COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

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

DATE: **July 21, 2021**
TIME: **1:00 – 3:00 PM**
LOCATION: **Zoom Video Conference Meeting**
Join Zoom Meeting:
https://zoom.us/j/97565380793?pwd=L1dhaUVybnMyK2tiZE95Q29jK3RDdz09
Meeting ID: 975 6538 0793
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The Commission meetings are open to the public. You may address the Commission on any agenda item before or during consideration of that item, and on other items of interest which are not on the agenda, but which are within the subject matter jurisdiction of the Commission. Public comment is limited to three (3) minutes and may be extended by Commission Chair as time permits.

NOTE: Please INPUT YOUR NAME if you would like to address the Commission.

AGENDA

I. CALL TO ORDER – Chairman Paul Rodriguez

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

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

III. CONSENT AGENDA (Commissioners/Public may request that an item be held for discussion. All matters are approved by one motion unless held.)

1. **MINUTES**
   May 19, 2021

2. **COMMITTEE REPORTS**
   2.1 Base Hospital Advisory Committee
   2.2 Data Advisory Committee
   2.3 Provider Agency Advisory Committee

3. **POLICIES**
   3.1 Reference No. 503: Guidelines for Hospitals Requesting Diversion of ALS/BLS Patients

3.2 Reference No. 503.1: Diversion Request Requirements for Emergency Department Saturation
3.3 Reference No. 503.2: Diversion Request Quick Reference Guide
3.4 Reference No. 521: Stroke Patient Destination
3.5 Reference No. 815: Honoring Prehospital Do Not Resuscitate Orders, Physician Orders for Life Sustaining Treatment and End of Life Option (Aid-in-Dying Drug)
3.6 Reference No. 816: Physician at the Scene

END OF CONSENT AGENDA

IV. BUSINESS

BUSINESS (OLD)

4.1 Prehospital Care of Mental Health and Substance Abuse Emergencies (Attachment)
  4.1.1 Ad Hoc Workgroup on the Pre-Hospital Care of Mental Health and Substance Abuse Emergencies – Recommendation Eight
4.2 Ambulance Patient Offload Time (APOT)
4.3 LA County COVID-19 Update – EMS Agency
4.4 EMS Commission Membership – Vote Required
  4.4.1 Paramedic Representation – California State Firefighters Association (CSFA) to California Professional Firefighters (CPF) (Attachments)

BUSINESS (NEW)

4.5 EMS Commission Composition and Nominating Entity (Attachment)
4.6 COVID-19 Meeting Guidance – Preparing to Reopen (Attachment)

V. LEGISLATION

VI. EMS DIRECTOR'S AND MEDICAL DIRECTOR'S REPORTS

CORRESPONDENCE

6.1 (05-19-2021) Distribution: Community Hospital Long Beach 9-1-1 Receiving Designation

VII. COMMISSIONERS' COMMENTS / REQUESTS

VIII. ADJOURNMENT

To the meeting of September 15, 2021

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/

MINUTES
MAY 19, 2021
Zoom Meeting

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

GUESTS

Jaime Garcia	Hospital Assn. Southern Cal.	Ryan Pok	Alhambra Schools
Jennifer Nulty	Torrance Fire Dept.	Bryan Wells	
Shelly Trites	Torrance Memorial	Shane Cook	
Caroline Jack	BHFD	Andy Reno	
Laurie Donegan	Memorial Care	Laura Leyman	
Ilse Wogau	LACO Fire		

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

I. CALL TO ORDER

The Emergency Medical Services (EMS) Commission meeting was held via Zoom Video Communications Conference Call due to the California Statewide Safer at Home Order related to the Coronavirus (COVID-19) pandemic. The meeting was called to order at 1:01 p.m. by Chairman Paul Rodriguez. A quorum was present with 17 Commissioners on the call.

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

Chairman Rodriguez welcomed meeting participants and provided instructions for joining Zoom by hyperlink, how to address the Commission, and how to make comments using the raise hand and chat features.

He announced this was National Emergency Medical Services (EMS) Week 2021 and thanked all EMS personnel for the outstanding and tireless work they do to care for the citizens of the County of Los Angeles.

Cathy Chidester, EMS Commission Executive Director, did roll call of the Commissioners.

Dr. Marianne Gausche-Hill, EMS Agency Medical Director, announced May 19 is "EMS for Children" Day. The National Pediatric Readiness Assessment started May 1 and goes to July 31, 2021. This is a quality improvement assessment of emergency departments (EDs) across the United States that identifies progress and gaps in effort to improve pediatric readiness. Hospitals will receive notifications soon, and the ED nurse managers and medical directors can go to pedsready.org to input their assessments.

III. CONSENT AGENDA

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

Motion/Second by Commissioners Cheung/Ower to approve the Consent Agenda was approved and carried unanimously.

1. MINUTES

March 17, 2021 Minutes were approved.

2. COMMITTEE REPORTS

2.1 Base Hospital Advisory Committee
2.2 Data Advisory Committee
2.3 Provider Agency Advisory Committee

3. POLICIES

No policies for review.

END OF CONSENT AGENDA

IV. BUSINESS

BUSINESS (OLD)

4.1 Prehospital Care of Mental Health and Substance Abuse Emergencies

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

Commissioner Cheung reported that efforts to address recommendations from the September 2016 report are ongoing. The current ad hoc committee is working on field treatment protocols for general agitation and agitated delirium, and a new Medical Control Guideline is being drafted. They are also reviewing protocols related to agitated delirium, restraint, and existing protocols on psychiatric behavioral emergencies, and have incorporated pediatric issues. A new, relevant Medical Control Guideline is in draft form that addresses the management and evaluation of suicidal patients. The ad hoc committee and sub workgroups will continue meeting and when ready, will submit the draft documents to the EMS Commission committees for review this summer.

4.2 Ambulance Patient Offload Time (APOT)

Richard Tadeo, EMS Agency Assistant Director, reported on the fourth quarter APOT report which reflects data including Care Ambulance and L.A. City Fire Department. The report also includes a new column which includes the number of records that had valid times to accurately calculate APOT. Policy revisions that would address APOT were incorporated into Reference 503, Guidelines for Requesting Ambulance Diversion, as well as Ref. 503.1, ED saturation policy. Both policies moved through the Base Hospital Advisory Committee (BHAC) and the Provider Agency Advisory Committee (PAAC) in April 2021. Some recommendations were made, which include the development of a quick reference guide (Reference 503.2) which will go the advisory committees in June. Reference 503 and 503.1 were approved by BHAC and PAAC and will be going to the Hospital Association of Southern California's Emergency Health Service Committee in June. All three policies should come to the EMS Commission in July for final recommendation for approval.

4.3 LA County COVID-19 Modeling – EMS Agency Data

Dr. Gausche-Hill reported that the COVID-19 modeling team reports that the numbers of COVID-19 patients are low and that hospitals have capacity. The COVID-19 variants are being tracked and so far projections do not indicate a surge in the next few months. Key points from the presentation included:

- The modeling tries to predict where we will be in the future. The Effective Transmissibility Rate "R" is still below one (<1) and is in the .9 range and likely overestimated in that some cases are COVID-19 positive, but not active COVID-19 cases.

- Five out of eight persons in Los Angeles are estimated to be protected from COVID-19; three out of eight through native infection; and two out of eight through vaccination.

- Over 500 vaccination sites in Los Angeles County.

- Cold, flu and fever were very high, but now quite low compared to 2019 and 2020.

- Cardiac arrests have always been above the 2019 levels but during the surge had over 40% increase and is finally coming down towards the 2019 levels.

- Traumatic injuries initially declined and then we saw an increase in trauma. As some rules around gathering relaxed, we saw a peak in January 2021.

4.4 EMS Update

Dr. Denise Whitfield, EMS Agency Director of Education, reported EMS Update 2021 has been released and distributed to all provider agencies and base hospitals and is offered online. The material focuses on medical out-of-hospital cardiac arrest for both adults and children, as well as traumatic out-of-hospital cardiac arrest, an update on the policy Reference 834, Assess, Treat and Release, and quality improvement modules addressing assessment and treatment of anaphylaxis and sepsis. Providers and base hospitals should be actively completing EMS Update between now and September 2021 when the new policies will go live.

BUSINESS (NEW)

4.5 EMS Commission Membership – Vote Required

4.5.1 Paramedic Representation – California State Firefighter's Association (CSFA) to California Professional Firefighters (CPF)

California Professional Firefighters (CPF) is requesting a change to the nominating organization for paramedic representation on the Los Angeles County EMS Commission Membership – Composition. Los Angeles County Code 3.20.040 (J) currently reads, *"A licensed paramedic nominated by the California State Firefighters Association, Emergency Medical Services Committee".*

CPF is requesting to change the Ordinance to read, "*A licensed paramedic nominated by the California Professional Firefighters*", on the basis that CSFA does not represent the overwhelming majority of active paramedics working in the field in Los Angeles County.

Commission recommendations were made to also change the verbiage to include *"a licensed paramedic actively engaged in clinical practice and accredited by Los Angeles County"* if this Ordinance item changes.

Following discussion, the commissioners requested that the EMS Agency staff follow up with CSFA and CPF to determine:

1. What are the membership percentages of Los Angeles County firefighter representatives in CPF and in CSFA?
2. Does CPF represent paramedics outside of fire agencies?
3. Does CPF include private and public providers?
4. Is participation obligatory for certain agencies or voluntary?

Motion/Second by Commissioners Uner/Cheung to table vote on Ordinance change to Paramedic Representation from California State Firefighter's Association (CSFA) to California Professional Firefighters (CPF), was held until further information can be brought back to the Commission, and vote to hold item was carried unanimously.

4.5.2 American Heart Association Representation

Executive Director Chidester is recommending a change in representation for the American Heart Association from *"a cardiologist"* to *"a physician"* on the Los Angeles County EMS Commission Membership – Composition. Los Angeles County Code 3.20.040 (B) currently reads, *"A cardiologist nominated by the American Heart Association, Western States Affiliate"*.

This change is recommended on the basis that the last two EMS Commission members nominated by the American Heart Association (AHA) have not been cardiologists. Additionally, the AHA has added Stroke and other conditions to their mission so a cardiologist specialty is not necessary.

Recommendations were made to change the Ordinance to read, *"A physician practicing within Los Angeles County nominated by the American Heart Association, Western States Affiliate".*

Motion/Second by Commissioners Hisserich/Caivano to request an Ordinance change to 3.20.040(B) to read, "A physician practicing within Los Angeles County nominated by the American Heart Association, Western States Affiliate", was approved and carried unanimously.

There was a request to remove the word "department" from Ordinance 3.20.040(C) as the Emergency Nurses Association took the word "department" out in 1995. This will be placed on the next EMS Commission Agenda for further discussion.

Ordinance 3.20, EMS Commission, will be reviewed further to identify the most appropriate place to add new text indicating all positions on the Commission should be held by someone practicing in Los Angeles County.

V. LEGISLATION

Correction to March 17, 2021 Minutes: AB 389 was incorrectly listed as AB 3389.

Ms. Chidester provided highlights of the following bills:
AB 7 - Subsidizes personal protective equipment (PPE) for the ambulance employees to purchase PPE, particularly multi-threat body protective gear.
AB 389 – Allows Request for Proposal contracting for emergency ambulance transportation. Allows fire departments to subcontract for emergency ambulance services.
AB 50 – Paramedics are licensed by the State EMS Authority, and if there are issues with the license (i.e., DUI or investigation), this bill would create a Board to oversee and hear appeals for paramedics' license actions.
AB 988 – National referral line allows 9-8-8 as a mental health crisis hotline.

VI. EMS DIRECTOR'S AND MEDICAL DIRECTOR'S REPORT CORRESPONDENCE:

Ms. Chidester reported on the following Correspondence:

6.1 (03-01-2021) Angela Wise, EMS Authority: EMS System Plan Update FY 2019-20
6.2 (03-15-2021) Chris Gordon, AMR-Inland Empire: Temporary Approval of AMR Inland Empire ALS Unit to Provide Standby ALS Coverage at State Vaccination Site
6.3 (03-10-20210 Distribution: COVID-19 EMS Directive #3 – Suspension of Service Area Boundaries
6.4 (03-15-2021) Assembly Member Freddie Rodriguez: EMS and COVID-19 Vaccination Issues
6.5 (03-15-2021) James R. West: Good Samaritan Hospital Service Area Boundaries and Ambulance Patient Offload Times
6.6 (03-15-2021) Distribution: Submission of Measure B Funding Proposals for 2021
6.7 (03-16-2021) Distribution: Sidewalk "Hands-Only" CPR
6.8 (04-09-2021) Distribution: General Public Ambulance Rates July 1, 2021 through June 30, 2022
6.9 (04-15-2021) Distribution: Pacific Gardens Medical Center 9-1-1 Receiving Hospital Designation

Dr. Gausche-Hill provided the YouTube video link for Item 6.7 on Sidewalk "Hands-Only" CPR and provided an overview of the Los Angeles County EMS System Report.

Ms. Chidester and Chairman Rodriguez congratulated Christy Preston, EMS staff, on her pending retirement, and thanked her on behalf of the entire EMS Commission for her work with the EMS Agency Trauma program and the Commission.

VII. COMMISSIONERS' COMMENTS / REQUESTS

None.

VIII. ADJOURNMENT:

Adjournment by Chairman Rodriguez at 2:23 pm to the meeting of July 21, 2021.

Motion/Second by Commissioners Ower/Salas to adjourn to the meeting of Wednesday, July 21, 2021, was approved and carried unanimously.

Next Meeting: Wednesday, July 21, 2021, 1:00-3:00pm
Join by Zoom Video Conference Call

Join Zoom Meeting
https://zoom.us/j/97565380793?pwd=L1dhaUVybnMyK2tiZE95Q29jK3RDdz09
Meeting ID: 975 6538 0793
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Recorded by:
Denise Watson
Secretary, Health Services Commission

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

BASE HOSPITAL ADVISORY COMMITTEE MINUTES

June 9, 2021

MEMBERSHIP / ATTENDANCE
VIA ZOOM

	REPRESENTATIVES		EMS AGENCY STAFF
☒	Carol Meyer., Chair	EMS Commission	Dr. Marianne Gausche-Hill
☒	Carole Snyder, RN., Vice Chair	EMS Commission	Dr. Nichole Bosson
☐	Atilla Uner, MD, MPH	EMS Commission	Richard Tadeo
☒	Lydia, Lam, MD	EMS Commission	Christine Clare
☒	Diego Caivano, MD	EMS Commission	Dr. Dipesh Patel
☒	Erick Cheung, MD	EMS Commission	Jackie Rifenburg
☒	Garry Olney	EMS Commission	Karen Rodgers
☒	Rachel Caffey	Northern Region	Sara Rasnake
☒	Melissa Carter	Northern Region	Fritz Bottger
☒	Charlene Tamparong	Northern Region, Alternate	Gary Watson
☒	Samantha Verga-Gates	Southern Region	David Wells
☒	Laurie Donegan	Southern Region	Dr. Denise Whitfield
☒	Shelly Trites	Southern Region	Christine Zaiser
☒	Christine Farnham, APCC President	Southern Region, Alternate	Dr. Pranav Shetty
☒	Paula Rosenfield	Western Region	Dr. Allen Chang
☐	Ryan Burgess	Western Region	Natalie Greco
☒	Susana Sanchez	Western Region, Alternate	
☒	Erin Munde	Western Region, Alternate	
☒	Laurie Sepke	Eastern Region	
☒	Alina Candal	Eastern Region	**GUESTS**
☐	Jenny Van Slyke	Eastern Region, Alternate	Dr. Saman Kashani, LACoFD
☒	Lila Mier	County Hospital Region	Dr. Hannah Carr, HGH Resident
☒	Emerson Martell	County Hospital Region	Dr. Brandon Wang, HGH Resident
☒	Yvonne Elizarraz	County Hospital Region, Alternate	
☒	Antoinette Salas	County Hospital Region, Alternate	
☒	Shira Schlesinger, MD	Medical Council Representative	
☐	Roger Yang, MD	Medical Council Representative, Alt.	
☐	Alec Miller	Provider Agency Advisory Committee	
☒	Jennifer Nulty	Provider Agency Advisory Committee, Alt.	
☒	Laarni Abdenoja	MICN Representative	
☐	Jennifer Breeher	MICN Representative, Alt.	
☒	Heidi Ruff	Pediatric Advisory Committee	
☒	Michael Natividad	Pediatric Advisory Committee, Alt.	

	PREHOSPITAL CARE COORDINATORS		
☒	Jessica Strange (SJS)	☒	Lorna Mendoza (SFM)
☒	Melissa Turpin (SMM)	☒	Karyn Robinson (GWT)
☐	Coleen Harkins (AVH)	☒	Erica Candelaria (QVH)

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

2. **APPROVAL OF MINUTES**: The meeting minutes for April 14, 2021, were approved as submitted.

M/S/C (Farnham/Sepke)

3. INTRODUCTIONS/ANNOUNCEMENTS:

3.1 National Pediatric Readiness Project

- Dr. Marianne Gausche-Hill:

  The National Pediatric Readiness Project is a national coalition of major organizations that care for children in emergency settings, with a goal to improve pediatric emergency care in the pre-hospital and hospital environment.

  Hospitals across the nation have the opportunity to take part in the National Pediatric Readiness Assessment, which is based on the 2018 guidelines. With participation, each hospital will receive a score (0-100) which can be compared to the national average of like hospitals, and a gap analysis which highlights pediatric readiness strengths and quality improvement opportunities.

  Each hospital is allowed only one assessment submission. In preparing for the assessment, visit www.pedsready.org and www.pediatricreadiness.org. The last day to submit the survey is July 31, 2021.

- Richard Tadeo:

  - After 37 years of service for Los Angeles County, Christy Preston has retired.
  - Michelle Williams, Chief Data Management, has left the EMS Agency. Overseeing Data Management, at this time, is Richard Tadeo, Christine Clare, and Sara Rasnake.
  - Funding for the Health Data Exchange (HED) project has been reimplemented and extended to December 31, 2021. Further information will be provided regarding this project.
  - At the request of the California Department of Public Health, Pacific Garden Medical Center (TRI) has been closed to 9-1-1.
  - Community Hospital Long Beach (LCB) has reopened as a 9-1-1 receiving hospital, effective May 24, 2021.

4. REPORTS & UPDATES:

4.1 2020 EMS Annual Data Report

The 9th issue of the Los Angeles County EMS System Report has been published and was presented by Dr. Marianne Gausche-Hill. Thank you to Richard Tadeo for his hard work putting together the report; and to all 9-1-1 Receiving Hospitals, EMS Provider Agencies, EMS Practitioners, and Mobile Intensive Care Nurses for their contribution.

