition on the line provided
- ED Diagnosis: Emergency department diagnosis as documented by a physician – is entered into TEMIS as an ICD-10 code

Additional Information

- **Required** field for all patients for whom the base hospital notified is also the receiving facility
- May be completed later by personnel other than the MICN/MD initially notified

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Notification Form
- Notification Log
- ED Records
- Other Hospital Records

DISPO COMM.

Definition

Space provided for documentation of any additional information related to the patient's disposition from the ED

Field Values

- Free text

Uses

- Space for documentation, if needed

Data Source Hierarchy

- Notification Form
- Notification Log
- ED Records
- Other Hospital Records

DIAGNOSIS

Definition

Emergency department diagnosis as documented by a physician

Field Values

- ICD-10 codes

Additional Information

- **Required** field for all patients for whom the base hospital notified is also the receiving facility
- May be completed later by personnel other than the MICN/MD initially notified

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Notification Form
- Notification Log
- ED Records
- Other Hospital Records

BASE CONTACTS

GEN INFO

LOG

Definition

Number assigned by the hospital to each base contact that coincides with its numbered entry on a base contact call log

Additional Information

- **Required** field for all base hospital contacts
- Format is unique to each individual hospital

Uses

- Unique patient identifier
- Assists in locating the coinciding audio file

Data Source Hierarchy

- Base Hospital Log
- Base Hospital Form

NOTIFICATION ONLY?

Definition

Field indicating whether record being entered into TEMIS was a notification call

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Field is auto-filled with “N” and should remain as “N” for all base contacts entered into TEMIS

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Audio Records

MCI PATIENT?

Definition

Field indicating whether the incident involved three or more patients

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Field is auto filled with “N” unless changed by user to “Y”

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

SEQUENCE NUMBER

Definition

Unique, alphanumeric EMS record number provided by the paramedic, and found pre-printed at the top right corner of EMS report form hard copies. Electronically assigned to ePCRs from approved providers

Additional Information

- **Required** field for all base hospital contacts: data entry cannot begin without this number
- Consists of two letters and six digits on pre-printed EMS Report Forms; or two letters, ten digits if obtained from an approved ePCR provider. Neither format should contain spaces.
- If sequence number is missing or incorrectly documented, every effort must be taken by the base hospital to obtain it – either by reviewing the audio recording, or by contacting the appropriate provider agency directly. Only after all efforts to obtain the actual sequence number have been exhausted may a request be made of the EMS Agency for assistance, or as a last resort, a 'dummy' sequence number, in a **timely** fashion.
- A fictitious sequence number **should not** be generated for any reason.

Uses

- Unique patient identifier
- Essential link between other EMS Agency databases

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records
- EMS Record
- Fire Station Logs
- EMS Agency

PG 2

Definition

Checkbox indicating that a Base Hospital Form supplemental page was used

Uses

- Use when extra space is needed for documentation of additional Drugs, ECGs, Treatments, and/or Comments

Data Source Hierarchy

- Base Hospital Form Page 2
- Base Hospital Form

DATE

Definition

Date of base hospital contact

Field Values

- Collected as MMDDYYYY

Additional Information

- **Required** field for all base hospital contacts
- Excluding midnight crossover from New Year's Eve to New Year's Day, the last two digits of the date must match the first two numeric digits in a 12-digit sequence number

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log

TIME

Definition

Time of day that base hospital contact was initiated

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log

LOCATION

Definition

Two-letter code indicating where the incident occurred

Field Values

AI	Airport/Transport Center	**ON**	Ocean
AM	Ambulance	**PA**	Park
BA	Beach	**PL**	Parking Lot
CL	Cliff/Canyon	**PO**	Pool
CO	Commercial Establishment	**PS**	Psych Urgent Care
DC	Dialysis Center	**PV**	Public Venue/Event
DO	Healthcare Provider's Office/Clinic	**RA**	Recreation Area
FA	Farm/Ranch	**RE**	Restaurant
FR	Freeway	**RI**	Residential Institution
FS	Fire Station	**RL**	Religious Building
GY	Health Club/Gym	**RS**	Retail Store
HO	Home	**RT**	Railroad Track
HT	Hotel	**RV**	River
IN	Industrial/Construction Area	**SB**	Sobering Center
JA	Jail	**SC**	School/College/University
LA	Lake	**ST**	Street/Highway
MB	Military Base	**UC**	Urgent Care
MC	Hospital/Medical Center	**WI**	Wilderness Area
NH	Nursing Home	**OT**	Other
OF	Office		

Additional Information

- Location codes are listed on the back of pages 1 and 4 of the Base Hospital Form
- Additional details can be written on the adjacent line: e.g., the name of the facility or business, or any other useful information

Uses

- Allows for data sorting and tracking by incident location
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PROVIDER CODE

Definition

Two-letter code for the EMS provider primarily responsible for the patient's prehospital care

Field Values

PUBLIC PROVIDERS			
AF	Arcadia Fire	**LV**	La Verne Fire
AH	Alhambra Fire	**MB**	Manhattan Beach Fire
AV	Avalon Fire	**MF**	Monrovia Fire
BA	Burbank Airport Fire	**MO**	Montebello Fire
BF	Burbank Fire	**MP**	Monterey Park Fire
BH	Beverly Hills Fire	**OT**	Other Provider
CC	Culver City Fire	**PF**	Pasadena Fire
CF	LA County Fire	**RB**	Redondo Beach Fire
CG	US Coast Guard	**SA**	San Marino Fire
CI	LA City Fire	**SG**	San Gabriel Fire
CM	Compton Fire	**SI**	Sierra Madre Fire
CS	LA County Sheriff	**SM**	Santa Monica Fire
DF	Downey Fire	**SP**	South Pasadena Fire
ES	El Segundo Fire	**SS**	Santa Fe Springs Fire
FS	U.S. Forest Service	**TF**	Torrance Fire
GL	Glendale Fire	**VE**	Ventura County Fire
LB	Long Beach Fire	**VF**	Vernon Fire
LH	La Habra Heights Fire	**WC**	West Covina Fire
PRIVATE PROVIDERS			
AA	American Professional Ambulance Corp.	**LT**	Liberty Ambulance
AB	Ambulife Ambulance, Inc.	**LY**	Lynch EMS Ambulance
AN	Antelope Ambulance Service	**MI**	MedResponse, Inc.
AR	American Medical Response	**MR**	MedReach Ambulance
AT	All Town Ambulance, LLC	**MT**	MedCoast Ambulance
AU	AmbuServe Ambulance	**MY**	Mercy Air
AW	AMWest Ambulance	**PE**	Premier Medical Transport
AZ	Ambulnz Health, Inc.	**PN**	PRN Ambulance, Inc.
CA	CARE Ambulance	**RE**	REACH Air Medical Service
CL	CAL-MED Ambulance	**RR**	Rescue Services (Medic-1)
CO	College Coastal Care, LLC	**RY**	Royalty Ambulance
EA	Emergency Ambulance	**SO**	Southern California Ambulance
EX	Explorer 1 Ambulance & Medical Services	**SY**	Symons Ambulance
FC	First Care Ambulance	**TR**	Trinity Ambulance
FM	Firstmed Ambulance Services, Inc.	**VA**	Viewpoint Ambulance, Inc.
GG	Go Green Ambulance	**WE**	Westcoast Ambulance
GU	Guardian Ambulance Service	**WM**	West Med/McCormick Ambulance Service
LE	Lifeline Ambulance		

Additional Information

- **Required** field for all base hospital contacts
- Refers to the EMS provider establishing base contact

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

PROVIDER UNIT

Definition

Alphanumeric apparatus code consisting of type of vehicle + numeric vehicle identifier for the paramedic unit establishing base contact

Field Values

- AB: Private Ambulance
- AT: Assessment Truck
- AE: Assessment Engine
- BK: Bike
- BT: Boat
- CT: Cart
- HE: Helicopter
- PE: Paramedic Engine
- PT: Paramedic Truck
- SQ: Squad
- RA: Rescue

Additional Information

- **Required** field for all base hospital contacts
- This is a free-text field – the values above reflect those commonly used by EMS providers

Uses

- System evaluation and monitoring

Data Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

PT. # __ OF __

Definition

Number identifying the patient amongst the total number of patients involved in an incident

Additional Information

- **Required** field for all base hospital contacts
- If there is only one patient write “Pt.# 1 of 1”
- If there are two patients, and the patient is identified by the paramedics as the second patient, write “Pt.# 2 of 2”

Uses

- Assists with patient identification and tracking
- Identifies multiple-patient incidents
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

AGE

Definition

Numeric value for the age (actual or best approximation) of the patient

Field Values

- Enter the numeric age value

Additional Information

- **Required** field for all base hospital contacts
- Must also indicate unit of age
- If the age is estimated, mark the “Est.” checkbox on the Base Hospital Form

Uses

- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

AGE UNITS

Definition

Checkboxes indicating units of measurement used to report the age of the patient

Field Values

- **Y**rs: Years – used for patients 2 years old or older
- **YE:** Years Estimated
- **M**os: Months – used for patients 1 month to 23 months old
- **ME:** Months Estimated
- **W**ks: Weeks – used for patients whose age is reported in weeks instead of months
- **WE:** Weeks Estimated
- **D**ays: Days – used for patients 1 to 29 days old
- **DE:** Days Estimated
- **H**rs: Hours – used for patients who are newborn and up to 23 hours old
- **HE:** Hours Estimated

Additional Information

- **Required** field for all base hospital contacts
- If the unit of age is estimated, mark the "Est." checkbox on the Base Hospital Form and enter the unit of age as "YE", "ME", "WE", "DE", or "HE"

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

GENDER

Definition

Checkbox indicating the gender of the patient

Field Values

- **M**: Male
- **F**: Female
- **N**: Nonbinary

Additional Information

- **Required** field for all base hospital contacts
- Patients who are undergoing or have undergone a hormonal and/or surgical sex reassignment should be coded using their stated preference
- Patients unable to state their preference should be coded per paramedic observation/judgment
- Nonbinary is a gender option within the State of California for individuals whose gender identity is not exclusively male or female

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

WEIGHT

Definition

Numeric value of the weight of the patient

Field Values

- Up to three-digit numeric field

Additional Information

- **Required** field for all pediatric base contacts and base contacts with the following provider impressions:
  - CPSC/CPMI (pediatric patients)
  - LABR (pediatric patients)
- All weights should be documented in kilograms
- For pediatric patients, document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape, if applicable
- If the pediatric patient is shorter or taller than the length-based pediatric resuscitation tape, mark the “Too Short” or “Too Tall” checkbox, and estimate the weight in kilograms

Uses

- Assists with determination of appropriate treatment
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- Audio Records

WEIGHT UNITS

Definition

Checkbox indicating unit of measurement used to report patient's weight

Field Values

- **K**g: Kilograms

Additional Information

- **Required** field for all pediatric base contacts and base contacts with the following provider impressions:
  - CPSC/CPMI (pediatric patients)
  - LABR (pediatric patients)
- All weights should be documented in kilograms only
- For pediatric patients, document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape, if applicable
- If the pediatric patient is shorter or taller than the length-based pediatric resuscitation tape, mark the "Too Short" or "Too Tall" checkbox, and estimate the patient's weight in kilograms

Uses

- Assists with determination of appropriate treatment
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PEDS WEIGHT COLOR CODE

Definition

Color that corresponds with the length of an infant or child as measured on a length-based pediatric resuscitation tape

Field Values

- Grey: **3**, **4**, or **5** kg (newborn infants)
- P**I**nk: 6-7 kg (~3 -6 mos)
- **R**ed: 8-9 kg (~7-10 mos)
- P**U**rple: 10-11 kg (~12-18 mos)
- **Y**ellow: 12-14 kg (~19-35 mos)
- **W**hite: 15-18 kg (~3-4 yrs)
- **B**lue: 19-22 kg (~5-6 yrs)
- **O**range: 24-28 kg (~7-9 yrs)
- Gr**E**en: 30-36 kg, or about 80 lbs (~10-12 yrs)
- **T**oo Tall: patient is longer than tape
- Too **S**hort: patient is shorter than tape

Additional Information

- **Required** field for all pediatric base contacts
- Document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape, if applicable
- If the pediatric patient is shorter or taller than the length-based pediatric resuscitation tape, mark the “Too Short” or “Too Tall” checkbox, and estimate the patient’s weight in kilograms

Uses

- Assists with determination of appropriate treatment
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

HOSPITAL CODE

Definition

Three-letter code for the base hospital contacted

Field Values

AMH	Methodist Hospital of Southern California	**NRH**	Dignity Health - Northridge Hospital Medical Center
AVH	Antelope Valley Hospital	**PVC**	Pomona Valley Hospital Medical Center
CAL	Dignity Health - California Hospital Medical Center	**PIH**	PIH Health Whittier Hospital
CSM	Cedars-Sinai Medical Center	**QVH**	Emanate Health Queen of the Valley Hospital
GWT	Adventist Health - Glendale	**SFM**	St. Francis Medical Center
HCH	Providence Holy Cross Medical Center	**SJS**	Providence Saint Joseph Medical Center
HGH	LAC Harbor - UCLA Medical Center	**SMM**	Dignity Health - Saint Mary Medical Center
HMH	Huntington Hospital	**TOR**	Torrance Memorial Medical Center
HMN	Henry Mayo Newhall Hospital	**UCL**	Ronald Reagan UCLA Medical Center
LCM	Providence Little Co. of Mary Medical Center Torrance	**USC**	LAC+USC Medical Center
LBM	MemorialCare Long Beach Medical Center		

Additional Information

- **Required** field for all base hospital contacts
- Codes are also listed on the back of pages 1 and 4 of the Base Hospital Form

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log

COMMUNICATION TYPE

Definition

Checkbox indicating the device used by the paramedic to establish base hospital contact

Field Values

- **R**adio: Radio
- **P**hone: Telephone/Cell Phone
- **V**MED28: formerly known as Hospital Emergency Administrative Radio (HEAR)

Additional Information

- **Required** field for all base hospital contacts

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form

CALL TYPE

Definition

Checkboxes indicating the level of EMS encounter

Field Values

- 9-1-1 **C**all: Paramedics establish base contact for online medical direction based upon a complete patient report (includes Against Medical Advice calls and calls downgraded from ALS to BLS)
- 9-1-1 R**E**-Triage: Patient, meeting the 9-1-1 trauma re-triage criteria defined in Reference No. 506, is transferred from the ED of an acute care facility emergently via 9-1-1 to the ED of a designated trauma center
- IF**T** (Interfacility Transfer): Patient is being transferred via ALS from one acute care facility to another

Additional Information

- **Required** field for all base hospital contacts

Uses

- System evaluation and monitoring
- Establishes system participants' roles and responsibilities

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ASSESSMENT

PROVIDER IMPRESSION

Definition

Four-letter code(s) representing the provider's impression of the patient's presentation

Field Values

ABOP	Abdominal Pain/Problems	**ELCT**	Electrocution	**PREG**	Pregnancy Complications
AGDE	Agitated Delirium	**ENTP**	ENT/Dental Emergencies	**LABR**	Pregnancy/Labor
CHOK	Airway Obstruction/Choking	**NOBL**	Epistaxis	**RARF**	Respiratory Arrest/Failure
ETOH	Alcohol Intoxication	**EXNT**	Extremity Pain/Swelling – Non-Traumatic	**SOBB**	Resp. Distress/Bronchospasm
ALRX	Allergic Reaction	**EYEP**	Eye Problem – Unspecified	**RDOT**	Resp. Distress/Other
ALOC	ALOC – Not Hypoglycemia or Seizure	**FEVR**	Fever	**CHFF**	Resp. Distress/Pulmonary Edema/CHF
ANPH	Anaphylaxis	**GUDO**	Genitourinary Disorder – Unspecified	**SEAC**	Seizure – Active
PSYC	Behavioral/Psychiatric Crisis	**DCON**	HazMat Exposure	**SEPI**	Seizure – Postictal
BPNT	Body Pain – Non-Traumatic	**HPNT**	Headache – Non-Traumatic	**SEPS**	Sepsis
BRUE	BRUE	**HYPR**	Hyperglycemia	**SHOK**	Shock
BURN	Burns	**HYTN**	Hypertension	**SMOK**	Smoke Inhalation
COMO	Carbon Monoxide	**HEAT**	Hyperthermia	**STNG**	Stings/Venomous Bites
CANT	Cardiac Arrest– Non-Traumatic	**HYPO**	Hypoglycemia	**STRK**	Stroke/CVA/TIA
DYSR	Cardiac Dysrhythmia	**HOTN**	Hypotension	**DRWN**	Submersion/Drowning
CPNC	Chest Pain – Not Cardiac	**COLD**	Hypothermia/Cold Injury	**SYNC**	Syncope/Near Syncope
CPMI	Chest Pain – STEMI	**INHL**	Inhalation Injury	**CABT**	Traumatic Arrest – Blunt
CPSC	Chest Pain – Suspected Cardiac	**LOGI**	Lower GI Bleeding	**CAPT**	Traumatic Arrest – Penetrating
BRTH	Childbirth (Mother)	**FAIL**	Medical Device Malfunction – Fail	**TRMA**	Traumatic Injury
COFL	Cold/Flu Symptoms	**NAVM**	Nausea/Vomiting	**UPGI**	Upper GI Bleeding
DRHA	Diarrhea	**BABY**	Newborn	**VABL**	Vaginal Bleeding
DIZZ	Dizziness/Vertigo	**NOMC**	No Medical Complaint	**WEAK**	Weakness – General
DEAD	DOA – Obvious Death	**ODPO**	Overdose/Poisoning/Ingestion		
DYRX	Dystonic Reaction	**PALP**	Palpitations		

Additional Information

- **Required** field for all base hospital contacts
- First copy of Provider Impression cannot be a null value
- Do not enter more than one copy of the same Provider Impression code
- Provider Impression codes are found on the back of pages 1 and 4 of the Base Hospital Form

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

CHIEF COMPLAINT CODES

Definition

Two-letter code(s) representing the patient's most significant medical or trauma complaints

