COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION
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EMERGENCY MEDICAL SERVICES ORIENTATION 2021

1. Introduction to EMS Agency Key Staff
2. History of EMS – Health & Safety Code 2.5, and Los Angeles County Code Ordinance 3.20
3. Role of the EMS Agency
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EMS Administration

> **Provides overall operational and medical leadership and management for the agency and the emergency medical system.**

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Section Summary

Provides overall operational and medical leadership and management for the agency and the emergency medical system.

Coordinates the meetings and activities of the EMS Commission, which is an advisory board to the Department of Health Services and the County Board of Supervisors.

Section Statistics

- **190 employees**
- **19 EMS Commissioners**
- **LA County's EMS System:**
  - **4,082 sq. miles**
  - **88 cities**
  - **10,272,648 population (2017)**
  - **719,452 EMS Calls (2017)**
  - **578,961 patient transports (2017)**
  - **36,384 trauma patients (2017)**
  - **3,761,020 ED visits**

49 Hospitals with Neonatal ICU
8 SART Centers
13 Disaster Resource Centers

EMS Provider Agencies

29 Public EMS Provider Agency
28 Licensed Basic Life Support Ambulance Operators
16 Licensed Advanced Life Support Ambulance Operators
15 Licensed Critical Care Transport Ambulance Operators
5 Licensed Ambulette Operators

2019 System Demographics

71 9-1-1 Receiving Hospitals
38 EDAP (Emergency Department Approved for Pediatrics)
7 Pediatric Trauma Centers
21 Paramedic Base Hospitals
36 STEMI Receiving Centers
34 Primary Stroke Centers
18 Comprehensive Stroke Centers
54 Perinatal Centers

EMS Practitioners

4,198 Accredited Paramedics
8,152 Certified EMTs by LA Co EMS Agency
840 Certified Mobile Intensive Care Nurses

Unique Facts or Interesting History

- **Los Angeles County has the largest multi-jurisdictional EMS system in the nation and was among the first to be developed in the world.**
- **The development of the paramedic system was spearheaded by forward thinkers who decided to take firefighters and train them to be paramedics**
- **On March 21, 2019 we celebrated 50 years of EMS in Los Angeles County.**
- **Los Angeles County helped initiate legislation that would permit paramedics to provide advanced medical life support. It was enacted on July 14, 1970, making California the first state with paramedics.**

Administrative Services

Section Summary

Fiscal Services
- Expenditure Management
- Procurement
- Revenue Management
- Ambulance Licensing Financial Review
- Review & approval of 1,000 claims on a monthly basis for payment of overflow transportation providers.

Grant Management
- Hospital Preparedness ($9 to $10 million annually)
- Homeland Security ($1 to $2 million annually)
- RDMHC Program

Reimbursement Programs
- Trauma Center Services claims processing
- Third party liability collections for paid trauma and PSIP claims
- Physicians Services for Indigents Programs – Coordinate Physicians Reimbursement Advisory Committee, set rates for reimbursement, develop enrollment packets for participation in program

Program Financial Auditing
- 13 private trauma centers
- Over 5,000 enrolled physicians in the Physician Services for Indigent Program (PSIP)

Contract/Contract Monitoring
- 20+ Contracts with 225 providers (mostly hospitals and fre departments)
- Oversight of annual contract monitoring of all providers

Personnel Management
(202 budgeted position 190 filled)

Facilities Management

Front Desk/ Reception
- General info to the public and prospective paramedic students and persons obtaining EMT certification (over 2,000 visitors a year)
- Over $2 million in revenue collected

> "The little engine that keeps EMS going"

Information Technology

“The IT Section provides Communications, Technical Support, Software Development and Geographical Information Systems support for the EMS Agency”

Section Summary

Information Technology is responsible for the management, development and maintenance of all technology related services throughout the EMS Agency. Included in these servces are the specialty areas of Application Development, Geographical Information Systems, Network and Security Administration, Telephone Services, Radio Communications, Mobile Communications and Help Desk Administration. Additionally, the Information Technology section helps support vendor based systems from both the hardware and software perspective.

Section Statistics

- **Supports the DHS Patient Transfer Center**
- **Maintains 15 remote mountain top transceivers**
- **Supports 250+ computer users in three locations**
- **Supports 30+ servers in the EMS Data Center**
- **Supports a Computer Aided Ambulance Dispatching System**
- **Web and Mobile based application development is the primary focus for Systems Development**
- **Supports the Mobile Hospital and the DHS Disaster Operations Center**

Unique Facts or Interesting History

- **The Patient Transfer Information System (PTIS-Online) is a web based application that collects data used to facilitate the transfer of patients from private medical facilities into County managed medical facilities. Coordinators from the Medical Alert Center (MAC) use an abundance of medical and patient demographic data to assure that patients, that are often indigent, are able to be cared for by a facility and staff that are best equipped to handle their individual needs.**
- **The STEMI/Stroke applications were developed by EMS-IT staff to capture, manage, and analyze a tremendous amount of data associated with the treatment of a STEMI or stroke patient.**

Certification and Program Approvals

Section Summary

Certification activities include issuing certification to EMT's and Mobile Intensive Care Nurses and accreditation of Paramedics in accordance with California State requirements and EMS Agency policies. We develop and administer the MICN certification and Paramedic accreditation exams for ALS personnel.

PEPSI, short for Prehospital Emergency Personnel System Information, is the database used to keep track of EMS personnel certified by the EMS Agency.

Program Approval activities involve the review, approval and monitoring of EMS training programs for Paramedics, EMTs, MICNs and Continuing Education. Based on national standards, State regulations and local policies, we ensure that quality education and training programs are available.

Other section responsibilities include supporting the EMS Commission's Education Advisory Committee.

Section Statistics

- **Certified EMS Personnel 2019**
  - **EMT's 8152**
  - **Paramedics - 4298**
  - **MICN's 840**

- **Approved EMS Training Programs 2019**
  - **EMT Programs**
  - **Fire and Public Safety Programs - 10**
  - **Educational Institutions - 23**
  - **EMS Continuing Education Providers - 79**
  - **Paramedic Programs - 4**

Unique Facts or Interesting History

Persons currently active in LA County with longest running certifications in our database as of June 2019 are:

- **Paramedics**
  James Goldsworthy, P 1011, DHS - first accredited Sept. 1, 1974
  David Frelinger, P 965, LAFD - first accredited May 26, 1975

- **MICNs**
  Dianne Atwood, N0966, first certified January 27, 1978
  Lynn Riley, N1043, first certified July 21, 1978
  Gigi Hentzen, N1160, first certified January 31, 1979

- **EMTs**
  Oscar Romero, E035305 - first certified May 9, 1983
  Chad Smith, E007621 - first certified June 14, 1983
  Howard Burkhart, E042736- first certified July 16, 1983

"The Prehospital Certification Section is responsible for the certification and accreditation of EMS personnel

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

EMS Commission

Section Summary

The EMS Commission is an advisory body to the Board of Supervisors and the Director of Health Services regarding County polices, programs, and standards for emergency medical care services throughout the County.

Their responsibilities include:

- Establishing criteria for the evaluation of the impact and quality of emergency medical care services throughout Los Angeles County;
- Conducting studies of the emergency medical care system, delineating problems and deficiencies, and recommending appropriate solutions;
- Acquiring and analyzing the information necessary for measuring the impact and the quality of emergency medical care services;
- Reporting its findings, conclusions and recommendations to the Board of Supervisors at least every twelve months;
- Reviewing and commenting on plans and proposals for emergency medical care services prepared by County departments; and
- Advising the Director and the Department of Health Services on the following matters:
  Policies, procedures, and standards to control the certification of mobile intensive care nurses and paramedics.
  Proposals of any public or private organization to initiate or modify a program of paramedic services or training.
  Paramedic services and training in all sectors of the community, including County agencies, community colleges, hospitals, and private companies.

Section Statistics

There are 19 members of the Commission, which represent the following agencies:

- **American College of Emergency Physicians (Emergency Department Physician)**
- **American Heart Association (Physician)**

> **“The EMS Commission is an advisory board to the Board of Supervisors and the Department of Health Services”**

- **Los Angeles County Ambulance Association**
- **Emergency Nurses’ Association (MICN)**
- **Hospital Association of Southern California (Hospital Administrator)**
- **Los Angeles County Fire Chiefs Association (Public Provider Agency representative)**
- **American College of Surgeons (Trauma Surgeon)**
- **Southern California Psychiatric Society (Psychiatrist)**
- **Los Angeles County Medical Association (Physician)**
- **California State Firefighters Association**
- **Los Angeles County Peace Officers Association (Law Enforcement representative)**
- **Los Angeles County Police Chiefs Association (Police Chief representative)**
- **Southern Californian Public Health Association**
- **League of California Cities (City Manager)**
- **Five public members, one nominated by each Supervisor**

Unique Facts or Interesting History

- **The EMS Commission was established by County Ordinance in 1979.**

Hospital Programs

Section Summary

“The Hospital Program Operations Section conducts contract monitoring, site visits, system monitoring and quality improvement activities”

Coordinate and conduct contract monitoring, site visits, data validation and evaluation of quality improvement programs for each hospital specialty program, as well as staffing, attending, and completing assignments for the various associated committees:

- 71 9-1-1 Receiving hospitals
- 15 Trauma Centers
  - THAC (Trauma Hospital Advisory Committee)
  - THAC Quality Improvement (QI) and Regional Meetings
  - THAC Data Committee
- 21 Base Hospitals
  - BHAC (Base Hospital Advisory Committee)
- 38 Emergency Departments Approved for Pediatrics (EDAP)

  10 Pediatric Medical Centers (PMC)
  - Pediatric Advisory Committee (PedAC)
  - ICAN (Interagency Council on [Child] Abuse and Neglect)
  - COPEM (Committee on Pediatric Emergency Medicine)
- 14 Sexual Assault Response Team (SART) facilities
- 36 STEMI (S-T Elevation Myocardial Infarction) Receiving Centers (SRC)
  - SRC Advisory Committee
- 52 Approved Stroke Centers (ASC)

  18 Comprehensive Stroke Centers

  34 Primary Stroke Centers
  - Stoke Advisory Committee
  - Stroke Data Collaborative
- Other miscellaneous meetings under Hospital Programs:
  - Maintain Prehospital Care Manual

Ambulance Programs

> **“Ambulance Programs oversees the private ambulance system in Los Angeles County.”**

Section Summary

Licenses private ambulance operators, private ambulance vehicles and ambulette (wheelchair or medical transportation vans) vehicles.

Monitors all ambulance operators to ensure compliance with the Los Angeles County Ambulance Ordinance.

Administers and monitors seven 9-1-1 Emergency Ambulance Transportation Agreements with Exclusive Operating Areas (EOAs). Ambulance Contractors. Conducts contract monitoring and monthly 9-1-1 response time audits to ensure contractual compliance.

Administers and monitors Transportation Overflow Agreements for the non-emergency transportation of County responsible patients.

Conducts periodic review and modification of the general ambulance public rates charged by operators to private patients.

Investigates complaints related to ambulance operations.

Section Statistics

- **There are 34 licensed ambulance operators (three also provide ambulette services), four licensed ambulette operators, one private air ambulance provider.**

Unique Facts or Interesting History

- **The first Los Angeles County Ambulance Ordinance was published in 1951.**
- **In 1987, the Board of Supervisors approved a new emergency ambulance transportation program which was developed to comply with a ruling by the Court of Appeal in City of Lomita, et al V. County of Los Angeles (1986) which held the County responsible for emergency ambulance services throughout the County, including the incorporated area.**
- **On July 28, 2011, the Los Angeles County Ambulance Ordinance was significantly revised. All ground and air ambulance operators who transport patients originating anywhere in Los Angeles County (both incorporated and unincorporated areas) are now required to obtain a Los Angeles County Ambulance Operator Business license.**

Prehospital Care Operations

“Prehospital Care Operations staff have highly specialized knowledge about the EMS system and serve as a resource to paramedic providers and hospitals.”

Section Summary

Coordinates and conducts advanced life support program reviews at public and private provider agencies to evaluate compliance with policies, procedures and applicable regulations.

Approves private provider agencies as specialty care transport programs (RN/RT) and conducts routine audits and program reviews to verify compliance with established standards.

Assists with the development and revision of treatment protocols and medical control guidelines for emergency field care of the 9-1-1 patient.

Coordinates the Commission on Accreditation for Air Medical Transport (CAMTS) surveys for the Los Angeles County Public Air Operations providers.

Approves and oversees the 1:1 alternate staffing programs for ALS interfacility transfers.

Approves and oversees EMT and public safety AED programs. Coordinates data capture of annual AED utilization by EMT and public safety AED programs.

Approves optional scope of practice applications for public safety and provider based EMT programs.

Approves pilot projects of EMS provider agencies.

Approves, reviews and monitors expanded scope of practice and trial study requests.

Liaisons with and oversees 9-1-1 dispatch centers.

Staffs the Provider Agency Advisory Committee.

Staffs Medical Advisory Council Committee.

Staffs the provider and base hospital Quality Improvement Committees.

Section Statistics

- **29 public provider agencies (fire departments)**
- **1 law enforcement agency approved for ALS level of care**
- **4 Helicopter EMS providers**
- **12 public dispatch centers**
- **62 approved EMT/Public Safety based AED providers**
- **14 ALS approved private ambulance companies**
- **10 approved 1:1 alternate staffing configuration providers for interfacility transfers**
- **19 Approved Critical Care Transport/Respiratory Therapy Programs**

Medical Alert Center

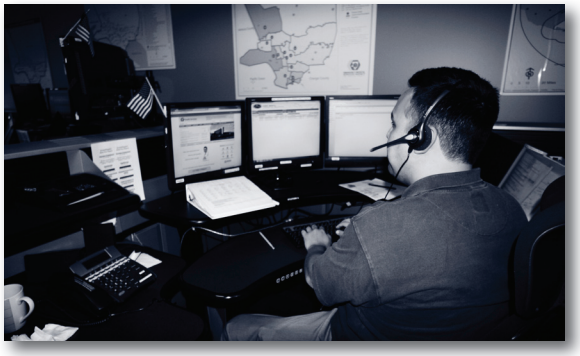
"The Medical Alert Center (MAC) coordinates the transfer of patients from private hospitals to county operated hospitals and tracks the bed availability and diversion status of 9-1-1 receiving hospitals 24 hours a day."

Section Summary

- Coordinate patient transfer activities to all licensed acute care hospitals operated by the Los Angeles County Department of Health Services.
- Manage multiple casualty incidents. Assist providers with patient destination information during MCIs.
- Coordinate hyperbaric chamber team response and scuba diving incidents.
- Coordinate placement of burn patients.
- Coordinate interfacility helicopter transfers requiring use of public EMS providers.
- Serve as the Control Point for the Hospital Emergency Administrative Radio (HEAR) and Rapid Emergency Digital Data Interface Network (ReddiNet).
- Monitor and document hospital diversion requests.

Section Statistics

- Number of patients presented for transfer per month: 944
- Number of patients presented for transfer per year: 11,331
- Number of patients transferred per month: 393
- Number of patients transferred per year: 4,713
- Number of MCI Drills per month: 3-4
- Number of MCI Drills per year: 42
- Number of Actual MCIs per month: 3-4
- Number of Actual MCIs per year: 43



Unique Facts or Interesting History

- The MAC is operational 24/7.
- It was created in 1971 in response to a physician strike-action that was pending at LAC+USC and created a need to divert patients from the County hospital. It was soon given the responsibility of making arrangements for all patient transfers from private hospitals into County hospitals.
- In 1972, Lockhead donated a hyperbaric chamber to LAC+USC and the MAC was assigned the task of coordinating transportation and physician coverage.
- Coordinates the mobilization of Hospital Emergency Response Teams (H.E.R.T.) in the event of a multi-casualty incident.

Ambulance Services

> **"The oldest operating ambulance company in the county."**

Section Summary

The County of Los Angeles has provided ambulance services to Department of Health Services (DHS) patients since 1897. Starting with a horse drawn vehicle, this is one of the oldest ambulance services in the State. Today, DHS operates a modern ambulance fleet, staffed with Emergency Medical Technicians (EMTs) to provide care and transportation to medically indigent patients, to and from County facilities.

The Department's Ambulance Services section is managed by the EMS Agency and handles 2,500-3,000 transports per month through our Central Dispatch Office (CDO). In addition to transporting patients to and from healthcare facilities, our EMT teams:

- Meet the emergency flight teams and their critical patient passengers arriving by helicopter from the helipad at LAC+USC Medical Center to the Emergency Department
- Respond to man-down calls on the campus of LAC+USC Medical Center and Harbor-UCLA Medical Center to provide care and transport to the Emergency Department.
- Provide transport of in-custody patients between the jails and health facilities.
- Transport specialized neonatal teams to infants in need of transfer to Neonatal Intensive Care Units at County facilities.
- Assist in special or unforeseen events such as responding to disasters. Helping the Hurricane Katrina victims that were relocated to the Dream Center in 2005, and assisting Public Health after the torrential rainstorms in Lynwood in 2004.

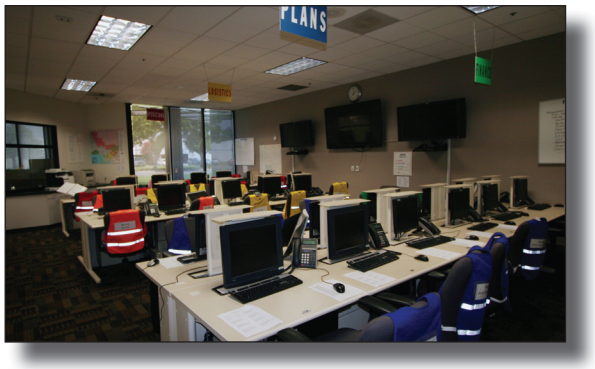
Any calls that cannot be handled by our Ambulance Serivices are contracted out to private ambulance companies, including calls that require paramedic or registered nurse level of care. Our Ambulance Services and Central Dispatch Office staff provide an invaluable service to County patients and hospitals. By efficiently moving patients, they help to decrease the congestion at DHS facilities and emergency departments. If you have any questions about the DHS Ambulance Services, contact Robert Moore at 562.347.1701, or Greg Chidely at 323.890.7390.

Unique Facts or Interesting History

- **Oldest operating ambulance company in the country.**

Disaster Programs

> **“Coordinates medical and health disaster response for Region I (San Luis Obispo, Santa Barbara, Ventura, LA, Orange Counties)”**



Section Summary

Hospital Preparedness Program (HPP) - Manages the US Department of Health and Human Services' HPP grant. The purpose of the program is to enhance LA County's healthcare system's capacities and capabilities to respond to an incident based on an all-hazards approach. Provides funding, consultation, and coordination of activities for 79 participating hospitals and other healthcare entities to enhance emergency preparedness. This program includes the Disaster Healthcare Volunteer (DHV) registry.

Emergency Coordination Program - Responsible for coordinating emergency preparedness activities for all Department of Health Services' (DHS) facilities. Responsible for maintaining and operating DHS' Department Operation Center, which is the disaster medical and health coordinator for LA County and Region I (San Luis Obispo, Santa Barbara, Ventura, Los Angeles, and Orange counties). This section also coordinates the Building Emergency Coordination program for DHS and the American Red Cross Blood Drives for all County departments.

Disaster Training Unit - Provides disaster preparedness and response training courses to healthcare personnel. These courses are offer ed free of charge.

Homeland Security Grants - Manages the Urban Area Security Initiative (UASI), and State Homeland Security Program (SHSGP) grant programs for DHS. Collaboratively works with multijurisdictional and multidisciplinary agencies to enhance LA County's emergency preparedness. Maintains a presence at the Joint Regional Intelligence Center to ensure that vital information is obtained in a secure and effi cient manner.

Response Resources - Over 45,000 sq. ft. of medical & health resources including 50 licensed vehicles.

Section Statistics

HPP participants - 79 hospitals and 52 community clinic organizations representing over 150 health center sites in LA County.

Disaster Training Unit - Over 27,000 people trained on emergency prepared-ness and response courses since 2002.

Hospital Disaster Management Training - trained 2,062 students on Hospital Command Center roles and responsibilities with a focus on hands-on training and simulated exercises since September 2007. This course received the 2009 California Emergency Services Association's Gold Award for contributions in the field of emergency management.

Disaster Healthcare Volunteers (DHV) - 3,458 Surge Unit and 1,813 Medical Reserve Corps registrants in the DHV registry.

County wide Blood Drives - Coordinates collection of approximately 3,000 units annually for the American Red Cross (ARC). LA County is ARC's largest account in Southern California.

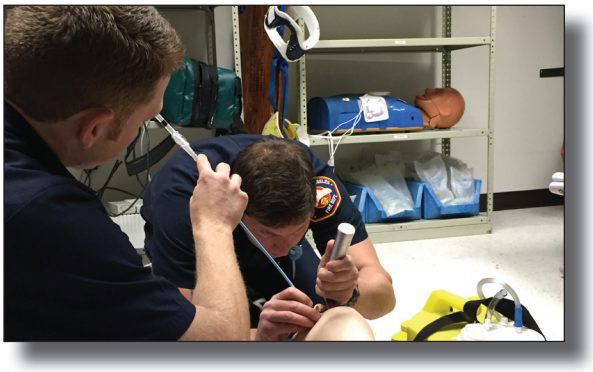
Unique Facts or Interesting History

Disaster Programs was the recipient of the 2007 LA County SuperSTARS award for Workplace Excellence. It is the "annual award bestowed on the County of Los Angeles' 'best and brightest.'"

Disaster Programs had a total of four staff people assigned to the section prior to 9/11. Currently, there are 20 staff people working in various emergency preparedness and response programs.

Paramedic Training Institute (PTI)

> **"To provide paramedic students with the cognitive psychomotor and affective skills necessary to provide the highest quality care to patients in the prehospital setting."**



Section Summary

PTI provides advanced life support training to paramedic students and coordinates the development of the annual EMS update.

Section Statistics

- **More than 4,800 paramedics trained since 1970**
- **Number of students per class: 27**
- **Number of classes per year: 4**
- **Total hours of training: 1094 hours**
- **Length of class: Approx 5.5 months**

Unique Facts or Interesting History

The Paramedic Training institute was one of the first paramedic training programs in the country. It started in 1969 as a pilot program at Harbor General Hospital under the direction of Dr. J. Michael Criley.

With the help of CCU nurse Carol Bebout, Dr. Criley began training firefighters to provide a wide range of medical care services at the scene of an emergency. The first class at PTI was composed of six Los Angeles Fire Department firefighters. Their training focused on the care of the cardiac patient and encompassed 192 hours of classroom training and experience in the emergency department.

By 1972, the hours required for certification rose to 1000.

In 1974, Dr. Ron Stewart was appointed as the director of PTI and his first objective was the modification of the training curriculum and materials. The resulting four-volume book, called the Paramedic Training Manuals, focused on specific field care, using pictures, terminology and examples that were suitable to the firefighters' background. This text was soon used as the basis of the core paramedic curriculum in paramedic programs nationwide.

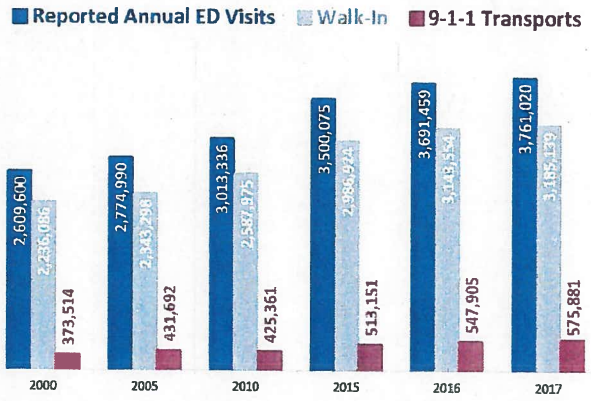
In 1995, PTI affiliated with El Camino Community College District and enhanced its standing as an academic program. Through this new partnership, PTI was able to provide college units to each graduate, accept private students sponsored by El Camino College, reduce the cost of tuition to the student/employer, and offset program costs.

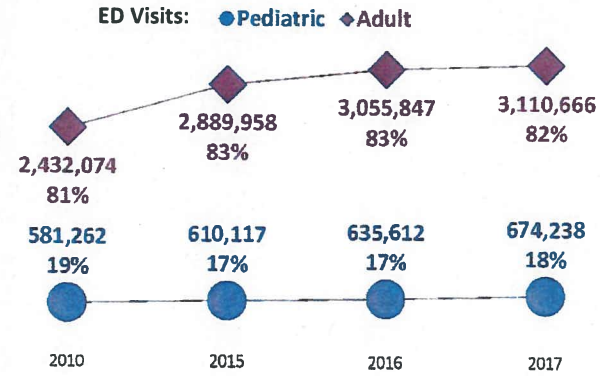
PTI continues to be one of the most innovative and recognized EMS training programs in the world and helped establish paramedic training programs in India, China and has visitors from all over the world.

It is nationally accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

Data Management Division

> **"The Data Management Division is responsible for all of the EMS Agency's data collection, analysis and management obligations."**





Section Summary

This relatively new unit was developed in 2015 to ensure that data management is well-coordinated, comprehensive and allows for system analysis. Efforts to integrate all the various databases continue to reduce redundancy. This new unit will ensure that data elements collected and the associated definitions will be standardized across all databases as most EMS related data are interrelated between EMS providers and hospitals.

This new section of the EMS Agency will support the reporting responsibilities of the other EMS units such as the Ambulance Licensing and Monitoring Sections, EMS Provider Programs, Hospital Programs, Office of Certification and Program Approvals, and Disaster Management and Response.

Current Data Bases

- **Trauma and Emergency Medicine Information System (TEMIS)**
  - **EMS Registry (9-1-1 responses and transports)**
  - **Paramedic Base Hospital Registry (On-Line Medical Direction)**
  - **Trauma Registry (Critically Injured Patients)**
- **STEMI Receiving Center Data**
- **LA Stroke Database**

Unique Facts or Interesting History

EMS providers have all converted their paper-based medical records to electronic patient care records (ePCR) due to the implementation of the Affordable Care Act (ACA). The ACA has also brought to the forefront the need for integration of EMS data systems and hospital data systems. In fact, the Office of the National Coordinator for Health Information Technology of the U.S. Department of Health and Human Services continues to work collaboratively with the State EMS Authority and the local EMS Agencies to address the need to implement Health Information Exchange (HIE) systems. This has been identified as a critical need to comply with the ACA and address disaster management needs such as patient tracking, mass casualty management, family reunification, etc. This section is responsible for seeking solutions, funding sources (i.e., grants), planning and implementation to support these initiatives.

State and Federal data reporting and submission requirements continue to increase and data collection requirements related to disease specific Specialty Care Centers continue to increase in complexity, all of which require the local EMS Agencies to provide complex patient level data reports. Specific functions of this unit include the following:

- Prepare and develop reports, and datasets in response to requests from the Board of Supervisors, hospitals, EMS providers and the public
- Provide technical assistance and consultation to hospital and EMS personnel regarding timely and accurate data collection and submission
- Support hospital and EMS provider reporting requirements
- Assist with research
- Support system wide quality improvement and performance monitoring activities

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Chapter 3.20 EMERGENCY MEDICAL SERVICES COMMISSION[1]

3.20.010 Continuation—Composition.

A. The Los Angeles County emergency medical services commission, which shall be referred to in this chapter as the "commission," is continued in accordance with California Health and Safety Code Sections 1751 and 1752.

B. The commission shall have 19 positions. A member of the commission shall be appointed to a vacant position by, and serve at the pleasure of, the board of supervisors, which shall be referred to in this chapter as the "board."

(Ord. 2011-0062 § 1, 2011: Ord. 90-0086 § 12(a), 1990: Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (part), 1979: Ord. 11179 § 1 (part), 1975: Ord. 4099 Art. 107 § 20501, 1942.)

3.20.020 Length of service—Vacancy.

A. Each member of the commission shall serve a term of four years at the pleasure of the board.

B. No member of the commission may serve more than two consecutive full periods of service as specified in subsection A of this section. The board may, by order, extend this length of service or waive this limit for individuals or the commission as a whole.

C. A member's position on the commission shall become vacant upon his or her death, resignation, or removal by the board. In the case of such a vacancy, the board shall appoint a successor to serve until the position next becomes vacant under subsection A of this section.

D. The provisions of Chapter 5.12 of the County Code shall not apply to the commission.

(Ord. 2011-0062 § 2, 2011: Ord. 90-0086 § 12(b), 1990: Ord. 12332 § 1 (part) 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (part), 1979: Ord. 11179 § 1 (part), 1975: Ord. 4099 Art. 107 § 20502, 1942.)

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[1]Note(s)—For statutory provisions on county emergency medical care committees, see Health & Safety Code § 1750 et seq.

Editor's note(s)—Ordinance 12332, passed April 7, 1981, entirely amended the provisions of Ord. 4099 Art. 107, the emergency medical services commission, with the effect of discontinuing six sections. Legislative history for the discontinued sections includes:

20505a	Ords. 12023 § 3 (part), 1979; 12040 § 1 (part), 1979.
20509 to 20511	Ords. 11179 § 1 (part), 1975; 12023 § 3 (part), 1979; 12040 § 1 (part), 1979; 12201 § 1 (part), 1980.
20512	Ords. 12023 § 3 (part), 1979; 12040 § 1 (part), 1979; 12201 § 1 (part), 1980.

3.20.040 Composition.

The commission shall be composed as follows:

A. An emergency medical care physician in a paramedic base hospital nominated by the California Chapter of the American College of Emergency Physicians;

B. A cardiologist nominated by the American Heart Association, Western States Affiliate;

C. A mobile intensive care nurse nominated by the California Chapter of the Emergency Department Nurses Association;

D. A hospital administrator nominated by the Healthcare Association of Southern California;

E. A representative of a public provider agency nominated by the Los Angeles Chapter of California Fire Chiefs Association;

F. A representative of a private provider agency nominated by the Los Angeles County Ambulance Association;

G. A trauma surgeon who practices in Los Angeles County at a designated trauma center nominated by the Southern California Chapter American College of Surgeons;

H. A psychiatrist nominated by the Southern California Psychiatric Society;

I. A physician nominated by the Los Angeles County Medical Association;

J. A licensed paramedic nominated by the California State Firefighters Association, Emergency Medical Services Committee;

K. Five public members, one nominated by each member of the Board of Supervisors. No public member shall be a medical professional or affiliated with any of the other nominating agencies;

L. A law enforcement representative nominated initially by the California Highway Patrol. After the first term of office for this position is completed, the law enforcement representative shall be nominated by the Los Angeles County Peace Officers Association;

M. A city manager nominated by the League of California Cities, Los Angeles County Chapter;

N. A police chief nominated by the Los Angeles County Police Chiefs Association;

O. A representative nominated by the Southern California Public Health Association.

(Ord. 2016-0008 § 1, 2016: Ord. 2011-0062 § 3, 2011: Ord. 2008-0006 § 1, 2008: Ord. 99-0027 § 1, 1999: Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (part), 1979: Ord. 11179 § 1 (part), 1975: Ord. 4099 Art. 107 § 20504, 1942.)

3.20.050 Compensation.

The members of the commission shall serve without compensation.

(Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (part), 1979: Ord. 11179 § 1 (part), 1975; Ord. 4099 Art. 107 § 20506, 1942.)

3.20.060 Chairperson.

The chairperson shall be appointed by the commission members in accordance with the commission's rules and regulations.

(Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (part), 1979: Ord. 4099 Art. 107 § 20505a, 1942.)

3.20.070 Functions and duties.

A. The commission shall perform all of the functions of the emergency medical care committee as defined in Health and Safety Code Sections 1750, et seq., and shall have the following duties:

1. To act in an advisory capacity to the board of supervisors and the director of health services regarding county policies, programs, and standards for emergency medical care services throughout the county, including paramedic services;

2. To establish appropriate criteria for evaluation and to conduct continuous evaluation on the basis of these criteria of the impact and quality of emergency medical care services throughout the county;

3. To conduct studies of particular elements of the emergency medical care system as requested by the board of supervisors, the director of health services or on its own initiative; to delineate problems and deficiencies and to recommend appropriate solutions;

4. To acquire and analyze the information necessary for measuring the impact and the quality of emergency medical care services;

5. To report its finding, conclusions, and recommendations to the board of supervisors at least every 12 months;

6. To review and comment on plans and proposals for emergency medical care services prepared by county departments;

7. To recommend, when the need arises, that the county engage independent contractors for the performance of specialized temporary or occasional services to the commission which cannot be performed by members of the classified service, and for which the county otherwise has the authority to contract;

8. To advise the department of health service and its director on the following matters:

   a. Policies, procedures, and standards to control the certification of mobile intensive care nurses and paramedics;

   b. Proposals of any public or private organization to initiate or modify a program of paramedic services or training;

9. To arbitrate differences in the field of paramedic services and training between all sectors of the community, including, but not limited to, county agencies, municipalities, public safety agencies, community colleges, hospitals, private companies, and physicians.

B. A decision of the commission regarding a matter which the commission hears under its arbitration function pursuant to subparagraph 9 hereinabove will be final and binding upon the parties who appeared before the commission on the matter unless the board of supervisors at any time promulgates policy which is inconsistent with such determination. Further, the commission shall refer to the board of supervisors and any other affected provider agency any such decision of the commission which will either affect the budget of the county, or any other provider agency, for the paramedic program, or operate to change an existing county-approved policy. Such decision shall not become final and binding unless adopted by the board of supervisors. Additionally, any such decision of the commission shall be advisory only if its implementation will affect any county paramedic program matter which the county health officer, the local emergency medical services agency, or board of supervisors has power to regulate pursuant to Health and Safety Code Sections 1480, et seq., and Health and Safety Code Sections 1797.200, et seq.

(Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (part), 1979: Ord. 11909 § 1, 1979: Ord. 11179 § 1 (part), 1975: Ord. 4099 Art. 107 § 20505, 1942.)

3.20.080 Self-government—Meetings.

The commission shall prepare and adopt rules and regulations for the internal government of its business and designating the time and place of holding its meetings, provided that such rules and regulations are not inconsistent with this or any other ordinance or statute.

(Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (part), 1979: Ord. 11179 § 1 (part), 1975: Ord. 4099 Art. 107 § 20507, 1942.)

3.20.090 Staff.

The director of health services shall provide the staff for the commission and subcommittees thereof.

(Ord. 12332 § 1 (part), 1981: Ord. 12201 § 1 (part), 1980: Ord. 12040 § 1 (part), 1979: Ord. 12023 § 3 (part), 1979: Ord. 11179 § 1 (part), 1975: Ord. 4099 Art. 107 § 20508, 1942.)

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

DATA FACTS

LOS ANGELES COUNTY EMS SYSTEM REPORT

MAY 1, 2021

ISSUE 9

Message from the Director and Medical Director

We are dedicating this issue of the EMS System Report to Michele Williams, Chief, Data Systems Management for our agency. Michele has worked with the EMS Agency for the past 9 years. She has served as the lead of our Data Management Section since 2018. Michele has been instrumental in moving the EMS Agency and our system to electronic data collection, ensuring data quality and consistency, and educating our providers and hospitals on the importance of quality data to direct our system and patient care.

Cathy Chidester
Director

Michele worked tirelessly, starting from scratch, to evolve our system from a predominantly pen and paper system to the 100% electronic system we have today. She has worked with each provider agency, hospital and digital system to convert LA County over to an entirely new platform. Her understanding of data management has enabled us to utilize this critical information to make vital decisions and conduct quality improvement and research on behalf of the over 10 million people who live in and visit our county. She dedicated countless hours this past year collecting and verifying COVID hospital assessment data which was critical to the county's understanding of the pandemic and provided support to policy decisions.

Dr. Marianne Gausche-Hill
Medical Director

Michele has recently left our EMS Agency to pursue personal goals. Her talent and drive will be sorely missed. I hope you will join us in wishing Michele the best in her new endeavors and thanking her for instilling excellence in our EMS program and systems.