To view the Annual Los Angeles County EMS System Report, visit http://file.lacounty.gov/SDSInter/dhs/1106985_2020EMSAnnualDataReport.pdf

4.2 EMS Update 2021

EMS Update 2021 became available May 1, 2021 and completion date is due by September 1, 2021. For hospital staff that wish to access EMS Update content (without CE credit), contact Dr. Denise Whitfield at, DWhitfield@dhs.lacounty.gov, and a link will be provided.

4.3 EmergiPress

Thank you to all the Pre-hospital Care Coordinators for topic suggestions and input. The next edition of EmergiPress will be available in June and will include a module on AV fistulas and bleeding.

Continue to submit feedback and suggestions for future topics to Dr. Denise Whitfield at, DWhitfield@dhs.lacounty.gov.

4.4 ECMO Pilot

The ECMO Pilot resumed April 21, 2021. Participating hospitals include Ronald Regan UCLA and Cedars Sinai, participating providers include Beverley Hills Fire, Culver City Fire, and specific Los Angeles County Fire Stations (Units in Inglewood 171-173, Ladera Heights, and West Hollywood). On May 3, 2021, LAC+USC Medical Center and Los Angeles City Fire were added to the Pilot. Further expansion to include Santa Monica Fire with transport to Ronald Regan UCLA, start date has yet to be determined.

As a reminder, pre-hospital care providers will contact the Base at the ECMO receiving center directly. However, if a Base Hospital that is not an ECMO receiving center should receive notification for a patient that may benefit from ECMO, remind the provider and reroute to the closest ECMO receiving hospital, if ECMO hospital is within 30 minutes.

i-gel Pilot

On June 1, 2021 the i-gel pilot began with Pasadena Fire, Culver City Fire, and Torrance Fire. During the pilot, paramedics will use the i-gel in lieu of the King Lt as the supraglottic airway device. The i-gel device contains a non-inflating cuff and can be left in place for up to 4 hours. We will keep you posted as additional providers are added to the pilot.

4.5 Data Collaboratives

SRC Collaborative:

- Recent publication: “Emergency Medical Services Responses to Out-of-Hospital Cardiac Arrest and Suspected ST-Segment-Elevation Myocardial Infarction During the COVID-19 Pandemic in Los Angeles”, https://www.ahajournals.org/doi/10.1161/JAHA.120.019635

  “Utility of Glucose Testing and Treatment of Hypoglycemia in Patients with Out-of-Hospital Cardiac Arrest” (Publication Attached)

- Ongoing project: Impact of COVID on Cardiac Arrest and STEMI volume, treatment, and outcome.

Stroke Data Collaborative:

- Ongoing project: Impact of COVID on stroke volume, treatment, and outcome.
- Analyzing effects on volume, patient outcomes, and impact projection of a growing two-tiered stroke system.
- Pending data: Frequency of thrombectomy among patients with low LAMS score.

Pediatrics:

- Collecting data on out of hospital cardiac arrest in the pediatric population, more to come on this topic.
- Future study: PediDOSE- impact of standardized medication dosing based on age. Additional information to come.

5. OLD BUSINESS:

None

6. NEW BUSINESS:

6.1 Base Hospital Form Revision

Base hospital form revisions were presented as information. As part of the changes and effective immediately, Base Hospitals are no longer required to submit the yellow copy of the base form to the EMS Agency.

There were no recommended changes at this time. Revised base hospital form will be implemented September 2021. Contact Christine Clare at, cclare@dhs.lacounty.gov, for any questions.

6.2 Ref. No. 503.2, Diversion Request Quick Reference Guide

Approved as presented.

M/S/C (Farnham/Trites)

6.3 Ref. No. 521, Stroke Patient Destination

Approved with recommended change:

- Page 2, A., remove the word “local”.
- Page 2, B., Simplify the language to include language from bottom of page. Suggested language: Perform LAMS on all patients with suspected stroke, including those with negative mLAPSS when concern for stroke remains
- Remove language: “Note: All patients with suspected stroke shall receive a LAMS to determine severity of stroke”

M/S/C (Farnham/Donegan)

6.4 Ref. No. 1317.15, Medical Control Guideline: Drug Reference - Diphenhydramine

Approved as presented.

M/S/C (Farnham/Donegan)

6.5 Ref. No. 1345, Medical Control Guideline: Pain Management

Approved as presented.

M/S/C (Farnham/Caivano)

7. **OPEN DISCUSSION:**

   None

8. **NEXT MEETING:** BHAC's next meeting is scheduled for **August 11, 2021**, location is to be determined.

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

   ACCOUNTABILITY: Lorrie Perez

9. **ADJOURNMENT:** The meeting was adjourned at 2:18 P.M.

Prehospital Emergency Care

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/ipec20

Utility of Glucose Testing and Treatment of Hypoglycemia in Patients with Out-of-Hospital Cardiac Arrest

Tiffany M. Abramson , Nichole Bosson , Angelica Loza-Gomez , Marc Eckstein & Marianne Gausche-Hill

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To link to this article: https://doi.org/10.1080/10903127.2020.1869873

Accepted author version posted online: 05 Jan 2021.

Utility of Glucose Testing and Treatment of Hypoglycemia in Patients with Out-of-Hospital Cardiac Arrest

Tiffany M. Abramson, MD[1], Nichole Bosson, MD, MPH[2, 3, 4], Angelica Loza-Gomez, MD[1], Marc Eckstein, MD, MPH[1,5], Marianne Gausche-Hill, MD[2, 3, 4]

[1]Keck School of Medicine of the University of Southern California, Department of Emergency Medicine, Division of Emergency Medical Services
[2]Los Angeles County Emergency Medical Services Agency
[3]Harbor-UCLA Medical Center and the Lundquist Research Institute at Harbor-UCLA
[4]The David Geffen School of Medicine at UCLA
[5]Los Angeles Fire Department, Emergency Medical Services Bureau

CORRESPONDING AUTHOR: Tiffany Abramson, MD Keck School of Medicine of the University of Southern California, 1200 N. State Street, Rm 1011 323-409-7053. Tiffany.abramson@med.usc.edu

Abstract

Objective

Many emergency medical services (EMS) protocols for out-of-hospital cardiac arrests (OHCA) include point-of-care (POC) glucose measurement and administration of dextrose, despite limited knowledge of benefit. The objective of this study was to describe the incidence of hypoglycemia and dextrose administration by EMS in OHCA and subsequent patient outcomes.

Methods

This was a retrospective analysis of OHCA in a large, regional EMS system from 2011-2017. Patients ≥18 years old with non-traumatic OHCA and attempted field resuscitation by paramedics were included. The primary outcomes were frequency of POC glucose measurement, hypoglycemia (glucose <60 mg/dl), and dextrose/glucagon administration

(treatment group). The secondary outcomes included field return of spontaneous circulation (ROSC), survival to hospital discharge (SHD), and survival with good neurologic outcome.

Results

There were 46,211 OHCAs during the study period of which 33,851 (73%) had a POC glucose test performed. Glucose levels were documented in 32,780 (97%), of whom 2,335 (7%) were hypoglycemic. Among hypoglycemic patients, 41% (959) received dextrose and/or glucagon. Field ROSC was achieved in 30% (286) of hypoglycemic patients who received treatment. Final outcome was determined for 1,714 (73%) of the hypoglycemic cases, of whom 120 (7%) had SHD and 66 (55%) had a good neurologic outcome. 27 of 32,780 (0.08 %) patients with a documented POC glucose result who were identified as hypoglycemic, received field treatment, and survived to discharge with good neurologic outcome. 48 (6%) of patients in the treatment group had SHD vs. 72 (8%) without treatment, risk difference -2.0% (95%CI -4.4%, 0.4%), p=0.1.

Conclusion

In this EMS system, POC glucose testing was common in adult OHCA, yet survival to hospital discharge with good neurologic outcome did not differ between patients treated and untreated for hypoglycemia. These results question the common practice of measuring and treating hypoglycemia in OHCA patients.

KEY WORDS: out of hospital cardiac arrest, hypoglycemia, dextrose, glucagon, point of care testing

Introduction

There are over 400,000 out of hospital cardiac arrests (OHCA) each year in the United States.[1] While the American Heart Association (AHA) and individual prehospital emergency medical services (EMS) systems have set guidelines for resuscitation, protocols vary.[2] One such practice for which there is variability, is the administration of dextrose during cardiac arrest. Hyperglycemia after cardiac arrest is associated with unfavorable outcomes, including decreased survival and neurologic function, however, less is known about hypoglycemia in cardiac arrest.[3,4] Insufficient data exists to demonstrate whether administration of dextrose during OHCA confers benefit, and existing data suggests that it may even be harmful.[4]

High quality CPR and early defibrillation are the most reliable predictors of survival, thus, training of emergency responders encourages prioritization of these interventions.[5–8] Rapidly addressing reversible causes can improve a patient's chance for a meaningful recovering. However, each additional procedure, such as obtaining intravenous access, delays on-scene time by at least one minute.[9] Unnecessary testing and treatment may detract from proven therapies, including continuous chest compressions and early defibrillation.

The 2005 AHA guidelines included identification and treatment of the reversible causes of OHCA including the "6H's" (hypoglycemia, hypoxia, hypovolemia, hypo- or hyperkalemia, hydrogen ions, hypothermia) and the "5T's" (trauma, tension pneumothorax, tamponade, toxins, thrombosis).[10] However, in the 2010 the AHA removed hypoglycemia from the list of reversible causes for adults with OHCA and it remained absent in the 2015 AHA update.[11,12] Neither the

addition nor subsequent removal of hypoglycemia as a reversible cause of OHCA is well supported by data. Currently, prehospital EMS protocols for POC glucose testing and treatment with dextrose during OHCA vary by system. Understanding the likelihood of the reversible cause, specifically hypoglycemia, existing and the effects of treatment, could help prioritize care in the field.

The objectives of this study are to evaluate a strategy to perform POC glucose testing in patients with OHCA, to describe the frequency of glucose measurement and treatment with dextrose, and to describe outcomes in patients with hypoglycemia during OHCA in a large, regional cardiac arrest system of care. To our knowledge, this is the first study to date to describe the incidence of hypoglycemia treatment by EMS for OHCA, and subsequent patient outcomes among those who were treated versus untreated for hypoglycemia.

Methods

Study design

This is a 6-year retrospective, cohort study of all OHCA patients treated by paramedics in Los Angeles County (LAC) from 2011-2017 with available prehospital data. The study was reviewed and approved with exception from informed consent by the Institutional Review Board of the University of Southern California (HS-18-00245).

Setting

Los Angeles County is a large metropolis, comprising 88 cities spanning over 4058 square miles with a population of 10.2 million. Los Angeles County EMS Agency operates a regional cardiac system of care for patients with ST elevation myocardial infarction (STEMI) and/or OHCA that has been previously described.[13,14] The LAC regional cardiac system includes seventy-one 9-1-1 receiving centers, of which 36 are STEMI Receiving Centers, which also serve as cardiac arrest receiving centers.

In LAC, EMS is provided by 30 fire-based provider agencies with approximately 4200 paramedics. Prehospital management throughout LAC is standardized via approved field treatment protocols. EMS providers transport patients resuscitated from OHCA to one of 36 designated cardiac arrest receiving centers. All cardiac arrest receiving centers are capable of providing immediate cardiac catheterization 24 hours per day, 7 days per week with cardiovascular surgeons available. In addition, all centers are required to collect data on outcome, have comprehensive quality improvement programs including internal policies for percutaneous coronary intervention (PCI), fibrinolysis, and targeted temperature management (TTM). At the time of this study, patients who did not obtain return of spontaneous circulation (ROSC) were either pronounced in the field or transported to the most accessible receiving hospital under the guidance of online medical direction.

Cardiac arrest receiving centers submit data on all adult patients with ROSC after OHCA to a single registry maintained by the LAC EMS Agency. Data abstraction from prehospital and hospital records is completed by registered nurses (RN) in the departments of emergency medicine or cardiology, or by quality improvement staff. Data elements include field ROSC,

survival to hospital discharge (SHD), and neurologic outcome (Cerebral Performance Category (CPC)). Completeness and accuracy of the entered data are reviewed by the EMS Agency with verification performed during site visits.

EMS Provider Agencies submit data on the field assessment and management of all patients to the LAC EMS Agency for entry into the LAC provider agency database. The provider agency database contains all management provided in the out-of-hospital setting, including point of care (POC) glucose testing and medication administration, as well as field outcome and disposition. Completeness and accuracy of the entered data are reviewed by the EMS Agency staff.

Selection of participants

Patients ≥18 years old in the LAC provider agency database with non-traumatic OHCA attended to by paramedics were included. Patients were excluded if no resuscitation was attempted by EMS (i.e., determined dead on arrival, or existence of a Do Not Resuscitate (DNR) order).

Measurements

The provider agency database was queried from 2011 through 2017 for all adult patients with non-traumatic OHCA. Study variables included age, sex, POC glucose measurement by EMS, dextrose (D50 or D10) and/or glucagon administration by EMS, return of spontaneous circulation (ROSC) in field, and receiving center if transported. For the majority of the study period, D50 was the dextrose concentration in use throughout LAC. In April 2017, the system transitioned to the use of D10. For patients transported to a cardiac arrest receiving center, the

LAC cardiac arrest registry was used to determine survival to hospital discharge (SHD) and CPC score at discharge.

Outcomes

The primary outcomes were frequency of point of care glucose measurement, hypoglycemia, and dextrose and/or glucagon administration. Hypoglycemia was defined as glucose <60 mg/dl. The secondary outcomes included field ROSC, SHD and survival with good neurologic outcome, defined as CPC 1 or 2 in hypoglycemic patients. Overall outcomes serve as a system reference.

Survival and survival with good neurologic outcome were determined considering data from both the provider agency database and the cardiac arrest registry. If a patient's resuscitation was terminated in the field, they were treated as deceased. If a patient was transported to a non-cardiac arrest receiving center, their outcome was treated as unknown, since, at the time of this study, these hospitals did not submit outcome data to the LA County EMS Agency. If a patient was transported to a cardiac arrest receiving center and included in the cardiac arrest registry, SHD and neurologic outcomes were determined from the registry. If a patient was transported to a cardiac arrest receiving center and not found in the cardiac arrest registry, they were counted as deceased, given the requirement to enter all patients with ROSC into the registry. Neurologic outcomes in the cardiac arrest receiving center database were recorded as CPC scores, which were documented by a hospital provider at time of discharge and entered into the cardiac arrest registry.

Analysis

Data were collected in a Microsoft Excel spreadsheet (Microsoft Corporation, Redmond WA). Statistical analyses were performed using SAS 9.4 (SAS Institute, Cary, NC). Descriptive outcomes were calculated as frequencies with proportions.

Results

During the study period, there were a total of 46,211 OHCAs (Figure 1). Of the OHCAs, 27,108 (58.7%) were male with a median age of 69 years (IQR 57-80). A POC glucose test was performed in 33,851 (73%) patients and glucose levels were documented in 32,780 (97%), of whom 2,335 (7%) were hypoglycemic. Among hypoglycemic patients, 959 (41%) received dextrose and/or glucagon by EMS.

Of the hypoglycemic patients, 15.3% (358) had a glucose level <20 mg/dl, 50.8% (1185) had a glucose level 20-39 mg/dl, and 33.9% (791) had a glucose level between 40-59 mg/dl. The frequency of treatment and outcome varied by the degree of hypoglycemia. (Table 1) Patients with glucose measurements <20 mg/dl less commonly received treatment compared with patients with a glucose measurement of 20-39 mg/dL and 40-59 mg/dl.

Field ROSC was achieved in 31% (14,182/46,211) of all OHCA systemwide. Rates of ROSC in patients without glucose testing, and those with glucose testing with normal and low blood sugars detected are shown in Figure 1. Field ROSC was achieved in 19% (2,346) of cases that did not have a POC glucose obtained. In patients who underwent POC glucose testing and have a documented glucose result, field ROSC was achieved in 35% (11,491/32,780) overall,

including 35% (10,779/30,445) of OHCA that were not hypoglycemic, 30% (286/959) of hypoglycemic patients who received treatment, and 31% (426/1,376) of hypoglycemic patients who did not receive treatment.

Final outcomes were determined for 33,690 (73%) of all OHCA in LAC during the study period. Field ROSC was achieved in 42% (14,182) of these cases. Overall, 8% (2,751) had SHD and 57% (1,567) of survivors had good neurologic outcomes.

Final outcomes were determined for 1,714 (73%) of the hypoglycemic cases, including 84% (805) of patients treated by EMS and 66% (909) of those not treated. Of all hypoglycemic cases with known final outcomes, 7% (120) had SHD and 55 % (66) of survivors had a good neurologic outcome. Among survivors with hypoglycemia, 40% (48) were treated in the field. In the 805 treated hypoglycemic cases with known outcomes, 6% (48) had SHD and 56% (27) of survivors had a good neurologic outcome. In the 909 untreated hypoglycemic cases with known outcomes, 8% (72) had SHD and 54% (39) of survivors had a good neurologic outcome. Risk differences for SHD and good neurologic outcome for treated versus untreated hypoglycemic cases were -2.0% (95%CI -4.4%, 0.4%), p=0.1 and 2.1% (95%CI -16.1%, 20.2%), p=0.8, respectively.

Among the 32,780 patients from whom a POC glucose test was performed and the result documented, there were 27 cases (0.08%) in whom hypoglycemia was detected and treated by EMS who survived with good neurologic outcome.

Discussion

In this study, we described the frequency of hypoglycemia, dextrose administration, and associated outcomes from OHCA in large, regional EMS system and found that survival of patients who are tested and treated with hypogylcemia is a rare occurance in OHCA. There was no difference in unadjusted outcomes for hypoglycemic patients regardless of field treatment with dextrose and/or glucagon - hypoglycemic patients had similar rates of SHD and survival with good neurologic outcome as the OHCA population in LAC in general.

Our data support delaying POC glucose testing until after ROSC is obtained. This is consistent with the 2010 and 2015 AHA guidelines which do not include hypoglycemia as a reversible cause of cardiac arrest that should be addressed during resuscitation.[11,12] Given the current lack of data demonstrating that treatment improves outcomes, better outcomes may be achieved by focusing on the fundamentals of OHCA resuscitation including maintaining continous high-quality CPR, as opposed to advanced life support (ALS) interventions such as checking POC glucose or administration of dextrose.[5]

Each intervention perfromed in the prehospital setting takes time, delays other inteventions, and may prolong scene time. A concern with frequent glucose testing and treatment, are delays in care associated with the testing, and if hypoglycemic, providing treatment. Although we could not find data on length of time it takes to perform POC glucose testing, it is likely to be at least 30 seconds to a minute. Prior prehospital studies have demonstrated that intravenous (IV) access, which is necessary for dextrose administration, is time consuming.[9,17] On average, obtaining prehospital IV access takes almost 2 minutes and can be even longer if other

interventions such as airway management or CPR are ongoing.[9] Multiple IV attempts may be needed to succesfully obtain access, further prolonging the amount of time dedicated to this intervention and potentially taking providers away from CPR and other time-criticial interventions.[17] Tasks that divert providers from therapies that are known to be helpful have the potential to negatively impact outcome. Each intervention performed during a time-critical emergency, such as OHCA, needs to be closely evaluated for the relationship between potential benefit and the potential cost of the time needed to perform the intervention.