Field Values – Trauma Codes

- **N**o **A**pparent Injury (**NA**): No complaint, or signs or symptoms of injury following a traumatic event
- **BU**rns/Elec. Shock (**BU**): Thermal or chemical burn, or electric shock
- **C**ritical **B**urn (**CB**): Patients ≥ 15 years of age with 2nd (partial thickness) and 3rd (full thickness) degree burns involving ≥ 20% Total Body Surface Area (TBSA) **OR** patients ≤ 14 years of age with 2nd and 3rd degree burns involving 10% TBSA
- SBP <**90** (<70 if under 1y) (**90**): Systolic blood pressure less than 90mmHg in a patient greater than one year of age (or systolic blood pressure less than 70mmHg in a patient less than one year of age) following a traumatic event
- **RR** <10/>29 (<20 if <1y) (**RR**): A sustained respiratory rate greater than 29 breaths/minute, or respiratory rate of less than 10 breaths/minute (or less than 20 breaths/minute in a patient less than one year of age), following a traumatic event
- **S**usp. Pelvic F**X** (**SX**): Suspected pelvic fracture, excluding isolated hip fractures from a ground level fall
- **S**pinal **C**ord Injury (**SC**): Suspected spinal cord injury, or presence of weakness/paralysis/paresthesia following a traumatic event
- **I**npatient **T**rauma (**IT**): Interfacility transfer (IFT) of an admitted, injured patient from one facility to an inpatient bed at another facility, excluding ER to ER transfers
- **U**ncontrolled **B**leeding (**UB**): Extremity bleeding requiring use of a tourniquet or hemostatic dressing
- **T**rauma Arrest (**BT** or **PT**): Cessation of cardiac output and effective circulation due to blunt or penetrating force
- **H**ead (**BH** or **PH**): Injury to the head or skull in the area from above the eyebrows to behind the ears, due to blunt or penetrating force. This code can also be applied in association with facial injuries when it is likely that the brain is involved
- GCS ≤**14** (**14**): Blunt force head injury associated with a Glasgow Coma Scale score of less than or equal to 14
- **F**ace/Mouth (**BF** or **PF**): Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to blunt or penetrating force
- **N**eck (**BN** or **PN**): Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to blunt or penetrating force
- **B**ack (**BB** or **PB**): Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to blunt or penetrating force
- **C**hest (**BC** or **PC**): Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to blunt or penetrating force
- **F**lail **C**hest (**FC**): Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations

- Tension **P**neum (**BP** or **PP**): Air enters the pleural space due to blunt or penetrating force, and creates pressure on chest organs. Signs and symptoms can include: SOB, tachypnea, decreased or absent lung sounds on one side, shock, neck vein distention, and/or tracheal deviation
- **A**bdomen (**BA** or **PA**): Injury to any of the abdominal quadrants, flanks, or pelvis due to blunt or penetrating force
- **D**iffuse Abd. Tender. (**BD**): Blunt force injury to the abdomen resulting in tenderness in two or more quadrants
- **G**enitals (**BG** or **PG**): Injury to the external reproductive structures due to blunt or penetrating force
- Buttoc**K**s (**BK** or **PK**): Injury to the buttocks due to blunt or penetrating force
- **E**xtremities (**BE** or **PE**): Injury or pain to the shoulders, arms, hands, legs, or feet due to blunt or penetrating force
- E**X**trem. above knee/elbow (**PX**): Penetrating force injury to an extremity, proximal to (above) the knee or elbow
- F**R**actures ≥ 2 long bones (**BR**): Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur)
- Amputat**I**on above wrist/ankle (**BI** or **PI**): Amputation proximal to (above) the wrist or ankle due to blunt or penetrating force
- Neur/**V**asc/Mangled (**BV** or **PV**): Injury to an extremity with neurological and/or vascular compromise, or that is crushed, degloved, or mangled due to blunt or penetrating force
- Minor **L**acerations (**BL** or **PL**): Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to blunt or penetrating force

Field Values – Medical Codes

- **A**bd/**P**elvic Pain (**AP**): Pain or discomfort in the abdomen or pelvic region not associated with trauma
- **A**gitated **D**elirium (**AD**): Acute onset of extreme agitation and combative or bizarre behavior that may be accompanied by paranoid delusions, hallucinations, aggression with unusual increase in human strength, and hyperthermia
- **A**llergic **R**eaction (**AR**): Acute onset of rash, hives, itching, redness of the skin, runny nose, facial and/or airway swelling, wheezing, shortness of breath, and/or abdominal pain in apparent reaction to ingestion or contact with a substance.
- **A**ltered **L**OC (**AL**): Any state of arousal other than normal, such as confusion, lethargy, combativeness, coma, etc., not associated with trauma
- **A**pneic **E**pisode (**AE**): Episode of cessation of respiration for a brief or prolonged period of time
- B**EH**avioral (**EH**): Abnormal behavior of apparent mental or emotional origin
- Bleeding **O**ther **S**ite (**OS**): Bleeding from a site not elsewhere listed that is not associated with trauma (e.g. dialysis shunt)
- Brief **R**esolved **U**nexplained Event (**RU**): An event occurring in an infant <1 year of age when the observer reports a sudden, brief, and now resolved episode of ≥1 of the following: cyanosis or pallor, absent, decreased, or irregular breathing, marked change in tone (hyper – or hypotonia), and altered level of responsiveness
- **C**ardiac **A**rrest (**CA**): Sudden cessation of cardiac output and effective circulation not associated with trauma

- **C**hest **P**ain (**CP**): Pain in the anterior chest occurring anywhere from the clavicles to the lower costal margins not associated with trauma
- **CH**oking/Airway Obstruction (**CH**): Acute onset of apnea, choking and/or difficulty breathing due to apparent partial or complete obstruction of the airway
- **C**ough/**C**ongestion (**CC**): Cough and/or congestion in the chest, nasal passages, or throat
- **D**evice (Medical) **C**omplaint (**DC**): Any complaint associated with a patient's existing medical device (e.g. G-tube, AICD, ventilator, etc.)
- **DI**zzy (**DI**): The patient complains of sensation of spinning or feeling off-balance. If associated with complaint of weakness, code both complaints
- **DO**A (**DO**): Patient is determined to be dead upon arrival of EMS, as per the Prehospital Care Manual
- **DY**srhythmia (**DY**): Cardiac monitor indicates an abnormal cardiac rhythm (SVT, VT, etc.)
- **FE**ver (**FE**): Patient exhibits or complains of an elevated body temperature
- **F**oreign **B**ody (**FB**): Patient complains of a foreign body anywhere in the body
- **GI** Bleed (**GI**): Signs or symptoms of gastrointestinal bleeding such as vomiting blood, coffee-ground emesis, melena, rectal bleeding, etc.
- **H**ead **P**ain (**HP**): Headache or any other type of head pain not associated with trauma
- **HY**poglycemia (**HY**): Patient is symptomatic and has a measured blood glucose level that is below normal
- **I**npatient **M**edical (**IM**): Interfacility transfer (IFT) of an admitted, ill (not injured) patient from one facility to an inpatient bed at another facility
- **LA**bor (**LA**): Patient is greater than 20 weeks pregnant, and experiencing signs or symptoms of labor such as uterine contractions, vaginal bleeding, spontaneous rupture of membranes, crowning, etc.
- **L**ocal **N**euro Signs (**LN**): Weakness, numbness, or paralysis of a body part or region – including slurred speech, facial droop, and/or expressive aphasia
- **N**ausea/**V**omiting (**NV**): Patient is vomiting, or complains of nausea and/or vomiting
- **N**ear **D**rowning (**ND**): Submersion causing water inhalation, unconsciousness, or death not associated with trauma
- **N**eck/**B**ack Pain (**NB**): Pain in any area from base of skull and the shoulders to the buttocks not associated with trauma
- **NeW**born (**NW**): Newborn infant delivered out of the hospital setting
- **N**o Medical **C**omplaint (**NC**): No complaint, or signs or symptoms of illness in a patient not involved in a traumatic event
- **NO**sebleed (**NO**): Bleeding from the nose, not associated with trauma
- **OB**stetrics (**OB**): Any complaints, signs, or symptoms which may be related to a known pregnancy (e.g., bleeding, abdominal pain/cramping, high blood pressure, edema, convulsions, severe headaches)
- **O**ther **P**ain (**OP**): Complaint of pain at a site not listed, and which is not associated with trauma (e.g. toothache, ear pain, etc.)
- **O**ver**D**ose (**OD**): Ingestion of or contact with a drug or other substance in quantities greater than recommended or generally practiced
- **P**alpitation**S** (**PS**): Sensation that the heartbeat is irregular or fast
- **PO**isoning (**PO**): Ingestion of or contact with a toxic substance
- **R**espiratory **A**rrest (**RA**): Sudden cessation of breathing not associated with trauma

- **SE**izure (**SE**): Convulsions or involuntary body movements or gaze (not associated with trauma), or signs, symptoms, or history of recent seizure
- **S**hortness of **B**reath (**SB**): Sensation of not being able to catch one's breath, and/or signs or symptoms of difficulty breathing such as gasping, wheezing, rapid respiratory rate, cyanosis, retractions, use of accessory muscles, etc.
- **SY**ncope (**SY**): Transient loss of consciousness, including sensation of "near syncope" when other associated symptoms such as weakness/dizziness do not apply
- **VA**ginal Bleeding (**VA**): Abnormal vaginal bleeding
- **WE**ak (**WE**): Patient complains of feeling weak, or exhibits signs or symptoms of decreased strength and/or muscle tone
- **OT**her (**OT**): Signs or symptoms not listed above, that are not associated with trauma

Additional Information

- **Required** field for all base hospital contacts
- First copy of Chief Complaint cannot be a null value
- Do not enter more than one copy of the same chief complaint
- If the patient has multiple complaints, enter in order of significance
- Two-letter codes for trauma chief complaints can be derived from the bolded, capitalized letters in the Trauma area of the Base Hospital Form
- Medical complaint codes are found on the back of pages 1 and 4 of the Base Hospital Form
- Medical complaints should not be documented with trauma complaints, unless it is suspected that a medical complaint preceded/caused the injury, or vice versa (e.g., chest pain/dizziness that caused an MVA, or seizure activity following a blow to the head.) Do not document a medical complaint such as "HP" (head pain) if the pain is due to a gunshot wound to the head – instead use only the trauma code of "PH."
- All trauma chief complaint codes also require a mechanism of injury

Uses

- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

LEVEL OF DISTRESS

Definition

Checkboxes indicating paramedics' impression of the level of discomfort or severity of illness of the patient, based on assessment of signs, symptoms, and complaints

Field Values

- **N**one: The patient appears well and has no acute signs or symptoms related to the incident. Advanced life support techniques and transportation may not be necessary
- Mil**D**: Indicates that the patient does not have a life-threatening problem. Advanced life support techniques and transportation may not be necessary
- **M**oderate: Patient may have a life-threatening problem, or the degree of patient discomfort is high. Advanced life support techniques, base hospital contact, and patient transportation are usually necessary
- **S**evere: Refers to a life-threatening condition. Advanced life support techniques, base hospital contact, and patient transportation are generally necessary

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

mLAPSS MET

Definition

Checkboxes indicating whether the patient met all Modified Los Angeles Prehospital Stroke Screen (mLAPSS) criteria

Field Values

- **Y**: Yes, patient met all mLAPSS criteria
- **N**: No, patient did not meet all mLAPSS criteria

Additional Information

- mLAPSS criteria include:
  - No history of seizures or epilepsy
  - Age ≥ 40
  - At baseline, patient is not wheelchair bound or bedridden
  - Blood glucose value between 60 and 400 mg/dL
  - Obvious asymmetry or unilateral weakness is observed in one or more of the following:
    - Facial Smile/Grimace
    - Grip
    - Arm Strength
- **Required** field for all base hospital contacts with a provider impression code of “STRK”, or a destination of Primary Stroke Center, “PSC”, or Comprehensive Stroke Center, “CSC”
- If mLAPSS performed, blood glucose value must also be documented
- Patients who meet mLAPSS criteria with LKWT < 24 hrs. should also have a LAMS performed and be transported, at a minimum, to the nearest available Primary Stroke Cener (PSC)
- Patients who do not meet mLAPSS criteria can still be transported to the nearest available PSC or Comprehensive Stroke Center (CSC) if the provider or base hospital still has a high suspicion of stroke or large vessel occlusion (LVO)

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Stroke Center Log
- Audio Records

LAST KNOWN WELL DATE

Definition

Date when the patient was last known to be well, symptom-free, or at baseline or usual state of health

Field Values

- Collected as MMDDYYYY

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “STRK”, a “Y” value for “mLAPSS Met”, or with a destination of “PSC” or “CSC” for suspected stroke
- If unknown, enter “Not Applicable” (F7)

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Stroke Center Log
- Audio Records

LAST KNOWN WELL TIME

Definition

Time of day when the patient was last known to be well, symptom-free, or at baseline or usual state of health

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “STRK”, a “Y” value for “mLAPSS Met”, or with a destination of “PSC” or “CSC” for suspected stroke
- If unknown, enter “Not Applicable” (F7)

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Stroke Center Log
- Audio Records

LAMS SCORE

Definition

Patient's total score for the Los Angeles Motor Scale (LAMS)

Field Values

- Numeric value range from 0 to 5

Additional Information

- LAMS includes 3 components:
  - Facial Droop
    - Absent=0
    - Present=1
  - Arm Drift
    - Absent=0
    - Drifts Down=1
    - Falls Rapidly=2
  - Grip Strength
    - Normal=0
    - Weak Grip=1
    - No Grip=2
- **Required** field for all base hospital contacts with a "Y" value for "mLAPSS Met"
- Patients with a LAMS score of < 4 should be transported to the nearest available PSC
- Patients with a LAMS score of ≥ 4 should be transported to the nearest available CSC
- LAMS can still be performed on patients who do not meet mLAPSS criteria if the provider or base hospital has a high suspicion of stroke or LVO

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Stroke Center Log
- Audio Records

PROTOCOL

Definition

Four- or five-digit code of the Medical Treatment Protocol (MTP) utilized by the EMS provider

Field Values

1201	Assessment		
1202	General Medical	**1202-P**	General Medical (Pediatric)
1203	Diabetic Emergencies	**1203-P**	Diabetic Emergencies (Pediatric)
1204	Fever/Sepsis	**1204-P**	Fever/Sepsis (Pediatric)
1205	GI/GU Emergencies	**1205-P**	GI/GU Emergencies (Pediatric)
1206	Medical Device Malfunction	**1206-P**	Medical Device Malfunction (Pediatric)
1207	Shock/Hypotension	**1207-P**	Shock/Hypotension (Pediatric)
1208	Agitated Delirium	**1208-P**	Agitated Delirium (Pediatric)
1209	Behavioral/Psychiatric Crisis	**1209-P**	Behavioral/Psychiatric Crisis (Pediatric)
1210	Cardiac Arrest	**1210-P**	Cardiac Arrest (Pediatric)
1211	Cardiac Chest Pain		
1212	Cardiac Dysrhythmia-Bradycardia	**1212-P**	Cardiac Dysrhythmia-Bradycardia (Pediatric)
1213	Cardiac Dysrhythmia-Tachycardia	**1213-P**	Cardiac Dysrhythmia-Tachycardia (Pediatric)
1214	Pulmonary Edema/CHF		
1215	Childbirth (Mother)	**1215-P**	Childbirth (Mother) (Pediatric)
		1216-P	Newborn/Neonatal Resuscitation (Pediatric)
1217	Pregnancy Complication	**1217-P**	Pregnancy Complication (Pediatric)
1218	Pregnancy/Labor	**1218-P**	Pregnancy/Labor (Pediatric)
1219	Allergy	**1219-P**	Allergy (Pediatric)
1220	Burns	**1220-P**	Burns (Pediatric)
1221	Electrocution	**1221-P**	Electrocution (Pediatric)
1222	Hyperthermia (Environmental)	**1222-P**	Hyperthermia (Environmental) (Pediatric)
1223	Hypothermia/Cold Injury	**1223-P**	Hypothermia/Cold Injury (Pediatric)
1224	Stings/Venomous Bites	**1224-P**	Stings/Venomous Bites (Pediatric)
1225	Submersion	**1225-P**	Submersion (Pediatric)
1226	ENT/Dental Emergencies	**1226-P**	ENT/Dental Emergencies (Pediatric)
1228	Eye Problem	**1228-P**	Eye Problem (Pediatric)
1229	ALOC	**1229-P**	ALOC (Pediatric)
1230	Dizziness/Vertigo	**1230-P**	Dizziness/Vertigo (Pediatric)
1231	Seizure	**1231-P**	Seizure (Pediatric)
1232	Stroke/CVA/TIA	**1232-P**	Stroke/CVA/TIA (Pediatric)
1233	Syncope/Near Syncope	**1233-P**	Syncope/Near Syncope (Pediatric)
1234	Airway Obstruction	**1234-P**	Airway Obstruction (Pediatric)

		1235-P	BRUE (Pediatric)
1236	Inhalation Injury	**1236-P**	Inhalation Injury (Pediatric)
1237	Respiratory Distress	**1237-P**	Respiratory Distress (Pediatric)
1238	Carbon Monoxide Exposure	**1238-P**	Carbon Monoxide Exposure (Pediatric)
1239	Dystonic Reaction	**1239-P**	Dystonic Reaction (Pediatric)
1240	HazMat	**1240-P**	HazMat (Pediatric)
1241	Overdose/Poisoning/Ingestion	**1241-P**	Overdose/Poisoning/Ingestion (Pediatric)
1242	Crush Injury/Syndrome	**1242-P**	Crush Injury/Syndrome (Pediatric)
1243	Traumatic Arrest	**1243-P**	Traumatic Arrest (Pediatric)
1244	Traumatic Injury	**1244-P**	Traumatic Injury (Pediatric)
1245	COVID		

Additional Information

- **Required** field for all base hospital contacts
- More than one protocol can be used
- Do not enter more than one copy of the same protocol number
- Protocol identified must correlate to the provider impression

Uses

- Allows for data sorting and tracking by protocol
- Assists with determination of appropriate treatment
- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- Audio Records

O/P,Q,R,S,T

Definition

Acronym used as a tool to assess and document the following symptom attributes:

- **O/P**: Onset/Provocation
- **Q**: Quality
- **R**: Region/Radiation/Relief
- **S**: Severity
- **T**: Time

Field Values

- Free text

Uses

- Prompts thorough assessment and documentation of patient's symptoms
- Assists with determination of appropriate treatment and transport

Data Source Hierarchy

- Base Hospital Form
- Audio Records

MEDICAL HX

Definition

Space to indicate previous medical problem(s) experienced by the patient, if applicable

Field Values

- Free text

Uses

- Prompts thorough assessment and documentation of patient's symptoms
- Assists with determination of appropriate treatment and transport

Data Source Hierarchy

- Base Hospital Form
- Audio Records

MEDICATIONS

Definition

Space to indicate medications currently being taken by the patient, if applicable

Field Values

- Free text

Additional Information

- Indicate patient compliance, if applicable
- Include nonprescription drugs and herbal supplements

Uses

- Assists with determination of appropriate treatment and transport

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ALLERGIES

Definition

Checkbox and space to indicate patient history of adverse reactions or allergies to medications or other substances, if applicable

Field Values

- Free text, or
- NKA: No known allergies checkbox

Additional Information

- If the patient has no known allergies, mark the “NKA” box
- Allergies to non-medication items may be listed if they are related to the current problem or potential treatments (e.g., adhesive tape, or latex)

Uses

- Patient safety

Data Source Hierarchy

- Base Hospital Form
- Audio Records

DNR/AHCD/POLST?