INSIDE THIS ISSUE:

SPECIAL POINTS OF INTEREST:

- EMS Mechanisms of Injury (pages 6 & 7)
- ED Disposition and Patient Type (page 11)
- Injury Severity Scores (pages 14-15)
- Paramedic Base Hospital Contact Volume (page 20)

2020 System Demographics

70 9-1-1 Receiving Hospitals

- 38 EDAP (Emergency Department Approved for Pediatrics)
- 10 Pediatric Medical Centers
- 7 Pediatric Trauma Centers
- 15 Trauma Centers
- 21 Paramedic Base Hospitals
- 36 STEMI Receiving Centers
- 18 Comprehensive Stroke Centers
- 34 Primary Stroke Centers
- 54 Perinatal Centers
- 44 Hospitals with Neonatal Intensive Care Unit
- 8 SART (Sexual Assault Response Team)
- 13 Disaster Resource Centers

EMS Provider Agencies

- 31 Public Safety EMS Provider Agencies
- 34 Licensed Basic Life Support Ambulance Operators
- 17 Licensed Advanced Life Support Ambulance Operators
- 20 Licensed Critical Care Transport Ambulance Operators
- 6 Licensed Ambulette Operators

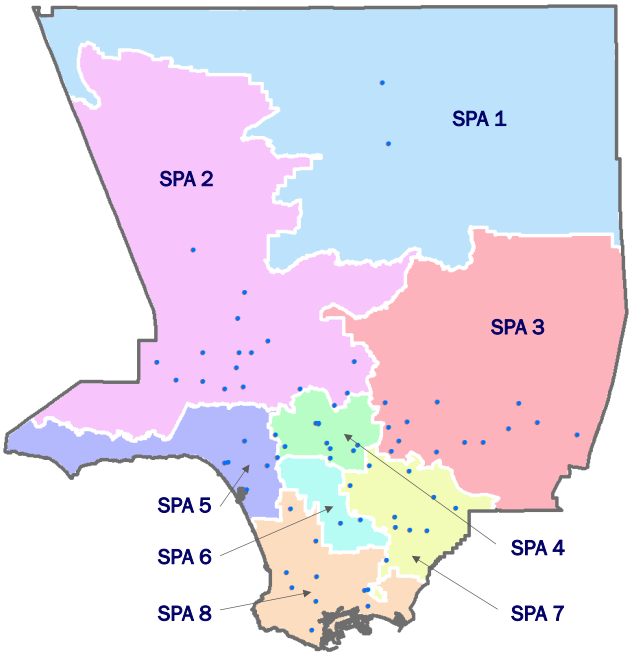
EMS Practitioners

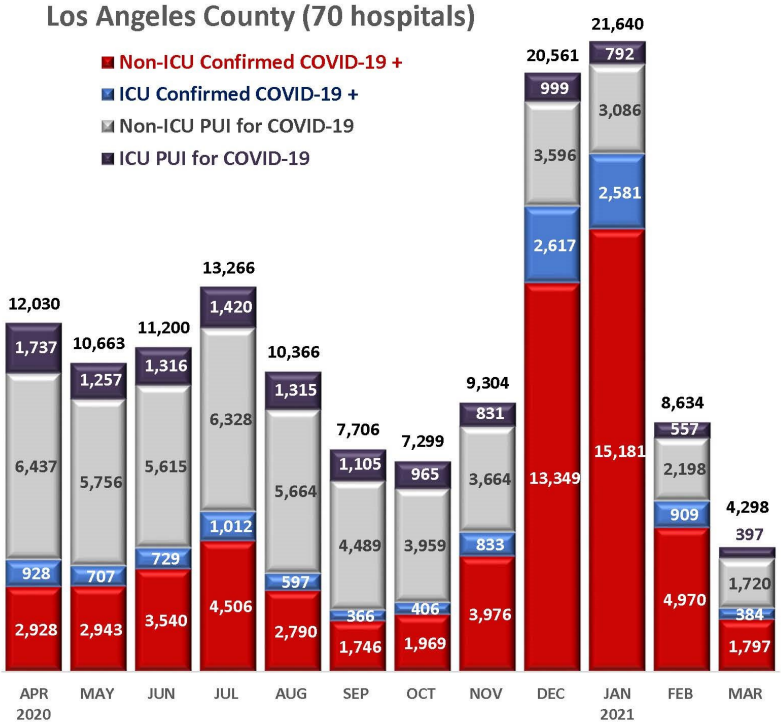
- 4,512 Accredited Paramedics
- 8,123 Certified EMTs by LA Co EMS Agency
- 883 Certified Mobile Intensive Care Nurses

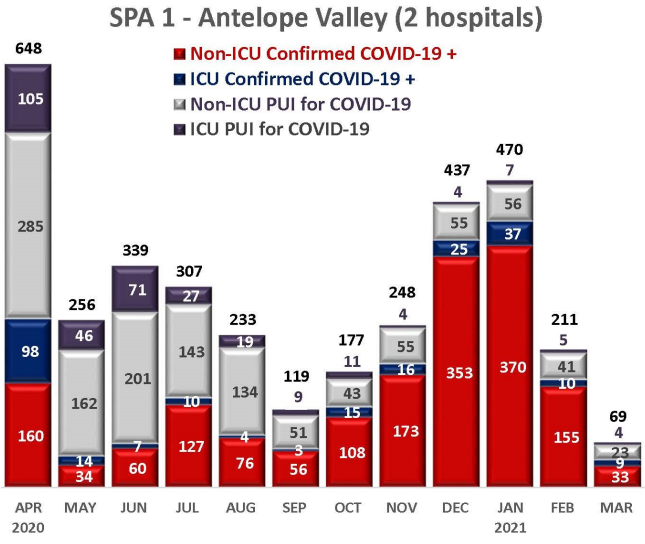
COVID-19 Hospitalizations by Month and by Service Planning Area (SPA)

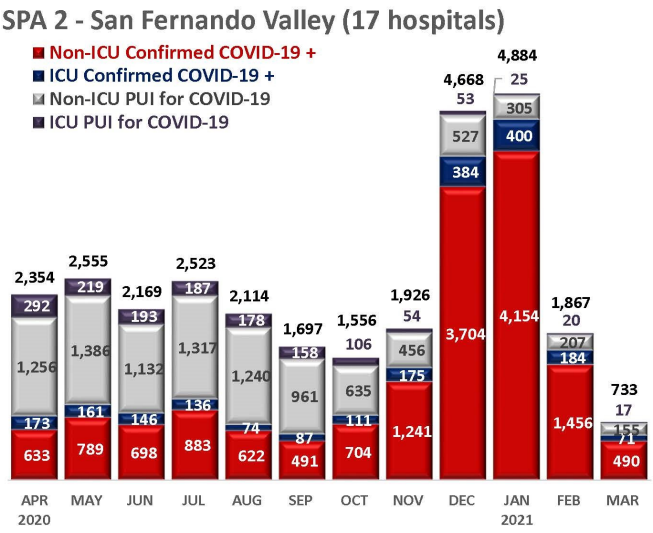
Confirmed and Person Under Investigation (PUI)

(Age 15 years and older)

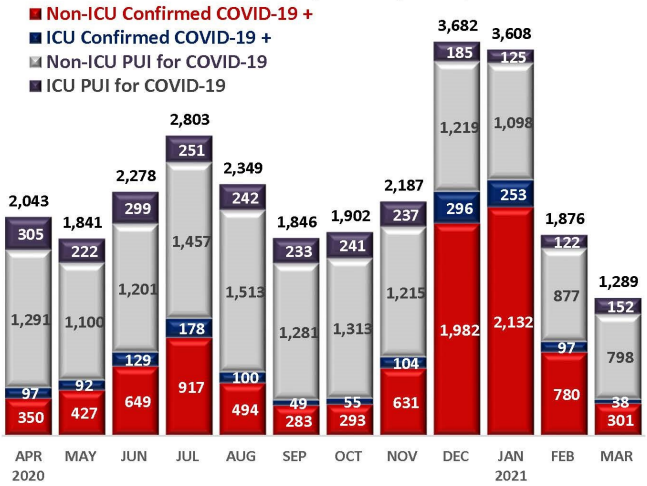




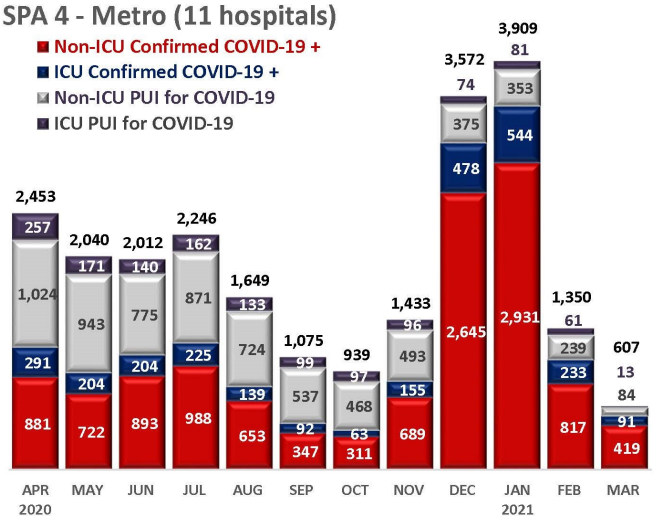




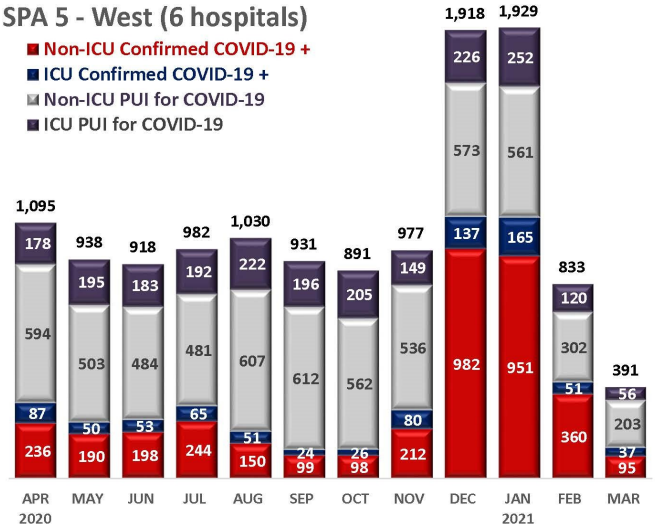
SPA 3 - San Gabriel Valley (13 hospitals)



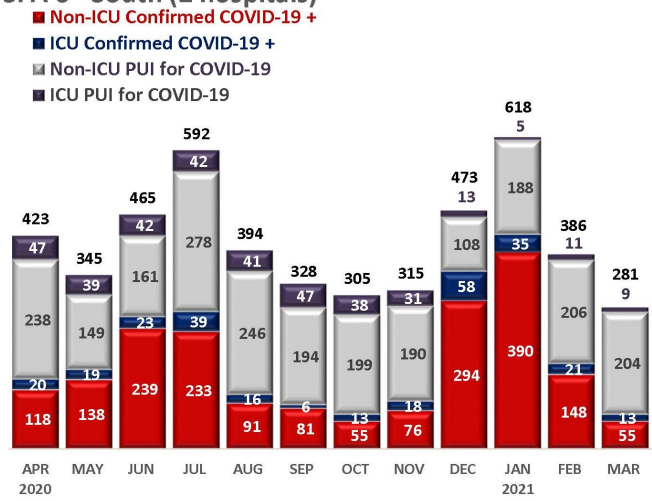
SPA 4 - Metro (11 hospitals)



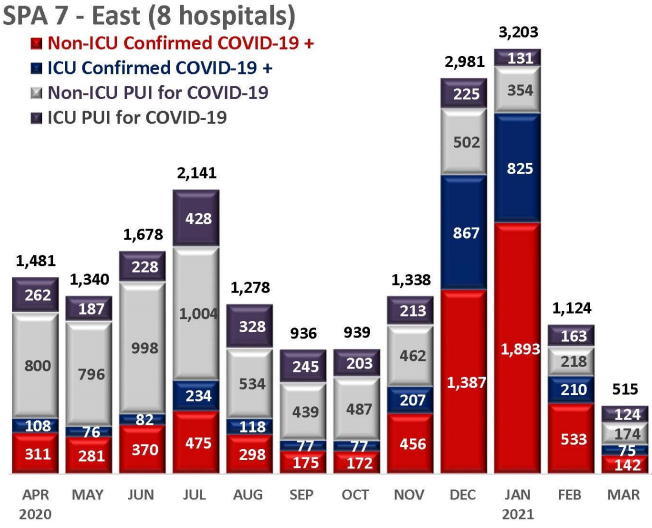
SPA 5 - West (6 hospitals)



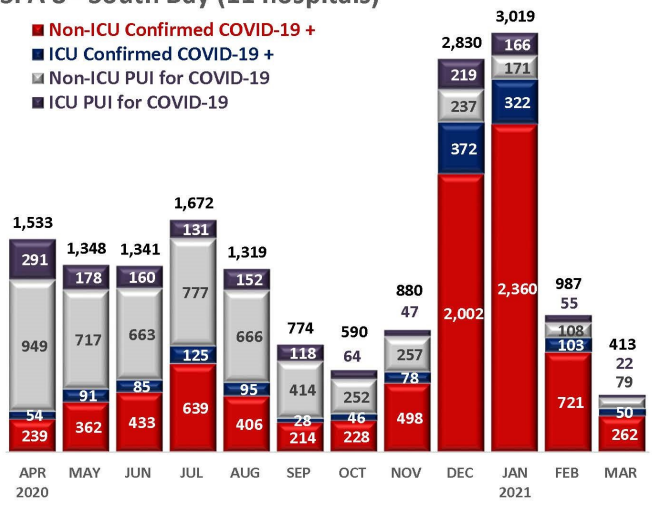
SPA 6 - South (2 hospitals)



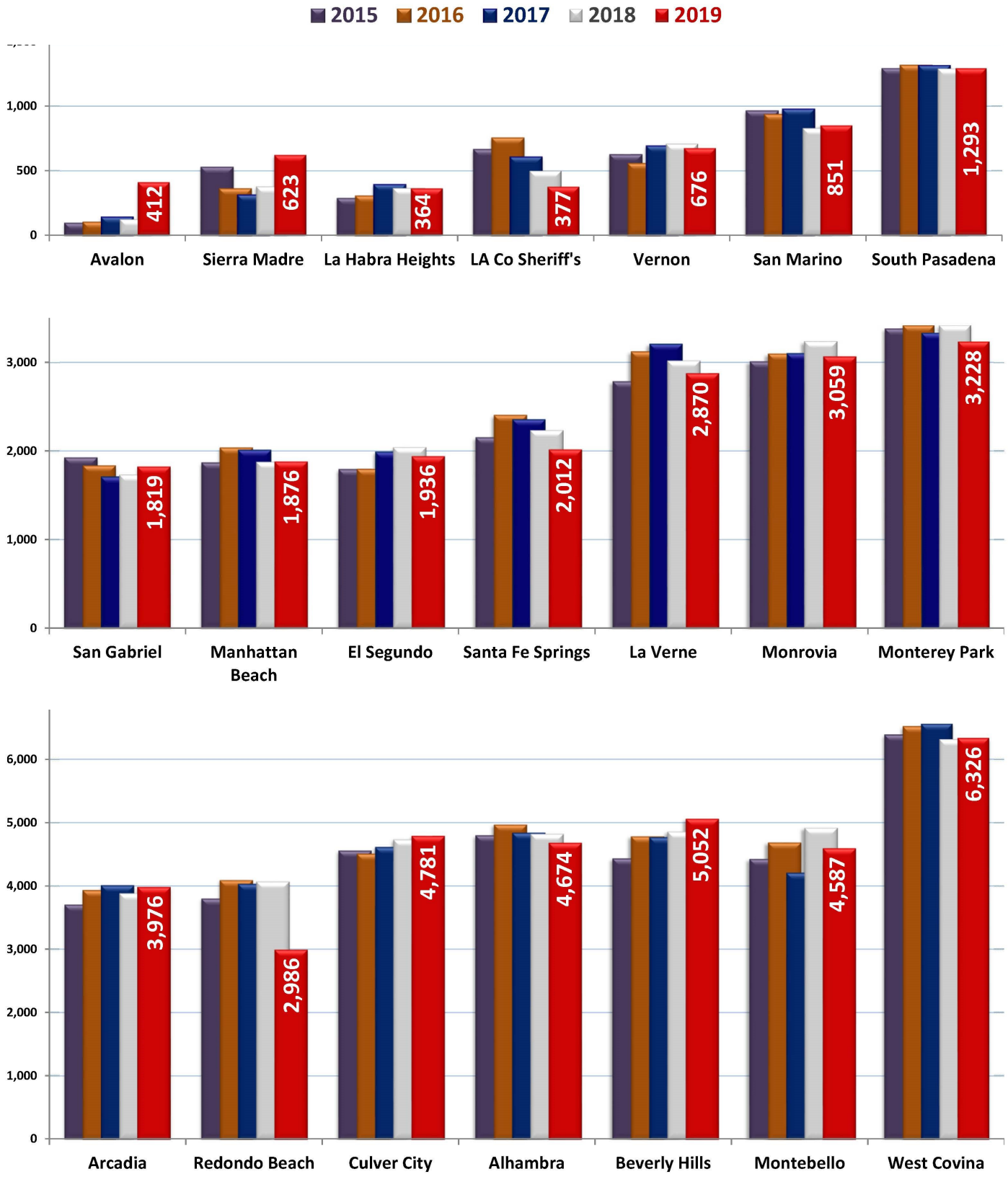
SPA 7 - East (8 hospitals)



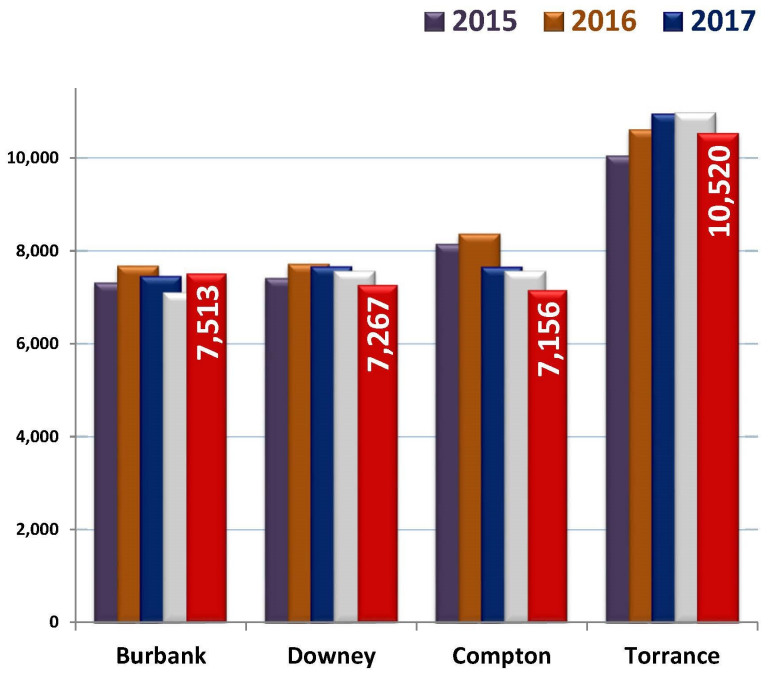
SPA 8 - South Bay (11 hospitals)

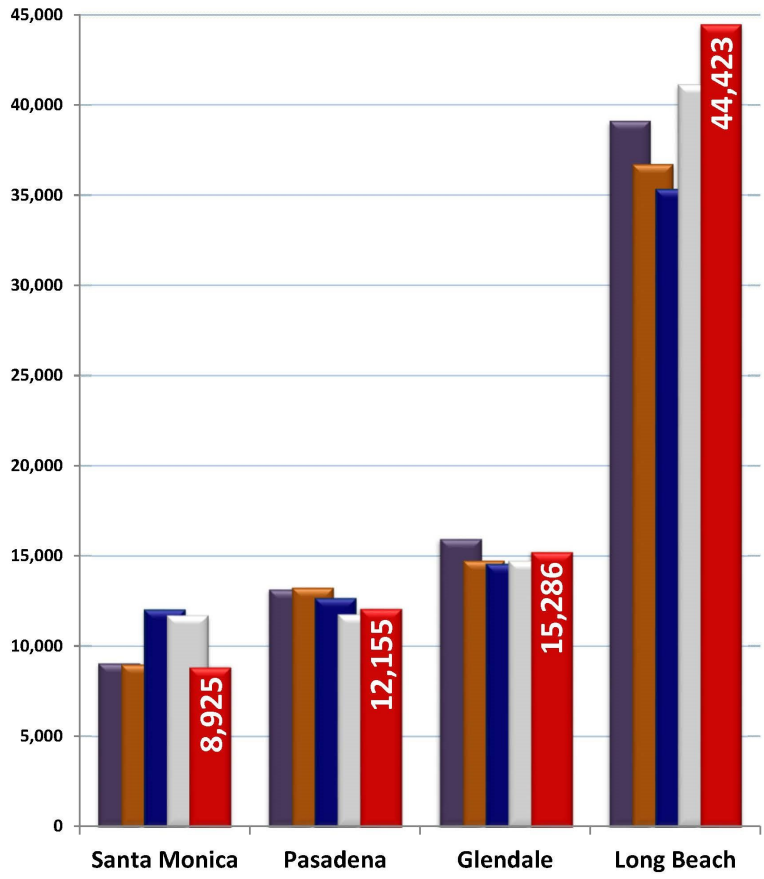


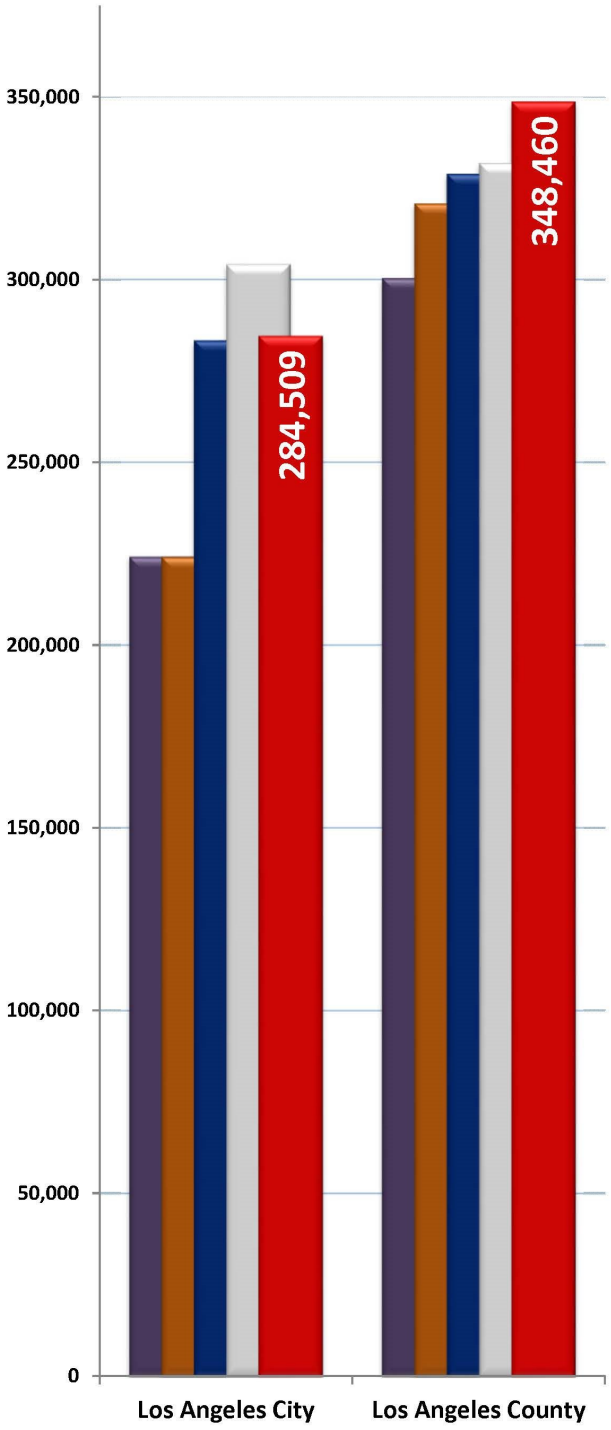
EMS Responses by 9-1-1 Jurisdictional Provider Agency



EMS Responses by 9-1-1 Jurisdictional Provider Agency







ADULT PROVIDER IMPRESSIONS (TOP 10)	2018	%	2019	%
Traumatic Injury	127,585	16%	112,114	14%
Behavioral / Psychiatric Crisis	59,823	7%	58,874	8%
Weakness - General	57,031	7%	53,333	7%
No Medical Complaint	55,124	7%	47,817	6%
Body Pain - Non-Traumatic	40,734	5%	43,654	6%
Abdominal Pain/Problems	37,592	5%	32,584	4%
Altered Level of Consciousness	31,245	4%	27,743	4%
Syncope / Near Syncope	26,312	3%	24,268	3%
Seizure - Postictal	23,159	3%	19,299	2%
Chest Pain - Suspected Cardiac	21,582	3%	17,947	2%
TOTAL - Top 10 Provider Impressions	480,742	59%	437,633	56%
TOTAL - Adult EMS Responses	819,320		777,556	

ADULT TRANSPORTS (TOP 10)	2018	%	2019	%
Traumatic Injury	83,518	16%	78,521	15%
Weakness - General	44,777	9%	42,942	8%
Behavioral / Psychiatric Crisis	41,367	8%	41,430	8%
Altered Level of Consciousness	34,109	6%	27,293	5%
Abdominal Pain / Problems	33,801	6%	30,062	6%
Body Pain - Non-Traumatic	33,547	6%	37,076	7%
Chest Pain - Suspected Cardiac	20,316	4%	17,411	3%
Syncope / Near Syncope	19,833	4%	19,136	4%
Respiratory Distress - Other	16,386	3%	16,558	3%
Seizure - Postictal	16,355	3%	17,205	3%
TOTAL - Top 10 Adult EMS Transports	344,009	65%	327,634	62%
TOTAL - Adult EMS Transports	526,568		527,233	

ADULT MECHANISMS OF INJURY (TOP 10)	2018	%	2019	%
Fall	45,502	34%	39,706	32%
Motor Vehicle Accident	36,039	27%	38,292	31%
Assault	16,544	12%	13,315	11%
Pedestrian/Bicycle struck by Motor Vehicle	8,561	6%	8,968	7%
Animal Bite	1,913	1%	2,473	2%
Sports / Recreational	2,164	2%	1,940	2%
Motorcycle / Moped Accident	2,378	2%	1,582	1%
Stabbing	1,485	1%	1,573	1%
Gunshot Wound	1,577	1.2%	1,462	1.2%
Accidental Self-Inflicted Injury	1,000	0.8%	1,100	0.9%
TOTAL - Top 10 Adult Mechanisms of Injury	117,163	88%	110,411	88%
TOTAL - Adult Mechanisms of Injury	132,868		125,465	

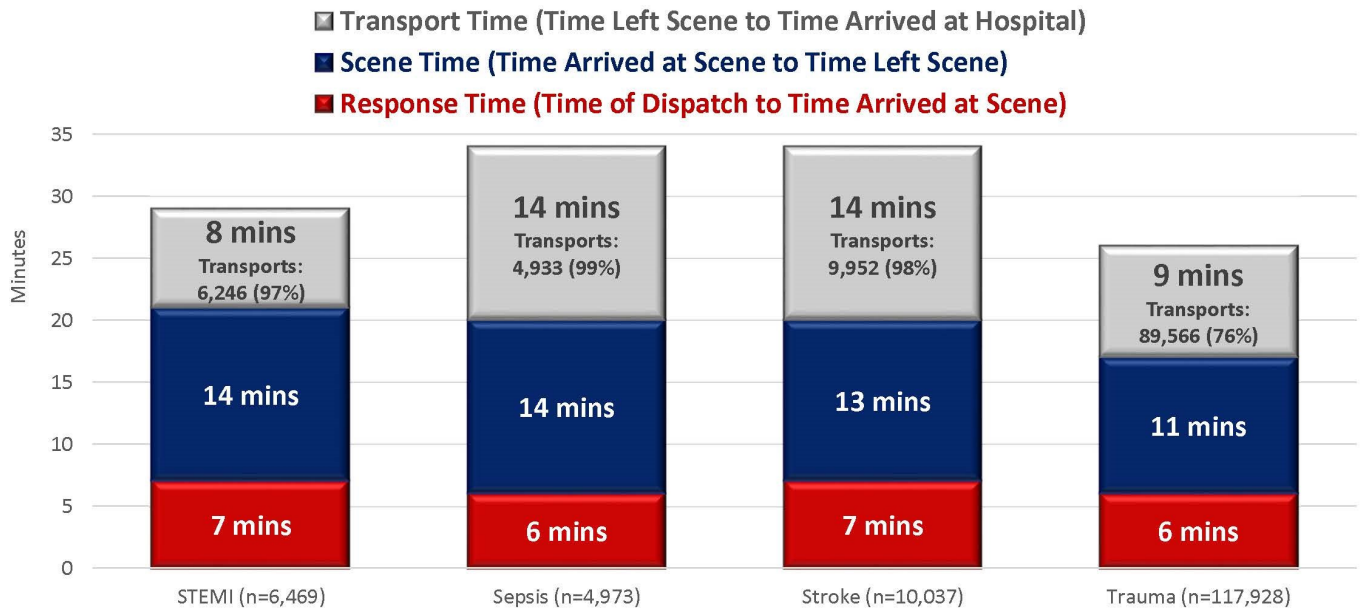
PEDIATRIC PROVIDER IMPRESSIONS (TOP 10)	2018	%	2019	%
Traumatic Injury	8,559	23%	8,234	23%
No Medical Complaint	5,377	15%	4,709	13%
Seizure - Postictal	4,533	12%	4,988	14%
Behavioral / Psychiatric Crisis	1,860	5%	1,827	5%
Cold / Flu	1,690	5%	1,771	5%
Fever	1,531	4%	1,467	4%
Respiratory Distress - Other	1,038	3%	1,050	3%
Respiratory Distress - Bronchospasm	1,026	3%	1,066	3%
Syncope / Near Syncope	989	3%	1,014	3%
Nausea / Vomiting	913	2%	907	3%
TOTAL - Top 10 Pediatric EMS Responses	27,516	75%	27,033	75%
TOTAL - Pediatric EMS Responses	36,919		36,151	

PEDIATRIC TRANSPORTS (TOP 10)	2018	%	2019	%
Traumatic Injury	5,328	22%	5,108	22%
Seizure - Postictal	4,234	18%	4,551	19%
Behavioral / Psychiatric Crisis	1,270	5%	1,166	5%
Fever	1,074	4%	1,023	4%
Cold / Flu	982	4%	947	4%
Respiratory Distress - Bronchospasm	855	4%	890	4%
Respiratory Distress - Other	848	4%	853	4%
Syncope / Near Syncope	784	3%	736	3%
Allergic Reaction	641	3%	636	3%
Seizure - Active	596	2%	567	2%
TOTAL - Top 10 Pediatric EMS Transports	16,612	69%	16,477	70%
TOTAL - Pediatric EMS Transports	24,031		23,517	

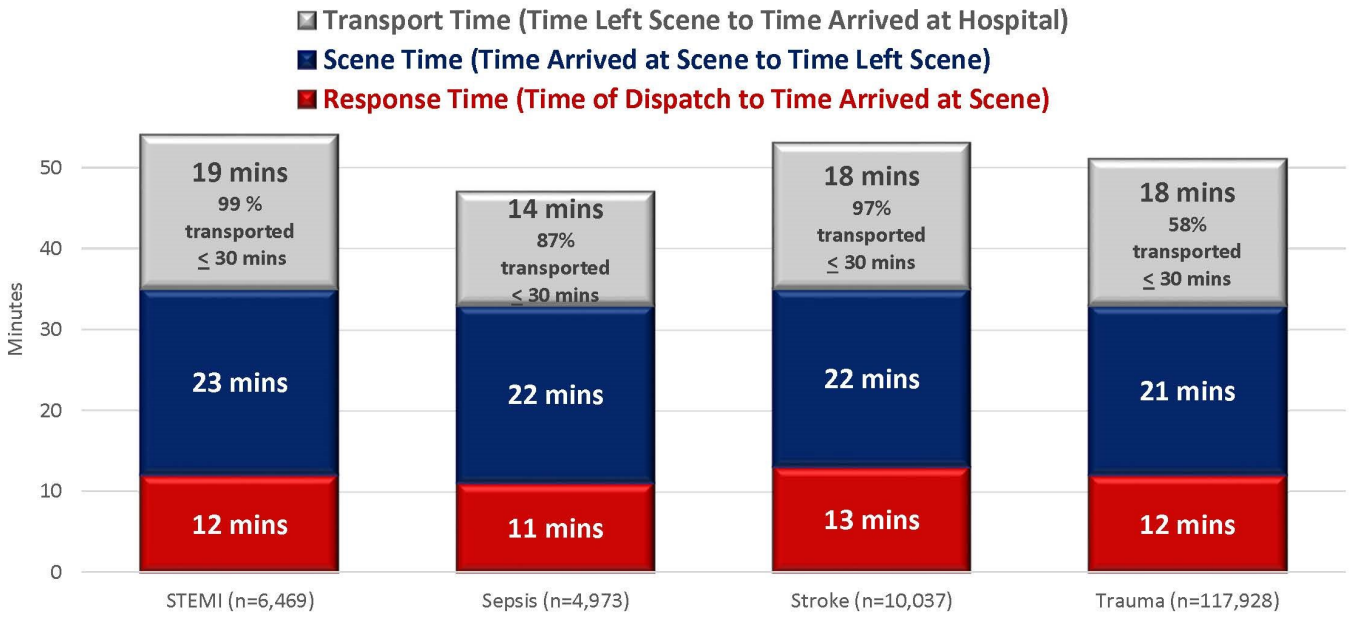
PEDIATRIC MECHANISMS OF INJURY (TOP 10)	2018	%	2019	%
Fall	3,215	31%	2,859	28%
Motor Vehicle Accident	2,503	24%	2,882	28%
Sports / Recreational	789	8%	758	7%
Pedestrian/Bicycle struck by Motor Vehicle	728	7%	778	8%
Animal Bite	328	3%	452	4%
Assault	475	5%	449	4%
Accidental Self-Inflicted Injury	133	1%	160	2%
Thermal Burn	93	1%	112	1%
Intentional Self-Inflicted Injury	44	0.4%	33	0.3%
Crush Injury	34	0.3%	29	0.3%
TOTAL - Top 10 Pediatric Mechanisms of Injury	8,342	80%	8,512	84%
TOTAL - Pediatric Mechanisms of Injury	10,416		10,123	

2019 EMS Times: Adult (Median)

LA County EMS Transport Time of ADULT Patients with Provider Impressions STEMI, Stroke, Sepsis and Traumatic Injuries