POC testing should drive treatment. In a recent study by Wang et al., glucose ≤150mg/dl was associated with worse outcomes from in-hospital cardiac arrest. However, treatment with dextrose did not improve outcomes.[15] Further, empiric dextrose administration may be harmful. There is evidence that dextrose administration during in-hospital cardiac arrest may be detrimental and can worsen cerebral ischemia.[4,16] Our data suggests that POC glucose testing in OHCA is not associated with improved outcome; the documented treatment rate for hypoglycemia in this cohort was only 41%, despite the fact that LAC treatment protocols at the time of the study dictated treatment for a measured glucose <60 mg/dL. It is unclear why a large percentage of patients did not receive this treatment. While in some cases, this may be due to documentation error, it is also possible that prioritization of interventions resulted in treatment delays even after hypoglycemia was identified. Further, a very large number of patients would need to be tested for hypoglycemia, though few would be identified as requiring treatment, and even fewer would have a positive outcome. In our cohort, treatment of hypoglycemia was not associated with improvement in outcome. It is possible that POC testing may actually worsen

outcomes, given the potential to delay other interventions. Once ROSC is achieved, POC glucose testing and treatment of documented hypoglycemia may be considered.

Limitations:

This was a retrospective analysis using registry data, as such we cannot determine causality and data are subject to the limitation of clinical documentation, i.e., documentation errors or incomplete information. A specific limitation of the database was the lack of information about co-morbidities including history of diabetes, use of anti-hyperglycemic agents or other medications that are associated with hypoglycemia. We are unable to assess temporality of the POC glucose check, dextrose or glucagon administration, and patient status in relation to these interventions given that the times, when available, were documented by the paramedics in retrospect and, therefore, were not precise enough. Additionally, the database does not reliably include resuscitation variables including initial rhythm, location, witness, bystander CPR for all patients. The objective of this study was to describe the frequency of hypoglycemia in OHCA, the frequency of treatment and the patient outcomes. Importantly, given the retrospective observational nature of the data, the missing data on arrest characteristics, along with the inability to account for individual patient risk factors, we were unable to provide risk adjusted odds for patient-centered outcome comparing hypoglycemic patients to non-hypoglycemic patients, or treated patients to non-treated patients. D50 was the dextrose concentration in use for the majority of the study. While some EMS systems, including LAC, have moved to a D10 concentration, we are unable to assess the effect of this change. Finally, we were unable to obtain outcomes on those that were tranpsorted to non-cardiac arrest recieving centers, since only cardiac arrest receiving centers submit outcome data to the registry.

Conclusion:

In this regional EMS system, POC glucose testing was common in adult OHCA, yet survival to hospital discharge with good neurologic outcome did not differ between patients treated and untreated for hypoglycemia. Outcomes for patients with hypoglycemia were similar to overall outcomes within the same system. Our data do not support POC glucose testing until after ROSC is achieved in adult OHCA.

CONFLICT OF INTEREST STATEMENT: *The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.*

ACKNOWLEDGEMENTS: The authors would like to thank all the cardiac arrest receiving center participants and the Los Angeles County EMS Agency staff who contributed to the patient registry and whose dedicated work provided the necessary data for this analysis

Previously presented in part at 2019 Annual NAEMSP meeting (Austin, Tx).

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Table 1. Frequency of treatment and outcomes by level of hypoglycemia.

	<20 mg/dL			20-39 mg/dL			40-59 mg/dL		
	N	%		N	%		N	%	
Frequency	358	15.3		1186	50.8		791	33.9	
Treatment									
None	317	88.5		650	54.8		409	51.7	
Dextrose	40	11.2		509	42.9		367	46.4	
Glucagon	0	0		19	1.6		11	1.4	
Dextrose + Glucagon	1	0.3		8	0.7		4	0.5	
Field ROSC	111	31		359	30.3		242	30.5	
SHD*	27	10.8		59	6.5		34	6.1	
CPC 1-2**	13	48.1		33	55.9		20	58.8	

ROSC= Return of Spontaneous Circulation; SHD=Survival to Hospital Discharge; CPC= Cerebral Performance Category

*Percent of known. Final outcomes available for: glucose <20mg/dl N=249, glucose 20-39 mg/dl N=905, glucose 40-59 mg/dl N=560.

**Percent of survivors.

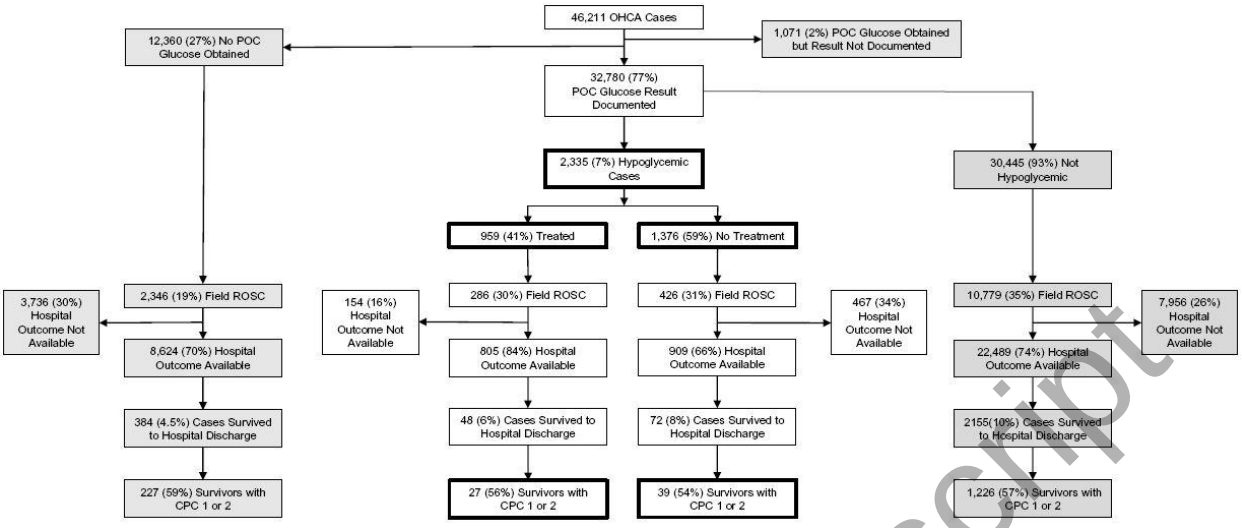

Figure 1.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County Board of Supervisors

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First District

Holly J. Mitchell
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
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Health Services
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EMERGENCY MEDICAL SERVICES COMMISSION
DATA ADVISORY COMMITTEE

MEETING NOTICE

Date & Time: Wednesday, June 9, 2021 10:00 A.M.
Location: Zoom Meeting

DATA ADVISORY COMMITTEE
DARK FOR JUNE 2021

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

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, June 16, 2021

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

MEMBERSHIP / ATTENDANCE

MEMBERS	ORGANIZATION
☑ Robert Ower, Chair	EMSC, Commissioner
☑ Kenneth Powell, Vice-Chair	EMSC, Commissioner
☐ Gene Harris	EMSC, Commissioner
☐ Paul Rodriguez	EMSC, Commissioner
☐ Brian Bixler	EMSC, Commissioner
☐ John Hisserich	EMSC, Commissioner
☑ Sean Stokes	Area A (Rep to Medical Council)
☐ Justin Crosson	Area A, Alt.
☑ Dustin Robertson	Area B
☐ Clayton Kazan, MD	Area B, Alt.
☑ Todd Tucker	Area C
☑ Ken Leasure	Area C, Alt.
☑ Ivan Orloff	Area E
☑ Kurt Buckwalter	Area E, Alt.
☑ Wade Haller	Area F
☑ Andrew Reno	Area F, Alt.
☐ Alec Miller	Area G *(Rep to BHAC)*
☑ Jennifer Nulty	Area G, Alt. *(Rep to BHAC, Alt.)*
☑ Doug Zabilski	Area H
☐ Anthony Hardaway	Area H, Alt.
☑ Matthew Potter	Area H, Alt. *(Rep to DAC)*
☑ Julian Hernandez	Employed Paramedic Coordinator
☑ Tisha Hamilton	Employed Paramedic Coordinator, Alt.
☐ Rachel Caffey	Prehospital Care Coordinator
☑ Jenny Van Slyke	Prehospital Care Coordinator, Alt.
☑ Andrew Respicio	Public Sector Paramedic
☑ Daniel Dobbs	Public Sector Paramedic, Alt.
☑ Maurice Guillen	Private Sector Paramedic
☐ Scott Buck	Private Sector Paramedic, Alt.
☑ Ashley Sanello, MD	Provider Agency Medical Director
☐ Vacant	Provider Agency Medical Director, Alt.
☑ Andrew Lara	Private Sector Nurse Staffed Ambulance Program
☐ Gary Cevello	Private Sector Nurse Staffed Ambulance Program, Alt.
☑ Michael Kaduce	EMT Training Program
☑ Scott Jaeggi	EMT Training Program, Alt.
☐ David Mah	Paramedic Training Program
☐ David Fillip	Paramedic Training Program, Alt.

EMS AGENCY STAFF (Virtual)	
Marianne Gausche-Hill, MD	Cathy Chidester
Nichole Bosson, MD	Richard Tadeo
Denise Whitfield, MD	Dipesh Patel, MD
Millicent Wilson, MD	Chris Clare
Elaine Forsyth	Natalie Greco
Cathlyn Jennings	Susan Mori
Lorrie Perez	John Quiroz
Sara Rasnake	Jennifer Calderon
Karen Rodgers	David Wells
Gary Watson	Laura Leyman
Christine Zaiser	

PUBLIC ATTENDEES (Virtual)	
Christina Eclarino	LA County Public Health
Nicole Steeneken	LACOFD
Adrienne Roel	Culver City FD
Luis Manjarrez	Glendale FD
Tina Ziolkowski	Los Angeles FD
Marc Cohen, MD	Three area FDs
Anathea Gordon	Los Angeles FD
Richard Oishi	Arcadia FD
Kristina Crews	LACoFD
Britney Alton	Burbank FD
Catherine Borman	Santa Monica FD
Roger Braum	Culver City FD
Craig Hammond	Glendale FD
Puneet Gupta, MD	LACoFD
Sheryl Gradney	Beverly Hills FD
Saman Kashani, MD	LACoFD
Nancy Alvarez	LACoFD
Angelica Loza-Gomez, MD	FD and Dispatch MD
Aspen Di-Ilolo	Monterey Park FD
Ryan Cortina	Burbank FD
Edmond St. Cyr	Burbank FD
Jennifer Breeher	Alhambra FD
Alex Wilkie	MedCoast Ambulance
Allen Chang, MD	EMS Fellow
Daniel Graham	Liberty Ambulance
Jack Feria	Symbiosis Amb
Ian Wilson	Premier Ambulance
Juan Espinoza	Cal-Med Ambu
Robert Aragon	Cal-Med Ambu
Misi Ferniz	Liberty Ambulance

1. **CALL TO ORDER:** 1:00 p.m.: Chair, Robert Ower, called meeting to order.

2. **INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS**

2.1 Committee Representatives

Chairman Ower welcomed the following new members to the Committee:

- Area C Representative, Alternate: Ken Leasure replacing Lyn Riley
- Area F Representative, Alternate: Andrew Reno replacing Brenda Bridwell

2.2 EMS Agency Staff Changes

Richard Tadeo announced the following personnel changes within the EMS Agency:

- STEMI Receiving Center Program Coordinator, Paula Rashi, retired in April 2021
- Trauma System Program Manager, Christy Preston, retired in May 2021
- Chief, EMS System Data Management, Michelle Williams, left the EMS Agency to pursue other goals.
- Data requests can be forwarded to either Chris Clare, Sara Rasnake or Richard Tadeo.

2.3 Hospital Resources

Richard Tadeo announced the following:

- Community Hospital Long Beach (LBC) – approved as a 9-1-1 receiving facility as of May 24, 2021
- Pacific Gardens Medical Center (TRI) – no longer an approved 9-1-1 receiving facility as of June 7, 2021.

3. **APPROVAL OF MINUTES (Kaduce/Jaeggi)** April 21, 2021 minutes were approved as written.

4. **REPORTS & UPDATES**

4.1 2020 EMS Annual Data Report *(Richard Tadeo)*

- The May 1, 2021 issue of Los Angeles County EMS System Report (Issue 9) was presented and reviewed with the Committee.
- Suggestions/recommendations for future annual reports may be emailed to Richard Tadeo at rtadeo@dhs.lacounty.gov.

4.2 Summary of EMS Report Form Changes *(Chris Clare)*

- Summary of changes to the patient care record (PCR) were provided to this Committee and will go into effect on July 1, 2021.
- PCR changes will be posted on the EMS Agency's webpage, including an updated Data Dictionary.

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

- Los Angeles County continues to report low COVID-19 cases. (<1% positivity rate, based on a 7-day average)
- Dr. Gausche-Hill emphasized the importance of receiving the vaccine since the COVID-19 vaccine has shown to be very effective against the COVID-19 virus and the many variants that are in our community.
- PPE Concern: Due to the many COVID-19 variances and other illnesses in our community, it is critical that everyone continue utilizing their PPE at this point.
- Firehouses: If everyone is immunized, there is no need to wear face coverings. However, those who have not been immunized [or if they have any underlying serious medical condition], should continue wearing a face covering.

- Healthcare Workers: Should continue wearing eye protection, surgical mask [preferable N-95], gloves; and for aerosolized generating medications and CPR, gown is to be worn.
- July 19, 2021 is the next EMS Agency's COVID-19 update, which continues to be via ZOOM conference call.

4.4 EMS Update 2021 *(Denise Whitfield, MD)*
- EMS Update continues throughout the County.
- Those who are interested in accessing the EMS Update material without receiving continuing education, may contact Dr. Whitfield at dwhitfield@dhs.lacounty.gov.

4.5 ITAC Update *(Denise Whitfield, MD)*
- There was no meeting in May 2021, due to no agenda items.
- Next meeting is scheduled for August 2, 2021 with the following topics up for review: dechoker devices, video laryngoscopy devices, and compact back boards.

4.6 EmergiPress *(Denise Whitfield, MD)*
- Next EmergiPress will be posted on the EMS Agency's webpage prior to the end of this month.
- Those interested in receiving the EmergiPress announcements may contact Dr Whitfield at dwhitfield@dhs.lacounty.gov

4.7 Research Collaboratives (*Nichole Bosson, MD)*
- STEMI and Cardiac Arrest Research Group: recently published manuscript in the Journal of American Heart Association; looking at the impact of COVID-19 on STEMI and out of hospital cardiac arrests.
- Stroke Research Group: will be looking at the projects with the Mobile Stroke Units and potentially expanding this resource; and adding additional stroke centers into our system.
- Trauma Research Group: Continuing to participate in and support the Southern California Trauma Consortium with upcoming projects to look at the use of imaging in pregnant trauma patients. Also, looking at possibly designing a trial on oxygenation use in trauma patients.
- Pediatric Research Group: Collecting data on out-of-hospital cardiac arrests and will develop projects as data continues to be collected.

4.8 ECMO Update *(Nichole Bosson, MD)*
- Pilot resumed in late-April 2021, with the expansion to include Los Angeles Fire Department; and LAC+USC as a receiving center.
- There are now four provider agencies and three ECMO capable centers.
- Santa Monica FD has begun utilizing the LUCAS device and is planning to join the ECMO pilot.

4.9 I-Gel® Pilot *(Nichole Bosson, MD)*
- On June 1, 2021, three provider agencies started this 4-month pilot (Pasadena FD, Torrance FD and Culver City FD).
- Los Angeles County FD will begin training one of their battalions next month.

4.10 PediDose *(Marianne Gausche-Hill, MD)*
- A National Institute of Health – funded project, based out of the Houston [Texas] EMS Agency, looking at standardized dosing, based on age, for children with seizures.

- Los Angeles County will be participating in a trial, possibly in 2022. Planning phases have begun, and the EMS Agency will be reaching out to all provider agencies.

5. UNFINISHED BUSINESS

There was no unfinished business.

6. NEW BUSINESS

6.1 Reference No. 503.2, Diversion Request – Quick Reference Guide *(Richard Tadeo)*

Policy reviewed and approved as written.

M/S/C (Van Slyke/Haller) Approved Reference No. 503.2 Diversion Request – Quick Reference Guide.

6.2 Reference No. 521, Stroke Patient Destination *(Richard Tadeo)*

Policy reviewed and approved as written.

M/S/C (Zabilski/Respecio) Approved Reference No. 521, Stroke Patient Destination.

6.3 Reference No. 1317.15, Medical Control Guideline: Drug Reference – Diphenhydramine *(Marianne Gausche-Hill, MD)*

Policy reviewed and presented as information only.

6.4 Reference No. 1345, Pain Management *(Marianne Gausche-Hill, MD)*

Policy reviewed and presented as information only.

7. OPEN DISCUSSION

7.1 PAAC Member Represented at Medical Advisory Committee
Committee unanimously agreed to have Sean Stokes (Area A Representative) represent the Committee at Medical Council. The alternate will be appointed at a later date.

7.2 Influenza Survey Monkey Deadline (Jennifer Calderone)
Providers were reminded to complete the Influenza Vaccination Reporting Survey that was sent out via email in April 2021. (Reminder email with survey link will be resent later today)

7.3 Future Face-to-Face Meetings (Commissioner Powell)
Commissioner asked if there was a timeline set regarding this meeting resuming in person. Richard Tadeo explained that the EMS Agency is looking into a possible hybrid model and a final decision is pending.

8. NEXT MEETING: August 18, 2021

9. ADJOURNMENT: Meeting adjourned at 2:02 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HOSPITAL)

SUBJECT: **GUIDELINES FOR HOSPITALS REQUESTING DIVERSION OF ALS/BLS PATIENTS**

REFERENCE NO. 503

PURPOSE: To outline the procedure for receiving hospitals and EMS providers to request diversion of advanced life support (ALS) and basic life support (BLS) patients.

AUTHORITY: Health & Safety Code, Division 2.5, Sections, 1797.220
California Code of Regulations, Title 13, Section 1105 (c)

DEFINITIONS:

Advanced Life Support Patient (ALS): A patient who requires paramedic assessment and/or intervention, including but not limited to patients meeting Base contact criteria outlined in Ref. No. 1200, Treatment Protocols, et al.

Basic Life Support Patient (BLS): A patient who **only** requires Emergency Medical Technician (EMT) assessment and/or intervention as listed in Ref. No. 802, Emergency Medical Technician (EMT) Scope of Practice.

PRINCIPLE:

1. A receiving hospital may request diversion of 9-1-1 ALS and/or BLS patients away from its emergency department (ED) when unable to care for additional patients due to inadequate staffing, equipment, and/or critical systems or infrastructure.