Definition

Checkbox indicating presence of a valid Do Not Resuscitate (DNR), Advance Healthcare Directive (AHCD), or Physician Order for Life Sustaining Treatment (POLST) form for the patient

Field Values

- **Y**: Yes
- **N**: No
- **U**: Unknown

Additional Information

- **Required** field for all base contacts with a provider impression code of “CANT”
- EMS personnel do not need to validate the authenticity of the document provided – should provide base hospital with the type of document and its contents

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PRIOR TO BASE MEDS

Definition

Checkboxes and spaces indicating medications and dosages administered prior to base contact, if applicable

Field Values

ADE	Adenosine	**KLC**	Ketorolac
ALB	Nebulized Albuterol	**MID**	Midazolam
AMI	Amiodarone	**NAR**	Narcan
ASA	Aspirin	**NTG**	Nitroglycerin
BIC	Sodium Bicarbonate	**OND**	Ondansetron
CAL	Calcium Chloride	**Morphine**	Morphine Sulfate
EPI	Epinephrine	**GLU/GLP**	Glucagon/Glucose Paste
FEN	Fentanyl	**D10**	10% Dextrose

Additional Information

- **Required** field for all base contacts with the following provider impressions:
  - ANPH
  - CANT
  - AGDE/PSYC (Midazolam given, also include route in narrative)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PRIOR TO BASE TXS

Definition

Checkboxes indicating treatments rendered prior to base contact, if applicable

Field Values

BMV	Bag-Mask Ventilation	**TC**P	Transcutaneous Pacing
CPAP	Continuous Positive Airway Pressure	**A**ED- **A**nalyzed	AED Analyzed Rhythm
ETT	Endotracheal Tube Intubation	**A**ED- **D**efibrillated	AED Defibrillated Patient
King	King Airway	Needle **TH**oracost.	Needle Thoracostomy
SMR	Spinal Motion Restriction	Tourniquet (**TK**)	Tourniquet
GLucometer	Glucometer Reading	**IV**/IO Fluid ____cc	IV/IO fluid amount in ccs
DEFibrillated X	Defibrillation & number of defibrillation attempts	**OT**her	Other Treatment Not Listed
CAR	Cardioversion		

Additional Information

- **Required** field for all base contacts with the following provider impressions:
  - ANPH
  - CANT
  - AGDE
- Checked Glucometer checkbox should be accompanied by the reading obtained
- Checked Defibrillated checkbox should be accompanied by the number of times defibrillation was performed
- Checked IV/IO Fluid checkbox should be accompanied by the number of ccs of fluid administered to the patient

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PHYSICAL

LOC

Definition

Checkboxes indicating the patient's initial level of consciousness

Field Values

- **A**lert: Patient is awake and responsive to the environment
- **O** X 3: Patient is oriented to person, time, and place
- **D**isoriented: Patient is not oriented to person, time, and/or place
- **C**ombative: Patient is physically resistant to interaction with on-scene personnel
- No**T** Alert: Patient is awake, but is drowsy or lethargic – may include intoxicated patients
- Nor**M**al for Patient: Patient's behavior, although not typical of most patients, is reported by family, caregivers, etc., to be the same as it was before the incident (e.g., patients who suffer from mental illness, dementia, developmental delays, etc.). Can also be used for infants and children who are age appropriate
- No **R**esponse: Patient is unresponsive to verbal and painful stimuli

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - AGDE
  - ANPH
  - BRUE
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 minutes)
- Mark all that apply

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

IUP_ WKS

Definition

Checkbox and space indicating the number of weeks of intrauterine pregnancy, if applicable

Additional Information

- **Required** field for all base contacts with the following provider impressions:
  - BRTH
  - PREG (if > 20 weeks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SEAC/SEPI (pregnant)
- Patients may only be able to provide the number of months, not weeks, of their pregnancy – in this case, pregnancies reported of greater than 4½ months can be assumed to be greater than 20 weeks
- Patients injured while at least 20 weeks pregnant meet trauma triage special considerations for transport to a trauma center

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

SUSPECTED DRUGS/ETOH?

Definition

Checkbox indicating that the situation, patient behavior, or statements made by the patient, family members or bystanders cause the paramedics to suspect that the patient's presentation may be related to alcohol and/or drug use

Additional Information

- **Required** field for all base contacts with the following provider impressions:
  - AGDE
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - ODPO (if signing out AMA)
  - SEAC/SEPI (pregnant or in status epilepticus)
- If checked, enter "E" into TEMIS on the Base 1 tab, in the 'Flag' field

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

EYE

Definition

Checkboxes indicating the Glasgow Coma Scale numerical value that corresponds to the patient's initial eye opening response to stimuli

Field Values

- **4**: Spontaneous – opens eyes spontaneously, no stimuli required
- **3**: To Verbal – opens eyes only when spoken to or asked
- **2**: To Pain – opens eyes only in response to noxious stimuli such as sternal rub or nail bed pressure
- **1**: None – patient does not open eyes in response to noxious stimuli

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - BRUE
  - STRK
  - BRTH
  - BABY
  - HOTN
  - AGDE
  - SHOK
  - ANPH
  - DYRX
  - CPSC/CPMI (pediatric patients)
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 minutes)
- GCS eye opening values are the same for adult and pediatric patients

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

VERBAL

Definition

Checkboxes indicating the Glasgow Coma Scale numerical value that corresponds to the patient's initial verbal response to stimuli

Field Values – Adult and Verbal Pediatric Patients

- **5**: Oriented x 3 – patient is oriented to person, time, and place
- **4**: Confused – patient may respond to questions coherently, but is disoriented or confused
- **3**: Inappropriate – random words or speech unrelated to questions or conversation
- **2**: Incomprehensible – makes incoherent sounds or moans only
- **1**: None – patient has no verbal response to noxious stimuli

Field Values – Infants and Toddlers

- **5**: Smiles and tracks objects, speech appropriate for age
- **4**: Cries but consolable, or confused
- **3**: Inconsistently consolable, or random words
- **2**: Moaning, incoherent sounds only
- **1**: No verbal response to noxious stimuli

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - BRUE
  - STRK
  - BRTH
  - BABY
  - HOTN
  - AGDE
  - SHOK
  - ANPH
  - DYRX
  - CPSC/CPMI (pediatric patients)
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 minutes)

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

MOTOR

Definition

Checkboxes indicating the Glasgow Coma Scale numerical value that corresponds to the patient's initial motor response to stimuli

Field Values

- **6**: Obedient – obeys verbal commands / spontaneous purposeful movement
- **5**: Purposeful – purposeful movement is made in response to noxious stimuli (e.g., attempts to push away or grab source of stimuli
- **4**: Withdrawal – withdraws body part from source of noxious stimuli
- **3**: Flexion –extremities move towards body core in response to noxious stimuli (decorticate posturing)
- **2**: Extension – extremities move away from body core in response to noxious stimuli (decerebrate posturing)
- **1**: None – patient has no motor response to noxious stimuli

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - BRUE
  - STRK
  - BRTH
  - BABY
  - HOTN
  - AGDE
  - SHOK
  - ANPH
  - DYRX
  - CPSC/CPMI (pediatric patients)
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 minutes)
- GCS motor values are the same for adult and pediatric patients

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TOTAL GCS

Definition

Sum of the initial three numerical values documented for each element of the Glasgow Coma Scale.

Field Values

- One- or two-digit numeric value between 3 and 15

Additional Information

- Maximum total score is 15, which is considered normal. Minimum score possible is 3, which may indicate severe or fatal brain injury
  - 3 to 8 may indicate severe brain injury
  - 9 to 13 may indicate moderate brain injury
  - 14 or 15 may indicate mild or no brain injury
- Space is provided for documentation of a repeat GCS, if applicable

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PUPILS

Definition

Checkboxes indicating findings from assessment of the patient's initial pupillary response to light

Field Values

- **P**ERL: Pupils are equal in size and react to light
- **U**nequal: Pupils are unequal in size
- P**I**npoint: Pupils are extremely constricted
- **F**ixed/Dilated: Pupils are dilated and do not react to light
- **C**ataracts: Cataracts in one or both eyes interfere with pupil exam
- **S**luggish: Pupils react to light slower than normal

Additional Information

- **Required** field for all base contacts with the following provider impressions:
  - STRK
  - AGDE (if able)
  - BRUE
  - CANT
  - ALOC (if persistent or unclear etiology)
  - PSYC (if able)
  - ODPO (if signing AMA)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if assessed)
  - TRMA (penetrating eye, CC=PH, CC=RR (if RR<10), or CC=14)

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

RESPIRATION

Definition

Checkboxes indicating findings from initial assessment of the patient's respiratory system

Field Values

- **C**lear: No abnormal sounds are heard on auscultation
- **N**ormal rate/effort: Breathing appears effortless and rate is within normal limits for patient
- Tidal Volume:
  - **N**: Normal depth of inspiration is observed
  - **+**: Increased depth of inspiration is observed
  - **-**: Decreased depth of inspiration is observed
- **W**heezes: Coarse, whistling sound heard on auscultation, associated with inspiration and/or expiration
- **R**ales: Rattling or crackling noises heard on auscultation, associated with inspiration
- R**H**onchi: Coarse, rattling or snoring sound heard on auscultation, associated with inspiration and/or expiration
- S**T**ridor: High-pitched, audible wheezing sound associated with inspiration and/or expiration
- **L**abored: Breathing appears to be difficult or requires extra effort
- **U**nequal: Chest rise or breath sounds diminished on one side
- **J**VD: Distended jugular veins are observed in the supine patient
- Accessory **M**uscle Use: Patient is using additional muscles to assist with difficulty breathing, such as those of the neck, shoulders, or abdomen
- **A**pnea: Patient is not breathing or stops breathing for periods of time
- **S**noring: Prolonged snorting sound/soft palate vibration that is audible during inspiration

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - BABY
  - DYRX
  - ANPH
  - BRUE
  - CANT
  - AGDE (tidal volume only)
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)

- ODPO (if signing AMA)
- PREG (if > 20 wks. with vaginal bleeding or delivery)
- LABR (if ≤ 14 years)
- SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
- SEAC/SEPI (pregnant or in status epilepticus)
- DRWN (if ALOC or needs decompression)
- TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

CAPNOGRAPHY

Definition

The numeric measurement of carbon dioxide present in exhaled air after endotracheal tube (ETT) or supraglottic airway (SGA) insertion, if applicable

Field Values

- Up to three-digit positive numeric values

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - CANT
  - STRK/HOTN/SHOK/CHOK/FAIL/SOBB/RDOT/SMOK/DRWN (if BMV used)

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

WAVEFORM?

Definition

Checkbox indicating whether a waveform is observed on the capnography tracing, if applicable

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - CANT
  - STRK/HOTN/SHOK/CHOK/FAIL/SOBB/RDOT/SMOK/DRWN (if BMV used)

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ADV AIRWAY

Definition

Checkboxes indicating initial assessment of findings after placement of an advanced airway, if applicable

Field Values

- BS after ETT/King: Mark appropriate box to indicate whether breath sounds are auscultated after placement of an endotracheal tube or King LTs-D
  - **Y**es
  - **N**o
- $ETCO_2$: Mark appropriate box to indicate presence or absence of CO_2 detected after placement of an endotracheal tube or King LTs-D:
  - **+**: present
  - **–**: absent

Additional Information

- **Required** field for all base hospital contacts with advanced airway placement in the field
- Associated provider impressions include:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CANT
  - CHOK (severe distress and/or respiratory arrest)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

SKIN

Definition

Checkboxes indicating findings from assessment of the patient's initial skin signs

Field Values

- **N**ML: All aspects of skin assessment (color, temperature, moisture, and appearance) are normal
- **P**ale: Skin appears abnormally pale, ashen, or gray
- Coo**L**/Cold: Skin feels cool or cold to touch
- **D**iaphoretic: Skin is sweaty or moist to touch
- **C**yanotic: Skin or lips appear blue
- **F**lushed: Skin appears red
- **H**ot: Skin feels warmer than normal or hot to touch
- Cap Refill No**R**mal: Capillary refill is less than or equal to 2 seconds
- Cap Refill D**E**layed: Capillary refill is greater than 2 seconds

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - BABY
  - DYRX
  - AGDE
  - ANPH
  - BRUE
  - CANT
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome or entrapment > 30 min)
- Capillary refill must be completed for all pediatric patients without a documented systolic blood pressure

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

GLUCOMETER

Definition

Numeric value of the patient's blood glucose measurement, if applicable

Field Values

- Up to three-digit positive numeric value
- #1: The initial blood glucose level
- #2: The second blood glucose level, if applicable

Additional Information

- **Required** field for all base hospital contacts if mLAPSS is performed, if Protocol 1232 is utilized, or for the following provider impressions:
  - STRK
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - ODPO (if signing AMA)
  - PREG/LABR (if history of diabetes or gestational diabetes)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (if CC=14)
  - HOTN/SHOK (if ALOC)
  - AGDE (if able)
- If equipment used yields an alpha reading indicating blood sugar is "LOW," enter the number "1"
- If equipment used yields an alpha reading indicating blood sugar is "HIGH," enter the number "999"

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

GLUCOMETER ORDERED?

Definition

Checkboxes indicating whether a glucometer was ordered by the base hospital, if applicable

Field Values

- **Y**: Yes
- **N**: No

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ECG

INITIAL RHYTHM

Definition

Two- or three-letter code indicating patient's initial cardiac rhythm from the cardiac monitor

Field Values

1HB	1st Degree Heart Block	**PEA**	Pulseless Electrical Activity
2HB	2nd Degree Heart Block	**PM**	Pacemaker Rhythm
3HB	3rd Degree Heart Block	**PST**	Paroxysmal Supraventricular Tachycardia
AFI	Atrial Fibrillation	**PVC**	Premature Ventricular Contraction
AFL	Atrial Flutter	**SA**	Sinus Arrhythmia
AGO	Agonal Rhythm	**SB**	Sinus Bradycardia
ASY	Asystole	**SR**	Sinus Rhythm
AVR	Accelerated Ventricular Rhythm	**ST**	Sinus Tachycardia
IV	Idioventricular Rhythm	**SVT**	Supraventricular Tachycardia
JR	Junctional Rhythm	**VF**	Ventricular Fibrillation
PAC	Premature Atrial Contraction	**VT**	Ventricular Tachycardia
PAT	Paroxysmal Atrial Tachycardia		

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - CANT
  - AGDE (if able)
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome or entrapment > 30 min)
- ECG codes are also found on the back of pages 1 and 4 of the Base Hospital Form
- Additional cardiac rhythm information can be documented in the Assessment section

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

12-LEAD ECG ORDERED?

Definition

Checkboxes indicating whether a 12-lead ECG was ordered by the base hospital, if applicable

Field Values

- **Y**: Yes
- **N**: No

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

12 LEAD ECG @

Definition

Time of day that a 12-lead ECG was performed, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts where a 12-lead ECG is performed
- 12-lead ECGs are required for the following provider impressions:
  - CPSC
  - CPMI
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, enter the 12-lead time from the STEMI ECG in this field
- If a poor quality ECG is repeated and the repeat ECG is of good quality, enter the time from the repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- 12-Lead ECG
- SRC Log
- Audio Records

EMS INTERPRETATION

Definition

Checkboxes indicating the EMS personnel's interpretation of the 12-lead ECG, if applicable

Field Values

- **N**orma**L**: EMS personnel interpretation indicates ECG is normal
- **AB**normal: EMS personnel interpretation indicates ECG is abnormal
- STE**MI**: EMS personnel interpretation indicates an ST-Elevation Myocardial Infarction, or manufacturer's equivalent

Additional Information

- **Required** field for all base hospital contacts where a 12-lead ECG is performed
- 12-lead ECGs are required for the following provider impressions:
  - CPSC
  - CPMI
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
- All 12-lead ECGs performed by EMS personnel need an EMS interpretation
- If EMS personnel interpretation indicates an ST-Elevation Myocardial Infarction the patient should be transported to the nearest available STEMI Receiving Center (SRC)
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, enter STEMI (two-letter code **MI**) in this field
- If a poor quality ECG is repeated and the repeat ECG is of good quality, enter the EMS interpretation of the repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- 12-Lead ECG
- SRC Log
- Audio Records

SOFTWARE INTERPRETATION

Definition

Checkboxes indicating the software's interpretation of the 12-lead ECG, if applicable

Field Values

- **N**orma**L**: Electronic interpretation indicates ECG is normal
- **AB**normal: Electronic interpretation indicates ECG is abnormal
- STE**MI**: Electronic interpretation indicates an ST-Elevation Myocardial Infarction

Additional Information

- **Required** field for all base hospital contacts where a 12-lead ECG is performed
- 12-lead ECGs are required for the following provider impressions:
  - CPSC
  - CPMI
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
- If electronic interpretation indicates an ST-Elevation Myocardial Infarction (or manufacturer's equivalent) the patient should be transported to the nearest available SRC
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, enter STEMI (two-letter code **MI**) in this field
- If a poor quality ECG is repeated and the repeat ECG is of good quality, enter the software interpretation of the repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- 12-Lead ECG
- SRC Log
- Audio Records

ARTIFACT?

Definition

Checkbox indicating whether artifact is observed on the 12-lead ECG tracing

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base hospital contacts where either the EMS or software interpretation of the 12-lead ECG indicates STEMI
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, use this field to indicate whether artifact is present
- Electronic artifact interferes with accurate ECG interpretation and may indicate need to repeat the ECG. If a poor quality ECG is repeated and the repeat ECG is of good quality, enter the quality of the repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- 12-Lead ECG
- Audio Records

WAVY BASELINE?

Definition

Checkbox indicating whether the baseline of the 12-lead ECG tracing moves with respiration

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base hospital contacts where either the EMS or software interpretation of the 12-lead ECG indicates STEMI
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, use this field to indicate whether a wavy baseline is present
- Wavy baseline can interfere with accurate ECG interpretation and may indicate need to reposition leads and repeat the ECG. If a poor quality ECG is repeated and the repeat ECG is of good quality, enter the quality of the repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- 12-Lead ECG
- Audio Records

PACED RHYTHM?

Definition

Checkbox indicating whether the 12-lead ECG or electronic interpretation indicates presence of a pacemaker-generated rhythm

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base hospital contacts where either the EMS or software interpretation of the 12-lead ECG indicates STEMI
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, use this field to indicate whether a paced rhythm is present
- Pacemakers can interfere with accurate ECG interpretation and must be reported

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- 12-Lead ECG
- Audio Records

ARREST

WITNESSED BY

Definition

Checkbox indicating witnesses to a patient's collapse due to cardiac arrest, if applicable

Field Values

- **C**itizen: Witnessed by a non-EMS person (e.g., law enforcement, nursing home personnel, bystanders, family, etc.)
- **E**MS: Witnessed by EMS personnel
- **N**one: Not witnessed

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of "CANT"

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

CPR BY

Definition

Checkbox indicating who performed CPR on a patient in cardiac arrest, if applicable

Field Values

- **C**itizen: CPR was initiated by a non-EMS person (e.g., law enforcement, nursing home personnel, bystanders, family, etc.)
- **E**MS: CPR was initiated by EMS
- **N**one: No CPR was initiated

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “CANT”

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ARREST TO CPR

Definition

Estimated time, in minutes, from the time of arrest to the time of initiation of CPR, if applicable

Field Values

- Collected as minutes

Additional Information

- **Required** field for all base hospital contacts with a witnessed, non-traumatic cardiac arrest/collapse
- If the arrest was unwitnessed, enter as “Not Applicable” (F7) in TEMIS
- If arrest was witnessed, but minutes from arrest to CPR is not provided, entered as “Not Documented” (F6) in TEMIS

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

RTN OF PULSE (ROSC)?