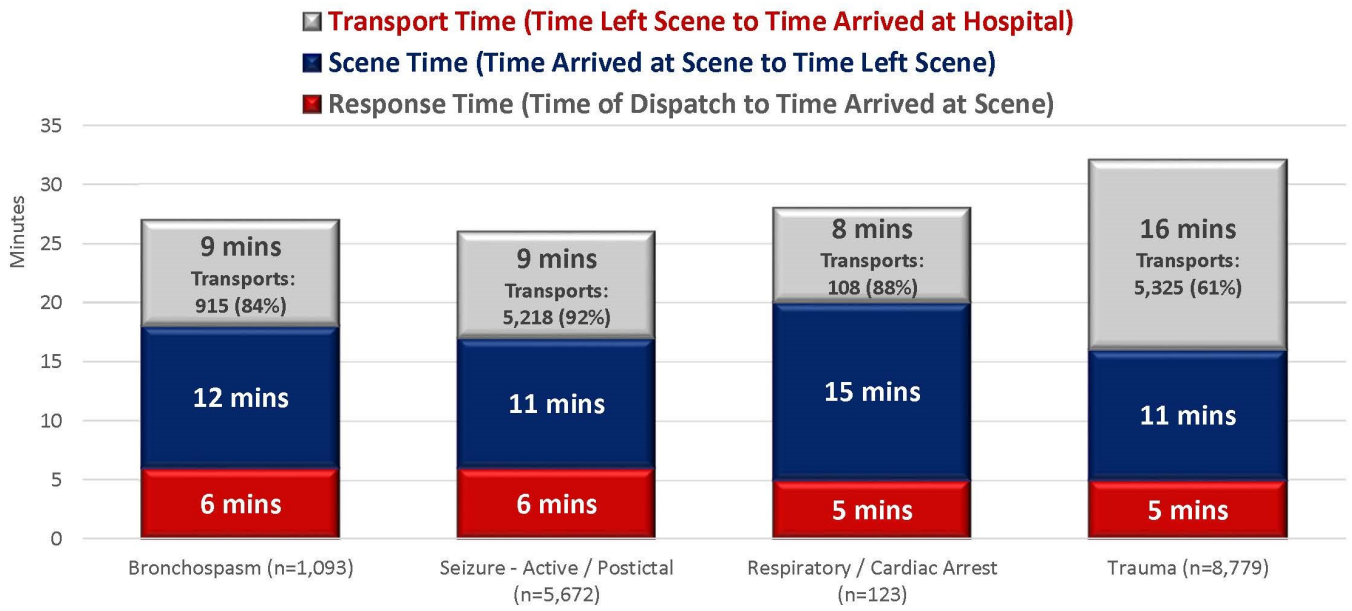


2019 EMS Times (90th Percentile)

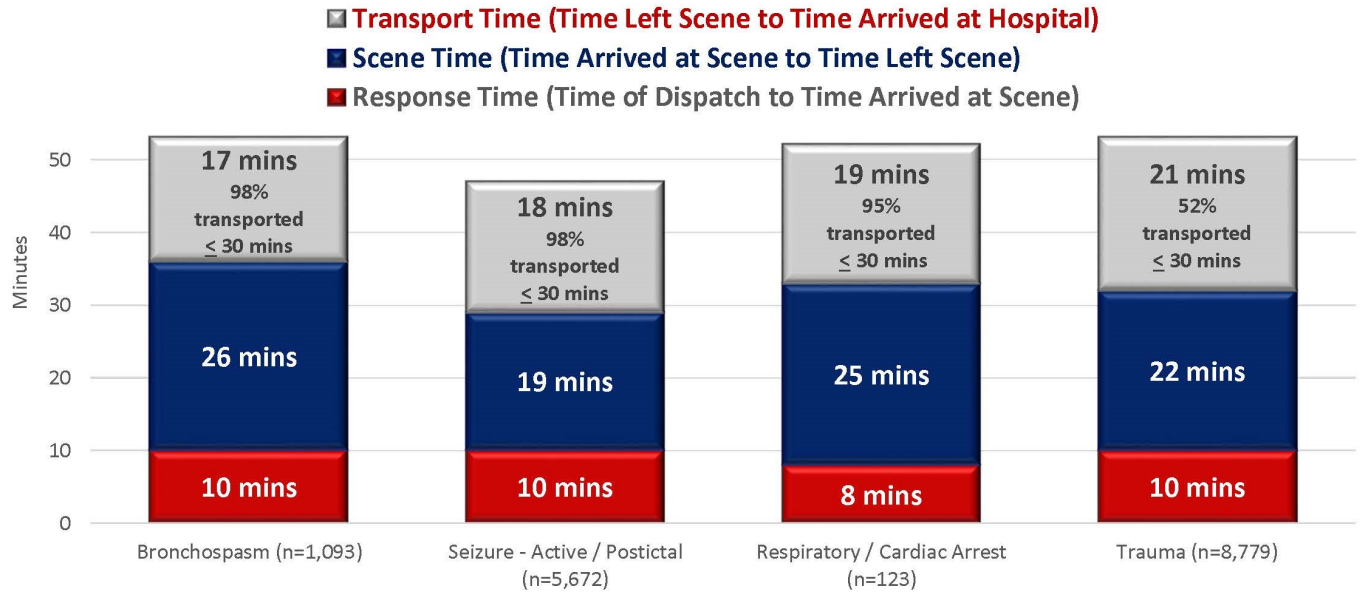


2019 EMS Times: Pediatric (Median)

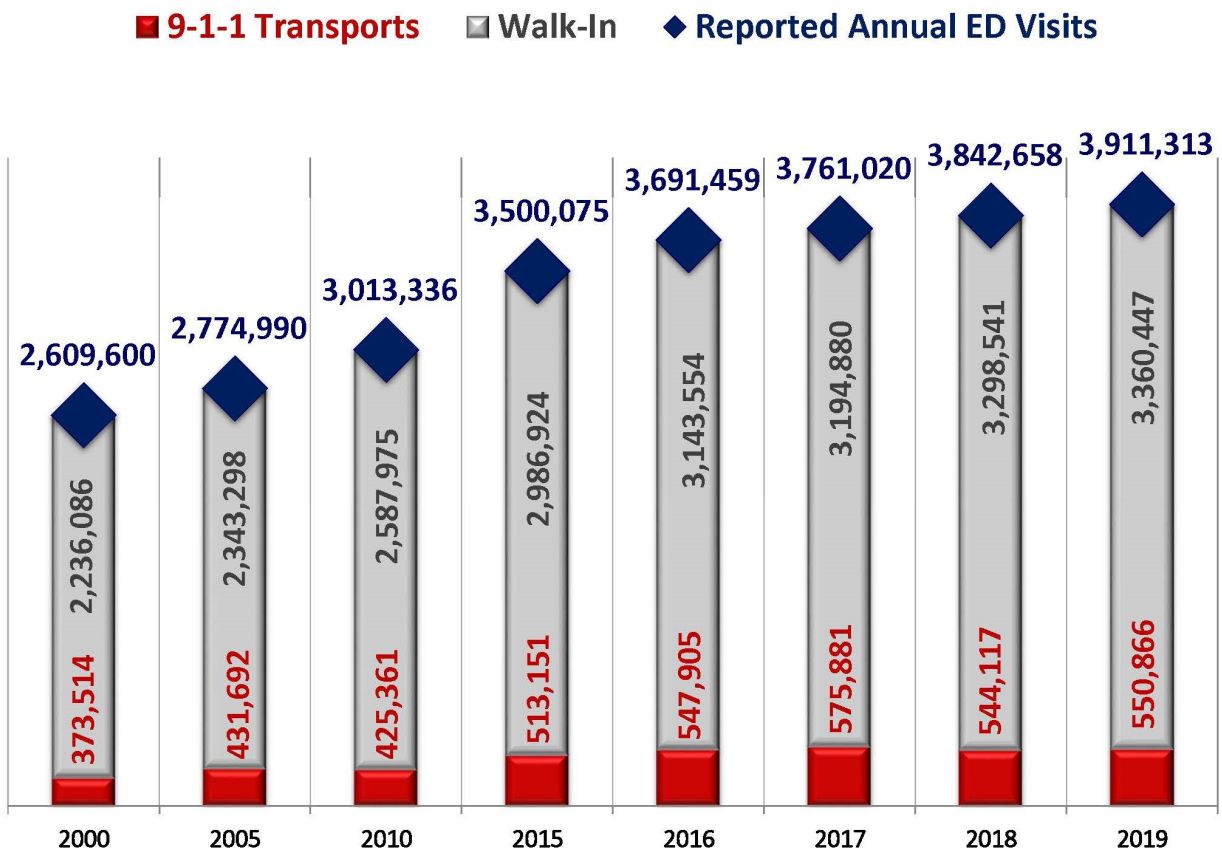
LA County EMS Transport Time PEDIATRIC Patients with Provider Impressions Bronchospasm, Seizure, Respiratory/Cardiac Arrest and Traumatic Injuries



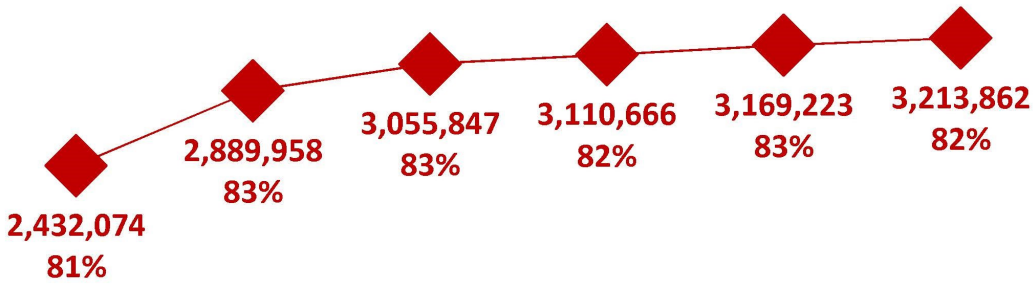
2019 EMS Times: Pediatric (90th Percentile)



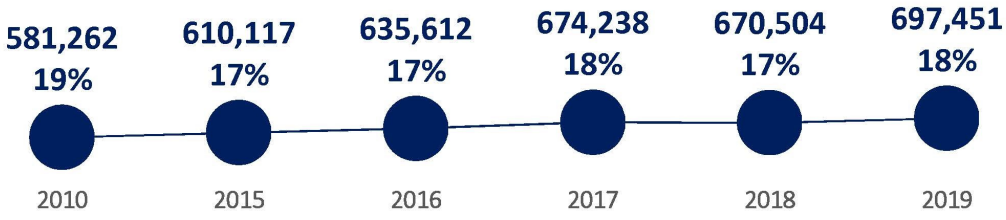
Emergency Department Volume



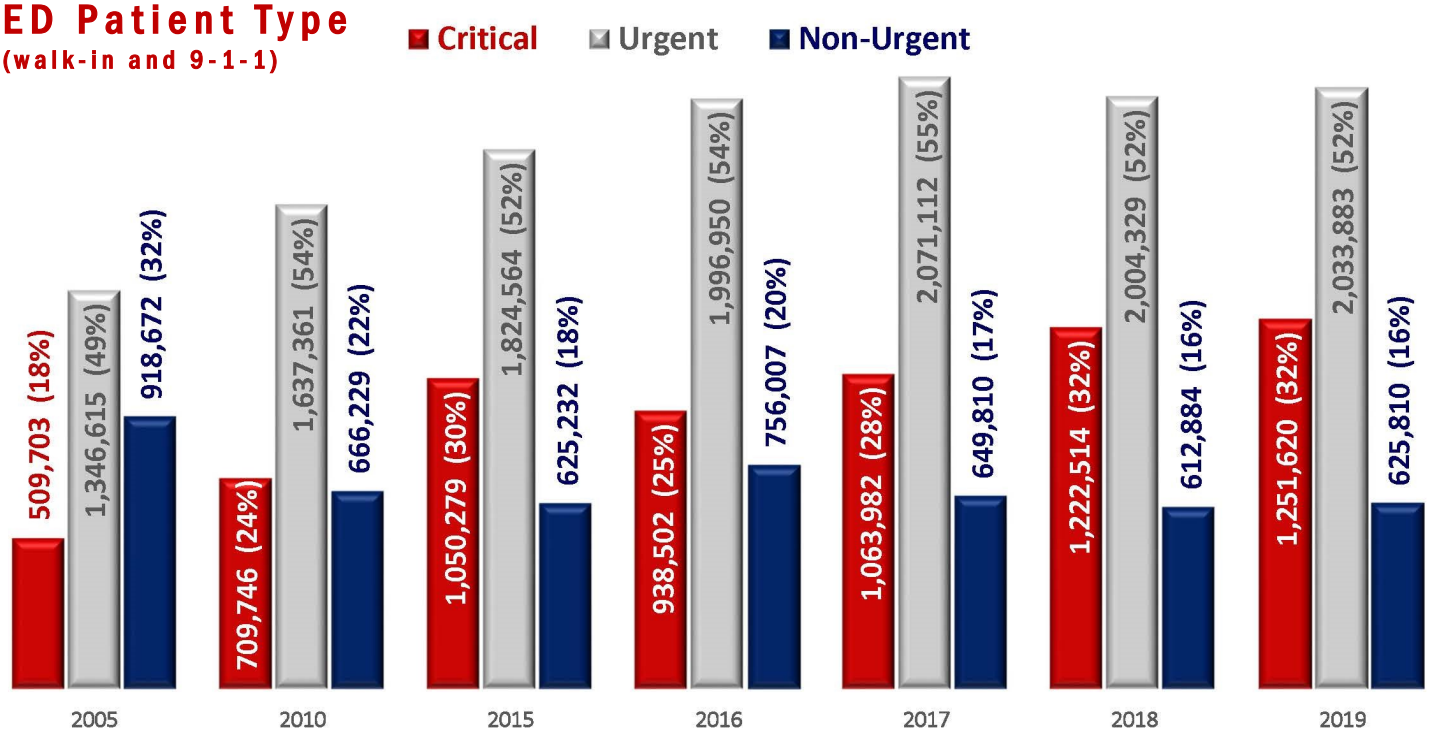
Adult:
15 years and older



Pediatric:
14 years and younger

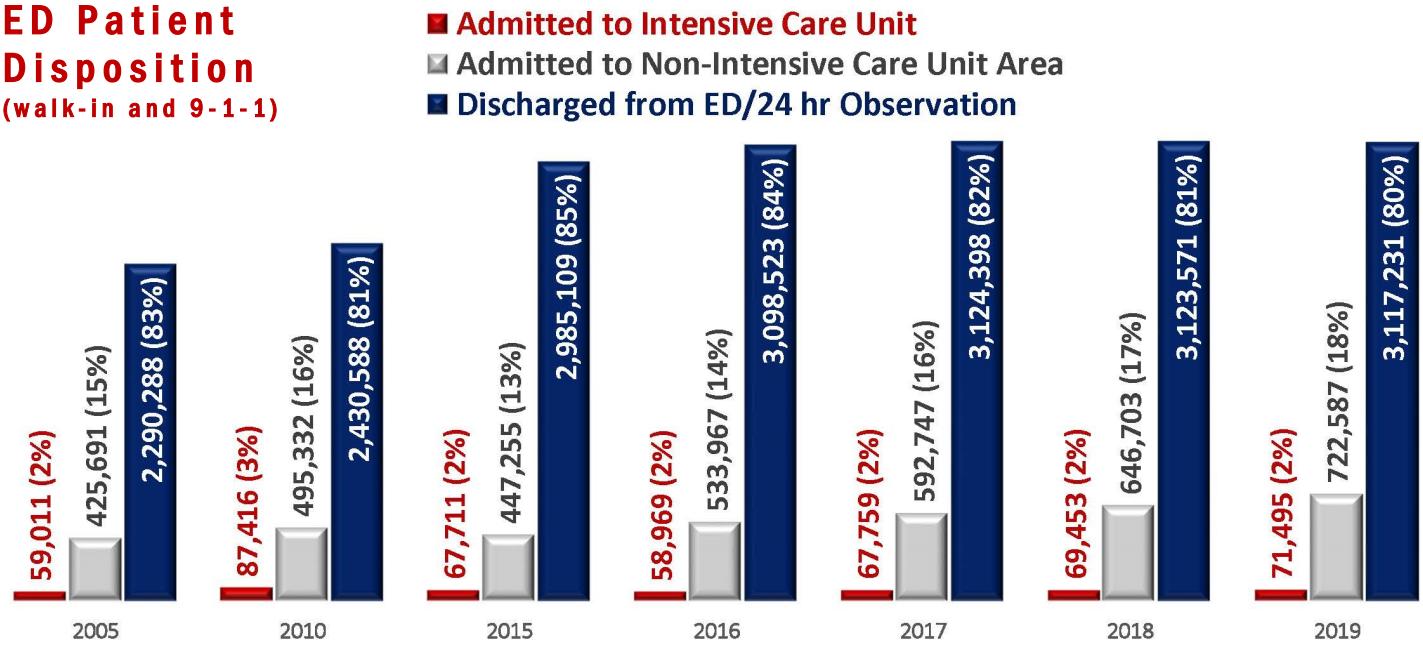


ED Patient Type
(walk-in and 9-1-1)

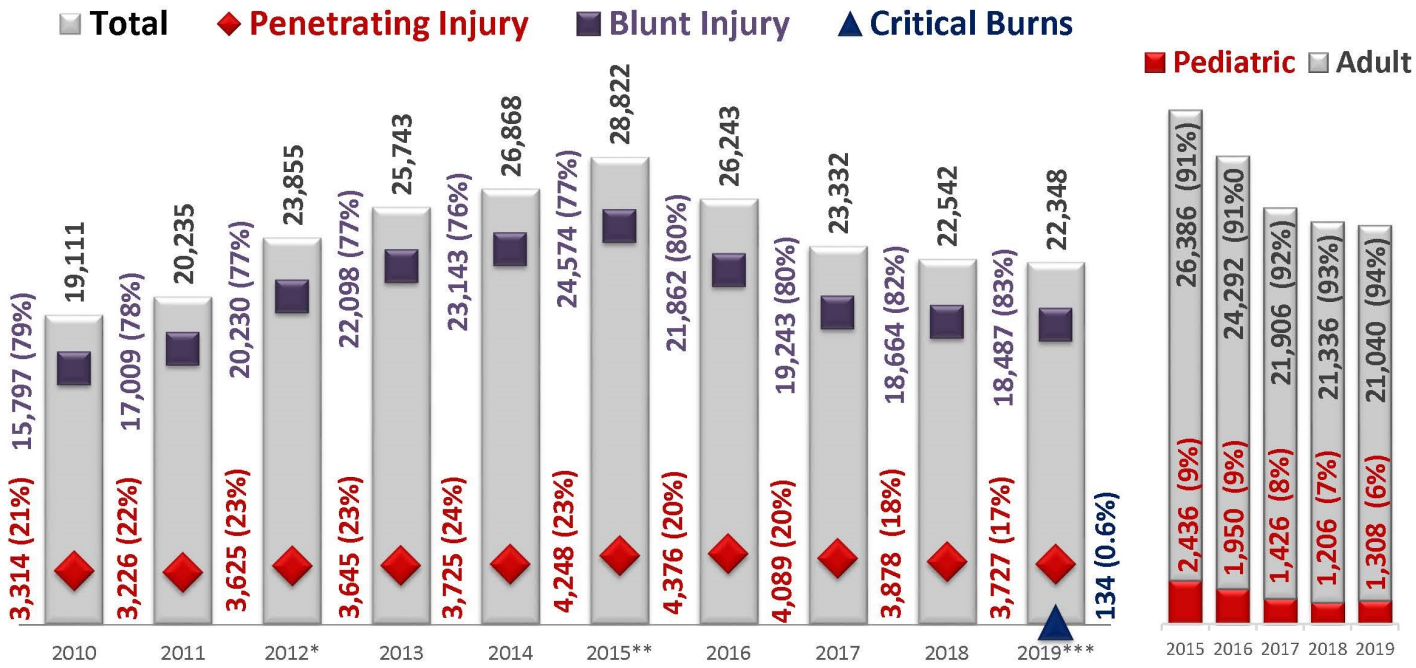


Critical—a patient presents an acute injury or illness that could result in permanent damage, injury or death (head injury, vehicular accident, shooting). Applicable Current Procedural Terminology (CPT) codes for this level of service would be 99284 (detailed history, detailed physical, and medical decision making of moderate complexity) or 99285 (medical decision making of high complexity) or 99291 (critical care, evaluation and management).
Urgent—a patient with an acute injury or illness, loss of life or limb is not an immediate threat to their well-being, or a patient who needs timely evaluation (fracture or laceration). Applicable CPT codes for this level of service would be 99282 (medical decision making of low complexity) or 99283 (medical decision making of moderate complexity).
Non-Urgent—a patient with a non-emergent injury, illness or condition; sometimes chronic; that can be treated in a non-emergency setting and not necessarily on the same day they are seen in the ED (pregnancy tests, toothache, minor cold, ingrown toenail). An applicable CPT code for this level of service would be 99281 (straight forward medical decision making).

ED Patient Disposition
(walk-in and 9-1-1)

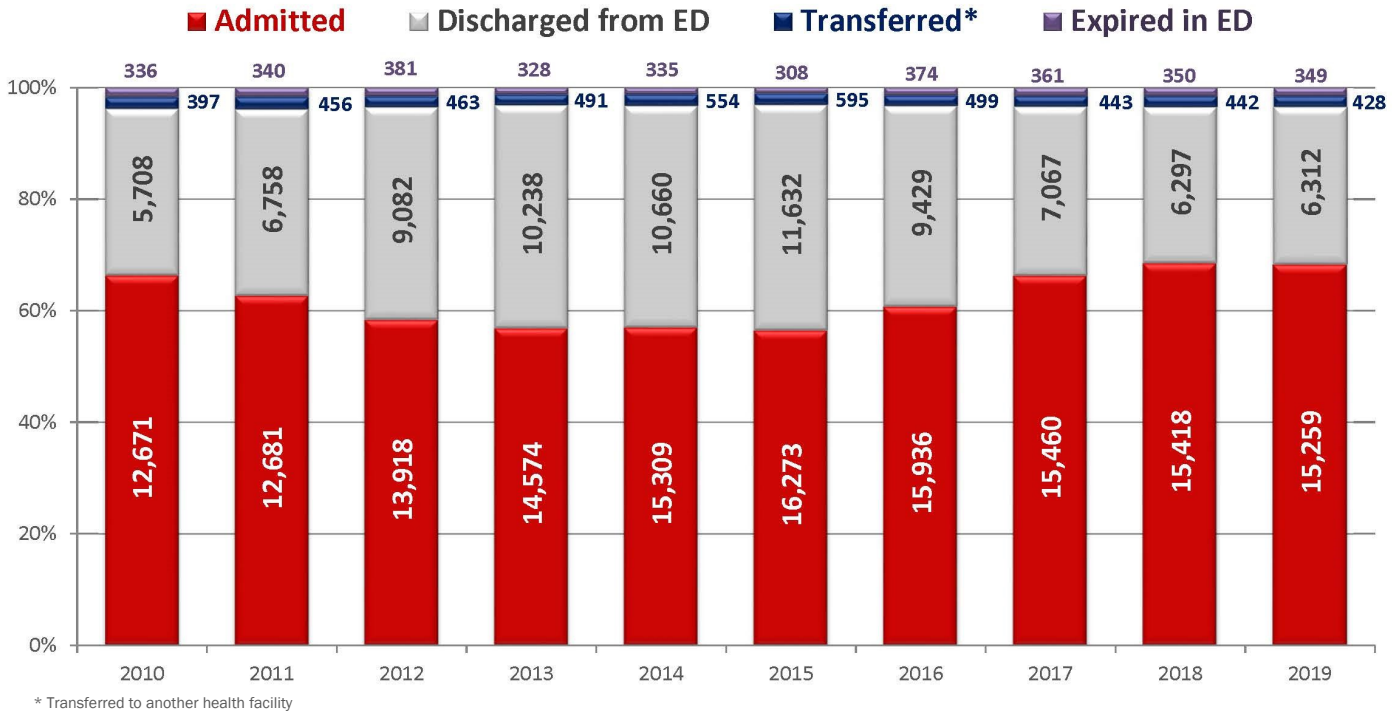


Trauma Center Volume



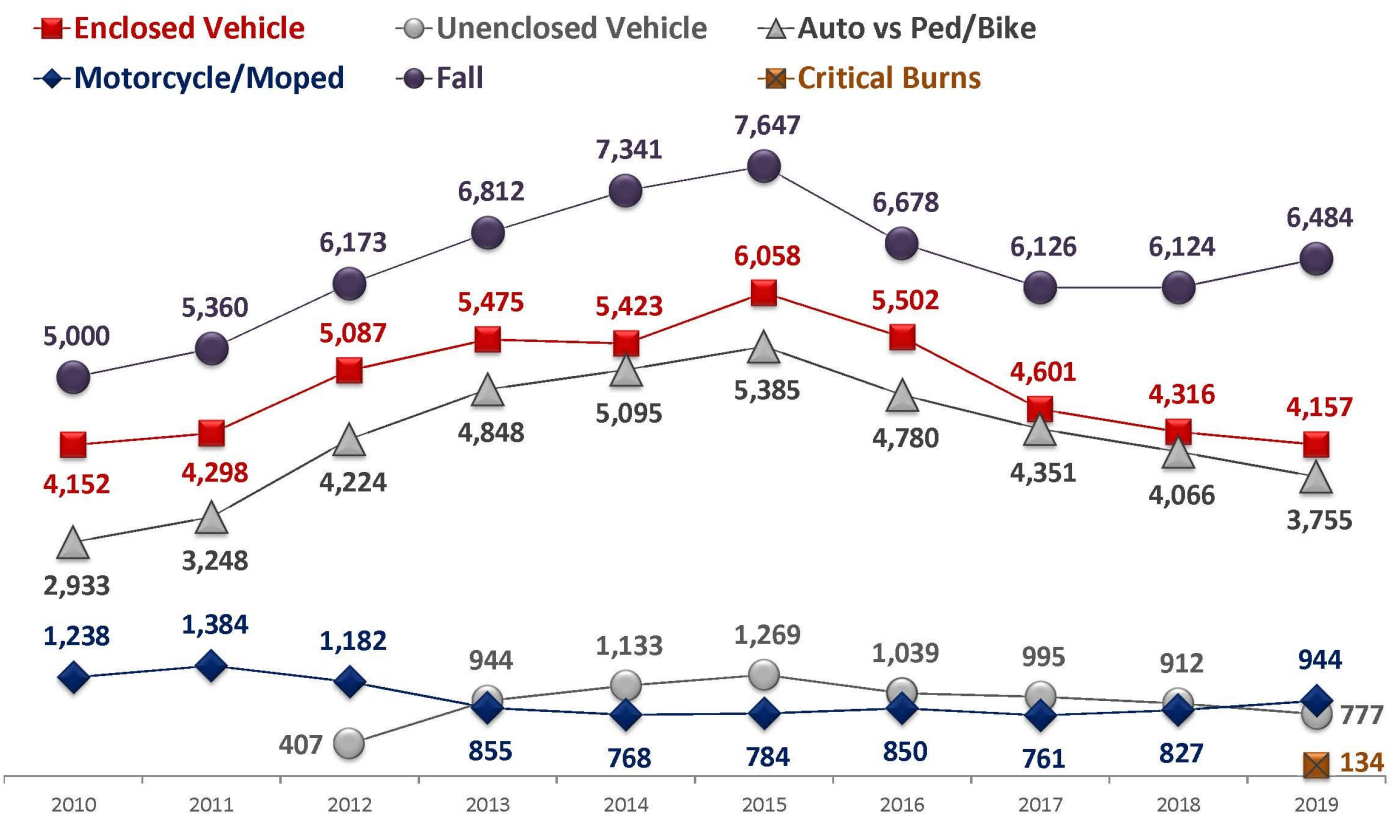
*2012: LA County adopted the Centers for Disease Control and Prevention Guidelines for Field Triage of Injured Patients
**2015 : Trauma Center Registry inclusion criteria was reduced.
***2019: Critical Burns added as a Trauma Center Criteria

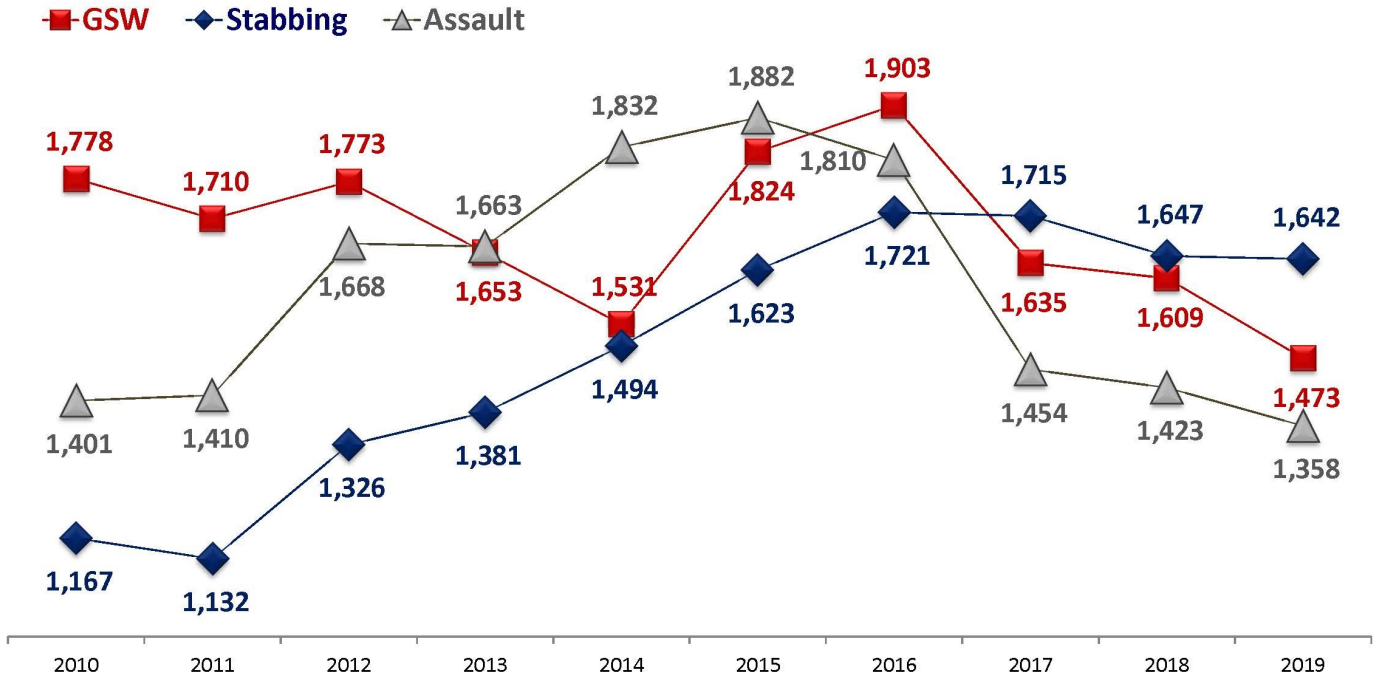
Patient Disposition of Trauma Center Patients



* Transferred to another health facility

Mechanism of Injury: Patients Transported to Trauma Centers

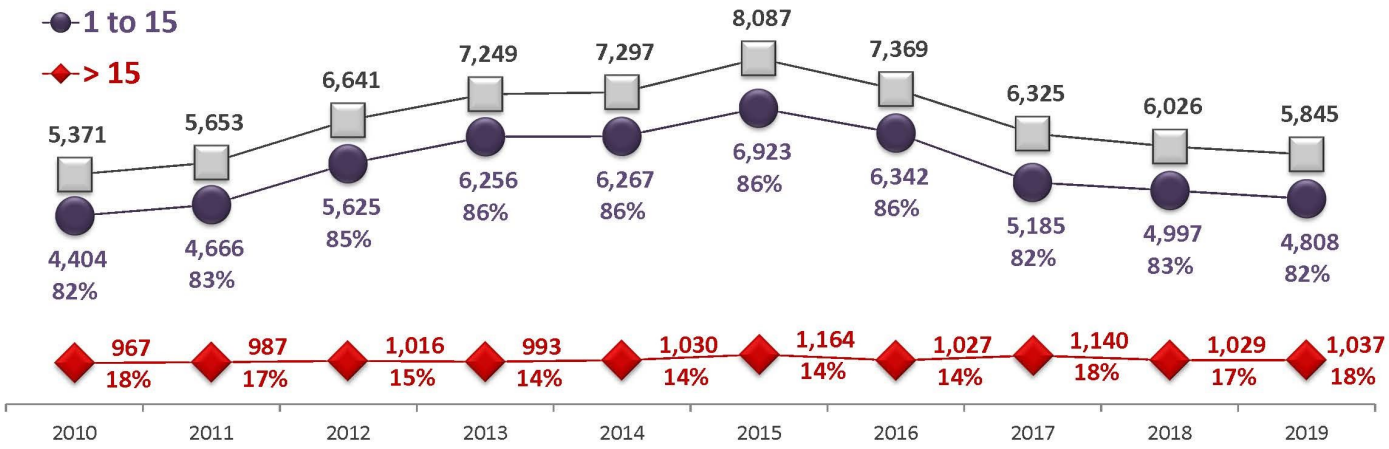




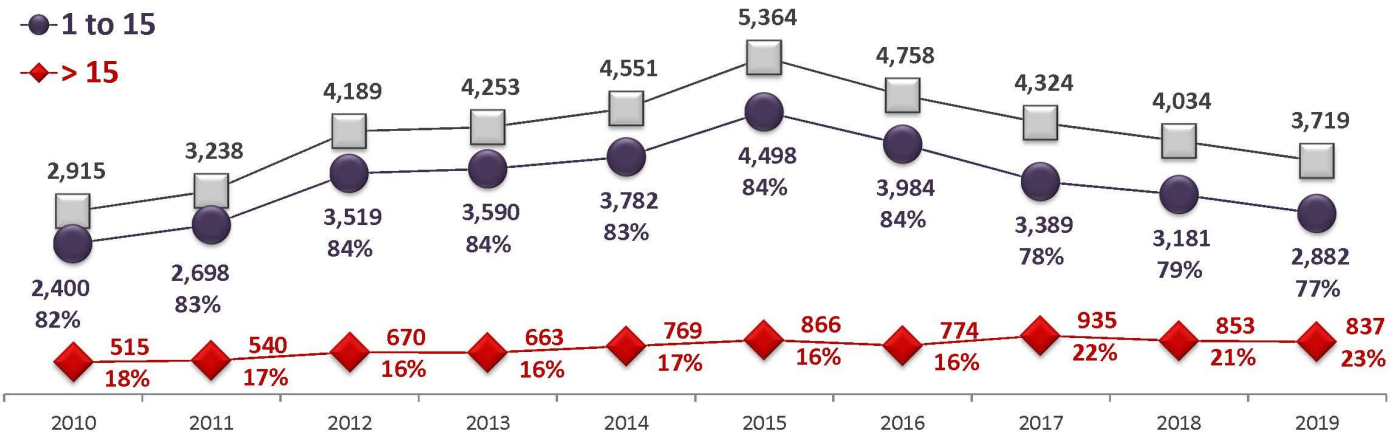
Injury Severity Score by Mechanism of Injury

Injury Severity Score (ISS): Is an established medical score to assess trauma severity. It correlates with mortality, morbidity and hospitalization time after trauma. It is used to define the term major trauma. A major trauma (or polytrauma) is defined as the ISS being greater than 15.