2. An EMS provider agency may request diversion of 9-1-1 ALS and/or BLS patient away from an ED that is unable to assume care of the patient due to prolonged ambulance patient offload time as outlined in Ref. No. 503.1

3. Base hospitals will honor diversion requests based on patient condition and available system resources.

4. Hospital diversion data are used in EMS system analysis, and to formulate critical early indicators of syndrome-specific illness outbreaks within the County.

POLICY:

I. In general, diversion requests shall be communicated through the ReddiNet system.

II. Each hospital shall maintain a current diversion policy which requires the decision to request diversion be made jointly by representatives of the hospital's administration, emergency department, specialty services, and nursing. The name and title of the authorizing hospital administrator or designee are required to complete the diversion request process.

III. EMS Agency staff may perform unannounced site visits to hospitals requesting diversion to ensure compliance with these guidelines.

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

PROCEDURE:

A. Receiving hospitals are responsible for maintaining and updating ReddiNet diversion status to ensure that accurate information is available for patient destination decisions. Telephone communication is necessary when the ReddiNet system is not operational or when a hospital is requesting diversion due to ED BLS or internal disaster. The Medical Alert Center (MAC) shall be notified via telephone at (866) 940-4401.

B. Diversion Request Categories

1. ED Saturation (ED ALS, ED BLS, Provider ED) – ED resources (beds, equipment and/or staff are fully committed or are not sufficient to care for additional incoming ALS and/or BLS patients. The procedure for requesting diversion due to ED saturation shall be in accordance with Ref. No. 503.1, Diversion Request Requirements for Emergency Department Saturation. ED BLS Diversion requires approval by the EMS Agency Administrator On-Duty (AOD) via the Medical Alert Center.

2. Computerized Tomography (CT) Scanner – Hospital is unable to provide essential diagnostic procedures due to lack of a functioning CT scanner.

3. Trauma (trauma centers and pediatric trauma centers only) – Hospital is unable to care for additional trauma patients because the trauma team is fully committed caring for trauma patients. The rationale for a temporary diversion request shall be communicated via the ReddiNet system using the applicable reason code. Reason codes include the following:

    a. Critical Equipment Unavailable: Diversion may be requested when critical equipment essential to definitive diagnosis or treatment of trauma patients is unavailable.

    b. Operating Room (OR) Unavailable: Diversion may be requested when both the primary and the back-up ORs and staff are fully encumbered caring for trauma patients to the extent that the care of additional trauma patients may be jeopardized.

    c. Trauma Team Encumbered: Diversion may be requested when trauma resources, including the trauma surgeon, are fully encumbered to the extent that the care of additional trauma patients may be jeopardized.

    d. Other: For any other circumstances in which the trauma center may become temporarily unable to meet contractual requirements, to the extent that the care of certain trauma patients may be jeopardized, the trauma center shall contact the EMS Agency to request a waiver in advance of the diversion. If a waiver is granted, the hospital and the MAC will jointly ensure that affected base hospitals and EMS provider agencies are properly advised of the nature and extent of the waiver.

4. Pediatric Medical Center (PMC) – Diversion may be requested only when critical equipment essential to definitive diagnosis or treatment of critical medical

pediatric patients is unavailable. Lack of available Pediatric Intensive Care Unit beds alone is not sufficient cause to request PMC diversion.

5. ST Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) – Diversion may be requested only when all cardiac catheterization laboratories (cath labs) are fully encumbered caring for STEMI patients, to the extent that the care of additional STEMI patients may be jeopardized. ED saturation is not sufficient cause to request SRC Diversion. The SRC may request diversion under any of the following conditions:

    a. The SRC is unable to perform emergent percutaneous coronary intervention because the cardiac cath staff is already fully committed to caring for STEMI patients in the cath lab. STEMI patients should be transported to the most accessible open SRC regardless of ED diversion status.

    b. The SRC experiences critical mechanical failure of essential cath lab equipment. SRCs must notify the EMS Agency SRC System Program Manager directly at (562) 378-1656 as to the nature of the mechanical failure or equipment issue if the anticipated diversion is expected to exceed 24 hours.

6. Stroke

    a. Primary Stroke Center (PSC): Diversion may be requested only when there is no means to perform diagnostic brain imaging – CT scan or MRI. The reason for diversion must be documented in ReddiNet. ED saturation is not sufficient cause to request PSC diversion.

    b. Comprehensive Stroke Center (CSC): Hospital is unable to care for additional stroke patients because the stroke team is fully committed caring for stroke patients. The rationale for a temporary diversion request shall be communicated via the ReddiNet system using the applicable reason code. Reason codes include the following:

        i. Critical Equipment Unavailable: Diversion may be requested when critical equipment essential to definitive diagnosis or treatment of stroke patients is unavailable.

        ii. Interventional Radiology (IR) Room Unavailable: Diversion may be requested when both the primary and back-up IRs and staff are fully encumbered caring for stroke patients to the extent that the care of additional stroke patients may be jeopardized.

        iii. Stroke Team Encumbered: Diversion may be requested when stroke resources, are fully encumbered to the extent that the car of additional stoke patients may be jeopardized.

7. Internal Disaster – Diversion of both ALS and BLS patients may be requested when a facility disruption threatens the ED or significant patient care services, to the extent that care of additional patients may be jeopardized.

a. A hospital requesting diversion due to internal disaster must notify the MAC by telephone and provide the name of the administrator authorizing the diversion and the rational for internal disaster. Appropriate rational include:

   i. Power outage impacting patient care, which cannot be sufficiently mitigated by emergency generators

   ii. Critical infrastructure or systems failure impacting patient care, which cannot be sufficiently mitigated by emergency back-up procedures

   iii. Fire

   iv. Bomb threat/explosion

   v. Flooding

   vi. Water disruption/contamination

   vii. Hazardous materials contamination of patient care areas

   viii. Other – Must be approved by the EMS Agency through the MAC or Health Facilities Inspection Division of the Department of Public Health. **Internal Disaster does not apply to work actions.**

b. For situations in which a hospital knows in advance that it will need to divert to internal disaster, hospital shall notify the EMS Agency in writing, well in advance of the scheduled diversion. It is the responsibility of the hospital to notify area base hospital(s) and all affected EMS provider agencies.

c. Upon request by the EMS Agency, a hospital shall submit an after-action report within 60 days of the incident when a hospital's diversion due to internal disaster is greater than four (4) hours.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 502, **Patient Destination**
Ref. No. 503.1, **Diversion Request Requirements for Emergency Department Saturation**
Ref. No. 503.2, **Diversion Request Quick Reference Guide**
Ref. No. 506, **Trauma Triage**
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 511, **Perinatal Patient Destination**
Ref. No. 512, **Burn Patient Destination**
Ref. No. 513, **ST Elevation MI Patient Destination**
Ref. No. 516, **Cardiac Arrest Patient Destination**

Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS/BLS Patients

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMSC Advisory Committees	Provider Agency Advisory Committee	4/21/2021	4/21/2021	
	Base Hospital Advisory Committee	4/14/2021	4/14/2021	Y
	Data Advisory Committee			
Other Committees / Resources	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Pediatric Advisory Committee			
	County Counsel			
	Other: HASC – EHS Committee	6/17/2021	6/17/2021	Y

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

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

Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS/BLS Patients

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Procedure B.1	BHAC 4/21/2021	Add "ED BLS Diversion requires approval by the EMS Agency Administrator On-Duty (AOD) via the Medical Alert Center"	Adopted
N/A	BHAC 4/21/2021	Develop a quick reference guide	Adopted

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

SUBJECT: **DIVERSION REQUEST REQUIREMENTS FOR EMERGENCY DEPARTMENT SATURATION** REFERENCE NO. 503.1

PURPOSE: To outline the minimum requirements for hospitals to be placed on diversion of advanced life support (ALS) and/or basic life support (BLS) patients due to emergency department (ED) saturation.

DEFINITIONS:

Advanced Life Support Patient (ALS): A patient who requires paramedic assessment and/or intervention, including but not limited to patients meeting Base contact criteria outline in Ref. No. 1200, Treatment Protocols, et al.

Ambulance patient offload time (APOT): Time interval between the arrival of an ambulance at the location outside the hospital ED where the patient will be unloaded from the ambulance and the time the patient is transferred to the ED gurney, bed, chair or other acceptable location and the emergency department assumes responsibility for care of the patient. The APOT Standard in Los Angeles County is an offload time within 30 minutes, 90% of the time. Currently, the data source for APOT is the EMS Providers' electronic patient care report completed by the transporting unit.

Basic Life Support Patient (BLS): A patient who **only** requires Emergency Medical Technician (EMT) assessment and/or intervention as listed in Ref. No. 802, Emergency Medical Technician (EMT) Scope of Practice.

Diversion: Hospital Diversion is a request by a hospital or an EMS provider agency to have ALS/BLS patients bypass a facility for a limited period of time and should be requested only when necessary. This is **not** an absolute **closure** (see Principle 7).

ED ALS Diversion Threshold: All ED treatment bays are full and 30% or greater of the ED has patients who fall into one or both categories below, including ED beds occupied by admitted patients but excluding fast track beds and waiting room patients.

(1) Resuscitative (unstable condition): the patient is hemodynamically unstable, requires an immediate airway or emergency medications. Other criteria: already intubated, apneic, pulseless, severe respiratory distress, acute mental status changes or unresponsive

(2) Immediate/Emergent (requires timely treatment): the patient has symptoms indicative of a potential threat to life and their condition is likely to change to "resuscitative" without aggressive intervention. Examples include but are not limited to the following: stable but active chest pain; stroke symptoms; abdominal pain in pregnancy or suspected pregnancy; suicidal or homicidal ideation; new onset confusion; lethargy or disorientation; severe pain

ED BLS Diversion: This is implemented on a case-by-case basis during periods of extreme surge of patients being transported via the 9-1-1 system (i.e. disease outbreak/

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

epidemic/pandemic) and requires the approval of the EMS Agency via the Medical Alert Center. The EMS Agency will evaluate the region to determine whether BLS Diversion is warranted.

EMS Provider Agency Diversion Threshold (Provider ED Diversion): Three ambulance crews (ALS and/or BLS) have each been waiting for over 30 minutes to transfer their patient to hospital equipment (gurney, wheelchair, chair, etc.).

Special considerations: Unusual circumstances that overwhelm ED resources and are documented by hospital administration.

PRINCIPLES:

1. High quality emergency medical services (EMS) is the result of prehospital care providers, emergency departments and hospitals working together as a team to care for ill and injured patients.

2. Prolonged diversion and APOT are not an emergency department problem alone; it is a hospital and EMS systemwide issue, both have negative impacts to the EMS providers' ability to respond to subsequent 9-1-1 calls which results in prolonged response times and may affect public safety and patient outcomes.

3. Each hospital shall have a diversion policy and a multidisciplinary team approach to ensure the ability of the facility to remain open and to flex to Surge Capacity, thereby preventing or minimizing time of hospital diversion and APOT.

4. As per EMTALA, the responsibility for patient care lies with the receiving facility once the patient being transported via ambulance arrives at the hospital property. Hospital staff shall make every effort to offload patients from ambulance gurneys as soon as possible.

5. Hospitals that have a consistently prolonged APOT should assign appropriate personnel to remain with patients while awaiting for an ER treatment bay in order to release EMS personnel back to the community.

6. Hospital personnel shall acknowledge and provide a visual assessment of patients arriving via ambulance within 10 minutes of arrival in the ED to determine whether the patient needs an ED treatment bay or can be sent to other areas of the emergency department.

7. In accordance with Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients, final authority for patient destination rests with the base hospital handling the call. Whether the diversion request will be honored depends on available system resources.

8. The State of California Emergency Medical Services Authority has adopted Standardized Methods for Data Collection and Reporting of APOT. The APOT Standard for Los Angeles County is 90% of all ambulance transports have an APOT of 30 minutes or less.

9. The accurate documentation by EMS providers of the time metrics for APOT is imperative to appropriately evaluate and monitor APOT.

POLICY:

I. Responsibilities Prior to reaching Hospital Diversion Threshold

A. ED Charge Nurse

1. Identifies that all ED treatment bays are occupied and patients are waiting for an open treatment bay.

2. Consults with all ED team members to determine if patient discharges or admissions can be expedited.

3. Ensures that all ED treatment bays are appropriately utilized.

4. Notifies the Laboratory and Radiology departments to expedite orders.

5. Notifies the Nursing Supervisor that the ED is near threshold.

B. Hospital Administration (CEO or administrative designee)

1. Consults with the ED physician and ED charge nurse.

2. Performs a walk-through of the ED and reviews options that can be utilized to prevent hospital diversion (CEO or administrative designee).

3. Assesses the ED for special considerations.

4. Activates the hospital's internal multidisciplinary surge plan.

5. Assesses the Medical/Surgical, Intensive Care and Telemetry units for available beds and possible discharges.

6. Expedites environmental services, ancillary services and patient admissions as necessary.

7. Approves diversion due to ED saturation via the ReddiNet when ED capacity reaches the defined diversion threshold.

8. Reassesses ED capacity during diversion with the goal of remaining open.

9. Monitors hospital diversion hours.

10. Includes diversion in the ED performance improvement process.

II. ED ALS Diversion

A. A hospital may request ED ALS Diversion via the ReddiNet for up to two hours at a time. At the end of the two hours of diversion, ReddiNet will automatically re-open the hospital to ALS 9-1-1 traffic. The hospital may request additional ED ALS diversion time in two-hour increments.

B. An EMS provider agency may request to put a hospital on ED ALS diversion (displayed on ReddiNet as Provider ED) when the EMS provider agency diversion threshold is met. Each EMS provider agency shall have a diversion

request policy that is consistent with the following guidelines:

1. EMS provider agency personnel who are waiting to offload and transfer care to hospital staff shall contact the EMS provider agency's on-duty supervisor and provide the following information:

    a. Units waiting to offload

    b. Time of arrival at hospital of the unit waiting the longest to offload

    c. Time of arrival at hospital of the unit waiting the shortest to offload

    d. Estimated time to offload, obtain from ED Charge Nurse

2. The EMS provider agency's on-duty supervisor shall:

    a. Physically visit the emergency department and verify the report provided by the transport crew(s).

    b. Collaborate with the charge nurse, on-duty physician, or house supervisor to identify alternatives to facilitate the transfer of the patients from EMS personnel to emergency department staff.

    c. If the EMS provider agency diversion threshold is met, contact the Medical Alert Center and request the facility to be placed on Provider ED ALS Diversion.

3. The Medical Alert Center shall:

    a. Obtain all the necessary information to verify diversion threshold is met.

    b. Place the hospital on Provider ED ALS diversion. Diversion will be for a two-hour period. At the end of the two-hour diversion, ReddiNet will automatically re-open the hospital to ALS 9-1-1 traffic. EMS providers may request additional ED ALS diversion time in two-hour increments.

    c. Notify hospital administration or designee that the hospital has been placed on Provider ED ALS diversion.

4. Hospital Administration (CEO or administrative designee)

    a. Reassess ED capacity during diversion with the goal of lifting the diversion status.

    b. Monitors diversion hours

    c. Includes diversion in the ED performance improvement process.

C. ED BLS Diversion

1. A hospital or an EMS provider agency may request to place a hospital on

ED BLS diversion by contacting the Medical Alert Center. ED BLS diversion requests will be considered for approval when the BLS Diversion Threshold is met and status of system resources.

2. ED BLS diversion will be approved for a four (4) hour period. At the end of the four-hour diversion, ReddiNet will automatically re-open the hospital to BLS 9-1-1 traffic. The hospital may request additional ED BLS diversion time by contacting the Medical Alert Center.

III. Diversion Audits

The EMS Agency reserves the right to conduct unannounced diversion audits as indicated.

IV. APOT

A. Hospitals have the responsibility to ensure policies and processes are in place that facilitates the rapid and appropriate transfer of patient care from EMS personnel within 30 minutes of arrival at the ED.

B. The EMS Agency will routinely analyze and report APOT data. Hospitals that do not meet the APOT Standard will be notified and may be requested to develop a corrective action plan.

C. After an evaluation of a hospital's status and regional/system resources, the EMS Agency may place a hospital on Specialty Care Center Diversion (e.g., Trauma, STEMI, Stroke) in addition to ED ALS and/or ED BLS Diversion in instances wherein the APOT is estimated to exceed 2 hours.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Patients**
Ref. No. 503.2, **Diversion Request Quick Reference Guide**
California EMSA: Ambulance Patient Offload Time (APOT) Standardized Methods for Data Collection and Reporting

Reference No. 503.1, Diversion Request Requirements for ED Saturation

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMSC Advisory Committees	Provider Agency Advisory Committee	4/21/2021	4/21/2021	
	Base Hospital Advisory Committee	4/14/2021	4/14/2021	Y
	Data Advisory Committee			
Other Committees / Resources	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Pediatric Advisory Committee			
	County Counsel			
	Other: HASC – EHS Committee	6/17/2021	6/17/2021	Y

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

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

REFERENCE NO. 503.1, Diversion Request Requirements for ED Saturation

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Definition: APOT	BHAC 4/14/21	Add the statement "The data source for APOT is the EMS Providers' electronic patient care report completed by the transporting unit."	Adopted
Definition: APOT	HASC – EHS Committee 6/17/21	Add "Currently" before the statement "The data source for APOT is the EMS Providers' electronic patient care report completed by the transporting unit."	Adopted
Policy IV.C.	BHAC 4/14/21	Add "After an evaluation of the hospital's status and regional/system resources" to the beginning of this policy section.	Adopted

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **DIVERSION REQUEST**
QUICK REFERENCE GUIDE

REFERENCE NO. 503.2

TYPE OF DIVERSION	REQUEST VIA / DURATION	RATIONALE
ED Saturation – ED ALS	Request via ReddiNet. Diversion will be for 2 hours. ReddiNet will automatically re-open hospital at the end of 2 hours	All ED treatment bays are full and 30% or greater of ED has patients are either in Resuscitative or Immediate/Emergent conditions.
ED Saturation – ED BLS	Hospital must contact the Medical Alert Center via telephone. Diversion will be for 4 hours. ReddiNet will automatically re-open hospital at the end of 4 hours.	Implemented on a case-by-case basis during periods of extreme surge of patients (i.e., disease outbreak/ epidemic/pandemic). Hospital must have at least 3 ambulance crews (ALS/BLS) waiting for over ***60 minutes*** to transfer patient to hospital equipment.
ED Saturation – Provider ED	EMS Provider must contact the Medical Alert Center. Diversion will be for 2 hours. ReddiNet will automatically re-open hospital at the end of 2 hours.	Hospital must have at least 3 ambulance crews (ALS/BLS) waiting for over ***30 minutes*** to transfer patient to hospital equipment.
Computerized Tomography (CT) Scanner	Request via ReddiNet, duration will be based on the resolution of inability to perform CT scans.	Unable to provide essential diagnostic procedures due to lack of a functioning CT scanner.
Trauma	Request via ReddiNet, duration will be based on the resolution of the rational for diversion.	Unavailable Critical Equipment or Operating Room, or Trauma Team Encumbered
Pediatric Medical Center (PMC)	Request via ReddiNet, duration will be based on the resolution of the rational for diversion.	Unavailable critical equipment that is essential to definitive diagnosis or treatment of medical pediatric patients. *Lack of available PICU beds alone is not sufficient cause to request PMC Diversion.*
ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC)	Request via ReddiNet, Diversion will be for 3 hours. ReddiNet will automatically re-open hospital at the end of 3 hours	Cardiac Catheterization laboratories (cath labs) are fully encumbered caring for STEMI patient or mechanical failure of critical cath lab equipment.
	Hospital must notify the EMS Agency SRC System Program Manager for mechanical failure/equipment issue that is expected to exceed 24 hours.	