Definition

Checkbox indicating whether return of spontaneous circulation (ROSC) occurred, which is defined as restoration of a spontaneous perfusing rhythm. Signs of ROSC include: palpable pulse, breathing (more than occasional gasp), a measurable blood pressure and/or a sudden rise in capnography to a normal to high reading, if applicable

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “CANT”
- Document “Yes” even if the pulses are lost prior to arrival at the receiving facility
- Adult patients with non-traumatic cardiac arrest, with or without ROSC, that are transported by 9-1-1 should be transported to the nearest available SRC
- Patients in traumatic arrest that are transported by 9-1-1 should be transported in accordance with trauma destination policies

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

RTN OF PULSE (ROSC) @

Definition

Time of day when ROSC occurs, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “CANT” with ROSC in the field
- Document the time of day ROSC occurs, even if the pulses are lost prior to arrival at the receiving facility
- If patient does not have ROSC, enter as “Not Applicable” (F7) in TEMIS

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

RESUS D/C @

Definition

Time of day when resuscitative measures were terminated or patient was pronounced dead by the base hospital, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “CANT” where resuscitative measures were discontinued in the field
- If the patient was transported, enter as “Not Applicable” (F7) in TEMIS

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

RESUS D/C RHYTHM

Definition

Two- or three-letter code identifying the cardiac rhythm reported when resuscitative measures were terminated or patient was pronounced dead by the base hospital, if applicable

Field Values

AGO	Agonal	**PEA**	Pulseless Electrical Activity
ASY	Asystole	**VF**	Ventricular Fibrillation
IV	Idioventricular Rhythm		

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “CANT” where resuscitative measures were discontinued in the field
- If the patient was transported, enter as “Not Applicable” (F7) in TEMIS
- PEA is not a defined rhythm, but rather a finding that may be present at time of pronouncement or termination of resuscitative measures where electrical activity and/or rhythm seen on the cardiac monitor does not produce a palpable pulse or auscultatable heartbeat

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TOTAL MIN. EMS CPR

Definition

Time in minutes from the initiation of CPR by EMS personnel, to the time when resuscitative measures were terminated or patient was pronounced dead by the base hospital, if applicable

Field Values

- Collected in minutes
- Up to two-digit positive numeric value

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “CANT” where resuscitative measures were discontinued in the field
- If the patient was transported, enter as “Not Applicable” (F7) in TEMIS

Uses

- Assists with determination of appropriate treatment and transport
- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

VITALS & TXS

O2 @ ___ LPM

Definition

Numeric value of the number of liters per minute of oxygen delivered to the patient, if applicable

Field Values

- One- or two-digit positive numeric value between 2 and 15

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - CANT
  - CHOK (severe distress and/or respiratory arrest)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - DRWN (if ALOC or needs decompression)
  - STRK/HOTN/SHOK/CPSC or CPMI (pediatric patients)/ANPH/BRUE/ALOC (if persistent or unclear etiology)/DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)/TRMA – if O2 given
  - BRTH (if O2 Sat < 94%)
- The oxygen delivery device used must also be indicated

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TITRATED?

Definition

Checkbox indicating that the number of liters per minute of oxygen ordered by the base hospital was given in a range, to be adjusted to desired effect, if applicable

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- The oxygen delivery device used must also be indicated

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

VIA

Definition

Checkboxes indicating the type of device used to deliver oxygen to the patient, if applicable

Field Values

- **N**C: Nasal Cannula
- **M**ask: Oxygen mask
- **B**MV: Bag-Mask Ventilation
- Blo**W** By: Oxygen delivery device is used to “blow” oxygen towards patient’s face
- E**X**isting Trach.: Patient is being oxygenated/ventilated via an existing tracheostomy tube
- **E**TT: Endotracheal Tube
- **K**ing: King LTS-D (laryngeal tube suction device)
- **C**PAP: Continuous Positive Airway Pressure

Additional Information

- The number of liters per minute of oxygen delivered must also be indicated

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

IV

Definition

Checkboxes indicating type of IV access ordered for the patient

Field Values

- **S**L: Saline Lock device
- **F**C: Fluid challenge –specified amount of IV fluid is ordered to be given over a specified amount of time. In the space provided, enter the number of ccs of IV fluid ordered
- **N**ot Ordered: No IV ordered
- **I**V Unable: Paramedics were not able to successfully establish an IV
- **R**efused: Patient refused to allow paramedics to establish IV access
- I**O**: Intraosseous device
- Pree**X**isting IV: Upon arrival of EMS personnel, the patient already had IV access established (by a clinic, urgent care, doctor's office, etc.)

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (If ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)
- IV status is required for the following provider impressions:
  - BRTH
  - DYRX
  - AGDE
  - ANPH
  - CANT

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TRANSCUTANEOUS PACING @ mA

Definition

Numeric value of the electrical current strength in milliamps (mA) required to achieve capture (as evidenced by a palpable pulse that corresponds with the rhythm observed on the cardiac monitor) during transcutaneous pacing, if applicable

Field Values

- Up to three-digit positive numeric value

Additional Information

- **Required** field for base hospital contacts with the provider impression code of “DYSR” for symptomatic bradycardia

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

RATE

Definition

Numeric value of the rate of capture during transcutaneous pacing (as evidenced by a palpable pulse that corresponds with the rhythm observed on the cardiac monitor), if applicable

Field Values

- Up to three-digit positive numeric value

Additional Information

- **Required** field for base hospital contacts with the provider impression code of “DYSR” for symptomatic bradycardia

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

CAPTURE?

Definition

Checkbox indicating whether mechanical capture (as evidenced by a palpable pulse that corresponds with the rhythm observed on the cardiac monitor) was achieved during transcutaneous pacing, if applicable

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for base hospital contacts with the provider impression code of “DYSR” for symptomatic bradycardia

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

NEEDLE THORACOSTOMY

Definition

Checkbox indicating whether a needle thoracostomy was ordered, if applicable

Field Values

- Y: Yes
- N: No

Additional Information

- If “Yes”, enter “TH” into TEMIS on the Base 2 tab, in the ‘Treatments’ field

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

SPINAL MOTION RESTRICTION?

Definition

Checkbox indicating whether the patient was placed in spinal motion restriction

Field Values

- Y: Yes
- N: No

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “TRMA”
- If “Yes”, enter “SM” into TEMIS on the Base 2 tab, in the ‘Treatments’ field

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

CMS INTACT

Definition

Checkboxes indicating whether patient's circulation, motor function, and sensation (CMS) were intact before and after spinal motion restriction, if applicable

Field Values

- **I**ntact **B**efore: CMS intact in all extremities prior to spinal motion restriction
- **I**ntact **A**fter: CMS intact in all extremities after spinal motion restriction

Additional Information

- CMS should always be assessed before and after spinal motion restriction
- If checked, "IB" and "IA" should be entered into TEMIS on the Base 2 tab, in the 'Treatments' field

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

SMR REFUSED

Definition

Checkboxes indicating that spinal motion restriction was refused by the patient, if applicable

Field Values

- Y: Yes
- N: No

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “TRMA”
- If “Yes”, enter “SR” into TEMIS on the Base 2 tab, in the ‘Treatments’ field

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TOURNIQUET

Definition

Checkbox indicating that a tourniquet (commercial) was applied to control extremity bleeding, if applicable

Additional Information

- If checked, “TK” should be entered into TEMIS on the Base 2 tab, in the ‘Treatments’ field

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TIME

Definition

Time of day that corresponds to the adjacent vital signs, ECG, and treatments fields

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- May write “PTC” if event occurred prior to base contact – enter as “Not Documented” (F6) in TEMIS
- Time on radio console should only be used if vital signs are repeated during the base contact. Time base contact was initiated should not be used as the time for vital signs obtained prior to base contact

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

B/P

Definition

Numeric values of the patient's systolic and/or diastolic blood pressure

Field Values

- Up to three-digit positive numeric value
- Documented as numeric systolic value/numeric diastolic value

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - DYRX
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)
- If the blood pressure is palpated, write "P" for the diastolic value – enter as "Not Documented" (F6) in TEMIS
- If patient is in cardiac arrest, systolic and diastolic values should be documented as "0"

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PULSE

Definition

Numeric value of the patient's palpated pulse rate

Field Values

- Up to three-digit positive numeric value

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - DYRX
  - BABY
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)
- Measured in beats palpated per minute
- If the cardiac monitor shows a rhythm that does not produce signs of perfusion, rate should be documented as "0"
- Do not enter the pulse rate associated with CPR, if CPR is in progress, rate should be documented as "0"

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

RR

Definition

Numeric values of the patient's initial, unassisted respiratory rate

Field Values

- Up to three-digit positive numeric value

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - DYRX
  - BABY
  - AGDE
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)
- Measured in breaths per minute
- If patient requires mechanical assistance, then only the unassisted rate, not the assisted rate, should be documented

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

O2 SAT

Definition

Numeric value of the patient's oxygen saturation in the prehospital setting

Field Values

- Up to three-digit percentage from 0 to 100

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - DYRX
  - BABY
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PAIN

Definition

Numeric value indicating the patient's subjective pain level

Field Values

- Up to two-digit value from 0 to 10

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - PREG (if 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)
- Pain level should be assessed whenever trauma or pain is the provider impression, a mechanism of injury exists, and before and after administration of pain medication

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

CO2

Definition

Numeric value indicating the concentration of carbon dioxide measured by capnography, if applicable

Field Values

- Up to three-digit positive numeric value

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - CANT
  - RARF
  - HOTN, SHOK, FAIL (VAD malfunction) – if BMV used

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ECG

Definition

Two- or three-letter code indicating the patient's subsequent rhythm(s) on the cardiac monitor, if applicable

Field Values

1HB	1st Degree Heart Block	**PEA**	Pulseless Electrical Activity
2HB	2nd Degree Heart Block	**PM**	Pacemaker Rhythm
3HB	3rd Degree Heart Block	**PST**	Paroxysmal Supraventricular Tachycardia
AFI	Atrial Fibrillation	**PVC**	Premature Ventricular Contraction
AFL	Atrial Flutter	**SA**	Sinus Arrhythmia
AGO	Agonal Rhythm	**SB**	Sinus Bradycardia
ASY	Asystole	**SR**	Sinus Rhythm
AVR	Accelerated Ventricular Rhythm	**ST**	Sinus Tachycardia
IV	Idioventricular Rhythm	**SVT**	Supraventricular Tachycardia
JR	Junctional Rhythm	**VF**	Ventricular Fibrillation
PAC	Premature Atrial Contraction	**VT**	Ventricular Tachycardia
PAT	Paroxysmal Atrial Tachycardia		

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - TRMA (crush syndrome or entrapment > 30 min) PRN
- Cardiac rhythm should be assessed and documented any time a change is noted, or after any cardiac-related treatments

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

DRUG/DEFIB

Definition

Space for documenting defibrillation/cardioversion and medication codes ordered by the base hospital

Field Values

ADE	Adenosine	**EPI**	Epinephrine
ALB	Nebulized Albuterol	**FEN**	Fentanyl
AMI	Amiodarone	**GLP**	Glucose Paste
ASA	Aspirin	**GLU**	Glucagon
ATR	Atropine	**KLC**	Ketorolac
BEN	Benadryl	**LID**	Lidocaine
BIC	Sodium Bicarbonate	**MID**	Midazolam
CAL	Calcium Chloride	**Morphine**	Morphine Sulfate
CAR	Cardioversion	**NAR**	Narcan
COL	Glucola	**NTG**	Nitroglycerin
D10	D10W	**OND**	Ondansetron
DEF	Defibrillation	**P-EPI**	Push-dose Epinephrine

Additional Information

- **Required** field for all base hospital contacts in which medications are ordered
- Each drug/defibrillation ordered should be written on a separate line so that the dose and results can be clearly documented
- Mark the “Refused” box if the patient refused medication administration and enter “Yes” into TEMIS on the Base 2 tab in the ‘Refused’ field
- Mark the “PRN” box if the medication and/or defibrillation are ordered as PRN and enter “Yes” into TEMIS on the Base 2 tab in the ‘PRN’ field

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

SEDs IN PAST 48 HRS

Definition

Checkboxes indicating whether the patient has used sexually enhancing drugs (SEDs) within the past 48 hours

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions, if Nitroglycerin is ordered:
  - CPSC
  - CPMI
- Use of SEDs must be assessed prior to ordering nitroglycerin for any patient, regardless of gender

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

DOSE

Definition

Space for numeric value of joules of defibrillation/cardioversion and/or dose of medication ordered by the base hospital

Field Values

- Up to three-digit positive numeric value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

DOSE UNITS

Definition

The units of medication to be administered or the amount of energy to be delivered for defibrillation/cardioversion

Field Values

- **gm:** grams
- **J:** joules
- **mcg:** micrograms
- **mEq:** milliequivalent
- **mg:** milligrams
- **mL:** milliliter

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ROUTE

Definition

Two-letter code indicating the route of medication administration ordered by the base hospital, if applicable

Field Values

- **IV**: Intravenous
- **IO**: Intraosseous
- **SQ**: Subcutaneous
- **IM**: Intramuscular
- **PO**: By Mouth (per os)/oral disintegrating tablets (ODT)
- **IN**: Intranasal/Inhalation (e.g., HHN)
- **SL**: Sublingual

Additional Information

- Drug route codes are listed on the back of pages 1 and 4 of the Base Hospital Form

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TX/RESULTS

Definition

Space for brief documentation of results of medications given or treatments rendered

Field Values

- "**-**": Deteriorated
- "**+**": Improved
- "**N**": No Change
- **0:** 0
- **1:** 1
- **2:** 2
- **3:** 3
- **4:** 4
- **5:** 5
- **6:** 6
- **7:** 7
- **8:** 8
- **9:** 9
- **10:** 10

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TRAUMA

TRAUMA

Definition

Checkboxes indicating the nature and location of the patient's injury, if applicable

Field Values

- **N**o **A**pparent Injury (**NA**): No complaint, or signs or symptoms of injury following a traumatic event
- **BU**rns/Elec. Shock (**BU**): Thermal or chemical burn, or electric shock
- **C**ritical **B**urn (**CB**): Patients ≥ 15 years of age with 2nd (partial thickness) and 3rd (full thickness) degree burns involving ≥ 20% Total Body Surface Area (TBSA) **OR** patients ≤ 14 years of age with 2nd and 3rd degree burns involving ≥10% TBSA
- SBP <**90** (<70 if under 1y) (**90**): Systolic blood pressure less than 90mmHg in a patient greater than one year of age (or systolic blood pressure less than 70mmHg in a patient less than one year of age) following a traumatic event
- **RR** <10/>29 (<20 if <1y) (**RR**): A sustained respiratory rate greater than 29 breaths/minute, or respiratory rate of less than 10 breaths/minute (or less than 20 breaths/minute in a patient less than one year of age), following a traumatic event
- **S**usp. Pelvic F**X** (**SX**): Suspected pelvic fracture, excluding isolated hip fractures from a ground level fall
- **S**pinal **C**ord Injury (**SC**): Suspected spinal cord injury, or presence of weakness/paralysis/paresthesia following a traumatic event
- **I**npatient **T**rauma (**IT**): Interfacility transfer (IFT) of an admitted, injured patient from one facility to an inpatient bed at another facility, excluding ER to ER transfers
- **U**ncontrolled **B**leeding (**UB**): Extremity bleeding requiring use of a tourniquet or hemostatic dressing
- **T**rauma Arrest (**BT** or **PT**): Cessation of cardiac output and effective circulation due to blunt or penetrating force
- **H**ead (**BH** or **PH**): Injury to the head or skull in the area from above the eyebrows to behind the ears, due to blunt or penetrating force. This code can also be applied in association with facial injuries when it is likely that the brain is involved
- GCS ≤**14** (**14**): Blunt force head injury associated with a Glasgow Coma Scale score of less than or equal to 14
- **F**ace/mouth (**BF** or **PF**): Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to blunt or penetrating force
- **N**eck (**BN** or **PN**): Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to blunt or penetrating force
- **B**ack (**BB** or **PB**): Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to blunt or penetrating force
- **C**hest (**BC** or **PC**): Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to blunt or penetrating force
- **F**lail **C**hest (**FC**): Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations

- Tension **P**neum (**BP** or **PP**): Air enters the pleural space due to blunt or penetrating force, and creates pressure on chest organs. Signs and symptoms can include: SOB, tachypnea, decreased or absent lung sounds on one side, shock, neck vein distention, and/or tracheal deviation
- **A**bdomen (**BA** or **PA**): Injury to any of the abdominal quadrants, flanks, or pelvis due to blunt or penetrating force
- **D**iffuse Abd. Tender. (**BD**): Blunt force injury to the abdomen resulting in tenderness in two or more quadrants
- **G**enitals (**BG** or **PG**): Injury to the external reproductive structures due to blunt or penetrating force
- Buttoc**K**s (**BK** or **PK**): Injury to the buttocks due to blunt or penetrating force
- **E**xtremities (**BE** or **PE**): Injury or pain to the shoulders, arms, hands, legs, or feet due to blunt or penetrating force
- E**X**tr ↑ knee/elbow (**PX**): Penetrating force injury to an extremity, proximal to (above) the knee or elbow
- F**R**actures ≥ 2 long bones (**BR**): Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur.
- Amputat**I**on ↑ wrist/ankle (**BI** or **PI**): Amputation proximal to (above) the wrist or ankle due to blunt or penetrating force
- Neur/**V**asc/Mangled (**BV** or **PV**): Injury to an extremity with neurological and/or vascular compromise, or that is crushed, degloved, or mangled due to blunt or penetrating force
- Minor **L**acerations (**BL** or **PL**): Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to blunt or penetrating force

Additional Information

- **Required** field for all base hospital contacts where patient is reported to be injured or a mechanism of injury is present
- Check all that apply - if the patient has multiple complaints, enter chief complaints in order of significance
- Codes beginning with “B” or “P” indicate Blunt or Penetrating injury, respectively
- Two-letter codes can be derived from the bolded, capitalized letters of the trauma descriptions – trauma codes should be listed in order of significance in the “Chief Complaint Code” fields
- Patients with injuries documented must also have a trauma provider impression code and mechanism of injury documented – and vice versa
- Medical complaints should not be documented with trauma complaints, unless it is suspected that a medical complaint preceded/caused the injury, or vice versa (e.g., chest pain/dizziness that caused an MVA, or seizure activity following a blow to the head.) Do not document a medical complaint such as “HP” (head pain) if the pain is due to a gunshot wound to the head – instead use only the trauma code of “PH.”
- Penetrating injuries may be inflicted by dull objects travelling at high velocity (e.g., bullets), sharp objects with a low velocity, or from a slashing or puncturing force
- Blunt injuries occur from forces that do not typically penetrate the skin (e.g., baseball bat) though lacerations may be caused by the tearing/crushing force of a blunt object or broken bones
- Injury descriptions listed in **red** meet trauma triage criteria for transport to the nearest available trauma center