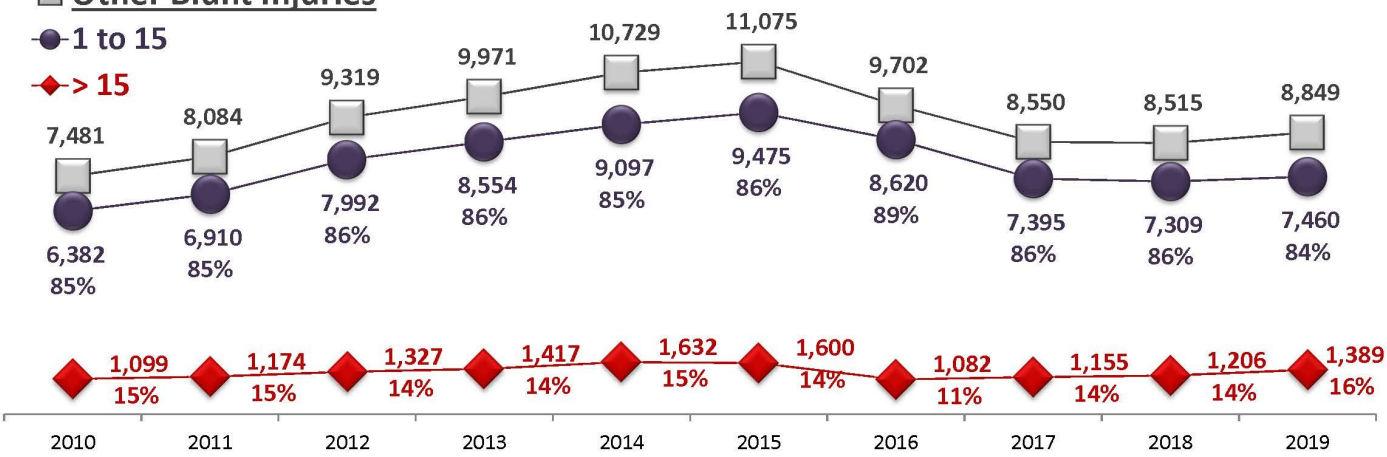
Motor Vehicle Accident



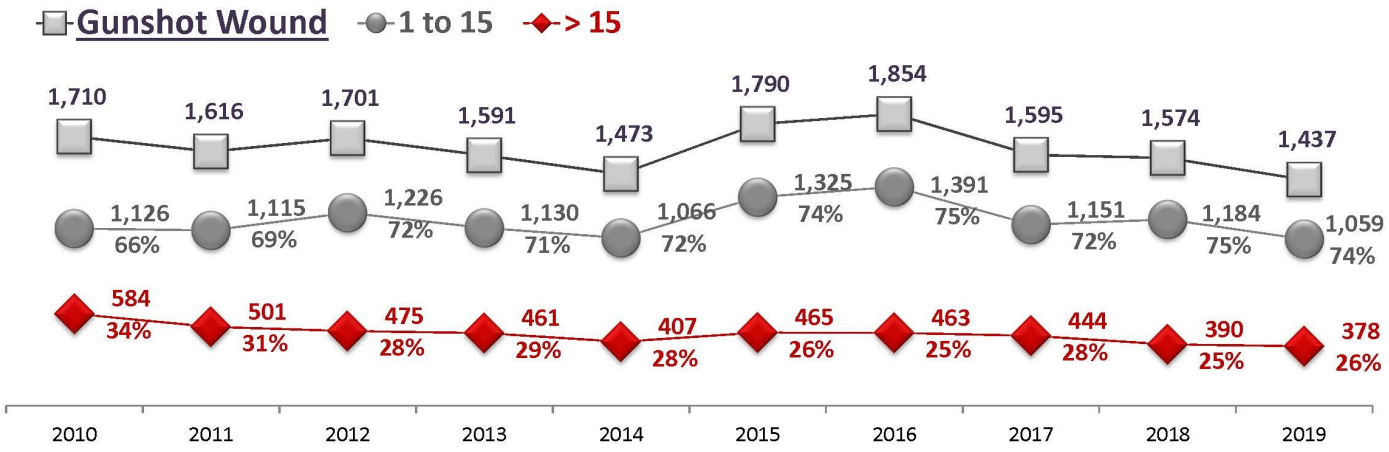
Automobile vs Pedestrian/Bicycle

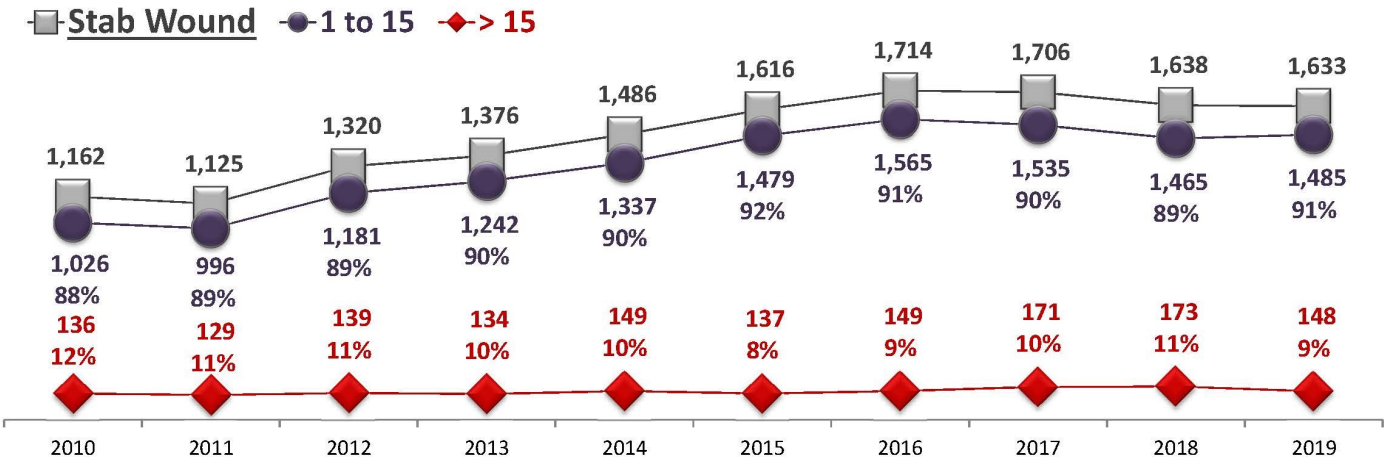


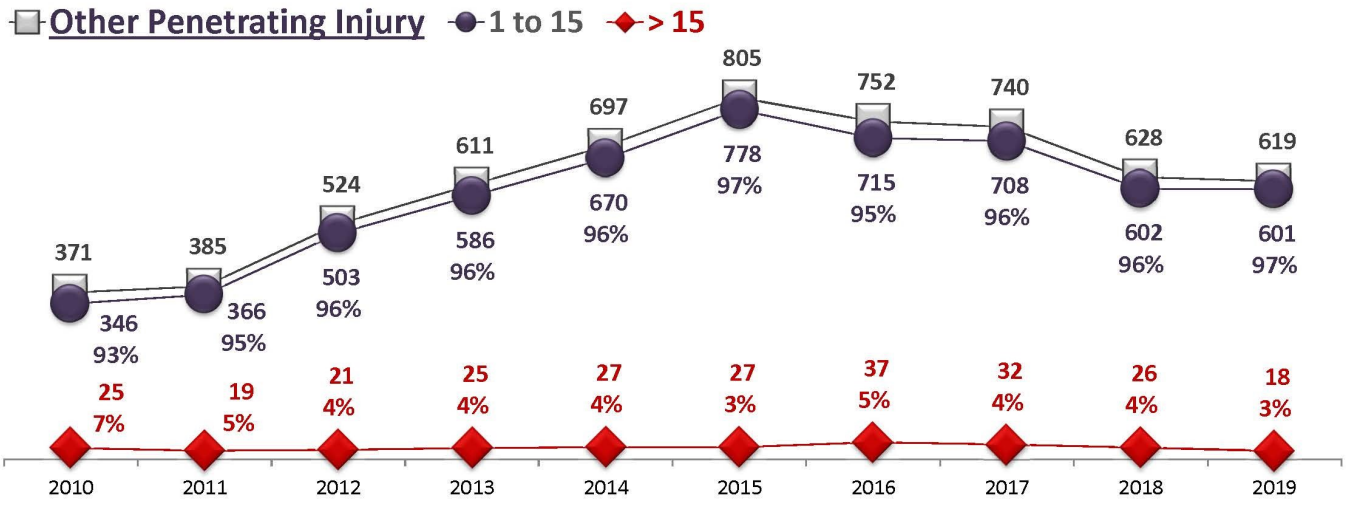
Other Blunt Injuries



Injury Severity Score by Mechanism of Injury



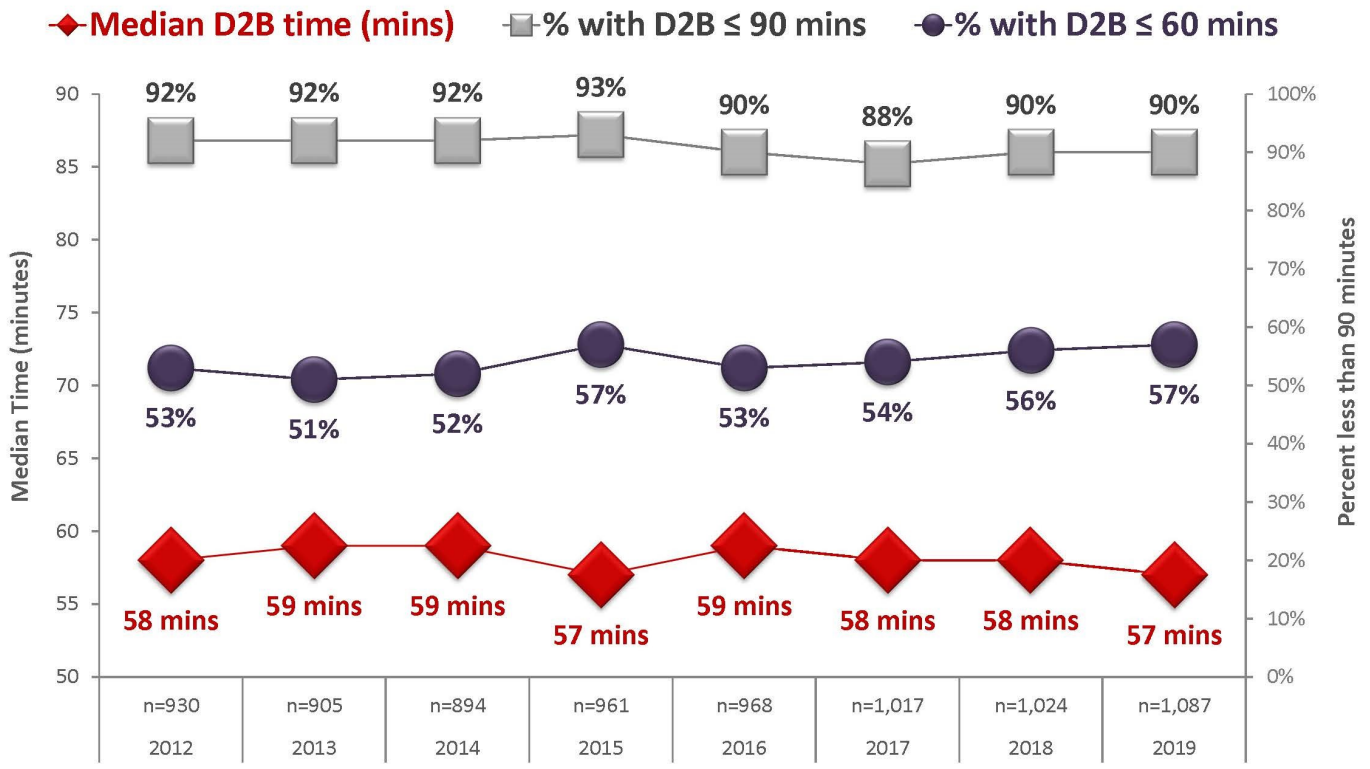




ST-Elevation Myocardial Infarction (STEMI)

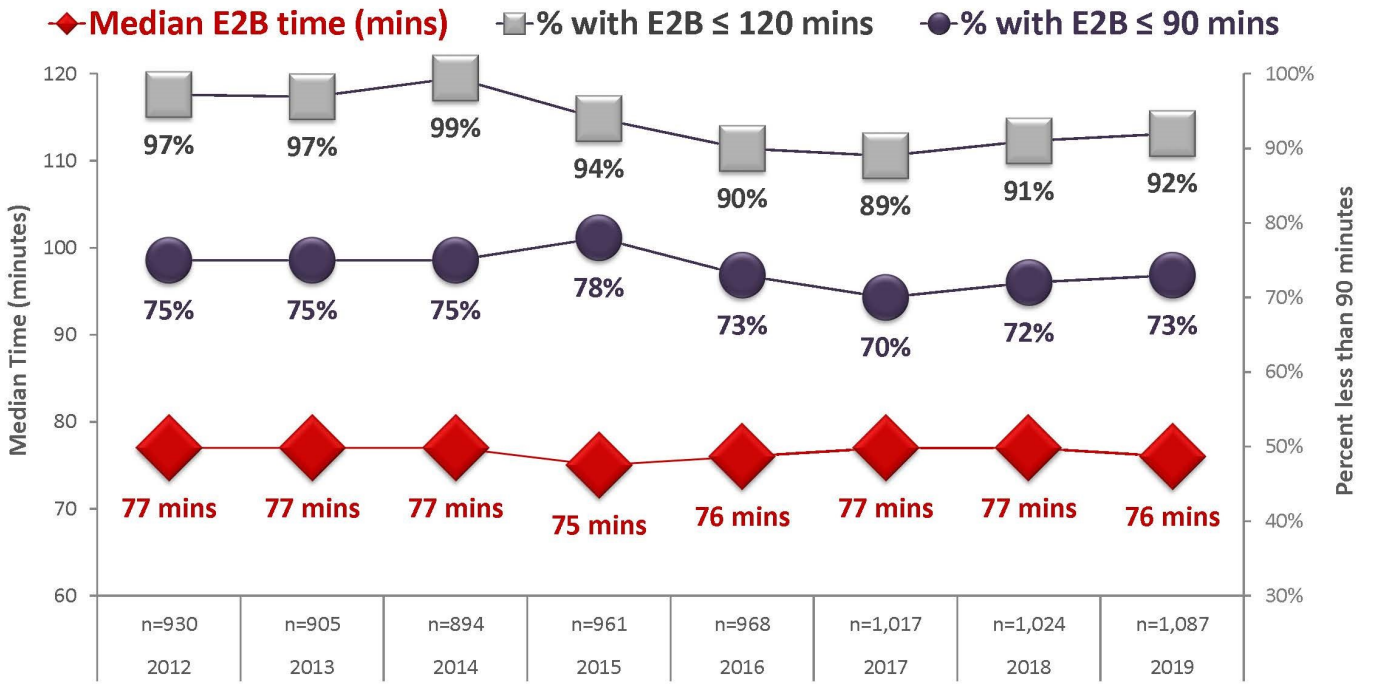
STEMI Receiving Center: Door-to-Device (D2B) Time

LA County Target: within 90 minutes 90% of the time and within 60 minutes 75% of the time



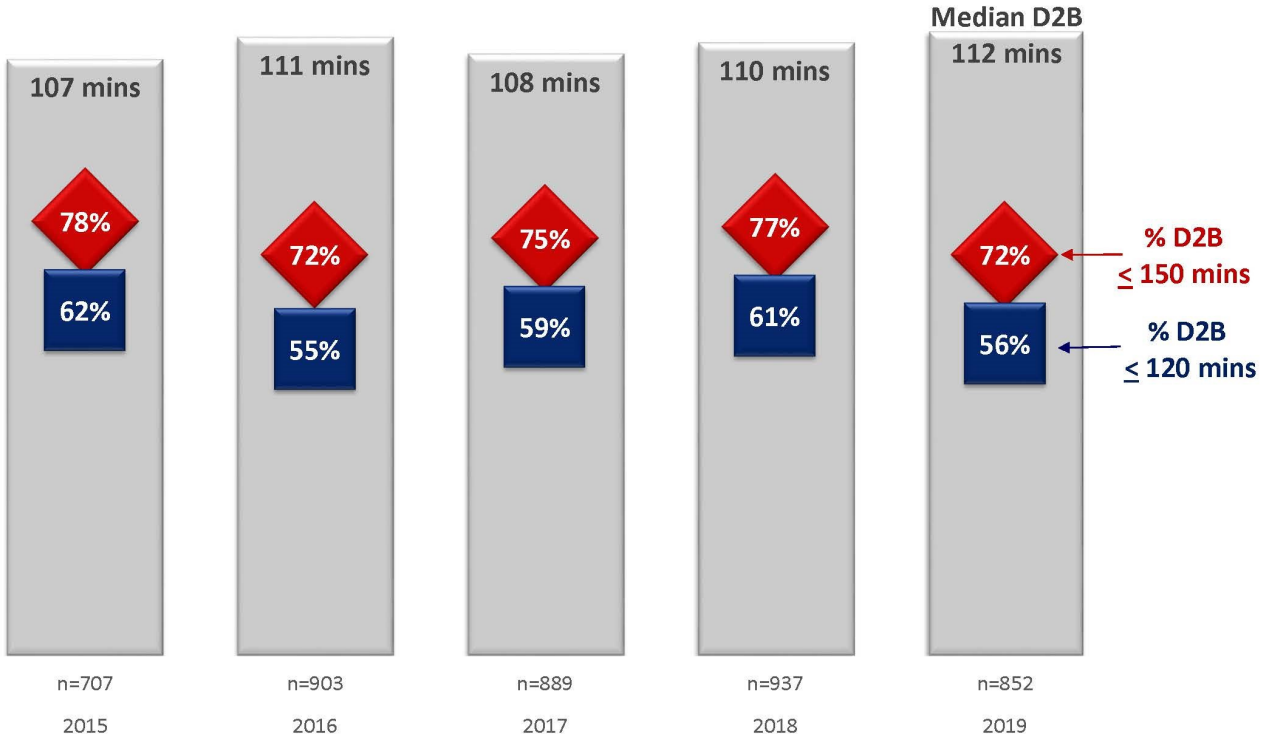
STEMI Receiving Center: EMS Medical Contact-to-Device (E2B) Time

LA County Target: within 120 minutes 90% of the time and within 90 minutes 75% of the time



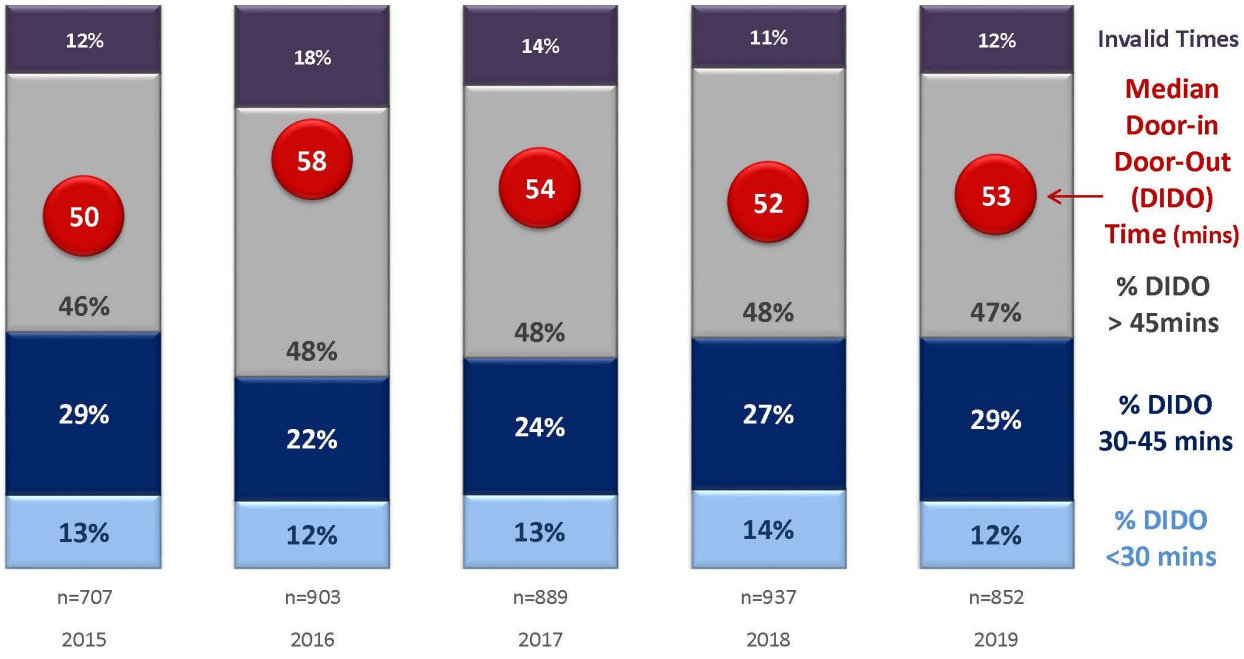
STEMI Referral Facility: Door-to-Device (D2B) Time

LA County Target: within 150 minutes 90% of the time and within 120 minutes 75% of the time

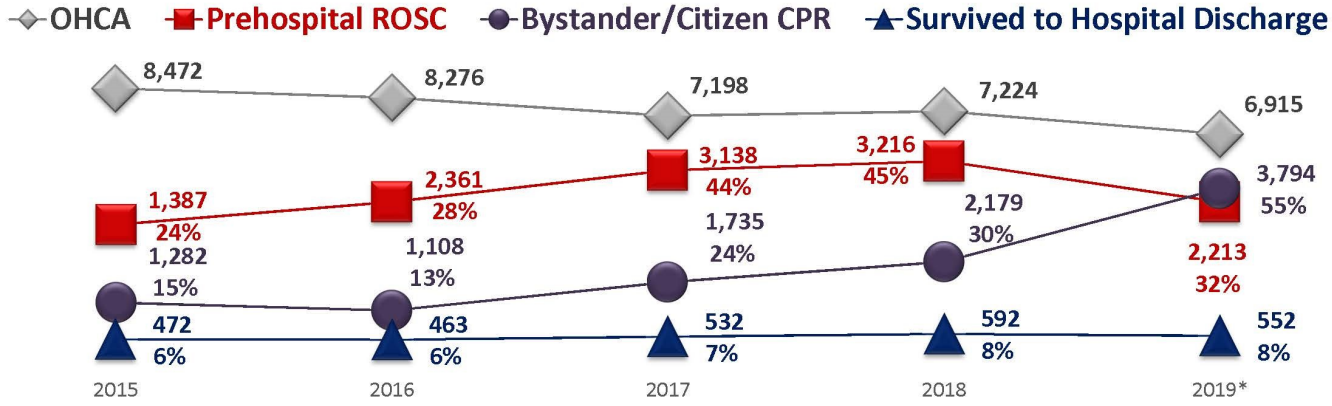


STEMI Referral Facility: Door-in Door-out (DIDO) Time

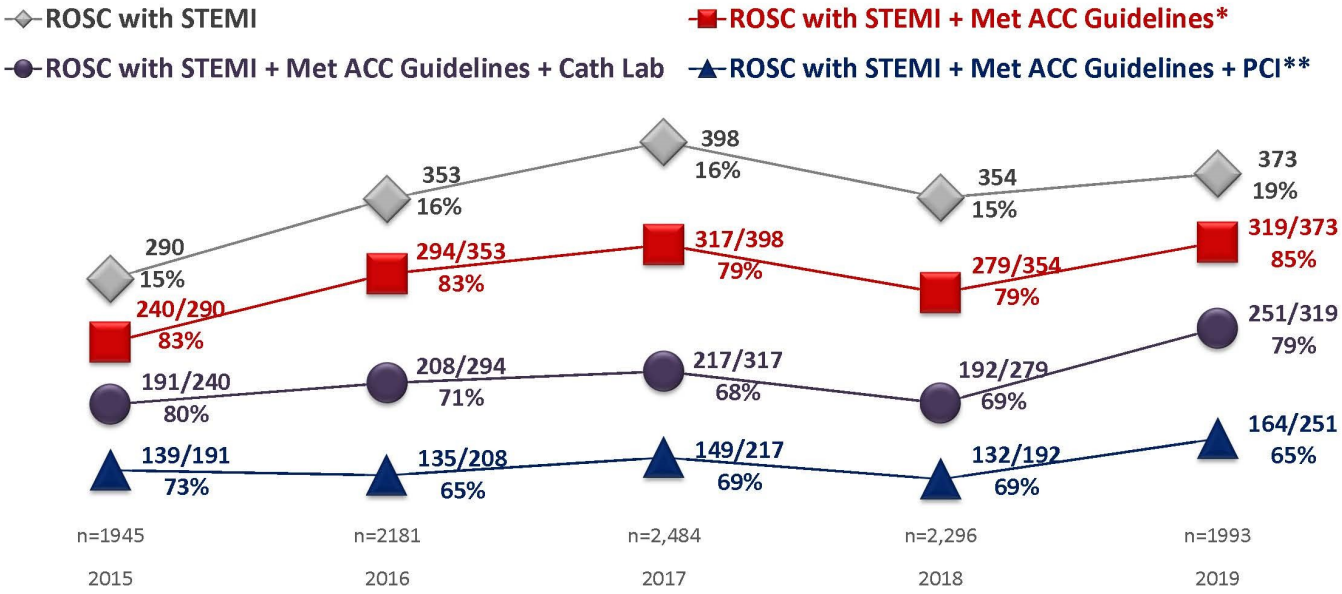
LA County Target: < 30 minutes



Out of Hospital Cardiac Arrest (OHCA)
Return of Spontaneous Circulation (ROSC)

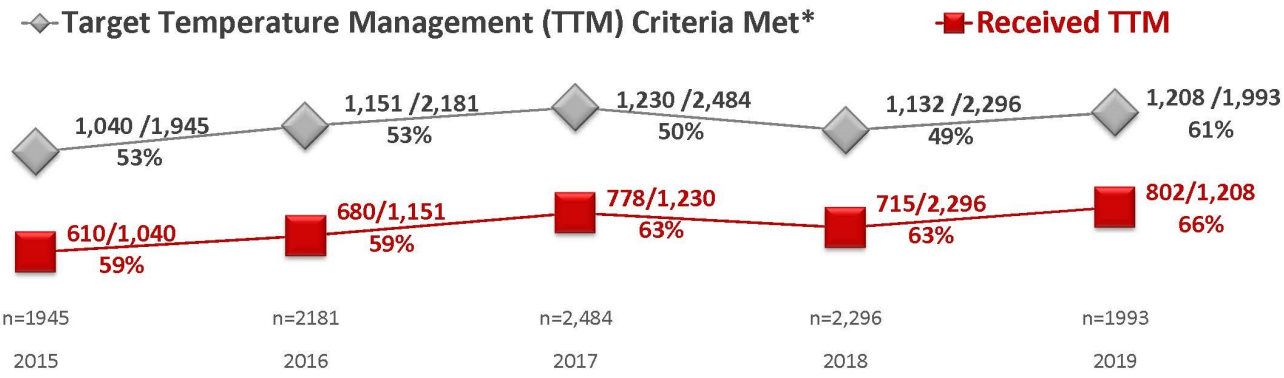


*2019 OHCA population is based on Provider Impression Cardiac Arrest Non-Traumatic, which was fully implemented April 1, 2019. DOAs were excluded. 2015-2018 OHCA population was based on Chief Complaint of Cardiac Arrest.



*ACC Guidelines for coronary angiography include: Age ≥18, pt did not expire, no DNR, no medical condition, treatment not refused and CL available.

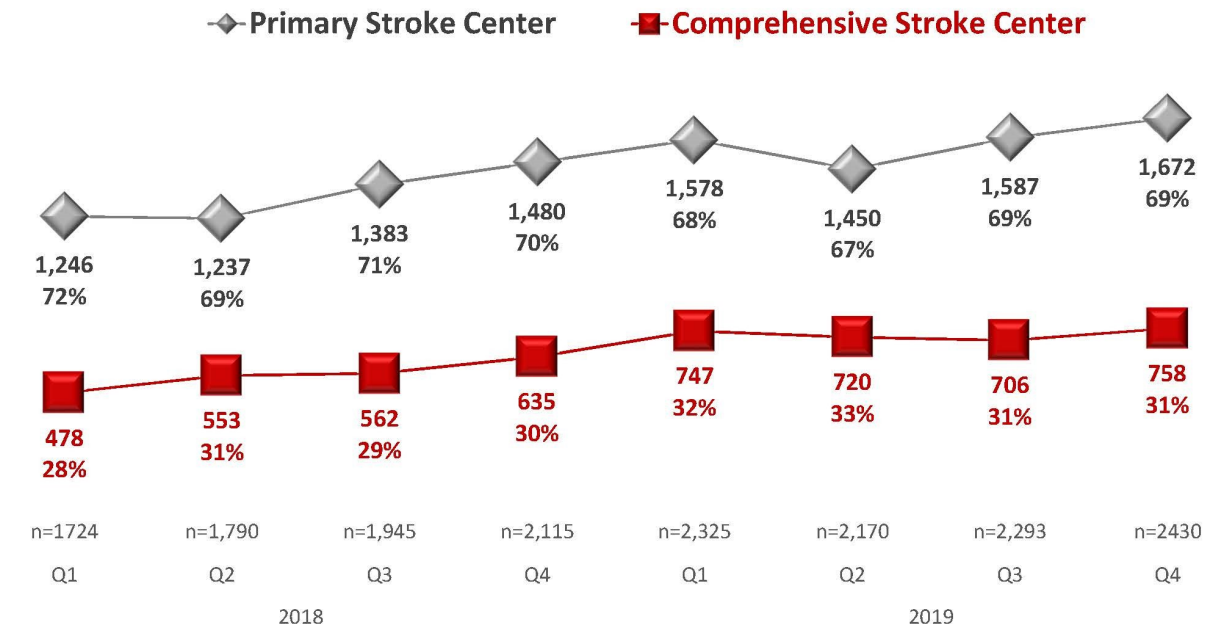
**PCI - Percutaneous Coronary Intervention is a procedure used to open or widen a narrowed or blocked coronary artery to restore blood flow supplying the heart.



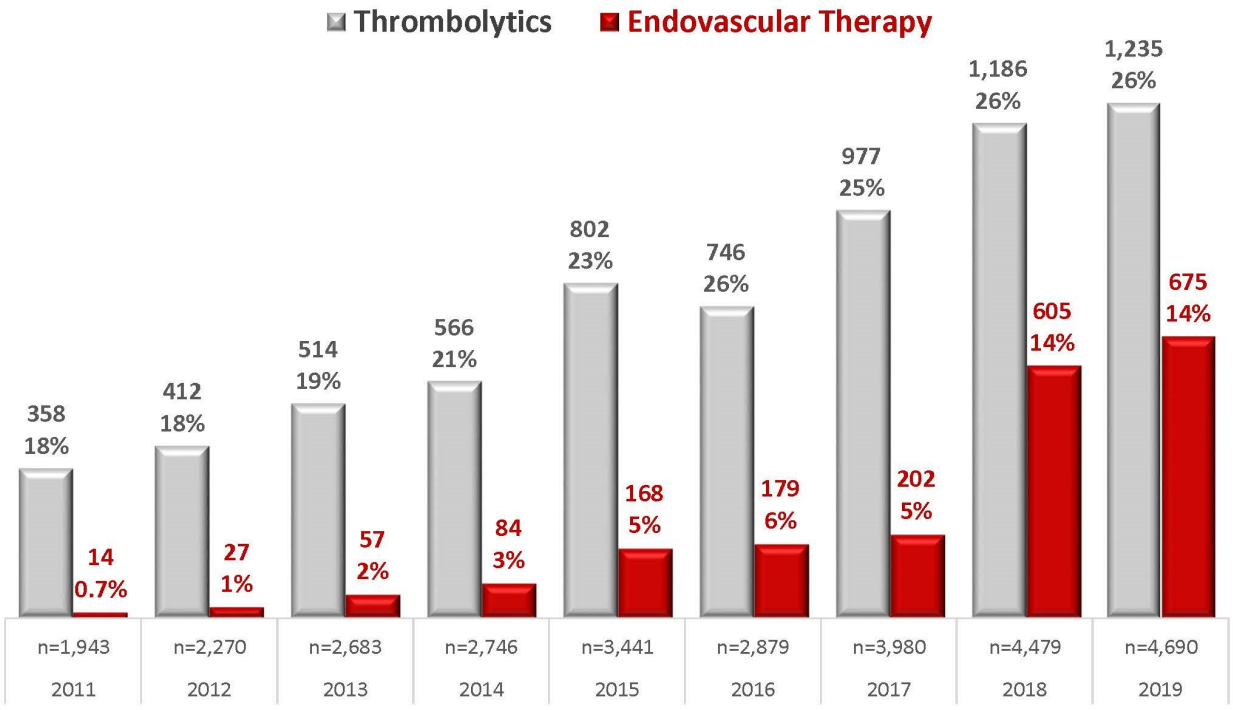
*TTM criteria excludes: died in ED, age <18, awake/responsive, end stage terminal illness, core temp <35 and pre-exiting DNR

Suspected Stroke Patient Destination

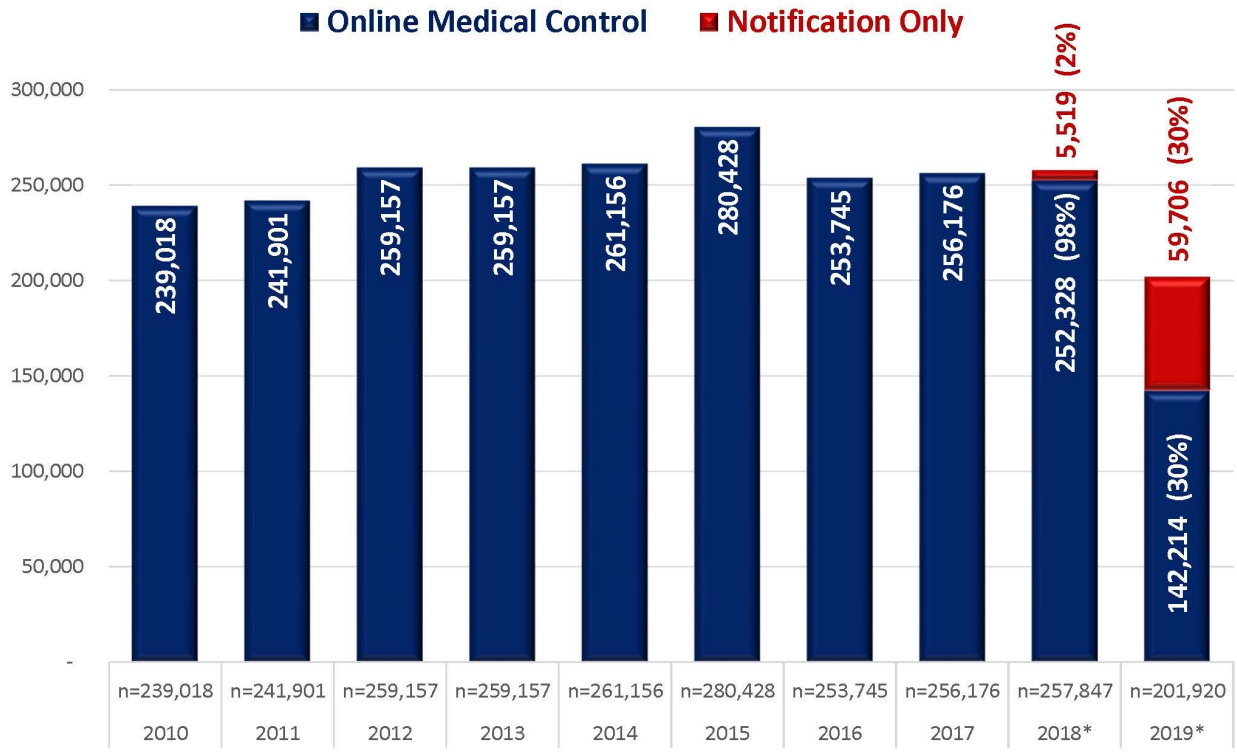
The routing of suspected stroke patients with large vessel occlusions based on a Los Angeles Motor Scale (LAMS) score of 4 or 5 to designated Comprehensive Stroke Centers began on January 8, 2018.



Treatment—All Ischemic Stroke



Paramedic Base Hospital Contact Volume



* Phased-in imlementation of New Treatment Protocols started in July 1, 2018 and was fully implemented in April 1, 2019. The New Treatment Protocols reduced the number of EMS responses requiring online medical control.

EMS AGENCY

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

10100 Pioneer Boulevard, Ste. 200
Phone: 562-378-1500
Web: http//ems.dhs.lacounty.gov

For data request please complete and submit Reference No. 622.1 at http://file.lacounty.gov/SDSInter/dhs/1006614_6222016-07-01.pdf

LOS ANGELES COUNTY COMMISSION MANUAL

This manual provides a guide to Los Angeles County processes, legal parameters, and protocols that affect the business of County Commissions. In addition, the manual details information on the role and duties of Commissioners when conducting meetings, developing agendas, advocating on legislative issues, and provides information on resources available while representing the County Board of Supervisors.

Executive Office, Board of Supervisors

Commserv@bos.lacounty.gov

(213) 974-1431

TABLE OF CONTENTS

Disclaimer: This manual contains general information, county policies and practices to be used as a commissioner guide. Contents within the guidelines are subject to change anytime without notice.

PREFACE

Welcome to the County of Los Angeles. We thank you for your dedication to public service in facilitating the important work of the County of Los Angeles through County Boards, Commissions, Committees, Oversight Boards, Task Forces, Working Groups, and Special District Agency Boards (collectively referred to as Commissions). This manual will outline your responsibilities and obligations as a Commissioner, on how to communicate your recommendations and findings to the Board of Supervisors (Board), and on other practical information in the conduct of your service.

Please take time to read through this manual to understand how business is handled by the various Commissions and the Board. You are expected to attend meetings regularly and to conduct the business of the Commission in a transparent, efficient, and professional manner. As you advocate for the community you represent, please remember your expertise is a valued, important, and essential factor in assisting the Board to reach their goals and strategic priorities for the County and the communities they serve.

I. ROLE OF COMMISSIONS IN COUNTY GOVERNMENT

Commissions serve a vital role in county government by gathering and analyzing public input and recommending options to the Board. The guiding principle of any Commission recommendation to the Board is that of addressing the overall public benefit. Some Commissions are authorized by the Board to take independent action (e.g., Regional Planning Commission, Civil Service Commission, Business License Commission, etc.); others serve in a fact-finding or advisory role and are not authorized to take action. These Commissions are advisory to the Board; therefore, may not take an official position for the County which has not been approved by the Board. *(See also Section VI. Legislation and Public Officials)*

A. Establishment of Commissions

Commissions were established to assist the Board with the varied duties and responsibilities of local government, and encourage citizen involvement, expertise and participation.

Commissions may be created by:

- State or Federal Law
- County Ordinance or Charter
- Action by the Board of Supervisors

Commissions are organized into seven categorical roles:

1. **Citizen Advisory Commissions** are local, state or federally mandated bodies whose primary role is to provide feedback and recommendations to the Board and/or County Departments on proposed or existing policies, procedures, programs and services.
2. **Administrative Board and Committees** are bodies tasked with providing essential administrative functions on behalf of or in conjunction with government entities.