TYPE OF DIVERSION	REQUEST VIA / DURATION	RATIONALE
Primary Stroke Center (PSC)	Requested via ReddiNet, duration will be based on resolution of the rational for diversion.	Unable to perform diagnostic brain imaging (CT scan or MRI).
Comprehensive Stroke Center (CSC)	Requested via ReddiNet, duration will be based on resolution of the rational for diversion.	Unavailable Critical Equipment or Interventional Radiological (IR) Room, or Stroke Team Encumbered
Internal Disaster	Hospital must notify the Medical Alert Center via telephone, duration will be based on resolution of the rational for internal disaster.	Power Outage Critical infrastructure or system failure impacting patient care Fire Bomb threat/explosion Flooding Water disruption/contamination HAZMAT in patient care areas *Internal Disaster does not apply to work actions.*

Reference No. 503.2, Diversion Request Quick Reference Guide

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMSC Advisory Committees	Provider Agency Advisory Committee	4/21/2021	4/21/2021	
	Base Hospital Advisory Committee	4/14/2021	4/14/2021	
	Data Advisory Committee			
Other Committees / Resources	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Pediatric Advisory Committee			
	County Counsel			
	Other: HASC – EHS Committee	6/17/2021	6/17/2021	

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **STROKE PATIENT DESTINATION** REFERENCE NO. 521

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

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

DEFINITIONS:

Primary Stroke Center (PSC): A 9-1-1 receiving hospital that has met the standards of a Center for Medicaid & Medicare Services (CMS) approved accreditation body as a Primary Stroke Center and has been approved as a Stroke Center by the Los Angeles (LA) County Emergency Medical Services (EMS) Agency.

Comprehensive Stroke Center (CSC): A 9-1-1 receiving hospital that has met the standards of a CMS approved accreditation body as a Comprehensive or Thrombectomy Capable Stroke Center and has been approved as a Comprehensive Stroke Center by the LA County EMS Agency. CSCs have subspecialty neurology and neurointerventional physicians available 24 hours a day and 7 days a week who can perform clot-removing procedures (i.e., thrombectomy).

Last Known Well Time: The **time** (military time) at which the patient was **last known** to be without the signs and symptoms of the current stroke or at his or her prior baseline.

Local Neurological Signs: Signs and symptoms that may indicate a dysfunction in the nervous system such as a stroke or mass lesion. These signs include: speech and language disturbances, altered level of consciousness, unilateral weakness, unilateral numbness, new onset seizures, dizziness, and visual disturbances.

Modified Los Angeles Prehospital Stroke Screen (mLAPSS): A screening tool utilized by prehospital care providers to assist in identifying patients who may be having a stroke.

Los Angeles Motor Score (LAMS): A scoring tool utilized by prehospital care providers to determine the severity of stroke on patients with suspected stroke. A large vessel involvement is suspected if the total LAMS score from the three categories is 4 or greater.

PRINCIPLES:

1. Patients experiencing a stroke should be transported to the most accessible facility appropriate to their needs. This determination will be made by the base hospital physician or Mobile Intensive Care Nurse after consideration of the guidelines established in this policy. Final authority for patient destination rests with the base hospital.

2. Basic Life Support units shall call an Advanced Life Support unit for suspected stroke patients.

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

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

4. Service area rules and/or considerations do not apply to suspected stroke patients.

5. Patients with a history of previous stroke with new or worsening deficits should be routed to the Stroke Center according to this policy.

POLICY:

I. Responsibility of the Provider Agency

A. Perform mLAPSS on all patients exhibiting neurological signs. The mLAPSS is positive if all of the following criteria are met:

1. No history of seizures or epilepsy

2. Age 40 years or older

3. At baseline, patient is not wheelchair bound or bedridden

4. Blood glucose between 60 and 400 mg/dL

5. Obvious asymmetry-unilateral weakness with any of the following motor exams:
   a. Facial Smile/Grimace
   b. Grip
   c. Arm Strength

B. Perform LAMS on ALL patients with suspected stroke

1. Facial droop — Total Possible Score = 1
   a. Absent = 0
   b. Present = 1

2. Arm drift — Total Possible Score = 2
   a. Absent = 0
   b. Drifts down = 1
   c. Falls rapidly = 2

3. Grip strength — Total Possible Score = 2
   a. Normal = 0
   b. Weak grip = 1
   c. No grip = 2

C. Transport the patient to the most appropriate stroke center in accordance with base hospital direction or section III of this policy.

D. Document the results of mLAPSS, LAMS, and last known well date and time in the designated areas on the Patient Care Record.

E. In order to ensure that proper consent for treatment can be obtained by hospital personnel, if possible, verbally report to the Base hospital and document the name and contact information of the family member, caregiver, or witness who can help verify the patient's last known well time in the Comments area of the Patient Care Record. When practical, transport the witness with the patient.

II. Responsibility of the Base Hospital

A. Provide medical direction and destination for all patients who meet mLAPSS criteria or have symptoms strongly suggestive of a stroke.

B. Determine patient destination based on stroke center status via the ReddiNet® system and section IV of this policy.

C. Notify the receiving stroke center if the base hospital is not the patient's destination.

D. Document the results of mLAPSS, LAMS, and last known well date and time in the designated areas on the Base Hospital Form.

E. Prompt prehospital care personnel to obtain and document witness contact information on the Patient Care Record.

III. Destination of Stroke Patients

All patients who have a positive mLAPSS and LKWT within 24 hours shall be transported to a LA County EMS Agency designated stroke center as follows:

A. Transport to the closest stroke center:

Patients with suspected acute onset stroke symptoms and a LAMS of 3 or less.

B. Transport to the CSC:

Patients with suspected acute onset stroke symptoms and a LAMS of 4 or greater, if transport time is less than 30 minutes. If transport time to the CSC is greater than 30 minutes, the patient shall be transported to the most accessible PSC.

C. Destination for patients with a positive mLAPSS whose LKWT is greater than 24 hours will be determined by the base hospital (i.e., consider stroke center destination if patient may benefit from stroke evaluation and management).

D. If there are no stroke centers (PSC or CSC) that are accessible by transport within the maximum allowable time of 30 minutes, the patient shall be transported to the most accessible receiving facility.

E. Ground transport is the preferred method of transport. Considerations for **dispatching** air ambulance transport shall include, but not limited to, the following:

1. Geographic isolation of incident location (e.g, Antelope Valley, Malibu,

Gorman, Catalina Island)
2. Immediate availability of air ambulance
3. Accessibility of a fully licensed and permitted helipad at the stroke center
4. Transport capability from helipad to the emergency department of the stroke center

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 322, **Stroke Receiving Center Standards**
Ref. No. 501, **Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No. 1200, **Treatment Protocols**
Ref. No. 1251, **Stroke/Acute Neurological Deficits**

Reference No. 521, Stroke Patient Destination

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMSC Advisory Committees	Provider Agency Advisory Committee	4/21/2021	4/21/2021	
	Base Hospital Advisory Committee	4/14/2021	4/14/2021	Y
	Data Advisory Committee			
Other Committees / Resources	Medical Council	6/8/21	6/8/21	
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Pediatric Advisory Committee			
	County Counsel			
	Other: Stroke Data Collaborative Committee	6/21/21	6/21/21	Y

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

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

Reference No. 521, Stroke Patient Destination

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy I.B.	BHAC 6/8/2021	Replace "If mLAPSS is positive and/or stroke is suspected despite negative mLAPSS, calculate…" with "Perform LAMS on ALL patients with suspected stroke."	Adopted
Policy I.B. Note	BHAC 6/8/2021	Delete "Note"	Adopted
Policy III.C.	Stroke Data Collaborative	Replace "rehabilitation" with "management"	Adopted

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **HONORING PREHOSPITAL DO NOT RESUSCITATE ORDERS, PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT AND END OF LIFE OPTION (AID-IN-DYING DRUG)**

REFERENCE NO. 815

PURPOSE: To allow EMS personnel to honor valid Do Not Resuscitate (DNR) orders or Physician Orders for Life-Sustaining Treatment (POLST) and other patient designated end-of-life directives in the field and act in accordance with the patient's wishes when death appears imminent.

AUTHORITY: California Health and Safety Code, Division 1, Part 1.8, Section 442 – 443
California Health and Safety Code, Division 2.5, Section 1797.220 and 1798
California Probate Code, Division 4.7 (Health Care Decisions Law)

DEFINITIONS:

Advance Health Care Directive (AHCD): A written document that allows an individual to provide healthcare instructions and/or appoint an agent to make healthcare decisions when unable or prefer to have someone speak for them. AHCD is the legal format for healthcare proxy or durable power of attorney for healthcare and living will.

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

Basic Life Support (BLS) measures: The provision of treatment designed to maintain adequate circulation and ventilation for a patient in cardiac arrest without the use of drugs or special equipment. Examples include:

- Assisted ventilation via a bag-mask device
- Manual or automated chest compressions
- Automated External Defibrillator (AED) – only if an EMT is on scene prior to the arrival of paramedics

Comfort measures: Medical interventions used to provide and promote patient comfort. Comfort measures applicable to the End of Life Option Act may include airway positioning and suctioning.

Do Not Resuscitate (DNR): DNR is a request to withhold interventions intended to restore cardiac activity and respirations. For example:

- no chest compressions
- no defibrillation
- no endotracheal intubation

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

- no assisted ventilation
- no vasoactive drugs

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

Physician Orders for Life Sustaining Treatment (POLST): A signed, designated physician order form that addresses a patient’s wishes about a specific set of medical issues related to end-of-life care. May be used for both adult and pediatric patients.

Resuscitation: Interventions intended to restore cardiac activity and respirations, for example:

- cardiopulmonary resuscitation
- defibrillation
- drug therapy
- other life saving measures

Standardized Patient-Designated Directives: Forms or medallion that recognizes and accommodates a patient’s wish to limit prehospital treatment at home, in long term care facilities or during transport between facilities. Examples include:

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

Supportive Measures: Medical interventions used to provide and promote patient comfort, safety, and dignity. Supportive measures applicable for POLST and AHCD may include but are not limited to:

- Airway maneuvers, including removal of foreign body
- Suctioning
- Oxygen administration
- Hemorrhage control
- Oral hydration
- Glucose administration
- Pain control (i.e., morphine)

Valid DNR Order for Patients in a Licensed Health Care Facility:

- A written document in the medical record with the patient's name and the statement “Do Not Resuscitate”, “No Code”, or "No CPR” that is signed and dated by a physician, or
- A verbal order to withhold resuscitation given by the patient’s physician who is physically present at the scene and immediately confirms the DNR order in writing in the patient’s medical record, or
- POLST with DNR checked, or
- AHCD when the instructions state resuscitation should be withheld/discontinued

Valid DNR Order for Patients at a Location Other Than a Licensed Facility:

- EMSA/CMA Prehospital Do Not Resuscitate Form, fully executed, or
- DNR medallion, or
- POLST with DNR checked, or
- AHCD when the instructions state resuscitation should be withheld/discontinued

PRINCIPLES:

1. The right of patients to refuse unwanted medical intervention is supported by California statute.

2. Withhold or discontinue patient resuscitation if a valid AHCD or standardized patient-designated directive is provided.

3. If the patient's personal physician will sign the death certificate, invasive equipment (i.e., intravenous line, endotracheal tube) used on the patient may be removed.

4. Patients are encouraged to utilize one of the standardized patient-designated directives to ensure that end-of-life wishes are easily recognizable. If the patient is in a private home, the DNR or POLST should be readily accessible or clearly posted.

5. Photocopies of all the patient-designated directives are acceptable.

6. After a good faith attempt to identify the patient, EMS personnel should presume that the identity is correct.

7. A competent person may revoke their patient-designated directive at any time.

8. An adult individual, eighteen years or older, who has the capacity to make medical decisions and has a terminal illness may receive a prescription for an aid-in-dying drug and self-administer the aid-in-dying drug in order to end his or her life in a humane and dignified manner.

9. A health care provider, including EMS personnel, shall not be subject to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating in good faith compliance with the End of Life Option Act.

POLICY:

I. General Procedures for EMS Personnel for Patients with a DNR, POLST or AHCD

   A. Confirm the patient is the person named in the patient-designated directive. This will normally require either the presence of a form of identification or a witness who can reliably identify the patient.

   B. Initiate BLS measures immediately on patients in cardiopulmonary arrest pending verification of a valid patient-designated directive or the criteria for discontinuing resuscitative measures outlined in Ref. No. 814, Determination/ Pronouncement of Death in the Field, Policy I, C, have been met.

C. Begin resuscitation immediately and contact the base hospital for further direction if family members/caretakers disagree or object to withholding resuscitation, or if EMS personnel have any reservations regarding the validity of the DNR directive.

D. Transport to the facility designated by the physician or family members if the patient‘s condition deteriorates during transport and they have a valid DNR. This includes 9-1-1 and non-9-1-1 transports.

E. For DNR Patients who have been discharged from hospital to home or skilled nursing facility and expire (cessation of respirations and no palpable pulses) during transport:

1. Do not initiate any resuscitation efforts.
2. Notify discharging hospital.
3. Transport back to discharging hospital.

F. Documentation of a DNR incident shall include, but is not limited to, the following:

1. Check the “DNR” box on the EMS Report Form.

2. Describe the care given. Print the base hospital physician’s name, if consulted, and the date of the DNR directive.

3. Note the removal of any invasive equipment.

4. Document DNR orders written in the medical record of a licensed facility, including, the date signed, physician name, and other appropriate information or provide a copy of the DNR with the EMS Report Form.

5. Provide a copy of the AHCD and/or other patient-designated directive with the EMS Report Form, when possible.

II. Directive-Specific Procedures

A. AHCD

1. A valid AHCD must be:

a. Completed by a competent person age 18 or older
b. Signed, dated, and include the patient’s name
c. Signed by two witnesses or a notary public
d. Signed by a patient advocate or ombudsman if the patient is in a skilled nursing facility

2. If the situation allows, EMS personnel should make a good faith effort to review the AHCD and/or consult with the patient advocate.

3. Base contact is required for any AHCD instructions other than withholding

resuscitation.

4. If the agent or attorney-in-fact is present, they should accompany the patient to the receiving facility.

B. State EMS Authority-Approved DNR Medallion

1. A medallion or bracelet attached to the patient is considered the most accurate form of identification for anyone not in a licensed facility.

2. Medallions are issued only after a copy of the DNR or POLST is received from an applicant. There are three (3) medallion providers approved in California; contact information:

a. Medic Alert Foundation
2323 Colorado Avenue
Turlock, CA 95382
Phone: 24-hour Toll Free Number (888) 633.4298
Toll Free FAX: (800) 863-3429
www.medicalert.org

b. Caring Advocates
2730 Argonauta Street
Carlsbad, CA 92009
Phone: 1-800-647-3223
www.caringadvocates.org

c. StickyJ Medical ID
10801 Endeavour Way #B
Seminole, FL 33777
Phone: 1-866-497-6265
www.stickyj.com

3. If the medallion is engraved “DNR”, treat in accordance with Ref. No. 815.1, Prehospital Do Not Resuscitate Form.

4. If the medallion is engraved “DNR/POLST” and the POLST is available, treat as indicated on the POLST.

5. If the medallion is engraved “DNR/POLST” and the POLST is **not available**, treat in accordance with the DNR until the valid POLST is produced.

3. Physician Orders for Life Sustaining Treatment (POLST)

1. The POLST must be signed and dated by the physician, and the patient or the legally recognized decision maker. No witness to the signatures is necessary.

2. The POLST is designed to supplement, not replace an existing AHCD. If the POLST conflicts with the patient's other health care instructions or advance directive, then the most recent order or instruction governs.

3. In general, EMS personnel should see the written POLST unless the patient's physician is present and issues a DNR order.

4. There are different levels of care in Sections A and B of the POLST. Medical interventions should be initiated, consistent with the provider's scope of practice and POLST instructions.

5. For patients who have a POLST requesting only comfort-focused care, EMS providers shall first attempt to meet the patient's comfort needs on scene by implementing supportive measures. Patients should not be transported unless their comfort needs cannot be met on scene and transport is in accordance with their wishes.

6. Contact the base hospital for direction in the event of any unusual circumstance.

III. End of Life Option Act

A patient who has obtained an aid-in-dying drug has met extensive and stringent requirements as required by California law. The law offers protections and exemptions for healthcare providers but is not explicit about EMS response for End of Life Option Act patients. The following guidelines are provided for EMS personnel when responding to a patient who has self-administered an aid-in-dying drug.

A. Within 48 hours prior to self-administering the aid-in-dying drug, the patient is required to complete a "Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner". However, there is no mandate for the patient to maintain the final attestation in close proximity of the patient. If a copy of the final attestation is available, EMS personnel should confirm the patient is the person named in the final attestation. This will normally require either the presence of a form of identification or a witness who can reliably identify the patient.

B. There are no standardized "Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner" forms but the law has required specific information that must be in the final attestation (see sample Ref. No. 815.3). If available, EMS personnel should make a good faith effort to review and verify that the final attestation contains the following information:

1. The document is identified as a "Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner"

2. Patient's name, signature, and dated

C. Provide comfort measures (airway positioning, suctioning) and/or

airway/ventilation measures when applicable.

D. Withhold resuscitative measures if patient is in cardiopulmonary arrest. If a POLST or AHCD is present, follow the directive as appropriate for the clinical situation.

E. The patient may at any time withdraw or rescind his or her request for an aid-in-dying drug regardless of the patient's mental state. In this instance, EMS personnel shall provide medical care based on the discussion with the patient and as per standard protocols. EMS personnel are encouraged to consult with their base hospital in these situations.

F. Family members may be at the scene of a patient who has self-administered an aid-in-dying drug. If there is objection to the End of Life Option Act, inform the family that comfort measures will be provided and consider Base Hospital contact for further direction.