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

MECHANISM OF INJURY

Definition

Checkboxes indicating how the patient was injured

Field Values

- Protective Devices – **H**e**L**met (**HL**): The patient riding on an unenclosed motorized vehicle/bicycle was wearing a helmet at the time of impact
- Protective Devices – **S**eat **B**elt (**SB**): Patient was wearing a seat belt at the time of impact
- Protective Devices – **A**ir**B**ag (**AB**): Airbag deployed at the time of impact and directly protected the patient
- Protective Devices – **C**ar **S**eat/Booster (**CS**): The patient was riding in a car seat or booster at the time of impact
- **E**nclosed **V**eh. (**EV**): Patient involved in collision while in an enclosed vehicle, such as an automobile, bus, or other enclosed motorized vehicle
- **Ej**ected (**EJ**): Patient was fully or partially thrown from a vehicle, including convertibles and trucks. Does **NOT** include motorcycles
- **EX**tricated @ (**EX**): Time of day that the patient was removed from the vehicle when use of a pneumatic tool was required
- **P**assenger **S**pace Intrusion (**PS**): Intrusion of greater than 12 inches into an occupied passenger space of a motor vehicle, or greater than 18 inches into an unoccupied passenger space – check this box if amount of intrusion is not known or not specified by paramedics
- **12**: Intrusion of greater than 12 inches into an occupied passenger space of a motor vehicle – check this box when amount of intrusion is specified by paramedics
- **18:** Intrusion of greater than 18 inches into an unoccupied passenger space – check this box when amount of intrusion is specified by paramedics
- **S**urvived **F**atal Accident (**SF**): The patient survived a collision where another person **in the same vehicle** was fatally injured
- Impact > **20**mph Unenclosed (**20**): An unenclosed transport crash (e.g., skateboard, bicycle, horse, etc.) hit an object with an estimated impact greater than 20mph
- Ped/Bike: **R**unover/**T**hrown/>20mph (**RT**): Pedestrian, bicyclist, or motorcyclist was struck by an automobile and is thrown, run over, or has an estimated impact of greater than 20mph
- **P**ed/**B**ike < 20mph (**PB**): Pedestrian, bicyclist, or motorcyclist struck by a motorized vehicle, who is NOT thrown or run over, at an estimated impact of less than 20 mph
- **M**otorcycle/**M**oped (**MM**): The patient was riding on a motorcycle or moped at the time of impact
- **TA**ser (**TA**): Injury due to the deployment of a conducted electrical weapon (CEW), e.g. Taser®
- **SP**orts/Rec (**SP**): Any injury that occurs during a sporting or recreational athletic activity, such as aerobics, football, jogging, etc.
- **AS**sault (**AS**): Patient was physically assaulted (kicked, punched, strangled, etc.) by means other than stabbing or shooting
- **ST**abbing (**ST**): A sharp or piercing instrument (e.g. knife, broken glass, ice pick, etc.) caused an injury which penetrated the skin

- **GS**W (**GS**): Gunshot Wound - injury was caused by discharge of a gun (accidental or intentional)
- **AN**imal Bite (**AN**): The teeth of a human, reptile, dog, cat, or other animal inflicted an injury, whether or not the skin was punctured. Insect bites and bee stings are not considered animal bites, and should be coded as "Other"
- **CR**ush (**CR**): Injury sustained as the result of external pressure being placed on body parts between two opposing forces
- **T**elemetry **D**ata (**TD**): Vehicle telemetry data is encountered that is consistent with high risk of serious injury
- **S**pecial **C**onsid. (**SC**): Injured patients that meet Special Considerations due to age greater than 55 years, pregnancy > 20 weeks, age greater than 65 years with a systolic BP of less than 110mmHg, or patients in blunt traumatic full arrest who, based on a paramedic's thorough patient assessment, believes transport is indicated
- **A**nti**C**oagulants (**AC**): Injured patient is on anticoagulant medication other than aspirin (excludes minor extremity injury)
- **FA**ll (**FA**): Any injury resulting from a fall from any height
- **>15** ft. (>10 ft. Peds) (**15**): A vertical, uninterrupted fall of greater than 15 feet for an adult or greater than 10 feet or 3 times the height of the child for a pediatric patient. This mechanism is a subcategory of "Fall." This does not include falling down stairs or rolling down a sloping cliff.
- **S**elf-Inflict'd/**A**ccid. (**SA**): The injury appears to have been accidentally caused by the patient
- **S**elf-Inflict'd/**I**ntent. (**SI**): The injury appears to have been intentionally caused by the patient
- **E**lectrical **S**hock (**ES**): Passage of an electrical current through body tissue because of contact with an electrical source
- **T**hermal **B**urn (**TB**): Burn caused by heat
- **H**azmat **E**xposure (**HE**): The patient was exposed to toxic or poisonous agents, such as liquids, gases, powders, foams, or radioactive material
- **W**ork- **R**elated (**WR**): Injury occurred while patient was working, and may be covered by Worker's Compensation
- **UN**known (**UN**): The cause or mechanism of injury is unknown
- **OT**her (**OT**): A cause of injury or uncontrolled bleeding that does not fall into any of the existing categories

Additional Information

- **Required** field for all base hospital contacts where patient is reported to be injured
- Check all that apply
- Two-letter codes can be derived from the bolded, capitalized letters of the mechanisms of injury (MOI) – MOIs should be listed in order of significance in the MOI code fields
- Patients with a MOI documented must also have a trauma chief complaint and provider impression code documented – and vice versa
- MOIs listed in **red** on the base hospital form meet trauma triage criteria for transport to the nearest available trauma center
- MOIs listed in **blue** on the base hospital form meet trauma guidelines for transport to the nearest available trauma center - strong consideration should be given to a trauma center destination

- Do not enter more than one copy of the same mechanism of injury
- Cannot have a MOI that is only Anticoagulants (AC) or Special Considerations (SC), an additional mechanism of injury must be entered
- If patient has uncontrolled bleeding due to a non-traumatic reason, such as a medical device failure (e.g. AV shunt bleeding), mechanism of injury should be documented as “OT”

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TRANSPORT

CODE ALL OPTIONS

Definition

Three-letter code for each of the potential patient destination facilities

Field Values

LOS ANGELES COUNTY 9-1-1 RECEIVING			
ACH	Alhambra Hospital Medical Center	KFW	Kaiser Foundation Hospital – West Los Angeles
AHM	Catalina Island Medical Center	LBM	MemorialCare Long Beach Medical Center
AMH	Methodist Hospital of Southern California	LCH	Palmdale Regional Medical Center
AVH	Antelope Valley Hospital	LCM	Providence Little Co. of Mary M.C. - Torrance
BEV	Beverly Hospital	MCP	Mission Community Hospital
BMC	Southern California Hospital at Culver City	MHG	Memorial Hospital of Gardena
CAL	Dignity Health - California Hospital Medical Center	MID	Olympia Medical Center
CHH	Children's Hospital Los Angeles	MLK	Martin Luther King Jr. Community Hospital
CHP	Community Hospital of Huntington Park	MPH	Monterey Park Hospital
CNT	Centinela Hospital Medical Center	NOR	LA Community Hospital at Norwalk
CPM	Coast Plaza Hospital	NRH	Dignity Health - Northridge Hospital Medical Center
CSM	Cedars-Sinai Medical Center	OVM	LAC Olive View-UCLA Medical Center
DCH	PIH Health Downey Hospital	PAC	Pacifica Hospital of the Valley
DFM	Cedars-Sinai Marina Del Rey Hospital	PIH	PIH Health Whittier Hospital
DHL	Lakewood Regional Medical Center	PLB	College Medical Center
ELA	East Los Angeles Doctors Hospital	PVC	Pomona Valley Hospital Medical Center
ENH	Encino Hospital Medical Center	QOA	Hollywood Presbyterian Medical Center
FPH	Emanate Health Foothill Presbyterian Hospital	QVH	Emanate Health Queen of the Valley Hospital
GAR	Garfield Medical Center	SDC	San Dimas Community Hospital
GEM	Greater El Monte Community Hospital	SFM	St. Francis Medical Center
GMH	Dignity Health - Glendale Memorial Hospital and Health Center	SGC	San Gabriel Valley Medical Center
GSH	PIH Health Good Samaritan Hospital	SJH	Providence Saint John's Health Center
GWT	Adventist Health - Glendale	SJS	Providence Saint Joseph Medical Center
HCH	Providence Holy Cross Medical Center	SMH	Santa Monica-UCLA Medical Center
HGH	LAC Harbor-UCLA Medical Center	SMM	Dignity Health - St. Mary Medical Center
HMH	Huntington Hospital	SOC	Sherman Oaks Hospital
HMN	Henry Mayo Newhall Hospital	SPP	Providence Little Co. of Mary M.C. - San Pedro
HWH	West Hills Hospital & Medical Center	TOR	Torrance Memorial Medical Center
ICH	Emanate Health Inter-Community Hospital	TRM	Providence Cedars-Sinai Tarzana Medical Center
KFA	Kaiser Foundation Hospital- Baldwin Park	UCL	Ronald Reagan UCLA Medical Center
KFB	Kaiser Foundation Hospital - Downey	USC	LAC+USC Medical Center
KFH	Kaiser Foundation Hospital – South Bay	VHH	USC Verdugo Hills Hospital
KFL	Kaiser Foundation Hospital – Sunset (Los Angeles)	VPH	Valley Presbyterian Hospital
KFO	Kaiser Foundation Hospital – Woodland Hills	WHH	Whittier Hospital Medical Center
KFP	Kaiser Foundation Hospital – Panorama City	WMH	Adventist Health - White Memorial

ORANGE COUNTY 9-1-1 RECEIVING			
ANH	Anaheim Regional Medical Center	LPI	La Palma Intercommunity Hospital
CHO	Children's Hospital of Orange County	PLH	Placentia Linda Hospital
KHA	Kaiser Foundation Hospital - Anaheim	SJD	St. Jude Medical Center
KFI	Kaiser Foundation Hospital - Irvine	UCI	UCI Medical Center
LAG	Los Alamitos Medical Center	WMC	Western Medical Center Santa Ana
SAN BERNARDINO COUNTY 9-1-1 RECEIVING			
ARM	Arrowhead Regional Medical Center	KFN	Kaiser Foundation Hospital - Ontario
CHI	Chino Valley Medical Center	LLU	Loma Linda University Medical Center
DHM	Montclair Hospital Medical Center	SAC	San Antonio Community Hospital
KFF	Kaiser Foundation Hospital - Fontana		
OTHER COUNTY 9-1-1 RECEIVING			
LRR	Los Robles Hospital & Med Ctr (Ventura)	SJO	St. John Regional Medical Center (Ventura)
SIM	Simi Valley Hospital (Ventura)	RCC	Ridgecrest Regional Hospital (Kern)
NON-BASIC HOSPITALS			
LBV	Long Beach VA	WVA	Wadsworth VA Medical Center

Additional Information

- **Required** field for all base hospital contacts
- A three-letter code for MAR must be documented for all patients, regardless of age
- A three-letter code for EDAP must be documented for all pediatric patients of less than or equal to 14 years of age

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

CHECK ACTUAL DESTINATION

Definition

Checkboxes indicating actual destination of patient

Field Values

- **M**AR: Most Accessible Receiving facility (licensed basic emergency department) that can be reached in the shortest amount of time. Depending on traffic and geography, this may not necessarily be the closest facility. Must be documented for all patients regardless of actual destination
- **E**DAP: Most accessible Emergency Department Approved for Pediatrics approved to receive patients of less than or equal to 14 years of age. Must be documented for all pediatric patients regardless of actual destination
- **T**C: Most accessible Trauma Center approved to receive critically injured patients. Must be documented for all adult patients that meet criteria, guidelines, or special considerations for transport to a TC, regardless of actual destination
- PT**C**: Most accessible Pediatric Trauma Center approved to receive critically injured pediatric patients of less than or equal to 14 years of age. Must be documented for all pediatric patients that meet criteria, guidelines, or special considerations for transport to a PTC, regardless of actual destination
- **P**MC: Most accessible Pediatric Medical Center approved to receive critically ill pediatric patients of less than or equal to 14 years of age. Must be documented for all pediatric patients that meet guidelines for transport to a PMC, regardless of actual destination
- **S**TEMI Receiving Center: Most accessible ST-Elevation Myocardial Infarction (STEMI) Receiving Center approved to receive patients with a suspected STEMI, or transported patients in non-traumatic cardiac arrest, regardless of ROSC. Must be documented for all patients who meet criteria for transport to a SRC, regardless of actual destination
- Prim**A**ry Stroke Center: Most accessible Primary Stroke Center approved to receive suspected stroke patients or patients with a positive mLAPSS exam. Must be documented for all patients who meet guidelines for transport to a PSC, regardless of actual destination
- Comprehensive Stro**K**e Center: Most accessible Comprehensive Stroke Center approved to receive patients with a positive mLAPSS exam and a LAMS score ≥ 4
- Peri**N**atal: Most accessible Perinatal Center approved to receive patients greater than or equal to 20 weeks pregnant. Must be documented for all patients who meet guidelines for transport to a Perinatal Center
- SA**R**T: Most accessible Sexual Assault Response Team facility approved to receive actual or suspected victims of sexual assault/abuse. Must be documented for patients who meet guidelines for transport to a SART Center
- **O**ther: Licensed basic emergency department that may also appropriately receive the patient in addition to those listed above. Most frequently used when the closest facility is inaccessible (e.g., is requesting diversion.) The reason for using “Other” as a destination must be documented in the “Destination Rationale” section

Additional Information

- **Required** field for all base hospital contacts where patients are transported by EMS personnel
- Check only the actual patient destination
- If more than one specialty center option applies, choose the option most applicable to the patient's presentation (e.g., pregnant pediatric patients, or sexually assaulted trauma patients)

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ETA

Definition

Estimated time of arrival (ETA) for each of the possible destinations documented

Field Values

- Collected as minutes

Additional Information

- **Required** field for each possible destination documented

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio records

CHECK ONE

Definition

Checkboxes indicating whether a specialty center destination was indicated for the patient

Field Values

- **S**pecialty Center **N**ot Required: Patient does not meet guidelines or criteria for transport to a specialty center
- **S**pecialty Center **R**equired/Criteria Met: Patient meets criteria or requirements for transport to a specialty center
- **S**pecialty Center **G**uidelines Met: Patient meets guidelines for transport to a specialty center

Additional Information

- **Required** field for all base hospital contacts
- Check one box only
- If more than one specialty center option applies, choose the option most applicable to the patient's presentation
- If patient meeting requirements, criteria, or guidelines is not transported to the closest specialty center, must indicate reason in the "Destination Rationale" section

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

DESTINATION RATIONALE

Definition

Checkboxes indicating the reason that the patient was transported to a facility other than the most accessible receiving facility or specialty center, if applicable

Field Values

- **E**D Saturation: Most accessible receiving facility or EDAP has requested diversion due to emergency department saturation
- Internal **D**isaster: Most accessible receiving facility or specialty center is closed due to internal disaster such as fire, flood, etc.
- **C**T Diversion: CT scanner at the most accessible receiving facility or specialty center is non-functioning
- I**F**T: Patient is being transferred from one facility to another
- SC Diversion **T**C/PTC: Most accessible TC/PTC is closed due to encumberment of the trauma team or OR
- SC Diversion **P**MC: Most accessible PMC is closed due to lack of critical equipment
- SC Diversion STE**MI**: Most accessible SRC is closed due to Cath lab encumberment or malfunction
- SC Diversion Prim**A**ry Stroke Center: Most accessible primary stroke center is closed when there is no means (CT scan or MRI) to perform diagnostic brain imaging
- SC Diversion Comprehensive Stro**K**e Center: Most accessible comprehensive stroke center is closed due to stroke resource encumberment or critical equipment/interventional radiology room unavailability
- SC Not Accessib**L**e: Specialty center not accessible due to transport time constraints or geography
- Jud**G**ment (Provider/Base): Patient does not meet specialty center criteria, requirements, or guidelines, but is transported to a specialty center based on Base or the Provider judgment; or, meets, but is not transported to a specialty center
- Shared Am**B**ulance: The patient does not meet specialty center criteria, requirements, or guidelines, but is transported to SC because they are sharing an ambulance with a patient who does meet SC criteria/guidelines/requirements
- Minimal In**J**uries: Patient meets trauma criteria or guidelines but is determined to have only minimal injuries which do not warrant transport to a specialty center
- **U**nmanageable Airway: Patient meets specialty center criteria, requirements, or guidelines, but airway cannot be adequately managed due to injury or illness, and patient's life may be jeopardized by transport to any facility but the closest
- **R**equested By: Patient is transported to a facility other than the most accessible receiving facility or specialty center by request from the patient, a family member, patient's private medical doctor (PMD), or other authorized person
- **O**ther: Patient is transported a facility other than the most accessible receiving facility or specialty center for any reason other than those listed above (use space below to briefly document reason)

Additional Information

- **Required** field for all base hospital contacts where the patient is transported to “Other,” (not the closest receiving facility or specialty center)

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PT TRANSPORTED VIA

Definition

Checkboxes indicating the type of transport unit used

Field Values

- **A**LS: An Advanced Life Support Transport unit in which patient was accompanied by at least one paramedic
- **B**LS: Basic Life Support Transport unit in which patient was accompanied by EMTs only
- **O**ther: Type of transport not listed above
- **H**elicopter ETA: Helicopter transport requested – indicate ETA of helicopter to scene
- **N**o Transport: Patient was not transported (must indicate reason for no transport in the "Reason for No Transport" field)

Additional Information

- **Required** field for all base hospital contacts

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

REASON FOR NO TRANSPORT

Definition

Checkboxes indicating reason why patient was not transported, if applicable

Field Values

- **A**MA: Patient refuses transport
- **D**OA: Patient is determined to be dead on arrival as per Prehospital Care Manual
- **U**nwarranted: Patient's condition does not require transportation to a hospital
- **T**.O.R.: Resuscitative measures are terminated by EMS personnel
- **P**ronounced by: Enter the name of the physician who pronounced the patient dead, if applicable
- **O**ther: Mark this box if the patient was not transported due a reason not listed above

Additional Information

- **Required** field for all base hospital contacts where the patient is not transported

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TIME CLEAR

Definition

The time of day that paramedic contact with the base hospital ends

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts
- Use one timepiece throughout call to ensure accurate time intervals

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form

TIME RECEIVING HOSPITAL NOTIFIED

Definition

The time of day that the receiving hospital was notified of an arriving patient

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Use one timepiece throughout call to ensure accurate time intervals

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form

NAME OF PERSON NOTIFIED

Definition

Space to document the name of the person at the receiving facility notified of an arriving patient

Field Values

- Free text

Additional Information

- Not necessary if the base hospital is the receiving facility
- Document whatever name is given – e.g., “Mary” or “Dr. Jones”