3. **Authorities of the County** are decision making bodies that approve funding for specific County projects, equipment and facilities.
4. **Interagency Coordination Committees** are entities that are concerned with inter-organizational coordination of policies, regulations, services and programs to better serve the needs of residents in specific subject areas.
5. **Joint Power Authorities and other agencies** are comprised of a group of bodies that are primarily concerned with the direct delivery and management of government services, programs, and public infrastructure.
6. **Special Districts** are independent government entities that provide specialized functions for clearly defined geographic areas.
7. **Ad-Hoc Committees and Task Forces** are temporary, special purpose committees that are created by the Board and/or other government entities to address pressing County matters.

II. COMMISSIONER RESPONSIBILITIES

A. Role and Responsibilities of a Commissioner

- Commissioners are encouraged to take an active role in helping the Commission fulfill its goals and objectives.
- Commissioners are responsible for attending meetings regularly to ensure a quorum, and to facilitate the business and meet the goals of the Commission.
- It is the responsibility of Commissioners to provide advance notice to the Chairperson, Executive Director, Commission Liaison, or Commission Staff, if they cannot attend a meeting.
- Commissioners are also responsible for reviewing meeting materials in advance of a meeting, and complying with the Ralph M. Brown Act (Brown Act) as set forth in state and local laws regarding public meetings.
- Commissioners should also have knowledge of the County's Strategic goals and the vision and priorities of the Board. (*See Appendix Section XII C. 2016 -2021 County Strategic Plan and County Strategic Priorities*)

B. Public Statements by Commissioners to Media and Other Organizations

Prior to responding in your capacity as a Commissioner to any inquiry from television, magazines, newspapers, or any other media outlets, the request should be discussed with the Executive Director, Commission Liaison, or Commission Staff to ensure Departmental policy and protocols are followed to respond to media inquiries.

When speaking to the media, Commissioners should not imply they are speaking on behalf of the Commission without prior approval from the body. Commissioners affiliated with non-county organizations should proactively clarify with reporters that they do not speak on behalf of the Commission and are only commenting as an individual affiliated with an outside organization. Commissioners comments (verbal or written) as a private citizen solely reflect your personal position and not as a representative of the Commission.

C. New Commissioner Orientation

All newly-appointed Commissioners are encouraged to attend an orientation session coordinated by the Executive Office of the Board relating to the County's Governance, legislative process and the Brown Act.

D. State Mandated Ethics and Other Trainings

California Government Code sections 53235 and 53235.1 require that any newly appointed local agency official and certain Commissioners receive two hours of training in local government ethics within one year of assuming the position and once every two years thereafter. The Executive Director, Commission Liaison, or Commission Staff will notify you if your Commission is required to complete this training.

Citizen Advisory Commissioners are also required to complete the Cultural Diversity Awareness and Sexual Harassment and Prevention Training and the County Policy of Equity Training. The Executive Director, Commission Liaison, or Commission Staff will notify you of your scheduled trainings.

E. Conflicts of Interest and Statement of Economic Interests (Form 700)

Commission members must keep their personal interests separate from their Commission duties and responsibilities, and avoid conflicts of interest. A conflict of interest occurs if Commission members allow their personal relationships, money (or the promise of money), or other outside factors to influence how they perform their Commission duties and responsibilities. A conflict of interest also exists if Commission members use information acquired in their capacity as Commission members for personal gain.

To avoid potential conflicts or the appearance of any conflicts, Commission members may not participate in discussions, deliberations, or recommendations regarding issues in which they have a personal or financial interest. In addition, they may not accept gifts from lobbyists or anyone doing business with the County or who may come before the Commission. This is against County policy and may be illegal.

Some Commissioners are required to complete and sign conflict of interest documentation (Statement of Economic Interests - Form 700) prior to commencing their Commission duties. Not all Commissioners are required to file a Form 700, because the filing requirement is based upon the authority and responsibilities of the Commission. If you have questions about whether or not you need to file, please contact your Executive Director, Commission Liaison, or Commission Staff.

F. Service at the Will of the Board of Supervisors

Generally, Commissioners serve at the pleasure of the Board and can be removed at any time.

G. Process for Resigning from a Commission

Letters or email of resignation can be submitted to their appointing authority and Board Office. Copies of the resignation should also be provided to the Chairperson, Executive Director, Commission Liaison, or Commission Staff.

H. Process for Filling Vacancies

It is the policy of the Board of Supervisors to give public notice of vacancies on Commissions and actively recruit qualified candidates. Vacancy information along with the Commission qualifications found on Commission's Fact Sheet is available on the Commission Services Membership Roster webpage at http://bos.lacounty.gov/Services/Commission-Services/Membership-Roster. Commissions are encouraged to forward letters of interest along with a biography, to the Board.

III. COMMISSION OFFICERS

A. Chairperson's/President's Duties

The duties of the Chairperson/President or Co-Chair if applicable, generally shall include, unless otherwise established by the bylaws, operating rules and/or ordinance of the Commission:

- Working with the Executive Director, Commission Liaison, or Commission Staff to prepare the meeting agenda to comply with Brown Act standards and timeframes.
- Presiding over all meetings by:
    - Calling the meeting to order at the scheduled time.
    - Verifying the presence of a quorum.
    - "Processing" all motions including (stating the motion prior to discussion, restating the motion just prior to the vote, and announcing the result of the vote, specifying who voted in favor, who voted against, and any abstentions and recusals).
    - Facilitating meetings by staying on track and adhering to time constraints.
    - Conducting the meeting in a fair and equitable manner.
    - Restraining the members when engaged in debate, within the rules of order to enforce the observance of order and decorum among the members.
    - Maintaining neutrality to facilitate debate.
    - Ensuring the work of the Commission is consistent with its intended purpose and mission.
- Be familiar with and conduct the meetings according to the Robert's Rules of Order, and/or bylaws and ordinance. (*See Appendix Section XII E. County of Los Angeles Procedural Rules for County Commissions and Committees Based on Robert's Rules of Order (Abridged) and in Compliance with the Brown Act)*
- For issues related to business processes, contact the Executive Director, Commission Liaison, or Commission Staff.

B. *Vice Chairperson's/President's Duties-if applicable*

The Vice Chairperson's/Vice President's duties shall generally include, unless otherwise established by the by-laws, operating rules and/or ordinance of the Commission:

- Assuming the role of the Chairperson/President, in the absence of the Chairperson/President.
- Working in collaboration with the Chairperson/President.

C. Election of Commission Officers

As indicated in the Commission's bylaws, Ordinance, or Board Directive, each body should organize the election of its Officers (Chairperson, Vice Chairperson, Treasurer, etc.). The Commission's bylaws or operating rules should contain the duties of its elected officers.

IV. ROLE OF THE DEPARTMENTS, EXECUTIVE DIRECTORS, COMMISSION LIAISONS, AND COMMISSION STAFF

A. Executive Directors, Commission Liaisons, Commission Staff

Administrative support provided by the assigned Executive Director, Commission Liaison, or Commission Staff who is responsible for providing leadership to the Commissions and assisting the Commissions with annual goals and objectives that align with the Board and/or Department priorities. The Executive Director, Commission Liaison, or Commission Staff serve as the point of contact for your Commission. Commissions are generally administratively assigned to County Departments as mandated by legislation, ordinance or Board order.

B. Relationship with Departments

County Departments may be a resource for Commissions to answer questions, provide data on the impact of issues being considered, clarify County policy, and generally keep Commissions current on issues related to the County's budget, legislation endorsed by the County, and information on available services.

V. COMMUNICATING WITH THE BOARD OF SUPERVISORS

The Board is always interested in facilitating the work of Commissions and welcomes any suggestions. Board members value information that alerts them to upcoming issues and concerns allowing them to respond proactively.

Commissions have various avenues of communicating and reporting their collective recommendations and findings to the Board, including an annual report to the Board of its activities and accomplishments. Another avenue for communication with the Board is through Commission approved correspondence. Commission approved letters/memos can be submitted to the Board to relay information or to obtain guidance on matters of Commission concern.

A. Recommendations to the Board of Supervisors

Recommendations approved by the Commission as a whole can be submitted to the Board via memos or written correspondence for consideration. It is recommended that you consult with your Executive Director, Commission Liaison or Commission Staff regarding correspondence guidelines and protocols for your respective departments when submitting memos or written correspondence on behalf of the Commission.

B. Consulting and Engaging with Board Offices

Commissioners may communicate with their District's assigned Board offices. However, protocol suggests that Commissioners work within the framework of the Commission and the Chairperson when information needs to be conveyed to or obtained from the Board as a whole, or to an individual Supervisor.

C. Commission Annual Reports

Each Commission should provide an update to the Board about its activities through an Annual Report. The Annual Report is to be completed by each Commission and approved at a regular Commission meeting. The Executive Director, Commission Liaison, or Commission Staff will transmit the Annual Reports to the Board. (*See Appendix Section XII A. Annual Report Template and Instructions)*

It is the Commission's responsibility to write its Annual Report. Some Commissions assign this task to a committee or a particular Commissioner, who will prepare a draft for Commission review. Once the content is approved by the Commission, the Executive Director, Commission Liaison, or Commission Staff can prepare the final documents and forward to the Board.

D. Sunset Review Evaluation

Every four years, a Sunset Review is conducted for each Citizen Advisory Commission, and others as designated as indicated on the Commission's Fact Sheet that can be accessed on the Commission Services Membership Roster webpage at http://bos.lacounty.gov/Services/Commission-Services/Membership-Roster. The Sunset Review will provide an opportunity for Commissions and stakeholders to evaluate their work and accomplishments, as well as allows Commissions to periodically review their ordinance and scope of work. The Sunset Review analysis is forwarded to the Audit Committee for assessment and recommendations to the Board for extension to the sunset review date and any changes to the Commissions' ordinances. *(See Appendix Section XII B. Sunset Review Evaluation Questionnaire and Instructions*)

VI. LEGISLATION AND PUBLIC OFFICIALS

A. How to Obtain Information on the Board of Supervisors Legislative Positions

Each year, the County's State and Federal Legislative Agendas are developed based on the political and economic climates in Sacramento and Washington, D.C. Through the County's Legislative Program, the Board adopts legislative goals and policies, enabling the County's advocates in Sacramento and Washington D.C., to effectively respond to legislative proposals that could significantly impact the County's finances or programs. The Legislative Agenda includes general principles and positions, as well as policy statements regarding issues of major County interest. These documents are updated annually, after consultation with County departments, the Board offices, the County's legislative representatives, and commissions and advisory boards. The Legislative Agendas are presented to the Board for consideration in December or January and once approved, provide a framework for ongoing advocacy throughout the year.

You can request a copy of the County's State and Legislative Agenda via the Executive Director, Commission Liaison, or Commission Staff, if applicable. Also, for additional information and status updates of bills for which the County has taken a position on, you may also review the State and Federal Legislation of County Interest report available through the Chief Executive Office (CEO) Legislative Affairs and Intergovernmental Relations office or website at https://ceo.lacounty.gov/legislative-affairs-and-intergovernmental-relations. For information on State legislation information, visit http://leginfo.legislature.ca.gov/.

B. Recommending a position of Commission Interest to the Board of Supervisors

Commissions may not take an official position for the County which has not been approved by the Board. County Commissions and other advisory bodies seeking a position on legislation or State Budget items are required to submit their recommendations to the CEO for review to determine if they are consistent with existing policy prior to taking an advocacy position. Upon completion of the review, the CEO will provide a copy of the review findings to be attached to the document containing the Commission's recommendations transmitted to the Board.

C. Engaging with other Jurisdictions and Elected Officials

Commissions can work with the Executive Director, Commission Liaison, or Commission Staff when engaging other jurisdictions, such as other counties, cities and elected officials in the work of the Commission when needed. Commissions should notify Board Offices before inviting or if they are informed that a state, or federal, or other local elected official will attend a Commission meeting, event or County facility.

VII. TYPES OF MEETINGS

A. Regular Meetings

Commissions hold regular meetings to conduct business, such as receiving and filing reports, discuss and take action on recommendations and vote to forward recommendations to the Board or other entities as deemed appropriate. The agenda for a regular meeting must be posted 72 hours in advance of the meeting in accordance with the Brown Act. The Executive Director, Commission Liaison, or Commission Staff attending the meetings assist the Commission Chair.

B. Special Meetings

The Chairperson/President or a majority of the appointed Commissioners may call a special meeting if deemed necessary and will coordinate with the Executive Director, Commission Liaison, or Commission Staff regarding availability of staff and a meeting room. The agenda of a special meeting must be posted 24 hours in advance of the meeting in accordance with the Brown Act and distributed to interested parties that have requested notification.

C. Planning Meetings

Commissions may work in coordination with the Executive Director, Commission Liaison, or Commission Staff to schedule to meet in planning sessions to develop their annual goals, review bylaws, and focus on Commission issues. These meetings are subject to the Brown Act and will be properly noticed, agendized, open to the public and require a quorum of members in attendance to conduct business.

VIII. COMMISSION MEETINGS

A. Process for Developing the Meeting Agenda

The Chairperson/President works with the Executive Director, Commission Liaison, or Commission Staff to coordinate the meeting agenda; however, the method by which the agenda is developed varies according to the procedures of the individual Commissions. A Commissioner may request that an item be placed on the agenda by submitting a request to the Chairperson. The Executive Director, Commission Liaison, or Commission Staff, in collaboration with the Chairperson, will ensure that the agenda follows standard formatting and language guidelines and Brown Act requirements.

B. Ralph M. Brown Act (Brown Act)

Commission meetings are subject to the Brown Act, which guarantees the public's right to attend and participate in Commission meetings. Agendas must be physically posted at the meeting site and accessible to the public. It is also highly encouraged for Commissions with websites to post current agendas and minutes online for public view. The agenda must include all items which will be discussed or acted upon by the Commission. Generally, the Commission cannot discuss, deliberate, or take action on any item not included on the agenda. Commissions must allow a member of the public to address the Commission on any agendized item before or during consideration of that item. Members of the public are also given the opportunity to address the Commission on any matter not on the agenda which is within the subject matter jurisdiction of the Commission. (*See Appendix Section XII E. County Counsel Guide to the Brown Act)*

C. Quorum Determination

A quorum is the minimum number of members who are required to be present at the meeting in order to conduct business. Generally, a quorum is a majority of the members of the body, unless otherwise established. Statue or bylaws may specify a higher (but not a lower) number.

D. Attendance Reports to the Board of Supervisors

Attendance information is maintained by the Executive Office of the Board, Commission Services Division and is provided to the Board quarterly for their review.

IX. COMMITTEES

A Commission may choose to create standing and/or ad-hoc committees that report to the full Commission to assist with Commission business and priorities.

A. Standing Committees

Standing committees have a continuing subject matter and have a meeting schedule fixed by formal action. Standing committees may not include a quorum of the entire Commission membership. All standing

committees are subject to the Brown Act and must be properly noticed, agendized, and open to the public, and have a quorum of the committee membership present to meet.

B. Ad-hoc Committees

Ad-hoc committees are established by the Commission for a limited purpose and time. The Chairperson/President can appoint Commissioners to serve on ad-hoc committees or an ad-hoc committee can be established by Commission vote. An ad-hoc committee may not include a quorum of the entire Commission membership.

X. CONDUCTING MEETINGS

A. Business Conducted at Commission Meetings

The application of Parliamentary Procedure is the best method to enable Commissions to determine the will of the Commission. The Procedures help create a balance between the rights of persons in the minority on specific issues to be heard with the rights of persons holding the majority position to prevail. All meetings should be conducted in accordance with Robert's Rules of Order to aid in conducting meetings in a fair and equitable manner. (*See Appendix Section XII E. County of Los Angeles Procedural Rules for County Commissions and Committees Based on Robert's Rules of Order (Abridged) and in Compliance with the Brown Act)*

The meetings are called to order by the Chairperson/President or Vice Chairperson/President in the absence of the Chairperson/President. If neither is in attendance, the Commission selects a Chairperson Pro Tempore to conduct the meeting.

B. Public Comment

Pursuant to the Brown Act, before or during consideration of each agenda item, the public must be given an opportunity to comment on the item, and have a right to comment on any agenda item or items that are within the jurisdiction of the Commission. The Chairperson/President establishes the amount of time public speakers are authorized to speak on each item. Generally, speakers fill out Request to Speak Forms, which will be provided to the Chairperson to call on speakers. A member of the public is not required to identify themselves, but must provide identifiable information allowing the Commission the reasonably call upon them to address the body. Also, a member of the public may record (audio/video) the meeting including their testimony before the Commission.

C. Distribution of Materials and Meeting Accommodations

The Brown Act states that documents being distributed by the Commission during meetings must be made available for review by the public. This applies to documents distributed prior to the meeting. Any material that is not prepared by the County or a Commissioner and is distributed during an open meeting must be made available for public inspection as soon as possible after the meeting. For example, if a member of the public submits a document to accompany his/her public comment statement, Commission staff retain the document as part of the meeting records, provide a copy of the document to the Commissioners following the meeting, and have it available upon request following the meeting.

XI. MISCELLANEOUS

A. Travel Expense Reimbursement

Commissioners can consult with their Executive Director, Commission Liaison or Commission Staff to determine whether they are authorized by County Code to travel on Commission related business (other than commission meetings) and are eligible for reimbursement of expenses incurred while conducting Commission business. Commissioners authorized to travel must make all air travel reservations through as mandated by the Board (*See County Code Section 5.40 and Fiscal Guidelines Chapter 13).*

B. Mileage Reimbursement

Commissioners can consult with their Executive Director, Commission Liaison or Commission Staff to determine whether they are eligible pursuant to County Code to receive mileage reimbursement for Commission business. A Commissioner who uses their private vehicles for travel on County Business, if eligible, may become certified as a Mileage Permittee for reimbursement of mileage at the current established rate. Mileage claim forms are provided by the Executive Director, Commission Liaison, or Commission Staff. Claims for mileage reimbursement are required be submitted within 30 days of County business conducted.

C. County Issued Materials

If applicable, County Commission Business cards may only contain information concerning the Commission, not personal business information. Commissioners may not use County-issued materials such as business cards and letterhead for personal correspondence purposes. If a "Commissioner" title is used for information purposes, you must include a disclaimer that you do not speak on behalf of the County of Los Angeles or the Commission for which you are a member.

D. Commissioner Parking

The Executive Director, Commission Liaison or Commission Staff will inform commissioners of available parking for commission meetings.

E. Commission Publications

Commissions may develop or produce informational and educational materials for distribution in hard copy or for inclusion on the Commission's website relating to their roles, responsibilities and meeting information. Material and information shall be in compliance with enabling legislation, federal and state laws, County Codes and Board policies.

F. Commission Webpages

Available Commission Websites are linked on the Executive Office Membership Roster website http://bos.lacounty.gov/Services/Commission-Services/Membership-Roster as the central location to obtain commissioners rosters, fact sheets and websites. To ensure that the County's commissions

website are consistent with information that various stakeholders have indicated they would like to access, it is recommended that at least the following information be included:

- A current agenda and past minutes
- An annual regular meeting schedule
- A description of the commission and its mission with creating authority (link to ordinance, board order, state or federal mandate establishing the body)
- Commission's annual report (if applicable)
- Commission members and officers

XII. APPENDIX

A. Annual Report Template and Instructions
A Template and Instructions on completing and submitting the Annual Report is attached

B. Sunset Review Evaluation Questionnaire and Instructions
A Template and Instructions on completing and submitting the completed questionnaire is attached.

C. County Strategic Plan and Major Priorities
A copy of the County Los Angeles Strategic Plan is attached; Los Angeles County Board of Supervisors Major Priorities can also be accessed at http://priorities.lacounty.gov.

D. Commission Bylaws, Ordinances, and/or Board Directives
See your Executive Director, Commission Liaison, or Commission Staff for additional information specific to your Commission.

E. Parliamentary Procedures
The following are attached:

- County of Los Angeles Procedural Rules for County Commissions and Committees Based on Robert's Rules of Order (Abridged) and in Compliance with the Brown Act
- County Counsel Guide to Brown Act Requirements

EMERGENCY MEDICAL SERVICES COMMISSION

NUMBER OF MEMBERS*

Nineteen, as follows:

a. One emergency medical care physician in a paramedic base hospital nominated by the California Chapter of the American College of Emergency Physicians

b. One cardiologist nominated by the American Heart Association, Western States Affiliate

c. One mobile intensive care nurse nominated by the California Chapter of the Emergency Nurses' Association

d. One hospital administrator nominated by the Healthcare Association of Southern California

e. One representative of a public provider agency nominated by the Los Angeles Chapter of California Fire Chiefs Association

f. One representative of a private provider agency nominated by the Los Angeles County Ambulance Association

g.* One trauma surgeon who practices in Los Angeles County at a designated trauma center nominated by the Southern California Chapter American College of Surgeons

h. One psychiatrist nominated by the Southern California Psychiatric Society

i. One physician nominated by the Los Angeles County Medical Association

j. A licensed paramedic nominated by the California State Firefighters Association, Emergency Medical Services Committee

k. Five public members, one nominated by each Supervisor. No public member shall be a medical professional or affiliated with any one of the other nominating agencies

l. One law enforcement representative nominated initially by the California Highway Patrol. After the first term of office for this position is completed, the law enforcement representative shall be nominated by the Los Angeles County Peace Officers Association

m. A City Manager nominated by the League of California Cities, Los Angeles County Chapter

n. A Police Chief nominated by the Los Angeles County Police Chiefs Association

o. A representative nominated by the Southern California Public Health Association

APPOINTMENT

By the Board of Supervisors

TERM OF OFFICE

Four Years. Each member shall serve at the pleasure of the Board.

No member of the Commission may serve more than two consecutive four year terms. The Board may, by order, extend the length of service or waive the limit for individuals or the Commission as a whole.

A member's position on the Commission shall become vacant upon his or her death, resignation, or removal by the Board. In the case of such a vacancy, the Board shall appoint a successor to fill the unexpired term.

COMPENSATION

None

MEETINGS

Held every third Wednesday of each odd month, at 1:00 p.m.; The Commission holds it's meetings in the Emergency Medical Services Agency Commission Hearing Room, 1st Floor at 10100 Pioneer Boulevard, Santa Fe Springs, California 90760.

The provisions of Chapter 5.12 of the County Code shall not apply to the Commission.

DUTIES

The Commission shall perform all the functions of the Emergency Medical Care Committee as defined in Sections 1750 et seq. of the Health and Safety Code and shall have the following duties:

a. Act in an advisory capacity to the Board of Supervisors and the Director of Health Services regarding County policies, programs, and standards for emergency medical care services throughout the County, including paramedic services.

b. Establish appropriate criteria for evaluation and conduct continuous evaluations on the basis of these criteria of the impact and quality of emergency medical care services throughout Los Angeles County.

c. Conduct studies of particular elements of the emergency medical care system as requested by the Board of Supervisors, the Director of Health Services or on its own initiative; delineate problems and deficiencies and to recommend appropriate solutions.

d. Acquire and analyze the information necessary for measuring the impact and the quality of emergency medical care services.

e. Report its findings, conclusions and recommendations to the Board of Supervisors at least every twelve months.

f. Review and comment on plans and proposals for emergency medical care services prepared by County departments.

g. Recommend, when the need arises, that Los Angeles County engage Independent contractors for the performance of specialized, temporary, or occasional services to the Commission which cannot be performed by members of the classified service, and for which the County otherwise has the authority to contract.

h. Advise the Director and the Department of Health Services on the following matters:

    1. Policies, procedures, and standards to control the certification of mobile intensive care nurses and paramedics

    2. Proposals of any public or private organization to initiate or modify a program of paramedic services or training

3. Arbitrate differences in the field of paramedic services and training between all sectors of the community, including but not limited to, County agencies, community colleges, hospitals, private companies, and physicians

A decision of the Commission regarding a matter which the Commission hears under its arbitration function pursuant to Subparagraph 9 hereinabove will be final and binding upon the parties who appeared before the Commission on the matter unless the Board of Supervisors at any time promulgates policy which is inconsistent with such determination.

The Commission shall refer to the Board of Supervisors and any other affected provider agency any such decision of the Commission which will either affect the budget of the county, or any other provider agency, for the paramedic program, or operate to change an existing County-approved policy. Such decision shall not become final and binding unless adopted by the Board of Supervisors. Additionally, any such decision of the commission shall be advisory only if its implementation will affect any County paramedic program matter which the County Health Officer, the local emergency medical services agency, or the Board of Supervisors, has power to regulate pursuant to Section 1480 et seq. and Section 1797.200 of the Health and Safety Code.

OATH

Required

AUTHORITY*

- Chapter 3.20 of the Los Angeles County Code and Health and Safety Code Sections 1792 and 1797 and 1797.270 et seq.;
- Board Order No. 56 of April 20, 1999, Ordinance No. 99-0027;
- Board Order No. 39 of February 6, 2008, Ordinance No. 2008-0006;
- Board Order Nos. 14 and 38 of November 1, 2011
- Board Order No. 39 of November 8, 2011, Ordinance No. 2011-0062;
- Board Order Nos. 15 and 37 of January 19, 2016
- Board Order No. 15 of January 26, 2016, Ordinance No. 2016-0008.

Created on:

*Revised: 02/11/16

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
(562) 378-1606 FAX (562) 941-5835

BYLAWS

Article I. General Commission Description

A. The Emergency Medical Services Commission (EMSC) acts in an advisory capacity to the Board of Supervisors and the Department of Health Services under County Ordinance Chapter 3.20.

B. The Chairperson shall have general supervision of all matters pertaining to the EMSC.

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

D. All EMSC meetings shall be open to the public. This policy shall be stated on all agendas.

E. EMSC agendas shall be posted ten calendar days in advance of the meeting.

Article II. Officers

The Officers shall consist of a Chair and a Vice Chair to be elected by the EMSC at its January meeting. Officers shall serve a term of one year or until their successors are elected. No EMSC member may serve more than two full terms in succession

Article III. Election and Replacement of Officers

A. Election of Officers:

1. At the November meeting, the Chair shall appoint three Commissioners to be a Nominating Committee, subject to the approval of the EMSC.

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

3. An election shall be conducted at the January meeting. If there is only one nominee for an office, the Chair can declare that the nominee is elected; otherwise, election shall be by majority vote of the Commission.

B. Replacement of Officers

1. If, for any reason, the Chair is unable to complete their term of office, the Vice Chair becomes Chair for the remainder of the term.

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

   a. The Chair shall appoint three commissioners to be a Nominating Committee, subject to the approval of the EMSC.

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

   c. Additional nominations may be made and the election shall be conducted in compliance with Article III, A, Sections 3 and 4 of these Bylaws.

   d. If neither the Chair nor Vice Chair is able to preside at any EMSC meeting, the following committee chairs shall serve as Chair Pro Tempore in the order listed:

      i. Chair, Provider Agency Advisory Committee
      ii. Chair, Base Hospital Advisory Committee
      iii. Chair, Data Advisory Committee
      iv. Chair, Education Advisory Committee

Article IV. Duties of Officers

A. The Chair shall:

1. Preside at all meetings of the EMSC.
2. Rule on all points of order.
3. Appoint the chair of each committee.
4. Be an ex-officio member of all committees.
5. Represent the EMSC at public functions or appoint an EMSC member to do so on their behalf.
6. Approve of all ministerial EMSC matters.
7. Sign all official documents.
8. Ensure that minutes are maintained.

B. The Vice Chair shall:

1. Perform the duties of the Chair in their absence.
2. Perform other duties as assigned to them by the Chair or the EMSC.

Article V. Committees

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

A. Standing Committees

1. Provider Agency Advisory Committee

This committee is responsible for all matters regarding prehospital licensure, certification and accreditation, policy development pertinent to the practice, operation and administration of prehospital care and the educational components associated with the delivery of prehospital care.

a. Chaired by an EMS Commissioner.
b. Two or more EMS Commissioners.
c. One representative from each major department and public geographic region:
    i. Area A - Western Region
    ii. Area B - Los Angeles County Fire Department
    iii. Area C - Northern Region
    iv. Area E - Southeast Region
    v. Area F - Long Beach Fire Department
    vi. Area G - South Bay Region
    vii. Area H - Los Angeles Fire Department
d. One currently employed paramedic coordinator, selected by the Los Angeles County Ambulance Association (LACAA).
e. One prehospital care coordinator selected by the Base Hospital Advisory Committee.
f. One public sector paramedic routinely assigned to an Advanced Life Support (ALS) Unit, selected by the Los Angeles Area Fire Chiefs Association (LAAFCA).
g. One private sector paramedic routinely assigned to an ALS Unit selected by the LACAA.
h. One provider agency medical director selected by the Medical Council.
i. One program director from an approved Paramedic Training program selected by the EMS Agency.
j. One program director from an approved EMT Training program selected by the EMS Agency.

2. Base Hospital Advisory Committee

This committee is responsible for all matters regarding MICN certification and policy development pertinent to the practice, operation and administration of prehospital care.

a. Chaired by an EMS Commissioner.
b. Two or more EMS Commissioners.
c. Two currently employed base hospital prehospital care coordinators from each of the major geographic regions.
    i. Northern Region
    ii. Southern Region
    iii. Western Region
    iv. Eastern Region
    v. County Region
d. One provider agency representative selected by the Provider Agency Advisory Committee.
e. One base hospital medical director selected by the Medical Council.
f. One currently employed MICN selected by the Association of Prehospital Care Coordinators (APCC).

3. Data Advisory Committee

This committee is responsible for all matters regarding quality of prehospital data, report generation, prehospital research and policy development impacting TEMIS.

a. Chaired by an EMS Commissioner
b. Two or more EMS Commissioners.
c. One base hospital administrator or assistant administrator, or a non-administrator duly authorized to represent a base hospital administrator/assistant administrator selected by the Hospital Association of Southern California (HASC).
d. One public sector paramedic provider representative selected by the Provider Agency Advisory Committee.
e. One public sector paramedic provider representative selected by the Los Angeles County Fire Department.
f. One public sector paramedic provider representative from the Los Angeles Fire Department.
g. One public sector paramedic provider representative from the Long Beach Fire Department.
h. One private sector paramedic provider representative selected by the LACAA.
i. One prehospital care coordinator selected by the Base Hospital Advisory Committee.
j. A trauma program manager and one physician selected by the Trauma Hospital Advisory Committee.
k. One base hospital medical director selected by the Medical Council.
l. One fire chief selected by the LAAFCA.

B. Scope and Responsibilities of Standing Committees

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

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

C. Officers and Composition of Standing Committees

1. The chair of each standing committee shall be a commissioner appointed by the EMSC Chair.

2. The term of each standing committee chair shall be one year. No chair shall serve more than two consecutive terms.

3. At least two commissioners shall serve on each standing committee.

4. No individual shall serve on more than two standing committees.

5. Each standing committee member may have an alternate except for the Base Hospital Advisory Committee, which has one alternate member per region. The alternate member votes or brings motions only when the regular member is not present.

D. Activity Requirements

1. Committees will be responsible for their own activities, including the location and frequency of meetings, designation of alternate chairs, and formation and composition of subcommittees, if desired. Generally, the committees meet during alternate months from the EMSC.

a. Minutes of committee meetings shall be maintained and distributed to all commissioners ten calendar days before the regular EMSC meeting.

b. At the EMSC's May meeting, each standing committee will submit its plans, priorities and activities for the year.

c. At the EMSC's July meeting, each standing committee will submit a report of the activities, findings and recommendations related to its goals.

E. Special Committees

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

   a. The task will be short term.

   b. The assignment falls outside the scope of the standing committees.

2. The special committee chair will be appointed by the EMSC Chair with the approval of the EMSC.

3. The EMSC Chair will determine the composition of the Special Committee in consultation with the Special Committee Chair. The Special Committee may include non-Commission members.

4. Special committees will be responsible for their own activities including location and frequency of meetings, designation of an alternate chair, and formation and composition of the subcommittees, if desired. Minutes of committee meetings will be written promptly and distributed to all EMSC members in a time frame determined by the EMSC.

Article VI. Meetings

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

B. A quorum is required for any official business, including regular and special meetings. A quorum shall consist of a majority of the sworn commissioners. Five commissioners constitute a quorum when the EMSC is hearing a matter under its arbitration function, as described in County Code Chapter 3.20, Section 3.20.070, Subsection 9.

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

D Executive sessions will be in accordance with provisions found in the State and local laws that govern such sessions.

E. Unless the voting on a motion is unanimous, the Secretary shall conduct a roll call vote.

F. Unless otherwise prescribed by these Bylaws, all EMSC meetings and all committee meetings shall be governed by Robert's Rules of Order, Revised.

Article VII. Amendments

These Bylaws may be amended by a three-fourths (3/4) vote of the sworn members of the EMSC if notice of intention to amend the Bylaws, setting forth the proposed amendments, has been sent to each member of the EMSC not less than ten days before the date set for consideration of the amendments.