G. Obtain a copy of the final attestation and attach it with the EMS Report Form, when possible.

CROSS REFERENCE:

Prehospital Care Manual

Ref. No. 502, **Patient Destination**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 814, **Determination/Pronouncement of Death in the Field**
Ref. No. 815.1, **EMSA/CMA Prehospital Do Not Resuscitate (DNR) Form**
Ref. No. 815.2, **Physician Orders for Life-Sustaining Treatment (POLST) Form**
Ref. No. 815.3, **Sample - Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner**
Ref. No. 815.4, **End of Life Option Field Quick Reference Guide**

Emergency Medical Services Authority #311: Do Not Resuscitate (DNR) and Other Patient-Designated Directives. EMS Personnel Guideline Limiting Prehospital Care, 6th Revision, October 2018

Reference No. 815, DNR, POLST, Aid-in-Dying Drug

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	2/17/2021	4/21/2021	N
	Base Hospital Advisory Committee	2/10/2021	4/14/2021	N
	Data Advisory Committee			
	Education Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council	6/8/2021	6/8/2021	N
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Pediatric Advisory Committee	6/8/2021	6/8/2021	N
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC/MICN)

SUBJECT: **PHYSICIAN AT THE SCENE** REFERENCE NO. 816

PURPOSE: To establish guidelines for interaction between paramedics and a patient's personal physician, or physicians at the scene of a medical emergency who may not be the patient's personal physician. The guidelines set forth in this policy are intended for physicians at the scene who are not responding as a Provider Agency Medical Director.

AUTHORITY: California Health and Safety Code, Section 1798.6(a) provides that "authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional at the scene of an emergency who is most medically qualified specific to the provision of rendering emergency medical care".

DEFINITIONS:

Approved EMS Physician: Includes the Medical Directors of the EMS Agency, Provider Agency Medical Directors, Medical Directors of an approved Los Angeles based Paramedic Training School, Base Hospital Medical Director or EMS Fellow in a Los Angeles based fellowship program as approved by the Medical Director of the EMS Agency.

Base Hospital Medical Director: A physician who is providing oversight for prehospital operations at a Base Hospital who meets the criteria outlined in Reference No. 308.

EMS Fellow: A physician who is participating in an accredited postgraduate sub-specialty training program (i.e., EMS/Disaster/Research) following successful completion of a residency program in emergency medicine or fellowship in pediatric emergency medicine.

Provider Agency Medical Director: A physician designated by an approved EMS Provider Agency to advise and coordinate the medical aspects of field care who meets the criteria outlined in Reference No. 411.

Physician at the Scene: A licensed physician who is not otherwise designated as an Approved EMS Physician

PRINCIPLES:

1. Although the law does not preclude a physician at the scene of a medical emergency from rendering patient care, it does prohibit them from directing paramedic personnel in advanced life support procedures. Such direction must come from the base hospital unless direct voice communication with the base hospital cannot be established or maintained. Approved EMS Physicians may direct paramedics in advanced life support procedures at the scene of a medical emergency.

2. Instructions by a private physician who is not on scene are subject to approval by the base hospital physician or Mobile Intensive Care Nurse (MICN) who is in direct voice contact with the paramedic.

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

3. An Approved EMS Physician may direct EMS personnel in lieu of base hospital contact.

POLICY:

I. Physician Identification

A. Paramedics shall obtain proper identification, consisting of a California Physicians and Surgeons License, and note the physician's name, license number, and license expiration date on the EMS Report Form.

B. When a physician on scene does not have identification or is in phone contact only, base hospital contact should be made to determine the extent of permissible interaction between the paramedics and the physician.

II. Patient Care

A. Paramedics shall contact the base hospital and notify them of the presence of the physician on scene. If base hospital contact cannot be established immediately, it shall be made as soon as possible and a full report rendered.

B. When communication cannot be established or maintained, paramedics may assist the physician and may provide advanced life support under the direction of the physician provided that their instructions are consistent with local EMS Agency policies and procedures.

C. If either the paramedics or the base hospital physician perceive any problem(s) with the instructions of the patient's personal physician or physician on scene, the base hospital physician or MICN should speak directly with this physician to clarify or resolve the issue. If this direct contact is not possible, paramedics should follow the direction of the base hospital so that patient care is not delayed or compromised.

D. When the physician on scene chooses to assume or retain responsibility for medical care, paramedics shall instruct the physician that they must take total responsibility for the care given. They must also accompany the patient until the patient arrives at a hospital and responsibility is assumed by the receiving physician <u>unless</u> relieved of the responsibility by the base hospital.

E. An Approved EMS Physician may direct clinical care at the scene independent of the Base Hospital. However, communication that medical care was directed by an Approved EMS Physician shall be documented on the EMS patient care record and communicated to the receiving hospital.

III. Patient Destination

A. Except when the physician on scene has accepted responsibility for patient care, patient destination shall be determined by the base hospital in accordance with EMS Agency policies.

B. When the physician at the scene has accepted full responsibility for patient care, the patient may be transported to a general acute care hospital with a licensed basic emergency department chosen by the physician at the scene.

C. If the paramedic provider agency determines that such transport would unreasonably remove the transport unit from the area, an alternate destination shall be agreed upon between the physician at the scene and the base hospital physician.

D. If the patient's condition permits, alternate transportation may be arranged.

E. If the patient's condition requires immediate transport, the decision of the base hospital physician or MICN shall be followed.

F. An Approved EMS Physician may direct patient disposition based on all Los Angeles County EMS Agency policies.

CROSS REFERENCE:

Prehospital Care Manual
Reference No. 308, **Base Hospital Medical Director**
Reference No. 411, **Provider Agency Medical Director**
Reference No. 502, **Patient Destination**
Reference No. 514, **Prehospital EMS Aircraft Operations**
Reference No. 803, **Los Angeles County Paramedic Scope of Practice**

Reference No. 816, Physician at the Scene

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	4/21/2021	4/21/2021	N
	Base Hospital Advisory Committee	4/14/2021	4/14/2021	N
	Data Advisory Committee			
	Education Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council	6/8/2021	6/8/2021	N
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Pediatric Advisory Committee	6/8/2021	6/8/2021	N
	County Counsel			
	Other:			

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

Health Services
LOS ANGELES COUNTY

May 26, 2021

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

FROM: Christina R. Ghaly, M.D.
Director, Department of Health Services

Jonathan E. Sherin, M.D., Ph.D.
Director, Department of Mental Health

SUBJECT: **EXPANDING THE ALTERNATE DESTINATION PROGRAM (ITEM NO. 21, AGENDA OF NOVEMBER 24, 2020)**

On November 24, 2020, the Board of Supervisors (Board) directed the Department of Health Services' (DHS) Emergency Medical Services (EMS) Agency to work with the Director of the Department of Mental Health (DMH) to report back to the Board in 180 days with the progress made on the Alternate Destination Program (ADP) and stated directives mentioned below:

1. Ensure that all Mental Health Urgent Care Center's (MHUCC) are appropriately approved, as receiving sites for the ADP;

2. Direct DMH, in collaboration with the Alternative Crisis Response Steering Committee, to continue to work on expansion of MHUCC, working closely with the EMS Agency to ensure all possible service areas can be connected; and

3. Direct the EMS Agency to reach out to all independent Fire Districts to invite them to participate in the ADP and educate on the process and training requirements.

In 2018, the EMS Agency began developing policies and procedures to allow emergency medical service providers (fire department and ambulance companies) to triage and transport patients with behavioral and/or psychiatric complaints to designated Psychiatric Urgent Care Centers (PUCC) and patients who have no medical complaint, but are intoxicated, to a designated Sobering Center (SC).

[1] The terms MHUCC and PUCC are used interchangeably.

In parallel, standards were also developed to outline the designation requirements for PUCC and SCs to receive patients transported via the 9-1-1 system. As of 2020, all of the required policies and procedures have been approved.

Receiving Sites for ADP
In early 2019, the EMS Agency began designating PUCCs and approving EMS providers, who meet criteria, to transport patients these facilities. The EMS Agency has approved one (1) SC located in downtown Los Angeles (LA) and the following six (6) PUCCs (Attachments):

Exodus Harbor-UCLA PUCC
1000 Carson St.
Torrance, California

Exodus MLK PUCC
12021 Wilmington Ave.
Los Angeles, California

Exodus Eastside PUCC
1920 Marengo St.
Los Angeles, California

David L. Murphy Sobering Center
640 Maple St.
Los Angeles, California

Star View Behavioral Health PUCC
3210 Long Beach Blvd.
Long Beach, California

Star View Behavioral Health PUCC
18501 Gale Avenue
City of Industry, California

Future designations include a third, Star View Behavioral Health PUCC, expected to open in the Lancaster/Palmdale area this year and a SC expected to open at the Mark Ridley-Thomas Behavioral Health Center Restorative Care Village, by the end of the calendar year 2021.

Alternate Crisis Response Steering Committee and MHUCC Expansion
In 2020, the Board directed DMH to create the Alternative Crisis Response Steering Committee, which is composed of various health, fire, law enforcement, legal, and social services agencies who are driving the development, expansion, coordination, and update of the health and human services crisis response system throughout LA County.

To date, three subcommittees have been formed: 1) the crisis call center network; 2) crisis mobile response teams; and 3) crisis stabilization and receiving facilities. To support MHU CC expansion efforts and ensure all possible service areas can be connected, Crisis Receiving Center subcommittee goals include standardizing procedures across the network consistent with Substance Abuse and Mental Health Services Administration's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. This work dovetails with that of the EMS Agency and the Community Paramedicine and Alternate Transportation motion.

Countywide implementation of standardized Behavioral/Psychiatric and Intoxicated Patient Destination policies is an area of opportunity, as is access to the very few numbers of PUCCs and SCs. The Alternative Crisis Response Steering Committee and EMS Agency anticipate greater participation as more PUCCs and SCs are developed (in addition to other stabilizing facilities such as crisis residential programs and peer respite).

ADP: Education and Training

The EMS Agency has approved certain paramedic squads of the LA City Fire Department to assess the patients and, if appropriate, transport to these designated SC and PUCCs. The Santa Monica Fire Department has requested approval to participate in the ADP and is in the process of meeting the education requirements for its personnel. The LA County Fire District is participating in this program through a pilot Telemedicine program and has begun to develop the training program for paramedics to participate in the ADP later this year.

The EMS Agency has informed all the fire departments in LA County of the program and has encouraged participation. Some LA City Fire Departments have also developed a process with their law enforcement to provide the transportation to the PUCC.

For DHS-related questions, you may contact me or your staff may contact Cathy Chidester, Director, EMS Agency, by email at CChidester@dhs.lacounty.gov. For DMH-related questions, you may contact Dr. Jonathan Sherin or your staff may contact Amanda Ruiz, Supervising Psychiatrist, by email at amaruiz@dmh.lacounty.gov.

CRG:JES:cc:jt

Attachments

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

STATEMENT OF PROCEEDINGS FOR THE

REGULAR MEETING OF THE BOARD OF SUPERVISORS

OF THE COUNTY OF LOS ANGELES HELD VIRTUALLY IN

ROOM 381B OF THE KENNETH HAHN HALL OF ADMINISTRATION

500 WEST TEMPLE STREET, LOS ANGELES, CALIFORNIA 90012

Tuesday, November 24, 2020

9:30 AM

21. Expanding the Alternate Destination Program

Recommendation as submitted by Supervisor Hahn: Instruct the Director of the Emergency Medical Services (EMS) Agency within the Department of Health Services to work with the Director of Mental Health to ensure that all Mental Health Urgent Care Centers (MHUCCs) are appropriately approved as receiving sites for our alternate destination program; instruct the Director of Mental Health, in collaboration with the Alternative Crisis Response Steering Committee, to continue to work on expansion of MHUCC, working closely with the EMS Agency to ensure all possible service areas can be connected; instruct the Director of the Emergency Medical Services Agency to reach out to all independent Fire Districts to invite them to participate in this program and educate them on the process and training requirements; and instruct the Director of Health Services, in collaboration with the Director of Mental Health, to report back to the Board in 180 days with the progress made on this program and the above directives. (20-6364)

Interested person(s) submitted written testimony.

Daryl Osby, Fire Chief, addressed the Board.

After discussion, on motion of Supervisor Hahn, seconded by Supervisor Barger, this item was duly carried by the following vote:

Ayes: 5 - Supervisor Solis, Supervisor Ridley-Thomas, Supervisor Kuehl, Supervisor Hahn and Supervisor Barger

Attachments: Motion by Supervisor Hahn
Report
Public Comment/Correspondence
Audio

The foregoing is a fair statement of the proceedings of the regular meeting, November 24, 2020, by the Board of Supervisors of the County of Los Angeles and ex officio the governing body of all other special assessment and taxing districts, agencies and authorities for which said Board so acts.

Celia Zavala, Executive Officer
Executive Officer-Clerk
of the Board of Supervisors

By 

Celia Zavala
Executive Officer

ATTACHMENT

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

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

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

June 3, 2019

Jan Price Toler, RN
Program Director
Exodus Urgent Care Center @ MLK
12021 Wilmington Avenue, Bldg. 10, Lot B
Los Angeles, California 90059

CERTIFIED

Dear Ms. Price:

9-1-1 ALTERNATE TRANSPORT DESTINATION CLINIC

This is to report that Exodus Martin Luther King Jr. Urgent Care Center (UCC) has successfully completed its site visit for designation as a receiving clinic participating in the Paramedic Alternative Destination Pilot Program (PAD), conducted by the Emergency Medical Services (EMS) Agency on April 25, 2019.

The EMS Agency received a response from the Exodus Recovery Headquarters (ERH) regarding missing documentation in ERH's Policies and Procedures Manual. The documentation received satisfactorily addressed the issues.

UCC is approved to participate as a receiving clinic for the PAD effective June 10, 2019. This approval is valid through the end of the pilot unless terminated by the EMS Agency or voluntary withdrawal by the UCC, as outlined in the EMS Agency's policy, Transport 9-1-1 to Approved Psychiatric or Sobering Center. It is understood the UCC must maintain compliance with all aspects of the policy pertinent to UCC while being an active participant in the Pilot.

Thank you for any commitment to the Los Angeles County EMS System and your voluntary participation in this Pilot Project. If you have any questions or concerns, please Contact John Telmos, Chief Prehospital Operations at (562) 378-1677.

Sincerely,

Cathy Chidester
Director

CC:jt:cj
05-24

c. Medical Director, Los Angeles City Fire Department
Kathy Shoemaker, Chief Clinical Officer, Exodus Recovery Inc.,
Andrew Osorio, Program Director Exodus Recovery Inc.
Chief, Data Systems, EMS Agency

ATTACHMENT

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

June 3, 2019

Rex Manuel, RN
Program Director
Exodus Eastside Urgent Care Center
1920 Marengo Street
Los Angeles, California 90033

CERTIFIED

Dear Mr. Manuel:

9-1-1 ALTERNATE TRANSPORT DESTINATION CLINIC

This is to report that Exodus Eastside Urgent Care Center (UCC) has successfully completed its site visit for designation as a receiving clinic participating in the Paramedic Alternative Destination Pilot Program (PAD), conducted by the Emergency Medical Services (EMS) Agency on April 25, 2019.

The EMS Agency received a response from the Exodus Recovery Headquarters (ERH) regarding missing documentation in ERH's Policies and Procedures Manual. The documentation received satisfactorily addressed the issues.

UCC is approved to participate as a receiving clinic for the PAD effective June 10, 2019. This approval is valid through the end of the pilot unless terminated by the EMS Agency or voluntary withdrawal by the UCC, as outlined in the EMS Agency's policy, Transport 9-1-1 to Approved Psychiatric or Sobering Center. It is understood the UCC must maintain compliance with all aspects of the policy pertinent to UCC while being an active participant in the Pilot.

Thank you for any commitment to the Los Angeles County EMS System and your voluntary participation in this Pilot Project. If you have any questions or concerns, please Contact John Telmos, Chief Prehospital Operations at (562) 378-1677.

Sincerely,

Cathy Chidester
Director

CC:jt:cj
05-25

c. Medical Director, Los Angeles City Fire Department
Kathy Shoemaker, Chief Clinical Officer, Exodus Recovery Inc.,
Andrew Osorio, Program Director Exodus Recovery Inc.
Chief, Data Systems, EMS Agency

ATTACHMENT

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

June 3, 2019

Hilary Aquino, MA
Assistant Vice President
David L. Murphy Sobering Center
640 Maple Street
Los Angeles, California 90014

CERTIFIED

Dear Ms. Aquino:

9-1-1 ALTERNATE TRANSPORT DESTINATION CLINIC

This is to report that Dr. David L. Murphy Sobering Center (SC) has successfully completed its site visit for designation as a receiving clinic participating in the Paramedic Alternative Destination Pilot Program (PAD), conducted by the Emergency Medical Services (EMS) Agency on May 1, 2019.

The EMS Agency received a response from the Exodus Recovery Headquarters (ERH) regarding missing documentation in ERH's Policies and Procedures Manual. The documentation received satisfactorily addressed the issues.

SC is approved to participate as a receiving clinic for the PAD effective June 10, 2019. This approval is valid through the end of the pilot unless terminated by the EMS Agency or voluntary withdrawal by the SC, as outlined in the EMS Agency's policy, Transport 9-1-1 to Approved Psychiatric or Sobering Center. It is understood the SC must maintain compliance with all aspects of the policy pertinent to SC while being an active participant in the Pilot.

Thank you for any commitment to the Los Angeles County EMS System and your voluntary participation in this Pilot Project. If you have any questions or concerns, please Contact John Telmos, Chief Prehospital Operations at (562) 378-1677.

Sincerely,

Cathy Chidester
Director

CC:jt:cj
05-26

c. Medical Director, Los Angeles City Fire Department
Kathy Shoemaker, Chief Clinical Officer, Exodus Recovery Inc.,
Andrew Osorio, Program Director Exodus Recovery Inc.
Chief, Data Systems, EMS Agency

ATTACHMENT

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

10100 Pioneer Blvd Suite 200
Santa Fe Springs CA 90670

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

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

June 3, 2019

Courtney Vance, RN
Program Director
Exodus Harbor-UCLA Urgent Care Center
1000 Carson Street, Bldg. 2 South
Torrance, California 90502-2004

CERTIFIED

Dear Ms. Vance:

9-1-1 ALTERNATE TRANSPORT DESTINATION CLINIC

This is to report that Exodus Harbor-UCLA Urgent Care Center (UCC) has successfully completed its site visit for designation as a receiving clinic participating in the Paramedic Alternative Destination Pilot Program (PAD), conducted by the Emergency Medical Services (EMS) Agency on April 25, 2019.

The EMS Agency received a response from the Exodus Recovery Headquarters (ERH) regarding missing documentation in ERH's Policies and Procedures Manual. The documentation received satisfactorily addressed the issues.

UCC is approved to participate as a receiving clinic for the PAD effective June 10, 2019. This approval is valid through the end of the pilot unless terminated by the EMS Agency or voluntary withdrawal by the UCC, as outlined in the EMS Agency's policy, Transport 9-1-1 to Approved Psychiatric or Sobering Center. It is understood the UCC must maintain compliance with all aspects of the policy pertinent to UCC while being an active participant in the Pilot.