Uses

- Provides documentation of communication

Data Source Hierarchy

- Base Hospital Form
- Audio Records

MICN/PHYSICIAN

Definition

Signature and certification/identification number of the MICN and/or Base physician contacted

Field Values

- Free text

Additional Information

- **Required** field for all base hospital contacts
- First initial and last name is sufficient for signature
- If **both** a MICN and a physician handle the call, or if a physician is consulted during the run, both names and numbers are documented
- Physician #s are created by each base hospital and are not assigned by Lancet Technology by ESO Solutions or the EMS Agency

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log

TRANSPORT SCENARIOS

Specialty Care Center Not Required

70 y/o female, short of breath x 2 hours, speaking in full sentences, in mild/moderate distress:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☒ **M**AR	PIH	7
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

DISPO

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking MAR
- Check Specialty Center: Not Required (SOB as described meets no specialty center criteria or guidelines as per Reference No. 502)
- Destination Rationale is left blank, as there is no deviation from destination principles

Pediatric: EDAP Required

2 y/o male, febrile, witnessed tonic/clonic seizure. No signs of trauma, GCS is improving:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	LCM	5
☒ **E**DAP (age ≤14)	LCM	5
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

DISPO

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☒ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and EDAP
- Indicate the actual destination by checking EDAP
- Check Specialty Center: Required/Criteria Met (EDAP specialty center is required for patients 14yrs of age or younger, as per Reference No. 510)
- Destination Rationale is left blank, as there is no deviation from destination principles

Pediatric: PTC Criteria

5 y/o female, fell from a second story window, GCS 4-6-5. CC = BB, PI=TRMA, MOIs = FA and 15:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	KFL	4
☐ **E**DAP (age ≤14)	UCL	7
☐ **T**C	| |	
☒ PT**C** (trauma, age ≤14)	UCL	7
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☒ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PTC
- Indicate the actual destination by checking PTC
- Check Specialty Center: Required/Criteria Met (MOI=15 is criteria for transport to a PTC as per Reference No. 506)
- Destination Rationale is left blank, as there is no deviation from destination principles

Pediatric: PTC Guideline

7 y/o female, auto vs bicycle at less than 5mph, wearing a helmet. CC = BE, PI=TRMA, MOIs = PB and HL:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	HEV	2
☒ **E**DAP (age ≤14)	AMH	8
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	USC	20
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☐ **R**equired/Criteria Met
☒ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☒ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PTC
- Indicate the actual destination by checking EDAP
- Check Specialty Center: Guidelines Met (Auto vs Ped/Bike at less than 20mph [PB] is a guideline for transport to a PTC as per Reference No. 506.) If more than one specialty center option applies, choose the option most applicable to the patient's presentation.
- Check Destination Rationale: Minimal Injuries, as this is the reason patient was not transported to the PTC

Pediatric: PMC Guideline

4 y/o male, witnessed tonic/clonic seizure. No signs of trauma, but GCS is not improving:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	SJS	8
☐ **E**DAP (age ≤14)	SJS	8
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☒ **P**MC (medical, age ≤14)	CHH	15
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☐ **R**equired/Criteria Met
☒ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PMC
- Indicate the actual destination by checking PMC
- Check Specialty Center: Guidelines Met (persistent altered mental status is a guideline for transport to a PMC, as per Reference No. 510)
- Destination Rationale is left blank, as there is no deviation from destination principles

Perinatal: Specialty Center Guidelines Met

24 y/o female, 22 weeks pregnant with abdominal cramping x 2 hours. No signs of trauma:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	ENH	5
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☒ Peri**N**atal (≥20wks pregnancy)	NRH	15
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☐ **R**equired/Criteria Met
☒ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and Perinatal Center
- Indicate the actual destination by checking Perinatal Center
- Check Specialty Center: Guidelines Met (patients who are at least 20 weeks pregnant and who appear to have a pregnancy related complaint or complication is a guideline for transport to a Perinatal, as per Reference No. 511)
- Destination Rationale is left blank, as there is no deviation from destination principles

PSC: Specialty Center Guidelines Met

50 y/o male, L facial droop x 1 hr., positive mLAPSS exam, LAMS Score = 2:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ **M**AR	HGH	5
	☐ **E**DAP (age ≤14)	| |	
	☐ **T**C	| |	
	☐ PT**C** (trauma, age ≤14)	| |	
	☐ **P**MC (medical, age ≤14)	| |	
	☐ **S**TEMI Receiving Center	| |	
	☒ Prim**A**ry Stroke Center	TOR	12
	☐ Comprehensive Stro**K**e Center	| |	
	☐ Peri**N**atal (≥20wks pregnancy)	| |	
	☐ SA**R**T	| |	
	☐ **O**ther	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☐ **N**ot Required ☐ **R**equired/Criteria Met ☒ **G**uidelines Met	☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center ☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway ☐ **R**equested by: ☐ **O**ther:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ **A**LS ☐ **B**LS ☐ **O**ther ☐ **H**elicopter-ETA: ____ ☐ **N**o Transport	☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther ☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and PSC
- Indicate the actual destination by checking PSC
- Check Specialty Center: Guidelines Met (positive mLAPSS exam & a LAMS score of 3 or less meets guidelines for transport to a PSC as per Reference No. 521)
- Destination Rationale is left blank, as there is no deviation from destination principles

CSC: Specialty Center Guidelines Met

62 y/o female, R arm drift and no R grip strength x 3 hours, positive mLAPSS exam, LAMS Score = 4:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ **M**AR	QOA	6
	☐ **E**DAP (age ≤14)	| |	
	☐ **T**C	| |	
	☐ PT**C** (trauma, age ≤14)	| |	
	☐ **P**MC (medical, age ≤14)	| |	
	☐ **S**TEMI Receiving Center	| |	
	☐ Prim**A**ry Stroke Center	QOA	6
	☒ Comprehensive Stro**K**e Center	KFL	9
	☐ Peri**N**atal (≥20wks pregnancy)	| |	
	☐ SA**R**T	| |	
	☐ **O**ther	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☐ **N**ot Required ☐ **R**equired/Criteria Met ☒ **G**uidelines Met	☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center ☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway ☐ **R**equested by: ☐ **O**ther:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ **A**LS ☐ **B**LS ☐ **O**ther ☐ **H**elicopter-ETA: ____ ☐ **N**o Transport	☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther ☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, PSC, and CSC
- Indicate the actual destination by checking CSC
- Check Specialty Center: Guidelines Met (positive mLAPSS exam & a LAMS Score of 4 or greater meets guidelines for transport to a CSC as per Reference No. 521)
- Destination Rationale is left blank, as there is no deviation from destination principles

Specialty Center Judgment

66 y/o male, crushing chest pain and SOB for 15min, Abnormal ECG, hx of MI, DM, HTN. MICN directs transport to SRC due to high suspicion of MI:

TRANSPORT

CODE all options, **CHECK** actual destination:	CODE	ETA
☐ **M**AR	CNT	5
☐ **E**DAP (age ≤14)	| | |	
☐ **T**C	| | |	
☐ PT**C** (trauma, age ≤14)	| | |	
☐ **P**MC (medical, age ≤14)	| | |	
☒ **S**TEMI Receiving Center	UCL	15
☐ Prim**A**ry Stroke Center	| | |	
☐ Comprehensive Stro**K**e Center	| | |	
☐ Peri**N**atal (≥20wks pregnancy)	| | |	
☐ SA**R**T	| | |	
☐ **O**ther	| | |	
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☒ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and SRC
- Indicate the actual destination by checking SRC
- Check Specialty Center Not Required
- Check Destination Rationale: Judgment

9-1-1 Interfacility Transfer

66 y/o male presented by private auto to a non-SRC facility, c/o crushing chest pain and SOB for 15min, ECG in ED shows STEMI. 9-1-1 is activated for rapid transport to closest SRC:

TRANSPORT

CODE all options, **CHECK** actual destination:	CODE	ETA
☐ **M**AR	CNT	0
☐ **E**DAP (age ≤14)	| | |	
☐ **T**C	| | |	
☐ PT**C** (trauma, age ≤14)	| | |	
☐ **P**MC (medical, age ≤14)	| | |	
☒ **S**TEMI Receiving Center	UCL	15
☐ Prim**A**ry Stroke Center	| | |	
☐ Comprehensive Stro**K**e Center	| | |	
☐ Peri**N**atal (≥20wks pregnancy)	| | |	
☐ SA**R**T	| | |	
☐ **O**ther	| | |	
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☒ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- *(Run Type at top right of form is IFT)*
- Enter hospital codes for the closest MAR and SRC
- Indicate the actual destination by checking SRC
- Destination Rationale is left blank, as there is no deviation from destination principles

ED Saturation

55 y/o female, c/o abdominal pain x 3 days. The closest facility has requested diversion due to ED saturation:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	NRH	5
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☒ **O**ther	MCP	12
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☒ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination
- Check Specialty Center: Not Required (AP as described meets no specialty center criteria or guidelines as per Reference No. 502)
- Destination Rationale is ED Saturation, as patient did not go to the MAR due to diversion request for ED Saturation

Specialty Center Diversion

17 y/o male, single stab wound to LUQ, CC = PA, PI=TRMA, MOI = ST. Most accessible trauma center has requested trauma diversion:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	MHG	8
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	SFM	10
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☒ **O**ther	HGH	15
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☒ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☒ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and TC
- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination
- Check Specialty Center: Required/Criteria Met (PA is criteria for transport to a TC as per Reference No. 506)
- Destination Rationale is SC Diversion: TC/PTC, as patient was not transported to closest TC due to diversion request

Conducted Electrical Weapon (CEW, aka Taser®)

34 y/o male, status post deployment of a conducted electrical weapon (CEW, trade name Taser®) dart to chest, minor laceration to chest, no other trauma or associated signs or symptoms. CC = PL, PI=TRMA, MOI = TA:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☒ **M**AR	PLB	3
	☐ **E**DAP (age ≤14)	| |	
	☐ **T**C	LBM	5
	☐ PT**C** (trauma, age ≤14)	| |	
	☐ **P**MC (medical, age ≤14)	| |	
	☐ **S**TEMI Receiving Center	| |	
	☐ Prim**A**ry Stroke Center	| |	
	☐ Comprehensive Stro**K**e Center	| |	
	☐ Peri**N**atal (≥20wks pregnancy)	| |	
	☐ SA**R**T	| |	
	☐ **O**ther	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☐ **A**LS ☒ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and TC
- Indicate the actual destination by checking MAR
- Check Specialty Center: Not Required (PL is not a criteria or guideline for transport to a TC as per Reference No. 506)
- Destination Rationale is left blank, as there is no deviation from destination principles

Minimal Injuries

17 y/o male, status post leg struck by car in parking lot, minor abrasion to foot, no deformity, no other trauma or associated signs or symptoms. CC = BE, PI=TRMA, MOI = PB:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☒ **M**AR	BMC	3
	☐ **E**DAP (age ≤14)	| |	
	☐ **T**C	UCL	15
	☐ PT**C** (trauma, age ≤14)	| |	
	☐ **P**MC (medical, age ≤14)	| |	
	☐ **S**TEMI Receiving Center	| |	
	☐ Prim**A**ry Stroke Center	| |	
	☐ Comprehensive Stro**K**e Center	| |	
	☐ Peri**N**atal (≥20wks pregnancy)	| |	
	☐ SA**R**T	| |	
	☐ **O**ther	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☐ **R**equired/Criteria Met
☒ **G**uidelines Met

PT TRANSPORTED VIA:

☐ **A**LS ☒ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☒ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and TC
- Indicate the actual destination by checking MAR
- Check Specialty Center: Guidelines Met (PB is a guideline for transport to a TC as per Reference No. 506)
- Destination Rationale is Minimal Injuries, as patient was not transported to the closest TC, due to minimal injuries

Shared Ambulance

8 y/o male, restrained rear passenger in a moderate speed MVA. Pt. c/o LLE pain only, no deformity noted. CC = BE, PI=TRMA, MOIs = EV, SB. Patient's mother was unrestrained driver and meets trauma criteria:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	DCH	3
☐ **E**DAP (age ≤14)	DCH	3
☐ **T**C	|__|__|	
☐ PT**C** (trauma, age ≤14)	LBM	20
☐ **P**MC (medical, age ≤14)	|__|__|	
☐ **S**TEMI Receiving Center	|__|__|	
☐ Prim**A**ry Stroke Center	|__|__|	
☐ Comprehensive Stro**K**e Center	|__|__|	
☐ Peri**N**atal (≥20wks pregnancy)	|__|__|	
☐ SA**R**T	|__|__|	
☒ **O**ther	SFM	8
Time Clear	|__|__|__|	
Time Receiving Hospital Notified	|__|__|__|	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
- ☐ **N**ot Required
- ☒ **R**equired/Criteria Met
- ☐ **G**uidelines Met

PT TRANSPORTED VIA:

- ☒ **A**LS ☐ **B**LS ☐ **O**ther
- ☐ **H**elicopter-ETA: ____
- ☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☒ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PTC
- Indicate the child's actual destination by checking Other (patient not transported to MAR, EDAP, or PTC) and enter the hospital code for the actual destination
- Check Specialty Center: Required/Criteria Met (EDAP, PMC or PTC is required for all pediatric patients)
- Destination Rationale is Shared Ambulance, as patient was transported to Other

Patient Request

82 y/o male, c/o cough and fever x 3 days, vital signs stable. Pt. is a Kaiser member and is requesting transport to Kaiser – which is accessible but not the MAR:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	DCH	3
☐ **E**DAP (age ≤14)	|__|__|	
☐ **T**C	|__|__|	
☐ PT**C** (trauma, age ≤14)	|__|__|	
☐ **P**MC (medical, age ≤14)	|__|__|	
☐ **S**TEMI Receiving Center	|__|__|	
☐ Prim**A**ry Stroke Center	|__|__|	
☐ Comprehensive Stro**K**e Center	|__|__|	
☐ Peri**N**atal (≥20wks pregnancy)	|__|__|	
☐ SA**R**T	|__|__|	
☒ **O**ther	KFB	6
Time Clear	|__|__|__|	
Time Receiving Hospital Notified	|__|__|__|	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
- ☒ **N**ot Required
- ☐ **R**equired/Criteria Met
- ☐ **G**uidelines Met

PT TRANSPORTED VIA:

- ☒ **A**LS ☐ **B**LS ☐ **O**ther
- ☐ **H**elicopter-ETA: ____
- ☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☒ **R**equested by: *Patient* ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination
- Check Specialty Center: Not Required (CC and FE, as described meet no specialty center criteria or guidelines as per Reference No. 502)
- Destination Rationale is Requested by: Patient, as patient did not go to the MAR due to patient request

AMA

36 y/o female, history of diabetes, status post altered mental status resolved with paramedic administration of D10 for blood glucose of 40. GCS now 4-6-5, vital signs stable. The patient has decided she does not want to be transported and wishes to sign out against medical advice:

TRANSPORT

CODE all options, CHECK actual destination:	CODE	ETA
☐ **M**AR	AMH	3
☐ **E**DAP (age ≤14)	| | |	
☐ **T**C	| | |	
☐ PT**C** (trauma, age ≤14)	| | |	
☐ **P**MC (medical, age ≤14)	| | |	
☐ **S**TEMI Receiving Center	| | |	
☐ Prim**A**ry Stroke Center	| | |	
☐ Comprehensive Stro**K**e Center	| | |	
☐ Peri**N**atal (≥20wks pregnancy)	| | |	
☐ SA**R**T	| | |	
☐ **O**ther	| | |	
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☐ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☒ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☒ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- No actual destination is indicated, as patient is not transported
- Check Specialty Center Not Required (adult with status post medical ALOC does not meet Specialty Center criteria or guidelines)
- Destination Rationale is left blank, as there is no destination
- Reason for No Transport is AMA

Hyperbaric Chamber

25 y/o male, status post scuba diving accident, GCS 2-1-4, no signs of trauma, helicopter transport 5 minutes away:

TRANSPORT

CODE all options, CHECK actual destination:	CODE	ETA
☐ **M**AR	AHM	3
☐ **E**DAP (age ≤14)	| | |	
☐ **T**C	| | |	
☐ PT**C** (trauma, age ≤14)	| | |	
☐ **P**MC (medical, age ≤14)	| | |	
☐ **S**TEMI Receiving Center	| | |	
☐ Prim**A**ry Stroke Center	| | |	
☐ Comprehensive Stro**K**e Center	| | |	
☐ Peri**N**atal (≥20wks pregnancy)	| | |	
☐ SA**R**T	| | |	
☒ **O**ther	USC	25
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☐ **A**LS ☐ **B**LS ☐ **O**ther
☒ **H**elicopter-ETA: 5
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☒ **O**ther: HBC

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination
- Check Specialty Center Not Required (an unconscious patient status post scuba diving accident shall go immediately to a MAC-listed hyperbaric chamber, as per Reference No. 518)
- Destination Rationale is Other: HBC (hyperbaric chamber)

DISPO (IF BASE IS RECEIVING HOSPITAL)

ED DIAGNOSES

Definition

ED diagnosis as documented by a physician

Field Values

- ICD-10 codes

Additional Information

- **Required** field for all patients for whom the base hospital contacted is also the receiving facility
- May be completed later by personnel other than the MICN/MD initially contacted or notified

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- ED Records
- Other Hospital Records

HOSPITAL DISPO

Definition

Checkboxes indicating the emergency department disposition of patients transported to the base hospital

Field Values

- **D**ischarged: Patient was discharged home from the emergency department
- **W**ard: Patient was admitted to a medical/surgical ward
- **S**tepdown: Patient was admitted to a Direct Observation Unit (DOU), Stepdown Unit, or Telemetry Unit
- **I**CU: Patient was admitted to an Intensive Care Unit or Cardiac Care Unit
- Obser**V**ation: Observation unit (provides < 24 hour stays)
- O**R**: Patient was transferred directly from the emergency department to the operating room
- **C**ath Lab: Patient was transferred directly from the emergency department to the Cardiac Catheterization Lab
- I**N**terventional Radiology: Patient was transferred directly from the emergency department to Interventional Radiology for embolization, angiography, etc.
- **E**xpired in ED: Patient died in the emergency department
- O**B**: Patient was admitted to an obstetrics department
- **T**ransferred to: Patient was transferred directly from the emergency department to another healthcare facility – document the name of the facility or the three-letter hospital code in the space provided
- **O**ther: Patient disposition other than those listed above – document disposition on the line provided

Additional Information

- **Required** field for all patients for whom the base hospital contacted is also the receiving facility
- May be completed later by personnel other than the MICN/MD initially contacted or notified

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- ED Records
- Other Hospital Records

DISPO COMM.