Adopted by the Commission 7/15/81

Amended: 3/17/82; 2/16/83; 2/15/84; 1/16/85; 3/19/86; 10/15/86; 4/18/90; 3/17/93; 7/17/96; 11/17/99; 5/19/04; 7/20/05; 11/17/10, 9/18/19

EMERGENCY MEDICAL SERVICES COMMISSION
STANDING COMMITTEE APPOINTMENTS
2021

COMMITTEE	2019	2020	2021
Provider Agency Advisory Committee ***PAAC***	*Chair:* ***Paul Rodriguez*** *Vice Chair:* ***Dave White*** *Commissioners:* *Brian Bixler* *Gene Harris* *Staff:* ***Gary Watson***	*Chair:* ***Paul Rodriguez*** *Vice Chair:* ***Dave White*** *Commissioners:* *Brian Bixler* *Gene Harris* *Staff:* ***Gary Watson***	*Chair:* ***Robert Ower, RN*** *Vice Chair:* ***Kenneth Powell*** *Commissioners:* *Gene Harris* *Paul Rodriguez* *Brian Bixler* *John Hisserich* *Staff:* ***Gary Watson***
Base Hospital Advisory Committee ***BHAC***	*Chair:* ***Robert Ower, RN*** *Vice Chair:* ***Erick Cheung, MD*** *Commissioners:* *Atilla Uner, MD, MPH* *Margaret Peterson, PhD* *Staff:* ***Lorrie Perez***	*Chair:* ***Robert Ower, RN*** *Vice Chair:* ***Carole Snyder, RN*** *Commissioners:* *Joe Salas* *Staff:* ***Lorrie Perez***	*Chair:* ***Carol Meyer, RN*** *Vice Chair:* ***Carole Snyder, RN*** *Commissioners:* *Atilla Uner, MD, MPH* *Lydia Lam, MD* *Diego Caivano, MD* *Erick Cheung, MD* *Garry Olney, DNP* *Staff:* ***Lorrie Perez***
Data Advisory Committee ***DAC***	*Chair:* ***Nerses Sanossian, MD*** *Vice Chair:* ***Pajmon Zarrineghbal*** *Commissioners:* *Lydia Lam, MD* *James Lott, PsyD* *Colin Tudor* *Staff:* ***Sara Rasnake***	*Chair:* ***Nerses Sanossian, MD*** *Vice Chair:* ***Pajmon Zarrineghbal*** *Commissioners:* *Lydia Lam, MD* *James Lott, PsyD* *Staff:* ***Sara Rasnake***	*Chair:* ***Jeffrey Rollman*** *Vice Chair:* ***Joe Salas*** *Commissioners:* *Nerses Sanossian, MD* *James Lott, PsyD* *Gloria Molleda* *Gary Washburn* *Staff:* ***Sara Rasnake***
Education Advisory Committee EAC	*Chair:* ***Carole Snyder, RN*** *Vice Chair:* ***Marc Eckstein, MD*** *Commissioners:* *Ellen Alkon, MD* *Gary Washburn* *Staff:* ***David Wells***	***Education Advisory Committee (EAC) Dissolved September 18, 2019***	***Education Advisory Committee (EAC) Dissolved September 18, 2019***

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES

EMS AGENCY MEETING SCHEDULE

2021

Note: Meeting dates and times are subject to change

Revised: August 12, 2020

COMMITTEE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
EMS Commission *(3rd Wednesday - ODD months)* ***1:00 pm***	20		17		19		21		15		17	
Base Hospital Advisory Committee *(2nd Wednesday - EVEN months)* ***1:00 pm***		10		14		9		11		13		8
Data Advisory Committee *(2nd Wednesday - EVEN months)* ***10:00 am***		10		14		9		11		13		8
Provider Agency Advisory Committee *(3rd Wednesday - EVEN months)* ***1:00 pm***		17		21		16		18		20		15
Pediatric Advisory Committee *(Tuesday – Quarterly)* ***10:00 am***			2			8			7			7
Medical Council *(Tuesday – Quarterly)* ***1:00 pm***			2			8			7			7
Trauma Hospital Advisory Committee *(4th Wednesday – ODD months)* ***1:00 pm***	27		24		26		28		22			1
EMS Orientation *(Last Tuesday - Quarterly)* ***8:00 am***	26			27			27			26		
Innovation, Technology and Advancement Committee *(1st Monday- Quarterly)* ***10:00 am***		1			3			2			1	
EMS QI Committee Base Hospital and Public Provider *(2nd Thursday – Quarterly)* ***1:00 pm***		11			13			12			18	
EMS Private Provider QI Committee *(1st Thursday – every 4th month)* ***1:00 pm***				1				5				2
ACN-Building Emergency Coordinators Meeting *(4th Wednesday– Quarterly)* ***9:00 am***	27			28			28			27		
Disaster Coalition Advisory Committee *(1st Wednesday – Every 4th month)* ***9:30 am***		3				2				7		

LOS ANGELES COUNTY

Emergency Medical Services Commission

Ad Hoc Committee
On
The Prehospital Care of
Mental Health and Substance Abuse Emergencies

FINAL REPORT

September 2016

Prehospital Care of
Mental Health and Substance Abuse Emergencies

Ad Hoc Committee Participants

Frank Binch
EMS Commissioner
Representing the 4th Supervisorial District

Brian Bixler
Los Angeles Police Department
EMS Commissioner
Representing the Peace Officers Association

Annadenise Briz
Los Angeles County Sheriff Department

Miriam Brown
Mental Health Clinical Program Manger III
Los Angeles County Department of Mental Health

Irma Castaneda, Ph.D.
Deputy Director, Emergency Outreach
Los Angeles County Department of Mental Health

Cathy Chidester, RN, MSN
Director, EMS Agency
Executive Director, EMS Commission

Erick Cheung, M.D.
Medical Director, UCLA Psychiatric Emergency Services
Vice Chair, EMS Commission
Representing the Southern California
Psychiatric Society

Herman DeBose, MSW, Ph.D.
Commissioner
Los Angeles County Mental Health Commission

Kay Fruhwirth, RN, MSN
Assistant Director, EMS Agency

Jaime Garcia
Regional Vice President
Hospital Association of Southern California

Larry Gasco
Commissioner
Los Angeles County Mental Health Commission

Marianne Gausche-Hill, M.D., FACEP, FAAP
Medical Director, EMS Agency

Bob Baker
Los Angeles County District Attorney

Clayton Kazan, M.D.
Medical Director, Los Angeles County Fire Department
Chair, EMS Commission
Representing the California Chapter of the American
College of Emergency Physicians

Ken Liebman
General Manager, AMR
Representing Los Angeles Ambulance Association

Sheila Mallet, RN
Nursing Director, Emergency Services
LAC+USC Psychiatric Emergency Services

Rick Moreno
Deputy Chief EMS Bureau
Los Angeles County Fire Department

Luana Murphy, MBA
President/Chief Executive Officer
Exodus Recovery

Martha Mullen, RN, MSN
Emergency Nurses Association

Rita Murray
Member, National Alliance on Mental Illness(NAMI)
Los Angeles County Council
President, NAMI Whittier
Representing NAMI Los Angeles County Council

Roderick Shaner, M.D.
Medical Director
Los Angeles County Department of Mental Health

Kathy Shoemaker, RN
Senior Vice President
Clinical Services/Urgent Care Centers Exodus Recovery

Jim Smith
Police Chief, Monterey Park
Representing Los Angeles Police Chiefs Association

Gary Tsai, M.D.
Medical Director and Science Officer
Substance Abuse Prevention and Control
Los Angeles County Department of Public Health

Dave White
Fire Chief, Culver City
EMS Commissioner
Representing Los Angeles Area Fire Chiefs Association

Contents

Introduction

The Ad Hoc Committee on the Prehospital Care of Mental Health and Substance Abuse [a,b] (MH/SA) Emergencies was created by a motion of the Los Angeles County Emergency Medical Services Commission (EMSC) on November 18, 2015 to address two broad goals:

1) To evaluate the current manner in which MH/SA emergencies are handled by the 9-1-1 system, and
2) To propose a short and long term vision to improve the quality of care and safety for the patients, families, neighbors and first responders.

Among the types of medical problems for which the public calls for an emergency response, MH/SA emergencies are unique as they involve a patchwork of various healthcare providers (not just EMS and paramedics) and law enforcement (LE) agencies.

As the result of the clear challenges in responding to MH/SA emergencies, several of the field response entities in Los Angeles have been developing individualized strategies to cope with the rising volume, complexity, and lack of resources for MH/SA patients. While noble and necessary, this has not resolved the problem of fragmentation of resources, nor the lack of uniform standards in the care provided.

The EMSC Ad Hoc Committee (hereafter referred to as the Committee) was composed of stakeholders from diverse disciplines and agencies through Los Angeles including:

- Los Angeles County Department of Health Services Emergency Medical Services (EMS) Agency
- Los Angeles Police Department (LAPD)
- Los Angeles County Sheriff's Department (LASD)
- Los Angeles Ambulance Association
- National Alliance on Mental Illness (NAMI)
- Los Angeles County Department of Mental Health (DMH)
- Los Angeles County Department of Public Health (DPH)
- California Branch of American College of Emergency Physicians (CAL-ACEP)
- Southern California Psychiatric Society
- Hospital Association of Southern California (HASC)
- LA Care
- HealthNet
- Board of Supervisors
- Exodus Mental Health Urgent Care Center (MHUCC)
- Los Angeles County Fire Department
- Los Angeles Area Fire Chiefs' Association
- Los Angeles County Mental Health Commission
- LAC+USC Medical Center Psychiatric Emergency Services
- Los Angeles County Police Chiefs' Association
- California State Firefighters' Association
- Peace Officers' Association of Los Angeles County
- Emergency Nurses Association

[a] The term substance abuse (SA) as used in this document is interchangeable with the term substance use disorder and both are used to define a dependence on alcohol and or drugs that is accompanied by intense and sometimes uncontrollable cravings and compulsive behaviors to obtain the substance.

[b] When using the term mental health and substance abuse (MH/SA) in this document it is acknowledged that the field responder's are providing "impressions" based on the person's exhibited behavior and history and not necessarily providing a diagnosis.

Background

There is substantial evidence to indicate that problems with the emergency care for patients with MH/SA emergencies are aggravated by the lack of coordination and integration of emergency, mental health, and substance abuse services. Experts have written about the significant dysfunction within each of the respective systems.

Emergency Department Services

The Institute of Medicine, in their landmark series of reports issued in 2006, strongly warned that emergency care in the United States (U.S.) is fragmented, underfunded, under-resourced, over-utilized, and overcrowded (see appendix for IOM key findings fact sheet). The demand for emergency care in the U.S. has grown rapidly; between 1993 and 2003 emergency department (ED) visits increased by 26% [1]. Meanwhile the number of EDs declined by 425.

Mental Health Services

At the same time, America's MH/SA systems have seen decades of severe contraction of acute care services (i.e. inpatient psychiatric hospital beds). Well-intentioned efforts to de-criminalize and de-institutionalize mental illness and substance abuse and remove afflicted individuals from jails, and an overall lack of availability and access to timely and appropriate community MH/SA services [2] compound the demand for services.

It is critical to understand the magnitude of people who suffer from mental illness and/or substance abuse. The burden of mental illness in the U.S. is great. Almost one in four adults suffers from a diagnosable mental disorder in any given year, and between 5% and 7% of adults suffer from a severe mental illness (SMI) [3,4]. The California Department of Mental Health estimated in 2007 that there were nearly two million people in the State of California in need of mental health services for SMI [3]. According to the California Health Care Foundation, 1 in 20 California adults suffers from a serious mental illness that causes substantial impairment in carrying out major life activities [5]. Mental illness is a leading cause of disability and suicide, and carries large social, economic, and personal costs [2,4].

Pediatric MH/SA Services:

The burden of MH/SA disorders in the pediatric and adolescent population, defined as <18 years of age, is large. In the United States 23% of children and adolescents have a MH/SA disorder and in the emergency settings nearly 70% of children and adolescents screen positive for at least one mental health disorder.[6,7]

Few emergency care providers have significant clinical experience with evaluating children and adolescents with MH/SA disorders and yet EMS and emergency department physicians are often faced with managing these children, performing a medical clearance evaluation, and referring them to limited inpatient and outpatient psychiatric services. A number of barriers exist to the provision of mental health services to children in emergency care systems. These barriers include knowledge gaps in pediatric psychiatric illness by emergency care providers, limitations of the prehospital and

ED settings to provide comprehensive evaluation, and lack of access to pediatric inpatient and outpatient mental health services.[8]

Substance Use Disorders Services

In California, approximately 2.3 million Californians need substance use disorder treatment, while only about 10% receive such care [Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009-2013]. Meanwhile, the number of people who need access to addiction substance abuse treatment through Medi-Cal is increasing and person with untreated substance use disorders are among the highest users of publicly funded health services. Additionally, billions of dollars are lost every year due to direct and indirect costs of addiction.

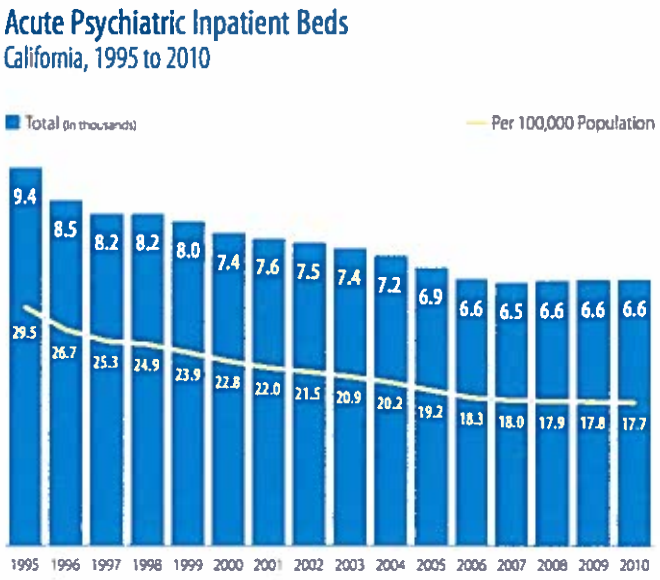
Resources for substance use disorders are limited. There are currently approximately 300 substance use disorder providers located throughout LA County, comprised of approximately 100 residential withdrawal management beds, 1,200 short term residential treatment beds, 3,000 intensive outpatient and outpatient treatment slots and 5,000 opioid treatment program slots (Substance Abuse Prevention and Control, LA County DPH). In LA County, approximately 18% of individuals who might need substance use treatment actually receive treatment. Although this penetration rate is higher than the 10% national average reported by SAMHSA, this data still demonstrates that the vast majority of individuals who would benefit from substance use treatment are not receiving it. Given that individuals with substance use disorders incur two to three times the total medical expenses of people without these conditions[12], and die an average of 26.1 years younger than the general population[13], this lack of treatment contributes to significant economic and human loss.

MH/SA Services in Emergency Departments

When MH/SA services and supports are unavailable or poorly coordinated, patients with unmet needs turn to the ED and the 9-1-1 system for care [9]. In the current healthcare delivery system, EDs are the only institutional providers required by federal law to evaluate anyone seeking care. In California, 8.4% of the population received care for a mental health problem in an ED in 2005, up from 2.7% in 2001[10].

In a 2010 survey of California EDs, over 75% of respondents reported that lack of inpatient beds was the primary reason for mental health boarding (patients waiting in the ED to be admitted), ED overcrowding, and extended lengths of stay [11]. Indeed, the reduction in psychiatric inpatient beds has been severe. In California between 1995 and 2011, there was a 30% decrease in psychiatric inpatient beds, from 9,353 to 6,367 [3]. The psychiatric bed-to-population ratio has steadily declined to an all-time low of 16.76 beds per 100,000 California residents, corresponding to a shortfall of 4,000 psychiatric beds [2,3] (see Figure 1).

Figure 1. Acute Psychiatric Inpatient Beds, California, 1995-2010 [5]



Estimating the number of annual MH/SA visits to EDs in LA County has been challenging due to inconsistent data reporting. However, the current best estimate is that there are approximately 150,000 MH/SA visits to LA County EDs annually. Additionally, in calendar year 2013 there were 490,701 EMS transports with 21,106 patients having a "behavioral" chief complaint. This number does not include MH/SA patients transported by other responders: LE, psychiatric mobile response teams (PMRT) and psychiatric evaluation teams (PET).

Committee Objectives

Focusing on prehospital care for MH/SA emergencies, the Committee posed a fundamental question: What happens when a person in LA County calls 9-1-1 with a MH/SA emergency?

Unlike the response for medical emergencies, which could be generally characterized as predictably delivered and uniformly regulated [c], the response to MH/SA emergencies is comparatively varied and lacks the same coordinated delivery and regulation. The main source of variation lies in the fact that two very different entities, LE or EMS agencies, may be dispatched as a result of a 9-1-1 call. The LA County DMH "Access Line" is a third entity that may be called by the public to respond to a MH/SA emergency, though notably it is distinctly separate from the 9-1-1 system. A call to the DMH Access Line could potentially trigger specific mental health teams to respond.

A number of questions naturally follow:

- When does LE respond, when does EMS respond, and how is this decided?
- What are the differences or similarities in the LE, EMS and DMH response?
- Is one response better than the other in terms of patient care, or patient preference?
- Do LE and EMS responses lead to different standards of care or outcomes for patients?

It is in this current climate of increased demand and decreased availability of MH/SA and emergency services, that the Committee was tasked to assess the current prehospital care for MH/SA emergencies, as the first step in developing a blue print for system improvement.

The main objectives of the committee focused on:

1. Generating a clear and comprehensive map of the process by which MH/SA emergencies are managed in the LA County EMS system, from a person placing a 9-1-1 call to destination (i.e. where the patient will be transported to).
2. Providing a coherent description of the multiple agencies and entities that can potentially respond to MH/SA emergencies
3. Describing the critical decision points in the MH/SA field responses for LE and EMS
4. Identifying sources of data that demonstrate the availability of services, or lack thereof, and/or data that exemplify the strain on the system
5. Articulating principles for change and improvement in the MH/SA emergency response system in LA County
6. Recommending specific areas for potential intervention by the EMS Agency, LE and EMS agencies, LA County Officials, or others.

MH/SA FIELD RESPONSE MAPS

Figures 2 and 3 display the process for EMS and LE response to MH/SA emergencies. Though the process starts with a call to 9-1-1 in both cases, once a decision has been made to dispatch EMS vs. LE, the processes, decision points, resources, and disposition options are unique to each discipline.

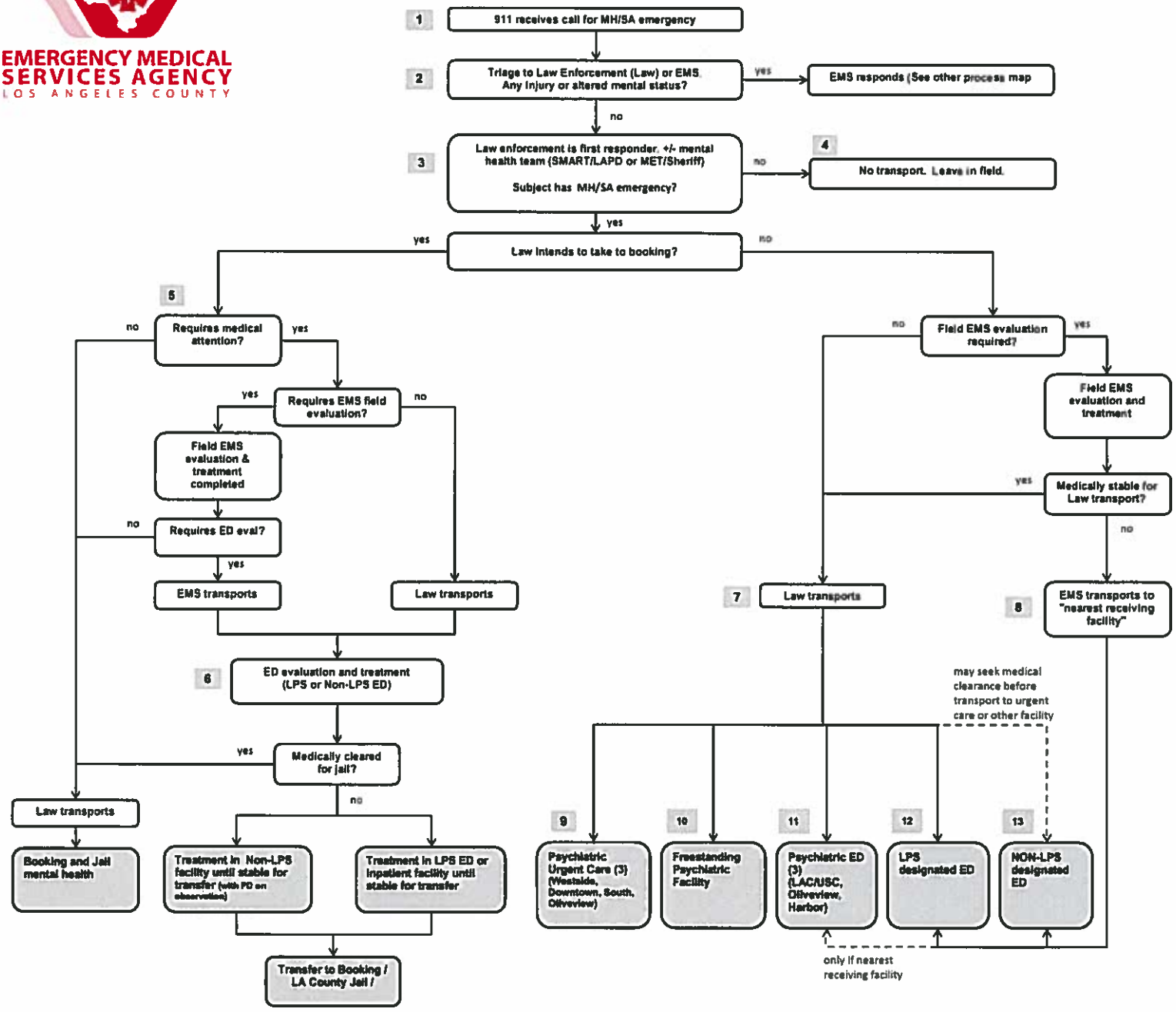
A detailed appendix is located at the end of this document which corresponds to the shaded grey numerals in each field response map, providing descriptions, areas of need, comments, recommendations, and barriers to change.

Figure 2

Los Angeles County Mental Health and Substance Abuse Emergency Response System

Process Map : Law Enforcement Response to MH/SA Emergencies (Approved 06/06/16)

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY



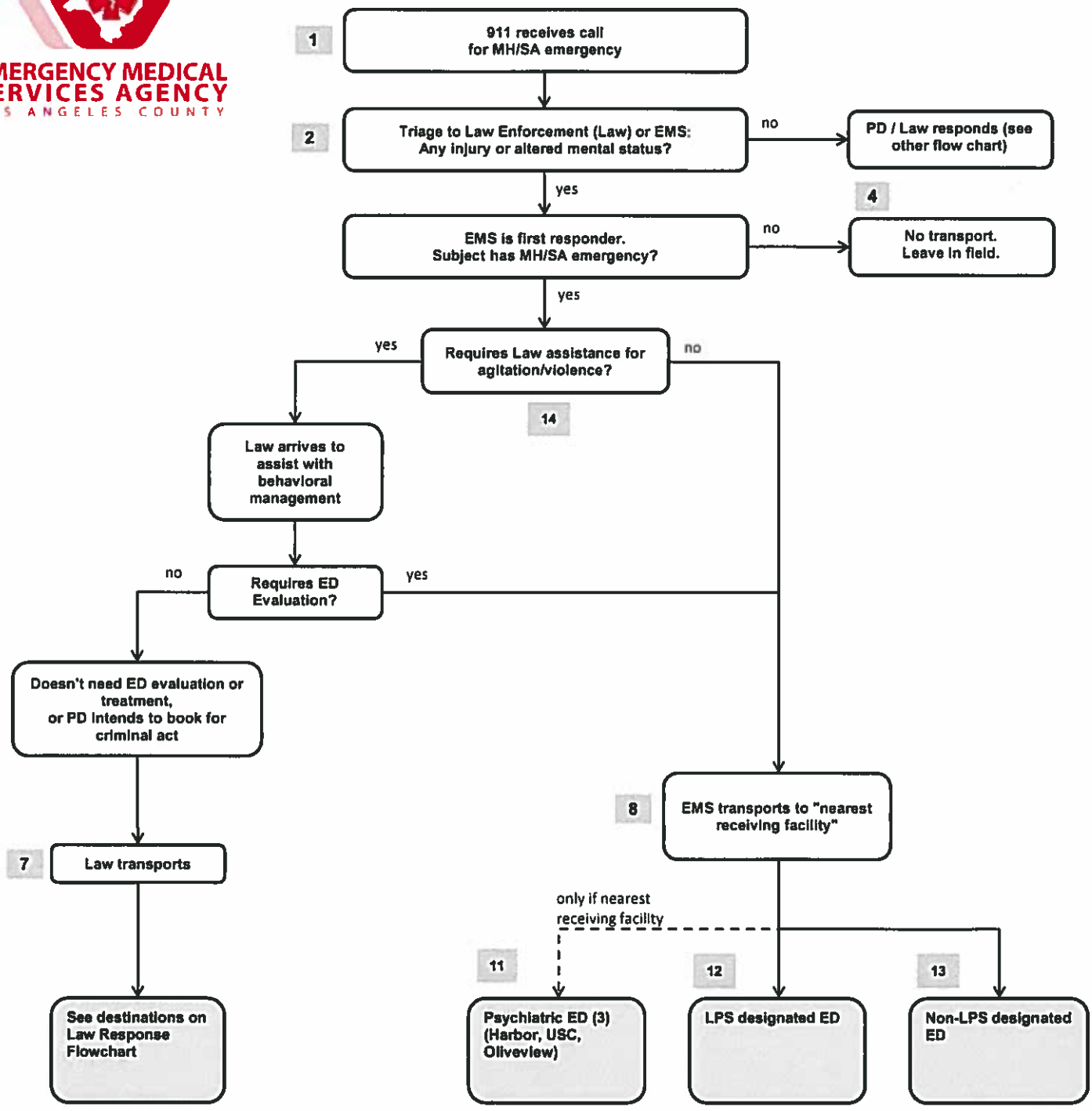
Abbreviations:
MH/SA: Mental Health and Substance Abuse, also commonly referred to as "behavioral"
Law: Law Enforcement Agency (Police Department, Sheriff's department)
EMS: Emergency medical services
ED: Emergency Department
LPS: Lanterman-petris-short (CA WIC 5150), referring to County designated mental health facilities

Figure 3

Los Angeles County Mental Health and Substance Abuse Emergency Response System

Process Map : EMS Response to MH/SA Emergencies (Approved 06/06/2016)

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY



Abbreviations:
MH/SA: Mental Health and Substance Abuse, also commonly referred to as "behavioral"
Law: Law Enforcement Agency (Police Department, Sheriff's department)
EMS: Emergency medical services
ED: Emergency Department
LPS: Lanterman-petris-short (CA WIC 5150), referring to County designated mental health facilities

Principles for evaluating current MH/SA emergency services and proposed changes

The Committee identified four major themes that should serve as fundamental guiding principles in evaluating both the current system and proposed changes.

1. MH/SA emergencies are medical emergencies, and, as such, are best treated from the point of first contact by medical/clinical personnel trained, equipped, and experienced to evaluate and manage the patient.

2. A proportion of MH/SA emergencies involve acute behavioral agitation, violence, threats of harm to self or others, or criminal activity, in which case they most likely require the combined response of EMS and LE.

3. MH/SA emergencies in adults and children are best treated in emergency facilities (transport destinations) that are appropriately designed and resourced to address MH/SA needs.

4. The system of prehospital care for MH/SA emergency patients should be based on established best practices, which are consistently applied throughout the County regardless of which agencies respond.

In addition to the above principles, the Committee underscored the fact that prehospital care response to MH/SA emergencies are just one component of the larger MH/SA and emergency systems in LA County. As such, this response is intimately related to, and impacted by, the lack of ready access to acute care services (e.g. inpatient psychiatric beds). In addition, it is impacted by patients' access (or lack thereof) to timely resources and treatment for non-emergent MH/SA problems, where case management and wrap-around care are needed to reduce the incidence of MH/SA emergencies

Committee Observations

A number of consensus observations were made by the Committee, with regard to the current MH/SA emergency response system:

1. The current MH/SA emergency field response is variable, and lacks uniformity and a source of central oversight. The dispatch of EMS or LE is based on local customs, and, in many circumstances, may be defaulted to LE as the first responder. LE officers are, therefore, often in a position of conducting clinical evaluations of MH/SA patients with a goal of determining whether the patient needs treatment, and to determine the best destination option, despite the lack of medical training.

2. The LE response, and more specifically the transport of patients in squad cars in handcuffs, has the undesirable effect of "criminalizing" persons with MH/SA emergencies.

3. LE agencies have made, and are continuing to make, valiant efforts to improve officers' training and interactions with MH/SA patients. Likewise, several agencies have developed MH/SA emergency response teams, staffed with specifically trained law or clinical personnel, to attempt to address the demand and risks of LE's response. Though an improvement upon the default response of routine LE, the availability of such specialized MH/SA response services remains limited and within the domain of LE (as opposed to within the domain of EMS).

4. The current EMS field treatment protocols for management of the acutely agitated person with a MH/SA emergency are limited to identification of patients with "agitated delirium" and treatment of these patients is limited to using chemical restraint (e.g. midazolam). The use of such agents for chemical restraint in MH/SA emergencies have not been well studied and often lack efficacy.

5. The current LE field protocols for management of the acutely agitated person with a MH/SA emergency are guided by department specific customs or training.

6. The current system provides several destination options to LE that increase the access to appropriate mental health care for patients with MH/SA emergencies (such as options to transport to Mental Health Urgent Care Centers (MHUCCs) or directly to freestanding Psychiatric Hospitals. Conversely, the current EMS destination is limited to emergency departments as per the State of California Health and Safety Code Division 2.5. This regulation appears to limit the timely access to appropriate mental health care for patients with MH/SA emergencies transported by EMS.

7. LA County EMS Agency Prehospital Care Reference No. 502, *Patient Destination* requires transportation to the "most appropriate receiving" facility. Generally, this is the "nearest emergency department". An exception to going to the nearest emergency

8. department includes transporting a patient to a specialized care center for pre-defined conditions such as stroke, ST elevation myocardial infarction (STEMI) and trauma. To date, there hasn't been the will of the community to create emergency specialty care designations for MH/SA care.

9. Many EDs that currently receive patients from EMS providers lack both sufficient resources and expertise to optimally manage MH/SA patients. Further, facilities that do not have authority to detain patients under WIC 5150 or 5585 (pediatric patients , 18 years of age), face significant barriers in securing a patient's transportation to an inpatient psychiatric hospital, resulting in lengthy patient boarding waiting for an evaluation by a PET or PMRT, then transfer to an available bed.

10. Substance use disorder services are largely unavailable or lack integration into the emergency and acute care system. Specifically LE and EMS providing field assessment and transport do not have acute substance detoxification services readily available as a destination option. Individuals with substance use disorders that arrive at an ED are often discharged with inadequate follow up or referrals to community resources for their addiction, as there are a scarcity of these resources and little to no options for referral. Additionally, EDs do not have an ability to transfer patients to detoxification services as there is limited or no access.

11. EMS providers have not sought LPS authority/certification to write involuntary detainments, though there is nothing prohibiting their application for such authority/certification.

Recommendations for change to the current MH/SA field response

Provided below is a summary of the final recommendations of the Committee based on their review of the current MH/SA field response maps. Details of these recommendations as they pertain to specific elements within the response maps can be found in the Appendix.

1. Modify and standardize the MH/SA emergency 9-1-1 triage criteria to match the field response (LE vs. EMS) to the type of emergency situation. Specifically: triage LE to patients who may be combative, violent, or exhibiting potential criminal behaviors, and triage EMS to all other MH/SA emergencies, including "agitated delirium". The net expected effect would be a decrease in responses where LE is the sole responder and a corresponding decrease in criminalization of mental illness and potential use of force, and an increase in the appropriate medicalization of MH/SA emergencies.

2. Investigate the potential of greater integration of co-deployed MH/SA and LE teams into the 9-1-1 first response systems. Consider a tiered approach to the dispatch of patrol units to MH/SA emergencies, such that MH/SA trained officers may preferentially respond to the scene.

3. Develop basic resource materials for persons with MH/SA emergencies who are not transported / left in the field, to increase access to mental health services when appropriate.

4. Standardize training/protocol across the County for all LE agencies regarding what constitutes a need for a medical evaluation by EMS providers.

5. Investigate the pros/cons of establishing MH/SA emergency specialized care centers, akin to the system for STEMI, trauma, stroke, etc., to improve the care for MH/SA emergencies.

6. Determine the feasibility (including regulatory and financial/economic or practical barriers) of alternate destinations to directly transport EMS patients to specialty EDs that demonstrate the capacity and expertise to care for MH/SA patients, to MHUCCs, or to other destinations that can provide the appropriate evaluation and treatment. Investigate and pursue the integration for substance abuse detoxification and rehabilitation services as destination options for EMS, LE and EDs.

7. Support regulatory changes to ensure parity for all populations, including the following key issues. Medi-Cal currently does not reimburse free standing mental health facilities for care to adult recipients. Further, the Drug Medi-Cal Organized Delivery System benefit program being implemented by DPH focuses on outpatient SA treatment and does not provide reimbursement for inpatient services. Finally, the Drug Medi-Cal Organized Delivery System benefit program contains annual limitations on residential treatment for substance use disorders for both youth and adult clients.

8. Develop additional treatment protocols (non-pharmacologic and pharmacologic) to address combative, agitated or potentially violent behavior in MH/SA adult and pediatric patients. Refer to the EMS Agency Medical Advisory Council to determine whether the EMS Agency should pursue the use of alternate agents for behavioral agitation as the result of acute psychosis, substance intoxication or withdrawal, delirium, and undetermined etiologies.

9. Explore the option of Sobering Centers as a patient destination for inebriates as these resources become more available in the community.

A future vision

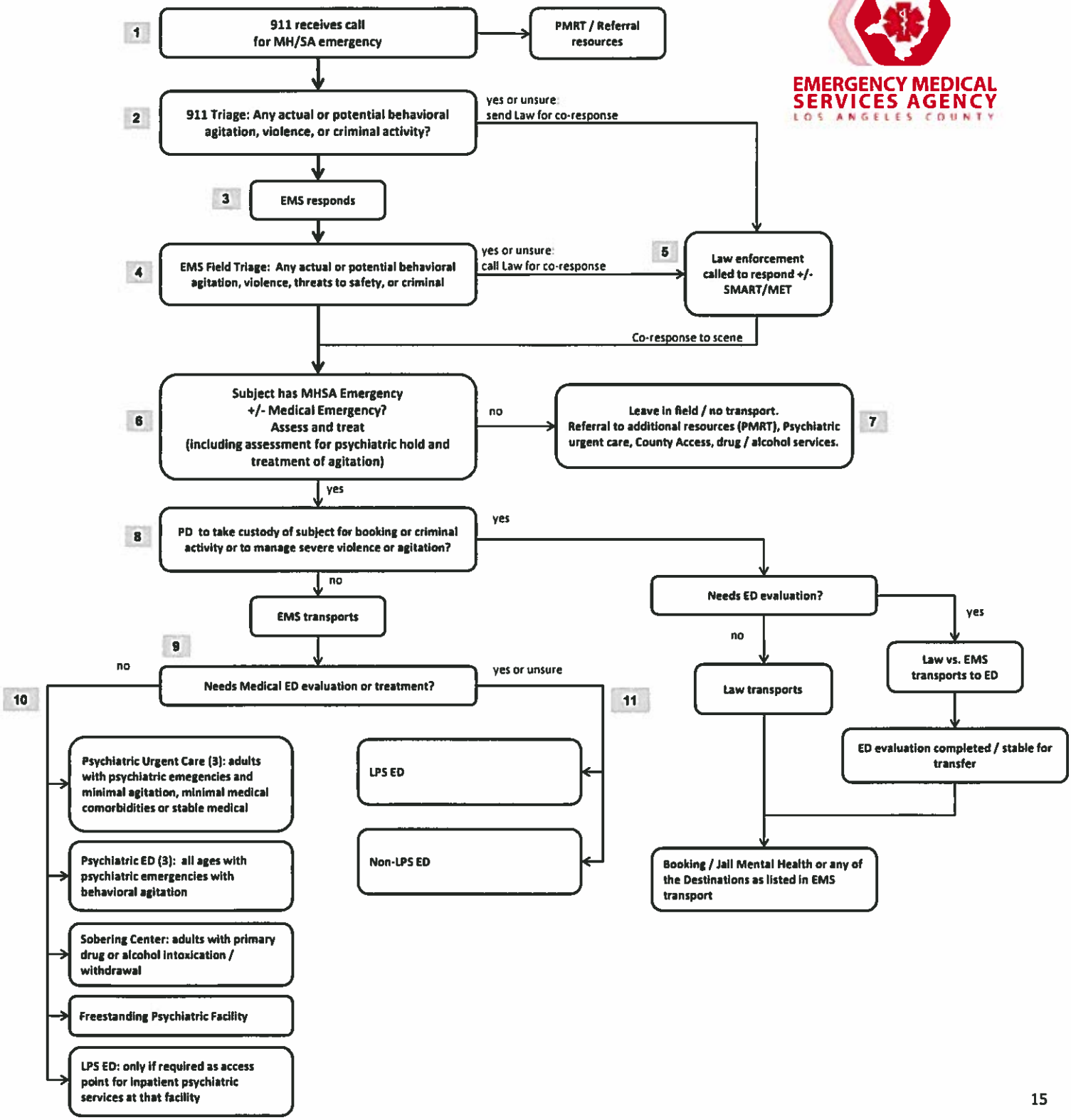
Having considered our current model, we shifted our focus to a combined vision of how to improve patient care for persons with MH/SA emergencies taking into account the Committee's principles and observations stated above.

Figure 4 proposes a fundamentally re-designed management algorithm to address MH/SA emergencies, consistent with the articulated principles and a primary focus on delivering higher quality patient care. Again, specific areas of focus are addressed in the appendix that corresponds to Figure 4.

Figure 4

Los Angeles County MH/SA Emergency Response System (Mental Health and Substance Abuse)

Process Map : Potential Field Response Map (Approved 6/1/16)



Concluding Remarks

MH/SA problems are prevalent, disabling, at times dangerous, and increasingly the cause for calls to the 9-1-1 system. In LA County, the field response to MH/SA emergencies is highly varied, with either a LE and/or EMS response based on non-uniformly standardized or regulated triage protocols. As a result, a person cannot reliably predict who will respond and how his or her MH/SA emergency will be evaluated and managed in the field, and, furthermore, how or where he or she will be transported to in the event that additional care is needed.

The current system has placed LE personnel frequently in the position of performing clinical evaluations for, and attempting to manage, MH/SA issues in the field. The Committee firmly asserts that MH/SA emergencies are medical emergencies, and as such are best addressed by trained healthcare personnel, whenever possible. Finally, the Committee fully recognizes that MH/SA emergencies are unique in their potential for first responders to encounter adult and pediatric patients who may be acutely agitated or potentially harmful to themselves or others. New protocols and training are necessary to tailor and equip the EMS and LE response to these situations, including training in verbal de-escalation as well as pharmacologic treatment protocols, in order to provide the highest quality of care and to minimize the use of force and potentially disastrous outcomes.

The Committee respectfully submits this analysis of the current field response system, with accompanying principles, observations, and specific recommendations, to the LA County EMSC.