Thank you for any commitment to the Los Angeles County EMS System and your voluntary participation in this Pilot Project. If you have any questions or concerns, please Contact John Telmos, Chief Prehospital Operations at (562) 378-1677.

Sincerely,

Cathy Chidester
Director

CC:jt:cj
05-23

c. Medical Director, Los Angeles City Fire Department
Kathy Shoemaker, Chief Clinical Officer, Exodus Recovery Inc.,
Andrew Osorio, Program Director Exodus Recovery Inc.
Chief, Data Systems, EMS Agency

ATTACHMENT

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

10100 Pioneer Blvd, Suite 200
Santa Fe Springs CA 90670

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Fax (562) 941-5835

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

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

February 22, 2021

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

CERTIFIED

Dear Mr. Albrecht:

PSYCHIATRIC URGENT CARE CENTER DESIGNATION (LONG BEACH)

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

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

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

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

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

ATTACHMENT

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

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

February 22, 2021

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

CERTIFIED

Dear Mr. Albrecht:

PSYCHIATRIC URGENT CARE CENTER DESIGNATION (CITY OF INDUSTRY)

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

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

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

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

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

ATTACHMENT

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

Tel (562) 347-1500
Fax (562) 941-5835

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

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

June 24, 2019

Marc Eckstein, MD
EMS Bureau Commander/Medical Director
Los Angeles Fire Department
200 North Main Street
Los Angeles, California 90012

CERTIFIED MAIL

Dear Dr. Eckstein:

APPROVAL OF ALTERNATE DESTINATION SOBERING AND BEHAVIORAL HEALTH COMMUNITY PARAMEDICINE PILOT PROJECT'S 018 AND 019

This is to advise you that the Los Angeles Fire Department (CI) is approved to participate in the Alternate Destination (ALTrans) Community Paramedicine Pilot Project's 018 and 019 as of Monday, June 24, 2019.

The Emergency Medical Services Authority (EMSA) approved the pilot project on June 10, 2019 and the office of Statewide Health Planning and Development (OSHPD) approved both pilots to commence as of Monday, June 24, 2019

On April 25, 2019, the Emergency Medical Services (EMS) Agency conducted site visits at the three psychiatric urgent care centers and the sobering center that are slated to participate in the ALTrans Program. All four facilities are in compliance with EMS Agency policy/procedures for the ALTrans Pilot Project.

On May 30, 2019, CI's Alternate Destination Response Unit (AD-15) was inventoried and approved as an advanced life support unit (ALS) and will operate Monday through Thursday 6:30 AM through 4:30 PM. AD - 15 is also approved to respond to ALS calls not affiliated with the ALTrans Pilot, at the normal ALS response level.

It is understood that pilot project data collection will be conducted by CI and the participating urgent care centers and sobering center. This data shall be made available to the EMS Agency, at minimum, monthly. Additionally, periodic meetings shall be established with the participating centers, CI, and the EMS Agency to review progress of the pilot and to discuss any adverse incidences.

ATTACHMENT

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

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Fax: (562) 941-5835

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

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

October 1, 2019

Clayton Kazan, MD
Medical Director
Los Angeles County Fire Department
Emergency Medical Services Bureau
1255 Corporate Center, Suite 212
Monterey Park, California 91754

CERTIFIED

Dear Dr. Kazan:

APPROVAL TO IMPLEMENT AN ADVANCE PROVIDER RESPONSE PILOT PROJECT

The Emergency Medical Services (EMS) Agency has reviewed the protocols for the new assessment resource, Advanced Provider Response Unit (APRU), and are in support of the 12-month pilot project. Los Angeles County (CF) Fire Department (CF) is approved to implement the Pilot as of Monday, October 7, 2019.

The two APRU vehicles (AP - 11 and AP - 17) were inspected on September 26, 2019 and both units met the requirements as outlined in Ref. No. 704, Assessment Unit Inventory. Any additional supplies or medications out of the paramedic scope of practice and not included on Ref No. 704, are under the direct control/oversight of the advanced practice provider.

As part of the approval process, CF is required to submit quarterly Pilot project reports to the EMS Agency containing at minimum, the following items:

- Number of patient contacts including diagnosis
- Number of patients where an upgrade to an acute care facility was necessary
- Adverse reactions or complications
- Appropriate statistical evaluation
- Summary of the 48-hour patient follow-up, to include any patients requiring emergency department follow-up or hospital admission

In addition to the above requirements, please report all Sentinel event within 24 hours of occurrence.

Quarterly reports should be addressed to me and are due 30 days after the end of each quarter, with the first report being due January 31, 2020.

Sincerely,

Marianne Gausche-Hill, M.D.
Medical Director

MGH:jt
09-35

c. Fire Chief, Los Angeles County Fire Department
Director, EMS Agency
Deputy Chief, EMS Bureau, Los County Fire Department

ATTACHMENT

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

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

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

February 28, 2020

Clayton Kazan, MD
Medical Director
Los Angeles County Fire Department
Emergency Medical Services Bureau
1255 Corporate Center, Suite 212
Monterey Park, California 91754

CERTIFIED

Dear Dr. Kazan:

TELEMEDICINE for ALTERNATE DESTINATION PILOT PROJECT APPROVAL

This letter is to confirm that Los Angeles County Fire Department (CF) has been approved by the Emergency Medical Services (EMS) Agency for the Telemedicine for Alternate Destination pilot project. The project is approved for 12 months at which time the pilot will be re-evaluated for efficacy and feasibility.

The quality improvement plan required for implementation and evaluation of the pilot requires CF to submit quarterly reports to the EMS Agency containing at minimum, the following items:

- Number of contacts for telemedicine consult
- Number of patients meeting inclusion criteria when physician was unavailable
- Number of patient contacts meeting inclusion criteria and transported to Exodus Recovery Services (EXM)
- Number of patient contacts meeting exclusion criteria transported to EXM or not transported
- Adverse reactions or complications
- Outcome data for patients transported to EXM to include the following:
  - Secondary transport to an emergency department or mental health facility
  - Treated at EXM and discharged or left against medical advice
- Appropriate statistical evaluation

In addition to the above requirements, please report all sentinel events within 24 hours of occurrence.

Quarterly reports should be addressed to me and are due 30 days after the end of each quarter, with the first report being due March 31, 2020.

Sincerely,

Marianne Gausche-Hill, M.D.
Medical Director

MGH:JT:sm
02-16

c. Fire Chief, Los Angeles County Fire Department
Director, EMS Agency
Deputy Chief, EMS Bureau, Los County Fire Department

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

Time Period January 1, 2021 through March 31, 2021

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

HOSPITAL	Total # of records	No. of valid records	% of valid records	Q1 2021							
				</=30 mins		31-60 mins		61-120 mins		>120 mins	
ANTELOPE VALLEY - NEWHALL REGION											
Antelope Valley Hospital	6,229	2,743	44%	1,766	64%	708	26%	197	7%	72	3%
Palmdale Regional Medical Center	2,447	1,105	45%	576	52%	277	25%	140	13%	112	10%
Henry Mayo Newhall Hospital	3,497	1,636	47%	1,299	79%	243	15%	76	5%	18	1%
ANTELOPE VALLEY TOTAL	*12,173*	*5,484*	45%	*3,641*	*66%*	*1,228*	*22%*	*413*	*8%*	*202*	*4%*
SAN FERNANDO VALLEY REGION											
Dignity Health-Northridge Hospital Medical Center	2,932	2,899	99%	2,770	96%	120	4%	9	0.3%		
West Hills Hospital and Medical Center	2,048	1,894	92%	1,711	90%	158	8%	22	1%	3	0.2%
Kaiser Foundation - Woodland Hills	754	694	92%	573	83%	67	10%	15	2%	4	0.6%
Encino Hospital Medical Center	248	247	100%	241	98%	3	1%	2	1%	1	0.4%
Providence Cedars-Sinai Tarzana Medical Center	1,360	1,341	99%	1,239	92%	69	5%	2	0%	1	0.07%
LAC Olive Medical Center	828	827	100%	786	95%	36	4%	5	1%		
Pacifica Hospital of the Valley	666	665	100%	648	97%	16	2%	1	0%		
Kaiser Foundation - Panorama City	808	808	100%	756	94%	50	6%	2	0%		
Providence Holy Cross Medical Center	1,796	1,761	98%	1,685	96%	69	4%	7	0%		
Mission Community Hospital	844	844	100%	818	97%	24	3%	2	0%		
Valley Presbyterian Hospital	1,288	1,285	100%	1,229	96%	46	4%	9	1%	1	0.08%
Sherman Oaks Hospital	1,273	1,270	100%	1,211	95%	43	3%	11	1%	5	0.4%
Providence Saint Joseph Medical Center	2,377	2,367	100%	2,180	92%	162	7%	23	1%	2	0.08%
Adventist Health Glendale	2,607	2,576	99%	2,454	95%	83	3%	34	1%	2	0.08%
Dignity Health-Glendale Memorial Hosp. and Health Ct	1,006	1,005	100%	958	95%	37	4%	9	0.9%	1	0.1%
USC Verdugo Hills Medical Center	771	610	79%	559	92%	38	6%	13	2%		
SAN FERNANDO VALLEY TOTAL	*21,606*	*21,093*	98%	*19,818*	*94%*	*1,021*	*5%*	*166*	*0.8%*	*20*	*0.09%*
SAN GABRIEL VALLEY REGION											
Huntington Hospital	2,870	2,325	81%	2,250	97%	70	3%	5	0.2%		
Alhambra Hospital	588	582	99%	559	96%	15	3%	6	1%	1	0.2%
San Gabriel Valley Medical Center	562	348	62%	314	90%	18	5%	12	3%	4	1%
Methodist Hospital of Southern California	1,879	1,088	58%	1,009	93%	51	5%	14	1%	14	1%
Greater El Monte Community Hospital	956	120	13%	95	79%	14	12%	5	4%	6	5%

% total may not equal 100% due to rounding.

Data source: LA TEMIS EMS Fire-Rescue 06-22-2021

Los Angeles County Emergency Medical Services Agency

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

Time Period January 1, 2021 through March 31, 2021

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

HOSPITAL	Total # of records	No. of valid records	% of valid records	Q1 2021							
				</=30 mins		31-60 mins		61-120 mins		>120 mins	
Garfield Medical Center	683	469	69%	449	96%	9	2%	8	2%	3	0.6%
Monterey Park Hospital	243	171	70%	163	95%	4	2%	3	2%	1	0.6%
Kaiser Foundation Hospital - Baldwin Park	1,013	206	20%	161	78%	24	12%	13	6%	8	4%
Emanate Health Inter-Community Hospital	1,226	346	28%	215	62%	89	26%	34	10%	8	2%
Emanate Health Queen of the Valley Hospital	1,496	462	31%	387	84%	53	11%	13	3%	9	2%
Emanate Health Foothill Presbyterian Hospital	1,022	135	13%	97	72%	27	20%	8	6%	3	2%
San Dimas Community Hospital	420	60	14%	52	87%	6	10%	2	3%		
Pomona Valley Hospital Medical Center	3,499	680	19%	568	84%	79	12%	23	3%	10	1%
SAN GABRIEL VALLEY TOTAL	*16,457*	*6,992*	42%	*6,319*	*90%*	*459*	*7%*	*146*	*2%*	*67*	*1%*
EAST REGION											
Beverly Hospital	706	119	17%	104	87%	13	11%	2	2%		
Whittier Hospital Medical Center	559	75	13%	63	84%	5	7%	5	7%	2	3%
PIH Health Hospital - Whittier	2,523	292	12%	210	72%	54	18%	23	8%	5	2%
PIH Health Hospital - Downey	1,391	776	56%	674	87%	60	8%	30	4%	12	2%
Kaiser Foundation Hospital - Downey	1,650	622	38%	467	75%	116	19%	28	5%	11	2%
Los Angeles Community Hospital at Norwalk	314	43	14%	35	81%	7	16%	1	2%		
Coast Plaza Hospital	599	67	11%	43	64%	12	18%	7	10%	5	7%
Lakewood Regional Medical Center	1,457	556	38%	329	59%	100	18%	73	13%	54	10%
EAST REGION TOTAL	*9,199*	*2,550*	28%	*1,925*	*75%*	*367*	*14%*	*169*	*7%*	*89*	*3%*
METRO REGION											
Dignity Health-California Hospital Medical Center	2,346	2,343	100%	1,959	84%	323	14%	59	3%	2	0.09%
Good Samaritan Hospital	2,423	2,418	100%	2,221	92%	184	8%	11	0.5%	2	0.08%
Adventist Health White Memorial	840	560	67%	478	85%	59	11%	18	3%	5	0.9%
Community Hospital of Huntington Park	1,235	385	31%	321	83%	50	13%	11	3%	3	0.8%
East Los Angeles Doctors Hospital	775	184	24%	168	91%	14	8%	1	0.5%	1	0.5%
LAC+USC Medical Center	5,214	4,628	89%	4,069	88%	499	11%	57	1%	3	0.06%
Children's Hospital Los Angeles	218	213	98%	208	98%	5	2%				
Hollywood Presbyterian Medical Center	1,877	1,877	100%	1,626	87%	217	12%	32	2%	2	0.1%
Kaiser Foundation Hospital - Los Angeles	860	847	98%	693	82%	122	14%	30	4%	2	0.2%

% total may not equal 100% due to rounding.

Data source: LA TEMIS EMS Fire-Rescue 06-22-2021

Los Angeles County Emergency Medical Services Agency

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

Time Period January 1, 2021 through March 31, 2021

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

HOSPITAL	Total # of records	No. of valid records	% of valid records	Q1 2021							
				</=30 mins		31-60 mins		61-120 mins		>120 mins	
Olympia Medical Center (Closed to 9-1-1 traffic March 24, 2021)	430	428	100%	401	94%	23	5%	3	0.7%	1	0.2%
Cedars Sinai Medical Center	3,797	3,396	89%	3,025	89%	331	10%	40	1%		
METRO REGION TOTAL	*20,015*	*17,279*	86%	*15,169*	*88%*	*1,827*	*11%*	*262*	*2%*	*21*	*0.1%*
WEST REGION											
Southern California Hospital at Culver City	920	920	100%	797	87%	95	10%	20	2%	1	0.1%
Kaiser Foundation Hospital - West Los Angeles	1,475	1,472	100%	1,323	90%	138	9%	11	0.7%		
Cedars Sinai Marina Del Rey Hospital	1,864	1,594	86%	1,406	88%	159	10%	18	1%	1	0.06%
Providence Saint John's Health Center	1,323	1,166	88%	1,077	92%	82	7%	7	0.6%		
Santa Monica - UCLA Medical Center	712	474	67%	436	92%	29	6%	9	2%		
Ronald Reagan UCLA Medical Center	1,524	1,432	94%	1,329	93%	78	5%	20	1%	1	0.07%
WEST REGION TOTAL	*7,818*	*7,058*	90%	*6,368*	90%	*581*	8%	*85*	1%	*3*	*0.04%*
SOUTH REGION											
Centinela Hospital Medical Center	3,129	2,492	80%	1,512	61%	457	18%	92	4%	17	0.7%
Memorial Hospital of Gardena	1,810	1,461	81%	1,277	87%	158	11%	24	2%	2	0.1%
Martin Luther King, Jr. Community Hospital	1,936	1,315	68%	775	59%	339	26%	91	7%	10	0.8%
St. Francis Medical Center	2,440	1,044	43%	544	52%	318	30%	134	13%	48	5%
LAC Harbor-UCLA Medical Center	3,206	2,095	65%	1,686	80%	278	13%	107	5%	24	1%
Kaiser Foundation Hospital - South Bay	1,428	1,038	73%	891	86%	124	12%	16	2%	7	0.7%
Torrance Memorial Medical Center	2,545	1,160	46%	838	72%	243	21%	70	6%	9	0.8%
Providence Little Company of Mary Med. Ctr.-Torrance	1,333	659	49%	541	82%	79	12%	34	5%	5	0.8%
Providence Little Company of Mary Med. Ctr.-San Pedr	1,941	1,406	72%	904	64%	243	17%	102	7%	18	1%
College Medical Center	660	605	92%	480	79%	90	15%	26	4%	9	1%
Dignity Health-St. Mary Medical Center	1,851	1,843	100%	1,557	84%	200	11%	77	4%	9	0.5%
MemorialCare Long Beach Medical Center	2,044	1,697	83%	1,453	86%	152	9%	64	4%	28	2%
Catalina Island Medical Center	2	2	100%	2	100%						
SOUTH REGION TOTAL	*24,325*	*16,817*	69%	*12,460*	*74%*	*2,681*	*16%*	*837*	*5%*	*186*	*1%*
ALL HOSPITALS	**111,593**	**76,530**	**69%**	**65,700**	**86%**	**8,164**	**11%**	**2,078**	**3%**	**588**	**0.8%**

% total may not equal 100% due to rounding.

Data source: LA TEMIS EMS Fire-Rescue 06-22-2021

PROUDLY SERVING THE ENTIRE CALIFORNIA FIRE SERVICE SINCE 1922 (/CSFA/CalFF)

DEPARTMENT DIRECTORY (/CSFA/CalFF/DeptDirectory)

(https://www.youtube.com/channel/UCNJjRLjIfzl6O97n7qS9AUg/videos) (https://twitter.com/csfafire)
(https://www.facebook.com/CaliforniaStateFirefightersAssociation) (https://twitter.com/csfafire) (https://instagram.com/csfafire)
(https://www.linkedin.com/company/california-state-firefighters'-association)

Who We Are

The California State Firefighters' Association (CSFA) is the oldest and largest statewide fire association representing thousands of fire service professionals from all elements of fire service. CSFA is committed to building a strong community for all firefighters. We are dedicated to delivering up-to-date information impacting Fire Services throughout the state of California and key knowledge needed to assist you. CSFA has worked at the state level since 1922 offering a strong voice with legislators who vote on benefits, working conditions and public safety issues.

Our Purpose

To foster and promote a better understanding among members, elected and appointed officials and the public; to encourage the maintenance of the civil service system; to promote the observance of high standards of conduct for firefighters; and to work for the enactment and maintenance of laws and regulations that benefit fire service personnel and protect life and property.

History

The California State Firefighters' Association began in 1922, when a small group of firefighters met in Fresno to discuss the state of the fire service in California. After some discussion, it was decided that the very best way to serve the public and firefighters was to form an organization to work towards enacting laws to protect the public from fire and to improve working conditions for firefighters. As a result of that first conference, the California State Firefighters' Association, Inc. was born. From this initial gathering, a membership of more than 16,000 has grown. Members include paid, volunteer, military and industrial firefighters, members of the California Department of Forestry, United States Forest Disaster Office, Office of Emergency Services (Fire and Rescue Division), State

Fire Marshal's Office, State Fire Service and Training Program and California state-employed firefighters. Time has proven that a consolidated effort of California's fire service through CSFA has helped all its branches.