Definition

Space provided for documentation of any additional information related to the patient's disposition from the ED

Field Values

- Free text

Uses

- Additional documentation, if needed

Data Source Hierarchy

- Base Hospital Form

XFER FROM ED TO

Definition

Three-letter code for the facility the patient was transferred to, if applicable

Field Values

LOS ANGELES COUNTY 9-1-1 RECEIVING			
ACH	Alhambra Hospital Medical Center	KFW	Kaiser Foundation Hospital – West Los Angeles
AHM	Catalina Island Medical Center	LBM	MemorialCare Long Beach Medical Center
AMH	Methodist Hospital of Southern California	LCH	Palmdale Regional Medical Center
AVH	Antelope Valley Hospital	LCM	Providence Little Co. of Mary M.C. - Torrance
BEV	Beverly Hospital	MCP	Mission Community Hospital
BMC	Southern California Hospital at Culver City	MHG	Memorial Hospital of Gardena
CAL	Dignity Health - California Hospital Medical Center	MID	Olympia Medical Center
CHH	Children's Hospital Los Angeles	MLK	Martin Luther King Jr. Community Hospital
CHP	Community Hospital of Huntington Park	MPH	Monterey Park Hospital
CNT	Centinela Hospital Medical Center	NOR	LA Community Hospital at Norwalk
CPM	Coast Plaza Hospital	NRH	Dignity Health - Northridge Hospital Medical Center
CSM	Cedars-Sinai Medical Center	OVM	LAC Olive View-UCLA Medical Center
DCH	PIH Health Downey Hospital	PAC	Pacifica Hospital of the Valley
DFM	Cedars-Sinai Marina Del Rey Hospital	PIH	PIH Health Whittier Hospital
DHL	Lakewood Regional Medical Center	PLB	College Medical Center
ELA	East Los Angeles Doctors Hospital	PVC	Pomona Valley Hospital Medical Center
ENH	Encino Hospital Medical Center	QOA	Hollywood Presbyterian Medical Center
FPH	Emanate Health Foothill Presbyterian Hospital	QVH	Emanate Health Queen of the Valley Hospital
GAR	Garfield Medical Center	SDC	San Dimas Community Hospital
GEM	Greater El Monte Community Hospital	SFM	St. Francis Medical Center
GMH	Dignity Health - Glendale Memorial Hospital and Health Center	SGC	San Gabriel Valley Medical Center
GSH	PIH Health Good Samaritan Hospital	SJH	Providence Saint John's Health Center
GWT	Adventist Health - Glendale	SJS	Providence Saint Joseph Medical Center
HCH	Providence Holy Cross Medical Center	SMH	Santa Monica-UCLA Medical Center
HGH	LAC Harbor-UCLA Medical Center	SMM	Dignity Health - St. Mary Medical Center
HMH	Huntington Hospital	SOC	Sherman Oaks Hospital
HMN	Henry Mayo Newhall Hospital	SPP	Providence Little Co. of Mary M.C. - San Pedro
HWH	West Hills Hospital & Medical Center	TOR	Torrance Memorial Medical Center
ICH	Emanate Health Inter-Community Hospital	TRM	Providence Cedars-Sinai Tarzana Medical Center
KFA	Kaiser Foundation Hospital- Baldwin Park	UCL	Ronald Reagan UCLA Medical Center
KFB	Kaiser Foundation Hospital - Downey	USC	LAC+USC Medical Center
KFH	Kaiser Foundation Hospital – South Bay	VHH	USC Verdugo Hills Hospital
KFL	Kaiser Foundation Hospital – Sunset (Los Angeles)	VPH	Valley Presbyterian Hospital
KFO	Kaiser Foundation Hospital – Woodland Hills	WHH	Whittier Hospital Medical Center
KFP	Kaiser Foundation Hospital – Panorama City	WMH	Adventist Health - White Memorial

ORANGE COUNTY 9-1-1 RECEIVING			
ANH	Anaheim Regional Medical Center	LPI	La Palma Intercommunity Hospital
CHO	Children's Hospital of Orange County	PLH	Placentia Linda Hospital
FHP	Fountain Valley Regional Hospital and Medical Center	SJD	St. Jude Medical Center
KHA	Kaiser Foundation Hospital - Anaheim	UCI	UCI Medical Center
KFI	Kaiser Foundation Hospital - Irvine	WMC	Western Medical Center Santa Ana
LAG	Los Alamitos Medical Center		
SAN BERNARDINO COUNTY 9-1-1 RECEIVING			
ARM	Arrowhead Regional Medical Center	KFN	Kaiser Foundation Hospital - Ontario
CHI	Chino Valley Medical Center	LLU	Loma Linda University Medical Center
DHM	Montclair Hospital Medical Center	SAC	San Antonio Community Hospital
KFF	Kaiser Foundation Hospital - Fontana		
OTHER COUNTY 9-1-1 RECEIVING			
LRR	Los Robles Hospital & Med Ctr (Ventura)	SJO	St. John Regional Medical Center (Ventura)
SIM	Simi Valley Hospital (Ventura)	RCC	Ridgecrest Regional Hospital (Kern)
NON-BASIC HOSPITALS			
LBV	Long Beach VA	WVA	Wadsworth VA Medical Center

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- ED Records
- Other Hospital Records

LAST

Definition

Patient's last name

Field Values

- Free text

Additional Information

- May be completed later by personnel other than the MICN/MD initially contacted
- Should contain letters only

Uses

- Patient identification
- Link between other databases

Data Source Hierarchy

- Base Hospital Form
- ED Records
- Other Hospital Records

FIRST

Definition

Patient's first name

Field Values

- Free text

Additional Information

- May be completed later by personnel other than the MICN/MD initially contacted
- Should contain letters only

Uses

- Patient identification
- Link between other databases

Data Source Hierarchy

- Base Hospital Form
- ED Records
- Other Hospital Records

M.I.

Definition

Patient's middle initial

Field Values

- Free text

Additional Information

- May be completed later by personnel other than the MICN/MD initially contacted
- Should contain letters only

Uses

- Patient identification
- Link between other databases

Data Source Hierarchy

- Base Hospital Form
- ED Records
- Other Hospital Records

MEDICAL RECORD

Definition

Patient's medical record #

Field Values

- Free text

Additional Information

- May be completed later by personnel other than the MICN/MD initially contacted
- Should contain numbers only

Uses

- Patient identification
- Link between other databases

Data Source Hierarchy

- Base Hospital Form
- ED Records
- Other Hospital Records

APPENDIX

BASE DATA ENTRY GUIDE

Scenario	Who	Enter Record Into TEMIS?
Public provider calls the receiving base hospital with a **NOTIFICATION** call for a patient who is en route to their facility	Base hospital receiving both the notification call and the patient	Yes
Public provider erroneously calls assigned base hospital with a **NOTIFICATION** call for a patient who is not being transported to the assigned base hospital; receiving facility is another base hospital	Assigned base hospital who took notification call but is not receiving the patient	No
	Base hospital receiving both the notification call from the assigned base hospital and the patient	Yes
Public provider erroneously calls assigned base hospital with a **NOTIFICATION** call for a patient who is not being transported to the assigned base hospital; receiving facility is not a base hospital but is a specialty center	Assigned base hospital that took notification call but is not receiving the patient	No
	Receiving facility (that is a specialty center) that is receiving both the notification call from the assigned base hospital and the patient	No; however, record will be entered, including outcome, into the specialty center database if patient meets inclusion criteria
Public provider erroneously calls assigned base hospital with a **NOTIFICATION** call for a patient who is not being transported to the assigned base hospital; receiving facility is not a base hospital or specialty center	Assigned base hospital that took notification call but is not receiving the patient	No
	Receiving facility (not a base or specialty center) that is receiving both the notification call from the assigned base hospital and the patient	No (eventual goal is to get outcomes from all receiving facilities into TEMIS)
Public provider calls their assigned base hospital with a ***BASE CONTACT***, the assigned base hospital is also the facility receiving the patient	Assigned base hospital	Yes (with outcome)
Public provider calls their assigned base hospital with a ***BASE CONTACT*** but the assigned base hospital is not the receiving facility, the receiving facility is another base hospital. The assigned base hospital notifies the other base hospital receiving the patient that a patient is en route to their facility	Assigned base hospital that received the base contact	Yes (no outcome)
	Base hospital receiving both the notification from the assigned base hospital and the patient	No

REQUIRED DATA FIELDS FOR ALL BASE HOSPITAL CONTACTS

Gen Info:

- Log and Sequence #
- Date and Time of Call
- Provider Code and Unit #
- Age, Age Units, and Gender of Patient
- Pediatric Weight (in kilograms, from length-based tape), if applicable
- Pediatric Weight Color Code, if applicable
- Hospital Code of base handling the run
- Communication and Call Type

Assessment:

- Provider Impression
- Chief Complaint
- Protocol #
- Medical History, if applicable
- Medications, if applicable
- Allergies, if applicable

Vitals/TXs:

- Medications (name) and interventions ordered (name), if applicable

Transport:

- Name of MAR with ETA
- Actual transport destination (if patient was transported)
- Check One
- Pt Transported Via
- Destination Rationale (if applicable)
- Reason for No Transport (if patient was not transported)
- Time Clear
- MICN # (if MICN handled the call)
- Physician # (if the physician handled the call or was consulted by the MICN)

Dispo:

- ED Diagnosis (if the base is the receiving facility)
- Disposition (if the base is the receiving facility)

REQUIRED DATA FIELDS FOR ALL REQUIRED BASE HOSPITAL CONTACTS BY PROVIDER IMPRESSION

PI=RARF

- LOC
- GCS
- Respiration
- Skin
- Capnography # & Waveform
- Initial Rhythm
- Adv. Airway (BS After ETT/King? & ETCO2?), if performed
- 12-Lead ECG information (12-Lead ECG @, EMS & Software Interpretation), if performed
- O2
- IV
- VS (BP, HR, RR, O2 Sat, CO2 #)

PI=STRK

- LOC
- GCS
- Pupils
- Respiration
- mLAPSS
- LAMS (if mLAPSS +)
- LKWD/LKWT
- Glucose
- Capnography # & Waveform, if BMV used
- Initial Rhythm
- 12-Lead ECG information (12-Lead ECG @, EMS & Software Interpretation), if performed
- Adv. Airway (BS After ETT/King? & ETCO2?), if performed
- O2, if given
- IV
- VS (BP, HR, RR, O2 Sat)
- Name of PSC & CSC with ETAs

PI=HOTN/SHOK

- LOC
- GCS
- Respiration
- Skin
- Initial Rhythm
- Capnography # & Waveform, if BMV used
- Adv. Airway (BS After ETT/King? & ETCO2?), if performed
- 12-Lead ECG information (12-Lead ECG @, EMS & Software Interpretation), if performed
- Glucose, if ALOC

- IV/IO
- O2, if given for PI=HOTN
- VS (BP, HR, RR, O2 Sat, CO2 # PRN)

PI=CPSC/CPMI (pediatric patients)

- Weight
- PWCC
- LOC
- GCS
- Respiration
- Skin
- Cap Refill
- Initial Rhythm
- 12-Lead ECG @
- EMS & Software Interpretation
- ECG Quality (artifact, wavy baseline, paced rhythm), for STEMIs
- SED use, if Nitroglycerin is ordered
- IV
- O2, if given
- VS (BP, HR, RR, O2 Sat, Pain)
- Name of EDAP & PMC with ETAs

PI=BRTH

- LOC
- GCS
- Respiration
- Skin
- IUP: _____ wks
- IV status
- O2 (if O2 < 94%)
- VS (BP, HR, RR, O2 Sat, Pain)
- Name of Perinatal with ETA

PI=BABY

- Weight
- PWCC
- GCS
- Respiration
- Skin
- Cap Refill
- VS (HR, RR, O2 Sat)
- Name of EDAP & Perinatal with ETAs

PI=DYRX
- GCS
- Respiration
- Skin
- IV status
- VS (BP, HR, RR, O2 Sat)

PI=AGDE
- LOC
- GCS
- Respiration (tidal volume only)
- Skin
- Pupils, if able
- Suspected Drugs/ETOH
- IV status
- Glucose & Initial Rhythm, if able
- VS (RR only)
- PTBC interventions and Midazolam administration, including Midazolam route

PI=ANPH
- LOC
- GCS
- Respiration
- Skin
- IV status
- O2
- PTBC interventions & medications, including medication route

PI=BRUE
- Weight
- PWCC
- LOC
- GCS
- Pupils
- Respiration
- Skin
- Cap Refill
- O2, if given
- Name of EDAP & PMC with ETAs

PI=CANT

- Pupils
- Respiration, including capnography # & waveform
- Skin
- Initial rhythm
- Witnessed by
- CPR by
- Arrest to CPR
- DNR status
- IV/IO status
- Adv. Airway (BS After ETT/King? & EtCO2?), if performed
- O2
- PTBC interventions and medications, including medication route
- ROSC?
- If ROSC: ROSC time, GCS, vitals 12-Lead ECG time, EMS & Software interpretation, quality (if STEMI)
- If TOR or pronounced: resus d/c time, resus d/c rhythm, total min EMS CPR, reason for no transport, MD name if pronounced
- Name of SRC with ETA

REQUIRED DATA FIELDS FOR BASE HOSPITAL CONTACTS FOR SPECIAL CIRCUMSTANCES BY PROVIDER IMPRESSION

PI=CHOK (severe distress and/or respiratory arrest)

- LOC
- GCS
- Respiration
- Skin
- Cap refill (pediatrics only)
- Capnography # & Waveform, if BMV used
- Adv. Airway (BS After ETT/King? & EtCO2?), if performed
- Initial Rhythm
- 12-Lead ECG information (12-Lead ECG @, EMS & Software Interpretation), if performed
- O2
- IV
- VS (BP, HR, RR, O2 Sat)
- Name of EDAP with ETA

PI=ALOC (if persistent or unclear etiology)

- LOC
- GCS
- Pupils, if able
- Respiration
- Skin
- Glucose
- Suspected Drugs/ETOH
- Initial Rhythm
- 12-Lead ECG information (12-Lead ECG @, EMS & Software Interpretation), if performed
- IV
- O2, if given
- VS (BP, HR, RR, O2 Sat)
- Narrative: signs of trauma or LN

PI=PSYC (Midazolam given)

- LOC
- GCS
- Pupils, if able
- Respiration
- Skin
- PTBC Medications
- Suspected Drugs/ETOH
- Glucose
- Initial Rhythm
- VS (BP, HR, RR, O2 Sat)

- Narrative: restraints needed?

PI=DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)

- LOC
- GCS
- Respiration
- Skin
- Cap Refill (pediatric patients)
- PTBC Medications
- Initial Rhythm
- 12-Lead ECG Time
- EMS & Software Interpretation
- O2 (if given)
- IV
- Pacing Information (if performed)
- VS (BP, HR, RR, O2 Sat, repeat rhythm)

PI=FAIL (VAD malfunction)

- LOC
- GCS
- Respiration
- Skin
- Cap Refill (pediatric patients)
- Capnography # & Waveform (if BMV used)
- Initial Rhythm
- IV
- VS (BP, HR, RR, O2 Sat, CO2 # (if BMV used))

PI=ODPO (if signing AMA)

- LOC
- GCS
- Pupils
- Respiration
- Skin
- Cap Refill (pediatric patients)
- Glucose
- Suspected Drugs/ETOH
- Initial Rhythm
- 12-Lead Information (if performed)
- VS (BP, HR, RR, O2 Sat)
- Narrative: intentional/accidental

PI=PREG (if > 20 wks. with vaginal bleeding or delivery)

- LOC
- GCS
- Respiration

- Skin
- IUP: ___ wks
- Glucose (if history of diabetes or gestational diabetes)
- IV
- VS (BP, HR, RR, O2 Sat, pain)
- Name of Perinatal and EDAP with ETAs
- Narrative: estimated blood loss (EBL), prenatal care

PI=LABR (if age ≤ 14 years)

- Weight (in kgs)
- PWCC
- LOC
- GCS
- Respiration
- Skin
- IUP: ___ wks
- Glucose (if history of diabetes or gestational diabetes)
- IV
- VS (BP, HR, RR, O2 Sat, pain)
- Name of Perinatal and EDAP with ETAs
- Narrative: prenatal care

PI=SOBB/RDOT/SMOK (severe distress or not improving with CPAP)

- LOC
- GCS
- Respiration
- Skin
- Cap Refill (pediatric patients)
- Capnography # & Waveform (if BMV used)
- Adv Airway (if performed)
- Initial Rhythm
- 12-Lead Information (if performed)
- O2
- IV
- VS (BP, HR, RR, O2 Sat)

PI=SEAC/SEPI (pregnant or in status epilepticus)

- LOC
- GCS
- Pupils
- Respiration
- Skin
- Cap Refill (pediatric patients)
- IUP: ___ wks
- Suspected Drugs/ETOH

- Glucose
- IV
- Initial Rhythm
- VS (BP, HR, RR, O2 Sat)
- Name of Perinatal with ETA (if pregnant)
- Narrative: due date, gravida/para, complications (if pregnant)

PI=DRWN (if ALOC or needs decompression)

- LOC
- GCS
- Pupils (if assessed)
- Respiration
- Skin
- Cap Refill (pediatric patients)
- Glucose
- Capnography # & Waveform (if BMV used)
- Adv Airway (if performed)
- Initial Rhythm
- 12-Lead Information (if performed)
- O2
- IV
- VS (BP, HR, RR, O2 Sat)
- Narrative: dive telemetry

PI=TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment >30 minutes)

- LOC
- GCS
- Pupils (penetrating eye, CC=PH, CC=RR (if RR<10), or CC=14)
- Respiration
- Skin
- Cap Refill (pediatric patients and crushed extremities)
- Adv Airway (if performed)
- Glucose (CC=14)
- Initial Rhythm
- 12-Lead Information (if performed)
- O2 (if given)
- IV
- SMR?
- Needle Thoracostomy?, if applicable
- Tourniquet (if applied)
- Trauma Complaint and MOI
- Extricated @ (if crush/entrapment)
- VS (BP, HR, RR, O2 Sat, pain, repeat rhythm (PRN))
- Name of PTC (pediatrics) and TC (adults) with ETAs
- Narrative: CMS of injured extremities