APPENDIX TO FIGURES 2 and 3: LE AND EMS FLOWCHARTS

The numerical items below correspond to the flowcharts for the current LE and EMS response to behavioral emergencies. Sub-items are categorized as follows:

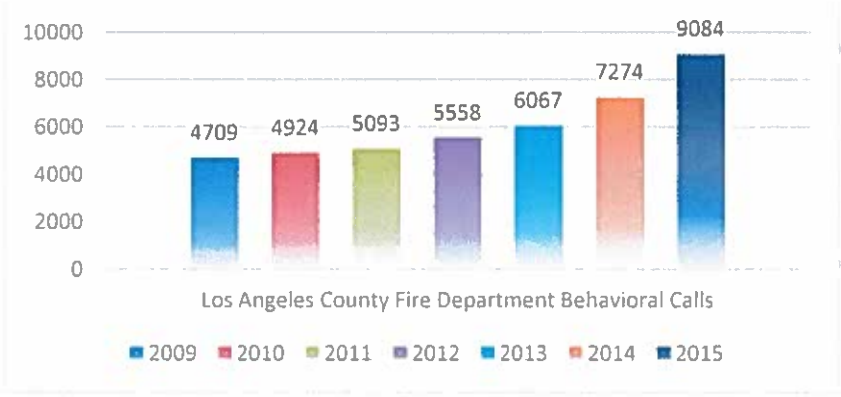
- Description
- Area of need
- Comment
- Recommendation
- Barriers to change

1. 9-1-1 receives call for MH/SA emergency:

   a. Description: All 9-1-1 calls are routed to the Public Safety Answering Point (PSAP). Most PSAPs are operated by LE, and, if the call taker determines that the call is medical, then they will, in most cases, transfer the call to an EMS call taker. There are a few PSAPs in LA County that handle both LE and EMS calls, but most medical related calls are transferred from LE to EMS call takers. There are more than 40 LE agencies and 13 EMS dispatching centers in LA County.

   b. Area of Need: It is unclear how many calls for MH/SA are received per year, or what proportion of all emergency 9-1-1 calls are related to MH/SA problems. The total quantity is difficult to discern because of poor data collection, but the expert consensus is that the demand for emergency services continues to rise.

      Below is a graph showing LA County Fire Department (LACoFD) dispatches for behavioral emergencies from 2009 – 2015. From 2013-2015, the department's overall EMS call volume rose by about 20%, while the behavioral emergency calls increased by 50%.



In 2016, the LA Police Department (LAPD) responded to approximately 18,000 MH calls, and the LA Fire Department (LAFD) responded to 11,500 calls. Some of these calls may have had response of both agencies.

2. Triage to LE vs. EMS:

    a. Description: The current 9-1-1 system is designed to triage based on the questions posed by the 9-1-1 call taker. In the LAPD, for example, if the caller indicates that the patient is having a MH/SA emergency, then police are dispatched. Only if the caller indicates that there is a medical emergency is there an EMS response.

    b. Comment: There is currently no known uniformity in the criteria used to triage the response to LE or EMS. As a result of this triage decision point, the 9-1-1/EMS system likely relies more heavily on the response of LE to MH/SA emergencies than perhaps desired. Concerns are raised about the training, ability and resources of LE to appropriately manage MH/SA emergencies, and such emergencies are likely better addressed by medically trained individuals.

    c. Area of need: It is unclear what percentage of 9-1-1 calls are triaged to LE vs. EMS in the current system. This is data that needs to be collected. It is currently unknown if other major counties in California have a triage system for MH/SA emergencies that is similar to Los Angeles, or whether any are designed in a way that reduces the use of LE as first responders.

    d. Recommendation: Consider modifying the MH/SA emergency triage criteria to match the field response (LE vs. EMS) to the type of emergency situation, i.e. triage LE specifically to patients who may have agitation, violence, or potential criminal behaviors and triage EMS to all other MH/SA emergencies.

    e. Barriers to change: Concerns for safety and training if EMS becomes the default first responder for MH/SA emergencies.

3. The availability of specialized and embedded mental health units ("SMART"/LAPD or "MET"/LA Sheriff) in law enforcement agencies is limited but possibly growing.

    a. Description: Mobile crisis units for mental health emergencies have several different monikers which vary based on the department that they are affiliated with:

        i. SMART (System-wide Mental Assessment Response Team) is associated with LAPD. They have 17 teams available per day on overlapping shifts with 24 hour coverage.

        ii. MET (Mental Evaluation Team) is associated with Los Angeles County Sheriff Department (LASD). They have eight teams providing coverage 18 hours/day with three additional teams to be added on September 1, 2016 and there are plans to expand to 23 teams over the next three years.

        iii. LE Teams are associated with 22 other local LE agencies. Eight additional METs affiliated with city police departments will be operational by September 30, 2016. Four additional METs are pending, including on with the LA World Airports. These METs operate according to the needs of each jurisdiction,

with most operating Monday-Friday between 9:00 a.m. until 8:00 p.m. Some METs operate on weekends depending on personnel resources.

iv. PMRT (Psychiatric Mobile Response Team) is associated with LAC DMH and are field-based teams that operate seven days a week from 8:00 a.m. until 2:00 a.m. These teams are geographically located in eight service areas and each team consists of eight to ten clinicians.

v. PET (Psychiatric Emergency Team) are associated with freestanding psychiatric hospitals.

vi. Other: There are other mobile crisis teams, which the LA County Metropolitan Transit Authority Crisis Response Unit (MTA-CRU) is an example of.

Embedded mental health units with LE are generally viewed as favorable responders to MH/SA emergencies, with better training to interact with this population. However, there is limited, or no, outcomes data regarding such entities. The availability of teams is limited by hours of operation, geographical access and mobility.

b. Comments: SMART and MET teams are not dispatched directly to calls and, thus, are not first responders. The SMART team can self-dispatch based on calls heard on the radio, and they are available on request of first responding patrol units. MET teams are dispatched on request of patrol deputies. The City of Houston Police Department utilizes a tiered response, which is considered a best practice, and is based on the intensity of the call and availability of their units.

i. Tier 1 – co-deployed Mental Health/LE team

ii. Tier 2 – Patrol unit that has received specialized mental health or crisis intervention training

iii. Tier 3 – Standard patrol unit.

It is noted that PMRT and PET are not accessible in the current 9-1-1 system algorithm

It is also noted that some freestanding psychiatric hospitals operate their own PET units, which are usually deployed to emergency departments to perform assessments for 5150 or 5585 (pediatric patients) and to facilitate transfer to their own psychiatric facility.

c. Recommendation: Investigate the potential of greater integration of co-deployed Mental Health/LE teams into the 9-1-1 first response systems. Consider a tiered approach to the dispatch of patrol units to MH/SA emergencies, such that MH/SA trained officers may preferentially respond to the scene.

d. Barriers to change: The main barrier to a widespread growth and integration of co-deployed teams is cost.

4. No transport, Leave in Field:

   a. Comment: Both LAPD and LASD provide a leaflet with resource information for MH/SA services. EMS providers do not have any standard information to give to these patients. DMH offers linkage through their ACCESS system, which funnels patients to their outpatient mental health programs.

   b. Recommendation: Investigate the development of basic resource materials for persons with MH/SA emergencies who are not transported, to increase access to mental health services when appropriate.

      DMH offered their ACCESS number, (800) 854-7771, to LE and EMS departments that are leaving patients in the field. LA County DMH should produce standard information that can be given out by both LE and EMS agencies outlining available outpatient mental health information and telephone numbers. It is essential that these resources receive patients regardless of payor status, redirecting them when necessary but never turning them away.

   c. Barriers to change: None

5. Requires medical attention:

   a. Comment: It is unclear what standard criteria are used, if any, by LE to determine whether the patient requires medical attention. LE officers are being asked to make a medical determination without any standardization of training. Current practice is to refer to EMS if there is an apparent injury or if the patient appears ill or has chronic medical problems.

   b. Recommendation: Standardization and training across the County for all LE agencies regarding what constitutes a need for a medical evaluation by EMS providers.

   c. Barriers to change: Apart from Peace Officer Standards and Training (POST), which is a state organization, there is not an easy way to ensure dissemination and standardization across all law enforcement agencies in LA County. The EMS Agency is part of the Department of Health Services and does not have any jurisdiction over the evaluation performed by peace officers in the field.

6. ED evaluation and treatment, ED at a Lanterman-Petris-Short (LPS) or non-LPS facility:

   a. Description: Current California law stipulates that patients on a 5150 or 5585 placed by LE should be brought to an LPS designated facility. Typically, this involves bringing the patient to the ED at an LPS designated facility, though there are some LPS designated hospitals without ED's that receive patients directly from LE under specific circumstances.

b. Comments: In practice, it is unclear how LE determines which ED to transport a patient to. The time from arrival at a specific facility until the facility staff take over the care, often referred to as "wall time" for LE officers is unknown, but may be a factor in determining which facility LE officers transport to. LE officers may generally transport to ED's that are closest to them, or those ED's who they have developed relationships or agreements with, or the ED that will lead to the least amount of wall time.

When patients on a 5150 hold are brought to ED's that are not located at LPS designated hospitals, then this is difficult for both the patient and the ED. These ED's are frequently ill equipped to manage MH/SA patients, lacking proper space, equipment, training, and experience. This results in poor and potentially unsafe treatment of the patient. Also, because of limited access to psychiatric inpatient bed capacity, these patients may be stuck waiting in an ED for several days for an inpatient bed to open up. This also impacts the ED holding the patient, reducing their available capacity and hampering their ability to provide emergency services to other patients.

7. LE transports:

a. Description: Some LE agencies frequently though not uniformly transport MH/SA patients in handcuffs in the back of a patrol car even if the patient is not aggressive or resistive. For example, LAPD policy requires that all MH/SA patients being transported in a patrol car have handcuffs applied. This is for the safety of the officer and the patient and to reduce use-of-force. LASD frequently utilizes handcuffs as well, but this is not in policy. As depicted in the flow chart, LE officers have a much greater range of destination options compared to EMS personnel. Health and Safety Code Division 2.5 stipulates that EMS personnel can only transport to an ED, and, per LA County EMS Agency policy, they must be transported to the "most appropriate receiving" ED (MAR), which may or may not be part of an LPS designated hospital. LE can transport to any ED, and they can bypass the nearest ED to transport to the nearest LPS designated hospital ED or County PES. Law enforcement can also transport to a MHUCC instead of an ED.

b. Comments: While method of transport is intended to reduce the potential for harm to the patient or the officer, it is a cause for major concern regarding the impact from a medical and patient's perspective on patients who are suffering MH/SA emergencies.

c. Recommendation: See Appendix item #2. If triage of MH/SA emergencies is re-calibrated to dispatch LE primarily to patients who have potentially combative, violent, or exhibiting criminal behaviors, then the number of transports of patients by LE would likely be reduced, thereby reducing the effect of "criminalization" of mental illness. The Committee believes that, when possible, transportation in an unmarked vehicle or ambulance versus a marked police vehicle is preferable both from patient safety and to reduced stigmatization.

d. Barriers to change: Standardization of management of MH/SA patients by LE across LA County is difficult because of a lack of a local governing body.

Delegation by LE of responsibility for maintaining custody of individuals detained under WIC 5150, aside from transfer of custody directly from LE to an LPS designated facility, is not clearly addressed in regulations. Therefore, EMS are sometimes hesitant to assume such responsibilities.

The Center for Medicare/Medicaid Services (CMS) has ruled that reduced stigmatization of patients does not constitute a medical need for ambulance transport. Thus, ambulance companies may not be reimbursed if this is the sole reason for utilizing ambulance transportation.

Health and Safety Code Division 2.5 and EMS Agency Prehospital Care Reference No. 502, *Patient Destination* limit destinations for emergency ambulance transportation. Any deviation from this could only be achieved through an authorized pilot study from the State EMS Authority (EMSA) or through a legislative change.

8. EMS transports to "most appropriate receiving facility":

a. Description: Current EMS Agency Prehospital Care Reference No. 502: *Patient Destination* requires EMS to transport to the nearest receiving facility, regardless of LPS designation status, and regardless of the availability of psychiatrists or appropriate resources (such as specialized facilities and staff for mental health emergencies). The options for patient destination are limited in comparison to law enforcement.

b. Comments: The EMS Agency has recognized the need for specialized care centers for certain types of medical illnesses (for example stroke, trauma, STEMI, pediatrics), which establishes resources and personnel that are specifically prepared to manage such emergencies.

c. Recommendation: Investigate the pros and cons of establishing MH/SA emergency specialized care centers to improve the care for MH/SA emergencies.

Consider a tiered system as outlined below:

i. Comprehensive Psychiatric Center with a PES (adult and pediatric facilities)
ii. ED at a LPS designated hospital
iii. MHUCC
iv. ED at a non-LPS designated hospital

d. Barriers to change: Hospitals have been reluctant in the past to become designated as psychiatric receiving centers. Federal law currently prohibits the use of federal Medi-Cal dollars for inpatient treatment. Hospitals are not reimbursed for providing SA services and the County's DPH Drug Medi-Cal programs appear to be focused on outpatient treatment not inpatient care.

9. MHUCC (Exodus Recovery Inc.):

   a. Description: Psychiatric or MHUCC provide intensive crisis services to individuals who would otherwise be taken to EDs. There are currently four 24/7 MHUCC's in Los Angeles County. A report to the LA County Board of Supervisors dated May 17, 2016 from DMH titled *Report Back on Collection of Standardized Urgent Care Center Data* provided April 2016 volumes from MHUCCs and this data is included below. Note that the estimated annualized total number of visits based on this monthly volume is 46,500.

SERVICES DELIVERED

Overall, 3,139 unique individuals were served by UCCs in the month of April. Some individuals received more than one visit; total visits to UCCs for that month was 3,875. Information for each UCC is as follows:

April 2016 Unique Clients Served and Visits to UCCs

Urgent Care Center	Unique Clients	Total Visits
DMH Olive View UCC	578	1,148
Exodus Eastside UCC	1,093	1,154
Exodus MLK UCC	868	937
Exodus Westside UCC	424	449
Telecare MHUCC	176	187
Total	3,139	3,875

Average length of stay in LPS-designated UCCs reflects the time spent in a crisis stabilization service which includes psychiatric evaluation, medication monitoring, case management, and crisis intervention. During April 2016, average time spent in UCCs for the four providing crisis stabilization was:

- Exodus Eastside UCC: 8.43 hours
- Exodus Foundation MLK UCC: 9.08 hours
- Exodus Westside UCC: 11.54 hours
- Olive View UCC: 12.03 hours*

*due to data entry lag, data reflects prior month's (March) length of stay

   b. The number of countywide admissions to acute ED's and psychiatric inpatient units within 30 days of MHUCC visit were 438 (14%). The number of countywide re-admissions to MHUCC's within 30 days of a previous visit were 253 (8%)

10. Free standing Psychiatric Facility:

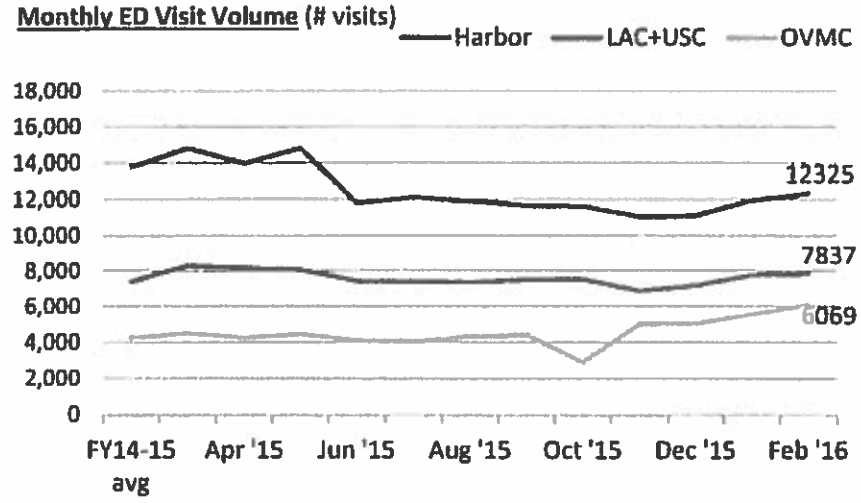
   a. Description: There are 11 free standing acute psychiatric hospitals in LA County, with a total licensed bed capacity of 1,334 (as of 2016). Data on the average daily census, average length of stay (ALOS), and beds by age groups was not available from LA County DPH Health Facilities division. According to HASC the ALOS for mental health admissions is eight days.

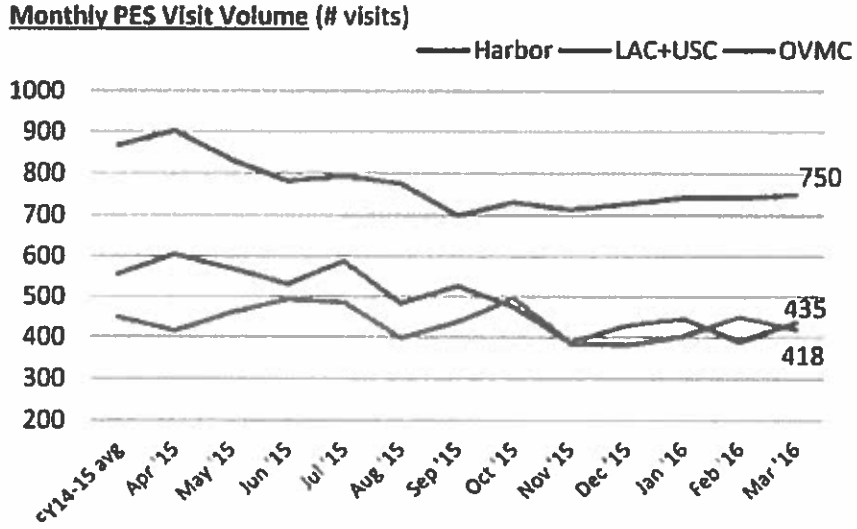
   b. Free standing psychiatric facilities often work collaboratively with local EDs and LE, in conjunction with their own PETs, to receive admissions to their hospitals. DMH also

has contracts with some of the free standing psychiatric facilities to accept LE transports.

11. PES:

a. Description: Three County hospitals, Harbor-UCLA Medical Center (Harbor), LAC+USC Medical Center (LAC+USC), and Olive View – UCLA Medical Center (OVMC) provide PES. These hospitals have facilities and staff that are specifically intended to treat MH/SA emergencies (restraint beds, showers, isolation rooms, video surveillance, trained personnel to manage agitated behaviors, mental health social workers, etc.). Monthly data for fiscal year 2015-2016 on ED volumes and PES volumes are shown graphically below. This data is taken from the DHS Dashboard Report published April 2016.





b. Comment: These facilities are likely the best suited for management of the acutely agitated or potentially violent patients with MH/SA emergencies, given their resources (availability of restraint beds, isolation rooms, and specific mental health staff).

12. ED at LPS designated hospital:

a. Description: There are 24 general acute care hospitals (including the 3 County hospitals) that are LPS designated and also have basic emergency services and are 9-1-1 receiving facilities. Self-report data on MH/SA ED Visit volumes (2013):

ED	MH/SA ED visits	All visits	% MH/SA visits of all-cause visits
LPS	66,812	1,069,399	6.25%
Non-LPS	71,146	2,113,153	3.37%

b.

ED	Pediatric MH/SA ED visit	% Pediatric MH/SA visits of all-age MH/SA visits
LPS	7,508	11.24%
Non-LPS	3,997	5.62%

ED	MH/SA Admissions	% (Admitted of all MH/SA visits)
LPS	39,500	59.12%
Non-LPS	33,098	46.52%

Comment: The availability of psychiatrists and mental health staff in ED's at LPS designated facilities varies. It is presumed, that a patient would be seen by a psychiatrist or mental health professional in a shorter period of time than compared to an ED at a non-LPS designated facility; however if 9-1-1 MH/SA transports were only directed to LPS designated facilities, the increase volume from the non-LPS designated facilities may increase delays.

13. ED at non-LPS designated facility:

    a. Description: There are 50 general acute care hospitals that have basic emergency services and are 9-1-1 receiving facilities, but who do not have LPS designation. Self-report data on MH/SA ED Visit volumes (2013) is shown above and compares ED MH/SA visits at LPS and non-LPS designated EDs.

    b. Comment: The availability of psychiatrists and mental health staff in ED's at non-LPS designated facilities varies. It is presumed, that most of these facilities do not have on-call psychiatrists and if they have access to on-call psychiatrists there are variable response times to when the patient may be evaluated.

14. Requires LE assistance for agitation / violence:

    a. Description: The current EMS protocols only address "agitated delirium," which is insufficient to address the broad spectrum of agitation or violent behaviors that can be manifested from MH/SA emergencies. Most first responders have major concerns regarding persons with MH/SA emergencies who are potentially dangerous, agitated or violent. It remains unclear what is the best response to the agitated or violent patient.

    b. Area of need: EMS providers in LA County lack access to any medication that can treat acute psychosis unless it has progressed to the point of agitated delirium. Midazolam, used for agitated delirium, can worsen patients whose agitation is due to acute psychosis.

    c. Comment: Further guidance and decision support is needed to improve the management of the agitated or violent patient. It is unclear how much training is provided or required, if any, for LE or EMS in de-escalation techniques

    d. Recommendation: Investigate the development of additional treatment protocols (non-pharmacologic and pharmacologic) to address MH/SA emergencies, in adults and children with concomitant agitation or violence. Refer to the EMS Agency Medical Advisory Council to determine whether the LA County EMS Agency should pursue the use of alternate agents for acute psychosis. Literature exists regarding successful prehospital use of neuroleptics and ketamine.

    e. Barriers to change: none

APPENDIX TO FIGURE 4: POTENTIAL FIELD RESPONSE MAP

The numerical items below correspond to the flowcharts for the "potential field response map" to MH/SA emergencies.

1. 9-1-1 receives call for MH/SA emergency:

    a. For cases that do not require immediate LE or EMS evaluation, consider whether it is possible to triage to a mobile crisis response team (SMART, MET, PMRT, PET etc.). The Committee believes that the presence of LE has the potential to escalate the behavioral condition and/or situation of vulnerable patients, and the specialized mobile crisis response teams are highly trained in MH/SA emergencies and behavioral de-escalation.

2. 9-1-1 Triage: any actual or potential behavioral agitation, violence, or criminal activity:

    a. Description: The current 9-1-1 system is designed to triage based on the following primary question posed by the PSAP 9-1-1 operator: "Does the patient have any injury or altered mental status?" If the answer is "yes" EMS is dispatched to respond. If the answer is "no" LE responds.

    b. This field response map has the 9-1-1 triage question re-oriented towards having EMS as the default first responder and LE would be triaged to the scene based on the presence or anticipation of agitated or violent behavior, or possible criminal activity.

3. EMS responds:

    a. EMS always responds to the scene, in keeping with the principle that MH/SA emergencies are a type of medical emergency, as well as to provide potential treatment for mental health emergencies (see appendix item #6).

4. EMS Field Triage:

    a. When EMS arrives on scene, personnel assessing the situation should attempt to determine if the person has any actual or potential for behavioral agitation, threats to safety, or criminal activity. If the answer is yes, then LE is called to co-respond to the scene to provide additional assistance to ensure the safety of the subject and others.

5. LE called to co-respond (+/- SMART/MET):

    a. LE is called to respond in cases where the subject has actual or potential behavioral agitation, violence, threats to safety, or criminal activity.

6. Subject has MH/SA emergency +/- other medical emergency:

    a. EMS will determine if the patient has an MH/SA emergency, and/or another medical emergency.

b. Field treatment protocol will be updated to address persons with MH/SA emergencies and concomitant agitation or violent behaviors, including de-escalation techniques, pharmacological treatment, and use/avoidance of restraints.

c. At this stage the subject should also be assessed for the potential need of an involuntary psychiatric hold (WIC 5150 or 5585 for pediatric patients).

i. LPS certification may perhaps be extended to EMS providers. The Committee noted that LE officers, with little medical training are permitted to determine the need for involuntary holds, but EMS providers are not. As a long term goal, we believe that EMS providers are capable of safely determining the need for involuntary holds and should be granted that power. The training for both LE and EMS should be a requirement for purposes of consistency and uniformity across the County.

7. Leave in field / no transport:

a. Resources to community MH/SA services should be made available for persons left in the field, including but not limited to PMRT, MHUCC, County DMH ACCESS, addiction treatment services. Technology advances such as a development of an application that could provide real time information on available MH/SA resources would be a great adjunct.

8. LE to take custody of subject for booking, or to manage severe violence or agitation:

a. A binary yes/no question to determine most appropriate mode of transport and to reduce the unnecessary use of handcuffs/squad car transport. The Committee recognizes that the placement of handcuffs and the use of a patrol vehicle have the potential to escalate a MH/SA emergency, occasionally with severe negative results. The Committee suggest that LE agencies consider the need to handcuff individuals based on patient behavior rather than policy. The improved response capabilities of specialized LE teams and ongoing MH/SA training of LE officers throughout the County will improve the ability to successfully de-escalate patients prior to transport.

9, 10, 11. Needs medical ED evaluation or treatment:

a. EMS personnel will determine if the patient requires medical evaluation or treatment, and if yes, then transport to the most appropriate receiving hospital ED, which may be a LPS or non-LPS designated facility. Currently, policy limits the EMS providers to transport only to the nearest receiving facility. Unfortunately, most ED's in LA County are non-LPS EDs, and, thus, they lack expertise, training, and equipment to optimally manage MH/SA patients. When a MH/SA patient presents to that ED and requires an involuntary hold, the process of transferring that patient to an LPS designated facility can take days. The Committee recommends that EMS providers be able to triage MH/SA patients in the field for the possible need for involuntary hold and, when need is determined, transport those patients preferentially to the ED of the nearest LPS

designated hospitals. Patients with MH/SA emergencies that are not believed to require an inpatient psychiatric hospitalization can be effectively managed at any ED, whether or not its hospital has LPS designation. This would provide the perfect opportunity to create a seamless process to transfer patients to a network MHUCC. This network needs to be robust and expanded beyond the current MHUCCs.

b. If no need for ED medical evaluation, then options for destination need to be expanded to MHUCC, County PES, Sobering Center, freestanding psychiatric facilities, or EDs at LPS designated facilities. A specific plan should be developed to address pediatric patients with MH/SA disorders. The MHUCC system has been shown to be a safe and effective alternative to EDs for LE transports. There is no reason to believe that EMS providers cannot have similar success. The patient benefits from the MH expertise of the MHUCC, the EDs benefit from a lower burden on MH/SA patients, and the EMS providers benefit from rapid offloading of their patients in order to free up resources for the next emergency call.

APPENDIX: IOM Fact Sheet on the Future of Emergency Care: Key Findings and Recommendations (June 2006)

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

FACT SHEET • JUNE 2006

The Future of Emergency Care: Key Findings and Recommendations

KEY FINDINGS

Many EDs and trauma centers are overcrowded. [Drawn from *Hospital-Based Emergency Care: At the Breaking Point*]

- Demand for emergency care has been growing fast—emergency department (ED) visits grew by 26 percent between 1993 and 2003.
- But over the same period, the number of EDs declined by 425, and the number of hospital beds declined by 198,000.
- ED crowding is a hospital-wide problem—patients back up in the ED because they can not get admitted to inpatient beds.
- As a result, patients are often "boarded"—held in the ED until an inpatient bed becomes available—for 48 hours or more.
- Also, ambulances are frequently diverted from overcrowded EDs to other hospitals that may be farther away and may not have the optimal services. In 2003, ambulances were diverted 501,000 times—an average of once every minute.

Emergency care is highly fragmented. [Drawn from *Emergency Medical Services At the Crossroads*]

- Cities and regions are often served by multiple 9-1-1 call centers.
- Emergency Medical Services (EMS) agencies do not effectively coordinate EMS services with EDs and trauma centers. As a result, the regional flow of patients is poorly managed, leaving some EDs empty and others overcrowded.
- EMS does not communicate effectively with public safety agencies and public health departments—they often operate on different radio frequencies and lack common procedures for emergencies.
- There are no nationwide standards for the training and certification of EMS personnel.
- Federal responsibility for oversight of the emergency and trauma care system is scattered across multiple agencies.

Critical specialists are often unavailable to provide emergency and trauma care. [Drawn from *Hospital-Based Emergency Care: At the Breaking Point*]

- Three quarters of hospitals report difficulty finding specialists to take emergency and trauma calls.
- Key specialties are in short supply. For example, the number of neurosurgeons declined between 1990 and 2002, while the number of trauma visits increased.
- On-call specialists often treat emergency patients without compensation due to high levels of uninsurance.
- These specialists also face higher medical liability exposure than those who do not provide on-call coverage.

The emergency care system is ill-prepared to handle a major disaster. [Drawn from all three reports]

- With many EDs at or over capacity, there is little surge capacity for a major event, whether it takes the form of a natural disaster, disease outbreak, or terrorist attack.
- EMS received only 4 percent of Department of Homeland Security first responder funding in 2002 and 2003.
- Emergency Medical Technicians in non-fire based services have received an average of less than one hour of training in disaster response.
- Both hospital and EMS personnel lack personal protective equipment needed to effectively respond to chemical, biological, or nuclear threats.

EMS and EDs are not well equipped to handle pediatric care. [Drawn from *Emergency Care for Children: Growing Pains.*]

- Most children receive emergency care in general (not children's) hospitals, which are less likely to have pediatric expertise, equipment, and policies in place for the care of children.
- Children make up 27 percent of all ED visits, but only 6 percent of EDs in the U.S. have all of the necessary supplies for pediatric emergencies.
- Many drugs and medical devices have not been adequately tested on, or dosed properly for, children.
- While children have increased vulnerability to disasters—for example, children have less fluid reserve, which leads to rapid dehydration—disaster planning has largely overlooked their needs.

Drawn from the Future of Emergency Care report series, 2006 • Institute of Medicine • www.iom.edu

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Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY 9-1-1 RECEIVING HOSPITAL

Time Period October 1, 2020 through December 31, 2020

APOT Standard: within 30 minutes, 90% of the time

HOSPITAL	Total # of records	No. of valid records	% of valid records	Q4 2020							
				</=30 mins		30-60 mins		60-120 mins		>120 mins	
ANTELOPE VALLEY - NEWHALL REGION											
Antelope Valley Hospital	8,908	3,900	44%	2,236	57%	1,004	26%	453	12%	207	5%
Palmdale Regional Medical Center	3,724	1,624	44%	821	51%	391	24%	235	14%	177	11%
Henry Mayo Newhall Hospital	4,864	2,252	46%	1,809	80%	304	13%	102	5%	37	2%
ANTELOPE VALLEY TOTAL	*17,496*	*7,776*	*44%*	*4,866*	*63%*	*1,699*	*22%*	*790*	*10%*	*421*	*5%*
SAN FERNANDO VALLEY REGION											
Dignity Health-Northridge Hospital Medical Center	3,082	3,034	98%	2,830	93%	178	6%	24	0.8%	2	0.07%
West Hills Hospital and Medical Center	2,151	1,976	92%	1,811	92%	143	7%	19	1%	3	0.2%
Kaiser Foundation - Woodland Hills	669	605	90%	485	80%	82	14%	22	4%	7	1%
Encino Hospital Medical Center	358	358	100%	342	96%	12	3%	3	0.8%	1	0.3%
Providence Cedars-Sinai Tarzana Medical Center	1,496	1,459	98%	1,332	91%	117	8%	9	0.6%	1	0.1%
LAC Olive Medical Center	953	916	96%	802	88%	71	8%	32	3%	11	1%
Pacifica Hospital of the Valley	643	643	100%	610	95%	19	3%	10	2%	4	0.6%
Kaiser Foundation - Panorama City	874	874	100%	754	86%	98	11%	20	2%	2	0.2%
Providence Holy Cross Medical Center	1,814	1,723	95%	1,624	94%	77	4%	21	1%	1	0.1%
Mission Community Hospital	996	996	100%	944	95%	42	4%	7	0.7%	3	0.3%
Valley Presbyterian Hospital	1,253	1,252	100%	1,179	94%	47	4%	20	2%	6	0.5%
Sherman Oaks Hospital	1,669	1,668	100%	1,519	91%	105	6%	32	2%	12	0.7%
Providence Saint Joseph Medical Center	2,449	2,436	99%	2,157	89%	244	10%	33	1%	2	0.08%
Adventist Health Glendale	2,127	2,083	98%	1,933	93%	115	6%	30	1%	5	0.2%
Dignity Health-Glendale Memorial Hosp. and Health Ctr	1,075	1,075	100%	990	92%	65	6%	15	1%	5	0.5%
USC Verdugo Hills Medical Center	978	674	69%	597	89%	48	7%	25	4%	4	0.6%
SAN FERNANDO VALLEY TOTAL	*22,587*	*21,772*	96%	*19,909*	*91%*	*1,463*	*7%*	*322*	*1%*	*69*	*0.3%*
SAN GABRIEL VALLEY REGION											
Huntington Hospital	2,566	2,272	89%	2,129	94%	99	4%	36	2%	8	0.4%
Alhambra Hospital	669	662	99%	631	95%	19	3%	10	2%	2	0.3%
San Gabriel Valley Medical Center	756	442	58%	373	84%	37	8%	23	5%	9	2%
Methodist Hospital of Southern California	2,310	1,096	47%	998	91%	54	5%	36	3%	8	0.7%
Greater El Monte Community Hospital	1,549	208	13%	130	63%	32	15%	28	13%	18	9%
Garfield Medical Center	800	514	64%	476	93%	20	4%	13	3%	5	1%

% total may not equal 100% due to rounding.

Data source: LA TEMIS EMS Fire-Rescue 04-21-2021

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY 9-1-1 RECEIVING HOSPITAL

Time Period October 1, 2020 through December 31, 2020

APOT Standard: within 30 minutes, 90% of the time

HOSPITAL	Total # of records	No. of valid records	% of valid records	Q4 2020							
				</=30 mins		30-60 mins		60-120 mins		>120 mins	
Monterey Park Hospital	328	208	63%	193	93%	6	3%	5	2%	4	2%
Kaiser Foundation Hospital - Baldwin Park	1,209	245	20%	136	56%	39	16%	41	17%	29	12%
Emanate Health Inter-Community Hospital	1,648	385	23%	248	64%	71	18%	33	9%	33	9%
Emanate Health Queen of the Valley Hospital	1,882	443	24%	311	70%	15	3%	9	2%	5	1%
Emanate Health Foothill Presbyterian Hospital	1,467	207	14%	118	57%	31	15%	26	13%	32	15%
San Dimas Community Hospital	804	138	17%	94	68%	19	14%	8	6%	17	12%
Pomona Valley Hospital Medical Center	4,905	920	19%	715	78%	123	13%	53	6%	29	3%
SAN GABRIEL VALLEY TOTAL	*20,893*	*7,740*	37%	*6,552*	*85%*	*565*	*7%*	*321*	*4%*	*199*	*3%*
EAST REGION											
Beverly Hospital	1,296	226	17%	180	80%	35	15%	10	4%	1	0.4%
Whittier Hospital Medical Center	1,250	185	15%	126	68%	30	16%	21	11%	8	4%
PIH Health Hospital - Whittier	3,391	443	13%	285	64%	102	23%	38	9%	18	4%
PIH Health Hospital - Downey	1,748	944	54%	753	80%	117	12%	63	7%	11	1%
Kaiser Foundation Hospital - Downey	1,865	733	39%	501	68%	180	25%	35	5%	17	2%
Los Angeles Community Hospital at Norwalk	444	34	8%	28	82%	2	6%	3	9%	1	3%
Coast Plaza Hospital	1,008	128	13%	75	59%	24	19%	17	13%	12	9%
Lakewood Regional Medical Center	1,949	665	34%	388	58%	144	22%	91	14%	42	6%
EAST REGION TOTAL	*12,951*	*3,358*	26%	*2,336*	*70%*	*634*	*19%*	*278*	*8%*	*110*	*3%*
METRO REGION											
Dignity Health-California Hospital Medical Center	2,357	2,346	100%	1,862	79%	364	16%	98	4%	22	0.9%
Good Samaritan Hospital	2,432	2,417	99%	2,005	83%	315	13%	82	3%	16	0.7%
Adventist Health White Memorial	1,013	611	60%	477	78%	82	13%	37	6%	15	2%
Community Hospital of Huntington Park	1,816	480	26%	329	69%	94	20%	41	9%	16	3%
East Los Angeles Doctors Hospital	1,220	332	27%	290	87%	32	10%	7	2%	3	1%
LAC+USC Medical Center	5,662	4,997	88%	4,261	85%	615	12%	108	2%	13	0.3%
Children's Hospital Los Angeles	203	191	94%	190	99%	1	0.5%				
Hollywood Presbyterian Medical Center	2,245	2,244	100%	1,916	85%	247	11%	67	3%	14	0.6%
Kaiser Foundation Hospital - Los Angeles	698	682	98%	516	76%	103	15%	55	8%	8	1%
Olympia Medical Center	1,040	1,031	99%	951	92%	63	6%	15	1%	2	0.2%
Cedars Sinai Medical Center	4,064	3,481	86%	2,965	85%	351	10%	87	2%	6	0.2%

% total may not equal 100% due to rounding.