Who We Are

California State Firefighters' Association is the state's oldest statewide fire service trade association. Since 1922 CSFA has been at the forefront as an advocate for improved working conditions, firefighter health and safety and laws designed to save life and property.

Member Benefits

From affordable life, auto and homeowner insurance to discounted training, and digital fire service trade journals delivered to your inbox, plus a wide variety of lifestyle and travel discounts, a membership in CSFA easily pays for itself.

Why Join Us?

CSFA is the only statewide fire service organization that serves the needs of all of the state's firefighters – paid career, paid call, volunteer, municipal, private and military and from all ranks – from fire science students to fire chiefs. CSFA gives you a voice on legislative matters in Sacramento.

Contact Us

Want to learn more? Call our Sacramento office at 800-451-2732 or send an e-mail to membership@csfa.net (mailto:membership@csfa.net)

Need Help?

Find a bad link? See a typo? Let us know at webmaster@csfa.net (mailto:webmaster@csfa.net)

CSFA Emergency Medical Services Committee

Committee Chairperson:

Scott Clough (mailto:cloughsa@aol.com), Sacramento Metro FD (retired)

CSFA Board Liaison

Brian Geiger (mailto:bryan.geiger@csfamail.com%20), LAFD

Purpose:

The purpose of the CSFA EMS Committee is to manage all prehospital care and EMS-related issues in support and advancement of the CSFA mission.

Functions:

1. Advocacy, Reactive - Evaluate proposed legislation and regulations affecting the EMS system and public health/safety, and provide guidance to the Board regarding CSFA's official position action plan.

2. Advocacy, Proactive - Identify aspects of the EMS system and public health/safety warranting improvement, and make recommendations to the Board regarding appropriate action.

3. Education - Provide firefighters education and training opportunities to enhance their prehospital care cognitive, psychomotor, and affective skills.

Download the annual committee report (http://www.csfa.net/csfa/images/csfa/PDFs/Committee-Reports/EMS_Committee_2016_Report.pdf)
EMS Links:

California Emergency Medical Services Authority
http://www.emsa.cahwnet.gov/ (http://www.emsa.cahwnet.gov/)

American Heart Association
http://www.americanheart.org/presenter.jhtml?identifier=1200000 (http://www.americanheart.org/presenter.jhtml?identifier=1200000)

American Red Cross
http://www.redcross.org/ (http://www.redcross.org/)

Tactical EMS (TEMS)
Strategies to Enhance Survival in Active Shooter and Intentional Mass Casualty Events: A Compendium (http://www.csfa.net/CSFA/CalFF/articles/Strategies_to_Enhance_Survival_in_Active_Shooter_and_Intentional_Mass_Mass_Casualty_Events.aspx)

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July 1, 2021

CALIFORNIA PROFESSIONAL FIREFIGHTERS

Joint Apprenticeship Committee
Labor-management fire training program with more than 146 participating departments serving more than 6,500 firefighter apprentices.

California Fire Foundation
Honoring the courage of fallen firefighters and their families and the perseverance and sacrifice of fire victims.

Firefighters Print & Design
Full-service union print shop, providing CPF members and corporate clients with high-impact printing at competitive prices.

Firestar Studios
Award-winning, state-of-the-art video and audio production, serving the fire service and corporate clients.

The CPF Callback Association
CPF's communication link with retired firefighters, keeping retirees in touch with the profession they love.

CPF Insurance Trust
Improving the lives of all professional firefighters and

One Voice ... One Vision

With a membership of more than 30,000, **California Professional Firefighters (CPF)** is the largest statewide organization dedicated exclusively to serving the needs of career firefighters. It is one of the nation's strongest and most influential public employee organizations.

Our Services

- **Governmental Advocacy:** CPF is the firefighter voice in Sacramento, working to build better health and safety, retirement benefits, local and state public safety funding and employee rights.
- **Political Action:** CPF is a visible force at all levels promoting candidates and causes that protect the well-being of public safety professionals.
- **Communications:** CPF publishes an award-winning newspaper, website and its own video news service, CPF Firevision, in addition to direct member communications. CPF also operates a full-service union print shop – Firefighters Print & Design.
- **Member Services:** CPF offers members personal exposure reporting (PER), retiree services (Callback Association) and extensive health and safety protection. CPF honors fallen firefighters through the California Fire Foundation, the California Firefighters Memorial and the California Firefighters Endowment.
- **Partnerships:** CPF co-sponsors the California Fire Fighter Joint Apprenticeship Committee (CFFJAC), and collaborates with labor and management on issues ranging from fire safety to pension protection.

The IAFF – Our National Voice

California Professional Firefighters is the officially chartered state council for the **International Association of Fire Fighters (IAFF)**, which represents more than 298,000 front line firefighters nationally. The partnership between IAFF and CPF was never closer than it was in 2005 and 2006. IAFF helped support CPF's fight against the Special Election and pension grab, and IAFF General President Harold Schaitberger personally rallied the troops in support of CPF's political endorsements.

Our Local Affiliates

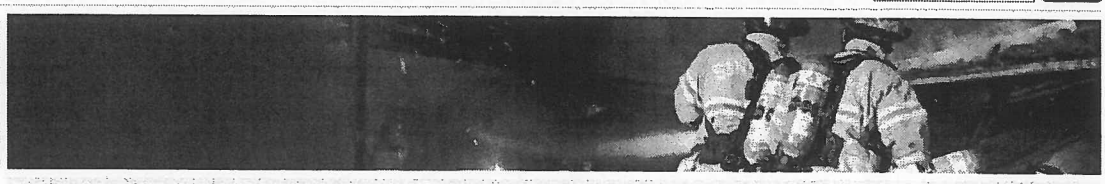
California Professional Firefighters derives its strength from more than 175 local affiliates, representing some 30,000 front line firefighters and paramedics. CPF services are directed to members through the leadership of these local affiliates.

CPF News

- CPF President Praises Newsom Commitment to Wildfire Response and Prevention
- All CPF Priority and Sponsored Bills Signed by Governor
- CPF Fire Wire: Surviving COVID-19
- Standing Against Injustice With the Communities We Serve
- WATCH: CPF Online Town Hall for Firefighters and Families
- Wildfire Response Will Remain A Priority in State Budget Revision

July 1, 2021

CALIFORNIA PROFESSIONAL FIREFIGHTERS



Home
About CPF
- President's Message
- CPF Convention 2020
- What CPF Means to You
- Our Local Affiliates
- The CPF Team
- CPF Committees
- California Fire Foundation
- Stay Connected to CPF
- Contact CPF

News and Events
Issues and Legislation
Political Action
Health and Safety
Serving Our Profession
Media Center
Int'l Assn. of Fire Fighters

CPF Committees

Through committees established either by resolution or at the direction of the CPF Executive Board, local union leaders and their members are able to influence and help direct policy and actions that further CPF's mission to protect the lives and livelihoods of firefighters and their families.

–

Health and Safety Committee

Provides policy recommendations for firefighter health & safety in order to support CPF's legislative and regulatory engagement and program and services development. *Established in 1978.*

EMS Committee

Provides policy recommendations for prehospital emergency medical services (EMS) and the expansion of fire-based EMS in order to support CPF's legislative and regulatory engagement in this area. *Established in 1994 (Read the resolution)*

Membership Activism Committee

Provide recommendations and educational resources to help increase activation and engagement of members at the local union level. *Established in 2018 (Read the resolution)*

Human Relations Committee

Provide support in assessing the cultural and diverse needs within the fire service and the communities we serve in order to affect needed change. *Established 2020 (Read the resolution)*

President's Ad Hoc Retirement Committee

Formed to monitor and engage in retirement system issues facing the various types of retirement systems in California in order to support CPF's legislative and program and services development. *Established in 2020, at direction of CPF President.*

CPF News

- CPF President Praises Newsom Commitment to Wildfire Response and Prevention
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Home

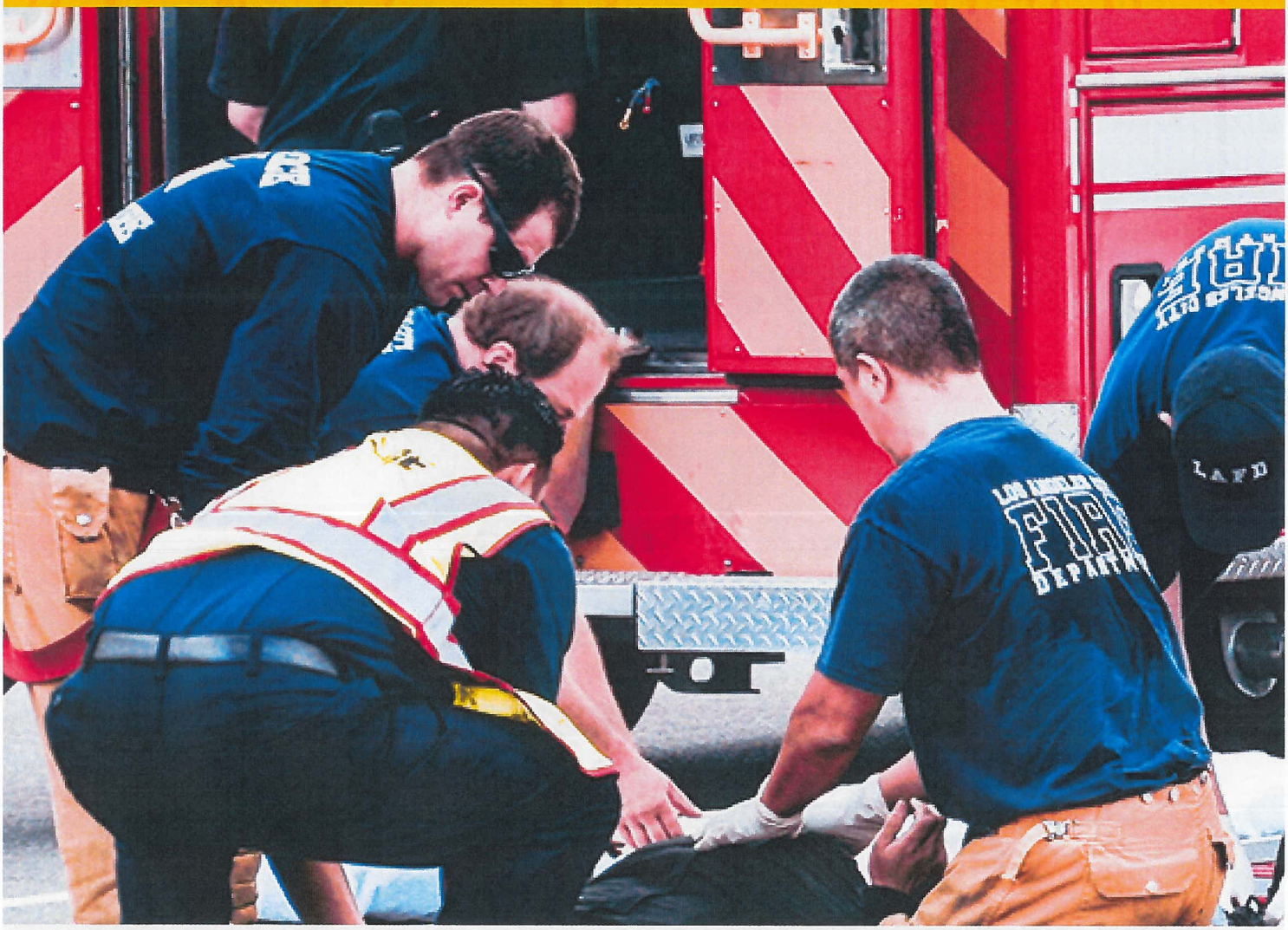
Giving California Paramedics a Voice in Policy

LEARN MORE

Join the Association

If you believe that front line EMS providers must have a greater role in developing its own destiny, we have a home for you. Join other paramedic professionals in advocating for our profession.

LEARN MORE



About the California Rescue & Paramedic Association

The California Rescue and Paramedic Association was created in 1979 as the advocate for the paramedic profession in California. As a senate rules committee-appointed member of the State EMS Commision, the CRPA helped to develop legislation that led to statewide licensing of paramedics, and participated in various initiatives such as the EMS Vision 2000 project. Most paramedic veterans will recall the education conferences that the CRPA held from 1981 to the mid 1990s.

The CRPA continues its advocacy efforts. Alliances with organizations such as the California

Paramedic Foundation, the San Diego Paramedic Association and the Sonoma County Paramedic Association ensures that an independent voice defending and promoting the EMS profession is heard at the state EMS Commision.

HISTORY OF EMS

Legislation

AB 453

Emergency Ambulance Employee Safety and Preparedness Act 2019-2020 Legislative Session Author by Assemblymember Chau Summary: Under current law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel...

READ MORE

AB 1116

Emergency Ambulance Employee Safety and Preparedness Act 2019-2020 Legislative Session Author by Assemblymember Grayson Summary: Would, until January 1, 2025, create the Firefighter Peer Support and Crisis Referral Services Pilot...

READ MORE

AB 1544

Community Paramedicine or Triage to Alternate Destination Act 2019-2020 Legislative Session Author by Assemblymember Gipson Summary: Would establish within the Emergency Medical Services System and the Prehospital Emergency Medical Care...

READ MORE

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;~~

A. An emergency medical care physician in a Los Angeles County 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;~~

B. A physician practicing within Los Angeles County 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;~~

C. A mobile intensive care nurse nominated by the Greater Los Angeles Chapter of the Emergency Nurses Association;

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

D. A hospital administrator nominated by the Hospital 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. An orthopedic general or neurological surgeon nominated by the Los Angeles Surgical Society;

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

H. A psychiatrist who practices in Los Angeles County 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;~~

J. A licensed paramedic who is accredited in Los Angeles County 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.~~

O. A representative practicing in Los Angeles County nominated by the Southern California Public Health Association.

EXECUTIVE OFFICE
BOARD OF SUPERVISORS
CELIA ZAVALA
EXECUTIVE OFFICER

COUNTY OF LOS ANGELES
EXECUTIVE OFFICE
BOARD OF SUPERVISORS

KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET, ROOM 383
LOS ANGELES, CALIFORNIA 90012
(213) 974-1411 • www.bos.lacounty.gov

June 7, 2021

TO: County Commissions

FROM: Celia Zavala
Executive Officer

SUBJECT: **COVID-19 Meeting Guidance – Preparing to Reopen**

Over the past 14 months, County of Los Angeles ("County") Commissions have been operating and hosting remote meetings under the provisions of Governor Gavin Newsom's Executive Order N-29-20 (superseding N-25-20) ("Executive Order"), which was signed on March 17, 2020. The Executive Order authorized local agencies to hold public meetings through teleconferencing and allowed public comment to be presented electronically. It also waived the requirements to post remote meeting locations and to make those locations accessible to the public for in-person attendance. In addition, on March 16, 2020, all County buildings were closed to the public as a precautionary measure to slow the spread of COVID-19. Under the foregoing rules, County Commissions have dramatically shifted the way they conduct their public business to maintain the health and safety of their staff and the public, while also continuing to include the public in the important work of their respective Commissions.

As the State and County's public health status improves, County Commissions should anticipate and plan for a return to conducting business in person. It is anticipated that on June 15, 2021, the Governor may announce the reopening of the State. Soon thereafter, the Chair of the Board of Supervisors may announce plans for the County. A group of local legislative bodies has asked the State to permit a 30-day transition period after any reopening is announced by the Governor so that cities and counties have time to effectively adjust to any new public health and safety requirements to ensure a coordinated and collaborative return to in-person public meetings. In a response from the Governor's Office, it was indicated that notice will be provided to affected stakeholders in advance of the rescission of the Executive Order to provide state and local agencies and boards time to meet statutory and logistical requirements.

To prepare for the eventual repeal of COVID-19-related Executive Orders, including those that allow local legislative bodies to hold public meetings remotely, and the re-opening of County buildings to the public, County Commissions may want to consider the following steps:

- Evaluate meeting space and alternative spaces to determine whether they are accessible to the public. Consider whether capacity limits will be necessary if social distancing remains in place.
- Evaluate interest by commissioners to continue teleconferencing for meetings and whether they can do so in compliance with Section 54953 of the Brown Act. Evaluate alternative remote locations for Brown Act compliance.[1]
- Evaluate whether you will continue to provide remote access for members of the public. If so, determine what technology, equipment, and staffing will be required to conduct the meetings.
- Determine whether additional logistical modifications are needed or should be considered to best accommodate your meetings.
- Determine wording for agendas or announcements that clearly identify how the public can participate in meetings (in-person and remotely).

Our office greatly appreciates your resiliency and leadership during the pandemic to guide County Commissions and to provide access to the public. We will provide additional guidance once we are informed how the State and County plan to reopen. For up-to-date information and news surrounding COVID-19, visit https://covid19.lacounty.gov/. Should you have any questions, you may contact Twila P. Kerr of my staff at (213) 974-1431.

CZ:tpk

[1] Please note that the Brown Act requires, among other things, posting of the agenda at the location of teleconferencing, accessibility of the public to attend, and that the location be ADA accessible. Please consult with your County Counsel for additional guidance.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

May 19, 2021

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

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

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

TO: Distribution

FROM: Cathy Chidester
Director, EMS Agency

SUBJECT: COMMUNITY HOSPITAL LONG BEACH 9-1-1 RECEVING DESIGNATION

Community Hospital Long Beach (LBC), located at 1720 Termino Avenue, Long Beach, CA, 90804, has been licensed by the State to operate as a general acute care hospital with Basic Emergency Services, and has been approved by the Emergency Medical Services (EMS) Agency as a 9-1-1 Receiving Hospital.

Effective, **Monday, May 24, 2021, at 8:00 a.m.**, LBC may begin receiving adult patients via the 9-1-1 system. At this time, LBC is not an Emergency Department Approved for Pediatrics (EDAP), a Perinatal Center, or any other specialty center.

Community Hospital Long Beach will be identified with the alpha code (LBC). The main ED telephone number is (562) 378-5397. The dedicated telephone number for receiving transport notification from base hospitals and/or provider agencies is:

(562) 735-4328

Please ensure that all hospital and prehospital personnel are notified of this change in status. If you have any questions, please contact Chris Clare, Chief, Hospital Programs at (562) 378-1661 or cclare@dhs.lacounty.gov.

05-03

c. Medical Director, EMS Agency
Chief Executive Officer, LBC
Emergency Services Medical Director, LBC
Emergency Services Nursing Director, LBC
Emergency Medical Services Commission
Medical Alert Center
Hospital Association of Southern California
Mandi Possner, CA Department of Public Health
Fire Chief, Long Beach Fire Department
Paramedic Coordinator, Long Beach Fire Department
Fire Chief, Los Angeles County Fire Department
EMS Director, Los Angeles County Fire Department
Prehospital Care Coordinators
All Licensed Ambulance Providers
ReddiNet®