PROVIDER IMPRESSION DEFINITIONS

Provider Impression (PI) Name	PI Code	Treatment Protocol (TP)	TP Code	Guidelines for use of PI
Abdominal Pain/Problems (GI/GU)	ABOP	GI/GU Emergencies	1205 1205-P	For any pain or problem in the abdominal/flank region that does not have a more specific PI, includes post-surgical complications.
Agitated Delirium	AGDE	Agitated Delirium	1208 1208-P	For Agitated Delirium only. NOT for psychiatric emergencies or other causes of agitation without delirium.
Airway Obstruction/ Choking	CHOK	Airway Obstruction	1234 1234-P	For any upper airway emergency including choking, foreign body, swelling, stridor, croup, and obstructed tracheostomy
Alcohol Intoxication	ETOH	Overdose/ Poisoning/Ingestion	1241 1241-P	For alcohol intoxication if it is the primary problem. Use of secondary PI if the patient has another acute emergency.
Allergic Reaction	ALRX	Allergy	1219 1219-P	For any simple allergic reaction that is isolated to the skin (hives/ urticarial only) and does not meet definition of anaphylaxis
ALOC - Not Hypoglycemia or Seizure	ALOC	ALOC	1229 1229-P	For altered mental status not attributed to a more specific PI (i.e., cause unknown). Use as secondary PI when cause known.
Anaphylaxis	ANPH	Allergy	1219 1219-P	For anaphylaxis.
Behavioral/ Psychiatric Crisis	PSYC	Behavioral/ Psychiatric Crisis	1209 1209-P	For psychiatric crisis that is the primary problem. NOT for anxiety/agitation secondary to medical etiology, use PI related to medical issue.
Body Pain – Non-Traumatic	BPNT	General Medical	1202 1202-P	For pain not related to trauma that is not localized to chest, abdomen, head, or extremity.
BRUE	BRUE	BRUE	1235-P	For a brief resolved unexplained event (BRUE). Patient must be ≤12 months of age and back to baseline on assessment.
Burns	BURN	Burns	1220 1220-P	For any burn injury to skin. For inhalation injury use PI Inhalation Injury. Use with PI Traumatic Injury if other trauma present.
Carbon Monoxide	COMO	Carbon Monoxide Exposure	1238 1238-P	For suspected or known carbon monoxide exposure.
Cardiac Arrest – Non-traumatic	CANT	Cardiac Arrest	1210 1210-P	For non-traumatic cardiac arrest in which any resuscitation is initiated, NOT dead on arrival

Provider Impression (PI) Name	PI Code	Treatment Protocol (TP)	TP Code	Guidelines for use of PI
Cardiac Dysrhythmia	DYSR	Cardiac Dysrhythmia – Bradycardia	1212 1212-P	For any bradycardic rhythm <60bpm.
Cardiac Dysrhythmia	DYSR	Cardiac Dysrhythmia – Tachycardia	1213 1213-P	For any tachydysrhythmia and for sinus tachycardia (ST) of unclear etiology. NOT for ST secondary to known cause – use more specific PI (e.g., Fever)
Chest Pain – Not Cardiac	CPNC	General Medical	1202 1202-P	For musculoskeletal and pleuritic pain and any chest pain that is NOT of possible cardiovascular etiology.
Chest Pain – STEMI	CPMI	Cardiac Chest Pain	1211	For any suspected STEMI, with or without chest pain.
Chest Pain – Suspected Cardiac	CPSC	Cardiac Chest Pain	1211	For any chest pain that is of possible cardiovascular etiology but NOT STEMI (e.g., NSTEMI, pericarditis, dissection).
Childbirth (Mother)	BRTH	Childbirth (Mother)	1215 1215-P	For delivery or imminent delivery of a fetus beyond the first trimester (12 weeks). For <12 weeks use PI Pregnancy Complications.
Cold / Flu Symptoms	COFL	General Medical	1202 1202-P	For minor respiratory illness in a patient without shortness of breath or wheezing; must have normal respiratory rate and O_2 sat (if available).
Diarrhea	DRHA	GI/GU Emergencies	1205 1205-P	For diarrhea without bleeding. NOT for melena, use PI Upper GI Bleeding.
Dizziness/Vertigo	DIZZ	Dizziness/Vertigo	1230 1230-P	For lightheadedness or vertigo, without syncope.
DOA – Obvious Death	DEAD	Cardiac Arrest	1210 1210-P	For non-traumatic cardiac arrest found dead on arrival such that no resuscitation is initiated.
Dystonic Reaction	DYRX	Dystonic Reaction	1239 1239-P	For suspected dystonic reaction (i.e., reaction, typically from antipsychotic medications, causing abnormal contraction of head and neck muscles.)
Electrocution	ELCT	Electrocution	1221 1221-P	For any electrocution injury.
ENT / Dental Emergencies	ENTP	ENT / Dental Emergencies	1226 1226-P	For a problem located in the ear, nose, throat area, except NOT epistaxis – use PI Epistaxis, NOT airway obstruction – use PI Airway Obstruction.
Epistaxis	NOBL	ENT / Dental Emergencies	1226 1226-P	For any bleeding from the nares.
Extremity Pain/ Swelling – Non-Traumatic	EXNT	General Medical	1202 1202-P	For pain, swelling, or other non-traumatic problem of an extremity, includes rashes and non-traumatic bleeding (e.g., varicose vein bleed).
Eye Problem – Unspecified	EYEP	Eye Problem	1228 1228-P	For any pain or problem of the eye or periorbital region, use with PI Traumatic Injury if a traumatic mechanism.

Provider Impression (PI) Name	PI Code	Treatment Protocol (TP)	TP Code	Guidelines for use of PI
Fever	FEVR	Fever	1204 1204-P	For reported or tactile fever that is NOT suspected sepsis. For sepsis use PI Sepsis.
Genitourinary Disorder – Unspecified	GUDO	GI/GU Emergencies	1205 1205-P	For urinary or genital related complaints, except NOT vaginal bleeding – use PI Vaginal Bleeding, NOT trauma-related – use PI Traumatic Injury.
HazMat Exposure	DCON	HAZMAT	1240 1240-P	For any hazardous material (chemical) exposure. May use with another PI (e.g., Inhalation Injury or Burns) when applicable.
Headache – Non-Traumatic	HPNT	General Medical	1202 1202-P	For non-traumatic headache or head pain.
Hyperglycemia	HYPR	Diabetic Emergencies	1203 1203-P	For patients with primary concern for hyperglycemia and/or associated symptoms (blurred vision, frequent urination or thirst) without more specific PI and those requiring field treatment. DO NOT list for incidental finding of hyperglycemia related to another illness.
Hypertension	HYTN	General Medical	1202 1202-P	For patients with primary concern for hypertension without symptoms related to a more specific PI. For symptomatic patients, use related PI as primary (e.g., Headache – Non-traumatic) and Hypertension as secondary. DO NOT list for incidental finding of hypertension.
Hyperthermia	HEAT	Hyperthermia (Environmental)	1222 1222-P	For environmental exposure causing hyperthermia, e.g., heat exhaustion and heat stroke, drugs may also be a contributing factor.
Hypoglycemia	HYPO	Diabetic Emergencies	1203 1203-P	For glucose <60mg/dL.
Hypotension	HOTN	Shock / Hypotension	1207 1207-P	For SBP <90mmHg in adults or <70mmHg in children with transient low BP or rapidly responds to fluid resuscitation and without signs of shock.
Hypothermia / Cold Injury	COLD	Hypothermia / Cold Injury	1223 1223-P	For environmental exposures causing hypothermia and/or frostbite injury.
Inhalation Injury	INHL	Inhalation Injury	1236 1236-P	For any signs/symptoms related to inhaling a gas or substance other than smoke or carbon monoxide.
Lower GI Bleeding	LOGI	GI/GU Emergencies	1205 1205-P	For bleeding from the rectum and/or bright red bloody stools.

Provider Impression (PI) Name	PI Code	Treatment Protocol (TP)	TP Code	Guidelines for use of PI
Medical Device Malfunction – Fail	FAIL	Medical Device Malfunction	1206 1206-P	For a medical device that fails, including VADs, insulin pumps, and shunts. Usually for internal devices, may be used for vent failure if patient is asymptomatic. For symptomatic patients, use PI related to symptoms (e.g., Automated Internal Defibrillator firing – use PI associated with complaint such as Cardiac Dysrhythmia – Tachycardia).
Nausea / Vomiting	NAVM	GI/GU Emergencies	1205 1205-P	For any nausea or vomiting without blood. Not for adverse reaction to opiate administration by EMS, manage with primary PI/TP.
Newborn	BABY	Newborn/Neonatal	1216-P	For any newborn deliveries in the field.
No Medical Complaint	NOMC	Assessment	1201	For patients without any medical, psychiatric or traumatic complaint and no signs of illness on assessment. Usually reserved for non-transports.
Overdose/ Poisoning/Ingestion	ODPO	Overdose/ Poisoning/ Ingestion	1241 1241-P	For any intentional or unintentional overdose/poisoning by any route, includes illicit substances and prescription medications, overdose and/or adverse reactions.
Palpitations	PALP	General Medical	1202 1202-P	For any patient complaint of palpitations (e.g., rapid heart rate beat, skipped beats, chest fluttering) with normal rate and rhythm on the ECG.
Pregnancy Complications	PREG	Pregnancy Complication	1217 1217-P	For any pregnancy-related condition that is not labor. Includes vaginal bleeding in pregnancy, hypertension, and complications of delivery.
Pregnancy / Labor	LABR	Pregnancy Labor	1218 1218-P	For contractions without imminent childbirth.
Respiratory Arrest / Failure	RARF	Respiratory Distress	1237 1237-P	For patients requiring positive-pressure ventilation and/or hypoxia despite 100% oxygen.
Respiratory Distress / Bronchospasm	SOBB	Respiratory Distress	1237 1237-P	For COPD/asthma exacerbations and any bronchospasms/wheezing not from pulmonary edema.
Respiratory Distress / Other	RDOT	Respiratory Distress	1237 1237-P	For patients with pulmonary disease that is not edema or bronchospasm, includes suspected pneumonia, PE, pneumothorax and non-pulmonary and unknown causes of respiratory distress.
Respiratory Distress / Pulmonary Edema / CHF	CHFF	Pulmonary Edema / CHF	1214	For congestive heart failure exacerbation.
Seizure – Active	SEAC	Seizure	1231 1231-P	For seizure witnessed by EMS, whether treated or not.

Provider Impression (PI) Name	PI Code	Treatment Protocol (TP)	TP Code	Guidelines for use of PI
Seizure – Postictal	SEPI	Seizure	1231 1231-P	For any seizure that stopped prior to EMS arrival and there is no further seizure activity during EMS contact.
Sepsis	SEPS	Fever / Sepsis	1204 1204-P	For patients with suspected sepsis (i.e., signs suggestive of sepsis including fever, tachycardia, suspected infection).
Shock	SHOK	Shock / Hypotension	1207 1207-P	For patients with poor perfusion not rapidly responsive to IV fluids.
Smoke Inhalation	SMOK	Inhalation Injury	1236 1236-P	For patients with smoke inhalation.
Stings / Venomous Bites	STNG	Stings / Venomous Bites	1224 1224-P	For snakes, scorpion, insects, and marine envenomations (stingrays, jelly fish). NOT for animal bites, use PI traumatic injury.
Stroke / CVA / TIA	STRK	Stroke / CVA / TIA	1232 1232-P	For suspected stroke or transient ischemic attack (stroke symptoms that resolve rapidly).
Submersion / Drowning	DRWN	Submersion	1225 1225-P	For any submersion injury, including drowning and dive (decompression) emergencies.
Syncope / Near Syncope	SYNC	Syncope / Near Syncope	1233 1233-P	For syncope (transient loss of consciousness). NOT for cardiac arrest, use PI Cardiac Arrest – Non-traumatic only.
Traumatic Arrest – Blunt	CABT	Traumatic Arrest	1243 1243-P	For cardiac arrest with blunt traumatic mechanism, including those declared deceased in the field by Ref. 814. NOT for trauma sustained after cardiac arrest, use PI Cardiac Arrest – Non- traumatic.
Traumatic Arrest – Penetrating	CAPT	Traumatic Arrest	1243 1243-P	For cardiac arrest with penetrating traumatic mechanism, including those declared deceased in the field by Ref. 814.
Traumatic Injury	TRMA	Traumatic Injury	1242 1242-P 1244 1244-P	For any trauma-related injury including crush injury and conducted electrical weapons (CEW). May use in addition to another PI when medical condition also present (e.g., for syncope with trauma – use PI Syncope and PI Traumatic Injury; for CEW use in patient with agitated delirium – use PI Agitated Delirium and PI Traumatic Injury).
Upper GI Bleeding	UPGI	GI/GU Emergencies	1205 1205-P	For vomiting blood or coffee ground emesis, and for melena (i.e., black, tarry stools).
Vaginal Bleeding	VABL	GI/GU Emergencies	1205 1205-P	For vaginal bleeding in the NON-pregnant patient. For vaginal bleeding in pregnancy use PI Pregnancy Complications.
Weakness – General	WEAK	General Weakness	1202 1202-P	For nonfocal weakness, general malaise, and any nonspecific ‘sick’ symptoms.

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

REFERENCE NO. 644, Base Hospital Documentation Manual

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	6/10/2020	6/10/2020	N
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee			
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT/PARAMEDIC/MICN)

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

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

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

DEFINITIONS:

Adult: A person at least eighteen years of age.

Minor: A person less than eighteen years of age.

Minor Not Requiring Parental Consent is a person who:

- Is 12 years or older and in need of care for a reportable medical condition or substance abuse
- Is pregnant and requires care related to the pregnancy
- Is in immediate danger of suspected physical or sexual abuse
- Is an emancipated minor

Emancipated Minor: A person under the age of 18 years is an emancipated minor if any of the following conditions are met:

- Married or previously married
- On active military duty
- The person has received a declaration of emancipation pursuant to Section 7122 of the California Family Code, which includes all of the following: at least fourteen (14) years of age, living separate and apart from their parents and managing their own financial affairs (may be verified by DMV Identification Card)

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

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

The lack of decision-making capacity may be:

- Temporarily lost (e.g., due to unconsciousness, influence of mind altering

APPROVED: Director, EMS Agency; Medical Director, EMS Agency

substances, mental illness, or cognitive impairment)
- Permanently lost (e.g., due to irreversible coma, persistent vegetative state, untreatable brain injury, or dementia)
- Never existed (i.e., due to profound neurodevelopmental disorder, those who are deemed by the Court as incompetent or a person under conservatorship)

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 are also considered to have an emergency medical condition.

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

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

Refusing Care Against Medical Advice (AMA): A patient or a legal representative of a patient who has decision-making capacity to refuse treatment and/or transport for an emergency medical condition.

"Release at Scene" (Patients not requiring transport): A patient who, after an assessment by EMS personnel, does not have an emergency medical condition and does not appear to require immediate treatment and/or transportation. These patients meet one or more of the following conditions:
- Deny a medical condition and decline need for treatment
- Called EMS personnel for assistance for non-medical related issues (i.e., public assists)
- Meet criteria for “Treat and Refer”

“Treat and Refer”: A patient who, after an assessment and treatment by EMS personnel, does not have an ongoing emergency medical condition, does not desire transport to the emergency department for evaluation, and is stable for referral to the patient’s regular healthcare provider or a doctor’s office or clinic.

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

PRINCIPLES:

1. An adult or emancipated minor who has decision-making capacity has the right to determine the course of their medical care including the refusal of care. These patients must be advised of the risks and consequences resulting from refusal of medical care.

2. A patient less than eighteen (18) years of age, with the exception of minors not requiring parental consent, must have a parent or legal representative to refuse evaluation, treatment, and/or transport for an emergency medical condition.

3. A patient determined by EMS personnel or the base hospital to lack decision-making capacity may not refuse care AMA or be released at scene. Mental illness, drugs, alcohol, or physical/mental impairment may impair a patient's decision-making capacity but are not sufficient to eliminate decision-making capacity. Patients who have attempted suicide, verbalized suicidal intent, or if other factors lead EMS personnel to suspect suicidal intent, should be regarded as lacking the decision-making capacity. Capacity determinations are specific only to the particular decision that needs to be made.

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

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

6. A patient or a legal representative of a patient may contact EMS for minor complaints in order to have an assessment performed and determination made of the seriousness of the complaint and need for treatment. In such cases, the EMS personnel may perform an assessment and for those who meet the definition of "Treat and Refer" may be treated at the scene and referred to the patient's medical home or primary care physician. If the patient or legal representative requests that the patient be transported despite assurance that transportation is not needed, EMS personnel should honor the request and transport the patient to the most appropriate receiving facility in accordance with applicable patient destination policies.

7. Patients who refuse treatment and/or transportation, and all those released at the scene are high risk patients and require additional quality review.

8. Certain patients are at increased risk of having a bad outcome if released on scene. These include patients with a medical complaint at extremes of age (≤ 12 months or ≥ 70 years old), patients with abnormal vital signs, and patients with high-risk chief complaints including chest pain, shortness of breath, abdominal pain, gastrointestinal or vaginal bleeding, and syncope. These patients are more challenging to fully evaluate in the field and should be transported to the emergency department.

POLICY:

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

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

   B. If the patient has an emergency medical condition as defined above and a BLS unit is alone on scene, an ALS unit should be requested for evaluation prior to

AMA.

C. When base hospital contact is made, contact should be made prior to the patient leaving the scene. Paramedics shall advise the base hospital of all the circumstances including care, transportation, reasons for refusal, and the patient's plans for follow-up care.

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

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

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

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

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

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

III. Patients Released at Scene

A. EMS personnel shall ensure that the patient does not have an ongoing emergency medical condition and that they or their legal representative as appropriate have the capacity to decline transport.

B. Patients with a medical complaint, and with the following high-risk features, are not appropriate for Release at the Scene and should be transported or sign a refusal of transport against medical advice:

1. Extremes of age (≤ 12 months or ≥ 70 years old)

2. Abnormal vital signs – except isolated asymptomatic hypertension

3. High risk chief complaints including chest pain, shortness of breath, abdominal pain, gastrointestinal or vaginal bleeding, and syncope

C. EMS personnel shall advise the patient or their legal representative as appropriate to seek follow-up treatment or immediate medical care, including re-contacting 9-1-1 if they develop symptoms at a later time. The advice given should be documented on the Patient Care Record. The following statement is recommended: "It appears that you do not require immediate care in the

emergency department. You should seek care with your regular healthcare provider or a doctor's office or clinic within 24 hours. If you have worsening symptoms recontact 9-1-1."

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

E. If the patient or the patient's legal representative requests that the patient be transported after assurance that transport in not needed; EMS personnel should honor the requests and transport to the Most Accessible Receiving Facility (MAR) for adults and to the closest Emergency Department Approved for Pediatrics (EDAP) for children.

IV. Documentation

A Patient Care Record must be completed for each patient encounter, including those refusing emergency medical evaluation, care and/or transportation against medical advice and those released at scene. EMS personnel shall ensure that documentation includes, at a minimum, the following:

A. Patient history and assessment, including absence of findings of an emergency medical condition or requirement to make Base Contact.

B. Description of the patient which clearly indicates their decision-making capacity.

C. For Refusal of Care Against Medical Advice (AMA):

1. What the patient is refusing (i.e., medical care, transport)

2. Why the patient is refusing care

3. Risk and consequences of refusing care as explained to the patient or legal representative

4. Statement that the patient understands the risks and consequences of refusing care

5. Signature of patient or legal representative refusing care

6. Patient's plan for follow-up care

7. If Treatment Protocol requires Base contact, Base contact should be made prior to leaving the patient on scene

D. For Release at Scene:

1. For Treat and Refer:

a. Assessment for all patients

b. Field treatments

c. Plan for follow-up care

2. For patients with no medical complaint who do not request treatment, document the situation and the assistance that was provided.

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

V. Quality Improvement

Each Provider Agency shall have a quality improvement program to review patient care records for the patient who refuse medical care or transport, or who were treated and released without Base Contact.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 832, **Treatment/Transport of Minors**
Ref. No. 1200, **Treatment Protocols**, et al.