Data source: LA TEMIS EMS Fire-Rescue 04-21-2021

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY 9-1-1 RECEIVING HOSPITAL

Time Period October 1, 2020 through December 31, 2020

APOT Standard: within 30 minutes, 90% of the time

HOSPITAL	Total # of records	No. of valid records	% of valid records	Q4 2020							
				</=30 mins		30-60 mins		60-120 mins		>120 mins	
METRO REGION TOTAL	*22,750*	*18,812*	83%	*15,762*	*84%*	*2,267*	*12%*	*597*	*3%*	*115*	*1%*
WEST REGION											
Southern California Hospital at Culver City	1,025	1,015	99%	846	83%	121	12%	35	3%	13	1%
Kaiser Foundation Hospital - West Los Angeles	1,836	1,655	90%	1,374	83%	225	14%	53	3%	3	0.2%
Cedars Sinai Marina Del Rey Hospital	1,969	1,635	83%	1,371	84%	192	12%	59	4%	13	0.8%
Providence Saint John's Health Center	1,527	1,305	85%	1,115	85%	137	10%	43	3%	10	0.8%
Santa Monica - UCLA Medical Center	818	571	70%	521	91%	36	6%	9	2%	5	0.9%
Ronald Reagan UCLA Medical Center	1,548	1,389	90%	1,257	90%	91	7%	35	3%	6	0.4%
WEST REGION TOTAL	*8,723*	*6,555*	75%	*6,484*	*99%*	*802*	*12%*	*234*	*4%*	*50*	*1%*
SOUTH REGION											
Centinela Hospital Medical Center	1,804	1,802	100%	1,248	69%	357	20%	111	6%	86	5%
Memorial Hospital of Gardena	1,874	1,853	99%	1,398	75%	47	3%	2	0.1%		
Martin Luther King, Jr. Community Hospital	2,026	1,162	57%	559	48%	321	28%	200	17%	82	7%
St. Francis Medical Center	3,671	1,515	41%	562	37%	379	25%	342	23%	231	15%
LAC Harbor-UCLA Medical Center	3,335	2,032	61%	1,620	80%	265	13%	102	5%	45	2%
Kaiser Foundation Hospital - South Bay	1,628	1,103	68%	845	77%	190	17%	53	5%	15	1%
Torrance Memorial Medical Center	3,162	1,379	44%	923	67%	306	22%	124	9%	26	2%
Providence Little Company of Mary Med. Ctr.-Torrance	1,126	578	51%	535	93%	36	6%	6	1%	1	0.2%
Providence Little Company of Mary Med. Ctr.-San Pedro	3,036	1,859	61%	1,236	66%	422	23%	157	8%	44	2%
College Medical Center	710	631	89%	491	78%	105	17%	24	4%	11	2%
Dignity Health-St. Mary Medical Center	2,040	2,033	100%	1,657	82%	222	11%	117	6%	37	2%
MemorialCare Long Beach Medical Center	2,437	1,922	79%	1,577	82%	174	9%	111	6%	60	3%
Catalina Island Medical Center	0	0									
SOUTH REGION TOTAL	*26,849*	*17,869*	67%	*12,651*	*71%*	*2,824*	*16%*	*1,349*	*8%*	*638*	*4%*
ALL HOSPITALS	**132,249**	**84,307**	**64%**	**68,560**	**81%**	**10,254**	**12%**	**3,891**	**5%**	**1,602**	**2%**

% total may not equal 100% due to rounding.

Data source: LA TEMIS EMS Fire-Rescue 04-21-2021

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

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November 18, 2020

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

FROM: Cathy Chidester
Executive Director

SUBJECT: **EMERGENCY MEDICAL SERVICES COMMISSION ANNUAL REPORT – FISCAL YEAR 2019-2020**

Attached is the Annual Report of the Emergency Medical Services (EMS) Commission for Fiscal Year 2019-2020. This report is being submitted to the Board of Supervisors in compliance with Los Angeles County Code Title 3, Chapter 3.20 Section 3.20.070.5. The attached report includes the EMS Commission's Mission, Historical Background, Annual Workplan, Prior Year Accomplishments, and Ongoing Long-Term Projects during the period of July 1, 2019, through June 30, 2020.

The EMS Commission is composed of 19 members who represent 13 emergency medical services associations and medical professional affiliates, five public members representing each Supervisor's District, and one member representing the cities in Los Angeles County.

The EMS Commission meets on the third Wednesday of every odd month from 1:00 p.m. to 3:00 p.m. at the EMS Agency. Due to the Coronavirus pandemic, the EMS Commission has conducted its meetings via Zoom Video Conferencing since May 20, 2020.

If you have any questions, please feel free to contact me at (562) 378-1604 or cchidester@dhs.lacounty.gov. You may also contact Denise Watson, Secretary, Health Services Commission, at (562) 378-1606 or dwatson@dhs.lacounty.gov.

CC:DW

Attachment

c: Christina R. Ghaly, M.D., Director of Health Services
Hal F. Yee, Jr., M.D., Ph.D., Chief Deputy Director, Clinical Affairs, DHS
Ed Morrissey, County Counsel
Celia Zavala, Executive Officer, Board of Supervisors
Health Deputies, Board of Supervisors
EMS Commissioners

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

December 15, 2020

TO: Supervisor Hilda L. Solis, Chair
Supervisor Holly J. Mitchell
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Cathy Chidester
Executive Director

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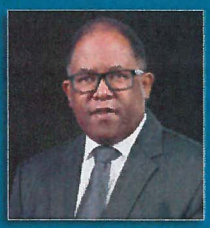
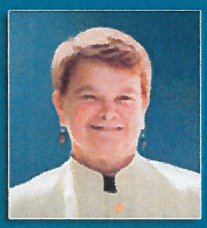
EMS Commissioners

LOS ANGELES COUNTY
EMERGENCY MEDICAL SERVICES COMMISSION
ANNUAL REPORT TO THE BOARD OF SUPERVISORS
FISCAL YEAR JULY 1, 2019 – JUNE 30, 2020

Hilda L. Solis
First District



Mark Ridley-Thomas
Second District



Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Emergency Medical Services Agency
10100 Pioneer Boulevard, Suite 200 Santa Fe Springs, CA 90670
Phone: (562) 378-1500 / Fax: (562) 941-5835
Website: http://ems.dhs.lacounty.gov

Ellen Alkon, MD
Southern California
Public Health Association

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Lydia Lam, MD
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Dr. Roxana Yoonessi-Martin
Los Angeles County Medical
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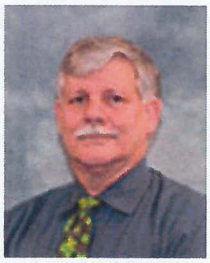

Mr. Robert Ower
Los Angeles County
Ambulance Association

Margaret Peterson, PhD
Hospital Association of
Southern California

Paul Rodriguez FF/Paramedic
Vice-Chair 2020
California State Firefighters'
Association

Mr. Joseph Salas
Vice-Chair 2019
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Ms. Diana Tang League of
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County Division

Atilla Uner, MD, MPH
California Chapter American
College of Emergency
Physicians

Mr. Gary Washburn
Public Member
Fifth
Supervisorial District

Fire Chief David White
Los Angeles Area Fire
Chiefs' Association

Mr. Pajmon Zarrineghbal
Public Member Fourth
Supervisorial District

Ms. Cathy Chidester
Executive Director
Director, EMS Agency

Ms. Denise Watson
Commission Liaison
EMS Agency Secretary

MISSION STATEMENT

To support and guide the Emergency Medical Services (EMS) Agency activities to ensure timely, compassionate and quality emergency and disaster medical services. The Emergency Medical Services Commission's (EMSC) complements the County's mission through improving the quality of life for the people and community of Los Angeles County.

HISTORICAL BACKGROUND

The EMSC was established by the Board of Supervisors (Board) in October 1979, and on April 7, 1981, the Board approved and adopted Ordinance No. 12332 of Title 3 – Advisory Commissions and Committees, Los Angeles County Code Chapter 3.20, Emergency Medical Services Commission, to establish the Commission in accordance with California Health and Safety Code Division 2.5 Sections:

1797.270 – Emergency Medical Care Committee Formation
1797.272 – Emergency Medical Care Committee Membership
1797.274 – Emergency Medical Care Committee Duties
1797.276 – Emergency Medical Care Committee Annual Report

On January 29, 2008, the Board approved amending the subject Ordinance to revise the selection of the licensed paramedic representative previously nominated by the California Rescue and Paramedic Association be made by the California State Firefighters' Association Emergency Medical Services Committee, as the previous entity had ceased to operate.

On November 1, 2011, the EMSC, in consultation with the Department of Health Services, amended the ordinance to add two Commission seats for the members nominated by the Los Angeles County Police Chiefs' Association (LACPCA) and Southern California Public Health Association (SCPHA) that would be beneficial to the EMSC and the County, and would allow for law enforcement and public health expert input. With this amendment, the addition of two Commission seats increased the number of commissioners from 17 to 19.

MEMBERSHIP

The EMSC is currently comprised of 19 commissioners who are non-County employees who act in an advisory capacity to the Board and the Director of Health Services. They advise on matters relative to emergency medical care and practices, EMS policies, programs and standards, including paramedic services throughout the County of Los Angeles. There is an Executive Director and a Commission Liaison who are County employees, and who serve as staff of the Commission.

FUNCTIONS AND DUTIES

The EMS Commission performs the functions of the Emergency Medical Care Committee as defined in Sections 1750 et seq. of the Health and Safety Code, and includes the following duties:

- Act in an advisory capacity to the Board of Supervisors and the Director of Health Services regarding County policies, programs, and standards for emergency medical care services throughout the County, including paramedic services.
- Establish appropriate criteria for evaluation and conduct continuous evaluations on the basis of these criteria of the impact and quality of emergency medical care services throughout LA County.
- Conduct studies of particular elements of the emergency medical care system as requested by the Board, the Director of DHS or on its own initiative; delineate problems and deficiencies and recommend appropriate solutions.

- Acquire and analyze the information necessary for measuring the impact and the quality of emergency medical care services.
- Report its findings, conclusions and recommendations to the Board at least every twelve months.
- Review and comment on plans and proposals for emergency medical care services prepared by LA County departments.
- Recommend, when the need arises, that LA County engages independent contractors for the performance of specialized, temporary, or occasional services to the EMSC, which cannot be performed by members of the classified service, and for which the LA County otherwise has the authority to contract.
- Advise the Director and the DHS on the policies, procedures, and standards to control the certification/accreditation of mobile intensive care nurses and paramedics.
- Advise the Director on proposals of any public or private organization to initiate or modify a program of paramedic services or training.
- To arbitrate differences in the field of paramedic services and training between all sectors of the community, including, but not limited to, county agencies, municipalities, public safety agencies, community colleges, hospitals, private companies, and physicians.

ANNUAL WORKPLAN

The EMS Commission's goals and objectives for the upcoming year support the County's mission, vision and strategic priorities through collaborative partnerships with County and City front-line workers, provider agencies, labor unions and the people of the communities we serve in the County of Los Angeles. Through our commitment to building quality health care systems to improve the lives of those we serve, we will provide better care and greater access to exceptional health care services for the residents of Los Angeles County. With systems in place that enrich people's lives through effective and caring services that they can access quickly in times of medical emergencies and disasters, we can create a healthier community.

Goals and Objectives:

- Review and recommend policies for adoption by the EMS Agency
- Advise on the impact of emergency medical care practices related to paramedic and EMT services and training
- Advise on EMS policies
- Monitor legislation affecting the EMS system
- Through Committee process, advise and recommend topics for education
- Conduct required public hearings.
- Evaluate and understand the interaction between law and fire in response to patients with behavioral health emergencies.
- Make recommendations to the EMS Agency on any changes that would improve the delivery of emergency response and care to behavioral health emergencies and substance abuse
- Continue to engage with law enforcement to support similar or overlapping response protocols, i.e., tactical EMS, use of restraint and midazolam in field, and dispatch and triage of 9-1-1 calls
- Continue to monitor APOT data and work with ambulance and hospital providers to reduce ambulance patient offload times (APOT) and recommend the best practices to address offload delays.
- Support the EMS Agency's efforts to ensure timely and accurate data submission from all EMS providers and Specialty Care Centers.
- Ensure constituent groups are aware of the Measure B process and allocations and participate on Measure B Advisory Board
- Maintain awareness of the EMS Agency's COVID-19 activities related to the coordination of response and data collection/analysis

ONGOING LONG-TERM PROJECTS

- Prehospital Care of Mental Health and Substance Abuse Emergencies: Continue to address the recommendation made by the Ad Hoc Committee and implement as addressed.
- Monitor legislation of interest to emergency medical services
- Support education efforts for Bystander, Hands-Only CPR training (Sidewalk CPR)
- Support the EMS Agency in efforts to ensure that individuals seen and assessed within the 9-1-1 system are transported to the appropriate destination that is best suited to meet their needs, i.e., sobering centers, emergency departments and psychiatric urgent care centers
- Monitor and support to ensure 9-1-1 ambulance transport readiness through supporting the Ad hoc Committee's ultimate recommendations to decrease ambulance patient offload times
- Monitor and support EMS pilot and trial studies to improve the delivery of emergency medical care and transportation.

ACCOMPLISHMENTS AND SIGNIFICANT OUTCOMES FISCAL YEAR (FY) 2019-2020

- Approved the FY 2018-19 EMSC Annual Report at the November 20, 2019 meeting
- Presented the Police Chiefs' response to the Mental Health and Substance Abuse Emergencies Report at the Los Angeles Area Police Chiefs' Conference
- Conducted the required public hearing on the Closure of Glendora Community Hospital's General Acute Care Services
- Approved the Impact Report and recommended submission to the Board of Supervisors for the Closure of Glendora Community Hospital's General Acute Care Services
- Approved EMS Commission Bylaws and Specific Committees
- Through the new Bylaws, discontinued the Education Advisory Committee and added two positions to the Provider Agency Advisory Committee to represent an EMT and Paramedic
- Approved nominating committee and standing committee selections
- Provided written support of Los Angeles Police Department's pilot project training program to divert 9-1-1 suicide ideation calls to the Suicide Prevention Hotline
- Recommended approval of Prehospital Care Policies to include Policy Reference Numbers:
  - 207: EMS Commission Advisory Committees
  - 304: Paramedic Base Hospital Standards
  - 316: Emergency Department Approved for Pediatric (EDAP) Standards
  - 318: Pediatric Medical Center (PMC) Standards
  - 320: ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) Standards
  - 320.3: SRC Performance Measures
  - 324: Sexual Assault Response Team (SART) Center Standards
  - 406: Authorization for Paramedic Provide Status
  - 412: AED Requirements
  - 412.1: AED Application
  - 412.2: AED Annual Report
  - 418: Authorization and Classification of EMS Aircraft
  - 451.1: Ambulance Licensing Administrative Fines
  - 451.1a: Private Ambulance Medical and Protective Equipment
  - 506: Trauma Triage
  - 506.2: 9-1-1 Trauma Re-Triage
  - 510: Pediatric Patient Destination
  - 608: Retention of Records
  - 612: Release of EMS Records

- 622: Release of EMS Data
- 701: Supply and Resupply of EMS Units
- 702: Controlled Drugs Carried on ALS Units
- 703: ALS Unit Inventory
- 710: Basic Life Support Ambulance Equipment
- 712: Nurse Staffed Specialty Care Transport Unit Inventory
- 713: RCP Staffed SCT Inventory
- 832: Treatment/Transport of Minors
- 901: Paramedic Training Program Approval
- 1350: Medical Control Guideline: Pediatric Patients

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

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(562) 378-1604
CChidester@dhs.lacounty.gov

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

December 26, 2019

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

FROM: Cathy Chidester
Executive Director

SUBJECT: **EMERGENCY MEDICAL SERVICES COMMISSION ANNUAL REPORT – FISCAL YEAR 2018/2019**

Attached is the Annual Report of the Emergency Medical Services Commission (EMSC) to the Board of Supervisors, which is submitted each Fiscal Year in compliance with Los Angeles County Code Title 3, Chapter 3.20, Section 3.20.070.5.

The Ordinance provides for 19 EMSC members. During this reporting period, all 19 positions were filled intermittently with brief periods of transitional gaps. At the time of this report, the EMS Commission has 19 sitting members.

The attached report describes the structure, membership and major activities of the Commission, policy approvals, and changes to the standing subcommittees during the period of July 1, 2018 through June 30, 2019.

If you have any questions, please feel free to contact me at (562) 378-1604.

CC:dw

Attachment

c: Christina R. Ghaly, M.D., Director of Health Services
Hal F. Yee, Jr., M.D., Chief Deputy Director, Health Services
Brian Chu, County Counsel
Celia Zavala, Executive Officer, Board of Supervisors
EMS Commission
Health Deputies, Board of Supervisors

LOS ANGELES COUNTY

EMERGENCY MEDICAL SERVICES COMMISSION

ANNUAL REPORT

TO THE

BOARD OF SUPERVISORS

JULY 1, 2018 – JUNE 30, 2019

Emergency Medical Services Agency
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670
Phone: (562) 378-1500 / Fax: (562) 941-5835
Website: http://ems.dhs.lacounty.gov

EMERGENCY MEDICAL SERVICES COMMISSION

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Peace Officers Association of Los Angeles County

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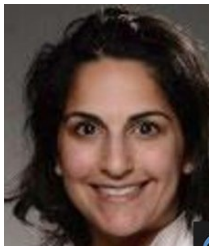

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Los Angeles County Medical Association

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Los Angeles County Ambulance Association

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California Chapter American College of Emergency Physicians

Mr. Gary Washburn
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Fifth
Supervisorial District

Fire Chief David White
Los Angeles Area Fire Chiefs' Association

Mr. Pajmon Zarrineghbal
Public Member
Fourth Supervisorial District

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Executive Director
Director, EMS Agency

Ms. Denise Watson
Commission Liaison
EMS Agency Secretary

MISSION STATEMENT

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- Conduct studies of particular elements of the emergency medical care system as requested by the Board, the Director of DHS or on its own initiative; delineate problems and deficiencies and recommend appropriate solutions.

- Acquire and analyze the information necessary for measuring the impact and the quality of emergency medical care services.
- Report its findings, conclusions and recommendations to the Board at least every twelve months.
- Review and comment on plans and proposals for emergency medical care services prepared by LA County departments.
- Recommend, when the need arises, that LA County engages independent contractors for the performance of specialized, temporary, or occasional services to the EMSC, which cannot be performed by members of the classified service, and for which the LA County otherwise has the authority to contract.
- Advise the Director and the DHS on the policies, procedures, and standards to control the certification of mobile intensive care nurses and paramedics. Proposals of any public or private organization to initiate or modify a program of paramedic services or training.
- To arbitrate differences in the field of paramedic services and training between all sectors of the community, including, but not limited to, county agencies, municipalities, public safety agencies, community colleges, hospitals, private companies, and physicians.

FOCUS IN PAST YEARS

- Community Paramedicine Pilot Project in the County
- Pre-hospital care of behavioral emergencies: The EMSC recommended that an Ad Hoc committee be identified to develop a blueprint for addressing behavioral emergencies in the pre-hospital setting
- Monitor legislation of interest to emergency medical services
- Implementation of electronic data using electronic Patient Care Record (ePCR) systems by all fire department 9-1-1 providers
- Bystander CPR training (Sidewalk CPR)
- Recognized the members of the Hospital Emergency Response Team (HERT) and Alhambra Fire Department who responded to a patient with a horrific industrial injury requiring the bilateral leg amputation on scene
- Developed and administered a survey on law enforcement dispatch and field response to mental health emergencies and issued report of findings
- Ambulance Patient Offload Time (APOT) Ad Hoc Workgroup recommended changes to the current Ref. 503.1 Request for Diversion
- Reviewed and recommended policies for adoption by the EMS Agency

ACCOMPLISHMENTS AND SIGNIFICANT OUTCOMES FISCAL YEAR (FY) 2018-19

- Approved the FY 2017-18 EMSC Annual Report at the September 19, 2018 meeting
- Presented results of the law enforcement dispatch and field response survey at the Los Angeles Police Chiefs' Association's Annual meeting
- Education Advisory Committee dissolved with two positions added to the Provider Agency Advisory Committee to represent an EMT and Paramedic
- Impact Report to the Board of Supervisors for the July 3, 2018 closure of Community Medical Center Long Beach
- Approved Prehospital Care Policies to include Policy Reference Numbers:
  - 312: Pediatric Liaison Nurse
  - 416: Assessment Unit
  - 503.1: Diversion Request Requirements for Emergency Department Saturation
  - 506: Trauma Triage
  - 516: Cardiac Arrest Patient Destination
  - 704: Assessment Unit Inventory

- 814: Determination/Pronouncement of Death in the Field
- 840: Medical Support During Tactical Operations
- 1006: Paramedic Accreditation
- 1010: Mobile Intensive Care Nurse (MICN) Certification
- 1011: Mobile Intensive Care Nurse (MICN) Field Observation

ANNUAL WORK PLAN

UPCOMING GOALS/OBJECTIVES

- Monitor legislation affecting the EMS system
- Educate stakeholders on EMS Update training and issues
- Advise the EMS Agency on minimal requests for 9-1-1 receiving hospital designation
- Review, provide feedback and support the ***"Ad Hoc Committee on Prehospital Care of Mental Health and Substance Abuse Emergencies' Final Report"*** **r**ecommendations
- Continue to monitor implementation of the amended Ref. 503, Requests for Diversion, and the effect on the EMS System
- Continue to monitor progress of APOT data and recommend the best practice related to the data for optimum results
- Continue engagement with County committees that have similar missions and interests
- Continue engagement with Department of Mental Health on issues related to assessment, treatment and transport of patients in mental health crisis
- Continue to engage with law enforcement to support similar or overlapping response protocols, i.e., Tactical EMS, use of Narcan, transport of injured canine teams
- Ensure timely and complete data submission from all EMS providers

ONGOING LONG-TERM PROJECTS

- Review and recommend approval of EMS Agency policies
- Implementation of the recommendations found in ***"Ad Hoc Committee on Prehospital Care of Mental Health and Substance Abuse Emergencies' Final Report"***
- Share the results of the law enforcement dispatch and field response survey with stakeholders and encourage implementation of recommendations
- Ensure that individuals seen and assessed within the 9-1-1 system are transported to the appropriate destination that is best suited to meet their needs, i.e., sobering centers, emergency departments and psychiatric urgent care centers
- Decrease ambulance patient offload times by monitoring Ref. 503 Diversion Requests and APOT data
- Support education efforts for bystander Hands-Only CPR (Sidewalk CPR)
- Support Los Angeles Police Department's pilot project to triage 9-1-1 calls related to suicidal ideation to the Suicide Hotline
- Arrive Alive ePCR Pilot Program as utilization of the Lucas device to treat patients in cardiac arrest
- Monitor Public Safety Naloxone Program Participation
- Paramedic Provider Program Approval
- Participate on Measure B Advisory Board Committee
- Medical Support During Tactical Operations Policy No. 840 – emergency medical transport of police dogs by ambulance during tactical operations when injured in the line of duty
- ECG Task Force
- Trauma Triage
- EMS Commission Bylaws Revised
- Data Agreement Use

- Master Agreements
- System-Wide Provider Impression Quality Improvement Fallout Tracking
- Revised Prehospital Treatment Protocols and Medical Control Guidelines
- Trauma System Status Report
- Paramedic Pioneers Look Back on 50 Years

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

Denise Watson
Commission Liaison
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COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
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http://ems.dhs.lacounty.gov

November 28, 2018

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

FROM: Cathy Chidester
Executive Director

SUBJECT: **EMERGENCY MEDICAL SERVICES COMMISSION ANNUAL REPORT – FY 2017/2018**

Attached is the Emergency Medical Services Commission's (EMSC) Report to the Board of Supervisors, which is submitted annually in compliance with County Code Chapter 3.20, Section 3.20.070.5.

The Ordinance provides for 19 EMS Commission members, and 18 of the positions were filled during the reporting period. The EMS Commission continually reviews its' membership structure, and the EMS Agency actively recruits to fill vacancies. Currently, all 19 positions are filled.

The attached report describes the structure, membership and major activities of the Commission, and the four standing subcommittees from July 1, 2017, through June 30, 2018.

If you have any questions, please feel free to contact me at (562) 378-1604.

CC:dw

Attachment

c: Director, Department of Health Services
County Counsel
Executive Officer, Board of Supervisors
EMS Commission
Health Deputies

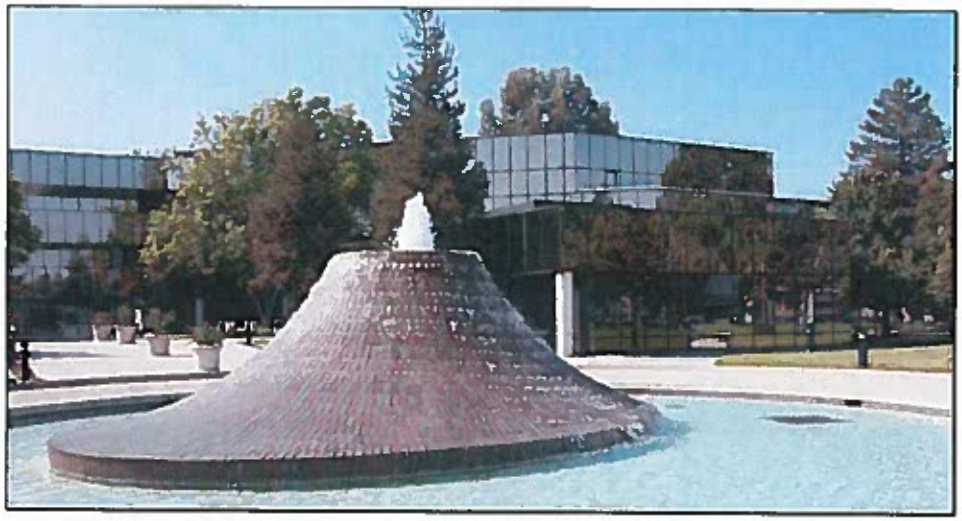
LOS ANGELES COUNTY

EMERGENCY MEDICAL SERVICES COMMISSION

ANNUAL REPORT

TO THE

BOARD OF SUPERVISORS



JULY 1, 2017 – JUNE 30, 2018

Emergency Medical Services Agency
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670

Telephone No. (562) 378-1500
Fax No. (562) 941-5835
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BOARD OF SUPERVISORS

Hilda L. Solis
First District

Mark Ridley-Thomas
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Sheila Kuehl
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Fifth District

Janice Hahn ~ Kathryn Barger ~ Sheila Kuehl ~ Hilda L. Solis ~ Mark Ridley-Thomas

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Public Member
Third Supervisorial District

Ellen Alkon, M.D.
he Southern California Public Health Association

Mr. Joseph Salas
Public Member
First Supervisorial District

Lt. Brian S. Bixler
Peace Officers Association of Los Angeles County

Marc Eckstein, M.D.
Los Angeles County Medical Association

Fire Chief David White
Los Angeles Area Fire Chiefs' Association

Lydia Lam, M.D.
American College of Surgeons

James Lott, Psy.D.
Public Member
Second Supervisorial District

Mr. Robert Ower
Los Angeles County Ambulance Association

Margaret Peterson, Ph.D.
Hospital Association of Southern California

FF/Paramedic Paul Rodriguez
CA State Fire Fighters' Association

Nerses Sanossian, M.D., FAHA
American Heart Association Western States Affiliate

Carole A. Snyder, RN
Emergency Nurses Association

Mr. Colin Tudor
League of California Cities/L.A. County Division

Mr. Gary Washburn
Public Member
Fifth Supervisorial District

Mr. Pajmon Zarrineghbal
Public Member
Fourth Supervisorial District

Atilla Uner, MD, MPH
California Chapter American College of Emergency Physicians (CAL/ACEP)

Ms. Cathy Chidester
Executive Director
Director, EMS Agency

Ms. Denise Watson
Commission Liaison
Secretary, EMS Agency

(Pending)
Los Angeles County Police Chiefs' Association

MISSION STATEMENT

To support and guide the Emergency Medical Services (EMS) Agency activities to ensure timely, compassionate and quality emergency and disaster medical services. The Emergency Medical Services Commission's (EMSC) mission complements the County's mission through improving the quality of life for the people and community of Los Angeles County (LA County).

REGULATORY FOUNDATION

State of California, Health and Safety Code Division 2.5, 1797.270 Emergency Medical Care Committee Formation

"An emergency medical care committee may be established in each county in the state"

1797.272, Emergency Medical Care Committee Membership

"The county board of supervisors shall prescribe the membership, and appoint the members, of the emergency medical care committee."

1797.274, Emergency Medical Care Committee Duties

1797.276, Emergency Medical Care Committee Annual Report

Los Angeles County Ordinance No. 12,332 – Chapter 3.20, EMS Commission

ROLES AND RESPONSIBILITIES

The Commission performs the functions defined in the California Health and Safety Code § 1797.274, Division 2.5, and Los Angeles County Ordinance No. 12,332 – Chapter 3.20, EMS Commission Act in an advisory capacity to the Board of Supervisors (Board) and the Director of Health Services (DHS) regarding County policies, programs, and standards for emergency medical care services throughout the County, including paramedic services.

- Establish appropriate criteria for evaluation and conduct continuous evaluations on the basis of these criteria of the impact and quality of emergency medical care services throughout LA County.
- Conduct studies of particular elements of the emergency medical care system as requested by the Board, the Director of DHS or on its own initiative; delineate problems and deficiencies and recommend appropriate solutions.
- Acquire and analyze the information necessary for measuring the impact and the quality of emergency medical care services.
- Report its findings, conclusions and recommendations to the Board at least every twelve months.
- Review and comment on plans and proposals for emergency medical care services prepared by LA County departments.

- Recommend, when the need arises, that LA County engages independent contractors for the performance of specialized, temporary, or occasional services to the EMSC, which cannot be performed by members of the classified service, and for which the LA County otherwise has the authority to contract.
- Advise the Director and the DHS on the policies, procedures, and standards to control the certification of mobile intensive care nurses and paramedics. Proposals of any public or private organization to initiate or modify a program of paramedic services or training.
- To arbitrate differences in the field of paramedic services and training between all sectors of the community, including, but not limited to, county agencies, municipalities, public safety agencies, community colleges, hospitals, private companies, and physicians.

HISTORICAL BACKGROUND

The EMSC was established by the Board in October 1979 and on April 7, 1981, your Board approved and adopted Ordinance No. 12332, of Title 3 – Advisory Commissions and Committees, Los Angeles County Code, Chapter 3.20, Emergency Medical Services Commission, to establish the Commission in accordance with California H&S Code Sections 1797.270, 1797.272, 1797.274, and 1797.276 was approved and adopted.

On January 29, 2008, the Board approved amending the subject ordinance to revise the selection of the licensed paramedic representative previously nominated by the California Rescue and Paramedic Association and Paramedic Association be made by the California State Firefighters Association, Emergency Medical Services Committee, as the previous entity had ceased to operate.

On November 1, 2011, EMSC, in consultation with DHS, amended the ordinance to add two Commission seats for the members nominated by the Los Angeles County Police Chiefs' Association (LACPCA) and Southern California Public Health Association (SCPHA) would be beneficial to the EMSC and the LA County and would allow for insightful law enforcement and public health expert input.

FOCUS IN PAST YEARS

- Community Paramedicine Pilot Project in the County
- Physician Services for Indigent Program (PSIP) – Proposed reimbursement rates
- Pre-hospital care of behavioral emergencies: The EMSC recommended that an Ad Hoc committee be identified to develop a blueprint for addressing behavioral emergencies in the pre-hospital setting
- Monitor legislation of interest to emergency medical services
- Long Beach Fire Department's two-year Rapid Medical Deployment (RMD) pilot project – 1+1 Paramedic staffing
- Implementation of electronic data using electronic Patient Care Record (ePCR) systems by all fire department 911 providers
- Bystander CPR training (Sidewalk CPR)

ACCOMPLISHMENTS AND SIGNIFICANT OUTCOMES 2017/2018

- Approved the 2015/2016 EMS Annual Report at the November 15, 2017 meeting
- Recognized the members of the Hospital Emergency Response Team (HERT) and Alhambra Fire Department who responded to a horrific industrial injury requiring the bilateral leg amputation on scene
- The Chair and Executive Director represented the EMS Commission at the District Attorney's Committee on Mental Health Issues, and presented the ***"Ad Hoc Committee on Prehospital Care of Mental Health and Substance Abuse Emergencies' Final Report"***

- Developed and administered a survey on law enforcement dispatch and field response to mental health emergencies and issued report of findings
- Ambulance Patient Offload Time (APOT) Ad Hoc Workgroup recommended changes to the current Ref. 503.1 Request for Diversion
- Reviewed and recommended thirty-nine (39) policies for adoption by the EMS Agency
- Recommended approval of Ref. 817, Regional Mobile Response Team to allow for the use of the Mobile Stroke Unit

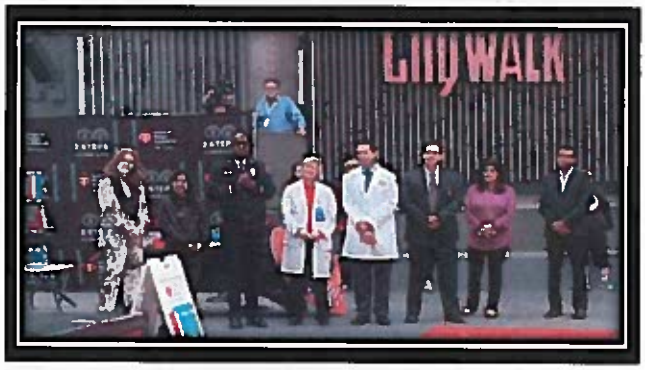
ANNUAL WORK PLAN

UPCOMING GOALS/OBJECTIVES

- Monitor legislation affecting the EMS system
- Educate stakeholders on EMS issues
- Review, provide feedback and support the ***"Ad Hoc Committee on Prehospital Care of Mental Health and Substance Abuse Emergencies' Final Report"*** recommendations
- Finalize the results of the law enforcement dispatch survey and review results with pertinent stakeholders
- Monitor implementation of the amended Ref. 503, Requests for Diversion, and the effect on the EMS System
- Continue to monitor progress of APOT data and recommend the best practice related to the data for optimum results
- Continue engagement with County committees that have similar missions and interests
- Continue engagement with Department of Mental Health on issues related to assessment, treatment and transport of patients in mental health crisis
- Continue to engage with law enforcement to support similar or overlapping response protocols, i.e., Tactical EMS, use of Narcan, transport of injured canine teams
- Ensure timely and complete data submission from all EMS providers by monitoring the progress of Stryker data system and Los Angeles County and City Fire Departments

ONGOING LONG-TERM PROJECTS

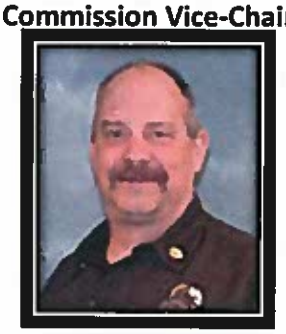
- Review and approve EMS Agency Policies
- The implementation of the recommendations found in ***"Ad Hoc Committee on Prehospital Care of Mental Health and Substance Abuse Emergencies' Final Report"***
- Finalize the dispatch survey results, share with stakeholders and encourage implementation of recommendations
- Ensure that individuals seen and assessed within the 9-1-1 system are transported to the appropriate destination that is best suited to meet their needs, i.e., sobering centers and psychiatric urgent care centers
- Decrease ambulance patient offload times by monitoring Ref. 503 Diversion Requests and APOT data
- Support education efforts for bystander Hands-Only CPR (Sidewalk CPR)



Commission Chair

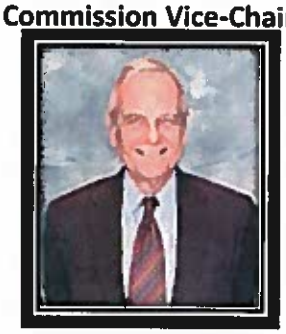
Erick H. Cheung, M.D.
2017/2018

Commission Vice-Chair



Fire Chief David White
2017

Commission Vice-Chair



John Hisserich, Dr.PH.
2018

Executive Director

Cathy Chidester, R.N.
2017/2018

Commission Liaison

Amelia Chavez
2017

Commission Liaison

Denise Watson
2018

MEETING DATES

July 19, 2017
September 20, 2017
November 15, 2017
January 17, 2018
March 21, 2018
May 16, 2018

Special Meeting:
April 11, 2018 - Public Hearing for the pending closure of Community Medical Center Long Beach